McKESSON
Empowering Healthcare

STAR 2000™

STAR PATIENT CARE REFERENCE GUIDE
Care Planning and Documentation Module

Release 17.0
October 2011

C17000061

Publication date

October 2011

Produced in Cork, Ireland

Product and version

STAR 2000 Release 17.0

Publication number

C17000061

Reader comments

Any comments or suggestions regarding this publication are welcomed and should be forwarded to the attention of

STAR 2000 Documentation Team
McKesson
Mail Stop ATHQ-3302
5995 Windward Parkway
Alpharetta, GA 30005

Preface

The *Care Planning and Documentation Module* of the *STAR Patient Care Reference Guide* provides detailed information for the Nursing Plan of Care process.

The information in this book corresponds to the order in which the various functions display on the STAR Patient Care system.

The *General Information Volume* is prerequisite reading for all other volumes of the *STAR Patient Care Reference Guide*. Successful use of the *Care Planning and Documentation Module* depends on your knowledge of the concepts covered in the *General Information Volume*.

Documentation Conventions

Documentation for McKesson's STAR 2000™ line of products follows these conventions:

Revisions
Text revisions are indicated by a change bar in the left margin. Paragraphs that contain grammatical changes that do not affect content are not marked.

Canadian Documentation
This volume may include documentation for Canadian users of this product. Complete sections of Canadian text are identified by "CN" and "CN Only."

Key Names
Named keys, such as SHIFT, CTRL, ALT, and ENTER, are displayed in this document in uppercase (capital) letters. A symbol key is written as text in this document followed by the symbol in parentheses, such as hyphen (-) and asterisk (*).

Key Chords
Key chords are key entries that require you to hold down one or more keys (typically, CTRL, ALT, or SHIFT) before pressing another key. In this document, key chords are displayed as the names of each key in the chord separated by a hyphen (-) (for example, CTRL-ALT-DEL).

Enter
ENTER is a key on a computer keyboard used to complete an entry on a STAR system. (This key may also be referred to as NEW LINE or NL in the STAR system.)

Data Entries
Letters or words you enter in response to the system are displayed in **bold** letters in this document. For example: Enter **Y** for Yes or **N** for No.

Selecting an Entry
This document often instructs you to "select an entry." The method you use to select an entry depends on whether you are using STAR from a terminal or IBM-compatible personal computer. Entry methods include:

- Entering the option number
- Using your arrow keys to highlight the option and pressing ENTER
- Clicking on the option using a mouse or other pointing device (PC only)

For more information about these options, see the *General Information Volume*.

Prompts
System prompts are displayed at the bottom of many STAR screens when the system requests an entry or displays a message. In this document, these prompts are indented and the text italicized, as shown in the following example:

Enter patient name--

Field Characteristics

STAR product documentation provides field explanation codes, in addition to a narrative description for each field on a screen. These codes display the maximum length of your entry in the field, the type of entry you make in the field, and whether the field is required. This information displays in the following format:

- DISPLAY ONLY for a field you cannot edit.
- For X-YY-Z field types, where:
  - X is the maximum number of characters permitted in the field:
    - P for a field length determined by a Parameter
    - T for a field length determined by a Table
    - U for a field having an Undefined length
  - YY is the type of entry technique permitted in the field:
    - A for Letters only
    - AC for Letters and Punctuation only (no numbers)
    - AN for Numerals and Letters only (no punctuation)
    - C for Characters (including punctuation)
    - N for Numerals only
    - NC for Numerals and Punctuation only (no letters)
  - Z is the requirement indicator of the field:
    - C if an entry is Conditionally required or optional
    - O if an entry is Optional to complete the function
    - R if an entry is required to complete the function

      NOTE: Facilities can designate that certain fields be Required. STAR product documentation does not display R for fields designated as Required by a facility.
  - For YY-Z field types, where YY is:
    - DATE for a field subject to the date entry conventions described in the *General Information Volume*.
    - SPECIAL FORMAT for a field having data entry requirements not conforming to standard format. The field definition contains the specific data entry requirements for the field.
    - TABLE LOOKUP for a field that enables you to select from a displayed table. See the *General Information Volume* for more information regarding this entry technique.
    - TIME for a field subject to the time entry conventions described in the *General Information Volume*.

    NOTE: For use of the Z position in this format, refer to the explanations for Z under X-YY-Z.

Table of Contents

Chapter 7 - STANDARD FILE MAINTENANCE

Chapter 8 - PRINT STANDARD FILE DOCUMENTS

Chapter 9 - BUILD AND FORMAT PCPS AND WORKSHEETS

Table of Illustrations

Introduction

Today's nursing department is key to hospital efforts to control costs while maintaining quality patient care. To meet these objectives, the professional nursing team needs a system of communication and data documentation that supports both increased productivity and quality care at the nursing staff level, and management decisions at the nursing administrative level. The *STAR Patient Care Reference Guide Care Planning and Documentation Module*, provides the dynamic communications link between nurses, physicians and ancillary services needed to reduce treatment costs while maintaining superior patient care. With the Care Planning module, staff nursing routines are streamlined through automation of the daily clerical workload and documentation of the many activities associated with individual patient care.

The *STAR Patient Care Reference Guide Care Planning and Documentation Module* contains the following chapters:

Chapter 1: Critical Pathways

This chapter discusses this comprehensive, multidisciplinary method of planning care among all the disciplines required for the care of a patient.

Chapter 2: Plan of Care Process

This chapter provides information about the Plan of Care Process the nurse uses to plan the patient's care in the hospital.

Chapter 3: Nursing Station Functions

This chapter provides information about ADLs, treatment orders, and station schedules.

Chapter 4: Vital Signs and Fluid Balances

This chapter explains the vital signs and fluid balances functions that enable the nursing staff to enter patient data into the system.

Chapter 5: Maternity Module

This chapter describes the different options which offer functionality specific to maternity-related information and needs.

Chapter 6: Reports

This chapter describes the documents, worksheets, and reports that are generated to aid the nurse in providing quality care.

Chapter 7: Standard File Maintenance

This chapter provides information about the standard files that must be built for the Care Planning and Documentation Module.

Chapter 8: Print Standard File Documents

This chapter contains examples of each Standard File Document you can print from the STAR Patient Care Nursing system.

Chapter 9: Build and Format PCPs and Worksheets

This chapter provides information on designing Patient Care Profiles (PCPs) and Worksheets that meet the needs of the facility.

Appendix A: Nursing Tables

This chapter contains a listing and explanations of some of the tables used by the Care Planning and Documentation Module.

Appendix B: Information Windows

This chapter provides information on using Information Windows, which displays patients' medical information, physicians of record, and pharmacy information. These information windows are available through Order Management and Nursing functions.

Chapter 1 - CRITICAL PATHWAYS

Illustrations

OVERVIEW OF CRITICAL PATHWAYS FUNCTION

Critical Pathways is a plan or protocol that provides a comprehensive, multidisciplinary method of planning care among all the disciplines required for the care of a patient. The pathway is set up for a particular diagnosis, with an expected outcome, and an expected length of stay. The pathway provides the necessary items for each day of the stay with the goal that upon completion of the Critical Pathway, the patient is ready for discharge.

Using Critical Pathways to Implement and Track Patient Care:

Display the menu for implementing and tracking patient care by selecting the Critical Pathways option from the Nursing main menu.

The following prompt displays for you to identify the patient:

Enter acct #,`-` bed code, first chars of name'-' [2N Census]--
'C' for Census

To avoid repeating how to select a patient through the entire section, the process and its related prompts are described below.

You can enter an equal sign (=) to display the last patient referenced, in addition to the options explained below. If the system does not have a last patient referenced loaded in memory, and you enter an equal sign (=), the following error message displays:

Error: Inactive account number!

The initial prompt displays again:

Enter acct #,`-` bed code, first chars of name'-' [2N Census]--
'C' for Census

- Account # access - You can directly access the patient by entering the account number. Using the account number allows access to inpatients or outpatients in beds currently on your station, inpatients or outpatients who have been on your station, and regular outpatient types. If you enter the account number of an inpatient or outpatient in bed who has never been on your station, the following error message displays:

  Error: Never in Station!

  The system does not allow access to the patient. The patient selection prompt displays again. If you enter an inactive account number, the system displays the following error message:

  Error: Inactive account number!

The system redisplays the patient selection prompt.

- Bed Code access - Inpatients or outpatients currently in a bed on the nursing station can be directly accessed by entering a hyphen (-) followed by the bed code for the patient's current bed as defined in the Location File. You can enter a station followed by a bed code if the patient has been on the current station but is now on another station, or if the current station has security access to view other stations on the system.

  If you enter an invalid bed code, the system displays the following error message before redisplaying the initial prompt.

  Error: Bed not found!

- Name access: - If you do not know the patient's account number or bed code, you can enter a portion of the patient's name and a hyphen (-) to perform a table lookup. The system displays a list of patients beginning with the characters entered, as shown following.

```
                    General Hospital Orders Processor
                                              Thu Feb 26, 2009 04:22 pm

No   Pat No       Stn  Rm-Bed   Patient Name            Srvc     PC  Cnd
 1 A 89275-00005  ICU  ICU-04   Dennard,Eve T.          Med           S
 2 A 89307-00002  1E   2111-1  !Jones,John James        Car      BRD  I
 3 A 89276-00008  ICU  ICU-01   Walton,Lamar            Lab           C
 4 A 89286-00003  IE   2110-2   Johnson,Molly           Med      VIP  OPS
 5 A 89286-00002  ICU  ICU-02  *Smith,Sydni             Car           C









Select #--
```

The listing includes all inpatients and outpatients in beds, but does not include regular outpatient types. For more information on fields contained in the Name Inquiry display, refer to the *General Information Volume* of the *STAR Patient Care Reference Guide*.

If you select a patient who is not currently on, or has never been on, your nursing station, the system displays the following error message before redisplaying the patient selection prompt.

Error: Never in Station!

If the system cannot locate any active patients with the characters entered, it displays the following error message before redisplaying the patient selection prompt.

Error: Name NOT Found!

- Station access - You can either display the census of the primary nursing station or a census of secondary nursing stations.

  - To select the default nursing station displayed in the prompt, you press ENTER. The census of the patients on the nursing station displays for your selection.

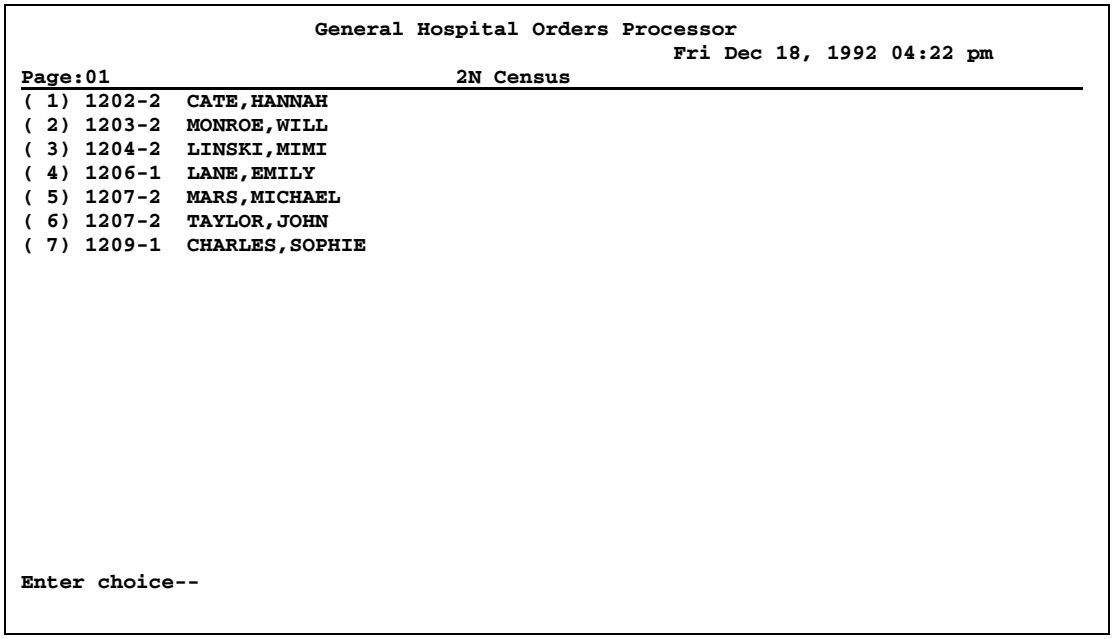
  - To display a list of secondary stations for the default nursing station, enter **C**. The following prompt displays when there are secondary stations:

    Enter station code [Primary Station Name]--

    The primary station is the default in the prompt. You can display a list of the secondary stations by entering hyphen (-) and ENTER. The census displays for the station you select from the list.

    Select the patient for whom you want to enter/display/print Critical Pathway information.

NOTE: If you press ENTER or enter C for census, a lowercase 'r' is displayed by the room and bed number when the census is displayed, indicating that the patient has PHI restrictions defined. PHI restrictions indicate with whom the patient's protected health information (PHI) should or should not be shared. The screen that is displayed includes the room-bed and the patient's last and first names, as shown in the following example:



NOTE: Information Windows displaying Patient Information, Physicians, and Pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in this function. During the download process, the system displays the following message:

Downloading Information Windows...Please Wait!

After the windows are downloaded, you can view them in any other nonpatient-specific function on STAR Patient Care. When you access a patient-specific function other than Order Management or Nursing functions, the downloaded information is cleared. The information is also cleared when you select a different patient in one of the functions where Information Windows are available.

For specific information regarding Patient, Physician, or Pharmacy Information Windows, refer to "Appendix B - INFORMATION WINDOWS".

Once you select the patient, the following screen displays with the options for implementing and tracking Critical Pathways:

```
                General Hospital Critical Pathways Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9708300003    ANDERSON,CLARE     F  01/01/55 2101-02 SILVA,JANET  MED 10 I/P 44
            Option No.  Option
            ----------------------------------------
                1       Assign/Status Critical Pathway
                2       Day of Stay Orders
                3       Variance Update

                4       Critical Pathway Report
                5       Multidisciplinary Plan
                6       Variance Report

                7       Department Orders
                8       Order Review
                9       Parent Order Review

               10       Custom Document Display/Print
               11       Radiology Results Inquiry
               12       Laboratory Results Inquiry
               13       Pharmacy Patient Profile Inquiry
Enter option number--
```

- The Assign/Status Critical Pathway function enables you to assign a pathway to a patient and then implement and track the elements planned for the patient. This selection enables you to inactivate or complete a Critical Pathway. A patient can have only one active Critical Pathway at a time. After you complete or inactivate the pathway, you can assign another Pathway or reassign the same Critical Pathway.

- The Day of Stay Orders function enables you to directly enter orders for a particular day of stay for a patient. After orders are selected from the Day of Stay, the details of the ordering process are the same as the ordering process documented in *Order Management/Charge Processing Volume I* of the *STAR Patient Care Reference Guide*. You can also enter a variance related to an order.

- The Variance Update function provides a direct means to enter and update variances for orders on the pathway. You enter a variance, including the cause, the actions taken, and any comments, whenever there is a deviation from the order set up for the pathway. For example, if you cancel the order or order the item for a different pathway day, you would enter a variance for the item to explain the action. The variance serves as documentation of the reason you deviated from the planned Critical Pathway.

- The Critical Pathway Report function enables you to display/print the pathway assigned to the patient. The report prints with the Patient Block information.

- The Multidisciplinary Plan (MDP) function enables you to display/print the individual pathway days for the patient. The MDP, which serves as a 24-hour chart document for the patient, displays/prints the items actually ordered for

each day of stay, grouped by categories of items. You can choose to print all orders, only orders with a specified status, or a combination of statuses. You can print orders with one or more of the following statuses: Active, Inactive, Complete, or Cancelled. You can print MDPs for active, inactive, and completed Critical Pathways.

The MDP includes the Patient Block information, in addition to the following:

- Medical Information Block with four lines of medical information that was entered using the Revise Patient function For more information on the Revise Patient function, refer to the *Order Management/Charge Processing Volume* of the *STAR Patient Care Reference Guide*.

- Patient History Block with up to six lines of miscellaneous information that was entered using the Patient History/Misc. function. The Patient History Block only prints when there is information entered for the patient, and only prints on page 1 of the MDP. The Patient History Block also prints on the Patient Care Profile (PCP).

  For information on using the Patient History/Misc. function, refer to "Chapter 3 - NURSING STATION FUNCTIONS". For information on how to set up standard text that prompts the caregiver to gather particular information for the Patient History, refer to "Chapter 7 - STANDARD FILE MAINTENANCE".

- The Variance Report function enables you to display/print a report of the variances that have been entered for this patient. The report includes the cause(s) of the variance from the pathway, the action(s) taken, and any comment text. You can enter variances using the following functions:

  - Variance Update

  - Day of Stay Orders

  - Order Review

  Variances can be entered on an order with any status (Active, Inactive, Complete, or Cancelled).

- You can update and inquire about orders entered for the Critical Pathway using the Order Review and Parent Order Review functions. Order Review enables you to enter variances for an active pathway and for orders that you cancel. Parent Order Review is an alternate way to access Order Review that initially displays only the parent orders for the selected patient. These functions are explained in *Order Management/ Charge Processing - Volume 1* of the *STAR Patient Care Reference Guide*.

- You can display and print the Custom Documents that are linked to the Critical Pathway or any other Custom Document. The Custom Document Display/Print function is explained in the *Order Management/Charge Processing Volume* of the *STAR Patient Care Reference Guide*.

- You can inquire about the results of STAR Laboratory and STAR Radiology tests and exams, as well as view the patient's STAR Pharmacy profile, when these products are part of the hospital system. The Results Inquiry functions are related to the ordering process and are documented fully in the *Order Management/Charge Processing Volume* of the *STAR Patient Care Reference Guide*. The Pharmacy Patient Profile Inquiry function is available only with Nursing. The Pharmacy Patient Profile Inquiry function is explained in the Critical Pathways chapter of this manual.

Building a Critical Pathway

You maintain standard files for the Critical Pathway. You can access file maintenance by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Critical Pathways from the Standard File Maintenance menu

The following menu is displayed:

```
               General Hospital Critical Pathways Processor
                                                  Mon Aug 31, 1992 04:18 pm
Critical Pathways Input Options

            Option No.  Option
            ---------------------------------------
                1       Build Critical Pathway Days
                2       Build Items per Critical Pathway Day
                3       Build Categories
                4       Resequence Critical Pathways
                5       Display/Print Critical Pathway









Enter option number--
```

- The Build Critical Pathway Days function enables you to build the days for a Critical Pathway.

- The Build Items per Critical Pathway Day function enables you to specify the items to be done for each day of stay.
- The Build Categories function enables you to build categories that are used to group the items for the pathway.
- The Resequence Critical Pathways function enables you to resequence the way the categories display/print after you make changes to the sequence in the Categories table.
- The Display/Print Critical Pathway function enables you to display or print any of the existing Critical Pathway files.

In addition to the above functions, you also need to maintain tables for the Critical Pathway. Refer to "MAINTAIN TABLES FOR CRITICAL PATHWAYS" on page 1-60 for more information on table maintenance functions.

NOTE: It is important to check the Live On Nursing field of the Station Parameters screen before using Critical Pathways. This parameter controls order statuses. When you enter an order, the status is Pending until the requested date/time is within the department time frame. The status changes depending on the setting in the Live on Nursing field:

- When the field is set to Yes, the system changes a Pending order to an Active status. The nurse changes the status to Complete when the order is considered to be completed.
- When the field is set to No, the system automatically changes a Pending order to a Complete status. The orders print on the Multidisciplinary Plan with the status of Complete. The Complete status prints even though the order may actually not be completed. The department time frame is set in the SIM Department table.

The following section, Terms & Concepts, explains the terms and concepts specific to Critical Pathways.

TERMS & CONCEPTS

This section defines terms and concepts specific to Critical Pathways. The terms and concepts are listed in alphabetical order.

ACTION TAKEN
When there is a variance from the way the Critical Pathway is built, such as not ordering an item planned for a Day of Stay, the user enters the action taken as a result of the variance. The user can select one or more entries from the Action Taken table or can enter freeform text.

CATEGORY
A category defines how items are grouped. For example, items from multiple departments may all be related to a general group such as Tests, Activities of Daily Living, or Treatments. The orders for a Critical Pathway display or print by category. You set up a category description for each type of order, and then designate the sequence in which you want the categories to display or print on the Pathway.

You can set up a default category for each SIM and non-SIM department in the SIM Department table. Since Interventions can be grouped in several different categories of orders, you can set up adefault at the department level for all interventions, and also set up a default for specific interventions at the item level, as necessary. The default category set for an intervention at the item level overrides the default set at the department level (Department I). The system uses the default category when you place additional orders using the Order Management Module, or when you order a Panel Master using the Critical Pathways function or the Order Management Module.

CRITICAL PATHWAY
Critical Pathways is a tool that supports the case management method of care. The Critical Pathway is a plan or protocol that provides a comprehensive, multidisciplinary method of planning care for a particular diagnosis, to achieve an expected outcome within an expected length of stay. The pathway provides the necessary items for each day of the stay, with the goal that upon completion of the Critical Pathway, the patient is ready for discharge.

DAY OF STAY
The Critical Pathway is composed of individual Days of Stay that make up the total expected length of stay for the Critical Pathway. You build the items to be ordered for each Day of Stay to achieve the expected outcome for the Critical Pathway. In addition, you link any Custom Documents to be ordered for that day of stay. When a patient has been assigned a Critical Pathway, the user can add additional orders to a day of stay, update orders for a day of stay, or record a variance from the pathway.

EXPECTED LENGTH OF STAY
Each Critical Pathway has an expected length of stay for that particular diagnosis or DRG. You define the Expected Length of Stay (ELOS) for each Critical Pathway in the build process.

MULTIDISCIPLINARY PLAN
The Multidisciplinary Plan (MDP) is the 24-hour chart document for the patient that displays/prints the items to be completed for the time period selected. The items include orders from all the disciplines that may be required for the care of a patient, such as physical therapy, radiology exams, and laboratory tests. Any combination of order statuses may be included on the report. You can print MDPs for active, inactive, and completed Critical Pathways.

ONGOING DAYS
You can designate an item to be done on more than one Day of Stay on a Critical Pathway. The system enables you to designate the days you want to repeat the item. You select two or more ongoing days for the item from a list of the days built for the Critical Pathway. The system automatically displays the item on each day you select. This streamlines the build procedure because you build the item only once.

VARIANCE
A variance occurs when a patient's care differs from the items built for the Critical Pathway. For example, you enter a variance when you do any of the following:

- Do not order or complete an item planned for a Day of Stay.
- Move an order to another Day of Stay.
- Add an order to a Day of Stay.
- Deviate from the Critical Pathway as defined by hospital procedures.

VARIANCE TYPE
A variance occurs when a patient's care differs from the items built for the Critical Pathway. The variance types are the general reasons for a variance occurring from the items built for a Critical Pathway.

The Variance Type Table is maintained by McKesson and contains the variance types used for the Critical Pathways function. There are four types of variances:

- Patient/Family - Variances related to the patient or the patient's family.
- Provider/Clinician - Variances related to any member of the healthcare team.
- External System - Variances related to the healthcare system that is external to the hospital.
- Internal System - Variances related to the healthcare system within the institution.

The user builds a table of variance causes for each type in the Variance Causes table. Refer to the "Variance Causes Table" on page 1-61 for specific reasons for the variance from the Critical Pathway.

VARIANCE CAUSE

The Variance Cause is the reason an item planned for a Day of Stay was not completed, or was completed at a time other than the time planned. You maintain specific causes for each of the four types of variances listed in the Variance Type table:

- Patient/Family Causes - Can include lack of family support, the patient's age, condition (such as pain or nausea), complications, or other comorbidities.
- Provider/Clinician Causes - Can include the caregiver's omission of an order planned for the Critical Pathway or a decision made by the healthcare team.
- External System Causes - Can include unavailable extended care facilities or home care, or the lack of third-party coverage.
- Internal System Causes - Can include an equipment malfunction, a closed department, lack of available appointments at the required time, or inadequate turnaround time for ancillary departments.

You maintain these causes in the Variance Causes table. Refer to the "Variance Causes Table" on page 1-61 for more information.

VERSION

When you make a change to a Critical Pathway, you are creating a variation or new version of the pathway. You can store the different versions you create of a Critical Pathway. By storing the versions, you can track and report how the changes affect patient outcomes and the pathway's usability.

The system assigns a Version Number of 1 (one) to each Critical Pathway you build. Whenever you edit the Critical Pathway, you have the option of storing the previous and current pathway as separate versions. The new version is assigned the next sequential number. All patient's assigned the Critical Pathway from this point forward are assigned the Critical Pathway with the highest version number. Patients retain the original Critical Pathway version they were assigned.

ASSIGN A CRITICAL PATHWAY TO A PATIENT

To plan, implement, and track a patient's care, you assign a Critical Pathway. The Critical Pathway is a plan or protocol that provides a comprehensive, multidisciplinary method of planning care among all the disciplines required for the care of a patient. The pathway is set up for a particular diagnosis, with an expected outcome, and an expected length of stay. The pathway provides the necessary items for each day of the stay with the goal that upon completion of the Critical Pathway, the patient is ready for discharge. The ability to inactivate or complete the Critical Pathway is available through this selection.

NOTES:

- A patient can have only one active Critical Pathway at a time, although a patient also can have inactive or completed pathways. After you complete or inactivate the Critical Pathway, you can assign another pathway or reassign the same Critical Pathway.

- If a patient who is on a Critical Pathway is discharged before the Critical Pathway is completed, the Critical Pathway is automatically completed as part of the discharge process.

You can access the Assign/Status Critical Pathway function by performing the following steps:

1. Select Critical Pathways from the Nursing main menu.

2. Select the patient.

3. Select Assign/Status Critical Pathway from the Critical Pathways menu.

The first time you assign a Critical Pathway to a patient, the following prompt displays:

Enter first letter(s)'-' or critical pathway code--

You can enter the code if you know it, or perform a table lookup to display a list of Critical Pathways for your selection. The following screen is displayed with the Critical Pathway you select:

```
          General Hospital Assign/Status Critical Pathway Processor
CABG                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92262-00001   WARD,MATTHEW       M  03/03/33 2102-1  ADAIR,FRANKLIMED 10 I/P 48
Day of Stay                                  Custom Document
Category        Dept Item                              Comment
1-PRE-OP                                    SURGICAL PROCEDURE PERMIT
TESTS           CAR  ELECTROCARDIOGRAM
                LAB  TYPE AND SCREEN                   6 UNITS
                LAB  CHEMISTRY PANEL
                LAB  PTT [PARTIAL THROMBOPLASTIN TIME
                LAB  CBC WITH AUTOMATED DIFF.          IF K<40 CALL STAT
                     Ongoing Days: 1,2,3
                LAB  BLOOD GASES                       ROOM AIR
                LAB  URINALYSIS WITH CULTURE
                RAD  CHEST AP & LAT
TX              A    VITAL.SIGN  BID
                T    TX-SHAVE PREP ----TO----          CHIN TO ANKLES
                T    TX-KAYEXALATE ENEMA
                T    TX-CONSENT, SIGN #2
                T    TX-PHISOHEX, SCRUB

Assign(A) or print(P) this critical pathway--
                                 next page(/)
```

The items display by Day of Stay. The system groups the items according to the categories and in the sequence defined in the Categories table. The Custom Documents linked to the Day of Stay are listed. The following information displays:

- Category
- Department
- Item description
- Comment entered when building the Critical Pathway

You can enter slash (/) and slash P (/P) to display the next or previous pages of the pathway.

The following prompt displays:

Assign(A) or print(P) this critical pathway--

You have the following choices:

- Enter **A** to assign the Critical Pathway to the patient.
- Enter **P** to print the Critical Pathway at the default printer for the CRT.

When you select the Print option, the Critical Pathway prints at the default printer for the CRT. For a patient example refer to *Figure 1.2* on page 1-49. When you select the Assign option, the following screen displays:

```
           General Hospital Assign/Status Critical Pathway Processor
 1000-MYOCARDIAL INFARCTION  Exp LOS:8            Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
9603900001    TAYLOR,TOM        F  05/12/85 2102-02 MILLER,JUSTINMED 10 IPR 42

 1 Status       2 Start Date     3 Start Time
   Active         02/20/09         07:00A
 4 Case Team                     5 Case Manager
   10 CPC CASE TEAM                 JOHNSON,JULIE
 6 Expected LOS                  7 Expected Outcome
    8
 8 Assigned By                   9 Assign Date/Time
   Cooper, Martha                   02/20/09 09:14A
10 Inactivated By               11 Inactive Date/Time

12 Completed By                 13 Complete Date/Time




Enter field number or '/' starting field number--
```

Field Explanations

1. STATUS (DISPLAY ONLY)
This field displays the current status of the Pathway. The first time you assign a Critical Pathway to a patient, the system automatically displays Active in the field. Types of statuses are Active, Inactive, and Complete. The following prompt displays when you access this field:

Enter status of active(A), inactive(I), or complete(C)--

Enter **I** to inactivate an Active pathway, or enter **C** to complete an Active pathway. When you enter **I** to inactivate the pathway, the following prompt displays:

Are you sure you want to inactivate this critical pathway? (Y/N)--

When you enter **C** to complete the pathway, the following prompt displays:

Are you sure you want to complete this critical pathway? (Y/N)--

Enter **Y** for Yes to confirm the change in status. Enter **N** for No to cancel the change in status.

You can change an entry of I (Inactive) or C (Complete) to A for Active before you accept the screen. Once you accept the screen, you cannot reactivate an Inactive or Complete pathway; however, you can reassign the pathway.

2. START DATE (DATE)
You enter the date on which you want to start the patient on the CriticalPathway. This is also the first Day of Stay. The following prompt displays:

Enter start date for first pathway day [T]--

The default for this field is **T** for Today. You cannot access this field if anyDay of Stay has a status of Active, that is, if any orders have been entered for the Day of Stay. Because the orders already have a date assigned, you cannot change the Start Date to a different date.

3. START TIME (TIME)
You enter the time when the Critical Pathway starts. This becomes the start time of the first and each subsequent Day of Stay. The system automatically enters the Start Time as the time that the first shift starts, according to the Hospital's Nursing Facility Parameters. You can edit the time; however once you accept the screen, you cannot edit this field.

4. CASE TEAM (25-A-O)
This field displays the name of the case team for this patient. When you select this field, the following prompt displays:

Enter case team or '-' to list--

Enter the name of the case team, if you know it, or perform a table lookup to display a list of case teams for your selection.

5. CASE MANAGER (25-A-O)
This field displays the name of the case manager for this patient. You have several options:

- Enter hyphen (-) and up to 25 alphabetical characters of the last name of the Case Manager.
- Perform a table lookup to display a list of employees for your selection.
- Enter the equal sign (=) to enter the signon name currently being used.

6. EXPECTED LOS (DISPLAY ONLY)
This field displays the expected length of stay for this Critical Pathway as built for the pathway in Standard File Maintenance.

7. EXPECTED OUTCOME (33-C-O)
This field enables you to enter up to 33 characters of text to state the expected outcome for this Critical Pathway. This is a freeform field.

8. ASSIGNED BY (DISPLAY ONLY)
This field displays the signon name of the caregiver whoassigned the Critical Pathway. You cannot edit this field.

9. ASSIGNED DATE/TIME (DISPLAY ONLY)
This field displays the system date and time that the Critical Pathway was assigned. You cannot edit this field.

10. INACTIVATED BY (DISPLAY/TABLE LOOKUP/25-A-R)
This field displays the signon name of the caregiver who changed the status of the Critical Pathway to Inactive in the Status field on this screen. You cannot edit this field after you accept the screen. When you access this field to change the name, the following prompt displays:

Enter last name'-' of Inactivated by, '-'free form, or '=' for self--

You have the following choices:

- Enter all or part of the last name and hyphen (-) to display a list of users for your selection. The list displays the names that start with the letters you entered.
- When the caregiver is not set up as a user on the system, you can enter hyphen (-) and enter the name of the caregiver.
- Enter equal sign (=) to enter the name with which you are signed on.

11. INACTIVE DATE/TIME (DISPLAY ONLY)
This field displays the system date/time the Critical Pathway was inactivated by changing the status to Inactive in the Status field on this screen. You cannot edit this field.

12. COMPLETED BY (DISPLAY/TABLE LOOKUP/25-A-R)
This field displays the signon name of the caregiver who changed the status of the Critical Pathway to Complete in the Status field on this screen. You cannot edit this field after you accept the screen. When you access this field to change the name, the following prompt displays:

Enter last name'-' of Completed by, '-'free form, or '=' for self--

You have the following choices:

- Enter all or part of the last name and hyphen (-) to display a list of users for your selection. The list displays the names that start with the letters you entered.
- When the caregiver is not set up as a user on the system, you can enter hyphen (-) and enter the name of the caregiver.
- Enter equal sign (=) to enter the name with which you are signed on.

13. COMPLETE DATE/TIME (DISPLAY ONLY)
This field displays the date/time the Critical Pathway was completed by changing the status to Complete in the Status field on this screen. You cannot edit this field.

Once you accept the screen, the message *Filed!* displays. When the status of the Critical Pathway is Active, the following screen displays with the items built for the current Day of Stay, as shown on the following screen:

```
          General Hospital Assign/Status Critical Pathway Processor
CABG                                          Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00007   WORTHINGTON,WILL  M  03/17/12 1208-2  ADAMS,HAROLD CCU 10 I/P 15
                        DAY 1 ICU   02/24 07:00am
Page:01                                                ##=Current Choices
     Category        Dept Item                                 Comment or Req Dt
( 1) TESTS           LAB  HEMOGLOBIN AND HEMATOCRIT            Q8H
( 2)                 LAB >BLOOD GASES                          PRN WEANING PROTOCOL
( 3) ACTIVITY        A    BED/MOBILE  DANGLE W/2 ASSIST
( 4)                 A    BATH/HYG  BEDBATH W/COMPLETE ASSIS
( 5)                 A    WEIGHT       QD BEDSCALE
( 6)                 A    RESP CARE  COUGH/DEEP BREATHE Q4/AT
( 7) DIET            DTY  CLEAR LIQUID                         WHEN ACTIVE
( 8) TEACHING        I    PAIN, MED FOR, AC
( 9)                 RT   IPPB TREATMENT (DAILY)




Enter choices to order, all(A), variance(V), next(N) day, prev(P) day--
                              end selection(NL)
```

The following prompt displays:

Enter choices to order, all(A), variance(V), next(N) day, prev(P) day--
end selection(NL)

You have the following options:

- You can order one or more of the listed items by entering the option numbers (up to 65 individual items), or A to order All items. You are now in the Order Management module of STAR Patient Care. The ordering screens display for each of the items. The ordering process is explained fully in the *Order Management/Charge Processing Volume* of the *STAR Patient Care Reference Guide*. When you finish with the ordering process, the following prompt displays:

  Order # 66 assigned. Enter additional orders? (Y/N) [N]--

  Enter **Y** to enter additional orders. Enter **N** when you are finished ordering. The Pathway Day of Stay list redisplays for you to select another day for which you want to enter orders. Once you activate orders from the selected day, the Day of Stay has a status of Active. You also can enter orders for a Day of Stay using the Day of Stay Orders option on the Critical Pathways menu. For more information refer to "DAY OF STAY ORDERS" on page 1-28.

- Press ENTER to redisplay the Critical Pathways Menu.

- Enter **N** for Next to display the items built for the next Day of Stay.
- Enter **P** for Previous to display the items built for the previous Day of Stay.
- Enter **V** to record a Variance for an item, as explained in the following information.

There may be symbols that display on the screen of Day of Stay orders. For an explanation of these symbols refer to "MAINTAIN TABLES FOR CRITICAL PATHWAYS" on page 1-60.

RECORD A VARIANCE

A variance is any deviation from the items planned for the Critical Pathway Day of Stay. You enter a variance when you do any of the following:

- Do not order or complete an item planned for a Day of Stay
- Move an order to another Day of Stay
- Add an order to a Day of Stay
- Deviate from the Critical Pathway as defined by hospital procedures

When you record a variance, the system enables you to enter the cause of the variance, any action taken as a result of the variance, and any comments.

Items with a variance display the letter *v* to the far right of the item on screens and reports.

You can record a variance using a variety of methods:

- The Variance Update function
- The Day of Stay Orders function
- The Order Review function or Parent Order Review function

The Day of Stay Orders function displays the orders planned for the Critical Pathway Day of Stay with the following prompt:

Enter choices to order, all(A), variance(V), next(N) day, prev(P) day--
end selection(NL)

Before starting the ordering process, the system displays the Order Review screen with active orders and the following prompt:

No more active orders!
Enter # to update, complete(C), variance(V), add(A) [A]--

The Order Review function displays the active orders with the following prompt:

No more active orders!
Enter # to update, complete(C), variance(V) [next page]--

NOTE: When you cancel an item in an ongoing order for any day of the patient's stay, the system cancels all subsequent items in the order. When you cancel an active or completed item of a recurring order, the system cancels only that item. When you cancel a pending item of a recurring order, the system cancels all subsequent items in the order.

For any of the above prompts, enter **V** for variance to record a variance. The following prompt displays:

Enter choices to record variance (e.g. 1,3,5-7)--
end selection(NL)

You can enter variances for items that have any of these statuses: Active, Inactive, Pending, Complete, or Cancelled.

During Order Review, when you cancel an order for a patient who has an active Critical Pathway, the following prompt displays:

Record a variance? (Y/N) [N]--

Enter **Y** for Yes to enable you to record a variance. The above prompt displays both for orders planned or added to the Critical Pathway. Enter **N** for No when you do not want to enter a variance for the order, and the information for the next order displays.

The screen that displays for entering a variance is the same as explained for the Variance Update Function following.

Variance Update Function

The Variance Update function provides quick, direct access for entering a variance. You can access this function by performing the following steps:

1. Select Critical Pathways from the Nursing main menu.
2. Select the patient.
3. Select Variance Update.

The screen of orders built for the current day displays, as shown on the following:

```
                General Hospital Variance Update Processor
CABG                                          Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00007   WORTHINGTON,WILL  M  03/17/12 1208-2  ADAMS,HAROLD CCU 10 I/P 15
                          DAY 1 ICU   02/24 07:00am
Page:01                                                ##=Current Choices
     Category        Dept Item                                Comment or Req Dt
( 1) TESTS           LAB  HEMOGLOBIN AND HEMATOCRIT           Q8H
( 2)                 LAB >BLOOD GASES                         PRN WEANING PROTOCOL
( 3) ACTIVITY        A    BED/MOBILE  DANGLE W/2 ASSIST
( 4)                 A    BATH/HYG  BEDBATH W/COMPLETE ASSIS
( 5)                 A    WEIGHT       QD BEDSCALE
( 6)                 A    RESP CARE  COUGH/DEEP BREATHE Q4/AT
( 7) DIET            DTY  CLEAR LIQUID                        WHEN ACTIVE
( 8) TEACHING        I    PAIN, MED FOR, AC
( 9)                 RT   IPPB TREATMENT (DAILY)




Enter choices to record variance, next day(N), or previous day(P)--
                               end selection(NL)
```

The following prompt displays:

Enter choices to record variance, next day(N), prev day(P)--
end selection(NL)

You have the following options:

- Enter the selection numbers for the order(s) for which you want to record a variance.
- Enter **N** for Next to display the items for the Next day.
- Enter **P** for Previous to display the items for the Previous day.
- Press ENTER to redisplay the Critical Pathways Menu.

The following screen is displayed:

```
          General Hospital Assign/Status Critical Pathway Processor
CABG                                              Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00007   WORTHINGTON,WILL  M  03/17/12 1208-2  ADAMS,HAROLD CCU 10 I/P 15
                        DAY 1 ICU   02/14 07:00am
      Dept  Description                          Comment
      A     BED/MOBILE  DANGLE W/2 ASSIST

 1 Variance Type         2 Recorded By                    3 Recorded Date/Time
->
 4 Variance Cause

 5 Action Taken                                           6 Comments



( 1) Patient/Family                    ( 3) Internal System
( 2) Provider/Clinician                ( 4) External System

Enter variance type--
```

The patient header information is at the top of the screen. The Day of Stay description and Start Day/Time are highlighted in the center of the screen. The item's department, description, and comment display for reference. The cursor is positioned in the Variance Type field and the Variance types display at the bottom of the screen.

Field Explanations

1. VARIANCE TYPE (1-N-R)
The Variance Type table displays with the current available variance types. The types include: Patient/Family, Provider/Clinician, Internal System, and External System. Refer to "TERMS & CONCEPTS" on page 1-11 for more information on each type. The following prompt displays:

Enter variance type--

Enter the option number of the variance type.

2. RECORDED BY (DISPLAY ONLY)
The signon name of the user recording the variance displays in this field.

3. RECORDED DATE/TIME (DISPLAY ONLY)
The Date and Time that the variance was recorded displays in this field.

4. VARIANCE CAUSE (2-N-R or TABLE LOOKUP)
This field enables you to enter the reasons for the variance. You can enter the Variance Cause code if you know it or perform a table lookup to display the list of available variance causes for the variance type entered in the Variance Type field.

Enter variance cause code or first letters'-' to list--

You can select one or more variance causes. The system displays as much of the causes as can display in the field, followed by et al., the Latin abbreviation for "and others", to indicate that there are other causes that have been selected but do not display.

NOTE: When you enter a Variance Cause code that is not valid for the Variance Type you selected in the Variance Type field, the following error message displays:

Error: Invalid code for this variance type!

If you want to enter this Variance Cause code, correct the entry in the Variance Type field first, and then reenter the Variance Cause.

Refer to "TERMS & CONCEPTS" on page 1-11 for more information on variance causes.

5. ACTION TAKEN (36-AN-0 or TABLE LOOKUP)
The information you enter in this field documents the action that was taken as a result of the variance. You have the following options:

- Enter the Action Taken code if you know it.
- Perform a table lookup to display a list of the available actions taken.
- Enter a hyphen (-) and up to 36 characters of text to enter an action taken that is not available in the Action Taken table.

You can select one or more Actions Taken. Refer to "TERMS & CONCEPTS" on page 1-11 on Actions Taken. This is an optional field.

6. COMMENT (FREEFORM)
You can enter up to three lines of text, with 75 characters of text on each line, if additional comments are necessary. This enables you to enter observations or evaluations of the variance for documentation purposes. The comments print on the Variance Report. This is an optional field.

Once you accept the screen, the message *Filed!* displays. The variances you enter print on the Variance Report. For more information refer to "Display/Print a Variance Report" on page 1-56.

CHANGE THE STATUS OF A CRITICAL PATHWAY

You can change the status of a patient's active Critical Pathway by selecting the Assign/Status Critical Pathway menu option. You can access the Assign/Status Critical Pathway function by performing the following steps:

1. Select Critical Pathways from the Nursing main menu.

2. Select the patient for whom you want to change the status.

3. Select Assign/Status Critical Pathway from the Critical Pathways menu.

When the Critical Pathway is active, the following screen is displayed:

```
          General Hospital Assign/Status Critical Pathway Processor
CABG                                          Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00007   WORTHINGTON,WILL  M  03/17/12 1208-2  ADAMS,HAROLD CCU 10 I/P 15

 1 Status       2 Start Date     3 Start Time    4 Case Manager
   Active         02/09/09         07:00am         M.DATRON
 5 Expected LOS                  6 Expected Outcome
   7
 7 Assigned By                   8 Assign Date/Time
   Harmon,William F              02/09/09 09:05a
 9 Inactivated By               10 Inactive Date/Time

11 Completed By                 12 Complete Date/Time









Enter field number or '/' starting field number--
```

For the field explanations for this function refer to the Field Explanations in this section. To change the status of the Critical Pathway, access the Status field. The following prompt displays:

Enter status of active(A), inactive(I), or complete(C)--

- Enter **I** to change the status to Inactive.

  After you enter **I** and press ENTER, the prompt displays to accept the screen. If you enter **Y** for Yes, the following prompt displays:

  Are you sure you want to inactivate this critical pathway (Y/N)--

  Enter **Y** for Yes to inactivate the Critical Pathway. Enter **N** for No when you do not want to inactivate the pathway. After inactivating a Critical Pathway, you

no longer can enter Day of Stay orders or record variances for the Critical Pathway.

- Enter **C** to change the status to Complete. You can no longer enter Day of Stay orders or record variances for this Critical Pathway.

  After you enter **C** and press ENTER, a prompt displays, enabling you to accept the screen. If you enter **Y**, the following prompt displays:

  Are you sure you want to complete this critical pathway (Y/N)--

  Enter **Y** for Yes to complete the Critical Pathway. Enter **N** for No when you do not want to complete the pathway. After completing a Critical Pathway, you no longer can enter Day of Stay orders or record variances for this Critical Pathway; however, you can still print the Multidisciplinary Plan and the Variance Report.

You can change an entry of I (Inactive) or C (Complete) to A for Active before you accept the screen. Once you accept the screen, you cannot reactivate an Inactive or Complete pathway, although you can reassign the pathway.

The status of the pathway does not affect the status of existing orders. If you try to enter Day of Stay orders or record variances for an inactive or complete pathway, the following error message displays:

No critical pathway exists for this patient!

You can use Order Review to update orders on inactive or complete pathways; however to print future active orders for inactive or complete pathways, you must print the Patient Care Profile or Active Order Worksheet.

NOTE: When you print the Patient Care Profile, the Plan of Care elements ordered for the Critical Pathway print as active orders. The elements do not print on the Plan of Care side of the Patient Care Profile.

Refer to Chapter 6: Reports for information on the Patient Care Profile. You can view or print the Multidisciplinary Plan and the Critical Pathway Report for a patient's current visit even after the pathway is inactive or complete.

DAY OF STAY ORDERS

You can directly display a Day of Stay for ordering using the Day of Stay Orders function, or if it is the first time the Critical Pathway is assigned, you can use the Assign/Status Critical Pathway functions to enter orders for each day of stay.

You can access this function by performing the following steps:

1. Select Critical Pathways from the Nursing main menu.
2. Select the patient for whom you want to enter orders.
3. Select Day of Stay Orders from the Critical Pathways menu.

The orders for the current day display. If you are viewing the Day of Stay Orders after the Expected Length of Stay has elapsed (there is no current day), the following screen displays for you to select the day:

```
              General Hospital Day of Stay Orders Processor
CABG                                              Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00007   WORTHINGTON,WILL  M  03/17/12 1208-2  ADAMS,HAROLD CCU 10 I/P 15

Page:01
     Pathway Day of Stay        Date/Time                 Status
( 1) PRE-OP                     02/02/09 0700am           Active
( 2) SURGERY                    02/10/09 0700am           Active
( 3) DAY 1 ICU                  02/11/09 0700am           Active
( 4) DAY 2 ICU                  02/12/09 0700am           Active
( 5) DAY 3 ICU                  02/13/09 0700am           Active
( 6) DAY 4 ICU                  02/14/09 0700am           Active
( 7) DAY 5 ICU                  02/15/09 0700am           Active
( 8) DAY 6 ICU                  02/17/09 0700am           Active




Enter choice--
```

The screen displays each Day of Stay for the Critical Pathway, along with the Start Date/Time and status of each day. The following prompt displays:

Enter choice--

Enter the option number of the Day of Stay for which you want to enter orders if different from the current Day of Stay. The following screen displays with the items built for the Day of Stay you selected or for the current day:

```
                General Hospital Day of Stay Orders Processor
MYOCARDIAL INFARCTION                              Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9308100003    HIGGINS,WILSON D  M  02/03/04 ICU-06  ADAIR,FRANK CMED 10 I/P 5
                          MI DAY 4   01/24 07:00am

    Category       Dept Item                              Comment or Req Dt
 1) TESTS          LAB ~17-HYDROXY CORTICOSTEROIDS        01/24 1211A    Act +
 2)                RAD ~XR CHEST PA & LAT  71020          01/24 1211A    Act +
 3) TREATMENTS     T   >IV ACCESS, MAINTAIN               01/24 0211P    Act
 4) THERAPIES      RT  >OXYGEN                            01/24 0800A    Act
 5) NUTRITION      DTY >LOW CHOLESTEROL - PD              NO ADDED SALT




Enter choices to order, all(A), variance(V), next(N) day, prev(P) day--
                                end selection(NL)
```

The following prompt displays:

Enter choices to order, all(A), variance(V), next(N) day, prev(P) day--
end selection(NL)

You have the following options:

- To order one or more of the items listed for the current day displayed, enter the option numbers (for example, 1,3,5-7), You can select up to 65 individual items on a Day of Stay order set.
- Enter **A** to order all items in the Day of Stay order set for the current day displayed.
- Enter **V** to record a variance.
- Enter **N** for Next to display the items for the Next day.
- Enter **P** for Previous to display the items for the Previous day.
- Press ENTER to redisplay the Critical Pathway Menu.

You can order panel masters, or any other ordering option available through Order Management). The ordering screens display for each of the items you select.

The ordering process is explained fully in the *Order Management/Charge Processing Volume* of the *STAR Patient Care Reference Guide*.

NOTE: When you place an order with a start date and start time that is greater than the Length of Stay built for the Critical Pathway, the system creates an additional Day of Stay for the pathway. The system indicates the additional Day of Stay with a plus sign (+).

When you change the start date and start time of an order built for a Day of Stay, the system indicates that the item was moved by printing/displaying an **m** next to the order on its current Day of Stay.

When you finish with the ordering process, the following prompt displays:

Order # 66 assigned. Enter additional orders? (Y/N) [N]--

- Enter **Y** to enter additional orders. The table of departments available for ordering redisplays. When you enter additional orders, the system indicates these orders with a plus sign (+) on the Multidisciplinary Plan.

  NOTES:

  - If the Carry Frequency Forward field in the Order Management Facility Options Processor is set to Yes, when placing multiple Day of Stay Orders for a Critical Pathway, the frequency selected on the first order carries forward on the next sequence of orders, if you are ordering from a single department.

  - You cannot order physician consults through the Day of Stay Orders function. When you select Department **C** for Consult Orders during the build process, you receive an error message:

    Error: Department 'C' not allowed!

    You can add Consult Orders as additional orders, using the Orders function on the Nursing main menu.

- Enter **N** if there are no additional orders. The Day of Stay list redisplays for you to select another day for which you want to enter orders.

Once you activate an order from the selected day, the Day of Stay has a status of Active, and prints on the Multidisciplinary Plan (MDP). You can also enter orders for a Day of Stay using the Assign/Status Critical Pathway function on the Critical Pathways menu.

The following table shows the symbols that may display on Critical Pathway screens and reports.

Critical Pathway Symbols Used on Screens and Reports

SYMBOL	DESCRIPTION	POSITION	ITEM STATUS
>	The item has been built on the Critical Pathway with Ongoing Days; therefore, the system treats the item as Recurring/ Ongoing.	Precedes the SIM item description.	Ongoing: All statuses Recurring: Inactive status
v	This item has a variance.	Far right of the Comment field.	All statuses.
m	This item has been moved from one Critical Pathway day to another day.The Requested Date/Time is different from the date built for the item on the Critical Pathway.	Far right of the Comment field.	All statuses.
+	This item is an additional order that was not planned for the Critical Pathway Day. This day is an additional Critical Pathway Day that was not planned for the Critical Pathway.	Far right of the Comment field. Far right of the Day of Stay Description	All statuses. Not applicable.

BUILD A CRITICAL PATHWAY

You build the Critical Pathways you want to have available for the caregiver to assign to a patient. Using Standard File Maintenance, there are several tasks required to build a Critical Pathway:

- Use the Build Critical Pathway Days function to build the days of stay for the Critical Pathway. You can link Custom Documents to the Critical Pathway using this function. This function is documented in this section.
- Use the Build Items per Critical Pathway Day function to specify the items to be completed for each day of stay on the Critical Pathway. This function is documented in this section.
- Use the Build Categories function to build categories that are used to group the items built for the pathway. You designate a sequence in which the categories print and display on all pathways. For more information on this function refer to the "Critical Pathway Categories Table" on page 1-65.
- Use the Resequence Critical Pathways function to resequence the way the categories display/print after you make changes to the sequence in the Categories table. For more information on this function refer to "Resequence Critical Pathways" on page 1-70.
- Use the Display/Print Critical Pathway function to display or print any of the existing Critical Pathways. For more information on this function refer to "Display/Print a Critical Pathway File" on page 1-44.

You maintain information in the following tables for Critical Pathways:

- Critical Pathways Categories table
- Variance Causes table
- Action Taken table
- Priorities table
- SIM Departments table
- Facility Parameters

The table entries you need to make are explained under the heading "MAINTAIN TABLES FOR CRITICAL PATHWAYS" on page 1-60.

Build Critical Pathway Days

When you use the Build Critical Pathway Days function, you make the following selections:

- Description of the Critical Pathway
- The expected length of stay
- The number, names, and sequence of the days of stay
- The Custom Documents you want to link to the Critical Pathway

The latest version of the Critical Pathways you build are available for table lookup when the user selects the Assign/Status Critical Pathway function.

You can access the Build Critical Pathway Days function by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Critical Pathways

The following menu is displayed:

```
                      Critical Pathways Processor
                                              Fri Dec 18, 1992 03:21 pm
Critical Pathways Input Options

                Option No.  Option
                ------------------------------------------

                  1       Build Critical Pathway Days
                  2       Build Items per Critical Pathway Day
                  3       Build Categories
                  4       Resequence Critical Pathways
                  5       Display/Print Critical Pathway









Enter option number--
```

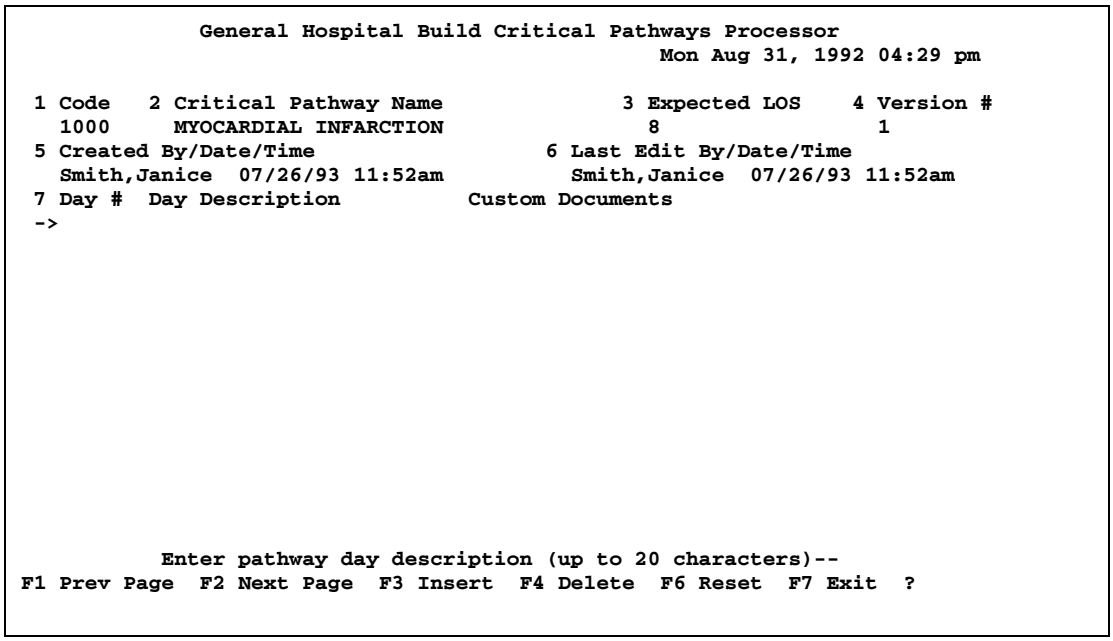
Select Build Critical Pathway Days from the Critical Pathways menu. Select the facility, when the hospital has multifacilities. The following prompt displays:

Enter first letter(s)'-' or critical pathway code--

You have the following options:

- Enter a unique numeric code of up to five digits when you want to add a new Critical Pathway.
- Enter the Critical Pathway code when you want to edit an existing Critical Pathway.
- Perform a table lookup to display a list of the existing Critical Pathways for your selection.

After you add or select a Critical Pathway, a screen similar to the following is displayed:



Field Explanations

1. CODE (DISPLAY ONLY)
The code of the Critical Pathway displays in this field.

2. CRITICAL PATHWAY NAME (33-AN-R)
You enter the name of the Critical Pathway in this field. This name displays in the list of Critical Pathways available for assignment to a patient during the Assign/Status Critical Pathway function. In addition, the name displays/prints on the Critical Pathway Report and the Multidisciplinary Plan. You can enter up to 33 alphanumeric characters in this field.

3. EXPECTED LOS (3-N-O)
Enter a number from 0 to 999 for the number of days you expect the patient to be on this Critical Pathway. This field defines the Expected Length Of Stay of the patient on this pathway.

4. VERSION # (DISPLAY ONLY)
The system assigns Version number 1 when you create the Critical Pathway. This field is Display Only. Thesystem assigns a new number when you edit the Critical Pathway and choose to create a new version number for the changed Critical Pathway. The system displays the prompt to create a new version number after you accept the screen. For a full explanation refer to the information about editing Critical Pathway versions later in this section.

Version numbers display in parentheses next to the Critical Pathway description only in standard file maintenance functions, such as Build Items per Critical Pathway Day. For example, TOTAL HIP REPLACEMENT (#2) displays to indicate this is the second version of this pathway. The version number does not display for user functions, such as Assign/Status a Critical Pathway.

5. CREATED BY/DATE/TIME (DISPLAY ONLY)
The system displays the name of the user who created the Critical Pathway, along with the date and time the pathway was created.

6. LAST EDIT BY/DATE/TIME (DISPLAY ONLY)
The system displays the name of the user who last edited the Critical Pathway, along with the date and time the pathway was edited.

The following fields are on a scrolling screen. You can use the arrow keys to move from item to item, and the TAB, ENTER, or arrow keys to move from field to field on the item. The function keys that display at the bottom of the scrolling screen give you additional options. A helping prompt displays for each field. For information on using the scrolling screen, refer to the *General Information Volume* of the *STAR Patient Care Reference Guide*.

4. DAY # (DISPLAY ONLY)
The entry in this field determines the sequence of the Day of Stay in the Critical Pathway. The system automatically displays the number of the day you are building. For example, the first day you build displays as 1; the next day you build displays as 2.

5. DAY DESCRIPTION (20-AN-R)
You can enter a description of the Day of Stay you are building. The description can be up to 20 alphanumeric characters. This description displays for the Day of Stay when you assign the Critical Pathway or build the orders for the Day of Stay.

WARNING: The system uses this field to link orders to the Day of Stay. When you delete a Day of Stay using the F4 function key (Delete), the system deletes all it.

6. CUSTOM DOCUMENT (35-AN-O)
You can link custom documents to a particular Day of Stay. You can enter the custom document code or perform a table lookup to select one or more documents from the list that displays.

After you complete the information for one day, the system displays the next consecutive number in the Day # field. When you finish adding the days of stay, press F7 to Exit the scrolling screen.

The prompt displays for you to accept the screen:

Accept this screen? (Y/N/D) [Y]--

You have the following options:

- Enter **N** for No to edit the fields. You cannot edit the Code field and Day # field which are Display Only.
- Enter **D** for Delete to delete the Critical Pathway. When you enter **D**, the following prompt displays:

  Are you sure you want to delete TOTAL HIP REPLACEMENT?--

  Enter **N** for No when you do not want to delete the Critical Pathway. Enter **Y** for Yes when you want to delete the Critical Pathway.

WARNING: The system deletes the Critical Pathway *and* all items linked to that Critical Pathway's Days of Stay.

- Enter **Y** for Yes or press ENTER to accept the screen. The following message displays when you added a new Critical Pathway:

  Filed!

When you display a Critical Pathway and make no edits, the following prompt displays:

Delete? [N]--

Enter **N** for No, or press ENTER, to exit without deleting the Critical Pathway. Enter **Y** for Yes when you want to delete the Critical Pathway and all items linked to the Critical Pathway's Day of Stay.

When you display an existing Critical Pathway and edit one of the fields, the following prompt displays after you accept the screen:

Create new version number? (Y/N) [N]--

- Enter **Y** for Yes when you want to retain the previous and current versions of the Critical Pathway. The system stores the Critical Pathway with your changes and assigns the next sequential version number. All patient's assigned the Critical Pathway from this point forward are assigned the Critical Pathway with this version number. Patients retain the original Critical Pathway version they were assigned. You cannot update a patient to a new version of a Critical

Pathway unless you deactivate the current pathway and reassign the new version.

You cannot edit a previous version of a Critical Pathway. You can, however, print the pathway using the Display/Print Critical Pathway function in Standard File Maintenance. For more information refer to "Display/Print a Critical Pathway File" on page 1-44.

Version numbers enable you to track and report how changes in the Critical Pathway affect patient outcomes and the pathway's usability. If your hospital has STAR KB_SQL, there is a report available that can track the variances for each version of a Critical Pathway.

The system displays the screen for building items, so you can make any necessary changes.

- Enter **N** for No if you want to apply your change(s) to the current version of the Critical Pathway.

  The system stores the Critical Pathway with your changes and retains the same version number.

NOTE: When you are building and changing Critical Pathways before they are assigned to patients, it is not necessary to create a new version number. Once you assign a Critical Pathway to a patient, you may want to create a new version number in order to track changes that are made and how they affect patient outcomes and the usability of the Critical Pathway.

For example, you would want to create a new version when you add a Day of Stay or increase/decrease the Length of Stay. You would not need to create a new version when you change the description of a Day of Stay or correct a typographical error, since these changes would not affect outcomes or usability.

Build Items per Critical Pathway Day

When you use the Build Items per Critical Pathway Day function, you link items to each Critical Pathway Day of Stay. You make the following selections for each item:

- Category
- SIM or non-SIM Department
- SIM Item Code and Description
- Comment
- Ongoing Days for which you want to order the item

NOTE: You need to build the Days of Stay before building the Items per Critical Pathway Day. This is because the system displays the list of Critical Pathway Days of Stay during entry in the Ongoing Days field when you build each item.

The Critical Pathway items you build are available for ordering when the user selects the Critical Pathway for a patient.

You can access the Build Items per Critical Pathway Day function by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Critical Pathways

The following menu is displayed:

```
                      Critical Pathways Processor
                                              Fri Dec 18, 1992 03:21 pm
Critical Pathways Input Options

                Option No.  Option
                -------------------------------------------

                  1       Build Critical Pathway Days
                  2       Build Items per Critical Pathway per Day
                  3       Build Categories
                  4       Resequence Critical Pathways
                  5       Display/Print Critical Pathway









Enter option number--
```

Select Build Items per Critical Pathway Day from the Critical Pathways menu. Select the facility, when the hospital has multiple facilities. The following prompt displays:

Enter first letter(s)'-' or critical pathway code--

You have the following options:

- Enter the numeric code of the Critical Pathway, if you know it.
- Perform a table lookup to display a list of the existing Critical Pathways for your selection.

After you select the Critical Pathway, the following screen displays with a list of the existing Days of Stay:

```
        General Hospital Build Critical Pathway Items per Day Processor
1889-TOTAL HIP REPLACEMENT (#1)                  Fri Sep 11, 1992 08:32 am


Page:01                  Pathway Days of Stay
( 1) 1-PRE-OP
( 2) 2-SURGERY
( 3) 3-POST-OP









Enter choice--
```

Enter the selection number of the day for which you want to build items. The following screen displays for you to link items to the Day of Stay:

```
              General Hospital Build Critical Pathways Processor
1889-TOTAL HIP REPLACEMENT (#1)                  Fri Sep 11, 1992 08:32 am
2-Day 2

Category   Dept SIM Code/Desc         Comment                  Ongoing Days
```

```
                  Enter first letter(s)'-' or category code--
     F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

The code, description, and version number of the Critical Pathway are highlighted in the upper left-hand corner of the screen. On the next line, the code and description of the Day of Stay display. The fields on this screen enable you to link items to this Day of Stay.

This is a scrolling screen. You can use the arrow keys to move from item to item, and the TAB, ENTER, or arrow keys to move from field to field on the item. The function

keys that display at the bottom of the scrolling screen give you additional options. A helping prompt displays for each field. For information on using the scrolling screen, refer to the *General Information Volume* of the *STAR Patient Care Reference Guide*.

Field Explanations

CATEGORY (2-N-R)
You can enter the Category code for the item you want to link to this Day of Stay, or you can perform a table lookup to display the list of categories available for your selection. This is the Category under which the item displays/prints on screens and reports. After you make your selection, the system displays the Category code and as much of the Category Description as can fit in the field.

DEPARTMENT (3-AN-R)
You can enter the Department Code of the ordering department, or you can perform a table lookup to display the list of ordering departments available for your selection.

SIM CODE/DESC (6-N-R)
You can enter the SIM code of the item or perform a table lookup to display the list of items available for your selection. The system displays the SIM code and as much of the item description as can fit in the field.

COMMENT (22-C-O)
This field enables you to enter up to 22 characters for a comment concerning the item. For example, you can enter *ORDER QSHIFT* as a message to the user placing the order. The comment displays and prints with the item until the item is ordered.

ONGOING DAYS (1-A-R)
You can enter additional days on which you want the order to be done. The following prompt displays:

Is this item ongoing or recurring? (Y/N) [N]--

Enter **N** for No when you do not want the system to repeat the order on another day on the Critical Pathway. Enter **Y** for Yes when you want the order do be ongoing that is, you want the system to repeat the order on additional days. The list of the Days of Stay built for the Critical Pathway display at the bottom of the screen. The following prompt displays:

Select the days that this order is to be done (e.g. 1,3,5-7)--
end selection (NL)

You must select the current day (the day on which you are entering the ongoing order) and one or more other days from the list.

You can enter the range of days using the hyphen (-) or comma (,), as in the example 1-3,5. This example highlights Day 1 through Day 3, and then repeats the order on Day 5. You can remove a day from selection by preceding the number with a hyphen

(-), as in the example, -3. This example removes highlighting from Day 3. Press ENTER when you finish selecting days.

After you accept the screen, the system automatically inserts the ongoing items in the days you select. The item displays in the category and department set up for the item. If you delete an item, the system deletes the item from the ongoing days you selected.

When you build an item with Ongoing Days, the system displays/prints the text on the Critical Pathway Report with *Ongoing Days: 1,2,3* underneath the item to indicate the days for which the item has been built. The item displays/prints on the MDP preceded by a greater-than sign (>).

- For Recurring items, the system displays/prints the greater-than sign (>) while the item is Inactive. Once the user orders the item, the initial order of the item is preceded by a caret (^) and the following orders are preceded by a tilde (~).

- For Ongoing items, the system displays/prints the greater-than sign (>) regardless of the status of the item (Inactive, Active, or Pending).

The Ongoing Days indicator prints in front of the item description, as in the example: >CBC WITH AUTOMATED DIFF. The frequency displays on the same line as the Comment. For an example refer to *Figure 1.1* on page 1-46.

When you finish linking items to the Day of Stay, press the F7 function key to exit the screen. The following prompt displays:

Accept screen? (Y/N)--

Enter **N** for No when you do not want to accept the screen. The system positions the cursor in the first item in the scrolling screen for you to make any edits.

Enter **Y** for Yes to accept the screen. The message *Filed!* displays and the list of Pathway Days of Stay redisplays for you to select another day. Press ENTER when you finish entering items for this Critical Pathway. The following prompt displays for you to select a different Critical Pathway for which you want to build items:

Enter first letter(s)'-' or critical pathway code--

When you finish building items for Critical Pathway, press F7 to exit the scrolling screen. The prompt displays for you to accept the screen.

When you display an existing Critical Pathway and edit one of the fields, the following prompt displays after you accept the screen:

Create new version number? (Y/N) [N]--

- Enter **Y** for Yes when you want to retain the previous and current versions of the Critical Pathway.

The system stores the Critical Pathway with your changes and assigns the next sequential version number. All patient's assigned the Critical Pathway from this point forward are assigned the Critical Pathway with this version number. Patients retain the original Critical Pathway version they were assigned. You cannot update a patient to a new version of a Critical Pathway unless you deactivate the current pathway and reassign the new version.

You cannot edit a previous version of a Critical Pathway. You can, however, print the pathway using the Display/Print Critical Pathway function in the standard file maintenance. Refer to "Display/Print a Critical Pathway File" on page 1-44.

Version numbers enable you to track and report how changes in the Critical Pathway affect patient outcomes and the pathway's usability. If your hospital has STAR KB_SQL, there is a report available that can track the variances for each version of a Critical Pathway.

The system files the new version and redisplays the screen with the Days of Stay for building items for additional days.

- Enter **N** for No if you want to apply your change(s) to the current version of the Critical Pathway.

  The system stores the Critical Pathway with your changes and retains the same version number.

NOTE: When you change a Critical Pathway before it is assigned to patients, it is not necessary to create a new version number. Once you assign a Critical Pathway to a patient, you may want to create a new version number in order to track changes that are made and how they affect patient outcomes and the usability of the Critical Pathway.

For example, you would want to create a new version when you add or delete items on a Day of Stay. You would not need to create a new version when you correct a typographical error, since these changes would not affect outcomes or usability.

After you make your selection, the screen with the available Days of Stay redisplays with the following prompt:

Enter choice--

You can select another Day when you want to make additional changes.

NOTE: When you make changes to items on more than one Day of Stay, and you want all the changes to be in the same Critical Pathway version, only create a new version for the firstday that you change. By selecting the No option for

the remaining edits, you do not create a new version and all subsequent changes are in the same Critical Pathway version.

After you finish building or changing items for the Days of Stay, press ENTER and the following prompt displays for you to select another Critical Pathway:

Enter first letter(s)'-' or critical pathway code--

After you finish making changes to Critical Pathways, press ENTER at the prompt and the Standard Files Critical Pathways Menu redisplays.

REPORTS FOR CRITICAL PATHWAYS

Display/Print a Critical Pathway File

You can display or print any of the Critical Pathway files. You can access the Display/ Print Critical Pathway function by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Critical Pathways
4. Display/Print Critical Pathway

Select the facility, if necessary. The following prompt displays:

Enter first letter(s)'-' or critical pathway code--

You have the following options:

- Enter the Critical Pathway code.
- Perform a table lookup to display a list of the existing Critical Pathways.

When you select multiple Critical Pathways from the table or a pathway that has only one version, the following prompt displays:

Display(D) or print(P) critical pathway [D]--

When you select a single Critical Pathway that has more than one version, the following prompt displays:

Enter version # or '-' to list [3]--

The default choice is the latest version of the Critical Pathway. Perform a table lookup or enter the number of the version you want to print. Once you select the version number, the display/print prompt displays:

Display(D) or print(P) critical pathway [D]--

You can display or print the Critical Pathway(s) you selected.

- Enter **D** to Display the Critical Pathway(s)
- Enter **P** to Print the Critical Pathway(s)

Display is the default.

The items display or print by Day of Stay. The items are grouped in the categories and according to the sequence set up in the Categories table. Within the categories, the items are grouped by department.

The Custom Documents linked to each day of stay are listed. The following information prints/displays for each item:

- Department
- Item description
- Comment entered for the item during the build

When you select the Display option, a screen like the following displays:

```
            General Hospital Display/Print Critical Pathway Processor
1234-CABG (#2)  Exp LOS:7                          Fri Dec 18, 1992 09:19 am
Day of Stay                                  Custom Document
Category        Dept Item                              Comment
1-PRE-OP                                     SURGICAL PROCEDURE PERMIT
TESTS           CAR  ELECTROCARDIOGRAM
                LAB  TYPE AND SCREEN                   6 UNITS
                LAB  CHEMISTRY PANEL
                LAB  PTT [PARTIAL THROMBOPLASTIN TIME
                LAB  CBC WITH AUTOMATED DIFF.          IF K<40 CALL STAT
                     Ongoing Days: 1,2,3
                LAB  BLOOD GASES                       ROOM AIR
                LAB  URINALYSIS WITH CULTURE
                RAD  CHEST AP & LAT
TX              A    VITAL.SIGN  BID
                T    TX-SHAVE PREP ----TO----          CHIN TO ANKLES
                T    TX-KAYEXALATE ENEMA
                T    TX-CONSENT, SIGN #2
                T    TX-PHISOHEX, SCRUB
ACTIVITY        A    AMBULATION  *AMBULATE, INDEPENDENT
CONSULTS        CNS  CONSULT ITEM WITH CHARGE          SOCIAL SERVICES

Press NL to continue viewing or print(P)--
                                  next page(/)
```

When you build an item with Ongoing Days, the system displays/prints the text *Ongoing Days: 1,2,3* underneath the item to indicate the days for which the item has been built.

You can press ENTER to continue viewing the Critical Pathway, or you can enter **P** to print the Critical Pathway. You can use slash (/) and slash P (/P) to display the next or previous pages of the display.

When you select the Print option, the Critical Pathway prints at the default printer for the PC. Refer below for an example of a printed report for a standard Critical Pathway file built in Standard File Maintenance.

Figure 1.1 Standard Critical Pathway Report

```
Fri Mar 26, 1993 03:19 pm                          STANDARD CRITICAL PATHWAY
                              GENERAL HOSPITAL                          Page 1
-------------------------------------------------------------------------------
Day of Stay                                    Custom Document
  Category         Dept Item                          Comment
-------------------------------------------------------------------------------

1000-MYOCARDIAL INFARCTION (#2)                Exp LOS: 7

1-MI DAY 1                                     CORONARY ARTERY DISEASE PG 1
                                               CORONARY ARTERY DISEASE PG 2
                                               CORONARY ARTERY DISEASE PG 3

  TESTS            CAR  ECG 12 LEAD X 3 DAYS
                        Ongoing Days: 1,2,3
                   LAB  CARDIAC PROFILE
                   LAB  PARTIAL THROMBOPLASTIN TIME
                   LAB  17-HYDROXY CORTICOSTEROIDS
                   RAD  XR CHEST PA & LAT  71020
  TREATMENTS       A    I & O  Q SHIFT
                        Ongoing Days: 1,2,3
                   T    PCA CONSENT
                        Ongoing Days: 1,2,3
                   T    IV ACCESS, MAINTAIN
                        Ongoing Days: 1,2,3,4,5
  ACTIVITY         A    BATH   Q 15 MIN                 UNTIL STABLE
                   A    NEUROLOGIC  Q 2H                Q 2H
  THERAPIES        RT   OXYGEN                          NASAL CANNULA
                        Ongoing Days: 1,2,3,4,5
  CONSULTS         CNS  DTY - CONSULTATION              CARDIAC DIET
  NUTRITION        DTY  LOW CHOLESTEROL - PD            NO ADDED SALT
                        Ongoing Days: 1,2,3,4,5,6
  IV'S/MEDS        T    IV SOLUTION/RATE
  NSG PROBLEM-O/C  O    CHEST PAIN, TRANSFER            TRANSFER E/O
                   P    PAIN, R/T MYOCARDIAL INFARCTION NCP
                   P    CARDIAC OUTPUT DECREASED R/T MI NCP
  NSG INTERVENTIO  I    CHEST PAIN STANDARD OF CARE     IMPL/INCLUDE ON CHART
                   I    CHEST PAIN, ASSESS
                   I    OPTIMIZE REST
                   I    ASSESS HEART RATE/RHYTHM

2-MI DAY 2
  TESTS            CAR  ECG 12 LEAD X 3 DAYS
                        Ongoing Days: 1,2,3
  TREATMENTS       A    I & O  Q SHIFT
                        Ongoing Days: 1,2,3
                   T    PCA CONSENT
                        Ongoing Days: 1,2,3
                   T    IV ACCESS, MAINTAIN
                        Ongoing Days: 1,2,3,4,5
```

Display/Print a Critical Pathway Report for a Patient

You can display or print the standard Critical Pathway after it has been assigned to a patient. The report is the same as the standard Critical Pathway Report except that a Patient Block prints at the bottom.

You can access the Critical Pathway Report function by performing the following steps:

1. Select Critical Pathways from the Nursing main menu.
2. Select the patient for whom you want to display/print the report.
3. Select Critical Pathway Report from the Critical Pathways menu.

The following prompt displays:

Display(D) or print(P) critical pathway [D]--

You can display or print the patient's Critical Pathway.

- Enter **D** to Display the Critical Pathway
- Enter **P** to Print the Critical Pathway

Display is the default.

The items display/print by Day of Stay. The items are grouped according to the categories set up for the Critical Pathway, in the sequence defined in the Categories table. Within the categories, the items are grouped by department. The following information displays:

- Category
- Department
- Item description
- Comment entered when building the Critical Pathway

When you select the Display option, the following screen displays:

```
              General Hospital Critical Pathway Report Processor
1234-CABG     Exp LOS:7                          Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92259-00005   CATE,SARA          F  02/14/21 1202-2  ALDEN,JOHN F ICU 10 I/P 51
Day of Stay                                  Custom Document
Category        Dept Item                          Comment
1-PRE-OP                                     SURGICAL PROCEDURE PERMIT
TESTS           CAR  ELECTROCARDIOGRAM
                LAB  TYPE AND SCREEN               6 UNITS
                LAB  CHEMISTRY PANEL
                LAB  PTT [PARTIAL THROMBOPLASTIN TIME
                LAB  CBC WITH AUTOMATED DIFF.      IF K<40 CALL STAT
                     Ongoing Days: 1,2,3
                LAB  BLOOD GASES                   ROOM AIR
                LAB  URINALYSIS WITH CULTURE
                RAD  CHEST AP & LAT
TX              A    VITAL.SIGN  BID
                T    TX-SHAVE PREP ----TO----      CHIN TO ANKLES
                T    TX-KAYEXALATE ENEMA
                T    TX-CONSENT, SIGN #2
                T    TX-PHISOHEX, SCRUB

Press NL to continue viewing or print(P)--
                                 next page(/)
```

When you build an item with Ongoing Days, the system displays/prints the text *Ongoing Days: 1,2,3* underneath the item to indicate the days for which the item has been built.

You can press ENTER to continue viewing the Critical Pathway, or you can enter **P** to print the Critical Pathway. You can use slash (/) and slash P (/P) to display the next or previous pages of the display.

When you select the Print option, the Critical Pathway prints at the default printer for the PC. Refer below for an example of the Critical Pathway Report for a patient.

Figure 1.2 Critical Pathway Report for a Patient

```
Wed Aug 26, 1992  10:02 am                          STANDARD CRITICAL PATHWAY
                              GENERAL HOSPITAL A                        Page 1
-------------------------------------------------------------------------------
Day of Stay                                      Custom Document
  Category          Dept Item                                Comment
-------------------------------------------------------------------------------

1234-CABG                                Exp LOS: 7
  1-PRE-OP                                    SURGICAL PROCEDURE PERMIT

  TESTS             CAR  ELECTROCARDIOGRAM
                    LAB  TYPE AND SCREEN                     6 UNITS
                    LAB  CHEMISTRY PANEL
                    LAB  PTT (PARTIAL THROMOBPLASTIN TIME
                    LAB  CBC WITH AUTOMATED DIFF.            IF K<40 CALL STAT
                         Ongoing Days: 1,2,3
                    LAB  BLOOD GASES      ROOM AIR
                    LAB  URINALYSIS WITH CULTURE
                    RAD  CHEST AP & LAT

  TX                A    VITAL.SIGN BID
                    T    TX-SHAVE PREP----TO----             CHIN TO ANKLES
                    T    TX-KAYEXALATE ENEMA
                    T    TX-CONSENT, SIGN #2
                    T    X-PHISOHEX, SCRUB

  ACTIVITY          A    AMBULATION  *AMBULATE, INDEPENDENT

  CONSULTS          CNS  CONSULT ITEM WITH CHARGE            SOCIAL SERVICES

  MEDS              I    MEDICATE FOR                        PRE-OP MEDS

  DIET              DTY  CARBOHYDRATE,LOCONC,HIPRO,6

  TEACHING          I    TEACHING, PT/FAMILY 16

  PROBLEM/NSG DX    P    125 ASSESS PT/FAM KNOW/UNDERSTAND

  DISCHARGE PLAN    D    1 IDENT PLAN/COMMUNITY RESOURCE
                    D    29 PT/FAM PARTI IN TX PLAN

  2-SURGERY

  TESTS             LAB  HEMOGLOBIN AND HEMATOCRIT        Q4H
                    LAB  BLOOD GASES

  TX                T    TX-CHEST TUBE, CLAMP

  ACTIVITY          A    BED/MOBILE REPOSITION/TURN Q2 W/1AST
                    T    TX-MONITOR FOR APNEA

  DIET              DTY  NPO

  DISCHARGE PLAN

-------------------------------------------------------------------------------
 Dx : 285.9-ANEMIA NOS                    | Case Mgr: Metzger,Jenny M
 Alg:                                     | St Dt/Tm/By: 08/18 07:00a Metzger,Jen
 Iso:                          Smk: UNK   | Ints/Signatures:
 Sgy:                                     | _____________  _____________  _____________
                              Type: I/P   | _____________  _____________  _____________
 2306-1                    92223-00007    | _____________  _____________  _____________
 Adm : 08/10/92      Dob: 01/21/63  29Y   | _____________  _____________  _____________
 Phys: CARNES,JAMES E           Level:    | _____________  _____________  _____________
 GILLIS,MARY ANNE                 Sex: F  | _____________  _____________  _____________
```

Display/Print a Multidisciplinary Plan

You can display or print a report of an active, inactive, or completed Multidisciplinary Plan (MDP) for a patient. The MDP includes all items built for the patient's Critical Pathway for the day(s) selected. In addition, the MDP includes any additional orders placed for the patient that were not already built for the Critical Pathway or any item moved to the Day of Stay you select to display/print.

You can access this function by performing the following steps:

1. Select Critical Pathways from the Nursing main menu.
2. Select the patient for whom you want to print the Multidisciplinary Plan.
3. Select Multidisciplinary Plan from the Critical Pathways menu.

NOTE: When the patient has never had a Critical Pathway assigned, the following error message displays:

No critical pathway exists for this patient!

The following screen displays when the patient has an active Critical Pathway:

```
            General Hospital Multidisciplinary Plan Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00007   WORTHINGTON,WILL  M  03/17/12 1208-2  ADAMS,HAROLD CCU 10 I/P 15

( 1)Critical Pathway: CABG
( 2)Start Day       :
( 3)Stop Day        :
( 4)Order Statuses  :
( 5)Display/Print   :

Page:01
     Pathway Day of Stay        Date/Time                  Status
( 1) PRE-OP                     02/02/09 0700am            Inactive
( 2) SURGERY                    02/10/09 0700am            Inactive
( 3) DAY 1 ICU                  02/11/09 0700am            Inactive
( 4) DAY 2 ICU                  02/12/09 0700am            Inactive
( 5) DAY 3 ICU                  02/13/09 0700am            Inactive
( 6) DAY 4 ICU                  02/14/09 0700am            Inactive
( 7) DAY 5 ICU                  02/15/09 0700am            Inactive
( 8) DAY 6 ICU                  02/17/09 0700am            Inactive

Enter choice [DAY 1 ICU]--
```

The bottom half of the screen displays each Pathway Day of Stay with the Date/Time it starts, and its current status. A plus sign (+) displays next to a day that was added to the Critical Pathway.

There may be symbols that display or print on the report. For an explanation of these symbols refer to “MAINTAIN TABLES FOR CRITICAL PATHWAYS” on page 1-60.

When the patient does not have an active Pathway, but does have an inactive or completed Pathway, a list of the pathways displays, as in the following example:

```
            General Hospital Multidisciplinary Plan Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00007   WORTHINGTON,WILL  M  03/17/12 1208-2  ADAMS,HAROLD CCU 10 I/P 15

( 1)Critical Pathway: CABG
( 2)Start Day       :
( 3)Stop Day        :
( 4)Order Statuses  :
( 5)Display/Print   :

Page:01
         Assign Dt/Tm     Critical Pathway                Status
( 1)     06/05/93 0236pm  COPD                            Inactive
( 2)     06/09/93 1114am  Total Hip                       Complete
( 3)     06/11/93 0108pm  Total Hip Rehab                 Complete




Enter choice--
```

Enter the selection number of the pathway you want to print.

Field Explanations

1. CRITICAL PATHWAY (DISPLAY or 1-A-R)
When the patient does not have an active Pathway, but does have an inactive or completed Pathway, a list of Critical Pathways assigned to the patient displays. Enter the selection number of the pathway you want to print.

When the patient has an active Critical Pathway, the description of the active Pathway automatically displays in this field. When you want to display/print the report for an inactive or completed Pathway, access the field by entering /1 (slash and 1). A list of Critical Pathways assigned to the patient displays, as in the previous screen example. The list includes the status of the Pathway. Enter the selection number of the Pathway you want to print.

2. START DAY (2-N-R)
You enter the number of the day with which you want the report to start. The current day displays as the default.

3. STOP DAY (2-N-R)
You enter the number of the day with which you want the report to end. The current day displays as the default.

4. ORDER STATUSES (1-A-R)
You have several options for selecting the orders you want to include on the MDP. You can limit the MDP to only certain types of order statuses. The following prompt displays:

Include Active(A), Inactive(I), complete(C), cancelled(D), or all(All) [A]--

You can limit the display/print of the MDP to one or any combination of the following statuses, or enter **ALL** to print all orders, regardless of status:

- Enter **A** to display/print only Active orders.
- Enter **I** to display/print only Inactive orders.
- Enter **C** to display/print only Complete orders.
- Enter **D** to display/print only Cancelled orders.
- Enter **ALL** to display/print all orders.
- Enter the combination of letters to display/print a combination of statuses (for example, AI for Active and Inactive orders).

Refer to the *Order Management/Charge Processing Volume* of the *STAR Patient Care Reference Guide* for more information on any of the order statuses.

5. DISPLAY/PRINT (1-A-R)
You can display or print the report. Enter **D** to display the report. Enter **P** to print the report. Display is the default.

Once you accept the screen, the MDP displays or prints at the CRT's default printer. The report prints the orders in detail for the selected day(s) of stay. A blank line prints between the days of stay. The orders for a day of stay display/print in the same order that they were built. The report displays/prints the following information:

- Patient header information or Patient Block
- Medical Information Block
- Patient History Block (only on page 1)
- Lines for the caregiver signatures
- Name of the Critical Pathway and Length of Stay
- The Day Description, including the date/time of start
- Custom documents linked to the pathway

- The order status(es) selected

NOTE: The Patient History Block only prints if information has been entered for the Patient using the Patient History/Misc. function on the Nursing Main Menu.

For each order:

- Category
- Department
- Item description
  - The first (^) or subsequent (~) orders of a Recurring order
  - Each order of an Ongoing order (>)
- Requested Date/Time
- Status of the order
- Frequency, if the Print Frequency field under Critical Pathways in the Nursing Facility Parameters Processor is set to Yes.

  NOTE: The frequency for each order prints on a separate line, which can considerably lengthen the MDP. Therefore, the default for the Print Frequency field is No.

- Comment entered on the order screen

When you select the Display option, the following screen is displayed:

```
              General Hospital Multidisciplinary Plan Processor
MYOCARDIAL INFARCTION - Active                    Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9308100003    HIGGINS,WILSON D  M  02/03/04 ICU-06  ADAIR,FRANK CMED 10 I/P 5
Category        Dept Item                                  Req DT/TM     Status
                     Freq    Order Comment                                (A)
1-MI DAY 1   02/22/93 07:00am
TESTS           CAR >ECG 12 LEAD                           02/22 02:00P  Act   v
                LAB  CARDIAC PROFILE                       02/22 02:00P  Act
                LAB  PARTIAL THROMBOPLASTIN TIME           02/22 02:00P  Act
                LAB ^17-HYDROXY CORTICOSTEROIDS            02/23 12:11A  Act
                LAB  CELL COUNT, BODY FLUID                02/22 02:16P  Act  +
                RAD ^XR CHEST PA & LAT  71020              02/23 12:11A  Act
TREATMENTS      A   >I & O Q SHIFT                         02/22 02:11P  Act
                      QID
                T   >PCA CONSENT                           02/22 02:11P  Act
                      BID
                     Obtain signed pt instruction sheet
                     sheet prior to initiating PCA:
                     Date:______ Time:______Initials:____

Press NL to continue viewing or print(P)--
                                 next page(/)
```

You can press ENTER to continue viewing or you can enter **P** to print the report. When there is more than one page to the report, you can use slash (/)and slash P (/P) to view next or previous pages.

When you select the Print option, the Multidisciplinary Plan prints at the default printer for the PC. See the following example of the MDP.

Figure 1.3 Multidisciplinary Plan

```
Fri Mar 26, 1993 03:20 pm                                MULTIDISCIPLINARY PLAN
                                GENERAL HOSPITAL                    Page 1
-------------------------------------------------------------------------------
Category        Dept Item                                  Req DT/TM    Status
                          Freq    Order Comment                          (A)
-------------------------------------------------------------------------------
MYOCARDIAL INFARCTION - Active
1-MI DAY 1   03/22/93 07:00am
TESTS           CAR >ECG 12 LEAD                           03/22 02:00P Act   v
                LAB  CARDIAC PROFILE                       03/22 02:00P Act
                LAB  PARTIAL THROMBOPLASTIN TIME           03/22 02:00P Act
                LAB ^17-HYDROXY CORTICOSTEROIDS            03/23 12:11A Act
                LAB  CELL COUNT, BODY FLUID                03/22 02:16P Act  +
                RAD ^XR CHEST PA & LAT  71020              03/23 12:11A Act
TREATMENTS      A   >I & O Q SHIFT                         03/22 02:11P Act
                         QID
                T   >PCA CONSENT                           03/22 02:11P Act
                         BID
                     Obtain signed pt instruction sheet
                     sheet prior to initiating PCA:
                     Date: 3/23  Time: 8am  Initials: KLS
                T   >IV ACCESS, MAINTAIN                   03/22 02:11P Act   v
                         BID
                     Maintain patent IV for emergency
                     access: Site: Rt arm   Size: 22 angio
                     Soln: .5% D5W          Rate: 75 cc/hr
ACTIVITY        A    BATH  Q 15 MIN                        03/22 02:11P Act
                         QD
                A    NEUROLOGIC Q 2H                       03/22 02:11P Act
                         QD
THERAPIES       RT  >OXYGEN                                03/22 08:00A Act
CONSULTS        CNS  DTY - CONSULTATION                    03/22 02:12P Act
IV'S/MEDS       T    IV SOLUTION/RATE                      03/22 02:14P Act
                         QD
                     IV Solution: .5% D5W
                     Bottle No: 3    Rate: 75   cc/hr
                     Time started: 9am   Completed:______
                     Balance: 200     cc at 2     pm
                     Tubing/dressing change due: 3/23 9am
NSG PROBLEM-O/C O    CHEST PAIN, TRANSFER                  03/22 02:14P Act
                         QD
                     (Transfer): chest pain controlled,
                     VSS, S-T segment elevation resolved,
                     hemodyn. stable: hemodyn. parameters
                     & cardiac rhythm stable.
-------------------------------------------------------------------------------
Past Medical History:History of COPD and Alzheimer's Disease
Notify for Emergency:Husband deceased, primary caretaker is son -- Dr. Paul
Bodenheimer (451) 333-4567.
Answers to the name "Emma" during periods of confusion.
Has hearing aid in left ear to be worn at all times.
-------------------------------------------------------------------------------
Prc: APHASIC                Prc: COMBATIVE              Prc: COMMUN BARRIER
O2 : CHEST PHYSIO TX        IV : CENTRAL VENOUS LINE    Cnd: FAIR
HT : 5'4.0" / 162.6cm    WT : 112lbs /50.9kg      BSA: 1.53sq m  Adv:  POWER OF A
Svc: MEDICAL             Pub: FAMILY MEMBERS ON   PC : BOARD ME  Org:  EYES ONLY
-------------------------------------------------------------------------------
 Dx : 902.21-INJURY GASTRIC ARTERY     | Case Mgr: DUBOIS,RENEE T
 Alg: PCN,BEE POLLEN,CATS,MILK PRODUCT,| St Dt/Tm/By: 03/22 07:00A Smert,Louis
 Iso: AIRBORNE DROPLET       Smk: NO   | Ints/Signatures:
 Sgy: 03/23/94  02.02-ELEVATE SKULL F  | _____________  _____________  _____________
                           Type: I/P   | _____________  _____________  _____________
 ICU-06                  9308100003    | _____________  _____________  _____________
 Adm : 03/22/93    Dob: 01/31/67  26Y  | _____________  _____________  _____________
 Phys: ADAIR,FRANK C         Level: 1  | _____________  _____________  _____________
 BURNER, BETTY                 Sex: F  | _____________  _____________  _____________
```

Display/Print a Variance Report

You can display or print a report of the variances entered for a patient's Critical Pathway. A variance occurs when a patient's care differs from the items built for the Critical Pathway. For example, you enter a variance when you do one of the following:

- Do not order or complete an item planned for a Day of Stay
- Move an order to another Day of Stay
- Add an order to a Day of Stay
- Deviate from the Critical Pathway as defined by hospital procedures

The user enters a cause for the variance, as well as the actions taken and any comments.

You can access the Variance Report function by performing the following steps:

1. Select Critical Pathways from the Nursing main menu.
2. Select the patient for whom you want to print a Variance Report.
3. Select Variance Report from the Critical Pathways menu.

The following screen displays:

```
                  General Hospital Variance Report Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00007   WORTHINGTON,WILL  M  03/17/12 1208-2  ADAMS,HAROLD CCU 10 I/P 15

( 1)Critical Pathway: CABG
( 2)Start Day       :
( 3)Stop Day        :
( 4)Display/Print   :

Page:01
     Pathway Day of Stay        Date/Time                  Status
( 1) PRE-OP                     02/02/09 0700am            Inactive
( 2) SURGERY                    02/10/09 0700am            Inactive
( 3) DAY 1 ICU                  02/11/09 0700am            Inactive
( 4) DAY 2 ICU                  02/12/09 0700am            Inactive
( 5) DAY 3 ICU                  02/13/09 0700am            Inactive
( 6) DAY 4 ICU                  02/14/09 0700am            Inactive
( 7) DAY 5 ICU                  02/15/09 0700am            Inactive
( 8) DAY 6 ICU                  02/17/09 0700am            Inactive

Enter choice [DAY 1 ICU]--
```

The bottom half of the screen displays each Pathway Day of Stay with the Date/Time it starts, and its current status.

There may be symbols that display or print on the report. For an explanation of these symbols refer to "MAINTAIN TABLES FOR CRITICAL PATHWAYS" on page 1-60.

Field Explanations

1. CRITICAL PATHWAY (DISPLAY or TABLE LOOKUP)
When the patient has an active Critical Pathway, the description of the active Pathway displays in this field. When you want to display/print the report for an inactive or completed Pathway, access the field by entering /1 (slash and 1). A list of Critical Pathways assigned to the patient displays, along with the status of the Pathway. You can select the Pathway for which you want to print the report.

When the patient is not active on a pathway but has a pathway with an inactive or complete status, you must select the pathway.

2. START DAY (2-N-R)
You enter the number of the day with which you want the report to start. The current day displays as the default.

3. STOP DAY (2-N-R)
You enter the number of the day with which you want the report to start. The current day displays as the default.

4. DISPLAY/PRINT (1-A-R)
You can display or print the report. Enter **D** to display the report. You can print the report from the display. Enter **P** to print the report. Display is the default.

Once you accept the screen, the Variance Report displays or prints. The report lists the variances by day of stay, then by variance type. The report displays/prints the following information:

- Patient header information or Patient Block
- Name of the Critical Pathway and LOS
- Item's department
- Item's description
- Type of variance
- Cause(s) of the variance
- Action(s) taken
- Comment on the variance
- Name of the person recording the variance

- Date/time the variance was recorded

When you select the Display option, the following screen is displayed:

```
               General Hospital Variance Report Processor
CABG                                          Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
92241-00007   WORTHINGTON,WILL  M  03/17/12 1208-2  ADAMS,HAROLD CCU 10 I/P 15
  Dept Description                      Order #  Req Date/Time     Status
  Variance Type          Action Taken                       Recorded By
  Variance Cause         Comment                            Recorded Date/Time
  Recorded By                           Recorded Date/Time
1-PRE-OP   02/11/09 07:00am

Variance Type: Provider/Clinician

  CAR  ELECTROCARDIOGRAM                                          Inactive
  Var Cause   :PHYSICIAN ORDER
  Action Taken:TEST DONE IN OFFICE DC PER MD
  Rec by: Datron,Milton W                  Rec Dt/Tm: 02/11/09 04:08pm

  |The patient had chest pains prior to administration of the electrocardiogram|
  |therefore it was not ordered per the Dr.'s instructions.                     |
  |                                                                             |


Press NL to continue viewing or print(P)--
                                next page(/)
```

You can press ENTER to continue viewing or you can enter **P** to print the report. When there is more than one page to the report, you can use slash (/)and slash P (/P) to view next or previous pages.

When you select the Print option, the Critical Pathway prints at the default printer for the PC.

Figure 1.4 Variance Report

```
Fri Mar 26, 1993 03:20 pm                    CRITICAL PATHWAYS VARIANCE REPORT
                            GENERAL HOSPITAL                          Page 1
                     Critical Pathway: MYOCARDIAL INFARCTION
-------------------------------------------------------------------------------
  Dept Description                        Order #  Req Date/Time     Status
-------------------------------------------------------------------------------

1-MI DAY 1   03/22/93 07:00A

Variance Type: Patient/Family

  CAR >ECG 12 LEAD                            1    03/22/93 02:00P   Active
  Var Cause   : LACK OF FAMILY SUPPORT, PATIENT AGE, PATIENT COMPLICATION,
                PATIENT CONDITION
  Action Taken: DEPARTMENT NOTIFIED, FAMILY NOTIFIED, ITEM REORDERED,
                PHYSICIAN NOTIFIED
  Rec By: Dubois,Rene                  Rec Dt/Tm: 03/22/93 02:18P
  |THE PATIENT WAS FEELING EXTREMELY ILL THIS MORNING AND REFUSED THIS TEST.  |
  |IT HAS BEEN RESCHEDULED FOR THE AM.                                        |

Variance Type: Provider/Clinician

  T   >IV ACCESS, MAINTAIN                    2    03/22/93 02:11P   Active
  Var Cause   : DECISION OF HEALTH CARE TEAM
  Action Taken: DEPARTMENT NOTIFIED, FAMILY NOTIFIED, PHYSICIAN NOTIFIED
  Rec By: Dubois,Renee                 Rec Dt/Tm: 03/22/93 02:20P
  |SINCE THE  PATIENT WAS FEELING SO POORLY, THE TEAM DECIDED TO START THE IV |
  |IN THE AM INSTEAD.                                                         |

5-MI DAY 5   03/26/93 07:00A

Variance Type: Patient/Family

  LAB ~17-HYDROXY CORTICOSTEROIDS             1    03/27/93 12:11A   Active   +
  Var Cause   : LACK OF FAMILY SUPPORT, PATIENT AGE, PATIENT COMPLICATION,
                PATIENT CONDITION
  Action Taken: DEPARTMENT NOTIFIED, FAMILY NOTIFIED,
                INCIDENT REPORT COMPLETED
  Rec By: Dubois,Renee                 Rec Dt/Tm: 03/26/93 01:29P
  |The patient was not feeling well and refused this test at the time that the|
  |lab tech showed up to do it. It has been rescheduled                       |

                                  End of Report


-------------------------------------------------------------------------------
 Dx : 786.50-CHEST PAIN NOS             | Case Mgr: -DUBOIS,RENEE T
 Alg: PCN,BEE POLLEN,CATS,MILK PRODUCT, | St Dt/Tm/By: 03/22 07:00A Smith,L. Mi
 Iso: Blood Precautions      Smk: UNK   | Ints/Signatures:
 Sgy: 03/24/93  02.02-ELEVATE SKULL F   | _____________  _____________  _____________
                           Type: I/P    | _____________  _____________  _____________
 ICU-06                 9308100003      | _____________  _____________  _____________
 Adm : 03/22/93    Dob: 02/03/04  89Y   | _____________  _____________  _____________
 Phys: ADAIR,FRANK C          Level:    | _____________  _____________  _____________
 HIGGINS,WILSON D               Sex: M  | _____________  _____________  _____________
```

MAINTAIN TABLES FOR CRITICAL PATHWAYS

You need to set up information in the following tables for Critical Pathways:

- SIM Department table
- Variance Causes table
- Action Taken table
- Priorities table
- Critical Pathway Categories table
- Facility Parameters

It is recommended to set up default categories in the following fields:

- The Default Category field of the SIM Department table.
- The Default Category field of an Intervention item (if the category is different from the one already set up in the SIM Department table).

Using Non-SIM Departments with Critical Pathways

Critical Pathways are comprised of both SIM and non-SIM department items linked to a Day of Stay. The non-SIM department handles orders for items such as Problems (P), Outcomes (O), Interventions (I), Treatments (T), Activities of Daily Living (A), and Discharge Planning (D).

These non-SIM items and their non-SIM departments (P, O, I, A, D) are built for use with Critical Pathways:

- Use Table Maintenance to set up information for the departments in the SIM Department table. You set up a default category for each non-SIM Department. For more information refer to "Default Categories" on page 1-68.
- Set up priorities for each of the non-SIM Departments in the appropriate Priorities table.
- Set up the specific items for each non-SIM Department as standard files using the Plan of Care processor. For example, use the Plan of Care Process to set up Interventions.

Refer to the *Order Management/Charge Processing Volume* of the *STAR Patient Care Reference Guide* for information about the SIM department. Refer to "Appendix A - NURSING TABLES" for information about Priorities tables. Refer to "Chapter 7 -

STANDARD FILE MAINTENANCE" for information on building non-SIM department items.

Variance Causes Table

The Variance Causes maintained in this table are used when there is a deviation from the planned Critical Pathway, and the user wants to record a variance. The user maintains specific causes for each of the four types of variances listed in the Variance Type table. McKesson maintains the Variance Type table. There are four types of variances in the table:

- Patient/Family
- Provider/Clinician
- External System
- Internal System

You set up Variance Causes for each of the Variance Types, as in the following examples:

- Patient/Family Causes - Can include lack of family support, the patient's age, condition (such as pain or nausea), complications, or other comorbidities.
- Provider/Clinician Causes - Can include the caregiver's omission of an order planned for the Critical Pathway or a decision made by the healthcare team.
- External System Causes - Can include unavailable extended care facilities or home care, or the lack of third-party coverage.
- Internal System Causes - Can include an equipment malfunction, a closed department, lack of available appointments at the required time, or inadequate turnaround time for ancillary departments.

You can access the Variance Causes table for Critical Pathways by selecting the following menu options:

1. Tables from the Data Processing main menu
2. Nursing Table Maintenance
3. Variance Causes from the list of tables

The following prompt displays:

Enter variance cause code--

You have the following choices:

- Enter a unique code to add a new Variance Cause. The code can be up to three numeric characters.
- Entering the code of an existing Variance Cause.
- Perform a table lookup to display a list of the variance causes for your selection.

The following screen shows an example of the entry screen for a variance cause:

```
              General Hospital Nursing Table Maintenance Processor
                                                    Tues Dec 1, 1992 03:57
Variance Causes
(1)  Code           : 777
(2)  Description    : PT Dept closed
(3)  Type           : Internal System

(4)  Edit by       : Datron,Milton
(5)  Edit date     : 07/14/92 02:00pm









Accept this screen? (Y/N) [Y]--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code assigned to the variance.

2. DESCRIPTION (33-AN-R)
You can enter up to 33 alphanumeric characters that describe the variance cause.

3. TYPE (TABLE LOOKUP)
The Variance Type identifies the main area that is responsible for the variance. You can choose from a table of available types from the Variance Type table that displays. The types currently include: Patient/Family, Provider/Clinician, Internal System, and External System. McKesson maintains this table.

4. EDIT BY (DISPLAY ONLY)
This field displays the name of the user who last updated this table.

5. EDIT DATE (DISPLAY ONLY)
This field displays the date that the table was last updated.

Once you complete the fields, the following prompt is displayed:

Accept this screen? (Y/N/'D'elete) [Y]--

You have the following choices:

- Enter **N** for No, or press ENTER, to edit the Description or Variance Type fields.
- Enter **Y** for Yes to accept the screen.
- Enter **D** for Delete to delete the variance cause. The Delete option displays when you edit an existing variance cause.

When you display a Variance Cause and make no edits, the following prompt is displayed:

Delete? [N]--

Enter **N** for No, or press ENTER, to exit without deleting the variance cause. Enter **Y** for Yes when you want to delete the Variance Cause. No is the default.

Impact

The variances you enter in the Variance Causes table:

- Are available for selection on the Variance Entry screen. Refer to "RECORD A VARIANCE" on page 1-21 for more information. The variance causes display for the variance type you select.
- Print on the Variance Report.

Action Taken Table

When there is a variance from the Critical Pathway, the user enters the action(s) taken on the Variance Entry screen. For example, the Critical Pathway plans a test at 10:00 AM, but there was emergency surgery at 9:00 AM. The user enters a Variance because the test will not be given; instead, the user cancelled the order and notified the physician. You build a table of the actions taken to meet the variance. The user can select one or more from the list when entering a Variance.

You can access the Action Taken table from Data Processing by selecting the following menu options:

1. Tables from the Data Processing main menu
2. Nursing Table Maintenance
3. Action Taken from the list of tables

The following prompt is displayed:

Enter action taken code--

You can add a new Action Taken or edit an existing Action Taken. You have the following choices:

- Enter a unique numeric code of up to four digits when you want to add a new Action Taken.
- Enter the Action Taken code if you know it.
- Perform a table lookup to display a list of the existing Action Taken codes for your selection.

The following screen is displayed:

```
              General Hospital Nursing Table Maintenance Processor
                                                  Fri Dec 18, 1992 03:19 pm
Action Taken
( 1)Code         : 1234
( 2)Description  : NOTIFIED PHYSICIAN

( 4)Edit by      : Trager,Jane P
( 5)Edit date    : 11/30/92









Accept this screen? (Y/N) [Y]--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the one to four-digit numeric code assigned to the Action Taken. You cannot edit this field. To display a different Action Taken, exit this screen and enter the correct Action Taken code at the *Enter action taken code* prompt.

2. DESCRIPTION (33-C-R)
You enter the description of the Action Taken in this field. You can enter up to 33 characters. The description displays/prints on the Variance Report.

3. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last edited this table.

4. EDIT DATE (DISPLAY ONLY)
This field displays the date that the table was last edited.

Once you complete the fields, the following prompt displays:

Accept this screen? (Y/N/'D'elete) [Y]--

You have the following choices:

- Enter **N** for No, or press ENTER, to edit the Description field.
- Enter **Y** for Yes to accept the screen.
- Enter **D** for Delete to delete the action taken. The Delete option displays when you edit an existing Action Taken.

When you display an Action Taken and make no edits, the following prompt displays:

Delete? [N]--

Press **N** for No or ENTER to exit without deleting the Action Taken. Enter **Y** for Yes when you want to delete the Action Taken. No is the default.

Critical Pathway Categories Table

The Critical Pathway displays or prints the orders for a Critical Pathway by category. You set up a category description for each type of item, and then designate the sequence in which you want the categories to display or print on the Critical Pathway.

If you change the sequence of the categories after you build any Critical Pathways, you need to use the Resequence Critical Pathways function. This function resequences the categories in the Critical Pathways to reflect the changes you made in the table. The categories display and print in the new order. Refer to "Resequence Critical Pathways" on page 1-70 for the procedure to resequence categories.

NOTE: Changes you make in the sequence of categories do not affect Pathways that are already assigned to a patient. The changes you make become effective for all Pathways assigned from this point forward.

You can access the Categories table from Data Processing by selecting the following menu options:

1. Tables from the Data Processing main menu
2. Nursing Table Maintenance

3. Critical Pathway Categories from the list of tables

You can access the Categories table from Nursing by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Critical Pathways
4. Build Categories

A screen displays with the following prompt:

Enter category code--

You can add a new category or edit an existing category. You have the following choices:

- Enter a unique numeric code of one or two digits when you want to add a new category.
- Enter the category code if you know it.
- Use table lookup to display a list of the existing category codes for your selection.

NOTE: You need to build a Category with the code of 0 (zero) and enter a description, such as Miscellaneous, that you want to display/print on screens and reports. The system uses this category when you place orders (using the Order Management Module) for items that do not have a default category set up for its department. Refer to "Default Categories" on page 1-68 for the procedure for setting up default categories. When all your SIM and non-SIM departments have a default category, the system does not need to use the Category 0.

The following screen is displayed:

```
              General Hospital Nursing Table Maintenance Processor
                                                    Fri Dec 18, 1992 03:19 pm
Critical Pathway Categories
( 1)Code          : 5
( 2)Description   : OUTCOMES
( 3)Sequence #    : 8

( 4)Edit by       : Trager,Jane P
( 5)Edit date     : 11/30/92









Accept this screen? (Y/N) [Y]--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the one or two-digit numeric code assigned to the category. You cannot edit this field. To display a different category, exit this screen and enter the correct category code at the *Enter category code* prompt.

2. DESCRIPTION (14-AN-R)
You enter the description of the category in this field. You can enter up to 14 alphanumeric characters. The description displays/prints on the Critical Pathway.

3. SEQUENCE NUMBER (2-N-R)
This field defines the order in which the various categories print. You enter a one or two-digit number to designate the position of this category in the sequence of categories that display/print. For example, if you enter a 5 for the sequence number, the category is listed as the fifth category on the Pathway if 4 others are built. When you enter a sequence number that is already in use, a prompt similar to the following displays:

Sequence # 4 already in use by ADLs!

When you change the sequence number of a category, you need to use the Resequence Critical Pathways function to resequence the way the categories display/ print on the Critical Pathways.

4. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last edited this table.

5. EDIT DATE (DISPLAY ONLY)
This field displays the date that the table was last edited.

Once you complete the fields, the following prompt displays:

Accept this screen? (Y/N/'D'elete) [Y]--

You have the following choices:

- Enter **N** for No, or press ENTER, to edit the Description or Sequence Number fields.
- Enter **Y** for Yes to accept the screen.
- Enter **D** for Delete to delete the category. The Delete option displays when you edit an existing category.

When you display a Category and make no edits, the following prompt displays:

Delete? [N]--

Enter **N** for No, or press ENTER, to exit without deleting the category. Enter **Y** for Yes when you want to delete the Critical Pathway Category. No is the default.

Impact

- The name of the category you enter in this screen displays/prints on the Critical Pathway.
- The category of orders displays/prints on the Critical Pathway in order of the sequence number you enter in this screen.

Default Categories

You can build default categories for all SIM and non-SIM departments. The system uses default categories in the following cases:

- When you place additional orders using the Order Management Module, the system uses the default category set up for the item's department.
- When you order a Panel Master through the Critical Pathways function or the Order Management Module, the system uses the default category set up for each Panel Item's department.

Because Interventions may be one of several possible categories, Critical Pathways enables you to build a default category at the Intervention item level.

NOTE: If you do not set up a default category for a Department or an Intervention item, the system uses the Category code 0 (zero) for orders you place using the Order Management Module.

DEFAULT CATEGORY IN THE SIM DEPARTMENT TABLE

You select the SIM or non-SIM department and enter the category you want to be the default category in the Default Category field. The system uses this default when you place orders using the Order Management Module. You can select from a table of available categories built in Nursing Tables.

You can access the SIM Department table by selecting the following menu options:

1. Tables from the Data Processing main menu
2. Table Maintenance

Select SIM Departments from the list of tables that display. Enter the code of the SIM or non-SIM department or perform a table lookup.

For more information on the SIM Departments table, refer to Appendix A: Tables in *Order Management/Charge Processing Volume* 2 of the *STAR Patient Care Reference Guide*.

DEFAULT CATEGORY FOR INTERVENTIONS

Interventions are the only types of items for which you can define a Default Category at the item level. The system uses this default when you place orders using the Order Management Module.

When you build an intervention, there is a Default Category field for you to define the default category for that item. The entry you make in the field overrides any entry you make in the SIM Department table for interventions.

To streamline the process, you can enter the most common default category in the SIM Department table for the Department I (Interventions) and then enter a different category at the item level for specific interventions.

You can enter default categories for individual interventions by selecting the following menu options:

1. File Maintenance
2. Standard File Maintenance
3. Standard Plan of Care

Select the appropriate facility (if necessary), then select the Intervention/Treatment option from the list of File Types that displays. For more information on building interventions, refer to "Chapter 7 - STANDARD FILE MAINTENANCE".

The following is an example of the screen for building Interventions.

```
              General Hospital Standard Plan of Care Processor
                                          Fri Dec 18, 1992 09:49 am

 1 File Type    2 Code      3 Print      4 Description
   T              1889
 5 Alias Description #1                   6 Alias Description #2

 7 Alias Description #3                   8 Alias Description #4

 9 Alias Description #5                  10 Alias Description #6

11 PCR                                   12 Default Category
                                         ->
13 Text

                 |                                   |
                 |                                   |
                 |                                   |
                 |                                   |
                 |                                   |


Enter default category for Critical Pathways--
```

Impact

- The entry in the Default Category field for an intervention item overrides any entry you make in the SIM Department table for Department I (Interventions).

- When you place an order for a patient using the Order Management Module, the system uses the default category for the intervention item. If there is no default category at the item level, the system checks for the default category at the department level (Department I). If there is no category set up at either level, the system uses Category 0 (zero).

Resequence Critical Pathways

Whenever you make a change in the sequence of categories in the Categories table (after you have built one or more Critical Pathways), you need to use the Resequence Critical Pathways function. This function resequences the way the categories display/print to reflect the changes you made.

By storing the Critical Pathway items in order of category sequence, the system can display/print Critical Pathways in the fastest, most efficient manner. The Resequence function enables you to re-sort the existing pathways into the new sequence when you make a change in the order of the categories. You only need to use this function after

you have made a change in the sequence of the categories and you have already built a Critical Pathway.

You can access this function by selecting the following menu options:

1. File Maintenance from the main Nursing menu
2. Standard File Maintenance
3. Critical Pathways
4. Resequence Critical Pathways

Select the appropriate facility, if necessary. When there have been no changes to the category sequences since the last resequence, the following message displays:

No category sequence changes have been made!

When there have been changes, the following prompt displays:

Are you sure you want to resequence all critical pathways? (Y/N) [N]--

When you enter **N** for No or press ENTER, the Critical Pathways file maintenance menu redisplays. When you enter **Y** for Yes, the system displays the message *Processing!*. When the processing completes, the menu redisplays. The next time you display or print a Critical Pathway, the categories display in the changed sequence.

NOTE: Changes you make in the sequence of categories do not affect Pathways that are already assigned to a patient. The changes you make become effective for all Pathways assigned from this point forward.

NURSING FACILITY PARAMETERS

A facility parameter enables you to retain Critical Pathway assignment and Variance information for a patient after historization. You set the Critical Pathways facility parameter for the number of days you want to retain Critical Pathway information for each patient. The maximum number of days you can retain the information is 999 days after the start date of the pathway.

The system retains the following patient-specific information for each Critical Pathway assigned:

- Status
- Expected Outcome
- Completed By
- Start Date/Time
- Assigned By
- Completed Date/Time
- Case Manager
- Assigned Date/Time
- Nursing Station
- Expected Length of Stay
- Inactivated By
- Version # of Path
- Inactivated Date/Time
- Patient Name (Only?)

The system retains the following information for each variance entered for a patient's Critical Pathway:

- Variance Type
- Recorded Date/Time
- Indicators (+,m,v)

- Variance Causes(s)
- Category
- Order Status
- Action(s) Taken
- SIM Department
- Ongoing Days
- Recorded By
- SIM Code

You can use McKesson's STAR KB_SQL product to write queries that generate reports. There are two queries set up for you that enable you to report on the variances for specific Critical Pathways and each of its versions. One STAR KB_SQL report gives details on variances per Day of Stay and per nursing station. For more information, refer to your McKesson representative.

You can access the Nursing Facility Parameters using the following menu options.

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Report Build Options
4. Nursing Facility Parameters

Select the facility, if necessary. The Nursing Facility Parameters screen is displayed. Enter a slash (/) to display the second parameters screen, as in the following example:

```
              General Hospital Nursing Facility Parameters Processor
GENERAL HOSPITAL A                                      Mon Sep 13, 1998 02:26 pm

 PATIENT ACUITY
 1 Admission Bed Override                2 Transfer Bed Override
   1111 ADMISSION TO UNIT                  5556 TRANSFER BED
 3 Acuity Retention          4 Historical Acuity Retention 5 Historical Key
   99                          999                         DRG
 ASSESSMENT / PLAN OF CARE
 6 Assessment Maint   7 Assessment History Retention      8 Master Problem List
   Weekly               1 D                               Yes
 9 Pending Authorization Status   10 Log Text  11 Report Name
   No                                No           NPLOG  Nursing Log Text Re
 CRITICAL PATHWAYS
12 Retention Days                 13 Print Frequency
   999                            ->
 MATERNITY RETENTION DAYS
14 Care Plans         15 Assessment       16 Labor & Delivery     17 Vital Signs
   9125                 9125                9125                    9125

Enter field number or '/' starting field number--
                      next(/) or previous screen (/P) [/]
```

This screen is fully documented in "Appendix A - NURSING TABLES". The only fields you use with Critical Pathways are the following.

Field Explanations

CRITICAL PATHWAYS

12. RETENTION DAYS (3-N-R)
You access this field and enter the number of days you want to retain Critical Pathway information for each patient. The maximum number of days you can retain the information is 999 days after patient historization. The system purges the information during midnight processing after the number of retention days you specify.

13. PRINT FREQUENCY (1-A-R)
This field enables you to specify whether you want the frequency for each order to print on the Multidisciplinary Plan (MDP) for a patient's Critical Pathway. Because the frequency prints on a separate line for each order, it can considerably lengthen the MDP.

If you enter **Y** for Yes, the frequency prints for every order on the MDP. The default is No.

PHARMACY PATIENT PROFILE INQUIRY

The Pharmacy Patient Profile function provides access to the patient's pharmacy profile.

NOTE: Employees assigned a Nursing main menu can access profiles only for patients who are currently on or have been on the nurse stations identified in the Station and Secondary Station(s) fields of the CRT Names table for the CRT from which the request is entered.

You can access this function by selecting the following menu options:

1. Critical Pathways from the Nursing main menu
2. Select the patient
3. Pharmacy Patient Profile Inquiry

The system displays the following prompt:

Enter order number, '-' to list orders, or (A) to view allergies--
(P) patient demographics

This prompt provides access to the patient's demographic information, allergy information, and medication order information. The procedures are documented as following:

- Enter **P** to display patient demographics. Refer to "Display Patient Demographics" on page 1-76 for information on this procedure.
- Enter **A** to view patient allergies. Refer to "Display Patient Allergies" on page 1-78 for information on this procedure.
- Enter the medication order number or perform a table lookup to display patient medication orders. Refer to "Display Patient Medication Orders" on page 1-80 for more information on this procedure.

Display Patient Demographics

If you enter **P** to display the patient's demographic information, the following screen is displayed:

```
             General Hospital Pharmacy Patient Profile Inquiry Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
00-00000001   MADRA,RICK         M  02/24/39 2103-01 DEAN,PHILLIP MED 10 I/P 7

Visit-Specific
  1 Adm Date/Time      2 Height               3 Weight               4 SCr
    02/17/09 12:14pm     5'10.0" / 177.8cm      150 lbs /68.2kg        0.9 mg/dl
  5 IBW        6 BSA         7 Diagnosis / complaint              8 CrCl
               1.85sq m      SICK                                   118.5 ml/min
  9 Smoker      10 Isolation            11 Precautions

 12 Precautions                         13 Precautions

 14 Diet
    Diet information is not available!

Pharmacy-Specific

 15 Comment                             16 Substance History
                                           Alcohol/Hvy
 17 Dosing      18 Smoker?  19 FDB Disease State Cd
    Unit dose      1PY         4001, 4030, 4250

Press NL--
```

Field Explanations

VISIT-SPECIFIC

1. ADM DATE/TIME (DISPLAY ONLY)
This field identifies the date and time that the patient was admitted to the hospital.

2. HEIGHT (DISPLAY ONLY)
This field contains the height entered for the patient using the Revise Patient Nursing function on STAR Patient Care. The system displays the height in terms of feet and inches and in metric units separated by a slash mark (/).

3. WEIGHT (DISPLAY ONLY)
This field contains the weight entered for the patient using the Revise Patient Nursing function on STAR Patient Care. The system displays the weight in terms of pounds and ounces and in metric units separated by a slash mark (/).

4. SCr (DISPLAY ONLY)
This field contains the serum creatinine value entered by pharmacy personnel for the patient.

5. IBW (DISPLAY ONLY)
This field contains the ideal body weight calculated for the patient in the Revise Patient Nursing function on STAR Patient Care. An ideal body weight is not calculated for all

patients. See the *Order Management/Charge Processing Volume* of the *STAR Patient Care Reference Guide* for additional information.

6. BSA (DISPLAY ONLY)
This field contains the body surface area calculated for the patient in the Revise Patient Nursing function on STAR Patient Care. Body surface area is not always calculated for every patient. See the *Order Management/Charge Processing Volume* of the *STAR Patient Care Reference Guide* for additional information.

7. DIAGNOSIS/COMPLAINT (DISPLAY ONLY)
This field contains the working diagnosis entered for the patient in Revise Patient Nursing on the STAR Patient Care System. This field may contain freeform complaint information until a working diagnosis is assigned. Once a working diagnosis is assigned, the system displays the ICD-9 code and description of the diagnosis.

8. CrCL (DISPLAY ONLY)
This field contains the creatinine clearance value for the patient entered in STAR Pharmacy.

9. SMOKER (DISPLAY ONLY)
This field indicates if the patient currently smokes cigarettes, cigars, or pipes. Yes indicates that the patient is a smoker, No indicates that he is not, and Unk indicates that it is not known if the patient is a smoker.

10. ISOLATION (DISPLAY ONLY)
If the patient should be isolated from other patients, this field contains the reason for the isolation.

11,12,13. PRECAUTIONS (DISPLAY ONLY)
These fields contain information about the patient that might play an important role in the health care of the patient. Some examples of typical precautions include Pregnant, Hemophiliac and Diabetic.

14. DIET (DISPLAY ONLY)
This field contains the patient's current diet information. Diet information is only available when both STAR Pharmacy and STAR Patient Care reside on the same central processing unit (CPU). If diet information is not available, this field contains the message *Diet information is not available!*.

PHARMACY-SPECIFIC

15. COMMENT (DISPLAY ONLY)
This field contains a freeform comment entered by the pharmacy department regarding the care of the patient.

16. SUBSTANCE HISTORY (DISPLAY ONLY)
This field contains the substance abuse history of the patient as defined on the Patient Demographics screen of the patient's STAR Pharmacy profile.

17. DOSING (DISPLAY ONLY)
This field indicates whether the patient's medications should be entered using the Unit Dose or Traditional dispensing method. The system uses this field to default the dispensing method during order entry.

18. SMOKER? (DISPLAY ONLY)
This field contains the number of *pack years* that the patient has smoked. This number is the result of the number of packs smoked per day times the number of years the patient has been smoking.

19. FDB DISEASE STATE CD (DISPLAY ONLY)
This field displays a list of the disease states codes for the patient.

When you finish viewing this screen, press ENTER. The system redisplays the Patient Profile Inquiry prompt.

Display Patient Allergies

If you enter **A** to view the allergy information entered for the patient on the STAR Pharmacy System, the Allergy Summary screen is displayed, as shown below:

```
          General Hospital Pharmacy Patient Profile Inquiry Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
00005-00034   HENDERSEN,CPT      M  02/03/04 2150-01 RADIOLOGY,FAXMED 10 I/P 120


 No. Allergy                        Type  Reaction                  Severity Sts
( 1) ASPIRIN                        Drug  ABNORMAL                  Severe   Ver
( 2) NKA                            Drug                                     Ina









Enter number to display--
                           (V)iew audit, (P)rint List
```

For detailed information about this screen, see "Allergy Summary Screen" in Chapter 6 in the *General Information Volume* of the *STAR Patient Care Reference Guide*. If you enter a number, the Allergy Detail screen is displayed, as shown below:

```
           General Hospital Pharmacy Patient Profile Inquiry Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
00005-00034   HENDERSEN,CPT      M  02/03/04 2150-01 RADIOLOGY,FAXMED 10 I/P 120

 1 Allergy Description                    2 Created By/Date
   ASPIRIN                                  Hardersen,Richard L  10/31/07 09:20
 3 Reaction                                              4 Severity
   ABNORMAL                                                9 Severe
 5 Sensitivity Type       6 Allergen Type   7 Reported By
   ADVERSE REACTION         Drug              HENDERSEN,CPT
 8 Relationship          9 Onset                            10 Abbreviation
   SELF                                                       ASPIRIN
11 Ingredient                      12 Edit Date           13 Edit By

14 STAR RX Comments                                     15 Source System
                                                           3494;ST09




Press NL--
```

For detailed information about this screen, see "Allergy Detail Screen" in Chapter 6 in the *General Information Volume* of the *STAR Patient Care Reference Guide*.

If you enter **V**, the Allergy Audit Trail screen is displayed, as shown below:

```
         General Hospital Pharmacy Patient Profile Inquiry Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
00005-00034   HENDERSEN,CPT      M  02/03/04 2150-01 RADIOLOGY,FAXMED 10 I/P 120


                              ALLERGY AUDIT TRAIL                        PT@RV
Date/Time        Act User           Adverse Drug/Class Reaction          Severity
11/28/08 03:22pm RVD Hardersen,Rich                                      I/P
11/28/08 03:16pm DEF Hardersen,Rich                                      I/P
11/28/08 03:14pm DEF Hardersen,Rich                                      I/P
10/31/08 09:20am Add Hardersen,Rich ASPIRIN            ABNORMAL          Severe
10/31/08 09:20am Ina                NKA
10/30/08 01:42am RVD Meril,Arthur                                        I/P
08/08/08 10:41am Add HBO,EMPLOYEE   NKA







Last page, or (V)iew old Pharmacy audit--
```

For detailed information about this screen, see "View an Allergy Audit Trail" in Chapter 6 in the *General Information Volume* of the *STAR Patient Care Reference Guide*.

When you finish viewing the Allergy Audit Trail, press **Enter** to return to the previous screen.

Enter **P** to print the Allergy Summary Report. For detailed information about this report, see "Allergy Summary List" in Chapter 6 in the Order Management/Charge Processing Volume of the *STAR Patient Care Reference Guide*.

Display Patient Medication Orders

To display the patient's medication orders, you can enter the number of a specific order or enter a hyphen (-) to select the desired orders from a list.

If you enter a hyphen (-), the following screen is displayed:

```
              General Hospital Patient Profile Inquiry Processor
Nurse Order Inquiry                                 Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
7313584       MARNER,ALICE      F  02/12/56 9900-1  KURTZ,JANE   MED 10 I/P 79
 1 All Orders        2 Meds or Sol       3 Order status
   Yes
                                         4 DC date









Accept this screen? (Y/N) [Y]--
```

This screen determines which orders the system displays on the list from which you can make your selection.

Field Explanations

1. ALL ORDERS (1-A-R)
You can display all of the patient's orders on the list. To include all orders, enter **Y**. When you want to display specific orders, enter **N**. The remaining fields on this screen enable you to define the specific orders you want to display. If you enter **Y** to include all orders, the system bypasses the remaining fields.

2. MEDS OR SOL (1-A-C)
This field determines if the system displays only medication orders, only solution orders, or both medication and solution orders on the list:

- To display only medication orders, enter **M**.

- To display only solution orders, enter **S**.
- To display both medication and solution orders, enter **B**.

If you enter Yes in the All Orders field, you cannot edit this field.

3. ORDER STATUS (7-C-C)
You can identify the specific order statuses you want to include in the list. Enter an equal sign (=) to include orders of all statuses, identify one or more specific statuses, or press ENTER to accept the default response (Active orders only).

The following list contains the status options and their option letters:

- A - Active
- H - Held
- D - Discontinued
- C - Cancelled
- N - Not Started

To select a single status, enter the letter of the desired status. To select multiple statuses, enter the appropriate letters separated by a comma (for example, A,H,N).

4. DC DATE (DATE-C)
You can identify the date of the earliest discontinued order that you want to include in the list of orders. The system includes all orders discontinued on or after the date entered in this field.

Press ENTER to include all of the patient's discontinued orders or enter a specific starting date using the date-entry techniques described in the General Information Volume of the *STAR Patient Care Reference Guide*.

After you accept this screen, the system displays a list of the patient's orders based upon the criteria established using this screen. Enter the number of the desired order.

If you select an order with multiple items, the system displays a list of the order's items. Enter the option numbers of the items for which you want to display order information.

DISPLAY MEDICATION ORDER

After you identify a specific medication order and select the desired items, the following screen is displayed for the first item:

```
              General Hospital Patient Profile Inquiry Processor
Nurse Order Inquiry                                 Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
7313584       MARNER,ALICE       F  02/12/56 9900-1  KURTZ,JANE   MED 10 I/P 79
 1 Item Name,Strength,Form
   937 PHENYTOIN SODIUM 100MG CAPSULE SR
 2 Dosage             3 Adm/Dose           4 Disp/Dose        5 Route
   100 MG               1 CAPSULE SR         1 CAPSULE SR     ORAL
 6 Frequency          7 Scheduled Days     8 Ordering Physician
   TID                  DAILY                16 KURTZ,JANE
 9 Administration Times
   07:00am,03:00pm,11:00pm
10 Start Date/Time  11 Stop Date/Time    12 ASO Type
   02/10/09 03:00p
13 Verification Required ?

14 Type             15 Sol Rate          16 Disp Interval   17 Infuse Over

18 Bottle Schedule                       19 Drug Rate


Press NL--
```

Field Explanations

1. ITEM NAME,STRENGTH,FORM (DISPLAY ONLY)
This field contains a description of the prescribed item including the formulary code, item name, strength, and dosage form. The Misc, HBO - Trade vs Generic parameter determines whether the system displays the item's brand name or the generic name.

2. DOSAGE (DISPLAY ONLY)
This field contains the dosage of the prescribed item.

3. ADM/DOSE (DISPLAY ONLY)
This field contains the quantity to administer per prescribed dose of the item.

4. DISP/DOSE (DISPLAY ONLY)
This field contains the quantity to dispense per prescribed dose of the item.

5. ROUTE (DISPLAY ONLY)
This field contains the prescribed route of administration for the order.

6. FREQUENCY (DISPLAY ONLY)
This field contains the prescribed frequency of administration for the item.

7. SCHEDULED DAYS (DISPLAY ONLY)
This field contains the schedule for administering the item.

8. ORDERING PHYSICIAN (DISPLAY ONLY)
This field contains the name and physician code of the prescribing physician.

9. ADMINISTRATION TIMES (DISPLAY ONLY)
This field contains the administration times scheduled for the medication item or solution order.

10. START DATE/TIME (DISPLAY ONLY)
This field contains the date and time when the item was first administered.

11. STOP DATE/TIME (DISPLAY ONLY)
This field contains the date and time after which the item should no longer be administered to the patient.

12. ASO TYPE (DISPLAY ONLY)
This field contains the automatic stop order (ASO) type assigned to the order. The system uses the order's ASO type to create notifications for review/renewal prior to the order's actual stop date and time.

13. VERIFICATION REQUIRED? (DISPLAY ONLY)
This field contains the verification indicator. Possible entries in this field include: Not required, Required before processing, and Required after processing. The Ord Mgt - Verification Req parameter determines the value displayed in this field.

14. TYPE (DISPLAY ONLY)
This field contains the abbreviated description of the solution order's IV type which is defined in the Solution Type Codes table. This field does not apply to medication orders and remains blank when a medication order is displayed.

15. SOL RATE (DISPLAY ONLY)
This field contains the order's prescribed rate of administration. This field does not apply to medication orders and remains blank when a medication order is displayed.

16. DISP INTERVAL (DISPLAY ONLY)
This field contains the interval at which solution bottles are dispensed. This field does not apply to medication orders and remains blank when a medication order is displayed.

17. INFUSE OVER (DISPLAY ONLY)
This field contains the amount of time required to administer one dose. This field does not apply to medication orders and remains blank when a medication order is displayed.

18. BOTTLE SCHEDULE (DISPLAY ONLY)
This field contains the bottle schedule for administering the drug. This field does not apply to medication orders and remains blank when a medication order is displayed.

19. DRUG RATE (DISPLAY ONLY)
This field contains the prescribed drug rate (the number of strength units per hour that should be administered to the patient). The system only calculates a drug rate if the Drug Rate field of the Solution Type Codes table contains a Yes entry for the order's solution type. This field does not apply to medication orders and remains blank when a medication order is displayed.

When you are finished viewing the order information, press ENTER to exit the screen. If you selected multiple ingredients of a multi-item order, the system automatically redisplays the screen for the next ingredient.

DISPLAY SOLUTION ORDER

After you select a specific solution order, the system displays the following prompt:

View (O)rder or (B)ottle information [O]--

To view the order information, enter **O**. To view bottle information, enter **B**.

Order Information

If you enter **O** to view order information, the following screen is displayed:

```
             General Hospital Patient Profile Inquiry Processor
Nurse Order Inquiry                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
7313584       MARNER,ALICE      F  02/12/56 9900-1  KURTZ,JANE   MED 10 I/P 79
 1 Item Name,Strength,Form
   104 D5LR INJECTION
 2 Dosage            3 Adm/Dose           4 Disp/Dose        5 Route
                       1000 ML              1,000 ML          INTRAVENOUS
 6 Frequency         7 Scheduled Days     8 Ordering Physician
                       DAILY                16 KURTZ,JANE
 9 Administration Times

10 Start Date/Time  11 Stop Date/Time    12 ASO Type
   09/04/09 04:39p
13 Verification Required ?
   Not required
14 Type             15 Sol Rate          16 Disp Interval   17 Infuse Over
   PRI                 125 ML/HR
18 Bottle Schedule                       19 Drug Rate
   QB EVERY BOTTLE

Press NL--
```

The system displays the same screen for both medication and solution orders. For more detailed information about a specific field refer to "Display Patient Medication Orders" on page 1-80.

Bottle Information

If you enter **B** to view bottle information, the system displays the following prompt:

Enter bottle numbers (e.g. 1,3,6-10), or `-` to list--

Enter the numbers of the bottles you want to view or enter a hyphen (-) and select the bottles from the list that displays. After you identify the desired bottles, the Bottle Information screen is displayed for the first bottle, as in the following example:

```
              General Hospital Patient Profile Inquiry Processor
Nurse Order Inquiry                                Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
7313584       MARNER,ALICE      F  02/12/56 9900-1  KURTZ,JANE   MED 10 I/P 79
Order: 5   Bottle: 3           Volume:  1000ML     Hang time: 02/21/09 0600am
   5  Next: Bottle 5 02/21/09 1000pm        Pri   Q8H   125   02/20       ACT
      DEXTROSE 5 %/1000 ML                       QB    QD    02/20




Press NL--
```

The bottle information includes the order number, bottle number, bottle volume, satellite code if dispensed from a satellite, the date and time at which the bottle should be or was administered, and the order summary reflecting the items in the bottle, their schedule information, and the order's frequency and rate at that time.

When you finish viewing the bottle information, press ENTER. If you select more than one bottle to view, the system displays the screen for the next bottle. If you have viewed all of the bottles selected, the system redisplays the following prompt:

View (O)rder or (B)ottle information [O]--

You can view additional order or bottle information, or enter period (.) ENTER to redisplay the Pharmacy Profile Inquiry prompt.

Chapter 2 - PLAN OF CARE PROCESS

This chapter provides information about the Plan of Care Process the nurse uses to plan the patient's care in the hospital. Access the Plan of Care Process through Defining Characteristics or by selecting the desired Plan of Care directly from the Plan of Care Menu. This chapter includes:

Illustrations

TERMS AND CONCEPTS

This section defines terms and concepts used with the Care Planning and Documentation module. The terms and concepts are listed in alphabetical order.

ACTIVE ORDERS
Active orders are physicians' orders, including associated preps and instructions, currently being performed for the patient. An example is a laboratory or radiology order. Active orders do not include medication orders.

ACTIVITIES OF DAILY LIVING (ADLs)
ADLs are activities required for a patient on a daily basis such as activity, hygiene and diet. When illness or injury prevents the patient from doing these activities, the nurse provides care to meet these requirements. ADLs are often physicians' orders where a nurse intervenes and places complementing orders.

DISCHARGE/EXPECTED OUTCOME
The Discharge/Expected Outcome is a measurable patient behavior to be accomplished by the patient prior to discharge from the facility.

DISCHARGE PLAN
The Discharge Plan is the long term plan which extends beyond the patient's hospitalization. Discharge Planning facilitates the patient's transition from hospital to home. All appropriate ancillary departments participate in the Discharge Plan for the patient.

INTERVENTIONS
Interventions are specific nursing actions performed to resolve an identified patient problem or to reach an identified patient expected outcome. Intervention examples are assessing, monitoring, teaching and providing hands-on care. Interventions can be a physician's order but do not require a medical order.

PATIENT CARE PROFILE (PCP)
The Patient Care Profile is a STAR Patient Care Nursing document usually printed for each shift. It contains information specific to the shift. This chart document replaces the non-automated hospital Kardex and Nursing Notes. The PCP can contain Active Orders, Treatments, ADLs, Plan of Care, Patient Demographics, Patient History and an area for Nursing Notes. Your facility can use the system-generated PCP or build and format its own PCPs.

PLAN OF CARE
The Nursing Plan of Care is the written plan of expected outcomes and interventions for meeting the patient's needs with an individualized set of standards.

PRECAUTIONS
Precaution information alerts the medical and nursing staff to any special patient condition. Examples of precautions are seizure precautions, NO BP (blood pressure) Rt arm, and NO CODE. Printing precautions is an option on the PCP and the Active Order work sheet.

PROBLEM/EXPECTED OUTCOME

The Problem/Expected Outcome is a statement of the patient's problem and a short-term expected outcome for resolving this problem. The problem is often the causative or contributing factor for the patient's illness, such as Impaired Mobility related to Fractured Femur.

TREATMENTS

Treatments are therapeutic activities or procedures a physician orders for a patient. How the procedure needs to be done can be defined, or ordered, by the nurse.

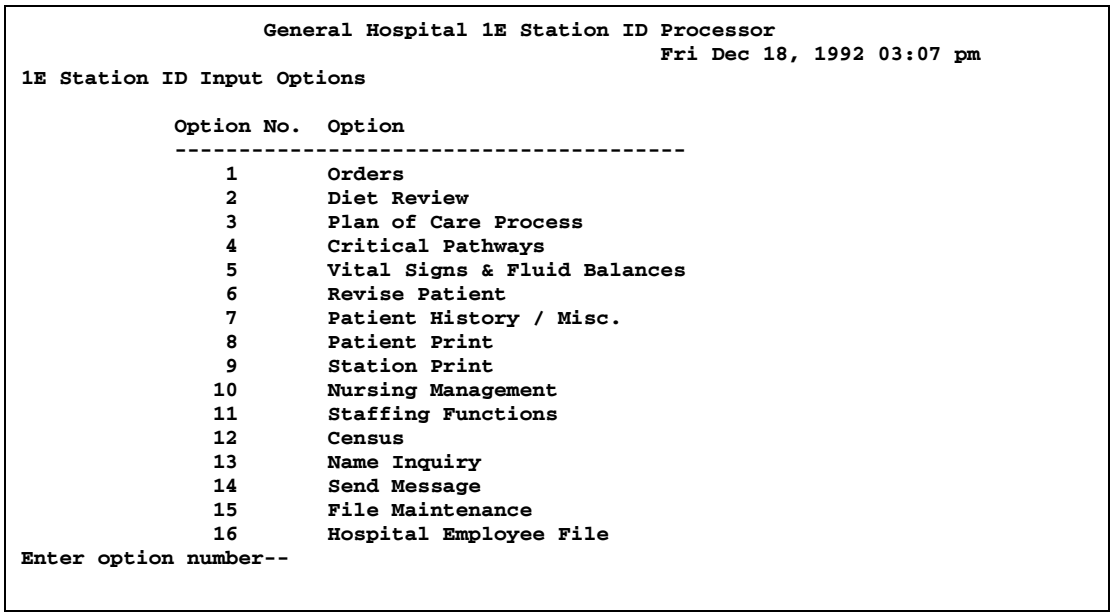
DEFINING CHARACTERISTICS

This function enables you to enter and maintain evaluative data by defining characteristics that provide selection of the appropriate Plan of Care based on patient problems. When you enter the system through Defining Characteristics, you can select a defined Plan of Care for the patient.

The components of Defining Characteristics are Level 1 - Systems, Level 2 - Signs and Symptoms, and Level 3 - Problems. The Defining Characteristics screens display a selection of category descriptions by station and body systems that correspond with the Patient's Assessment or History form. You can select multiple body systems. Once you identify the body systems, the system displays a list of signs and symptoms for each body system. The screen following signs and symptoms contains the problems associated with each selected sign or symptom. Problems from this list determine the Plan of Care that displays for selection when you continue into the Plan of Care process. The Plan of Care list is composed of selected combinations of these Defining Characteristics.

The system stores the results of each selection for printing or modification during the patient's hospitalization. The system also retains the employee ID of the nurse entering the information and the appropriate date and time.

The following screen is a sample Main Menu that displays at a Nursing Station. To access the Defining Characteristics function, select the Plan of Care Process option from this menu.



```
                  General Hospital 1E Station ID Processor
                                                 Fri Dec 18, 1992 03:07 pm
1E Station ID Input Options

             Option No.  Option
             ----------------------------------------
                 1       Orders
                 2       Diet Review
                 3       Plan of Care Process
                 4       Critical Pathways
                 5       Vital Signs & Fluid Balances
                 6       Revise Patient
                 7       Patient History / Misc.
                 8       Patient Print
                 9       Station Print
                10       Nursing Management
                11       Staffing Functions
                12       Census
                13       Name Inquiry
                14       Send Message
                15       File Maintenance
                16       Hospital Employee File
Enter option number--
```

The following prompt displays for you to select the patient:

Enter acct #, '-'bed code, first chars of name'-' [2N Census]--
'C' for Census

NOTE: Information Windows displaying Patient Information, Physicians, and Pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in this function. During the download process, the system displays the following message:

Downloading Information Windows...Please Wait!

After the windows are downloaded, you can view them in any other nonpatient-specific function on STAR Patient Care. When you access a patient-specific function other than Order Management or Nursing functions, the downloaded information is cleared. The information is also cleared when you select a different patient in one of the functions where Information Windows are available.

For specific information regarding Patient, Physician, or Pharmacy Information Windows, refer to "Appendix B - INFORMATION WINDOWS".

After you select the patient, the following Plan of Care submenu displays:

```
                  General Hospital Plan of Care Processor
                                                    Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00007   WORTHINGTON,WILL  M  03/17/12 1208-2  ADAMS,HAROLD CCU 10 I/P 15
            Option No.  Option
            ---------------------------------------
                1       Defining Characteristics
                2       Patient Assessment
                3       Recommended Plan of Care/Outcomes
                4       Plan of Care
                5       Discharge/Exp Outcome
                6       Problem/Exp Outcome
                7       Discharge Plan
                8       Intervention/Treatments
                9       ADL's / Misc.
               10       Problem List
               11       Display Patient Care Profile

 Print         12       Patient Care Profile
               13       Nursing Plan of Care

Enter option number--
```

If levels were previously selected for the patient, the system displays the following screen when you select Defining Characteristics from the Plan of Care menu. The following screen lets you view the levels that were linked for this patient. If no Characteristics were defined for the patient, the system does not display the following screen.

```
            General Hospital Defining Characteristics Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90018-00006   ELLIOT,ELLEN       F  03/17/60 1202-1  ZELLER, JD   OTH 10 I/P 40

     Level 1   Level 2   Level 3

     DISEASE MUSCULOSKETAL/CONNECTIVE
               PATHOLOGICAL FRACTURES
                         IMMOBILITY









Press NL--
```

Field Explanations

1. LEVEL 1 (DISPLAY ONLY)
The field displays the Level 1 component assigned to the patient as the beginning or first level for the patient's Defining Characteristic group.

2. LEVEL 2 (DISPLAY ONLY)
This field displays the symptom selected and linked to the related body system in the first level.

3. LEVEL 3 (DISPLAY ONLY)
This field displays the problem associated with the symptom linked to the bodysystem. Using this problem, the system selects the appropriate Plan of Care for the patient.

Next, the system prompts you to press the ENTER key. The system then displays a Defining Characteristics menu similar to the following screen. From this menu, select a set of Defining Characteristics for the patient. This menu contains the Level 1 body systems from which to select.

```
            General Hospital Defining Characteristics Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90018-00006   ELLIOT,ELLEN       F  03/17/60 1202-1  ZELLER, JD   OTH 10 I/P 40

                          Defining Characteristics Menu
( 1) DISEASE MUSCULOSKETAL/CONNECTIVE
( 2) DISEASE/DISORDER EAR,NOSE,THROAT
( 3) DISEASE/DISORDER CIRCULATORY SYS
( 4) DISEASE/DISORDER RESPIRATORY SYS
( 5) MENTAL DISORDERS









Enter choices (e.g. 1,3,7-9) or `-`choices to remove--
                                end selection(NL)
```

Select the Level 1 body system(s) and the system displays the Level 2 signs and symptoms for selection as shown on the next screen.

The following screen links Level 2 signs and symptoms to the related body system. The Level 1 body system displays above the list of Level 2 components. You can link multiple signs and symptoms to the selected Level 1.

```
            General Hospital Defining Characteristics Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90018-00006   ELLIOT,ELLEN       F  03/17/60 1202-1  ZELLER, JD   OTH 10 I/P 40

Level 1:  DISEASE MUSCULOSKETAL/CONNECTIVE



Page:01                              Level 2                  ##=Current Choices
( 1) WOUND DEBRIDEMENT/SKIN GRAPH        (11) SEPTIC ARTHRITIS
( 2) KNEE PROCEDURES                     (12) TENDONITIS,MYOSITIS & BURSITIS
( 3) FOOT PROCEDURES
( 4) GANGLION HAND PROCEDURES
( 5) ARTHROSCOPY
( 6) FRACTURE OF FEMUR
( 7) FRACTURE OF HIP & PELVIS
( 8) SPRAINS,STRAINS,DISLOCATIONS
( 9) OSTEOMYELITIS
(10) PATHOLOGICAL FRACTURES

Enter choices, `-`choices to remove, or plans(P)--
                                end selection(NL)
```

Select the Level 2 signs and symptoms to link to the selected Level 1 and the system displays the Level 3 problems as shown on the following screen. This screen displays the problems associated with the Level 2 signs and symptoms. Levels 1 and 2 display above the list of problems. You can select multiple problems from this screen.

```
            General Hospital Defining Characteristics Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90018-00006   ELLIOT,ELLEN       F  03/17/60 1202-1  ZELLER, JD   OTH 10 I/P 40

Level 1:  DISEASE MUSCULOSKETAL/CONNECTIVE Level 2:  PATHOLOGICAL FRACTURES


Page:01                              Level 3                  ##=Current Choices
( 1) IMMOBILITY









Enter choices, `-`choices to remove, or plans(P)--
                               end selection(NL)
```

Select problems from the list. To access the Plan of Care function, enter **P** then press ENTER. The system displays a Plan of Care list linked to the selected characteristics. See the following screen example.

This screen contains the Plan of Care list linked to the characteristics defined for the patient. You can select multiple plans. A Plan of Care currently being used for the patient has two pound signs (##) next to its description.

```
            General Hospital Defining Characteristics Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90018-00006   ELLIOT,ELLEN       F  03/17/60 1202-1  ZELLER, JD   OTH 10 I/P 40









Page:01                            Plan of Care               ##=Current Choices
( 1) ACTIVITY INTOLERANCE









Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                               end selection(NL)
```

After you select the Plan of Care, the system displays the Plan of Care Update screens in the order selected. The Plan of Care Update screen is part of the Plan of Care process. Refer to "PLAN OF CARE PROCESS" on page 2-10 for information about the Plan of Care screens.

PLAN OF CARE PROCESS

The Plan of Care process is an organized group of activities that are individualized to meet the needs of a specific patient. When initiating the Plan of Care, the nurse determines what care the patient requires in order to achieve the highest level of wellness and then defines a plan to care for the patient. Nurses can easily create an individualized Plan of Care by selecting or adding components from a user-defined standardized Plan of Care.

The following are benefits of the Plan of Care:

- It is individualized for each patient.
- It is flexible for building.
- It encourages quality patient care by standardizing the basic care plan.
- It provides for accurate recording of up-to-date information by encouraging revisions each shift.

The Plan of Care is composed of the following components:

PLAN OF CARE
This is the name of the Plan of Care you want to use. It often is the Nursing Diagnosis.

DISCHARGE/EXPECTED OUTCOME
The Discharge/Expected Outcome is a measurable patient behavior(s) to be accomplished by the patient prior to being discharged from the facility.

PROBLEM/EXPECTED OUTCOME
The Problem/Expected Outcome is a statement of the patient's problem and a short-term expected outcome to resolve the problem. The Problem is often the causative or contributing factor of the patient's illness such as *Impaired Mobility Related to Fractured Femur*.

DISCHARGE PLAN
The Discharge Plan is the long term plan that extends beyond the patient's hospitalization. Discharge planning assists the patient's transition from the hospital to the home. All appropriate ancillary departments participate in the total discharge plan for the patient.

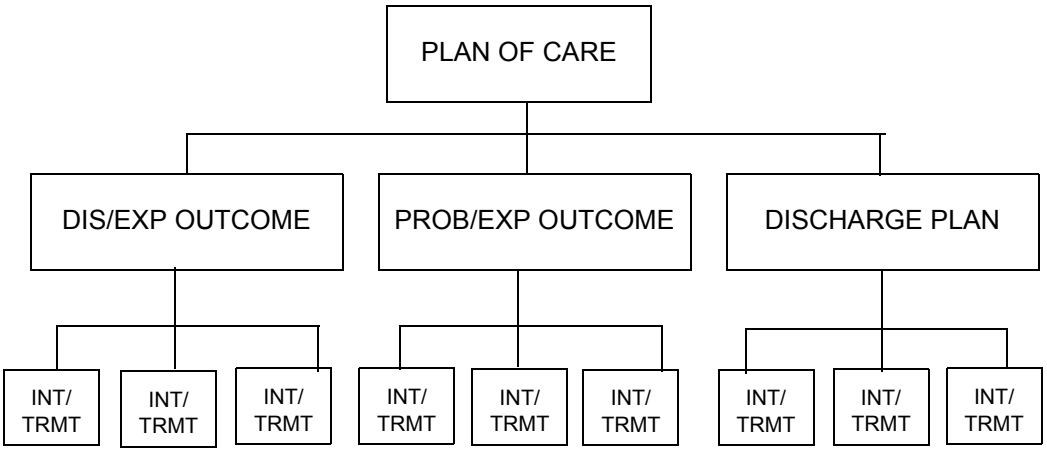
INTERVENTIONS
Interventions are specific nursing actions performed to resolve an identified problem or reach an identified expected outcome for the patient. Interventions include assessing, teaching, monitoring and providing hands-on care. Interventions may be a physician's order but do not always require a medical order.

TREATMENTS
Treatments are therapeutic activities or procedures a physician orders for a patient. How the procedure is done may be *ordered*, or defined, by the nurse.

Relationship of Components

The following diagram shows a Plan of Care and its components. Beginning at the lowest level, interventions and treatments are linked to specific Discharge/Expected Outcomes, Problem/Expected Outcomes and Discharge Plans. The expected outcomes, in turn, are linked to a Plan of Care. Any number of Plan of Care components can be added at each level.

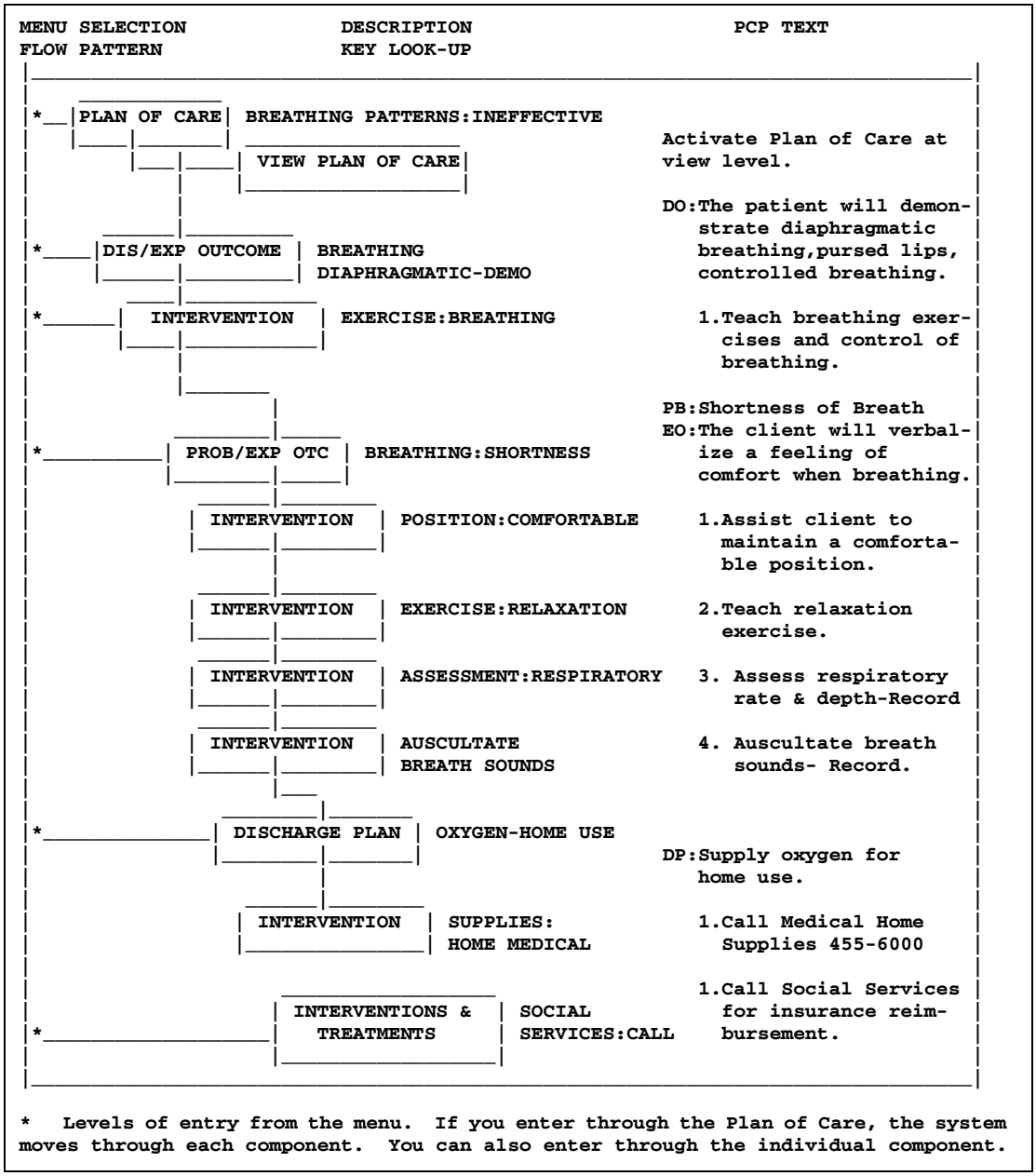
When you build the interventions using the Interventions/Treatments option from the Standard Plan of Care menu, the interventions display in the order you built them. When you build the expected outcomes and discharge plans using the options from the Standard Plan of Care menu, the expected outcomes and discharge plans display in the order they are linked to a Plan of Care. When the interventions and outcomes are active and you view them on the summary screen, they display in the order built.



Plan of Care Flow

Following is a diagram which illustrates the flow of the Plan of Care process. This diagram begins with choosing the Plan of Care, viewing the Plan of Care and moving through discharge/expected outcomes, problem/expected outcomes, discharge plans and interventions. Numerous levels of entry exist, each marked with an asterisk (*). You can begin with the Plan of Care itself and the system leads you through the successive components, or you can enter through any one of the individual components.

Figure 2.1 Plan of Care Process Flowchart



Navigating the Plan of Care

As you choose your Plan of Care and move through the Plan of Care process screens, the system displays information to keep you informed of your exact position within the Plan of Care. The following is an example of a screen that displays while viewing a Plan of Care:

```
                        General Hospital Plan of Care Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):        ABDOMINAL SURGERY

Discharge Outcome (1 of 6):   ABDOMINAL SURGERY
EO:(Discharge) VSS; Wound healing w/out s/s of infection. Bowel function WNL
   Pain controlled; Understands D/C instructions.

Problem Outcome (2 of 6):     BREATHING PAT INEFFECT, INCISION
PB:TD__/__Ineffective breathing pat- tern r/t:  op site/incision pain.
EO:Respiratory rate & effort WNL with good chest expansion.

Intervention (1 of 5):        ASSESS RESPIRATORY STATUS, POST-O
  :Assess post-op respiratory status Q 2H for type, frequency & character of
   respirations:_____________________


Press NL to continue viewing, `A` to activate, `P` for pending auth status--
```

The name of the Plan of Care you selected to view is highlighted in the middle of each screen. The system follows the name with a component indicator that shows that you are viewing one Plan of Care (1 of 1), since you can only view one Plan of Care at a time. The screen displays the name of the Plan of Care at the top of each screen.

The name of the current component(s) is highlighted and includes a component indicator that shows the total number of Discharge/Expected Outcomes, Problem/ Expected Outcomes, or Discharge Plans that are included in the Plan of Care you are viewing. The indicator also shows you which component you are currently viewing.

In the above example, there are six components linked to the Plan of Care, and two are currently on the screen. You are viewing the Discharge/ Expected Outcome, which is the first component (1 of 6). The screen also is displaying the second component, the Problem/Expected Outcome (2 of 6).

The component indicator for the interventions/treatments displays the number of interventions/treatments that are linked to the current component you are viewing (not the total number for the Plan for Care). In the above example, you are viewing the first of five (1 of 5) interventions linked to the Problem/Expected Outcome you are viewing.

The following is an example of the screen that displays when you activate a Plan of Care and are selecting the specific components you want to include for the patient:

```
                General Hospital Plan of Care Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):  CHEST PAIN                                      Active
Discharge Plan (1 of 1):  ARRANGE FOR HOME CARE                         Active

 1 Description                      2 Type                        3 Status
   KNOWLEDGE OF ANALGESICS            Intervention (2 of 2)        Inactive
 4 Action      5 Print   6 Shifts  7 Added by               8 Date Added
->               Yes                Jones,Michele J          01/13/04 02:36pm
 9 Text                          10 Completed by          11 Date Completed

  |Assess pt's knowledge of analgesics/ pain medications:_____________________  |
  |_____________________________________                                         |
  |                                                                              |



Activate(A), pend(P), delete(D), or revise(R) intervention--  |
                        / next screen  /P prev screen
```

The name of the current Plan of Care is highlighted in the upper-left corner of each screen. The system follows the name with a component indicator that shows the sequence of this Plan of Care in your selection. For example, if you selected two Plans of Care, and the current plan was your first selection, the system displays 1 of 2 after the name of the Plan of Care.

The name of the current component is highlighted and the component indicator shows the sequence of this component in your selection. For example, if you selected six Expected Outcomes, and the current Expected Outcome was your second selection, the system displays 2 of 6 after the name of the Expected Outcome.

The system also displays the status of each of the components, for example, Complete or Active.

This clear definition of your exact location, and the current status of each component, aids in the process of adding, activating or tailoring a Plan of Care.

Inquiry Screen

Two screens are common to each of the five components in the Plan of Care process: the Plan of Care Inquiry and Plan of Care Update screens. Descriptions of each are on the following pages. The two screens are specifically used for the Plan of Care process and are not related to the Order Inquiry and Order Review functions in the STAR Patient Care Order Management/Charge Processing Module.

The system first displays the Plan of Care Inquiry screen. It contains a list of components associated with the Patient's Profile and the Plan of Care chain.

The following example shows the Plan of Care Inquiry screen for Plans of Care. The screen is the same for the other components.

```
                    General Hospital Plan of Care Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE       F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

No.    Type           Status     Description
                                                          ##=Current Choices
( 1)   Plan of Care   Active     FEVER OF UNKNOWN ORIGIN-PEDIATRIC









Enter choices (e.g. 1,3,5-7) or add(A) plan of care--
                               end selection(NL)
```

Field Explanations

1. NO. (DISPLAY ONLY)
This field shows the line number for selecting the component you want to update.

2. TYPE (DISPLAY ONLY)
This field shows the type of component; for example, Plan of Care, Discharge/ Expected Outcome, Problem/Expected Outcome, Discharge Plan or Intervention/ Treatments.

3. STATUS (DISPLAY ONLY)
This field shows the status of the component: Active, Inactive, Deleted, or Completed. Deleted components display only during the current update process. An additional status of Pending Authorization may be available during the Plan of Care process. A facility parameter designates whether this status is available. For more information on this status refer to the Pending Authorization section.

4. DESCRIPTION (DISPLAY ONLY)
This field shows the descriptive key look-up word(s) used for calling the component to the screen.

The system displays the following prompt at the bottom of the screen:

Enter choices (e.g. 1,3,5-7) or add(A) plan of care--

Enter the number to update from the displayed list, or enter **A** to add a Plan of Care.

Update Screen

The system displays the second screen: the Update Screen. This screen contains information specific to the individual component and provides you with the opportunity to add/edit pertinent information.

The following is a sample Discharge/Expected Outcome Update screen:

```
                  General Hospital Plan of Care Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE       F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):  CHEST PAIN                                    Active

 1 Description                        2 Type                        3 Status
   CHEST PAIN, TRANSFER                 Dis/Exp Outcome (1 of 1)     Active
 4 Action      5 Print  6 Shifts   7 Added by              8 Date Added
->               Yes      123       Jones,Michele J         01/13/04 02:25pm
 9 Text                            10 Completed by         11 Date Completed

Oc|(Transfer): chest pain controlled, VSS, S-T segment elevation resolved,    |
  |hemodyn. stable: hemodyn. parameters & cardiac rhythm stable.              |
  |                                                                           |



Revise(R), complete(C), delete(D) dis/exp outcome or go to interventions(I)--  |
                        / next screen  /P prev screen
```

Field Explanations

1. DESCRIPTION (DISPLAY ONLY)
This field shows the descriptive key lookup word(s) for calling the component to the screen. This can be up to 32 characters and is defined in Standard File Maintenance.

2. TYPE (DISPLAY ONLY)
This field shows the component type; for example, Plan of Care, Discharge/Expected Outcome, Problem/Expected Outcome, Discharge Plan, or Intervention/Treatment.

3. CURRENT STATUS (DISPLAY ONLY)
This field shows the current status of the component; for example, Active, Inactive, Pending Authorization, Completed or Deleted. This field is Inactive when you first add the component but changes when you activate, complete or delete the component.

4. ACTION (1-A-R)
This field contains the action for this component. The following prompt displays:

Activate(A), pend(P), delete(D), or revise(R) dis/exp outcome--

Enter **A** to activate the component, **P** to designate the component as Pending Authorization, **D** to delete the component or **R** to Revise the component. Note that you can revise the component without activating it. A facility parameter designates whether the pend action displays in the prompt. For more information on this status refer to the

Pending Authorization section. This prompt also varies depending on the current status of the component accessed.

5. PRINT (1-A-R)
This field designates whether the component prints on the Patient Care Profile (PCP). Enter **Y** to print the component. Enter **N** to not print the component on the PCP. A component that has a Pending Authorization status prints with a status of Pending on the Plan of Care and Discharge Plan, and with an exclamation point (!) on the Patient Care Profile.

6. SHIFTS (3-N-R)
This field designates the shifts at which the component is to print on the PCP: 1 = Day Shift, 2 = Evening Shift, and 3 = Night Shift. Enter 123 to print all three shifts, 12 to print on day and evening, 1 to print on day and 2 to print on evening shift. When you try to accept the screen without entering the shift(s) in this field, you receive the following error message:

Shifts to Print are required!

7. ADDED BY (DISPLAY ONLY)
This field shows the name of the individual signed-on to the system.

8. DATE ADDED (DISPLAY ONLY)
This field shows the current date.

9. TEXT (180-C-O)
This field shows the instructions that print on the Patient Care Profile (PCP). This text contains instructions for the caregiver to follow. The freeform box contains 3 lines of 75 characters each. This text field displays on all component Update screens except the Plan of Care.

10. COMPLETED BY (DISPLAY ONLY)
The system automatically displays the name of the nurse who completes the component.

11. DATE COMPLETED (DISPLAY ONLY)
The system automatically enters the date the nurse completes the component.

ACTION FUNCTIONS

One prompt on this screen contains action functions you can initiate on the Plan of Care component. The actions applicable to the Plan of Care process are:

- Activate
- Revise
- Complete

- Reactivate
- Delete
- Expected Outcomes
- Interventions
- Designate as Pending Authorization

You can activate, designate as pending authorization, revise, or complete all the Plan of Care components - Plan of Care, Discharge/Expected Outcome, Problem/Expected Outcome, Discharge Plan and Intervention/Treatments. Only completed components can be reactivated, and only active and inactive components can be deleted.

ACTIVATE
The component is currently a part of the patient's care and planning and needs to print on the Patient Care Profile (PCP). When a component is activated, the system moves through the component and its linked components. For example, when a Discharge/ Expected Outcome is activated, the interventions linked with the expected outcome display for selection and activation.

REVISE
This action indicates that information needs to be changed on a component. This function affects only the chosen component. For example, a problem/expected outcome is chosen to view or change. The system returns to the problem/expected outcome screen but does not display its linked interventions.

COMPLETE
This action indicates complete criteria. The component no longer needs to be a part of that patient's planning or must print on the PCP. The system does provide an option to print completed items on the PCP.

REACTIVATE
A completed Plan of Care and its components can be activated again for the same patient. The reactivated Plan of Care replaces the original, completed Plan of Care on Plan of Care printouts.

DELETE
This action removes the component from the Nursing Plan of Care. The system prompts you to delete or file the component as inactive. The component can be reactivated. Components are linked through Standard File Maintenance functions.

EXPECTED OUTCOMES
This action specifies that you want to view the components (Discharge/Expected Outcome, Problem/Expected Outcomes and Discharge Plans) linked to the displayed Plan of Care.

INTS
This action specifies that you want to view the interventions linked to the displayed Expected Outcome or Plan.

PEND
This action specifies that you want to designate this element as Pending Authorization. This element does not become active until reviewed and activated. This option displays only when a facility parameter designates this status as being available. This status is designed to allow student nurses or new employees to build a Plan of Care which is not activated until reviewed by an experienced or licensed staff member.

This status can apply to the entire Plan of Care or to one or more elements of the Plan of Care. When reviewed, the status of the Plan of Care or elements can be changed to active. The system does not calculate acuity values as long as the elements have a *Pending* status.

The pending status prints elements on the Plan of Care and Discharge Plan as having a status of *Pending*. On the Patient Care Profile, an exclamation point (!) prints in front of the element that has a Pending Authorization status.

Plan of Care

The nurse uses the Plan of Care option to enter the Plan of Care components and begin selecting the appropriate Plan of Care for the patient.

After you select the Plan of Care Process from the station menu and identify the patient, the system displays the following submenu from which to select the Plan of Care option.

```
                  General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
90330-00003   LANE,EMILY         F  02/14/80 1205-1  ADAMS,FRANK CSUR 10 I/P 2
             Option No.  Option
             ----------------------------------------
                 1       Defining Characteristics
                 2       Patient Assessment
                 3       Recommended Plan of Care/Outcomes
                 4       Plan of Care
                 5       Discharge/Exp Outcome
                 6       Problem/Exp Outcome
                 7       Discharge Plan
                 8       Intervention/Treatments
                 9       ADLs/Misc.
                10       Problem List
                11       Display Patient Care Profile

    Print        12       Patient Care Profile
                 13       Nursing Plan of Care
                 14       Assessment Reports

 Enter option number--
```

After you select Plan of Care from the submenu, the system displays the Plan of Care Inquiry screen:

```
                    General Hospital Plan of Care Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE       F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

No.    Type          Status     Description
                                                          ##=Current Choices
( 1)   Plan of Care  Active     CHEST PAIN
( 2)   Plan of Care  Active     FEVER OF UNKNOWN ORIGIN-PEDIATRIC









Enter choices (e.g. 1,3,5-7) or add(A) plan of care--
                               end selection(NL)
```

From this screen, you can select multiple plans, add a new Plan of Care or update an existing Plan of Care.

If entering a new Plan of Care, enter **A** to Add, then press ENTER. The system displays a screen with the following prompt:

Enter plan of care code or starting letter(s)`-`--

Enter the appropriate code or starting letters of the Plan of Care, or a hyphen (-) to display a table listing for selecting the Plan of Care.

Once you select the Plan of Care, the system displays the Plan of Care forviewing prior to activating. The view function enables the nurse to ensure the most appropriate Plan of Care has been selected for the patient.

```
                    General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):        ABDOMINAL SURGERY

Discharge Outcome (1 of 6):   ABDOMINAL SURGERY
EO:(Discharge) VSS; Wound healing w/out s/s of infection. Bowel function WNL
   Pain controlled; Understands D/C instructions.

Problem Outcome (2 of 6):     BREATHING PAT INEFFECT, INCISION
PB:TD__/__Ineffective breathing pat- tern r/t:  op site/incision pain.
EO:Respiratory rate & effort WNL with good chest expansion.

Intervention (1 of 5):        ASSESS RESPIRATORY STATUS, POST-O
  :Assess post-op respiratory status Q 2H for type, frequency & character of
   respirations:_____________________


Press NL to continue viewing, `A` to activate, `P` for pending auth status--
```

You can view the Plan of Care in its entirety, enter **A** to activate it, or enter **P** to designate its status as Pending Authorization.

NOTE: If you select an active Plan of Care from the list shown on the previous screen, the following prompt displays:

Complete (C) or delete (D) plan of care or go to expected outcomes (O)--

You can enter **C** to complete the Plan of Care or **D** to delete it. If you enter **O** (Expected Outcomes), the system displays a screen containing a list of Discharge/Expected Outcome. (If Discharge/Expected Outcomes are not set up, the system displays a list of Problem/Expected Outcomes.)

When you enter **A** to activate the Plan of Care, the system displays a screen containing a list of Discharge/Expected Outcomes (shown in the following screen example). If Discharge/Expected Outcomes have not been built by the facility, the system displays a screen containing a list of Problem/Expected Outcomes.

PLAN OF CARE - DISCHARGE/EXPECTED OUTCOME

The Discharge/Expected Outcome is the second component of the Plan of Care process. The Discharge/Expected Outcome refers to behaviors to be accomplished by the patient prior to discharge from the hospital.

NOTE: The Discharge/Expected Outcome function can be selected through the Plan of Care process or from the Nursing main menu. When Discharge/Expected Outcome is selected through the Plan of Care process, only Discharge/ Expected Outcomes for the specific Plan of Care selected are displayed (not all Discharge/Expected Outcomes associated with the patient). The

Discharge/Expected Outcomes display in the order they were built. For more information about selecting the function from the main menu refer to the Discharge/Expected Outcome section.

```
                    General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE       F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):  CHEST PAIN                                      Active

No.    Type               Status     Description
                                                          ##=Current Choices
( 1)   Dis/Exp Outcome    Active     CHEST PAIN, TRANSFER
( 2)   Dis/Exp Outcome    Inactive   CHEST PAIN, DISCHARGE









Enter choices (e.g. 1,3,5-7) or add(A) dis/exp outcomes--
                               end selection(NL)
```

From this screen, you can select multiple Discharge/Expected Outcomes to update, or you can add a Discharge Expected Outcome.

If you want to add a new Discharge/Expected Outcome, enter **A**. The following prompt displays:

Enter dis/exp outcome code or starting letter(s) --

Identify the desired discharge/expected outcome by entering the exact code of the discharge/expected outcome, the starting letters of the Discharge/Expected Outcome followed by a hyphen (-) to select from a specified list, or a hyphen (-) to select from a list.

Once the Discharge/Expected Outcome is selected, the following Update screen displays. For field explanations refer to the Discharge/Expected Outcome Update screen.

```
                    General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):  CHEST PAIN                                      Active

 1 Description                        2 Type                        3 Status
   CHEST PAIN, DISCHARGE                 Dis/Exp Outcome (1 of 1)    Active
 4 Action      5 Print  6 Shifts   7 Added by              8 Date Added
->               Yes      123        Jones,Michele J         01/13/04 02:25pm
 9 Text                            10 Completed by         11 Date Completed

Oc|(Transfer): chest pain controlled, VSS, S-T segment elevation resolved,    |
  |hemodyn. stable: hemodyn. parameters & cardiac rhythm stable.               |
  |                                                                            |



Revise(R), complete(C), delete(D) dis/exp outcome or go to interventions(I)--  |
                        / next screen  /P prev screen
```

This Discharge/Expected Outcome can be activated, deleted or revised. (When adding a new Discharge/Expected Outcome, the system first prompts you to enter the shifts to print and enter text.)

When you activate a Discharge/Expected Outcome, the system continues to display the interventions associated with the Discharge/Expected Outcome. You can activate specific interventions.

When you delete the Discharge/Expected Outcome, the system gives you the Yes/No option to delete all interventions. When you enter **Y** for Yes, the system deletes the Discharge/Expected Outcome and its intervention/treatments. When you enter **N**, the system redisplays the previous prompt (shown on the above screen) and does not delete anything. This option is provided to ensure you do not delete a Discharge/ Expected Outcome and its associated components accidentally or without thinking carefully about using the delete option.

When you revise the Discharge/Expected Outcome, you can update the Action, Print, Shifts and Text fields.

The selected action displays in the Action field and you are prompted to accept the screen if no changes need to be made.

If the Discharge/Expected Outcome is Inactive, the following prompt displays:

Activate(A), pend(P), delete(D), or revise(R) dis/exp outcome--

Enter **A**, **P**, **D**, or **R** to activate, designate as Pending Authorization, delete, or revise the Discharge/Expected Outcome. A facility parameter designates whether the pend action displays in the prompt. Refer to the Pending Authorization section for more information on this action.

If the Discharge/Expected Outcome is Active, the following prompt displays:

Revise(R), complete(C), or delete(D) dis/exp outcome or go to interventions(I)--
/next screen, /p prev screen

Enter **R**, **C** or **D** to revise, complete or delete the Discharge/Expected Outcome. Enter **I** to continue to the intervention/treatments linked to the Discharge/Expected Outcome.

If the Discharge/Expected Outcome is Completed, the following prompt displays:

Reactivate plan of care (Y/N) or go to expected outcome (O)--
/next screen, /p prev screen

NOTE: A specific Discharge/Expected Outcome can be linked to only one Plan of Care for a patient. This is because the component is completed/ performed only once. If you Complete and then Reactivate the Discharge/Expected Outcome, the completed Discharge/Expected Outcome no longer displays with its previous component. The reactivated element now displays with the new component to which it is linked.

Impact

When you accept the screen, the system stores the component in the Patient file. The component contains the status currently selected in the Action field. Active and completed items are available for you to print on the PCP.

PLAN OF CARE - PROBLEM/EXPECTED OUTCOME

The Problem/Expected Outcome is the third component of the Plan of Care process. The Problem/Expected Outcome refers to the patient's problem, followed by a short-term expected outcome to attempt to solve that problem.

NOTE: The Problem/Expected Outcome function can be selected through the Plan of Care process or from the Nursing main menu. When you select Problem/ Expected Outcome through the Plan of Care process, only the Problem/ Expected Outcomes for the specific Plan of Care selected are displayed (not all Problem/Expected Outcomes associated with the patient). The Problem/ Expected Outcomes display in the order they were built. For more information about selecting the function from the main menu, refer to "Problem/Expected Outcome" on page 2-34.

```
                    General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):  CHEST PAIN                                      Active

No.    Type              Status     Description
                                                          ##=Current Choices
( 1)   Prob/Exp Outcome   Inactive   PAIN, CARDIAC RELATED
( 2)   Prob/Exp Outcome   Inactive   CARDIAC OUTPUT, DECREASED
( 3)   Prob/Exp Outcome   Inactive   CARDIAC OUTPUT, R/T DYSRHYTHMIAS
( 4)   Prob/Exp Outcome   Inactive   COPING, INEFFECT R/T CHEST PAIN
( 5)   Prob/Exp Outcome   Inactive   ANXIETY, GENERAL
( 6)   Prob/Exp Outcome   Inactive   KNOWLEDGE DEF CHEST PAIN




Enter choices (e.g. 1,3,5-7) or add(A) prob/exp outcomes--
                               end selection(NL)
```

If entering a new Problem/Expected Outcome, enter the appropriate code, the starting letters of the Problem/Expected Outcome, or a hyphen (-) to display a table listing from which you can select the Problem/Expected Outcome.

Once the Problem/Expected Outcome is selected, the following Update screen displays. For field explanations refer to the "Update Screen" on page 2-16.

```
                    General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):  CHEST PAIN                                      Active

 1 Description                      2 Type                       3 Status
   PAIN, CARDIAC RELATED              Prob/Exp Outcome (1 of 1)    Inactive
 4 Action      5 Print  6 Shifts   7 Added by              8 Date Added
->               Yes                Jones,Michele J         01/13/04 02:27pm
 9 Text                           10 Completed by         11 Date Completed

Pb|TD:__/__ Pain/alteration in comfort r/t: myocardial ischemia/chest pain.   |
Oc|Pain is absent or controlled.  Pt states pain relieved.  Vital signs       |
  |within normal limits.                                                      |



Activate(A), pend(P), delete(D), or revise(R) prob/exp outcome--  |
                        / next screen  /P prev screen
```

The Problem/Expected Outcome may be activated, deleted, or revised. (When adding a new Problem/Expected Outcome, the system first prompts you to enter the shifts to print and enter text.)

When you activate a Problem/Expected Outcome, the system then continues to display the interventions associated with the Problem/Expected Outcome. You can activate specific interventions.

When you delete the Problem/Expected Outcome, the system gives you the Yes/No option to delete all interventions. When you enter **Y** for Yes, the system deletes the Problem/Expected Outcome and its intervention/treatments. When you enter **N** for No, the system redisplays the previous prompt (see line on the above screen) and does not delete anything. This option is provided to ensure you do not delete a Problem/ Expected Outcome and its associated components accidentally or without thinking carefully about using the delete option.

When you revise the Problem/Expected Outcome, you can update the Action, Print, Shifts and Text fields.

The selected action displays in the Action field and you are prompted to accept the screen if no changes need to be made.

If the Problem/Expected Outcome is Inactive, the following prompt displays:

Activate(A), pend(P), delete(D), or revise(R) prob/exp outcome--

Enter **A**, **P**, **D**, or **R** to activate, designate as Pending Authorization, delete, or revise the Problem/Expected Outcome. A facility parameter designates whether the pend action displays in the prompt. For more information on this action refer to the Pending Authorization section.

If the Problem/Expected Outcome is Active, the following prompt displays:

Revise(R), complete(C), delete(D) prob/exp outcome or go to interventions(I)--

Enter **R**, **C** or **D** to revise, complete or delete the Problem/Expected Outcome. Enter **I** to continue to the intervention/treatments linked to the Problem/Expected Outcome.

If the Problem/Expected Outcome is Completed, the following prompt displays:

Reactivate prob/exp outcome (Y/N) or go to interventions(I) [N]--
/ next screen /P prev screen

NOTE: A specific Problem/Expected Outcome can be linked to only one Plan of Care for a patient. This is because the component is completed/ performed only once. If you complete and then reactivate the Problem/Expected Outcome, the completed Problem/Expected Outcome no longer displays with its previous component. The reactivated element now displays with the new component to which it is linked.

Impact

When you accept the screen, the system stores the component in the Patient file. The component contains the status currently selected in the Action field. Active and completed items are available for you to print on the PCP.

PLAN OF CARE - DISCHARGE PLAN

The Discharge Plan, the fourth component of the Plan of Care process, is a long-term expected outcome which expands beyond the patient's hospital stay. Discharge planning assists the healthcare team in providing a smooth transition from the hospital to home.

NOTE: The Discharge Plan function can be selected through the Plan of Care process or from the Nursing main menu. The Discharge Plans display in the order they were built. For more information about selecting the function from the main menu refer to the Discharge Plan section.

```
                    General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):  CHEST PAIN                                      Active

No.    Type               Status     Description
                                                          ##=Current Choices
( 1)   Discharge Plan   Inactive   ARRANGE FOR HOME CARE









Enter choices (e.g. 1,3,5-7) or add(A) discharge plans--
                               end selection(NL)
```

If entering a new Discharge Plan, enter the appropriate code, the starting letters of the Discharge Plan, or a hyphen (-) to displaya table listing from which you can select the Discharge Plan.

Once the Discharge Plan is selected, the following Update screen is displayed. For field explanations, please refer to the “Update Screen” on page 2-16.

```
                  General Hospital Plan of Care Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):  CHEST PAIN                                      Active

 1 Description                        2 Type                        3 Status
   ARRANGE FOR HOME CARE                Discharge Plan (1 of 1)      Inactive
 4 Action      5 Print  6 Shifts   7 Added by              8 Date Added
->               Yes                 Jones,Michele J         01/13/04 02:35pm
 9 Text                           10 Completed by         11 Date Completed

Pl|ARRANGE FOR HOME VISITING NURSE SERVICE                                  |
  |                                                                         |
  |                                                                         |



Activate(A), pend(P), delete(D), or revise(R) discharge plan--  |
                        / next screen  /P prev screen
```

This Discharge Plan may be activated, deleted or revised. (When adding a new Discharge Plan, the system first prompts you to enter the shifts to print and enter text.)

When you activate a Discharge Plan, the system then continues to display the interventions associated with the Discharge Plan. You can activate specific interventions.

When you delete the Discharge Plan, the system gives you theYes/No option to delete all interventions. When enter **Y** for Yes, the Discharge Plan and its intervention/ treatments are deleted. When you enter **N** for No, the system redisplays the previous prompt (shown on the above screen) and does not delete anything. This option is provided to ensure you do not delete a Discharge Plan and its associated components accidentally or without thinking carefully about using the delete option.

When you revise the Discharge Plan, you can update the Action, Print, Shifts, and Text fields.

The selected action displays in the Action field and you are prompted to accept the screen if no changes need to be made.

If the Discharge Plan is Inactive, the following prompt displays:

Activate(A), pend(P), delete(D), revise(R) discharge plan or go to interventions(I)--

Enter **A**, **P**, **D**, or **R** to activate, designate as Pending Authorization, delete, or revise the Discharge Plan. A facility parameter designates whether the pend action displays in the prompt. For more information on this action, refer to the Pending Authorization section.

If the Discharge Plan is Active, the following prompt is displayed:

Revise(R), complete(C), delete(D) discharge plan or go to interventions(I)--

Enter **R**, **C** or **D** to revise, complete or delete the Discharge Plan. Enter **I** to continue to the Intervention/treatments linked to the Discharge Plan.

If the Discharge Plan is Completed, the following prompt displays:

Reactivate discharge plan (Y/N) or go to interventions(I) [N]--
/ next screen /P prev screen

NOTE: A specific Discharge Plan can be linked to only one Plan of Care for a patient. This is because the component is completed/performed only once. If you Complete and then Reactivate the Discharge Plan, the completed Discharge Plan no longer displays with its previous component. The reactivated element now displays with the new component to which it is linked.

Impact

When you accept the screen, the system stores the component in the Patient file. The component contains the status currently selected in the Action field. Active and completed items are available for you to print on the PCP. The Discharge Plan also can be printed as a separate document from the Plan of Care.

PLAN OF CARE - INTERVENTION/TREATMENT

Intervention/Treatment is the fifth component of the Plan of Care process. Interventions and Treatments are specific tasks the nurse performs to achieve the defined Discharge/Expected Outcome, Problem/Expected Outcomes and Discharge Plans.

NOTE: The Intervention/Treatment screens can be selected through the Plan of Care process or from the Nursing main menu. (Intervention/Treatment plans are linked to specific Discharge/Expected Outcome, Problem/ Expected Outcomes, or Discharge Plans and display after the specific component is selected and activated.) The interventions/treatments display in the order they were built. For more information about selecting the function from the main menu, refer to "Intervention/Treatment" on page 2-39.

From this screen, prompts display enabling you to either add a new intervention/ treatment, or update an existing one.

If entering a new intervention/treatment, enter the appropriate code, the starting letters of the intervention/treatment, or a hyphen (-) to display a table listing from which you can select the intervention/treatment. Once the intervention/treatment is selected, its Update screen displays as follows. For field explanations refer to the "Update Screen" on page 2-16.

```
                  General Hospital Plan of Care Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care (1 of 1):  CHEST PAIN                                      Active
Discharge Plan (1 of 1):  ARRANGE FOR HOME CARE                         Active

 1 Description                      2 Type                        3 Status
   KNOWLEDGE OF ANALGESICS            Intervention (2 of 2)        Inactive
 4 Action      5 Print   6 Shifts  7 Added by               8 Date Added
->               Yes                Jones,Michele J          01/13/04 02:36pm
 9 Text                          10 Completed by          11 Date Completed

  |Assess pt's knowledge of analgesics/ pain medications:_____________________  |
  |_____________________________________                                         |
  |                                                                              |



Activate(A), pend(P), delete(D), or revise(R) intervention--  |
                        / next screen  /P prev screen
```

To bypass this intervention/treatment and continue to the next intervention/treatment linked to the expected outcome or plan, press ENTER. Look at the component indicator on the screen to see which intervention the system is displaying.

When you activate an intervention/treatment, the system then continues to the next Intervention/treatment associated with the expected outcome or plan.

When you delete the intervention/treatment, the system displays:

Accept this screen? [Y]--

If you press ENTER (using the Yes default), the system deletes the Intervention/ treatment. It displays on the Inquiry Screen as Deleted.

When you revise the intervention/treatment, you can update the Action, Print, Shifts, and Text fields.

The selected action displays in the Action field and you are prompted to accept the screen if no changes need to be made.

If the intervention/treatment is Inactive, the following prompt displays:

Activate(A), pend (P) delete(D), or revise(R) intervention--

Enter **A**, **P**, **D**, or **R** to activate, designate as Pending Authorization, delete, or revise the intervention/treatment. A facility parameter designates whether the pend action displays in the prompt. For more information on this action refer to the Pending Authorization section.

Press ENTER to continue to the next intervention/treatment linked to the expected outcome or plan.

If the intervention/treatment is Active, the following prompt displays:

Revise(R), complete(C), or delete(D) intervention--

If the Intervention/treatment is Completed, the following prompt displays:

Reactivate Intervention? (Y/N) [N]--

NOTE: A specific intervention/treatment can be linked to only one component of a patient's Plan of Care. This is because the intervention/treatment is completed/performed only once. If you complete and then reactivate the intervention/treatment, the completed Intervention/treatment no longer displays with its previous component. The reactivated element now displays with the new component to which it is linked.

Impact

When you accept the screen, the system stores the component in the Patient file. The component contains the status currently selected in the Action field. Active and completed items are available for you to print on the PCP.

Discharge/Expected Outcome

The Discharge/Expected Outcome refers to behaviors to be accomplished by the patient prior to discharge from the hospital. When you select Discharge/Expected Outcome from the Nursing main menu, the following screen displays:

NOTE: The Discharge/Expected Outcome function can be selected either from the Nursing main menu or through the Plan of Care process. (Refer to Plan of Care - Discharge/Expected Outcome for more information about selecting the function through Plan of Care.) When this function is selected through the main menu, the system displays all Discharge/ Expected Outcomes associated with the patient, not just the Discharge/Expected Outcomes for a specific Plan of Care. The Discharge/Expected Outcomes display in the oder they were built.

```
                General Hospital Discharge/Exp Outcome Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73


No.    Type              Status     Description
                                                          ##=Current Choices
( 1)   Dis/Exp Outcome   Inactive   CHEST PAIN, TRANSFER
( 2)   Dis/Exp Outcome   Inactive   CHEST PAIN, DISCHARGE









Enter choices (e.g. 1,3,5-7) or add(A) dis/exp outcomes--
                               end selection(NL)
```

From this screen, you can select multiple Discharge/Expected Outcomes to update, or you can add a Discharge/Expected Outcome.

If you want to add a new Discharge/Expected Outcome, enter **A**. The following prompt displays:

Enter dis/exp outcome code or starting letter(s) --

Identify the desired discharge/expected outcome by entering the exact code of the discharge/expected outcome, the starting letters of the Discharge/Expected Outcome followed by a hyphen (-) to select from a specified list, or a hyphen (-) to select from a list.

Once the Discharge/Expected Outcome is selected, the following Update screen is displayed. For field explanations, refer to the field descriptions for the "Update Screen" on page 2-16.

```
               General Hospital Discharge/Exp Outcome Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care: CHEST PAIN                                              Active

 1 Description                        2 Type                       3 Status
   CHEST PAIN, TRANSFER                 Dis/Exp Outcome (1 of 1)     Inactive
 4 Action      5 Print  6 Shifts   7 Added by              8 Date Added
->               Yes                 Jones,Michele J         01/13/04 02:35pm
 9 Text                           10 Completed by         11 Date Completed

Oc|(Transfer): chest pain controlled, VSS, S-T segment elevation resolved,    |
  |hemodyn. stable: hemodyn. parameters & cardiac rhythm stable.              |
  |                                                                           |



Activate(A), pend(P), delete(D), or revise(R) dis/exp outcome--  |
                        / next screen  /P prev screen
```

This Discharge/Expected Outcome can be activated, deleted or revised. (When adding a new Discharge/Expected Outcome, the system first prompts you to enter the shifts to print and enter text.)

When you activate a Discharge/Expected Outcome, the system continues to display the interventions associated with the Discharge/Expected Outcome. You can activate specific interventions.

When you delete the Discharge/Expected Outcome, the system gives you the Yes/No option to delete all interventions. When you enter **Y** for Yes, the system deletes the Discharge/Expected Outcome and its intervention/treatments are deleted. When you enter **N** for No, the system redisplays the previous prompt (shown on the above screen) and does not delete anything. This option is provided to ensure you do not delete a Discharge/Expected Outcome and its associated components accidentally or without thinking carefully about using the Delete option.

When you revise the Discharge/Expected Outcome, you can update the Action, Print, Shifts, and Text fields.

The selected action displays in the Action field and you are prompted to accept the screen if no changes need to be made.

If the Discharge/Expected Outcome is Inactive, the following prompt displays:

Activate(A), pend(P), delete(D), or revise(R) prob/exp outcome--

Enter **A**, **P**, **D**, or **R** to activate, designate as Pending Authorization, delete, or revise the Discharge/Expected Outcome. A facility parameter designates whether the pend action displays in the prompt. For more information on this action refer to the Pending Authorization section.

If the Discharge/Expected Outcome is Active, the following prompt displays:

Revise(R), complete(C), delete(D) dis/exp outcome or go to interventions(I)-- /next screen, /p prev screen

Enter **R**, **C** or **D** to revise, complete or delete the Discharge/Expected Outcome. Enter **I** to continue to the intervention/treatments linked to the Discharge/Expected Outcome.

If the Discharge/Expected Outcome is Completed, the following prompt displays:

Reactivate dis/exp outcome (Y/N) or go to interventions(I) [N]--
/next screen, /p prev screen

NOTE: A specific Discharge/Expected Outcome can be linked to only one Plan of Care for a patient. This is because the component is completed/ performed only once. If you Complete and then Reactivate the Discharge/Expected Outcome, the completed Discharge/Expected Outcome no longer displays with its previous component. The reactivated element now displays with the new component to which it is linked.

Impact

When you accept the screen, the system stores the component in the Patient file. The component contains the status currently selected in the Action field. Active and completed items are available for you to print on the PCP.

Problem/Expected Outcome

The Problem/Expected Outcome refers to the patient's problem, followed by a short-term expected outcome to attempt to solve that problem. When you select Problem/ Expected Outcome from the Nursing main menu, the following screen displays:

NOTE: The Problem/Expected Outcome function can be selected either from the Nursing main menu or through the Plan of Care process. (Refer to Plan of Care - Problem/Expected Outcome for more information about selecting the function through Plan of Care.) When this function is selected through the main menu, the system displays all Problem/Expected Outcomes associated with the patient, not just the Problem/Expected Outcomes for a specific Plan of Care. The Problem/Expected Outcomes display in the order they were built.

```
                General Hospital Problem/Exp Outcome Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73



No.    Type              Status     Description
                                                          ##=Current Choices
( 1)   Prob/Exp Outcome   Inactive   THERMOREGULATION, ALT PEDS
( 2)   Prob/Exp Outcome   Inactive   GAS EXCHANGE INPAIRED R/T SEPSIS
( 3)   Prob/Exp Outcome   Inactive   SENSORY-PERCEPTUAL ALTERATION
( 4)   Prob/Exp Outcome   Active     FLUID VOL DEFICIT, PEDS
( 5)   Prob/Exp Outcome   Inactive   PHYSIOLOGICAL STATUS, R/T SEPSIS
( 6)   Prob/Exp Outcome   Inactive   SLEEP PATTERN DISTURBANCEE
( 7)   Prob/Exp Outcome   Active     FAMILY PROCESSES, ALTERED/PEDS
( 8)   Prob/Exp Outcome   Inactive   ANXIETY, GENERAL
( 9)   Prob/Exp Outcome   Inactive   CARDIAC OUTPUT, DECREASED
(10)   Prob/Exp Outcome   Inactive   KNOWLEDGE DEF CHEST PAIN
(11)   Prob/Exp Outcome   Inactive   CARDIAC OUTPUT, R/T DYSRHYTHMIAS

Enter choices (e.g. 1,3,5-7) or add(A) prob/exp outcomes--
                        end selection(NL)  next page(/)
```

If entering a new Problem/Expected Outcome, enter the appropriate code, the starting letters of the Problem/Expected Outcome, or a hyphen (-) to display a table listing from which you can select the Problem/Expected Outcome. Once the Problem/Expected Outcome is selected, the following Update screen is displayed. For field explanations refer to the Discharge/Expected Outcome Update screen.

```
                General Hospital Problem/Exp Outcome Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care: FEVER OF UNKNOWN ORIGIN-PEDIATRIC                        Active

 1 Description                      2 Type                      3 Status
   THERMOREGULATION, ALT PEDS         Prob/Exp Outcome (1 of 1)    Inactive
 4 Action      5 Print  6 Shifts   7 Added by              8 Date Added
->               Yes                Jones,Michele J         11/02/04 03:37pm
 9 Text                           10 Completed by         11 Date Completed

Pb|TD:__/__ Altered body temperature r/t:_____________________________       |
Oc|Patient will have normal body temp. w/in 24 hours of DC.                  |
  |                                                                          |



Activate(A), pend(P), delete(D), or revise(R) prob/exp outcome--  |
                        / next screen  /P prev screen
```

The Problem/Expected Outcome may be activated, deleted or revised. (When adding a new Problem/Expected Outcome, the system first prompts you to enter the shifts to print and enter text.)

When you activate a Problem/Expected Outcome, the system then continues to display the interventions associated with the Problem/Expected Outcome. You can activate specific interventions.

When you delete the Problem/Expected Outcome, the system gives you the Yes/No option to delete all interventions. When you enter **Y** for Yes, the Problem/Expected Outcome and its intervention/treatments are deleted. When you enter **N** for No, the system redisplays the previous prompt (see line on the above screen) and does not delete anything. This option is provided to ensure you do not delete a Problem/ Expected Outcome and its associated components accidently or without thinking carefully about using the delete option.

When you revise the Problem/Expected Outcome, you can update the Action, Print, Shifts, and Text fields.

The selected action displays in the Action field and you are prompted to accept the screen if no changes need to be made.

If the Problem/Expected Outcome is Inactive, the following prompt displays:

Activate(A), pend(P), delete(D), or revise(R) prob/exp outcome--

Enter **A**, **P**, **D**, or **R** to activate, designate as Pending Authorization, delete, or revise the Problem/Expected Outcome. A facility parameter designates whether the pend action displays in the prompt. For more information on this action refer to the Pending Authorization section.

If the Problem/Expected Outcome is Active, the following prompt displays:

Revise(R), complete(C), delete(D) prob/exp outcome or go to interventions(I)--

Enter **R**, **C** or **D** to revise, complete or delete the Problem/Expected Outcome. Enter **I** to continue to the intervention/treatments linked to the Problem Expected Outcome.

If the Problem/Expected Outcome is Completed, the following prompt displays:

Reactivate prob/exp outcome (Y/N) or go to interventions(I) [N]--
/ next screen /P prev screen

NOTE: A specific Problem/Expected Outcome can be linked to only one Plan of Care for a patient. This is because the component is completed/ performed only once. If you Complete and then Reactivate the Problem/Expected Outcome, the completed Problem/Expected Outcome no longer displays with its previous component. The reactivated element now displays with the new component to which it is linked.

Impact

When you accept the screen, the system stores the component in the Patient file. The component contains the status currently selected in the Action field. Active and completed items are available for you to print on the PCP.

Discharge Plan

The Discharge Plan is a long-term expected outcome which expands beyond the patient's hospital stay and assists the patient in his or her transition from the hospital to home. When you select Discharge Plan from the Nursing main menu, the following screen displays:

```
                    General Hospital Discharge Plan Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE       F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73


No.    Type              Status     Description
                                                          ##=Current Choices
( 1)   Discharge Plan    Active     ARRANGE FOR HOME CARE









Enter choices (e.g. 1,3,5-7) or add(A) discharge plans--
                                end selection(NL)
```

NOTE: The Discharge Plan function can be selected either from the Nursing main menu or through the Plan of Care process. (Refer to "Plan of Care - Discharge Plan" on page 2-27 for more information about selecting the function through Plan of Care.) When this function is selected through the main menu, the system displays all Discharge Plans associated with the patient, not just the Discharge Plans for a specific Plan of Care. The Discharge Plans display in the order they were built.

If entering a new Discharge Plan, enter the appropriate code, the starting letters of the Discharge Plan, or a hyphen (-) to displaya table listing from which you can select the Discharge Plan. Once the Discharge Plan is selected, the following Update screen displays. For field explanations refer to the "Update Screen" on page 2-16.

```
                General Hospital Discharge Plan Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care         :  CHEST PAIN                                        Active

 1 Description                        2 Type                        3 Status
   ARRANGE FOR HOME CARE FOLLOW-UP      Discharge Plan (1 of 1)      Inactive
 4 Action      5 Print  6 Shifts   7 Added by              8 Date Added
->               Yes                 Jones,Michele J         01/13/04 02:50pm
 9 Text                           10 Completed by         11 Date Completed

Pl|COORDINATE HOME CARE FOLLOWUP WITH SOCIAL SERVICES                          |
  |                                                                            |
  |                                                                            |


Activate(A), pend(P), delete(D), or revise(R) discharge plan--  |
                         / next screen  /P prev screen
```

This Discharge Plan may be activated, deleted or revised. (When adding a new Discharge Plan, the system first prompts you to enter the shifts to print and enter text.)

When you activate a Discharge Plan, the system then continues to display the interventions associated with the Discharge Plan. You can activate specific interventions.

When you delete the Discharge Plan, the system gives you theYes/No option to delete all interventions. When you enter **Y** for Yes, the system deletes the Discharge Plan and its intervention/treatments. When you enter **N** for No, the system returns to the previous prompt (shown on the above screen) and does not delete anything. This option is provided to ensure you do not delete a Discharge Plan and its associated components accidentally or without thinking carefully about using the delete option.

When you revise the Discharge Plan, you can update the Action, Print, Shifts, and Text fields.

The selected action displays in the Action field and you are prompted to accept the screen if no changes need to be made.

If the Discharge Plan is Inactive, the following prompt displays:

Activate(A), pend(P), delete(D), or revise(R) prob/exp outcome--

Enter **A**, **P**, **D**, or **R** to activate, designate as Pending Authorization, delete, or revise the Discharge Plan. A facility parameter designates whether the pend action displays in the prompt. For more information on this action refer to the Pending Authorization section.

If the Discharge Plan is Active, the following prompt displays:

Revise(R), complete(C), delete(D) discharge plan or go to interventions(I)--

Enter **R**, **C** or **D** to revise, complete or delete the Discharge Plan. Enter **I** to continue to the intervention/treatments linked to the Discharge Plan.

If the Discharge Plan is Completed, the following prompt displays:

Reactivate discharge plan? (Y/N) [N]--

NOTE: A specific Discharge Plan can be linked to only one Plan of Care for a patient. This is because the component is completed/performed only once. If you Complete and then Reactivate the Discharge Plan, the completed Discharge Plan no longer displays with its previous component. The reactivated element now displays with the new component to which it is linked.

Impact

When you accept the screen, the system stores the component in the Patient file. The component contains the status currently selected in the Action field. Active and completed items are available for you to print on the PCP. The Discharge Plan also can be printed as a separate document from the Plan of Care.

Intervention/Treatment

Interventions and treatments are specific tasks the nurse performs to achieve the defined Discharge/Expected Outcome, Problem/Expected Outcomes, and Discharge Plans. When you select Intervention/Treatment from the Nursing main menu, the following screen displays:

NOTE: The Intervention/Treatment function can be selected either from the Nursing main menu or through the Plan of Care process. (Refer to"Plan of Care - Intervention/Treatment" on page 2-29 for more information about selecting the function through Plan of Care.) When this function is selected through the main menu, the system displays all Intervention/Treatment plans associated with the patient, not just the Intervention/Treatment plans for a specific Plan of Care. The interventions/treatments display in the order they were built.

```
               General Hospital Intervention/Treatments Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001 JONES,KAYCE         F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73



No.    Type           Status     Description
                                                          ##=Current Choices
( 1)   Intervention   Inactive   KNOWLEDGE OF ANALGESICS
( 2)   Intervention   Active     SEPSIS/FLUID VOLUME DEFICIT, STAN
( 3)   Intervention   Active     PARENT COPING SKILLS, ASSESS
( 4)   Intervention   Inactive   NPO, ORAL HYGIENE
( 5)   Intervention   Inactive   FOOD TOLERANCE
( 6)   Intervention   Inactive   HYDRATION, INFANT
( 7)   Intervention   Active     ACTIVITY PATTERN
( 8)   Intervention   Active     FAMILY INVOLVEMENT IN CARE
( 9)   Intervention   Active     COPING, FAMILY SUPPORT


Enter choices (e.g. 1,3,5-7) or add(A) interventions--
                               end selection(NL)
```

From this screen, prompts display requesting you to either add a new intervention/ treatment or update an existing one.

If entering a new intervention/treatment, enter the appropriate code, the starting letters of the intervention/treatment, or a hyphen (-) to display a table listing from which you can select the intervention/treatment.

NOTE: You can add a maximum of 42 interventions to any Plan of Care element.

Once the intervention/treatment is selected, its Updatescreen displays as follows. For field explanations, please refer to the "Update Screen" on page 2-16.

```
               General Hospital Intervention/Treatments Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9330-600-001  JONES,KAYCE        F  11/29/83 4105-01 SHERIDON,MATTMED 10 I/P 73

Plan of Care:  CHEST PAIN                                              Active
Discharge Plan:  ARRANGE FOR HOME CARE                                 Active

 1 Description                      2 Type                      3 Status
   KNOWLEDGE OF ANALGESICS            Intervention (1 of 1)       Inactive
 4 Action      5 Print   6 Shifts  7 Added by              8 Date Added
->               Yes                Jones,Michele J         01/13/04 02:36pm
 9 Text                           10 Completed by         11 Date Completed

  |Assess pt's knowledge of analgesics/ pain medications:_____________________  |
  |_____________________________________                                         |
  |                                                                              |



Activate(A), pend(P), delete(D), or revise(R) intervention--  |
                        / next screen  /P prev screen
```

To bypass this intervention/treatment and continue to the next intervention/treatment linked to the expected outcome or plan, press ENTER. Look at the component indicator on the screen to see which intervention the system is displaying.

When you activate an intervention/treatment, the system then continues to the next intervention/treatment associated with the expected outcome or plan.

When you delete the intervention/treatment, the system displays:

Accept this screen? [Y]--

If you press ENTER (using the Yes default), the system deletes the intervention/ treatment. It displays on the Inquiry Screen as Deleted.

When you revise the intervention/treatment, you can update the Action, Print, Shifts and Text fields.

The selected action displays in the Action field and you are prompted to accept the screen if no changes need to be made.

If the Intervention/Treatment is Inactive, the following prompt displays:

Activate(A), pend(P), delete(D), or revise(R) intervention--

Enter **A**, **P**, **D**, or **R** to activate, designate as Pending Authorization, delete, or revise the intervention/treatment. A facility parameter designates whether the pend action displays in the prompt. For more information on this action refer to the Pending Authorization section.

Press ENTER to continue to the next intervention/treatment linked to the expected outcome or plan.

If the intervention/treatment is Active, the following prompt displays:

Revise(R), complete(C), or delete(D) intervention--

If the intervention/treatment is Completed, the following prompt displays:

Reactivate Intervention? (Y/N) [N]--

NOTE: A specific intervention/treatment can be linked to only one component of a patient's Plan of Care. This is because the intervention/treatment is completed/performed only once. If you complete and then reactivate the intervention/treatment, the completed intervention/treatment no longer displays with its previous component. The reactivated element now displays with the new component to which it is linked.

Impact

When you accept the screen, the system stores the component in the Patient file. The component contains the status currently selected in the Action field. Active and completed items are available for you to print on the PCP.

Chapter 3 - NURSING STATION FUNCTIONS

With the *Care Planning and Documentation Module*, the nurse can place orders for ADLs and treatments. The orders capture information that prints on the Patient Care Profile for the requested date and shift. The nurse can also access the STAR Patient Scheduling Module to view scheduled events for patients. This chapter provides information about the following functions:

ADL AND TREATMENT ORDERS

ADL Orders

The ADL Order screen is used to capture information for the ADL toprint on the Patient Care Profile (PCP) for the requested date and shift.

TIP: For non-SIM ADL orders to print on the PCP, you must build the order so there is an occurrence on every shift. That guarantees that the ADL order prints on the PCP in case the PCP is printed for just one or two shifts and not for the entire day. There is also a field in the Station Parameters Processor under PCP Parameters that you can set so that either the Frequency code, Scheduled Days code, both, or neither prints on the PCP. The parameter is the PCP Freq/Sched Days Code field. For more information, see "Appendix A - NURSING TABLES".

You can access this function by performing the following steps:

1. Select Orders from the Nursing main menu.
2. Select the patient for whom you want to order ADLs.
3. Select Department Orders.
4. Select ADLs from the list of order departments.

NOTE: Information Windows displaying Patient Information, Physicians, and Pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in this function. During the download process, the system displays the following message:

Downloading Information Windows...Please Wait!

After the windows are downloaded, you can view them in any other nonpatient-specific function on STAR Patient Care. When you access a patient-specific function other than Order Management or Nursing functions, the downloaded information is cleared. The information is also cleared when you select a different patient in one of the functions where Information Windows are available.

For specific information regarding Patient, Physician, or Pharmacy Information Windows, refer to "Appendix B - INFORMATION WINDOWS". When there are active orders for the patient, the following screen displays:

```
                General Hospital Department Orders Processor
 ADL's Order                                    Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9606400001    HAMILTON,KATIE     F  07/07/66 2101-01 AKER,TOM     ONC 10 I/P 112

Orders for  Selected Departments During the 24 Hours Ending  02/09/09
                                                  Req Dt/Tm      Type       Dept
 No Ord# Dep Description                          START STOP   FREQ  SCHED  Status
 1   39  A   BATH -Q SHIFT                        02/09 23:00P  Order-Act
 2   39  A   BATH -Q SHIFT                        02/09 04/09  PRN   ALL    In proc
 3   39  A   BATH -Q SHIFT                        02/09 15:00P  Order-Cmp









                          No more active orders!
Enter add(A), # for detail, `*` for options (C,D,H,R,X) [A]--
```

You have a choice of the following:

- Select one of the active orders to view information about the order. You can Complete (C), Discontinue (D), Cancel (X), Hold (H), Resume (R), or enter # to display an order's details. For more information on this process, refer to *Order Management/Charge Processing Volume 1* of the *Star Patient Care Reference Guide*. The information contained on the screen that displays is the same as the screen that displays for you to Add a new ADL, as explained following.

- Enter **A** to add a new ADL. Add is the default.

The system prompts you for the ADL(s) to be ordered for the patient. ADLs are divided into Categories and Category elements. Two screens display for selection of the ADL Categories and the Category elements. The following screen is an example of the ADL Menu screen which contains the ADL Categories. You can select one or multiple ADL Categories from the list.

```
                  General Hospital Department Orders Processor
 ADL's Order                                          Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9606400001    HAMILTON,KATIE     F  07/07/66 2101-01 AKER,TOM     ONC 10 I/P 112

                                    ADL Menu
 ( 1) VITAL SIGNS                        (16) NEUROVASCULAR CHECKS
 ( 2) B/P                                (17) NEUROLOGICAL CHECKS
 ( 3) FEEDING                            (18) CIRCULATION/VASCULAR CHECKS
 ( 4) TOILET                             (19) MEASURE
 ( 5) BATH                               (20) MONITORING
 ( 6) AMBULATE                           (21) RANGE OF MOTION
 ( 7) CHAIR                              (22) PROSTHESIS
 ( 8) BEDREST                            (23) PASTORAL CARE
 ( 9) OUT OF BED                         (24) SAFETY
 (10) BED POSITION                       (25) TRANSPORT
 (11) REPOSITION/TURN
 (12) HYGIENE
 (13) ELIMINATION
 (14) WEIGHT
 (15) I & O

Enter choices (e.g. 1,3,5-7) or `-`choices to remove--
```

After you select the ADL Category from the previous screen, the system displays a screen like the following example. This screen contains the Category elements linked to the selected Category. The elements display in the order built. You can select one or multiple Category elements.

```
                General Hospital Department Orders Processor
                                                     Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9606400001    HAMILTON,KATIE     F  07/07/66 2101-01 AKER,TOM     ONC 10 I/P 112
 Category: BATH

Page:01                          Category elements             ##=Current Choices
 ( 1) Q SHIFT                              (15) AXILLARY TEMP
 ( 2) Q DAY                                (16) ORAL TEMP
 ( 3) BID                                  (17) APICAL PULSE
 ( 4) TID
 ( 5) QID
 ( 6) Q 6H
 ( 7) Q 4H
 ( 8) Q 4H WHILE AWAKE
 ( 9) Q 4H X 24H POST-OP
 (10) Q 2H
 (11) Q 1H
 (12) Q 30 MIN
 (13) Q 15 MIN
 (14) RECTAL TEMP

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                 end selection(NL)
```

NOTE: After you select the Category elements, the following prompt displays:

Choose more tests? (Y/N) [N]--

To continue to the ADL order screen(s), press ENTER.

The following screen is an example of the ADL order screen. The patient's Account Number, Name, Sex, Birthdate, Room, Attending Physician, Medical Service, and Status display across the top of the screen. A highlighted number on the right displays the sequence number of the item in the order.

```
                General Hospital Department Orders Processor
ADL's Order                                          Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9708300003    ANDERSON,CLAY      F  01/01/55 2101-02 SILVA,DANIEL MED 10 I/P 26

 1 ADL Category   2 Element Description         3 Initials 4 Print Loc
   ROM              ACTIVE ROM Q SHIFT            M W        Department
 5 Priority     6 Frequency     7 Schedule Days
   TIMED          QOD             DAILY
 8 Times

 9 Start Date 10 Start Time    11 Duration     12 Stop Date   13 Stop Time
   02/18/09      13:49            3 Days          02/20/09       23:59
14 Ordering Physician
   2064 *COLE TAYLOR & ASSOC




Enter field number or '/' starting field number--
```

Field Explanations

1. ADL CATEGORY (DISPLAY ONLY)
This field displays the ADL Category description from the ADL Standard File. This field cannot be edited. If the item needs to be changed, the order should be aborted and an alternate item selected.

2. ELEMENT DESCRIPTION (DISPLAY ONLY OR 25-AN-R)
This field displays the ADL element description. This field cannot be edited unless a parameter is set during the file build. The parameter is the Description Change field and is located in the Create ADLs function.

3. INITIALS (3-A-R)
If security is implemented for the person placing the order, the person's initials automatically display and cannot be edited. If security is not implemented, the system requires entry of the initials of the person placing the order.

3. PRINT LOCATION (1-A-O)
This field enables you to redirect the printed requisition for the order to a location other than the receiving department (for example, to the actual patient location or ordering location). This field is only accessible when the original order is placed; it cannot be revised.

NOTE: All occurrences generated for this order are printed to the same location identified by the parent order. If at some point you want to change the location for future occurrences, you must cancel, complete, or discontinue (whichever applies) the original order and enter a new parent to redefine the print location.

When this field is accessed, the following prompt displays:

Enter printer location code or '-' to list--

Enter the code for the location you want if you know it, or press hyphen (-)and ENTER to select from a list of available printers. You can select one of these hardcoded options:

- A - Patient Nurse Station (patient location at time the order becomes active)
- B - Ordering CRT (at the time the order is originated)
- C - Patient Nurse Station & Department
- D - Department (only)
- E - Ordering CRT & Department

For options A and C, the Patient Nurse Station is defined as the station where the patient is located at the time the occurrence order becomes active. Therefore, if the patient has future pending occurrences and is transferred to a new location, upon transfer, the system redirects pending orders (that is, any that have not yet printed) to the new patient location.

For SIM items that are most often redirected, you can designate the print location where the orders should be redirected on the Default Order Values screen in the Service Item Master processor. If the SIM item has a default print location attached to it, the location automatically is displayed in the Print Location field. To redirect the requisition, access this field during initial order placement and change the print location.

4. PRIORITY (TABLE LOOKUP)
This field indicates the manner in which the treatment should be performed (for example, ASAP, pre-op, routine). When you access the Priority field, the following prompt displays:

Enter table code or '-' for table--

Enter the priority code if you know it, or enter a hyphen (-) to display the list of valid priorities for the ordering department. The ordering department can require the entry of a priority.

If the Start Date/Time Entry field on the Priority table for this priority is set to Time Only or Neither Date/Time, the system automatically fills in the Start Date field on the order screen. These two entries are designed specifically to prevent you from entering or editing the Start Date field.

Five fields depend on the value in the Priority field: Start Date, Start Time, Duration, Stop Date, and Stop Time. Each time you modify the Priority field, the system clears these five fields and either recalculates new values for each or prompts you to enter new values.

5. FREQUENCY (5-C-R) or (TABLE LOOKUP)
This field displays the frequency code for the order. Using the value in the Duration field, the system calculates the Stop Date and Stop Time fields. The following prompt displays:

Enter description '-' or code--

Enter the code or the full description for the desired frequency if you know it, or enter the first few letters of the description and a hyphen (-) to select from a list of frequencies that partially match the criteria. If you do not know either the code or description at all, enter a hyphen (-) and select the desired frequency from the displayed Frequency table.

TIP: If you want to ensure that non-SIM ADL orders print on the PCP, you must build the order so there is an occurrence on every shift. That guarantees that the ADL order prints on the PCP in case the PCP is printed for just one or two shifts and not for the entire day.

The following conditions apply:

- If times are defined for the frequency in the Times field of the Frequency table, then the times appear in the Times field in this screen, and the first time from the Frequency table is used for the frequency selected. The system calculates the Start Date and Start Time fields based on these parameters.

- If no scheduled days are associated with the frequency, the system blanks out the Schedule Days field.

- If a schedule is associated with the frequency, the system fills the Schedule Days field on this screen with that schedule and sets the Duration field to the value specified for the associated schedule.

Five fields depend on the value in the Frequency field: Start Date, Start Time, Duration, Stop Date, and Stop Time. Each time you modify the Frequency field, the system clears these five fields and recalculates new values for each.

If the Duration field in the Scheduled Days table associated with this frequency is set to 1 Occurrence, then the system sets default values in the Duration, Stop Date, and

Stop Time fields. However, you can enter **/6** to return to the Duration or Stop Date field and either blank it out or change it. For any other duration (for example, Q6H), the system does not enter default values in these fields.

6. SCHEDULE DAYS (20-AN-R) or (TABLE LOOKUP)
This field identifies the default scheduled days on which the item should occur (for example, daily), which is defined in the Schedule field on the Frequency table.

To revise the default scheduled days, enter the code assigned to a specific schedule, or enter a hyphen (-) and select the desired schedule from the displayed Schedule table.

If you revise the frequency in the Frequency field, the system updates the Schedule Days field with the schedule associated with the new frequency. If no schedule is associated with a frequency, the system blanks out this field.

If the Schedule Days field is filled in with a schedule that is defined as Scheduled Days, the following prompt displays:

```
Page:01                          Scheduled Days
( 1) ALL DAYS OF WEEK      ( 5) EVERY THIRD DAY       ( 9) MONDAY THRU FRIDAY
( 2) DAILY                 ( 6) MON. WED. FRI.        (10) ONCE
( 3) EVERY DAY             ( 7) MON/WED/THUR          (11) ONE TIME
( 4) EVERY OTHER DAY       ( 8) MONDAY AND FRIDAY     (12) PRN

Enter choice--                                  next page(/)
```

After you enter your choice of days, the Scheduled Days field then fills in with up to seven days of the week (for example, Su M Tu W Th F Sa). The following prompt displays:

Enter first letters '-' or schedule code--

If you do not make any selections at the prompt and you press ENTER, the following error message displays:

Error: Field Required!

If the frequency you select is of a PRN schedule type, the following message displays:

PRN selected, no occurrences generated!

If the frequency you select is of a PRN schedule type, the Duration field does not accept occurrences. The following error message displays:

PRN frequency cannot have occurrences selected or as defaults!

The ordering screen accepts a duration only of Days or Hours. If you fill in an ordering screen with a frequency that has a schedule that was defined as PRN, and you attempt to change the Schedule field, the following error message displays:

Error: Frequency has PRN schedule type, field cannot be edited!

You must change the Frequency field first, and the default schedule associated with it is updated.

7. TIMES (65-C-O)
This field identifies the specific times that a treatment or task should be administered. The system automatically fills this field using the Times field for the patient's nurse station, as defined in the Frequency table.You can revise the default times. Enter the desired times using military time (the 24:00 clock), or standard time (the 12:00 clock, with A for am and P for pm).You can enter up to 16 times on the Order screen; however, only a limited number displays during the order process due to field size. If you need a larger number than 16, use an interval.

The following prompt displays:

Enter times--

You can access this field based on whether the chosen frequency is defined using times or interval, and whether the Allow Times Edit? field in the Frequency table is set to Yes or No. The following conditions apply to accessing and editing the Times field on all order screens:

Frequency type	Allow Times Edit? field setting	Cursor stops in Times field?	Can edit Times field?
Interval	Yes or No	No	No
Times	Yes	No	Yes
	No	No	No
No times, no interval	Yes	Yes	Yes
	No	No	No

8. START DATE (DATE-R)
This field identifies the date when the order is to begin generating occurrences. You are always prompted to enter the start date, except under the following conditions:

- The Start Date/Time Entry field on the Priority table for the order's priority is set to either Time Only or Neither [for neither date nor time]. These two priorities are specifically designed to prevent the user from entering or editing the Start Date field. In this case, the system automatically fills this field with today's date.

- If you are in an ordering session with multiple orders and the Carry Freq Forward field in the Order Management Facility Options table is set to Yes, then both the start date and start time from the first order carries forward to all other orders in the session. If you change the start date and start time during the

ordering process, the new start date and time carries forward from that point to the rest of the orders in the session.

However, if the order's duration is 1 Occurrence as defined in the Schedule Days table assigned to the frequency entered, then the Duration, Stop Date and Stop Time fields also default in an order session. If the frequency is other than 1 Occurrence (for example, Q6H), then the Duration, Stop Date, and Stop Time fields are not defaulted in an order session.

If the frequency does not have a specific time associated with it, the system requests a Start Date in this field. You can either enter the date, use the shortcuts (for example, T, T+1) or leave the field null and have the program calculate the appropriate date. If the frequency does not have a specific time associated with it, you must manually enter a date; the system does not accept a default date. You must either enter a valid date or use a shortcut entry. For order-entry techniques, see the *STAR Patient Care Reference Guide, General Information Volume*.

The Start Date field depends on the values in the Priority and Frequency fields. Each time you modify either of these fields, the system clears the Start Date field and recalculates a new value for it.

If you accessed the ordering process from STAR Patient Scheduling, this field contains the time indicated in the Appointment field on the appointment screen.

If you enter an invalid start date for the selected frequency, the following error message displays:

Start Date is invalid for this freq! Press NL.

If you enter a valid start date for the selected frequency, but the Department Days Valid is incorrect, the following error message displays:

Start Date is invalid for this item & dept!. Press NL.
Start Time is invalid for this department!. Press NL.

The following prompt displays:

Enter new order start date--

If the system is unavailable for some reason, and you need to enter an order that requires a requisition, you can use this field. If you do not require a requisition, you should typically enter a charge for the procedure rather than a backdated order. The hospital controls the number of days in the past that the Start Date can be set to in the SIM Departments table. If you enter a date that exceeds the department's valid number of back days, the system displays the following error message before redisplaying the original prompt:

Error: Date precedes admission/registration date or departmental limit!

This same prompt displays if you enter a date that precedes the patient's admission date. The Start Date is intended to be equal to today's date or some date in the future; however, if you enter a date that is within the department's valid number of back days, the system accepts the entry and displays the following warning message:

WARNING: Less than current date and time!

The hospital also controls the number of days in the future to which the Start Date can be set. If you enter a date that exceeds the department's valid number of days in the future, the system displays the following error message before redisplaying the original prompt:

Error: Date exceeds departmental limit!

9. START TIME (TIME-R)
This field identifies the time when the order is to begin generating occurrences. The following prompt displays:

Enter start time--

Enter the time using one of the time-entry techniques described in the *STAR Patient Care Reference Guide, General Information Volume*.

The Start Time field depends on the values in the Priority and Frequency fields. Each time you modify either of these fields, the system clears the Start Time field and recalculates a new value for it.

- If Times are specified and the start date is greater than today, the system uses a default prompt of the first time specified.

- If Times are specified and the start date is not greater than today, the system calculates the time based on current time. If the default start time is for a date/time other than today, the prompt includes the default start date. Here are some examples:

  Enter start time for yesterday [04:00pm]--
  Enter start time for Monday 06/25 [04:00pm]--

If you accept the default start time, or enter an override start time, the system sets the start date to the date displayed in the prompt. To override the start date and start time, enter the date and time, separated by a space (for example, T 2P, 06/26,T N).

After you enter a start time, the system verifies that the start date and start time is not later than the stop date and stop time.

If a duration is specified, the system automatically calculates a default stop date and stop time.

If you accessed the ordering process from STAR Patient Scheduling, this field contains the time specified in the Appointment field on the appointment screen.

The start date and time associated with an order is intended to be equal to or some time after the current date and time. However, if you enter a time that causes the start date and time to be prior to the current date/time, the system accepts the entry and displays the following warning message:

WARNING: Less than current date and time!

If the date you enter is past the cutoff time specified for the department and the priority selected, the system accepts the entry after the following warning message displays:

WARNING: Past cutoff time!

If your institution has set the Back Date Orders field in the SIM Departments table to No, then backdating and backtiming of orders is disallowed in most situations (see note below). If you enter a time in this field that is earlier than the current time, the system displays the following error message before redisplaying the original prompt:

Error: Time precedes departmental limit!

NOTE: If your institution has set the Back Date Orders field in the SIM Departments table to No, then backdating and backtiming of orders is disallowed, except under the following condition: If an order is placed that contains a frequency that has "times" associated with it, setting the field to No causes the function to work as if the Back Date Orders field was set to 0. If an order is placed that contains a frequency that does not have "times" associated with it, the selection of a time prior to the current system time gives the error message and does not allow you to continue until the appropriate response is selected.

If you enter a time in this field that is earlier than the current time, the system displays the following error message before redisplaying the original prompt:

Error: Time precedes departmental limit!

You receive this same error message if the frequency for the order does not have predefined times associated with it and you enter a start time prior to the current time. In each case, you must enter a valid time before preceding.

If your institution has set the Back Date Orders field in the SIM Departments table to zero, then backdated orders are allowed if they are less than one day in the past (on the current day from midnight to 11:59 pm.) The ordering screen accepts a backdated time from the current time for the current day and then displays the following warning message:

Warning: Less than current date and time!

You receive this same error message if the frequency for the order has predefined times associated with it and you enter a start time prior to the current time. In each case, although you receive this error message, the cursor moves to the next field and you can continue working.

For orders with a priority of STAT, the STAT field on the Priority table is set to *Yes*, and the order's start time is the current system time. Any predefined times associated with the order are cleared out. The current system time is captured as the start time on the first order, and that time is used on all orders in the set. This ensures that orders are grouped correctly for STAR Laboratory accession numbers.

10. DURATION (10-AN-O)
This field specifies the period of time that the order remains active. If a default duration is specified for the ordered item in the Default Order Values table (in the Service Item Master Processor), then the system fills this field with the default duration. If no default duration is specified there, but a duration *is* specified on the Scheduled Days table associated with the frequency for this order, then that duration is displayed. For more information on default durations, see the Default Order Values table and Scheduled Days table in "Appendix A - NURSING TABLES". You can override either default duration by entering a duration in this field.

The Duration field depends on the values in the Priority and Frequency fields. Each time you modify either of these fields, the system clears the Duration field and recalculates a new value for it.

If you enter the duration here, the system calculates the stop date and stop time. The following prompt displays:

Enter order duration ##Hours, ##Days or ##Occurrences or (I)ndefinite--

This field is required. If you want the order to be open ended, enter **I** for Indefinite. The Stop Date and Stop Time fields are bypassed.

WARNING: If you enter **I** for Indefinite to specify an open-ended order, then the parent order generates occurrences continuously until the order is discontinued or cancelled, or the patient is discharged. See the end of this field explanation for more consequences of leaving an order open ended.

If you enter a number in place of the **##** and do not follow it with **H**, **D** or **O**, another prompt displays:

Enter (H)ours, (D)ays or (O)ccurrences--

- To specify duration in terms of hours, enter the number of hours with a suffix of H (48H).

- To specify duration in terms of days, enter the number of days with a suffix of D (2D).

- To specify duration in terms of occurrences, enter the number of occurrences with a suffix of O (6O).

Suppose you place an order with a start date and time of March 5 at 2:00 pm. Based on the information you enter, the system calculates the duration in one of the following ways:

If the duration or default is defined in terms of...	Then the system calculates the duration as beginning with the...	In this example, the Stop Date and Time is...
Days Example: 2 days	Start Date at 12:00 midnight and ending Today+ 1 at 11:59 pm	March 6th at 11:59 pm
Hours Example: 24 hours	Start Date and Time and ending at exactly 24 hours	March 6th at 1:59 pm
Occurrences Example: 4 occurrences	Start Date and Time and ending exactly when the last occurrence should be scheduled, based on whether the frequency is defined as times or interval.	For a frequency of *times* defined as 9:00 am and 3:00 pm, the Stop Date and Time is March 7th at 9:00 am For a frequency of *interval* defined as every 6 hours (Q6H), the Stop Date and Time is March 6th at 8:00 am

If you enter an order that has times associated with the frequency and you enter a start time that is not one of the predefined times associated with the order's frequency, and the duration is 1 Occurrence (either entered manually in the Duration field or because the Recurring field in the Priority table is set to No), then the following error message is displayed:

Error: Invalid start time and/or duration.

If you enter **I** for Indefinite, the duration is ongoing and the following occurs:

- Occurrences continue to generate daily until the patient is discharged, depending on what the interval is set to in the Scheduled Days table (for example, every 1 day, every 2 days).

- When the patient is discharged, a Discontinue is sent for all active patient orders (In Proc).

- Active occurrences with request times that have passed remain active.

- Active occurrences with request times that have not passed are cancel-requested (Order-Cnc).
- Pending occurrences are cancelled. Cancel requisitions are generated with a cancel reason of Patient Discharged.
- The audit of the parent and occurrences is updated with the reason of Patient Discharged.
- Any future orders placed that currently have no occurrences do not generate any occurrences.
- You must manually cancel or complete active occurrences. You can complete active occurrences from the department.

11. STOP DATE (DATE-C)
This field identifies the date that the order stops generating occurrences. If you enter a duration in terms of occurrences, hours, or days, the system automatically fills this field with a revisable, system-calculated stop date, and this field becomes required.

The Stop Date field depends on the values in the Priority and Frequency fields. Each time you modify either of these fields, the system clears the Stop Date field and recalculates a new value for it.

You can revise the calculated stop date in response to the following prompt:

Enter stop date--

If you enter a stop date that is before the start date, the system displays an Invalid Date message and does not accept your entry. If you change the stop date, the Duration field blanks out. If you want the order to be open-ended, leave the Stop Date field blank.

12. STOP TIME (10-C-C)
This field identifies the time that this order stops generating occurrences. If the Stop Date field contains a response, this field is required. If you entered a duration in terms of occurrences, hours, or days, the system automatically fills this field with a revisable, system-calculated stop time, and this field is required.

The Stop Time field depends on the values in the Priority and Frequency fields. Each time you modify either of these fields, the system clears the Stop Time field and recalculates a new value for it.

You can revise the default stop time in response to the following prompt:

Enter stop time--

If you want the order to be open-ended, leave the Stop Time field blank.

13. ORDERING PHYSICIAN (28-AN-R)
This field indicates the physician who is placing the order for the patient. This field is required. If you accessed the ordering process from STAR Patient Scheduling, this field contains the entry in the Referring Physician field on the appointment screen.

The following prompt displays:

Enter name'-', (-') for staff, (\-)NSCG, table code, [R]--
'-'name to override, or Physicians of Record(R)

Use one of the following methods to make an entry:

- Enter the physician's name if you know it.
- Enter a hyphen and apostrophe (-')to display a list ofthe staff for your selection.
- Enter a backslash and hyphen (\-) to display a list of the NSCG for your selection.
- Enter **R** or press ENTER to display a table of the patient's physicians of record. The table displays the physician's name, office location (if your facility is using multiple office processing), and the relationship of the physician to the patient. You can select a physician of record from this table.
- Enter a hyphen (-) to view a listing of the Physician table if you do not know the ordering physician's code. Due to the size of the Physicians table, enter the first few characters of the physician's last name, followed by a hyphen (-), to reduce the list to be viewed.
- Enter the code of the ordering physician, if you know it.
- Enter the physician's name as an override by entering a hyphen (-) before the physician's name, if the physician who is placing the order is not in the Physician table.

If you enter a physician table code or a physician of record, you are prompted to select the physician's office location, if the following three conditions are met:

- The hospital-controlled facility option for the second office address is set to Yes.
- The selected physician's multiple office address parameter is set to Yes.
- The selected physician is not already a physician of record.

If you enter an override physician as the ordering physician, address processing does not occur.

Impact

After you accept this screen, the following processing takes place:

- The system assigns an order number and a Pending status to the order. When the requested date/time is within the Days and Hours Valid window, the order changes to an Active status.
- The ADL order displays and can be accessed through Order Review for revisions, completions, or cancellations.
- No charges are generated for ADL orders due to their non-SIM department status.

Output

Requisitions do not print for ADL orders.

Treatment Orders

The Treatment Order screen is used to capture information for the treatment to print on the Patient Care Profile for the requested date and shift.

TIP: For non-SIM treatment orders to print on the PCP, you must build the order so there is an occurrence on every shift. That guarantees that the treatment order prints on the PCP in case the PCP is printed for just one or two shifts and not for the entire day.

You can access this function by performing the following steps:

1. Select Orders from the Nursing main menu.
2. Select the patient for whom you want to order treatments.
3. Select Department Orders.
4. Select Treatments from the list of order departments.

NOTE: Information Windows displaying Patient Information, Physicians, and Pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in this function. During the download process, the system displays the following message:

Downloading Information Windows...Please Wait!

After the windows are downloaded, you can view them in any other nonpatient-specific function on STAR Patient Care. When you access a

patient-specific function other than Order Management or Nursing functions, the downloaded information is cleared. The information is also cleared when you select a different patient in one of the functions where Information Windows are available.

For specific information regarding Patient, Physician, or Pharmacy Information Windows, refer to "Appendix B - INFORMATION WINDOWS".

Once you identify the department and patient, the system prompts you to select the treatment to be ordered for the patient. The following screen is an example of the Treatment list from which you can select one or multiple treatments.

```
                    General Hospital Treatment Processor
TREATMENTS Order                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
90018-00006   ELLIOT,ELLEN      F  03/17/60 1202-1  ZELLER,JD    OTH 10 I/P 37




Page:02              Item Descriptions, `*`-Routine Order    ##=Current Choices
( 1) ANGIO, SANDBAG FOR                  (11) BANDAGES, ACE TO CALVES
( 2) ANGIO, SEND WITH TO                 (12) BATH, SITZ
( 3) AQUA-K PAD                          (13) BED, CIRCO-ELECTRIC
( 4) ARM SLING                           (14) BED, CLINITRON
( 5) AROM                                (15) BEDBOARDS
( 6) ASA, NO PRODUCTS                    (16) BEDCRADLE
( 7) ASSERTIVENESS TR WORKBOOK           (17) BEDREST, POST-ANGIO
( 8) ASSESS AND EVALUATE PAIN            (18) BELZ, POST-RECTAL, CATHETER
( 9) BANDAGES, ACE TO KNEES              (19) BELZ, POST-RECTAL, VS, BLEED, ICE
(10) BANDAGES, ACE TO THIGH              (20) BELZ, POST-RECTAL,DAY 3 POST-OP

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
               end selection(NL)  next page(/)  previous page(/P)
```

After you select the treatment(s), the following prompt displays:

Choose more tests? (Y/N) [N]--

To continue to the treatment order screen(s), press ENTER.

The following screen is an example of the Treatment Order screen. You can edit the existing text by accessing the text field and using the function keys (F1-F5) which display across the screen. Once you enter the data and accept the screen, the system assigns an order number to this treatment.

```
              General Hospital Department Orders Processor
TREATMENTS Order                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9708300008    FRANCIS,LINDA      F  01/01/66 2103-01 SILVA,DANIEL MED 10 I/P 26

 1 Item                                    2 Initials      3 Print Loc
   4341 URINE SPECIMEN, 24 HOUR              M W             Department
 4 Priority
  NOW
 5 Frequency   6 Schedule Days      7 Times
   PRN           ALL DAYS OF WEEK     7:00,15:00,23:00
 8 Start Date  9 Start Time    10 Duration      11 Stop Date  12 Stop Time
   02/18/09      15:00            5 Days           02/22/09      23:59
13 Ordering Physician                    14 Text
   2066 *DUNWOODY GROUP                  ->

                |24 hour urine specimen for:_________|
                |Start date:________ Time:_____am/pm |
                |Stop date: ________ Time:_____am/pm |
                |                                    |
                |                                    |

Edit text? (Y/N) [N]--  |
```

NOTE: For Nursing files that display/print the Plan of Care component text, please note that the format may differ from the examples in this section:

- If your facility has run the conversion associated with user-formatted PCPs and Worksheets, the text displays/prints on three lines of 75 characters each.
- If your facility has not run the conversion, the text displays/prints on five lines of 36 characters each.

Field Explanations

1. ITEM (DISPLAY ONLY)
This field displays the treatment description from the Treatment Standard File. This field cannot be edited. If the item needs to be changed, the order should be aborted and an alternate item selected.

2. INITIALS (3-A-R)
If security is implemented for the person placing the order, her initials automatically display and cannot be edited. If security is not implemented, the system requires entry of the initials of the person placing the order.

3. PRINT LOCATION (1-A-O)
This field enables you to redirect the printed requisition for the order to a location other than the receiving department (for example, to the actual patient location or ordering location). This field is only accessible when the original order is placed; it cannot be revised.

NOTE: All occurrences generated for this order are printed to the same location identified by the parent order. If at some point you want to change the location for future occurrences, you must cancel, complete, or discontinue (whichever applies) the original order and enter a new parent to redefine the print location.

The prompt for this field is:

Enter printer location code or '-' to list--

Enter the code for the location you want if you know it, or enter a hyphen (-) and ENTER to select from a list of available printers. You can select one of these hardcoded options:

- A - Patient Nurse Station (patient location at time the order becomes active)
- B - Ordering CRT (at the time the order is originated)
- C - Patient Nurse Station & Department
- D - Department (only)
- E - Ordering CRT & Department

For options A and C, the Patient Nurse Station is defined as the station where the patient is located at the time the occurrence order becomes active. Therefore, if the patient has future pending occurrences and is transferred to a new location, upon transfer, the system redirects pending orders (that is, any that have not yet printed) to the new patient location.

For SIM items that are most often redirected, you can designate the print location where the orders should be redirected on the Default Order Values screen in the Service Item Master processor. If the SIM item has a default print location attached to it, the location is automatically displayed in the Print Location field. To redirect the requisition, access this field during initial order placement and change the print location.

4. PRIORITY (TABLE LOOKUP)
This field indicates the manner in which the treatment should be performed (for example, ASAP, pre-op, routine). When you access the Priority field, the following prompt displays:

Enter table code or '-' for table--

Enter the priority code if you know it, or enter a hyphen (-) to display the list of valid priorities for the ordering department. The ordering department can require the entry of a priority.

If the Start Date/Time Entry field on the Priority table for this priority is set to Time Only or Neither Date/Time, the system automatically fills in the Start Date field on the order screen. These two entries are designed specifically to prevent you from entering or editing the Start Date field.

Five fields depend on the value in the Priority field: Start Date, Start Time, Duration, Stop Date, and Stop Time. Each time you modify the Priority field, the system clears these five fields and either recalculates new values for each or prompts you to enter new values.

5. FREQUENCY (5-C-R) or (TABLE LOOKUP)
This field displays the frequency code for the order. Using the value in the Duration field, the system calculates the Stop Date and Stop Time fields. The following prompt displays:

Enter description '-' or code--

Enter the code or the full description for the desired frequency if you know it, or enter the first few letters of the description and a hyphen (-) to select from a list of frequencies that partially match the criteria. If you do not know either the code or description at all, enter a hyphen (-) and select the desired frequency from the displayed Frequency table.

NOTE: If you want to ensure that non-SIM treatment orders print on the PCP, you must build the order so there is an occurrence on every shift. That guarantees that the treatment order prints on the PCP in case the PCP is printed for just one or two shifts and not for the entire day.

The following conditions apply:

- If times are defined for the frequency in the Times field of the Frequency table, then the times appear in the Times field in this screen, and the first time from the Frequency table is used for the frequency selected. The system calculates the Start Date and Start Time fields based on these parameters.

- If no scheduled days are associated with the frequency, the system blanks out the Schedule Days field.

- If a schedule is associated with the frequency, the system fills the Schedule Days field on this screen with that schedule and sets the Duration field to the value specified for the associated schedule.

Five fields depend on the value in the Frequency field: Start Date, Start Time, Duration, Stop Date, and Stop Time. Each time you modify the Frequency field, the system clears these five fields and recalculates new values for each.

If the Duration field in the Scheduled Days table associated with this frequency is set to 1 Occurrence, then the system sets default values in the Duration, Stop Date, and

Stop Time fields. However, you can enter /6 to return to the Duration or Stop Date field and either blank it out or change it. For any other duration (for example, Q6H), the system does not enter default values in these fields.

6. SCHEDULE DAYS (20-AN-R) or (TABLE LOOKUP)
This field identifies the default scheduled days on which the item should occur (for example, daily), which is defined in the Schedule field on the Frequency table. The Schedule Days, in which case the predetermined days display in the field.

To revise the default scheduled days, enter the code assigned to a specific schedule, or enter a hyphen (-) and select the desired schedule from the displayed Schedule table.

If you revise the frequency in the Frequency field, the system updates the Schedule Days field with the schedule associated with the new frequency. If no schedule is associated with a frequency, the system blanks out this field.

If the Scheduled Days field is filled in with a schedule that is defined as Scheduled Days, the following prompt displays:

```
Page:01                          Scheduled Days
( 1) ALL DAYS OF WEEK      ( 5) EVERY THIRD DAY       ( 9) MONDAY THRU FRIDAY
( 2) DAILY                 ( 6) MON. WED. FRI.        (10) ONCE
( 3) EVERY DAY             ( 7) MON/WED/THUR          (11) ONE TIME
( 4) EVERY OTHER DAY       ( 8) MONDAY AND FRIDAY     (12) PRN

Enter choice--                                  next page(/)
```

After you enter your choice of days, the Scheduled Days field then fills in with up to seven days of the week (for example, Su M Tu W Th F Sa). The following prompt displays:

Enter first letters '-' or schedule code--

If you do not make any selections at the prompt and you press ENTER, the following error message displays:

Error: Field Required!

If the frequency you select is of a PRN schedule type, the following message displays:

PRN selected, no occurrences generated!

If the frequency you select is of a PRN schedule type, the Duration field does not accept occurrences. The following error message displays:

PRN frequency cannot have occurrences selected or as defaults!

The ordering screen accepts a duration only of Days or Hours.If you fill in an ordering screen with a frequency that has a schedule that wasdefined as PRN, and you attempt to change the Schedule field, the following error message displays:

Error: Frequency has PRN schedule type, field cannot be edited!

You must change the Frequency field first, and the default schedule associated with it is updated.

7. TIMES (65-C-O)
This field identifies the specific times that a treatment or task should be administered. The system automatically fills this field using the Times field for the patient's nurse station, as defined in the Frequency table.You can revise the default times. Enter the desired times using military time (the 24:00 clock), or standard time (the 12:00 clock, with A for am and P for pm).

You can enter up to 16 times on the Order screen; however, only a limited number displays during the order process due to field size. If you need a larger number than 16, use an interval.

The following prompt displays:

Enter times--

You can access this field based on whether the chosen frequency is defined using times or interval, and whether the Allow Times Edit? field in the Frequency table is set to Yes or No. The following conditions apply to accessing and editing the Times field on all order screens:

Frequency type	Allow Times Edit? field setting	Cursor stops in Times field?	Can edit Times field?
Interval	Yes or No	No	No
Times	Yes	No	Yes
	No	No	No
No times, no interval	Yes	Yes	Yes
	No	No	No

8. START DATE (DATE-R)
This field identifies the date when the order is to begin generating occurrences. You are always prompted to enter the start date, except under the following conditions:

- The Start Date/Time Entry field on the Priority table for the order's priority is set to either Time Only or Neither [for neither date nor time]. These two priorities are specifically designed to prevent the user from entering or editing the Start Date field. In this case, the system automatically fills this field with today's date.

- If you are in an ordering session with multiple orders and the Carry Freq Forward field in the Order Management Facility Options table is set to Yes, then both the start date and start time from the first order carries forward to all the other orders in the session. If you change the start date and start time during the ordering process, the new start date and time carries forward from that point on to the rest of the orders in the session.

  However, if the order's duration is 1 Occurrence as defined in the Schedule Days table assigned to the frequency entered, then the Duration, Stop Date and Stop Time fields also defaults in an order session. If the frequency is other than 1 Occurrence (for example, Q6H), then the Duration, Stop Date, and Stop Time fields are not defaulted in an order session.

If the frequency does not have a specific time associated with it, the system requests a Start Date in this field. You can either enter the date, use the shortcuts T, T+1, and so on, or leave the field null and have the program calculate the appropriate date. If the frequency does not have a specific time associated with it, you must manually enter a date; the system does not accept a default date. You must either enter a valid date or use a shortcut entry. For order-entry techniques, see the *STAR Patient Care Reference Guide*, *General Information Volume*.

The Start Date field depends on the values in the Priority and Frequency fields. Each time you modify either of these fields, the system clears the Start Date field and recalculates a new value for it.

If you accessed the ordering process from STAR Patient Scheduling, this field contains the time indicated in the Appointment field on the appointment screen.

If you enter an invalid start date for the selected frequency, the following error message displays:

Start Date is invalid for this freq! Press NL.

If you enter a valid start date for the selected frequency, but the Department Days Valid is incorrect, the following error message displays:

Start Date is invalid for this item & dept!. Press NL.
Start Time is invalid for this department!. Press NL.

The following prompt displays:

Enter new order start date--

You can use this field when you need to enter an order initiated while the system is unavailable for some reason, and require a requisition. If you do not require a requisition, you should typically enter a charge for the procedure rather than a backdated order. The hospital controls the number of days in the past that the Start Date can be set to in the SIM Departments table. If you enter a date that exceeds the

department's valid number of back days, the system displays the following error message before redisplaying the original prompt:

Error: Date precedes admission/registration date or departmental limit!

This same prompt displays if you enter a date that precedes the patient's admission date.The Start Date is intended to be equal to today's date or some date in the future; however, if you enter a date that is within the department's valid number of back days, the system accepts the entry and displays the following warning message:

WARNING: Less than current date and time!

The hospital also controls the number of days in the future to which the Start Date can be set. If you enter a date that exceeds the department's valid number of days in the future, the system displays the following error message before redisplaying the original prompt:

Error: Date exceeds departmental limit!

9. START TIME (TIME-R)
This field identifies the time when the order is to begin generating occurrences. The following prompt displays:

Enter start time--

Enter the time using one of the time-entry techniques described in the *STAR Patient Care Reference Guide, General Information Volume*.

The Start Time field depends on the values in the Priority and Frequency fields. Each time you modify either of these fields, the system clears the Start Time field and recalculates a new value for it.

- If Times are specified and the start date is greater than today, the system uses a default prompt of the first time specified.
- If Times are specified and the start date is not greater than today, the system calculates the time based on current time. If the default start time is for a date/ time other than today, the prompt includes the default start date. Here are some examples:

  Enter start time for yesterday [04:00pm]--
  Enter start time for Monday 06/25 [04:00pm]--

If you accept the default start time, or enter an override start time, the system sets the start date to the date displayed in the prompt. To override the start date and start time, enter the date and time, separated by a space (for example, T 2P, 06/26,T N).

After you enter a start time, the system verifies that the start date and start time is not later than the stop date and stop time.

If a duration is specified, the system automatically calculates a default stop date and stop time.

If you accessed the ordering process from STAR Patient Scheduling, this field contains the time specified in the Appointment field on the appointment screen.

The start date and time associated with an order is intended to be equal to or some time after the current date and time. However, if you enter a time that causes the start date and time to be prior to the current date/time, the system accepts the entry and displays the following warning message:

WARNING: Less than current date and time!

If the date you enter is past the cutoff time specified for the department and the priority selected, the system accepts the entry after the following warning message displays:

WARNING: Past cutoff time!

If your institution has set the Back Date Orders field in the SIM Departments table to No, then backdating and backtiming of orders is disallowed in most situations (see note below). If you enter a time in this field that is earlier than the current time, the system displays the following error message before redisplaying the original prompt:

Error: Time precedes departmental limit!

NOTE: If your institution has set the Back Date Orders field in the SIM Departments table to No, then backdating and backtiming of orders is disallowed, except under the following condition: If an order is placed that contains a frequency that has "times" associated with it, setting the field to No causes the function to work as if the Back Date Orders field was set to 0. If an order is placed that contains a frequency that does not have "times" associated with it, the selection of a time prior to the current system time gives the error message and does not allow you to continue until the appropriate response is selected.

If you enter a time in this field that is earlier than the current time, the system displays the following error message before redisplaying the original prompt:

Error: Time precedes departmental limit!

You receive this same error message if the frequency for the order does not have predefined times associated with it and you enter a start time prior to the current time. In each case, you must enter a valid time before preceding.

If your institution has set the Back Date Orders field in the SIM Departments table to zero, then backdated orders are allowed if they are less than one day in the past (on

the current day from midnight to 11:59 pm). The ordering screen accepts a backdated time from the current time for the current day. However, the system displays the following warning message:

Warning: Less than current date and time!

You receive this same error message if the frequency for the order has predefined times associated with it and you enter a start time prior to the current time. In each case, although you receive this error message, the cursor moves to the next field and you can continue working.

For orders with a priority of STAT, the STAT field on the Priority table is set to Yes, and the order's start time is the current system time. Any predefined times associated with the order is cleared out. The current system time is captured as the start time on the first order , and that time is used on all orders in the set. This ensures that orders are grouped correctly for STAR Laboratory accession numbers.

10. DURATION (10-AN-R)
This field specifies the period of time that the order remains active. If a default duration is specified for the ordered item in the Default Order Values table (in the Service Item Master Processor), then the system fills this field with the default duration. If no default duration is specified there, but a duration *is* specified on the Scheduled Days table associated with the frequency for this order, then that duration is displayed. For more information on default durations, see the Default Order Values table and Scheduled Days table in Appendix A: Tables. You can override either default duration by entering a duration in this field.

The Duration field depends on the values in the Priority and Frequency fields. Each time you modify either of these fields, the system clears the Duration field and recalculates a new value for it.

If you enter the duration here, the system calculates the stop date and stop time. The following prompt displays:

Enter order duration ##Hours, ##Days or ##Occurrences or (I)ndefinite--

This field is required. If you want the order to be open ended, enter **I** for Indefinite. The Stop Date and Stop Time fields are bypassed.

WARNING: If you enter **I** for Indefinite to specify an open-ended order, then the parent order generates occurrences continuously until the order is discontinued or cancelled, or the patient is discharged. See the end of this field explanation for more consequences of leaving an order open ended.

If you enter a number in place of the ## and do not enter H, D, or O after the number, another prompt displays:

Enter (H)ours, (D)ays or (O)ccurrences--

- To specify duration in terms of hours, enter the number of hours with a suffix of H (48H).
- To specify duration in terms of days, enter the number of days with a suffix of D (2D).
- To specify duration in terms of occurrences, enter the number of occurrences with a suffix of O (6O).

Suppose you place an order with a start date and time of March 5 at 2:00 pm. Based on the information you enter, the system calculates the duration in one of the following ways:

If the duration or default is defined in terms of...	**Then the system calculates the duration as beginning with the...**	**In this example, the Stop Date and Time is...**
Days Example: 2 days	Start Date at 12:00 midnight and ending Today+ 1 at 11:59 pm	March 6th at 11:59 pm
Hours Example: 24 hours	Start Date and Time and ending at exactly 24 hours	March 6th at 1:59 pm
Occurrences Example: 4 occurrences	Start Date and Time and ending exactly when the last occurrence should be scheduled, based on whether the frequency is defined as times or interval.	For a frequency of *times* defined as 9:00 am and 3:00 pm, the Stop Date and Time is March 7th at 9:00 am For a frequency of *interval* defined as every 6 hours (Q6H), the Stop Date and Time is March 6th at 8:00 am

If you enter an order that has times associated with the frequency and you enter a start time that is not one of the predefined times associated with the order's frequency, and the duration is 1 Occurrence (either entered manually in the Duration field or because the Recurring field in the Priority table is set to No), then an error message is displayed:

Error: Invalid start time and/or duration.

If you enter **I** for Indefinite, the duration is ongoing and the following occurs:

- Occurrences continue to generate daily until the patient is discharged, depending on what the interval is set to in the Scheduled Days table (for example, every 1 day, every 2 days).

- When the patient is discharged, a Discontinue is sent for all active patient orders (In Proc).
- Active occurrences with request times that have passed remain active.
- Active occurrences with request times that have not passed are cancel-requested (Order-Cnc).
- Pending occurrences are cancelled. Cancel requisitions are generated with a cancel reason of Patient Discharged.
- The audit of the parent and occurrences is updated with the reason of Patient Discharged.
- Any future orders placed that currently have no occurrences do not generate any occurrences.
- You must manually cancel or complete active occurrences. You can complete active occurrences from the department.

11. STOP DATE (DATE-C)
This field identifies the date that the order stops generating occurrences. If you enter a duration in terms of occurrences, hours or days, the system automatically fills this field with a revisable, system-calculated stop date, and this field becomes required.

The Stop Date field depends on the values in the Priority and Frequency fields. Each time you modify either of these fields, the system clears the Stop Date field and recalculates a new value for it.

You can revise the calculated stop date in response to the following prompt:

Enter stop date--

If you enter a stop date that is before the start date, the system displays an Invalid Date message and does not accept your entry. If you change the stop date, the Duration field blanks out. If you want the order to be open-ended, leave the Stop Date field blank.

12. STOP TIME (10-C-C)
This field identifies the time that this order stops generating occurrences. If the Stop Date field contains a response, this field is required. If you entered a duration in terms of occurrences, hours or days, the system automatically fills this field with a revisable, system-calculated stop time, and this field is required.

The Stop Time field depends on the values in the Priority and Frequency fields. Each time you modify either of these fields, the system clears the Stop Time field and recalculates a new value for it.

You can revise the default stop time in response to the following prompt:

Enter stop time--

If you want the order to be open-ended, leave the Stop Time field blank.

13. ORDERING PHYSICIAN (28-AN-R)
This field indicates the physician who is placing the order for the patient. This field is required. If you accessed the ordering process from STAR Patient Scheduling, this field contains the entry in the Referring Physician field on the appointment screen.

The following prompt displays:

Enter name'-', (-') for staff, (\-)NSCG, table code, [R]--
'-'name to override, or Physicians of Record(R)

Use one of the following methods to make an entry:

- Enter the physician's name if you know it.
- Enter a hyphen and apostrophe (-')to display a list ofthe staff for your selection.
- Enter a backslash and hyphen (\-) to display a list of the NSCG for your selection.
- Enter **R** or press ENTER to display a table of the patient's physicians of record. The table displays the physician's name, office location (if your facility is using multiple office processing), and the relationship of the physician to the patient. You can select a physician of record from this table.
- Enter a hyphen (-) to view a listing of the Physician table if you do not know the ordering physician's code. Due to the size of the Physicians table, enter the first few characters of the physician's last name, followed by a hyphen (-), to reduce the list to be viewed.
- Enter the code of the ordering physician, if you know it.
- Enter the physician's name as an override by entering a hyphen (-) before the physician's name, if the physician who is placing the order is not in the Physician table.

If you enter a physician table code or a physician of record, you are prompted to select the physician's office location if the following three conditions are met:

- The hospital-controlled facility option for the second office address is set to Yes.
- The selected physician's multiple office address parameter is set to Yes.

- The selected physician is not already a physician of record.

If you enter an override physician as the ordering physician, address processing does not occur.

14. TEXT (180-C-O or 225-C-O)
This field enables you to edit the text for a treatment order. The prompt for the field displays as follows:

Edit text ? (Y/N) [N]

The default for the prompt is set to No, but your facility can change the default to Yes under Station Parameters. Refer to "Appendix A - NURSING TABLES".

If you enter **Y** for Yes at the prompt, you can access to the text editor. The text box enables you to enter freeform text in the available lines. The function keys available in the Text Editor are:

F1	F2	F3	F4	F5
Del Line	Ins Line	Done	Del Char	Ins Char

Impact

After this screen is accepted, the following processing takes place:

- The system assigns an order number and a Pending status to the order. When the requested date/time is within the Days and Hours Valid window, the order changes to an Active status.

- The treatment order displays and can be accessed through Order Inquiry and Order Update for revisions, completions, or cancellations.

- No charges are generated for treatment orders due to their non-SIM department status.

Output

Requisitions do not print for treatment orders.

STATION SCHEDULE

If the Nursing main menu for your nursing station has the Station Schedule option, then nursing staff can access the *STAR Patient Scheduling Module* of the *STAR Patient Care Reference Guide* to view scheduled events for patients. In some cases, you can also access the fields in the Patient Scheduling processor to make changes to appointment information.

Each resource department controls whether nursing staff can edit schedules. This is determined by the setting in the Nursing Access field on the Resource Department Code table, which is a STAR Patient Scheduling table. Please refer to the *STAR Patient Scheduling Module* of the *STAR Patient Care Reference Guide* for more information.

If your nursing station has not been given edit access, then you must phone any appointment changes to the appropriate scheduling department so they can be updated by a scheduling staff person.

Chapter 4 - VITAL SIGNS AND FLUID BALANCES

Illustrations

INTRODUCTION

Vital signs and fluid balances are clinical data collected from the patient. The Vital Signs and Fluid Balances functions enable the nursing staff to enter patient data into the system. If the Pathways Care Manager interface is active, the data is automatically transferred from the hand-held Pathways Care Manager terminal to the STAR Patient Care system.

When your nursing station does not use Pathways Care Manager, you can enter the patient data using the Chart Vital Signs and Revise Vital Signs functions.

When your nursing station uses Pathways Care Manager, the vital signs and fluid balances are electronically transmitted from the Pathways Care Manager terminal to STAR Patient Care. The data is entered at the bedside, sent to STAR Patient Care, and stored. Because the data is automatically transmitted from Pathways Care Manager, there is no need to use the Chart Vital Signs or Revise Vital Signs functions. These functions are not available in the Pathways Care Manager environment.

In either environment, STAR Patient Care uses the data for compiling reports of the vital signs and fluid balances for the patient. You can view or print the reports for today's date, for the last 48 hours, for the current shift, or for a range of dates and shifts.

Menu Access to Chart or Revise Vital Signs and Fluid Balances

You access the Vital Signs and Fluid Balances function from the main Nursing menu:

```
                  General Hospital 1E Station ID Processor
                                                Fri Dec 18, 1992 03:07 pm
1E Station ID Input Options

            Option No.  Option
            ----------------------------------------
                1       Orders
                2       Diet Review
                3       Plan of Care Process
                4       Critical Pathways
                5       Vital Signs & Fluid Balances
                6       Revise Patient
                7       Patient History / Misc.
                8       Patient Print
                9       Station Print
               10       Nursing Management
               11       Staffing Functions
               12       Census
               13       Name Inquiry
               14       Send Message
               15       File Maintenance
               16       Hospital Employee File
Enter option number--
```

The Vitals & Fluids menu is displayed:

```
                  General Hospital Vitals & Fluids Processor
                                                  Fri Dec 18, 1992 05:31 pm
Vitals & Fluids Input Options

             Option No.  Option
             ---------------------------------------
                 1       Chart Vital Signs
                 2       Revise Vital Signs

                 3       Last 48 Hour Vital Signs
                 4       Today's Vital Signs
                 5       Current Shift Vital Signs
                 6       Vital Signs by Date & Shift

                 7       Chart Fluid Balances
                 8       Revise Fluid Balances

                 9       Last 48 Hour Fluid Balances
                10       Today's Fluid Balances
                11       Current Shift Fluid Balances
                12       Fluid Balances by Date & Shift

Enter option number--
```

The functions enable you to chart or revise vitals signs and fluid balances, as well as quickly view or print the data.

Function Flow - Vital Signs & Fluid Balances

SELECT THE PATIENT(S) TO CHART OR REVISE

After you access one of the chart or revise options on the Vital Signs & Fluid Balances menu, the system asks for identification of the patient. The following prompt asks you to identify the patient:

Enter acct #, `-`bed code, first chars of name`-` [Station Name Census]--
`C` for Census

You can enter an equal sign (=) to display the last patient referenced in addition to the additional options listed below. If the system does not have a last patient referenced loaded in memory, and you enter an equal sign (=), the following error message displays:

Error: Inactive account number!

The prompt redisplays.

- Account # Access - The patient can be directly accessed by entering the account number. Using the account number allows you access to inpatients or outpatients in beds currently on your station, inpatients or outpatients that have ever been on your station and regular outpatient types. If you enter the account

number of an inpatient or outpatient in bed that has never been on your station, the following error message displays:

Error: Never in Station!

and does not allow access to the patient. The prompt is redisplayed. If you enter an inactive account number, the system displays the following error message:

Error: Inactive account number!

and redisplays the prompt.

- Bed Code Access - Inpatients or outpatients currently in a bed on the nursing station can be directly accessed by entering a hyphen (-) followed by the bed code for the patient's current bed as defined in the Location File. Only valid bed codes for your station are allowed to be entered. If you enter an invalid bed code, the system displays the following error message before redisplaying the prompt:

  Error: Bed not found!

- Name Access - If you do not know the patient's account number or bed code, you can enter a portion of the patient's name. The system displays a list of patients beginning with the characters entered, as shown below:

```
                General Hospital Chart Vital Signs Processor
                                                 Fri Jun 18, 2004 04:22 pm

No   Pat No       Stn  Rm-Bed   Patient Name              Srvc   PC  Cnd
 1 A 89275-00005  ICU  ICU-04   Smith,Eve T.              Med        S
 2 A 89307-00002  1E   2111-1  !Dennard,John James        Lab    BRD I
 3 A 89276-00008  ICU  ICU-01   Miller,Lamar              Rad        C
 4 A 89286-00003  1E   2110-2   Jones,Molly               Med    VIP OPS
 5 A 89286-00002  ICU  ICU-02  *Walton,Sydni              Car        C









Select #--
```

The listing includes all inpatients and outpatients in beds, but does not include regular outpatient types. For more information on fields contained in the Name Inquiry display, refer to the *General Information Module* of the *STAR Patient Care Reference Guide*.

If you select a patient that is not currently on, or has never been on your nursing station, the system displays the following error message before redisplaying the prompt:

Error: Never in Station!

If the system cannot locate any active patients with the characters entered, it displays the following error message before redisplaying the prompt:

Error: Name NOT Found!

- Station Census - You can either display the census of the primary nursing station or a census of secondary nursing stations that includes the room-bed and the patient's last and first names, as in the following example:

```
                General Hospital Chart Vital Signs Processor
                                                  Fri Dec 18, 1992 04:22 pm
Page:01                            2N Census
( 1) 1202-2  CATE,HANNAH
( 2) 1203-2  MONROE,WILL
( 3) 1204-2  LINSKI,MIMI
( 4) 1206-1  LANE,EMILY
( 5) 1207-2  MARS,MICHAEL
( 6) 1207-2  TAYLOR,JOHN
( 7) 1209-1  CHARLES,SOPHIE









Enter choice--
```

  - To select the default nursing station displayed in the prompt, you press ENTER. The census of the patients on the nursing station displays for your selection.

  - To display a list of secondary stations for the default nursing station, enter **C**. The following prompt displays:

    Enter station code [2N]--

    The primary station is the default in the prompt. You can display a list of the secondary stations by pressing hyphen (-) and ENTER. The census displays for the station you select. Select the patient for whom you want to enter an order.

NOTE: Information Windows displaying patient information, physicians, and pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in this function. During the download process, the system displays the following message:

Downloading Information Windows...Please Wait!

After the windows are downloaded, you can view them in any other nonpatient-specific function on STAR Patient Care. When you access a patient-specific function other than Order Management or Nursing functions, the downloaded information is cleared. The information is also cleared when you select a different patient in one of the functions where Information Windows are available.

For specific information regarding Patient, Physician, or Pharmacy Information Windows, refer to "Appendix B - INFORMATION WINDOWS".

SELECT THE PATIENT(S) FOR A REPORT

After you access one of the options for reporting on vital signs or fluid balances from the Vital Signs & Fluid Balances menu, the system asks for identification of the patient(s). The following prompt asks you to identify the station or patient:

Enter station(S), `-` to list bed groups, or [census]--

- Station Access - You can display the report for all the patients on the station. Enter **S** to display the report for all patients on the current station. The report displays for each patient on the station.

- Bed Group Access - Enter hyphen (-) to display a list of the available bed groups. When you select a bed group, the report displays for each patients in the bed group.

- Station Census - Enter **C** to display the census of the current nursing station that includes the room-bed and the patient's last and first names, as in the following example:

```
                General Hospital Chart Vital Signs Processor
                                                    Fri Dec 18, 1992 04:22 pm
Page:01                              2N Census
( 1) 1202-2  CATE,HANNAH
( 2) 1203-2  MONROE,WILL
( 3) 1204-2  LINSKI,MIMI
( 4) 1206-1  LANE,EMILY
( 5) 1207-2  MARS,MICHAEL
( 6) 1207-2  TAYLOR,JOHN
( 7) 1209-1  CHARLES,SOPHIE









Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                 end selection(NL)
```

You can select one or more of the patients.

Graph Vital Signs and Fluid Balances Data

When you exit the display of vital signs or fluid balances, the following prompt displays if your hospital has purchased McKesson's WEM product and your workstation and ID have been set up to enable its use:

Graph this data? (Y/N)--

When you enter **N** for No, or press ENTER, the Vital Signs and Fluid Balances menu redisplays. When you enter **Y** for Yes, the vital sign elements display on the screen for you to select the vital signs you want to display for this patient, as in the following example:

```
                General Hospital Print Vital Signs Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
91231-00001   ABBOTT, BUDDY      M  01/01/82 2K07-2  WILLS,JEFFREYDIG 10 I/P 29

                From 02/12/09 Shift 1  Thur 02/13/09 Shift 3
Page:01                          Vital Signs                ##=Current Choices
( 1) 01-Temp - Adult
( 2) 02-Temp - PEDS
( 3) 03-Pulse-FEMALE
( 4) 04-Pulse-MALE
( 5) 05-Respirations
( 6) 06-Blood Pressure
( 7) 07-Weight
( 8) 08-Pulse - PEDS
( 9) 09-Pressure-PEDS
(10) 10-Apgar Score
(11) 11-CVP
(12) 12-Pressures
(13) 13-Resp - PEDS
(14) 14-Head Circ - A

Enter choices (e.g.) 1,7,5-9) or '-' choices to remove(max. 3)--
                                 end selection(NL)
```

You can select a maximum of three vital sign elements that you want to graph for this patient. You can enter the selections in one of the following ways:

- Enter one number at a time and press ENTER.
- Enter the three numbers separated by commas and press ENTER.
- Enter a range of three consecutive numbers, for example, 3-5 and press ENTER.

The number(s) you select highlight and flash on the screen. Press ENTER to accept the selection(s). When you select more than the maximum, the following message displays:

Error: Maximum of 3 vitals

The vital sign elements redisplay for your selection.

When you finish selecting vital sign elements, press ENTER. The following message displays:

Generating Graph...

The data displays on your PC as a two-dimensional line graph. Each vital displays as a graphed line, with a different symbol for each element at the observation points. An example of the graph is shown in the *WEM User's Guide*. Refer to the *WEM User's Guide* for information about using graphed data.

NOTE: You can display a maximum of 15 observations. When there are more than 15 observations, the following message displays:

Error: Maximum of 15 Observations - Please reduce the date/shift interval

When you are displaying data for more than one patient, the system skips to the next patient. Reduce the date/shift period for this patient to display less than 15 observations.

CHART VITAL SIGNS

The Chart Vital Signs screen is used to enter the data collected when recording patient vital signs. This function is available only in a non-Pathways Care Manager (non-Horizon Clinicals®) environment.

NOTE: The term *Charted* indicates the actual performed date and time that the Vital Signs were taken; *Charted By* indicates the person who actually collected the data.

After you select the patient, the following screen displays:

```
                General Hospital Vital Signs Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41
   1 Charted Date   2 Charted Time   3 Charted By  4 Entered By









 Enter chart date [T]--
```

After the date is entered, the next prompt displays:

Enter chart time --

The system prompts you to select AM or PM if you are entering non-military time.

After you enter the time, the system prompts for the Charted By initials:

Enter the charted by initials--

The system automatically enters the Entered By initials as the initials of the user who signed on.

When you have completed all entries, the system displays a prompt to accept the data:

Accept this screen? (Y/N) [Y]--

After you enter **Y** for Yes to accept the screen, the following screen displays:

```
              General Hospital Chart Vital Signs Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
00000-00000

   1 Charted Date   2 Charted Time    3 Charted By    4 Entered By
       02/12/09       08:00A            NAB             MWL

   VITAL SIGN        VALUE      UNIT      SITE        EQUIP        MODIFIER

   Temp - ADULT  :
   Temp - PEDS   :
   Pulse- FEMALE :
   Pulse- MALE   :
   Respirations  :
   Blood Pressure:
   Weight        :
   Height        :
   Circumference :


                  F1|Prev Page|F2|Next Page|F6|Reset|F7|Exit ?
```

Press ENTER or the arrow keys to move through each selection.

Field Explanations

DATE/TIME/INITIALS (DISPLAY ONLY)
The Date, Time, Charted By and Entered By fields are for the time the data was actually captured and the initials of the person who collected the data. The system automatically enters the initials of the person entering the data.

The remaining fields are built as tables in Standard File Maintenance with the exception of Value, which is a freeform field. Depending on the particular Vital Sign, a field may or may not be applicable.

VITAL SIGNS (14-A-R)
This field contains the various user-defined category descriptions of Vital Signs that are collected and recorded per hospital or unit procedure. The description length is 14 characters and the number of Vital Signs that can be entered is unlimited.

VALUE (7-N-O)
This numeric field is used to enter the patient's data for the selected element. The value is the charted result of the vital sign to be stored and printed on the chart document. The value displays in the format 9999.99.

UNIT (8-N-C)
This field is required if applicable to the particular Vital Sign. It refers to the unit of measurement pertinent to the selected Vital Sign. For example, after 98.6 is entered as the value for temperature, the unit option for Fahrenheit (F) or Centigrade (C) displays.

SITE (8-A-O)
This field is used to record the site where the Vital Sign was taken, if applicable. The field contains an eight-character description length.

EQUIPMENT (8-A-O)
This field is used to record the equipment used to collect the particular vital sign data. This field contains an eight-character description length.

MODIFIER (8-A-O)
This field is for further definition of the vital sign taken. It is a characteristic of the particular category that provides clinical data (for example, Blood Pressure - laying pressure or standing pressure).

REVISE VITAL SIGNS

The Revise Vital Signs function is accessed from the Vital Signs & Fluid Balances menu. The Revise Vital Signs screen is used to make changes to an already charted data entry. As in a manual charting environment, each original item that is charted and the revision is displayed for review. A chart element can be deleted, which also is reflected on-line. A maximum of four revisions can be made per charted data element.

This function is available only in a non-Pathways Care Manager (non-Horizon Clinicals®) environment. After you select the patient, the following screen displays:

```
                General Hospital Vital Signs Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41









Enter vital sign code to revise or '-' to list --
```

If the code is unknown, press the hyphen (-) key for a table lookup of available vital signs with their code numbers. The following screen displays:

```
               General Hospital Revise Vital Signs Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41




Page:01                            Vital Signs
( 1) 01-Temp - ADULT                     (10) 10-Height-PEDS
( 2) 02-Pulse                            (11) 11-Resp - PEDS
( 3) 03-Respirations                     (12) 12-Pulse - PEDS
( 4) 04-Blood Pressure                   (13) 13-Pressures
( 5) 05-Weight                           (14) 14-Press - PEDS
( 6) 06-Temp - PEDS                      (15) 15-Press - Newbrn
( 7) 07-Apgar Score
( 8) 08-Height
( 9) 09-Length-Newborn

Enter choice--
```

After the code is entered, or the appropriate vital sign is selected from the table lookup, the next screen displays with the following prompt:

Enter date to revise or `-` to list --

In most cases, the date to revise is the current date; however, any date during the patient's length of stay can be revised. The date can be entered or selected from a table lookup of available dates. Available dates are those days with charted data for the selected element. The following screen displays:

```
                General Hospital Revise Vital Signs Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41




Page:01                           Dates for Pulse
( 1) 02/05/09
( 2) 02/06/09
( 3) 02/07/09




Enter choice--
```

After you enter the date, the following screen displays:

```
                General Hospital Vital Signs Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10  I/P 41

                      VITAL SIGN: Temperature

     CHARTED DATE/ TIME/  BY   VALUE  UNIT    SITE   EQUIPMENT   MODIFIER

       02/13/09    08:00a  QAW   102.8   F     oral     IVAC
  Rev 02/13/09    08:00a  QAW   101.8   F     oral     IVAC









          F1| Prev Page F2| Next Page F5| Delete F6| Reset F7| ?
```

You can use the Revise function to make revisions or deletions.

Revisions

To make revisions, press ENTER to move the cursor to the appropriate element to be revised. Enter the revision and exit the screen. The revised chart entry displays the current correct date. When that same date and element screen is entered the next

time, the system displays the original chart data with *Rev* at the beginning of the line. The newly revised data displays above the original *Rev* line.

The purpose of displaying each revision is to view any changes made to the data so that an error made in charting on a manual chart can be corrected.

Deletions

To delete a chart entry after entering the Revise screen, press the ENTER key to move the cursor to the appropriate element to be deleted. Press the F5 key to delete the line. The system displays the following prompt to confirm your action:

Are you sure you want to delete this entry? (Y/N) --

Enter **Y** for Yes to delete the entry. After the entry is deleted, the line displays again with *Del* at the beginning of the line. As with revisions, all deletions continue to display with *Del* to indicate that a charted entry was deleted.

LAST 48 HOUR VITAL SIGNS

You can quickly view or print the vital signs for a patient for the last 48 hours. The vital signs display for the 48 hours previous to the current time. After you select the patient, a screen displays with the Vital Signs for the 48 hours previous to the current time:

```
              General Hospital Last 48 Hour Vital Signs Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 5

                                  Last 48 Hours
DATE                                                                  CHT   ENT
  TIME    VITAL SIGN      VALUE  UNIT  SITE      EQUIPMENT  MODIFIER  BY    BY

02/17/09
  08:00am Temp - Adult    100.0   F    O         I                    mwd   MWD
  12:00noon                98.8   F    O         I                    mwd   MWD
  04:00pm                 102.0   F    O         I                    mwd   MWD
  06:00pm                 102.8   F    O         I                    lat   MWD
02/18/09
  08:00am Temp - Adult    101.0   F    O         I                    MWD   MWD
  12:00noon                98.8   F    0         I                    MWD   MWD
  02:00pm                 104.4*  F    0         I                    MWD   MWD
  04:00pm                 103.8   F    0         I                    MWD   MWD



Press NL to continue or print(P)--
```

The following prompt displays:

Press NL to continue or print(P)--

You have the following options:

- Press ENTER to view additional data, or view the next patient when you selected more than one patient. When you selected only one patient, pressing ENTER at the end of the report redisplays the Vital Signs & Fluid Balances menu.

- Enter **P** to print the report. The Vital Signs & Fluid Balances menu redisplays. Below is an example of the Last 48 Hours Vital Signs Report.

Figure 4.1 Last 48 Hours Vital Signs Report

Fri Dec 18, 1992 02:28 pm Page 1

GENERAL HOSPITAL
VITAL SIGNS REPORT
Last 48 Hours

Rm-Bd	Patient Name	Sex	Age	Diagnosis	Physician
1202-2	CATE,SARA	F	71Y	CHEST PAIN NOS	ALDEN,JOHN F

DATE TIME	VITAL SIGN	VALUE (*=ABNORMAL)	UNIT	SITE	EQUIPMENT	MODIFIER	CHT BY	ENT BY
12/17/92								
08:00am	Temp - Adult	100.0	F	O	I		mwd	MWD
12:00noon		98.8	F	O	I		mwd	MWD
04:00pm		102.0	F	O	I		mwd	MWD
06:00pm		102.8	F	O	I		lat	MWD
12/18/92								
08:00am		101.0	F	O	I		MWD	MWD
12:00noon		98.8	F	0	I		MWD	MWD
02:00pm		104.4*	F	0	I		MWD	MWD
04:00pm		103.8	F	0	I		MWD	MWD
12/17/92								
08:00am	Respirations	24						
12:00noon		22						
04:00pm		28						
06:00pm		24					lat	MWD
12/18/92								
08:00am		20					MWD	MWD
12:00noon		22					MWD	MWD
02:00pm		28					MWD	MWD
04:00pm		24					MWD	MWD
12/17/92								
08:00am	Pulse	82					mwd	MWD
12:00noon		80					mwd	MWD
04:00pm		88					mwd	MWD
06:00pm		86					lat	MWD
12/18/92								
08:00am		86					MWD	MWD
12:00noon		72					MWD	MWD
02:00pm		88					MWD	MWD
04:00pm		80					MWD	MWD
12/17/92								
08:00am	Blood Pressure	120/76			D		mwd	MWD
12:00noon		118/80			D		mwd	MWD
04:00pm		124/88			D		mwd	MWD
06:00pm		128/90			D		lat	MWD
12/18/92								
08:00am		118/80			D		MWD	MWD
12:00noon		118/82			D		MWD	MWD
02:00pm		128/90			D		MWD	MWD
04:00pm		120/84			D		MWD	MWD

End of Report

TODAY'S VITAL SIGNS

You can quickly view or print today's vital signs for a patient. Select the Today's Vital Signs option from the Vital Signs & Fluid Balances menu. After you select the patient, a screen displays with the Vital Signs taken since midnight of the current day:

```
               General Hospital Today's Vital Signs Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10  I/P 5

                              Today Since Midnight
DATE                                                                    CHT   ENT
  TIME    VITAL SIGN      VALUE  UNIT  SITE      EQUIPMENT  MODIFIER   BY    BY

02/18/09
  02:00am Temp - Adult    100.0   F    O         I                     MWD   MWD
  08:00am                 101.0   F    O         I                     MWD   MWD
  12:00noon                98.8   F    0         I                     MWD   MWD
  02:00pm                 104.4*  F    0         I                     MWD   MWD
  04:00pm                 103.8   F    0         I                     MWD   MWD
02/18/09
  02:00am Respirations     19                                          MWD   MWD
  08:00am                  20                                          MWD   MWD
  12:00noon                22                                          MWD   MWD
  02:00pm                  28                                          MWD   MWD
  04:00pm                  24                                          MWD   MWD
02/18/09
  02:00am Pulse            76                                          MWD   MWD
  08:00am                  86                                          MWD   MWD
  12:00noon                72                                          MWD   MWD
  02:00pm                  88                                          MWD   MWD
  04:00pm                  80                                          MWD   MWD

Press NL to continue or print(P)--
```

The following prompt displays:

Press NL to continue or print(P)--

You have the following options:

- Press ENTER to view additional data, or view the next patient when you selected more than one patient. When you selected only one patient, pressing ENTER at the end of the report redisplays the Vital Signs & Fluid Balances menu.

- Enter **P** to print the report. The Vital Signs & Fluid Balances menu redisplays. Below is an example of the Today's Vital Signs Report.

Figure 4.2 Today's Vital Signs Report

```
Fri Dec 18, 1992 02:28 pm                                          Page 1
                              GENERAL HOSPITAL
                             VITAL SIGNS REPORT
                            Today Since Midnight
_____________________________________________________________________________
Rm-Bd   Patient Name        Sex   Age   Diagnosis              Physician
1202-2  CATE,SARA            F    71Y   CHEST PAIN NOS         ALDEN,JOHN F
_____________________________________________________________________________

DATE                (*=ABNORMAL)                                    CHT   ENT
  TIME    VITAL SIGN      VALUE  UNIT  SITE     EQUIPMENT  MODIFIER  BY    BY

12/18/92
  02:00am Temp - Adult    100.0   F    O        I                    MWD   MWD
  08:00am                 101.0   F    O        I                    MWD   MWD
  12:00noon                98.8   F    0        I                    MWD   MWD
  02:00pm                 104.4*  F    0        I                    MWD   MWD
  04:00pm                 103.8   F    0        I                    MWD   MWD
12/18/92
  02:00am Respirations     19                                         MWD   MWD
  08:00am                  20                                         MWD   MWD
  12:00noon                22                                         MWD   MWD
  02:00pm                  28                                         MWD   MWD
  04:00pm                  24                                         MWD   MWD
12/18/92
  02:00am Pulse            76                                         MWD   MWD
  08:00am                  86                                         MWD   MWD
  12:00noon                72                                         MWD   MWD
  02:00pm                  88                                         MWD   MWD
  04:00pm                  80                                         MWD   MWD
12/18/92
  02:00am Blood Pressure 114/80            D                          MWD   MWD
  08:00am                118/80            D                          MWD   MWD
  12:00noon              118/82            D                          MWD   MWD
  02:00pm                128/90            D                          MWD   MWD
  04:00pm                120/84            D                          MWD   MWD

                                  End of Report
```

CURRENT SHIFT VITAL SIGNS

You can quickly view or print the vital signs for a patient for the current shift. Select the Current Shift Vital Signs option from the Vital Signs & Fluid Balances menu. After you select the patient, a screen displays with the Vital Signs for the current shift:

```
            General Hospital Current Shift Vital Signs Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 5

                                  Current Shift
DATE                                                                    CHT   ENT
  TIME    VITAL SIGN      VALUE  UNIT  SITE      EQUIPMENT  MODIFIER  BY    BY

02/18/09
  08:00am Temp - Adult    101.0   F    O         I                    MWD   MWD
  12:00noon                98.8   F    0         I                    MWD   MWD
02/18/09
  08:00am Respirations      20                                        MWD   MWD
  12:00noon                 22                                        MWD   MWD
02/18/09
  08:00am Pulse             86                                        MWD   MWD
  12:00noon                 72                                        MWD   MWD
02/18/09
  08:00am Blood Pressure 118/80                 D                    MWD   MWD
  12:00noon              118/82                 D                    MWD   MWD

                                 End of Report

Press NL to continue or print(P)--
```

The following prompt displays:

Press NL to continue or print(P)--

You have the following options:

- Press ENTER to view additional data, or view the next patient when you selected more than one patient. When you selected only one patient, pressing ENTER at the end of the report redisplays the Vital Signs & Fluid Balances menu.

- Enter **P** to print the report. The Vital Signs & Fluid Balances menu redisplays. Below is an example of the Current Shift Vital Signs Report.

Figure 4.3 Current Shift Vital Signs Report

```
Fri Dec 18, 1992 02:28 pm                                          Page 1
                              GENERAL HOSPITAL
                             VITAL SIGNS REPORT
                                Current Shift
_____________________________________________________________________________
Rm-Bd   Patient Name        Sex   Age   Diagnosis              Physician
1202-2  CATE,SARA            F    71Y   CHEST PAIN NOS         ALDEN,JOHN F
_____________________________________________________________________________

DATE                (*=ABNORMAL)                                    CHT   ENT
  TIME    VITAL SIGN      VALUE  UNIT  SITE     EQUIPMENT  MODIFIER  BY    BY

12/18/92
  08:00am Temp - Adult    101.0   F    O        I                    MWD   MWD
  12:00noon                98.8   F    0        I                    MWD   MWD
12/18/92
  08:00am Respirations      20                                        MWD   MWD
  12:00noon                22                                        MWD   MWD
12/18/92
  08:00am Pulse            86                                        MWD   MWD
  12:00noon                72                                        MWD   MWD
12/18/92
  08:00am Blood Pressure 118/80              D                       MWD   MWD
  12:00noon             118/82               D                       MWD   MWD

                                End of Report
```

VITAL SIGNS BY DATE & SHIFT

You can view or print the vital signs for a patient for a specified date and shift. Select the Vital Signs by Date & Shift option from the Vital Signs & FluidBalances menu. After you select the patient, a screen displays for you to specify the date and shift:

```
           General Hospital Vital Signs by Date & Shift Processor
Station: 2 NORTH                                  Fri Dec 18, 1992 05:35 pm


( 1)Patient(s)     : 1204-2  CATE,ANNIE

( 2)Start Date     :
( 3)Start Shift    :

( 4)Stop Date      :
( 5)Stop Shift     :

( 6)Display/Print  :




Enter start date [T]--

 [Help]  [List]  [Next]  [Previous]  [Date]  [Time]  [Exit]  [LogOff]  [View]
```

Field Explanations

1. PATIENT(S) (DISPLAY ONLY)
This field displays the patient(s) you selected.

2. START DATE (DATE)
This field enables you to enter the date with which you want the report to start. Enter the date in the standard format or press ENTER to enter the default, **T**, for Today.

3. START SHIFT (1-N-R)
This field enables you to enter the shift with which you want the report to start. Enter the number of the shift or press ENTER to enter the default, **1**, for the first shift.

4. STOP DATE (DATE)
This field enables you to enter the date with which you want the report to stop. Enter the date in the standard format or press ENTER to enter the default, **T**, for Today.

5. STOP SHIFT (1-N-R)
This field enables you to enter the shift with which you want the report to stop. Enter the number of the shift or press ENTER to enter the default, Start Shift, which is the same shift as entered in the Start Shift field.

6. DISPLAY/PRINT (1-A-R)
You can display or print the report. The following prompt displays:

Display(D) or print(P) report? [D]--

Enter **P** to print the report. Enter **D** to Display the report. You can also print the report from the screen display. The report prints at the default printer for the CRT. The default is Display.

Once you accept the screen, the report prints at the default CRT or displays as in the following example:

```
              General Hospital Vital Signs by Date & Shift Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LENORE MED 10 I/P 41

                 From 02/17/09 Shift 2  Thru 02/17/09 Shift 2
DATE                                                                    CHT   ENT
  TIME    VITAL SIGN      VALUE  UNIT  SITE      EQUIPMENT  MODIFIER  BY    BY

02/17/09
  04:00pm Temp - Adult    102.0   F    O         I                    mwd   MWD
  06:00pm                 102.8   F    O         I                    lat   MWD
02/17/09
  04:00pm Respirations     28
  06:00pm                  24                                        lat   MWD
02/17/09
  04:00pm Pulse            88                                        mwd   MWD
  06:00pm                  86                                        lat   MWD
02/17/09
  04:00pm Blood Pressure 124/88              D                       mwd   MWD
  06:00pm                128/90              D                       lat   MWD

                                  End of Report

Press NL to continue or print(P)--
```

The following prompt displays:

Press NL to continue or print(P)--

You have the following options:

- Press ENTER to view any additional data, or to view the next patient when you selected more than one patient. When you selected only one patient, pressing ENTER at the end of the report redisplays the Vital Signs & Fluid Balances menu.

- Enter **P** to print the report. The Vital Signs & Fluid Balances menu redisplays. Below is an example of the Vital Signs By Date & Shift Report.

Figure 4.4 Vital Signs By Date & Shift Report

```
Fri Dec 18, 1992 02:28 pm                                          Page 1
                              GENERAL HOSPITAL
                             VITAL SIGNS REPORT
                  From 12/17/92 Shift 2  Thru 12/17/92 Shift 2
_____________________________________________________________________________
Rm-Bd   Patient Name         Sex   Age   Diagnosis              Physician
1202-2  CATE,SARA             F    71Y   CHEST PAIN NOS         ALDEN,JOHN F
_____________________________________________________________________________

DATE                 (*=ABNORMAL)                                    CHT   ENT
  TIME    VITAL SIGN       VALUE  UNIT  SITE      EQUIPMENT  MODIFIER  BY    BY

12/17/92
  04:00pm Temp - Adult     102.0   F    O         I                    mwd   MWD
  06:00pm                  102.8   F    O         I                    lat   MWD
12/17/92
  04:00pm Respirations      28
  06:00pm                   24                                        lat   MWD
12/17/92
  04:00pm Pulse             88                                        mwd   MWD
  06:00pm                   86                                        lat   MWD
12/17/92
  04:00pm Blood Pressure 124/88              D                        mwd   MWD
  06:00pm                128/90              D                        lat   MWD

                                  End of Report
```

CHART FLUID BALANCES

The Chart Fluid Balances function is accessed from the Vital Signs & Fluid Balances menu. The Chart Fluid Balances screen is used to enter the data collected when recording patient's fluid intake and output. This function is available only in a non-Pathways Care Manager environment.

After you choose the function, the system displays the following prompt in order to enter the patient. The station selection has already been made.

Enter acct #, `-` bed code, first chars of name'-' [2N Census]--
'C' for Census

Patient selection is performed in the normal manner as described in the *General Information Volume* of the *STAR Patient Care Reference Guide*.

NOTE: The term Charted indicates the actual performed time when the intakes and outputs were collected and calculated.

After you select the patient, the following screen displays:

```
                General Hospital Fluid Balances Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005  CATE,ANNIE          F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41
   1 Charted Date    2 Charted Time    3 Charted By    4 Entered by
                                                       GJW









 Enter chart date [T]--
```

After you enter the date, the system prompts you to enter the chart time and the Charted By initials:

Enter chart time--
Enter the charted by initials--

The system automatically enters the Entered By initials using the initials of the user who signed on.

When you have completed all entries, the system displays a prompt to accept the data:

Accept this screen? (Y/N) [Y]--

After you enter **Y** for Yes for accept the screen, the following screen displays:

```
                General Hospital Chart Fluid Balance Processor
                                                  Tue Feb 24, 2009 02:25 pm
 No          Name              Sex    BD     Room    Physician    SVC ICD Status
92241-00005  CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41
   1 Charted Date    2 Charted Time    3 Charted By    4 Entered By
     02/12/09            8:00 am           EE              MWL

     INTAKE               VALUE   UNIT     OUTPUT              VALUE   UNIT

     Oral           (Vol):          cc     Urine         (Vol):          cc
     Tube feeding   (Vol):          cc     Incontinent   (Occ):
     IV Fluid       (Vol):          cc     BM            (Occ):
     Blood          (Vol):          cc     Emesis        (Vol):          cc
     Platelets      (Vol):          cc     NG Tube       (Vol):          cc
     Breast Feeding (Occ):          cc     Diapering     (Occ):



     |F1|Prev Page|F2|Next Page|F6|Reset|F7|Exit|?|
```

Field Explanations

DATE/TIME/INITIALS (DISPLAY ONLY)
The Date, Time, Charted By and Entered By fields are for the time the data was actually captured and the initial of the person who collected the data. The system automatically enters the initials of the person entering the data.

INTAKE (DISPLAY ONLY)
This field contains the various user-defined element descriptions of the types of Intake that is collected for the patient. The Intake descriptions are built as tables in Standard File Maintenance. The description length is 14 characters and the number ofelements that can be entered is unlimited. The value is indicated by volume or number of occurrences.

OUTPUT (DISPLAY ONLY)
This field contains the various user-defined element descriptions of the types of Output that is measured for the patient. The Output descriptions are built as tables in Standard File Maintenance. The description length is 14 characters and the number of elements that can be entered is unlimited. The value is indicated either by volume or number of occurrences.

VALUE (7-N-O)
This numeric field is used to enter the patient's data for the selected element. The value is the charted result of the intake and/or output measurement to be stored and printed on the chart document. The value displays in the format 9999.99.

UNIT (8-A-C)
This field is required if the selected Input or Output measurement is recorded by volume. The field refers to the unit of measurement pertinent to the selected element. For example, after entering 1000 to IV fluid intake, the unit would be cc to indicate the correct measurement. The unit field is built in Standard File Maintenance and contains an eight-character description length if needed.

REVISE FLUID BALANCES

The Revise Fluid Balances screen is used to make changes to an already charted data entry. As in a manual charting environment, each original item that is charted and the revision displays for review. A chart element can be deleted, which is also reflected on-line. A maximum of four revisions can be made per charted data element.

This function is available only in a non-Pathways Care Manager environment. After you select the patient, the following screen displays:

```
                General Hospital Fluid Balances Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
 92241-00005  CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41









Enter fluid code to revise or `-` to list--
```

If the code is unknown, press the hyphen (-) key for a table lookup of available fluids to chart against with their code numbers. The following screen displays:

```
              General Hospital Revise Fluid Balances Processor
                                                Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41




Page:01                              Fluids
( 1) 01-Urine - vol                      (10) 10-NG tube
( 2) 02-Oral                             (11) 11-Blood
( 3) 03-IV                               (12) 12-Platelets
( 4) 04-Urine - occ                      (13) 13-IBPB
( 5) 05-Tube feeding                     (14) 14-TPN
( 6) 06-Hyperaliment                     (15) 16-Cont IV Drips
( 7) 07-Lipids                           (16) 17-Foley Cath
( 8) 08-Emesis-vol                       (17) 18-Other
( 9) 09-Emesis-occ                       (18) 19-NPO

Enter choice--
                                  next page(/)
```

After you enter the code or select the fluidfrom the table lookup, a screen displays with the following prompt:

Enter date to revise or `-` to list--

In most cases, the date to revise is the current date; however, any date during the patient's length of stay can be revised. Enter the date or select from a table lookup of available dates, as in the following example. Available dates are those days with charted data for the selected element.

```
              General Hospital Revise Fluid Balances Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE        F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41




Page:01                       Dates for Urine - vol
( 1) 02/12/09
( 2) 02/13/09
( 3) 02/14/09




Enter choice--
```

After you enter the date, the following screen displays:

```
                General Hospital Fluid Balance Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
 92241-00005  CATE,ANNIE        F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41

                           FLUID BALANCE : Oral

      CHARTED DATE/TIME/  BY     VALUE  UNIT     ENTERED DATE/TIME/  BY

      02/12/09  04:00P   NAB      240    cc       02/12/09  04:10P  MWL









        F1|Prev Page F2|Next Page F5|Delete F6|Reset F7|Exit ?
```

You can use the Revise function to make revisions or deletions.

Revisions

To make revisions, press the ENTER key to move the cursor to the appropriate element to be revised. Enter the revision and exit the screen. The revised chart entry displays the current correct date. When that same date and element screen is entered the next time, the system displays the original chart data with *Rev* at the beginning of the line. The newly revised data displays above the original *Rev* line.

The purpose of displaying each revision is to view any changes made to the data so that an error made in charting on a manual chart can be corrected.

Deletions

To delete a chart entry after entering the revise screen, press the ENTER key to move the cursor to the appropriate element to be deleted. Press the F5 key to delete the line. The system displays the following prompt to confirm your action:

Are you sure you want to delete this entry? (Y/N) --

Enter **Y** for Yes to delete the entry. After the entry is deleted, the line displays again with *Del* at the beginning of the line. As with revisions, all deletions continue to display with *Del* to indicate that a charted entry was deleted.

LAST 48 HOUR FLUID BALANCES

You can quickly view or print the fluid balances for a patient for the last 48 hours. Select the Last 48 Hour Fluid Balances option from the Vital Signs & Fluid Balances menu. After you select the patient, a screen displays with the Fluid Balances for the 48 hours previous to the current time:

```
            General Hospital Last 48 Hour Fluid Balances Processor
Station 2 NORTH                                    Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE        F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 5

                         Last 48 Hour Fluid Balances
                     Day          Evening          Night          Totals
                 7:00am-2:59pm   3:00pm-10:59pm  11:00pm-6:59am

02/17/09

INTAKE
    IV               525.0          625.0          375.0          1525.0 cc
    ORAL             135.0           90.0           90.0           315.0 cc
                    -------        -------        -------        -------
    * TOTAL IN       660.0          715.0          465.0          1840.0 cc

OUTPUT
    URINE            150.0          120.0           90.0           360.0 cc
    EMESIS            30.0            -              -              30.0 cc
                    -------        -------        -------        -------
    * TOTAL OUT      180.0          120.0           90.0           390.0 cc

Press NL to continue or print(P)--
```

The following prompt displays:

Press NL to continue or print(P)--

You have the following options:

- Press ENTER to view any additional data, or to view the next patient when you selected more than one patient. When you selected only one patient, pressing ENTER at the end of the report redisplays the Vital Signs & Fluid Balances menu.

- Enter **P** to print the report. The Vital Signs & Fluid Balances menu redisplays. There is an example of the report below.

Figure 4.5 Last 48 Hour Fluid Balances Report

GENERAL HOSPITAL
Last 48 Hour Fluid Balances

Rm-Bd	Patient Name	Sex	Age	Diagnosis	Physician
1209-2	LINK,ROBERT	M	42Y	CHEST PAIN NOS	ADAMS,HAROLD

	Day 07:00am-02:59pm	Evening 03:00pm-10:59pm	Night 11:00pm-06:59am	Totals
12/17/92				
INTAKE				
IV	525.0	625.0	375.0	1525.0 cc
ORAL	135.0	90.0	90.0	315.0 cc
* TOTAL IN	660.0	715.0	465.0	1840.0 cc
OUTPUT				
URINE	150.0	120.0	90.0	360.0 cc
EMESIS	30.0	-	-	30.0 cc
* TOTAL OUT	180.0	120.0	90.0	390.0 cc
* TOTAL IN	660.0	715.0	465.0	1840.0 cc
* TOTAL OUT	180.0	120.0	90.0	390.0 cc
** TOTAL NET	+480.0	+595.0	+375.0	+1450.0 cc
Urine-occ	1	3	1	5
Emesis-occ	1	-	-	1
12/18/92				
INTAKE				
IV	200.0	360.0	350.0	910.0 cc
ORAL	600.0	120.0	90.0	810.0 cc
* TOTAL IN	800.0	480.0	440.0	1720.0 cc
OUTPUT				
* TOTAL OUT	.0	.0	.0	.0 cc
* TOTAL IN	800.0	480.0	440.0	1720.0 cc
* TOTAL OUT	.0	.0	.0	.0 cc
** TOTAL NET	+800.0	+480.0	440.0	+1720.0 cc
Urine-occ	2	1	1	4

End of Report

TODAY'S FLUID BALANCES

You can quickly view or print today's fluid balances for a patient. Select the Today's Fluid Balances option from the Vital Signs & Fluid Balances menu. After you select the patient, a screen displays with the Fluid Balances taken since midnight of the current day:

```
              General Hospital Today's Fluid Balances Processor
Station 2 NORTH                                    Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 5

                          Today's Fluid Balances
                    Day          Evening          Night          Totals
                7:00am-2:59pm   3:00pm-10:59pm  11:00pm-6:59am

02/18/09

INTAKE
    IV               200.0          360.0          350.0          910.0 cc
    ORAL             600.0          120.0           90.0          810.0 cc
                    -------        -------        -------        -------
    * TOTAL IN       800.0          480.0          440.0         1720.0 cc

OUTPUT
                    -------        -------        -------        -------
    * TOTAL OUT          .0             .0             .0             .0 cc


Press NL to continue or print(P)--
```

The following prompt displays:

Press NL to continue or print(P)--

You have the following options:

- Press ENTER to view any additional data, or to view the next patient when you selected more than one patient. When you selected only one patient, pressing ENTER at the end of the report redisplays the Vital Signs & Fluid Balances menu.
- Enter **P** to print the report. The Vital Signs & Fluid Balances menu redisplays.

Figure 4.6 Today's Fluid Balances Report

Fri Dec 18, 1992 09:48 am Page 1

GENERAL HOSPITAL
Today's Fluid Balances

Rm-Bd	Patient Name	Sex	Age	Diagnosis	Physician
1209-2	LINSKI,MIMI	F	72Y	CHEST PAIN NOS	BAAB,GARY H

	Day 07:00am-02:59pm	Evening 03:00pm-10:59pm	Night 11:00pm-06:59am	Totals
12/18/92				
INTAKE				
IV	200.0	360.0	350.0	910.0 cc
ORAL	600.0	120.0	90.0	810.0 cc
* TOTAL IN	800.0	480.0	440.0	1720.0 cc
OUTPUT				
* TOTAL OUT	.0	.0	.0	.0 cc
* TOTAL IN	800.0	480.0	440.0	1720.0 cc
* TOTAL OUT	.0	.0	.0	.0 cc
** TOTAL NET	+800.0	+480.0	440.0	+1720.0 cc
Urine-occ	2	1	1	4

End of Report

CURRENT SHIFT FLUID BALANCES

You can quickly view or print the fluid balances for a patient for the current shift. Select the Current Shift Fluid Balances option from the Vital Signs & Fluid Balances menu. After you select the patient, a screen displays with the fluid balances for the current shift:

```
            General Hospital Current Shift Fluid Balances Processor
Station 2 NORTH                                    Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE        F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 5

                        Current Shift Fluid Balances
                     Day          Evening          Night          Totals
                 7:00am-2:59pm   3:00pm-10:59pm  11:00pm-6:59am

02/18/09

INTAKE
    IV                200.0                                          200.0 cc
    ORAL              600.0                                          600.0 cc
                     -------                                        -------
    * TOTAL IN        800.0                                          800.0 cc

OUTPUT
                     -------
    * TOTAL OUT          .0                                              .0 cc

Press NL to continue or print(P)--
```

The following prompt displays:

Press NL to continue or print(P)--

You have the following options:

- Press ENTER to view any additional data, or to view the next patient when you selected more than one patient. When you selected only one patient, pressing ENTER at the end of the report redisplays the Vital Signs & Fluid Balances menu.
- Enter **P** to print the report. The Vital Signs & Fluid Balances menu redisplays.

Figure 4.7 Current Shift Fluid Balances Report

```
Fri Dec 18, 1992 09:48 am                                          Page 1
                              GENERAL HOSPITAL
                          Current Shift Fluid Balances
_____________________________________________________________________________
Rm-Bd   Patient Name         Sex   Age   Diagnosis              Physician
1209-2  LINSKI,MIMI           F    72Y   CHEST PAIN NOS         BAAB,GARY H
_____________________________________________________________________________

                     Day          Evening          Night          Totals
                07:00am-02:59pm 03:00pm-10:59pm 11:00pm-06:59am

12/12/92

INTAKE
    IV                200.0                                        200.0 cc
    ORAL              600.0                                        600.0 cc
                     -------                                      -------
    * TOTAL IN        800.0                                        800.0 cc

OUTPUT
                     -------
    * TOTAL OUT          .0                                           .0 cc

    * TOTAL IN        800.0                                        800.0 cc
    * TOTAL OUT          .0                                           .0 cc
                     -------                                      -------
    ** TOTAL NET     +800.0                                       +800.0 cc

    Urine-occ           2                                            2

                                  End of Report
```

FLUID BALANCES BY DATE & SHIFT

You can view or print the fluid balances for a patient for a specified date and shift. Select the Fluid Balances by Date & Shift option from the Vital Signs & Fluid Balances menu. After you select the patient, a screen displays for you to specify the date and shift:

```
          General Hospital Fluid Balances by Date & Shift Processor
Station 2 NORTH                                    Fri Dec 18, 1992 05:36 pm


( 1)Patient(s)     : 1204-2  CATE,ANNIE

( 2)Start Date     :
( 3)Start Shift    :

( 4)Stop Date      :
( 5)Stop Shift     :

( 6)Display/Print  :




Enter start date [T]--

 [Help]  [List]  [Next]  [Previous]  [Date]  [Time]  [Exit]  [LogOff]  [View]
```

Field Explanations

1. PATIENT(S) (DISPLAY ONLY)
This field displays the patient(s) you selected.

2. START DATE (DATE)
This field enables you to enter the date with which you want the report to start. Enter the date in the standard format or press ENTER to enter the default, **T**, for Today.

3. START SHIFT (1-N-R)
This field enables you to enter the shift with which you want the report to start. Enter the number of the shift or press ENTER to enter the default, **1**, for the first shift.

4. STOP DATE (DATE)
This field enables you to enter the date with which you want the report to stop. Enter the date in the standard format or press ENTER to enter the default, **T**, for Today.

5. STOP SHIFT (1-N-R)
This field enables you to enter the shift with which you want the report to stop. Enter the number of the shift or press ENTER to enter the default, Start Shift, which is the same shift as entered in the Start Shift field.

6. DISPLAY/PRINT (1-A-R)
You can display or print the report. The following prompt displays:

Display(D) or print(P) report? [D]--

Enter **D** to Display the report. Enter **P** to print the report. The default is Display.

Once you accept the screen, the report prints at the default printer for the CRT or displays as shown on the following screen:

```
          General Hospital Fluid Balances by Date & Shift Processor
Station                                              Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
92241-00005   CATE,ANNIE         F  02/14/21 1204-2  ROOTH,LEN    MED 10 I/P 41

                From 02/17/09 Shift 3  Thru 02/17/09 Shift 3
                      Day          Evening          Night          Totals
                7:00am-2:59pm   3:00pm-10:59pm  11:00pm-6:59am

02/17/09

INTAKE
    IV                                                 375.0           375.0 cc
    ORAL                                                90.0            90.0 cc
                                                       -------         -------
    * TOTAL IN                                         465.0           465.0 cc

OUTPUT
    URINE                                               90.0            90.0 cc
    EMESIS                                               -               -   cc
                                                       -------         -------
    * TOTAL OUT                                         90.0            90.0 cc

Press NL to continue or print(P)--
```

The following prompt displays:

Press NL to continue or print(P)--

You have the following options:

- Press ENTER to view any additional data, or to view the next patient when you selected more than one patient. When you selected only one patient, pressing ENTER at the end of the report redisplays the Vital Signs & Fluid Balances menu.
- Enter **P** to print the report. The Vital Signs & Fluid Balances menu redisplays.

Figure 4.8 Fluid Balance Report by Date and Shift

```
                              GENERAL HOSPITAL
                            FLUID BALANCE REPORT
                  From 12/17/92 Shift 3  Thru 12/17/92 Shift 3
_____________________________________________________________________________
Rm-Bd   Patient Name        Sex   Age   Diagnosis              Physician
1209-2  LINK,ROBERT          M    42Y   CHEST PAIN NOS         ADAMS,HAROLD
_____________________________________________________________________________

                    Day          Evening          Night          Totals
                07:00am-02:59pm 03:00pm-10:59pm 11:00pm-06:59am

12/17/92

INTAKE
    IV                                            375.0          375.0 cc
    ORAL                                           90.0           90.0 cc
                                                  -------        -------
    * TOTAL IN                                    465.0          465.0 cc

OUTPUT
    URINE                                          90.0           90.0 cc
    EMESIS                                          -              -   cc
                                                  -------        -------
    * TOTAL OUT                                    90.0           90.0 cc

    * TOTAL IN                                    465.0          465.0 cc
    * TOTAL OUT                                    90.0           90.0 cc
                                                  -------        -------
    ** TOTAL NET                                 +375.0         +375.0 cc

    Urine-occ                                       1              1
    Emesis-occ                                      -              -

                              End of Report
```

Chapter 5 - MATERNITY MODULE

Illustrations

MATERNITY MENU

The STAR Nursing Maternity Menu contains several different options which offer functionality specific to maternity-related information and needs. Additionally, some Maternity menu items access submenus and screens different from those in the standard nursing menus.

When you access an OB nursing station, the Maternity menu displays, as shown on the following screen:

```
                    General Hospital OB Station ID Processor
                                                 Fri Mar 15, 1996 10:40 am
OB Station ID Input Options

           Option No.  Option
           ----------------------------------------
                       1       Orders
                       2       Case Team Access
                       3       Plan of Care Process
                       4       Critical Pathways
                       5       Labor & Delivery Clinical Questions
                       6       Vital Signs & Fluid Balances
                       7       Diet Review
                       8       Revise Patient Nursing
                       9       Patient Print
                      10       Station Print
                      11       Nursing Management
                      12       Name Inquiry
                      13       Census
                      14       Send Message

Enter option number--
```

The Maternity menu includes the following options, which are not present on standard nursing menus:

- Case Team Access
- Labor and Delivery Clinical Questions

Standard nursing menus include the following options, which are not present on the Maternity menu:

- Patient Flowsheets
- Patient History/Misc.
- Staffing Functions
- File Maintenance
- Hospital Employee File

Case Team Access

Case Team Access provides a new way to access inpatients and outpatients. Upon admitting maternity patients, you can establish them as linked to a Case Team Manager. This link allows you to easily access and process patient information on those patients that are part of a defined Case Team, through the Maternity menu option. Case Team Access functions similarly to the nursing station census access of patients.

When you select the Case Team Access menu option, the following prompt displays:

Enter acct #, '-' bed code, first chars of name'-' [C]--
'C' for Case Team

You can access patient information directly by entering the patient account number, bed code, or name.

Enter **C** for Case Team to access a listing of the existing Case Teams available. Select one of the Case Teams from the listing to gain access to patients linked to that Case Team. After you have made your selection, the Case Team menu displays:

```
                  General Hospital Case Team Access Processor
                                                    Tue Feb 24, 2009 02:25 pm
 No       Name         Sex   BD   Room   Physician   SVC ICD Status
9607300001    SMITH,MIRIAM      F  01/01/70 4302-02 SMITH,TAYLOR OBS 10 OB  2

             Option No.  Option
             ----------------------------------------
                 1       Department Orders
                 2       Routine Orders
                 3       Nourishment
                 4       Laboratory Results Inquiry
                 5       Radiology Results Inquiry
                 6       Order Update
                 7       Order Inquiry

                 8       Plan of Care Process
                 9       Critical Pathways
                10       Labor and Delivery Clinical Details
                11       Print Labor & Delivery Clinical Details

 Enter option number--
```

This menu contains the most frequently used nursing functions. It also includes options for processing, viewing, and printing Labor and Delivery Clinical Details.

DEFINING CASE TEAMS

You can define a Case Team and assign a Case Team Manager for a patient through the Case Team table. Access this table through the Table Maintenance listing. When you select Case Team from the list, the following prompt displays:

Enter a case team or '-' to list--

To define a new Case Team, enter a 4-character numeric code. The following prompt displays:

Add this code 'XXXX' (Y/N) [Y]--

where 'XXXX' is the code that you entered. If you enter **N** for No, the system displays the previous prompt again. When you enter **Y** for Yes, the Case Team table displays, as shown on the following screen:

```
                  General Hospital Table Maintenance Processor
                                                    Fri Mar 15, 1996 12:16 pm
Case Team
( 1)Code           : 15
( 2)Description    :
( 3)Case Team Mgr  :
( 4)Edit by        :
( 5)Edit date      :









Enter description--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the Case Team code. You cannot edit this field.

2. DESCRIPTION (22-AN-R)
This field displays a description for the Case Team. When you access this field, the following prompt displays:

Enter description--

Enter up to a 22-character description for the Case Team.

3. CASE TEAM MGR (TABLE LOOKUP)
This field displays a manager for the Case Team. When you access this field, the following prompt displays:

*Enter system ID, ' * ' employee number, last name or '-' to list--*
'-'name to override

Specify a Case Team manager directly by entering the employee number and name. Enter an override Case Team manager by entering a hyphen (-) and the override name.

When you enter a hyphen (-) to choose a Case Manager from an employee list, the following prompt displays:

Include only the active employees? [Y]--

When you enter **Y** for Yes, a list of active employees displays. If you enter **N** for No, a comprehensive employee listing displays, including active and inactive employees. The employee you select from the list displays in the Case Team Manager field.

NOTE: You should only assign Case Team Managers from the list of active employees.

4. EDIT BY (DISPLAY ONLY)
This field displays the name of the user who last updated this table.

5. EDIT DATE (DISPLAY ONLY)
This field displays the date that the table was last updated.

Once you complete the fields, press ENTER to exit the screen. The following prompt displays:

Accept this screen? (Y/N) [Y]--

Enter **N** for No to continue editing theDescription or Case Team Manager fields. Enter **Y** for Yes to accept the screen. The default for this prompt is **Y**.

When you access an existing Case Team, but make no edits, the following prompt displays:

Delete? [N]--

Enter **N** for No to exit without deleting the Case Team information. Enter **Y** for Yes to delete the Case Team. The default is **N**.

Labor and Delivery Clinical Questions

It is important to collect specific information for maternity patients after labor and delivery. This information assists in analyzing performance and improving patient care. Using the Labor and Delivery Clinical Questions, departments can build and link various questions and prompts to existing abstracting information. You can enter both current and abstracted information directly through the Maternity menu at a nursing station, without having to re-enter existing information.

The maternity questions/prompts provide you with maximum flexibility and control. Once these questions/prompts are in place and linked to corresponding STAR functions such as Assessment and Abstracting, the Labor and Delivery Clinical Details process becomes available through the Maternity menu.

The system processes the Labor and Delivery Clinical questions and responses in the following ways:

- Logs for reporting
- Verifies against normal ranges
- Retains with the patient's archived information in MPI
- Cross links to existing abstracting and assessment information

NOTE: You can enter the correct field or record number that corresponds to an external file (such as the government required information for the CIHI in Canada). The system converts existing information, if necessary (table response conversion code), and sends to the external file. You can later transmit or capture this additional information.

The maternity questions/prompts and their responses are available for reporting and analysis, and provide the basis of obstetric history for a patient's current pregnancy. You can view additional information linked to the Labor and Delivery Clinical questions/ responses through MPI Inquiry. You cannot revise Labor and Delivery information after you have entered it and archived the patient.

NOTE: *You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report, and the criteria selected for the report. For more information, see the STAR Audit Service Reference Guide.*

Select the Labor and Delivery Clinical Questions option from the Maternity menu to access the Labor and Delivery Clinical Details screen for review/entry. After you select a patient, the following prompt displays:

Enter Clinical Details concerning the Labor, Delivery or Both (L/D/B) [B]--

If you enter **L** for Labor, the Labor Details Clinical Questions screen displays, listing labor-specific questions and default responses. If you enter **D** for Delivery or **B** for Both, and the process is accessed through the stand alone function, the following prompt displays:

Enter number of births [1]--

The default response is 1 (one). If you enter a number other than 1, questions display in turn for each baby, by number. The number you enter displays as the default response the next time you next access the prompt.

When there are multiple babies, the responses for the previous baby become the default responses for all subsequent baby questions (for example, baby 2 displays baby 1 responses by default, baby 3 displays baby 2 responses by default).

When you are revising the Labor and Delivery questions/responses, if you increase the number of births, another set of questions displays for the additional baby. If you decrease the number, the system no longer displays the later entries, depending on the amount by which you decrease the number. (For example, if you enter information for three babies, and then enter two to the 'number of births' prompt, the last baby you entered previously is no longer accessible.)

NOTE: It is important to answer the questions in the same order as the admissions were done, so that the Labor and Delivery questions/responses correspond to the proper admission (for example, baby 1 corresponds to Baby 1 Girl). This ensures that the appropriate abstract updates with the correct information for the baby, if there is a link to abstracting.

After you enter the number of births, the Labor and Delivery Clinical Questions screen displays, as shown on the following screen.

```
        General Hospital Labor & Delivery Clinical Questions Processor
                                                    Tue Feb 24, 2009 02:25 pm
 No       Name         Sex   BD   Room   Physician   SVC ICD Status
9607300001    SMITH,MIRIAM      F  01/01/70 4302-02 SMITH,TAYLOR OBS 10 OB  2

 Labor and Delivery Details                                  Births: 1
 Baby 1
 Clinical Question           Response
 Elect C/S Indication        PREVIOUS
 C/S Method of Delivery      Skip
 Forceps/Ventouse Ind        Skip
 Emerg C/S Reason            Skip
 Perineal Condition          Skip
 Other Trauma                NONE
 Placenta Del Method         OXYTOCICS/CCT
 Weight of Placenta             .5
 Placenta Description        APPARENTLY COMPLETE
 Placenta Condition          HEALTHY
 Membranes Condition         COMPLETE
 Number Cord Vessels            3
 Cord Blood Taken            NO
 Cord Blood Reason           Skip
 Enter code or first letters'-' to list
                   F1Prev Page  F2Next Page  F6 Reset  F7  Exit   ?
```

If you entered **L** to the initial prompt, the header above the questions displays Labor Details. If you entered **D**, the header displays *Delivery Details*. If you entered **B**, the header displays Labor and Delivery Details.

All questions display as built in the Labor and Delivery Clinical Questions table. This screen is very similar to the questions portion of Clinical Ordering Details. The response editing restrictions are controlled by the information entered while building the questions. Refer to "Building Labor and Delivery Questions" on page 5-10 for more information.

A prompt displays in the lower left of the screen that corresponds to the format or type of data required for the active response field. Examples of these prompts are as follows:

Enter code or first letters'-' to list
Enter numeric value with decimal
Enter date
Enter text up to 10 characters

If any of your responses are outside of the defined normal range for that field, a message displays this information, but allows you to override the normal range. An example message would be:

'190.2' is outside of normal range (95-106), Accept? (Y/N)--

When you reach the final question, the list does not advance any further. Press F7 to exit the screen.

The questions that display on the Labor and Delivery Clinical Questions screen are determined by the following factors:

- Your selection of L, D, or B at the clinical details prompt dictates that either labor, delivery or both types of questions display.
- Questions display depending on the Inpatient/Outpatient parameters of the question table. Some questions may display for inpatients that do not for outpatients.
- Questions display depending on your response to certain individual questions, and whether subsequent questions should be skipped because of that response.
- When you enter multiple births, all questions indicated as relating to baby information display as many times as there are babies. There may be different questions to be answered if the responses are different for each baby due to the skip question processing.

NOTE: You cannot edit the Baby field in the header. It simply displays a numerical reminder as to which baby's information you are entering.

The questions and responses are available within STAR Patient Care, when a patient is active or inactive. Active patient information is available through the Labor and Delivery Clinical Questions option from the Maternity menu. Inactive patient information is available through the Maternity Information Processor in MPI Inquiry, as specified for a particular patient and visit.

NOTE: Once a patient has become inactive, you cannot adjust or modify any of the Labor and Delivery Clinical Detail information. The maternity information remains as it was at the time of historization and is only available through the patient's record stored in the MPI. It does not print on any of the Patient Care or Nursing reports or forms, but is available for display, and printing through the MPI.

Impact/Output

Once you complete the Labor and Delivery Clinical Questions information for a patient, it is available through several associated menu options. It also begins to build and impact several other functions and processes, depending on the question definition. Questions may or may not print on the Labor and Delivery Clinical Detail Information print outs, depending on whether they were initially displayed, as well as the internal/ external flags.

When questions are designated as internal, they do not appear when you request an External report. If the report requested is Internal, then all questions associated with the labor and delivery print, with their associated responses.

If a particular question indicated that it should be saved for transfer to an external file, such as the CIHI in Canada or an HL7 interface, the interface response you enter is used when creating the file. These file responses may or may not use the conversion code capability, depending on the valid table responses to the file, as compared to the responses within this processing.

You can build Assessment and Abstracting information according to the questions and their responses, depending on the question definitions. The system updates Abstracting immediately online.

NOTE: Based on the report fields of the question builder, some of this data may be available for active and/or inactive (discharged) patient queries.

BUILDING LABOR AND DELIVERY QUESTIONS

The Labor and Delivery Clinical Questions exist as a table. You can access the table through Nursing Table Maintenance. When you enter the Labor and Delivery Clinical Questions option from the Nursing Table listing, the following prompt displays:

Enter option #, move (M) or add (A)--
/ for next page

Enter an option number from the list of defined questions to edit or delete it. The Labor and Delivery Clinical Questions table displays with the fields completed as defined for the selected question.

Enter **M** to Move one of the existing questions to a different location within the listing. The following prompt displays:

Enter from option number (',' to option number) to move--

Enter **A** to Add a new question to the listing.

Enter # to insert before, or at end (E)--

Specify an addition at a particular location within the list by entering an option number to add before. Enter **E** to add a new question at the end of the list. The following prompt displays:

Enter labor and delivery question code--

Enter a code for the new question, up to five digits. After you enter a code, press ENTER. The following prompt displays:

Add this code 'XXXXX'? (Y/N) [Y]--

where 'XXXXX' represents the new code number. If you enter **N** for No, the previous prompt displays. When you enter **Y** for Yes to add the code, the Labor and Delivery Clinical Questions table displays, as shown on the following screen:

```
            General Hospital Nursing Table Maintenance Processor
                                                Mon Mar 18, 1996 09:14 am

 Labor and Delivery Clinical Questions
 1 Code           2 Description           3 Format        4 I/P Req  5 O/P Req
   5008             Method of Delivery      Table Lookup    Yes/Yes    Yes/Yes
 6 I/P Reports    7 O/P Reports           8 Text Length   9 Value Format
   External         External
10 Normal Ranges 11 Low Value  12 High Value      13 Low Value  14 High Value

15 Interface #   16 Baby Info  17 Labor/Delivery  18 Inquiry    19 Stats
   Yes                           Both               Yes           Yes
20 Conv Code     21 Skip Questions  22 Asmnt Link                 23 Abstrct Link
   3                See table                                     Mat & New
24 Discharge Sum 25 Edit by                        26 Edit date
   No               Harrell,Julie                     10/21/95 2235




Enter field number or '/' starting field number--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the Labor and Delivery Clinical Question code, as assigned when the question is originally defined. This field cannot be edited.

2. DESCRIPTION (20-C-R)
This field displays the question description that displays in the Labor and Delivery information entry screen. When you access the field, the following prompt displays:

Enter labor and delivery question description--

You can enter upper and lower case letters, up to twenty characters.

NOTE: You cannot edit this description when the maternity module is live.

3. FORMAT (1-A-R)
This field indicates the format for the response to the question. When you access the field, the following prompt displays:

Is response a value (V), table lookup (T), text (X) or date (D)--

If you enter **V** for Value, the system assumes that there may be a particular format for the response value, as well as low and high values associated with a normal range.

If you enter **T** for Table Lookup, you need to build the appropriate table selections for the response. The scrolling screen for building the lookup table displays at the bottom of the screen, as shown on following screen:

```
              General Hospital Nursing Table Maintenance Processor
                                                    Mon Mar 18, 1996 12:33 pm
  Labor and Delivery Clinical Questions
  1 Code            2 Description           3 Format        4 I/P Req  5 O/P Req
    4999              Place of Delivery    -> Table Lookup    Yes/Yes    Yes/Yes
  6 I/P Reports     7 O/P Reports           8 Text Length   9 Value Format
    External          External
 10 Normal Ranges 11 Low Value  12 High Value      13 Low Value  14 High Value

 15 Interface #   16 Baby Info  17 Labor/Delivery  18 Inquiry    19 Stats
                     No            Labor              Yes           Yes
 20 Conv Code     21 Skip Questions  22 Asmnt Link                 23 Abstrct Link
    3                See table          No                         None
 24 Discharge Sum 25 Edit by                        26 Edit date
 Code    Description                          Conversion Code   Discharge Sum
 1       Domestic Address                     1                 No
 2       NHS Consultant Ward                  2                 No
 3       NHS GP Ward                          3                 No
 4       NHS Cons/GP Ward                     4                 No
 5       Private Hospital                     5                 No
 6     Other Hosp/Institut               6              No
Enter description
     F1Prev Page   F2Next Page   F3 Insert   F4 Delete   F6 Reset   F7 Exit   ?
```

If you enter **X** for Text in the Format field, you must define the length of the free form text response, from one to fifty characters, in the Text Length field.

If you enter **D** for Date, you must enter a valid date while responding. The general information guidelines as they apply to the system's date format determine the date entry format (International, European or American).

NOTE: If you later edit this field and change the specified response value, the system clears all related fields in the table, and you must re-enter field response information.

4. I/P REQUIRED (SPECIAL FORMAT)
This field specifies if a question should be asked for an inpatient or in-house outpatient type and if the question requires a response. When you access this field, the following prompt displays:

Is response required for I/P or inhouse O/P patient types? (Y/N) [N]--

Enter **Y** for Yes if the question requires a response for inpatients or in-house outpatients. Enter **N** for No if this a response is not required for this question. The following prompt displays:

Should question be asked for I/P or inhouse O/P? (Y/N) [N]--

Enter **Y** for Yes if the question should be asked. Enter **N** for No if the question does not apply to inpatients or in-house outpatients and does not need to be asked.

Your entry in this field displays in a No/No or Yes/No format. The default response is *No/No*, indicating that the question should not be asked, and that a response is not required.

5. O/P REQUIRED (SPECIAL FORMAT)
This field determines if a question should be asked for an outpatient not in a bed and if the question requires a response. When you access this field, the following prompt displays:

Is response required for non-inhouse O/P patient types? (Y/N) [N]--

Enter **Y** for Yes if the question requires a response for an outpatient not in a bed. Enter **N** for No if this a response is not required for this question. The following prompt displays:

Should question be asked for non-inhouse O/P? (Y/N) [N]--

Enter **Y** for Yes if the question should be asked. Enter **N** for No if the question does not apply to outpatients not in a bed and does not need to be asked.

Your entry in this field displays in a No/No or Yes/No format. The default response is *No/No*, indicating that the question should not be asked and that a response is not required.

6. I/P REPORTS (8-A-R)
This field determines whether this question should be included on external or internal reports when printing this question for an inpatient or in-house outpatient type. When you access this field, the following prompt displays:

Is question/response external for I/P clinical reports? (Y/N/NL) [NL]--

When you enter **Y** for Yes, External displays in the field. When you enter **N** for No, 'Internal' displays in the field. Press ENTER to skip this field and advance to the next field. The default response is ENTER.

7. O/P REPORTS (8-A-R)
This field determines whether this question should be included on external or internal reports when printing this question for an outpatient who is not in a bed. When you access this field, the following prompt displays:

Is question/response external for O/P clinical reports? (Y/N/NL) [NL]--

When you enter **Y** for Yes, External displays in the field. When you enter **N** for No, 'Internal' displays in the field. Press ENTER to skip this field and advance to the next field. The default response is ENTER.

8. TEXT LENGTH (2-N-C)
This field is accessible only if you select Text in the Format field. In the case when Text is the specified Format, this field is required. When you access this field, the following prompt displays:

Enter length of text response (1-50)--

Enter a number to define the length of a text response to this question. Valid lengths are from one to fifty characters, due to the screen size and the space allotted to the question/prompt description field.

9. VALUE FORMAT (8-A-C)
This field is accessible only if you select Value in the Format field. When you access this field, the following prompt displays:

Should the value contain a decimal (D) point, slash (S), or neither [NL]--

Enter **D** for Decimal if the response value is required to contain a decimal point. Enter **S** for Slash if the response value is required to contain a slash.

Press ENTER to enter the default, Neither, as the value format. The field displays as blank when a decimal or slash is not specified.

10. NORMAL RANGE (3-A-C)
This field is accessible only if you select Value in the Format field. When you access this field, the following prompt displays:

Are normal ranges associated with this value? (Y/N) [N]--

Enter **Y** for Yes if there are normal ranges associated with this value. Enter **N** for No if normal ranges are not associated with this value. The default response is No.

11. LOW VALUE (7-N-C)
This field is required when you select Value in the Format field and specify that there are normal ranges associated with this value. When you access this field, the following prompt displays:

Enter low value for the normal range--

Enter the value considered to be the lowest acceptable value within the normal range. This field formats according to the specified Value Format.

12. HIGH VALUE (7-N-C)
This field is required when you select Value in the Format field and specify that there are normal ranges associated with this value. When you access this field, the following prompt displays:

Enter high value for the normal range--

Enter the value considered to be the highest acceptable value within the normal range. This field formats according to the specified Value Format.

NOTE: Fields 13 and 14 (the second low and high values) are accessible only if you selected Slash in the Value Format field. (An example of a question for which the response would contain a Slash/Value range is blood pressure.)

15. INTERFACE # (TABLE LOOKUP)
This field accesses a McKesson-controlled table that contains the maternity file for use by the CIHI in Canada or HL7 interfacing, and their corresponding beginning characters in the interface records. When you access this field, the following prompt displays:

Link to interface? (Y/N)--

If you enter **Y** for Yes, the following prompt displays:

Enter interface code or '-' to list--

Enter the appropriate interface code, or choose the field description of the external file corresponding to this question from the table listing to pass the information to the Flat File.

If you enter **N** for No, the field displays as blank.

16. BABY INFO (3-A-R)
This field indicates whether the question is baby-specific and should be asked multiple times when processing information on multiple babies. When you access this field, the following prompt displays:

Repeat question for each baby? (Y/N) [N]--

If you enter **Y** for Yes, each question is indexed by baby, and repeated for all subsequent babies. If you enter **N** for No, the response to subsequent babies defaults to the response for the previous baby. You can override the response when necessary. The default for this field is No.

17. LABOR/DELIVERY (1-A-R)
This field determines when the question should be asked in relation to processing the labor, delivery, or both question sets. When you access this field, the following prompt displays:

Ask question for labor (L), delivery (D), or both (B)?--

Enter **L** for Labor, **D** for Delivery, or **B** for Both. When users access the Labor and Delivery Clinical Questions, they indicate which set of questions to which they are responding. When they indicate Labor, only those questions with this field set to Labor or Both display. When theyindicate Delivery, only those questions with this field set to Delivery or Both display. When they indicate Both, only those questions with this field set to Both display.

18. INQUIRY (3-A-O)
This field flags the question/response to make it accessible in future assessment inquiries on historized maternity patients. When you access this field, the following prompt displays:

View in Maternity Inquiry? (Y/N)--

Enter **Y** for Yes, or **N** for No. This field does not have a default response.

The entry in this field determines whether or not the question is included in the Maternity Inquiry/Print process. Maternity Inquiry/Print is a searching function that identifies and sorts maternity patients based on the user-defined search parameters. (For example, you can identify all the maternity patients within a facility that were over the age of thirty and regular smokers when they delivered.) After you perform the search, the system identifies all patients who fit the criteria in a table display of patient information. You can also print a report of the search results.

19. STATS (3-A-O)
This field determines whether the question influences patient statistics. When you access this field, the following prompt displays:

Compile statistics? (Y/N)--

Enter **Y** for Yes, or **N** for No. This field does not have a default response.

The entry in this field determines whether or not the question is included in the Labor and Delivery Statistics parameters. Labor and Delivery Statistics is a searching function that analyzes maternity patient information based on the search parameters you enter. (For example, you can identify all the maternity patients within a facility that delivered multiple babies by emergency C-section during a specific time period.) After you perform the search, the system identifies the number of patients who fit the criteria in a table display. You can also print a report of the search results.

20. CONVERSION CODE (2-N-C)
This field displays the length of the conversion code field of a lookup table when *Table* is the response format.

When you access the lookup table scrolling screen, the system assigns each line item a code (up to two numbers). You enter the lookup table item description (up to

nineteen characters). The typical scrolling screen driver options display at the bottom of the screen during the maintenance of the lookup table selections.

NOTE: The only limitation as to the number of valid table entries is the two-digit code.

You can enter a conversion code if needed, though it is not required. The system uses conversion codes to translate the scrolling screen driver code number to another code.

When you enter conversion code values in the lookup table scrolling screen, they determine the length of the conversion code used to enter table responses. If you do not make an entry in this field, then that portion of the scrolling screen is bypassed when entering table responses. When responding to table driven questions, users can select multiple responses.

NOTE: When you delete table responses, the system checks the skip subsequent questions field for this question to determine if this response was one that initiated skipping of questions. If so, the response cannot be deleted until the skip question is adjusted accordingly.

21. SKIP QUESTIONS (SPECIAL FORMAT)
This field indicates whether the function that enables you to skip subsequent related questions based on the response to a certain previous question is active. When you access this field, a table displays at the bottom of the screen, as shown on the following screen:

```
              General Hospital Nursing Table Maintenance Processor
                                                    Mon Mar 18, 1996 01:32 pm
 Labor and Delivery Clinical Questions
 1 Code            2 Description           3 Format        4 I/P Req  5 O/P Req
   5003              Onset of Labor          Table Lookup    Yes/Yes    Yes/Yes
 6 I/P Reports     7 O/P Reports           8 Text Length   9 Value Format
   External          External
10 Normal Ranges 11 Low Value  12 High Value      13 Low Value  14 High Value

15 Interface #   16 Baby Info  17 Labor/Delivery  18 Inquiry    19 Stats
                    No            Labor             Yes           Yes
20 Conv Code     21 Skip Questions  22 Asmnt Link                 23 Abstrct Link
   3             -> See table                                     Mat & New
24 Discharge Sum 25 Edit by                        26 Edit date
CODE      DESCRIPTION                   SKIP QUESTION
1         SPONTANEOUS                   Yes-5004,5005
2         INDUCED                       No
3         ELECTIVE CAESARIAN            No


                      Skip related questions? (Y/N)--
               F1Prev Page   F2Next Page   F6 Reset   F7  Exit   ?
```

You must define the response(s) that prompt the skip process in the table. Enter the associated question/prompts that should be skipped. The following prompt displays at the bottom of the screen:

Skip related questions? (Y/N)--

If you enter **N,** No is displayed in the field, and the cursor advances to the next field. If you enter **Y** for Yes, you can then indicate that an existing question be skipped. To adjust skipped questions, you simply add a new question to be skipped, or delete a question from the file that indicates it should be skipped. Any questions identified as being skipped does not print or display, if the response to the previous question indicates they should not. As with any table driven field, you can access the questions through their code or you can perform an alphabetic search.

NOTE: The system only skips those questions described for each Labor and Delivery Question. In other words, if question A requires questions B, C, and D to be skipped, and D requires questions E and F to be skipped, the system only skips questions B, C, and D.

Once you have selected appropriate questions, a table display of the selected options displays for verification and review. This processing is similar to that of the Departmental table, or Scheduling Departments field of the CRT Names table.

NOTE: You should consider the Skip Questions capability when entering the Labor and Delivery Clinical questions during the file build. When ever possible the questions that skip subsequent questions should be entered last, to allow for the skipped questions to be entered.

22. ASMNT LINK (TABLE LOOKUP)
This field can indicate that a question is similar to an assessment question used in Obstetric History Assessments. When you establish a link, the system begins to build the current pregnancy's Obstetric History assessment. You can perform this task at the time the current patient is archived, eliminating the need to update more than one place as changes occur throughout the patient's visit. When you access this field, the following prompt displays:

Is there a related assessment question to be linked? (Y/N) [N]--

If you enter **N** for No, the screen continues processing and advances to the next field.

If you enter **Y** for Yes, the system displays the assessment question table. You can perform an alpha table lookup, enter the code, or perform a general '-' lookup to specify an existing assessment for the link.

If the Labor and Delivery question Format field is defined as anything other than Table, you are not allowed to access this field.

When the Labor and Delivery question Format field is defined as Table, an additional scrolling screen displays to map the question responses to the appropriate assessment responses. When you have made the assessment link, the system requires an assessment response for each of the available table entries. The linked response is the valid entry for entering obstetric history assessments.

23. ABSTRCT LINK (TABLE LOOKUP)
This field specifies a link to the McKesson table containing of all of the maternity abstracting fields, including a cross-link of table responses. When you access this field, the following prompt displays:

Is there a related abstract question to be linked? (Y/N) [N]--

If you enter **N** for No, the field displays None and the screen advances. If you enter **Y** for Yes, another prompt displays, as follows:

Enter abstract link code or '-' to list--

You can enter the code of the link directly, or enter a hyphen (-) to select from a listing. If the current Labor and Delivery question relates to an existing field in the abstracting screen flows, you can cross-link it here. When a question is linked to the abstracting screen flow, it appears in the abstracting screens once it is linked and answered for a patient.

If you revise this field through the Labor and Delivery process, it updates the abstract, following the same rules as are currently used for information revision to abstracting. The system continues to revise the information until it has been accessed (or has completed) through the abstract process. The system does not automatically update abstracting after the medical audit personnel has reviewed it.

24. DISCHARGE SUM (3-A-O)
This field defines whether or not information from completed Labor and Delivery Details print on a maternity patient's Discharge Summary report. When you access this field, the following prompt displays:

Print on discharge summaries? (Y/N)--

Enter **Y** for Yes, or **N** for No. The Discharge Summary is a patient specific form/report that summarizes an inpatient's stay. For more information, refer to "Chapter 6 - REPORTS".

24. EDIT BY (DISPLAY ONLY)
This field displays the name of the user who last edited the Labor and Delivery Clinical Questions table. You cannot edit this field.

24. EDIT DATE (DISPLAY ONLY)
This field displays the most recent edit date of the Labor and Delivery Clinical Questions table. You cannot edit this field.

When you have completed all required fields, press ENTER. The following prompt displays:

Enter field number or '/'starting field number--

You can enter the number of a field to access it and enter changes, assuming the field can be edited. If you press ENTER again, the following prompt displays:

Accept this screen? (Y/N) [Y]--

If you enter **N** for No, the screen displays the previous prompt again. If you enter **Y** for Yes, the system processes the Labor and Delivery Clinical Questions information and displays the following message:

Filed!

NOTES:

1. Be careful when defining labor and delivery clinical questions/prompts not to force duplicate entry of data whenever possible. Much patient- related data is available though the system, and is accessible through a number of functions.

2. Once the maternity module is live, the table codes and descriptions are locked and cannot be edited or revised. After the department is active, the only option for deleting questions/prompts is "filed as deleted." This ensures that adjustments or reusing of table codes and descriptions does not affect the long term storage of this data. Prior to being Live, you can delete or adjust these codes.

3. When you delete questions/prompts, the system checks all Skip Subsequent Questions fields. If you specify that a question should be skipped due to a certain response, it is deleted as well. If you have defined that only questions be skipped for a specific question/prompt, then the Skip Subsequent Questions field changes from Yes to No. The system displays a warning to this effect.

4. McKesson recommends that questions/responses be table driven, values, or dates as frequently as possible. You should word questions/responses in such a fashion as to minimize the typing requirements of the clinicians. It may be useful to set up hospital wide accepted abbreviations that can be used to reduce keying time as much as possible.

Printing Maternity Information

The Maternity menu provides the means by which users can print maternity information for active maternity patients. The standard Patient Print menu includes options that you can use while the mother and baby are active patients, if the information is complete.

Maternity information is not always complete at the time of discharge (such as the baby's name). You can access and print maternity information through the MPI access lookup capability once a patient is inactive. Refer to "HISTORICAL MATERNITY INFORMATION" on page 5-45 for information on accessing these options in the MPI.

The Patient Print menu displays as shown below:

```
                    General Hospital Patient Print Processor
                                                 Thu Mar 21, 1996 10:02 am
Patient Print Input Options

            Option No.  Option
            ---------------------------------------
                1       Patient Care Profile
                2       Nursing Plan of Care
                3       Care Reference Sheet
                4       Discharge Plan
                5       Discharge Summary
                6       PCP Nursing Notes
                7       Order History
                8       Custom Document Display/Print
                9       Print Patient Label
               10       Maternity Information Print
               11       Assessment
               12       Assessment History
               13       Assessment Worksheet
               14       Problem List
               15       Problem List History

Enter option number--
```

When you select the Maternity Information Print option, the following screen displays:

```
                General Hospital Maternity Information Print Processor
                                                 Wed Mar 13, 1996 09:21 am
Maternity Information Print Input Options

            Option No.   Option
            ------------------------------------------------
                1        Print Notification of Birth
                2        Print Labor & Delivery Details
                3        Maternity Inquiry/Print
                4        Labor and Delivery Statistics









Enter option number--
```

NOTE: The print options on this page provide information in printed report form. You cannot view either of these reports on screen.

PRINT NOTIFICATION OF BIRTH

The print capability for Notification of Birth is available in the Maternity Information Print submenu from the standard Patient Print option. These menus are available to nursing stations (also the Case Manager/Team access) for active patients.

When you select the Print Notification of Birth option, the following prompt displays:

Enter acct #, '-'bed code, first chars of name'-' [OB Census]--
'C' for Census

You can identify the patient by directly entering the account number, bed code, or partial last name. Enter **C,** or press ENTER for the default OB Census, to select a patient from a census listing. After you have selected a patient, the screen displays the patient information in the header *and displays the following prompt:*

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

After you enter a number, the system displays the following message:

Printing!

If you attempt to print a Notification of Birth for a patient who is not a newborn, the following error message displays:

Error: Patient must be a Newborn!

Figure 5.1 Notification of Birth

```
                                General Hospital A
District: 00001120             NOTIFICATION OF BIRTH              Serial No. 3

Child's Information:
Child's Name : SMITH, PATRICIA LEE                Sex: F Female    DOB: 03/25/96 20:13
Address      : 123 MAIN STREET
               APARTMENT 1                        Place of Birth: GENERAL HOSPITAL A
               ATLANTA, GA                        Phone     : (404) 222-2222
               30346                              Language  :  E ENGLISH

Ethnic Origin: 2 CAUCASIAN

Birthweight : 8lbs 6oz/3.807kg          Gestation   : 48 weeks      No. Born/Birth Order:4/1
Head Circum : 0'9.0" / 20.3 cm          Birth Length: 1'9.5" / 54.6 cm
Birth Status: 1 Livebirth                         VDRL Result : Negative
Apgar @5 min: 1 Apgar Code 1                      Date of Death:

Family's Information:                             One Parent Family?  Y / N

Mother's Name: SMITH, REBECCA                       DOB: 01/01/70
Marital Status: M Married
Previous Live Births:           Previous Still Births   :          Previous C-Sections:
Previous Abortions  :           Previous Neonatal Deaths:
Cesarean Section    : No

Mother's Occ : HOMEMAKER                          NHS No.: 123123123123
Father's Occ: TRUCK DRIVER

Registered GP: 99999 JONES,JOSEPH P               Ante-Natal GP: TAYLOR,SAM
               123 DOCTOR CENTER                                 321 DOCTOR CENTER
               SUITE TWO                                         SUITE FOUR
               ATLANTA, GA                                       ATLANTA, GA
               30346                                             30346

Special Factors:
     01 RUBELLA                                   21 RESPIRATORY DISTRESS
     12 PROLONGED/DIFFICULT LABOR


Name of Person Notifying     : _____________________________________________  Status:___________

Signature of Person Notifying: _____________________________________________  Date:_____________
```

Birth Notification Serial Number

When you print a Notification of Birth for a baby, the system prints the corresponding serial number for the baby in the upper right corner of the report. You can later use this serial number to identify a report for which you want to print additional copies.

The Birth Notification Serial Number table is available through the Nursing Tables Maintenance menu. When you select Birth Notification Serial Number, the following table displays:

```
                    General Hospital Table Maintenance Processor
                                                    Tue Mar 19, 1996 09:17 am
Birth Notification Serial # Assignment
( 1)Current Number: 0001
( 2)New Number    :









Enter unit number (NL for no change)--
```

PRINT LABOR & DELIVERY DETAILS

The print capability for Labor and Delivery Clinical Detail Information is available in the Maternity Information Print submenu from the standard Patient Print option. These menus are available to nursing stations for active patients.

NOTE: You can also access and print Labor and Delivery Clinical Detail Information for inactive patients through the MPI. For additional information, refer to "Chapter 9 - BUILD AND FORMAT PCPS AND WORKSHEETS".

You must enter information for several parameters prior to printing Labor and Delivery Clinical Detail information. When you select the Print Labor & Delivery Details option, the following prompt displays:

Enter acct #, '-'bed code, first chars of name'-' [OB Census]--
'C' for Census

You can identify the patient by directly entering the account number, bed code, or partial last name. Enter **C,** or press ENTER for the default station census, to select a patient from a listing. After you have selected a patient, the following screen displays:

```
          General Hospital Print Labor & Delivery Details Processor
                                                  Fri Dec 17, 2009 02:25 pm
 No       Name          Sex  BD   Room   Physician   SVC ICD Status
9607300001    SMITH,MIRIAM      F  01/01/70 4302-02 SMITH,TAYLOR OBS 10 OB  7

 ( 1)Demographic:
 ( 2)Abstract   :
 ( 3)Labor      :
 ( 4)Internal   :
 ( 5)Delivery   :
 ( 6)Internal   :
 ( 7)# of Copies:









 Print demographic information? (Y/N) [Y]--
```

These parameters determine which sections of the report prints.

Field Explanations

1. DEMOGRAPHIC (3-A-O)
This field displays whether or not the patient's demographic information prints as part of the Labor and Delivery Clinical Details report. When you access this field, the following prompt displays:

Print demographic information? (Y/N) [Y]--

Enter **Y** for Yes, or **N** for No. The default for this field is Yes.

2. ABSTRACT (7-A-O)
This field displays whether or not abstracting information prints as part of the report. When you access this field, the following prompt displays:

Print abstract information for mother (M), newborn (N) or both (B)? [B]--

Enter **M** for Mother to include only the abstracting information for the mother. Enter **N** for Newborn to include only the abstracting information for the baby. Enter **B** for Both to include the abstracting information for both the mother and the baby. The default for this field is B.

3. LABOR (3-A-O)
This field displays whether or not the labor details print as part of the report. When you access this field, the following prompt displays:

Print labor information? (Y/N) [Y]--

Enter **Y** for Yes, or **N** for No. The default for this field is Yes.

4. INTERNAL (3-A-O)
This field displays whether or not the internal labor questions print as part of the report. When you access this field, the following prompt displays:

Print internal labor questions? (Y/N) [Y]--

Enter **Y** for Yes, or **N** for No. If internal questions exist, but you choose not to print them, asterisks appear at the report header to indicate that internal questions apply but do not print. The default for this field is Yes.

5. DELIVERY (3-A-O)
This field displays whether or not the delivery details print as part of the report. When you access this field, the following prompt displays:

Print delivery information? (Y/N) [Y]--

Enter **Y** for Yes, or **N** for No. The default for this field is Yes.

6. INTERNAL (3-A-O)
This field displays whether or not the internal delivery questions print as part of the report. When you access this field, the following prompt displays:

Print internal delivery questions? (Y/N) [Y]--

Enter **Y** for Yes, or **N** for No. If internal questions exist, but you choose not to print them, asterisks appear at the report header to indicate that internal questions apply but do not print. The default for this field is Yes.

NOTE: If you enter **N** for No for any of these parameters, that parameter information does not print on the report, and the subsequent sections are moved up.

7. NUMBER OF COPIES (1-N-O)
This field determines the number of copies to print. Each one prints as a separate report on the spooler or printer.

When you access this field, the system displays the following prompt:

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

When you have completed the fields, press ENTER. The following prompt is displayed:

Accept this screen? (Y/N) [Y]--

If you enter **N** for No, the Labor and Delivery Details parameter screen displays and you can edit any of the parameter fields. If you enter **Y** for Yes, the system process the parameter information and displays the following message:

Printing!

Figure 5.2 Labor and Delivery Clinical Details Report

```
                                  General Hospital A                        Page 1
03/17/96 10:58A          Labor and Delivery Clinical Details Report
-------------------------------------------------------------------------------
SMITH, REBECCA                        Account No. 1234567890
Admit Date: 03/13/96                  Discharge Date: 03/16/96
-------------------------------------------------------------------------------
                                Demographic Information

Birthdate: 01/01/70                             SS#:123-45-6789
Address: 123 MAIN STREET                        Family Phys: JONES,JOSEPH
         APARTMENT 1
         ATLANTA, GA  30346
-------------------------------------------------------------------------------
                                 Abstract Information




-------------------------------------------------------------------------------
                                    Labor Details

Question                        Response
--------                        --------
Delivery as Intended            YES
Place of Delivery               Skip
Original Intention              Skip
Reason for Change               Skip
Change Reason Comm              Skip
Onset of Labor                  SPONTANEOUS
Method of Induction             Skip
Reason for Induction            Skip
Method C/S Delivery             LOWER SEGMENT ELECT
Elect C/S Indication            PREVIOUS C/S
Method of Delivery              Skip
Labor Accelerated               Skip
Acceleration Reason             Skip
Acceleration Method             Skip
Emerg C/S Reason                Skip
Labor Complications             Skip
Transfer of Care                Yes
-------------------------------------------------------------------------------
```

```
                                  General Hospital A                        Page 2
03/17/96 10:58A          Labor and Delivery Clinical Details Report
-------------------------------------------------------------------------------
SMITH, REBECCA                        Account No. 1234567890
Admit Date: 03/13/96                  Discharge Date: 03/16/96
-------------------------------------------------------------------------------
                                   Delivery Details


Baby 1

Question                          Response
--------                          --------
Elect C/S Indication              Previous C/S
Method of Delivery                Skip
Forceps /Ventouse Ind             Skip
Emerg C/S Reason                  Skip
Perineal Condition                Skip
Other Trauma                      NONE
Placenta Del Method               MATERNAL EFFORT
Weight of Placenta                     .5
Placenta Description              APPARENTLY COMPLETE
Placenta Condition                HEALTHY
Membranes Condition               COMPLETE
Number Cord Vessels                    3
Cord Blood Taken                  NO
Cord Blood Reason                 Skip
Blood Loss                             10
Stage 3 Complication              NONE
Anesthetic/Labor                  EPIDURAL 2ND STAGE
Analgesia in Labor                ACUPUNCTURE
Oxytocics/Other I/L               SYNTOMETRINE
Gestation in Weeks                     38
Outcome of Delivery               Live Birth
Baby's Sex                        Male
Length (CMS)                           20
Transfer of Care                  Yes
Outcome of Delivery
APGAR SCORE 1
Resus Method                      METHOD 1
-------------------------------------------------------------------------------



End of Report!
```

MATERNITY INQUIRY/PRINT

The Maternity Inquiry/Print option enables you to compile and print maternity patient information based on user-defined search criteria. You can enter parameters and perform a search on specific subsets of maternity patients as a means of follow-up analysis on labor and delivery practices and results in your facility.

When you select the Maternity Inquiry/Print option from the Maternity Information Print submenu, the Maternity Inquiry/Print screen displays:

```
              General Hospital Maternity Inquiry/Print Processor
                                                Wed Apr 10, 1996 10:29 am

                                  Search Criteria
No.    ( Inclusion                Match    Data                          ) And/Or
1        AGE IN YEARS, PATIEN     >=       35                              And
2        Onset of Labor          FIL      SPONTANEOUS

                              Enter And(A) or Or(O)
     F1Prev Page  F2Next Page  F3 Insert   F4 Delete   F6 Reset   F7  Exit  ?
```

NOTE: When you enter information in this screen, the prompts that display are specific to the type/nature of the information you are defining. Some entries are numerical and some are codes/descriptions selected from a table listing. The prompts discussed in the following example may or may not be exactly the same as the prompts that display when you define search criteria, but are provided to offer some guidance as to the functionality of the Maternity Inquiry/Print processor.

You can enter various search criteria information, each parameter on its own line, until you have defined the search to include only specific maternity patients. When you first access the screen the following prompt displays:

Insert left parenthesis? (Y/N) [N]--

Enter **Y** for Yes or **N** for No. The default response is No.

NOTE: Inserting parentheses instructs the search to operate similar to an algebraic equation in defining the active line search criteria entry. Criteria included within a set of parentheses are considered together.

After you have specified whether or not to insert left parenthesis, the following prompt displays:

Enter inclusion code or '-' to list

You can enter a search criteria inclusion code directly, or enter a hyphen (-) to access a table listing of inclusion code descriptions. The inclusion entry defines the basis of the search. One of the inclusion descriptions is Labor and Delivery Questions. When you pick the Labor and Delivery Questions option, a table listing of all defined Labor and Delivery Clinical Questions for which the Inquiry field is set to *Yes* in the Labor and Delivery Clinical Questions screen are available for selection as an inclusion parameter.

Select an inclusion description by entering the line option number to the left of the description. The selected description displays in the Inclusion field, and the following prompt displays:

Enter code or '-' to list

You can enter a match code directly, or enter a hyphen (-) to access a table listing of match code descriptions. The match code defines the relationship between the inclusion (search basis) and the corresponding data (search condition). After you have entered a match code, the following prompt displays:

Enter data or '-' to list

You can enter a data description directly, or enter a hyphen (-) to access a table listing of data descriptions appropriate to the specified inclusion. The data entry defines the condition of the search inclusion parameter. After you have entered a valid data entry, the following prompt displays:

Insert right parenthesis? (Y/N) [N]--

Enter **Y** for Yes or **N** for No. The default response is No.

NOTE: If you insert left parenthesis, you must also insert right parenthesis to correctly define the criteria within the parentheses.

After you have specified whether or not to insert right parenthesis, the following prompt displays:

Enter And (A) or Or (O)--

This prompt is only relevant when you are entering multiple lines of search criteria. Enter **A** for And to combine two lines of defined search criteria. Enter **O** for Or to conditionally include one or the other of two lines of defined search criteria.

Repeat the search criteria definition process for as many search criteria parameters as necessary to thoroughly define your search. When you have completed search criteria entry, press F7 to end the entry process. The following prompt displays:

Hardcopy? (Y/N) [N]--

Enter **Y** for Yes to generate a print out of the search results. *The system displays the following prompt:*

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

Enter **N** for No if you do not want to print the search results, but only want to view the information. After you respond to this prompt the system compiles the appropriate maternity patient information, as defined by the search criteria. When the compilation is complete, the system displays the search results, as shown on the following screen:

```
                  General Hospital Maternity Inquiry/Print Processor
                                              Wed Apr 10, 1996 12:06 pm

Total searched:  8            Labor:   2          Delivery:  4
     Name                     Account Number      Labor/Delivery        Baby
( 1) WHITE,MARY               9519800001          Labor
( 2) WHITE,MARY               9519800001          Delivery               1
( 3) TAYLOR,SARAH             9608600004          Labor
( 4) TAYLOR,SARAH             9608600004          Delivery               1
( 5) TAYLOR,SARAH             9608600004          Delivery               2
( 6) TAYLOR,SARAH             9608600004          Delivery               3




Press NL--
```

Field Explanations

TOTAL SEARCHED (DISPLAY ONLY)
This field displays the total number of maternity patients included in the search, including both active and inactive (discharged) patients.

LABOR (DISPLAY ONLY)
This field displays the number of labor-specific patients (mothers) included in the results of the search.

DELIVERY (DISPLAY ONLY)
This field displays the number of delivery-specific patients (babies) included in the results of the search.

NAME (DISPLAY ONLY)
This field displays the patient name. The name is always the mother's name, and it displays for the entry corresponding to the mother, as well as for each baby.

ACCOUNT NUMBER (DISPLAY ONLY)
This field displays the mother's account number.

LABOR/DELIVERY (DISPLAY ONLY)
This field displays either Labor or Delivery as an indicator that the line entry is a mother (labor) or a baby (delivery).

BABY (DISPLAY ONLY)
This field only displays information for baby line entries. A number corresponding to the birth order number displays for each baby. When a mother only delivers one baby,

the number is one. When a mother delivers multiple babies, the number corresponds to the baby number entered in the Labor and Delivery Clinical Questions.

Press ENTER to exit the screen and return to the Maternity Information Print menu.

LABOR AND DELIVERY STATISTICS

The Labor and Delivery Statistics option enables you to compile maternity patient statistics based on user-defined search criteria. You can enter parameters and perform a search on specific subsets of maternity patients as a means of generating raw statistics for analyzing labor and delivery practices and results in your facility.

When you select the Labor and Delivery Statistics option from the Maternity Information Print submenu, the Labor and Delivery Statistics screen displays, as shown on the following screen:

```
              General Hospital Labor and Delivery Statistics Processor
                                                  Wed Apr 10, 1996 10:41 am

 1 Labor and Delivery Question           2 Delivery Methods
->
 3 Display Statistics                    4 Start date       5 End date









Enter labor and delivery question code or `-` to list--
```

Field Explanations

1. LABOR AND DELIVERY QUESTION (TABLE LOOKUP)
This field enables you to specify the Labor and Delivery Question/response on which you want to search. When you access this field, the following prompt displays:

Enter labor and delivery question code or '-' to list--

You can enter the question code directly, or enter a hyphen (-) to select a question from the Labor and Delivery Clinical Questions table listing. The table includes only those questions for which the Starts field is set to *Yes* in the Labor and Delivery Clinical Questions screen that defines the question.

2. DELIVERY METHODS (TABLE LOOKUP)
This field enables you to specify a delivery method. When you access the field, a table listing of defined Delivery Methods displays at the bottom of the screen. You can select

one or more delivery methods by entering the option number to the left of the delivery method description.

3. DISPLAY STATISTICS (A-1-R)
This field indicates how the statistics display. When you access this field, the following prompt displays:

Display statistics by Birth Status (S) or Birth Type (T)--

Enter **S** for Birth Status to view the results according to the recorded status of the delivery. Enter **T** for Birth Type to view the results according to the type of delivery.

4. START DATE (DATE FORMAT)
This field indicates the starting date for the range over which the statistical analysis occurs. Maternity patients that are/were active after this date (and before the end date) are included in the statistics.

5. END DATE (DATE FORMAT)
This field indicates the ending date for the range over which the statistical analysis occurs. Maternity patients that are/were active before this date (and after the start date) are included in the statistics.

After you have completed your field entries, the system prompts you to accept the screen. Enter **N** for No to continue editing the field information. Enter **Y** for Yes to begin the statistical analysis.

When the system completes the statistical compilation, the following screen displays:

```
                General Hospital Labor and Delivery Statistics Processor
                                                    Wed Apr 10, 1996 10:45 am
L&D Question: Placenta Description                  Total Births: 6
              BREECH      BREECH EXT  ELECTIVE C  LOW FORCEP
APPARENTLY COMPLETE
   NORMAL          0            0           0           0
   POST TERM       0            0           0           0
   PRETERM         0            0           0           0
   STILLBORN       0            0           0           0
   TERM            0            0           0           0
APPARENTLY COMPLETE,PROBABLY COMPLETE
   NORMAL         -2            0           0           0
   POST TERM       0            0           0           0
   PRETERM         0            0           0           0
   STILLBORN       0            0           0           0
   TERM            0            0           0           0



Press NL--
```

Field Explanations

L&D QUESTION (DISPLAY ONLY)
This field displays the selected Labor and Delivery Question for which the statistics were compiled. All possible responses to the question are addressed in the statistics, each in a separate section. In this example, there are two different responses:

- Apparently Complete
- Apparently Complete, Probably Complete.

TOTAL BIRTHS (DISPLAY ONLY)
This field displays the total number of deliveries evaluated for the statistical compilation. This is the number of maternity patients/deliveries during the period of time between the start and end dates.

DELIVERY METHODS (DISPLAY ONLY)
The Delivery Methods are listed across the top of the statistical information, and are a direct representation of your Delivery Methods specification(s).

DISPLAY STATISTICS (DISPLAY ONLY)
The statistics display according to Birth Status or Birth Type. When you specify Birth Status, statistics are compiled for Normal, Post Term, Preterm, Stillborn, and Term deliveries. When you specify Birth Type, statistics are compiled for Multiple, Single, Triplets, or Twins deliveries.

Press ENTER to exit the screen and return to the Maternity Information Print menu.

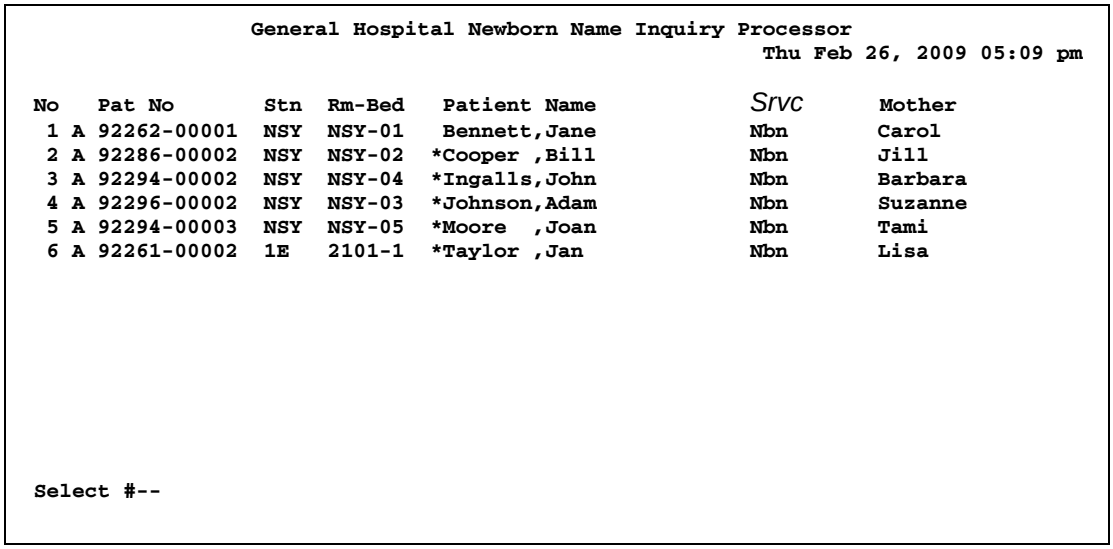
Newborn Name Inquiry

The Newborn Name Inquiry option is available through the Maternity menu. This option provides functionality very similar to the standard Name Inquiry, with one exception: instead of the patient classification and condition displaying, the system displays the mother's first name for any baby. The display of the mother's first name is helpful for accurately identifying babies when there are multiple babies with the same last name in the system.

When you select the Newborn Name Inquiry option, the following prompt displays:

Enter acct #, '-'bed code, first chars of name'-' [OB Census]--
'C' for Census

You can identify the newborn by directly entering the account number, bed code, or partial last name. Enter **C,** or press ENTER for the default OB Census, to select a newborn from a census listing. After you have selected a newborn, the following screen displays:


General Hospital Newborn Name Inquiry Processor
Thu Feb 26, 2009 05:09 pm
No Pat No Stn Rm-Bed Patient Name Srvc Mother
1 A 92262-00001 NSY NSY-01 Bennett,Jane Nbn Carol
2 A 92286-00002 NSY NSY-02 *Cooper ,Bill Nbn Jill
3 A 92294-00002 NSY NSY-04 *Ingalls,John Nbn Barbara
4 A 92296-00002 NSY NSY-03 *Johnson,Adam Nbn Suzanne
5 A 92294-00003 NSY NSY-05 *Moore ,Joan Nbn Tami
6 A 92261-00002 1E 2101-1 *Taylor ,Jan Nbn Lisa
Select #--

MATERNITY STATISTICAL REPORTS

STAR Patient Care provides three reports that summarize statistical information related to maternity services and service providers. When you select the Statistical and Demand Reports option from the initial Patient Care menu, the following screen displays:

```
              General Hospital Statistical and Demand Reports Processor
                                                  Wed Jul 07, 2004 05:29 pm
Statistical and Demand Reports Input Options

             Option No.  Option
             ----------------------------------------
                 1       Census Summary Statistics Report
                 2       O/P Clinic and A&E Services Activity Report
                 3       Maternity Services by Provider Report
                 4       Maternity Services - Professional Advice Report
                 5       Expired Health Card Number Report
                 6       I/P Census Summary Report by Day, Month or Period
                 7       Daily E/R Visit Report
                 8       Period Emergency Statistics Report
                 9       Period Discharge Patient Days Summary
                10       Patient Care Statistics
                11       MSP Exception Report
         12      Unknown Opt Out Preference Report


Enter option number--
```

The O/P Clinic and A&E Services Activity Report, Maternity Services by Provider Report, and Maternity Services - Professional Advice Report options access the three maternity statistical reports. These options are explained in the following sections.

O/P Clinic and A&E Services Activity Report

The O/P Clinic and A&E Services Activity Report compiles information on maternity patient appointments within a range of dates, based on the selected providers. When you select the O/P Clinic and A&E Services Activity Report option from the Statistical Reports menu, the following screen displays:

```
    General Hospital O/P Clinic and A&E Services Activity Report Processor
                                                  Tue Jun 11, 1996 08:33 am

 1 Providers to include
 ->
  2 Start date               3 End date









Enter provider code
```

Field Explanations

1. PROVIDERS TO INCLUDE (TABLE LOOKUP)
This field displays the codes of all providers'patients to be included in the report. Enter the provider code directly, or enter a hyphen (-) to select from a table listing of defined providers. You can enter multiple providers.

2. START DATE (DATE FORMAT)
This field indicates the beginning date for the range during which data should be compiled. The start date must be less than the end date.

3. END DATE (DATE FORMAT)
This field indicates the ending date for the range during which data should be compiled. The end date must be less than today's date and greater than the start date.

After you complete this screen, the system compiles maternity patient information that falls within the set parameters and print the O/P Clinic and A&E Services Activity Report, as shown 0n the following screen.

Figure 5.3 O/P Clinic and A&E Services Activity Report

```
Wed Jul 03, 1996 11:22 am                                                Page 1
                              General Hospital
                         Consultant Outpatient Clinic Activity and
                      Accident and Emergency Services Activity Report
                                From 01/01/96 to 07/03/96

                                                 Consultants
                                    Referrals    initiated
                                    attendances  attendances   GP Written
Specialty                Code
                                    Seen  DNA    Seen  DNA     requests
-------------------------------------------------------------------------------



-------------------------------------------------------------------------------
Totals


Accident and Emergency Services Activity

First Attendances:            Follow up Attendances                    Total:


End of Report
```

The first part of this report includes outpatient service activities for maternity patients, sorted by provider and date. Patients included in this section of the report must have Patient Type specifying the provider and outpatient category set to Clinic.

Field Explanations

REFERRAL ATTENDANCES SEEN
This field includes all appointments with the referring source equal to GP Referral, A&E Referral, Consultation not A&E, Self, or Other and an appointment status of Check-in (I) or Walk-in (W).

REFERRAL ATTENDANCES DNA
This field includes all appointments with the referring source equal to GP Referral, A&E Referral, Consultation not A&E, Self, or Other and an appointment status of No Show (N) or Auto (X).

CONSULTANTS INITIATED ATTENDANCES SEEN
This field includes all appointments with the referring source equal to Consultant Follow-up Emergency Admit or Consultant Follow-up Domicillary Admit, and an appointment status of Check-in (I) or Walk-in (W).

CONSULTANTS INITIATED ATTENDANCES DNA
This field includes all appointments with the referring source equal to Consultant Follow-up Emergency Admit or Consultant Follow-up Domicillary Admit, and an appointment status of No Show (N) or Auto (X).

GP WRITTEN REQUESTS
This field includes all appointments with the referring source equal to GP Referral.

The second part of the O/P Clinic and A&E Services Activity Report includes accident and emergency service activities for maternity patients, sorted by provider and date. Patients included in this section of the report must have Patient Type specifying the provider and outpatient category not equal to Emergency.

FIRST ATTENDANCES
This field includes the total number of appointments with the visit admission date equal to the appointment date or not a new visit appointment.

FOLLOW UP ATTENDANCES
This field includes the total number of appointments with the visit admission date not equal to the appointment date or a new visit appointment.

Maternity Services by Provider Report

The Maternity Services by Provider Report compiles information on maternity patient appointments within a range of dates, based on the selected providers. When you select the Maternity Services by Provider Report option from the Statistical Reports menu, the following screen displays:

```
      General Hospital Maternity Services by Provider Report Processor
                                                  Tue Jun 11, 1996 08:34 am

 1 Providers to include
 ->
  2 Start date               3 End date









Enter provider code
```

Field Explanations

1. PROVIDERS TO INCLUDE (TABLE LOOKUP
This field displays the codes of all providers'patients to be included in the report. Enter the provider code directly, or enter a hyphen (-) to select from a table listing of defined providers. You can enter multiple providers.

2. START DATE (DATE FORMAT)
This field indicates the beginning date for the range during which data should be compiled. The start date must be less than the end date.

3. END DATE (DATE FORMAT)
This field indicates the ending date for the range during which data should be compiled. The end date must be less than today's date and greater than the start date.

After you complete this screen, the system compiles maternity patient information that falls within the set parameters and print the Maternity Services by Provider Report, as in the following example.

Figure 5.4 Maternity Services by Provider Report

```
Wed Jul 03, 1996 11:28 am                                                Page 1
                              General Hospital
                      Maternity Services: GP Maternity Clinics
                             From 01/01/96 to 07/03/96

                                                 Consultants
                                  Referrals      initiated
                                  attendances    attendances    GP Written
Clinic Function          Code
                                  Seen  DNA      Seen  DNA      requests
-------------------------------------------------------------------------------

Ante-natal               01

Post-natal               02

-------------------------------------------------------------------------------
Totals                   03       0     0       0     0        0            0


End of Report
```

This report provides information for two categories of maternity patients, ante-natal and post-natal. Fields display ante-natal information for appointments with patient visit for maternity patients with appointment type post-natal indicator set to No. Fields display post-natal information for appointments with patient visit for maternity patients with appointment type post-natal indicator set to Yes.

Field Explanations

REFERRAL ATTENDANCES SEEN
This field includes all appointments with the referring source equal to GP Referral, A&E Referral, Consultation not A&E, Self, or Other and an appointment status of Check-in (I) or Walk-in (W).

REFERRAL ATTENDANCES DNA
This field includes all appointments with the referring source equal to GP Referral, A&E Referral, Consultation not A&E, Self, or Other and an appointment status of No Show (N) or Auto (X).

CONSULTANTS INITIATED ATTENDANCES SEEN
This field includes all appointments with the referring source equal to Consultant Follow-up Emergency Admit or Consultant Follow-up Domicillary Admit, and an appointment status of Check-in (I) or Walk-in (W).

CONSULTANTS INITIATED ATTENDANCES DNA
This field includes all appointments with the referring source equal to Consultant Follow-up Emergency Admit or Consultant Follow-up Domicillary Admit, and an appointment status of No Show (N) or Auto (X).

GP WRITTEN REQUESTS
This field includes all appointments with the referring source equal to GP Referral.

Maternity Services - Professional Advice Report

The Maternity Services - Professional Advice Report compiles information on maternity patient appointments within a range of dates, based on the selected providers. When you select the Maternity Services - Professional Advice Report option from the Statistical Reports menu, the following screen displays:

```
    General Hospital Maternity Services - Professional Advice Report Processor
                                                    Tue Jun 11, 1996 08:35 am

 1 Providers to include
 ->
  2 Start date               3 End date









Enter provider code
```

Field Explanations

1. PROVIDERS TO INCLUDE (TABLE LOOKUP)
This field displays the codes of all providers'patients to be included in the report. Enter the provider code directly, or enter a hyphen (-) to select from a table listing of defined providers. You can enter multiple providers.

2. START DATE (DATE FORMAT)
This field indicates the beginning date for the range during which data should be compiled. The start date must be less than the end date.

3. END DATE (DATE FORMAT)
This field indicates the ending date for the range during which data should be compiled. The end date must be less than today's date and greater than the start date.

After you complete this screen, the system compiles maternity patient information that falls within the set parameters and print the Maternity Services by Provider Report, as in the following example.

Figure 5.5 Maternity Services - Professional Advice Report

```
Wed Jul 03, 1996 11:32 am                                                    Page 1
                                  General Hospital
                Maternity Services: Professional Advice and Support Programs
                                  From 01/01/96 to 07/03/96

                       PART A - ACTIVITY AT CLINICS RUN ONLY BY MIDWIVES

Program                                 Total Number of Contacts
-------------------------------------------------------------------------------
Ante-natal
Post-natal
-------------------------------------------------------------------------------
TOTAL                                   0
-------------------------------------------------------------------------------


                                  PART B - DOMICILIARY VISITS
-------------------------------------------------------------------------------
Program                       Total          Staff group making contact
                                          Midwives            Health Visitors
-------------------------------------------------------------------------------
Ante-natal
Post-natal
-------------------------------------------------------------------------------
TOTAL                         0            0                        0

Comment:




End of Report
```

The first part of this report includes information on activity at clinics run only by midwives, sorted by provider and date. It is further divided by two categories of maternity patients, ante-natal and post-natal. Fields display ante-natal information for appointments with patient visit for maternity patients with appointment type post-natal indicator set to *No*. Fields display post-natal information for appointments with patient visit for maternity patients with appointment type post-natal indicator set to Yes.

Field Explanations

TOTAL NUMBER OF CONTACTS
This field indicates the total number of patients seen at a specific midwife clinic during the specified time period. The information is separated between ante-natal and post-natal maternity patients.

The second part of the Maternity Services - Professional Advice Report includes information on domiciliary visit activity, sorted by provider and date. It is further divided by two categories of maternity patients, ante-natal and post-natal.

PROGRAM ANTE-NATAL
This total includes all appointments with patient visit for maternity patients with appointment type post-natal indicator set to No for which the Type of Clinic is set to Domiciliary.

PROGRAM ANTE-NATAL STAFF GROUP MAKING CONTACT MIDWIVES
This total includes all appointments with patient visit for maternity patients with appointment type post-natal indicator set to No for which the Type of Clinic is set to Domiciliary and the Resource type indicator is set to Midwife.

PROGRAM ANTE-NATAL STAFF GROUP MAKING CONTACT HEALTH VISITORS
This total includes all appointments with patient visit for maternity patients with appointment type post-natal indicator set to No for which the Type of Clinic is set to Domiciliary and the Resource type indicator is set to Health Visitor.

PROGRAM POST-NATAL
This total includes all appointments with patient visit for maternity patients with appointment type post-natal indicator set to Yes for which the Type of Clinic is set to Domiciliary.

PROGRAM POST-NATAL STAFF GROUP MAKING CONTACT MIDWIVES
This total includes all appointments with patient visit for maternity patients with appointment type post-natal indicator set to Yes for which the Type of Clinic is set to Domiciliary and the Resource type indicator is set to Midwife.

PROGRAM POST-NATAL STAFF GROUP MAKING CONTACT HEALTH VISITORS
This total includes all appointments with patient visit for maternity patients with appointment type post-natal indicator set to Yes for which the Type of Clinic is set to Domiciliary and the Resource type indicator is set to Health Visitor.

HISTORICAL MATERNITY INFORMATION

STAR Patient Care retains maternity patient information in the MPI. This allows the for the review of past assessments, labor and delivery clinical details, and other pertinent information relating to maternity patients.

You can view and/or print existing maternity patient information through MPI Inquiry. When you access MPI Inquiry, the system prompts you to select a patient for review. After you have selected a patient, the Master MPI menu displays. Select the Visit Information option and specify a visit for the patient. When you have selected a maternity patient and a maternity-related visit, the Visit MPI menu displays:

```
                        General Hospital Processor
                                                        Fri Mar 22, 1996 10:00 am
  No.          Name              Sex    BD    List    Physician     Spc   Status
2-00003-95    BENNETT,MARTHA     F  12/12/68 L/D-01  GOLDEN,SAMUEL OBS   MAT 333
            Option No.  Option
            ---------------------------------------
   VISIT         1       Medical Detail
                 2       Patient Employer Page
                 3       Guarantor Page
                 4       Guarantor Employer Page
                 5       Relative Information
                 6       Insurance Process
                 7       Wait List Page
                 8       Miscellaneous Information
                 9       User Defined Fields
                10       Visit History
                11       Physician Page
                12       Surgery Information
                13       Problem List
                14       Maternity Information
                15       Disposition Information

Enter option number--
```

When you select the Maternity Information option, the following menu displays:

```
               General Hospital Maternity Information Processor
                                                   Fri Mar 22, 1996 10:00 am
  No.          Name              Sex    BD    List    Physician     Spc   Status
2-00003-95    BENNETT,MARTHA     F  12/12/68 L/D-01  GOLDEN,SAMUEL OBS   MAT 333

            Option No.  Option
            ---------------------------------------
   Display       1       Patient Assessment
                 2       Display Patient Care Profile
                 3       Vital Signs by Date and Shift
                 4       Fluid Balance by Date & Shift
                 5       Labor and Delivery Clinical Details

   Print         6       Assessment Reports
                 7       Patient Care Profile
                 8       Nursing Plan of Care
                 9       Labor and Delivery Clinical Details
                10       Discharge Summary


Enter option number--
```

From this menu you select options that display and/or print information related to the selected patient visit, as shown in the header. The function associated with options one through five display maternity patient information. The function associated with options six through ten print maternity patient information. You cannot edit any of the information displayed or printed by these options.

Patient Assessment

The availability of maternity patient assessment in the MPI allows easy review of past assessments and expedites the entry of future assessments for a particular maternity patient. The display Patient Assessment and print Assessment Reports option of the Maternity Information Processor provide access to the maternity patient assessments. These options function in the same way as the View Patient Assessment and Patient Assessment Report options available elsewhere in STAR Patient Care.

When you select the Patient Assessment option and there are assessments associated with the active patient visit, a screen displays the existing assessments available for the selected maternity patient. Specify the assessment you want to view by choosing the corresponding assessment type from the listing and select the date.

The Assessment Reports option functions similarly to the active patient Assessment Report function. The difference is that the system provides one report with variable information included on the report rather than providing five different report formats for inactive patients.

The display Patient Assessment and print Assessment Reports functions are explained in detail in the appropriate sections of the *Patient Assessment Module* of the *STAR Patient Care Reference Guide.* Please refer to these sections for instruction on using the assessment functions.

Patient Care Profile

The system retains Patient Care Profiles for maternity patients in the MPI which is available for viewing. Additionally, when you assign patient care plans to maternity patients, if the maternity patient has an active maternity visit, or an inactive one from last ten months, the plan entered on the previous visit is brought forward.

Refer to “Patient Care Profile” on page 6-3 for more information.

Vital Signs and Fluid Balances

Vital Signs and Fluid Balances information is an integral part of the maternity process, especially during labor and delivery. You can gather information such as fetal heart rate and cervix dilation, in addition to normal vital signs and fluids information. The system retains this information after archiving, using the new parameter added to the nursing facility parameters.

The Maternity menu provides options for charting and reviewing vital signs and fluid information. Refer to "Vital Signs and Fluid Balances" on page 5-46 for explanations of these functions.

Labor and Delivery Clinical Details

The Labor and Delivery Clinical Details option provides table access to the labor and delivery information for the selected patient and visit. This table is constructed by entering answers to several specific questions regarding the labor and delivery process and outcome. Refer to "Labor and Delivery Clinical Questions" on page 5-6 for detailed information on building and using the questions that generate the Labor and Delivery Clinical Details table.

Nursing Plan of Care

The Nursing Plan of Care is a written plan of expected outcomes and interventions for meeting the patient's needs with an individualized set of standards. In regards to maternity patients, the plan operates in the same manner as it would for any patient. The Nursing Plan of Care option is present on this menu to provide quick access to the plan of care for a specific maternity patient. For more information, refer to "Chapter 6 - REPORTS".

Discharge Summary

The Discharge Summary is a report that summarizes an inpatient's stay. You can print this patient-specific form/report on demand, for distribution directly to the patient upon discharge, or reference for the attending physician. The Discharge Summary contains the following information:

- Patient, Visit, and Discharge Information
- Diagnosis/Procedure Information
- Referring and Attending Physician(s)
- Next Scheduled Appointments
- Insurance Plans

The Discharge Summary is available through the Clinical Facility Parameters option from the Hospital Facility Options menu. For more information, refer to "Chapter 6 - REPORTS".

Chapter 6 - REPORTS

The *Care Planning and Documentation Module* generates documents, worksheets, and reports to aid the nurse in providing quality care. Listed below are all the documents described in this chapter:

Illustrations

NURSING DOCUMENTS

For Nursing files that display/print the component text, please note that the format may differ from the examples in this section:

- If your facility has run the conversion associated with user-formatted PCPs and Worksheets, the text displays/prints on three lines of 75 characters each.
- If your facility has not run the conversion, the text displays/prints on five lines of 36 characters each.

Patient Care Profile

The Patient Care Profile (PCP) provides patient information and designates the care to be given during a shift. The profile can include a Plan of Care, physician orders, treatments, ADLs, patient demographics, and pertinent Patient History. If the station is live with the Patient Assessment module, Assessment Orders and Problem Lists can also print on the PCP. The PCP replaces the traditional and manually written Kardex, which usually contains physician orders, a Nursing Plan of Care, patient demographics, and a brief Patient History. By combining medical and nursing information on one concise, easy-to-use form, the PCP completely and accurately organizes the patient's day to day care.

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report and the criteria selected for the report. For more information, see the STAR Audit Service Reference Guide.

You can access the PCP print function by selecting the following menu options:

1. Patient Print from the Nursing main menu
2. Patient Care Profile

You can print the PCP by station, bed group or patient. The following prompt displays:

Enter station(S), `-` to list bed groups, or [2N Census]--

If you enter **S** for Station, a PCP prints for all beds on the station.

If you enter a hyphen (-), the bed groups defined for the facility display. Select a bed group and only PCPs for that group prints.

If you press ENTER, a table displays the census for the station. You can select multiple patients.

NOTE: You can also print the PCP for a patient using the Print Patient Care Profile option on the Plan of Care menu. Perform the following steps to access this option:

1. Select Plan of Care Process from the Nursing main menu.
2. Select the patient from the prompt.
3. Select Patient Care Profile from the Print section of the menu.

After you select the appropriate patient(s), the following screen displays:

```
               General Hospital Patient Care Profile Processor
                                                    Mon Mar 01, 2010 12:35 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
08191-00002   ***                F  01/01/67 2101-01 DONER,TEST XXMED 9  I/P 601

( 1)PCP             : 1 EAST PATIENT CARE PROFILE
( 2)PCP for         : 2101-01

( 3)Start Shift     :
( 4)Start Date      :

( 5)Stop Shift      :
( 6)Stop Date       :

( 7)Show Completes? :
( 8)Number of Copies:




Enter start shift for PCP--
```

Field Explanations

1. PCP (DISPLAY or TABLE LOOKUP)
This field displays the default PCP for the station if one is defined in the Station Parameters screen. If your facility has user-formatted PCPs, you can access the field and select a different PCP format.

2. PCP FOR (DISPLAY ONLY)
This field displays the bed code(s) of the patient(s) for whom the PCPs are being printed.

3. START SHIFT (1-N-R)
This field indicates the shift from which you want the system to beginning pulling data to print on the PCP: Shift 1, 2 or 3. The following prompt displays:

Enter start shift for PCP--

4. START DATE (DATE)
This field indicates the date on which you want the system to start pulling data to print on the PCP. If you press ENTER at the following prompt, the system defaults to today's date.

Enter start date for PCP [T]----

5. STOP SHIFT (1-N-R)
This field indicates the shift from which you want the system to stop pulling data to print on the PCP: Shift 1, 2 or 3. If you press ENTER at the following prompt, the system defaults to the first shift.

Enter stop shift for PCP [1]--

6. STOP DATE (DATE)
This field indicates the date on which you want the system to stop pulling data to print on the PCP. If you press ENTER at the following prompt, the system defaults to today's date.

Enter stop date for PCP [T]--

7. SHOW COMPLETES? (1-A-R)
This field determines whether or not completed Plan of Care components should print on the PCP. The following prompt displays:

Include completed Plan of Care elements on PCP? (Y/N) [N]--

Enter **Y** to include Plan of Care components with a status of Complete on the PCP. Enter **N** to exclude completed components on the PCP.

8. NUMBER OF COPIES (1-N-O)
This field determines the number of copies to print. Each one prints as a separate report on the spooler or printer.

When you access this field, the system displays the following prompt:

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

The following prompt displays:

Accept this screen? (Y/N) [Y]--

Press ENTER to accept the screen or enter **N** for No to update the current screen. When you press ENTER, the system displays the message *Processing!* and generates the PCP. The following pages contain a description and an example of the system-generated PCP. If your facility builds and formats its own PCPs, the PCP can include a wide variety of information, as defined by your facility. Refer to “Chapter 9 - BUILD

AND FORMAT PCPS AND WORKSHEETS" for complete information.

When generating the PCP, you can choose to *not* print all occurrences of an order, which eliminates lengthy and less useful reports. To choose to not print all occurrences of an order, set the Collapse Occurrences field that displays on the SIM Departments screen to Yes. If you select Yes, then the PCP and worksheets print only one occurrence from a parent order. For example, if Vital Signs are ordered Q2H, only one occurrence prints on the PCP even though three were generated for that shift. The default for this field is No.

Output

The PCP may be printed for one or more patients. The sort is by walk-order if PCPs are being printed for the entire station, by bed group order if they are printed for a selected bed group, or by room and bed order if multiple patients are selected from the list of occupied beds.

Each page is numbered sequentially. The last page also prints the word End indicating the end of the report.

The following information prints for each patient on the system-generated PCP:

Medical side (right or left column depending on facility parameter)

- ADLs
- Current Diet and Instructions
- Precautions
- Assessment Orders (if the Patient Assessment module is installed)
- Active Orders (including Preps & Special Instructions)
- Orders with a frequency of PRN (as needed), which automatically go to a Complete status. PRN orders never generate an active occurrence, so they are an exceptional category that must be included on the PCP after they are completed.

  The information that prints is from the parent order. Once a PRN order is placed, it prints on the PCP regardless of whether an occurrence has been added. The PRN order continues to print until the parent order is cancelled or discontinued or the patient is discharged.
- Orders that have a status of Pending Authorization. Pending elements are preceded by an exclamation point (!)
- Medications and Solutions (If STAR Pharmacy is live on station)

- Treatments
- Physician Consults
- Patient History Text

Nursing side (right or left column depending on facility parameter)

- Problem List (If Assessment module is installed)
- Plan of Care
- Discharge/Expected Outcomes
- Problem/Expected Outcomes
- Discharge Plans
- Interventions

NOTE: An area for Nurses Notes and signature block prints at the bottom of the Patient Care Profile.

The patient block prints in one of four locations depending on a facility parameter (top/bottom, left/right). The following information prints in the patient block:

- Diagnosis
- Allergies
- Isolation
- Smoking Status
- Surgery Date and Procedure
- Patient Type
- Room and Bed Number
- Medical Record Number
- Account Number
- Admission Date
- Date of Birth and Age

- Attending Physician
- Patient Name
- Sex

Figure 6.1 System-Generated Patient Care Profile

```
                                GENERAL HOSPITAL                              Page 1
                                   ATLANTA, GA                                   End
ADL'S / MISC.                                    |PROBLEM LIST
  ACTIVITY    AMBULATE                           |
  VITAL SIGN  V/S Q 4 HR                         |PLAN OF CARE
  BATH        SELF TUB                           |
  FEEDING     FORCE FLUIDS                       |PC:ANXIETY/FEAR
12/12 D CLEAR LIQUID                             |EO:REDUCE CHILD'S FEAR OF A HOSPITAL BY
                                                 |   ACQUAINTING HER WITH THE PERSONNEL
ASSESSMENT ORDERS                                |   AND SURROUNDINGS.
                                                 | 1:ACQUAINT PATIENT WITH HER
ACTIVE ORDERS                                    |   SURROUNDINGS.  ALLOW FAVORITE TOY,
  CBC W DIFF              12/12  07:00A          |   ANIMAL OR OBJECT TO REMAIN WITH
  CHEST PA & LAT          12/12  07:00A          |   CHILD DURING HOSPITALIZATION.
Medications:                                     |EO:HOSPITAL PERSONNEL WILL PROVIDE
Solutions:                                       |   SUPPORT TO THE CHILD AND FAMILY AND
                                                 |   WILL NOT BE A SOURCE OF ANXIETY.
                                                 | 1:IN CHILDREN'S TERMINOLOGY, EXPLAIN
                                                 |   ALL PROCEDURES PRIOR TO
TREATMENTS                                       |   IMPLEMENTING.  UTILIZE DOLLS FOR
                          12/12  11:58A          |   DRAMATIZATION IF NECESSARY.
 1:DO NOT ADMINISTER ASPIRIN PRODUCTS            | 2:INCLUDE FAMILY IN ALL ACTIVITIES OF
                          12/12  11:56A          |   THE CHILD'S CARE.
 2:IV @ KO RATE, DC WHEN TOLERATING              | 3:ENCOURAGE CHILD TO VERBALIZE HER
   LIQUIDS.                                      |   FEELINGS ABOUT HER SURGERY AND
                          12/12  11:55A          |   HOSPITALIZATION.
 3:FORCE FLUIDS POST OPERATIVELY TO              |DP:1.FOLLOWING DISCHARGE: ACTIVITY  AS
   COMPENSATE FOR THE INABILITY TO               |   TOLERATED.
   SWALLOW SOLID FOODS.                          |   2.INCREASE DIET AS TOLERATED.
                          12/12  11:53A          |   3.MEDICATION AS INDICATED PER D/C
 4:SURGERY PERMIT SIGNED FOR T&A TO BE           |   INSTRUCTION SHEET.
   DONE BY DR. WOODBURN.                         |
                                                 |
CONSULTATIONS                                    |
  GOLDEN,SAMUEL ADAMS   CARDIOLOGIST             |

PAST MEDICAL HISTORY: RECURRING HISTORY OF UPPER RESPIRATORY INFECTION &
STREP THROAT.  NORMAL CHILDHOOD ILLNESSES.
FAMILY TO NOTIFY: MOTHER @ 555-0000 IF NOT WITH CHILD.

DATE   TIME         NURSING NOTES




 Dx : TONSILLITIS                                |INT   |SIGNATURE
 Alg: SULFA DRUGS                                |      |
 Iso:                          Smk: NO           |      |
 Sgy: 12/11/92  TONSILLECTOMY                    |      |
                              Type: I/P          |      |
 1204-1  0000-1049-34   90057-00002              |
 Adm : 12/11/92    Dob: 03/17/87  2Y             | Fri Dec 18,1992 10:47am      Shift 1
 Phys: WOODBURN,ROBERT LOUIS Level: 1            |
 CHARLES, ELLEN                Sex: F            | PATIENT CARE PROFILE
```

Nursing Plan of Care

The Nursing Plan of Care provides a copy of the total, individualized Plan of Care for a specific patient. The system can print active, inactive and completed elements, and it prints the date, time and initials of theindividual completing or updating the element. Patient Demographic information also prints on the Plan of Care. This Plan of Care

may be a permanent part of the chart providing a document with the patient's summary of care for the hospitalization.

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report, and the criteria selected for the report. For more information, see the *STAR Audit Service Reference Guide*.

To access the Plan of Care print function, select Patient Print from the Nursing Main Menu, then select Nursing Plan of Care. (This print function also resides on the Plan of Care submenu.) The following prompt displays:

Enter acct #, `-` bed code, first chars of name'-' [2N Census]--
'C' for Census

If you enter an account number, you can access a specific patient. If you enter a hyphen (-) followed by a bed code, you can access a specific patient.

If you enter the beginning letters of the patient's name, the hyphen (-) and press ENTER, the system displays a list of patients with the same beginning characters. The more letters of the patient's last name you enter, the more specific the patient listing is.

If you press ENTER to select the default, the census of the primary station displays for you to select a specific patient.

If you enter **C** for Census, the following prompt displays:

Enter station code [1E]--

Enter the station code to display the census of the secondary station. Select a specific patient.

NOTE: Information Windows displaying patient information, physicians, and pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in this function. During the download process, the system displays the following message:

Downloading Information Windows...Please Wait!

After the windows are downloaded, you can view them in any other nonpatient-specific function on STAR Patient Care. When you access a patient-specific function other than Order Management or Nursing functions, the downloaded information is cleared. The information is also cleared when you select a different patient in one of the functions where Information Windows are available.

For specific information regarding Patient, Physician, or Pharmacy Information Windows, refer to "Appendix B - INFORMATION WINDOWS".

After you select the patient, the following screen is displayed:

```
                General Hospital Nursing Plan of Care Processor
                                                  Thu Dec 17, 2009 05:28 pm
  No          Name              Sex    BD     Room     Physician     SVC ICD Status
90057-00002   CHARLES,ELLEN      F  03/17/87 1204-1  WOODBURN,ROBEPED 10 I/P 4

( 1)Inactives?   :
( 2)Completes?   :
( 3)# of Copies  :









Include inactive elements? (Y/N) [N]--
```

Field Explanations

1. INACTIVES (1-A-R)
This field determines whether or not inactive Plan of Care components should print on the Plan of Care. The following prompt displays:

Include inactive elements? (Y/N) [N]--

Enter **Y** to include Plan of Care components with a status of Inactive on the Plan of Care. Enter **N** to exclude inactive components on the Plan of Care.

2. COMPLETES (1-N-R)
This field determines whether or not completed Plan of Care components should print on the Plan of Care. This prompt displays:

Include completed elements? (Y/N) [Y]--

Enter **Y** to include Plan of Care components with a status of Complete on the Plan of Care. Enter **N** to exclude completed components on the Plan of Care.

3. # OF COPIES (1-N-O)
This field determines the number of copies to print. Each one prints as a separate report on the spooler or printer.

When you access this field, the system displays the following prompt:

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

The following prompt displays:

Accept this screen? (Y/N) [Y]--

Press ENTER to accept the screen or enter **N** to update the current screen. When you press ENTER, the following prompt displays:

Print Plan of Care? (Y/N) [Y]--

Press ENTER to print the Plan or enter **N** to return to the Patient Print menu. When you press ENTER, the message *Printing!* displays and generates the Plan of Care. Following is a description and an example of a Plan of Care.

NOTE: When you discharge a patient from a nursing station using the Discharge function on the Nursing Management menu, you are asked whether you want to print a completed Plan of Care. This eliminates having to exit the function to print the completed Plan of Care. You receive this prompt only if the Plan of Care at DIS field in the Station Parameters has been set to offer the option.

Please refer to the *Order Management/Charge Processing Volume* of the *STAR Patient Care Reference Guide* for more information about using the function during discharge. Refer to "Chapter 7 - STANDARD FILE MAINTENANCE" of this volume for information on how to set this field on the Nursing Station Parameters screen.

The Plan of Care provides a copy of the total individualized Plan of Care for the selected patient.

The following information prints for the selected patient:

- All plans of care (selected for the patient) with their associated expected outcomes and interventions
- The date that each Plan of Care component was added, last updated and completed
- The initials of the person who added, last updated, and completed each component
- The status (inactive, active, pending, complete) of each component

The patient block prints on the bottom left corner of the report. The system-generated block contains the following information:

- Diagnosis

- Allergies
- Isolation
- Smoking Status
- Surgery Date and Procedure
- Patient Type
- Room and Bed Number
- Medical Record Number
- Account Number
- Admission Date
- Date of Birth and Age
- Attending Physician
- Patient Name
- Sex

Your facility can build and format its own patient block and include a wide variety of information, as explained in “Chapter 9 - BUILD AND FORMAT PCPS AND WORKSHEETS”.

Figure 6.2 Plan of Care, Page 1

```
                              GENERAL HOSPITAL                          Page 1
                                 ATLANTA, GA
-------------------------------------------------------------------------------
ADDED BY/DATE                 UPDATED BY/DATE                 COMPLETED BY/DATE
-------------------------------------------------------------------------------
  12/12/92 10:35am
Plan of Care                  ANXIETY/FEAR
     12/12/92 10:36am CEH                                     Inactive
   Prob/Exp Outcome       PB:ANXIETY/FEAR RELATED TO
                          EO:REDUCE SYMPTOMS RELATED TO ANXIETY

     12/12/92 10:36am          12/12/92 10:46am              Active
   Prob/Exp Outcome       EO:REDUCE CHILD'S FEAR OF A HOSPITAL BY
                             ACQUAINTING HER WITH THE PERSONNEL
                             AND SURROUNDINGS.

       12/12/92 10:46am       12/12/92 10:47am              Active
     Intervention           :ACQUAINT PATIENT WITH HER
                             SURROUNDINGS.  ALLOW FAVORITE TOY,
                             ANIMAL OR OBJECT TO REMAIN WITH
                             CHILD DURING HOSPITALIZATION.

     12/18/92 10:36am          12/18/92 10:49am              Active
   Prob/Exp Outcome       EO:HOSPITAL PERSONNEL WILL PROVIDE
                             SUPPORT TO THE CHILD AND FAMILY AND
                             WILL NOT BE A SOURCE OF ANXIETY.

       12/18/92 10:49am                                      Inactive
     Intervention           :REFER TO SOCIAL SERVICES

       12/18/92 10:49am                                      Inactive
     Intervention           :REFER TO PASTORAL CARE

       12/18/92 10:49am       12/18/92 10:54am              Active
     Intervention           :IN CHILDREN'S TERMINOLOGY, EXPLAIN
                             ALL PROCEDURES PRIOR TO
                             IMPLEMENTING.  UTILIZE DOLLS FOR
                             DRAMATIZATION IF NECESSARY.

       12/18/92 10:49am       12/18/92 10:50am              Active
     Intervention           :INCLUDE FAMILY IN ALL ACTIVITIES OF
                             THE CHILD'S CARE.




-------------------------------------------------------------------------------
 Dx : TONSILLITIS                        |
 Alg: SULFA DRUGS                        |
 Iso:                      Smk: NO       |
 Sgy: 12/11/92  TONSILLECTOMY            |
                          Type: I/P      |
 1204-1  0000-1049-34   90057-00002      |
 Adm : 12/11/92    Dob: 03/17/87  2Y     |     Fri Dec 18, 1992 10:41 am
 Phys: WOODBURN,ROBERT LOUIS Level: 1    |
 CHARLES,ELLEN               Sex: F      |        NURSING PLAN OF CARE
```

Figure 6.3 Plan of Care, Page 2

```
                              GENERAL HOSPITAL                          Page 2
                                 ATLANTA, GA
--------------------------------------------------------------------------------
ADDED BY/DATE                UPDATED BY/DATE                  COMPLETED BY/DATE
--------------------------------------------------------------------------------

        12/18/92 10:49am       12/18/92 10:51am               Active
      Intervention           :ENCOURAGE CHILD TO VERBALIZE HER
                              FEELINGS ABOUT HER SURGERY AND
                              HOSPITALIZATION.

      Dis/Exp Outcome         EO:UTILIZE RESOURCES AND SKILLS TO DEAL
                              WITH ANXIETY

        12/18/92 10:37am       12/18/92 10:55am               Active
      Discharge Plan          PL:1.FOLLOWING DISCHARGE: ACTIVITY  AS
                              TOLERATED.
                              2.INCREASE DIET AS TOLERATED.
                              3.MEDICATION AS INDICATED PER D/C
                              INSTRUCTION SHEET.









--------------------------------------------------------------------------------
 Dx : TONSILLITIS                          |
 Alg: SULFA DRUGS                          |
 Iso:                        Smk: NO       |
 Sgy: 12/12/92  TONSILLECTOMY              |
                            Type: I/P      |
 1204-1  0000-1049-34   90057-00002        |
 Adm : 12/11/92    Dob: 03/17/87  2Y       |     Fri Dec 18, 1992 10:41 am
 Phys: WOODBURN,ROBERT LOUIS Level: 1      |
 CHARLES,ELLEN                 Sex: F      |        NURSING PLAN OF CARE
```

Care Reference Sheet

The Care Reference Sheet provides a copy of a standard Plan of Care. It contains the Plan of Care name with all linked Discharge/Expected Outcomes, Problem/Expected Outcomes, the Discharge Plan, and associated Intervention/Treatments.

To access the Care Reference Sheet print function, select Patient Print from the Nursing main menu, and select Care Reference Sheet. The following prompt displays:

Enter acct #, `-` bed code, first chars of name'-' [2N Census]--
'C' for Census

If you enter an account number, you can access a specific patient.

If you enter a hyphen (-) followed by a bed code, you can access a specific patient.

If you enter the beginning letters of the patient's name, the hyphen (-) and press ENTER, the system displays a list of patients with the same beginning characters. The more letters of the patient's last name you enter, the more specific the patient listing is.

If you press ENTER to select the default, the census of the primary station displays for you to select a specific patient.

If you enter **C** for Census, the following prompt displays:

Enter station code [1E]--

Enter the station code to display the census of the secondary station. Select a specific patient.

NOTE: Information Windows displaying Patient Information, Physicians, and Pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in this function. During the download process, the system displays the following message:

Downloading Information Windows...Please Wait!

After the windows are downloaded, you can view them in any other nonpatient-specific function on STAR Patient Care. When you access a patient-specific function other than Order Management or Nursing functions, the downloaded information is cleared. The information is also cleared when you select a different patient in one of the functions where Information Windows are available.

For specific information regarding Patient, Physician, or Pharmacy Information Windows, refer to "Appendix B - INFORMATION WINDOWS".

After you select the patient, the following screen is displayed:

```
              General Hospital Care Reference Sheet Processor
                                                  Thu Dec 17, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
90057-00002   CHARLES,ELLEN     F  03/17/87 1204-1  WOODBURN,ROBEPED 10 I/P 4

( 1)Plan of Care     :
( 2)Number of Copies :









Enter code or starting letter(s)`-` --
```

Field Explanations

1. PLAN OF CARE (TABLE LOOKUP)
This field enables you to specify which Standard Plan of Care you want to print. The following prompt displays:

Enter code or starting letter(s) `-` --

If the Plan of Care code is known, enter the code. If the code is not known, enter a hyphen (-) and press ENTER for a list of the Plans Of Care. Select a Plan of Care.

2. NUMBER OF COPIES (1-N-O)
This field determines the number of copies to print. Each one prints as a separate report on the spooler or printer.

When you access this field, the system displays the following prompt:

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

The following prompt displays:

Accept this screen? (Y/N) [Y]--

Press ENTER to accept the screen or enter **N** to update the current screen. When you press ENTER, the system displays:

Printing!

and generates the Care Reference Sheet. The following pages contain a description and an example of a Care Reference Sheet.

Output

The Care Reference Sheet provides a copy of a Plan of Care and its associated expected outcomes and interventions. It is important to note the difference between the Nursing Plan of Care and the Care Reference Sheet: the Nursing Plan of Care

contains the Plan of Care individualized to the patient while the Care Reference Sheet prints a single Plan of Care selected from the Standard file.

The following information prints for the patient selected:

- The Plan of Care description
- All expected outcomes linked to the Plan of Care

- All interventions linked to the expected outcomes

The patient block prints on the bottom left corner of the report. The system-generated block contains the following information:

- Diagnosis
- Allergies
- Isolation
- Smoking Status
- Surgery Date and Procedure
- Patient Type
- Room and Bed Number
- Medical Record Number
- Account Number
- Admission Date
- Date of Birth and Age
- Attending Physician
- Patient Name
- Sex

Your facility can build and format its own patient block and include a wide variety of information, as explained in “Chapter 9 - BUILD AND FORMAT PCPS AND WORKSHEETS”.

Figure 6.4 Care Reference Sheet, Page 1

```
                              GENERAL HOSPITAL A                        Page 1

--------------------------------------------------------------------------------
ANXIETY/FEAR

       Prob/Exp Outcome       EO:REDUCE ANXIETY RELATED TO
                                 HOSPITALIZATION

             Intervention       :ORIENT TO PHYSICAL ENVIRONMENT

             Intervention       :EXPLAIN PROCEDURES AND ACTIVITIES
                                 PRIOR TO OCCURRENCE

             Intervention       :ENCOURAGE VERBALIZATION OF FEELINGS
                                 AND CONCERNS

             Intervention       :DECREASE ENVIRONMENTAL STIMULI BY


       Prob/Exp Outcome       PB:ANXIETY/FEAR RELATED TO
                              EO:REDUCE SYMPTOMS RELATED TO ANXIETY

             Intervention       :UTILIZE RELAXATION TECHNIQUES.
                                 LISTENING TAPES, EXERCISE,
                                 DIVERSIONAL ACTIVITIES, RECREATIONAL
                                 THERAPY

             Intervention       :ASSESS NEED FOR PRN MEDICATION AND
                                 ADMINISTER TO PREVENT ESCALATION OF
                                 ANXIETY

       Prob/Exp Outcome       EO:WILL VERBALIZE STEPS OF PROBLEM
                                 SOLVING PROCESS

             Intervention       :INSTRUCT IN PROBLEM SOLVING PROCESS
                                 A. IDENTIFY SYMPTOMS OF ANXIETY,
                                 B. IDENTIFY CAUSE OF ANXIETY,
                                 C. FORM PLAN TO REDUCE ANXIETY,
                                 D. IMPLEMENT PLAN, AND
                                 E. EVALUATE.

       Prob/Exp Outcome       EO:UTILIZE SUPPORTIVE PERSONNEL




--------------------------------------------------------------------------------
 Dx : TONSILLITIS                        |
 Alg: SULFA DRUGS                        |
 Iso:                          Smk: NO   |
 Sgy: 12/12/92  TONSILLECTOMY            |
                              Type: I/P  |
 1204-1  0000-1049-34   90057-00002      |
 Adm : 12/11/92    Dob: 03/17/87  2Y     |     Fri Dec 18, 1992 10:40 am
 Phys: WOODBURN,ROBERT LOUIS Level: 1    |
 CHARLES,ELLEN                 Sex: F    |        CARE REFERENCE SHEET
```

Figure 6.5 Care Reference Sheet, Page 2

```
                              GENERAL HOSPITAL A                        Page 2

--------------------------------------------------------------------------------

             Intervention       :REFER TO SOCIAL SERVICES

             Intervention       :REFER TO PASTORAL CARE

             Intervention       :REFER TO CONTINUUM OF CARE
                                 COORDINATOR

             Intervention       :INCLUDE FAMILY/ S.O. IN EDUCATION
                                 AND CARE

             Intervention       :ENCOURAGE INTERACTION WITH STAFF
                                 WHEN ANXIETY PROVOKING SITUATION
                                 ARISES

       Dis/Exp Outcome        EO:UTILIZE RESOURCES AND SKILLS TO DEAL
                                 WITH ANXIETY

       Discharge Plan         PL:1.ACTIVITY AS TOLERATED W/ PERIODS
                                 OF REST.
                                 2.DIET TO SOFT AS TOLERATED.
                                 3.MEDICATION PER INSTRUCTION ON D/C
                                 INSTRUCTION SHEET.









--------------------------------------------------------------------------------
 Dx : TONSILLITIS                        |
 Alg: SULFA DRUGS                        |
 Iso:                          Smk: NO   |
 Sgy: 12/12/92  TONSILLECTOMY            |
                              Type: I/P  |
 1204-1  0000-1049-34   90057-00002      |
 Adm : 12/11/92    Dob: 03/17/87  2Y     |     Fri Dec 18, 1992 10:40 am
 Phys: WOODBURN,ROBERT LOUIS Level: 1    |
 CHARLES,ELLEN                 Sex: F    |     CARE REFERENCE SHEET
```

Discharge Plan

The Discharge Plan, a component of the Plan of Care process, is printed separately in order for all disciplines involved to obtain a copy of the document. The Plan contains instructions for post-hospitalization care and is reviewed with the patient and family.

To access the Discharge Plan print function, select Patient Print from the Nursing Main Menu, and select Discharge Plan. The following prompt displays:

Enter acct #, `-` bed code, first chars of name'-' [2N Census]--
'C' for Census

If you enter an account number, you can access a specific patient.

If you enter a hyphen (-) followed by a bed code, you can access a specific patient.

If you enter the beginning letters of the patient's name, the hyphen (-) and press ENTER, the system displays a list of patients with the same beginning characters. The more letters of the patient's last name you enter, the more specific the patient listing is.

If you press ENTER to select the default, the census of the primary station displays for you to select a specific patient.

If you enter **C** for Census, the following prompt displays:

Enter station code [1E]--

Enter the station code to display the census of the secondary station. Select a specific patient.

NOTE: Information Windows displaying patient information, physicians, and pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in this function. During the download process, the system displays the following message:

Downloading Information Windows...Please Wait!

After the windows are downloaded, you can view them in any other nonpatient-specific function on STAR Patient Care. When you access a patient-specific function other than Order Management or Nursing functions, the downloaded information is cleared. The information is also cleared when you select a different patient in one of the functions where Information Windows are available.

For specific information regarding Patient, Physician, or Pharmacy Information Windows, refer to Appendix B: Information Windows.

After you select the patient, the system displays the following prompt:

Enter number of copies to print (1/5) [1]--

Enter the number of copies you want. The system displays the following prompt:

Print? (Y/N) [Y]--

If you enter **N**, the system does not print the Discharge Plan and returns to the Patient Print menu. If you press ENTER, the message *Printing!* displays and generates the Discharge Plan. The following pages contain a description and an example of a Discharge Plan.

Output

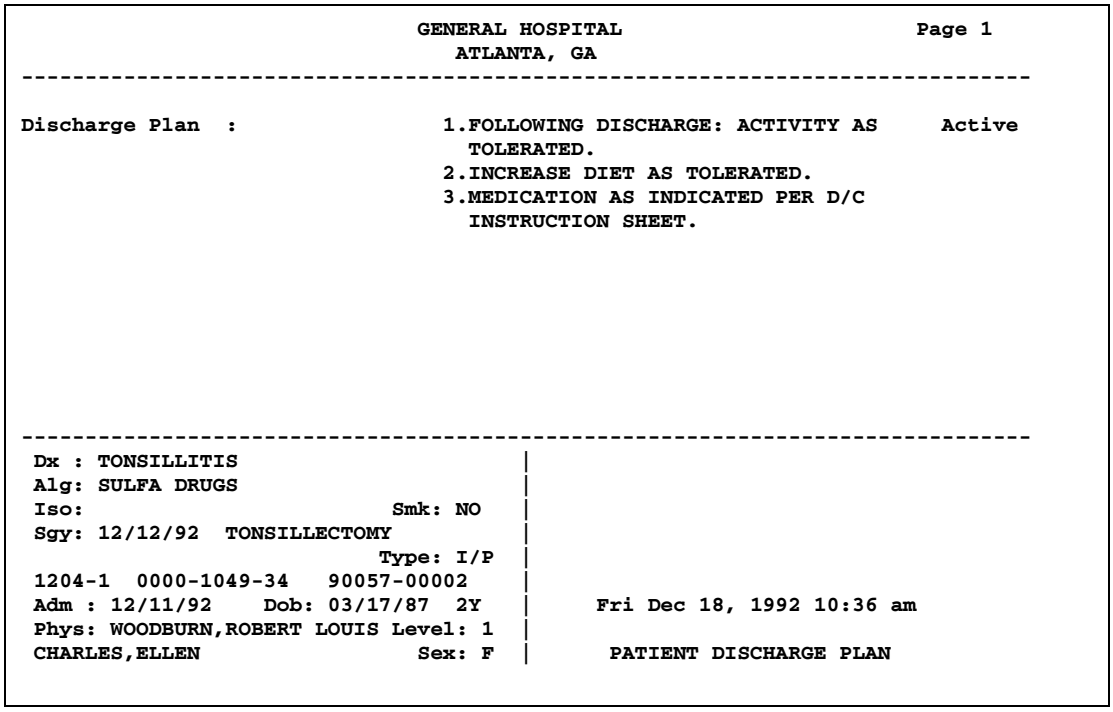
The Discharge Plan contains instructions for post-hospitalization care and is reviewed with the patient and family.

The following information prints on this report:

- All Discharge Plans linked to the patient and having a status of Active.
- All Discharge Plans linked to the patient and having a status of Pending Authorization. The system prints *Pending* to indicate this status.
- The patient block prints on the bottom left corner of the report. The system-generated patient block includes the following information:
  - Diagnosis
  - Allergies
  - Isolation
  - Smoking Status
  - Surgery Date and Procedure
  - Patient Type
  - Room and Bed Number
  - Medical Record Number
  - Account Number
  - Admission Date
  - Date of Birth and Age
  - Attending Physician
  - Patient Name
  - Sex

  Your facility can build and format its own patient block and include a wide variety of information, as explained in "Chapter 9 - BUILD AND FORMAT PCPS AND WORKSHEETS".

Figure 6.6 Discharge Plan



```
                                GENERAL HOSPITAL                          Page 1
                                   ATLANTA, GA
--------------------------------------------------------------------------------

Discharge Plan  :                 1.FOLLOWING DISCHARGE: ACTIVITY AS     Active
                                    TOLERATED.
                                  2.INCREASE DIET AS TOLERATED.
                                  3.MEDICATION AS INDICATED PER D/C
                                    INSTRUCTION SHEET.









--------------------------------------------------------------------------------
 Dx : TONSILLITIS                        |
 Alg: SULFA DRUGS                        |
 Iso:                          Smk: NO   |
 Sgy: 12/12/92  TONSILLECTOMY            |
                              Type: I/P  |
 1204-1  0000-1049-34   90057-00002      |
 Adm : 12/11/92    Dob: 03/17/87  2Y     |     Fri Dec 18, 1992 10:36 am
 Phys: WOODBURN,ROBERT LOUIS Level: 1    |
 CHARLES,ELLEN                 Sex: F    |      PATIENT DISCHARGE PLAN
```

Inpatient Discharge Summary

The Discharge Summary is a summary of an inpatient's stay. The summary is a patient specific form/report that you can print on demand. The Discharge Summary is available only for inpatients and contains the following sections of information:

- Patient Information
- Visit Information
- Insurance Plans
- Referring Physician
- Discharge Information
- Diagnosis/Procedure Information
- Attending Physician(s)
- Procedures
- Next Scheduled Appointments
- Notes

Two parameters must be set to determine the scheduling and insurance information that prints on the Discharge Summary. These parameters are located on the Clinical Parameters, in the Hospital Facility Options tables.

To access the Discharge Summary parameters for scheduling and insurance, perform the following steps:

- Select Tables from the Main Menu screen.
- Select Hospital Facility Options.
- Select Clinical Facility Parameters.

The following screen displays:

```
                  General Hospital Clinical Parameters Processor
                                                 Thu Aug 09, 2007 02:58 am
Model Hospital A         Last Edit by: Hardersen,Michael L 08/02/07 1528
 STAR Scheduling            1 Visit Check-In Link
                              Yes
 Physician                  2 2nd Office Address      3 HPP Ord Request Active
                              Yes                       Yes
 Care Manager               4 Live on Care Mgr
                              No
 Discharge Summary          5 # of Appointments       6 Insurance Plans
                              5                         Primary only
 Allergy Tool               7 Severity/Reaction       8 Verify Allergen Types
                              No                        DA
                            9 Allergy Review Reqd
                              Yes/2/ER,ER1,ER2,ER3,ERQ




Enter field number or '/' starting field number--
```

Field Explanations

1. VISIT CHECK-IN LINK
Enter **Y** for Yes if you are using the Visit Check-In link in Clinical Management. Enter **N** for No if you are not using the link.

2. 2ND OFFICE ADDRESS
Enter **Y** for Yes if you want a second office address to display for the physician. Enter **N** for No if you do not want a second office address to display.

3. HPP ORD REQUEST ACTIVE
Enter **Y** for Yes if your facility uses the Order Request module in Horizon*WP*® Physician Portal; enter **N** for No if your facility does not use this module.

4. LIVE ON CARE MGR
Enter **Y** for Yes if your station is Live on Care Manager; enter **N** for No if your station is not Live on Care Manager.

5. # OF APPOINTMENTS
You can make an entry of up to 99 in this field for the number of future appointments to display on the Discharge Summary. If you enter 1, only one appointment prints on the summary.

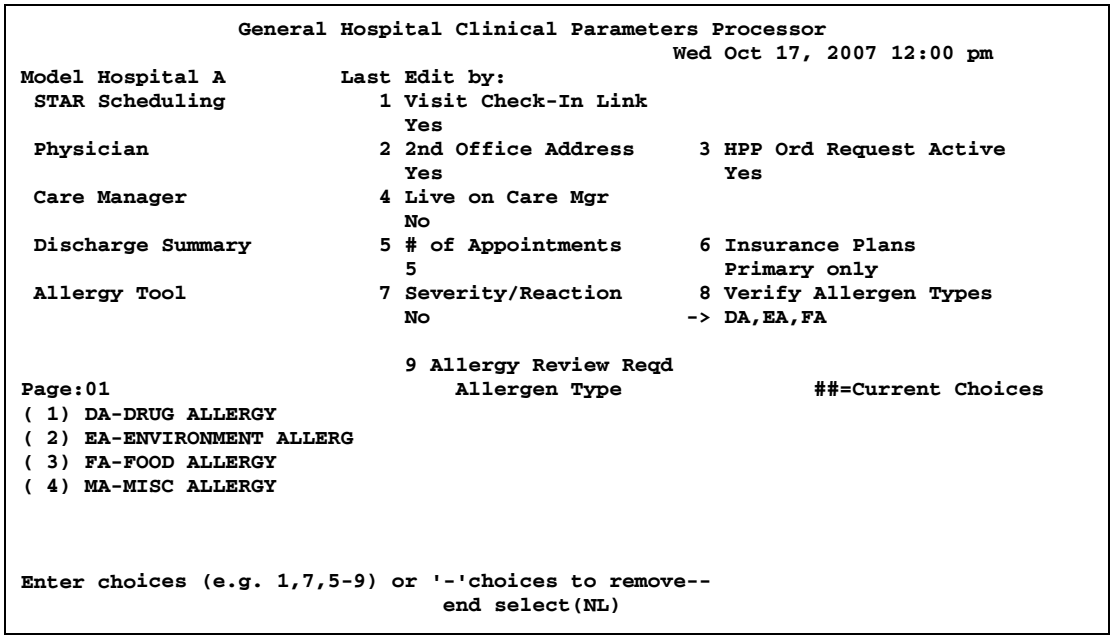
6. INSURANCE PLANS
This field determines if all or only primary insurances print on the summary. If you enter P, only the primary insurance prints. If you enter A for All, then all four insurances print.

7. SEVERITY REACTION (1-A-R)
This field determines if the system requires entry of an allergy reaction and allergy severity when a patient allergy is added or revised. When you access this field, the system displays the following prompt:

Is Allergy Reaction and Severity required? [N] -

The default for the prompt is No. To require entry of a reaction and severity, enter **Y**. If the reaction and severity should be optional, enter **N**. If this field is not defined, the system does not require entry of the reaction and severity.

8. VERIFY ALLERGEN TYPES (Table Lookup-O)
This field determines which allergen types require verification. When an allergy is entered or revised, the system checks the user's allergy privileges setting. If the user does not have verify privileges, the system then checks the Allergen Type of the allergy against this parameter. If they match, the system sets the allergy as needing verification. For example, a facility may choose to require only drug allergens as needing verification, require all allergen types to require verification, or require no entries to be flagged as needing verification. When the field is selected, the following table is displayed:



Allergen types are presented in a table format. Enter choices from the table by selecting the appropriate numbers. The selections are highlighted. To remove a choice, type a hyphen (**-)** and the number. To end selection, press ENTER. If an allergen type is highlighted, it is treated by the system as requiring verification. If no allergen types are highlighted, then no allergies require verification. For highlighted entries, the two-letter code for each selection is displayed in the field.

9. ALLERGY REVIEW REQD (SPECIAL FORMAT-O)
This field defines whether allergy review is required for new admits, a change in patient type, and allergy add/updates. If allergy review is required, the system displays parameters that allow you to define the number of defers allowed for the review process and to exempt up to five patient types from the allergy review functionality.

When you access this field, the following prompt is displayed:

Require Allergy rev for new admits/allergy updates(Y)es/(N)o-- '

Enter **Y** for Yes to make the allergy review check mandatory, or enter **N** for No to prevent allergy review checks.

When you enter Y, the following prompt is displayed:

Enter # of Allergy Review Defers allowed (0-3)--

If a zero (0) is entered, you are not permitted to defer the allergy review during any of the order entry processes.

Enter a number from 1 to 3 to define the number of allergy review defers permitted for each new admit, new or updated allergen, or a change in patient type.

The system displays the following prompt:

Enter patient type code-- |

You can enter a hyphen (-) and select from the table of patient type codes to define the patient types to exempt from the required allergy review check:

```
                  General Hospital Clinical Parameters Processor
                                                    Wed Oct 17, 2007 04:58 am
Patient Type Codes       Last Edit by: Slade,Krista L 09/12/07 1015
 STAR Scheduling            1 Visit Check-In Link
                              Yes
 Physician                  2 2nd Office Address     3 HPP Ord Request Active
                              Yes                      Yes
 Care Manager               4 Live on Care Mgr
                              No
 Discharge Summary          5 # of Appointments      6 Insurance Plans
                              5                        Primary only
 Allergy Tool               7 Severity/Reaction      8 Verify Allergen Types
                                                       DA
Page:01                        Patient Type Codes             ##=Current Choices
( 1) ADV-Advance Admission Inpatient     ( 8) CBP-CONTRACT BILL PATIENT
( 2) ARI-ALICE'S I/P                     ( 9) CE-CONTRACT ENVIRONMENTAL
( 3) BED-BED RESERVATION  w/FOLDER       (10) CP-CONTRACT PROFICIENCY
( 4) CNA-Cancel Admission with Orders-   (11) PS2-CONTRACT PSEUDO UNIT# 2
( 5) PSE-CON - PSEUDO UNIT #             (12) CR-CONTRACT RESEARCH
( 6) CON-Contract Account                (13) CSO-CONTRACT SINGLE OCCURRANCE
( 7) CBC-CONTRACT BILL CLIENT            (14) CV-CONTRACT VETERINARY

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
               end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

The selection of patient types is optional and the number of patient types which can be exempted from allergy review is limited to five. You have the option to either select none, one or multiples of up to a total of five from the table.

After the selection of patient types for exemption, press ENTER to accept the screen and return to the Clinical Parameters screen. The Allergy Review Reqd field displays the selections in the following format: Yes/2/ER,ER1,ER2,ER3,ERQ.

If you select more than five patient types from the list, the following error message is displayed:

Error: Limit is 5!

If you decide not to include any patient types for exemption, press ENTER or (.) period ENTER to return to the Clinical Parameters screen.

NOTE: The Allergy Review Reqd field in the Clinical Parameters Processor controls only the allergy review alert prompts for Patient Care and does not affect either the Radiology or the Pharmacy modules.

PRINTING A DISCHARGE SUMMARY

To print a discharged patient's Discharge Summary, select Patient Print from the Nursing Main Menu, and then select Discharge Summary. The following prompt displays:

Enter acct #, '-' bed code, first chars of name '-' [2N Census]-'C' for Census

If you enter an account number, you can access a specific patient. If you enter a hyphen (-) followed by a bed code, you can access a specific patient. If you enter the beginning letters of the patient's name, the hyphen (-), and press ENTER, the system displays a list of patients with the same beginning characters. The more letters of the patient's last name that you enter, the more specific the patient listing is. If you press ENTER to select the default, the census of the primary station displays for you to select a specific patient. If you enter **C** for Census, the following prompt displays:

Enter station code [1E]--

Enter the station code to display the census of the secondary station. Select a specific patient. After you select the patient, the following prompt displays:

Enter number of copies to print (1/5) [1]-- |

After you enter your choice, the system displays the following prompt:

Print? (Y/N) [Y]--

If you enter **N**, the system does not print the Discharge Summary and returns to the Patient Print menu. If you press ENTER, the message *Printing!* displays and generates the Discharge Summary. The following prompt displays:

Enter Unit Number, name, '=' for current--'-' Social Security No, '#' Corporate No, '%' for soundex, '' Account No*

Upon selecting a patient, the following screen displays:

```
                General Hospital Physician MPI Access Processor
                                  <New Msgs>      Tue Mar 19, 1996 12:36 pm
   No.          Name             Sex    BD 000000153     SMITH,JOANNA      F  01/01/65

No Pt Acct Nmbr   Adm Date Dsch Date Typ Attending Dr.  Service FC Dsch Status
 1 A9607200008    03/12/96 03/13/96  CON
 2 A9503000008    01/30/95 09/20/95  I/P SMITH,TAYLOR    MED    S  HOM
 3 A9424400004    09/01/94 09/02/94  OPO SMITH,JACKSON   MED    S  HME
 4 A9403800001    02/07/94 03/01/94  I/P SMITH,HANNAH    MED    S  5
 5 A9331400007    11/10/93 11/11/93  I/P SMITH,HANNAH    MED    S  5
 6 A9327300001    09/30/93 10/01/93  I/P SMITH,HANNAH    MED    S  5









Select visit--
```

After you select the visit you want to view, the following prompt displays if you are not the patient's physician of record:

You are not a physician of record for this patient! Continue? (Y/N) [N]--

If you enter **N** for No, you return to the Select visit prompt. If you enter **Y** for Yes, the following screen displays:

```
                General Hospital Phys MPI Access Processor
                                                 Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
9607200008    SMITH,JOANNA      F  01/01/65                          10  DIS

             Option No.  Option
             ----------------------------------------
  Orders          1      Selected Departments
                  2      All Active/Pending
                  3      Charge Inquiry
                  4      Pharmacy Profile Inquiry
                  5      Consultation
  Clinical        6      Laboratory Orders
                  7      Radiology Orders
                  8      Last 48 Hour Flowsheet
                  9      Additional Flowsheet Options
                 10      Appointment Processor
  Information    11      Admission Information
                 12      Medical Records Information
                 13      Patient Appointment Inquiry
                 14      Add/Remove Patients From List
  Print          15      Information Cards
                 16      Face Sheets

 Enter option number--
```

If you select Admission Information, then Discharge Summary, the following screen displays:

```
                  General Hospital Discharge Summary Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name             Sex    BD    Room    Physician    SVC ICD Status
9503000008    SMITH,JOANNA      F  01/01/65         SMITH,TAYLOR MED 10 DIS HOM

( 1)Discharge Plan      : No









Enter field number or '/' starting field number--
```

After you make an entry in the Discharge Plan field, the following prompt displays:

Print? (Y/N) [Y]--

If you enter **N**, the system does not print the Discharge Summary and returns to the Patient Print menu. If you press ENTER, the message Printing! displays and generates the Discharge Summary. If you select this option and the patient is not discharged, the following message displays:

Patient not discharged!

Following is a description of a Discharge Summary.

Output

The Discharge Summary contains the following information:

- The Patient Information block prints on the top of the report and includes the following information:
  - Social Security Number
  - Corporate Number
  - Address
  - Date of Birth
  - Age
  - Marital Status
  - Sex
  - Primary Care Physician
- Visit Information

- Diagnosis/Procedure Information
- Attending Physician Information
- Procedures
- Next Scheduled Appointments
- Notes

Your facility can build and format its own patient block and include a wide variety of information, as explained in Chapter 9: Build and Design PCPs and Worksheets.

PCP Nursing Notes

The PCP Nursing Notes provide additional pages of nursing notes to be printed as needed. Patient demographics automatically print on the nursing notes. The nursing notes' pages are numbered in sequence with the current PCP.

To access this function, select PCP Nursing Notes from Patient Print on the Nursing main menu.

The following prompt displays:

Enter acct #, `-` bed code, first chars of name'-' [2N Census]--
'C' for Census

If you enter an account number, you can access a specific patient.

If you enter a hyphen (-) followed by a bed code, you can access a specific patient.

If you enter the beginning letters of the patient's name, the hyphen (-) and press ENTER, the system displays a list of patients with the same beginning characters. The more letters of the patient's last name you enter, the more specific the patient listing is.

If you press ENTER to select the default, the census of the primary station displays for you to select a specific patient.

If you enter **C** for Census, the following prompt displays:

Enter station code [1E]--

Enter the station code to display the census of the secondary station. Select a specific patient.

NOTE: Information Windows displaying Patient Information, Physicians, and Pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a

patient in this function. During the download process, the system displays the following message:

Downloading Information Windows...Please Wait!

After the windows are downloaded, you can view them in any other nonpatient-specific function on STAR Patient Care. When you access a patient-specific function other than Order Management or Nursing functions, the downloaded information is cleared. The information is also cleared when you select a different patient in one of the functions where Information Windows are available.

For specific information regarding Patient, Physician, or Pharmacy Information Windows, refer to "Appendix B - INFORMATION WINDOWS".

After you select the patient, the following prompt displays:

Enter PCP series # to print [Current]--

If you know the series #, enter the number. If you need notes for the current PCP, press ENTER.

The system displays the following prompt:

Enter number of copies to print (1/5) [1]--

Enter the number of copies you want.

The system displays the message:

Printing #!

Following are a description and an example of Nursing Notes.

Output

The PCP Nursing Notes provides an additional page for the nurse to handwrite notes when there is not enough room in the space provided on the PCP. If the hospital is using sequence numbers on the PCPs, the desired sequence number can be entered to print on the page of nursing notes.

The following information prints on this report:

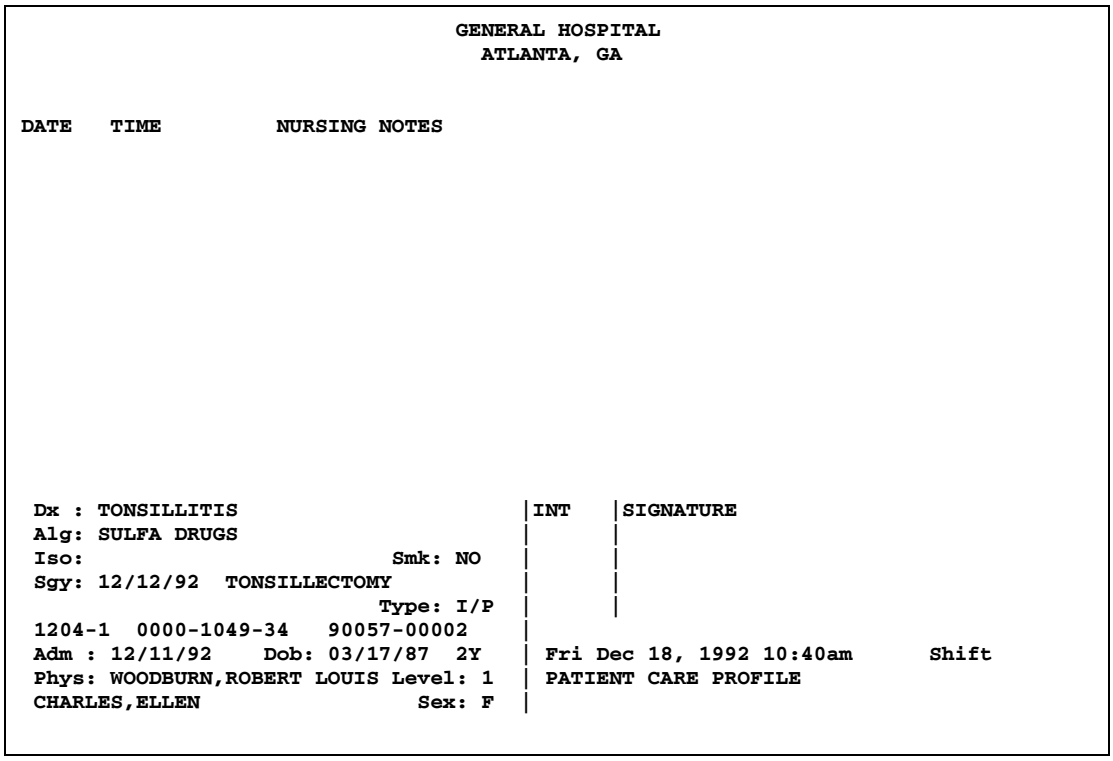
- The headings for date, time, and nursing notes
- The signature block

- The patient block prints on the bottom left corner of the report. The system-generated patient block includes the following information:

  - Diagnosis
  - Allergies
  - Isolation
  - Smoking Status
  - Surgery Date and Procedure
  - Patient Type
  - Room and Bed Number
  - Medical Record Number
  - Account Number
  - Admission Date
  - Date of Birth and Age
  - Attending Physician
  - Patient Name
  - Sex

  Your facility can build and format its own patient block and include a wide variety of information, as explained in "Chapter 9 - BUILD AND FORMAT PCPS AND WORKSHEETS".

Figure 6.7 Nursing Notes



NURSING WORKSHEETS AND REPORTS

ADL Worksheet

The ADL Worksheet provides a list of patients and their ADL orders for a specified nursing station. A station-specific parameter indicates which ADL categories to include on the worksheet. The worksheet can be printed for the entire station, a selected bed group, or one or more patients selected from a list of occupied beds.

The ADL Worksheet function is on the Station Print menu. Select Station Print from the Nursing main menu.

The following prompt displays if theCRT has secondary nursing stations defined in the CRT Names table (Table Maintenance):

Enter station code [2N]--

You can press ENTER to select the primary station, or you can enter a hyphen (-) for a table display of the secondary stations defined for the CRT. If the nursing station code entered is not defined or is not a station that is assigned to this CRT, the system displays this error message:

Error: Not on file!

After the station code has been selected (if necessary), the following prompt displays:

Enter station(S), `-` to list bed groups, or [2N Census]--

If you enter **S** for Station, all beds on the station print on the worksheet.

If you enter hyphen (-), a table of all bed groups defined for the facility displays. If a bed group is selected, then only those beds in the bed group print on the worksheet.

If you press ENTER, the census for the station displays. You can select one or more patients.

The next prompt that displays is:

Enter shift # to print or all(A)--

After you enter a shift **#** or enter **A** for all, the system displays the following prompt:

Enter number of copies to print (1/5) [1]--

Enter the number of copies you want. The system displays the following prompt:

Printing Worksheet!

The ADL Worksheet prints on the default printer assigned to the CRT in the CRT Names table (Table Maintenance.)

When generating the Patient Care Profile, you can choose to *not* print all occurrences of an order, which eliminates lengthy and less useful reports. To choose to not print all occurrences of an order, set the Collapse Occurrences field that displays on the SIM Departments screen to Yes. If you select Yes, then the PCP and worksheets print only one occurrence from a parent order. For example, if Vital Signs are ordered Q2H, only one occurrence prints on the PCP even though four were generated for that shift. The default for this field is No.

Output

Upon completion, the ADL Worksheet prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance in Data Processing.

The ADL Worksheet provides a list of patients and their ADL orders for a specified nursing station. A station-specific parameter indicates which ADL categories to include on the worksheet.

The worksheet may be printed for one or more patients. The sort is by walk-order if printing for the entire station, by bed group order if printing for a selected bed group, or by room and bed order if multiple patients are selected from the list of occupied beds.

Unoccupied beds print on the worksheet if printing by station or bed group.

The following information prints on this report:

- Station, Room and Bed
- Patient Name
- Unit Number (MPI)
- Account Number
- Patient Date of Birth / Age
- Diagnosis
- Attending Physician
- All active ADLs ordered for the patient
- Shift to print
- The total number of patients on the report

Figure 6.8 ADL Worksheet

```
Tue Feb 19, 2008 11:17 am                              ADL'S / MISC. WORKSHEET
                         WINDWARD MEDICAL UNIVERSITY                    Shift A
Station 1 EAST                 ALPHARETTA, NY                           Page 1
-------------------------------------------------------------------------------
RM-BD    PATIENT                           ADL'S / MISC.
UNIT NUMBER (MPI)    ACCOUNT NUMBER
BD/AGE
DIAGNOSIS
PHYSICIAN
-------------------------------------------------------------------------------
2101-01 HENDERSEN,JESS
A100008276           00005-00754
02/03/04  104Y

RADIOLOGY,FAX TEST
-------------------------------------------------------------------------------
2101-02 BEST,JOHN
A100007435           06212-00012
07/31/06  18M
NEWBORN
RADIOLOGY,FAX TEST
-------------------------------------------------------------------------------
2102-01

-------------------------------------------------------------------------------
2102-02 RAFFERTY,JAMES
A100008175           00005-00495
09/02/07  5M
001.0-CHOLERA D/T VIB CHOLERAE
COLEMAN,MICHAEL J
-------------------------------------------------------------------------------
2103-01

-------------------------------------------------------------------------------
2103-02 RICHARDSON,JENNIFER
A100007572           07033-00003
02/03/04  104Y
001.1-CHOLERA D/T VIB EL TOR
RADIOLOGY,FAX TEST
-------------------------------------------------------------------------------
2104-01 RUSHTON,SANFORD R
A100007726           07143-00001
02/02/32  76Y
001.0-CHOLERA D/T VIB CHOLERAE
JEKYL SECOND,JONAS
-------------------------------------------------------------------------------
2104-02 BUSH,TIMOTHY
A100007707           07137-00001
06/03/24  83Y
001.0-CHOLERA D/T VIB CHOLERAE
ADAIR,FRANK
```

Incomplete Items

The Incomplete Items report provides a list of patients and their incomplete orders for a specified nursing station. An incomplete order is any order that is active up to the current date and shift the report is run. The report can be printed for the entire station, a selected bed group, or one or more patients selected from a list of occupied beds.

The Incomplete Items Report function is on the Station Print menu. Select Station Print from the Nursing main menu.

The following prompt displays if theCRT has secondary nursing stations defined in the CRT Names table (Table Maintenance):

Enter station code [2N]--

You can press ENTER to select the primary station, or you can enter a hyphen (-) for a table display of the secondary stations defined for the CRT. If the nursing station code entered is not defined or is not a station that is assigned to this CRT, the system displays this error message:

Error: Not on file!

After the station code has been selected (if necessary), the following prompt displays:

Enter station(S), `-` to list bed groups, or [2N Census]--

If you enter **S**, all beds on the station print on the worksheet.

If you enter hyphen (-), a table of all bed groups defined for the facility displays. If a bed group is selected, then only those beds in the bed group print on the worksheet.

If you press ENTER, the census for the station displays. You may select one or more patients.

The system displays the message:

Printing!

The Incomplete Items report prints on the default printer assigned to the CRT in the CRT Names table (Table Maintenance.)

Output

Upon completion, the Incomplete Items report prints on the default printer associated with the requesting terminal identified in the CRT Names table under Table Maintenance in Data Processing. Below is an example of the report.

Figure 6.9 Incomplete Items Report

```
Fri Dec 18, 1992 03:09 pm                                          INCOMPLETE ITEMS
                              GENERAL HOSPITAL                          Page 1
Station 2 NORTH                 ATLANTA, GA
--------------------------------------------------------------------------------
RM-BD    PATIENT
           DATE/TIME TO DO            TEST CODE/DESCRIPTION                  PCR
CODE/DESCRIPTION
             PREPS AND SPECIAL INSTRUCTIONS
--------------------------------------------------------------------------------
1204-1  CHARLES,ELLEN
           12/12/92   11:48am
           590101 ACTIVITY AMBULATE                7003  CALL LIGHT WITHIN REACH
           12/12/92   11:48am
           700001 VITAL SIGNS V/S Q 4 HR           7772  V/S Q4H
           12/12/92   11:48am
           010002 BATH SELF TUB                    7012  BATH GEN- SELF TUB
           12/12/92   11:48am
           310006 FEEDING FORCE FLUIDS             0038  FORCE FLUIDS
           12/13/92   07:00am
           5727 CBC W DIFF
           12/13/92   07:00am
           2001 CHEST PA & LAT
           12/12/92   11:58am
           9211 NO ASA PRODUCTS
           12/12/92   11:55am
           9192 IV @ TKO, D/C AFTER TAKING FLUIDS
           12/12/92   11:54am
           9088 FORCE FLUIDS
           12/12/92   11:53am
           9096 SIGN PERMIT
           12/12/92   11:51am
           9157 RECREATIONAL THERAPY

--------------------------------------------------------------------------------

                            End of Report
```

Custom Worksheet

The Custom Worksheet provides the capability to create numerous worksheets to meet your facility's individual needs. Your hospital selects parameters that determine the types of patient data that prints on the worksheet. The selections can be stored in the system and recalled for subsequent worksheet printings; therefore the Custom Worksheet has endless possibilities and could ultimately replace the existing nursing worksheets (ADL, Active Order, and General).

Two menus contain the Custom Worksheet function: Standard File Maintenance and Station Print. The worksheets are created from the Standard File Maintenance menu and print from the Station Print menu.

To print the Custom Worksheet function, select Station Print and then Custom Worksheet. The system displays the following prompt if the terminal has secondary nursing stations defined:

Enter station code [2N]--

You can press ENTER to select the primary station, or you can enter a hyphen (-) for a table display of the secondary stations defined for the terminal. If the nursing station code entered is not defined or is not a station assigned to this terminal, the system displays the error message:

Error: Not on file!

After you select the station code, the system displays the following prompt:

Enter station(S), `-` to list bed groups, or [2N Census]--

Enter **S** and all beds on the station print on the worksheet. Enter a hyphen (-) and the system displays a table of the bed groups defined for the facility. Select a bed group and those beds in the bed group print on the worksheet. Press ENTER and the system displays the census for the primary station. You can select one or more patients from this display.

The following prompt displays for you to enter the custom worksheet to print:

Enter worksheet code or `-` to list--

You can enter a code or select a worksheet from the table. The system displays the display only information with the following prompt:

Print Worksheet? (Y/N) [Y]--

If you press ENTER for the default of Yes, the system displays:

Compiling and Printing!

and returns to the menu. If you enter **N**, the system returns to the menu.

After you complete this function, the Custom Worksheet prints on the default printer associated with the CRT. The following pages contain a description and an example of the Custom Worksheet.

You can choose to not print all occurrences of an order, which eliminates lengthy and less useful reports. To choose to not print all occurrences of an order, set the Collapse Occurrences field that displays on the SIM Departments screen to Yes. If you select Yes, then the PCP and worksheets print only one occurrence from a parent order. For example, if Vital Signs are ordered Q2H, only one occurrence prints on the PCP even though four were generated for that shift. The default for this field is No.

Output

The purpose of the Custom Worksheet is to provide the nurse with his/her own customized patient worksheets. The name of the menu option is Custom Worksheet, but the title which prints on the report is determined by the parameters set under Standard File Maintenance.

This worksheet is printed on demand and is printed in walk order if you select the station to print, bed group order if you select a bed group to print, and room-bed order if you select individual patients to print.

The worksheet contains the following information regardless of the parameters set:

- Station, Room, and Bed
- Patient Name
- Age
- Sex
- Diagnosis
- Attending Physician

The worksheet may contain any combination of the following types of patient data:

- ADLs (for all or selected categories)
- Diet (including nourishments and modifiers)
- Orders (for all or selected departments)
- Preps & Special Instructions
- Treatments
- Treatment Date
- IV Therapy
- Oxygen Therapy
- Patient History
- Physician Consults
- Medical Page Information (including Admission Date, LOS, Isolation, Allergies, Smoker, Precautions, Level of Care, Condition, Height, Weight, Surgery Date and Surgical Procedure).

NOTE: If you want orders with a frequency of PRN (as needed) to print on a Custom Worksheet, you must set the PRNs field in the Custom Worksheet Processor to Yes. PRN orders automatically go to a Complete status and never generate an active occurrence, so normally they would not appear on the worksheet. For more information, see "Chapter 7 - STANDARD FILE MAINTENANCE".

You can also determine the shifts to print and the number of blank lines between patients and the number of lines per unoccupied bed under Standard File Maintenance.

Figure 6.10 Custom Worksheet

```
Fri Dec 18, 1992  02:25 pm                              SHIFT SUMMARY WORKSHEET
                              General Hospital A
Station 2N  2 North               Atlanta,GA                              Page 1
 RM-BD     PATIENT NAME    SEX  AGE   DIAGNOSIS                  PHYSICIAN
 1205-1    LANE,EMILY       F   10Y   540.0-*AC APPEND W PERI    ADAIR,FRANK C

              Adm Date: 12/11/92  02:50pm    Pt. Type: I/P         LOS: 5
          Isolation:                    Condition:
              Smoker:  NO                   Level of Care:
              Ht:                           Wt:
              Surgery Date:  12/12/92       Surg: APPENDECTOMY
              Allergies:  DAIRY PRODUCTS, SULFA DRUGS
              Precautions:

                      Diet:  DIET AS TOLERATED

                             SERVE LARGE PORTION.  FOOD WELL DONE IF POSSIBLE.
                             09/30 D DIET AS TOLERATED

                             Morning Nourishment:  APPLE, P-NUT BUTTER, MILK

                      ADLs:  HYGIENE      BEDSIDE W/ ASSISTANCE
                             INTAKE/OUT   RECORD Q SHIFT
                             VITAL SIGNS  V/S Q 2 HR
                             VITAL SIGNS  B/P Q SHIFT WHILE AWAKE

           Active Orders: CBC W DIFF                    12/12/92   05:03pm  #4
                          ELECTROLYTES                  12/12/92   05:03pm  #4
                          BILIRUBIN TOTAL               12/12/92   05:03pm  #4
                          BUN AND CREATININE            12/12/92   05:03pm  #4
                          ABDOMEN FLAT&UPRIGHT          12/13/92   07:00am  #6
                            1:Clear liquid supper.
                            2:May substitute 2 oz. castor oil
                            3:Patient should void prior to exam.
                            4:Administer Citrate of Magnesia, 10 oz.,
                              at 1100
                            5:Regular evening meal.
                            6:Patient should remove all
                              antiperspirants, body powder, or
                              perfume prior to exam.
                            7:Administer tap water enema (200 cc min) at 0600.
                           CHEST PA & LAT           12/13/92   07:00am  #5
                Treatments:    1:Sheepskin while on bedrest.     12/13  02:21pm

Total Patients:  1

End of Report
```

NOTE: If you placed a nourishment on hold, it prints in the active orders section of the Patient Care Profile with *Hold* in the Time field. For example:

*ENSURE 10 - CHOCOLATE 10.9 *Hold**

PRINT VITAL SIGNS AND FLUID BALANCES

There are numerous Vital Signs and Fluid Balances reports available that provide a chart document for the collected and recorded patient data. The reports include charted elements that can be selected by shift, date, and time. You can either display or print the reports. You can also print from the screen display of the report.

When you select the Vital Signs & Fluid Balances option from the main menu, the following screen displays:

```
                  General Hospital Vitals & Fluids Processor
                                                  Fri Dec 18, 1992 05:31 pm
Vitals & Fluids Input Options

             Option No.  Option
             ---------------------------------------
                 1       Chart Vital Signs
                 2       Revise Vital Signs

                 3       Last 48 Hour Vital Signs
                 4       Today's Vital Signs
                 5       Current Shift Vital Signs
                 6       Vital Signs by Date & Shift

                 7       Chart Fluid Balances
                 8       Revise Fluid Balances

                 9       Last 48 Hour Fluid Balances
                10       Today's Fluid Balances
                11       Current Shift Fluid Balances
                12       Fluid Balances by Date & Shift

Enter option number--
```

The functions enable you to chart or revise vitals signs and fluid balances, as well as quickly view or print the data. You can print the following reports for Vital Signs:

- Last 48 Hour Vital Signs
- Today's Vital Signs
- Current Shift Vital Signs
- Vital Signs by Date & Shift

You can print the following reports for Fluid Balances:

- Last 48 Hour Fluid Balances
- Today's Fluid Balances
- Current Shift Fluid Balances
- Fluid Balances by Date & Shift

For complete information on how to print each of these reports and for examples of each of the reports, refer to “Chapter 4 - VITAL SIGNS AND FLUID BALANCES”.

Chapter 7 - STANDARD FILE MAINTENANCE

This chapter provides information about the standard files that must be built for the Care Planning and Documentation Module.

NURSING FILES

For Nursing files that print the component text, please note that the format may differ from the examples in this section:

- If your facility has run the conversion associated with user-formatted PCPs and Worksheets, the text displays/prints on three lines of 75 characters each.
- If your facility has not run the conversion, the text displays/prints on five lines of 36 characters each.

Standard Plan of Care

To begin building the Plan of Care files, select File Maintenance from the Nursing Main Menu, then Standard File Maintenance. The menu shown below displays.

```
             General Hospital Standard File Maintenance Processor
                                                  Fri Dec 18, 1992 12:52 pm
Standard File Maintenance Input Options

            Option No.  Option
            ----------------------------------------
                1       Standard Plan of Care
                2       Critical Pathways
                3       Standard Assessments
                4       ADL's/Misc.
                5       Treatment Orders
                6       Vital Signs & Fluid Balances
                7       Defining Characteristics
                8       Routine Orders
                9       Preps and Special Instructions
               10       Custom Documents
               11       Standard Text - Patient History
               12       Station Parameters
               13       Report Build Options
               14       Print Standard Files
               15       Custom Worksheet


Enter option number--
```

Select Standard Plan of Care. The standard Plan of Care files you must build are shown following. The Plan of Care components are built in the opposite order from the way they display on the screen. Build the Plan of Care files in the following order:

1. Intervention/Treatment
2. Discharge/Expected Outcome
3. Discharge Plan
4. Problem/Expected Outcome
5. Plan of Care

It is important to follow this order, as Intervention/Treatments must exist before you can add them to Problem/Expected Outcomes, Discharge Plans and Discharge/ Expected Outcomes. And Problem/Expected Outcomes, Discharge Plans and Discharge/ Expected Outcomes must exist before you can add them to a Plan of Care.

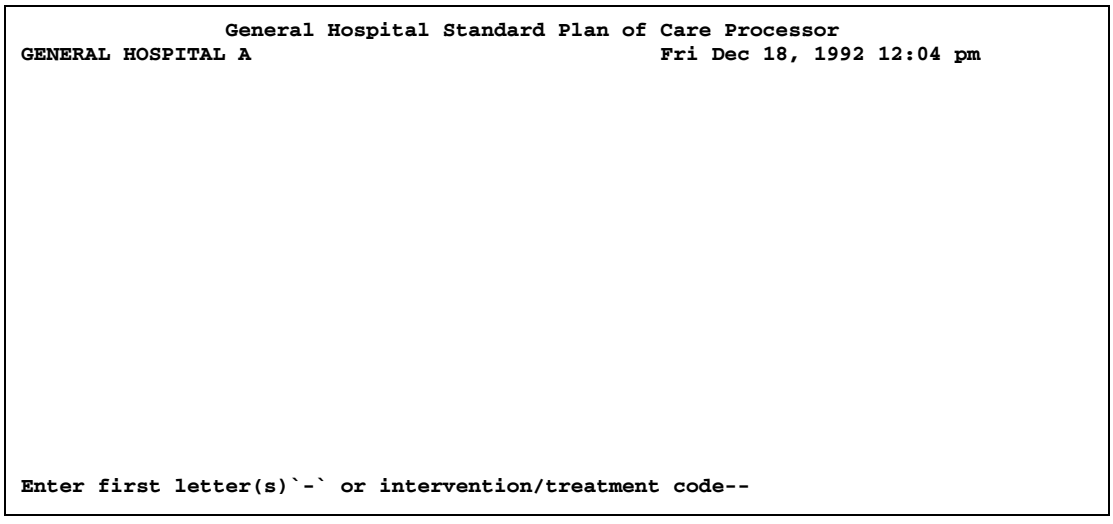
NOTE: When you build the interventions using the Interventions/Treatments option from the Standard Plan of Care menu, the interventions display in the order you link them to an expected outcome. When you build the expected outcomes and discharge plans using the options from the Standard Plan of Care menu, the expected outcomes and discharge plans display in the order they are linked to a Plan of Care. When the interventions and outcomes are active, they display in numerical order.

```
               General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                 Fri Dec 18, 1992 12:04 pm

Page:01                           File Types
( 1) Plan of Care
( 2) Discharge/Expected Outcome
( 3) Discharge Plan
( 4) Problem/Expected Outcome
( 5) Intervention/Treatment









Enter choice--
```

INTERVENTION/TREATMENT

After you select Intervention/Treatment from the Standard Plan of Care menu, the following screen displays:

```
               General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                 Fri Dec 18, 1992 12:04 pm
```



From this prompt you have the following options:

- Enter the beginning letters of the intervention/treatment, followed by a hyphen (-), to access any existing intervention/treatments with the same first letters.
- Enter a hyphen (-) to access the list of all intervention/treatments currently added to the system.
- Enter the code of the intervention/treatment, up to four digits. (You should have a list of the codes and intervention/treatment text to add to the system from your installation workshops.)

```
               General Hospital Standard Plan of Care Processor
Model Hospital A                                    Tue Apr 08, 1997 12:44 pm

 1 File Type    2 Code      3 Print      4 Description
   T             4341        Yes          URINE SPECIMEN, 24 HOUR
 5 Alias Description #1                  6 Alias Description #2
   24 HOUR URINE SPECIMEN                ->
 7 Alias Description #3                  8 Alias Description #4

 9 Alias Description #5                 10 Alias Description #6


11 PCR                                  12 Default Category

13 Text          14 Custom Document

                 |24 hour urine specimen for:_________|
                 |Start date:________ Time:_____am/pm |
                 |Stop date: ________ Time:_____am/pm |
                 |                                    |
                 |                                    |


Enter alias description #2--
```

Field Explanations

1. FILE TYPE (DISPLAY ONLY)
This field displays the file type you are adding or updating. The system automatically enters **T** for Intervention/Treatment.

2. CODE (DISPLAY ONLY)
This field displays the numerical code you entered on the prompt leading to this screen.

3. PRINT (1-A-R)
This field specifies whether or not this intervention should print on the Patient Care Profile (PCP). Valid responses are **Y** for Yes and **N** for No. The system defaults to Yes.

4. DESCRIPTION (33-C-R)
This field contains the description, or most commonly used name for this component. You can enter up to 33 characters.

ALIAS DESCRIPTIONS #1 - #6 (33-C-O)
The nurse can look up Plan of Care components by entering the beginning characters of the description. This field contains another name, in addition to the one in the Description field, by which you can access this component on the system. The system prompts you to enter another description, or you can press ENTER to bypass this field.

11. PCR (4-N-O)
This field defines a PCR (Patient Care Requirement) code for this component. The PCR code is used by the Acuity and Staffing module. You can enter a hyphen (-) to display a table look up of valid PCR codes.

12. DEFAULT CATEGORY (TABLE LOOKUP)
This field is used by Critical Pathways to group the intervention on the pathway. For more information on categories, refer to Chapter 1: Critical Pathways.

13. TEXT (180-C-R or 225-C-R)
This field provides freeform lines for you to enter the purpose or instructions for this component. This text prints on the PCP if you responded Yes to the Print field on this screen. When the cursor moves to the text field, the following prompt displays:

Edit text? (Y/N) [Y]--

To enter text, enter **Y** for Yes. When you do not want to enter text, enter **N** for No. The system default is Yes. If you are adding the component for the first time, the system does not accept a response of No - the system beeps and displays the message:

Error: Text required!

If you enter **Y** for Yes or press ENTER, the cursor displays at the beginning of the box containing the freeform lines. The following function keys display across the bottom of the screen:

F1	F2	F3	F4	F5
Del Line	Ins Line	Done	Del Char	Ins Char

Enter the text for this component, using the function keys F1-F5, explained below:

Function Key	Function
Fl	Deletes the line containing the cursor
F2	Inserts a blank line on the line containing the cursor, moving the present line down one line
F3	Indicates you have completed entering the text
F4	Deletes the character beneath the cursor
F5	Inserts a blank space beneath the cursor for entry of a missing character. (For example, enter the word montor. Place the cursor on t. Press F5. Enter i in the blank space displaying to the left of t.)

After entering the text, press the F3 function key.

14. CUSTOM DOCUMENT (33-AN-O or TABLE LOOKUP)
This field links a Custom Document to a treatment. You can select more than one document. For information on Custom Documents, refer to the *Order Management/ Charge Processing Volume* of the *STAR Patient Care Reference Guide*.

When the treatment item is ordered, the Custom Document(s) selected in this field automatically print. The prompt for this field is:

Enter first letters`-` or document code--

- Enter the first letters of a document description, followed by a hyphen, to select from an alpha listing of documents with the same first letters. Enter the numbers of the document descriptions you want, separated by commas, and press ENTER. Each document you select is displayed in the field.

- If you know the codes for the documents you want, enter each one, separated by a comma, and press ENTER. Each document you select is displayed in the field.

The code for each document is displayed in this field. When you have completed each field on the screen, the following prompt displays:

Accept this screen? (Y/N) [Y] --

Press ENTER to accept the screen. If you enter **N** for No, you can make changes to the screen. You can update every field, except File Type.

The following screen is an example of a table lookup of intervention/treatments that have been added to the system. The components list in alphabetical order. You can view each page by entering a slash (/) to scroll to the next page or entering a slash followed by a P (/P) to see the previous page. You can select an intervention/treatment to update from this screen.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm









Page:62                        Intervention/Treatment
( 1) VITAL SIGNS, POST-OP ROUTINE        (11) WATER GLASS, REMOVE FROM BEDSIDE
( 2) VITAL SIGNS,CHECK SITE,POST-ANGIO   (12) WBC, MONITOR
( 3) VOID IN TUB/SHOWER                  (13) WEAR EYE SHIELD AT HS
( 4) VOIDING PATTERN, ESTABLISH          (14) WEEKEND PASS
( 5) VS CHANGES, NOTIFY MD               (15) WEIGH
( 6) VULNERABLE ADULT EVALUATION         (16) WEIGH FOR DIALYSIS
( 7) WALKER, ASSIST                      (17) WEIGHT LOSS MOTIVATION
( 8) WALKER, INSTRUCT                    (18) WEIGHT LOSS, MOTIVATION
( 9) WALKWAY UNOBSTRUCTED                (19) WEIGHT LOSS, POSITIVE REINFORCE
(10) WATER PITCHER, REMOVE FROM BEDSIDE

Enter choice--
                           next page(/)  previous page(/P)
```

Impact

This function creates a new intervention/treatment that is stored in the Intervention/ Treatment Standard File and displays on table lookups of intervention/treatments when linking an intervention/treatment to other components through Standard File Maintenance. It also displays with the list of linked intervention/treatments when the nurse is selecting Plan of Care components for the patient.

Output

- The text for this component prints on the PCP.
- If you have linked Custom Documents to the treatment, when the treatment is ordered, the designated documents automatically print to the default printer for the CRT.

PROBLEM/EXPECTED OUTCOME

After you select Problem/Expected Outcome from the Standard Plan of Care menu, the following screen displays:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                Fri Dec 18, 1992 12:04 pm









Enter first letter(s)`-` or problem/expected outcome--
```

From this prompt, you can either:

- Enter the beginning letters of the Problem/Expected Outcome, followed by a hyphen (-), to access any existing Problem/Expected Outcomes with the same first letters.
- Enter a hyphen (-) to access the list of all Problem/Expected Outcomes currently added to the system.
- Enter the code of the Problem/Expected Outcome, up to four digits. (You should have a list of the codes and Problem/Expected Outcome data to add to the system from your installation workshops.)

When you enter the new code, the following screen displays for data entry:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   PO             6463     ->
 5 Alias Description #1                   6 Alias Description #2

 7 Alias Description #3                   8 Alias Description #4

 9 Alias Description #5                  10 Alias Description #6

11 PCR                                   12 Text Type

13 Text

                 |                                    |
                 |                                    |
                 |                                    |
                 |                                    |
                 |                                    |

Print on PCP (Y/N) [Y]--
```

Field Explanations

1. FILE TYPE (DISPLAY ONLY)
This field displays the file type you are adding or updating. The system automatically enters PO for Problem/Expected Outcome.

2. CODE (DISPLAY ONLY)
This field displays the numerical code you entered on the prompt leading to this screen.

3. PRINT (1-A-R)
This field specifies whether or not the Problem/Expected Outcome text should print on the Patient Care Profile (PCP). Valid responses are **Y** for Yes and **N** for No. The system defaults to Yes.

4. DESCRIPTION (33-C-R)
This field contains the description, or most commonly used name for this component. You can enter up to 33 characters.

ALIAS DESCRIPTIONS #1 - #6 (33-C-O)
The nurse can look up Plan of Care components by entering the beginning characters of the description. This field contains another name, in addition to the one in the Description field, by which you may access this component on the system. The system prompts you to enter another description, or you can press ENTER to bypass this field.

11. PCR (4-N-O)
This field defines a PCR (Patient Care Requirement) code for this component. The PCR code is used by the Acuity and Staffing system. You can enter a hyphen (-) to display a table lookup of valid PCR codes.

12. TEXT TYPE (TABLE LOOKUP)
This required field specifies the text format for this component. The following table displays at the bottom of the screen:

(1) Problem (2) Exp Outcome (3) Plan (4) Prob/Exp Outcome

followed by the prompt:

Enter text type-- |

The text type for the Problem/Expected Outcome is number 4, Problem/Expected Outcome. When you select the text type, the system updates the text freeform box with headers to the left:

```
Problem:          |     You have two lines, 36 characters|
                  |     each, to enter the Problem text.|
Expected Outcome: |     You have three lines, 36|
                  |     characters each, to enter the |
                  |     Expected Outcome text.|
```

13. TEXT (180-C-R or 225-C-R)
This field provides freeform lines for you to enter the purpose or instructions for this component. This text prints on the PCP if you responded Yes to the Print field on this screen. When the cursor moves to the text field, the following prompt displays:

Edit text? (Y/N) [Y]--

To enter text, enter **Y** for Yes. When you do not want to enter text, enter **N** for No. The system default is Yes. If you are adding the component for the first time, the system does not accept a response of No - the system beeps and displays the message:

Error: Text required!

If you enter **Y** for Yes or press ENTER, the cursor displays at the beginning of the box containing the freeform lines. The following function keys display:

F1	F2	F3	F4	F5
Del Line	Ins Line	Done	Del Char	Ins Char

Enter the text for this component, using the function keys F1-F5, explained below:

Function Key	Function
Fl	Deletes the line containing the cursor
F2	Inserts a blank line on the line containing the cursor, moving the present line down one line
F3	Indicates you have completed entering the text
F4	Deletes the character beneath the cursor
F5	Inserts a blank space beneath the cursor for entry of a missing character. (For example, enter the word montor. Place the cursor on t. Press F5. Enter i in the blank space displaying to the left of t.)

After entering the text, press the F3 function key. The following prompt displays:

Accept this screen? (Y/N) [Y] --

Press ENTER to accept the screen. If you enter **N** for No, you can make changes to the screen. You can update every field, except File Type.

After you accept the screen, the system provides screens and prompts to link intervention/treatments to the Problem/Expected Outcome, to specify whether the intervention/treatment is a treatment or an intervention, to edit the existing text of the intervention/treatment, or to delete an intervention/treatment currently linked to the Problem/Expected Outcome.

The following screen displays after you accept the previous screen used to add or update the Problem/Expected Outcome. From this screen, you can add an intervention/treatment to the Problem/Expected Outcome. You can add, or link, up to 42 intervention/treatments to a Problem/Expected Outcome. You also can delete an intervention/treatment currently linked to the Problem/Expected Outcome or edit the text of an intervention/treatment currently linked to the Problem/Expected Outcome.

The following example does not display any intervention/treatments at this point. After you add an intervention/treatment, the example displays the addition.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   PO             6463        Yes          PROBLEM/EXPECTED OUTCOME


          No.       Type   Code    Element Description









Enter add(A), delete(D), or edit text(E) [A]--  |
```

Add an Intervention/Treatment

Enter **A** to begin the process of adding the first intervention/treatment to the Problem/ Expected Outcome. The following prompt displays:

Enter # to insert before [End]--

This line enables you to add the intervention/treatment at the end of the list of intervention/treatments already added, or to insert it before another intervention/ treatment on the list. At this time you press ENTER to add the component at the end, since there is not a list created yet.

The next prompt asks you to select the intervention/treatment:

Enter first letter(s)'-' or code--

You can enter beginning letters followed by ahyphen (-), and the system displays a list of the intervention/treatments which begin with those letters. You can enter the code, up to four digits. If you do not know the code, or the description of the intervention/ treatment on the system, enter a hyphen (-) to display an alphabetical list of all the intervention/treatments.

After you select the intervention/treatment, the system displays the element you have specified:

Add: 6015 ALERTNESS, SKIN COLOR AND TEMP

The following prompt then displays:

Define as treatment(T) or intervention(I) [I]--

Enter **T** for Treatment or **I** for Intervention. The system default is I.

The system returns to the screen below:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   PO             6463        Yes          PROBLEM/EXPECTED OUTCOME


          No.       Type   Code    Element Description

            1       I      6015    ALERTNESS, SKIN COLOR AND TEMP









Enter add(A), delete(D), or edit text(E) [A]--  |
```

The intervention/treatment displays on this screen, and you can proceed as described above to add another one.

Delete an Intervention/Treatment

Enter **D** to delete an intervention/treatment from the Problem/Expected Outcome. The following prompt displays:

Enter # to delete--

Enter the number displaying under the No. column—this is the number of the intervention/treatment on the list of linked components—and press ENTER. The system displays the list and renumbers any components remaining below the deleted component.

Edit an Intervention/Treatment

Enter **E** to edit an intervention/treatment already added to the Problem/Expected Outcome. The following prompt displays:

Enter # to edit--

Enter the number displaying under the No. column (this is the number of the intervention/treatment on the list of linked components) and press ENTER. The

system displays the description and text of the selected intervention/ treatment, along with the editor function keys (F1-F5), as shown in example on the following screen.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   PO             6015        Yes          PROBLEM/EXPECTED OUTCOME

 Element Description
   ALERTNESS, SKIN COLOR AND TEMP
                               Text

                  |OBSERVE FOR ALERTNESS, SKIN COLOR   |
                  |AND TEMPERATURE                     |
                  |                                    |
                  |                                    |
                  |                                    |




F1        F2        F3        F4        F5
Del Line  Ins Line  Done      Del Char  Ins Char
```

You can use this screen to edit the text of an intervention/treatment. Changing the intervention/treatment on this screen updates it in the Standard File. It is not updated just for this specific Problem/Expected Outcome.

The following screen is an example of a table lookup of Problem/Expected Outcomes which have been added to the system.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm


Page:01                            Problem/Expected Outcome
( 1) ABG LEVEL                            (11)
( 2) ABLE TO MAKE CHOICES                 (12) ADOL PSYCH UNIT ORIENT
( 3) ACTIVITIES OF DAILY LIVING           (13) AIRWAY PATENT
( 4) ACTIVITY INTOLERANCE INTS            (14) ALIGNMENT, BODY
( 5) ACTIVITY RESTRIC, KNOWLEDGE OF       (15) ALTERED THOUGHT PROCESSES
( 6) ACTIVITY INCREASE                    (16) AMBULATION, MOBILITY REGIME
( 7) ACTIVITY TOLERANCE                   (17) ANXIETY CAUSING STIMULI, REDUCE
( 8) ACTIVITY, REWARD IN                  (18) ANXIETY REL TO HOSPITAL, REDUCE
( 9) ADEQUATE VENTILATION                 (19) ANXIETY, METHODS TO CONTROL
(10) ADJUST TO SELF IMAGE CHANGES         (20) ARTERIAL BLOOD GAS LEVELS







Enter choice--
                                   next page(/)
```

The components list in alphabetical order. You can view each page by entering a slash (/) to scroll to the next page or entering a slash followed by a P (/P) to see the

previous page. You can select a Problem/Expected Outcome to update from this screen.

Impact

This function creates a new Problem/Expected Outcome which is stored in the Problem/Expected Outcome Standard File and displays on table lookups of Problem/Expected Outcomes when linking the Problem/Expected Outcome to a Plan of Care through Standard File Maintenance. It also displays with the list of linked Problem/Expected Outcomes when the nurse is selecting Plan of Care components for the patient.

Output

The text for this component prints on the PCP.

DISCHARGE PLAN

After you select Discharge Plan from the Standard Plan of Care menu, the following screen displays:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm









Enter first letter(s)`-` or discharge plan code--
```

From this prompt you have the following options:

- Enter the beginning letters of the Discharge Plan followed by a hyphen (-) to access any existing Discharge Plans with the same first letters.
- Enter a hyphen (-) to access the list of all Discharge Plans currently added to the system.

- Enter the code of the Discharge Plan up to four digits. (You should have a list of the codes and Discharge Plan data to add to the system from your installation workshops.)

When you enter the new code, the following screen displays for data entry:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   DP             6463     ->
 5 Alias Description #1                   6 Alias Description #2

 7 Alias Description #3                   8 Alias Description #4

 9 Alias Description #5                  10 Alias Description #6

11 PCR                                   12 Text Type

13 Text

                 |                                    |
                 |                                    |
                 |                                    |
                 |                                    |
                 |                                    |

Print on PCP (Y/N) [Y]--
```

Field Explanations

1. FILE TYPE (DISPLAY ONLY)
This field displays the file type you are adding or updating. The system automatically enters DP for Discharge Plan.

2. CODE (DISPLAY ONLY)
This field displays the numerical code you entered on the prompt leading to this screen.

3. PRINT (1-A-R)
This field specifies whether or not the Discharge Plan text should print on the Patient Care Profile (PCP). Valid responses are **Y** for Yes and **N** for No. The system defaults to Yes.

4. DESCRIPTION (33-C-R)
This field contains the description, or most commonly used name for this component. You may enter up to 33 characters.

5-10. ALIAS DESCRIPTIONS #1 - #6 (33-C-O)
The nurse can look up Plan of Care components by entering the beginning characters of the description. This field contains another name, in addition to the description in the Description field, by which you may access this component on the system.

The system prompts you to enter another description, or you can press ENTER to bypass this field.

11. PCR (4-N-O)
This field defines a PCR (Patient Care Requirement) code for this component. The PCR code is used by the Acuity and Staffing system. You can enter a hyphen (-) to display a table lookup of valid PCR codes.

12. TEXT TYPE (TABLE LOOKUP)
This required field specifies the text format for this component. The following table displays at the bottom of the screen:

(1) Problem (2) Exp Outcome (3) Plan (4) Prob/Exp Outcome

followed by the prompt:

Enter text type-- |

The text type for the Discharge Plan is number 3, Plan. When you select the text type, the system updates the text freeform box with headers to the left:

```
Plan: |     You have five lines, 36|
      |     characters each, to enter the|
      |     Discharge Plan.|
```

13. TEXT (180-C-R or 225-C-R)
This field provides freeform lines for you to enter the purpose or instructions for this component. This text prints on the PCP if you responded Yes to the Print field on this screen. When the cursor moves to the text field, the following prompt displays:

Edit text? (Y/N) [Y]--

To enter text, enter **Y** for Yes. When you do not want to enter text, enter **N** for No. The system default is Yes. If you are adding the component for the first time, the system does not accept a response of No - the system beeps and displays the following message:

Error: Text required!

If you enter **Y** for Yes or press ENTER, the cursor displays at the beginning of the box containing the freeform lines. The following function keys display:

F1	F2	F3	F4	F5
Del Line	Ins Line	Done	Del Char	Ins Char

Enter the text for this component, using the function keys F1-F5, explained below:

Function Key	Function
Fl	Deletes the line containing the cursor
F2	Inserts a blank line on the line containing the cursor, moving the present line down one line
F3	Indicates you have completed entering the text
F4	Deletes the character beneath the cursor
F5	Inserts a blank space beneath the cursor for entry of a missing character. (For example, enter the word montor. Place the cursor on t. Press F5. Enter i in the blank space displaying to the left of t.)

After entering the text, press the F3 function key. The following prompt displays:

Accept this screen? (Y/N) [Y] --

Press ENTER to accept the screen. If you enter **N** for No, you can make changes to the screen. You can update every field, except File Type.

After you accept the screen, the system provides screens and prompts to link intervention/treatments to the Discharge Plan, to specify whether the intervention/ treatment is a treatment or an intervention, to edit the existing text of the intervention/ treatment, or to delete an intervention/treatment currently linked to the Discharge Plan. The next pages describe these screens and prompts.

The following screen displays after you accept the previous screen used to add or update the Discharge Plan.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   DP             6463        Yes          DISCHARGE PLAN


          No.       Type   Code    Element Description









Enter add(A), delete(D), or edit text(E) [A]--  |
```

From this screen, you can add an intervention/treatment to the Discharge Plan. There is no limit on the number of intervention/treatments which can be added, or linked, to a Discharge Plan. You also can delete an intervention/treatment currently linked to the Discharge Plan or edit the text of an intervention/treatment currently linked to the Discharge Plan. The example below does not display any interventions/treatments at this point. After you add an intervention/treatment, the example displays the addition.

Add an Intervention/Treatment

Enter **A** to begin the process of adding the first intervention/treatment to the Discharge Plan. The following prompt displays:

Enter # to insert before [End]--

This line enables you to add the intervention/treatment at the end of the list of intervention/treatments already added, or to insert it before another intervention/ treatment on the list. At this time you press ENTER to add the component at the end, since there is not a list created yet.

The next prompt enables you to select the intervention/treatment:

Enter first letter(s)'-' or code--

You can enter beginning letters followed by a hyphen (-), and the system displays a list of the interventions/treatments that begin with those letters. You can enter the code, up to four digits. If you do not know the code, or the description of the intervention/ treatment on the system, enter a hyphen (-) to display an alphabetical list of all the intervention/treatments.

After you select the intervention/treatment, the system displays the element you have specified, for example:

Add: 6015 ALERTNESS, SKIN COLOR AND TEMP

followed by the prompt:

Define as treatment(T) or intervention(I) [I]--

Enter **T** for Treatment or **I** for Intervention. The system default is **I**.

The system returns to the screen below. The intervention/treatment displays on this screen, and you can proceed as described above to add another one.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   DP             6463        Yes          DISCHARGE PLAN


          No.       Type   Code    Element Description

            1       I      6015    ALERTNESS, SKIN COLOR AND TEMP









Enter add(A), delete(D), or edit text(E) [A]--  |
```

Delete an Intervention/Treatment

Enter **D** to delete an intervention/treatment from the Discharge Plan. The following prompt displays:

Enter # to delete--

Enter the number displaying under the No. column—this is the number of the Intervention/Treatment on the list of linked components—and press ENTER. The system displays the list and renumbers any components remaining below the deleted component.

Edit an Intervention/Treatment

Enter **E** to edit an intervention/treatment already added to the Discharge Plan. The following prompt displays:

Enter # to edit--

Enter the number displaying under the No. column—this is the number of the intervention/treatment on the list of linked components—and press ENTER. The system displays the description and text of the selected Intervention/treatment, along with the editor function keys (F1-F5), as shown in example on the following screen.

You can use this screen to edit the text of an intervention/treatment. Changing the intervention/treatment on this screen updates it in the Standard File. It is not updated just for this specific Problem/Expected Outcome.

```
               General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   DP             6015        Yes          DISCHARGE PLAN

 Element Description
   ALERTNESS, SKIN COLOR AND TEMP
                                Text

                  |OBSERVE FOR ALERTNESS, SKIN COLOR   |
                  |AND TEMPERATURE                     |
                  |                                    |
                  |                                    |
                  |                                    |




F1        F2        F3        F4        F5
Del Line  Ins Line  Done      Del Char  Ins Char
```

The following screen is an example of a table lookup of Discharge Plans that have been added to the system. The components list in alphabetical order. You can view each page by entering a slash (/) toscroll to the next page or entering a slash followed by a **P** (/P) to see the previous page. You can select a Discharge Plan to update from this screen.

```
               General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm









Page:01                          Discharge Plan
( 1) ACT INDEP AND RESP (ADOL PSYCH)
( 2) HOME MAINTENANCE-POST-OP
( 3) POST-OP HOME MAINTENANCE
( 4) VERBALIZE HOME CARE INSTRUCTIONS







Enter choice--
```

Impact

This function creates a new Discharge Plan which is stored in the Discharge Plan Standard File and displays on table lookups of Discharge Plans when linking the Discharge Plan to a Plan of Care through Standard File Maintenance. It also displays

with the list of linked Discharge Plans when the nurse is selecting Plan of Care components for the patient.

Output

The text for this component prints on the PCP.

DISCHARGE/EXPECTED OUTCOME

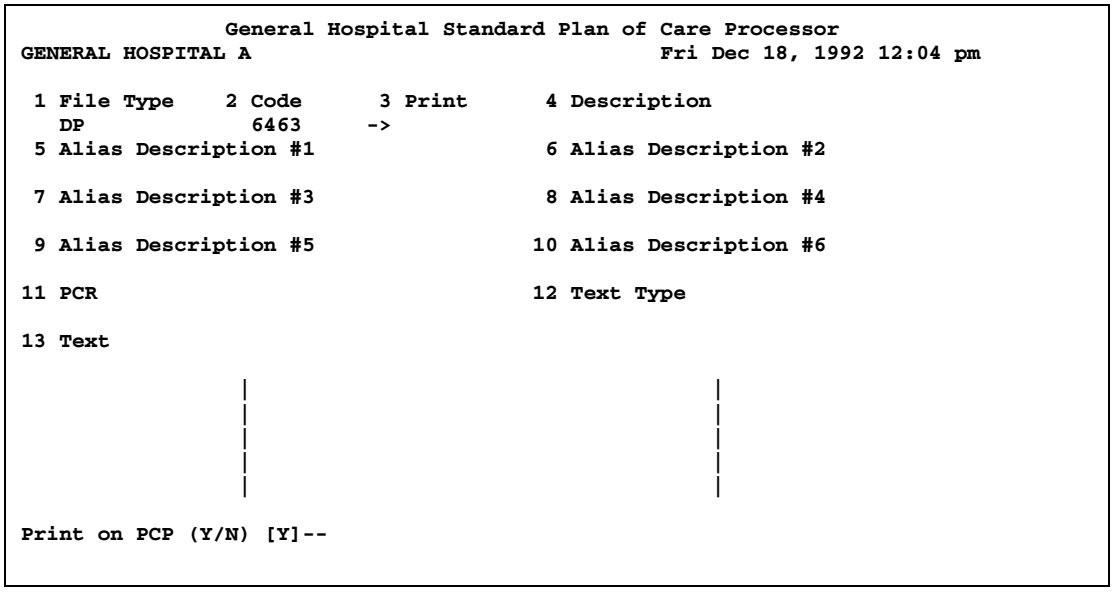
After you select Discharge/Expected Outcome from the Standard Plan of Care menu, the following screen displays:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm









Enter first letter(s)`-` or dis/exp outcome--
```

From this prompt, you have the following options:

- Enter the beginning letters of the Discharge/Expected Outcome, followed by a hyphen (-), to access anyexisting Discharge/Expected Outcome with the same first letters.
- Enter a hyphen (-) to access the list of all Discharge/Expected Outcomes currently added to the system.
- Enter the code of the Discharge/Expected Outcome, up to four digits. (You should have a list of the codes and Discharge/Expected Outcome data to add to the system from your installation workshops.)

When you enter the new code, the following screen displays for data entry:



Field Explanations

1. FILE TYPE (DISPLAY ONLY)
This field displays the file type you are adding or updating. The system automatically enters *DO* for Discharge/Expected Outcome.

2. CODE (DISPLAY ONLY)
This field displays the numerical code you entered on the prompt leading to this screen.

3. PRINT (1-A-R)
This field specifies whether or not the Discharge/Expected Outcome text should print on the Patient Care Profile (PCP). Valid responses are **Y** for Yes and **N** for No. The system defaults to Yes.

4. DESCRIPTION (33-C-R)
This field contains the description, or most commonly used name for this component. You may enter up to 33 characters.

5-10.ALIAS DESCRIPTIONS #1 - #6 (33-C-O)
The nurse can look up Plan of Care components by entering the beginning characters of the description. This field contains another name, in addition to the description in the Description field, by which you may access this component on the system.

The system prompts you to enter another description, or you can press ENTER to bypass this field.

11. PCR (4-N-O)
This field defines a PCR (Patient Care Requirement) code for this component. The PCR code is used by the Acuity and Staffing system. You can enter a hyphen (-) to display a table lookup of valid PCR codes.

12. TEXT TYPE (TABLE LOOKUP)
This required field specifies the text format for this component. The following table displays at the bottom of the screen:

(1) Problem (2) Exp Outcome (3) Plan (4) Prob/Exp Outcome

followed by the prompt:

Enter text type-- |

The text type for the Discharge/Expected Outcome is number 2, Expected Outcome. When you select the text type, the system updates the text freeform box with a header on the left:

```
Expected Outcome:|You have five lines, 36|
      |characters each, to enter the|
      |Discharge/Expected Outcome.|
      |      |
      |      |
```

13. TEXT (180-C-R or 225-C-R)
This field provides freeform lines for you to enter the purpose or instructions for this component. This text prints on the PCP if you responded Yes to the Print field on this screen. When the cursor moves to the text field, the following prompt displays:

Edit text? (Y/N) [Y]--

To enter text, enter **Y** for Yes. When you do not want to enter text, enter **N** for No. The system default is Yes. If you are adding the component for the first time, the system does not accept a response of No; the system beeps and displays the following message:

Error: Text required!

If you enter **Y** for Yes or press ENTER, the cursor displays at the beginning of the box containing the freeform lines. The following function keys display:

F1	F2	F3	F4	F5
Del Line	Ins Line	Done	Del Char	Ins Char

Enter the text for this component using the function keys F1-F5, which are explained below:

Function Key	Function
Fl	Deletes the line containing the cursor
F2	Inserts a blank line on the line containing the cursor, moving the present line down one line
F3	Indicates you have completed entering the text
F4	Deletes the character beneath the cursor
F5	Inserts a blank space beneath the cursor for entry of a missing character. (For example, enter the word montor. Place the cursor on t. Press F5. Enter i in the blank space displaying to the left of t.)

After entering the text, press the F3 function key. The following prompt displays:

Accept this screen? (Y/N) [Y] --

Press ENTER to accept the screen. If you enter **N** for No, you can make changes to the screen. You can update every field, except File Type.

After you accept the screen, the system provides screens and prompts to link intervention/treatments to the Discharge/Expected Outcome. This is done so that you can specify whether the intervention/treatment is a treatment or an intervention, to edit the existing text of the intervention/treatment, or to delete an intervention/treatment currently linked to the Discharge/Expected Outcome.

The following screen displays after you accept the previous screen used to add or update the Discharge/Expected Outcome.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   DO             6463        Yes          DISCHARGE/EXPECTED OUTCOME


          No.       Type   Code    Element Description









Enter add(A), delete(D), or edit text(E) [A]--  |
```

From this screen, you can add an intervention/treatment to the Discharge/ Expected Outcome. There is no limit on the number of intervention/treatments which can be added, or linked, to a Discharge/Expected Outcome. You also can delete an intervention/treatment currently linked to the Discharge/Expected Outcome or edit the text of an intervention/treatment currently linked to the Discharge/Expected Outcome.

Add an Intervention/Treatment

Enter **A** to begin the process of adding the first intervention/treatment to the Discharge/Expected Outcome. The following prompt displays:

Enter # to insert before [End]--

This line enables you to add the intervention/treatment at the end of the list of intervention/treatments already added, or to insert it before another intervention/ treatment on the list. At this time you press ENTER to add the component at the end, since there is not a list created yet.

The next prompt prompts the selection of the intervention/treatment:

Enter first letter(s)'-' or code--

You can enter beginning letters followed by ahyphen (-), and the system displays a list of the intervention/treatments that begin with those letters. You can enter the code, up to four digits. If you do not know the code, or the description of the intervention/ treatment on the system, enter a hyphen (-) to display an alphabetical list of all the intervention/treatments.

After you select the intervention/treatment, the system displays the element you have specified, for example:

Add: 6015 ALERTNESS, SKIN COLOR AND TEMP

followed by the prompt:

Define as treatment(T) or intervention(I) [I]--

Enter **T** for Treatment or **I** for Intervention. The system default is **I**.

The system returns to the screen below. The intervention/treatment displays on this screen, and you can proceed as described above to add another one.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   DO             6463        Yes          DISCHARGE/EXPECTED OUTCOME


          No.       Type   Code    Element Description

            1       I      6015    ALERTNESS, SKIN COLOR AND TEMP









Enter add(A), delete(D), or edit text(E) [A]--  |
```

Delete an Intervention/Treatment

Enter **D** to delete an intervention/treatment from the Discharge/Expected Outcome. The following prompt displays:

Enter # to delete--

Enter the number displaying under the No. column (this is the number of the Intervention/Treatment on the list of linked components) and press ENTER. The system displays the list and renumbers any components remaining below the deleted component.

Edit an Intervention/Treatment

Enter **E** to edit an intervention/treatment already added to the Discharge/Expected Outcome. The following prompt displays:

Enter # to edit--

Enter the number displaying under the No. column (this is the number of the intervention/treatment on the list of linked components) and press ENTER. The system displays the description and text of the selected intervention/treatment, along with the editor function keys (F1-F5), as shown in example on the following screen.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   DO             6015        Yes          DISCHARGE/EXPECTED OUTCOME

 Element Description
   ALERTNESS, SKIN COLOR AND TEMP
                               Text

                  |OBSERVE FOR ALERTNESS, SKIN COLOR   |
                  |AND TEMPERATURE                     |
                  |                                    |
                  |                                    |
                  |                                    |




F1        F2        F3        F4        F5
Del Line  Ins Line  Done      Del Char  Ins Char
```

You can use this screen to edit the text of an intervention/treatment. Changing the intervention/treatment on this screen updates it in the Standard File; in other words, it is not updated just for this specific Problem/Expected Outcome.

The screen below is an example of a table lookup of Discharge/Expected Outcomes which have been added to the system. The components list in alphabetical order. You can view each page by entering a slash (/) to scroll to the next page or entering a slash followed by a **P** (/P) to see the previous page. You can select a Discharge/Expected Outcome to update from this screen.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm









Page:01                          Discharge/Expected Outcome
( 1) ACT INDEPENDENTLY AND RESPONSIBLY   (11) CARDIAC LIMITS, ACTIVITY WITHIN
( 2) ACTIVITY TOLERANCE                  (12) CARDIAC, VERBALIZE SYMPTOMS
( 3) ACTIVITY WITHIN CARDIAC LIMITS      (13) COMMUNICATION, METHOD OF
( 4) AIRWAY CLEARANCE, OPTIMAL           (14) CONSTIPATION, BOWEL PROGRAM
( 5) ALTERED THOUGHT PROCESSES           (15) COPING MECH EFFECTIVE AFTER DIS
( 6) ANXIETY, RESOURCES TO DEAL W ANX    (16) DIARRHEA, BOWEL PROGRAM
( 7) BOWEL MOVEMENTS, CONTROL OF         (17) DIS PLAN/LONG TERM EO DEVEL
( 8) BOWEL PROGRAM, CONSTIPATION         (18) DIVERSIONAL ACTIVITIES, RESOURCES
( 9) BOWEL PROGRAM, DIARRHEA             (19) DIVERSIONAL ACTIVITY, SATISFIED
(10) BREATHING PATTERNS, EFFECTIVE       (20) EFFECTIVE BREATHING PATTERNS

Enter choice--
                                  next page(/)
```

Impact

This function creates a new Discharge/Expected Outcome which is stored in the Discharge/Expected Outcome Standard File and displays on table lookups of Discharge/Expected Outcomes when linking the Discharge/Expected Outcome to a Plan of Care through Standard File Maintenance. It also displays with the list of linked Discharge/Expected Outcomes when the nurse is selecting Plan of Care components for the patient.

Output

The text for this component prints on the PCP.

PLAN OF CARE

After you select Plan of Care from the Standard Plan of Care menu, the following screen displays:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm









Enter first letter(s)`-` or plan of care code--
```

From this prompt you have the following options:

- Enter the beginning letters of the Plan of Care followed by a hyphen (-), to access any existing Plan of Care with the same first letters.
- Enter a hyphen (-) to access the list of all Plans of Care currently added to the system.
- Enter the code of the Plan of Care, up to four digits. (You should have a list of the codes and Plan of Care data to add to the system from your installation workshops.)

When you enter the new code, the following screen displays for data entry:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type       2 Code               3 Description
   PC                0342              ->
 4 Alias Description #1                 5 Alias Description #2

 6 Alias Description #3                 7 Alias Description #4

 8 Alias Description #5                 9 Alias Description #6

10 PCR









Enter description--
```

Field Explanations

1. FILE TYPE (DISPLAY ONLY)
This field displays the file type you are adding or updating. The system automatically enters PC for Plan of Care.

2. CODE (DISPLAY ONLY)
This field displays the numerical code you entered on the prompt leading to this screen.

3. DESCRIPTION (33-C-R)
This field contains the description, or most commonly used name for this component. You may enter up to 33 characters.

4-9. ALIAS DESCRIPTION #1 - #6 (33-C-O)
The nurse can look up Plan of Care components by entering the beginning characters of the description. This field contains another name, in addition to the description in the Description field, by which you may access this component on the system.

The system prompts you to enter another description, or you can press ENTER to bypass this field.

10. PCR (4-N-O)
This field defines a PCR (Patient Care Requirement) code for this component. The PCR code is used by the Acuity and Staffing system. You can enter a hyphen (-) to display a table lookup of valid PCR codes.

After entering data in the above fields, the following prompt displays:

Accept this screen? (Y/N/D) [Y]--

Press ENTER to accept the screen. If you enter **N** for No, you can make changes to the screen. You can update every field, except File Type. If you enter **D**, the system deletes the Plan of Care.

After you accept the screen, the system provides screens and prompts to add Discharge/Expected Outcomes, Discharge Plans, and Problem/Expected Outcomes to the Plan of Care, or to delete components currently added, or linked, from the Plan of Care. You cannot add or delete intervention/treatments at the Plan of Care level, nor can you edit text for a linked component at the Plan of Care level.

The following screen displays after you accept the previous screen used to add or update the Plan of Care:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type       2 Code                3 Description
   PC                0342                  PLAN OF CARE


          No.       Type   Code    Element Description









Enter add(A) or delete(D) [A]--  |
```

From this screen, you can add Discharge/Expected Outcomes, Problem/Expected Outcomes and Discharge Plans to the Plan of Care. There is no limit to the number of components which can be added, or linked, to a Plan of Care. You also can delete a component currently linked to the Plan of Care.

Add a Component

Enter **A** to begin the process of adding the first component to the Plan of Care. The following prompt displays:

Enter file type to add (DO,DP,PO)--

For example purposes, enter **PO** and proceed to enter a Problem/Expected Outcome. The remaining example screens and lines refer to Problem/Expected Outcomes, but the process is exactly the same if you are adding a Discharge/Expected Outcome or Discharge Plan.

After you enter the file type (DO is Discharge/Expected Outcome, DP is Discharge Plan, PO is Problem/Expected Outcome), the next prompt displays:

Enter # to insert before [End]--

This line enables you to add the component at the end of the list of components already added, or to insert it before another component on the list. At this time you press ENTER to add the component at the end, since there is not a list created yet.

The following prompt displays for you to select the component:

Enter first letter(s)'-' or PG code--

You can enter beginning letters followed by a hyphen (-), and the system displays a list of the Problem/Expected Outcomes which begin with those letters. You can enter the code, up to four digits. If you do not know the code, or the description of the Problem/Expected Outcome on the system, enter a hyphen (-) to display an alphabetical list of all the Problem/Expected Outcomes.

After you select the Problem/Expected Outcome, the system returns to the screen below. The Problem/Expected Outcome displays on this screen, and you can proceed as described above to add another Problem/Expected Outcome, Discharge/Expected Outcome or Discharge Plan.

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm

 1 File Type    2 Code      3 Print      4 Description
   PC             6463        Yes          PLAN OF CARE


          No.       Type   Code    Element Description

            1       PO     4007    BREATH SOUNDS, NORMAL/IMPROVED









Enter add(A) or delete(D) [A]--  |
```

Delete a Component

Enter **D** to delete a component from the Plan of Care. The following prompt displays:

Enter # to delete--

Enter the number displaying under the No. column—this is the number of the component on the list of linked components—and press ENTER. The system displays the list and renumbers any components remaining below the deleted component.

The following screen is an example of a table lookup of a Plan of Care that has been added to the system. The Plan of Care list is in alphabetical order. You can view each page by entering a slash (/) to scroll to the next page or entering a slash followed by a **P** (/P) to see the previous page. You can select a Plan of Care to update from this screen.

```
               General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm









Page:01                              Plan of Care
( 1) ACTIVITY INTOLERANCE                 (11) BOWEL ELIMINATION, CONSTIPATION
( 2) AIRWAY CLEARANCE, INEFFECTIVE        (12) BOWEL ELIMINATION, DIARRHEA
( 3) ALT IN COMFORT-PAIN                  (13) BOWEL ELIMINATION, INCONTINENCE
( 4) ALT IN FAMILY PROCESSES              (14) BREATHING PATTERNS, INEFFECTIVE
( 5) ALT IN NUTRITION, LESS THAN REQ      (15) CARDIAC OUTPUT
( 6) ALT IN NUTRITION, MORE THAN REQ.     (16) CARDIAC OUTPUT, ALTERATION IN-DEC
( 7) ALT IN ORAL MUCUS MEMBRANES          (17) COMFORT, ALTERATION IN- PAIN
( 8) ALT IN TISSUE PERFUSION              (18) COPING, INEFFECTIVE FAMILY
( 9) ALT IN URINARY ELIMINATION           (19) COPING, INEFFECTIVE INDIVIDUAL
(10) ANXIETY/FEAR                         (20) DISTURBANCE IN SELF CONCEPT

Enter choice--
                                    next page(/)
```

Impact

This function creates a new Plan of Care which is stored in the Plan of Care Standard File and displays on table lookups of Plans of Care when the nurse is selecting a Plan of Care.

Output

The text for the component prints on the PCP.

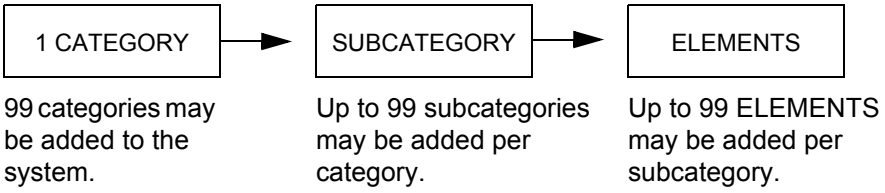
ADLs

To understand data entry of ADLs (Activities of Daily Living), you must understand these terms:

- Categories
- Subcategories
- Elements

ADLs are divided into general groups called "categories". Examples are: Activity, Hygiene (Bath), Vital Signs and Diet. Categories are divided into specific groups, usually unit-specific, called "subcategories". Examples are General, 2N. Subcategories are further divided into specific, directional items called "elements". Examples of elements under the category *Hygiene* are: Bed, Complete, Partial, Self, Tub, W/Assist, and Shower.

The system allows the entry of 99 categories, 99 subcategories and 99 elements:



The category is added first to the system, followed by the addition of the subcategory and its related elements.

NOTE: Only categories and elements display for the nurse to select. When entering ADLs for a patient, the nurse does not see the subcategory. Creating a subcategory on Standard File Maintenance allows you to enter a greater amount of unit-specific data.

As units go Live, additions and changes specific to the unit may be entered, and an ADL menu is built for the unit through Station Parameters. Categories, subcategories and elements can be added, updated, or deleted.

After you access ADLs on the Standard File Maintenance submenu, the system displays another menu containing three functions:

1. Create ADLs
2. Build ADL Menus
3. Station Parameters

CREATE ADLS

After you select Create ADLs from the ADL submenu, the following screen displays:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm









Enter first letter(s)`-` or category code--
```

From this prompt you have the following options:

- Enter the beginning letters of the ADL category, followed by a hyphen (-), to access any existing ADL categories with the same first letters.
- Enter a hyphen (-) to access the list of all ADL categories currently added to the system.
- Enter the ADL category code up to two digits. (You should have a list of the codes and ADL Category data to add to the system from your installation workshops.)

After you specify the ADL category, the following screen displays:

```
                  General Hospital Create ADLs Processor
GENERAL HOSPITAL A                                Fri Dec 18, 1992 03:26 pm

 1 Category                2 Description
   32                     -> ACTIVITY
 3 Subcategory             4 Description
   00                       GENERAL









Enter category description--           |
```

Field Explanations

1. CATEGORY (DISPLAY ONLY)
This field displays the numerical code you entered on the prompt leading to this screen.

2. DESCRIPTION (33-C-R)
This field contains the descriptive name for this ADL category. You can enter up to 33 characters.

3. SUBCATEGORY (2-N-O)
This field contains the code. You can enter a two-digit code and the description in the next field, or you can enter a hyphen (-) to display a table lookup of subcategories already added to the system.

4. DESCRIPTION (33-C-R)
This field contains the descriptive name for this ADL subcategory. You may enter up to 33 characters. If you selected the subcategory from a table in the Subcategory field, the system automatically displays the description here.

After you complete these fields, the following prompt displays:

Accept this screen? (Y/N/D) [Y]--

Respond with Yes to accept the screen. The following screen displays for you to add begin adding ADL elements:

```
                    General Hospital Create ADLs Processor
GENERAL HOSPITAL A                                 Fri Dec 18, 1992 03:26 pm

 1 Category                2 Description
   32                     -> MEASUREMENT
 3 Subcategory             4 Description
   01                       GENERAL

   Element      Description                PCR Code









Enter element to edit or add--  |
```

Enter the element's two-digit code. The following screen displays, enabling you to add ADL element data:

```
                    General Hospital Create ADLs Processor
GENERAL HOSPITAL A                                 Fri Dec 18, 1992 03:26 pm

 1 Category                2 Description
   32                     -> MEASUREMENT
 3 Subcategory             4 Description
   00                       GENERAL

 1 Element                 2 Description

 3 PCR Code                                              4 Description Change







Enter element description--
```

Field Explanations

The following fields are display only from the previous screen and cannot be edited: Category, Description, Subcategory and Description.

1. ELEMENT (DISPLAY ONLY)
This field displays the two-digit code for the ADL element you are adding.

2. DESCRIPTION (33-C-R)
This field contains the descriptive name for the ADL element. You can enter up to 33 characters.

3. PCR CODE (4-N-O)
This field contains the PCR code (Patient Care Requirement code) applicable for this ADL element. This field is usedif your hospital is using the Staffng and Acuity module. You can enter the code, up to four digits, or enter a hyphen (-) to display the PCR code table for selection.

4. DESCRIPTION CHANGE (1-A-O)
This field determines whether or not the nurse is allowed to change the element description when ordering the ADL. Valid values are Y for Yes and N for No. Enter **Y** to allow description change during ordering. Enter **N** to not allow description change during ordering.

After you complete the above fields, the following prompt displays:

Accept this screen? (Y/N/D) [Y]--

You can accept the screen by entering **Y** for Yes, not accept the screen by entering **N** for No, or delete the element by entering **D** for Delete.

When you accept the screen, the system returns to the following screen. You can add another element from this screen.

```
                    General Hospital Create ADLs Processor
GENERAL HOSPITAL A                              Fri Dec 18, 1992 03:26 pm

 1 Category                2 Description
   32                     -> ACTIVITY
 3 Subcategory             4 Description
   01                       GENERAL

   Element    Description                  PCR Code

      12      AMBULATE BID w/assist of one  0034 Assist of one









Enter element to edit or add--  |
```

The following screen shows examples of ADL categories which have been added to the system:

```
                General Hospital Standard Plan of Care Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 12:04 pm


Page:12                           Categories

( 1) 01 - ACTIVITY
( 2) 49 - FEEDING
( 3) 12 - HYGIENE
( 4) 44 - INTAKE/OUTPUT
( 5) 22 - SAFETY









Enter choice--
                        next page(/)  previous page(/P)
```

The following screen shows examples of ADL elements which have been added to the system:

```
                    General Hospital Create ADLs Processor
GENERAL HOSPITAL A                                  Fri Dec 18, 1992 03:26 pm

 1 Category                 2 Description
   32                      -> ACTIVITY
 3 Subcategory              4 Description
   01                         GENERAL

   Element      Description                PCR Code

      30        DANGLE                     0076
      35        INCREASE AMBULATION        0008
      40        SIT/CHAIR FOR MEALS        0031
      41        SIT/CHAIR 15-20 MIN BID    0032
      42        SIT/CHAIR 60 MIN TOL       0033
      43        SIT/CHAIR TID AS TOL       0034
      44        SIT/CHAIR QID AS TOL       0035
      45        SIT/CHAIR AD LIB           0030
      50        TREADMILL                  0037


Enter element to edit or add--  |
```

The following examples of lists illustrate how two units may have two different sets of elements for the same category. Both lists fall under the category Activity. By adding different subcategories to the category Activity, you can add separate elements to each subcategory, creating streamlined, customized ADL lists for each nursing station. (Remember, the subcategories do not display on the nurse's screen; the nurse sees only the categories and elements.)

ACTIVITY LIST FOR UNIT A	ACTIVITY LIST FOR UNIT B
01 AMBULATE QID	01 AMBULATE TO TUB OR SHOWER
02 BEDSIDE COMMODE	02 AMBULATE AS TOL
03 BRPS	03 ASSIST OF TWO (2)
04 BRPS AD LIB, SIT TO SHAVE	04 BRPS
05 DANGLE	05 BRPS WITH ASSIST
06 INCREASE AMBULATION	06 BEDSIDE COMMODE
07 SIT/CHAIR FOR MEALS	07 CANE
08 SIT/CHAIR 15-20 MIN BID	08 CHAIR AS TOL
09 SIT/CHAIR 60 MIN TID	09 CHAIR FOR MEALS
10 SIT/CHAIR TID AS TOL	10 DANGLE
11 SIT/CHAIR QID AS TOL	11 ENCOURAGE ACTIVITY
12 SIT/CHAIR AD LIB	12 ELEVATE HOB
13 UP IN ROOM AD LIB	13 ELEVATE FOB
14 UP WITH ASSIST IN HALL	14 PIVOT
15 UP AD LIB IN HALL	15 STAND AT BEDSIDE
16 UP AS TOL	16 UP AD LIB
17 WHEELCHAIR TO SHOWER	17 UP IN ROOM
18 CANE	18 UP IN WHEELCHAIR
19 CRUTCHES	19 UP WITH ASSIST
20 WALKER	20 WALKER
21 WALKING BELT	21 WALKING BELT
22 WHEELCHAIR	
23 ASSIST WITH ACTIVITIES	
24 WITH 02 @	
25 TREADMILL BID	

BUILD ADL MENUS

The ADL menu provides quick access to a list of 30 frequently used ADLs that are selected for a nursing station. Each nursing station may have its own menu or several units may share one menu.

The function to build the menu is located on the ADLs submenu (on the Standard File Maintenance submenu.)

Upon selection, (if STAR Patient Care is configured for a multifacility institution and your CRT can access more than one facility), a list of available facilities displays. After you select the appropriate facility, the following prompt displays:

Add(A), Copy(C), or Revise(R) menu--

Add

If you are creating a new ADL menu, enter **A** to add. The following prompt displays:

Enter new name--

Enter a description for the new menu and press ENTER. The system then displays the following prompt:

Enter #, move(M) or add(A)--

Enter **A** to add, and the next prompt displays:

Enter # to insert before, or add end(E)--

Enter the option to insert before or **E** to add to the end and press ENTER. When adding a new menu, enter **E** and press ENTER. The following screen displays to enable you to add an item to the menu:

```
         General Hospital Build Defining Characteristics Menus Processor
MENU NAME                                          Fri Dec 18, 1992 04:04 pm

                                    ADL Menu
( 1)Category      : 59-ACTIVITY
( 2)Subcategory   : 04-1 EAST
( 3)Screen Display: ACTIVITY









Enter first letter(s)`-` or code--
```

Field Explanations

1. CATEGORY (TABLE LOOKUP-R)
This field contains the code and description of the Category to be added to the menu. The system accepts both a code entry or table look up for this field.

2. SUBCATEGORY (TABLE LOOKUP-O)
This field contains the code and description of the subcategory to be added to the menu. The system accepts both a code entry or table look up for this field.

3. SCREEN DISPLAY (33-AN-R)
This field contains the description that displays on the menu for the current ADL. The system fills this field with the item description. Generally, this field is the same as the ADL category description, but you can override it with an alternate description.

After the ADL category (and subcategory) is entered and you press ENTER, the following prompt is displayed:

Accept this screen? (Y/N) [Y]--

If you enter **N** for No, the system redisplays the ADL menu and promps you for insertions.

If you enter **Y** for Yes, or press ENTER, the system accepts the entry and redisplays the menu with the item just added. Below is an example of an ADL Menu with four Defining Characteristics added:

```
                  General Hospital Build ADL Menus Processor
ADL MENU - 1 EAST                                  Fri Dec 18, 1992 04:05 pm

                                          ADL Menu
( 1) ACTIVITY
( 2) BEDREST
( 3) AMBULATION AIDS
( 4) RESPIRATIONS
```

The system returns to the prompt:

Enter # to insert before, or at the end (E)--

If you want to continue to add new items, enter the option number to insert before or **E** to add to the end. Press ENTER to return to the prompt:

Enter #, move(M), or add(A)--

Enter **M** if you want to rearrange two or more items on the menu. For information regarding moves refer to "Move" on page 7-45.

Press ENTER at the previous prompt when you are finished editing the menu. The system asks the following question:

Accept? (Y/N) [Y]--

If you enter **N** for No, the system remains in the menu processor and allows further editing of the menu displayed.

If you enter period (.) and press ENTER, the system exits the function, and no updates are made in the system.

If you enter **Y** for Yes, the following processing takes place:

- All edits made to the menu are stored in the system.
- If a new menu was added, it is available for assignment to a nursing station using the Station Parameters function.

Revise

If you want to revise an existing ADL menu, enter **R** and press ENTER. The system enables you to modify the menu description with the following prompt:

Enter new name [no change]--

Enter a new description for the menu if desired. Press ENTER if you want to retain the current name.

The system then displays the following prompt:

Enter #, move(M), or add(A)--

For further explanation of the options regarding this prompt refer to "Add" on page 7-42.

Copy

If you want to copy an existing menu to a new menu, enter **C** to copy. The system displays a table of existing ADL menus. Select the menu to you want to copy. The system then displays the following prompt:

Enter new name--

Enter the name of the new menu and press ENTER. The system then displays all the category descriptions on the menu along with the following prompt:

Enter #, move(M), or add(A)--

For further explanation of the options regarding this prompt refer to “Add” on page 7-42 under the heading .

Move

If you want to move a menu item, the following prompt displays:

Enter from option number (`,` to option number) to move--

Enter the option number of the item to begin the move, followed by a comma, followed by the option number of the item to end the move. If you want to move only one item, enter the item number to be moved without the comma. The comma is only necessary if you are moving a group of items to a new location on the menu.

The system then asks where to insert the selected item(s). The following prompt displays:

Enter option # to move `x` after (`B` for before first item)--

where `x` is the option number of the item or group of items to be moved.

After a valid option number is entered, the system moves the item(s) and redisplays the menu. The system returns to the prompt:

Enter from option number (`,` to option number) to move--

Press ENTER to return to the prompt:

Enter #, move(M), or add(A)--

Impact

After you accept the screen, the following processing takes place:

- All edits made to the menu are stored in the system.
- If a new menu was added, it is available for assignment to a nursing station using the Station Parameters function.

ASSIGN ADL MENUS

To have the menu available for Plan of Care, the ADL menu must be assigned to a nursing station. Select the Station Parameters function on the Defining Characteristics submenu (or on any other submenu). Enter the station code and go to the ADL menu field. Select the desired description from the table displayed and accept the screen.

The menu is now available within the ADL function on the Plan of Care submenu.

Treatment Orders

You can order treatments through the Order Management/Charge Processing Module of STAR Patient Care. For a nurse to be able to select treatments during order entry, you must create a file for treatments for the ordering side. This process involves entering treatment order descriptions and alias descriptions, and then treatments from the intervention/treatment file (already built) to the newly created treatment order.

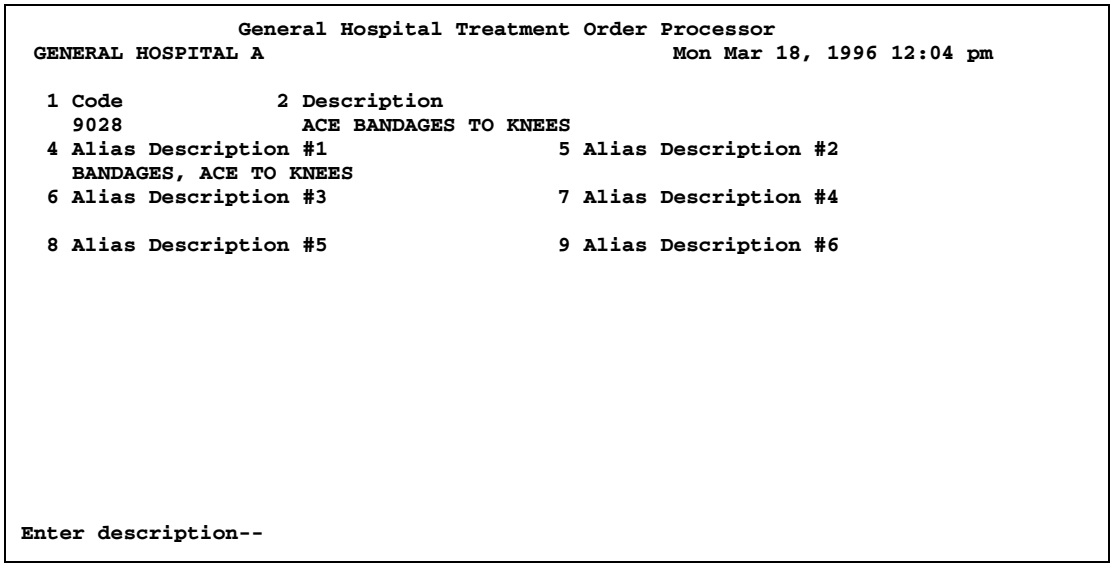
Linking the Treatment from the Plan of Care file to the treatment order name eliminates having to enter the Treatment text again. In the Pathways Care Manager environment, set up treatments to treatment orders at a 1:1 ratio. This is so that if nurses need to place orders on the STAR side of the interface (for example, if the interface is down when the orders are placed), treatments display as orders. After you select Treatment Orders from the Standard File Maintenance Menu, the following screen displays:

```
                  General Hospital Treatment Order Processor
GENERAL HOSPITAL A                              Mon Mar 18, 1996 12:04 pm









Enter first letter(s)`-` or treatment order code--
```

From this prompt you have the following options:

- Enter the beginning letters of the treatment order, followed by a hyphen (-), to access any treatment orders with the same first letters.
- Enter a hyphen (-) to access the list of all treatment orders currently added to the system.
- Enter the code of the treatment order, up to four digits. (You should have a list of the codes and treatment order data to add to the system from your installation workshops.)

When you enter the new code, the following screen displays for data entry:



Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the numerical code you entered on the prompt leading to this screen.

2. DESCRIPTION (33-C-R)
This field contains the description, or most commonly used name for this treatment order. You may enter up to 33 characters.

ALIAS DESCRIPTIONS #1 - #6 (33-C-O)
The nurse can look up Treatment Orders by entering the beginning characters of the description. This field contains another name, in addition to the description in Field 4, by which you may access this treatment order on the system. The system prompts you to enter another description, or you can press ENTER to bypass this field. After entering data in the above fields, the following prompt displays:

Delete? (N)--

Press ENTER to accept the screen. If you enter **N** for No, the system deletes the treatment order. After you accept the screen, the system provides screens and prompts to add, or link, treatments to the treatment order, delete treatments from the treatment order and edit the treatment text.

The following screen displays after you accept the previous screen used to add or update the treatment order. From this screen, you can add, or link, treatments to the treatment order, delete treatments from the treatment order and edit the treatment text.

NOTE: Up to 42 treatments may be added to a treatment order.

The following example does not display any components at this point. After you add a component, the example displays the addition.

```
                  General Hospital Treatment Order Processor
GENERAL HOSPITAL A                                  Mon Mar 18, 1996 12:04 pm

1 Code            2 Description
  9028              ACE BANDAGES TO KNEES


         No.       Type   Code    Element Description

Enter add(A), delete(D), or edit text (E)--
```

ADD A TREATMENT

Enter **A** to begin the process of adding the first treatment to the treatment order. The following prompt displays:

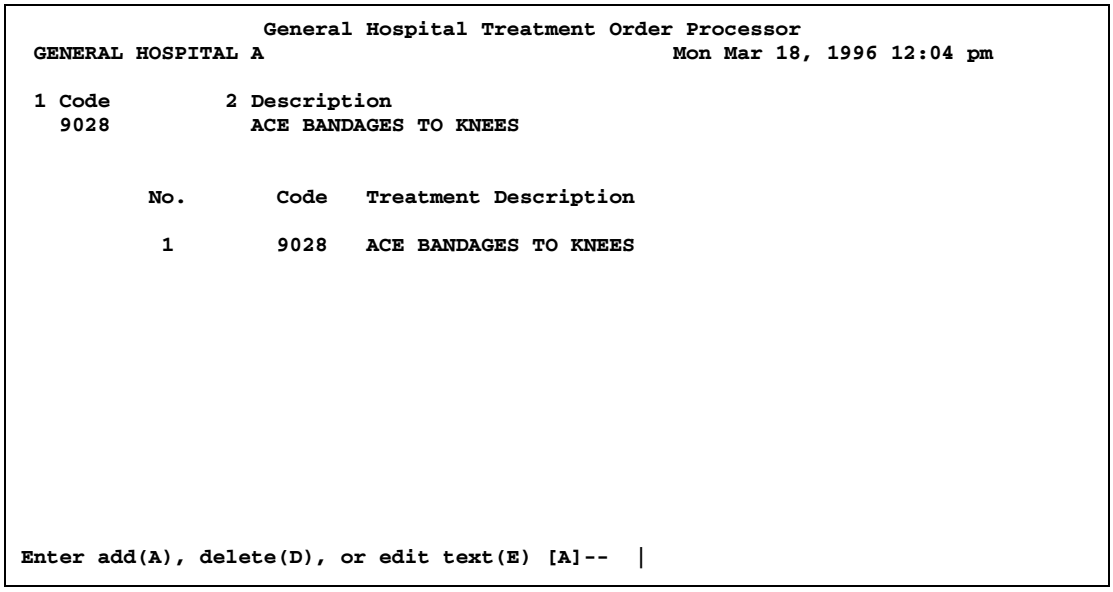
Enter # to insert before [End]--

This line enables you to add the treatment at the end of the list of treatments already added, or to insert it before another treatment on the list. At this time press ENTER to add the treatment at the end, since a list is not created.The next prompt prompts the selection of the treatment:

Enter first letter(s)'-' or code--

You can enter the beginning letters of the treatment followed by a hyphen (-), and the system displays a list of the treatments that begin with those letters. Another option is to enter the code up to four digits. If you do not know the code, or the description of the intervention/treatment on the system, enter a hyphen (-) to display a list of all the intervention/treatments.

After you select the treatment, the system returns to the screen below. The treatment displays on this screen, and you can proceed as described above to add another one.



DELETE A TREATMENT

Enter **D** to delete a treatment from the treatment order. The following prompt displays:

Enter # to delete--

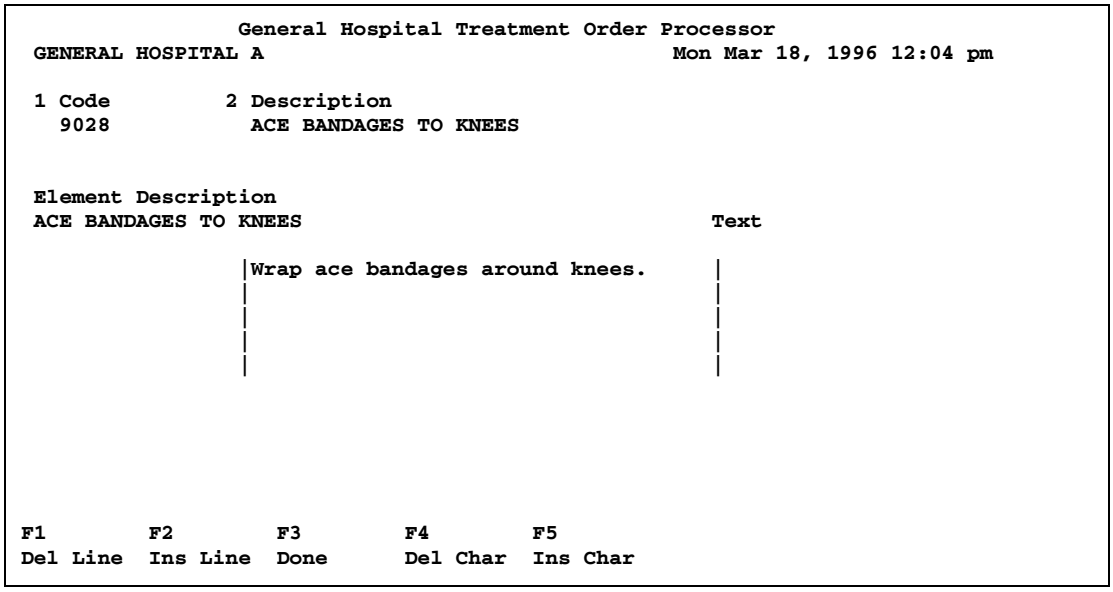
Enter the number displaying under the No. column. This is the number of the treatment on the list of linked components. Press ENTER. The system displays the list and renumbers any treatments remaining below the deleted treatment.

EDIT A TREATMENT

Enter **E** to edit a treatment already added to the treatment order. The following prompt displays:

Enter # to edit--

Enter the number displaying under the No. column. This is the number of the Treatment on the list of linked components. Press ENTER. The system displays the description and text of the selected treatment, along with the editor function keys (F1-F5), as shown on the following screen:



You can use this screen to edit the text of a treatment. Changing the treatment on this screen updates it in the Standard File. It is not updated just for this specific treatment order.Press the F3 function key when you have edited the text. The system returns to the previous screen and the following prompt displays:

Enter add(A), delete(D), or edit text(E)--

You may add, delete, or edit another treatment as described above.

Defining Characteristics

The Defining Characteristics maintenance function provides a means of adding and modifying the levels of patient assessment known as *Defining Characteristics*. These levels are typically structured as follows:

- Level 1 - Systems
- Level 2 - Signs & Symptoms
- Level 3 - Problems
- Level 4 - Plans of Care

This example uses all four levels. However, the system also allows Plans of Care to be linked at any of the other levels. For example, if a hospital chooses to have only three levels, the Plans of Care would be linked to Signs & Symptoms instead of Problems.

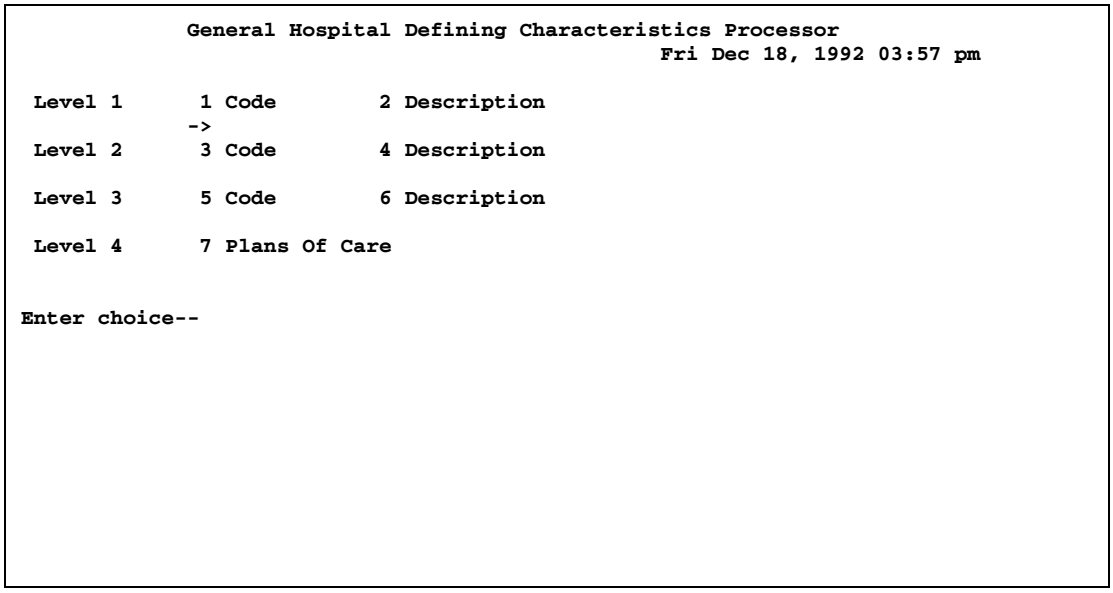
It is important to note that plans of care can be linked to only one level. The system does not allow Plans of Care to be linked to Signs & Symptoms and Problems.

There are three separate functions that must be performed to make Defining Characteristics available for the Plan of Care process.

1. Build the Defining Characteristics Standard File.
2. Create the Defining Characteristics Menu.
3. Assign the menu using the Station Parameters screen.

BUILD STANDARD FILE

The Defining Characteristics build function is located on the Standard File Maintenance submenu.



Field Explanations

1. CODE (2-N-R)
This field contains the two-digit code assigned to Level 1, Body Systems.

2. DESCRIPTION (33-AN-R)
This field contains the descriptive name for Level 1, Body Systems.

3. CODE (2-N-R)
This field contains the two-digit code assigned to Level 2, Signs and Symptoms.

4. DESCRIPTION (33-AN-R)
This field contains the descriptive name of Level 2, Signs and Symptoms.

5. CODE (2-N-R)
This field contains the two-digit code assigned to Level 3, the Problem.

6. DESCRIPTION (33-AN-R)
This field contains the descriptive name of Level 3, the Problem. Multiple problems can be added to link to Levels 1 and 2.

7. PLAN OF CARE
When the cursor is at this field, the system displays the list of plans of care already linked and the following prompt:

Enter add(A) or delete(D) plan of care [A]--

If you enter **A** to add, the following prompt displays:

Enter # to insert before [END]--

If you press ENTER or enter a valid **#** to insert before, the following prompt displays:

Enter first letter(s)`-` or code--

Once a valid Plan of Care code is entered (or selected from the table display), the system redisplays the list of plans of care and returns to the prompt:

Enter add(A) or delete(D) plans of care [A]--

If you enter **D** to delete, the following prompt displays:

Enter # to delete--

Once a valid number to delete is entered, the system redisplays the list of plans of care and returns to the prompt:

Enter add(A) or delete(D) plan of care [A]--

After all additions and deletions are complete, you must press period (.) and ENTER to get the *Accept screen? (Y/N)* prompt. If you enter **Y** to accept, the list of plans of care is stored in the standard file, and the system prompts for another level. If you enter **N**, the system returns to the previous prompt.

Impact

After you accept the screen, the following processing takes place:

- The Plan of Care list is linked and stored in the standard file for Defining Characteristics.

- If a new Level 1 code was entered, this level is available to be placed on a Defining Characteristics menu.

The Defining Characteristics menu provides quick access to a list of 30 frequently used LEVEL 1 descriptions that are selected for a nursing station. Each nursing station can have its own menu or several units can share one menu.

The Menu Build function is located on the Defining Characteristics submenu (on the Standard File Maintenance submenu.)

After you select this function (if STAR Patient Care is configured for a multifacility institution and your CRT can access more than one facility), a list of available facilities displays. Select the appropriate facility.

The following prompt displays:

Add(A), Copy(C), or Revise(R) menu--

Add

If you are creating a new Defining Characteristics menu, enter **A** to add. The system then displays the following prompt:

Enter new name--

Enter a description for the new menu and press ENTER. The system then displays the following prompt:

Add all(ALL) or add one(A)--

If you want to add the first 30 Level 1 descriptions to the menu, enter **ALL**. If you want to add a single (item) description, enter **A**.

The following prompt displays:

Enter # to insert before, or add end(E)--

Enter the option to insert before or **E** to add to the end and press ENTER. The following screen displays to enable you to add an item to the menu.

```
         General Hospital Build Defining Characteristics Menus Processor
MENU NAME                                          Fri Dec 18, 1992 04:04 pm

                          Defining Characteristics Menu
( 1)Table Item    : ACTIVITY - EXERCISE
( 2)Screen Display: ACTIVITY - EXERCISE









Enter first letter(s)`-` or code--
```

Field Explanations

1. TABLE ITEM (TABLE LOOKUP-R)
This field contains the code and description of the Level 1 item to be added to the menu. The system accepts both a code entry or table look up for this field.

2. SCREEN DISPLAY (33-AN-R)
This field contains the description that displays on the menu for the current item. The system fills this field with the item description. Generally, this field is the same as the item description, but you can override it with an alternate description.

After the item is entered and you press ENTER, the following prompt displays:

Accept this screen? (Y/N) [Y]--

If you enter **N** for No, the system redisplays the Defining Characteristics menu and the prompt prompting for insertions.

If you enter **Y** for Yes, or press ENTER, the system accepts the entry and redisplays the menu with the item added. Below is an example of a Defining Characteristics Menu with four Defining Characteristics added.

```
        General Hospital Build Defining Characteristics Menus Processor
MENU NAME                                          Fri Dec 18, 1992 04:05 pm

                          Defining Characteristics Menu
( 1) ACTIVITY-EXERCISE
( 2) COGNITION-PERCEPTION
( 3) COPING-STRESS TOLERANCE
( 4) ELIMINATION
```

The system returns to the prompt:

Enter # to insert before, or at the end (E)--

If you want to continue to add new items, enter the option number to insert before or **E** to add to the end. Press ENTER to return to the prompt:

Enter #, move(M), or add(A)--

Enter **M** if you want to rearrange two or more items on the menu. For information regarding moves refer to "Move" on page 7-56 under the heading Build Standard File.

Press ENTER at the previous prompt when you are finished editing the menu. The system asks the question:

Accept? (Y/N) [Y]--

If you enter **N** for No, the system remains in the menu processor and allows further editing to the menu displayed.

If you enter period (.) and press ENTER, the system exits the function, and no updates are made in the system.

If you enter **Y** for Yes, the following processing takes place:

- All edits made to the menu are stored in the system.
- If a new menu was added, it is available for assignment to a nursing station using the Station Parameters function.

Revise

If you want to revise an existing Defining Characteristics menu, enter **R** and press ENTER. The system enables you to modify the menu description with the following prompt:

Enter new name [no change]--

Enter a new description for the menu if desired. Press ENTER if you want to retain the current name.

The system then displays the following prompt:

Enter #, move(M), or add(A)--

For further explanation of the options regarding this prompt refer to "Add" on page 7-53 under the heading Build Standard File.

Copy

If you want to copy an existing menu to a new menu, enter **C** to copy. The system displays a table of existing Defining Characteristics menus. Select the menu to copy from. The system then displays the following prompt:

Enter new name--

Enter the name of the new menu and press ENTER. The system then displays all the Level 1 descriptions on the menu along with the following prompt:

Enter #, move(M), or add(A)--

For further explanation of the options regarding this prompt refer to "Add" on page 7-53 under the heading Build Standard File.

Move

The following prompt displays:

Enter from option number (`,` to option number) to move--

Enter the option number of the item to begin the move, followed by a comma, followed by the option number of the item to end the move. If you want to move only one item, enter the item number to be moved without the comma. The comma is only necessary if you are moving a group of items to a new location on the menu.

The system then asks where to insert the selected item(s). The following prompt displays:

Enter option # to move `x` after (`B` for before first item)--

where `x` is the option number of the item or group of items to be moved.

After a valid option number is entered, the system moves the item(s) and redisplays the menu. The system returns to the prompt:

Enter from option number (`,` to option number) to move--

Press ENTER to return to this prompt:

Enter #, move(M), or add(A)--

Impact

After you accept the screen, the following processing takes place:

- All edits made to the menu are stored in the system.
- If a new menu was added, it is available for assignment to a nursing station using the Station Parameters function.

Assign Menu to Nursing Station

To have the menu available for assessment and care planning, the Defining Characteristics menu must be assigned to a nursing station. Select the Station Parameters function on the Defining Characteristics submenu (or on any other submenu). Enter the station code and go to the Defining Characteristics menu field. Select the desired description from the table displayed and accept the screen.

The menu is now available within the Defining Characteristics function on the Plan of Care submenu.

Patient History Text

The Standard Text - Patient History function provides the nursing station with the ability to build standard text paragraphs which in turn can be assigned to one or more units. These paragraphs can be literals that prompt the nurse to gather particular information from the patient (for example, patient history, medical history, person to notify.) Since the text paragraph prints on the Patient Care Profile and Active Order Worksheet, the information is readily accessible to the nurse.

The text paragraphs are assigned to nursing stations on the Station Parameters screen's Standard Text for Pt. History field. The assignment of standard text is optional; if a station does not have a standard text paragraph assigned, it can still use the Patient History/Misc. function (on the main menu).

The following screen is a sample Standard Text - Patient History screen:

```
          General Hospital Standard Text - Patient History Processor
                                                  Fri Dec 18, 1992 04:15 pm

 1 Code           2 Description
   3                PT HISTORY TEXT - 2N
 3 Text
->

   |PAST HOSPITAL ADMISSIONS:                                                |
   |                                                                         |
   |PAST ILLNESSES:                                                          |
   |                                                                         |
   |PERSON TO NOTIFY:                                                        |
   |                                                                         |




F1        F2        F3        F4        F5
Del Line  Ins Line  Done      Del Char  Ins Char
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the numeric code assigned to this text paragraph.

2. DESCRIPTION (33-AN-R)
This field contains the description of the test paragraph. A table of all the text paragraph descriptions displays on the Staton Parameters screen if the Standard Text for Pt. History field is accessed.

3. TEXT (1-A-O)
This field indicates whether or not the text is to be edited. If you enter **Y** for Yes, the system displays the text editor shown on the previous screen example. If you enter **N** for No, the following prompt displays:

Accept this screen? Y/N [Y]--

After you accept the screen, the system beeps, displays the message *Filed!* and prompts you to access or add another standard text code.

Impact

After you accept this screen, the following processing takes place:

- The code, description, and text are stored in the nursing standard file.
- The newly stored paragraph is available to be assigned to a nursing station using the Station Parameters function.

Output

No reports are generated as a result of this function.

VITAL SIGNS AND FLUID BALANCES

To build Vital Signs and Fluid Balances, select Standard File Maintenance from the Nursing Main Menu. The following screen displays:

```
          General Hospital Standard File Maintenance Processor
                                              Fri Dec 18, 1992 5:05 pm
Standard File Maintenance Input Options

          Option No.  Option
          ------------------------------------------------
              1       Standard Plan of Care
              2       Standard Assessments
              3       ADLs
              4       Treatment Orders
       ->     5       Vital Signs & Fluid Balances
              6       Defining Characteristics
              7       Routine Orders
              8       Preps and Special Instructions
              9       Custom Documents
             10       Standard Text - Patient History
             11       Station Parameters
             12       Print Standard Files
             13       Custom Worksheet


Enter option number--
```

Build Vital Signs

After you enter the number for the Vital Signs & Fluid Balances option, the following screen displays:

```
           General Hospital Vital Signs & Fluid Balances Processor
                                              Fri Dec 18, 1992 05:55pm
 Vital Signs & Fluid Balances Input Options

          Option No.     Option
          -------------------------

 BUILD         1          Vital Signs
               2          Fluid Balance

 PRINT         3          Vital Signs
               4          Fluid Balance









  Enter option number--
```

Select the option number for Vital Signs. The following prompt displays:

Enter first letter(s) `-` or vital sign code.

An unlimited number of data elements can be added.

Enter the first code (for example, 01). After the code is entered, the following screen displays:

```
                General Hospital Build Vital Signs Processor


1 Code                   2 Description        3 Value Format
  01                       Temperature

4 Normal Range  5 Low Value  6 High Value  7 Low Value  8 High Value









Enter vital sign description--
```

Field Explanations

1. CODE (DISPLAY ONLY)
The code is a two-digit number that displays in numerical order of the codes.

It is important to remember that the codes should be built according to the manner that the nurse is accustomed to charting the vital signs. For example, TPR (temperature, pulse and respirations) would be built 01, 02 and 03, respectively.

2. DESCRIPTION (14-AN-R)
The description is the vital sign description. The system displays a prompt for the vital sign entry:

Enter vital sign description--

3. VALUE FORMAT (1-A-R)
The value format allows the entry for the vital sign to contain a decimal point or a slash. The following prompt displays:

Should the value contain a decimal (D) point, a slash (S) or neither[NL]--

4. NORMAL RANGES (1-A-O)
This field indicates where the normal ranges for the vital sign are linked.

The following prompt displays:

Define normal ranges at the unit(U), site(S) or vital(V) sign level?--

If the normal ranges are linked at the vital sign level, the screen that is displayed allows entry of the values in the next two fields.

5. LOW VALUE (7-N-C)
The low value for the normal range is entered in this field. Entry is required if the Normal range is selected. The following prompt displays:

Enter low value for the normal range--

6. HIGH VALUE (7-N-C)
The high value for the normal range is entered in this field. Entry is required if the Normal range is selected. The following prompt displays:

Enter high value for the normal range--

NOTE: Fields 7 and 8 can be accessed only if a slash was selected in the Value Format field. These fields are for blood pressure only.

7. LOW VALUE (7-N-C)
The low value for the second value in the blood pressure is entered in this field. Entry is required if the normal range is selected. The following prompt displays:

Enter low value for the second value--

8. HIGH VALUE (7-N-C)
The high value for the normal range is entered in this field. Entry is required if the normal range is selected. The following prompt displays:

Enter high value for the second value--

If the normal range is not linked at the vital sign level, select the level where the normal ranges are linked from the following prompt:

Define normal ranges at the unit(U), site(S) or vital(V) sign level?--

To define normal ranges at the site, enter **S** for Site. The following screen displays:

```
              General Hospital Vital Sign Processor
                                        Fri Dec 18, 1992 05:55 pm

   1 Code            2 Description          3 Value Format


   4 Normal Range  5 Low Value  6 High Value  7 Low Value  8 High Value
     Site









   Edit units(U), sites(S), equipment(E) or modifiers(M)--
```

The prompt allows entry of the applicable elements: units, sites, equipment, or modifiers.

To define normal ranges at the unit, enter **U** for Unit. The following screen displays:

```
              General Hospital Vital Signs Processor
                                         Fri Dec 18, 1992 05:55 pm

   1 Code             2 Description      3 Value Format


   4 Normal Range  5 Low Value  6 High Value  7 Low Value  8 High Value
     Site

TYPE        CODE     DESCRIPTION      LOW VALUE     HIGH VALUE
Unit









     F1|Prev Page|F2|Next Page|F3|Insert|F4|Delete|F6|Reset|F7|Exit ?
```

The code is an alpha code containing up to three characters; the description is 14 characters in length. The code is typically the beginning letter of the description, so that the nurse or recorder can enter the letter without having to perform a table look-up for selection.

Repeat the same process for the remaining elements: site, equipment, or modifiers. The scrolling screen allows entry of normal ranges at the selected level.

Build Fluid Balances

After you select Vital Signs & Fluid Balances from the Standard File Maintenance Menu, the following screen displays:

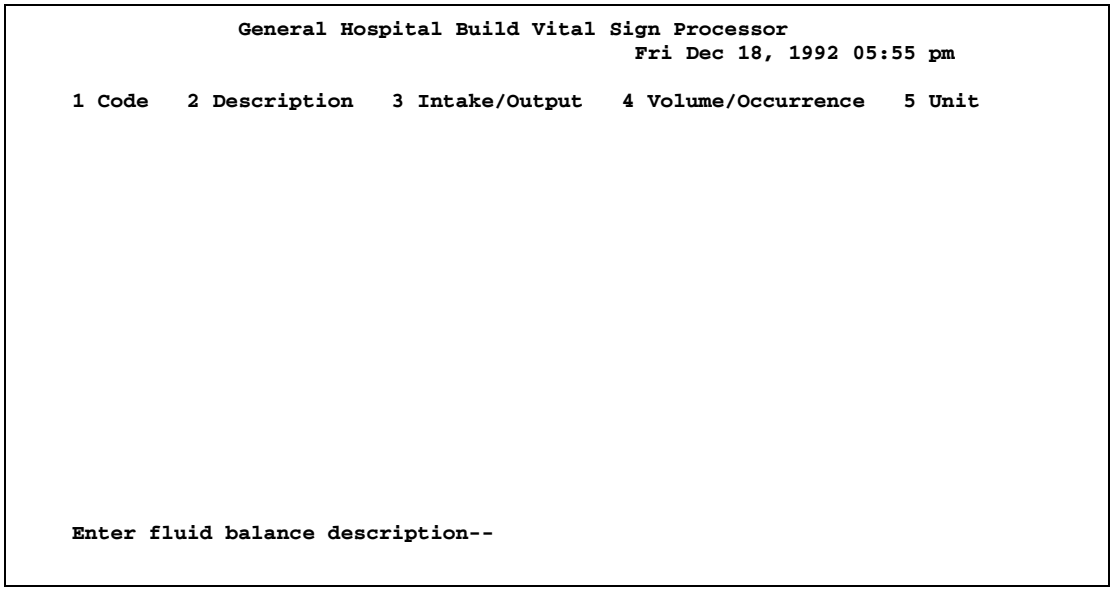
```
          General Hospital Vital Signs & Fluid Balances Processor
                                                  Fri Dec 18, 1992 05:55 pm
Vital Signs & Fluid Balances Input Options

       Option No.         Option
       ------------------------------------

BUILD       1             Vital Signs
            2             Fluid Balance

PRINT       3             Vital Signs
            4             Fluid Balance









  Enter option number--
```

Enter the option number of the element you wish to build. The following screen displays:

Enter first letter(s) `-` or fluid balance code.

An unlimited number of elements can be added.

Enter the first code (for example, 01), and the following screen displays:



Field Explanations

1. CODE (DISPLAY ONLY)
The code contains two digits which display in numerical order of the codes. It is important to remember that the codes should be built according to the level of frequency that the element is used.

2. DESCRIPTION (14-AN-R)
The description is the fluid balance element description. The following prompt displays:

Enter fluid balance description--

3. INTAKE/OUTPUT (1-N-O)
This field indicates if the fluid balance element is an intake or output element:

Is this an intake (I) or output (O) fluid?--

4. VOLUME/OCCURRENCE (1-N-R)
This field indicates if the element is calculated by volume or occurrences:

Does this fluid balance require volume (V) or occurrence (O) data? [O]--

If the element is calculated by volume, enter **V**. If the element is calculated by the number of occurrences, enter **O**.

5. UNIT (3-AN-O)
This field enables you to enter a new abbreviation for the unit. The default is cc.

CUSTOM WORKSHEET

The Custom Worksheet enables you to create numerous worksheets to meet your hospital's or departments individual needs. You select parameters that determine what types of patient data prints on the worksheet. The selections can be stored in the system and recalled for subsequent worksheet printings. Therefore, the Custom Worksheet has endless possibilities and could ultimately replace the existing nursing worksheets (ADL, Active Order, and General).

Two menus contain the Custom Worksheet function: Standard File Maintenance and Station Print. The worksheets are created from the Standard File Maintenance menu and are printed from the Station Print menu.

After accessing the Custom Worksheet function from the Station Maintenance menu, the following prompt displays if the CRT has secondary nursing stations defined:

Enter station code [2N]--

You can press ENTER to select the primary nursing station default, or you can enter a hyphen (-) for a table display of the secondary stations defined for the CRT. If the nursing station code entered is not defined or is not a station that is assigned to this CRT, then the following error message displays:

Error: Not on file!

After the station code has been selected (if necessary), the following prompt displays:

Enter worksheet code, `-` to list, or add(A)--

If you enter **A** to add, a blank Custom Worksheet screen displays in fill mode for you to enter information.

If you enter a code that does not exist, you can also add the code and define the new worksheet at this point. The following prompt displays:

Add this code `xxx`? (Y/N) [N]--

If you press ENTER for the default of No, the system returns to the prompt that enables you to enter the worksheet code. If you enter **Y** for Yes, the screen displays in edit mode with the code filled in. You must fill in all fields.

If you enter a valid pre-defined code or select a code from the table display, the following Custom Worksheet screen displays with all the field values entered from the last edit.

```
                General Hospital Custom Worksheet Processor
Station: 1 EAST                                  Thu Dec 17, 2009 05:14 pm

 REPORT FORMAT
 1 Worksheet Code      2 Worksheet Name
   1                     ORDER WORKSHEET
 3 # Blanks Between Patients  4 # Blanks per Unoccupied Bed    5 # of Copies
   2                            2                               2

 PATIENT DATA
 6 ADLs           7 ADL Categories                             8 Diet
   No                                                           Yes
 9 Treatments    10 Treatment Date     11 Oxygen Therapy     12 IV Therapy
   No                                     No                    No
13 Orders        14 Departments                              15 Preps & Spec Inst
   Yes              All                                        Yes
16 PRNs          17 Departments
   Yes              All
18 Phys Consults 19 Patient History    20 Medical Page Info. 21 Shifts to Print
   No               No                    No                    123


Print Worksheet? (Y/N) [Y]--
```

Field Explanations

1. WORKSHEET CODE (4-N-R)
This required field is display only, unless you are adding a new worksheet to the system. If adding a new worksheet, the system prompts you to enter a code.

2. WORKSHEET NAME (25-AN-R)
This field is required when you are adding a new worksheet, and can be edited. This description prints as the name of the worksheet on the report.

3. # BLANKS BETWEEN PATIENTS (1-N-O)
This field indicates how many blank lines print after the patient data. Up to nine blank lines can print. The default is two (2).

4. # BLANKS PER UNOCCUPIED BED (1-N-O)
This field indicates how many blank lines print for unoccupied beds. The only information that prints for an unoccupied bed is the room and bed number. Up to nine blank lines can print. The default is one (1).

5. # OF COPIES (1-N-O)
This field indicates the number of copies to print. This field should be set for each custom worksheet. If not set, the default is one (1) copy.

6. ADLs (1-A-O)
This field indicates whether ADLs print on the worksheet. The default is Yes.

7. ADL CATEGORIES (U-AN-O)
This field can be accessed only if the ADL field was answered Yes. The system displays the station-specific ADL menu and allows you to select one or more categories (or all) to print on the worksheet. The default is All.

8. DIET (1-A-O)
This field indicates whether the patient's diet (including nourishments, modifiers and instructions) print on the worksheet. The default is Yes.

9. TREATMENTS (1-A-O)
This field indicates whether treatment text print on the worksheet. The default is Yes.

10. TREATMENT DATE (1-A-O)
This field is indicates whether the date that the treatment was entered into the system prints on the worksheet. The default is Yes.

11. OXYGEN THERAPY (1-A-O)
This field indicates whether oxygen therapy prints on the worksheet. The default is Yes.

12. IV THERAPY (1-A-O)
This field indicates whether IV therapy prints on the worksheet. The default is Yes.

13. ORDERS (1-A-O)
This field indicates whether active and pending orders print on the worksheet. The default is Yes. If you set this field to Yes, you must also complete the associated Departments field.

Completed orders do not print on this worksheet, except for PRN orders if so indicated in the PRNs field and associated Departments field on this screen.

14. DEPARTMENTS (TABLE LOOKUP-C)
This field can be accessed only if the Orders field is set to Yes. It enables you to select the departments for which you want orders (except PRN orders) to print on the worksheet. The system displays a table of all SIM departments for the facility, and you can select one, several, or all. Orders from each selected department print on the worksheet.

15. PREPS & SPECIAL INSTRUCTIONS (1-A-O)
This field can be accessed only if the Order field is answered Yes. This field is indicates whether Preps and Special Instructions print on the worksheet, after the associated order. The default is Yes.

16. PRNS (1-A-O)
This field indicates whether orders with a frequency of PRN should print on the worksheet. PRN orders automatically go to a Complete status, so they never generate an active occurrence. Therefore, they would not appear on the worksheet even if you set the Orders field on this screen to Yes (unless you also set this field to Yes).

For PRN orders that print, the information that prints is from the parent order. Once a PRN order is placed, it prints on the worksheet regardless of whether an occurrence has been added. The PRN order continues to print until the parent order is cancelled or discontinued or the patient is discharged.

17. DEPARTMENTS (TABLE LOOKUP-C)
This field can be accessed only if the PRNs field is set to Yes. The system displays a table of all SIM departments for the facility, and you can select one, several, or all. PRN orders from each selected department print on the worksheet.

18. PATIENT HISTORY (1-A-O)
This field indicates whether or not patient history text prints on the worksheet. The default is Yes.

19. PHYSICIAN CONSULTS (1-A-O)
This field indicates whether or not physician consultants print on the worksheet. If so, the physician's name and specialty print. The default is Yes.

20. MEDICAL PAGE INFO (1-A-O)
This field indicates whether or not the medical page information prints on the worksheet. This information includes the following fields: Diagnosis, Allergies, Surgery Date and Procedure, Precautions, Admission Date, LOS, Condition, Level of Care, Smoker, Pt Type, Isolation, Height and Weight. The default is Yes.

21. SHIFTS TO PRINT (3-N-R)
This field accepts all combinations of shifts 1,2,3. ADLs and treatments ordered for the specified shift(s) print on the worksheet. The default is shifts 123.

NOTE: When generating the Patient Care Profile Custom Worksheet, you can choose to *not* print all occurrences of an order, which eliminates lengthy and less useful reports. To choose to not print all occurrences of an order, set the Collapse Occurrences field on the SIM Departments table to Yes. If you select Yes, then the PCP and worksheets print only one occurrence from a parent order. For example, if Vital Signs are ordered Q2H, only one occurrence prints on the PCP even though four were generated for that shift. The default for this field is No.

Impact

When you accept this screen, the following processing takes place:

- The system stores the worksheet information in the Standard File.
- The worksheet is now available to print, using the Custom Worksheet function on the Station Print menu.

Chapter 8 - PRINT STANDARD FILE DOCUMENTS

This chapter contains examples of each Standard File Document you can print from the STAR Patient Care Nursing system. To understand how these files are created, see Chapter 7: Standard File Maintenance.

Illustrations

NURSING FILES

For Nursing files that print the component text, the format may differ from the examples in this section:

- If you facility has run the conversion associated with user-formatted PCPs and Worksheets, the text displays/prints on three lines of 75 characters each.
- If your facility has not run the conversion, the text displays/prints on five lines of 36 characters each.

Print Standard Plan of Care

The Print Standard Plan of Care function provides a numeric or alphabetic listing of each Plan of Care in the Standard File. The alphabetic listing has several print options including whether or not to print the expected outcomes and interventions which are linked to the Plan of Care.

You can access the Print Standard Plan of Care function by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Print Standard Files
4. Standard Plan of Care

If necessary, enter the appropriate facility. The following prompt displays:

Enter alphabetic(A) or numeric(N) print [A]--

If you enter **N** for numeric, the following prompt displays:

Print numerical list for standard plans of care? (Y/N) [Y]--

If you enter **Y** for Yes, the report prints on the printer defined for your terminal. If you enter **N** for No, the Print Standard Files menu redisplays.

If you enter **A** for alphabetic print, the following screen displays:

```
                General Hospital Standard Plan of Care Processor
                                                Fri Dec 17, 2009 11:03 am

( 1)Print DO's, PO's, DP's   : Yes
( 2)Print text?              : Yes
( 3)Print elements?          : Yes
( 4)Print element text?      : Yes
( 5)Starting letter(s)       : CA
( 6)Ending letter(s)         : CO
( 7)Number of Copies         :









Accept this screen? (Y/N)-- [Y]
```

Field Explanations

1. PRINT DO's, PO's, DP's (1-A-O)
This field indicates whether or not the Discharge/Expected Outcomes, Problem/ Expected Outcomes, and Discharge Plans that are linked to the Plan of Care should print on the report. The default is Yes.

2. PRINT TEXT? (1-A-O)
This field indicates whether or not the text of the Discharge/Expected Outcomes, Problem/Expected Outcomes, and Discharge Plans that are linked to the Plan of Care should print on the report. The default is Yes.

3. PRINT ELEMENTS? (1-A-O)
This field indicates whether or not the Interventions/Treatments which are linked to the Discharge/Expected Outcomes, Problem/Expected Outcomes, and Discharge Plans (that are linked to the Plan of Care) should print on the report. The default is Yes.

4. PRINT ELEMENT TEXT? (1-A-O)
This field indicates whether or not the Intervention/Treatment text should print on the report. The default is Yes.

5. STARTING LETTER(S) (TABLE LOOKUP)
This field indicates the Plan of Care to print or the starting letter(s) of the Plan of Care to print on the report. To print an individual Plan of Care, enter the Plan of Care code or a hyphen (-) for a table lookup. To print eachPlan of Care that begins with A, enter **A**.

6. ENDING LETTER(S) (U-A-C)
This field is used with the Starting Letter(s) field to determine the range of Plans of Care to print. It is used only if the report is printing more than one Plan of Care. The default is the value of the Starting Letter(s) field. To print each Plan of Care that begins with A, enter A for both Starting Letter(s) and Ending Letter(s).

7. NUMBER OF COPIES (1-N-O)
This field determines the number of copies to print. Each one prints as a separate report on the spooler or printer.

When you access this field, the system displays the following prompt:

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

Output

After you accept this screen, the Standard Plan of Care Report prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance.

The Standard Plan of Care Report provides an alphabetic or numeric listing of each Plan of Care in the Standard file.

The sort is alphabetic or numeric depending on the screen option.

The following information prints on this report:

- Plan of Care code
- Plan of Care description
- Associated Discharge/Expected Outcomes, Problem/Expected Outcomes, Discharge Plans (including their codes, description, and text)
- Associated Interventions (including their codes, description, and text)

Figure 8.1 Standard Plan of Care

```
Fri Dec 18, 1992 01:44 pm                                  STANDARD PLAN OF CARE
                              GENERAL HOSPITAL A                        Page 4

                        SELECTION CRITERIA -- CA thru CO
------------------------------------------------------------------------------
CODE   DESCRIPTION
       EXPECTED OUTCOMES
                  TEXT
                  ELEMENTS
                              ELEMENT TEXT
------------------------------------------------------------------------------

4002   CARDIAC OUTPUT, ALTERATION IN-DEC

       PO   4009  OPTIMAL CARDIAC OUTPUT

                  DECREASED CARDIAC OUTPUT
                  MAINTAIN ADEQUATE PERFUSION

                  Int  6015  ALERTNESS, SKIN COLOR AND TEMP

                             OBSERVE FOR ALERTNESS, SKIN COLOR
                             AND TEMPERATURE....

                  Int  6017  INTAKE AND OUTPUT

                             MONITOR INTAKE AND OUTPUT

                  Int  6016  MONITOR HEART RHYTHM

                             MONITOR HEART RHYTHM

                  Int  6010  PERIPHERAL PULSE

                             OBSERVE PRESENCE OF PERIPHERAL PULSE

                  Int  4032  POSITION FOR OPT CIRC AND COMFORT

                             POSITION FOR OPTIMAL CIRCULATION AND
                             COMFORT

                  Int  6011  BLEEDING, OBSERVE FOR

                             OBSERVE FOR PRESENCE OF UNCONTROLLED
                             OR DELAYED BLEEDING SOURCE

       DO   0011  ACTIVITY WITHIN CARDIAC LIMITS

                  WILL ACHIEVE ACTIVITY WITHIN
                  LIMITS OF PRESCRIBED HEART RATE____
```

Figure 8.2 Standard Plan of Care

```
Fri Dec 18, 1992 01:44 pm                                  STANDARD PLAN OF CARE
                              GENERAL HOSPITAL A                    Page 5

                        SELECTION CRITERIA -- CA thru CO
------------------------------------------------------------------------------
CODE   DESCRIPTION
       EXPECTED OUTCOMES
                TEXT
                ELEMENTS
                            ELEMENT TEXT
------------------------------------------------------------------------------
                Int  3015  REFERRAL TO CARDIAC REHAB

                           REFERRAL TO CARDIAC REHAB FOR
                           EXERCISE PRESCRIPTION AND WORK
                           SIMPLIFICATION METHODS

                Int  7048  AVOID FATIGUE, INSTRUCT

                           INSTRUCT TO PLAN ACTIVITIES TO AVOID
                           FATIGUE

                Int  6016  MONITOR HEART RHYTHM

                           MONITOR HEART RHYTHM

       DO   0012  CARDIAC, VERBALIZE SYMPTOMS

                CUSTOMER WILL VERBALIZE ABSENCE OF
                WEAKNESS OR FATIGUE AFTER ACTIVITY

                Int  7047  REPORT CARDIAC SYMPTOMS

                           INSTRUCT TO REPORT CHEST PAIN,
                           PALPITATIONS, DIZZINESS & WEAKNESS

                Int  6015  ALERTNESS, SKIN COLOR AND TEMP

                           OBSERVE FOR ALERTNESS, SKIN COLOR
                           AND TEMPERATURE....

1011   COPING, INEFFECTIVE FAMILY

       PO   4123  CHEMICALLY DEP FAMILY WILL COPE

                INEFFECTIVE COPING RELATED TO
                CHEMICALLY DEPENDENT FAMILY MEMBER
                FAMILY WILL SUPPORT CHEM DEP MEMBER
                IN SEEKING TREATMENT AND WILL COPE
                EFFECTIVELY AS A UNIT
```

Print Report Formats

You can print the report formats you set up for PCPs and Worksheets using the Print Report Formats function. After you select Print Report Formats from the Print Standard Files Menu, the following menu displays:

```
              General Hospital Critical Pathways Processor
                                                  Mon Aug 31, 1992 04:18 pm
Report Formats Input Options

            Option No.  Option
            ----------------------------------------
                1       Patient Care Profile Reports
                2       Worksheet Reports









Enter option number--
```

Select the option for the type of report format you want to print; either Patient Care Profile Reports or Worksheet Reports.

After you select the facility, if necessary, one of the following prompts displays, depending on whether you select the report for the PCP or Worksheet formats:

Print user defined PCP formats? (Y/N) [Y]--
Print user defined Worksheet formats? (Y/N) [Y]--

To print the report, enter **Y** for Yes. The message Printing displays and the report prints at the default printer for the requesting CRT. The Report Formats Menu redisplays.

To cancel the print request, enter **N** for No. The Report Formats Menu redisplays.

Following are examples of the Patient Care Profile Reports and the Worksheet Reports.

Figure 8.3 Patient Care Profile Reports

```
Tue Mar 29, 1994 04:52 pm                    Parameterized PCP Format Report
                                MODEL HOSPITAL A                        Page 1
------------------------------------------------------------------------------
PCP Code: 564
PCP Name: ICU PCP
Blank Lines at TOP: 2
Skip Cell if Blank: No
Pt. Block Location: Top Left
Associated Block: A34 ASSO. PT. BLOCK
Page Footer: A98 TEXT
Cell Order     Cell Description
   1           9    PLAN OF CARE
   2           876  ACTIVE ORDERS, CHRONO
   3           852  TEST COMMENT
   4           6    MEDICAL INFORMATION
PCP Code: 99
PCP Name: GENERAL NURSING PCP
Blank Lines at TOP: 0
Skip Cell if Blank: No
Pt. Block Location: Top Right
Associated Block: 102 ASSOCIATED PT BLOCK
Page Footer:
Cell Order     Cell Description
   1           765  DIETARY CELL
   2           104  PATIENT HX
   3           100  ACTIVE ORDERS
   4           101  ADL'S
   5           108  PLAN OF CARE

PCP Code: 100
PCP Name: CCU PCP
Blank Lines at TOP: 0
Skip Cell if Blank: No
Pt. Block Location: Top Right
Associated Block: 5 ASSOCIATED PATIENT BLOCK
Page Footer:
Cell Order     Cell Description
   1           103  MEDICAL INF
   2           104  PATIENT HX
   3           100  ACTIVE ORDERS
   4           114  TREATMENTS C COLON
   5           107  PHYSICIAN CONSULTS
   6           101  ADL'S
   7           105  MED ORDERS
   8           108  PLAN OF CARE
   9           110  PROGRESS NOTES
PCP Code: 912
PCP Name: LAB PCP
Blank Lines at TOP: 0
Skip Cell if Blank: Yes
Pt. Block Location: Top Right
Associated Block: A34 ASSO. PT. BLOCK
Page Footer:
Cell Order     Cell Description
   1           199  TEST - LAB ORDERS
```

Figure 8.4 Worksheet Reports

```
Tue Mar 29, 1994 04:52 pm                Parameterized Worksheet Format Report
                                  MODEL HOSPITAL A                        Page 1
-------------------------------------------------------------------------------
Worksheet Code: 95
Worksheet Name: ADL WORKSHEET
Include Cell Titles?: No

Cell Order     Cell Description
   1           87   WORKSHEET PATIENT IDENTIFIER
   2           4    ADL'S ALL

Worksheet Code: 956
Worksheet Name: NURSING ASSISTANT WORKSHEET-NSY
Include Cell Titles?: No
Cell Order     Cell Description
   1           949  PATIENT IDENTIFIER LINE
   2           A23  ADL
   3           15   ACTIVE ORDERS, REVERSE CHRONO
```

Print Discharge Outcomes

The Print Discharge Outcomes function provides a numeric or alphabetic listing of all discharge/expected outcomes in the Standard File. The alphabetic listing has several print options including whether or not to print the Interventions which are linked to the Discharge Outcome(s).

You can access the Print Discharge Outcomes function by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Print Standard Files
4. Discharge Outcomes

If necessary, enter the appropriate facility. The following prompt displays:

Enter alphabetic(A) or numeric(N) print [A]--

If you enter **N** for numeric, the following prompt displays:

Print numerical list for discharge outcomes? (Y/N) [Y]--

If you enter **Y** for Yes, the report prints on the printer defined for your terminal. If you enter **N** for No, the Print Standard Files menu redisplays. If you enter **A** for alphabetic print, the following screen displays:

```
                  General Hospital Discharge Outcomes Processor
                                                  Fri Dec 18, 1992 11:03 am

( 1)Print text?          : Yes
( 2)Print elements?      : Yes
( 3)Print element text? : Yes
( 4)Starting letter(s)   : CA
( 5)Ending letter(s)     : CO









Accept this screen? (Y/N)-- [Y]
```

Field Explanations

1. PRINT TEXT? (1-A-O)
This field indicates whether or not the Discharge Outcome text should print on the report. The default is Yes.

2. PRINT ELEMENTS? (1-A-O)
This field indicates whether or not the interventions/treatments which are linked to the Discharge Outcomes should print on the report. The default is Yes.

3. PRINT ELEMENT TEXT? (1-A-O)
This field indicates whether or not the intervention/treatment text should print on the report. The default is Yes.

4. STARTING LETTER(S) (TABLE LOOKUP)
This field indicates the Discharge Outcome to print or the starting letter(s) of Discharge Outcomes to print on the report. To print an individual Outcome, enter the Discharge Outcome code or a hyphen (-) for a table lookup. To print all Discharge Outcomes that begin with A, enter **A**.

5. ENDING LETTER(S) (U-A-C)
This field is used with the Starting Letter(s) field to determine the range of Discharge Outcomes to print. It is used only if the report is printing more than one Discharge Outcome. The default is the value of the Starting Letter(s) field. To print all Discharge Outcomes that begin with A, enter **A** for both Starting Letter(s) and Ending Letter(s).

Output

After you accept this screen, the Discharge/Expected Outcome Report prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance.

The Discharge/Expected Outcome Report provides an alphabetic or numeric listing of all Discharge Outcomes in the Standard file.

The sort is alphabetic or numeric, depending on the screen option.

The following information prints on this report:

- Discharge Outcome code
- Discharge Outcome description
- Associated Interventions (including their codes, description, and text)

Figure 8.5 Standard Discharge/Expected Outcome Report

```
Fri Dec 18, 1992 01:47 pm                    STANDARD DISCHARGE/EXPECTED OUTCOME
                            GENERAL HOSPITAL A                          Page 1
                        SELECTION CRITERIA -- CA thru CO
--------------------------------------------------------------------------------
CODE   DESCRIPTION
           TEXT
           ELEMENTS
                         ELEMENT TEXT
--------------------------------------------------------------------------------
 0011  CARDIAC LIMITS, ACTIVITY WITHIN

           WILL ACHIEVE ACTIVITY WITHIN
           LIMITS OF PRESCRIBED HEART RATE____

           Int    3015  REFERRAL TO CARDIAC REHAB

                        REFERRAL TO CARDIAC REHAB FOR
                        EXERCISE PRESCRIPTION AND WORK
                        SIMPLIFICATION METHODS

           Int    7048  AVOID FATIGUE, INSTRUCT

                        INSTRUCT TO PLAN ACTIVITIES TO AVOID
                        FATIGUE

           Int    6016  MONITOR HEART RHYTHM

                        MONITOR HEART RHYTHM

 0012  CARDIAC, VERBALIZE SYMPTOMS

           CUSTOMER WILL VERBALIZE ABSENCE OF
           WEAKNESS OR FATIGUE AFTER ACTIVITY

           Int    7047  REPORT CARDIAC SYMPTOMS

                        INSTRUCT TO REPORT CHEST PAIN,
                        PALPITATIONS, DIZZINESS & WEAKNESS

           Int    6015  ALERTNESS, SKIN COLOR AND TEMP

                        OBSERVE FOR ALERTNESS, SKIN COLOR
                        AND TEMPERATURE....

 0022  COMMUNICATION, METHOD OF

           CUSTOMER WILL ESTABLISH METHOD OF
           COMMUNICATION

           Int    4008  ENCOURAGE ATTEMPTS TO COMMUNICATE
```

Print Discharge Plans

The Print Discharge Plan function provides a numeric or alphabetic listing of all Discharge Plans in the Standard File. The alphabetic listing has several print options including whether or not to print the Interventions which are linked to the Discharge Plan(s).

You can access the Print Discharge Plans function by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Print Standard Files
4. Discharge Plans

If necessary, enter the appropriate facility. The following prompt displays:

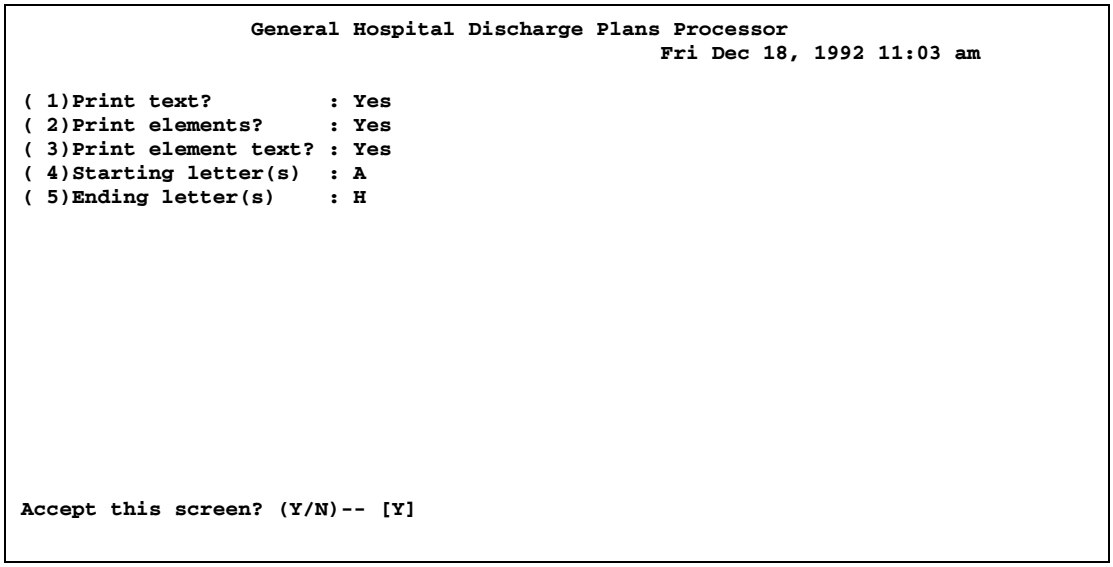
Enter alphabetic(A) or numeric(N) print [A]--

If you enter **N** for numeric, the following prompt displays:

Print numerical list for discharge plans? (Y/N) [Y]--

If you enter **Y** for Yes, the report prints on the printer defined for your terminal. If you enter **N** for No, the Print Standard Files menu redisplays.

If you enter **A** for alphabetic print, the following screen displays:



Field Explanations

1. PRINT TEXT? (1-A-O)
This field indicates whether or not the Discharge Plan text should print on the report. The default is Yes.

2. PRINT ELEMENTS? (1-A-O)
This field indicates whether or not the interventions/treatments that are linked to the Discharge Plans should print on the report. The default is Yes.

3. PRINT ELEMENT TEXT? (1-A-O)
This field indicates whether or not the intervention/treatment text should print on the report. The default is Yes.

4. STARTING LETTER(S) (TABLE LOOKUP)
This field indicates the Discharge Plan to print or the starting letter(s) of Discharge Plans to print on the report. To print an individual Expected Outcome, enter the Discharge Plan code or a hyphen (-) for a table lookup. To print all Discharge Plans that begin with A, enter **A**.

5. ENDING LETTER(S) (U-A-C)
This field is used with the Starting Letter(s) field to determine the range of Discharge Plans to print. It is used only if the report is printing more than one Discharge Plan. The default is the value of the Starting Letter(s) field. To print all Discharge Plans that begin with A, enter **A** for both Starting Letter(s) and Ending Letter(s).

Output

After you accept this screen, the Discharge Plan Report prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance.

The Discharge Plan Report provides an alphabetic or numeric listing of all Discharge Plans in the Standard file.

The sort is alphabetic or numeric, depending on the screen option.

The following information prints on this report:

- Discharge Plan code
- Discharge Plan description
- Associated Interventions (including their codes, description, and text)

Figure 8.6 Standard Discharge Plan

```
Fri Dec 18, 1992 01:48 pm                          STANDARD DISCHARGE PLAN
                              GENERAL HOSPITAL A                      Page 1

                       SELECTION CRITERIA -- A thru H
-------------------------------------------------------------------------------
CODE   DESCRIPTION
           TEXT
           ELEMENTS
                        ELEMENT TEXT
-------------------------------------------------------------------------------
 0054  ACT INDEP AND RESP (ADOL PSYCH)

           SHOW ABILITY TO ACT INDEPENDENTLY
           AND RESPONSIBLY

           Int    3033  EXPECTED OUTCOME, DIS, PT. SET

                        ASSIST (NAME) TO SET EXPECTED OUTCOMES FOR
                        DISCHARGE (SPECIFY EXPECTED OUTCOMES)

           Int    3034  OUTSIDE RESOURCES, ENC TO SEEK

                        ENCOURAGE PT TO SEEK OUTSIDE
                        RESOURCES

 1000  HOME MAINTENANCE-POST-OP

           PATIENT WILL MAINTAIN POST-OP
           COURSE

           Int    4075  ADLS INDEPENDENT

                        ENCOURAGE INDEPENDENT ADLS

           Int    7056  INSTRUCT IN BOWEL PROGRAM

                        INSTRUCT CUSTOMER/S.O. IN BOWEL
                        TRAINING PROGRAM

           Int    7042  SUPPLIES FOR HOME CARE

                        INSTRUCT IN OBTAINING HOME CARE
                        SUPPLIES

           Int    3007  SOCIAL SERVICE REFERRAL

                        REFER TO SOCIAL SERVICES
```

Print Problem Outcomes

The Print Problem Outcomes function provides a numeric or alphabetic listing of all Problem Outcomes in the Standard File. The alphabetic listing has several print options including whether or not to print the interventions which are linked to the Problem Outcome(s).

You can access the Print Problem Outcomes function by selecting the following menu options:

1. File Maintenance from the Nursing main menu

2. Standard File Maintenance
3. Print Standard Files
4. Problem Outcomes

If necessary, enter the appropriate facility.

The following prompt displays:

Enter alphabetic(A) or numeric(N) print [A]--

If you enter **N** for numeric, the following prompt displays:

Print numerical list for problem outcomes? (Y/N) [Y]--

If you enter **Y** for Yes, the report prints on the printer defined for your terminal. If you enter **N** for No, the Print Standard Files menu redisplays. If you enter **A** for alphabetic print, the following screen displays:

```
                  General Hospital Problem Outcomes Processor
                                                Fri Dec 18, 1992 11:04 am

( 1)Print text?          : Yes
( 2)Print elements?      : Yes
( 3)Print element text?  : Yes
( 4)Starting letter(s)   : A
( 5)Ending letter(s)     : A









Accept this screen? (Y/N)-- [Y]
```

Field Explanations

1. PRINT TEXT? (1-A-O)
This field indicates whether or not the Problem Outcome text should print on the report. The default is Yes.

2. PRINT ELEMENTS? (1-A-O)
This field indicates whether or not the interventions/treatments that are linked to the Problem Outcomes should print on the report. The default is Yes.

3. PRINT ELEMENT TEXT? (1-A-O)
This field indicates whether or not the intervention/treatment text should print on the report. The default is Yes.

4. STARTING LETTER(S) (TABLE LOOKUP)
This field indicates the Problem Outcome to print or the starting letter(s) of Problem Outcomes to print on the report. To print an individual Problem/Expected Outcome, enter the Problem Outcome code or a hyphen (-) for a table lookup. To print all Problem Outcomes that begin with A, enter **A**.

5. ENDING LETTER(S) (U-A-C)
This field is used with the Starting Letter(s) field to determine the range of Problem Outcomes to print. It is used only if the report is printing more than one Problem Outcome. The default is the value of the Starting Letter(s) field. To print all Problem Outcomes that begin with A, enter **A** for both Starting Letter(s) and Ending Letter(s).

Output

After you accept this screen, the Problem/Expected Outcome Report prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance.

The Problem/Expected Outcome Report provides an alphabetic or numeric listing of all Problem Outcomes in the Standard file.

The sort is alphabetic or numeric, depending on the screen option.

The following information prints on this report:

- Problem Outcome code
- Problem Outcome description
- Associated Interventions (including their codes, description, and text)

Figure 8.7 Standard Problem/Expected Outcome Report

```
Fri Dec 18, 1992 03:37 pm                    STANDARD PROBLEM/EXPECTED OUTCOME
                              GENERAL HOSPITAL A                      Page 1

                       SELECTION CRITERIA -- A thru A
--------------------------------------------------------------------------------
CODE   DESCRIPTION
           TEXT
           ELEMENTS
                         ELEMENT TEXT
--------------------------------------------------------------------------------
 5050  ACTIVITY INTOLERANCE INTS

           Int    3066  REPORT SUSPECTED NEGLECT OR ABUSE

                        UTILIZE APPROPRIATE CHANNELS TO
                        REPORT SUSPECTED NEGLECT OR ABUSE

           Int    4057  ATMOSPHERE OF ACCEPTANCE

                        PROVIDE ATMOSPHERE OF ACCEPTANCE

           Int    9072  ACCU-CHECKS

                        Accu-checks (frequency)

 4047  ACTIVITY RESTRIC, KNOWLEDGE OF

           KNOWLEDGE DEFICIT, ACTIVITY
           RESTRICTIONS
           CUSTOMER WILL VERBALIZE RESTRICTIONS
           OF ACTIVITIES

           Int    7016  ACTIVITY RESTRICTION, INSTRUCTION

                        INSTRUCT CUSTOMER IN ACTIVITY
                        RESTRICTION ORDERED BY PHYSICIAN
```

Print Interventions & Treatments

The Print Intervention & Treatment function provides a numeric or alphabetic listing of all Interventions in the Standard File. The alphabetic listing has several print options including whether or not to print the Intervention text.

You can access the Print Interventions & Treatments function by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Print Standard Files
4. Interventions & Treatments

In the following section, the term *Intervention* applies to both Interventions and Treatments.

If necessary, enter the appropriate facility. The following prompt displays:

Enter alphabetic(A) or numeric(N) print [A]--

If you enter **N** for numeric, the following prompt displays:

Print numerical list for intervention/treatments? (Y/N) [Y]--

If you enter **Y** for Yes, the report prints on the printer defined for your terminal. If you enter **N** for No, the Print Standard Files menu redisplays. If you enter **A** for alphabetic print, the following screen displays:

```
            General Hospital Interventions & Treatments Processor
                                                  Fri Dec 18, 1992 11:04 am

( 1)Print text?          : Yes
( 2)Starting letter(s)   : AB
( 3)Ending letter(s)     : ADAP









Accept this screen? (Y/N)-- [Y]
```

Field Explanations

1. PRINT TEXT? (1-A-O)
This field indicates whether or not the intervention text should print on the report. The default is Yes.

2. STARTING LETTER(S) (TABLE LOOKUP)
This field indicates the Intervention to print or the starting letter(s) of Interventions to print on the report. To print an individual item, enter the intervention code or a hyphen (-) for a table lookup. To print all interventions that begin with A, enter **A**.

3. ENDING LETTER(S) (U-A-C)
This field is used withthe Starting Letter(s) field to determine the range of Interventions to print. It is used only if the report is printing more than one Intervention. The default is the value of the Starting Letter(s) field. To print all Interventions that begin with A, enter **A** for both Starting Letter(s) and Ending Letter(s).

Output

After you accept this screen, the Intervention/Treatment Report prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance.

The Intervention/Treatments Report provides an alphabetic or numeric listing of all Interventions in the Standard file.

The sort is alphabetic or numeric, depending on the screen option.

The following information prints on this report:

- Intervention code
- Intervention description
- Intervention text

Figure 8.8 Standard Interventions Report

```
Fri Dec 18, 1992 03:37 pm                                STANDARD INTERVENTIONS
                              GENERAL HOSPITAL A                        Page 2

                        SELECTION CRITERIA -- AB thru ADAP
------------------------------------------------------------------------------
CODE   DESCRIPTION                                          PCR
                  TEXT
------------------------------------------------------------------------------
4123   ACTIVITIES, STRUCTURE/INV PEERS
                  STRUCTURE ACTIVITIES FOR PATIENT;
                  INVOLVE IN ACTIVITIES WITH PEERS

5037   ACTIVITY LIMITATIONS, REINFORCE
                  REINFORCE ACTIVITY LIMITATIONS

4022   ACTIVITY PLAN, INVOLVE PT
                  INVOLVE PT IN PLANNING ACTIVITY

5015   ACTIVITY RESTRICTION ADOL PSYCH
                  PLACE ON APPROPRIATE ACTIVITY
                  RESTRICTIONS (SPECIFY)

7016   ACTIVITY RESTRICTION, INSTRUCTION
                  INSTRUCT CUSTOMER IN ACTIVITY
                  RESTRICTION ORDERED BY PHYSICIAN

3003   ACTIVITY, INCREASE AS TOL
                  INCREASE ACTIVITY AS TOLERATED TO
                  IMPROVE STAMINA

4157   ACTIVITY, PROVIDE FAILPROOF
                  PROVIDE FAILPROOF ACTIVITY FOR PT.

4158   ACTIVITY, PROVIDE STRUCTURE FOR
                  PROVIDE STRUCTURE FOR PATIENT
                  ACTIVITY

3004   ACTIVITY,INCREASE TO AMBULATION
                  INCREASE ACTIVITY AND PROGRESS TO
                  AMBULATION

5027   ADAPTION TO LOSS, ASSESS
                  ASSESS STAGE OF ADAPTATION TO LOSS

7011   ADAPTIVE COMMUNICATION TECHNIQUES
                  INSTRUCT CUSTOMER/S.O. IN TECHNIQUES
                  OF ADAPTIVE COMMUNICATION

4010   ADAPTIVE EQUIPMENT
                  USE ADAPTIVE EQUIPMENT/ALPHABET
                  BOARD/TABLET/ SIGN LANGUAGE
```

Print ADLs / Misc.

The Print ADLs / Misc. function provides a numeric or alphabetic listing of all ADLs in the Standard File. The alphabetic listing has several print options including whether or not to print the subcategories and elements.

You can access the Print ADLs / Misc. function using the by selecting menu options:

1. File Maintenance from the Nursing main menu

2. Standard File Maintenance
3. Print Standard Files
4. ADLs / Misc

If necessary, enter the appropriate facility. The following prompt displays:

Enter alphabetic(A) or numeric(N) print [A]--

If you enter **N** for numeric, the following prompt displays:

Print numerical list for ADLs? (Y/N) [Y]--

If you enter **Y** for Yes, the report prints on the printer defined for your terminal. If you enter **N** for No, the Print Standard Files menu redisplays.

If you enter **A** for alphabetic print, the following screen displays:

```
                  General Hospital ADLs / Misc. Processor
                                              Fri Dec 18, 1992 11:04 am

( 1)Print subcategories  : Yes
( 2)Print elements       : Yes
( 3)Starting letter(s)   : A
( 4)Ending letter(s)     : B









Accept this screen? (Y/N)-- [Y]
```

Field Explanations

1. PRINT SUBCATEGORIES (1-A-O)
This field indicates whether or not the ADL subcategories should print on the report. The default is Yes.

2. PRINT ELEMENTS (1-A-O)
This field indicates whether or not the ADL elements should print on the report. The default is Yes.

3. STARTING LETTER(S) (TABLE LOOKUP)
This field indicates the ADL to print or the starting letter(s) of ADLs to print on the report. To print an individual ADL, enter the ADL code or a hyphen (-) for a table lookup. To print all ADLs that begin with A, enter **A**.

4. ENDING LETTER(S) (U-A-C)
This field is used with the Starting Letter(s) field to determine the range of ADLs to print. It is used only if the report is printing more than one ADL. The default is the value of the Starting Letter(s) field. To print all ADLs that begin with A, enter **A** for both Starting Letter(s) and Ending Letter(s).

Output

After you accept this screen, the ADLs/Misc. Report prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance.

The ADLs/Misc. Report provides an alphabetic or numeric, listing of all ADLs in the Standard file.

The SORT is alphabetic or numeric depending on the screen option.

The following information prints on this report:

- ADL category
- ADL subcategory
- ADL elements
- PCR description

Figure 8.9 Standard ADLs / Misc. Report

```
Fri Dec 18, 1992 03:38 pm                                STANDARD ADLS / MISC
                              GENERAL HOSPITAL A                      Page 1

                        SELECTION CRITERIA -- A thru B
-------------------------------------------------------------------------------
CATEGORY
     SUBCATEGORY
          ELEMENT                                  PCR
-------------------------------------------------------------------------------
 1) ACTIVITY
      1) GENERAL
            1) ACTIVITY AS TOLERATED               ACTIVITY AS TOLERATED
            2) AMBULATE AS TOLERATED               AMBULATE AS TOLERATED
            3) AMBULATE BID                        AMBULATE BID
            4) AMBULATE TID                        AMBULATE TID
            5) AMBULATE W/ ASSIST OF 1             AMBULATE W. ASSIST OF 1
            6) AMBULATE W/ ASSIST OF 2             AMBULATE W/ ASSIST OF 2
            7) AMBULATE W/ CRUTCHES                AMBULATE W/ CRUTCHES
            8) AMBULATE W/ CANE, ETC.              AMBULATE W/ CANE, ETC.
            9) ASSIST 1ST TIME OOB - 1             ASSIST 1ST TIME OOB W/1
           10) BEDREST STRICT                      BEDREST STRICT
           11) BEDSIDE COMMODE                     INTAKE/OUTPUT-Q SHIFT
      2) 1 NORTH
            1) AMBULATE
            2) CHAIR
            3) GERI-CHAIR
            4) WALKER
            5) BRPS
            6) BEDSIDE COMMODE
            7) AMBULATE AS TOL                     AMBULATE AS TOLERATED
            8) AMBULATE BID                        AMBULATE BID
            9) AMBULATE QID
           10) IN HALLWAY
           11) IN LOBBY
           12) CHAIR FOR MEALS
           13) WHEELCHAIR
           14) WALKING BELT
           15) AS TOLERATED
           16) BY SELF
           17) WITH ASSISTANCE
           18) RESTRICT TO UNIT
      3) 2 NORTH
            1) AMBULATE BID
            2) AMBULATE TID
            3) AMBULATE QID
            4) AMBULATE 6 X /DAY
            5) AMBULATE AS TOL
            6) ASSIST OF TWO (2)
            7) ASSIST OF MANY
            8) BEDREST
            9) BEDSIDE COMMODE
```

Print ADL Station Menus

The Print ADL Station Menus function provides the nurse station with a printed copy of the ADL menu assigned to the station.

You can access the Print ADL Station Menus function by selecting the following menu options:

1. File Maintenance from the Nursing main menu

2. Standard File Maintenance

3. Print Standard Files

4. ADL Station Menus

The following screen displays with the ADL menu that is assigned to the specified station:

```
                General Hospital ADL Station Menus Processor
                                                Fri Dec 18, 1992 11:05 am

( 1)Category to print  :
( 2)Print elements     :
                                    ADL Menu
( 1) ACTIVITY
( 2) VITAL SIGNS
( 3) INTAKE/OUTPUT
( 4) HYGIENE
( 5) SAFETY









Enter choice to print [ALL]--
```

Field Explanations

1. CATEGORY TO PRINT (2-N-O)
This field indicates which ADL category displayed on the screen should print. The default is ALL categories.

2. PRINT ELEMENTS (1-A-O)
This field indicates whether or not the ADL elements should print on the report. The default is Yes.

Output

After you accept this screen, the ADL Station Menus Report prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance.

The ADL Station Menus Report provides a listing of one or all ADLs on a station-specific menu.

The sort is the order that the ADLs display on the menu.

The following information prints on this report:

- Nursing station
- ADL category
- ADL subcategory
- ADL elements
- PCR description

Figure 8.10 ADL Station Menus Report

```
Fri Mar 26 1993 03:38 pm                                    ADL STATION MENUS
                              GENERAL HOSPITAL A                      Page 1
                                  Station 2N
                              ADL Menu:  MED/SURG
-------------------------------------------------------------------------------
CATEGORY
    ELEMENTS                                  PCR
-------------------------------------------------------------------------------
 1) ACTIVITY-1 NORTH
     1) AMBULATE
     2) CHAIR
     3) GERI-CHAIR
     4) WALKER
     5) BRPS
     6) BEDSIDE COMMODE                       INTAKE/OUTPUT-Q SHIFT
     7) AMBULATE AS TOL                       AMBULATE AS TOLERATED
     9) AMBULATE BID                          AMBULATE BID
    10) AMBULATE QID                          AMBULATE QID
    11) IN HALLWAY
    12) IN LOBBY
    13) CHAIR FOR MEALS
    14) WHEELCHAIR
    15) WALKING BELT
    16) BY SELF
    17) WITH ASSISTANCE
    18) RESTRICT TO UNIT
    19) SPECIFY

 2) BEDREST-GENERAL
     1) BED MOBILITY W/ ASSIST
     2) FLAT
     3) FLAT - PRONE
     4) FLAT - SUPINE
     5) LIE PRONE BID
     6) LOGROLL
     7) ON LEFT SIDE
     8) ON RIGHT SIDE
     9) STAND TO VOID
    10) STAND TO WEIGH
    11) STRICT
    12) TURN Q 2 H
    13) TURN Q 3 H
    14) TURN W/ ASSIST OF TWO
    15) TURN W/ PILLOW BTWN LEGS
    16) W/ BRPS
    17) W/ COMMODE
```

Print Defining Characteristics

The Print Defining Characteristics function provides a numeric or alphabetic listing of all Defining Characteristics in the Standard File. The alphabetic listing can be printed for one or more Level 1 codes.

You can access the Print Defining Characteristics function by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Print Standard Files
4. Defining Characteristics

If necessary, enter the appropriate facility. The following prompt displays:

Enter alphabetic(A) or numeric(N) print [A]--

If you enter **N** for numeric, the following prompt displays:

Print numerical list for defining characteristics? (Y/N) [Y]--

If you enter **Y** for Yes, the report prints on the printer defined for your terminal. If you enter **N** for No, the Print Standard Files menu redisplays.

If you enter **A** for alphabetic print, the following screen and prompt display:

```
            General Hospital Defining Characteristics Processor
                                                Fri Dec 18, 1992 11:05 am

( 1)Level 1 to print    :









Enter first letter(s)`-` or level 1 code to print [ALL]--
```

Field Explanations

1. LEVEL 1 CODE (TABLE LOOKUP)
This field indicates the Level 1 code to print on the report. Enter the code to print or a hyphen (-) to display all the codes in the standard file. If you want to print all the Level 1 codes, press ENTER for the default, which is ALL.

Output

After you accept this screen, the Defining Characteristics Report prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance.

The Defining Characteristics Report provides a listing of all Defining Characteristics in the Standard file.

The sort is alphabetic or numeric, depending on the screen option.

The following information prints on this report:

- Level 1 description(s)
- Level 2 description(s)
- Level 3 codes and descriptions

Figure 8.11 Defining Characteristics Report

```
Fri Dec 18, 1992 02:07 pm                    STANDARD DEFINING CHARACTERISTICS
                              GENERAL HOSPITAL A                        Page 3

                            SELECTION CRITERIA -- ALL
--------------------------------------------------------------------------------
LEVEL 1
     LEVEL 2
         LEVEL 3
                 PLANS OF CARE
--------------------------------------------------------------------------------
DISEASE/DISORDER EAR,NOSE,THROAT
     CLEFT LIP
     RHINOPLASTY
     MYRINGOTOMY
     EAR,NOSE,THROAT MALIGNANCY
     DISEQUILIBRIUM
     EPISTAXIS
     EPIGLOTTITIS
         AIRWAY OBSTRUCTION
                 4005  AIRWAY CLEARANCE, INEFFECTIVE
     OTITIS MEDIA
     LARYNGOTRACHEITIS

DISEASE MUSCULOSKETAL/CONNECTIVE
     WOUND DEBRIDEMENT/SKIN GRAPH
     KNEE PROCEDURES
     FOOT PROCEDURES
     GANGLION HAND PROCEDURES
     ARTHROSCOPY
     FRACTURE OF FEMUR
     FRACTURE OF HIP & PELVIS
     SPRAINS,STRAINS,DISLOCATIONS
     OSTEOMYELITIS
     PATHOLOGICAL FRACTURES
         IMMOBILITY
                 4007    MOBILITY, IMPAIRED PHYSICAL
                 4006    ACTIVITY INTOLERANCE
     SEPTIC ARTHRITIS
     MEDICAL BACK PROBLEMS
     TENDONITIS,MYOSITIS & BURSITIS

DISEASE/DISORDER KIDNEY/URINARY T
     KIDNEY TRANSPLANT
     PROSTATECTOMY
     TRANSURETHRAL PROCEDURES
     RENAL FAILURE
     KIDNEY/URINARY TRACT NEOPLASMS
     URINARY STONES
     URETHRAL STRICTURE
```

Print Defining Characteristics Station Menu

The Print Defining Characteristics Station Menu function provides the nurse station with a printed copy of the Defining Characteristics menu assigned to the station.

You can access the Print Defining Characteristics Menu function by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance

3. Print Standard Files

4. Defining Characteristics Station Menus

If necessary, enter the appropriate facility and station code.

The following screen displays with the Defining Characteristics menu that is assigned to the specified station:

```
        General Hospital Defining Characteristics Station Menus Processor
Station: 2 NORTH                                  Fri Dec 18, 1992 11:06 am

( 1)Level 1 to print :

                         Defining Characteristics Menu
( 1) DISEASE MUSCULOSKETAL/CONNECTIVE
( 2) DISEASE/DISORDER EAR,NOSE,THROAT
( 3) DISEASE/DISORDER CIRCULATORY SYS
( 4) DISEASE/DISORDER RESPIRATORY SYS.
( 5) MENTAL DISORDERS
( 6) DISEASE/DISORDER OF NERVOUS SYS.




Enter choice to print [ALL]--
```

Field Explanations

1. LEVEL 1 TO PRINT (2-N-O)
This field indicates which Level 1 code displayed on the screen should print. The default is ALL Level 1 items.

Output

After you accept this screen, the Defining Characteristics Station Menus report prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance.

The Defining Characteristics Station Menus Report provides a listing of one or all Defining Characteristics on a station specific menu.

The sort is in the order the Level 1 descriptions display on the menu.

The following information prints on this report:

- Nursing station
- Level 1 description(s)
- Level 2 description(s)
- Level 3 codes and descriptions

Figure 8.12 Defining Characteristics Station Menus Report

```
Fri Oct 24, 1997 10:29 am                    STANDARD DEFINING CHARACTERISTICS
                                MODEL HOSPITAL A                        Page 1
                                 Station: 1 EAST
                              SELECTION CRITERIA -- ALL
------------------------------------------------------------------------------
LEVEL 1
     LEVEL 2
         LEVEL 3
                 PLANS OF CARE
------------------------------------------------------------------------------


ANEMIA
                 0003
                 0012    PNEUMONIA
                 0010    TOTAL JOINT REPLACEMENT
                 0008

APPENDECTOMY
     R/O APPENDICITIS

         APPENDECTOMY
                 0006

ARTHROSCOPY

BACK/NECK PROCEDURES
     HERNIATED LUMBAR DISC
         LUMBAR LAMINECTOMY
                 0006
                 0008

CA BONE
     SPINE CA
                 0008
     BONE METS
     SPINAL CORD COMPRESSION
                 0008
                 0005

CA COLON
     COLON CA
                 0007
                 0010    TOTAL JOINT REPLACEMENT
                 0009

CA KIDNEY
     KIDNEY CA

CA LUNG
     LUNG CA
                 0003
     DYSPNEA

CA OVARY
     OVARIAN CA
                 0008


CA PROSTATE
```

Print Treatment Orders

The Print Treatment Orders function provides a numeric or alphabetic listing of all Treatment Orders in the Standard File. The alphabetic listing has several print options including whether or not to print the individual Treatments that make up the order.

You can print Standard Files for Treatment Orders function by selecting the following menu options:

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Print Standard Files
4. Treatment Orders

If necessary, enter the appropriate facility. The following prompt displays:

Enter alphabetic(A) or numeric(N) print [A]--

If you enter **N** for numeric, the following prompt displays:

Print numerical list for Treatment Orders? (Y/N) [Y]--

If you enter **Y** for Yes, the report prints on the printer defined for your terminal. If you enter **N** for No, the Print Standard Files menu redisplays.

If you enter **A** for alphabetic print, the following screen displays:

```
                General Hospital Treatment Orders Processor
                                                Fri Dec 18, 1992 11:06 am

( 1)Print treatments?    : Yes
( 2)Starting letter(s)   : A
( 3)Ending letter(s)     : Z









Accept this screen? (Y/N)-- [Y]
```

Field Explanations

1. PRINT TREATMENTS (1-A-O)
This field indicates whether or not the individual treatments should print on the report. The default is Yes.

2. STARTING LETTER(S) (TABLE LOOKUP)
This field indicates the treatment order to print or the starting letter(s) of the treatment order to print on the report. To print an individual treatment order, enter the Treatment Order code or a hyphen (-) for a table lookup. To print all treatment orders that begin with A, enter **A**.

3. ENDING LETTER(S) (U-A-C)
This field is used with the Starting Letter(s) field to determine the range of treatment orders to print. It is used only if the report is printing more than one treatment order. The default is the value of the Starting Letter(s) field. To print all treatment orders that begin with A, enter **A** for both Starting Letter(s) and Ending Letter(s).

Output

After you accept this screen, the Treatment Orders Report prints on the default printer associated with the requesting terminal as identified in the CRT Names table under Table Maintenance.

The Treatment Orders Report provides an alphabetic or numeric listing of all Treatment Orders in the Standard file.

The sort is alphabetic or numeric, depending on the screen option.

The following information prints for each treatment order on this report:

- Treatment order code and description
- Treatment code
- Treatment description
- Treatment text
- PCR code and description

Figure 8.13 Standard Treatment Orders Report

```
Fri Dec 18, 1992 02:08 pm                          STANDARD TREATMENT ORDERS
                              GENERAL HOSPITAL A                      Page 3

                       SELECTION CRITERIA -- CA thru CE
------------------------------------------------------------------------------
CODE   DESCRIPTION
       TREATMENTS                        PCR
------------------------------------------------------------------------------
9084   CARDIAC EDUCATION PROGRAM

       9084 CARDIAC EDUCATION PROGRAM

9100   CARDIAC REHAB

       9100 CARDIAC REHAB

9012   CATH CARE

       9012 CATH CARE

9202   CATH SITE LOCATION

       9202 CATH SITE LOCATION

9067   CATHETER IRRIGATION

       9067 CATHETER IRRIGATION

9212   CATHETER REMOVED POST-TUR

       9212 CATHETER REMOVED POST-TUR

9171   CATHETER, INSERT FOLEY

       9171 CATHETER, INSERT FOLEY

9198   CATHETERIZATION, STRAIGHT

       9198 CATHETERIZATION, STRAIGHT

8087   CCU ROUTINE, TRANSFER OUT

       8087 CCU ROUTINE, TRANSFER OUT

9044   CENTRAL LINE SITE CARE

       9044 CENTRAL LINE SITE CARE
```

Chapter 9 - BUILD AND FORMAT PCPS AND WORKSHEETS

Illustrations

BEFORE YOU START

Overview

McKesson enables you to design Patient Care Profiles (PCPs) and Worksheets that meet the needs of your facility. You can create multiple PCPs and Worksheets that reflect the requirements of different nursing stations, or you can build multiple formats for use on the same station. For example, you can design a PCP with the information needed by the Critical Care Unit, and a different one for Station 1 East.

The tasks for building user-formatted PCPs and Worksheets are documented in this section.

TASKS TO CREATE A USER-FORMATTED PCP OR WORKSHEET

Following are the main tasks to create a user-formatted PCP or Worksheet that meets the specific needs of your departments, nursing stations, and facility.

1. **Build blocks of information, or cells.**

   The cells include headers and titles that you define. In addition, you designate which information you want the system to print in the block. You can build an unlimited number of report cells.

   For example, you type the title *Clinical Orders* and then designate the cell type of Active Orders. The Active Orders cell type enables you to format the cell for active orders from any department(s) you want to specify. For information on building cells refer to"Procedure: Access the Report Cell Builder" on page 9-53.

2. **For the PCP only, build the Patient Demographic Block.**

   The PCP prints the Patient Demographic Block that you build using this function. This block automatically prints on all online nursing documents. Even if you do not build a user-formatted PCP, you can use the Patient Demographic Block that you design for the nursing documents. For information on how to build the Patient Demographic Block refer to"BUILD THE PATIENT DEMOGRAPHIC BLOCK FOR THE FACILITY" on page 9-12.

3. **Define the format of the PCP or Worksheet.**

   You list the order in which you want the system to print the cells that have the information you want. In this way, you can design the PCP by combining the cells that have the information required by the specific station or staff position.

   - For information on how to define theformat of the PCP, refer to "Define the Format for the PCP" on page 9-109.

- For information on how to define the format of the Worksheet, refer to "Preview the Worksheet You Built" on page 9-130.

4. **Preview the report using the display or print option.**

   By viewing the report before using it as a Worksheet, or assigning it as the default PCP for a station using the Station Parameters function, you can ensure the PCP/ Worksheet is printing the proper headings and information in the format you want.

   - For information on how to display or print the PC, refer to "Preview the PCP You Built" on page 9-114.

   - For information on how to display or print the Worksheet, refer to "Preview the Worksheet You Built" on page 9-130.

5. **Make any necessary changes in the report.**

   Refer to the task where you want to make the changes, such as building cells, building the Patient Block, or defining the format. Refer to the appropriate sections.

6. **For the PCP only, set parameters for the stations.**

   You set station parameters related to use of the user-formatted PCP, such as assigning a default PCP to a station. For fields explanations refer to "Set Up Stations for User-Formatted PCPs" on page 9-121. The facility parameters are used only for the system-generated PCP. For field explanations refer to "Set Up the Facility for the System-Generated PCP" on page 9-125.

The system provides reports that aid you in building and using your PCPs and Worksheets:

- Forms Library Report
- Report Formats

The Forms Library Report lists the information you can retrieve from the system. You can sort the report by either the Internal Library Description or the Alias. For information on how to print this report refer to "PRINT A FORMS LIBRARY REPORT" on page 9-137.

The Report Formats function enables you to print all the formats you have set up for PCPs and Worksheets. You can either print the Parameterized PCP Format Report or the Parameterized Worksheet Format Report. For information on how to print these reports refer to "PRINT REPORT FORMATS" on page 9-140.

THE SYSTEM-GENERATED PCP

STAR Patient Care provides a system-generated PCP that is already set up for you. The system-generated PCP prints in a two-column vertical format and is documented in "Chapter 6 - REPORTS". You cannot reformat the system-generated PCP; however, there are facility parameters that can affect the way the PCP prints.

For more information refer to "Set Up the Facility for the System-Generated PCP" on page 9-125. A parameter in the Station Parameters screen enables you to define whether a station uses the system-generated PCP or the user-formatted PCPs you create. For information on this parameter refer to "Set Up Stations for User-Formatted PCPs" on page 9-121.

Terms and Concepts

ALIAS
When you want the system to print patient information in a report cell, you specify the information using the Internal Library Name so that the system can find the data. The system provides a table lookup for the Internal Library Name using either the Internal Library Name's Description or the Alias(es) for the description. An Alias is a short alternate for the Description. There can be up to three aliases for a Description. You can print a report that lists the information by Description or Alias. For more information refer to "PRINT A FORMS LIBRARY REPORT" on page 9-137.

For example if you enter the alias DIAGNOSIS, the system displays a list of options that match the letters you entered. In this example, you can select from a list of the Internal Library Names that include Diagnosis. You can select the Diagnosis code only, the Diagnosis description only, literals used for forms, Working Diagnosis/ Complaint, Admitting Diagnosis/Complaint, Diagnosis/Reason, and so on. See also Internal Library Name.

CELL
A Cell is a block of information that you can designate to print on the PCP. You design the block by designating specific locations within the cell where you want the system to print information that is stored in its library of patient data. You can type headers and column titles to label the information. For example, you can type a header of ADLs to print at a certain column/line position, and then designate the column/line position where you want the system to print the specific ADLs ordered for the patient. You can build an unlimited number of report cells.

CELL TYPE
There are general categories of cells related to the type of information being requested. For example, the Active Orders cell type is related to information on a patient's Active Orders. There can be an unlimited number of cells within a Cell Type. Each Cell Type has its own build process.

COLUMNS
Each space on the screen is designated as a column with a unique column number. For example, the third space on the screen is Column number 3. You use column numbers to designate the exact placement and length of fields of information that you want to print on the PCP. The system displays guides that show the column numbers, as in the following example:

```
          1         2         3
12345678901234567890123456789012345678
Dr:   CARTER,JAMES E
```

The system displays the current line information with numbers that show each of the column positions. The shaded area shows the amount of space the system reserves for the information. In this example, the system reserves 3 spaces for the literal *Dr:* and up to 18 spaces for the name of the Attending Physician. For information the system retrieves, the system displays the example output in the sample line.

The numbers on the first line (1,2,3) mark the column positions by tens (in this example, the tenth, twentieth, and thirtieth positions). The numbers on the second line mark each column position.

Using the two numbers, you can locate the specific number of the column. For example, the 2 on the top line (equal to 20) and the 4 on the second line (where the shading ends) mark 24 as the column number where the space for the Attending Physician's name ends. The system reserves the column numbers 6 through 24 for the doctor's name.

INTERNAL LIBRARY NAME
The system stores patient information in a data library. Each piece of information has an internal library name that enables the system to find that type of information in the library. For example, Blood Pressure is stored by the system with an Internal Library Name of CAO231F. The letters in the library name tell the system details about the data, such as where it is stored. Each internal library name has a standard language Description associated with it, in this case, BLOOD PRESSURE.

When you build a report cell, and you want the system to retrieve information from the database, you select the Internal Library Name for the information you want to print. You can print a report that lists the information by Description or Alias. For more information refer to “PRINT A FORMS LIBRARY REPORT” on page 9-137. See also Alias.

LITERAL
A literal is a heading or title that labels the information that follows. For example, in the Patient Demographic Block, the literal *Alg:* may be used as an abbreviation of the header Allergies. The information that you define to print next to the literal is the actual data for the patient, in this case, the patient's allergies. You can define your own literals for each report cell that you build.

PATIENT CARE PROFILE (PCP)
The Patient Care Profile is a STAR Patient Care Nursing document that is usually printed for each shift. The PCP contains information for one patient that is specific to the shift. You can use the Report Build Options to design and format PCPs that can contain many types of patient information, such as Active Orders, Treatments, ADLs, Plans of Care, Patient Demographics, Patient History, and an area for Nursing Notes. PCPs can be printed for outpatients as well as inpatients. Patients can be selected from the station census, name inquiry, and account numbers.

PATIENT IDENTIFIER
To save space, the Patient Demographic Block prints only on the first page of the PCP. A one-line patient identifier automatically prints at the bottom of all subsequent pages.

For an inpatient, the identifier includes the following information:

- Patient Name
- Station
- Room/Bed
- Medical Record Number
- Attending Physician

For an outpatient, the identifier includes the following:

- Patient Name
- Patient Type
- Medical Record Number
- Attending Physician

Example of a User-Formatted PCP

Below is an example of a user-formatted PCP for the 1E nursing station. This PCP combines cells of information that are defined to print in the following order:

- Additional Medical Information
- ADLs
- Clinical Orders
- Medication Orders

- Text cell for Additional Orders This Shift
- Physician Consultations

The term **continued** at the bottom indicates there is a second page of the PCP.

Figure 9.1 Example of User-formatted PCP

```
Mon Nov 29, 1993 09:36 am                                          1 EAST PCP
                        MODEL HOSPITAL A                             Page 1
                    11/29/93 Shift 1 thru 11/29/93 Shift 1
_____________________________________________________________________________
______|_____________________________________|WISEMAN,DALLAS          Age:35Y
______|_____________________________________|Dx:SICK
______|_____________________________________|
______|_____________________________________| 9303400001        000000016
______|_____________________________________|ADM:02/03/93  03:59pm   LEVEL:
______|_____________________________________|ISO:
______|_____________________________________|PRECAUTION:
______|_____________________________________|PRECAUTION:
______|_____________________________________|PRECAUTION:
_____________________________________________________________________________
ADDITIONAL MEDICAL INFORMATION
Allg:POLLEN
SPOUSE       WISEMAN,KIMBRA;ROBERTS    (404)938-4803
_____________________________________________________________________________
ADL'S
               ** No information available at time of printing**
_____________________________________________________________________________
CLINICAL ORDERS
ORD #:     11/23 0217P ECG 12 LEAD
ORD #:     11/23 0300P ECG 12 LEAD
ORD #:     11/23 0600P ELECTRODES
ORD #:     11/23 0700P HOLTER MONITOR/WMC
ORD #:     11/23 1000P ECG 12 LEAD
ORD #:     03/17 1226P PARTIAL THROMBOPLASTIN TIME
ORD #:     03/17 1245P CARDIAC PROFILE
_____________________________________________________________________________
MEDICATION ORDERS
   4  10/12/93    TYLENOL W/CODEI 1 TABLET,ORAL
      06:00am,01:00pm,05:00pm,09:00pm
   6  10/22/93    ASPIRIN 325 MG,ORAL
      06:00am,01:00pm,05:00pm,09:00pm
   7  10/22/93    ASPIRIN 325 MG,ORAL
      06:00am,01:00pm,05:00pm,09:00pm
   5  10/12/93    ZESTRIL 5 MG,ORAL
      08:00am,06:00pm
_____________________________________________________________________________
ADDITIONAL ORDERS THIS SHIFT:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
PHYSICIAN CONSULTATIONS
LEES,JACK R          SUR (404)124-5656 |
_____________________________________________________________________________
                              *continued*
```

Example of a User-Formatted Worksheet

Below is an example of a user-formatted Worksheet for the 1E nursing station's Nursing Assistant for Shift 1. This Worksheet combines cells of information that are defined to print in the following order for the beds the nursing assistant is covering:

- Patient Identifier Information
- Diets
- ADLs

Figure 9.2 Example of User-formatted Worksheet

```
Mon Mar 28, 1994 08:40 am                    1 EAST NURSING ASSISTANT WRKSHT
                          MODEL HOSPITAL A                            Page 1
                    03/28/94 Shift 1 thru 03/28/94 Shift 3
_____________________________________________________________________________
CCU-02   JOHNSON,MIKE                        CHEST PAIN NOS
_____________________________________________________________________________
ADL'S
AMBULATE      AD LIB                   |
_____________________________________________________________________________
CCU-07   JONES,KAYCE                       GASTROENTERITIS
_____________________________________________________________________________
ADL'S
BATH          ASSIST/PARTIAL           |  REFERRAL      Q 4H
_____________________________________________________________________________
DIET AND NUTRITION
ORD #:     01/05 0549P FRUIT EXCHANGE UP TO 40 CALORIES
ANY FRUIT EXCEPT GRAPES AND BANAN
_____________________________________________________________________________
ORD #:     01/05 0549P FRUIT EXCHANGE UP TO 40 CALORIES
ANY FRUIT EXCEPT GRAPES AND BANAN
_____________________________________________________________________________
CCU-09   CRAFT,KRISTINE L                   CHOLERA D/T VIB EL TOR
_____________________________________________________________________________
ADL'S
AMBULATE      AD LIB                   |  REFERRAL      Q 4H
_____________________________________________________________________________
```

BUILD THE PATIENT DEMOGRAPHIC BLOCK FOR THE FACILITY

Overview

The system provides a standard Patient Demographic Block already set up for you. The system-generated block automatically prints on all nursing documents. If you want the block to include additional or different information, you can build a user-formatted Patient Demographic Block that includes the specific information your facility uses most often. The block you create using the builder replaces the system-generated block and becomes the standard format for all nursing documents in STAR Patient Care, including any user-formatted PCPs. Use the following guidelines if you want to build a user-formatted Patient Demographic Block.

- You can determine how much space to allot to each item, truncating the information as necessary.
- You can enter the literal names, or headings, that your facility uses.
- You can change the format of the block to respond to changes in your facility's patient information needs.

The size of the block is fixed at 9 lines by 36 characters. You have complete flexibility of information placement within that space.

When you build a user-formatted patient block, the system stores the block as a temporary version. You can continue to make changes to the block until you are ready to activate the temporary version. If you decide you want to use the system-generated patient block, just delete the current active version of the user-formatted patient block. The system defaults to the system-generated patient block for all nursing documents if there is not a user-formatted Patient Demographic Block available.

When you build a user-formatted patient block, an associated block is defined to print next to the Patient Demographic Block and is equal in size, 9x36. This enables you to make maximum use of the space on your PCP. You can build this block to contain freeform text. For more information on the procedure refer to "Associated Patient Block Report Cell" on page 9-82. For example, this block can be used for a Signatures Block by entering signature lines in the block.

The patient block and the Associated Block print only on page 1 of the PCP. You can designate the patient block to print in any of the four corner positions. The Associated Block prints next to the patient block.

A one-line patient identifier automatically prints at the bottom of all subsequent pages. The identifier includes the following information for an inpatient:

- Patient Name
- Station
- Room/Bed
- Medical Record Number
- Attending Physician

For an outpatient, the identifier includes the following:

- Patient Name
- Patient Type
- Medical Record Number
- Attending Physician

EXAMPLE OF A SYSTEM-GENERATED PATIENT BLOCK

Following is an example of the system-generated Patient Demographic Block. The system defaults to this patient block unless you have activated a user-formatted Patient Demographic Block.

```
_____|_____| Dx : ABDOMINAL PAIN
_____|_____| Alg: POLLEN
_____|_____| Iso:                          Smk: NO
_____|_____| Sgy:
_____|_____|                              Type: I/P
_____|_____| 2101-01 000000016       9303400001
_____|_____| Adm : 02/03/93     Dob: 12/14/57 35Y
_____|_____| Phys: ADAMS,HAROLD R        Level:
_____|_____| WISEMAN,DALLAS               Sex: M
_____|_____|_____________________________________
```

EXAMPLE OF A USER-FORMATTED PATIENT DEMOGRAPHIC BLOCK

Following is an example of a user-formatted Patient Demographic Block that is defined to print in the upper or lower right-hand corner of the PCP. The Associated Block, in this example a Signatures Block, prints next to the Patient Block.

```
_____________________________________________________________________
_____|_____________________________|WISEMAN,DALLAS            Age:35Y
_____|_____________________________|Dx:ABDOMINAL PAIN
_____|_____________________________|
_____|_____________________________| 9303400001        000000016
_____|_____________________________|ADM:02/03/93  03:59pm   LEVEL:
_____|_____________________________|ISO:
_____|_____________________________|PRECAUTION: COMBATIVE
_____|_____________________________|PRECAUTION: CONFUSED
_____|_____________________________|PRECAUTION:
_____________________________________________________________________
```

EXAMPLE OF A PATIENT IDENTIFIER FOR AN INPATIENT

Following is an example of a Patient Identifier for an inpatient. The system automatically generates the identifier.

```
                              *continued*
_____________________________________________________________________
WISEMAN,BRENT DALLAS       1E 2101-01    000000016   Phy:ADAMS,HAROLD R
```

EXAMPLE OF A PATIENT IDENTIFIER FOR AN OUTPATIENT

Following is an example of a Patient Identifier for an outpatient. The system automatically generates the identifier.

```
                                                          *continued*
_____________________________________________________________________
WISEMAN,BRENT DALLAS       O/P        000000016    Phy:DOCTOR,ADMITTING
```

Quicksteps for Building the Patient Demographic Block

Quicksteps are designed for experienced users who may need a reminder on how to perform a task. When you need more complete information, use the fully documented procedure. Refer to the Table of Contents at the beginning of this section for the page numbers for each procedure.

ACCESS THE PATIENT DEMOGRAPHIC BLOCK FOR EDITING

1. Select File Maintenance from the Nursing main menu.
2. Select Standard File Maintenance.
3. Select Report Build Options.

4. Select Pt. Demographic Block Builder.
5. Choose the facility, if multifacility.
6. Continue with the Quicksteps for adding, editing, deleting, or copying a line.

CHANGE LINES ON THE PATIENT DEMOGRAPHIC BLOCK

Add or Edit a Line on the Patient Block

1. You have the following choices:
   - Enter **A** to add a line.
   - Enter **E** to edit a line that has information.
2. Enter the number of the line where you want to add or edit information.
3. Continue with the Quicksteps for adding, editing, deleting, or moving fields of information in a line on the Patient Block.

Delete a Line on the Patient Block

1. Enter **D** to delete a line of information from the block.
2. Enter the number of the line where you want to delete all information.
3. Enter **Y** for Yes to confirm the deletion request.
4. You have the following choices:
   - Make changes to other lines.
   - Press ENTER when you finish making changes.
5. Enter **Y** for Yes to accept the changes to the block.
6. Continue with the Quicksteps for activating, displaying or deleting the patient block.

Copy a Line on the Patient Block

1. Enter **C** to Copy a line of information on the block.
2. Enter the number of the line you want to copy from.
3. Enter the number of the line you want to copy to.
4. You have the following choices:
   - Make changes to other lines.

- Press ENTER when you finish making changes.

5. Enter **Y** for Yes to accept the changes to the block.
6. Continue with the Quicksteps for activating, displaying or deleting the patient block.

CHANGE FIELDS ON A LINE IN THE PATIENT DEMOGRAPHIC BLOCK

Add or Edit a Field of Information in a Line on the Patient Block

1. You have the following choices:
   - Enter **A** to add a line.
   - Enter **E** to edit a line that has information.
2. Enter the column number where you want to add or edit a field.
3. You have the following choices:
   - To have system retrieve information, select a Library Name.
   - Make any necessary changes to the Library Name or Display Length fields.
   - To print a heading/literal, press ENTER to bypass the Library Name field.
   - Enter the heading/literal you want to print.
   - Enter the heading/literal in the Example Output field to make sure the system has room to print.
   - Make any necessary changes to the screen.
4. When you finish, press ENTER to accept the screen.
5. You have the following choices:
   - If you want to make additional changes to the fields on this line, refer to the Quicksteps for adding, editing, deleting, or moving fields of information.
   - If you are finished changing fields on this line, press ENTER.
6. You have the following choices:
   - If you want to make additional changes to lines on the patient block, refer tothe Quicksteps for adding, editing, deleting, or copying lines.
   - If you are finished changing lines, press ENTER.

7. Enter **Y** for Yes to accept the changes.
8. Continue with the Quicksteps for activating, displaying or deleting the patient block.

Delete a Field on a Line in the Patient Block

1. Enter **D** to delete a field on the line.
2. Enter the number of the column where you want to delete a field.
3. Enter **Y** for Yes to delete the field.
4. You have the following choices:
   - If you want to make additional changes to the fields on this line, refer to the Quicksteps for adding, editing, deleting, or moving fields of information.
   - If you are finished changing fields on this line, press ENTER.
5. You have the following choices:
   - If you want to make additional changes to lines on the patient block, refer tothe Quicksteps for adding, editing, deleting, or copying lines.
   - If you are finished changing lines, press ENTER.
6. Enter **Y** for Yes to accept the changes.
7. Continue with the Quicksteps for activating, displaying or deleting the patient block.

Move a Field on a Line in the Patient Block

1. Enter **M** to move a field on the line.
2. You have the following choices:
   - Enter a new column number.
   - Enter a plus sign (+) and the number of columns to move to the right.
   - Enter a minus sign (-) and the number of columns to move to the left.
3. When you finish moving fields, press ENTER.
4. You have the following choices:
   - If you want to make additional changes to the fields on this line, refer to the Quicksteps for adding, editing, deleting, or moving fields of information.

- If you are finished changing fields on this line, press ENTER.

5. You have the following choices:

   - If you want to make additional changes to lines on the patient block, refer tothe Quicksteps for adding, editing, deleting, or copying lines.

   - If you are finished changing lines, press ENTER.

6. Enter **Y** for Yes to accept the changes.

7. Continue with the Quicksteps for activating, displaying or deleting the patient block.

ACTIVATE, DISPLAY, OR DELETE THE PATIENT BLOCK

Activate the Temporary Patient Demographic Block

1. If the Patient Block does not already display, follow the Quicksteps to access the Patient Demographic block.

2. If the prompt to add, edit, delete or copy lines is displaying, press ENTER.

3. Enter **A** to Activate the patient block.

4. Enter **Y** for Yes to activate the patient block.

Display the Patient Demographic Block

1. If the Patient Block does not already display, follow the Quicksteps to access the Patient Demographic block.

2. If prompt to add, edit, delete or copy lines, displays press ENTER.

3. Enter **D** to Display the patient block.

4. Select the patient you want to use to display the patient block.

5. You have the following choices:

   - To activate or delete the patient block, continue with the appropriate Quicksteps.

   - To exit the Pt. Demographic Block function, press ENTER.

Delete the Patient Demographic Block

1. If the Patient Block does not already display, follow the Quicksteps to access the Patient Demographic block.

2. If the prompt to add, edit, delete or copy lines is displaying, press ENTER.

3. Enter **R** to Delete the patient block.
4. You have the following choices:
   - To delete the current active version, enter **A**.
   - To delete the temporary version, enter **T** or press ENTER.
5. Enter **Y** for Yes to confirm you want to delete the block.
6. You have the following choices:
   - To display or delete the remaining patient block, continue with the appropriate Quicksteps.
   - To exit the Pt. Demographic Block function, press period (.) ENTER.

Access the Builder for the Patient Block

Once you access the builder for the Patient Demographic Block, you can perform a variety of tasks:

- Add information to a new line in the block.
- Edit information in a line in the block.
- Delete a line of information from the block.
- Copy a line of information to another line on the block.

When you select a line to add or edit information, you have the following options:

- Add a new field to the line.
- Edit a field in the line.
- Delete a field from the line.
- Move a field to a different place on the line.

PROCEDURE: ACCESS THE PATIENT DEMOGRAPHIC BLOCK BUILDER

When you want to access the Patient Demographic Block Builder, perform the following steps:

1. Select File Maintenance from the Nursing main menu.

The Standard File Maintenance menu displays:

```
              General Hospital File Maintenance Processor
                                                  Fri Feb 19, 1993 08:15 am
File Maintenance Input Options

             Option No.  Option
             ----------------------------------------
                 1       Standard File Maintenance
                 2       Staffing File Maintenance









Enter option number--
```

2. Select Standard File Maintenance. The Standard File Maintenance menu displays:

```
         General Hospital Standard File Maintenance Processor
                                        Fri Feb 19, 1993 08:15 am
Standard File Maintenance Input Options

             Option No.  Option
             ----------------------------------------
                 1       Standard Plan of Care
                 2       Critical Pathways
                 3       Standard Assessments
                 4       ADL's/Misc.
                 5       Treatment Orders
                 6       Vital Signs & Fluid Balances
                 7       Defining Characteristics
                 8       Routine Orders
                 9       Preps and Special Instructions
                10       Custom Documents
                11       Standard Text - Patient History
                12       Station Parameters
                13       Report Build Options
                14       Print Standard Files
                15       Custom Worksheet

Enter option number--
```

3. Select Report Build Options. The Report Build Options Menu displays:

4. Select Pt. Demographic Block Builder.

5. Select the facility, if multifacility. When there is a temporary version, the system displays the following message:

   Loading temporary version

When there is no temporary version, the system loads the active version and displays the following message:

Loading active version

The system displays the current temporary (or active) version of the Patient Demographic Block, as in the following screen example:

```
          General Hospital Pt. Demographic Block Builder Processor
Patient Block                                    Tue Nov 02, 1993 10:20 am

1  WHITFIELD,HAMILTON LEE
2  Dx:ABDOMINAL PAIN
3
4  MR#: 255-76-21-14 Acct#: 1234567-8
5
6  Phys: CARTER,JAMES E
7
8
9  1N 1101-1









Add(A), edit(E), delete(D) or copy(C) lines--
```

The changes you make to the block are stored as a temporary version. The system does not use this version until you activate it. The following prompt displays for you to make changes to the block:

Add(A), edit(E), delete(D) or copy(C) lines--

6. You have the following choices:

   - To Add information to a line, enter **A**. For more information refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22.
   - To Edit information on a line, enter **E**. For more information refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22.
   - To Delete information from a line, enter **D**. For more information refer to "Procedure: Delete a Line in the Patient Demographic Block" on page 9-24.
   - To Copy information on a line, enter **C**. For more information refer to "Procedure: Copy a Line in the Patient Demographic Block" on page 9-27.
   - To activate, delete, or display the block, press ENTER. For more information refer to "Activate, Display, or Delete the Patient Block" on page 9-38.

Change Lines in the Patient Block

You can change the lines in the Patient Demographic Block to contain the information used by your facility. You can perform one of the following procedures:

To...	See...
add information to a line	"Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22
edit information on a line	"Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22
delete information on a line	"Procedure: Delete a Line in the Patient Demographic Block" on page 9-24
copy information on a line	"Procedure: Copy a Line in the Patient Demographic Block" on page 9-27

The patient block has a maximum of nine lines. You select the line where you want to change, copy, or delete the information. Once you select the line, you can add, edit, delete, or move the fields of information using one of the procedures to change fields on the patient block. For more information refer to "Change Fields on a Line in the Patient Block" on page 9-29.

PROCEDURE: ADD OR EDIT A LINE ON THE PATIENT DEMOGRAPHIC BLOCK

When you want to add or edit information in a line on the Patient Demographic Block, perform the following steps:

1. Access the Patient Demographic Block builder. For more information refer to "Access the Builder for the Patient Block" on page 9-19. The following screen is displayed:

```
            General Hospital Pt. Demographic Block Builder Processor
Patient Block                                        Tue Nov 02, 1993 10:20 am

1  WHITFIELD,HAMILTON LEE
2  Dx:ABDOMINAL PAIN
3
4  MR#: 255-76-21-14 Acct#: 1234567-8
5
6  Phys: CARTER,JAMES E
7
8
9  1N 1101-1









Add(A), edit(E), delete(D) or copy(C) lines--
```

The screen displays the following prompt for you to make changes to the block:

Add(A), edit(E), delete(D) or copy(C) lines--

2. You have the following choices:

   - Enter **A** to Add information to a line on the block.
   - Enter **E** to Edit a line that already contains information.

   When you try to edit a blank line, the following error message displays:

   Error: Line 7 does not exist

   Use the Add option to edit a blank line. One of the following prompts displays:

   Enter line number to add--
   Enter line number to edit--

3. Enter the number of the line where you want to add or edit information. The screen displays the following information:

   - The number of the line where you are adding the information - Line 3 in the previous screen example.
   - The line's current information displays with numbers that show each of the column positions. For example:

```
          1         2         3
12345678901234567890123456789012345678
Dr:   CARTER,JAMES E
```

The shaded area shows the amount of space the system reserves for the information. In this example, the system reserves 3 spaces for the literal *Dr:* and up to 18 spaces for the name of the Attending Physician. For information the system retrieves, the system displays the example output in the sample line.

The numbers on the first line (1,2,3) mark the column positions by tens - in this example, the tenth, twentieth, and thirtieth positions. The numbers on the second line mark each column position.

Using the two numbers, you can locate the specific number of the column. For example, the 2 on the top line (equal to 20) and the 4 on the second line (where the shading ends) mark 24 as the column number where the space for the Attending Physician's name ends. The system reserves the column numbers 6 through 24 for the doctor's name.

Col field
The Col field displays the number of the column where the information starts to print.

Width field
The Width field displays how many columns are available for the information to print. In this example, up to 18 characters of the doctor's name can print, from column 6 through column 24.

Description field
The Description field displays the information that would print if you entered a literal, such as Dr:. If you designate for the system to retrieve information, the Library Name's description displays in this field, as in the example Attending Physician.

The screen displays the following prompt:

Enter add(A), edit(E), delete(D), move(M) fields--
next line(/) or previous line(/P)

For procedure information on adding, editing, deleting, or moving fields on a line, refer to

- “Procedure: Add or Edit a Line on the Patient Demographic Block” on page 9-22),
- “Procedure: Delete a Line in the Patient Demographic Block” on page 9-24, or
- “Procedure: Move a Field on a Line in the Patient Demographic Block” on page 9-36.

PROCEDURE: DELETE A LINE IN THE PATIENT DEMOGRAPHIC BLOCK

When you want to delete a line of information from the Patient Demographic Block, perform the following steps:

NOTE: If you only want to delete part of the information on a line refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22. After you select the line for editing, you follow the procedure for deleting one or more of the fields on the line. The system deletes information from the line, leaving a blank line in the position.

1. Access the Patient Demographic Block builder. (For more information refer to "Access the Builder for the Patient Block" on page 9-19.) The following screen displays:

```
            General Hospital Pt. Demographic Block Builder Processor
Patient Block                                      Tue Nov 02, 1993 10:20 am

1  WHITFIELD,HAMILTON LEE
2  Dx:ABDOMINAL PAIN
3
4  MR#: 255-76-21-14 Acct#: 1234567-8
5
6  Phys: CARTER,JAMES E
7
8
9  1N 1101-1









Add(A), edit(E), delete(D) or copy(C) lines--
```

The screen displays the following prompt for you to make changes to the block:

Add(A), edit(E), delete(D) or copy(C) lines--

2. Enter **D** to delete a line of information from the block.

The following prompt displays:

Enter line number to delete--

3. Enter the number of the line where you want to delete all of the information.The following prompt displays:

Line 3 will be deleted
Accept (Y/N)? [N]--

4. You have the following choices:

- To delete the line of information, enter **Y** for Yes. The system deletes the information from the line. The line you selected is now blank. The prompt to add, edit, delete, or copy lines redisplays.

To cancel the deletion request, press ENTER or enter **N** for No. The prompt to add, edit, delete, or copy lines redisplays.

5. When you finish deleting lines, you have the following choices:

   - To edit a line, enter **E** and "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22.

   - To add a line, enter **A** and refer to "Procedure: Add or Edit a Lineon the Patient Demographic Block" on page 9-22.

   - To copy a line, enter **C** and refer to "Procedure: Copy a Line in the Patient Demographic Block" on page 9-27.

   - Press ENTER when you finish making changes to the block. The following prompt displays:

     Accept these changes? (Y/N)--

6. You have the following choices:

   - To make additional changes, enter **N** for No. The system redisplays the prompt for you to add, edit, delete, or copy lines.

     To accept the changes and store the block as the temporary version, enter **Y** for Yes. The system displays the following message:

     Temporary version filed!

     The following prompt displays:

     Display(D), activate(A), or delete(R) patient block? [D]--

     Refer to the one of the following procedures to activate, delete, or display the patient block:

     - To activate the block refer to "Procedure: Activate the Temporary Patient Demographic Block" on page 9-39.

     - To display the Patient Block refer to "Procedure: Display the Patient Demographic Block" on page 9-40.

     - To delete the active or temporary block refer to "Procedure: Delete the Active or Temporary Patient Block" on page 9-41.

You can also activate the patient block directly from the screen you use to display the patient block.

PROCEDURE: COPY A LINE IN THE PATIENT DEMOGRAPHIC BLOCK

When you want to copy a line of information on the Patient Demographic Block, perform the following steps:

1. Access the Patient Demographic Block builder. For more information refer to "Access the Builder for the Patient Block" on page 9-19.

The following screen displays:

```
            General Hospital Pt. Demographic Block Builder Processor
Patient Block                                    Tue Nov 02, 1993 10:20 am

1  WHITFIELD,HAMILTON LEE
2  Dx:ABDOMINAL PAIN
3
4  MR#: 255-76-21-14 Acct#: 1234567-8
5
6  Phys: CARTER,JAMES E
7
8
9  1N 1101-1









Add(A), edit(E), delete(D) or copy(C) lines--
```

The screen displays the following prompt for you to make changes to the block:

Add(A), edit(E), delete(D) or copy(C) lines--

2. Enter **C** to Copy a line of information from the block. The following prompt displays:

Enter line number to copy--

3. Enter the number of the line that has the information you want to copy. The following prompt displays:

Copy line 3 to line number--

4. Enter the number of the line to which you want to copy the information.

The system copies information to the line you entered. The prompt to add, edit, delete, or copy lines redisplays.

5. When you finish copying lines, you have the following choices:

- To add a line, enter **A** and refer to "Procedure: Add or Edit a Lineon the Patient Demographic Block" on page 9-22.

- To edit a line, enter **E** and refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22.

- To delete a line, enter **D** and refer to "Procedure: Delete a Line in the Patient Demographic Block" on page 9-24.

- Press ENTER when you finish making changes to the block. The following prompt displays:

  Accept these changes? (Y/N)--

6. You have the following choices:

   - To make additional changes, enter **N** for No. The system redisplays the prompt for you to add, edit, delete, or copy lines.

     To accept the changes and store the block as the temporary version, enter **Y** for Yes. The system displays the following message:

     Temporary version filed!

     The following prompt displays:

     Display(D), activate(A), or delete(R) patient block? [D]--

     Refer to the one of the following procedures to activate, delete, or display the patient block:

     - To activate the block refer to "Procedure: Activate the Temporary Patient Demographic Block" on page 9-39.

     - To display the Patient Block refer to "Procedure: Display the Patient Demographic Block" on page 9-40.

     - To delete the active or temporary block refer to "Procedure: Delete the Active or Temporary Patient Block" on page 9-41.

You can also activate the patient block directly from the screen you use to display the patient block.

Change Fields on a Line in the Patient Block

You can perform a variety of functions on the fields on a line in the patient block:

To...	See...
add a field of information to a line	"Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22
edit a field of information on a line	"Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22
delete a field of information on a line	"Procedure: Delete a Line in the Patient Demographic Block" on page 9-24
move a field of information to another position on the line	"Procedure: Move a Field on a Line in the Patient Demographic Block" on page 9-36

You can print a Forms Library Report to assist you in identifying the information you want the system to retrieve in the fields. Refer to "PRINT A FORMS LIBRARY REPORT" on page 9-137 for the procedure to print the report.

IMPACT

Once you accept the changes, they become part of the temporary version of the patient block. The changes do not become part of the active version that prints on nursing documents until you activate the temporary version.

PROCEDURE: ADD OR EDIT A FIELD ON A LINE IN THE PATIENT BLOCK

You perform the following procedure when you want to add or edit a field on a line in the patient block.

1. To add or edit a line on the patient block refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22. The screen displays the following prompt:

   Enter add(A), edit(E), delete(D), move(M) fields--
   next line(/) or previous line(/P)

2. You have the following choices:

   - To Add a field to a blank line on the block, enter **A**.
   - To Edit a field on a line with information, enter **E**.

   One of the following prompts displays:

Enter column number to add--
Enter column number to edit--

3. Enter the number of the column where you want to add or edit a field.

   NOTE: When you are editing a field, use the column number that displays in the Col field.

   The following screen displays:

```
        Applications Testing Database Pt. Demographic Block Builder Processor
Patient Block                                        Tue Nov 02, 1993 10:20 am
Line 3
         1         2         3
12345678901234567890123456789012345678


      Column 1
( 1)Library Name  :
( 2)Description   :
( 3)Example Output:
( 4)Display Length:









Enter alias'-' or *Internal name'-' to lookup--
```

   - If you are adding a field, the screen entries are blank.
   - If you are editing a field, the screen displays entries. Skip to Step 8.

   The cursor is in the Library Name field. The following prompt displays:

   *Enter alias'-' or *Internal name'-' to lookup--*

   This prompt enables you to choose an item from the library of information stored by the system. The Alias is standard language for the coded Internal Library Name.

4. You have the following choices:

   - Define a literal - When the information you want to add is a literal or heading, and does not require the system to retrieve any information, press ENTER to bypass this field. The cursor moves to the Description field. This field is required. Go on to Step 6.
   - Retrieve System Data - When you want the system to retrieve information from its library, perform one of the following:

- Enter part or all of the alias name and hyphen (-) to perform a table lookup.

  The bottom of the screen displays a list of aliases that start with the letters you enter. The Internal Library Name and Description display for each alias.

- Enter asterisk (*) followed by part or all of the Internal Library Name and hyphen(-) to perform a table lookup of internal names for the information.

  The bottom of the screen displays a list of the Internal Library Names and their Descriptions.

```
     Applications Testing Database Pt. Demographic Block Builder Processor
Patient Block                                        Tue Nov 02, 1993 10:20 am
Line 3
         1         2         3
12345678901234567890123456789012345678


     Column 1
( 1)Library Name  :
( 2)Description   :
( 3)Example Output:
( 4)Display Length:

    Alias   Name                              Description                Page: 05
 1) ADDR                                      RELATIVE 1'S ADDRESS
            CAR141F                           Address

 2) ADDR                                      RELATIVE 2'S ADDRESS
            CAR142F                           Address

 3) ADDR                                      GUARANTOR'S EMPLOYER ADDR
            CAUP41F                           Address
Enter choice--
                       next page(/)  previous page(/P)
```

5. Enter the selection number of the Alias or Internal Library Name or you want to enter.

   The system automatically displays entries in the Description, Example Output, and Display Length fields, as in the following example:

```
      Applications Testing Database Pt. Demographic Block Builder Processor
Patient Block                                      Tue Nov 02, 1993 10:20 am
Line 3
         1         2         3
12345678901234567890123456789012345678


      Column 1
( 1)Library Name  : CAR141F
( 2)Description   : RELATIVE 1'S ADDRESS
( 3)Example Output: 1234 ANY STREET
( 4)Display Length: 24









Accept this screen? (Y/N) [Y]--
```

The following prompt displays:

Enter field number or '/' starting field number--

Go on to Step 8.

6. Description field - Enter up to 20 characters as a description of the heading or literal. You use this field to enter a description of the literal you want to enter. For example, if you want the system to print the literal *Dr:*, you enter Doctor to describe the literal. The system does not print the description on the Patient Demographic Block. The description is for your information only.

7. Example Output field - The cursor moves to the Example Output field for you to enter the text of the heading or literal that you want to print. The system prints the text you enter, such as *Dr:*, on the Patient Demographic Block.

   Literals are used to label the system-retrieved information in the next patient block field, such as the Attending Physician's name. You bypassed the Library Name field because you don't want the system to retrieve any information; you only want to enter a literal. This field is required.

   Enter up to 36 characters for the heading or literal you want to print. The maximum length of a line in the patient block is 36 characters. The system also displays the characters you enter in the Example Output field in the sample line on the screen. The sample text enables you to determine how the heading/literal prints on the block, as well as enable you to view the column numbers that are available for the remaining information you want to add to the line.

Display Length field - After you enter the Example Output, the system automatically enters the number of characters in the Display Length field. The following prompt displays for you to make additional changes.

Enter field number or '/' starting field number--

8. Access the fields you want to change. You can only access the Library Name field (to change to a different alias) or the Display Length field to change the number of columns available for the information.

   NOTE: If you decrease the display length for information the system retrieves, you may cause the system to truncate the display. For example, if the doctor's name requires a display length of 18, and you change the length to 12, only the first twelve characters of the name displays/prints.

9. When you finish making changes, accept the screen. The prompt displays for you to add or edit another column.

10. When you finish adding or editing columns, press ENTER. The system redisplays the prompt for you to add, edit, delete or move additional fields.

11. You have the following choices:

    - If you want to add or edit additional fields, repeat this procedure starting from Step 2.
    - If you want to delete (refer to "Procedure: Delete a Field on a Line in the Patient Block" on page 9-34), or move (refer to "Procedure: Move a Field on a Line in the Patient Demographic Block" on page 9-36) other fields.
    - If you are finished changing fields, go on to the next step.

12. When you finish changing fields on the line, press ENTER. The system redisplays the prompt for you to add, edit, delete or copy lines. Refer to one of the other procedures if you want to add, edit, delete, or copy information on another line.

    - To Add information to a line refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22.
    - To Edit information on a line refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22.
    - To Delete information on a line refer to "Procedure: Delete a Line in the Patient Demographic Block" on page 9-24.
    - To Copy information on a line refer to "Procedure: Copy a Line in the Patient Demographic Block" on page 9-27.

13. If you are finished making changes to the lines, press ENTER. The system displays the following prompt:

    Accept these changes? (Y/N)

14. You have the following choices:

    - To make additional changes, enter **N** for No. The system redisplays the prompt for you to add, edit, delete, or copy lines.
    - To accept the changes and store the block as the temporary version, enter **Y** for Yes. The system displays the following message:

      Temporary version filed!

      The following prompt displays:

      Display(D), activate(A), or delete(R) patient block? [D]--

      Refer to the one of the following procedures to activate, delete, or display the Patient Block:

      - To activate the block refer to "Procedure: Activate the Temporary Patient Demographic Block" on page 9-39.
      - To display the Patient Block refer to "Procedure: Display the Patient Demographic Block" on page 9-40.
      - To delete the active or temporary block refer to "Procedure: Delete the Active or Temporary Patient Block" on page 9-41.

You can also activate the patient block directly from the screen you use to display the patient block.

PROCEDURE: DELETE A FIELD ON A LINE IN THE PATIENT BLOCK

You can perform the following procedure when you want to delete one or more of the fields on a line in the Patient Block.

1. To add or edit a line on the Patient block refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22. The screen displays the following prompt:

   Enter add(A), edit(E), delete(D), move(M) fields--
   next line(/) or previous line(/P)

2. Enter **D** to delete a field. The following prompt displays:

   Enter column number to delete--

3. Enter the number of the column where you want to delete a field.

   The screen displays the information for the patient block field with the following prompt:

   Delete this field (Y/N)? [N]--

4. You have the following choices:

   - To delete the field, enter **Y** for Yes. The system deletes the field. The prompt to add, edit, delete, or move fields redisplays. The system removes the field from the list of fields, as well as from the display on the sample line.

   - When you want to cancel the delete request, press ENTER or enter **N** for No. The system redisplays the prompt for you to add, edit, delete, or move additional fields.

     If you want to add, edit, or move additional fields on the line, refer to the following procedures:

     - To add a field of information refer to"Procedure: Add or Edit a Field on a Line in the Patient Block" on page 9-29.

     - To edit a field of information refer to "Procedure: Add or Edit a Field on a Line in the Patient Block" on page 9-29.

     - To move a field of information refer to "Procedure: Move a Field on a Line in the Patient Demographic Block" on page 9-36.

5. If you are finished making changes to the fields, press ENTER. The system displays the prompt to add, edit, delete, or copy lines.

   - To add information to a line refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22.

   - To edit information on a line refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22.

   - To delete information on a line refer to"Procedure: Delete a Line in the Patient Demographic Block" on page 9-24.

   - To copy information on a line refer to "Procedure: Copy a Line in the Patient Demographic Block" on page 9-27.

6. If you are finished making changes to the lines, press ENTER. The following prompt displays:

   Accept these changes? (Y/N)

7. You have the following choices:

   - To make additional changes, enter **N** for No.

   - To accept the changes and store the block as the temporary version, enter **Y** for Yes. The system displays the following message:

     Temporary version filed!

     The following prompt displays:

     Display(D), activate(A), or delete(R) patient block? [D]--

     Refer to the one of the following procedures to activate, delete, or display the patient block:

     - To activate the block refer to "Procedure: Activate the Temporary Patient Demographic Block" on page 9-39.

     - To display the Patient Block refer to "Procedure: Display the Patient Demographic Block" on page 9-40.

     - To delete the active or temporary block refer to "Procedure: Delete the Active or Temporary Patient Block" on page 9-41.

You can also activate the patient block directly from the screen you use to display the patient block.

PROCEDURE: MOVE A FIELD ON A LINE IN THE PATIENT DEMOGRAPHIC BLOCK

When you want to move a field of information to another position on a line of the Patient Demographic Block, perform the following procedure.

1. To add or edit a line on the Patient block refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22. The screen displays the following prompt:

   Enter add(A), edit(E), delete(D), move(M) fields--
   next line(/) or previous line(/P)

2. To Move a field, enter **M**. The following prompt displays:

   Enter new column number or (+/-) offset

3. You have the following choices:

   - Enter a new column number.

- Enter a plus sign (+) and the number of columns you want to move the text to the right.

- Enter a minus sign (-) and the number of columns you want to move to the left.

When you enter a valid column number, the system moves the field on the sample line and changes the column number in the Col field. The system redisplays the prompt for you to move additional fields.

NOTE: The column number you enter cannot be already occupied. If you enter a column number that is already occupied or out of range (greater than the block size of 36 columns), you receive one of the following error messages:

Error: Column 31 already occupied
Error: Column 40 out of range.

You can determine if the space is occupied by referring to the sample line at the top of the screen. When there is no highlighting underneath the column number, the space is not occupied. You also must be sure that there is enough space following the new column number so that the system can fit the field's display length. The display length displays in the Width field.

For example, the Attending Physician field has a display length of 18 and there are 20 columns before the next field starts. There are two columns, or spaces, between the two fields. If you enter a new column number, the Attending Physician field moves over five spaces, and since there are only two spaces between the fields, you receive an error message. This is because the column numbers 3-5 are already occupied by the next field.

4. When you finish moving fields, press ENTER twice to redisplay the prompt to add, edit, delete, or move additional fields.

   - To add a field refer to "Procedure: Add or Edit a Field on a Line in the Patient Block" on page 9-29.

   - To edit a field refer to "Procedure: Add or Edit a Field on a Line in the Patient Block" on page 9-29.

   - To delete a field refer to "Procedure: Delete a Field on a Line in the Patient Block" on page 9-34.

5. When you finish adding fields, press ENTER. The system redisplays the prompt for you to add, edit, delete, or copy lines.

- To Edit information on a line refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22.

- To Delete information on a line refer to "Procedure: Add or Edit a Line on the Patient Demographic Block" on page 9-22.

- To Copy information on a line refer to "Procedure: Copy a Line in the Patient Demographic Block" on page 9-27.

6. When you finish making changes to the lines, press ENTER. The following prompt displays:

   Accept these changes? (Y/N)--

7. You have the following choices:

   - To make additional changes, enter **N** for No. The system redisplays the prompt for you to add, edit, delete, or copy lines.

   - To accept the changes and store the block as the temporary version, enter **Y** for Yes. The system displays the following message:

     Temporary version filed!

     The following prompt displays:

     Display(D), activate(A), or delete(R) patient block? [D]--

     Refer to the one of the following procedures to activate, delete, or display the Patient Block:

     - To activate the block refer to "Procedure: Activate the Temporary Patient Demographic Block" on page 9-39.

     - To display the Patient Block refer to "Procedure: Display the Patient Demographic Block" on page 9-40.

     - To delete the active or temporary block refer to "Procedure: Delete the Active or Temporary Patient Block" on page 9-41.

You can also activate the patient block directly from the screen you use to display the patient block.

Activate, Display, or Delete the Patient Block

You can activate, display, or delete the patient block using one of the following procedures:

- To activate the patient block refer to "Procedure: Activate the Temporary Patient Demographic Block" on page 9-39.
- To display the patient block refer to"Procedure: Display the Patient Demographic Block" on page 9-40.
- To delete the patient block refer to "Procedure: Delete the Active or Temporary Patient Block" on page 9-41.

You can also activate the patient block from the patient block display.

PROCEDURE: ACTIVATE THE TEMPORARY PATIENT DEMOGRAPHIC BLOCK

You can activate the temporary Patient Demographic Block using the following procedure. The system deletes the current Patient Demographic Block and replaces it with the version you activate. The system prints the patient block you activate on online nursing documents.

1. If you are not already in the Patient Demographic Block function refer to "Access the Builder for the Patient Block" on page 9-19 to access the temporary version of the Patient Demographic Block.
2. Press ENTER if the following prompt is displaying:

   Add(A), edit(E), delete(D) or copy(C) lines--

   The following prompt enables you to display the temporary patient block:

   Display(D), activate(A), or delete(R) patient block? [D]--

   NOTE: If there is no temporary version, the option to activate does not display in the prompt.
3. Enter **A** to Activate the temporary patient block. The following prompt displays:

   Activate temporary patient block? (Y/N) [N]--
4. You have the following choices:
   - When you want to cancel the activate request, enter **N** for No. The prompt to display, activate, or delete redisplays.
   - When you want to activate the temporary version, enter **Y** for Yes. The system displays the message *Activated.* The Report Build menu displays with the options for building user-formatted PCPs.

PROCEDURE: DISPLAY THE PATIENT DEMOGRAPHIC BLOCK

You may want to display the Patient Demographic Block before activating it. Displaying the Patient Demographic Block enables you to check that the headers and information are printing the way you want. You can activate the patient block from the display.

1. If you are not already in the Patient Block function refer to "Procedure: Access the Patient Demographic Block Builder" on page 9-19 to access the temporary version of the Patient Demographic Block.

2. Press ENTER if the following prompt is displaying:

   Add(A), edit(E), delete(D) or copy(C) lines--

   The following prompt enables you to display the temporary patient block:

   Display(D), activate(A), or delete(R) patient block? [D]--

   NOTE: If there is no temporary version, the option to activate does not display in the prompt.

3. Enter **D** to Display the temporary patient block. The system displays the patient selection prompt:

   Enter acct #, '-'bed code, first chars of name'-' [1E Census]--
   'C' for Census

4. Select the patient you want to use to display a sample of the patient block. You can use any of the options on the prompt or press ENTER to display the station's Census and make your selection. Refer to "Chapter 1 - CRITICAL PATHWAYS" in this manual for further information on the options. For complete information on how to select a patient from the prompt, refer to the *Patient Processing Module* of the *STAR Patient Care Reference Guide*.

   NOTE: Information Windows which display patient information, physicians, and pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in this function. During the download process, the system displays the following message:

   Downloading Information Windows...Please Wait!

   After the windows are downloaded, you can view them in any other nonpatient-specific function on STAR Patient Care. When you access a patient-specific function other than Order Management or Nursing functions, the downloaded information is cleared. The information is also cleared when you select a different patient in one of the functions where Information Windows are available. For specific information regarding Patient, Physician, or Pharmacy Information Windows, refer to "Appendix B - INFORMATION WINDOWS".

The system displays the temporary patient block using actual patient information, as shown on the following screen:

```
            General Hospital Pt. Demographic Block Builder Processor
Patient Block                                      Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9329-400-003  KING,SANDRA        F  01/01/20 2103-01 COOPER,JEFF  MED 10 I/P 13

Active Patient Block                    Temporary Patient Block
KING,CONNIE L.                         |KING,CONNIE L.
Dx:428.9-*HEART FAILURE NOS            |Dx:428.9-*HEART FAILURE NOS
                                       |
MR#: 00000-05-47  Acct#: 8580          |MR#: 00000-05-47  Acct#: 8580
                                       |
Phys: JENSON,DALE                      |Phys: JENSON,DALE
                                       |MR#: 00000-05-47  Acct#: 8580
                                       |
1E 21-B SERVICE: MED                   |1E 21-B SERVICE: MED









Display(D), activate(A), or delete(R) patient block? [D]--
```

This enables you to view how the information prints on the block so you can make any necessary changes. The prompt to display, activate, or delete continues to display:

(Display(D), activate(A), or delete(R) patient block? [D]--

5. You have the following choices:

   - When you do not want to activate or delete the block, press period (.) ENTER to exit the patient block function. The Report Build Options menu displays.
   - To activate the temporary patient block refer to "Procedure: Activate the Temporary Patient Demographic Block" on page 9-39.
   - To delete one of the patient blocks, enter **R** for Delete. The following prompt displays:

     Delete active(A) or temporary(T) patient block [T]--

     To delete one of the patient blocks refer to "Procedure: Delete the Active or Temporary Patient Block" on page 9-41.

PROCEDURE: DELETE THE ACTIVE OR TEMPORARY PATIENT BLOCK

You can delete either the active or temporary patient block:

- When you delete the temporary block, the system loads the active block the next time you want to make changes to the block.

- When you delete the active block, the system reverts to the system-generated Patient Block for printing on nursing documents.

1. If you are not already in the Patient Block function refer to "Procedure: Access the Patient Demographic Block Builder" on page 9-19 to access the temporary version of the Patient Demographic Block.

2. Press ENTER if the following prompt displays:

   Add(A), edit(E), delete(D) or copy(C) lines--

   The following prompt enables you to delete the active or temporary patient block:

   Display(D), activate(A), or delete(R) patient block? [D]--

   NOTE: If there is no temporary version, the option to activate does not display in the prompt.

3. Enter **R** to Delete one of the patient blocks. The following prompt displays:

   Delete active(A) or temporary(T) patient block? [T]--

4. You have the following choices:

   - To delete the current active version, enter **A**.
   - To delete the temporary version, enter **T** or press ENTER.

   Depending on your entry, one of the following prompts displays to confirm that you want to delete the block:

   Delete temporary patient block? (Y/N) [N]--
   Delete active patient block? (Y/N) [N]--

5. You have the following choices:

   - To delete the block, enter **Y** for Yes. The system displays the message *Deleted!* and deletes the block.

     If you delete the active patient block, the system defaults to the system-generated Patient Demographic Block. Refer to "Example of a System-Generated Patient Block" on page 9-13 to see the example.

     If you delete the temporary patient block, the next time you access the Patient Demographic Block function, the system loads the active version for editing. The edits you make become the new temporary version. The active version is unchanged until you activate the temporary version.

   - To cancel the deletion request, enter **N** for No or press ENTER. The system redisplays the prompt to display, activate, or delete the patient block.

BUILD AND DESIGN REPORT CELLS

Overview

The Report Cell Builder enables you to build and design cells for the PCPs and Worksheets that you can design to meet the needs of the various stations, staffs, and departments. By designing your own cells, you can build multiple PCPs and Worksheets that satisfy the variety of requirements in your nursing area.

In addition to building an unlimited number of PCPs and Worksheets, you can also build an unlimited number of Report Cells.

Once you access the Report Cell Builder, you can build a variety of cells for the PCP or Worksheet.

To build this cell...	Refer to...
Active Orders	“Quicksteps to Build an Active Orders Cell” on page 9-44
ADLs	“Quicksteps to Build an ADLs Cell” on page 9-48
Associated Patient Block	“Quicksteps to Build an Associated Patient Block Cell” on page 9-48
Medical Information	“Quicksteps to Build a Medical Information Cell” on page 9-49
Medications Orders	“Quicksteps to Build a Medications Orders Cell” on page 9-49
Patient History	“Quicksteps to Build a Patient History Cell” on page 9-50
Physician Consultations	“Quicksteps to Build a Physician Consultations Cell” on page 9-50
Plan of Care	“Quicksteps to Build a Plan of Care Cell” on page 9-50
PRN Orders	“Quicksteps to Build a PRN Orders Cell” on page 9-51
Problem List	“Quicksteps to Build a Problem List Cell” on page 9-51
Progress Notes	“Quicksteps to Build a Progress Notes Cell” on page 9-52
Solution Orders	“Quicksteps to Build a Solutions Orders Cell” on page 9-52
Text	“Quicksteps to Build a Text Cell” on page 9-52

The build for the Active Orders cell and the Medical Information cells is the same as the build for the lines and fields in the Patient Demographic Block. The only difference is that the line length is longer.

You access the Report Cell Builder screen to select the Cell Type you want to build. You use this screen to build the title of the cell and any column headings for the information you want the system to retrieve. The Report Cell Builder screen is the same for all Cell Types. Once you accept the screen, depending on the cell type, other screens display for you to enter information. The specific procedures for each cell type are in the procedures on the pages noted above. If you want to delete a cell you built refer to “Delete a Report Cell” on page 9-106.

Quicksteps to Build Report Cells

Quicksteps are designed for experienced users who may need a reminder on how to perform a task. When you need more complete information, use the fully documented procedure. Refer to the Table of Contents at the beginning of this section for the page numbers of the fully documented procedures with overview, impacts, and steps.

Access the Report Cell Builder

1. Select File Maintenance from the Nursing main menu.
2. Select Standard File Maintenance.
3. Select Report Build Options.
4. Select Report Cell Builder.
5. Choose the facility, if multifacility.
6. You have a choice to add or edit report cells:
   - Enter a new cell code to build a new report cell.
   - Enter an existing cell code to edit an existing report cell.
7. Enter up to 36 alphanumeric characters for the Cell Description.
8. Enter up to 78 characters for the title and/or column headings on each line, with a maximum of two lines.
9. Press the F3 key when you finish entering the information.
10. Continue with the Quicksteps for the type of cell you want to build.

QUICKSTEPS TO BUILD AN ACTIVE ORDERS CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the Active Orders cell type.
3. Enter the selection number for one of the following Test Sorts:
   - Alphabetical
   - Requested Date/Time
   - Reverse Chronological
   - System

4. You have the following choices for printing the Preps and Special Instructions:
   - To include Preps and Special Instructions, enter **Y** for Yes.
   - To exclude Preps and Special Instruction, enter **N** for No.
5. You have the following choices for printing Therapy Order Text:
   - To include Therapy Order Text, enter **Y** for Yes.
   - To exclude Therapy Order Text, enter **N** for No.
6. Select the Department(s) for which you want to print active orders.
7. Press the F7 key to exit the department selection screen. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.
8. Once you accept the screen, you can add, edit, delete, or move the lines on the screen by following the appropriate Quicksteps below.

Delete a Line on the Active Orders Report Cell

1. Enter **D** to delete a line of information from the Report Cell.
2. Enter the number of the line where you want to delete all information.
3. Enter **Y** for Yes to confirm the deletion request.
4. You have the following choices:
   - Make changes to other lines.
   - Press ENTER when you finish making changes.
5. Enter **Y** for Yes to accept the changes to the Report Cell.

Copy a Line on the Active Orders Report Cell

1. Enter **C** to Copy a line of information on the report cell.
2. Enter the number of the line you want to copy from.

3. Enter the number of the line you want to copy to.
4. You have the following choices:
   - Make changes to other lines.
   - Press ENTER when you finish making changes.
5. Enter **Y** for Yes to accept the changes to the report cell.

Add or Edit a Line on the Active Orders Report Cell

1. You have the following choices:
   - Enter **A** to add a line.
   - Enter **E** to edit a line that has information.
2. Enter the number of the line where you want to add or edit information.
3. Continue with the Quicksteps for adding, editing, deleting, or moving fields of information in a line on the Report Cell.

Add or Edit a Field on a Line in the Active Orders Report Cell

1. You have the following choices:
   - Enter **A** to add a line.
   - Enter **E** to edit a line that has information.
2. Enter the column number where you want to add or edit a field.
3. You have the following choices:
   - To have system retrieve information, select a Library Name.
   - Make any necessary changes to the Library Name or Display Length fields.
   - To print a heading/literal, press ENTER to bypass the Library Name field.
   - Enter the heading/literal you want to print.
   - Enter the heading/literal in the Example Output field to make sure the system has room to print.
   - Make any necessary changes to the screen.

4. When you finish, press ENTER to accept the screen.
5. You have the following choices:
   - If you want to make additional changes to the fields on this line, refer to the Quicksteps for adding, editing, deleting, or moving fields of information.
   - If you are finished changing fields on this line, press ENTER.
6. You have the following choices:
   - If you want to make additional changes to lines on the report cell, refer to the Quicksteps for adding, editing, deleting, or copying lines.
   - If you are finished changing lines, press ENTER.
7. Enter **Y** for Yes to accept the changes.

Delete a Field on a Line in the Active Orders Report Cell

1. Enter **D** to delete a field on the line.
2. Enter the number of the column where you want to delete a field.
3. Enter **Y** for Yes to delete the field.
4. You have the following choices:
   - If you want to make additional changes to the fields on this line, refer to the Quicksteps for adding, editing, deleting, or moving fields of information.
   - If you are finished changing fields on this line, press ENTER.
5. You have the following choices:
   - If you want to make additional changes to lines on the report cell, refer to the Quicksteps for adding, editing, deleting, or copying lines.
   - If you are finished changing lines, press ENTER.
6. Enter **Y** for Yes to accept the changes.

Move a Field on a Line in the Active Orders Report Cell

1. Enter **M** to move a field on the line.
2. You have the following choices:

- Enter a new column number.
- Enter a plus sign (+) and the number of columns to move to the right.
- Enter a minus sign (-) and the number of columns to move to the left.

3. When you finish moving fields, press ENTER.
4. You have the following choices:
   - If you want to make additional changes to the fields on this line, refer to the Quicksteps for adding, editing, deleting, or moving fields of information.
   - If you are finished changing fields on this line, press ENTER.
5. You have the following choices:
   - If you want to make additional changes to lines on the report cell, refer to the Quicksteps for adding, editing, deleting, or copying lines.
   - If you are finished changing lines, press ENTER.
6. Enter **Y** for Yes to accept the changes.

QUICKSTEPS TO BUILD AN ADLS CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the ADLs cell type.
3. Select one, multiple, or all ADLs.
4. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.

QUICKSTEPS TO BUILD AN ASSOCIATED PATIENT BLOCK CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the Associated Patient Block cell type.
3. You have the following choices:

- To accept the entries, enter **Y** for Yes.
- To edit the entries, enter **N** for No and access fields for editing.
- To delete the cell, enter **D** for Delete.

4. Enter the text or underlines in the cell.
5. Press F3 to complete and exit the cell.

QUICKSTEPS TO BUILD A MEDICAL INFORMATION CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the Medical Information cell type.
3. Refer to the Quicksteps for the Active Orders cell type above, starting with Step 7.

QUICKSTEPS TO BUILD A MEDICATIONS ORDERS CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the Medication Orders cell type.
3. You have the following choices:
   - To include scheduled medications only, enter **S** for Scheduled.
   - To include PRN medications only, enter **P** for PRNs.
   - To include both scheduled and PRN medications, enter **B** for Both.
4. You have the following choices:
   - To include administration times, enter **Y** for Yes.
   - To exclude administration times, enter **N** for No.
5. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.

QUICKSTEPS TO BUILD A PATIENT HISTORY CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the Patient History cell type.
3. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.

QUICKSTEPS TO BUILD A PHYSICIAN CONSULTATIONS CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the Physician Consultations cell type.
3. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.

QUICKSTEPS TO BUILD A PLAN OF CARE CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the Plan of Care cell type.
3. You have the following choices for printing the name of the Plan of Care.
   - To include the name, enter **Y** for Yes.
   - To exclude the name, enter **N** for No.
4. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.

QUICKSTEPS TO BUILD A PRN ORDERS CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the PRN Orders cell type.
3. Enter the selection number for one of the following Test Sorts:
   - Alphabetical
   - Requested Date/Time
   - Reverse Chronological
   - System
4. You have the following choices for printing the Preps and Special Instructions:
   - To include Preps and Special Instructions, enter **Y** for Yes.
   - To exclude Preps and Special Instruction, enter **N** for No.
5. You have the following choices for printing Therapy Order Text:
   - To include Therapy Order Text, enter **Y** for Yes.
   - To exclude Therapy Order Text, enter **N** for No.
6. Select the Department(s) for which you want to print PRN orders.
7. Press the F7 key to exit the department selection screen. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.
8. Once you accept the screen, you can add, edit, delete, or move the lines on the screen by following the appropriate Quicksteps under “Active Orders Report Cell” on page 9-58.

QUICKSTEPS TO BUILD A PROBLEM LIST CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the Problem List cell type.

3. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.

QUICKSTEPS TO BUILD A PROGRESS NOTES CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the Progress Notes cell type.
3. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.

QUICKSTEPS TO BUILD A SOLUTIONS ORDERS CELL

1. Access the Report Cell Builder.
2. Enter the selection number for the Solutions Orders cell type.
3. Select the Solution types you want to print.
4. You have a choice for the administration times:
   - To include the administration times, enter **Y** for Yes.
   - To exclude the administration times, enter **N** for No.
5. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.

QUICKSTEPS TO BUILD A TEXT CELL

1. Access the Report Cell Builder.

2. Enter the selection number for the Patient History cell type.
3. Enter the number of text lines you want to reserve for the cell.
4. You have the following choices:
   - To accept the entries, enter **Y** for Yes.
   - To edit the entries, enter **N** for No and access fields for editing.
   - To delete the cell, enter **D** for Delete.
5. Enter the text you want to print on the lines.
6. Press F3 when you finish entering text.

Procedure: Access the Report Cell Builder

When you want to access the Report Cell Builder to build report cell types, perform the following steps.

1. Select File Maintenance from the Nursing main menu. The Standard File Maintenance menu displays:

```
                General Hospital File Maintenance Processor
                                                Fri Feb 19, 1993 08:15 am
File Maintenance Input Options

            Option No.  Option
            ---------------------------------------
                1       Standard File Maintenance
                2       Staffing File Maintenance









Enter option number--
```

2. Select Standard File Maintenance. The Standard File Maintenance menu displays:

```
             General Hospital Standard File Maintenance Processor
                                        Fri Feb 19, 1993 08:15 am
Standard File Maintenance Input Options

            Option No.  Option
            ---------------------------------------
                1       Standard Plan of Care
                2       Critical Pathways
                3       Standard Assessments
                4       ADL's/Misc.
                5       Treatment Orders
                6       Vital Signs & Fluid Balances
                7       Defining Characteristics
                8       Routine Orders
                9       Preps and Special Instructions
               10       Custom Documents
               11       Standard Text - Patient History
               12       Station Parameters
               13       Report Build Options
               14       Print Standard Files
               15       Custom Worksheet

Enter option number--
```

3. Select Report Build Options.

4. Select Report Cell Builder.

5. Select the facility, if multifacility. The following prompt displays:

   Enter first letter(s)'-' or cell code--

6. You can either

   - edit an existing cell (see "Edit an Existing Cell" on page 9-54), or
   - add a new cell (see "Add a New Cell" on page 9-55).

EDIT AN EXISTING CELL

If you want to edit an existing cell, you can select the cell through one of the following methods:

- Enter the cell code.

- Perform a table lookup and make your selection from the list of cells that display, as in the following example. (The cells that display are the report cells already built for your facility.)

```
            General Hospital Database Report Cell Builder Processor
                                                Thu Nov 04, 1993 09:45 am

 1 ADL Categories
->
Page:01                          ADL Categories              ##=Current Choices
( 1) AMBULATE                             (16) DRESSING
( 2) AMBULATION AIDS                      (17) ELIMIN
( 3) AP PULSE                             (18) ELIMINATE
( 4) B/P                                  (19) FEEDING
( 5) BATH SITZ                            (20) FHT
( 6) BATH                                 (21) FORMULA
( 7) BED POSIT                            (22) HOUSING,PRESENT
( 8) BED TYPE                             (23) NURSERY
( 9) BEDREST                              (24) HYGIENE
(10) BLOOD PRESSURE                       (25) I & O
(11) BP,P,R,F&F - PP TRANSITION           (26) INTAKE/OUT
(12) CARD REHAB LEVEL 3400                (27) LEVEL
(13) CC TEST R                            (28) MEASURE
(14) CHAIR                                (29) MEASUREMENTS
(15) CIRC/VASC                            (30) MISC

Enter choices (eg. 1,7,5-9), `-`choices to remove or all(A)--
                        end selection(NL)  next page(/)
```

Once you select the cell, access the fieldyou want to change. For detailed procedures on editing individual cell types, refer to the table of contents for the section.

ADD A NEW CELL

To add a new cell, enter up to three digits of a unique number for the code. The following screen displays:

```
            General Hospital Database Report Cell Builder Processor
                                                Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99     ->
 3 Cell Print Description/Title


 4 Cell Type









Enter description--
```

Field Explanations

1. CODE (DISPLAY ONLY)
The Code field displays the cell code you entered to add the cell. The cursor is in the Cell Description field. The following prompt displays:

Enter description--

2. CELL DESCRIPTION (32-AN-R)
Enter up to 32 alphanumeric characters to describe the cell you want to create. You must enter a description that is unique from any other Report Cell Description. The description you enter here displays as the name of the cell block when you perform a table display of existing cells. This description does not print on the cell block.

3. CELL PRINT DESCRIPTION/TITLE (156-AN-O)
The contents of this field print as the first two lines of the report cell. You can use this field to enter a title. You can also enter column headings for cell types where you define information for the system to retrieve.

NOTE: You may want to write down the column numbers for each heading for reference when you are in the build screen for the Active Orders cell type. By noting the column positions, you can line up the information the system retrieves with the column headings you enter in this field. If they do not line up, you can always redisplay the previous screen and change the positions of the headings.

For example, you set up an Active Orders cell type and enter a column heading of Ord # (Order Number) in column position 8 of the Cell Print Description/Title field. After you accept the screen, and the cell builder for the Active Orders Cell Type displays, you define column position 8 as the position where the system retrieves the order number. By defining the same column positions, you line up the information with the headings.

Enter a maximum of 78 characters (including punctuation) for the heading on each line, with a maximum of two lines.

NOTE: You cannot use the colon (:) character in the description/title, since the system reserves it for its own use in this field.

You can design the cell so there is a blank line between the title and the information that prints. You enter the title on the first line and press ENTER to position the cursor on the second line. The system prints the heading, a blank line, and then the information you define for system retrieval.

The bottom of the screen displays function keys you can use while editing the text:

Key	Function
F1 (Del Line)	Deletes the line where the cursor is positioned.
F2 (Ins Line)	Inserts a line above the line where the cursor is positioned.
F3 (Done)	Exits the text-entry screen.
F4 (Del Char)	Deletes the character where the cursor is positioned.
F5 (Ins Char)	Inserts a space in front of the character where your cursor is positioned. You can then enter the character you want to insert.

The top of the entry area has two rows of numbers to denote the column numbers. The numbers on the first line (1,2,3...) mark the column positions by tens - in this example, the tenth, twentieth, and thirtieth positions. The numbers on the second line mark each column position.

Press F3 when you finish entering text for the description.

4. CELL TYPE (TABLE LOOKUP)
Select the type of report cell you want to build, as in the following example:

```
             General Hospital Database Report Cell Builder Processor
                                                  Wed Nov 10, 1998 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                              Cell Types
( 1) AO-Active Orders                      (11) PRN Orders
( 2) AD-ADL's                              (12) SL-Solution Orders
( 3) AB-Associated Patient Block           (13) TX-Text
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

The screen displays the types of cells you can build. Refer to the procedure for the cell type you want to build. (See page 9-43.)

The Active Orders and Medical Information cell types use the same build process as the Patient Demographic Block, enabling you to define information for the system to retrieve. Other cell types, such as Patient History and Problem List, do not require you to select the information you want to retrieve. The Text cell type enables you to design miscellaneous types of cells.

Active Orders Report Cell

The Active Orders Report Cell prints in a single-column, horizontal format that is 78 characters wide and prints as many lines as necessary to print the information requested. The system is not restricted to ten lines for printing the information you define for retrieval. The system prints as many lines of system information as exists for each type of data you defined.

You can select a SIM or non-SIM department for which to print the active orders. This enables you to select clinical departments, as well as the plan of care element departments, such as ADLs, Treatments, Problems, and Outcomes. For example, you may want to build a report cell that prints only Nourishment Active Orders.

The following is an example of an Active Orders Report Cell:

```
CLINICAL ORDERS
ORD #: 14   11/23 0217P ECG 12 LEAD
ORD #: 11   11/23 0300P ECG 12 LEAD
ORD #: 9    11/23 0600P ELECTRODES
ORD #: 7    11/23 0700P HOLTER MONITOR/WMC
ORD #: 4    11/23 1000P ECG 12 LEAD
ORD #: 3    11/24 1226P PARTIAL THROMBOPLASTIN TIME
ORD #: 2    11/24 1245P CARDIAC PROFILE
```

When building the Active Orders cell, you may want to group departments about which you want to print similar information or print information used by one type of user. By grouping in this way, you may only have to enter the information headings once and the user is able to quickly find the relevant information in the same area. Also, when you build user-formatted PCPs and Worksheets for different groups in the facility, you include the cells with information designed for those groups.

For example, you want to print information about active orders for the Nourishment and Dietary departments. By putting them in the same Active Orders cell, the caregiver can find the relevant information for both in the same section of the report. You can vary the information headings for each department, although this takes up some of the available ten lines.

NOTE: You can build an Active Orders cell for ADLs using this build; however, there is a specific Report Cell available for ADLs that prints the ADLs in a system-defined format, alphabetically by category. For the ADL Report Cell explanation refer to "ADLs Report Cell" on page 9-78. In addition, while you can build this cell to include departmental consult orders (Department Consults), Physical Consults require a different build. For the procedure for building a report cell for Physician Consultations refer to "Quicksteps to Build a Physician Consultations Cell" on page 9-50.

The system enables you to designate the format in which you want the active orders to print. You can specify for the system to print the orders according to one of the following sorting methods:

- Alphabetical
- System
- Requested Date/Time
- Reverse Chronological

You can also include the following information at the end of each order:

- Preps and Special Instructions
- Text entered in the Instructions field on the Therapy Orders screen

NOTE: If a department you select does not have any active orders, the system does not print the column headings for the department nor any blank lines. The system skips printing the cell or the part of the cell where the department is defined to print. For example, if you build a Clinical Active Orders Cell that is defined to print Radiology and Laboratory orders, and there are no Laboratory orders, the system prints only the Radiology orders.

PROCEDURE: BUILD A CELL FOR ACTIVE ORDERS

When you want to build a cell for active orders, complete the following procedure.

1. Access the Report Cell Builder using the following Quicksteps.
   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
   - Select Report Cell Builder.
   - Choose the facility, if multifacility.

   Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

2. Enter the selection number for the Active Orders cell type. The following screen displays:

```
                General Hospital Report Cell Builder Processor
                                                Wed Nov 10, 1993 02:51 pm

 1 Test Sort               2 Preps and Special Instructions 3 Order Text
->
 4 Departments

Page:01                              Test Sort
( 1) Alphabetical
( 2) Requested Date/Time
( 3) Reverse Chronological
( 4) System









Enter choice--
```

Complete each field as described in the following field explanations.

Field Explanations

1. TEST SORT (TABLE LOOKUP)
The bottom half of the screen displays a table of choices for sorting the tests (orders) on the report. The following prompt displays:

Enter choice--

Enter the selection number for the order in which you want the active orders to print on the report. You have the following choices:

- Alphabetical - The system sorts the active orders in alphabetical order by department.
- Requested Date/Time - The system sorts the active orders for each department in order of the Requested Date/Time, from oldest to most recent.
- Reverse Chronological - The system sorts the active orders for each department in reverse order of Requested Date/Time, from most recent to oldest.
- System - The system sorts the active orders for each department in numerical order using a system-generated internal order number.

2. PREPS AND SPECIAL INSTRUCTIONS (1-A-R)
The prompt for this field is:

Include preps and special instructions? (Y/N) [Y]--

- To print each order's associated preps and special instructions at the end of each order, enter **Y** for Yes.
- To exclude preps and special instructions from printing on the report, enter **N** for No.

3. ORDER TEXT (1-A-R)
The prompt for this field is:

Print order text? (Y/N) [N]--

Order text is the text entered in the Instructions field of the Therapy Orders screen. The Therapy Order screen enables the user to enter up to three lines of text with 36 characters on each line.

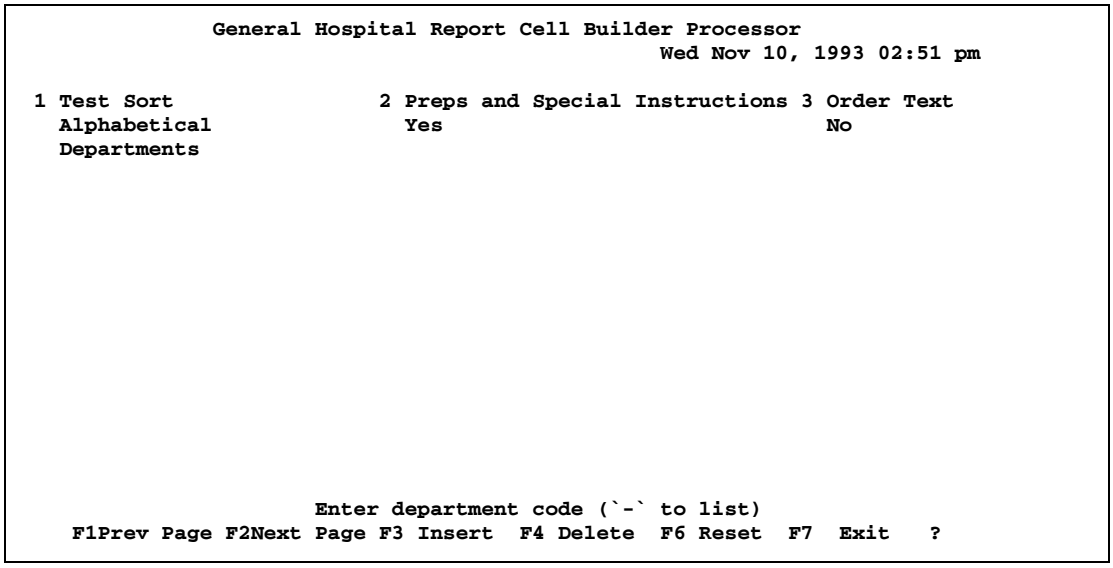
The system provides the Order Text field on the Active Orders Cell build screen to enable you to print the therapy order text at the end of each order. The lines in the Active Order Cell are 78 characters in length. The longer line length enables the system to save lines by word-wrapping the text. If you do not print the text using this field, you define lines (in a following step) for the system to retrieve each of the three 36-character lines of Therapy Order text.

- To print text associated with the Therapy order at the end of each order, enter **Y** for Yes.

  NOTE: If you enter **Y**, do not define Therapy text when you build the lines of information that you want the system to print for each order in the cell. If you do, the text prints twice.

- To exclude printing order text at the end of each Therapy order, enter **N** for No.

4. DEPARTMENTS (1-A-R)
With the cursor in this field, the following screen displays:



This field enables you to select the departments for which you want to print the active orders. The following prompt displays at the bottom of the screen:

Enter department code ('-' to list)

Options for inserting and deleting lines display at the bottom of the screen:

- F1 (Prev Page): Move to the previous page of the screen display
- F2 (Next Page): Move to the next page of the screen display
- F3 (Insert): Insert a department above the position of the cursor
- F4 (Delete): Delete a department at the position of the cursor
- F6 (Reset): Reset the line to the original display
- F7 (Exit): Exit the department entry screen
- ?: Help or policy and procedure information entered by your facility

You have the following choices for selecting one department at a time:

- Enter the department code. The system displays the description of the SIM department as entered in the SIM Departments table.
- Perform a table lookup and make your selection. The system displays the department code and the description of the SIM department as entered in the SIM Departments table.

Enter any additional departments for which you want to print active orders on the report. When you are finished, press F7 to exit the department entry screen. The following screen displays:

```
              General Hospital Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   97        CLINICAL ORDERS
 3 Cell Print Description/Title
   CLINICAL ORDERS
   ORD #  ITEM                                REQ. DT/TM
 4 Cell Type
   Active Orders

                           Additional Information
 1 Test Sort               2 Preps and Special Instructions 3 Order Text
   Alphabetical              Yes                               No
 4 Departments
   A,S









Accept this screen? (Y/N/D) [Y]--
```

The bottom of the Report Cell Builder screen displays the information you entered for the Active Orders Cell Type. This area of the screen is marked with the heading Additional Information.

The following prompt displays:

Accept this screen? (Y/N/D) [Y]--

- To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.

  When you want to access the fields in the Additional Information area of the screen, access the Cell Type field.

- To delete the Active Orders cell, enter **D** for Delete. The Delete option displays only when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

  Are you SURE you wish to delete this code? (Y/N)--

  - To delete the cell, enter **Y** for Yes.

  - To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

- To accept the entries you made for the Active Orders cell type, press ENTER or enter **Y** for Yes. The message *Filed!* displays and then the following screen:

```
              General Hospital Report Cell Builder Processor
Active Orders                                    Tue Nov 02, 1993 10:20 am

1
2
3
4
5
6
7
8
9
10









Add(A), edit(E), delete(D) or copy(C) lines--
```

The screen displays the following prompt for you to make changes to the block:

Add(A), edit(E), delete(D) or copy(C) lines--

You can define lines in the Active Orders Cell to contain the information used by your facility. You can perform one of the following procedures:

To...	See...
add a line of information to the cell	“Add or Edit a Line on the Active Orders Report Cell” on page 9-46
edit a line of information in a cell	“Add or Edit a Line on the Active Orders Report Cell” on page 9-46
delete a line of information from a cell	“Delete a Field on a Line in the Active Orders Report Cell” on page 9-47
copy a line of information to another line in the cell	“Copy a Line on the Active Orders Report Cell” on page 9-45

The cell has a maximum of ten lines you can use to define information for system retrieval. Once you add information to a line, you can edit, delete, or copy the information. First you select the line where you want to change or delete the information. After you select the line,you can add, edit, delete, or move the fields using one of the procedures to change fields on the report cell. For more information refer to “Change Fields on a Line in the Report Cell” on page 9-72.

Change Lines in the Report Cell

You can change the lines in the Report Cell to contain the information used by your facility. You can perform one of the following procedures:

To...	See...
add a line of information to the cell	"Add or Edit a Line on the Active Orders Report Cell" on page 9-46
edit a line of information in a cell	"Add or Edit a Line on the Active Orders Report Cell" on page 9-46
delete a line of information from a cell	"Delete a Line on the Active Orders Report Cell" on page 9-45
copy a line of information to another line in the cell	"Copy a Line on the Active Orders Report Cell" on page 9-45

The cell has a maximum of ten lines. You select the line where you want to change or delete the information. Once you select the line, you can add, edit, delete, or movethe fields using one of the procedures to change fields in the report cell. For more information refer to "Change Fields on a Line in the Report Cell" on page 9-72.

Add or Edit a Line on the Report Cell

When you want to add or edit information in a line on the Active Orders Cell, perform the following steps.

1. Access the Report Cell Builder using the following Quicksteps.
   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
   - Select Report Cell Builder.
   - Choose the facility, if multifacility.

   Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

2. Build the Active Orders Cell. For more information refer to"Active Orders Report Cell" on page 9-58. The following screen displays:

```
                General Hospital Report Cell Builder Processor
Active Orders                                      Tue Nov 02, 1993 10:20 am
Line 3
         1         2         3         4         5         6         7
12345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012345678


Col Width Description                   Col Width Description









Enter add(A), edit(E), delete(D), move(M) fields--
                       next line(/) or previous line(/P)
```

The screen displays the following information:

- The number of the line where you are adding the information - Line 3 in the previous screen.
- Any current line information displays with numbers that show each of the column positions. For example:

```
         1         2         3         4         5         6         7
1234567890123456789012345678901234567890123456789012345678901234567890123456789012345678
```

Ord# Item Description

If there is existing information, the underlined area shows the amount of space the system reserves for the information. In this example, the system reserves five spaces for the order number and up to 34 spaces for the item's description. For information the system retrieves, the system displays the example output in the sample line.

The numbers on the first line (1,2,3) mark the column positions by tens; in this example, the tenth, twentieth, and thirtieth positions. The numbers on the second line mark each column position.

Using the two numbers, you can locate the specific number of the column. For example, the 4 on the top line (equal to 40) and the 1 on the second line (where the shading ends) mark 41 as the column number where the space for the Item's Description ends. The system reserves the column numbers 8 through 41 for the item's description.

Field Explanations

COL
This field displays the number of the column where the information starts to print.

WIDTH field
This field displays how many columns are available for the information to print. In this example, up to 33 characters of the item's description can print.

DESCRIPTION
This field displays the description of the information, in this example order description.

The screen displays the following prompt:

Enter add(A), edit(E), delete(D), move(M) fields--
next line(/) or previous line(/P)

Refer to one of the following procedures:

To...	See...
add a field of information to a line	"Add or Edit a Line on the Report Cell" on page 9-65
edit a field of information on a line	"Add or Edit a Line on the Report Cell" on page 9-65
delete a field of information on a line	"Delete a Field on a Line in the Report Cell" on page 9-76
move a field of information to another position on the line	"Move a Field on a Line in the Report Cell" on page 9-77

Delete a Line in the Active Orders Cell

When you want to delete a line of information from the Active Orders Cell, perform the following steps:

NOTE: If you only want to delete part of the information on a field refer to "Add or Edit a Line on the Report Cell" on page 9-65. After you select the line for editing, you follow the procedure for deleting one or more of the fields on the line.

IMPACT:The system deletes the information from the line, leaving a blank line in the position.

1. Access the Report Cell Builder using the following menu options.
   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.

- Select Report Cell Builder.
- Choose the facility, if multifacility.

Refer to"Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

2. Build the Active Orders Cell. For more information refer to "Active Orders Report Cell" on page 9-58. The following screen displays:

```
                General Hospital Report Cell Builder Processor
Active Orders                                        Tue Nov 02, 1993 10:20 am

1
2
3
4
5
6
7
8
9
10









Add(A), edit(E), delete(D) or copy(C) lines--
```

The screen displays the following prompt for you to make changes to the block:

Add(A), edit(E), delete(D) or copy(C) lines--

3. Enter **D** to Delete a line of information from the cell. The following prompt displays:

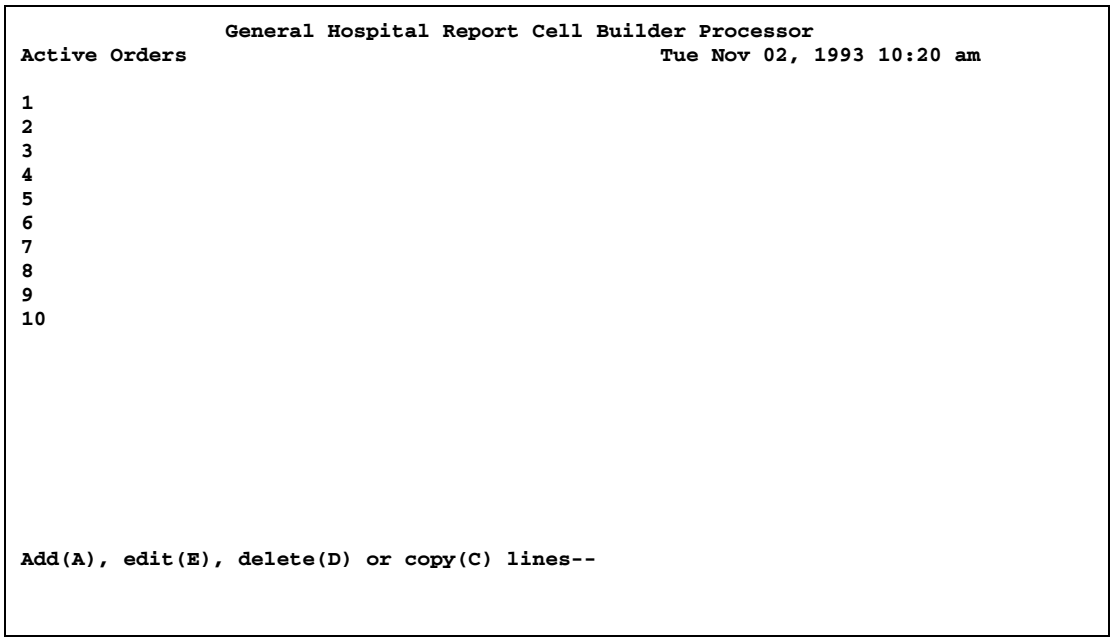
Enter line number to delete--

4. Enter the number of the line where you want to delete all of the information. The following prompt displays:

Line 3 will be deleted Accept (Y/N)? [N]--

You have the following choices:

- To delete the line of information, enter **Y** for Yes. The system deletes the information from the line. The line you selected is now blank. The prompt to add, edit, delete, or copy lines redisplays.



The screen displays the followng prompt for you to make changes to the cell:

Add(A), edit(E), delete(D) or copy(C) lines --

You have the following choices:

- Enter **A** to add information to a line on the cell.
- Enter **E** to edit a line that already contains information. When you try to edit a blank line, the following error message displays:

Error: Line 7 does not exist

Use the Add option to edit a blank line. One of the following prompts displays:

Enter line number to add --

Enter line number to edit --

3. Enter the number of the line where you want to add or edit information. A screen similar to the following displays:

- To cancel the deletion request, press ENTER or enter **N** for No. The prompt to add, edit, delete, or copy lines redisplays.

5. When you finish deleting lines, you have the following choices:

   - To edit a line, enter **E** and refer to "Add or Edit a Line on the Report Cell" on page 9-65.

   - To add a line, enter **A** and refer to "Add or Edit a Line on the Report Cell" on page 9-65.

   - To copy a line, enter **C** and refer to "Copy a Line in the Active Orders Cell" on page 9-70.

6. Press ENTER when you finish making changes to the cell. The following prompt displays:

   Accept these changes? (Y/N)--

   You have the following choices:

   - To make additional changes, enter **N** for No. The system redisplays the prompt for you to add, edit, delete, or copy lines.

   - To accept the changes and store the cell, enter **Y** for Yes. The system displays the message *Filed!* The following prompt displays, enabling you to build another cell:

     Enter first letter(s)'-' or cell code--

Copy a Line in the Active Orders Cell

When you want to copy a line of information in the Active Orders Cell, perform the following steps:

1. Access the Report Cell Builder using the following menu options:

   - Select File Maintenance from the Nursing main menu.

   - Select Standard File Maintenance.

   - Select Report Build Options.

   - Select Report Cell Builder.

   - Choose the facility, if multifacility.

Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

2. Build the Active Orders Cell. For more information refer to "Active Orders Report Cell" on page 9-58. The following screen displays:

```
                General Hospital Report Cell Builder Processor
Active Orders                                    Tue Nov 02, 1993 10:20 am

1
2
3
4
5
6
7
8
9
10









Add(A), edit(E), delete(D) or copy(C) lines--
```

The screen displays the following prompt for you to make changes to the block:

Add(A), edit(E), delete(D) or copy(C) lines--

3. Enter **C** to Copy a line of information from the block. The following prompt displays:

Enter line number to copy--

4. Enter the number of the line that has the information you want to copy. The following prompt displays:

Copy line 3 to line number--

5. Enter the number of the line to which you want to copy the information. The system copies information to the line you entered. The prompt to add, edit, delete, or copy lines redisplays.

6. Press ENTER when you finish making changes to the cell. The following prompt displays:

Accept these changes? (Y/N)--

- To make additional changes, enter **N** for No. The system redisplays the prompt for you to add, edit, delete, or copy lines.

- To accept the changes and store the cell, enter **Y** for Yes. The system displays the message *Filed!* The following prompt displays, enabling you to build another cell:

  Enter first letter(s)'-' or cell code--

Change Fields on a Line in the Report Cell

You can perform a variety of functions on the fields that are on a line in the report cell:

To...	See...
add a field of information to a line	"Add or Edit a Field on a Line in the Report Cell" on page 9-72
edit a field of information on a line	"Add or Edit a Field on a Line in the Report Cell" on page 9-72
delete a field of information on a line	"Delete a Field on a Line in the Report Cell" on page 9-76
move a field of information to another position on the line	"Move a Field on a Line in the Report Cell" on page 9-77

You can print a Forms Library Report to assist you in identifying the information you want the system to retrieve in the fields. For the procedure to print the report refer to "PRINT A FORMS LIBRARY REPORT" on page 9-137.

NOTE: Once you accept the changes, the changes are effective for the report cell.

Add or Edit a Field on a Line in the Report Cell

You perform the following procedure when you want to add or edit a field on a line in the report cell.

1. To add or edit a line on the report cell refer to "Add or Edit a Line on the Report Cell" on page 9-65. The screen displays the following prompt:

   Enter add(A), edit(E), delete(D), move(M) fields--
   next line(/) or previous line(/P)

   - To add a field to a blank line on the cell, enter **A**.

   - To edit a field on a line with information, enter **E**. One of the following prompts displays:

     Enter column number to add--
     Enter column number to edit--

2. Enter the number of the column where you want to add or edit a field. When you are editing a field, use the column number that displays in the Col field. The following screen displays:

```
                    General Hospital Report Cell Builder
Patient Block                                    Tue Nov 02, 1993 10:20 am
Line 3
         1         2         3
12345678901234567890123456789012345678


      Column 1
( 1)Library Name  :
( 2)Description   :
( 3)Example Output:
( 4)Display Length:









Enter alias to lookup--
```

If you are adding a field, the screen entries are blank. If you are editing a field, the screen displays entries. Enter information into the fields according to the field explanations.

Field Explanations

1. LIBRARY NAME (TABLE LOOKUP)
The prompt for this field is:

*Enter alias'-' or *Internal name'-' to lookup--*

This prompt enables you to choose an item from the library of information stored by the system. The alias is standard language for the coded Library Name.

You have the following choices:

- Define a literal - When the information you want to add is a heading or literal, and does not require the system to retrieve any information, press ENTER to bypass this field.

- Retrieve System Data - When you want the system to retrieve information from its library, perform one of the following:

  - Enter part or all of the alias name and hyphen (-) to perform a table lookup. The bottom of the screen displays a list of aliases that start with the letters you enter. The Internal Library Name and Description display for each alias.

- Enter asterisk (*) followed by part or all of the Internal Library Name and hyphen(-) to perform a table lookup of internal names for the information. The bottom of the screen displays a list of aliases that start with the letters you enter. The Library Name and description display for each alias.

```
                  General Hospital Report Cell Builder
Patient Block                                    Tue Nov 02, 1993 10:20 am
Line 3
         1         2         3
12345678901234567890123456789012345678


      Column 1
( 1)Library Name  :
( 2)Description   :
( 3)Example Output:
( 4)Display Length:

    Alias   Name                           Description               Page: 05
 1) ADDR                                   RELATIVE 1'S ADDRESS
            CAR141F                        Address

 2) ADDR                                   RELATIVE 2'S ADDRESS
            CAR142F                        Address

 3) ADDR                                   GUARANTOR'S EMPLOYER ADDR
            CAUP41F                        Address
Enter choice--
                      next page(/)  previous page(/P)
```

- Enter the selection number of the Alias or Internal Library Name you want to enter. The system automatically displays entries in the Description, Example Output, and Display Length fields, as shown on the following screen:

```
                  General Hospital Report Cell Builder
Processor
Patient Block                                    Tue Nov 02,
1993 10:20 am
Line 3
         1         2         3
12345678901234567890123456789012345678


      Column 1
( 1)Library Name  : CAR141F
( 2)Description   : RELATIVE 1'S ADDRESS
( 3)Example Output: 1234 ANY STREET
( 4)Display Length: 24









Accept this screen? (Y/N) [Y]--
```

2. DESCRIPTION (20-AN-R)
You use this field to enter a description of the literal you want to enter. For example, if you want the system to print the literal *Dr:*, you enter Doctor to describe the literal. The system does not print this description on the report cell; it is for your information only. Enter up to 20 characters as a description of the heading or literal.

3. EXAMPLE OUTPUT (78-AN-R)
Enter the text of the heading or literal you want to print. The system prints the text you enter, such as *Dr:* on the report cell.

Literals are used to label the system-retrieved information in the next patient block field, such as the Attending Physician's name. You bypassed the Library Name field because you don't want the system to retrieve any information; you only want to enter a literal.

The maximum length of a line in the report cell is 78 characters. The system also displays the characters you enter in the Example Output field in the sample line on the screen. The sample text enables you to determine how the heading/literal prints on the block, as well as enable you to view the column numbers that are available for the remaining information you want to add to the line.

4. DISPLAY LENGTH (2-N-R)
After you enter the Example Output, the system automatically enters the number of characters in the Display Length field.

The following prompt displays for you to make additional changes.

Enter field number or '/' starting field number--

Continue to Step 3.

3. Access any fields you want to change. You can only access the Library Name field (to change to a different alias) or the Display Length field to change the number of columns available for the information.

   NOTE: If you decrease the display length for information the system retrieves, you may cause the system to truncate the display. For example, if the doctor's name requires a display length of 18, and you change the length to 12, only the first twelve characters of the name displays/prints.

4. When you finish making changes, accept the screen. The prompt displays for you to add or edit another column.

5. When you finish adding or editing columns, press ENTER. The system redisplays the prompt for you to add, edit, delete or move additional fields.

6. When you finish changing fields on the line, press ENTER. The system redisplays the prompt for you to add, edit, delete, or copy lines.

7. If you are finished making changes to the lines, press ENTER. The system displays the following prompt:

   Accept these changes? (Y/N)

   - To make additional changes, enter **N** for No. The system redisplays the prompt for you to add, edit, delete, or copy lines.

   - To accept the changes, enter **Y** for Yes. The system displays the message *Filed!* The following prompt displays, enabling you to build another cell:

     Enter first letter(s)'-' or cell code--

Delete a Field on a Line in the Report Cell

You can perform the following procedure when you want to delete one or more of the fields on a line in the report cell.

1. To add or edit a line on the report cell refer toSee "Add or Edit a Line on the Report Cell" on page 9-65. The screen displays the following prompt:

   Enter add(A), edit(E), delete(D), move(M) fields--
   next line(/) or previous line(/P)

2. Enter **D** to delete a field. The following prompt displays:

   Enter column number to delete--

3. Enter the number of the column where you want to delete a field. The screen displays the information for the field with the following prompt.

   Delete this field (Y/N) ? [N]--

   - To delete the field, enter **Y** for Yes. The system deletes the field. The prompt to add, edit, delete, or move fields redisplays. The system removes the field from the list of fields, as well as from the display on the sample line.

   - When you want to cancel the delete request, press ENTER or enter **N** for No. The system redisplays the prompt for you to add, edit, delete, or move additional fields.

     If you want to add, edit, or move additional fields on the line, refer to the following procedures:

     - "Add or Edit a Field on a Line in the Report Cell" on page 9-72

     - "Move a Field on a Line in the Report Cell" on page 9-77

4. When you finish making changes to the fields, press ENTER. The system displays the prompt to add, edit, delete, or copy lines.

5. When you finish making changes to the lines, press ENTER. The following prompt displays:

   Accept these changes? (Y/N)

   - To make additional changes, enter **N** for No.
   - To accept the changes, enter **Y** for Yes. The system displays the message *Filed!* The following prompt displays, enabling you to build another cell.

     Enter first letter(s)'-' or cell code--

Move a Field on a Line in the Report Cell

Follow this procedure when you want to move a field of information to another position on the line.

1. To add or edit a line on the report cell refer toSee "Add or Edit a Line on the Report Cell" on page 9-65. The screen displays the following prompt:

   Enter add(A), edit(E), delete(D), move(M) fields--
   next line(/) or previous line(/P)

2. To Move a field, enter **M**. The following prompt displays:

   Enter new column number or (+/-) offset

   You have the following choices:

   - Enter a new column number.
   - Enter a plus sign (+) and the number of columns you want to move the text to the right.
   - Enter a minus sign (-) and the number of columns you want to move to the left.

   When you enter a valid column number, the system moves the field on the sample line and changes the column number in the Col field. The system redisplays the prompt for you to move additional fields.

   NOTE: The column number you enter cannot be already occupied. If you enter a column number that is already occupied or out of range (greater than the cell size of 78 columns), you receive one of the following error messages:

Error: Column 31 already occupied
Error: Column 80 out of range.

You can determine if the space is occupied by referring to the sample line at the top of the screen. When there is no highlighting underneath the column number, the space is not occupied. You also must be sure that there is enough space following the new column number so that the system can fit the field's display length. The display length displays in the Width field.

For example, the Ord# field has a display length of 5 and there are 2 columns before the next field starts. There are two columns, or spaces, between the two fields. If you enter a new column number that would move the Ord# field over five spaces, and there are only two spaces between the fields, you receive an error message because the column numbers 10-12 are already occupied by the next field.

3. When you finish moving fields, press ENTER twice to redisplay the prompt to add, edit, delete or move additional fields.

4. When you finish adding fields, press ENTER. The system redisplays the prompt for you to add, edit, delete, or copy lines.

5. When you finish making changes to the lines, press ENTER. The following prompt displays:

   Accept these changes? (Y/N)--

   - To make additional changes, enter **N** for No. The system redisplays the prompt for you to add, edit, delete, or copy lines.

   - To accept the changes, enter **Y** for Yes. The system displays the message *Filed!* The following prompt displays, enabling you to build another cell:

     Enter first letter(s)'-' or cell code--

ADLs Report Cell

The ADLs Report Cell prints in a two-column, horizontal format that is 78 characters wide and includes as many lines as necessary to print the information requested. The system prints the ADLs alphabetically by category description and includes the ADL Type and ADL Description.

TIP: If you want to ensure that non-SIM ADL orders always print on the PCP, you must build the ADL orders so there is an occurrence on every shift. That guarantees that the ADL order prints on the PCP in case the PCP is printed for just one or two shifts and not for the entire day. For more information, see "Chapter 3 - NURSING STATION FUNCTIONS".

There is also a field in the Station Parameters Processor under PCP Parameters that you can set so that either the Frequency code, Scheduled Days code, both, or neither prints on the PCP in this cell. The parameter is the PCP Freq/Sched Days Code field. For more information, see "Appendix A - NURSING TABLES".

The following is an example of an ADLs Report Cell:

```
ADL'S
AMBULATE      AD LIB                    |
```

1. Access the Report Cell Builder using the following menu options:

   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
   - Select Report Cell Builder.
   - Choose the facility, if multifacility.

   Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

   The cursor is in the Cell Type field. A selection screen displays for you to choose the type of report cell you want to build, as in the following example:

```
            General Hospital Database Report Cell Builder Processor
                                                 Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                            Cell Types
( 1) AO-Active Orders                    (11) SL-Solution Orders
( 2) AD-ADL's                            (12) TX-Text
( 3) AB-Associated Patient Block
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

2. Enter the selection number for the ADLs Cell Type. The following screen displays with a list of ADLs for you to select the ones you want to print in this cell:

```
               General Hospital Report Cell Builder Processor
                                                Wed Nov 10, 1993 02:51 pm

 1 ADL Categories
->
Page:01                           ADL Categories              ##=Current Choices
( 1) AMBULATE                             (16) DRESSING
( 2) AMBULATION AIDS                      (17) ELIMIN
( 3) AP PULSE                             (18) ELIMINATE
( 4) B/P                                  (19) FEEDING
( 5) BATH                                 (20) FHT
( 6) BATH                                 (21) FORMULA
( 7) BED POSIT                            (22) HOUSING,PRESENT
( 8) BED TYPE                             (23) HOWARD ADL
( 9) BEDREST                              (24) HYGIENE
(10) BLOOD PRESSURE                       (25) I & O
(11) BP,P,R,F&F - PP TRANSITION           (26) INTAKE/OUT
(12) CARD REHAB LEVEL 3400                (27) LEVEL
(13) CC TEST R                            (28) MEASURE
(14) CHAIR                                (29) MEASUREMENTS
(15) CIRC/VASC                            (30) MISC

Enter choices (eg. 1,7,5-9), `-`choices to remove or all(A)--
                        end selection(NL)  next page(/)
```

The following prompt displays:

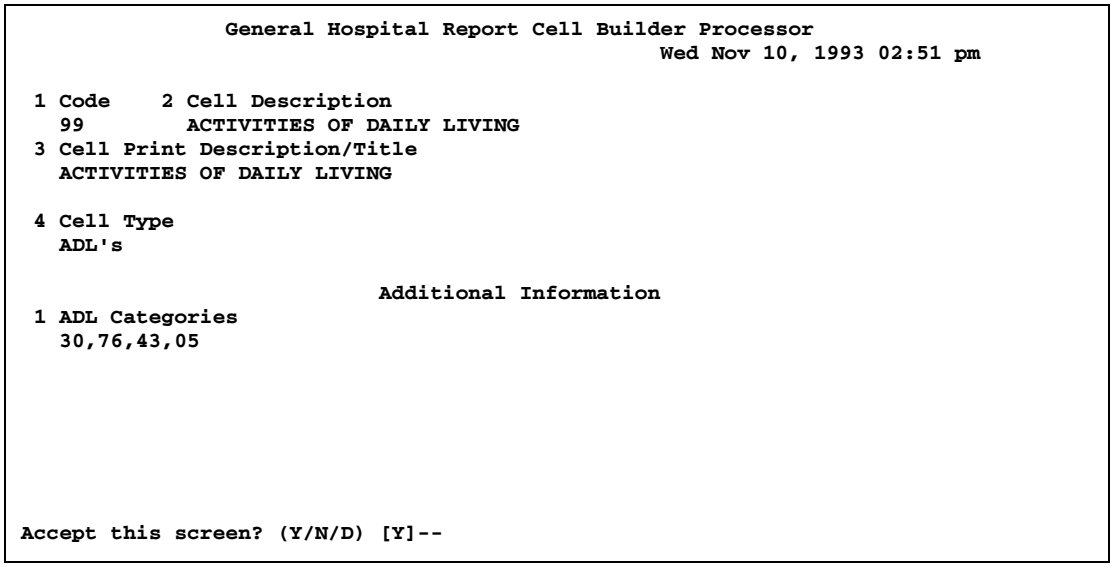
Enter choices (eg. 1,7,5-9), `-`choices to remove or all(A)--
end selection(NL) next page(/)

The current selections are highlighted.

3. Make your selections using one of the following methods:

   - To select all the ADLs to print, enter **A** for All.
   - To select one or more of the ADLs, enter the selection numbers of the ADLs. You can select multiple ADLs by entering the selection numbers separated by commas for single ADLs or a hyphen (-) to select a range (for example, 1,7,5-9).
   - To remove one of the choices enter hyphen (-) and the selection number of the ADL.
   - To view additional ADLs, enter slash (/) to view the next page or slash P (/P) to view the previous page. The next and previous page options do not display if there are no additional pages of ADLs.

4. When you finish selecting ADLs, press ENTER. The following screen displays:



The bottom of the Report Cell Builder screen displays an area marked with the heading Additional Information. The system displays the ADL codes for each of the ADLs you selected. The following prompt displays:

Accept this screen? (Y/N/D) [Y]--

- To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.

  NOTE: When you want to access the fields in the Additional Information area of the screen, access the Cell Type field.

- To delete the ADLs cell, enter **D** for Delete. The Delete option only displays when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

  Are you SURE you wish to delete this code? (Y/N)--

  - To delete the cell, enter **Y** for Yes.

  - To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

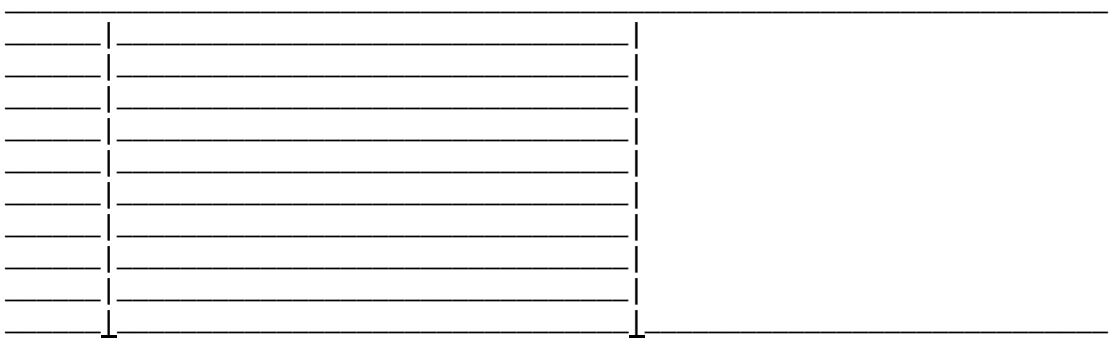
  - To accept the entries you made for the ADLs cell type, press ENTER or enter **Y** for Yes.

  The system displays the message *Filed!*. The cell is now available to print on the report.

Associated Patient Block Report Cell

The Associated Patient Block prints next to the Patient Demographic Block. The block is 9 lines by 38 characters. The system prints the Associated Patient Block to the left or right of the Patient Demographic Block, depending on where you select to print the Patient Demographic Block. You select where to print the Patient Demographic Block in the PCP Format Parameters. For more information refer to "Define the Format for the PCP" on page 9-109.

For example, you may want to build the Associated Patient Block as a block for Signatures and Initials, as shown in the following example:



1. Access the Report Cell Builder using the following menu options:

   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
   - Select Report Cell Builder.
   - Choose the facility, if multifacility.

   Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays. The cursor is in the Cell Type field and a selection screen displays for you to choose the type of report cell you want to build, as in the following example:

```
            General Hospital Database Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                              Cell Types
( 1) AO-Active Orders                      (11) SL-Solution Orders
( 2) AD-ADL's                              (12) TX-Text
( 3) AB-Associated Patient Block
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

2. Enter the selection number for the Associated Patient Block. The system enters your selection in the Cell Type field and displays the prompt for you to accept the screen:

   Accept this screen? (Y/N/D) [Y]--

   - To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.

   - To delete the Associated Patient Block cell, enter **D** for Delete. The Delete option only displays when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

     Are you SURE you wish to delete this code? (Y/N)--

     - To delete the cell, enter **Y** for Yes.

     - To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

To accept the entries you made for the Associated Patient Block Cell Type, press ENTER or enter **Y** for Yes. The system displays the message *Filed!* and the following screen displays:

```
              General Hospital Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm
           1         2         3
   12345678901234567890123456789012345678901
01|                                          |
02|                                          |
03|                                          |
04|                                          |
05|                                          |
06|                                          |
07|                                          |
08|                                          |
09|                                          |









F1        F2        F3        F4        F5
Del Line  Ins Line  Done      Del Char  Ins Char
```

Options for entering and editing text display at the bottom of the screen:

Key	Function
F1 (Del Line)	Deletes the line where the cursor is positioned.
F2 (Ins Line)	Inserts a line above the line where the cursor is positioned.
F3 (Done)	Exits the text-entry screen.
F4 (Del Char)	Deletes the character where the cursor is positioned.
F5 (Ins Char)	Inserts a space in front of the character where your cursor is positioned. You can then enter the character you want to insert.

NOTE: You can create underlines (_) for signatures using the SHIFT and hyphen (-) keys. You can create vertical lines using the SHIFT and backslash (\) keys.

3. Enter the text or underlines in the cell.

4. When you are finished entering/editing text, press the F3 function key. The system stores the Associated Patient Block.

Medical Information Report Cell

The Medical Information Report Cell prints in a single-column, horizontal format that is 78 characters wide and up to 18 lines of defined fields of information. The system prints as many lines as necessary to print the information requested.

The Medical Information cell includes physicians of record information for use with the Report Cell Builder. This enables you to add physicians of record, their specialty, and their phone number to User-Defined PCPs and Worksheets. Physicians of record include Admitting, Attending, Referring, Primary, Ante-Natal, Shared, and Emergency Room physicians.

You build the Medical Information Report Cell in the same way as you build the Active Orders Cell Type but select the Medical Information cell type in the Cell Type field. Refer to "Active Orders Report Cell" on page 9-58 for more information.

Here is an example of a Medical Information Report Cell:

```
ADDITIONAL MEDICAL INFORMATION
Allg:POLLEN
SPOUSE       WISEMAN,KIMBRA;ROBERTS    (404)938-4803
```

NOTE: This cell is useful for printing primary Diet information on the Patient Care Profile.

Medications Orders Report Cell

The Medications Orders Report Cell enables you to print Medication orders on the PCP that are scheduled or that are as-needed by the patient (PRNs). The system determines the format of how the cell prints. You only have to designate whether you want only scheduled medications to print, only PRNs to print, or both scheduled medications and PRNs to print.

The system prints the following information for both types of orders:

- Order number
- Description
- Frequency
- Administration Times
- Scheduled Days

The list prints sorted by Order status.

Here is an example of a Medication Orders Report Cell:

```
MEDICATION ORDERS
   4  10/12/93    TYLENOL W/CODEI 1 TABLET,ORAL
      06:00am,01:00pm,05:00pm,09:00pm
   6  10/22/93    ASPIRIN 325 MG,ORAL
      06:00am,01:00pm,05:00pm,09:00pm
   7  10/22/93    ASPIRIN 325 MG,ORAL
      06:00am,01:00pm,05:00pm,09:00pm
   5  10/12/93    ZESTRIL 5 MG,ORAL
      08:00am,06:00pm
```

1. Access the Report Cell Builder using the following menu options:

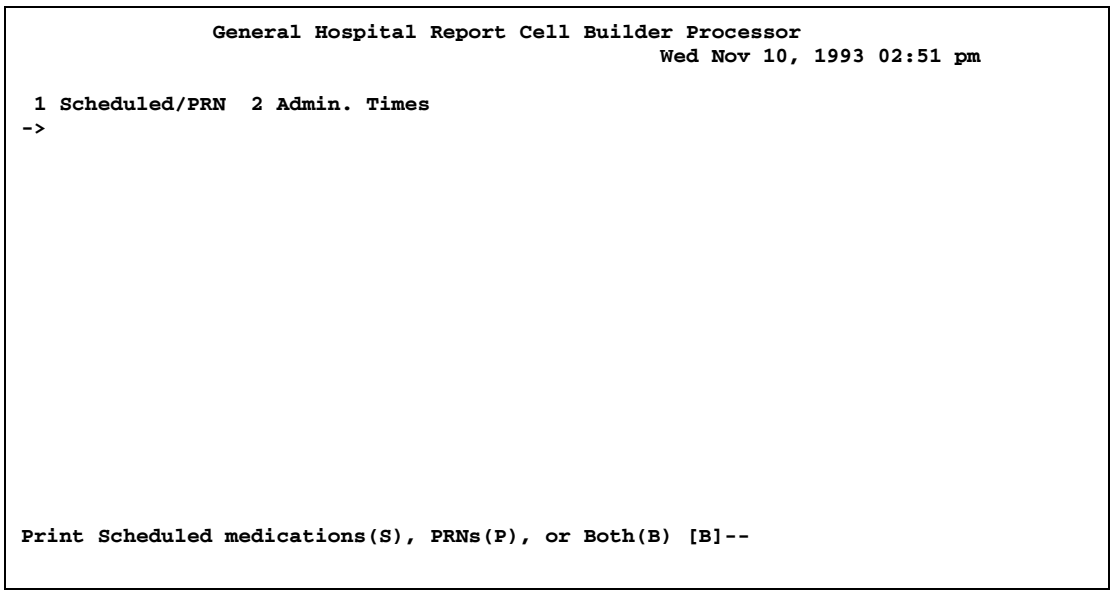
   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
   - Select Report Cell Builder.
   - Choose the facility, if multifacility.

   Refer to “Procedure: Access the Report Cell Builder” on page 9-53 if you need to see menu displays.

   The cursor is in the Cell Type field and a selection screen displays for you to choose the type of report cell you want to build, as shown on the following screen:

```
            General Hospital Database Report Cell Builder Processor
                                                 Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                            Cell Types
( 1) AO-Active Orders                    (11) SL-Solution Orders
( 2) AD-ADL's                            (12) TX-Text
( 3) AB-Associated Patient Block
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

2. Enter the selection number for the Medications Orders Cell Type. The following screen displays for you to select the medications orders you want to print in this cell:



Complete the fields as described below.

Field Explanations

1. SCHEDULED/PRN (1-A-R)
The prompt for this field is:

Print Scheduled medications(S), PRNs(P), or Both(B) [B]--

- To select scheduled medication orders only, enter **S**. The system prints scheduled medications only.
- To select PRNs, enter **P**. The system prints PRN medication orders only.
- To select both scheduled medication orders and PRN orders, enter **B** for Both. The system prints both scheduled medications and PRN orders.

2. ADMIN. TIMES (1-A-R)
The prompt for this field is:

Print administration times? (Y/N) [N]--

- To print administration times for the scheduled medication and/or PRN orders, enter **Y** for Yes.

- To eliminate the printing of administration times for the scheduled medication and/or PRN orders, enter **N** for No. The Report Cell Builder screen redisplays:

```
              General Hospital Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Meds/Sols
 3 Cell Print Description/Title
   Medications/Solutions

 4 Cell Type
   Medications Orders

                            Additional Information
 1 Scheduled/PRN  2 Admin. Times
   Both             Yes









Accept this screen? (Y/N/D) [Y]--
```

The bottom of the Report Cell Builder screen displays an area marked with the heading Additional Information. The system displays the field entries you selected.

The following prompt displays:

Accept this screen? (Y/N/D) [Y]--

- To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.

  NOTE: When you want to access the fields in the Additional Information area of the screen, access the Cell Type field.

- To delete the Medications Orders cell, enter **D** for Delete. The Delete option only displays when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

  Are you SURE you wish to delete this code? (Y/N)--

  - To delete the cell, enter **Y** for Yes.

  - To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

- To accept the entries you made for the Medications Orders cell type, press ENTER or enter **Y** for Yes. The system displays the message *Filed!*. The cell is now available to print on a report.

Patient History Report Cell

The Patient History Report Cell prints in a single-column, horizontal format that is 75 characters wide and up to 6 lines deep. The system prints the Patient History text that is defined as the default in the Standard Text for Pt. History field of the Station Parameters screen.

NOTE: Please note that the Patient History text does not print unless the standard text has been edited for the patient using the Patient History/Misc. option on the Nursing main menu.

```
_____________________________________________________________________________
RELATIVE/SPOUSE'S NAME                    RELATIVE/SPOUSE'S PHONE NUMBER

_____________________________________________________________________________
```

1. Access the Report Cell Builder using the following menu options:

   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
   - Select Report Cell Builder.
   - Choose the facility, if multifacility.

   Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

   The cursor is in the Cell Type field and a selection screen displays for you to choose the type of report cell you want to build, as shown on the following screen:

```
             General Hospital Database Report Cell Builder Processor
                                                 Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                            Cell Types
( 1) AO-Active Orders                    (11) SL-Solution Orders
( 2) AD-ADL's                            (12) TX-Text
( 3) AB-Associated Patient Block
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

2. Enter the selection number for the Patient History Cell Type. The following prompt displays:

   Accept this screen? (Y/N/D) [Y]--

   - To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.

   - To delete the Patient History cell, enter **D** for Delete. The Delete option only displays when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

     Are you SURE you wish to delete this code? (Y/N)--

     - To delete the cell, enter **Y** for Yes.

     - To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

   - To accept the entries you made for the Patient History cell type, press ENTER or enter **Y** for Yes. The system displays the message *Filed!*. The cell is now available to print on a report.

Physician Consultations Report Cell

The Physician Consultations Report Cell prints in a two-column format. The system prints the following information:

- Physician name
- Primary specialty code
- Primary office phone number with area code

The sort is by physician name in alphabetical order.

The following is an example of a Physician Consultations Report Cell:

```
PHYSICIAN CONSULTATION REQUESTS
 Name              Spec    Phone      Name              Spec   Phone
AUSTIN,MARK        IM               | KNIGHT,RICHARD   INT   393-4521
```

NOTE: You can build an Active Order cell that includes departmental consult orders (Department Consults). Physician Consultations require a specific build, as documented in this procedure.

1. Access the Report Cell Builder using the following menu options:

   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
   - Select Report Cell Builder.
   - Choose the facility, if multifacility.

   Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

   The cursor is in the Cell Type field and a selection screen displays for you to choose the type of report cell you want to build, as shown on the following screen:

```
            General Hospital Database Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                            Cell Types
( 1) AO-Active Orders                    (11) SL-Solution Orders
( 2) AD-ADL's                            (12) TX-Text
( 3) AB-Associated Patient Block
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

2. Enter the selection number for the Physician Consultations Cell Type. The following prompt displays:

   Accept this screen? (Y/N/D) [Y]--

   - To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.
   - To delete the Physician Consultations cell, enter **D** for Delete. The Delete option only displays when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

Are you SURE you wish to delete this code? (Y/N)--

- To delete the cell, enter **Y** for Yes.
- To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

- To accept the entries you made for the Physician Consultations cell type, press ENTER or enter **Y** for Yes. The system displays the message *Filed!*. The cell is now available to print on the report.

Plan of Care Report Cell

The Plan of Care Report Cell enables you to print the Plan of Care name and all its elements, including

- Discharge Plan,
- Outcomes,
- Interventions,
- Problems, and
- Expected Outcomes.

You select whether or not you want the name of the Plan of Care to print.

The system determines the format of how the cell prints depending on whether or not you converted your text files for use with the horizontal format of the user-formatted PCP. The user-formatted PCP's horizontal format is one column of 3x75. Unconverted text files are in a 5x36 format. Unconverted text files print in a two-column format.

```
PLAN OF CARE
PC:ABDOMINAL SURGERY
DO:(Discharge) VSS; Wound healing w/out s/s of infection. Bowel function WNL
   Pain controlled; Understands D/C instructions.
PB:TD:__/__ Potential for infection r/t surgical incision:____abdominal ____
EO:Surgical incision healing w/out s/s of infection.
 1:Assess for s/s of infection: (fever, chills, swelling, redness, pain,
   drainage, increased WBC, etc) Evaluation:_____
```

1. Access the Report Cell Builder using the following menu options:
   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.

- Select Report Build Options.
- Select Report Cell Builder.
- Choose the facility, if multifacility.

Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

The cursor is in the Cell Type field and a selection screen displays for you to choose the type of report cell you want to build, as in the following example:

```
            General Hospital Database Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                            Cell Types
( 1) AO-Active Orders                    (11) SL-Solution Orders
( 2) AD-ADL's                            (12) TX-Text
( 3) AB-Associated Patient Block
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

2. Enter the selection number for the Plan of Care Cell Type. The following screen displays:

```
             General Hospital Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Plan of Care
->









Include Plan of Care name? (Y/N) [Y]--
```

The cursor is in the Plan of Care field. The following prompt displays:

Include Plan of Care name? (Y/N) [Y]--

- To print the Plan of Care name, press ENTER or enter **Y** for Yes. The system prints the name of the Plan of Care at the top of the cell.
- To exclude the Plan of Care name, enter **N** for No. The system prints the Plan of Care without the name at the top. The Report Cell Builder screen redisplays:

```
               General Hospital Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   93        Plan of Care
 3 Cell Print Description/Title
   Patient's Plan of Care

 4 Cell Type
   Plan of Care

                            Additional Information
 1 Plan of Care Name
   Yes









Accept this screen? (Y/N/D) [Y]--
```

The bottom of the Report Cell Builder screen displays an area marked with the heading Additional Information. The system displays the field entries you selected.

The following prompt displays:

Accept this screen? (Y/N/D) [Y]--

- To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.

  NOTE: When you want to access the fields in the Additional Information area of the screen, access the Cell Type field.

- To delete the Plan of Care cell, enter **D** for Delete. The Delete option only displays when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

  Are you SURE you wish to delete this code? (Y/N)--

  - To delete the cell, enter **Y** for Yes.

- To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

- To accept the entries you made for the Plan of Care cell type, press ENTER or enter **Y** for Yes. The system displays the message *Filed!*. The cell is now available to print on the report.

PRN Orders Report Cell

The PRN Order Report Cell enables you to print orders with a frequency of PRN (as needed) on the PCP. PRN orders require a separate report cell definition because they automatically go to a Complete status and never generate an active occurrence. Therefore, they cannot be picked up by the Active Orders cell. PRN orders are the only completed orders that can be included on the PCP.

The information that prints is from the parent order. Once a PRN order is placed, it prints on the PCP regardless of whether an occurrence has been added. The PRN order continues to print until the parent order is canceled or discontinued or the patient is discharged.

You define a PRN Orders Report Cell exactly the same way that you define an Active Orders Report Cell except

- You must choose PR for PRN Orders as the cell type, and
- The Library Names available are for the parent order information, as follows:
  - Item Description
  - Comment
  - Frequency
  - Interval
  - Start Date
  - Start Time
  - Stop Date
  - Stop Time
  - Days On/Off
  - Order Duration
  - Schedule

To build a PRN Orders Report Cell, follow the instructions under “Active Orders Report Cell” on page 9-58.

Problem List Report Cell

The Problem List Report Cell enables you to print the list of the patient's problems, including:

- Problem number
- Date of entry
- Problem Description

The system determines the format of how the cell prints. The list prints in a two-column format.

1. Access the Report Cell Builder using the following menu options:
   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
   - Select Report Cell Builder.
   - Choose the facility, if multifacility.

   Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

   The cursor is in the Cell Type field and a selection screen displays for you to choose the type of report cell you want to build, as shown on the following screen:

```
            General Hospital Database Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                            Cell Types
( 1) AO-Active Orders                    (11) SL-Solution Orders
( 2) AD-ADL's                            (12) TX-Text
( 3) AB-Associated Patient Block
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

2. Enter the selection number for the Problem List Cell Type. The following prompt displays:

   Accept this screen? (Y/N/D) [Y]--

   - To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.

   - To delete the Problem List cell, enter **D** for Delete. The Delete option only displays when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

     Are you SURE you wish to delete this code? (Y/N)--

     - To delete the cell, enter **Y** for Yes.

     - To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

   - To accept the entries you made for the Problem List cell type, press ENTER or enter **Y** for Yes. The system displays the message *Filed!*. The cell is now available to print on the report.

Progress Notes Report Cell

The Progress Notes Report Cell enables you to leave room for notes by nurses or any of the other persons involved in the multidisciplinary care of the patient.

The system prints the title of the cell and any column headings you enter in the Cell Print Description/Title field. The system leaves the rest of the cell blank through the end of the page.

The following is an example of the Progress Notes Report Cell:

```
Progress Notes
Date/Time       Notes
```

NOTE: To ensure there is room for printing through the end of the page, always list this cell last when defining the order for the format of the report.

1. Access the Report Cell Builder using the following menu options:

   - Select File Maintenance from the Nursing main menu.

   - Select Standard File Maintenance.

- Select Report Build Options.
- Select Report Cell Builder.
- Choose the facility, if multifacility.

Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

The cursor is in the Cell Type field and a selection screen displays for you to choose the type of report cell you want to build, as shown on the following screen:

```
            General Hospital Database Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                            Cell Types
( 1) AO-Active Orders                    (11) SL-Solution Orders
( 2) AD-ADL's                            (12) TX-Text
( 3) AB-Associated Patient Block
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

2. Enter the selection number for the Progress Notes cell type. The following prompt displays:

   Accept this screen? (Y/N/D) [Y]--

   - To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.
   - To delete the Progress Notes cell, enter **D** for Delete. The Delete option only displays when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

     Are you SURE you wish to delete this code? (Y/N)--

     - To delete the cell, enter **Y** for Yes.

- To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

- To accept the entries you made for the Progress Notes cell type, press ENTER or enter **Y** for Yes. The system displays the message *Filed!*. The cell is now available to print on the report.

Solution Orders Report Cell

The Solution Orders Report Cell enables you to print Solution orders that are scheduled or that are as-needed by the patient (PRNs). You can select all or some of the Solution Types built for your facility.

The system determines the format of how the cell prints. You only have to designate which solutions you want to print and whether to print the administration times for the solutions.

The system prints the following information for both types of orders:

- Order number
- Description
- Frequency
- Rate
- Administration Times

The list prints sorted by Order status and Requested Date/Time.

The following is an example of the Solution Orders Report Cell:

```
Solution Orders
   1   01/07/94 08:39A  CIMETIDINE-NACL 0.9% ,Ent 125ml/hr
       09:00am,09:00pm
```

1. Access the Report Cell Builder using the following menu options:

   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
   - Select Report Cell Builder.

- Choose the facility, if multifacility.

Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

The cursor is in the Cell Type field and a selection screen displays for you to choose the type of report cell you want to build, as shown in the following example:

```
            General Hospital Database Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                            Cell Types
( 1) AO-Active Orders                    (11) SL-Solution Orders
( 2) AD-ADL's                            (12) TX-Text
( 3) AB-Associated Patient Block
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

2. Enter the selection number for the Sdution Orders Cell Type. The following screen displays:

```
              General Hospital Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Solution Types                      2 Admin. Times
->
Page:01                           Solution Types
( 1) Primary
( 2) Piggyback
( 3) Infusion
( 4) TPN
( 5) Irrigation
( 6) Syringe
( 7) Chemothrpy
( 8) Enteral
( 9) FatEmulsn
(10) Advantage









Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
                                 end selection(NL)
```

Complete the fields as explained below.

Field Explanations

1. SOLUTION TYPES (TABLE LOOKUP)
The table of Solution Types available for your facility displays with the following prompt:

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
end selection(NL)

The table of Solution Types is maintained on STAR Pharmacy. Please refer to the *Tables Volume* of the *STAR Pharmacy Reference Guid*e for further information on this table.

Enter the selection numbers of the Solution Types you want to print in the cell. You can select multiple types by separating the numbers with a comma (,), or you can use the hyphen (-) to print a range of types, for example 5-9.

2. ADMIN. TIMES (1-A-R)
The prompt for this field is:

Print administration times? (Y/N) [N]--

- To print administration times for the solution orders, enter **Y** for Yes.

  NOTE: The system prints administration times only if the ordered item has administration times available.

- To eliminate the printing of administration times for solution orders, enter **N** for No. The Report Cell Builder screen redisplays:

```
               General Hospital Report Cell Builder Processor
                                                Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Solutions
 3 Cell Print Description/Title
   Solution Orders

 4 Cell Type
   Solution Orders

                            Additional Information
 1 Solution Types             2 Admin. Times
                                 Yes









Accept this screen? (Y/N/D) [Y]--
```

The bottom of the Report Cell Builder screen displays an area marked with the heading Additional Information. The system displays the field entries you selected. The following prompt displays:

Accept this screen? (Y/N/D) [Y]--

- To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.

  NOTE: When you want to access the fields in the Additional Information area of the screen, access the Cell Type field.

- To delete the Solution Orders cell, enter **D** for Delete. The Delete option only displays when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

  Are you SURE you wish to delete this code? (Y/N)--

  - To delete the cell, enter **Y** for Yes.

  - To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

- To accept the entries you made for the Solution Orders cell type, press ENTER or enter **Y** for Yes. The system displays the message *Filed!*. The cell is now available to print on the report.

Text Report Cell

The Text Report Cell enables you to create additional areas for handwritten notes on the report. For example, you may want to define an area of the PCP for writing physician orders that are added on the current shift.

The system prints the cell in a single column format. You can define the number of lines you want the system to reserve for the handwritten area. You can reserve up to 18 lines.

The following is an example of a Text Report Cell:

```
_____________________________________________________________________
ADDITIONAL ORDERS THIS SHIFT:
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
```

1. Access the Report Cell Builder using the following menu options:

   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
   - Select Report Cell Builder.
   - Choose the facility, if multifacility.

   Refer to "Procedure: Access the Report Cell Builder" on page 9-53 if you need to see menu displays.

   The cursor is in the Cell Type field and a selection screen displays for you to choose the type of report cell you want to build, as shown in the following example:

```
             General Hospital Database Report Cell Builder Processor
                                                  Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   99        Treatments
 3 Cell Print Description/Title
   TREATMENTS

 4 Cell Type
->
Page:01                            Cell Types
( 1) AO-Active Orders                    (11) SL-Solution Orders
( 2) AD-ADL's                            (12) TX-Text
( 3) AB-Associated Patient Block
( 4) MI-Medical Information
( 5) MD-Medications Orders
( 6) NN-Patient History
( 7) PH-Physician Consultations
( 8) PC-Plan of Care
( 9) PL-Problem List
(10) PN-Progress Notes

Enter choice--
```

2. Enter the selection number for the Text Cell Type. The following screen displays:

```
                General Hospital Report Cell Builder Processor
                                                Wed Nov 10, 1993 03:02 pm

 1 Text Lines
->









Enter number of text lines--   |
```

3. The cursor is in the Text Lines field. The following prompt displays:

   Enter number of text lines-- |

   NOTE: If you are editing this cell type and change the number of text lines to a smaller number, the system deletes the lines from the text screen. Any text you entered on the deleted lines is deleted with the lines. There is an example of the text screen in Step 5.

   Enter the number of text lines you want to reserve, up to a maximum of 18. The Report Cell Builder screen redisplays:

```
              General Hospital Report Cell Builder Processor
                                                Wed Nov 10, 1993 03:02 pm

 1 Code    2 Cell Description
   91        TEXT
 3 Cell Print Description/Title
   PROGRESS NOTES
   Date/Time                 Notes
 4 Cell Type
   Text

                            Additional Information
 1 Text Lines
   4









Accept this screen? (Y/N/D) [Y]--
```

4. The bottom of the Report Cell Builder screen displays an area marked with the heading Additional Information. The system displays the field entries you selected. The following prompt displays:

   Accept this screen? (Y/N/D) [Y]--

   - To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The code field is display only; however, you can change any of the other fields on the screen.

     NOTE: When you want to access the fields in the Additional Information area of the screen, access the Cell Type field.

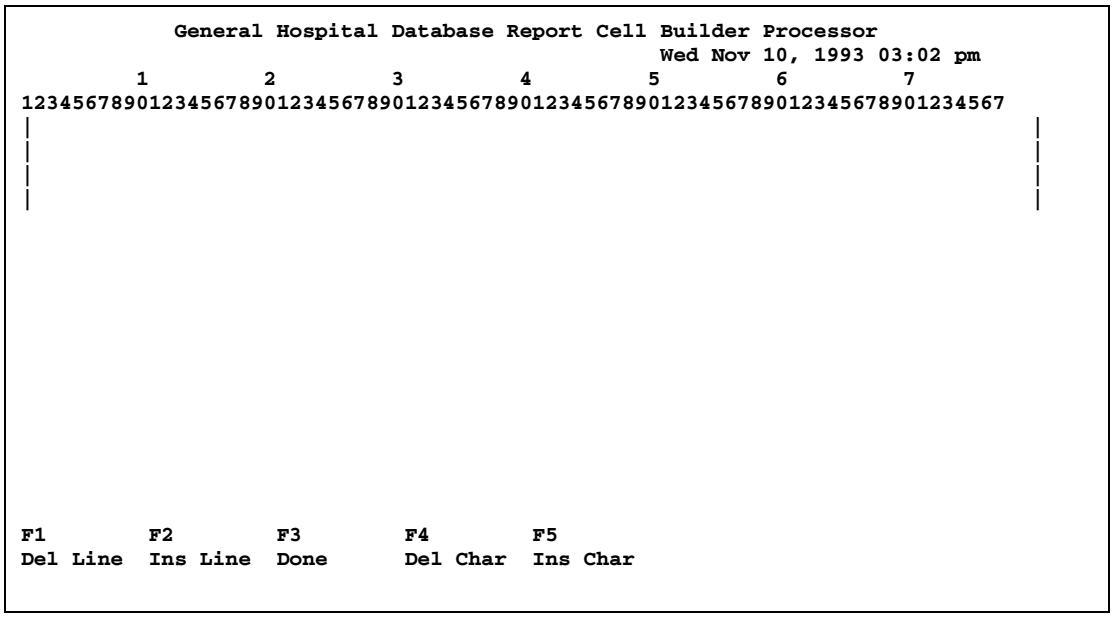
   - To delete the Text cell, enter **D** for Delete. The Delete option displays only when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

     Are you SURE you wish to delete this code? (Y/N)--

     - To delete the cell, enter **Y** for Yes.

     - To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

   - To accept the entries you made for the Text cell type, press ENTER or enter **Y** for Yes. The system displays the message *Filed!*. The following screen displays for you to enter any text you want to print in the text area of the report.



5. Enter the text you want to print on the lines. The bottom of the screen displays function keys you can use while editing text:

Key	Function
F1 (Del Line)	Deletes the line where the cursor is positioned.
F2 (Ins Line)	Inserts a line above the line where the cursor is positioned.
F3 (Done)	Exits the text-entry screen.
F4 (Del Char)	Deletes the character where the cursor is positioned.
F5 (Ins Char)	Inserts a space in front of the character where your cursor is positioned. You can then enter the character you want to insert.

   The top of the entry area has two rows of numbers to denote the column numbers. The numbers on the first line (1,2,3...) mark the column positions by tens; in this example, the tenth, twentieth, and thirtieth positions. The numbers on the second line mark each column position.

6. Press F3 when you finish entering text. The system redisplays the prompt for you to build or edit another cell.

   NOTE: If you press ENTER on the last available line (for example, on line 8 when you selected 8 lines to print), the system automatically files the screen and you do not have to press the F3 key to exit.

The cell is now available to print on the report.

Delete a Report Cell

If you no longer use a Report Cell, you can delete it. Whenever you display and use report cells, the prompt to accept the screen displays a D for Delete option. The following procedure explains a more direct procedure for deleting a report cell.

QUICKSTEPS

1. Select File Maintenance from the Nursing main menu.
2. Select Standard File Maintenance.
3. Select Report Build Options.
4. Select Report Cell Builder.
5. Choose the facility, if multifacility.
6. Enter code or perform table lookup and make a selection.
7. Press ENTER.

8. You have a choice:
   - To cancel delete request, press ENTER.
   - To delete the report cell, enter **Y** for Yes. You have another choice:
     - To cancel the delete request, enter **N** for No.
     - To delete the report cell, enter **Y** for Yes.

PROCEDURE: DELETE A REPORT CELL YOU BUILT

Perform the following steps when you want to delete a report cell.

1. Access the Report Build Options menu using the following menu options:
   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
2. Select Report Cell Builder.
3. Choose the facility, if multifacility. The following prompt displays:

   Enter first letter(s)'-' or cell code--

   Enter the code for the report cell you want to delete, or perform a table lookup and make your selection from the list of cells that display. The screen displays for the report cell you selected. For example, a screen similar to the following would appear for a Problem List report cell.

```
          General Hospital Database Report Cell Builder Processor
                                                Wed Nov 10, 1993 02:51 pm

 1 Code    2 Cell Description
   89        Problem List
 3 Cell Print Description/Title
   PATIENT PROBLEM LIST

 4 Cell Type
   Problem List









Enter field number or '/' starting field number--                          |
```

The following prompt displays:

Enter field number or '/' starting field number--

5. Press ENTER. The following prompt displays:

Delete? (N)--

- To cancel the delete request, press ENTER to enter the default of No.
- To delete the report cell, enter **Y** for Yes. The following prompt displays:

Are you SURE you wish to delete this code? (Y/N)--

  - To cancel the delete request, enter **N** for No.
  - To delete the report cell, enter **Y** for Yes. The system displays the message *Deleted!* and redisplays the following prompt for you to add or edit other report cells.

DESIGN USER-FORMATTED PCPS

Define the Format for the PCP

After you build the report cells and define the Patient Demographic Block, the next step in building a user-formatted PCP is to define the format of the PCP. You use the report cells like building blocks, choosing the appropriate cells for the purpose of the PCP you want to print.

After building the individual cells, you define the format of the PCP by selecting the specific cells you want to print, as well as the order in which you want them to print.

You can create an unlimited number of PCP formats.

QUICKSTEPS

1. Select File Maintenance from the Nursing main menu.
2. Select Standard File Maintenance.
3. Select Report Build Options.
4. Select PCP Format Parameters.
5. Choose the facility, if multifacility.
6. Enter code or perform table lookup and make a selection.
7. Enter PCP name.
8. You have a choice for location to print patient block:

To print...	Type...
top left	TL
bottom left	BL
top right	TR
bottom right	BR

9. Enter code or perform table lookup to select Associated Patient Block:
10. Enter code or perform table lookup to select Page Footer cell.
11. You have a choice of whether to skip printing cells that are blank:
    - To skip printing cells with no information, enter **N** for No.

- To print cells even if no information, enter **Y** for Yes.

12. Enter number of additional blank lines to print at the top of report.

13. Select the report cells in the order you want them to print on the report.

14. Press **F3** when you finish selecting cells.

15. Accept the screen when you finish changing entries on the screen.

PROCEDURE: DEFINE THE FORMAT OF A PCP

Perform the following steps when you want to set up the format for a PCP. You can tailor the format to include report cells used by specific nursing units.

1. Access the PCP Format Parameters function using the following menu options:

   - File Maintenance from the Nursing main menu
   - Standard File Maintenance
   - Report Build Options
   - PCP Format Parameters

   If you need to see the menus for each of these selections refer to "Procedure: Access the Report Cell Builder" on page 9-53.

2. If necessary, select the facility. The following prompt displays:

   Enter first letter(s)'-' or PCP code--

   You have the following choices:

   - To edit the format of an existing PCP, you can select the PCP by one of the following methods:
     - Enter the PCP code.
     - Perform a table lookup and make your selection from the list of PCPs that display.
   - To define the format for a new PCP, enter a unique, alphanumeric code of up to three characters for the PCP. The following screen displays:

```
              General Hospital PCP Format Parameters Processor
                                                  Wed Nov 17, 1993 10:51 am

 1 Code   2 Report Name                                  3 Patient Block Loc
   456       ->
 4 Associated Pt. Block              5 Page Footer

 6 Skip Blank Cell                   7 Blank lines at TOP

 8 Edit By                  9 Edit Date

10 Cell Print Order









Enter PCP name--                                  |
```

To enter a new PCP code, complete each field on the screen as described below.

Field Explanations

1. CODE (DISPLAY ONLY)
The system automatically displays the PCP code you entered at the previous prompt in the PCP Code field.

2. REPORT NAME (32-AN-R)
The prompt for this field is:

Enter PCP name--

Enter up to 32 characters for the name of the PCP. The name you enter prints on the PCP and displays when you perform a table lookup of PCP codes.

3. PATIENT BLOCK LOC (2-A-R
This field enables you to define where you want the Patient Demographic Block to print. The prompt for this field is:

Enter top left(TL)/right(TR) or bottom left(BL)/right(BR)-

Enter one of the following commands to print the block in the portion of the PCP that you choose.

To print the block in this portion of the PCP...	Type...
top left	TL
Top right	TR
Bottom left	BL
Bottom right	BR

The system prints the block in the portion of PCP that you designate. Depending on the entry you make here, the system prints the Associated Patient Block in the location next to the Patient Demographic Block. For example, if you select to print the Patient Demographic Block in the bottom right portion of the PCP, the system automatically prints the Associated Patient Block next to it, in the bottom left portion of the PCP. For information on how to build the Associated Patient Block refer to "Associated Patient Block Report Cell" on page 9-82.

4. ASSOCIATED PT. BLOCK (TABLE LOOKUP)
This field enables you to select one of the Associated Patient Block cells you have set up. The following prompt displays:

Enter first letter(s)'-' or cell code--

Enter the cell code if you know it, or enter a hyphen (-) to perform a table lookup and select from a list of the available Associated Patient Block cells.

5. PAGE FOOTER (TABLE LOOKUP)
This field enables you to select one of the available Text cells that you built for the Page Footer. The Page Footer prints at the bottom of every page other than the first page. The purpose of the Page Footer is to repeat patient information on each page. The Page Footer does not print on the first page, since the first page has the Patient Demographic Block. Refer to "Text Report Cell" on page 9-102 for information on how to build a Text cell for the Page Footer.

The following prompt displays:

Enter first letter(s)'-' or cell code--

Enter the cell code if you know it, or enter a hyphen (-) to perform a table lookup to from a list of the available Text cells.

6. SKIP BLANK CELL (1-A-R)
This field enables you to skip printing cells that do not contain information. The following prompt displays:

Skip printing the cell if no information exists to print? (Y/N)--

- To skip printing the cell if there is no information, enter **Y** for Yes.

- To print the cell (its title and any column headings) even if there is no information, enter **N** for No.

7. BLANK LINES AT TOP (1-N-R)
This field enables you to have the system start printing up to nine lines below the top margin. This enables you to use Hospital stationary that requires a greater margin. The following prompt displays:

Enter number of additional blank lines to print at top of page [0]--

- To leave blank lines, enter the number of blank lines you want to print at the top.
- To leave no extra blank lines, press ENTER for the default of 0 (zero).

8. EDIT BY (DISPLAY ONLY)
This field displays the name of the last person who edited the screen.

9. EDIT DATE (DISPLAY ONLY)
This field displays the date and time of the last edit.

10. CELL PRINT ORDER (TABLE LOOKUP)
This field is used to select the report cells you want to include. You select the cells one at a time in the order you want them to print on the PCP. You can change the order of the cells using the function key options available across the bottom of the screen.

The following prompt displays:

Enter cell code or '-' to list

Enter the cell code if you know it, or enter a hyphen (-) to perform a table lookup and select from a list of the available cells.

NOTE: The system prints the cells on the PCP in the order you select them. For this reason, you need to select the Progress Notes cell last. The Progress Notes cell reserves blank space through the end of the page.

The bottom of the screen displays function keys you can use to rearrange the list of cells:

Key	Function
F1 (Del Line)	Deletes the line where the cursor is positioned.
F2 (Ins Line)	Inserts a line above the line where the cursor is positioned.
F3 (Done)	Exits the text-entry screen.
F4 (Del Char)	Deletes the character where the cursor is positioned.
F5 (Ins Char)	Inserts a space in front of the character where your cursor is positioned. You can then enter the character you want to insert.

Press F3 when you finish selecting the cells. The following prompt displays:

Accept this screen? (Y/N/D) [Y]--

- To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The PCP Code, Edit By, and Edit Date fields are display only; however, you can change any of the other fields on the screen.

- To delete this PCP, enter **D** for Delete. The Delete option displays only when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

  Are you SURE you wish to delete this code? (Y/N)--

  - To delete the cell, enter **Y** for Yes.

  - To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

- To accept the entries you made for this PCP, press ENTER or enter **Y** for Yes. The system displays the message *Filed!*. The prompt displays for you to add or edit another PCP.

Preview the PCP You Built

OVERVIEW

Once you define the format for the PCP using the cells you built, you may want to preview the PCP to ensure that the PCP prints as expected. If you want to make changes, you can edit the cells or redefine the format of the PCP to match the way you want it to print. The following procedure enables you to display or print the PCP you built. If you would prefer to print a sample of the PCP, refer to Chapter 6: Reports for an example of a PCP.

QUICKSTEPS

1. Sign on to the station for which you are building the format.
2. Select Plan of Care Process from the Nursing main menu.
3. Select the patient.
4. Select Display Patient Care Profile.
5. Optional: Access the PCP field and select a different format.
6. Enter number of shift you want to start printing PCP.

7. Enter date for which you want to start printing PCP.
8. Enter number of shift you want to stop printing PCP.
9. Enter date for which you want to stop printing PCP.
10. You have a choice for including completed plan of care elements:
    - To include plan of care elements, enter **Y** for Yes.
    - To exclude plan of care elements, enter **N** for No.
11. Accept the screen when you finish changing entries on the screen.

PROCEDURE: DISPLAY THE PCP YOU BUILT

Follow this procedure when you want to display the PCP you built. The caregiver uses this same procedure to display the PCP for a patient.

1. Sign on to the station for which you are building the PCP. This enables you to test how the PCP would print for the station or department.
2. Select Plan of Care Process from the Nursing main menu. The prompt to select a patient displays:

   Enter acct #, `-`bed code, first chars of name`-` [1E Census]--
   `C` for Census

3. Select the patient using one of the options in the prompt. Refer to Chapter 1: Critical Pathways for complete information on how to select a patient. Since this is for display purposes, you can press ENTER to display a census of the default station and select a patient.

The Plan of Care menu displays:

```
                  General Hospital Plan of Care Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9303400001    WISEMAN,CHARLES    M  12/14/57 2101-01 ADAMS,HAROLD MED 10 I/P 289
            Option No.  Option
            ---------------------------------------
                1       Defining Characteristics
                2       Patient Assessment
                3       Recommended Plan of Care/Outcomes
                4       Plan of Care
                5       Discharge/Exp Outcome
                6       Problem/Exp Outcome
                7       Discharge Plan
                8       Intervention/Treatments
                9       ADL's / Misc.
               10       Problem List
               11       Display Patient Care Profile

 Print         12       Patient Care Profile
               13       Nursing Plan of Care
               14       Assessment Reports

Enter option number--
```

4. Select Display Patient Care Profile. The following screen displays:

```
                   General Hospital Display PCP Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
9303400001    WISEMAN,CHARLES    M  12/14/57 2101-01 ADAMS,HAROLD MED 10 I/P 289

( 1)PCP            : STATION 1E PCP
( 2)PCP for        : 2101-01  WISEMAN,DALLAS

( 3)Start Shift    :
( 4)Start Date     :

( 5)Stop Shift     :
( 6)Stop Date      :

( 7)Show Completes?:









Enter start shift for PCP--
```

Complete the fields as described below.

Field Explanations

1. PCP
This field displays the default PCP set up for the station to which you are signed on. If the PCP field is blank, your facility is set up to use the system-generated PCP. You can access this field to display a different PCP for the patient. Even if your facility uses the system-generated PCP, you are able to access the user-formatted PCPs.

To display a different PCP, access the PCP field by pressing ENTER at the prompt in the Start Shift field. This action displays the prompt that enables you to access the fields on the screen:

Enter field number or '/' starting field number--

Enter the field number of the PCP field. The following prompt displays:

Enter description'-' or PCP code--

Enter the PCP code if you know it, or enter a hyphen (-) to perform a table lookup and select from a list of the available user-formatted PCPs.

2. PCP FOR
This field displays the patient you selected and their room-bed. This field is display only.

3. START SHIFT
This field enables you to enter the shift with which you want the PCP to start. The system prints the data starting with this shift. For example, if you have an Active Orders cell, the system prints the active orders that are valid starting with this shift.

The following prompt displays:

Enter start shift for PCP--

Enter the number of the shift with which you want the PCP to start printing data.

4. START DATE
This field enables you to designate the date on which you want the system to start pulling data to print on the PCP. The system starts pulling data for this date, starting with the shift you entered in the Start Shift field. The following prompt displays:

Enter start date for PCP [T]--

Enter the date for which you want the PCP to start printing data. The default is **T** for Today's date.

5. STOP SHIFT
The following prompt displays:

Enter stop shift for PCP [1]--

Enter the number of the shift on which you want the PCP to stop. This is the shift after which the system stops pulling data for the PCP. The system prints data on the PCP for the Start and Stop Shifts you enter and all the shifts in between. The default is the first shift.

6. STOP DATE
The following prompt displays:

Enter stop for PCP [T]--

This field enables you to designate the date with which you want the system to stop pulling data to print on the PCP. The system stops pulling data for this date, ending with the shift you entered in the Stop Shift field. The default is T for Today's date.

7. SHOW COMPLETES?
You can choose whether to include Plan of Care elements that have a Complete status. The following prompt displays:

Include completed plan of care elements? (Y/N) [N]--

- To include Plan of Care elements that have a status of Complete, enter **Y** for Yes.
- To exclude Plan of Care elements that have a Complete status, enter **N** for No.

Continue to Step 5.

5. Accept the screen when you finish entering/editing data. The system displays the following menu:

```
                  General Hospital Display PCP Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
97-08300003   ANDERSON,CLARE     F  01/01/52 101-02               A   10 I/P 345
            Option No.  Option
            ----------------------------------------
                1       Display Plan of Care
                2       Display ADL's / Misc.
                3       Display Active Orders
                4       Display PRN Orders
                5       Display Treatments
                6       Display Consultations
                7       Display Patient History
                8       Display Assessment Order
                9       Display Problem List
               10       Display Patient Block




Enter option number--
```

6. Select a menu item from the menu. Depending on the menu item you select, the corresponding portion of the PCP for the patient displays. The system displays data according to the Start and Stop entries you made for the shift and date. The display of Plan of Care elements with a status of Complete depends on the entry in the Show Completes? field.

If you selected Display Active Orders, here is an example of the portion of a PCP that would be displayed:

```
               General Hospital Display Active Orders Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
97-08300003   ANDERSON,CLARK     M  01/01/52 101-02               A   10 I/P 345

ACTIVE ORDERS
  ECG 12 LEAD----------  02/14/2009 12:26pm
  CAR - CONSULTATION     12/04/2009 02:00pm
   INSTR LR 1
   INSTR LR 2
   12497 LR
  24 HOUR AMBULATORY EE  02/26/2009 02:00pm
  EEG / BRAINMAPPING     02/14/2009 12:42pm
    TEST
  CARDIAC PROFILE        02/11/2009 11:00am
  PARTIAL THROMBOPLASTI  02/11/2009 10:36am
  17-HYDROXY CORTICOSTE  02/11/2009 10:36am
  CARDIAC PROFILE        02/23/2009 10:11am
  PARTIAL THROMBOPLASTI  02/23/2009 10:11am
  17-HYDROXY CORTICOSTE  02/23/2009 10:11am


Press NL--
```

7. Press ENTER to return to the Display PCP Processor and select another part of the PCP to view. Following is an example of the portion of the PCP that would be displayed if you selected Display Patient Block:

```
            General Hospital Display Patient Block Processor
                                                  Tue Feb 24, 2009 02:25 pm
  No          Name              Sex    BD    Room    Physician    SVC ICD Status
97-08300003   ANDERSON,CLARK     M  01/01/52 101-02               A   10 I/P 345

PATIENT BLOCK
 Dx : 789.01-ABDOMINAL PAIN RT UPP QU  |
 Alg: NURSING FREE FORM ALLERGIES+COMPU|
 Iso:                          Smk: UNK  |
 Sgy:                                    |
                              Type: I/P  |
 2101-02 000000896      97-08300003     |
 Adm : 02/24/09    Dob: 01/01/55  43Y  |
 Phys:                        Level: 1  |
 ANDERSON,CLARK                 Sex: M  |









Press NL--
```

8. When you viewed all portions of the PCP that you want to view, press period and ENTER to exit from the Display PCP Processor.

Change a PCP You Built

When you preview a PCP and want to make changes, you can do the following:

- Reformat the cell. Refer to "Procedure: Access the Report Cell Builder" on page 9-53.
- Change the order in which the cells print. Refer to "Define the Format for the PCP" on page 9-109.

Delete a PCP You Built

If you no longer use a PCP format, you can delete it. If you no longer use a Report Cell, you can delete it. Whenever you display and use report cells, the prompt to accept the screen displays a D for Delete option. The following procedure explains a more direct procedure for deleting a report cell.

QUICKSTEPS

1. Select File Maintenance from the Nursing main menu.
2. Select Standard File Maintenance.
3. Select Report Build Options.
4. Select PCP Format Parameters.
5. Choose the facility, if multifacility.
6. Enter code or perform table lookup and make a selection.
7. Press ENTER.
8. You have a choice:
   - To cancel delete request, press ENTER.
   - To delete the PCP, enter **Y** for Yes. You have another choice:
     - To cancel delete request, enter **N** for No.
     - To delete the PCP, enter **Y** for Yes.

PROCEDURE: DELETE A PCP YOU BUILT

Perform the following steps when you want to delete a PCP format. If you only want to delete a report cell, refer to "Delete a Report Cell" on page 9-106.

1. Access the Report Build Options menu using the following menu options:
   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.
2. Select PCP Format Parameters.
3. Choose the facility, if multifacility. The following prompt displays:

   Enter first letter(s)'-' or cell code--

   Enter the code for the PCP format that you want to delete if you know it, or enter a hyphen (-) to perform a table lookup and select from the list of PCP formats that display.
4. The following prompt displays:

   Enter field number or '/' starting field number--
5. Press ENTER. The following prompt displays:

   Delete? (N)--

   - To cancel the delete request, press ENTER to enter the default of No.
   - To delete the PCP format, enter **Y** for Yes. The following prompt displays:

     Are you SURE you wish to delete this code? (Y/N)--

     - To cancel the delete request, enter **N** for No.
     - To delete the PCP format, enter **Y** for Yes. The system displays the message *Deleted!*.

Set Up Stations for User-Formatted PCPs

You have the flexibility to set up each station to use the PCPs differently. You set these parameters on the Station Parameters screen. The screen has headings for sections of related parameters. On the first screen that displays, there are headings for Acuity Parameters and PCP Parameters. You enter settings in the PCP Parameters fields for the user-formatted PCP. For complete information on the Station Parameters, refer to "Appendix A - NURSING TABLES".

QUICKSTEPS

1. Select File Maintenance from the Nursing main menu.

2. Select Standard File Maintenance.
3. Select Report Build Options.
4. Select Station Parameters.
5. Choose the facility, if multifacility.
6. Access User Formatted PCP field.
7. You have a choice of whether to use PCPs defined by your facility:
    - To use hospital-defined PCPs, enter **Y** for Yes.
    - To use system-generated PCP, enter **N** for No.
8. Access Laser Print field.
9. Define whether or not your facility uses a laser printer for the PCP:
    - To define that you do not use a laser printer, enter **N** for No.
    - To define a laser printer, enter **Y** for Yes. You have a choice to select the type of laser printer:
        - To select a laser printer listed in the prompt, enter **Y** for Yes.
        - To select a different laser printer, enter **N** for No.
        - Enter alternate printer format.

PROCEDURE: SET UP STATIONS FOR USER-FORMATTED PCPS

Perform the following steps when you want to set up astation for user-formatted PCPs.

1. Access the Report Build Options screen by selecting the following menu options:
    - File Maintenance from the Nursing main menu
    - Standard File Maintenance
    - Station Parameters
2. After you select the Station Parameters option, the following prompt displays:

    Enter outpatient (O), maternity (M), station code or '-' to list--

- Enter **O** for Outpatient to access Station Parameters for outpatients. The screen displays 'Outpatient Parameters' in the upper left corner, but field functionality is the same.

  NOTE: The Acuity Parameters fields are accessible from the Outpatient Parameters screen, but entries in these fields have no effect within STAR Patient Care functions, as Acuity is not calculated for outpatients.

- Enter **M** for Maternity to access Station Parameters for maternity patients. The screen displays 'Maternity Parameters' in the upper left corner, but field functionality is the same.

- If you know the nursing station code, enter it directly.

- Enter a hyphen (-) to access a listing of all established stations within your facility.

When you select a station, the Station Parameters screen displays with the selected station name in the upper left corner. The following screen is a sample Station Parameters screen:

```
                General Hospital Station Parameters Processor
1 NORTH Station Parameters                          Fri Dec 18, 1992 04:16 pm

 1 Live on Nursing  2 Def Characteristics Menu    3 ADL Menu
   Yes                FACILITY A MENU               MED/SURG
 4 ADL Frequencies  5 Plan of Care at DIS   6 Standard Text for Pt. History
   Yes                No                       GENERAL
 Acuity Parameters
 7 Live on Acuity   8 Patient Attrib. Menu        9 Second Pt. Attrib. Menu
   Yes                CHECK-LIST                   PROFILE-DRIVEN
                   10 Station Attrib. Menu       11 Bed Override Menu
                      NSG UPDATE                   BED OVERRIDE MENU
 PCP Parameters
12 User Formatted PCP      13 Laser Printer      14 PCP Default Format Name
   Yes                        Standard              Station 1 North
15 PCP Plan of Care Name   16 PCP Treatment Date
   Yes                        Yes




Enter field number or '/' starting field number--
```

The name of the station for which you are displaying the station parameters displays in reverse video in the upper left portion of the screen.

3. Complete the fields under PCP Parameters in the lower portion of the screen, according to the following field explanations. For complete information about the fields on this screen, refer to Chapter 2: High Level Tables in the *Tables Volume* of the *STAR Patient Care Reference Guide*.

Field Explanations - PCP Parameters

12. USER FORMATTED PCP (1-A-O)
Use this field to select whether you want the station to use the PCPs defined by your facility, or the McKesson system-generated PCP. The following prompt displays:

Use hospital defined PCP format? (Y/N) [N]--

- To use the McKesson system-generated, vertical format PCP, enter **N** for No.

  NOTE: Even if you enter No in this field, if there are hospital-defined PCPs, the user can select them as necessary when using the PCP print function.

- To use PCPs defined by your facility, enter **Y** for Yes. If you choose this option, you must enter a name in the PCP Default Name field.

13. LASER PRINTER (1-A-O)
If you use a Laser Printer, you can print shaded lines on the PCP. To define a printer other than a laser, enter **N** for No. To define a laser printer, enter **Y** for Yes. The following prompt displays:

Is it a C.Itoh LIPS, HP LaserJet, or Kyocera F-Series printer? (Y/N)--

- If the laser printer is one of the choices in the prompt, enter **Y** for Yes. The word Standard displays in the field to indicate the standard laser printers used by McKesson.

- If the laser printer is not one of the choices in the prompt, enter **N** for No.

  Enter alternate printer format routine--

  Enter the alternate printer format. If you do not know the format routine, refer to the printer's vendor.

14. PCP DEFAULT FORMAT NAME (3-N-O) or (TABLE LOOKUP)
This field enables you to define a default PCP for the station when you set the User Formatted PCP field to Yes. If you enter No in the User Formatted PCP field, you cannot access this field. The following prompt displays:

Enter first letter(s)'-' or PCP code--

If you entered Yes in the User Formatted PCP field, you must complete this field. Enter the PCP code if you know it, or enter a hyphen (-) to perform a table lookup and select from a list of available user-formatted PCPs.

The PCP you select automatically displays in the PCP field when you print a PCP for a patient or a station. By entering the most commonly used PCP format in this field, you can reduce the need users to perform a table lookup or enter a code to select the

PCP. If necessary, users can reaccess the field and change the default to a different user-formatted PCP. If you make no entry in this field, the system enables users to perform a table lookup and make their own selection for the PCP to print.

15. PCP PLAN OF CARE NAME (DISPLAY ONLY)
This field is used only for system-generated PCPs and is display only.

16. PCP TREATMENT DATE (DISPLAY ONLY)
This field is used only for system-generated PCPs and is display only.

Set Up the Facility for the System-Generated PCP

You can set up your facility for using the system-generated PCP. You do not need to make any entries in these fields if you are using only the user-formatted PCPs. The Nursing Facility Parameters screen enables you to set options for your facility for the following areas:

- Nursing Shifts
- Order Management
- Patient Care Profile
- Patient Acuity
- Assessment / Plan of Care
- Critical Pathways

Refer to "Appendix A - NURSING TABLES" for information on all of the parameters.

DESIGN USER-FORMATTED WORKSHEETS

Define the Format for the Worksheet

After you build the report cells, the next step in building a user-formatted Worksheet is to define the format of the Worksheet. You use the report cells like building blocks, choosing the appropriate cells for the purpose of the Worksheet you want to print.

For example, you can design a Worksheet for nursing assistants that lists the ADLs and treatments they need to perform for their specific patients. After building the individual cells, you define the format of the Worksheet by selecting the specific cells you want to print, as well as the order in which you want them to print.

You can create an unlimited number of Worksheet formats.

QUICKSTEPS

1. Select File Maintenance from the Nursing main menu.
2. Select Standard File Maintenance.
3. Select Report Build Options.
4. Select Worksheet Format Parameters.
5. Choose the facility, if multifacility.
6. Enter code or perform table lookup and make a selection.
7. Enter Worksheet name.
8. You have the following choices for including cell titles:
    - To print cell titles with the report cells, enter **Y** for Yes.
    - To eliminate printing cell titles, enter **N** for No.
9. Select the report cells in the order you want them to print on the report.
10. Press F3 when you finish selecting cells.
11. Accept the screen when you finish changing entries on the screen.

PROCEDURE: DEFINE THE FORMAT OF A WORKSHEET

Perform the following steps when you want to set up the format for a Worksheet. You can tailor the format to include report cells used by specific nursing positions.

1. Access the Worksheets Format Parameters function using the following menu options:

   - File Maintenance from the Nursing main menu
   - Standard File Maintenance
   - Report Build Options
   - Worksheet Format Parameters

   If you need to see the menus for each of these selections refer to"Procedure: Access the Report Cell Builder" on page 9-53.

2. If necessary, select the facility. The following prompt displays:

   Enter first letter(s)'-' or worksheet code--

   You have the following choices:

   - To edit the format of an existing Worksheet, you can select the Worksheet by one of the following methods:
   - Enter the Worksheet code.
   - Perform a table lookup and make your selection from the list of Worksheets that display.
   - To define the format for a new Worksheet, enter a unique, alphanumeric code of up to three characters for the Worksheet.

After you have made your choice, the following screen is displayed:

```
            General Hospital Worksheet Format Parameters Processor
                                                Wed Nov 17, 1993 10:51 am

 1 Worksheet Code           2 Worksheet Name
   232                      ->
 3 Include Cell Titles?     4 Edit By                    5 Edit Date

 6 Cell Print Order









Enter Worksheet name--                                  |
```

Complete the required fields as explained below.

Field Explanations

1. WORKSHEET CODE (DISPLAY ONLY)
The system automatically displays the Worksheet code in the Worksheet Code field. This is the code you entered at the previous prompt.

2. WORKSHEET NAME (33-AN-R)
The cursor is in the Worksheet Name field. The prompt for this field is:

Enter Worksheet name--

Enter up to 33 characters for the name of the Worksheet. The name you enter prints on the Worksheet and displays when you perform a table lookup of Worksheet codes.

3. INCLUDE CELL TITLES? (1-A-R)
This field enables you to define whether you want to print the titles for the cells you include on the Worksheet. The prompt for this field is:

Include cell titles? (Y/N) [N]--

To print the titles of the report cells on the Worksheet, enter **Y** for Yes. To prevent the report cell titles from printing on the Worksheet, enter **N** for No.

NOTE: If space is a factor in your design, including the cell titles prints additional lines.

4. EDIT BY (DISPLAY ONLY)
This field displays the name of the last person who edited the screen.

5. EDIT DATE (DISPLAY ONLY)
This field displays the date and time of the last edit.

6. CELL PRINT ORDER (TABLE LOOKUP)
Use this field to select the report cells you want to include. You select the cells one at a time in the order you want them to print on the Worksheet. You can change the order of the cells using the function key options available across the bottom of the screen.

NOTE: It is recommended that you build and include a Patient Identifier cell, using the Medical Information cell type, to enable you to include patient identification information on the Worksheet. You may want to include the patient name, room-bed, and diagnosis.

The prompt for this field is:

Enter cell code or '-' to list

Enter the cell code if you know it, or enter a hyphen (-) to perform a table lookup and select from a list of the available cells.

NOTE: The system prints the cells on the Worksheet in the order you select them.

The bottom of the screen displays function keys you can use to rearrange the list of cells:

Key	Function
F1 (Del Line)	Deletes the line where the cursor is positioned.
F2 (Ins Line)	Inserts a line above the line where the cursor is positioned.
F3 (Done)	Exits the text-entry screen.
F4 (Del Char)	Deletes the character where the cursor is positioned.
F5 (Ins Char)	Inserts a space in front of the character where your cursor is positioned. You can then enter the character you want to insert.

Press F3 when you finish selecting the cells.

Continue to step 3.

3. When you have completed all required fields on the screen, this prompt displays:

   Accept this screen? (Y/N/D) [Y]--

   - To make changes to the entries you made, enter **N** for No. The prompt displays for you to access the fields you want to change. The Worksheet Code, Edit By, and Edit Date fields are display only; however, you can change any of the other fields on the screen.

   - To delete this Worksheet, enter **D** for Delete. The Delete option displays only when you are editing a cell. The following prompt displays to confirm you want to delete the cell:

     Are you SURE you wish to delete this code? (Y/N)--

     - To delete the cell, enter **Y** for Yes.

     - To cancel the deletion request, enter **N** for No. The prompt to add or edit a cell redisplays.

   - To accept the entries you made for this Worksheet, press ENTER or enter **Y** for Yes. The system displays the message *Filed!*. The prompt displays for you to add or edit another Worksheet.

Preview the Worksheet You Built

OVERVIEW

Once you define the format for the Worksheet using the cells you built, you may want to preview the Worksheet to ensure that the Worksheet prints as expected. If you want to make changes, you can edit the cells or redefine the format of the Worksheet to match the way you want it to print. The following procedure enables you to display or print the Worksheet you built. If you would prefer to print a sample of the Worksheet, refer to "Chapter 6 - REPORTS" for an example of a Worksheet.

QUICKSTEPS

1. Sign on to the station for which you are building the format.
2. Select Station Print from the Nursing main menu.
3. Select User Defined Worksheet.
4. If there are secondary stations, select the station.
5. Select the patient.
6. Enter the code or perform a table lookup to select the Worksheet.
7. Enter number of shift you want to start printing Worksheet.
8. Enter date for which you want to start printing Worksheet.
9. Enter number of shift you want to stop printing Worksheet.
10. Enter date for which you want to stop printing Worksheet.
11. You have the following choices for including completed plan of care elements:
    - To include plan of care elements, enter **Y** for Yes.
    - To exclude plan of care elements, enter **N** for No.
12. You have the choice of displaying or printing the format:
    - To display the format, enter **D** for Display.
    - To print the format, enter **P** for Print.
13. Accept the screen when you finish changing entries on the screen.

PROCEDURE: DISPLAY THE WORKSHEET YOU BUILT

Follow this procedure when you want to display or print the Worksheet you built. The caregiver uses this same procedure to display the Worksheet for a patient.

1. Sign on to the station for which you are building the Worksheet. This enables you to test how the Worksheet prints.

2. Select Station Print from the Nursing main menu.

3. Select User Defined Worksheet from the Station Print menu. The following prompt displays for you to select the primary station or secondary station:

   Enter station code [1E]--

4. Press ENTER to select the primary station or perform a table lookup to display a list of the available secondary stations and make your selection. The following prompt displays:

   Enter station(S), '-' to list bed groups, name inquiry(N), or [1E Census]--

   Refer to the *Patient Processing Volum*e or *Order Management/Charge Processing Volume I* of the *STAR Patient Care Reference Guide* for complete information on how to select a patient or patients from this prompt.

5. After you make your selection, the following screen displays:

```
          General Hospital Display User Defined Worksheets Processor
Station: 1 EAST                                  Fri Dec 18, 2009 10:46 am



( 1)Worksheet       :
( 2)Worksheet for   : 2101-01  TEST,DMJPHARM

( 3)Start Shift     :
( 4)Start Date      :

( 5)Stop Shift      :
( 6)Stop Date       :

( 7)Show Completes? :

( 8)Display/Print   :
( 9)Number of Copies:




Enter description`-` or worksheet code--
```

Complete the fields on this screen as described below.

Field Explanations

1. WORKSHEET (TABLE LOOKUP)
Select the worksheet you want to print. You can print any of the Worksheets that were built using the Worksheet Format Parameters screen.

Enter the Worksheet code is you know it, or enter a hyphen(-) to perform a table lookup and select from a list of the available User-defined Worksheets.

2. WORKSHEET FOR (DISPLAY ONLY)
The Worksheet For field displays the patient(s) you selected and their room/bed.

3. START SHIFT (1-N-R)
This field enables you to enter the shift with which you want the Worksheet to start. The system prints the data starting with this shift. For example, if you have an Active Orders cell, the system prints the active orders that are valid starting with this shift.

The following prompt displays:

Enter start shift for worksheet--

Enter the number of the shift with which you want the Worksheet to start printing data.

4. START DATE (DATE FORMAT)
This field enables you to specify the date on which you want the system to start pulling data to print on the Worksheet. The system starts pulling data from this date, starting with the shift you entered in the Start Shift field. The following prompt displays:

Enter start date for worksheet [T]--

Enter the starting date for which you want the Worksheet to include data. The default is T for Today's date.

5. STOP SHIFT FIELD (1-N-R)
The following prompt displays:

Enter stop shift for worksheet [1]--

Enter the shift for which you want the Worksheet to stop. This is the shift after which the system stops pulling data for the Worksheet. The system prints data on the Worksheet for the Start and Stop Shifts you enter and all the shifts in between. The default is the first shift.

6. STOP DATE (DATE FORMAT)
This field enables you to designate the date with which you want the system to stop pulling data to print on the Worksheet. The system stops pulling data for this date, ending with the shift you entered in the Stop Shift field. The following prompt displays:

Enter stop for worksheet [T]--

The default is T for Today's date.

7. SHOW COMPLETES? (1-A-R)
You can decide whether to include Plan of Care elements that have a Complete status. The following prompt displays:

Include completed plan of care elements? (Y/N) [N]--

To include Plan of Care elements that have a status of Complete, enter **Y** for Yes. To exclude Plan of Care elements that have a Complete status, enter **N** for No.

8. DISPLAY/PRINT (1-A-R)
The following prompt displays:

Display(D) or print(P) [D]--

To display the Worksheet, enter **D** for Display. To print the Worksheet, enter **P** for Print. To see an example of a printed Worksheet refer to "Example of User-formatted PCP" on page 9-10.

9. NUMBER OF COPIES (1-N-O)
This field determines the number of copies to print. Each one prints as a separate report on the spooler or printer.

When you access this field, the system displays the following prompt:

Enter number of copies to print (1/5) [1]-- |

Enter a number from 1 to 5 or press ENTER to accept the default of 1.

When you have completed all required fields, continue to step 6.

6. Accept the screen when you finish entering/editing data. The system displays the Worksheet for the patient(s). The system displays data according to the Start and Stop entries you made for the shift and date. The display of Plan of Care elements with a status of Complete depends on the entry in the Show Completes? field.

Here is an example of a portion of a Worksheet that displays:

```
Mon Mar 28, 1994 08:40 am                          1 EAST NURSING ASSISTANT WKSHT
                              MODEL HOSPITAL A                                Page 1
                         03/28/94 Shift 1 thru 03/28/94 Shift 3
_____________________________________________________________________________
CCU-02   JOHNSON,MIKE                          CHEST PAIN NOS
_____________________________________________________________________________
ADL'S
AMBULATE      AD LIB                    |
_____________________________________________________________________________
CCU-07   JONES,KAYCE                           GASTROENTERITIS
_____________________________________________________________________________
ADL'S
BATH          ASSIST/PARTIAL            |  REFERRAL      Q 4H
_____________________________________________________________________________
DIET AND NUTRITION
ORD #:     01/05 0549P FRUIT EXCHANGE UP TO 40 CALORIES
ANY FRUIT EXCEPT GRAPES AND BANAN
_____________________________________________________________________________
ORD #:     01/05 0549P FRUIT EXCHANGE UP TO 40 CALORIES
ANY FRUIT EXCEPT GRAPES AND BANAN


Press NL--
```

7. Press ENTER to display additional screens of the Worksheet. When you finish displaying the Worksheet, the Station Print menu redisplays.

Change a Worksheet You Built

When you preview a Worksheet and want to make changes, you can do the following:

- Reformat the cells.
- Change the order in which the cells print.

To reformat the cells, follow the procedures for building the cells. For information on the building of reports refer to “Procedure: Access the Report Cell Builder” on page 9-53.

To change the order in which the cells print, refer to “Procedure: Define the Format of a Worksheet” on page 9-126.

Delete a Worksheet You Built

If you no longer use a Worksheet format, you can delete it. If you no longer use a Report Cell, you can delete it. Whenever you display and use report cells, the prompt to accept the screen displays a D for Delete option. The following procedure explains a more direct procedure for deleting a report cell.

QUICKSTEPS

1. Select File Maintenance from the Nursing main menu.

2. Select Standard File Maintenance.
3. Select Report Build Options.
4. Select Worksheet Format Parameters.
5. Choose the facility, if multifacility.
6. Enter code or perform table lookup and make a selection.
7. Press ENTER.
8. You have the following choices:
    - To cancel delete request, press ENTER.
    - To delete the Worksheet, enter **Y** for Yes. You have a choice:
        - To cancel delete request, enter **N** for No.
        - To delete the Worksheet, enter **Y** for Yes.

PROCEDURE: DELETE A WORKSHEET YOU BUILT

Perform the following steps when you want to delete a Worksheet format. If you only want to delete a report cell refer to"Delete a Report Cell" on page 9-106.

1. Access the Report Build Options menu using the following menu options:
    - Select File Maintenance from the Nursing main menu.
    - Select Standard File Maintenance.
    - Select Report Build Options.
2. Select Worksheet Format Parameters.
3. Choose the facility, if multifacility. The following prompt displays:

    Enter first letter(s)'-' or cell code--

    Enter the code for the Worksheet format that you want to delete if you know it, or enter a hyphen (-) to perform a table lookup and select from the list of Worksheet

formats that display. The screen displays the Worksheet format you selected. For example, a screen similar to the following would display for a Worksheet format.

```
        General Hospital Worksheet Format Parameters Processor
                                                Wed Nov 17, 1993 10:51 am

 1 Worksheet Code           2 Worksheet Name
   456                        STATION 1E TREATMENT WORKSHEET
 3 Include Cell Titles?     4 Edit By                    5 Edit Date

 6 Cell Print Order
   ( 1) 767-ACTIVE ORDER, REQ DATE TIME
   ( 7) 1-CLINICAL ORDERS (CHRONO)
   ( 9) 92-MEDICATIONS
   (10) 95-SOLUTIONS









Enter PCP name--                                |
```

The following prompt displays:

Enter field number or '/' starting field number--

5. Press ENTER. The following prompt displays:

   Delete? (N)--

   - To cancel the delete request, press ENTER to enter the default of No.
   - To delete the Worksheet format, enter **Y** for Yes. The following prompt displays:

     Are you SURE you wish to delete this code? (Y/N)--

     - To cancel the delete request, enter **N** for No.
     - To delete the Worksheet format, enter **Y** for Yes. The system displays the message *Deleted!*.

PRINT A FORMS LIBRARY REPORT

The system stores patient information in a data library. Each piece of information has an internal library name that enables the system to find that type of information in the library. For example, Blood Pressure is stored by the system with an Internal Library Name of CAO231F. The letters in the library name tell the system details about the data, such as where it is stored.

Each internal library name has a standard language Description associated with it, in this case, BLOOD PRESSURE. When you want the system to print patient information in a report cell, you specify the information using the Internal Library Name so that the system can find the data. When you build a report cell, the system provides a table lookup for the Internal Library Name using either the Internal Library Name's Description or the Alias(es) for the description. An Alias is a short alternate for the Description. There can be up to three aliases for a description.

You can print a Forms Library Report to list the available data for inclusion on the user-formatted PCP or Worksheet. The report lists the data either by the Library Name Description or by the Alias.

The report prints the following:

- The Description of the library element.
- Up to three Aliases for the library element.
- Example Output that is an example of the information that the system could print for the element.
- Length of the element as it is defined in the Forms Library.
- Internal Name that the system uses to locate the information.

Quicksteps

1. Select File Maintenance from the Nursing main menu.
2. Select Standard File Maintenance.
3. Select Report Build Options.
4. Select Forms Library Report.
5. You have the following choices:
   - To sort the report by Alias, enter **A** for Alias.
   - To sort the report by Description, enter **D** for Description.

6. You have the following choices:

   - To cancel print request, enter **N** for No.
   - To print the report, enter **Y** for Yes.

Procedure: Print a Forms Library Report

Perform the following steps when you want to print a Forms Library Report.

1. Access the Report Build Options menu:

   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Report Build Options.

2. Select Forms Library Report. The following prompt displays:

   Sort library elements by alias(A) or by description(D) [A]--

   - To sort the report by Alias, enter **A** for Alias.
   - To sort the report by Description, enter **D** for Description.

3. The following prompt displays to confirm that you want to print the report:

   Print library elements (Y/N) [Y]--

   - To cancel the print request, enter **N** for No.
   - To print the report, enter **Y** for Yes or press ENTER. The system displays the following message:

     Compiling and Printing

The report prints at the requesting CRT's default printer. Below is an example of the Forms Library Report sorted by Alias.

Figure 9.3 Forms Library Report

```
Mon Mar 28, 1994 02:35 pm Applications Testing Database              Page 1
                              Forms Library Report

Description                          Alias
  (Alias)
   Example Output                                              Lgth  Int. Name
--------------------------------------------------------------------------------
#-POLICY NUMBER                      POLICY NUMBER-#
  POLNBR                              Policy Number
   #:7865-6623                                                 23  CAI159F
ABSTRACT COMPLETE DATE               ABSTRACT COMPLETE DATE
  ABSDATE                             Abstract Complete Date
   02/03/85                                                     8  CAEK62F
ACCIDENT DATE AND TIME               ACCIDENT DATE AND TIME
  DATETH                              Date/Time - $H format
   01/01/84 1:00 am                                            18  CAVP141F
ACCIDENT TYPE                        ACCIDENT TYPE
CAEK62F
ACCIDENT DATE AND TIME               ACCIDENT DATE AND TIME
  DATETH                              Date/Time - $H format
   01/01/84 1:00 am                                            18  CAVP141F
ACCIDENT TYPE                        ACCIDENT TYPE
   FALL                                                        19  CAVQ81F
ACCIDENT WORK RELATED                ACCIDENT WORK RELATED
  IND                                 Indicator (Yes/No Flag)
   YES                                                          3  CAVP111F
ACCOUNT                              EXTERNAL ACCOUNT NUMBER
   89250-0026                                                  15  CAMP132F
ADMISSION SOURCE CODE                ADMISSION SOURCE CODE
  ADMSRC                              Admission Source Code
   4                                                           2  CAVP241F
ADMISSION TYPE CODE                  ADMISSION TYPE CODE
  ADMTYPE                             Admission Type Code
   4                                                           2  CAVP231F
ADMIT/REG PHYSICIAN                  PHYSICIAN ADMIT/REG
```

PRINT REPORT FORMATS

You can print the report formats you set up for PCPs and Worksheets using the Print Report Formats function. The report lists the report code, report description, report cells included, and any other information set up in the format parameters for the PCP or Worksheet. The function enables you to print either the Parameterized PCP Format Report or the Parameterized Worksheet Format Report.

Quicksteps

1. Select File Maintenance from the Nursing main menu.
2. Select Standard File Maintenance.
3. Select Print Standard Files.
4. Select Report Formats.
5. You have the following choices:
   - To print the PCP formats, select Patient Care Profile Reports.
   - To print the Worksheet format reports, select Worksheet Reports.
6. Select the facility, if multifacility.
7. You have the following choices:
   - To cancel print request, enter **N** for No.
   - To print the report, enter **Y** for Yes.

Procedure: Print a Format Report for PCPs or Worksheets

Perform the following steps when you want to print a Forms Library Report.

1. Access the Report Build Options menu using the following menu options:
   - Select File Maintenance from the Nursing main menu.
   - Select Standard File Maintenance.
   - Select Print Standard Files.
   - Select Report Formats.

   The following menu displays:

```
                General Hospital Report Formats Processor
                                                Mon Aug 31, 1992 04:18 pm
Report Formats Input Options

            Option No.  Option
            ----------------------------------------
                1       Patient Care Profile Reports
                2       Worksheet Reports









Enter option number--
```

2. You have the following options for the type of report format you want to print:

   - To print the Parameterized PCP Format Report, select Patient Care Profile Reports.

   - To print the Parameterized Worksheet Format Report, select Worksheet Reports.

3. Select the facility, if multifacility. One of the following prompts displays, depending on whether you select the report for the PCP or Worksheet formats:

   Print user defined PCP formats? (Y/N) [Y]--
   Print user defined Worksheet formats? (Y/N) [Y]--

   - To cancel the print request, enter **N** for No. The Report Formats Menu redisplays.

   - To print the report, enter **Y** for Yes. The message *Printing* displays and the report prints at the default printer for the requesting CRT. The Report Formats Menu redisplays.

Following is an example of the Patient Care Profile Report and the Worksheet Report.

Figure 9.4 Patient Care Profile Reports

```
Tue Mar 29, 1994 04:52 pm                    Parameterized PCP Format Report
                                MODEL HOSPITAL A                        Page 1
--------------------------------------------------------------------------------
PCP Code: 564
PCP Name: ICU PCP
Blank Lines at TOP: 2
Skip Cell if Blank: No
Pt. Block Location: Top Left
Associated Block: A34 ASSO. PT. BLOCK
Page Footer: A98 TEXT
Cell Order     Cell Description
   1           9    PLAN OF CARE
   2           876  ACTIVE ORDERS, CHRONO
   3           852  TEST COMMENT
   4           6    MEDICAL INFORMATION

PCP Code: 99
PCP Name: GENERAL NURSING PCP
Blank Lines at TOP: 0
Skip Cell if Blank: No
Pt. Block Location: Top Right
Associated Block: 102 ASSOCIATED PT BLOCK
Page Footer:
Cell Order     Cell Description
   1           765  DIETARY CELL
   2           104  PATIENT HX
   3           100  ACTIVE ORDERS
   4           101  ADL'S
   5           108  PLAN OF CARE

PCP Code: 100
PCP Name: CCU PCP
Blank Lines at TOP: 0
Skip Cell if Blank: No
Pt. Block Location: Top Right
Associated Block: 5 ASSOCIATED PATIENT BLOCK
Page Footer:
Cell Order     Cell Description
   1           103  MEDICAL INF
   2           104  PATIENT HX
   3           100  ACTIVE ORDERS
   4           114  TREATMENTS C COLON
   5           107  PHYSICIAN CONSULTS
   6           101  ADL'S
   7           105  MED ORDERS
   8           108  PLAN OF CARE
   9           110  PROGRESS NOTES

PCP Code: 912
PCP Name: LAB PCP
Blank Lines at TOP: 0
Skip Cell if Blank: Yes
Pt. Block Location: Top Right
Associated Block: A34 ASSO. PT. BLOCK
Page Footer:
Cell Order     Cell Description
   1           199  TEST - LAB ORDERS
```

Figure 9.5 Worksheet Reports

```
Tue Mar 29, 1994 04:52 pm                Parameterized Worksheet Format Report
                                  MODEL HOSPITAL A                          Page 1
-------------------------------------------------------------------------------
Worksheet Code: 95
Worksheet Name: ADL WORKSHEET
Include Cell Titles?: No
Cell Order     Cell Description
   1           87   WORKSHEET PATIENT IDENTIFIER
   2           4    ADL'S ALL

Worksheet Code: 956
Worksheet Name: NURSING ASSISTANT WORKSHEET-NSY
Include Cell Titles?: No
Cell Order     Cell Description
   1           949  PATIENT IDENTIFIER LINE
   2           A23  ADL
   3           15   ACTIVE ORDERS, REVERSE CHRONO
```

Appendix A - NURSING TABLES

INTRODUCTION

This chapter contains a listing and explanation of some of the tables used by the Care Planning and Documentation Module. Each table listed above is presented with its purpose and use, the screen or screens used in completing it, a detailed explanation of the screen fields involved, and the impact of the processes affected by the table.

For information regarding tables related to the Critical Pathways function, see the Critical Pathway Categories and Variance Causes sections in "Chapter 1 - CRITICAL PATHWAYS".

For information regarding the table related to the Maternity Module: Labor and Delivery Clinical Questions, see "Chapter 5 - MATERNITY MODULE".

In addition to the preceding tables, the *Care Planning and Documentation Module* has access to numerous other tables that are described in detail in the *Tables Volume* of the *STAR Patient Care Reference Guide*. These tables are listed below:

• Accommodations	• Method of Transportation
• Bed Statuses	• Occupation Codes
• Cancellation Reasons	• Oxygen Therapy
• Central Supply Sources	• Patient Classification
• Churches	• Physicians
• Conditions	• Precautions
• CRT Names	• Publicity Codes
• Denominations	• Routine Orders
• Discharge Status/Disposition	• State Abbreviations
• Employment Information Data	• Transfer Reasons
• Employment Status Codes	• Type of Service
• Isolation	• User Defined Fields
• IV Therapy	• ZIP Codes
• Marital Status	

NURSING CARE TYPE TABLE

This is an optional table that allows PCRs to be grouped into direct care element *buckets* or categories. The system allows entry of ten care types.

You can access this table by selecting the following menu options:

1. Tables from the Data Processing main menu
2. Nursing Table Maintenance
3. Nursing Care Type

After selecting the appropriate facility, if necessary, the following prompt displays:

Enter care type bucket--

You can enter the Nursing Care Type table code or press hyphen (-) and ENTER to display a list of codes from which you can select. There is one screen involved in this transaction. After you enter the code, the following screen displays:

```
             General Hospital Nursing Table Maintenance Processor
                                                Fri Dec 18, 1992  04:15  pm
Nursing Care Type
( 1)Code         : 01
( 2)Description  : Plan of Care
( 3)Abbreviation : PC

( 4)Edit by      : Emily Lane
( 5)Edit date    : 12/12/92 1:30 pm









Enter field number or '/' starting field number--
```

Field Explanations

1. CODE (DISPLAY ONLY)
The system displays the two-character alphanumeric code for the Nursing Care Type table.

2. DESCRIPTION (33-AN-R)
This field contains the description of the Nursing Care Type entry.

3. ABBREVIATION (2-A-R)
The system displays the abbreviation of the above Nursing Care Type.

4. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last updated this table entry.

5. EDIT DATE (DISPLAY ONLY)
The system displays the date and time that this table entry was last updated.

Once these fields are completed, you have the option of accepting or editing the screen. If you accept the screen, the transaction is complete.

Impact

The Edit Date and Edit By fields reflect the new date associated with the individual and date of the change.

After you accept this screen, the following takes place:

- The table entry is added, deleted, or revised as appropriate.
- The table listing reflects any changes made.

PRIORITIES TABLE

ADLs, Assessments, Discharge Plans, Interventions, Problem/ Expected Outcomes, Treatments

The STAR Patient Care System enables the user to define parameters, by priority, for each non-SIM department that has an associated order screen. Each of these parameters controls the user's responses to the Start Date and Start Time fields on each specific order screen. These parameters are set through each department's Priority table.

The non-SIM department handles orders for items such as Problems (P), Outcomes (O), Interventions (I), Treatments (T), Activities of Daily Living (A), and Discharge Planning (DP). Critical Pathways requires you to set up priorities for each of the non-SIM Departments in the appropriate Priority table.

You identify the ordering priorities for each non-SIM department, such as Now or Timed. By using the options available on the Priority table, start date and start time for these priorities can be controlled to accommodate the way each non-SIM department work needs to be performed. For example, the Discharge Plans non-SIM department would probably not have a STAT priority.

It is suggested that whenever possible, a universal definition for common priorities be defined. This makes it easier for ordering personnel if all definitions of ASAP, STAT, Now, Timed, and so forth, are the same across all SIM and Non-SIM departments. If this cannot be achieved, the system allows unique definitions of each priority, as well as unique priorities.

For examples of the appropriate field settings for various priorities, as well as general considerations when setting up priorities, refer to the *Tables Volume* of the *STAR Patient Care Reference Guide*.

You can access this table by selecting the following menu options:

1. Tables from the Data Processing main menu

2. Nursing Table Maintenance

Select the Priority table for the non-SIM department, for example *Priorities, Outcome*. The following prompt displays:

Enter priority--

You can enter the priority code or perform a table lookup to display the list of codes. After you enter the code, the following screen is displayed if you are accessing an Order Priorities table:

```
                    General Hospital Table Maintenance Processor
                                                Fri Mar 19, 2004 11:08 am
Order Priorities (LAB)
Department: HBOC Laboratory
 1 Code        2 Description          3 Short Description 4 Additional Charge
   13            FLUOROSCOPY            Fluor               No
 5 Start Date/Time Entry              6 Recurring         7 Cutoff Time
   Date and Time                        No                  05:00pm
 8 Additional Days   9 Order Category/Status  10 Default Order Frequency
                       Routine                  Q12H EVERY TWELVE HOURS



                         * LABORATORY/RADIOLOGY ONLY *
11 Label/Request Generation      12 Default Time         13 Collapse Status
                                    10:00am

14 Accession at Order            15 Edit By              16 Edit Date
   No                               Holmes,Joseph E         05/14/99 11:46a



Enter field number or '/' starting field number--
```

If you are accessing a Priorities table, the following screen is displayed:

```
                  General Hospital Table Maintenance Processor
                                                Mon Mar 22, 2004 09:47 am
Priorities, Respiratory Therapy

 1 Code        2 Description          3 Short Description  4 Additional Charge
   14            AEROSOL TREATMENT      AER TRT              No
 5 Start Date/Time Entry    6 Recurring  7 Cutoff Time     8 Additional Days
   Date Only                  Yes          10:00am
 9 STAT                                  10 Default Order Frequency
                                            Q12H EVERY TWELVE HOURS
11 Edit By                               12 Edit Date
   SMITH,JAN                                03/07/04 10:16a









Enter field number or '/' starting field number--
```

When you select a priority to edit that has a linked frequency in a Priorities or Order Priorities table, the following warning is displayed before allowing you to proceed:

Warning! Default Frequency Linked for Order Entry! Continue (Y/N) [Y] --

Enter N for No to leave the priority unchanged, or Y for Yes to change the priority.

The Priority table is an ALLSTAR table. That means the table enables all STAR products to access common clinical fields, giving users more functionality and control. For STAR Patient Care, only fields 1 through 9 are accessible. Fields 10 through 13 apply only to STAR Laboratory or STAR Radiology (Field 10 only). The Edit By and Edit Date fields (#14 and #15) apply to all departments and are display only. For information on fields 10 through 13, refer to the *STAR Laboratory Reference Guide*.

Field Explanations

NOTE: The following field explanations are for the Order Priorities table; however, all of the fields in the Priorities table are also in the Order Priorities table except for the STAT field. This field is documented after the Default Order Frequency field explanation.

1. CODE (DISPLAY ONLY)
The system displays the priority code selected or previously entered. This code is a one or two-character alphabetic code. The non-SIM department handles orders for items such as Problems (P), Outcomes (O), Interventions (I), Activities of Daily Living (A), and Discharge Planning (DP).

These non-SIM items and their non-SIM departments (P, O, I, A, DP) must be built for use with Critical Pathways:

- Set up each category of care as a SIM department in the SIM Department table. For example, set up the category as a SIM department and enter the name of the non-SIM department, for example ADLs, in the Default Category field. This ensures that all items (ADLs) linked to this department print in this category.

2. DESCRIPTION (19-C-R)
The system requires you to enter the Priority description.

3. SHORT DESCRIPTION (7-AN-R)
The system requires you to enter a short description for this priority. This description appears on the requisitions and in Order Inquiry.

4. ADDITIONAL CHARGE (1-A-O)
The system enables you to specify whether there is an additional charge if this priority is selected when you order procedures. An example of this might be an additional charge associated with STAT orders to compensate for the interruption of typical work flow. You can enter **Y** for Yes or **N** for No. The default is No, with no charge associated.

If you set this field to Yes, and if a SIM charge item is identified in the McKesson tables, and the priority charge is set to either (A)ll or (I)nitial, an additional charge is created. If the you set the table to (A)ll, then all occurrences generated with this priority have an additional charge generated when the status of each occurrence becomes active. If you set the table to (I)nitial, then the first or initial occurrence generated with this priority

have an additional charge generated when the status of the occurrence becomes active.

5. START DATE/TIME ENTRY (1-A-O)
The following prompt displays:

When ordering, allow entry of start date only (D), start time only (T), both date and time (B) or neither (N) [N]--

The system enables you to specify whether the Start Date and Start Time fields are accessible when an order is placed using this priority. You can enter **D** for access to the Start Date field only, **T** for access to the Start Time field only, **B** to indicate access to both the Start Date and Start Time fields, or **N** for neither. The default is neither.

If a date or time field is not accessible, the system fills in either the current system date and time or the calculated date and time using the information entered in the Cutoff Time and Additional Days fields. If data entry is allowed in these fields (they are not display only), the cutoff information is used to display warning messages to the users, but the system accepts any valid dates and times within the specified days parameters of the SIM department.

6. RECURRING? (1-A-O)
The system enables you to specify whether a recurring order can be placed when using this priority. The following prompt displays:

Can this priority be recurring? (Y/N) [Y]--

Enter **Y** for Yes or **N** for No. The default is Yes. As orders are placed, if this field is set to Yes and this priority is selected, you can place recurring orders on the order screen. If this field is set to No and this priority is selected, you cannot place recurring orders on the order screen. The duration defaults to 1 occurrence, and the Start Date/Time displays exactly as the Stop Date/Time.

7. CUTOFF TIME (15-C-O)
During order entry, the system compares the start date and time entered with the system date and cutoff time for the order's priority. This field is used to determine the cutoff time to be used in this calculation.

If the start time entered is past the cutoff time specified for the order's priority, the system displays a warning message:

WARNING: Past cutoff time!

You can override this warning message and place the order as entered.

If the system calculates the start date and time automatically (no entry is allowed), the Cutoff Time and Additional Day fields on the Priority table are used to calculate the start date and time. Refer to the *General Information Volume* of the *STAR Patient Care*

Reference Guide for details concerning the options available for entering times. Refer to the General Order Screen in "Chapter 1 - CRITICAL PATHWAYS" of *Order Management/Charge Processing Volume 1* of the *STAR Patient Care Reference Guide*, for details on how the Start Date and Start Time fields are affected by the cutoff time for the priority.

8. ADDITIONAL DAYS (1-N-O)
The system enables you to specify the number of days to add to the system date if

- the Start Date is not entered on the order screen because the Start Date/Time Entry field for this priority is set todisallow users from entering a start date, and
- the order is placed beyond the cutoff date and the default response was chosen to calculate the start date.

If Start Date entry is allowed and the date entered on the order screen is not past the cutoff date, then this field is ignored.

9. ORDER CATEGORY/STATUS (1-A-R)
This field enables you to place an order with a default frequency of Once, even if the one occurrence has times associated with it. The following prompt displays:

Enter ordering status of priority-- |
Routine(R), Stat(S)

- Enter **S** for Stat if you want the order to be administered immediately upon ordering. On the order screen, the order's start time is the current system time, and any predefined times associated with the order is cleared out. The current system time is captured as the start time on the first order, and that time is carried forward on all orders in the set. This ensures that orders are grouped correctly.

  NOTE: When a multiple-order set is placed using a frequency that has predefined times and a priority for which this field is set to STAT, the predefined times are cleared out for each order within the order set. This ensures that all orders are generated.

- Enter **A** for ASAP if you want the order to be administered as soon as possible upon ordering. On the order screen, the order's start time is the current system time, and any predefined times associated with the order is cleared out. The current system time is captured as the start time on the first order, and that time is carried forward on all orders in the set. This ensures that orders are grouped correctly.

- Enter **R** for Routine to indicate any ordering status *other than* STAT. On the order screen, if the Recurring field is set to No and you set this field to Routine, the system prompts you for the order's start date and time. The Duration field is automatically filled with 1 Occurrence.

9. STAT (1-A-R)
This field determines if you want the order to be administered immediately upon ordering.

Is this priority STAT? (Y/N) [N]--

Enter **Y** for Yes Or **N** for No.

10. DEFAULT ORDER FREQUENCY (TABLE LOOKUP)
When this field is accessed, the following prompt is displayed:

Enter the Default Order Frequency '-' to list --

Enter the Frequency code or perform a dash lookup to select from the Frequency table. This field allows you to select a default frequency to link to the priority during order entry. This frequency is automatically displayed in the Frequency field and cannot be edited.

NOTE: In a multi-facility environment, if multiple facilities are using a department and the Frequency table is split by facility, the Default Order Frequency field in the Priority table of this department is not accessible to link a frequency. This field does not differentiate the frequencies in the split tables since the Frequency table is split by facility.

14. ACCESSION AT ORDER (1-A-R)
This field determines if, at the time of ordering, you want to accession the specimens collected from this patient, the ID of the collector, any appropriate comments, and the collection date and time. When you access this field, the following prompt is displayed:

Allow accessioning at order time (Y/N)--

Enter **Y** for yes or **N** for No.

15. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last updated this table entry if they were signed on with security.

16. EDIT DATE (DISPLAY ONLY)
After the system displays the date that the table entry was last updated, complete the following:

- Set up priorities for each of the non-SIM departments in the appropriate Priorities table.

- Set up the specific items for each non-SIM department as standard files using the Plan of Care processor. For example, use the Plan of Care Process to set up interventions.

Once these fields are completed, you have the option of accepting or editing the screen. If you accept the screen, the transaction is complete.

Impact

The Edit Date and Edit by fields reflect the new date associated with the individual and date of the charge if they were signed on with security.

Upon acceptance of this screen, the following takes place:

- The table entry is added, deleted, or revised as appropriate.
- The table listing reflects any changes made.
- The system validates the entries in the Start Date and Start Time fields of the ordering screen according to the information entered in this table.
- You can demand print the Priorities or Order Priorities Report, and then review the default frequencies defined for each priority.

As you exit the screen, you can choose to print the Priorities/Order Priorities Report. Following is an example of this report:

```
03/22/04 12:31pm          STAR Development System                    Page   1
             RESPIRATORY THERAPY Priorities, Respiratory Therapy

Code  Description          Short Desc  Entry Allowed            Category/Status
Cutoff   Recur   Days  Charge   Label/Request  Collapse  Accn/Ord
      Default Frequency
--------------------------------------------------------------------------------
13    ASAP                 ASAP        Neither Date nor Time    STAT
         No      No    No       N/A            N/A       N/A
      STAT - STAT

15    BID                  BID         Date and Time            STAT
         Yes     No    No       N/A            N/A       N/A
      Q12H - EVERY TWELVE HOURS

55    NEW PRIORITY         1234567     Neither Date nor Time    STAT
         Yes     No    No       N/A            N/A       N/A
      QID - FOUR TIMES PER DAY

3     PRE-OP               Pre-Op      Date and Time            STAT
         No      No    No       N/A            N/A       N/A
      TH - TOM'S TEST

9     PRN                  PRN         Date and Time            STAT
         Yes     No    No       N/A            N/A       N/A
      PRN - PRN

1     ROUTINE              ROUTINE     Date and Time            STAT
         Yes     No    No       N/A            N/A       N/A
      RT-ABG - ROUTINE ABG 4 STANDARD DEPT TIMES

8     RTN ABG X 4 PER DAY  RTNABG      Date Only                STAT
         Yes     No    No       N/A            N/A       N/A
      RT-ABG - ROUTINE ABG 4 STANDARD DEPT TIMES

2     STAT                 STAT        Time Only                STAT
06:00pm  No      No    Yes      N/A            N/A       N/A
      STAT - STAT

4     TIMED                TIMED       Date and Time            STAT
         Yes     No    No       N/A            N/A       N/A
      Q6H - EVERY 6 HOURS

14    TIMED 12N & 12MN     12N&12M     Date Only                STAT
10:00am  Yes     No    No       N/A            N/A       N/A
      Q12H - EVERY TWELVE HOURS

5     TIMED 6A/6P          TM6A&6P     Date and Time            STAT
         Yes     No    No       N/A            N/A       N/A
      Q12H - EVERY TWELVE HOURS

7     TMRW                 TMRW        Date and Time            STAT
         Yes     No    No       N/A            N/A       N/A


6     TODAY                TODAY       Time Only                STAT
         Yes     No    No       N/A            N/A       N/A
      PRN - PRN


                              End of Report
```

TITLES TABLE

This table describes the titles of the personnel within the hospital.

You can access this table by selecting the following menu options:

1. Tables from the Data Processing main menu
2. Table Maintenance

Select the Titles table from the list that displays. The following prompt displays:

Enter title--

You can enter the title code or press hyphen (-) and ENTER to display a list of codes from which you can select. After you enter the code, the following screen displays:

```
                General Hospital Table Maintenance Processor
                                                Fri Dec 18, 1992 04:15 pm

Titles
( 1)Code          : MD
( 2)Description   : Medical Doctor

( 3)Edit by       : Margie Winn
( 4)Edit date     : 12/12/92 2:15 pm









Enter field number or '/' starting field number--
```

Field Explanations

1. CODE (DISPLAY ONLY)
The system displays the three-character alphabetic code for the Titles table.

2. DESCRIPTION (19-AN-R)
The system requires you to enter the description of the Titles entry.

3. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last updated this table entry.

4. EDIT DATE (DISPLAY ONLY)
The system displays the date and time that this table entry was last updated.

Once these fields are completed, you have the option of accepting or editing the screen. If you accept the screen, the transaction is complete.

STATION PARAMETERS

The Station Parameters function enables you to set various station-specific indicators in the system regarding menus, worksheet selections, and staffing/acuity.

You can access the Station Parameters function by selecting the following menu options from the Nursing main menu:

1. File Maintenance
2. Staffing File Maintenance or Standard File Maintenance
3. Station Parameters

NOTE: You can also access the Station Parameters function by selecting Report Build Options from the Standard File Maintenance menu.

After you select the Station Parameters option, the following prompt displays:

Enter outpatient (O), maternity (M), station code or '-' to list--

Enter **O** for Outpatient to access Station Parameters for outpatients. The screen displays 'Outpatient Parameters' in the upper left corner, but field functionality is the same.

NOTE: The Acuity Parameters fields are accessible from the Outpatient Parameters screen, but entries in these fields have no effect within STAR Patient Care functions, as Acuity is not calculated for outpatients.

Enter **M** for Maternity to access Station Parameters for maternity patients. The screen displays 'Maternity Parameters' in the upper left corner, but field functionality is the same.

If you know the nursing station code, enter it directly. Enter a hyphen (-) to access a listing of all established stations within your facility. When you select a station from the list, the Station Parameters screen displays with the selected station name in the upper left corner. The following screen is a sample Station Parameters screen.

```
               General Hospital Station Parameters Processor
NURSERY Station Parameters                          Thu Apr 03, 1997 02:03 pm


 1 Live on Nursing  2 Def Characteristics Menu    3 ADL Menu
   Yes                FACILITY A MENU             NURSERY
 4 Plan of Care at DIS  5 Standard Text for Pt. History      6 Default Edit Txt
   No                     NURSERY                           ->
 Acuity Parameters
 7 Live on Acuity   8 Patient Attrib. Menu        9 Second Pt. Attr. Menu
   Yes                CHECK-LIST                  CHECK-LIST
                   10 Station Attrib. Menu       11 Bed Override Menu
                                                    B/O TEST MENU
 PCP Parameters
12 User Formatted PCP      13 Laser Printer      14 PCP Default Format Name


15 PCP Plan of Care Name   16 PCP Treatment Date 17 PCP Freq/Sched Days Code
   No                         No

Default prompt for editing Treatment order text (Y/N) [N]--  |
```

Field Explanations

1. LIVE ON NURSING (1-A-O)
This field indicates whether or not the station is Live on the Care Planning and Documentation Module. This indicator enables a hospital to go Live with a limited number of nursing stations if desired. A station can use the Patient Attributes function in the Patient Acuity and Nurse Staffing Module whether or not this field is set to Yes. The default is No.

2. DEFINING CHARACTERISTICS MENU (TABLE LOOKUP)
This field contains the name of the menu that displays within the Defining Characteristics function. This field is required for all nursing stations that use Defining Characteristics.

3. ADL MENU (TABLE LOOKUP)
This field contains the name of the ADL menu that displays for ADL orders. This field is required for all nursing stations.

4. PLAN OF CARE AT DIS (1-A-R)
This field enables you to designate whether or not the system offers the option of printing a completed Plan of Care during the Discharge function. The following prompt displays:

Do you want the print plan of care option at discharge? (Y/N) [N]--

When you enter **N** for No, the prompt offering the print option does not display during Discharge. When you enter **Y** for Yes, and a patient is being discharged from a nursing station, the following prompt displays:

Print completed plan of care for PATIENT NAME? (Y/N) [Y]--

The prompt displays only for a discharge, not when you enter an intent to discharge.

5. STANDARD TEXT FOR PT. HISTORY (TABLE LOOKUP-O)
This field indicates which patient history text paragraph is assigned to the station.

6. DEFAULT EDIT TXT (1-A-O)
In Order Review, you can edit text by selecting the Edit Text option for a parent treatment parent order. This field determines the default for the prompt on the screen where you edit text for this type of order. The default is set to No for nursing stations. The prompt that displays for this field is:

Default prompt for editing Treatment order text (Y/N) [N]--,

Enter **Y** for Yes to change the default to Yes on the editing screen for parent treatment orders in Order Review. This can be set for each nursing station.

Acuity Parameters

7. LIVE ON ACUITY (1-A-O)
This field indicates whether or not the station is Live on the Patient Acuity and Nurse Staffing Module. Enter **Y** for Yes to have the system accumulate PCR codes and values for all patients on the station. The default is No.

8. PATIENT ATTRIB. MENU (TABLE LOOKUP)
This field contains the name of the first menu that displays for the Patient Attribute function. This field is optional for all nursing stations.

9. SECOND PATIENT ATTRIB. MENU (TABLE LOOKUP)
This field contains the name of the second menu that displays for the Patient Attribute function. This field is optional for all nursing stations.

10. STATION ATTRIB. MENU (TABLE LOOKUP)
This field contains the name of the menu that displays for the Station Attribute function. This field is optional for all nursing stations.

11. BED OVERRIDE MENU (TABLE LOOKUP)
This field contains the name of the menu that displays for the Bed Override function. This field is optional for all nursing stations.

PCP Parameters

12. USER FORMATTED PCP (1-A-O)
You use this field to select whether you want the station to use the PCPs defined by your facility, or the McKesson system-generated PCP. The following prompt displays:

Utilize user formatted PCP? (Y/N) [N]--

To use the McKesson system-generated, vertical format PCP, enter **N** for No. To use PCPs defined by your facility, enter **Y** for Yes.

NOTE: Even if you enter No in this field, if there are hospital-defined PCPs, the user can select them as necessary when using the PCP print function.

13. LASER PRINTER (1-A-O)
This field indicates whether or not the station is using a laser printer. If you are using a laser printer, you also designate whether you use a standard McKesson printer or another printer.

14. PCP DEFAULT NAME (3-N-O) or (TABLE LOOKUP)
This field enables you to define a default PCP for the station when you set the User Formatted PCP field to Yes. If you enter **N** for No in the User Formatted PCP field, you cannot access this field.

The following prompt displays:

Enter first letter(s)'-' or PCP code--

You can enter the PCP code or perform a table lookup to display a list of the available user-formatted PCPs. The PCP you select automatically displays in the PCP field when you print a PCP for a patient or a station. By entering the most commonly used PCP format in this field, you can reduce the need for the user to perform a table lookup or enter a code to select the PCP. If necessary, the user can reaccess the field and change the default to a different user-formatted PCP. If you make no entry in this field, the system enables the user to perform a table lookup and make their own selection for the PCP to print.

15. PCP PLAN OF CARE NAME (1-A-O)
This field is used for the system-generated PCP only. This field indicates whether or not Plan of Care names should print on the Patient Care Profile. If this field is set to Yes, the Plan of Care name prints above the associated expected outcomes that are linked to the Plan of Care. The default is No.

16. PCP TREATMENT DATE (1-A-O)
This field is used for the system-generated PCP only. This field indicates whether or not the date and time of treatment should print on the Patient Care Profile. If this field is set to Yes, the date and time prints on the line above the treatment order text. The default is No.

17. PCP FREQ/SCHED DAYS CODE (1-A-O)
This field is used to determine whether you want the Frequency code, both the Frequency code and Scheduled Days code, or neither to print for ADLs on PCPs. The following prompt displays:

Print (F)req code, Freq/(S)ched Days code or (N)either for ADLs on PCPs [N]--

- Enter **F** if you want the Frequency code to print on PCPs.
- Enter **S** if you want both the Frequency and Scheduled Days codes to print on PCPs.

- Enter **N** if you want neither the Frequency nor the Scheduled Days code to print on PCPs.

After you accept the previous screen, the system displays a second Station Parameters screen. The following screen is a sample of the second Station Parameters screen:

```
                General Hospital Station Parameters Processor
1 NORTH Station Parameters                          Tue Mar 03, 1998 10:53 am

 Worksheet Parameters
 1 ADL Worksheet Categories
   All
 2 Active Order Worksheet
   All
 3 PRN Departments on Worksheet
->
 4 Treatments   5 Consultations    6 Patient History   7 Precautions
   Yes            Yes                Yes                 Yes
 Assessment Parameters
 8 Assessment Menu          9 Order Notice Printer
   MED/Surg                   1E
10 Asmt Change Tone        11 Group Change Tone       12 Prob List at Discharge
   No                         No                         No
13 Problem List on PCP     14 Problem List on Active Order Worksheet
   Yes                        No



Enter field number or '/' starting field number--
```

Field Explanations

1. ADL WORKSHEET CATEGORIES (TABLE LOOKUP)
This field indicates which ADL categories print on the ADL Worksheet. The default is ALL.

2. ACTIVE ORDER WORKSHEET (TABLE LOOKUP)
This field indicates which department orders print on the Active Order Worksheet. The default is ALL.

You can choose to not print all occurrences of an order, which eliminates lengthy and less useful reports. To choose to not print all occurrences of an order, set the Collapse Occurrences field on the SIM Departments table to Yes; then the PCP and worksheets print only one occurrence from a parent order. For example, if Vital Signs are ordered Q2H, only one occurrence prints on the PCP even though three were generated for that shift. The default for this field is No.

3. PRN DEPARTMENTS ON WORKSHEET (TABLE LOOKUP-O)
This field indicates whether orders with a frequency of PRN (as needed) should print on the Active Order Worksheet. PRN orders automatically go to a Complete status so they never generate an active occurrence. Therefore, they would not appear on the Active Order Worksheet unless this field is set to Yes.

You can select to print PRN orders for all departments, certain departments only, or not at all. If you leave this field blank, no PRN orders print on the Active order Worksheet.

For PRN orders that print, the information that prints is from the parent order. Once a PRN order is placed, it prints on the Active Order Worksheet regardless of whether an occurrence has been added. The PRN order continues to print until the parent order is cancelled or discontinued or the patient is discharged.

4. TREATMENTS (1-A-O)
This field indicates whether or not treatments should print on the Active Order Worksheet. The default is No.

5. CONSULTATIONS (1-A-O)
This field indicates whether physician consults should print on the Active Order Worksheet. The default is No.

6. PATIENT HISTORY (1-A-O)
This field indicates whether patient history text should print on the Active Order Worksheet. The default is No.

7. PRECAUTIONS (1-A-O)
This field indicates whether precautions should print on the Active Order Worksheet. The default is No.

ASSESSMENT PARAMETERS

8. ASSESSMENT MENU (TABLE LOOKUP-O)
This field specifies which Assessment Menu displays on this station. The table of Assessment Menus built in Standard File Maintenance displays for selection. Examples of user-defined Assessment Menus are Admission Assessment, Critical Care Assessment, Dietary Assessment, Medical/Surgical Assessment and Psychiatric Assessment.

9. ORDER NOTICE PRINTER (TABLE LOOKUP-R)
This required field identifies the printer on which the Assessment Order Notice prints for the nursing station. The system prompts you to enter the *spooler report name* of the nursing station's printer. You can enter the printer code or perform a table lookup and make your selection.

10. ASMT CHANGE TONE (1-A-O)
As the caregiver enters responses to Assessment questions, the system moves from one Question Detail screen to the next. If the caregiver is answering questions from several Assessments, he/she may not notice when the system has moved into a different Assessment. (The system displays the description of the Assessment at the top of the Question Detail screen.) This field determines whether the system alerts the caregiver with a beep when the system moves to a new Assessment. Enter **Y** for Yes to activate the system beep; enter **N** for No if you do not want to activate the beep. The default is No.

11. GROUP CHANGE TONE (1-A-O)
As the caregiver enters responses to Assessment questions, the system moves from one Question Detail screen to the next. If the caregiver is answering questions from several Groups, he/she may not notice when the system has moved into a different Assessment Group. (The system displays the description of the Group at the top of the Question Detail screen.) This field determines whether the system alerts the caregiver with a beep when the system moves to a new Group. Enter **Y** to activate the system beep. Enter **N** for No if you do not want to activate the beep. The default is No.

12. PROB LIST AT DISCHARGE (1-A-O)
This field determines whether you want the prompt *Update Problem List?* to be displayed during discharge. This gives you the opportunity to decide whether the Problem List for the patient is updated at that time of discharge.

If you want the prompt to be displayed upon discharged, enter **Y** for Yes. If you do not want the prompt to be displayed, enter **N** for No. The default is No.

13. PROBLEM LIST ON PCP (1-A-O)
This field determines whether the patient's Problem List prints on the Patient Care Profile (PCP). Enter **Y** for Yes if you want the Problem List to print on the PCP. Enter **N** for No if you do not want the Problem List to print on the PCP. The default is No.

14. PROBLEM LIST ON ACTIVE ORDER WORKSHEET (1-A-O)
This field determines whether the patient's Problem List prints on the Active Order Worksheet. Enter **Y** if you want the Problem List to print on the Active Order Worksheet. Enter **N** if you do not want the Problem List to print on the Worksheet. The default is No.

Impact

After you accept the screen, the following processing takes place:

- The data entered on the screen is stored for the selected station in the Standard file. The table listing reflects any changes made.
- All functions use the newly stored parameters.
- The parameters for outpatients or maternity outpatients are available for use with the nursing product functions. The system makes adjustments for all nursing programs and functions that use these parameters to determine the patient type prior to implementing any of the parameters.
- Some of the parameters on the second screen also exist in the CRT Names table. If the CRT performing this function has entries in these fields and they are blank in the Station Parameters screen, the system uses the CRT parameters.

NURSING FACILITY PARAMETERS

The Nursing Facility Parameters screen enables you to set options for your facility for the following areas:

- Nursing Shifts
- Outpatient Shifts
- Patient Care Profile
- Patient Acuity
- Assessment/Plan of Care
- Critical Pathways
- Maternity Retention Days

You can access the Nursing Facility Parameters by selecting the following menu options.

1. File Maintenance from the Nursing main menu
2. Standard File Maintenance
3. Report Build Options
4. Nursing Facility Parameters

Select the facility, if necessary. The Nursing Facility Parameters screen displays:

```
             General Hospital Nursing Facility Parameters Processor
GENERAL HOSPITAL A                                  Mon Sep 13, 1993 02:26 pm

 NURSING SHIFTS
 1 Number of Shifts   2 Shift 1       3 Start Time      4 PCR Housekeep Time
   3                    DAY             07:00A            14:30P
                      5 Shift 2       6 Start Time      7 PCR Housekeep Time
                        Evening         15:00P            22:30P
                      8 Shift 3       9 Start Time     10 PCR Housekeep Time
                        Night           23:00P            06:30A
 OUTPATIENT SHIFTS
                     11 Shift 1      12 Shift 2        13 End Time
                        07:00A          17:00P            20:00P
 PATIENT CARE PROFILE
14 Patient Block Loc    15 PCP Seq #             16 Nursing EO Loc
   Top Right               No                       Right
17 Rx Orders            18 Med Sched/PRN         19 Solution Types
   Meds/Solutions          Both                     Pri,Pgy,Inf,TPN,Irr,Syr,



Enter field number or '/' starting field number--
                    next screen(/) or previous screen(/P) [/]
```

Field Explanations:

NURSING SHIFTS

1. NUMBER OF SHIFTS (1-N-R)
This field defines the number of shifts used by the PCP and associated documents, as well as for certain order calculations.

NOTE: This field should be set up upon system initialization and then only changed if necessary.

The following prompt displays:

Enter number of shifts (2 or 3) [3]--

Enter the number of shifts for your facility.

2. SHIFT 1 (10-AN-R)
This field enables you to define the name of the first shift. The name you enter here displays on nursing orders screens and prints on nursing documentation.

The following prompt displays:

Enter name for Shift 1 [Day]--

The default for the description of the first shift is Day. The system prints Day shift on the screens/reports.

3. START TIME (10-N-R)
This field defines the start time for the first shift. Typically, a hospital with three shifts has their first shift beginning at 7:00 am. The following prompt displays:

Enter start time for Shift 1--

Enter the time the shift officially starts. This field is important for the calculation of when nursing/departmental orders become active for a particular PCP.

NOTE: The start time of shift 1 must be sooner than the start times of any subsequent shifts (2 and/or 3).

NOTE: Use a full hour to define each shift. This ensures that the system displays the correct occurrence information in those functions defined by shifts. For example, a start time of 0723 and an end time of 0822 is considered a full hour. If the end time was 0823, the shift would be considered one minute longer than a full hour.

4. PCR HOUSEKEEP TIME (10-N-O)
This function calculates the total Patient Care Requirements (direct and indirect), total station requirements, level of care, and required staffing based on levels, or required staffing, and variance based on PCRs. It is run shortly before Nursing Administration needs to project staffing requirements for the next shift.

Enter time to housekeep PCR codes for Shift 1 (near end of shift)--

Enter the time of day that the system should run housekeeping for this shift automatically.

5. SHIFT 1 (10-AN-R)
This field enables you to define the name of the second shift. The name you enter here displays on nursing orders screens and prints on nursing documentation.

The following prompt displays:

Enter name for Shift 2 [Evening]--

The default for the description of the second shift is Evening. The system prints Evening shift on the screens/reports.

6. START TIME (10-N-R)
This field defines the start time for the second shift. The following prompt displays:

Enter start time for Shift 2--

Enter the time the shift officially starts. This field is important for the calculation of when nursing/departmental orders become active for a particular PCP.

7. PCR HOUSEKEEP TIME (10-N-O)
This function calculates the total Patient Care Requirements (direct and indirect), total station requirements, level of care, and required staffing based on levels, or required staffing, and variance based on PCRs. It is run shortly before Nursing Administration needs to project staffing requirements for the next shift.

Enter time to housekeep PCR codes for Shift 2 (near end of shift)--

Enter the time of day that the system should run housekeeping for this shift automatically.

8. SHIFT 3 (10-AN-R)
This field enables you to define the name of the third shift. The name you enter here displays on nursing orders screens and prints on nursing documentation.

The following prompt displays:

Enter name for Shift 3 [Night]--

The default for the description of the third shift is Night. The system prints Night shift on the screens/reports.

9. START TIME (10-N-R)
This field defines the start time for the third shift. The following prompt displays:

Enter start time for Shift 3--

Enter the time the shift officially starts. This field is important for the calculation of when nursing/departmental orders become active for a particular PCP.

10. PCR HOUSEKEEP TIME (10-N-O)
This function calculates the total Patient Care Requirements (direct and indirect), total station requirements, level of care, and required staffing based on levels, or required staffing, and variance based on PCRs. It is run shortly before Nursing Administration needs to project staffing requirements for the next shift.

Enter time to housekeep PCR codes for Shift 3 (near end of shift)--

Enter the time of day that the system should run housekeeping for this shift automatically.

OUTPATIENT SHIFTS

11. SHIFT 1 (Time Format)
This field defines the start time or beginning of the first outpatient shift.

12. SHIFT 2 (Time Format)
This field defines the time the second outpatient shift starts, if one applies. If there is not a second shift, leave this field blank.

13. END TIME (Time Format)
This field defines the ending time for the outpatient shifts. If you have not entered a time for the second shift, the system uses the time in this field as the end time for the first shift. If you have entered a time for the second shift, then the start of the second shift signifies the end of the first shift (as with inpatients).

PATIENT CARE PROFILE

14. PATIENT BLOCK LOC (2-A-R)
This field is for use only with the system-generated PCP. The following prompt displays:

Enter top left (TL)/right (TR) or bottom left (BL)/right (BR)--

Use this field to designate where you want the Patient Demographic Block to print on the PCP.

To print the patient block in the...	Type...
Top-left corner	TL
Top-right corner	TR
Bottom-left corner	BL
Bottom-right corner	BR

15. PCP SEQ # (1-A-R)
This field is for use only with the system-generated PCP.The system counts the PCPs that are printed for a patient. You can designate for the system to print the number of the current PCP in the sequence of the PCPs that have been printed. The following prompt displays:

Should the sequence # print on the PCP (Y/N) [Y]--

Enter **N** for No if you do not want the Sequence Number to print on the PCP. Enter **Y** for Yes if you want the Sequence Number to print in the report header.

16. NURSING EO LO(1-A-R)
This field is only for use with the system-generated PCP. The system-generated PCP is a two-column horizontal format. This field enables you to define which column is the Plan of Care side. The other side of PCP contains the physician's orders. The following prompt displays:

Print nursing expected outcomes on right (R) or left (L)--

Enter **R** for Right to print the Plan of Care in the right column. Enter **L** for Left to print the Plan of Care in the left column.

17. RX ORDERS (1-A-R)
This field is only for use with the system-generated PCP. This field indicates which information from STAR Pharmacy is to print on the PCP, if any. The following prompt displays:

Display (M)edications, (S)olutions, or (B)oth?--

If you do not want to print any Pharmacy information, press ENTER at the prompt. If you do want to print Pharmacy information, enter one of the following:

- To print Medications only, enter **M**.
- To print Solutions only, enter **S**.
- To print both Medications and Solutions, enter **B** for Both.

18. MED SCHED/PRN (1-A-R)
This field is only for use with the system-generated PCP. This field indicates which information from STAR Pharmacy is to print on the PCP, if any. The following prompt displays:

Print scheduled medications, PRNs, or both (S/P/B)?--

If you do not want to print any Pharmacy information, press ENTER at the prompt. If you do want to print Pharmacy information, enter one of the following:

- To print Scheduled medications only, enter **S**.
- To print PRN medications only, enter **P**.
- To print both scheduled and PRN medications, enter **B** for Both.

19. SOLUTION TYPES (TABLE LOOKUP)
This field is only for use with the system-generated PCP. Choose which solutions from the solution type table that are to be included if solutions are included in the choice to print on the PCP.

The second Nursing Facility Parameters screen contains additional options. Enter a backslash (/) to advance from the first Nursing Facility Parameters screen to the second. The screen displays as follows:

```
            General Hospital Nursing Facility Parameters Processor
GENERAL HOSPITAL A                                    Mon Sep 13, 1993 02:26 pm

 PATIENT ACUITY
 1 Admission Bed Override               2 Transfer Bed Override
   1111 ADMISSION TO UNIT                 5556 TRANSFER BED
 3 Acuity Retention         4 Historical Acuity Retention 5 Historical Key
   99                         999                          DRG
 ASSESSMENT / PLAN OF CARE
 6 Assessment Maint   7 Assessment History Retention      8 Master Problem List
   Weekly               1 D                               Yes
 9 Pending Authorization Status   10 Log Text  11 Report Name
   No                                No           NPLOG  Nursing Log Text Re
 CRITICAL PATHWAYS
12 Retention Days                 13 Print Frequency
   999                            ->
 MATERNITY RETENTION DAYS
14 Care Plans        15 Assessment       16 Labor & Delivery     17 Vital Signs
   9125                 9125                9125                    9125

Enter field number or '/' starting field number--
                      next(/) or previous screen (/P) [/]
```

Field Explanations

PATIENT ACUITY

1. ADMISSION BED OVERRIDE (TABLE LOOKUP)
This field enables you to assign a bed override status whenever a patient is admitted to the facility.

The following prompt displays:

Enter admission bed override code or '-' to list--

Enter the admission bed override code or perform a table lookup and make your selection.

2. TRANSFER BED OVERRIDE (TABLE LOOKUP)
This field enables you to assign a transfer bed override status whenever a patient is transferred to the facility.

The following prompt displays:

Enter transfer bed override code or '-' to list--

Enter the transfer bed override code or perform a table lookup and make your selection.

3. STAFFING RETENTION (1-N-R)
You use this field to designate the number of days that you want to retain staffing data on the system. You can enter a number from 1 to 99.

The following prompt displays:

Enter number of days to retain staffing data on the system (1-99)--

Enter the number of days you want to retain the station, room and bed acuity totals on the system.

4. HISTORICAL RETENTION (3-N-R)
You can retain historical data for acuity for up to one year. The following prompt displays:

Enter number of days to retain staffing historical data, 0 for none (to 999)--

Enter the number of days, from 0 to 999 that you want to retain historical acuity data. The system stores the acuity data sent to TRENDSTAR for the period you indicate in this parameter.

5. HISTORICAL KEY (1-A-R)
This field enables you to store the staffing historical data by DRG or by Diagnosis. The following prompt displays:

Do you wish to store Staffing Historical Data by DRG(D) or Diagnosis(X)?--

To store the DRG with the staffing historical data, enter D for DRG. To store the Diagnosis, enter X for Diagnosis. The system stores the DRG or Diagnosis with the patient acuity data depending upon the entry in this field.

ASSESSMENT/PLAN OF CARE

6. ASSESSMENT MAINT (1-A-O)
The Assessment Maint field enables you to define how often the system runs automatic maintenance of the Assessment files. The maintenance function removes stray codes left from deletions of file components that are attached to responses (PCR codes, Problems, Plan of Care elements) or to an Assessment (Assessment Orders). Enter D for a Daily Run Cycle for Assessment File Maintenance. Enter W for a Weekly Run Cycle. The system defaults to Weekly.

7. ASSESSMENT HISTORY RETENTION (3-N-O)
This field enables you to retain versions of assessment standard files. When you make changes to the assessment standard file, the system retains the previous version of the file for patients that currently have that assessment. When you perform an initial assessment after that, the system uses the new version. You can enter up to 999 days to retain a version of an assessment.

8. MASTER PROBLEM LIST (1-A-O)
This parameter enables the facility to retain patient Problem information across visits. The Problems are ongoing patient Problems that are valid from visit to visit, such as blindness or deafness. When the caregiver adds a Problem to the patient's Problem List, the caregiver designates whether that Problem is to be copied to the Master Problem List during patient historization.

The following prompt displays for this field:

Retain Master Problem List? (Y/N) [N]--

- Enter **Y** for Yes if you want the system to copy designated patient Problems during patient historization. When the patient is readmitted, the system automatically lists the Problems on the patient's Problem List.

- Enter **N** for No if you do not want the system to copy the Problems to the Master Problem List.

9. PENDING AUTHORIZATION STATUS (1-A-R)
You can designate whether an additional status of Pending Authorization is available during the Plan of Care process. The status means a Plan of Care or element does not become active until reviewed and activated.

The following prompt displays:

Use Pending Authorization status in care planning? (Y/N) [N]--

This field controls whether the user utilizes the pending authorization status in the care planning process. This status would be utilized in the event that the hospital requires that an RN review the PCP prior to its full activation.

10 LOG TEXT (1-A-R)
You can designate that text entered for a patient during the care planning process, prints to a report. You define the name of the report in the Report Name field on this screen.

Log text changes? (Y/N)--

To log the text changes, enter **Y** for Yes. When you do not want to log text changes, enter **N** for No. This report can be helpful in a Go Live process to determine if certain texts are appropriate for the nursing stations involved.

11. REPORT NAME (8-AN-O)
You use this field to enter the name of the report where you want to log Plan of Care text, if you entered Yes in the Log Text field on this screen. The system checks that the report name exists in the spooler report file. The base report name for this field is NPLOG. This field is required if you entered Yes in the Log Text field.

Enter report name to log text--

Enter the report name where you want to log the text.

CRITICAL PATHWAYS

12. RETENTION DAYS (3-N-R)
You access this field and enter the number of days that the system should retain Critical Pathway information for each patient. The maximum number of days you can retain the information is 999 days after patient historization. The system purges the information during midnight processing after the number of retention days you specify.

13. PRINT FREQUENCY (1-A-R)
This field enables you to specify whether you want the frequency for each order to print on the Critical Pathway and Multidisciplinary Plan (MDP). Because the frequency prints on a separate line for each order, it can considerably lengthen the printed documents.

If you enter Y for Yes, the frequency prints for every order on both documents. The default is No.

MATERNITY RETENTION DAYS

14. CARE PLANS (4-N-O)
This field specifies the length of time maternity care plans should be retained in the system. Retention values are in days, and valid entries range from 1-9125. If you leave the field blank, the system deletes care plan information upon historization.

It is typical to keep maternity care plans for a minimum of nine months, and advisable to keep them for about five years. This not only enables the review of previous assessments, but also allows the information related to this pregnancy to be brought forward at future maternity visits. You can view retained maternity care plan information, but you cannot edit it once a patient has been historized. If a maternity patient has a new maternity visit within 10 months of a previous maternity visit, the care plan information from the most recent (or active) previous maternity visit can be brought forward as a basis for the care plan for the newly created maternity information.

NOTE: Keeping maternity records on-line has a substantial disc impact.

15. ASSESSMENT (4-N-O)
This field specifies the length of time maternity assessment records should be retained in the system. Retention values are in days, and valid entries range from 1-9125. If you leave the field blank, the system deletes maternity assessment records upon historization.

It is typical to keep maternity assessment records for a minimum of nine months, and advisable to keep them for about five years. This not only enables the review of previous assessments, but also allows the information related to this pregnancy to be brought forward at future maternity visits. You can view retained maternity care plan information, but you cannot edit it once a patient has been historized.

16. LABOR & DELIVERY (4-N-O)
This field specifies the length of time the labor and delivery information should be retained in the system. Retention values are in days, and valid entries range from 1-9125. If you leave the field blank, the system deletes labor and delivery information upon historization.

It is typical to keep labor and delivery information for a minimum of nine months, and advisable to keep them for about five years to allow for the review of previous labor and delivery information. You can view retained maternity care plan information, but you cannot edit it once a patient has been historized.

17. VITAL SIGNS (4-N-O)
This field specifies the length of time the vital signs and fluids information should be retained in the system. Retention values are in days, and valid entries range from 1-9125. If you leave the field blank, the system deletes vital signs and fluids information upon historization.

Appendix B - INFORMATION WINDOWS

INFORMATION WINDOWS

You can display the Patient Information, Physician Information, and Pharmacy Profile Information Windows if you meet the following criteria:

- You must be using McKesson's WEM product on an IBM-compatible personal computer
- Your PC and host ID computer must be set up to enable the use of Information Windows

For more information about using Information Windows, refer to the *WEM User's Guide*.

Information Windows displaying patients' medical information, physicians of record, and pharmacy information are available through Order Management and Nursing functions. Information is downloaded into the windows upon selection of a patient in these functions. During the download process, the system displays the following message:

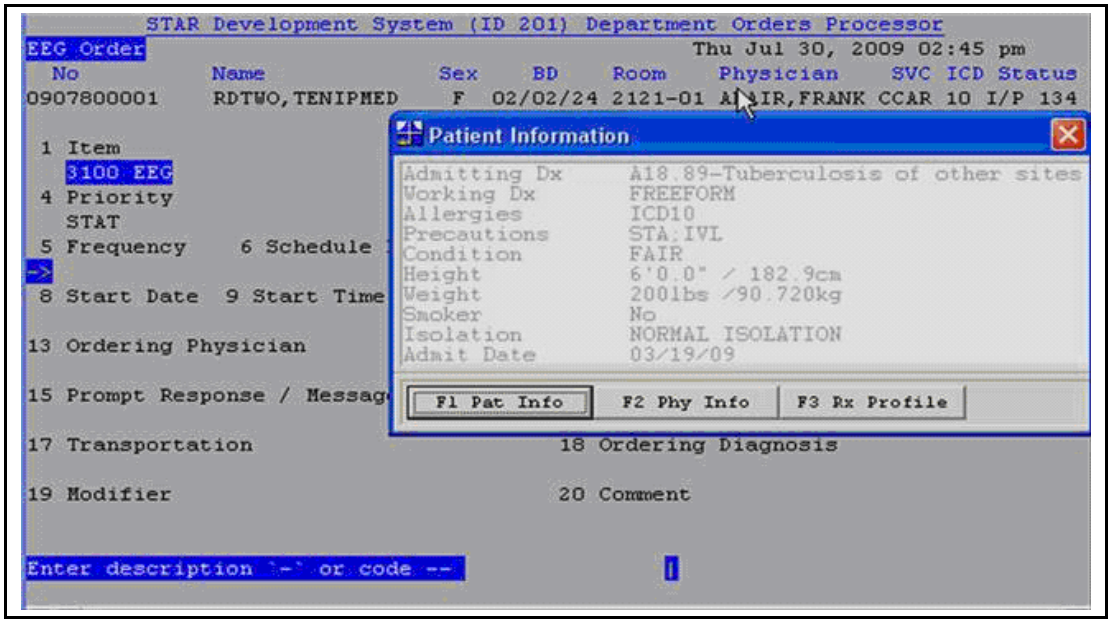
Downloading Information Windows...Please Wait!

NOTE: Pharmacy information is only available when STAR Pharmacy is in the system network.

The information is cleared when you select a different patient in one of the functions where Information Windows are available or when you access a different function from the Nursing menu.

Patient Information

To view the following Patient Information window, select **Tools**, **Information Windows** from the menu bar.



The Patient Information Window is displayed on the right side of the screen. The patient's medical data is displayed, which includes the following:

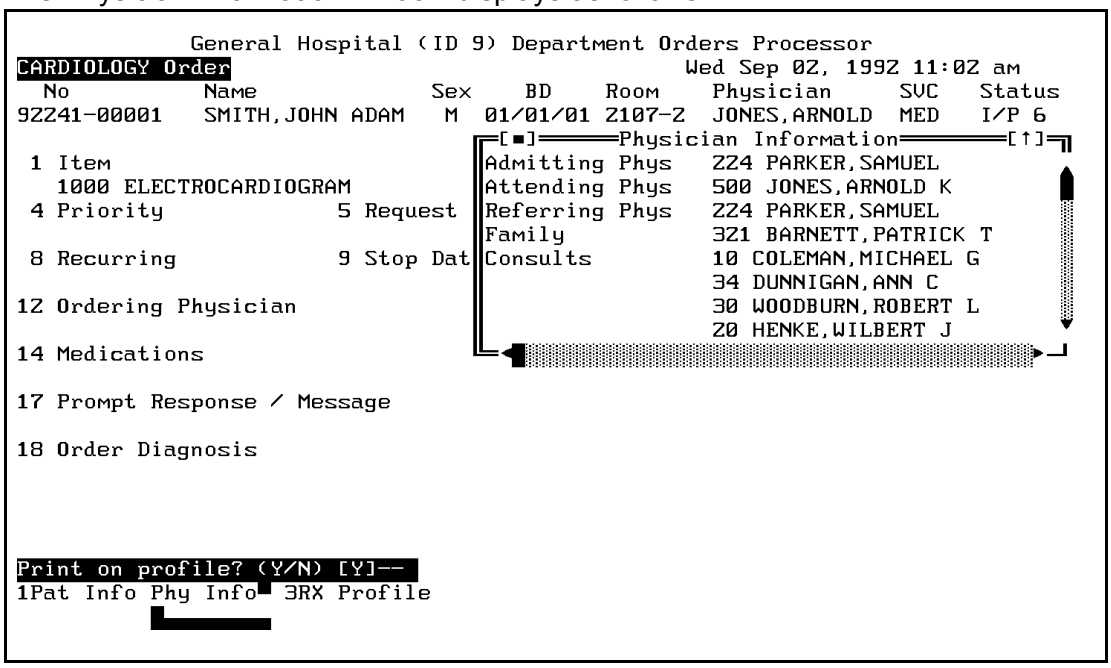
• Admitting diagnosis	• Height
• Working diagnosis	• Weight
• Logged allergies	• Smoking status
• Precautions	• Isolation
• Condition	• Admit date

To scroll through the available information, press the Up Arrow, or Down Arrow key. Press the ESC key to exit Information Windows, F2 to view the Physician Information Window, or F3 to view the Pharmacy Profile Information Window.

For more information about using Information Windows, refer to the *WEM User's Guide*.

Physician Information

The Physician Information window displays as follows:



Notice that the Phys Info option in the lower left corner is highlighted. The Physician Information Window displays on the right side of the screen under the patient demographic information. The following physicians are displayed (if they are logged):

- Admitting Physician
- Attending Physician
- Referring Physician
- Family Physician
- Consulting Physicians

When applicable, you can press the Up Arrow or Down Arrow key to scroll through the physicians of record. Press the ESC key to exit Information Windows, F1 to view the Patient Information Window, or F3 to view the Pharmacy Profile Information Window.

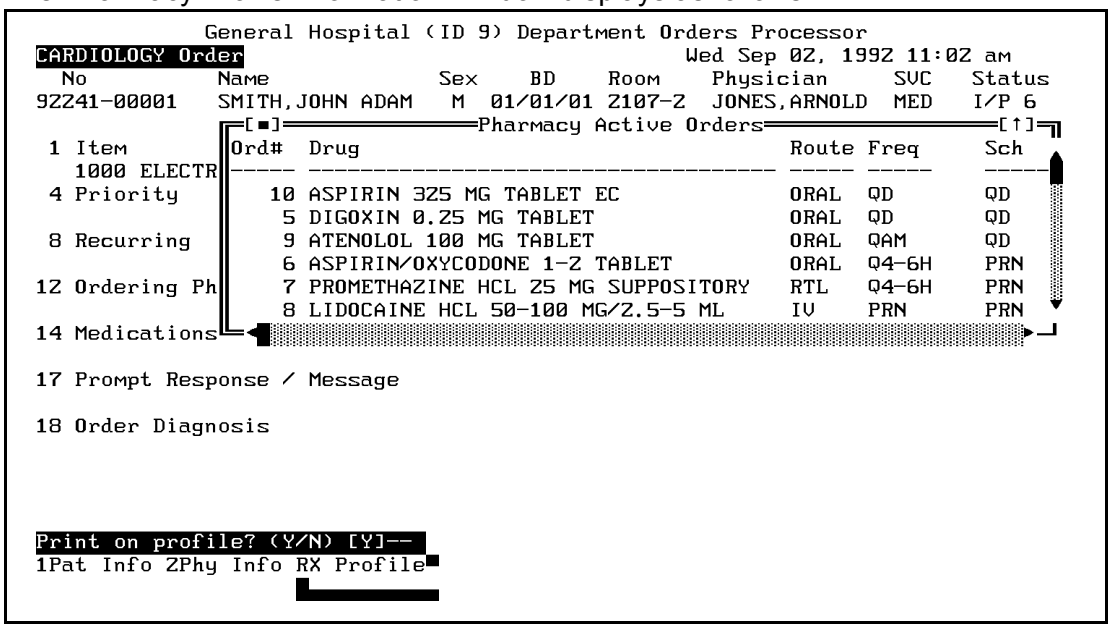
If the patient has more consulting physicians than can display in the Information Window, the system notifies you on the last line with the following message:

More Consultants...see Revise Patient - Physician

For more information about using Information Windows, refer to the *WEM User's Guide*.

Pharmacy Profile

The Pharmacy Profile Information Window displays as follows:



Notice that the Rx Profile option in the lower left corner is highlighted. The Pharmacy Profile Information Window displays on the right side of the screen under the patient demographic information. The Pharmacy Profile Information Window information includes the following:

- Medication order number
- Drug information
- Drug administration route
- Drug administration frequency
- Drug schedule

The drug information includes the formulary name, the strength of the drug, and the dosage form.

NOTE: The Rx Profile Information Window does not display when STAR Pharmacy is not in the system network.

If a patient has more active orders than can display in the Information Window, the system displays the following message:

*** INCOMPLETE LIST ** Use Profile Inquiry for a complete display.*

When you access a patient who does not have any active pharmacy orders, the following message displays:

No active orders for selected account.

When applicable, you can press the Up Arrow or Down Arrow key to scroll through the active medication orders. Press the ESC key to exit Information Windows, F1 to view the Patient Information Window, or F2 to view the Physician Information Window.

For more information about using Information Windows, refer to the *WEM User's Guide*.

Patient Preparation Instructions

The new Preps information window contains patient preparation instructions from up to three sources:

- The STAR Radiology Patient Preparation Instructions function, usually found on the Radiology system's Order Management menu. Information entered here appears in the window under the heading <Dept>-Defined Preps, where <Dept> is actually a STAR Radiology department code, like RAD.
- The STAR Scheduling SIM Item Scheduling Instructions function, usually found on Scheduling's Resource Maintenance menu. Information entered here appears in the window under the heading Scheduling Instructions.
- The STAR Nursing Preps and Special Instructions function, usually found on STAR Nursing's Standard File Maintenance menu. Information entered here appears in the window under the heading Nursing Preps.

Throughout the Scheduling application, the information window indicator appears in one of three situations:

- When a screen displays a SIM item with a defined prep in the Visit Reason field
- When the Visit Reason field is revised to include a SIM item with a defined prep
- When a single SIM item with a defined prep is selected from a table

The Preps information window can be accessed in the following STAR Scheduling processors:

- Appointments
- Walk-in
- Copy Appointment

- Revise Patient Appointment
- Patient Appointment Inquiry/Audit
- Check In/Out
- Resource/Department Schedule (on the Schedule Census menu)

For more information regarding Information Windows, refer to the *WEM User's Guide*.

Index

■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Care Planning and Documentation Module* for Release 17.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

Other Comments:

Thanks for your help in improving the documentation.

Your Name and Position _____

Hospital/Organization Name _____

Telephone Number _____

May we contact you? Yes or No (circle one)

■

McKesson
STAR 2000 Documentation Team

Fold here

Place
Stamp
Here

STAR 2000 Documentation Team
McKesson
Mail Stop ATHQ-3302
5995 Windward Parkway
Alpharetta, GA 30005

Fold here