



Instructors & Students Training Manual



Meditech Order Management Training Manual Table of contents

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General Information

SYSTEM SECURITY AND CONFIDENTIALITY

Introduction

Information Security in the healthcare industry means protecting employee and company information, but also includes the patient information gathered in behalf of a patient during treatment. Practicing good Information Security helps insure **confidentiality, integrity,** and **availability** of the information we use, and helps build public trust.

Security Measures

- Use only your own unique **User ID** and **Password** to access any system or application.
- Always exit the system before leaving work.
- Create a “hard to guess” password and never share it.
- Change your password frequently (upon system request, or if you believe your password has been seen, guessed or disclosed).
- If applicable, activate your **screen saver** password with a **timeout** from 5 minutes (public area) to 20 minutes (private office).

Existing and pending federal and state laws make each person responsible for correct and appropriately used information. The laws:

- Protect the confidentiality of individuals’ information.
- Set standards for both electronic and personal security measures.

Company Security Policy **IS.SEC.001** details an individual’s responsibility for the protection of sensitive and confidential information generated as a part of normal day-to-day healthcare business.

Use the guidelines that follow to help you practice good Information Security.

Data Access

- Treat all information as if it were about you or your family.
- Access only those systems you are officially **authorized** to access.
- Access only the information you need to do your job.
- Only share sensitive and confidential information with others who have a **“need to know.”**
- Keep sensitive and confidential information in a locked cabinet or drawer when not in use.

What is the role of the individual?

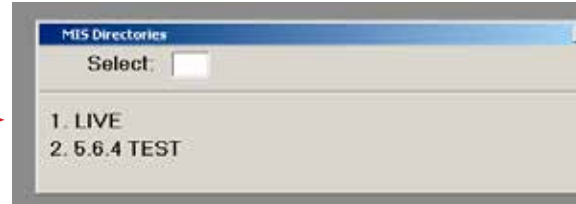
You must make a commitment to:

- Never intentionally **bypass** or turn off security measures, including anti-virus software.
- Exit applications and systems as soon as you complete your work.
- Be aware of your surroundings. Who is able to view information or watch when PIN numbers or Passwords are entered?
- Always keep portable equipment/devices with you and in your sight.
- “Log off” and “shut down” your PC before leaving work each day.

Logging IN or Signing IN

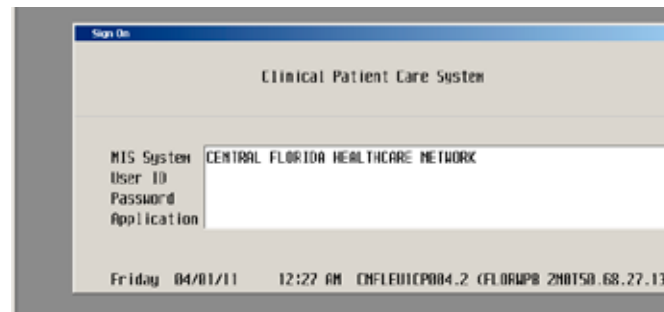
For Training Purposes you will be logging into Test Mode Session, then use RT Arrow in to suspend—To bring back the session enter password into the below box.

Logging On
Choose #2 Tests



Note: When logging on you will NOT see a cursor moving. Also, you CANNOT use the BACKSPACE key when entering a password. If you need to erase while entering a password, press the F10 key and then reenter the password.

YOU WILL NOT SEE THE PASSWORD



The date and time appear on the bottom of the screen. The other sequences of letters and numbers represent the "NAME" or address of the PC. You may be asked to provide this when you call the IT & S HELP DESK (Ex. *35629)

USER ID: FNUR.C

UNIVERSAL ID: 1TESTIN



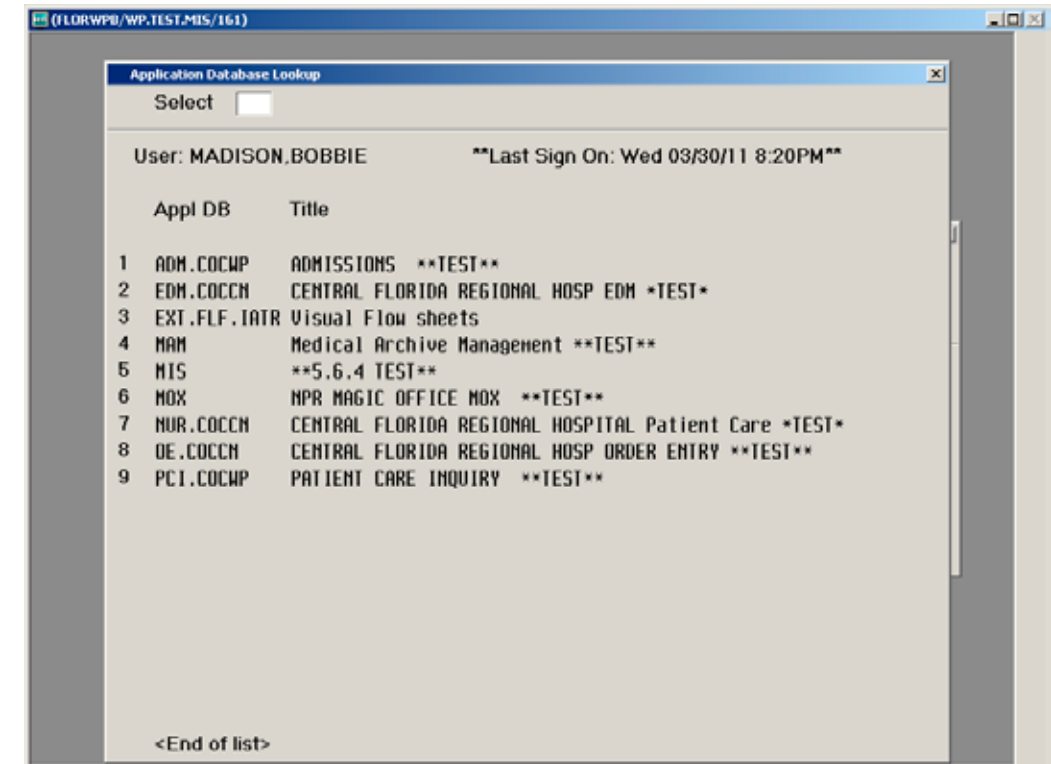
Application Mnemonic

PASSWORD: Unique to your User ID and you select it. It must be at least (7) characters in length and contain at least one (1) number. Your password is confidential and ONLY YOU should know it, so keep it a secret! When entering the password, the cursor will not appear to move on the screen.

Periodically, your password will expire. Once prompted, choose a new password and press the ENTER key. You will then be prompted to enter the same password again. If you feel someone has

guessed your password, please call IT & S Helpdesk and request to have your password changed. You will be asked for your Authentication Code which may be the last four of your SSN or your Universal ID (¾ ID)

Once you have entered your password and you press the ENTER key, the application list will appear. The number of applications appearing on your menu will depend on the type of position access within the facility.



Application Mnemonic

- ADM
- EDM
- MAM
- MIS
- MOX
- NUR
- OE
- PCI

Application Function

- Admission Module
- Emergency Department Module
- Medical Archive Management
- Meditech Database
- e-mail and Occurrence Reporting
- Nursing Module
- Order Entry (CPOE)
- Patient Care Inquiry

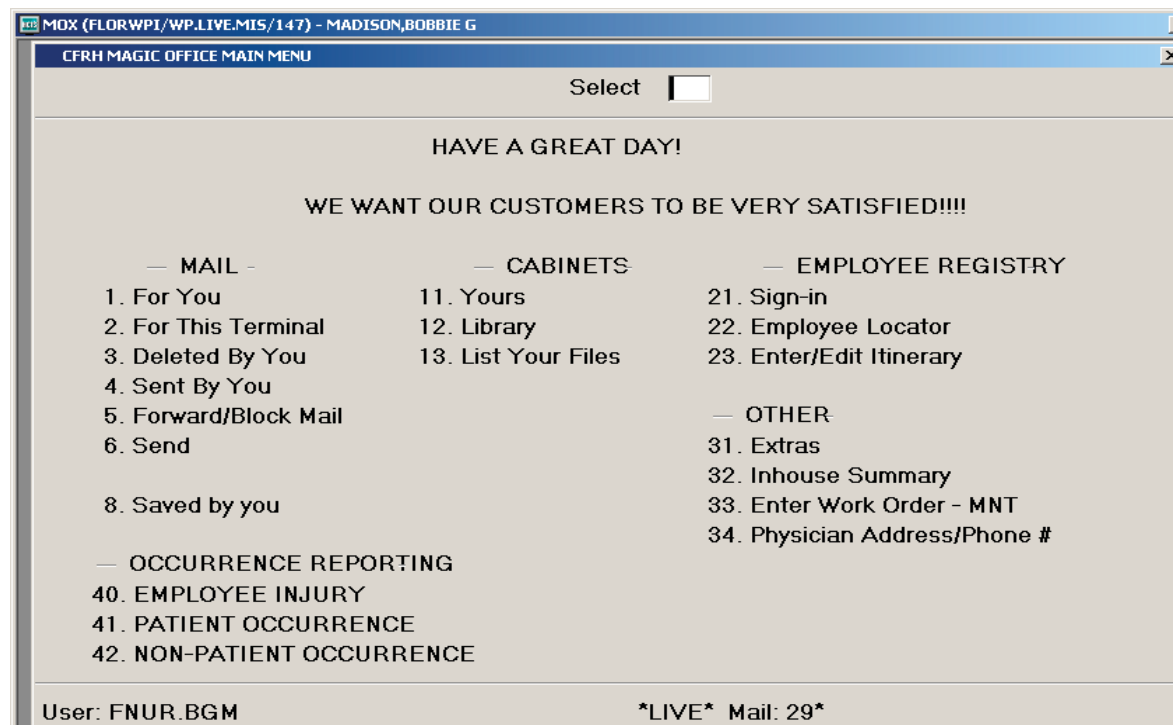
Keyboard Function Keys

Special Function – Laptop and Keyboard Function Keys

(Most commonly used keys are highlighted below). F9, F11, F12

- F1, F2 & F3 keys are used for education
- F4 is the GET key. Press F4 then F9 to get Canned Text
- F5 is the Recall key
- F6 is Previous Field Key
- F7 Begin Line Key
- F8 End of Line Key
- **F9 Look Up Responses Key**
- F10 Delete Line Key
- **F11 Exit WITHOUT saving changes Key**
- **F12 Save, File & OK Key**
- Rt Control Key The Checkmark Key (Press the Rt CTRL key and a check mark will appear)
- Shift F8 The On-Line Documentation key (Use this key for explanations on how to answer queries Shift Rt Control Key Use this combination to move to the next level for documentation (used within the POC- Plan of Care)
- Space Bar then Press the Enter key allows you to return to previous patient
- To Suspend a session Press the Shift & F12 (Hot Key). At red box move highlighted bar to Suspend Session, then use Rt Arrow in to suspend—To bring back the session enter password into the below box.

(MOX) Magic Office



Above the occurrence report, In MOX you will find the Occurrence Reports. Do not fill out an occurrence report alone. You will need assistance from a staff member.

Occurrence Reports

An occurrence report is: a report that is completed by an employee, who has knowledge of an occurrence event, has witnessed the event or was involved in the event. Occurrence/Notification reports should be completed by the end of the shift in which the event took place and forwarded to your Supervisor. The notification process is very simple. You can complete a notification online in Meditech or complete the occurrence report form when Meditech is unavailable. An occurrence report should be filled out objectively. Briefly state the facts involved in the occurrence and avoid drawing conclusions or placing blame. Never reference the occurrence report in the medical record and never print/copy an occurrence report for any reason. Occurrence reports are strictly confidential.

Three types of notifications are available:

- **EMPLOYEE INJURY:**
Only for employee Health related events, i.e. employee injury, employee exposure, employee needle stick, etc...
- **PATIENT OCCURRENCE:**
Use anytime a patient name is referenced directly or indirectly involved
- **NON-PATIENT OCCURRENCE:**
Use for visitors falls, staff or visitor lost belongings, concerns student nurses etc...

Patient ID

Account Number The number assigned to the patient for "this specific visit". Everything related to this patient visit (charges, orders, etc.) will be associated with this number. This number will "change with each visit". To look up a patient select PCI from the application database, arrow down to appropriate option and enter requested information.

Full Name Type in the full name, beginning with the last name, comma, and first name. A list from the MPI (Master Patient Index) will appear. Search through the list to find the patient. The patient that is "currently in house" will display in the system in black color. The patients names that are faded are past visits and should not be selected. Following verification of the account number and visit date, type in the "number" next to the patients listed name. The next prompt for verification will then appear.

Partial Name Type 2-3 letters of the patient's last name and then press F9 lookup. The MPI will appear with "all" the patients whose last names begin with those 2-3 letters. Select the number next to the patient and press ENTER. Ensure the patient is listed in the account number matches.

GEMMs & STATUS BOARD

GEMMS (GRAPHICALLY Enhanced Meditech Magic Software) is a feature which changes your Meditech screen to look and feel like windows. This allows the utilization of the point & click capabilities of the mouse, and use of the Status Board.

Status Board

The Status Board is a new tool that allows you to view patient information while providing quick links to frequently used routines. Display refreshes every 60 seconds with new data.

The Status board screen is similar to a whiteboard, enabling you to view current information about your patients. Located across the top are Colum Headers--For example, Room/Bed, Temp Loc, Patient Name, Age, Sex etc. etc. etc... (each unit/Area/User may have different headers).

"Clicking" on a header allows for sorting of a patient's by room number, name, etc...

Rm/Bed	PT Name	Admit Dx	Next Int	Results	Orders
t LOC	Status Admit Date	Age/Sex DOB	Next Med	Diet	Code
F.217-0	MEDITECH566, TRAIN			F.PDOC	Stat
	ADM IN 09/05/13	47 M 01/24/66			
F.351-0	TESS, ALLEN TEST	CHF PNUMONIA	PRN	Lab	Stat
	ADM IN 05/08/13	56 M			
F.352-0	MCCARTNEY, PAUL TE		PRN		Xfer
	ADM IN 05/08/13	44 M			
F.353-0	PRESLY, ELVIS TEST		0900 Standard		Stat
	ADM IN 05/08/13	52 M			
F.354-0	WHITE, SNOW TEST	CHF	0900 Standard		Stat
	ADM IN 05/08/13	68 F			
F.355-1	Computrition, Cent		PRN		Ack
	ADM IN 06/20/12	63 F 08/08/50			
F.355-2	Computrition, Cent		PRN		
	ADM IN 06/20/12	26 F 09/09/87			
F.356-0	COLE, ANTHONY TEST	CHF/PNEUMONIA	0900 Standard		Stat
	ADM IN 05/08/13	74 M			
F.357-0	DOE, JOHN TEST	CHF	0900 Standard		Stat
	ADM IN 05/08/13	52 M			
F.389-1	MEDITECH566, DONNA		PRN	F.PDOC	New
	ADM IN 09/05/13	48 F 01/01/66			
F.504-1	MEDITECH, TEST		0600 Focused	F.CPUL	Stat
	ADM IN 10/05/12	46 M		CARBOHYDR	AND

Patient Status Lookup Colors

- Active Inpatients = Blue
- Outpatients, PRE, SCH = Black
- Discharged Patients = Gray
- Admission/Registered with today's Date = Red

If more than 1 patient with the same last name appears, then the patients' names display with a yellow background.

- Res" indicates results are from more than one source/department
- Results of a lab have been viewed = Yellow
- Clinical results are abnormal high/low or critical high/low = Pink
- Uncollected Specimens = Blue

Status Board Desktop Buttons

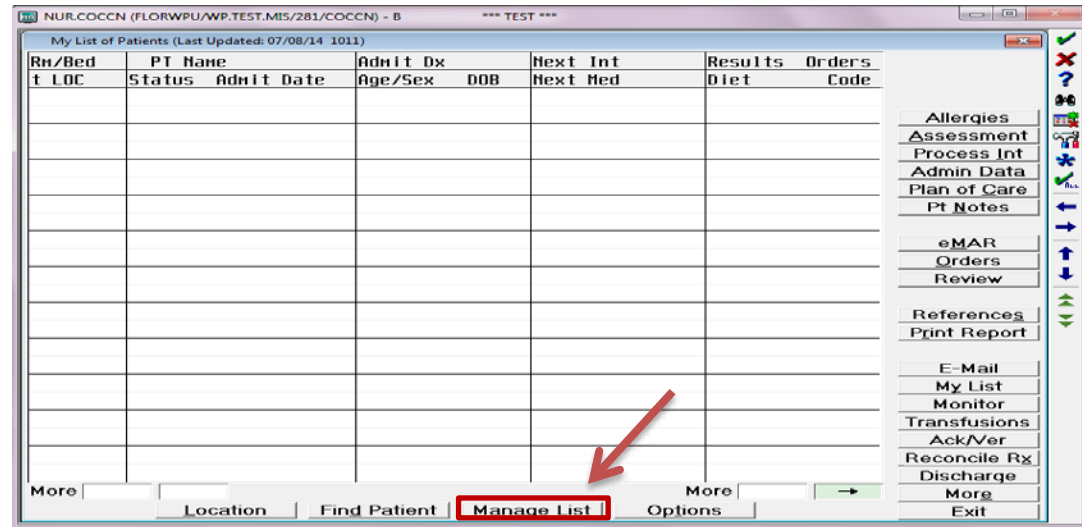
- Allergies = View/Enter/Edit Patient Allergies
- Assessments = Enter, edit, or view an admission assessment or history form
- Process Int = Process intervention Screen is patient documentation
- Enter/Edit Administrative Data = Enter/edit basic patient data should be completed after doing the patient's history
- Enter Edit Plan of Care (POC) = To enter/edit a care plan that is tailored to fit an individual patient's needs
- Patient Notes = Enter, edit or view notes about a patient
- eMAR = Access to administer Medication
- Orders = Enter Orders Order Sets via CPOE
- Review = CPOE Clinical Review/ PCI Patient Care Inquiry & Other buttons (Labs V/SMeds etc.etc.)
- References = Encompasses JACHO, Krames, Healthstream, Clinical pharmacology & WebMD
- Print Reports = Allows easy access to several specific screens i.e. Print census, Bed roster, Work Order requests etc.etc
- E-Mail = MOX in house email system
- My-List = Refreshes the Status Board List
- Monitor = Access IATRIS's
- Transfusions = Access BCTA
- Ack/Ver = Acknowledge/Verify patients order individually all names son Status board
- Reconcile Rx = Access Medication Reconciliation via CPOE
- Discharge=Used when discharging a patient

Allergies
Assessment
Process Int
Admin Data
Plan of Care
Pt Notes
eMAR
Orders
Review
References
Print Report
E-Mail
My List
Monitor
Transfusions
Ack/Ver
Reconcile Rx
Discharge
More
Exit

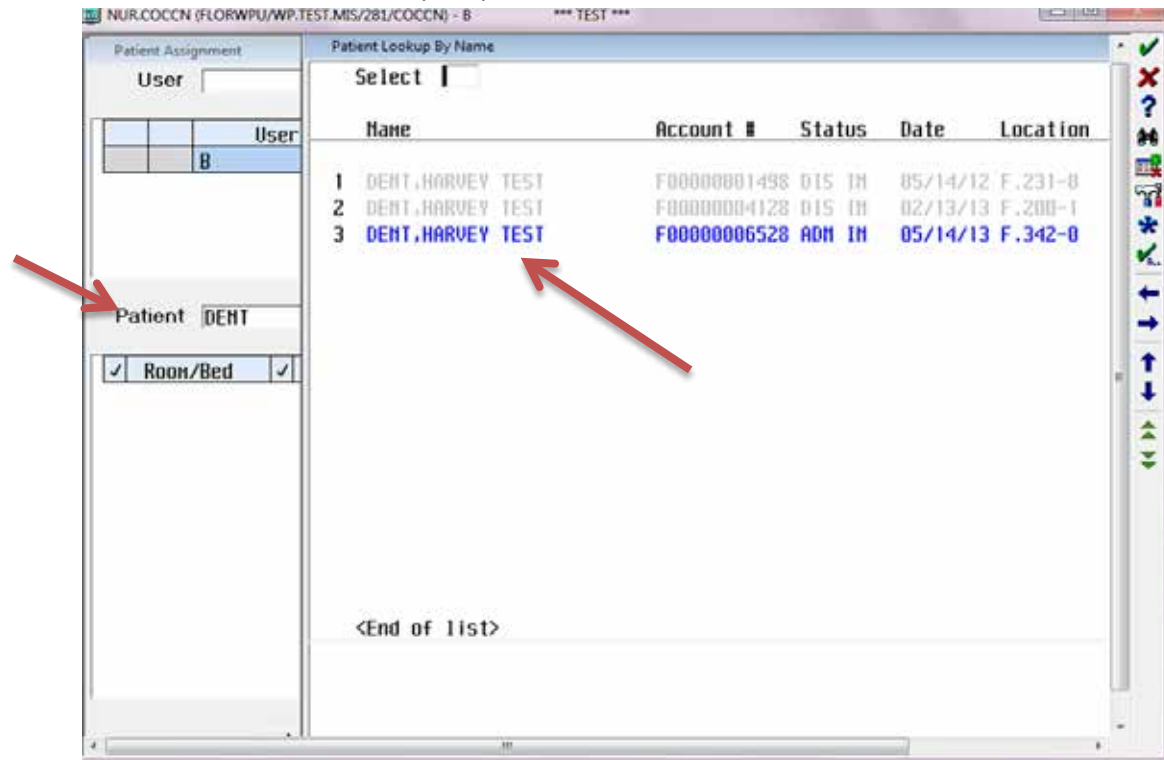
MANAGE LIST:

You will need to manage your list on the Status Board. (when you manage your list, your patients will remain on your status board until they depart the floor, are discharged from the hospital, or you yourself remove them from your list).

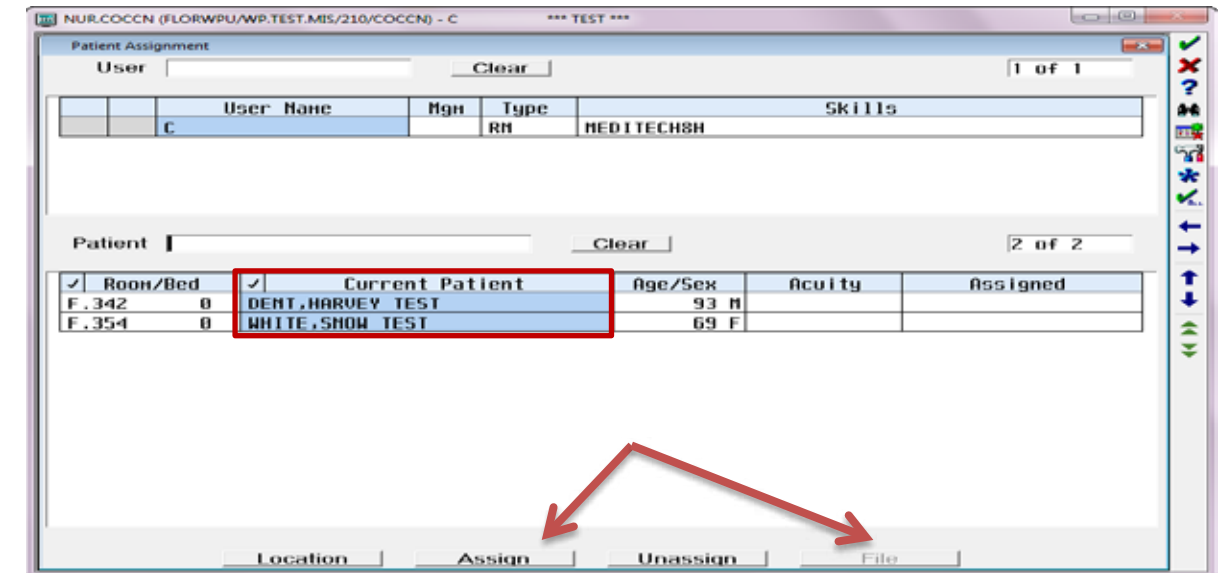
1. Go to manage your list.



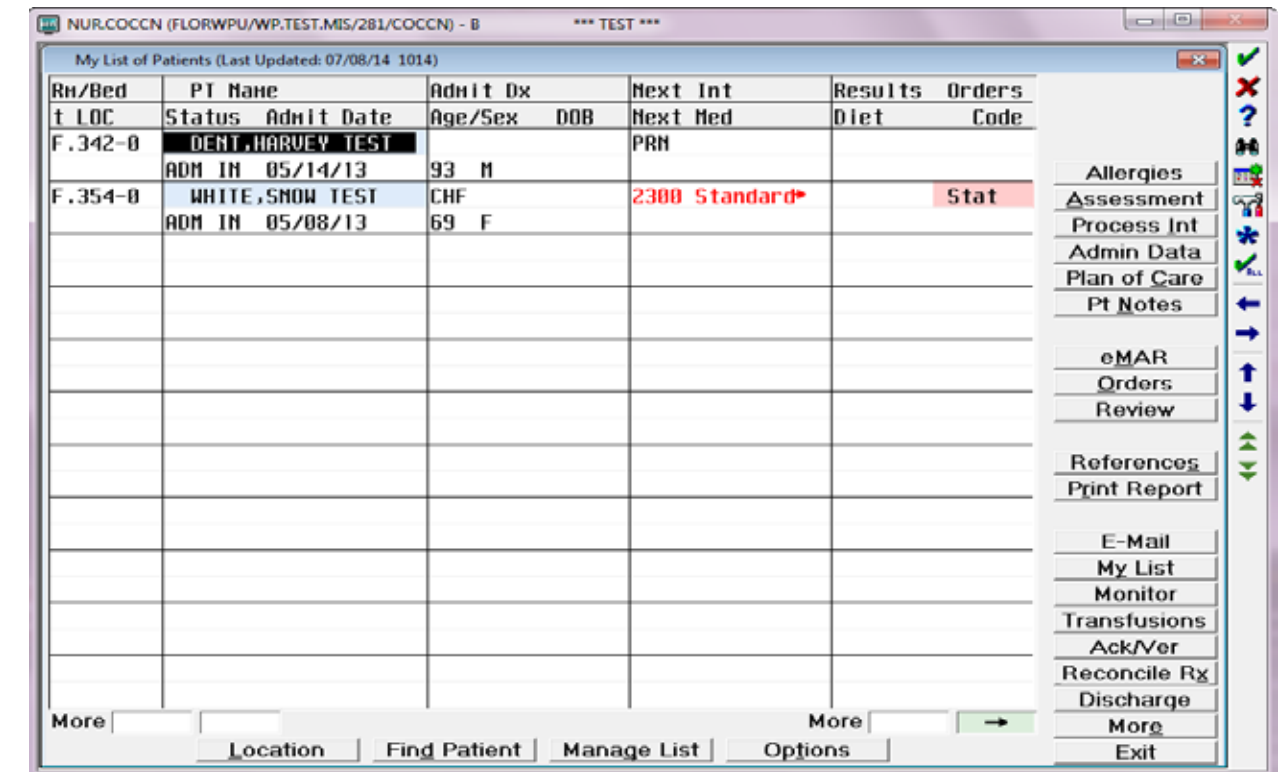
2. Go to Patient and type in your patient's name. (in order to select your patient from the list, use **F9** to find your patients name.) ***Make sure you select the correct patient and correct admission date for your patient.



3. For additional patients, repeat step # 2.



4. After you have added your patients to the list and they are highlighted in Blue, you will **Assign** them to your list and then **File**.
5. This is what your Status Board will look like with your managed patients.



Status Board

Rm/Bed	PT Name	Admit Dx	Next Int	Results	Orders
t LOC	Status Admit Date	Age/Sex DOB	Next Med	Diet	Code
F.215-0	MEDITECH566, TRAIN		PRN	Lab	
F.CCL	ADM IN 09/05/13	48 M 01/23/66	1100 DIGOXIN	CARBOHYDR	
F.216-0	MEDITECH566, TRAIN			F.PDOC	Stat
F.2W	ADM IN 09/05/13	48 M 01/24/66			
F.217-0	MEDITECH566, TRAIN		PRN	F.PDOC	Stat
	ADM IN 09/05/13	48 M 01/24/66	1100 DIGOXIN		
F.314-0	STACKHOUSE, SOOKIE		PRN		Stat
	ADM IN 05/14/13	81 F	1100 DIGOXIN	CARBOHYDR	
F.315-0	GORDON, LIEUTENANT		0900 Standard		Stat
	ADM IN 05/14/13	56 M	1100 PROMETHA	CARBOHYDR	
F.317-0	CREME, NIVEA TEST	PNEUMONIA	PRN		Stat
	ADM IN 06/24/13	60 F 06/01/54	1100 DIGOXIN	REGULAR D	
F.328-0	FOX, LUCIUS TEST		PRN		Stat
	ADM IN 05/14/13	69 M	1100 DIGOXIN	REGULAR D	
F.329-0	JOKER, SMILING TEST		PRN		Ack
F.2W	ADM IN 05/14/13	78 M	1100 DIGOXIN	HEART HEA	
F.330-0	WAYNE, BRUCE TEST		PRN		Stat
	ADM IN 05/14/13	45 M	1100 PROMETHA		
F.337-0	ROBINS, DEMELZA TE		PRN		Unc
	ADM IN 05/14/13	71 M		LOW FAT/L	
F.339-0	EVIL, URSULA TEST		PRN		Ack
	ADM IN 02/20/13	26 F		1800 CHO	

Note the 3 columns above, can provide current information regarding your patients.

Column #1: This shows you when your medications are due next; all meds in **RED** are late.

Column #2: Lets you know when you have new results to view, or a Doctor has posted a new entry. If a RES (result), or Lab is in a pink or yellow box, it indicates that the values are not within normal range.

Pink is a critical result, either too high or too low. The color **green** is a normal result, entry or order.

Yellow indicates that the level is nearing a critical value. Could you please add: Under results, you can view the patient's diet order.

Column #3: This is where you can see any order the Doctor has put in on your patient. Again note the colors, **Pink** is a Stat order, **Green** can either be Ack, New or Unc. (uncollected specimen). Only the nurse caring for the patient can Acknowledge an order for everyone else it will show up as a new order.

*****You must constantly look at your orders so that you will be able to see if you have any new**

Rm/Bed	PT Name	Admit Dx	Next Int	Results	Orders
t LOC	Status Admit Date	Age/Sex DOB	Next Med	Diet	Code
F.200-1	MEDITECH566, TRAIN1		2256 LCTRACKE		
F.200-2	MEDITECH566, TRAIN2	CHF	2300 Standard		
	ADM IN 09/04/13	48 F 01/02/66		CARBOHYDR	
F.317-0	CREME, NIVEA TEST	PNEUMONIA	PRN		Stat
	ADM IN 06/24/13	60 F 06/01/54	1100 DIGOXIN	REGULAR D	
F.339-0	EVIL, URSULA TEST		PRN		New
	ADM IN 02/20/13	26 F	1100 DIGOXIN	1800 CHO	
F.342-0	DENT, HARVEY TEST		2300 Standard		Ack
	ADM IN 05/14/13	93 M	1100 DIGOXIN		

There are 3 types of orders **STAT**, need to be done immediately, **NEW**, allows everyone to see what new orders the Doctor has written, **ACK**, only the nurse caring for the patient can acknowledge orders, however, for everyone else they will show as NEW. Also note the **yellow** background for the name above, this indicates that there are 2 people with the same last name on the floor, the **black** background indicates the patient you are working with, **blue** is a normal background for the patient's name.

E-MAR (Electronic Medication Administration Record)

61/F 04/11/53 162.56 cm 62. F.3E F.364-0 ADM IN
 Full Code CrCl 65.05 ml/min Cr 0.8 mg/dL
 Allergy Patient Allergies Not Entered AdvReac propoxyphene

Start	Stop	Status	Medication	Sched Time	Today		
					Tue	Wed	Thu
08/26/14 1000	11/24/14 1001	Active	Metoprolol XL 25 mg PO DAILY Metoprolol... (Give 1 TAB.SR.24H of ...)	1000	1031	1000	1000
08/26/14 1000	11/24/14 1001	Active	Oxybutynin 5 mg PO BID Oxybutynin 5 MG... (Give 1 TAB of 5 mg)	1000 2200	1031 2241	1000 2200	1000 2200
08/26/14 1300	11/24/14 1301	Active	Pantoprazole Sodium 40 mg IV BID Pantoprazo... (Give 1 vial of 40 mg...)	1000 2200	1245 2240	1000 2200	1000 2200
08/26/14 0600	11/24/14 0601	Active	Nitroglycerin Oi... 1 inch TOPICAL Q6HR Nitroglycer... (Give 1 UOPKT of 1 inch)	0600 0600 1200 1800	0622 1248 1749 2242	0517 1200 1800	0600 0600 1200 1800

E-MAR (Electronic Medication Administration Record)

Session Summary
 CREME, NIUEA TEST F00000006948/F0000000665 F.3W F.317-0 ADM IN
 60/F 06/01/54 157.48 cm 56.68 kg 1.57 m2 CrCl NO RESULT AVAILABLE
 Allergy aspirin, Sulfadiazine AdvReac

Friday August 22, 2014 1144

Orders	Scheduled Date-Time	Administered Date-Time	Given	Dose/Volume
<input checked="" type="checkbox"/> Digoxin 0.25 mg PO 1100	08/22 1100	08/22 1143	Yes	0.25 MG

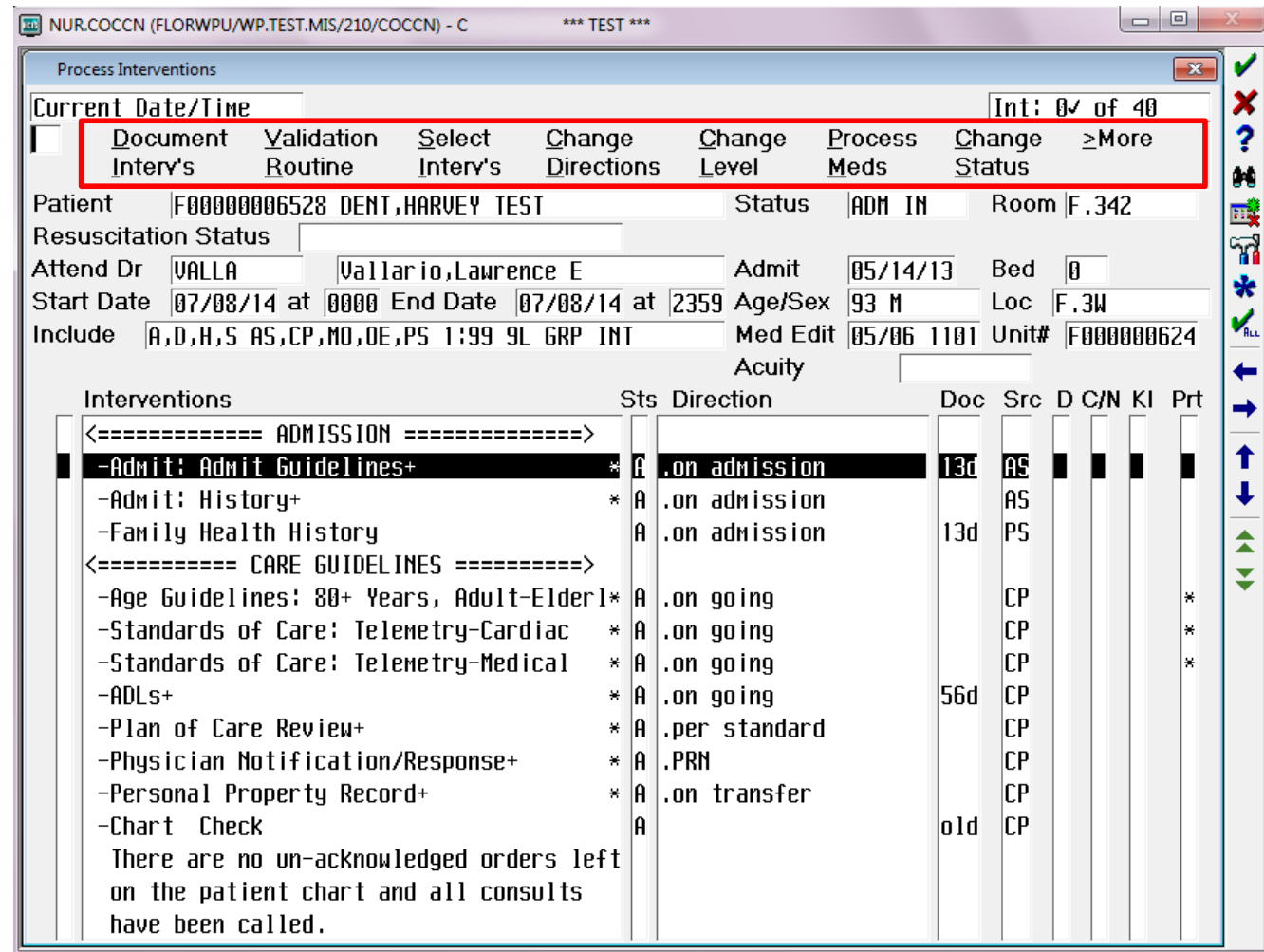
Return to eMAR | Save and Exit | Save and Recompile | Manual Barcode

- The **green** column as seen above indicates when the medication is scheduled to be given. Note that these times are determined by the pharmacy and cannot be changed. You have 1 hour before and 1 hour after the scheduled time to administer your medications before you are late. (# 7)
- The administration of medication allows you to view 3 days at a time. Notice the darker colored **blue** indicates today's date. (# 8)
- Medications that have been given are light **gray** in color, meds that have not been given have a **gray box** with white writing, medication's that are due have a **green box** with black numbers, medications that are late are **pink** with black writing. (# 9)

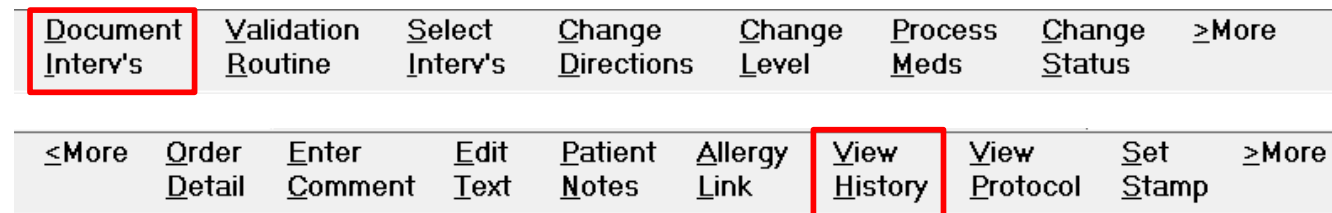
- After clicking on submit it will bring you to this screen, it lets you once again confirm the medications to be given to patient. You have 2 options, either save and exit (brings you back to status board), or save and recompile (brings you back to medication screen). *Note, if you need a co-signer for a medication you will have to have them sign before you are able to submit.

PROCESS INTERVENTION

Is where you will complete all your documentation for patient care.



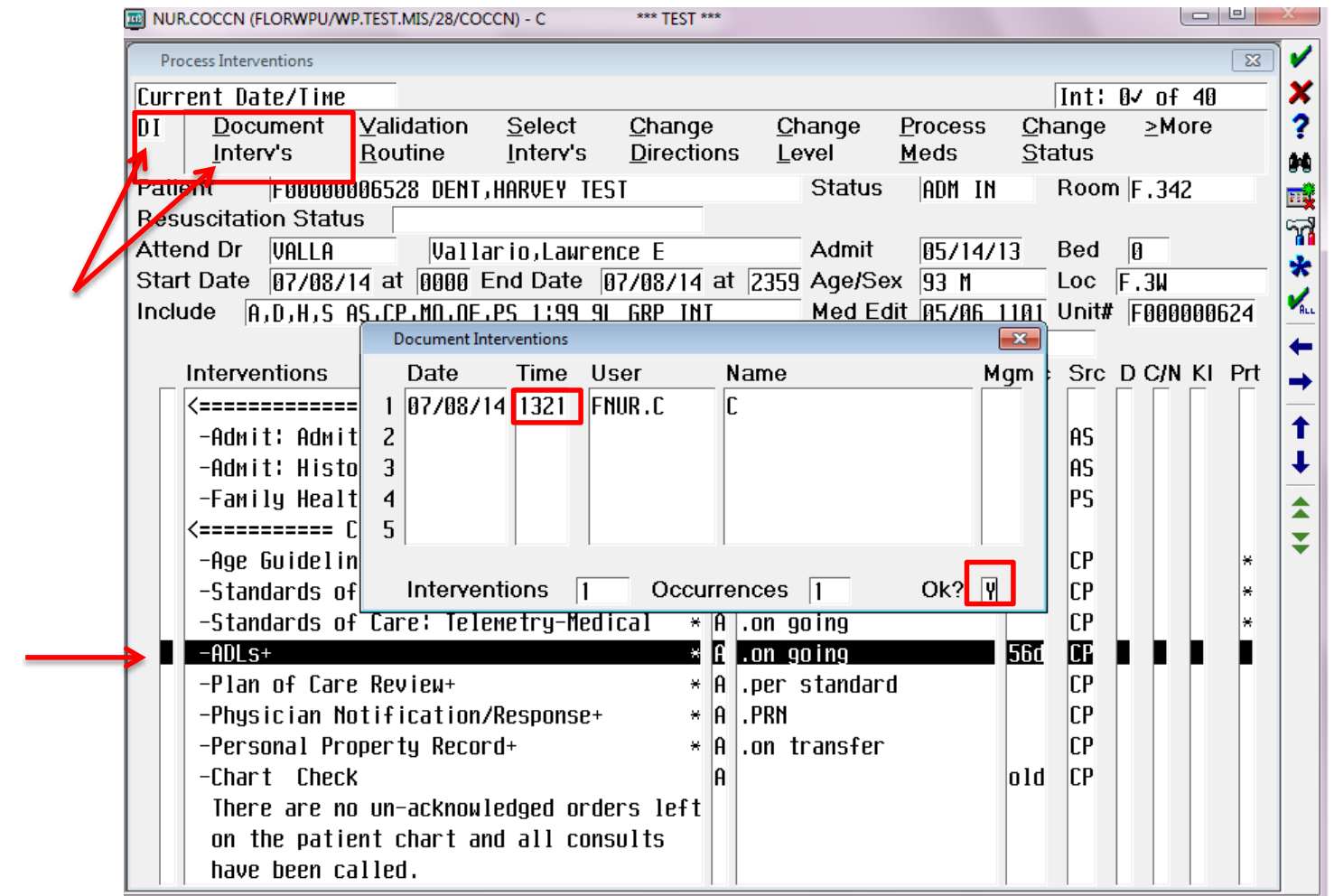
The verb strip (located in the red box above), is used for all of your charting. The most commonly used is Document Interv's and View History. (Indicated below in red box).



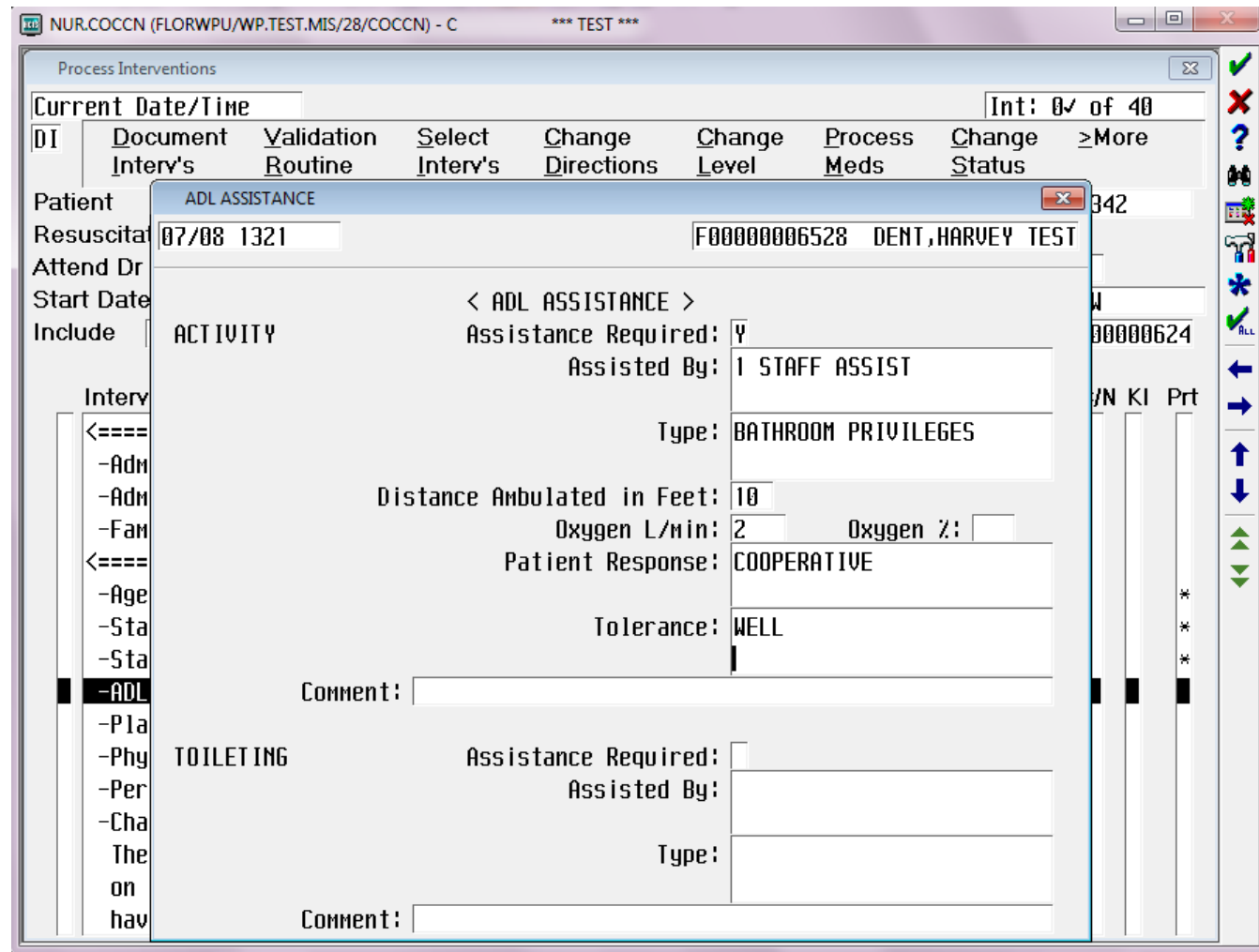
***Notice how certain letters are underlined, for example the D and I are underlined in Document Interv's., thus when you go into your documentation you would type in DI.

Listed below are areas that you will need to chart on:

1. **ADLs:** After you highlight the ADLs in black, you type DI (where the cursor is blinking) and you are ready to start your charting, notice how the cursor is blinking where the time is, this allows you to adjust the time to when you actually gave the care.



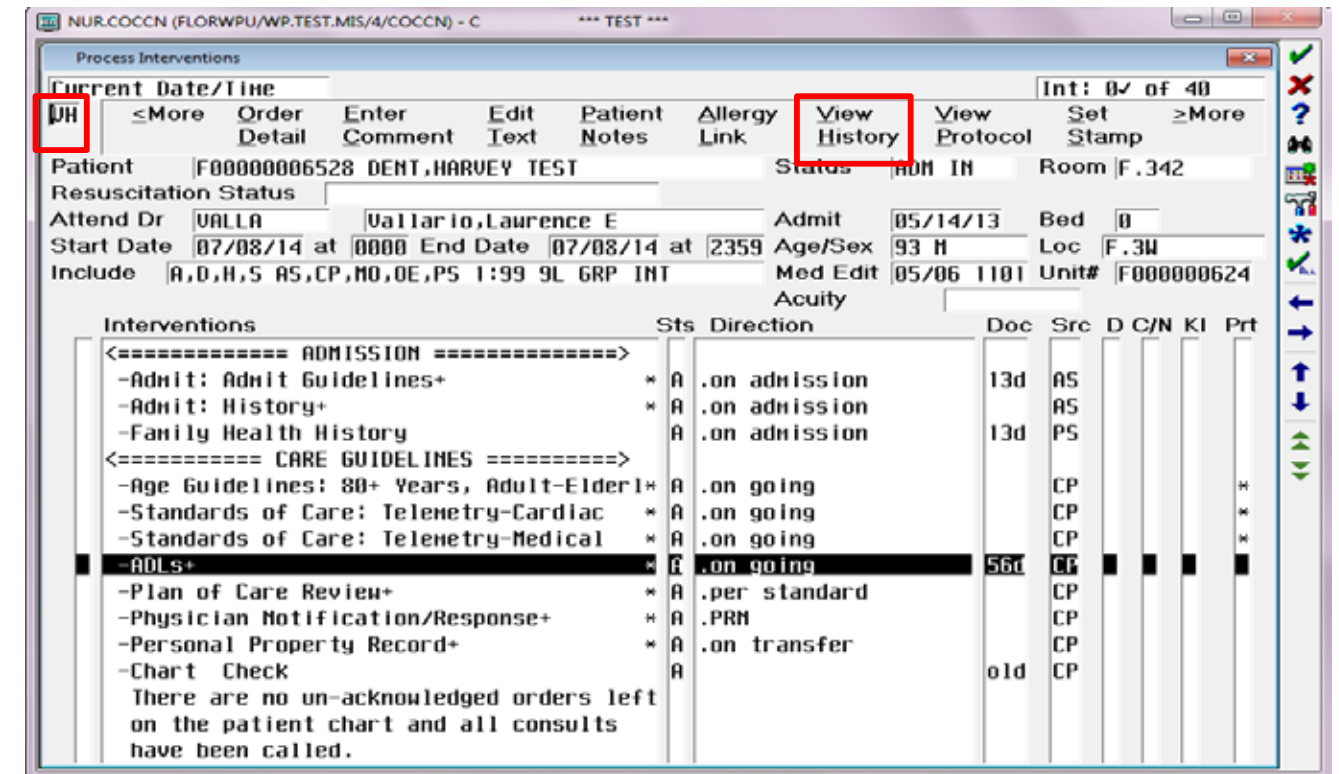
Complete your charting by using the **F9** (look up key) to fill in the blanks. Once you have completed the entire ADLs, press **F12** to file/save the information.



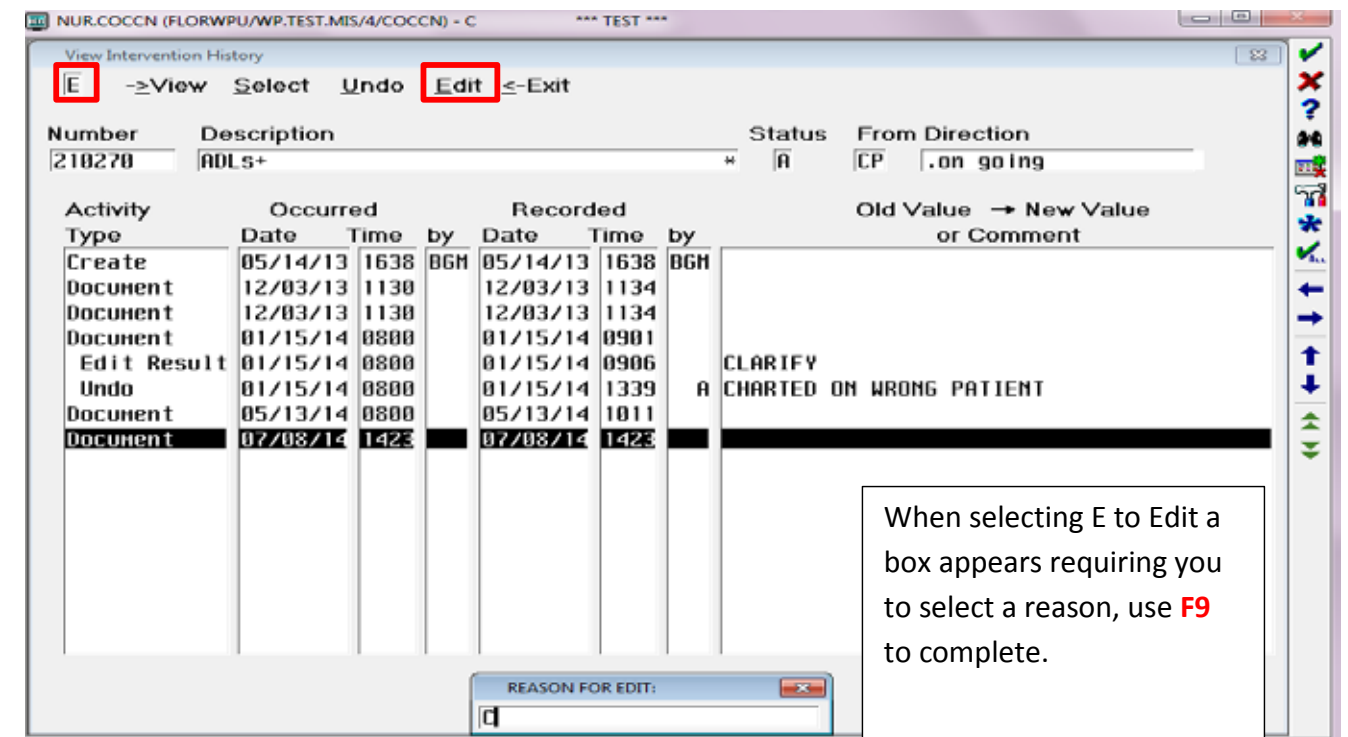
2. Height
3. Weight
4. Vital signs
5. Intake and Output
6. Shift Evaluation (depending on rotation).

VIEW HISTORY

If you have made an error, or wish to add anything to your charting, you have 24 hours to **Change, Edit** or **Undo** any of your charting.



Type VH (for View History), then select the intervention you need. EX: View, Undo or Edit.



When selecting E to Edit a box appears requiring you to select a reason, use **F9** to complete.

Clinical Review





This allows you to view all of your patient's orders, documentations, or results.

Rn/Bed	Pt Name	Admit Dx	New Order	Results	Orders		
t LOC	Status	Admit Date	Age/Sex	DOB	Next Med	Diet	Code
F.109-0	CPOE,GRULLON	PNEUMONIA	Unc				Unc
F.291-1	CPOE,AGARD	CP	Ack	F.PDOC	Ack	NOTHING	
F.291-2	CPOE,PATIENTCF	COPD	Ack		Ack	NOTHING	*FULL

Buttons along the right side of the screen allow various functions.

Clinical Review & ICONS

Icons

-  is for on line Help (Hold Shift Key and press F8)
-  A patient's orders can now be printed for "Current", "All", or "Session"...
-  MOX mail
-  Allows the user to access the intranet or internet.

If under Clinical Review--the Constant Navigation Button Review (At bottom of screen) changes to PCI (patient Care information)

View a patient's record examining details such as:

- Orders
- Lab Data
- Current Medications
- Dictated Reports
- Nursing Graphic Data i.e. Height, Weight, I & O's Assessments

Color Coding

- Black** Black type indicates information present
- Blue** Blue type indicates new information not seen by user (once viewed color changes from blue to black)
- Gray** Grayed-Out-or "Low lit" buttons indicates No information, or routine is not accessible. The color Gray under headings means-Information can be obtained if that query is selected.
- Green** Green type means headings or demographic information (not changeable)
- Yellow** Results highlighted in Yellow are out-of-range (High or Low)
- Pink** Results highlighted in Pink are critical values

Allergies/ADRs: sertraline HCl (From ZOLOFT), duloxetine HCl (From Cymbalta), ... (More)

Selected Visit Lifetime Summary

*Hematology	*Coagulation	*Urines	Other Body Source	Miscellaneous
*Blood Gas	*Chemistry	Toxicology	Immunology	*Serology

Previous Page Next Page

	Mar 03, 14 14:10	Mar 02, 14 07:55	Feb 27, 14 22:00
Puncture Site	R Radial	R Radial	R Radial
HCO3	27.3 H	28.8 H	23.7
POC ABG pH	7.459 H	7.444	7.347 C
POC ABG pCO2	38.5	41.9	43.3
POC ABG pO2	80	67 L	90
ABG Total CO2	28 H	30 H	25
ABG O2 Saturation	96	94	96
ABG Base Excess	3.0 H	5.0 H	-2.0 L
Allen Test	Pass	Pass	Pass
Respiration Rate	18	18	12

? 🏠 📄 📊 📈

PCI Order Document Discharge Sign Return

Pt Summary
 Problem List
 Special Panel
 Daily Review
 Order History
 Vital Signs
 I + O
 LAB
 Microbiology
 Blood Bank
 Pathology
 Medications
 Imaging
 Other Reports
 Notes History
 Assessments
 Other Menu
 Reconcile Meds
 More | Less
 Other Visits

Function Buttons

Buttons along the right side of the screen (Function Buttons) allow various functions.

Patient Summary

Patient's problems View Only (ADM/Demographics can also be viewed by clicking on the header) (Example, update/change Allergies)- (ambulatory meds mean Home Meds) My Personal Note is a reminder you can type for yourself...it can be viewed under Patient Summary

Special Panel

Are for specialty areas and the view/results will show information specific to that specialty. Example, Diabetic Patient or Cardiac patient

Daily Review

It is an option to view the patient data for the last 24 hours. It is a combined display of current recent data (Will also show the previous five days)

Order History

Review of the orders (Orders also gives you a review of Orders)

Vital Signs, I & O, Lab, Microbiology, Blood Bank, Pathology

View or Graph results from specific category of selected visit or Lifetime Summary (click on the Gray)

Medications

View of medications can be sorted by Generic or Trade name. To view medication detail click on the medication (Gray) Example, last dose administered/ history

Imaging

Click on the gray to get into imaging reports (X-Ray reports, Procedure reports)

Other Reports

Not imaging Example Progress Notes

Notes History

Progress and Nurses notes can be sorted by selecting Notes or Assessment (Assessments documentation of nursing module)

Assessments

This will list clinical assessments completed in nursing and ER modules. Data is presented in chronologic order based on the filed date/time. (Sorting can be done by clicking on the header)

Other Menu

For physicians to reconcile medications and build special panels

Other Visits

Other visits can be selected by checking the specific visit and clicking on selected under View.

Return

Will return you to the previous screen



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