Nurses Notes (NH)

Nurse Main Access Screen

Nursing Main Access			
Main Menu	NH Nurse	DON / ADON	Restorative Nurse
	AL Nurse	Wound Nurse	CNA
	ICF Nurse	Infection Control	RA / Care Assistant

Part 1: Nurse Access

Clicking the NH Nurse button opens the NH Nurse Access screen.

Nurse	Daily Tasks	Charting	Chart Review	Other
Nurse Main Menu	Shift Report	Nurses Note	View Chart	Physician Orders
	To Do List	Admission Assessment	Reports	Care Plans
	BM List	Assessments	CNA Review	Edit CNA Assignments
	eMAR / eTAR	SBAR	Document Management	Edit Nursing To Do List
	Lab Calendar			Schedules
	RN Cosign			Write Internal Memo

Daily Tasks Buttons

Shift Report

Click the Shift Report button to open all shift report options available. Select name(s), click OK, click onto a specific task, and click Load to view the shift report. The shift reports are setup to populate the following data for the time frame specified by the task:

- New/discontinued physician orders
- Stop and Watch items reported by the CNA/Care Assistant
- Entries detailing medications that were held, refused, or signed out
- PRN medications administered
- Medication errors
- Nurses notes
- Fall notes
- Incident notes
- Neuro check notes

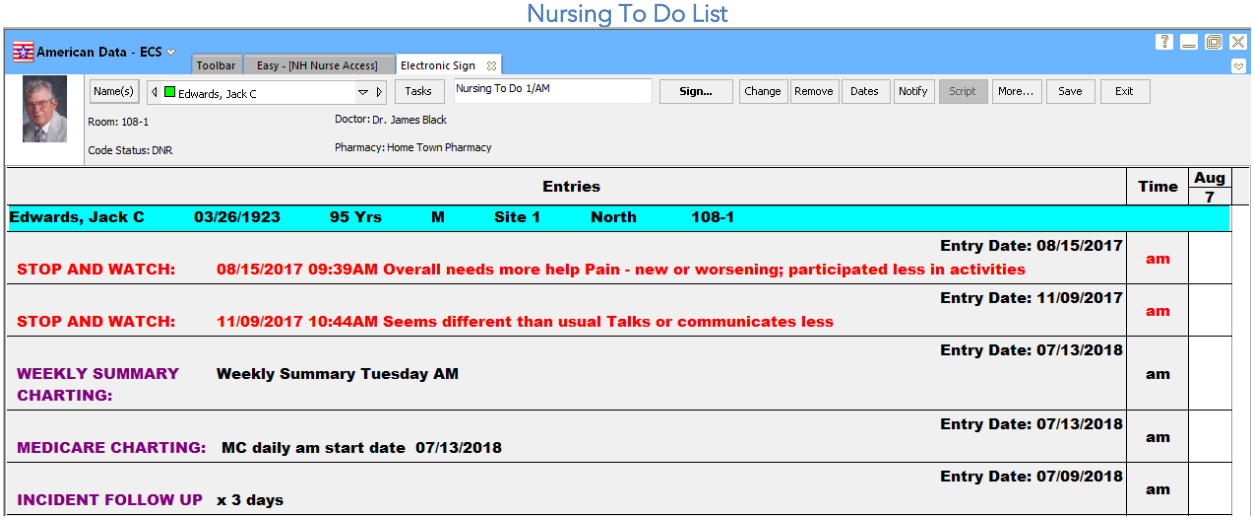
To Do List

Click the To Do List button to open additional choices for each shift or an option for all shifts. Select name(s), click OK, click onto a specific task, and click Load to view the To Do List.

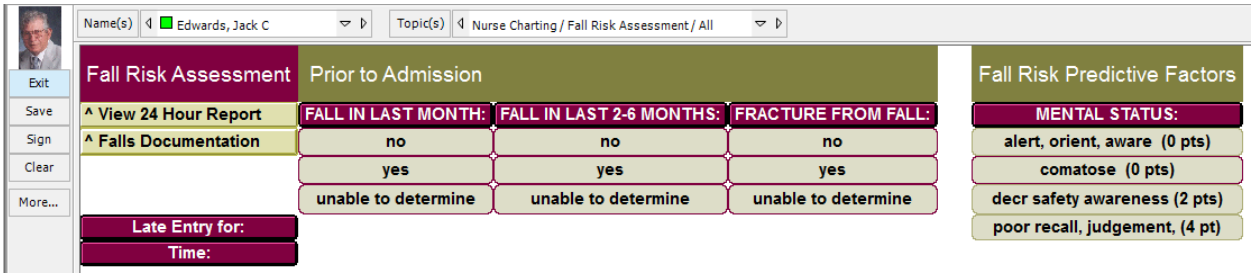
View / Sign To Do List

To document on a task item, click in the cell on the right under today's date. A Write screen will load allowing the user to document the assessment/note/etc.

Nursing To Do List



Write screen



Document a note by working from left to right and clicking on question words and canned phrases. Add additional free type where prompted or necessary. When finished documenting on this screen, click Sign. This will save the entry and load the next Write screen or take the user back to the To Do List.

When finished charting on the To Do List, click **Save** to save initials and **Exit** to return to the Nurse Access screen. When the To Do List closes, an Exception Report will display showing items on the To Do List that were left blank. The user may choose **Return** to open the To Do List again or **Exit** to go back to the Nurse Access screen.

BM List

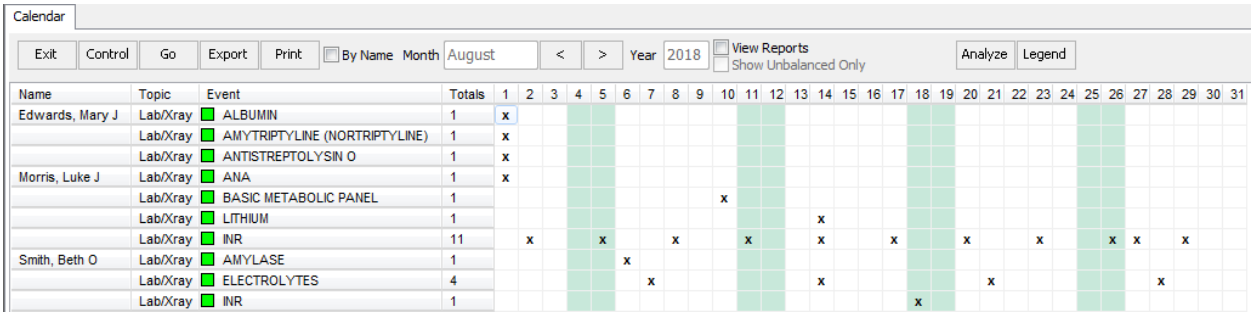
The **BM List** button will take the user to a view screen which displays a list of residents for whom nurse aides have charted a small BM or no BM for the past 3 days. Nurses will typically use this list to determine which residents may need PRN laxatives. The list can be reviewed or printed if desired using the **Print** button underneath **More…** at the top of the screen. Click the **Exit** button to return to the prior Nurse Access screen.

eMAR/eTAR

Please reference the *Electronic Sign* handout.

Lab Calendar

The **Lab Calendar** button displays a report showing residents who have labs scheduled for the current month. Select a different date range by clicking onto **Control**. The report may be printed by clicking on the **Print** button at the top of the screen. Click the **Exit** button at the top of the screen to return to the Nurse Access screen.



RN Cosign

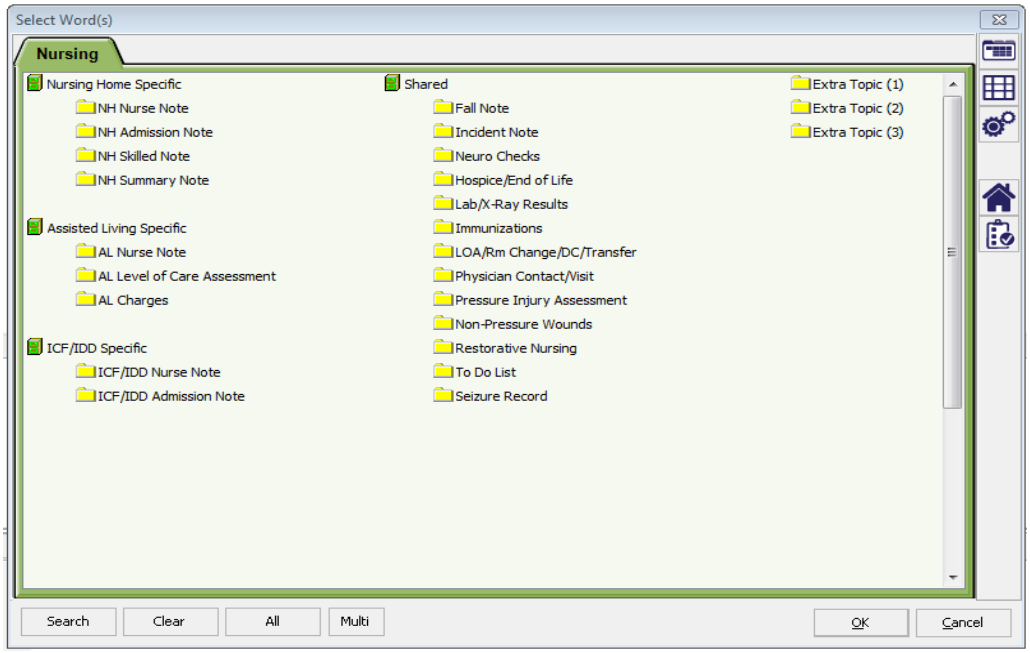
The **RN Cosign** button will open an Electronic Cosign screen displaying all the physician orders on the selected residents which require a nurse's co signature. This functionality is used

if the facility requires an RN to sign off on Physician Orders that are transcribed by LPNs/HUCs/Care Assistants/Med Assistants/etc.
Click in the box under the date to enter the user's initials and cosign the entry. Orders may be reviewed and cosigned all at once using the **Sign All** button at the top of the screen. When finished, click the **Exit** button to return to the prior Access screen.

Charting Buttons

Nurses Note

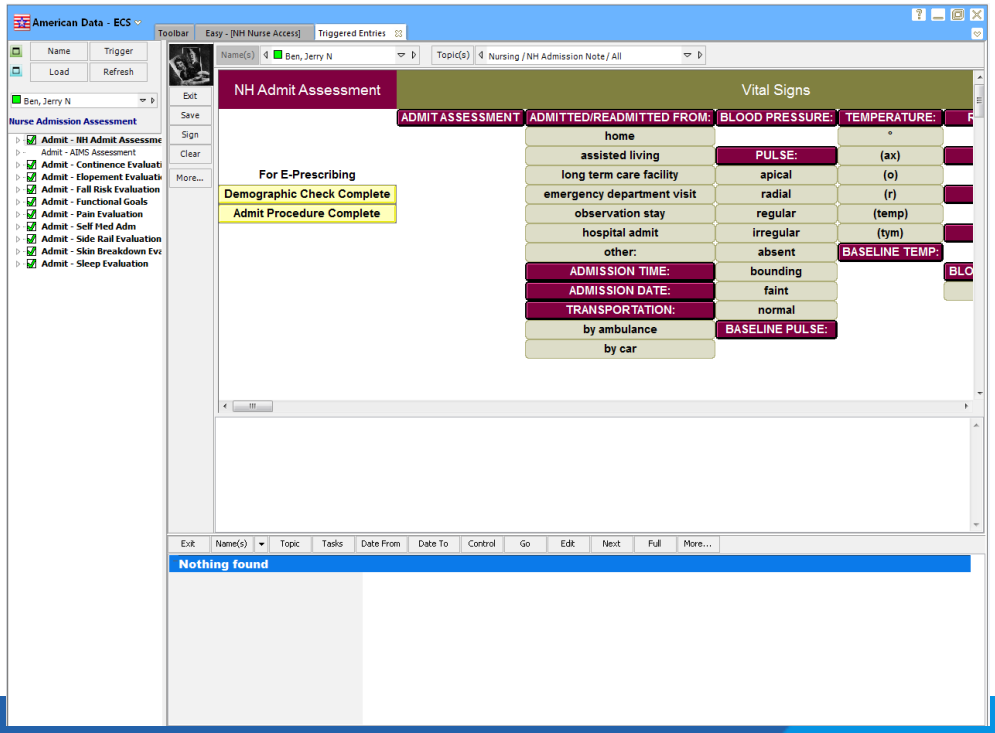
Click onto the **Nurses Note** button to access all the different nurse note topics available. Select name(s) needing to document on. Examples of topics available include a Nurses Note, Progress Note, Fall Note, Immunizations, Physician/Consult Contact, etc. Select the appropriate topic based on the charting needs. Select more than one topic at a time by holding down the **Ctrl** key on keyboard or by clicking the **Multi** button prior to selecting topics. Click **OK** once the appropriate topic(s) are selected.



Admission Assessment

The **Admission Assessment** button loads a trigger Write screen that displays specific documentation requirements based on tasks that have already been completed, potentially by a prior user.

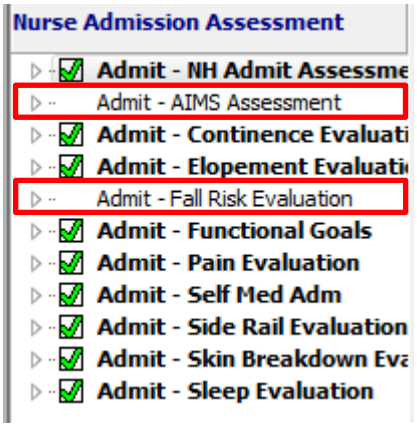
Click the Admission Assessment button and select the desired name. A 3-way split screen will



appear. The top right half of the screen is a Write screen, the bottom right half is a view screen, and the left half of the screen is a trigger list. The view screen will display previous charting or relevant information.

Icons in the Trigger Screens	
(Green)	Maximizes the View screen.
(Blue)	Maximizes the Write screen.
Name	Opens the Name Selection screen.
Load	Brings up the information into the Write/View screen allowing the user to work the trigger.
Trigger	Reloads the trigger list or allows the user to select a different set of triggers.
Refresh	Refreshes the screen.

1. Once this screen is initially loaded, the first incomplete topic will display in the write screen.
2. Document the notes by working from left to right and selecting the appropriate words on the screen and adding in free type where needed.
3. When finished documenting on that triggered area, click the next trigger that has a green checkmark. The checkmark next to the trigger previously worked will now turn Red, indicating that it has been completed. To load the new trigger, click the Load icon above the trigger list. This will save all charting in the prior topic and load the new topic.
4. Click the Exit button to return to the Nurse Access screen.



If a second user would enter the Admission Assessment, they would then see items without a green checkmark if they have already been completed. As seen below, the user would be presented with all assessments that are not yet completed (signified with a green checkmark) and those which have already been completed will have nothing listed to the left. The user will be unable to load a topic which has already been completed via a trigger screen.

Assessments

Click onto the Assessments button to access all the different assessment topics available. Select name(s) needing to document on. Examples of topics available include AIMS, Bladder & Bowel Continence, Fall Risk, McGeer, Oral Health, Pain, Sleep, etc. Select the appropriate topic based on the charting needs. Select more than one topic at a time by holding down the Ctrl key on keyboard or by clicking the Multi button prior to selecting topics. Click OK once the appropriate topic(s) are selected.

SBAR

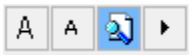
Click onto the **SBAR** button to complete the SBAR Communication Form. Select name(s) needing to document on. Work through the topic from left to right and click on words within the screen as well as include free type where needed. Once completed, preview the SBAR form to Print/Fax it to the necessary person. Or click **Sign** to save the documentation and exit back to the nurse access screen.

Chart Review Buttons

View Chart

The View Chart button allows the user to review selected information. Select the desired name(s) and click **OK**. Once inside the View Screen, click either **Topic** or **Task**, and select the desired Section/Topic or load the desired Task. Then click **Go**. To narrow the dates for review, click onto **Date From** and/or **Date To** and click **Go**. The View screen may be printed by clicking on the **Print** button located under the **More…** option. Click **Exit** to return to the Nurse Access screen.

- Adjust the font size by clicking **More…** and clicking on the big or little "A."
- Search for words within the view screen by clicking **More…** and onto the magnifying glass symbol. Type in the text to be searched and click OK. This feature will search both words that were clicked on within a topic as well as free text.
    - Click the arrow to the right of the search feature to have it bring you to the next found word.



Topic

Clicking onto **Topic** allows the user to navigate through the Sections and Topics that they have access to. Users may even select a specific word within a topic to narrow their search down further. For example, if a user wants to view any "Observed Falls," they would click Topic > Nursing > Double click into Fall Note > click onto the "observed fall" word and click **OK** and then **Go**.

Task

Clicking onto **Task** allows the user to load a pre-determined task item. Once a task is highlighted, click **Load**, and **Go**. Examples of Tasks include: Blood Pressures, Diagnoses, Fall Lis Past 31 Days, Infections – Unresolved, Medication Review (Psychotropics), Pain Review, and Vital Signs.

Control Button

The Control button within the View screen gives the user more options as to how they would like to view the information. Some more popular options within here are listed below:

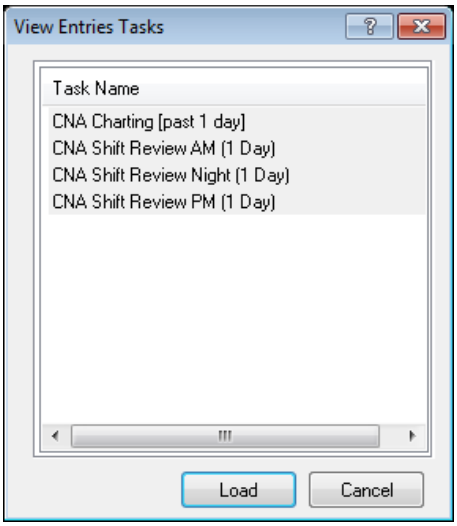
- Filter Tab
    - *D/C'd Entries* – Displays all discontinued entries.
    - *Users* – Use this to narrow down the charting being viewed based on the user(s) who entered it in. This is a great tool for auditing specific user(s) charting.

- *Free Text* – Allows the user to search within the charting on the view screen for a specific free typed word. If wanting to search through all the fall notes for a specific caregiver's name, simply enter the name in the Free Text box, click OK and Go.

- Look Tab
  - *Separator* – For ease of viewing, the user may choose to add lines/spaces between entries or topics.
  - *Order* – Allows the user to determine the order in which the entries display on the screen.
  - *Show Name of Initials* – Displays the full name and title of the person who entered/discontinued each entry.
  - *Free Text Highlighter* – Used frequently in troubleshooting as it will turn all free text on the view screen blue.
  - *Show Topic Name* – Displays the topic that the entry was documented in.

Reports

Clicking the **Reports** button will display a list of all the reports available to the user. First select name(s) and then highlight the desired Report(s), select Start/End dates if desired, and click **OK**. The report may be printed using the printer icon at the top of the screen. Click the **Exit** button at the top of the screen to return to the Nurse Access screen.



CNA Review

The **CNA Review** button loads a selection window showing the CNA view tasks. Select the desired name(s) and **OK**, and then the desired task(s) and click **Load**. This will display all charting completed on that shift or in the past one day. Click the **Exit** button at the top of the screen to return to the Nurse Access screen.

Document Management

This button will load the **Document Management** access screen where documents may be uploaded and/or viewed. Utilize a button within the **Add New** columns to add in a new document, such as a signed fall/incident report, H & P, or admission paperwork. To view scanned and electronically signed documents, click onto the **View Documents** button in the **View** column.

Other Buttons

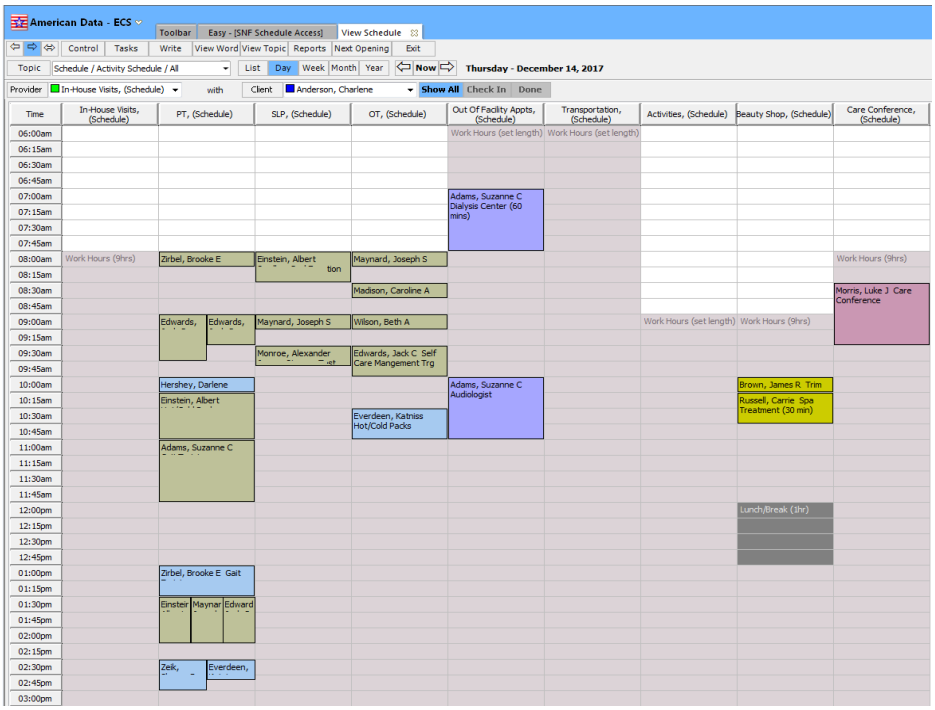
Other buttons in the Nurse Access Screen will allow the user to view, document, and edit in other areas of the chart. For specific information regarding using the buttons titled Physician Orders, Care Plans, and Edit CNA Assignments, please refer to handouts specifically regarding these areas.

Edit Nursing To Do List

1. To initiate or edit the Nursing To Do List, click the **Edit To Do List** button, select name(s), and click OK.
2. A Write screen will appear. Entries appearing at the bottom of the screen show what is already in the To Do List for this resident.
3. Working from left to right, select items to add to the nursing to do list. Select a start date, and an end date if desired. To edit the items in the To Do list, refer to Editing Nurses Notes below.

Schedules

The **Schedules** button will display all scheduler tasks available to the user. Click into any of the View options to see that specific schedule or select any of the Schedule options to add in a new appointment. Scroll down and scroll over to view the entire day. Double-click the box with the appointment to view details of that appointment. Change the dates viewed by clicking on the **Day/Week/Month/Year** buttons at the top of the screen, or by clicking the forward and back arrows by the **Now** button. Click the **Exit** button at the top of the screen to return to the Nurse Access screen.



Write Internal Memo

1. Click on the **Write Internal Memo** button.
2. Once in the Internal Memo topic, the user will be presented with a pop up that states, "This task has clients associated with it. Do you want to override your currently selected clients?" Always click **Yes**. (Messages written in this topic most likely will not have anything that belongs in their medical record, which is why a fake client is created to attach to this Internal Memo task so that all the messages written are on the fake client's record.)

3. Document the message to be sent.
4. Make sure to select to whom the message will be sent. The user can choose a user group(s), or click **pick user on Save** for a user list to pop up once the entry is saved; the user can then select the individual(s) to whom the message will be sent.

Part 2: Editing and Printing Nurse Charting

Edit Nurse Charting

1. Follow steps above for viewing information.
2. Click the entry that needs to be edited. The entry will turn red. This is called 'tagging' the entry.
3. Click the **Edit** button.
4. Click the desired editing feature. Refer to the table below for editing features.
5. When using Append, DC and Explain or DC and Copy, make the desired change and then click the **Next** button.
6. Click **Go** to see the changes.

Editing Feature	Function	Example
Append / Append All	Information is permanently attached to the entry; further editing will not be able to be done to the entry except to discontinue	Cosigning a student's documentation
New	A new, separate entry made in the same topic area	Not typically used when editing department notes. Can be used to see where an entry was charted
Copy	An exact copy of the entry is made	An entry was accidentally discontinued and needs to be made active again
Copy One (All) to Other Resident[s]	An exact copy of the entry is made and placed in another resident's chart	An entry was accidentally made in the wrong resident's chart. Use ALL if more than one entry was selected
Discontinue and Append	Entry is discontinued and user is taken to a Write screen to document additional notes	An error was made in documenting the entry and the user would like to explain why the entry is being discontinued
Discontinue and New	Entry is discontinued, a new entry is made in its place	Not typically used when editing department notes
Discontinue and Copy	Entry is discontinued, copy of entry is displayed allowing user to make changes to the original entry	User forgot to use a button word when documenting and would like to 'insert' the word into the entry
Discontinue	Entry is discontinued	Not typically used when editing department notes
Discontinue All	All highlighted entries are discontinued for one resident	Not typically used when editing department notes

Discontinue Multiple Resident Entries	All highlighted entries are discontinued for multiple residents	Not typically used when editing department notes
Skip	Allows user to skip a highlighted entry	Highlighted an entry that does not need editing

Part 3: Examples

Chart a Fall Note

1. Click onto the **Nurse Note** button underneath the Charting column.
2. Select the name and click **OK**.
3. Select the **Fall Note** topic underneath the Shared Category. Click **OK**.
4. Work from left to right within the charting screen selecting all appropriate options. Be sure to select an item from each of the columns.
5. At the end of the note, click **Chart Fall Investigation (QA)** to chart information not needed in the initial fall report. Or click **Preview Fall Report** to view the full report. Clicking either of these options will save the fall note and bring you to the selected option. If not needing to complete either of these options at this time, click **Sign** which will save the entry and return you back to the Nurse Access screen.

*Charting a fall note will automatically add Incident Follow Up onto the Nursing To Do List for all shifts for the next three days.

*Charting that the resident hit their head or marking that question as unknown will automatically add Neuro Checks onto the Nursing To Do List.

Chart a Medicare/Skilled Note

1. Click onto the **Nurse Note** button underneath the Charting column.
2. Select the name and click **OK**.
3. Select the **NH Skilled Note** topic underneath the Nursing Home Specific Category. Click **OK**.
4. Work from left to right within the charting screen selecting all appropriate options. Be sure to address the reasoning that the resident needs to receive skilled care from a nurse. Include justifications for the care being provided as well as include the reasoning behind care being received.
5. At the end of the note, click **Sign** to save the documentation and return to the Nurse Access screen.

View/Print a Diagnosis Report

1. Click onto the **Reports** button underneath the Chart Review column.
2. Select the name(s) and click **OK**.
3. Select the **Diagnosis List** report and click **OK**.

4. Print the report by clicking the printer icon or click **Exit** to exit the screen once completed.

View/Print a 60 Day Review Report for the MD

1. Click onto the **Reports** button underneath the Chart Review column.
2. Select the name(s) and click **OK**.
3. Select the **60 Day Chart Review for MD** report and click **OK**.
4. Print the report by clicking the printer icon or click **Exit** to exit the screen once completed.

View a resident's blood pressure entries

1. Click onto the **View Chart** button underneath the Chart Review column.
2. Select the name(s) and click **OK**.
3. Click onto **Tasks**, highlight **Blood Pressures**, and click **Load**. Click **Go.**
4. Click **Exit** once finished viewing the blood pressure entries and to return to the Nurse Access screen.