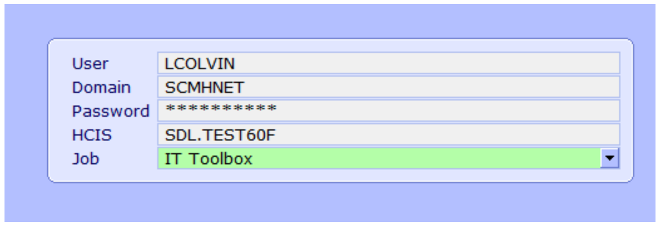
Meditech Guide

Welcome to SCH. We are happy you have chosen to come to work with us. This is a step-by-step guide on how to use the hospital's side of Meditech. We understand this may seem overwhelming at first, but we hope that with this guide you will feel comfortable with Meditech. Please know that this guide was built in the test system of Meditech to comply with HIPAA laws. Also know that we are only a phone call away and are happy to assist you. Feel free to call, email, or stop by the Informatics department anytime.

Table of Contents

Entering into Meditech

The above icon is how you will enter into Meditech. Be sure you are clicking on the icon that says "Live" and not "Test". When you sign on you will be presented with a screen as shown below. This screen is where you will state which job location you will be working at. Everyone has a default “job” based on your hired position. If you are working in a different location than your default, you will have to switch jobs by signing out of Meditech and back in. Below are the steps on how to switch job functions.

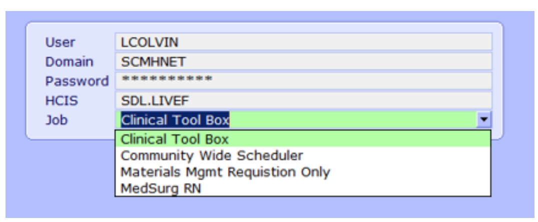


Switching Job Functions

Depending on which department you are working in, will depend on how you sign into Meditech. Please follow the steps below.

1. Click on the Meditech icon

2. Use the drop down arrow to choose the proper “Job” then click <Signon> if it doesn’t automatically sign in once you choose your job.

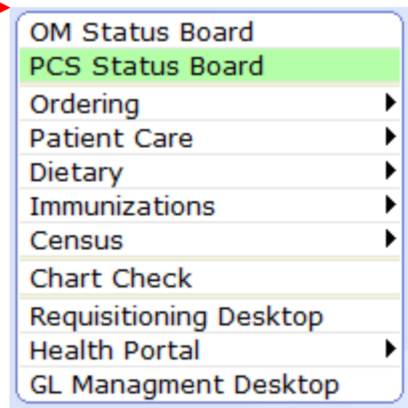


From here, you will continue normal workflow. Remember, if you go from Med-Surg to ED or OB, it’s important you change jobs or you will not have the side panel options you may need.

Menu

Once you have logged in, you will be presented with the menu below. Not everyone will have the exact same options to choose from on the menu screen. Access is determined by which department you are working for and your job title. As for this guide, we are showing the steps for a nurse on the med-surg floor.

In this menu you will choose take you to the bed-board med-surg floor. (Shown below)



PCS Status Board, which will listing all current patients on

PCS Status Board

(What the Status Board can tell you)

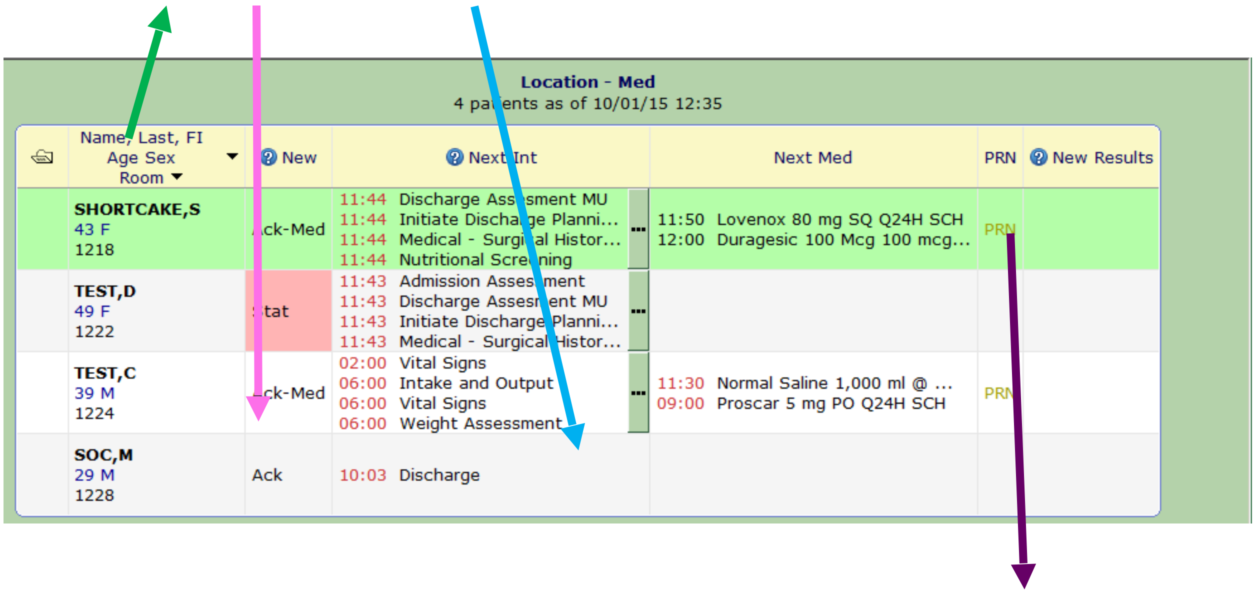
Displays which department you are viewing and the number of patients

Patient Name - Age - Sex - Room

Displays next medication

Informs the nurse there are new results on their patient. Clicking in this column will open up that result.

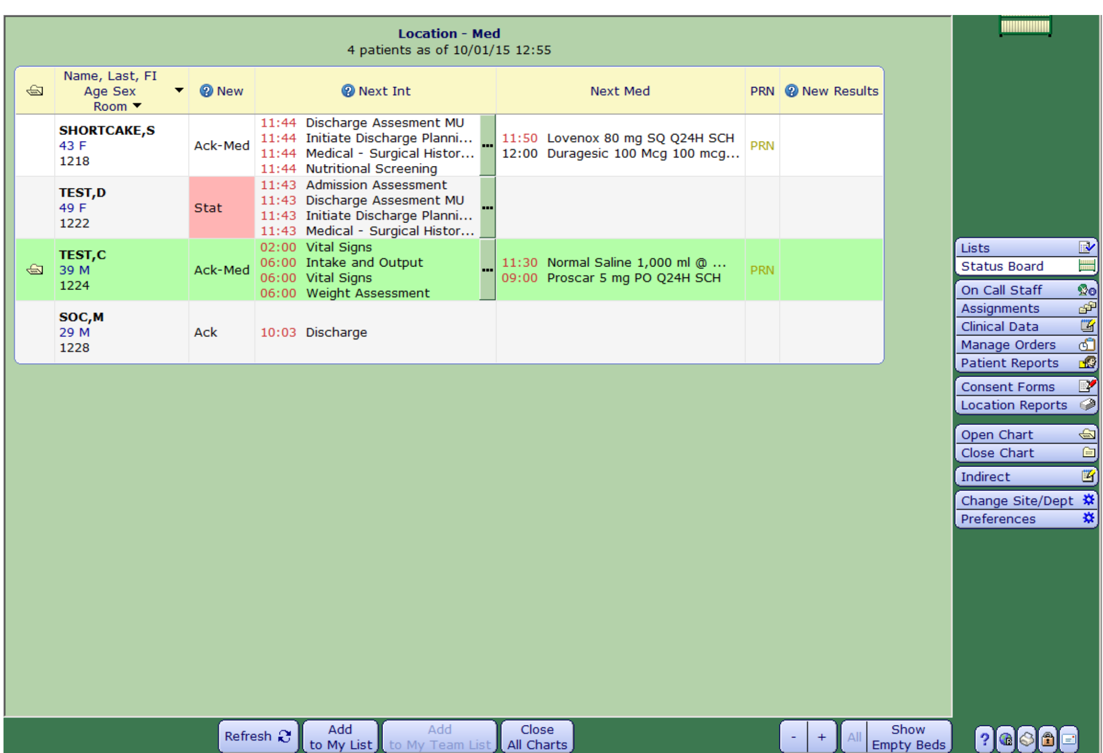
Displays next intervention due.



Displays any new orders

The PRN column represents patient having a PRN medication available. By clicking in this box, the patient's medication list will open. Clicking the PRN a second time will open up to the MAR.

PCS Status Board Navigation



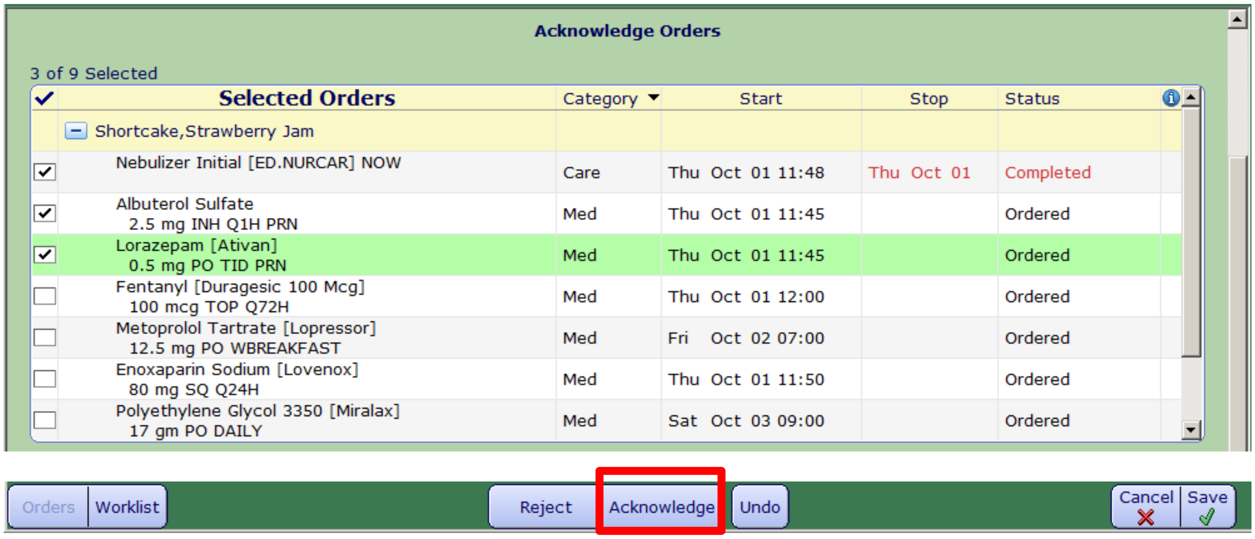
When you click on PCS Status Board, you will see a list of all admitted patients. From this screen you can open charts, acknowledge orders, view next interventions due, view next medication due, view new results, create your own personalized list of patients, and change departments. Each one of these will be explained in further detail below.

1. **Open chart -** There are two ways to open charts.
   a) Highlight patient name and click <Open Chart> on the right
   b) Click in the column to the left of the patient's name.

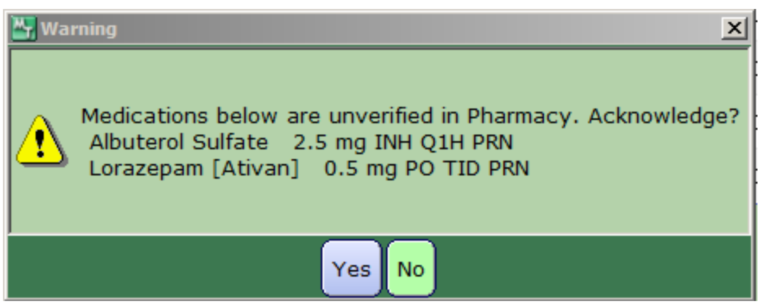
***Note** If a patient's chart is opened, there will be an open file icon next to the patient name as shown above.*

2. **Acknowledge Orders -** Clicking in the column "New" will launch an acknowledge screen where you will be able to acknowledge any newly entered orders. (Acknowledge Screen is shown on the next page).

To acknowledge orders from this screen, click <Acknowledge> on the right side panel. By clicking the <Acknowledge> button, the screen will appear with a white box to the left of the orders. Place a checkmark next to the orders you would like to acknowledge (as shown below), and click the <Acknowledge> footer button.

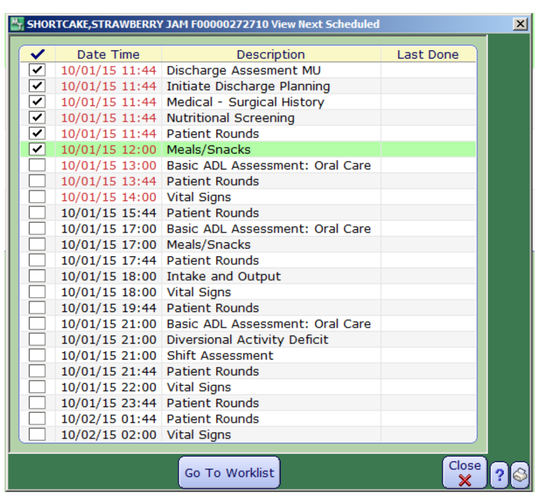


If the medication/s are unverified by the pharmacist, a warning will pop up asking if you would like to continue with acknowledging the order. (Shown below) If you click <Yes>, you will be taken back to the above screen, and you can then click <Save>. Once you save, you will be back to the first image on this page, and you can click <Exit to Status Board> on the side panel to return to your patient list.

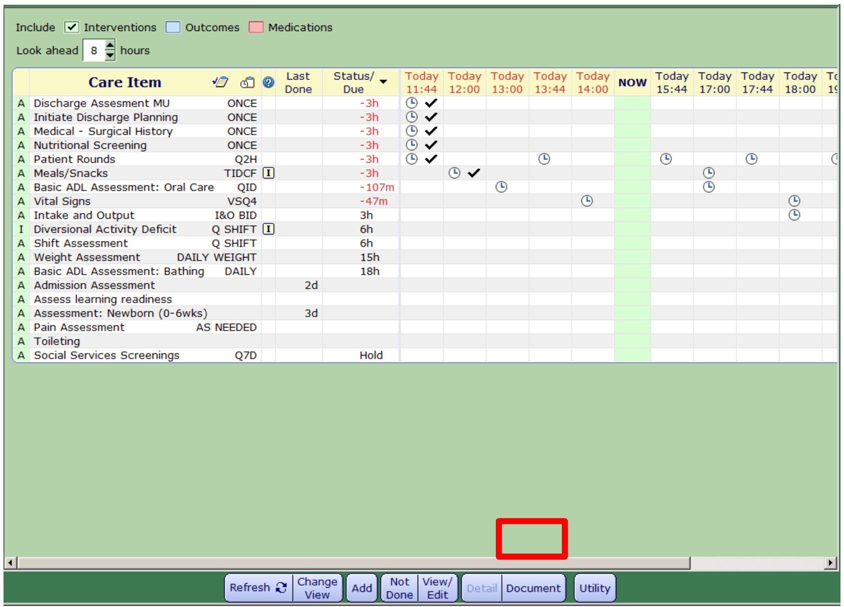


3. **View upcoming interventions - "Next Int"**

Under the "Next Int" a list of the next four interventions from the patient's worklist will be shown here. If the time is in black, the intervention is coming up. If the time is in red the intervention is past due. By clicking in the "Next Int" column, a window will pop up that you can place checkmarks next to the interventions. Check what you would like to document and click <Go To Worklist>.



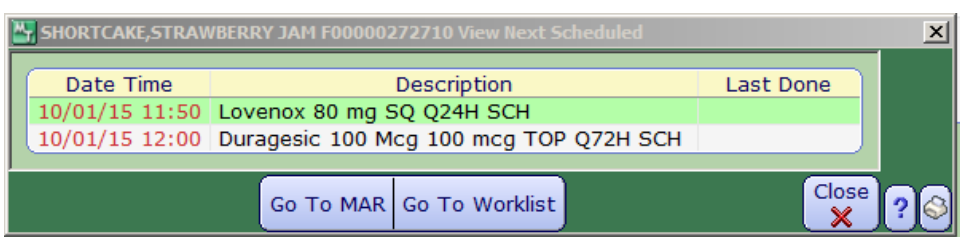
The patient's worklist will be launched with black checkmarks indicated next to the items checked on the above screen.



To document the interventions checked, click <Document>.

*****IMPORTANT***** It is *YOUR* responsibility to remove all clocks on your assigned patients for your shift. Do not leave any clocks for the oncoming nurse to clean up.

4. **View upcoming medications -** In the "Next Med" column, the patient's four next due medications will be listed. If a medication was not signed off on the MAR, the time will be displayed in red. Clicking in the next med column, a pop up window will display the next meds due.

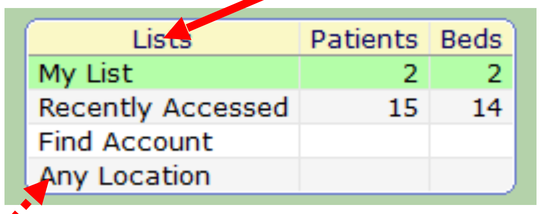


From here, you can click either <Go To MAR> or <Go To Worklist> so you can document medication/s given. - *Best Practice* is to document from the MAR. (Instructions on how to use the MAR can be found on page 26)

5. **View new results -** If the patient has new results, these will display under the "New Results" column. The result will only give a location of the result/s such as

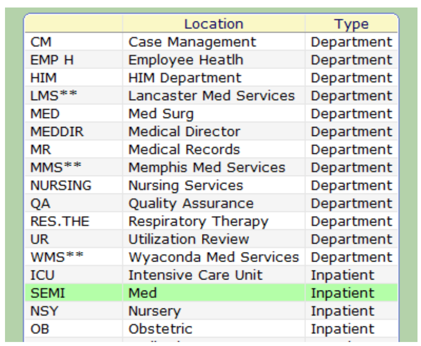
Chemistry, Coagulation, Hematology, etc. This column will also display any new reports (Rpt)

6. **Create "My List" -** You can create your own patient list by highlighting the patient name and clicking the footer button <Add to My List>. After you have selected all your patients one by one, click <Lists> on the right-hand panel, then <My List> (shown below)



Lists	Patients	Beds
My List	2	2
Recently Accessed	15	14
Find Account		
Any Location		

7. **Change departments -** To change departments, click <Lists> on the right-hand panel and choose <Any Location> (see image above) A list of all locations will appear which you can choose from.

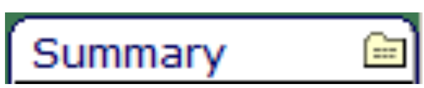


	Location	Type
CM	Case Management	Department
EMP H	Employee Heatlh	Department
HIM	HIM Department	Department
LMS**	Lancaster Med Services	Department
MED	Med Surg	Department
MEDDIR	Medical Director	Department
MR	Medical Records	Department
MMS**	Memphis Med Services	Department
NURSING	Nursing Services	Department
QA	Quality Assurance	Department
RES.THE	Respiratory Therapy	Department
UR	Utilization Review	Department
WMS**	Wyaconda Med Services	Department
ICU	Intensive Care Unit	Inpatient
SEMI	Med	Inpatient
NSY	Nursery	Inpatient
OB	Obstetric	Inpatient

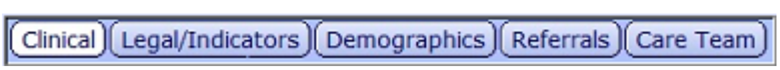
***Note** When you move from department to department, best practice is to switch jobs.*

Inside a patient's chart

(Panel by panel)

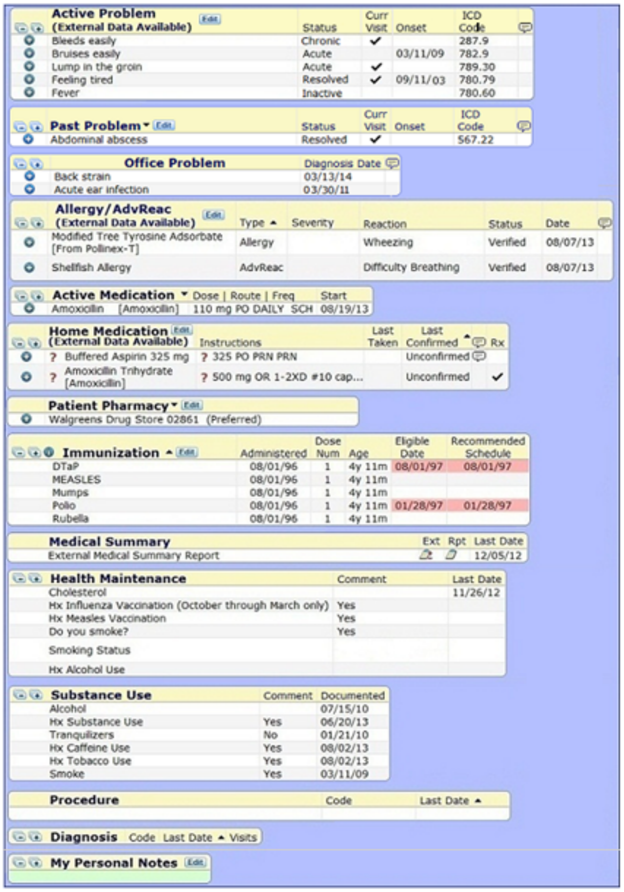


When you open a patient's chart, you will be opened to the Summary panel which consist of five different tabs.



Clinical Page

Use the Clinical Summary Panel to review the selected patient's clinical information (for example, Active Medications). This information includes data collected during all of the patient's visits to any health care organization and physician's practice.



On the summary page, please be sure to fill in the patient allergies, home medications, pharmacy, and immunizations.

Legal/Indicators

This tab will display the patient's resuscitation status, primary language, if the patient has an advance directive, living will, power of attorney, and if they are an organ donor. This will also have a box of insurance cards that you can click on to view. ****IMPORTANT**** *DO NOT* use this tab to verify patient's current insurance. Insurance listed on this screen is a list of all current and historical insurance cards scanned.

Demographics

This screen will display all demographics, including; MPI Data, Demographics, Next of Kin, Person to Notify, Employer, Guarantor, Insurances, and Prescription Drug Plans. ****IMPORTANT**** The insurance listed here is also just a list of current and historical insurances. *DO NOT* use this tab to verify patient insurance.

Referrals

Use this screen to view information about the provider referrals associated with a patient.

Care Team

Use the Care Team screen to view a list of this patient's care providers for the current visit. Initially, the screen displays the providers entered during registration (that is, Primary Care

Physician, Attending Provider, Admitting Provider, Family Provider, ED Provider, or Other Provider).

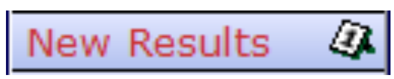
Use this panel to review visit information. The panel opens first to a screen with non-clinical information. ***This is where you verify current insurance***.

Status	ADM IN
Account #	F00000272732
Reg Date/Time	10/06/15 09:13
Reason for Visit	ANEMIA
Facility	Scotland County Hospital
Location	Med
Room/Bed	1227 1

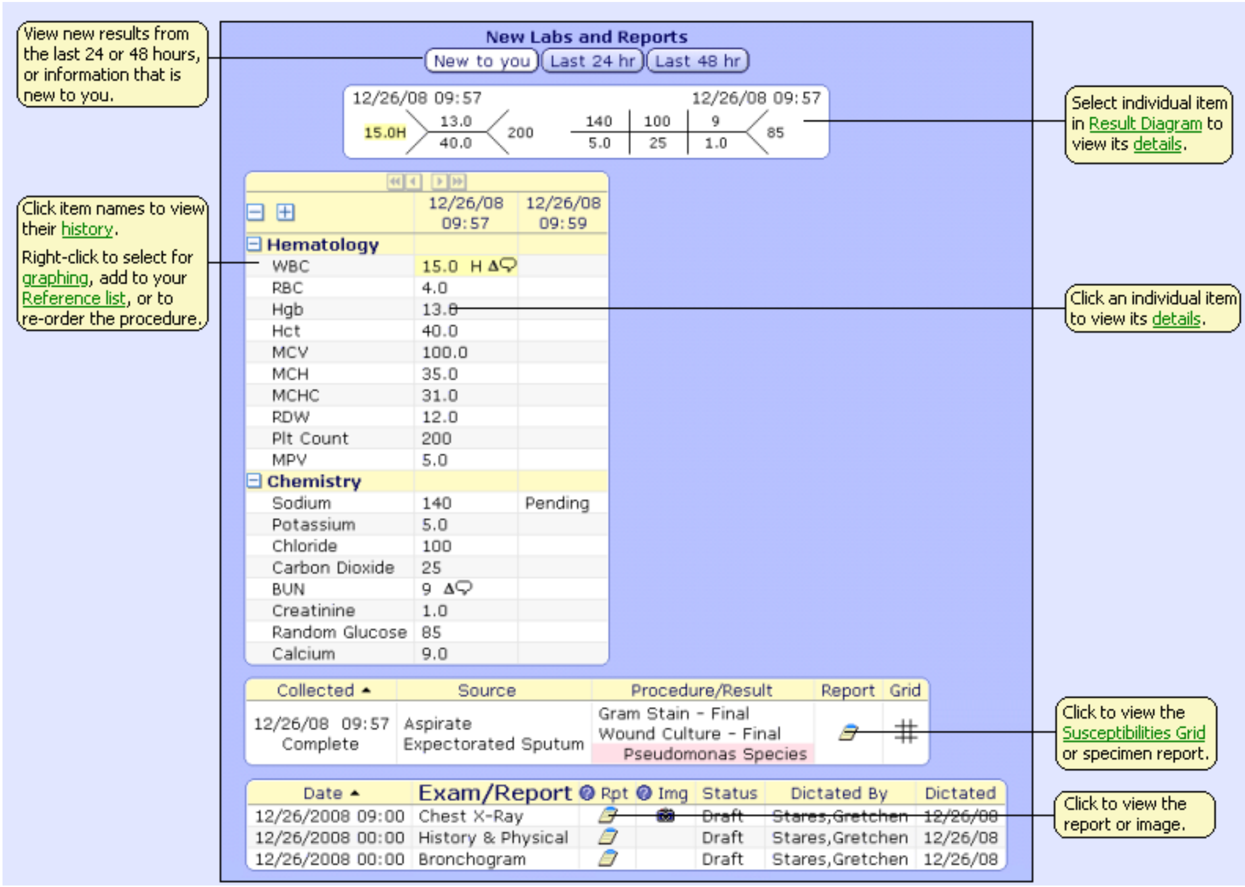
Attending	Davis,Jeffrey, DO
Admitting	Davis,Jeffrey, DO
Insurances	SELF PAY

Use this screen to send a notice to a physician and/or view all notices sent for a particular patient. ****Physicians will not be able to send a notice to a nurse or respond to a notice from a nurse. They are only able to view what the nurse sent them.****

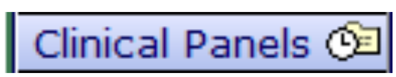
To view all notices on a particular patient, click <All> and toggle through “Current”, “Acknowledged”, and “Monitor List”.



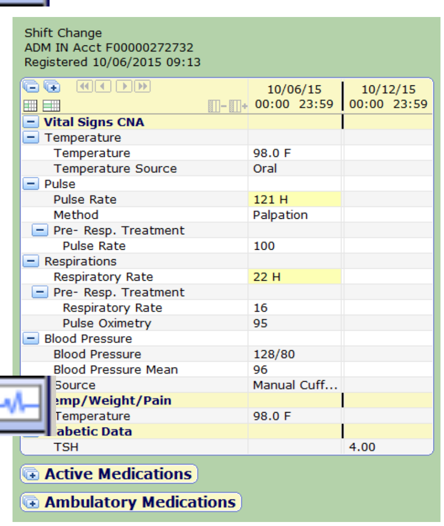
Use this panel to review recent patient data, or to quickly obtain the newest data.

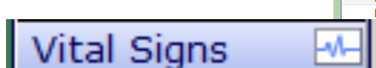


The new results flowsheet includes information about laboratory results and reports. Different tables can appear for different types of information when new results exist. Laboratory results are sorted by category, which you can expand and collapse using the + and - symbols.

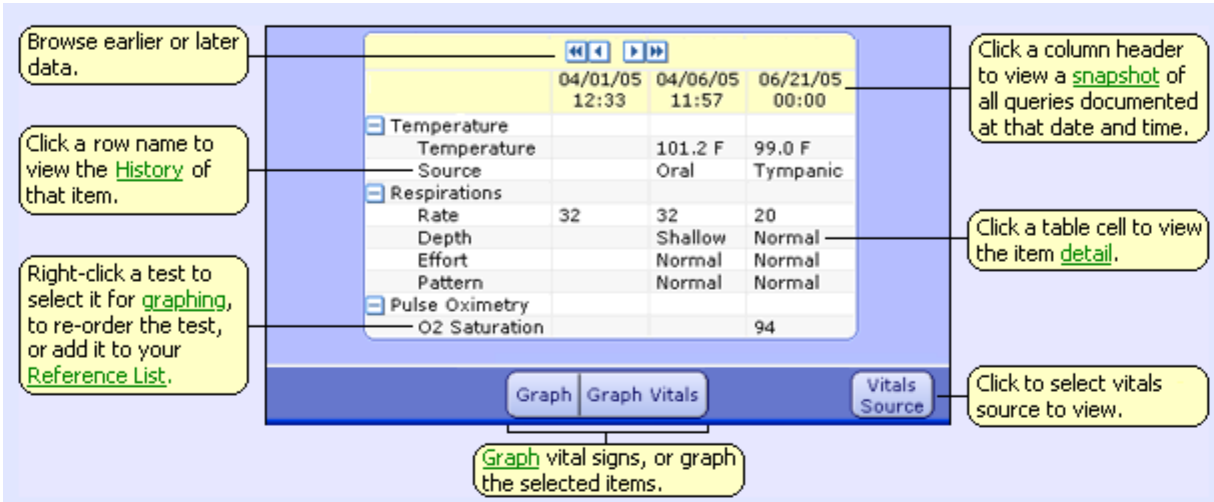


Clicking on this panel will open up a menu list where you can select the specific Clinical Panel you want to view. When you select a panel the data appears in a flowsheet. (As shown)



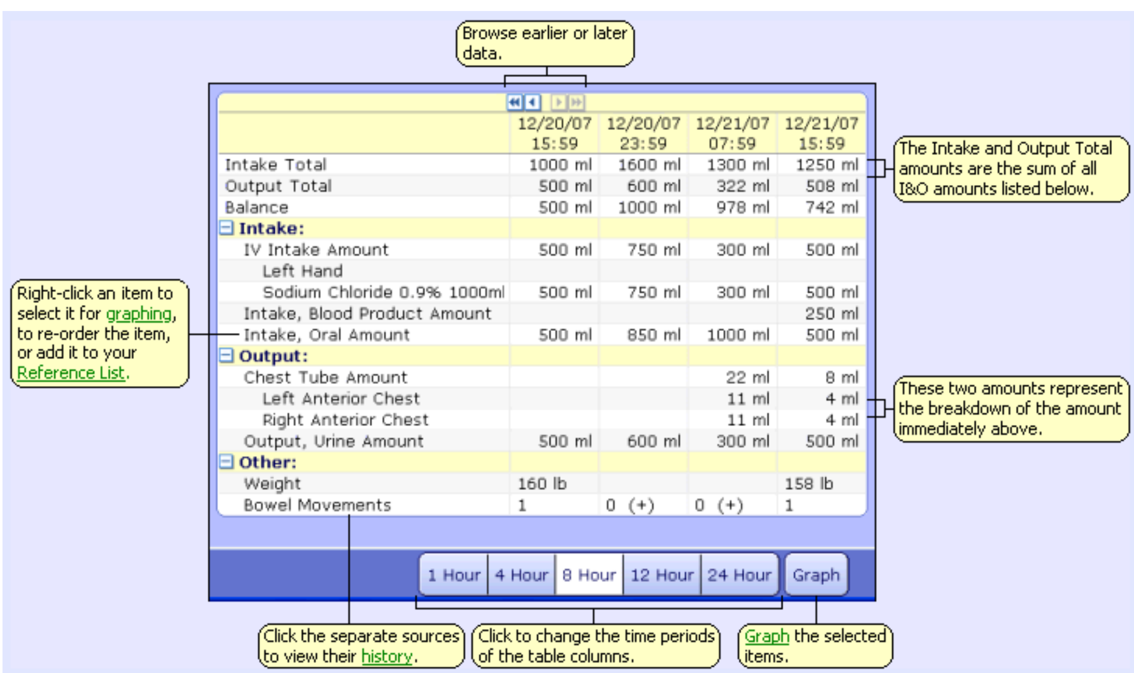


Use this screen to view patient vital signs. The date and



time that the information was recorded appears in the column header. If a response includes a text, a comment symbol appears.

The I & O panel displays numerical intake and output values recorded from assessments, or from other MEDITECH applications.



If the patient has a bowel movement documented, you can view the details by:

Click on the actual number of bowel movements.

Other:			
Percent Meal Consumed		100	(+)
# Voids		2	
# Bowel Movements		1	
Weight	142 lb		1

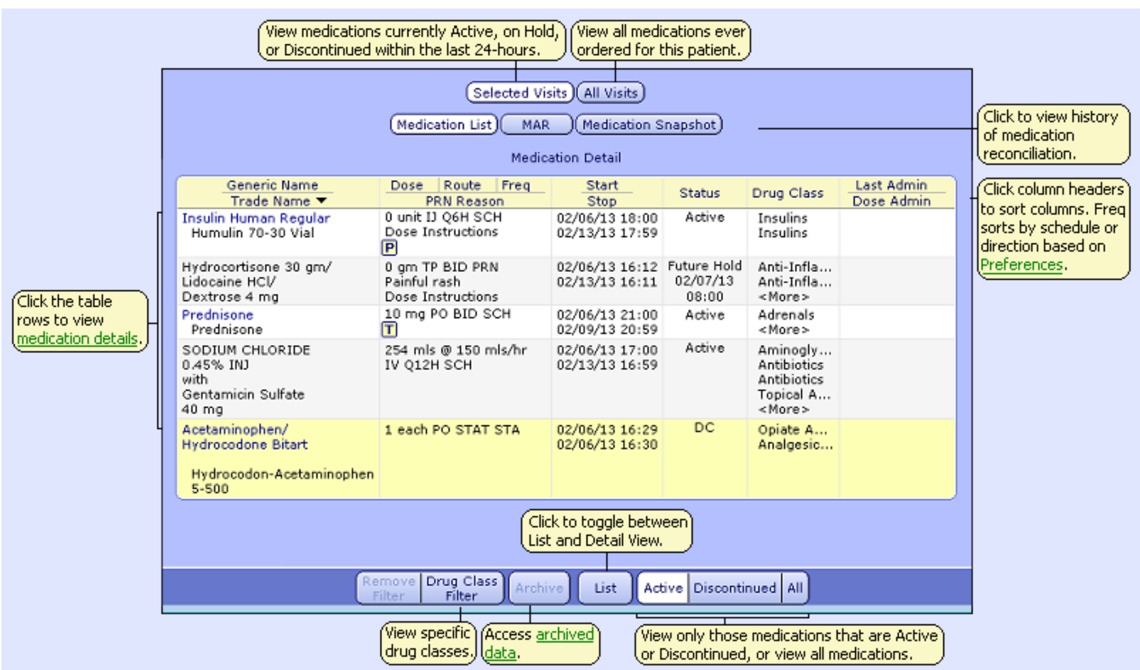
Then click inside the 'group' and you will be pulled to the intake and output documentation for that time. Once done, you can close out and you will be brought back to the I & O tab.

Bowel Movements

Documented	Result	Units	Range	Group
07/12/2015 18:00	1	bowel movements		

Medications

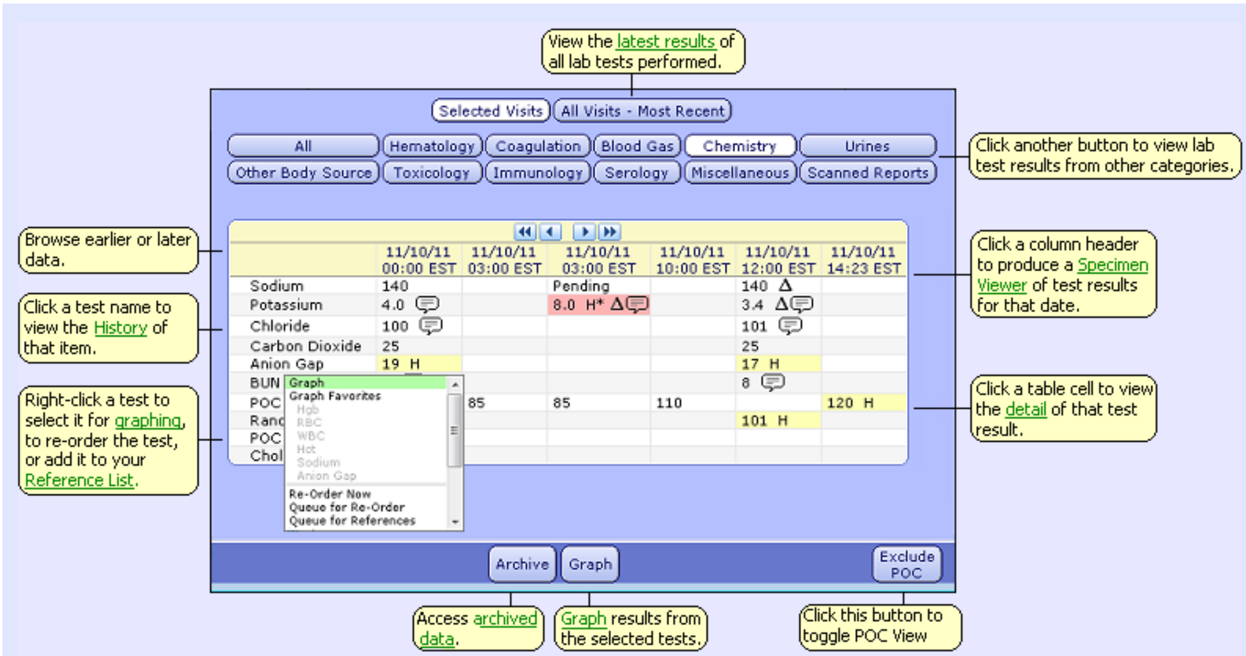
Use this screen to view detailed information about the medications associated with your patient.



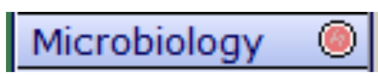
Click the table rows to view further details for the listed medications. Click the MAR button to view medications listed on the MAR. The P- and T-icons indicate that the medication has a protocol and/taper schedule associated with the medication. You can view the details on the Prot/Taper screen on the Medication Detail screen.

Laboratory

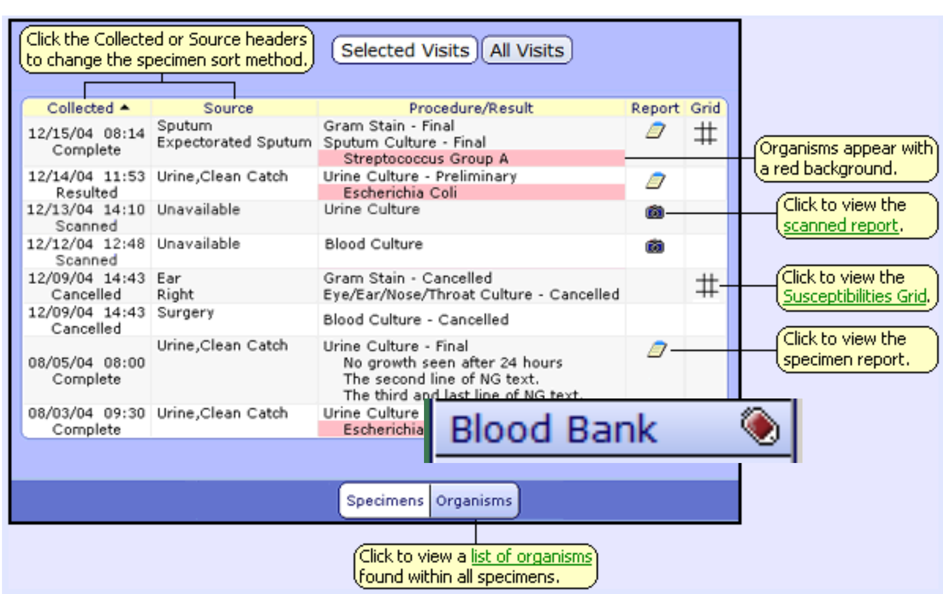
Use this screen to view laboratory test results.



The most recent data appears in the right-most column. Buttons at the top of the screen provide access to the different categories of lab tests for which the patient has data, if no data is available the button does not appear. When new data exists since prior access, the button appears in red.



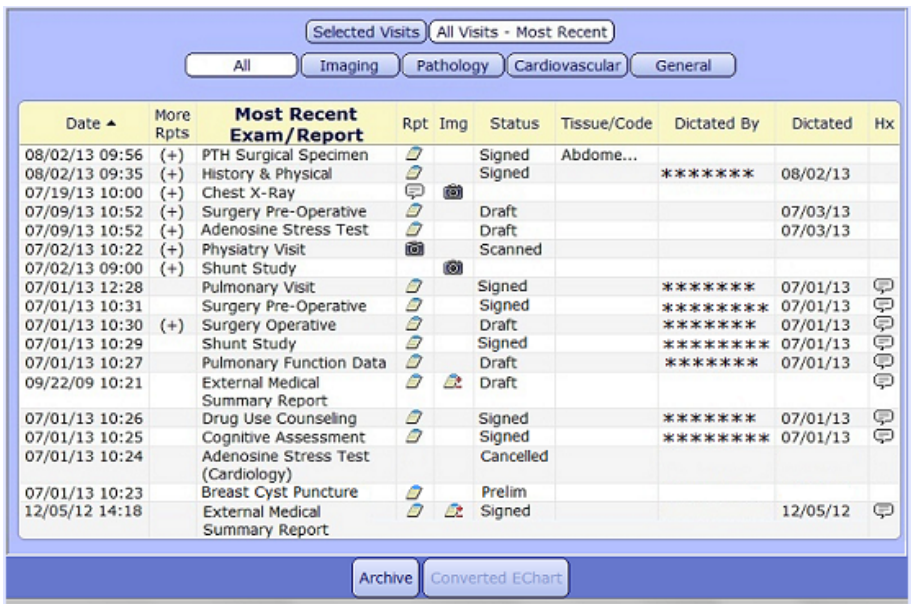
Use this panel to view microbiology specimen data. The panel opens first to the Specimen screen, which sorts specimens by their collection date in reverse chronological order (most recent data at the top of the list).



Each table row contains information for one specimen. The icons in the Report and Grid columns provide access to Specimen Inquiry reports and susceptibilities grids, when these items are available.

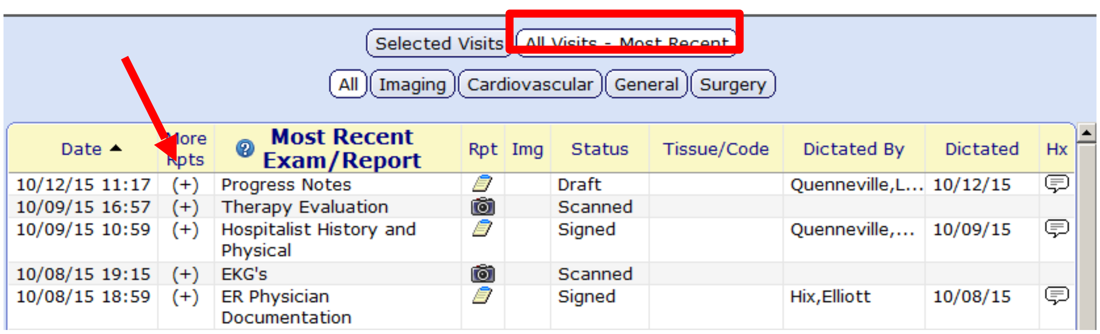
This panel displays the patient’s blood type. We do not have all privileges to the blood bank tab, so you will not see product summary, transfusions, or reports.

Use this panel to view reports and images for selected visits or most recent data across all visits. You can also view reports by category such as Imaging or Pathology.



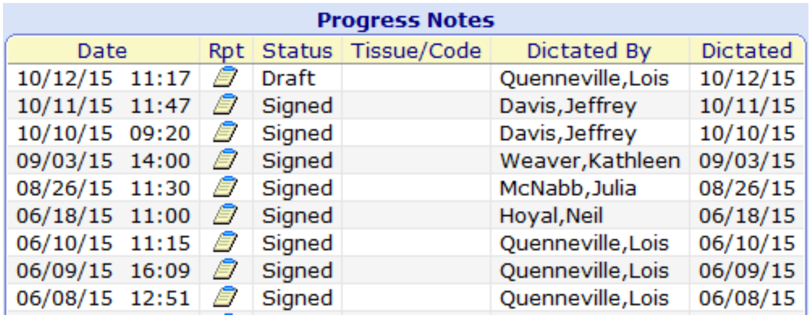
Date	More Rpts	Most Recent Exam/Report	Rpt	Img	Status	Tissue/Code	Dictated By	Dictated	Hx
08/02/13 09:56	(+)	PTH Surgical Specimen			Signed	Abdome...			
08/02/13 09:35	(+)	History & Physical			Signed		*******	08/02/13	
07/19/13 10:00	(+)	Chest X-Ray							
07/09/13 10:52	(+)	Surgery Pre-Operative			Draft			07/03/13	
07/09/13 10:52	(+)	Adenosine Stress Test			Draft			07/03/13	
07/02/13 10:22	(+)	Physiatry Visit			Scanned				
07/02/13 09:00	(+)	Shunt Study							
07/01/13 12:28		Pulmonary Visit			Signed		*******	07/01/13	
07/01/13 10:31		Surgery Pre-Operative			Signed		********	07/01/13	
07/01/13 10:30	(+)	Surgery Operative			Draft		*******	07/01/13	
07/01/13 10:29		Shunt Study			Signed		********	07/01/13	
07/01/13 10:27		Pulmonary Function Data			Draft		*******	07/01/13	
09/22/09 10:21		External Medical Summary Report			Draft				
07/01/13 10:26		Drug Use Counseling			Signed		*******	07/01/13	
07/01/13 10:25		Cognitive Assessment			Signed		********	07/01/13	
07/01/13 10:24		Adenosine Stress Test (Cardiology)			Cancelled				
07/01/13 10:23		Breast Cyst Puncture			Prelim				
12/05/12 14:18		External Medical Summary Report			Signed			12/05/12	

__Viewing clinic notes from hospital chart__: (Hospital progress notes will be listed here as well)



Date	More Rpts	Most Recent Exam/Report	Rpt	Img	Status	Tissue/Code	Dictated By	Dictated	Hx
10/12/15 11:17	(+)	Progress Notes			Draft		Quenneville,L...	10/12/15	
10/09/15 16:57	(+)	Therapy Evaluation			Scanned				
10/09/15 10:59	(+)	Hospitalist History and Physical			Signed		Quenneville,...	10/09/15	
10/08/15 19:15	(+)	EKG's			Scanned				
10/08/15 18:59	(+)	ER Physician Documentation			Signed		Hix,Elliott	10/08/15	

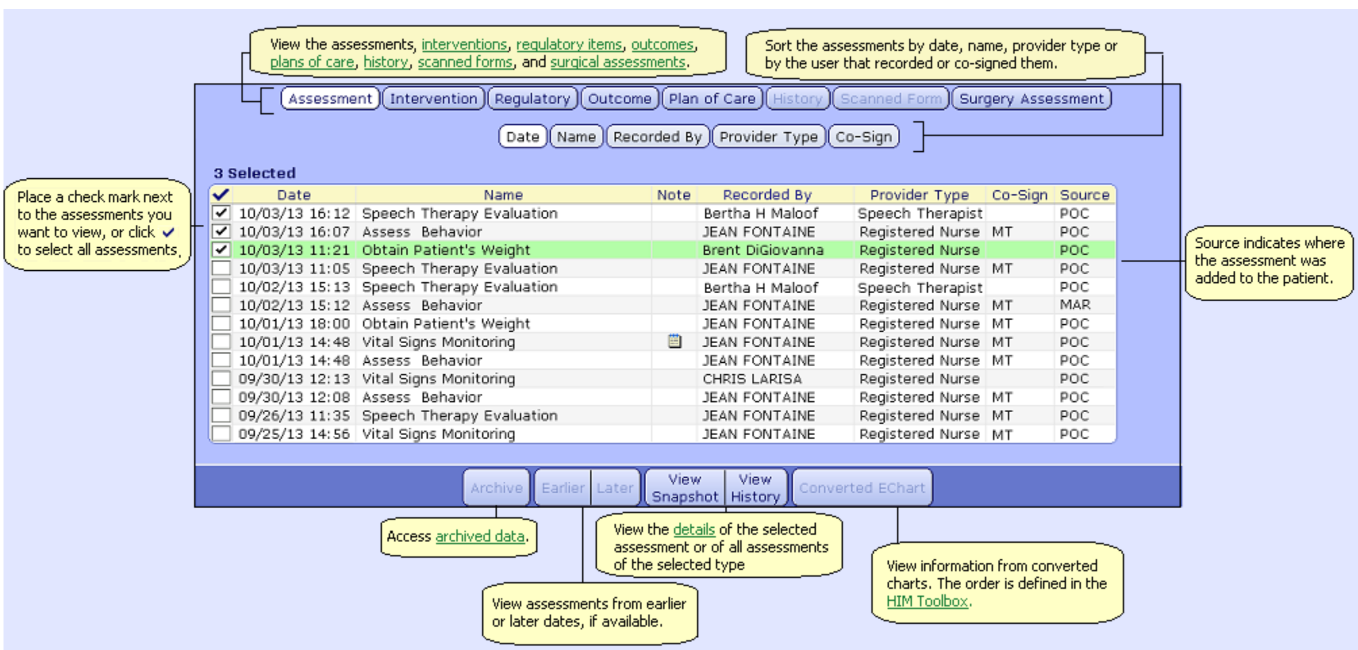
1. Click <All Visits – Most Recent>
2. Click < (+) > next to “Progress Notes” and a list of all progress notes will appear.



Date	Rpt	Status	Tissue/Code	Dictated By	Dictated
10/12/15 11:17		Draft		Quenneville,Lois	10/12/15
10/11/15 11:47		Signed		Davis,Jeffrey	10/11/15
10/10/15 09:20		Signed		Davis,Jeffrey	10/10/15
09/03/15 14:00		Signed		Weaver,Kathleen	09/03/15
08/26/15 11:30		Signed		McNabb,Julia	08/26/15
06/18/15 11:00		Signed		Hoyal,Neil	06/18/15
06/10/15 11:15		Signed		Quenneville,Lois	06/10/15
06/09/15 16:09		Signed		Quenneville,Lois	06/09/15
06/08/15 12:51		Signed		Quenneville,Lois	06/08/15

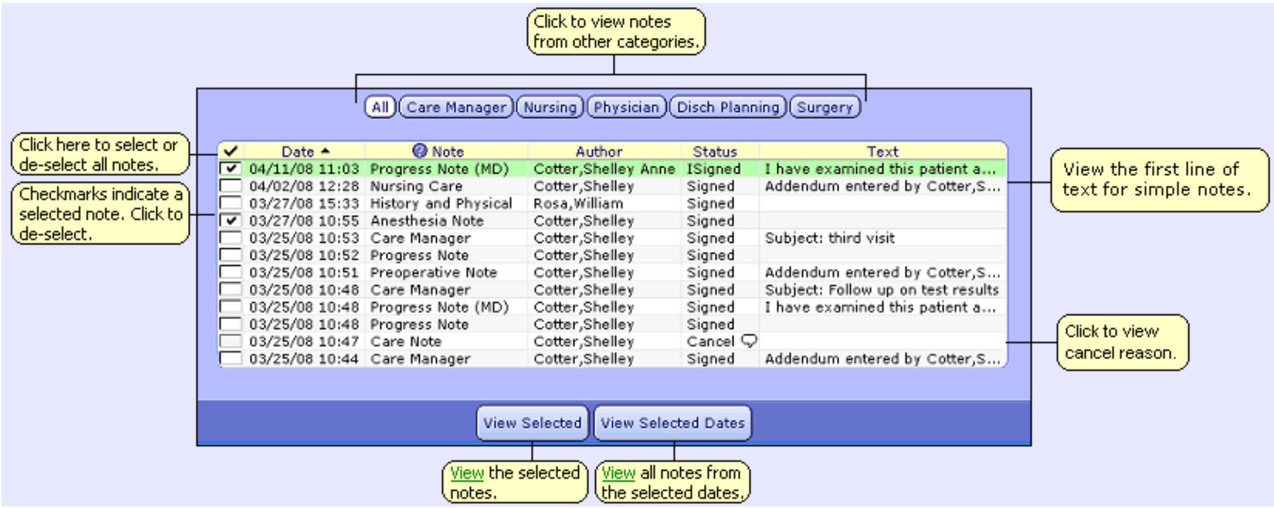
3. Click on the progress note that you want to view. If it is a clinic progress note, the system will open up a window in MPM. When you are done reviewing the note, you may close out and you will be directed back to the above image.

Use this screen to view a list of the assessments documented for a patient. Click the assessment to view it's details.



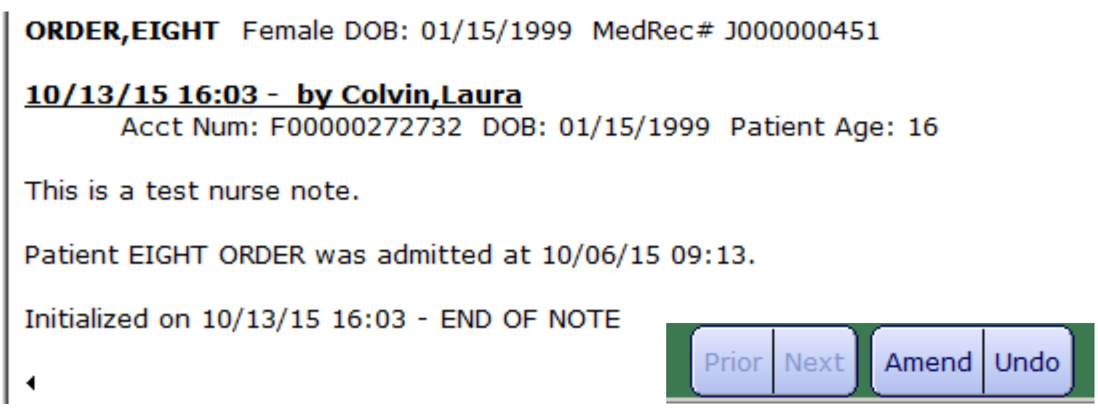
✓	Date	Name	Note	Recorded By	Provider Type	Co-Sign	Source
✓	10/03/13 16:12	Speech Therapy Evaluation		Bertha H Maloof	Speech Therapist		POC
✓	10/03/13 16:07	Assess Behavior		JEAN FONTAINE	Registered Nurse	MT	POC
✓	10/03/13 11:21	Obtain Patient's Weight		Brent DiGiovanna	Registered Nurse		POC
	10/03/13 11:05	Speech Therapy Evaluation		JEAN FONTAINE	Registered Nurse	MT	POC
	10/02/13 15:13	Speech Therapy Evaluation		Bertha H Maloof	Speech Therapist		POC
	10/02/13 15:12	Assess Behavior		JEAN FONTAINE	Registered Nurse	MT	MAR
	10/01/13 18:00	Obtain Patient's Weight		JEAN FONTAINE	Registered Nurse	MT	POC
	10/01/13 14:48	Vital Signs Monitoring		JEAN FONTAINE	Registered Nurse	MT	POC
	10/01/13 14:48	Assess Behavior		JEAN FONTAINE	Registered Nurse	MT	POC
	09/30/13 12:13	Vital Signs Monitoring		CHRIS LARISA	Registered Nurse		POC
	09/30/13 12:08	Assess Behavior		JEAN FONTAINE	Registered Nurse	MT	POC
	09/26/13 11:35	Speech Therapy Evaluation		JEAN FONTAINE	Registered Nurse	MT	POC
	09/25/13 14:56	Vital Signs Monitoring		JEAN FONTAINE	Registered Nurse	MT	POC

Use this screen to view signed notes for the selected patient. You can also edit your own notes from this panel.



The panel opens to a list of all signed notes for the selected patient. If notes from specific categories exist, buttons appear at the top of the screen that allow you to view notes from only those categories (such as Physician or Nursing).

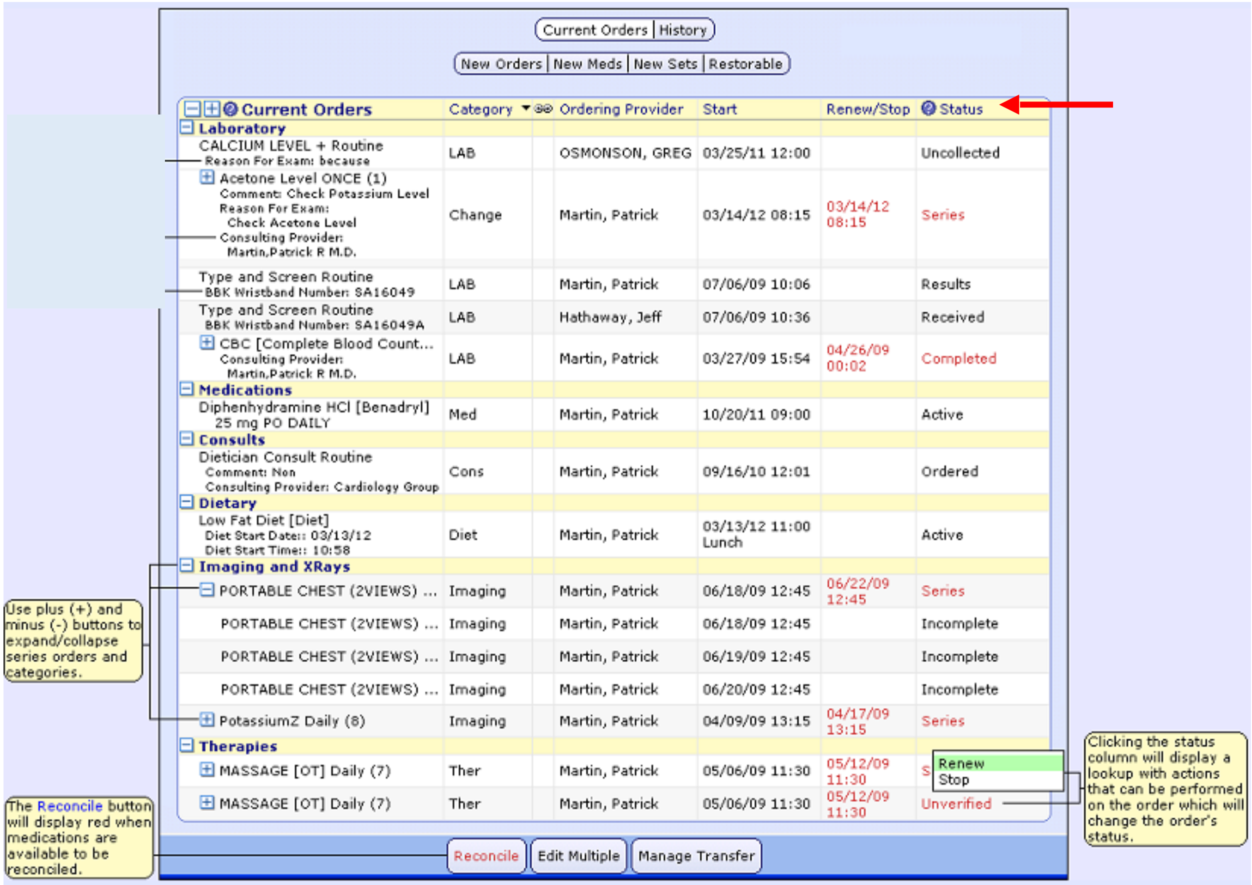
When you open a note, it will appear as shown below.



To amend a note, click <Amend>. To undo a note, click <Undo>. ****IMPORTANT** You can amend notes created by others, but you cannot undo other's notes.**

The Current Orders is used to view, enter, and edit acute orders, medications, and order sets.

You can sort by category, ordering provider, start, renew/stop, or status by clicking on the header.

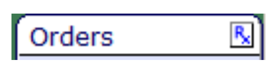


Left-Clicking the name of the order or medication will bring the user to the Manage Order List screen where details can be viewed and edits can be performed on the selected item.

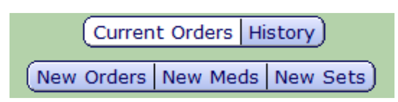
“Orders” is where you place orders for patients that are currently here or who have a pre-registration number and will be seen in outpatient.

<u>How to enter orders:</u>

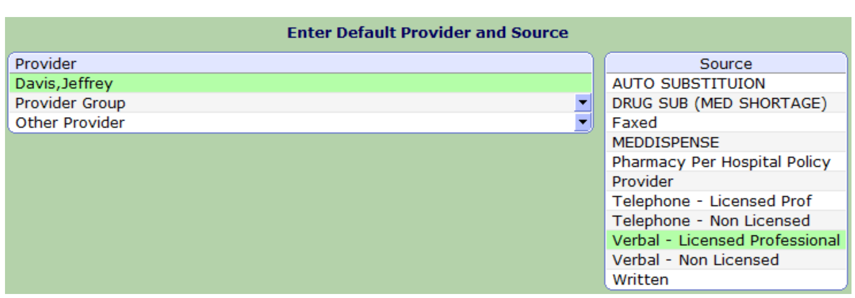
1. Once you have opened the patient’s chart, click the <Orders> tab.

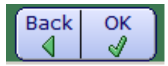


2. Click <New Orders>, <New Meds>, or <New Sets>



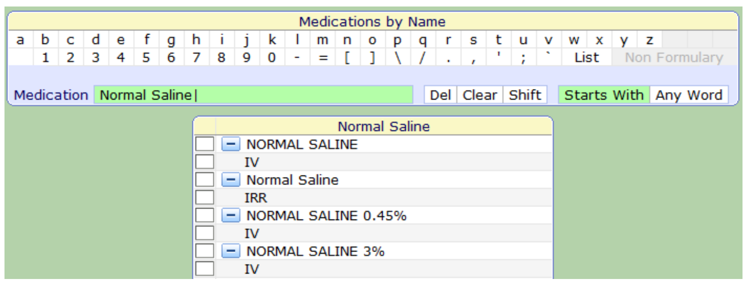
3. Choose the ordering provider and source of order.



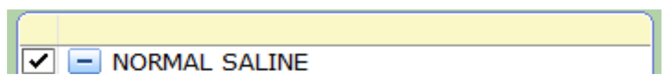
4. Click <OK> footer  button.

5. Click <Name>

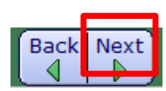
6. Type the name of the med/order that you are needing to enter.

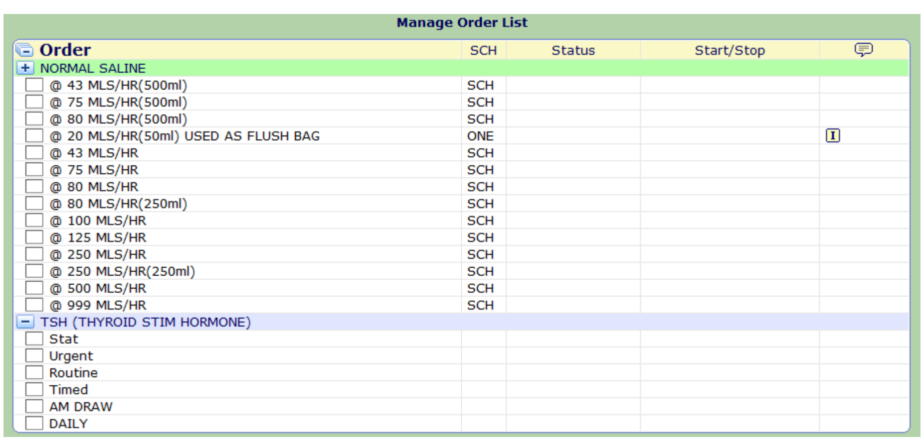


7. Place a check mark next to the order.



8. You may either press the <Next> footer button to enter the details of the order, or you may search for another order/med. If you search for another order/med you will see orders are being queued at the top. When you have finished checking all the order/meds, and you press next, you will be able to edit all orders/meds from one screen. (Shown below with 2 medication orders).

9. (I pressed the next footer button once I had searched for all my orders), and I was taken to the manage orders screen (shown on  next page).

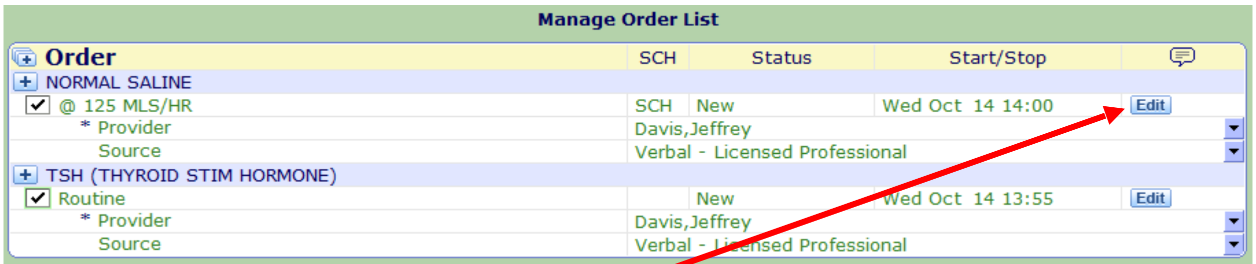


next

10. Place a checkmark to the correct order

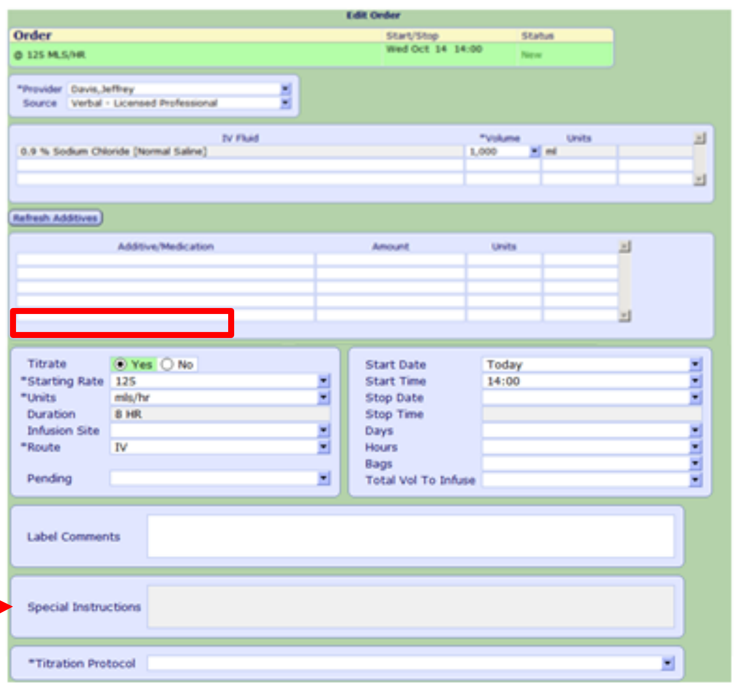
string. (If the rate you need is not shown, you can edit it. This is demonstrated below) If there are any red edit you will not be allowed to move on until the fields with asterisks are filled in.

11. Once you place a checkmark next to the order string, all other options will be minimized as shown.



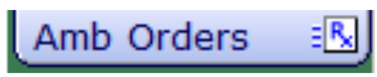
12. To edit the order string, click <Edit> and the edit order screen will open. (If the order is correct at this point, skip to # 14)

13. From the Edit Order screen you can change the rate, start date/time, or add comments/special instructions. If the order is to be titrated, click the yes radial button and choose the correct titration protocol. Once the order is edited, click <OK>



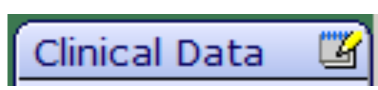
14. After all edits have been made to the individual orders, you will be directed back to the Manage Order List and you can click the <OK> footer button.

15. You will be directed back to the current orders list where the orders you have just entered will reflect New in the status column. To save the orders entered, click <Save>.

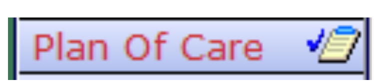


Ambulatory orders are where you enter orders for patients that will be coming back after discharge to have a test performed. To enter an ambulatory order follow the same steps as entering an inpatient order. The only difference when entering these orders will be you are required to enter a reason for exam.

Use this routine to enter, edit,



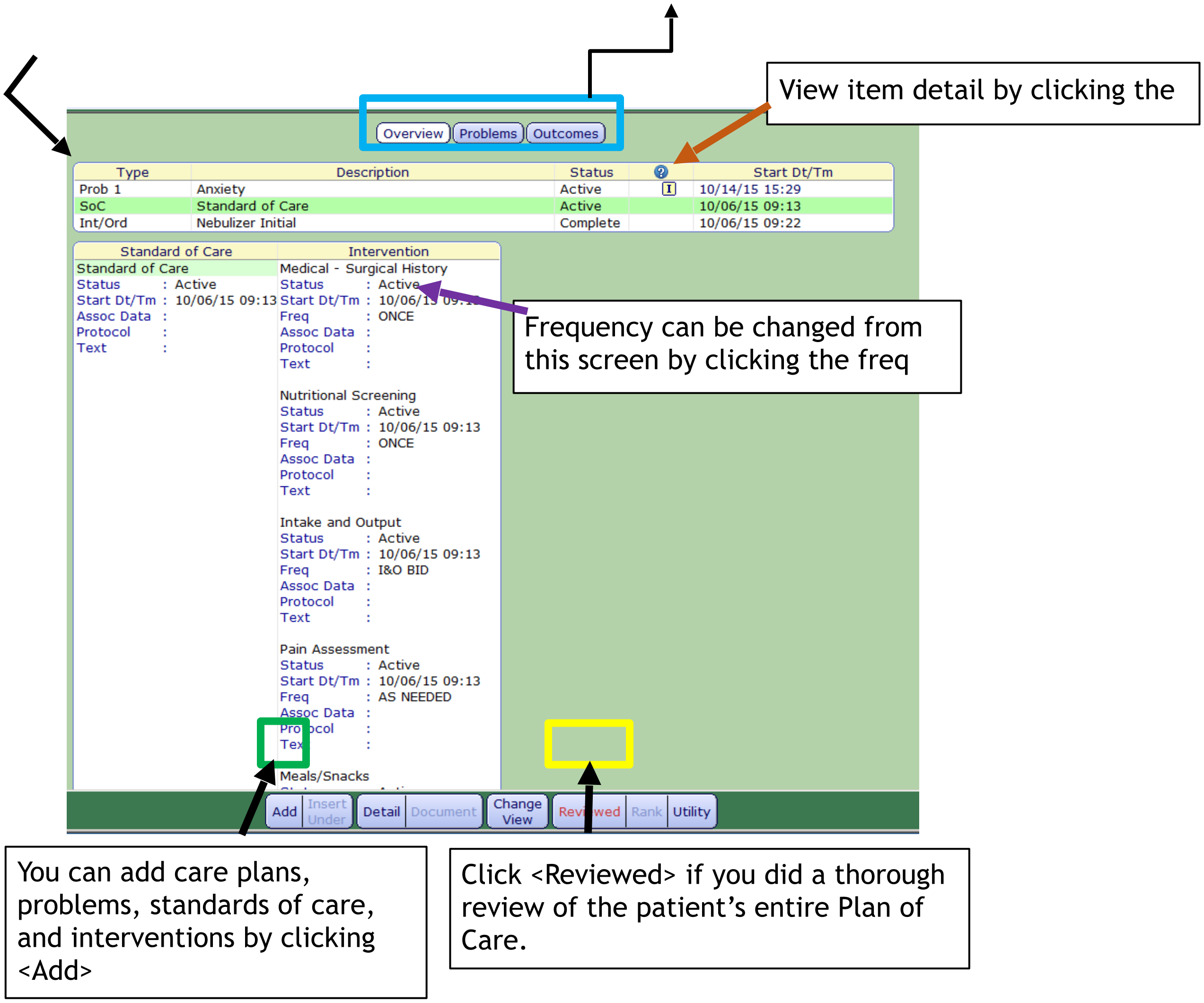
or view information for a selected account.

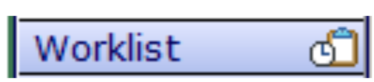


Use this screen to view and edit a patient's plan of care.

Use these panels to toggle through overview, problems, and outcomes.

Click on the description to read about each problem or care plan.





Use this screen to list and document patient interventions, outcomes, and medications.

When a patient gets admitted, a set of care items will automatically populate the worklist. Throughout the patient's stay, items will be added based on orders entered and care plans. Most items have a default of how often they are to be recorded. The frequency of these care items can be adjusted through the plan of care tab as shown on the previous page, or as shown in the below image.

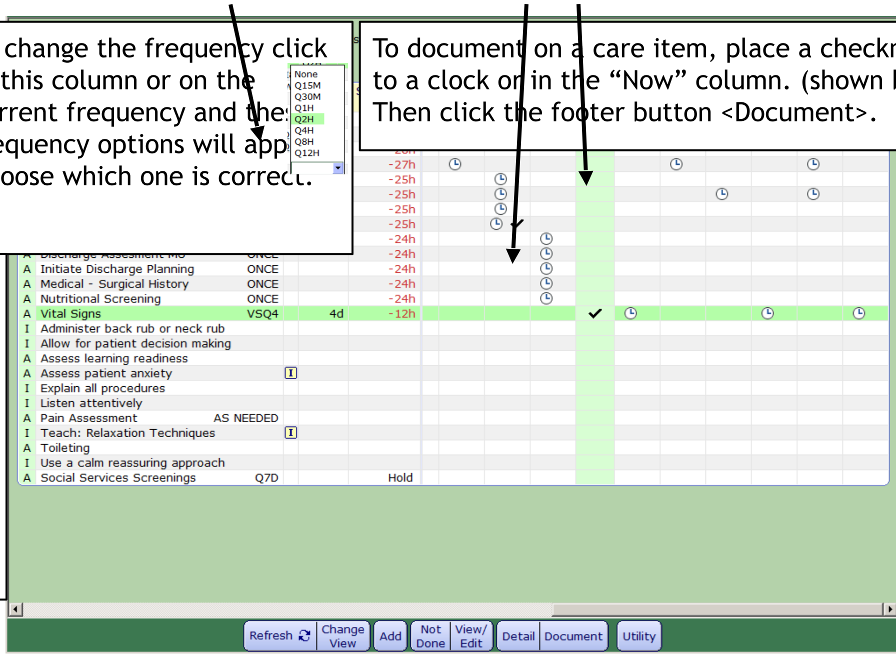
The clocks represent the time the item is due. It is important to not leave any clocks on your patients prior to leaving your shift.

To change the frequency click in this column or on the current frequency and the frequency options will app Choose which one is correct.

To document on a care item, place a checkmark next to a clock or in the "Now" column. (shown below) Then click the footer button <Document>.

Checkmark what you want to include on your worklist. Although you can include medications to your worklist, it is **NOT** best practice to document meds from here. Always document meds from the MAR.

ing.



Click <Add> to manually add care items for patients.

<View/Edit> allows you to view all recorded documentation on the care item highlighted. You may edit your own documentation. **It is

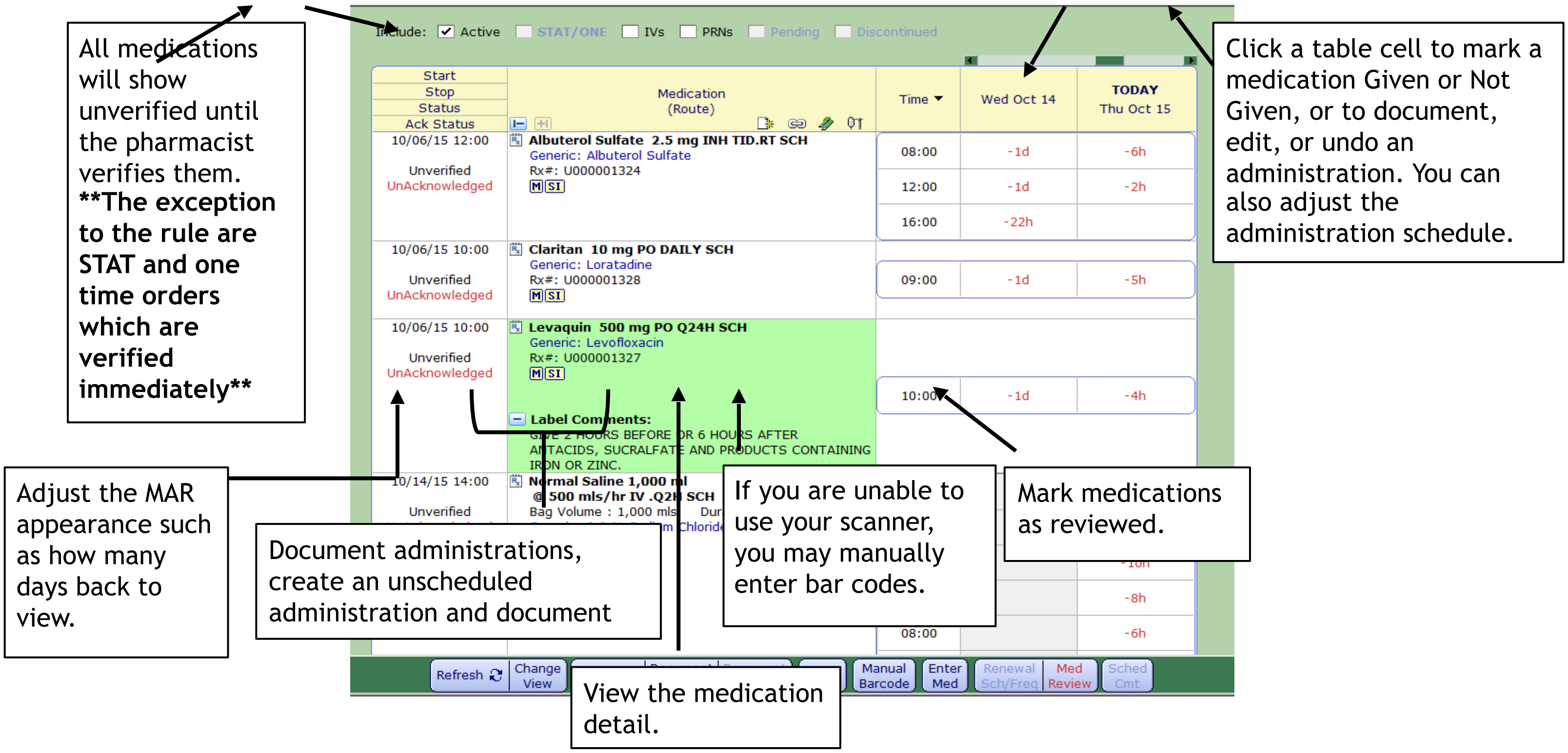
<Detail> shows the detailed information about patient care documentation, the history of who's done what to that care item, and the flowsheet of individual's entries on this care item. You will not be able to edit your documentation from the <Detail>.

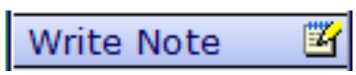
Use the MAR (medication administered administration record) to document medications. When you click on the MAR you will be required to enter your PIN.

The MAR will default to include "Active" medications.

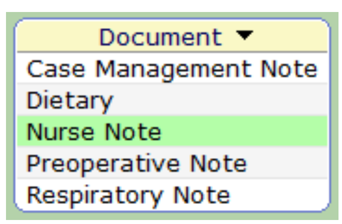
Use the scroll bar to view information from other dates.

Click the "M" to read/print the Monograph.

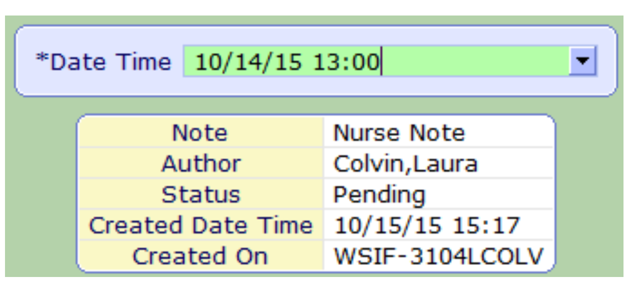




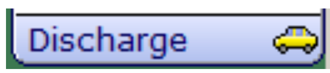
Use this panel to enter a new note into the patient's chart. When you first click this panel, you will have to choose what type of note you will be entering.



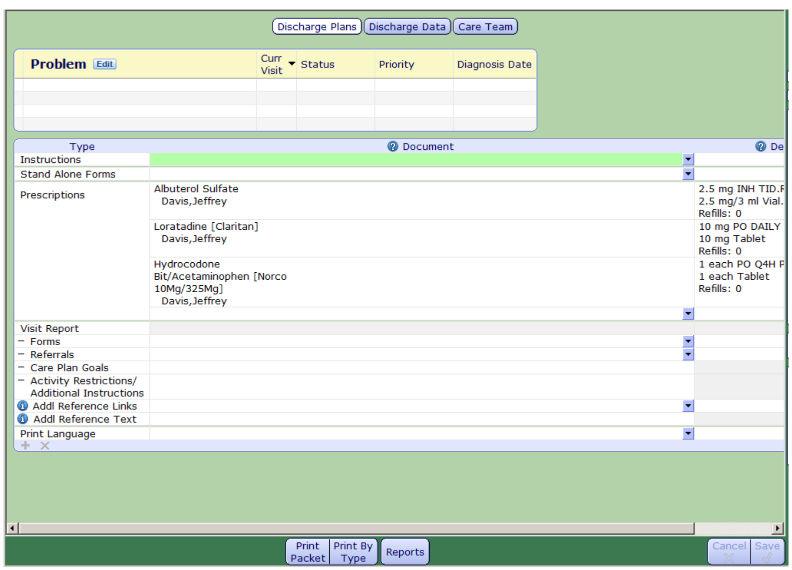
After you choose the type of note you will be taken to a free text box where you have unlimited space to document. If you need to change the date and/or time on the note, you can click <Detail> on the right side panel and change this information. (see below)



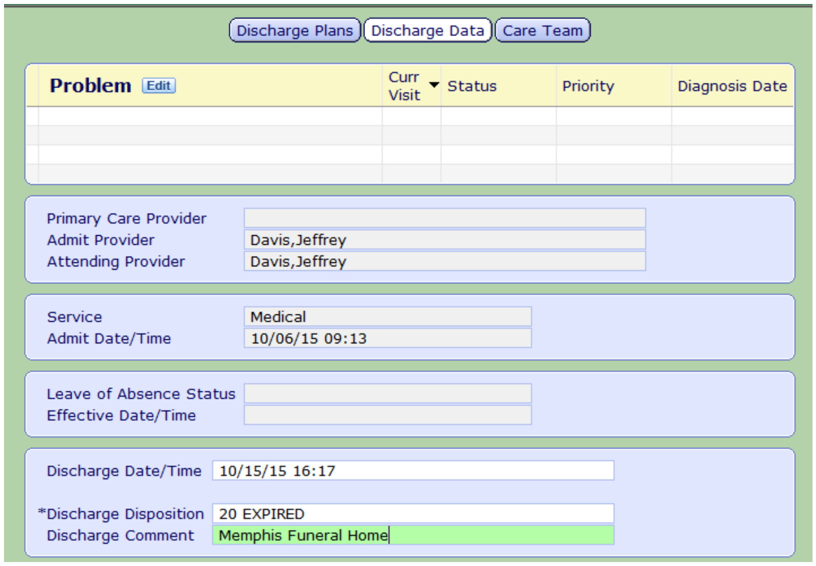
At this time we do not use the TAR (treatment administration record).



Use this screen to create and complete any forms necessary for patient discharge. A lot of this information will flow from the doctor's discharge summary.



Before finishing the patient's discharge, click the <Discharge Data> tab at the top and enter the discharge date/time and disposition. ****IMPORTANT**** If the patient has expired, enter the funeral home where the body was transferred to in the discharge comment. (shown below)

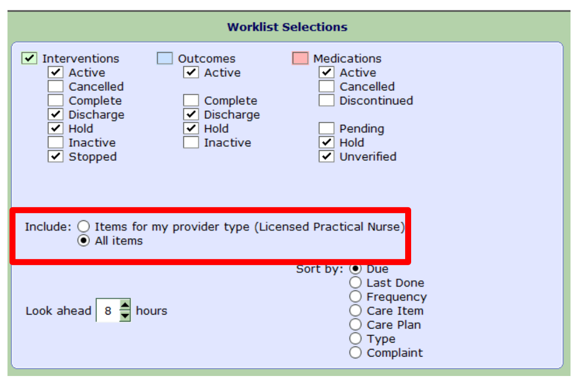


Frequently Asked Questions

Q: The worklist isn't showing everything I need to document on, how do I fix this?

A: While on the worklist, click the <Change View> footer button. In the middle of this page, it says "Include"…this should be set to "All items".

After you choose "All items", click the footer button, <Save to Preferences>.

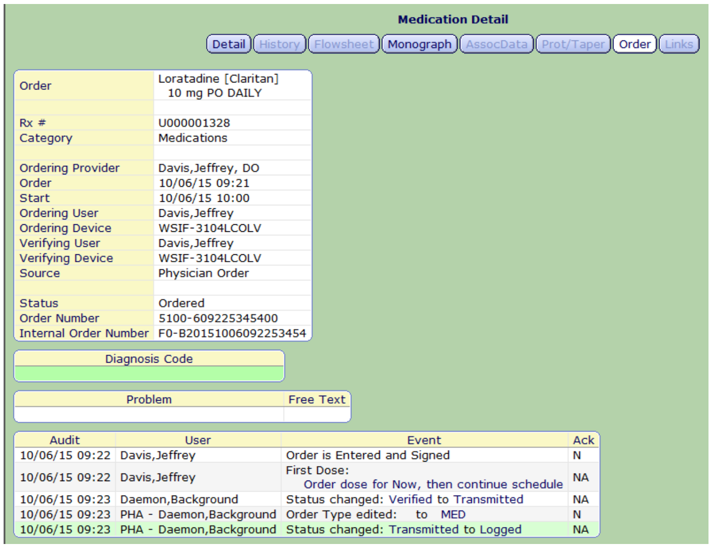


Q: Why isn't respiratory therapy getting orders on inpatients?

A: When entering an order for respiratory therapy, the frequency must be .RT (example: QID.RT, TID.RT)

Q: Where do I look to see if the physician signed the verbal order I entered?

A: Go to the MAR – highlight the medication you want to know about – Click the <Detail> footer button – You will be taken to the medication detail – Click the <Order> tab at the top. At the bottom of the screen you will see the audit log of this order.



Q: Why can't I discontinue a medication from a patient's home med list?

A: Once an edit has been made to that medication on the home med list, the medication cannot be discontinued until you save and go back in.

Q: I need to document/edit a medication on a patient in the past, but can't find the date on the MAR, how am I to chart it?

A: If the medication administration is past 90 days, you will not be able to chart on the MAR or enter a nurses note. If it is within the 90 day window, go to the MAR – click the footer button <Change View> - change the "Days into the past to view MAR" to 90 – click <OK> - use the scroll bar on the MAR to back to the date you need.

Q: I administered a patient's insulin, filled in the assessment from the MAR, but the clock is still on my worklist, why did is the clock still there after I filled in the assessment?

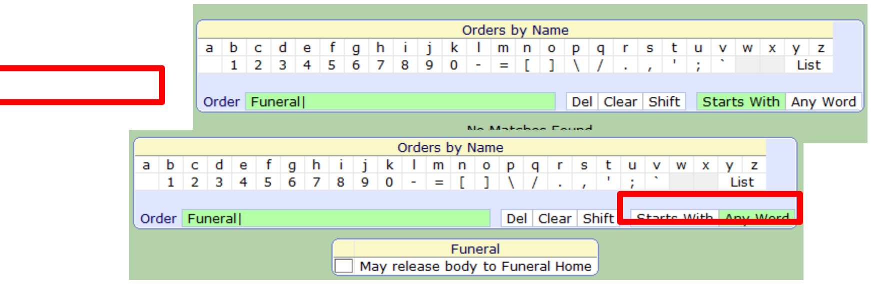
A: When documenting insulin on the MAR, an assessment will be required; however, this will not remove the clock on your worklist. Unfortunately, you will have to fill out both assessments.

Q: Why is the I&O tab showing tomorrow's date with time of 0659?

A: The panel defaults to 24 Hour view. When set to 24 hours, the columns divide themselves up to 24 hour intervals and displays the relevant data closest to each column time.

Q: I'm trying to enter orders, but what I want isn't showing up when I search and I know the order is there, how am I to find it?

A: When searching for orders, the search will default to “Starts With” to the right of the search box. Change this to “Any word” and if you type any of the words that are in the order, the order will appear. (See example below)



Did You Know???

- If you have questions, you can click the  in the bottom right corner of the screen and it will give you information about the screen you are currently on.
- If you have an error pop up on your screen, you can click the  in the bottom right corner and that will print a screen shot of your current screen.
- The patient header offers a lot of pertinent information such as: Name, DOB, age, room number, code status, last entered height/weight, allergies, and account numbers.
-