

# Status Board Icons

## Allergies

(Click icon with mouse)

To enter, edit, confirm or view allergies

LOCATION	NAME	NEXT MED	new results	Last Pain Med
ROOM	AGE DOB SEX	Call Patient	RESTRAIN DATE	ALLERGIES
NM.3RD	<del>BB ONE, TEST</del>			
NM.0302-1	99 01/01/10 F			*Ciprofloxac
NM.3RD	BB TWO, TEST	PRN		
NM.0302-2	89 02/02/20 M			*Ciprofloxac

Allergies  
Admin Data  
Assessment

Allergy Management

CARTIER, SUSAN - 39/F J. IE J.106/A Unit No: J00000057  
160.02 ch 58.967 kg ADM IN Acct No: J0000025999

Allergies for Interaction Checks (1)	Type	Severity	Date	Verified
Oxycodone (From Percocet)	Allergy	Severe	02/02/09	Yes

- Uncoded Allergies (3)

Allergy	Type	Severity	Date	Verified
BLACK-EYED PEAS HIVES	Allergy	Unknown	07/25/08	
CAPOTIN	Allergy	Unknown	02/02/09	
PIZZA	Allergy	Unknown	02/02/09	

View Details  
New  
Delete  
Edit  
Confirm  
Verify  
Audit Trail  
Select All  
Deselect All  
Undo All  
File  
Return

Once on the **Allergy Management** screen, click on the **New** button...

... and **type in the first 3 or 4 letters of the allergy**. Using type-ahead functionality, the selection list will narrow down and let you choose the allergy from the list.

Allergy/Adverse Drug Reaction Lookup - All

Allergy/Adverse Drug Reaction

Allergy/Adverse Drug Reaction	Other Name	Category
Latanoprost		Drug
Latex		Drug

More

Type  Allergy  Adverse Reaction

Severity  Mild  Severe  
 Intermediate  Unknown

Verified  Yes  No

Reaction

Comment

OK Cancel

Allergy/Adverse Drug Reaction      Other Name      Category  
 Latanoprost           Drug  
 Latex           Drug

More

Type  
 Allergy    Adverse Reaction

Severity  
 Mild       Severe  
 Intermediate       Unknown

Verified  
 Yes  
 No

Reaction  
 Redness, itching

***Pick*** patients allergy by clicking on it (will highlight)

***Determine:***

**Type:** (Allergy/Adverse Reaction)

**Severity:**

**Reaction:** free text

and click **OK** to **File**.

Remember the Severity Rules:  
**Severe** = Life threatening  
**Mild** = All others  
***DO NOT USE INTERMEDIATE***

The added Allergy will appear in **green** text. **Remember to FILE**

Allergies you document from the lookup will appear as "Coded" allergies, meaning they are eligible for allergy checking. ***Uncoded allergies are NOT checked against patients medications.***

CARTIER, SUSAN - 39/F      J.1E J.106/A      Unit No: J000000057  
 160.02 cm 58.967 kg      ADH III      Acct No: J0000025999

- Allergies for Interaction Checks (2)	Type	Severity	Date	Verified
Oxycodone (From Percocet)	Allergy	Severe	02/02/09	Yes
Latex (Latex) Redness, itching	Allergy	Mild	03/11/09	Yes
<b>- Uncoded Allergies (3)</b>				
BLACK-EYED PEAS	Allergy	Unknown	07/25/08	
HIVES	Allergy	Unknown	02/02/09	
CAPOTIN	Allergy	Unknown	02/02/09	
PIZZA	Allergy	Unknown	02/02/09	

### Allergy Management

RN, THIRTY - 83/F  
167.6 cm 75 kg

NM.3RD NM.0301/1  
ADM IN

Unit No:NM00000228  
Acct No:NM0000014112

- Allergy/ADR for Interaction Checks(0)	Type	Severity	Date	Ver	Cmt
- Uncoded Allergy/ADR(0)					

- View Details
- New
- Delete
- Edit
- Confirm
- Verify
  - NKA
  - Unobtn
- Audit Trail
- Select All
- Deselect All
- Undo All
- File
- Return

If the patient has No Known Allergies or the information is Unobtainable make the appropriate selection here.

ALL patients MUST have an allergy indicator of some kind, even if it is NKA.

If the information is Unobtainable, communicate this during handoff until a family member can provide it or the patient becomes responsive and can communicate their allergies. This MUST be updated once available.



# Editing an Allergy

Allergy Management

CARTIER, SUSAN - 39/F      J.1E J.106/A      Unit No: J000000057  
160.02 cm 58.967 kg      ADM IN      Acct No: J00000025999

- Allergies for Interaction Checks (2)	Type	Severity	Date	Verified
Oxycodone (From Percocet)	Allergy	Severe	02/02/09	Yes
<b>Latex (Latex) Redness, itching</b>	<b>Allergy</b>	<b>Mild</b>	<b>03/11/09</b>	<b>Yes</b>
- Uncoded Allergies (3)				
BLACK-EYED PEAS HIVES	Allergy	Unknown	07/25/08	
CAPOTIN	Allergy	Unknown	02/02/09	
PIZZA	Allergy	Unknown	02/02/09	

View Details  
New  
Delete  
Edit  
Confirm  
Verify  
Audit Trail  
Select All  
Deselect All  
Undo All  
File  
Return

Select an allergy by clicking on it (highlights in blue).

Click the Edit button.

Make necessary edits  
(Type, Severity Reaction or  
Comment)

Click OK and File

Allergy/Adverse Drug Reaction Lookup - All

Allergy/Adverse Drug Reaction    Uncoded    Drug    Non-Drug  
Latex    Multiple    All

Allergy/Adverse Drug Reaction    Other Name    Category

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Type    Severity    Verified  
 Allergy     Adverse Reaction     Mild     Severe     Yes  
 Intermediate     Unknown     No

Reaction  
Anaphylactic shock

Comment

OK    Cancel

# Deleting an Allergy

The screenshot shows the 'Allergy Management' window for patient CARTIER, SUSAN. The table lists allergies for interaction checks and uncoded allergies. The 'Iodine (Iodine)' allergy is selected. The 'Delete' button is highlighted, and a confirmation dialog box asks 'Delete 1 of 1 selected allergies?' with 'Yes' and 'No' options.

- Allergies for Interaction Checks (3)	Type	Severity	Date	Verified
Iodine (Iodine)	Allergy	Mild	03/11/09	Yes
Oxycodone (From Percocet)	Allergy	Severe	02/02/09	Yes
Latex (Latex) Anaphylactic shock	AduReac	Severe	03/11/09	Yes

- Uncoded Allergies (3)	Type	Severity	Date	Verified
BLACK-EYED PEAS HIVES	Allergy	Unknown	07/25/08	
CAPOTIN	Allergy	Unknown	02/02/09	
PIZZA	Allergy	Unknown	02/02/09	

Select an allergy by clicking on it (highlights in blue).

Click the **Delete** button and answer prompt to confirm deletion.

Allergy is then deleted and removed from the Allergy Management screen.

**Remember to File.**

The screenshot shows the 'Allergy Management' window after the Iodine allergy has been deleted. The table now shows two allergies for interaction checks and three uncoded allergies. The 'Delete' button is no longer visible.

- Allergies for Interaction Checks (2)	Type	Severity	Date	Verified
Oxycodone (From Percocet)	Allergy	Severe	02/02/09	Yes
Latex (Latex) Anaphylactic shock	AduReac	Severe	03/11/09	Yes

- Uncoded Allergies (3)	Type	Severity	Date	Verified
BLACK-EYED PEAS HIVES	Allergy	Unknown	07/25/08	
CAPOTIN	Allergy	Unknown	02/02/09	
PIZZA	Allergy	Unknown	02/02/09	

Allergy Management

Borne, April - 64/F      J.1E J.102/A      Unit No: J000001902  
ADH IN      Acct No: J0000025812

- Allergies for Interaction Checks (3)	Type	Severity	Date	Verified
Sulfa (Sulfonamides) (Sulfa (Sulfonamides))	Allergy	Mild	02/11/09	Yes
Bee Pollens (Bee Pollens)	Allergy	Mild	02/11/09	Yes
Iodine (Iodine)	Allergy	Mild	02/11/09	Yes
- Uncoded Allergies (0)				

View Details  
New  
Delete  
Edit  
Confirm  
Verify  
Audit Trail  
Select All  
Deselect All  
Undo All  
File  
Return

## Confirming Existing Coded Allergies

Select all allergies by **clicking on Select All** (turns all allergies **blue**, but only Coded allergies will be confirmed)

Click **View Details** button to review allergy, reaction and comments and make any necessary edits.

View Details

View Allergy Details

Allergy  
Sulfa (Sulfonamides)

Type	Severity	Date	Verified
Allergy	Mild	02/11/09	Yes

Reaction

Close

View Allergy Details

Allergy  
Bee Pollens

Type	Severity	Date
Allergy	Mild	02/11/09

View Allergy Details

Allergy  
Iodine

Type	Severity	Date	Verified
Allergy	Mild	02/11/09	Yes

You will cycle through View Details on all allergies selected.

**Allergy Management**

Borne, April - 64/F      J.1E J.102/A      Unit No: J000001902  
 ADM IN      Acct No: J00000025812

- Allergies for Interaction Checks (3)	Type	Severity	Date	Verified
Sulfa (Sulfonamide Antibiotics) (Sulfa (Sulfonamides))	Allergy	Mild	03/17/09	Yes
Bee Pollens (Bee Pollens)	Allergy	Mild	03/17/09	Yes
Iodine (Iodine)	Allergy	Mild	03/17/09	Yes
- Uncoded Allergies (0)				

View Details  
 New  
 Delete  
 Edit  
 Confirm  
 Verify  
 Audit Trail  
 Select All  
 Deselect All  
 Undo All  
 File  
 Return

Once allergies have been reviewed, click on the **Confirm** button and click **Yes** to confirm the selected allergies

**Yes/No Confirmation**

Confirm 3 of 3 selected allergies?

Yes    No

**Allergy Management**

Borne, April - 64/F      J.1E J.102/A      Unit No: J000001902  
 ADM IN      Acct No: J00000025812

- Allergies for Interaction Checks (3)	Type	Severity	Date	Verified
Sulfa (Sulfonamide Antibiotics) (Sulfa (Sulfonamides))	Allergy	Mild	03/23/09	Yes
Bee Pollens (Bee Pollens)	Allergy	Mild	03/23/09	Yes
Iodine (Iodine)	Allergy	Mild	03/23/09	Yes
- Uncoded Allergies (0)				

View Details  
 New  
 Delete  
 Edit  
 Confirm  
 Verify  
 Audit Trail  
 Select All  
 Deselect All  
 Undo All  
 File  
 Return

The date column will be updated to the current date. Click **OK** and **File**

15	03/23/09	1256	CARTIER, SUSAN
Allergy	Sulfa (Sulfonamide Antibiotics)		
Old	Date: 03/17/09		
New	Date: 03/23/09 (Update)		
16	03/23/09	1256	CARTIER, SUSAN
Allergy	Bee Pollens		
Old	Date: 03/17/09		
New	Date: 03/23/09 (Update)		
17	03/23/09	1256	CARTIER, SUSAN
Allergy	Iodine		
Old	Date: 03/17/09		
New	Date: 03/23/09 (Update)		

The confirmation appears on the audit trail.

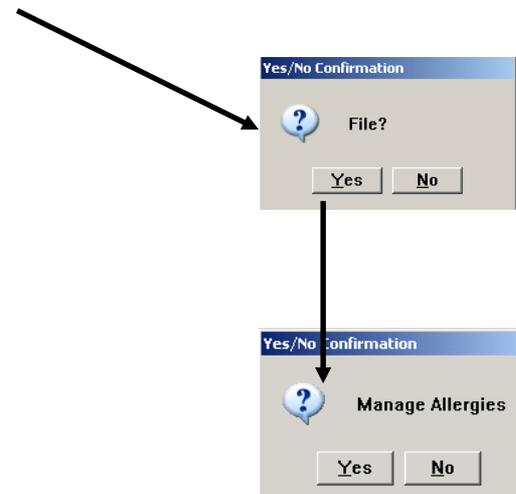
**Admin Data** (Click with mouse or Type "A")

- Document Ht, Wt, Allergies, Code Status, Isolation status, Religion and lists equipment being used by patient (IV, O2 etc).
- The Admin Data routine must be completed upon every admission as answers will flow from Nursing to Order Entry. When filed you will be prompted to Manage Allergies - yes or no.

Enter/Edit Administrative Data

Patient NM0000010734 RN, ONE A/S 99 F Admit 06/05/09  
Temporary Location Loc NH.3RD Status ADM IN  
Rm NH.0301  
Hold Tray: Date Meal Release Bd 1 Unit No. NM00000001  
Condition Visitors Allowed  
Cmt Ht 5 ft 6 in 167.64 cm  
Visit Rsn PNEUMONIA Wt 150 lb 0.25 oz 68.046 kg  
Allergies  
Observation Patient  
Date in Time in  
Date out Time out

IV? Y  
OXYGEN? Y  
Prosthetics? N  
Code Status DNR  
Does pt require isolation? N  
Isolation Type  
Patient's Religion: CAT CATHOLIC  
BMI



To Manage Allergies, follow procedure on previous pages

## PI Loc/List

(Click icon with mouse)

- Allows documentation of one intervention on several patients at one time

## eMAR

(Click on or Type "M")

- Allows documentation of Medications. See eMAR Manual for details

## Print Report

(Click on or Type "R")

- Where all Printing options are located

## Review

[CLINICAL REVIEW] (Click on or Type "I")

- View a patient's record, examine details such as:
  - (a) Orders
  - (b) Medications (current and past)
  - (c) Administrative Data
  - (d) Laboratory Data
  - (e) Radiology & other dictated reports
  - (f) Assessments
  - (g) Patient's Notes
  - (h) Patient Care Documentation Profile (Blood glucose trending, education documentation, pain management)
  - (g) Old records can be reviewed

## Orders

(Click on or Type "O")

- Enter orders for nursing interventions, tests, diets, consults and treatments.

- **1. Quick Start**

- The Quick Start screen is a short screen that can be documented on by the Unit Secretary, PCT (if working as a secretary), or the Nurse. **This is the first thing to do when a patient is admitted.**
- From **Status Board** click on the **Assessment** Icon
- Click **Enter Form**, this allows you to go forward and enter the document.
- **"ADMISSION QUICK START"** is on the first line. **Double click** on it or **Rt arrow**.
- Choose the **"type of patient"** you are caring for.
- Choose **"Age of Patient"** choose the developmental age of the patient.
- **If patient's admission diagnosis is for a Total Hip or Total Knee surgery, put a Y next to the appropriate question.** File, F12, or
- After you File, a box will appear and ask you if you want to **"Add Checked Problems to the Plan of Care?"** Always enter a **"Y"** and press ENTER.
- You are now in the **ENTER/EDIT PLAN OF CARE ROUTINE.**
- Press **ENTER** a second time until the problems are added to the Problem section in the center of the screen
- **Press F12 or  and "File Plan of Care"** This will file the Standard of Care and Age Guidelines.
- When the screen is filed, the Standards of Care and the Age Development Guidelines will be loaded into the care plan. Included within the Standards of Care are all the interventions that are needed to document on a continual basis, i.e., the department specific Standards of Practice, Vital Signs, Intake, Output, Shift Assessment, etc.

- **2. Admission Assessment /Admission History**
- **Assessment/History Forms:** From Status Board, make sure that your patient is highlighted and click on the **Assessment** icon. **Double click** or **Rt Arrow on Enter Form** and select **Admission Assessment or Admission History** to fill out. If Assessments or History have been done on this patient a (→) arrow will appear next to the assessment along with the date and time under Last documented. This does not guarantee that the form was completed. Incomplete forms are corrected in another routine. If the user is unsure as to which type of response is required, press the F9 (or click on binoculars ) LOOKUP key. All fields that the cursor lands on are required to be answered. If the cursor skips a field, it may be due to the previous answer and it does not require an answer. In the assessment routine, you can pass a required answer BUT you cannot file the document until all required answers are done. **DO NOT CLICK PAST FIELDS.** Enter an answer in each field and press the <Enter> key to continue. In other routines, required answers will make you answer them immediately press the  (file) key (or click on the green  mark) and answer “Y” to the box that appears. The letter “F” will automatically default in the box, hit ENTER to file. Do not change your options, leave at ‘F’ to File. **You must “File” or your information will be lost.**
- On the last page of **Admission Assessment** user will determine Care Plan Problems based on your assessment. User is encouraged to keep the Care Plan SIMPLE. Pick problems based on the patients admission diagnosis, pain, and safety. Upon filing a screen a questions will appear asking if the user wants to add “**Checked Problems to the Plan of Care?**” if satisfied with list, answer ‘Y’ – **Yes and [ENTER].**
- **Care plans must be evaluated and updated every shift for every patient; this is done in Process Interventions. Part A must be completed at the start of shift and Part B at the end of shift.**