# Locating historical data in clinical review

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**Recently an issue has been brought to our attention regarding viewing patient data through Lifetime summary. For complete, accurate information, and the safety of your patients, please follow these steps when looking up data from previous visits:**

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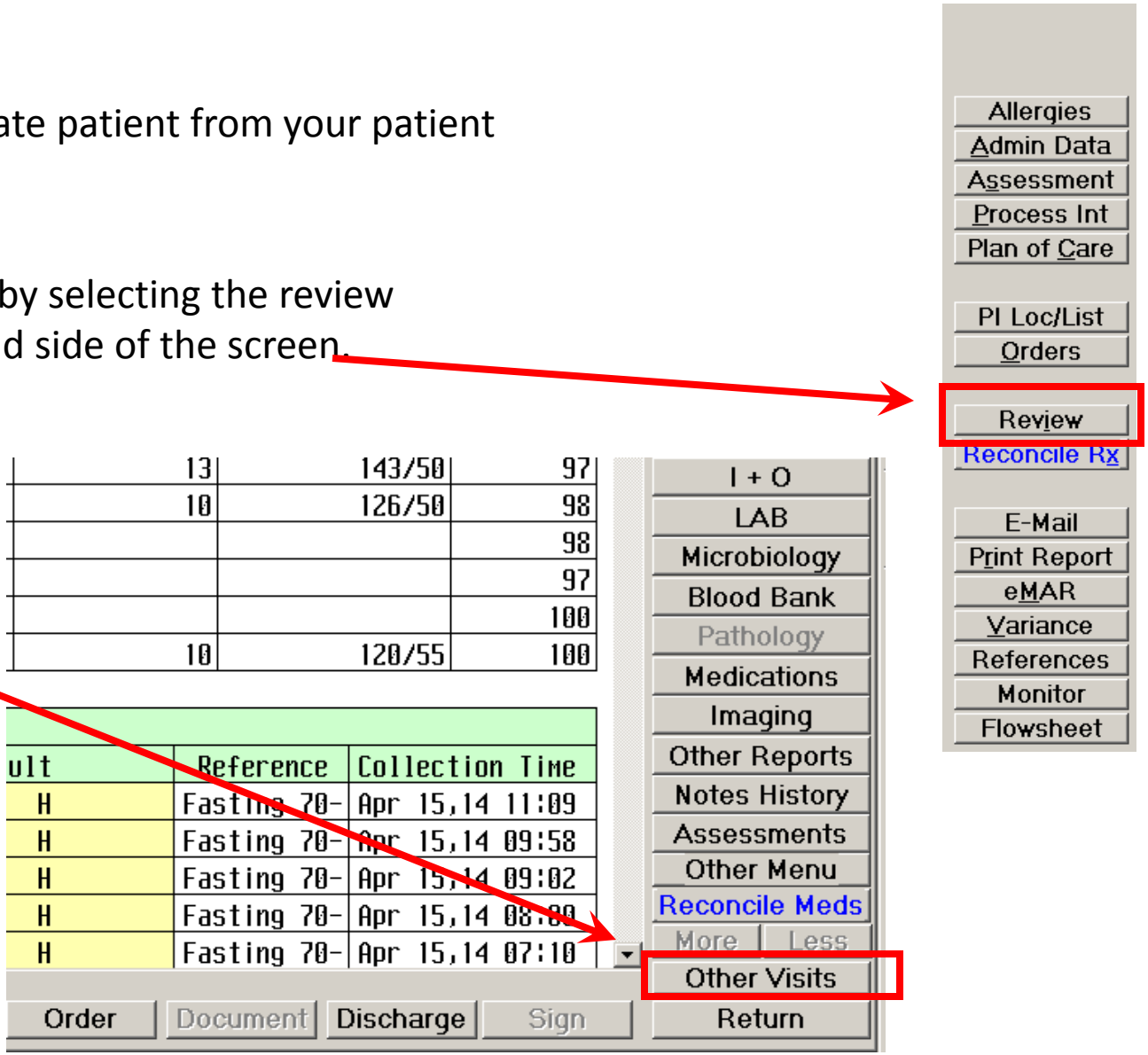
# Locating historical data in clinical review

1) Select the appropriate patient from your patient list

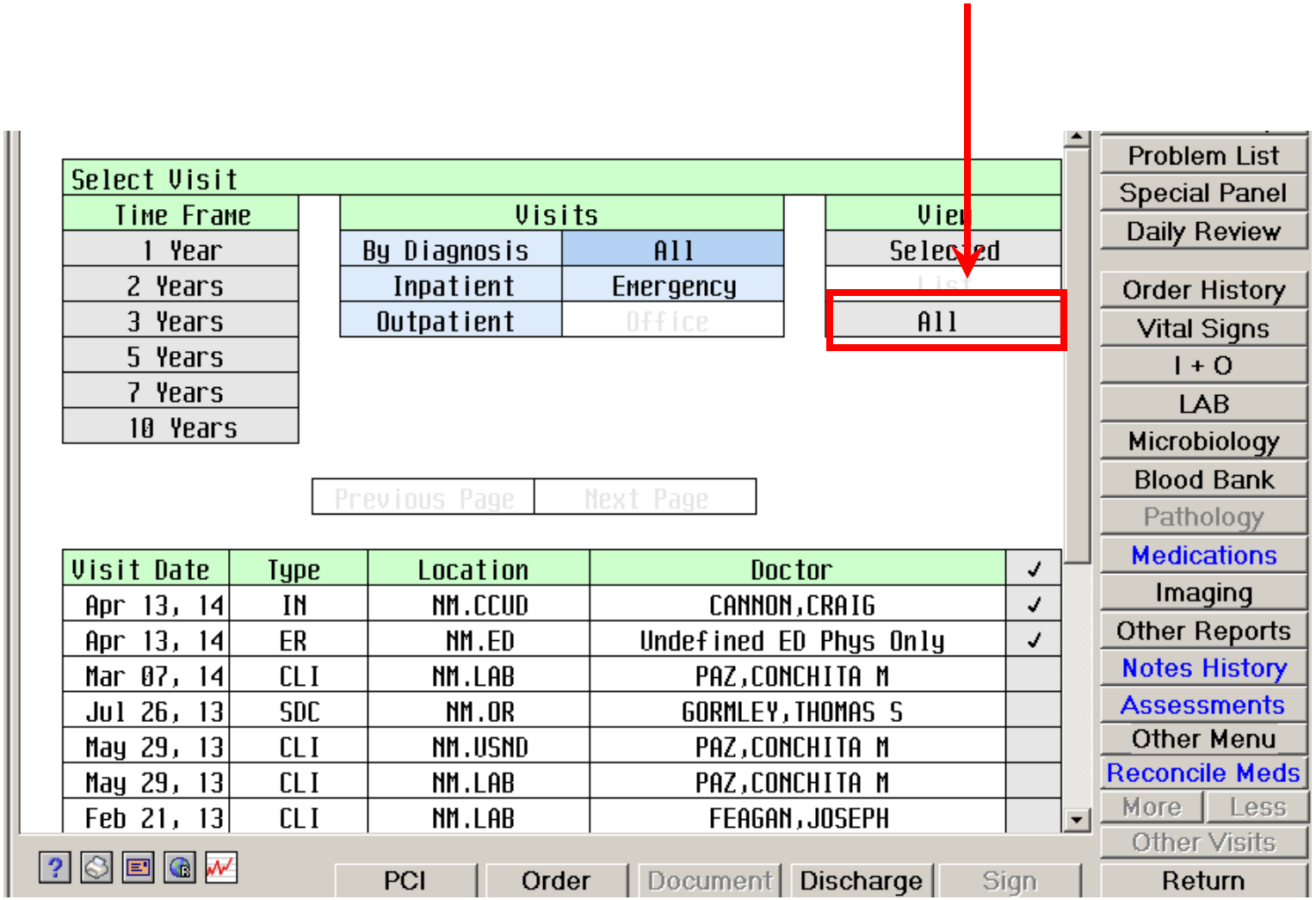
2) Enter clinical review by selecting the review button on the right hand side of the screen.

3) Select other visits on the bottom right of the screen



# Locating historical data in clinical review

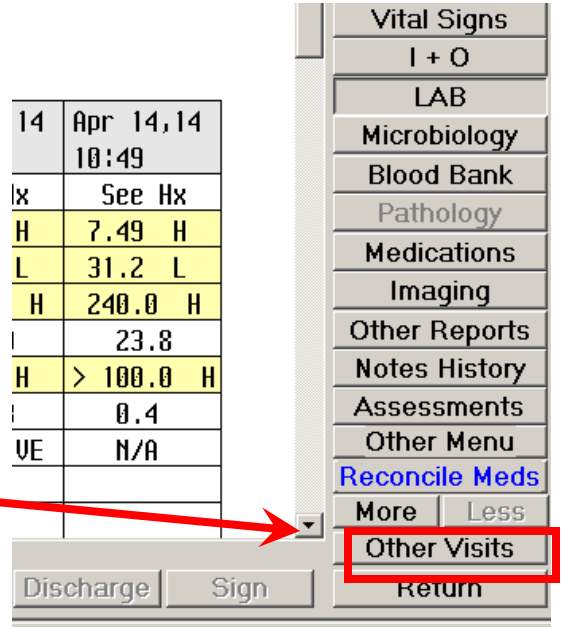
4) Select the grey box [All] to enter historical Data to all Previous hospital visits.



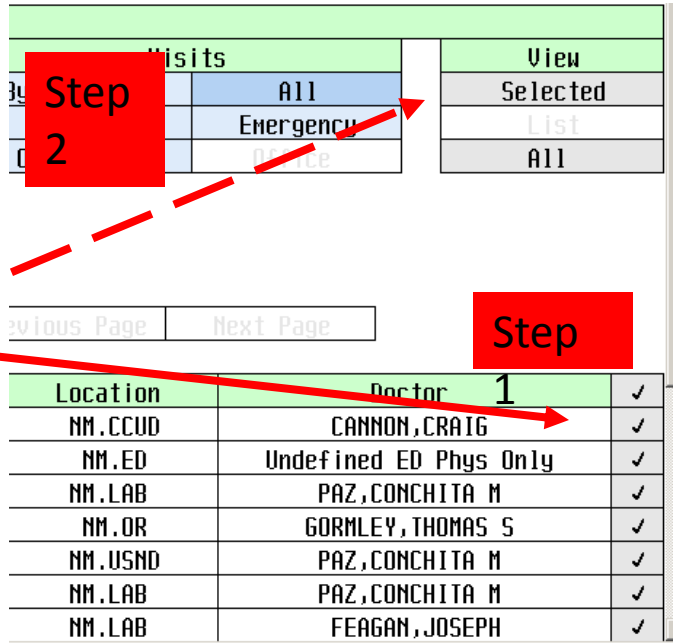
# Locating historical data in clinical review

By selecting [All] will bring up all historical data for that patient. Select the appropriate section to review data.

Once data review is complete to return to current visit to place orders reselect Other visits in the bottom right of the review screen.




All the visits will be checked. Select the top grey check box to deselect all visits then select the current visit and click on the grey box [Selected].




***NOTE. If in all visits or wrong account date the order option will be disabled. Review and reselect appropriate visit.***

# LANGUAGE ACCESS DOCUMENTATION IN MEDITECH

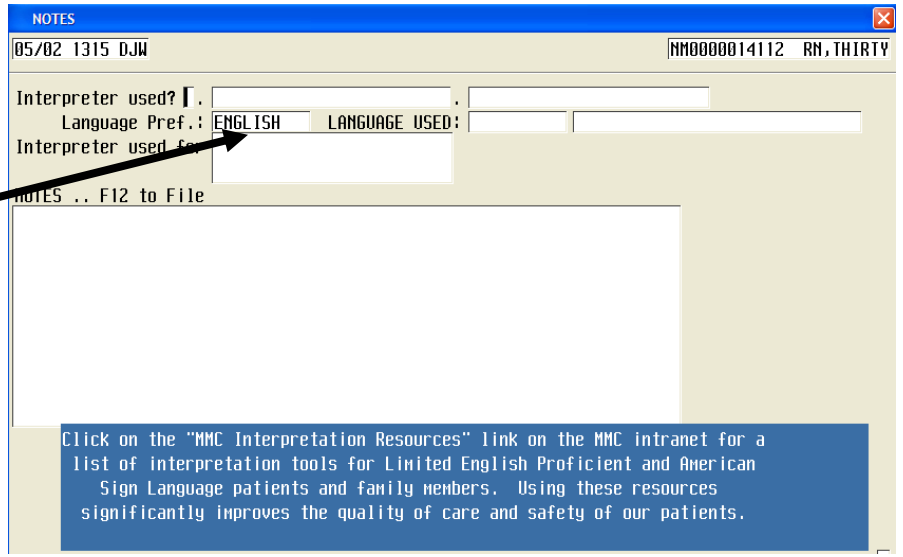
Appropriate communication is very important for safe and compassionate care.

**Documentation method #1: Patient Notes**

If you did not require the services of one of our many interpretive resources, enter **N** and the cursor will jump to the Note field and you can enter your Note.

HOWEVER, if you requested assistance from a DUAL-ROLE INTERPRETER, MARTTI or CYRACOM, you Will enter **Y** and will be required to enter data in the subsequent fields.

MEDITECH will also help you to make this decision by providing the language preference your patient indicated on admission!




The following will be required:
The SERVICE used, FULL NAME/OPERATOR NUMBER of the individual who assisted you,


the LANGUAGE used for the interaction and the GENERAL CATEGORY of the items they interpreted.

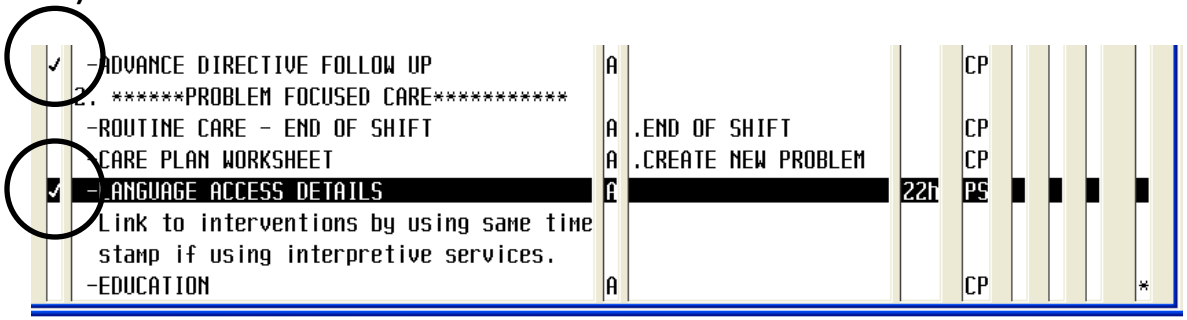
If the language specified by the patient is not on the F9 list, it can be free texted in. The General categories are as follows; please provide further detail in your note

| | |
|---|---|
| 1 Routine Care | 5 Discharge plan/instruct. |
| 2 Education/Answer question | 6 Provider at bedside |
| 3 Procedure/Intervention | 7 Other:See note for detail |
| 4 Consents | |

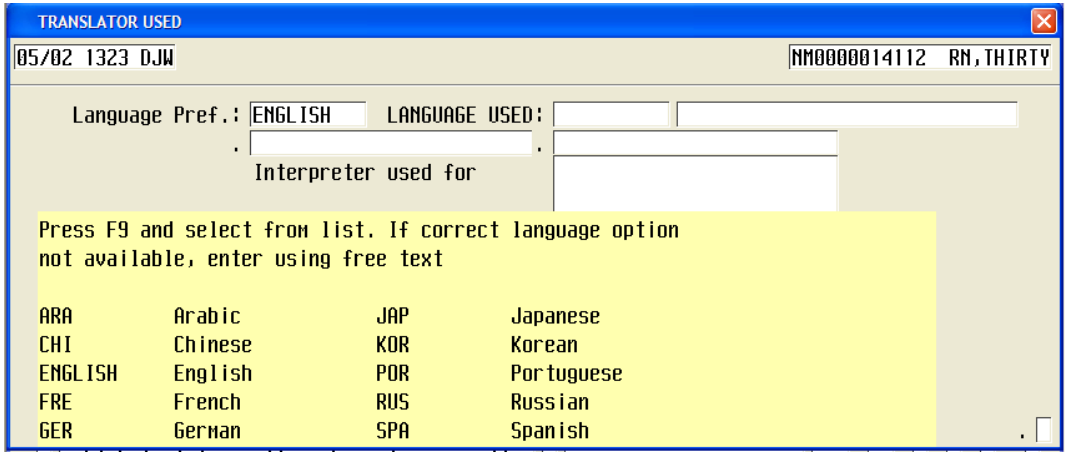
## Documentation method #2: Language Access Linking

For interventions you complete using an interpreter that have existing documentation screens follow these steps:

In PROCESS INTERVENTIONS select the intervention you wish to document as well as the LANGUAGE ACCESS DETAILS intervention (SHIFT+Rt CTRL will checkmark the highlighted intervention).



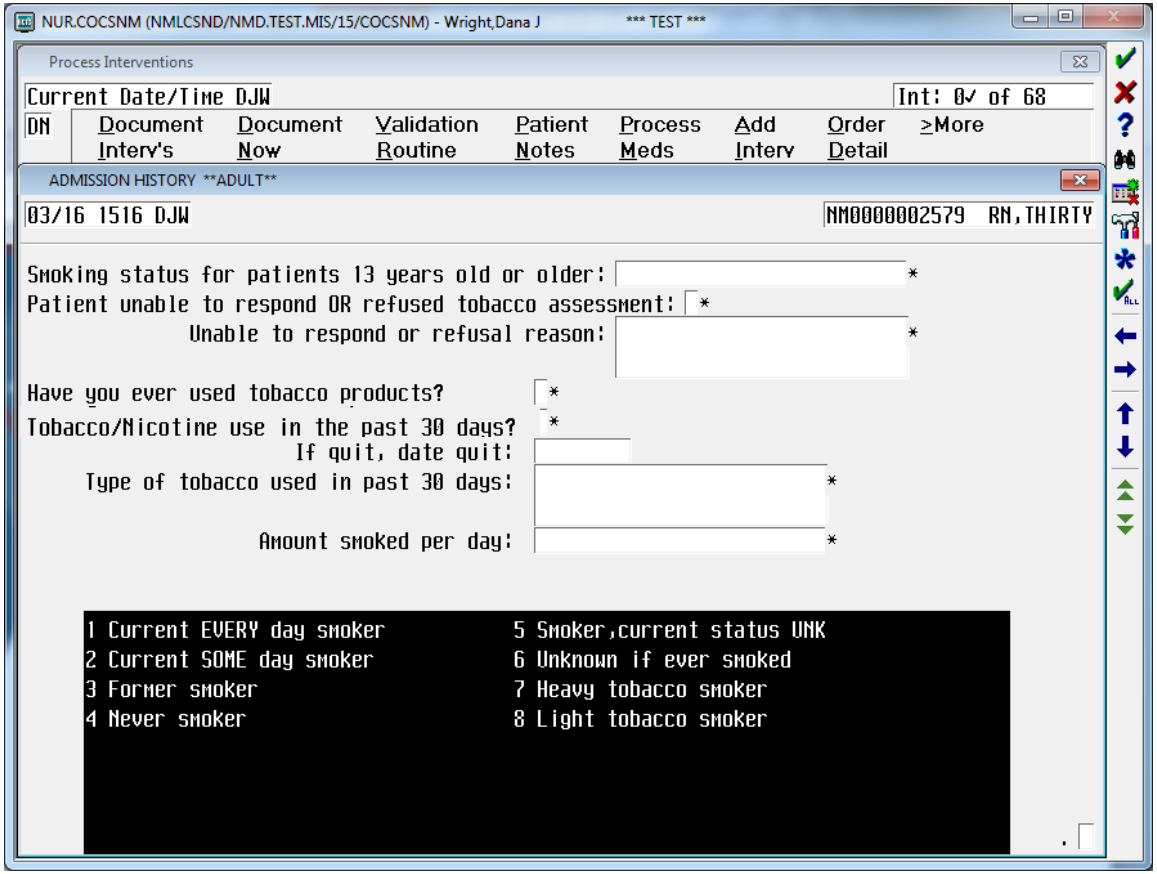

Doing this will apply the same timestamp to both interventions showing that they were done simultaneously (pressing SHIFT+Rt CTRL again after documenting will remove the checkmarks). The fields in the LANGUAGE ACCESS DETAILS intervention are the same as those in the Patient Notes and will require those same details.



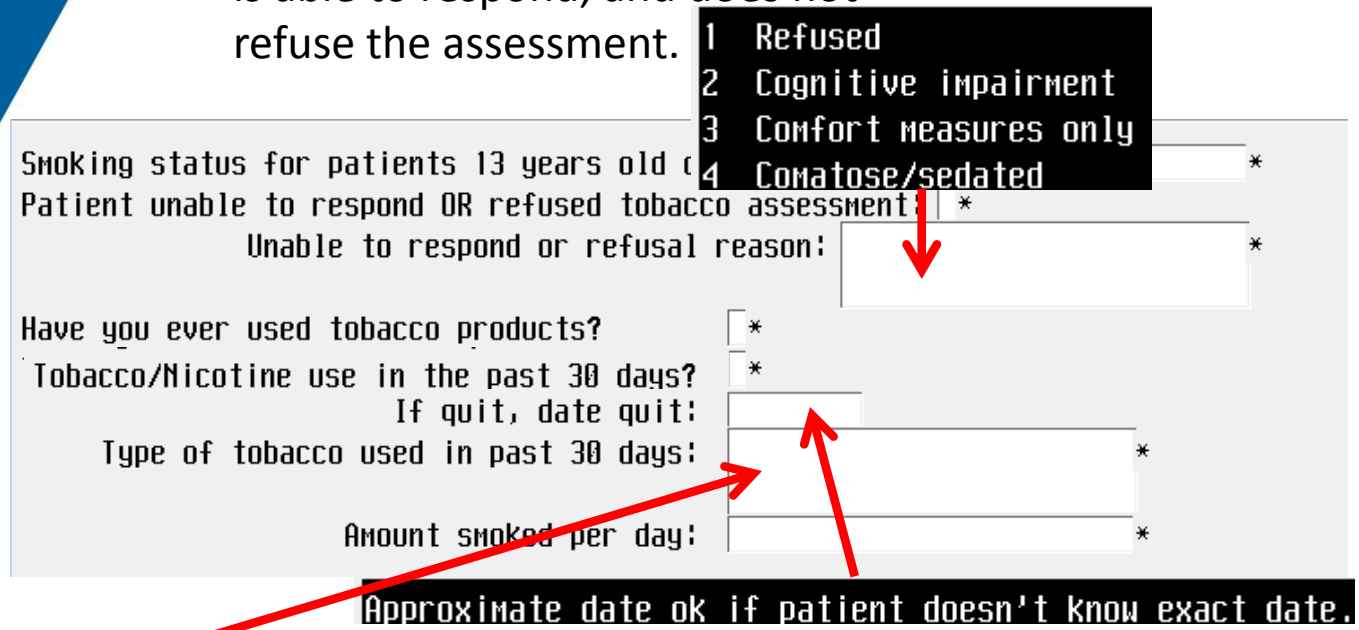
# Smoking Cessation: Admission History

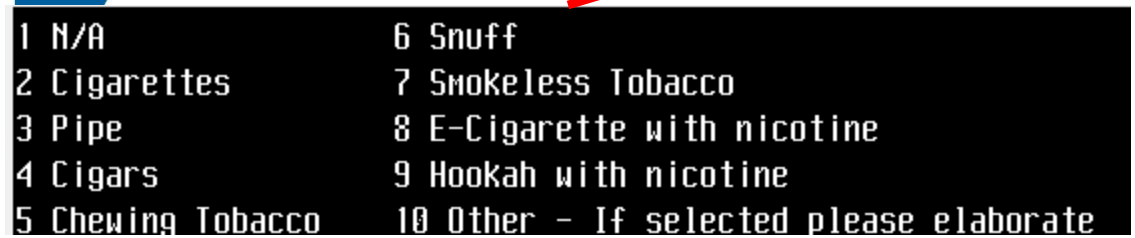
For additional information please contact Deirdre Jensen ext. 5346

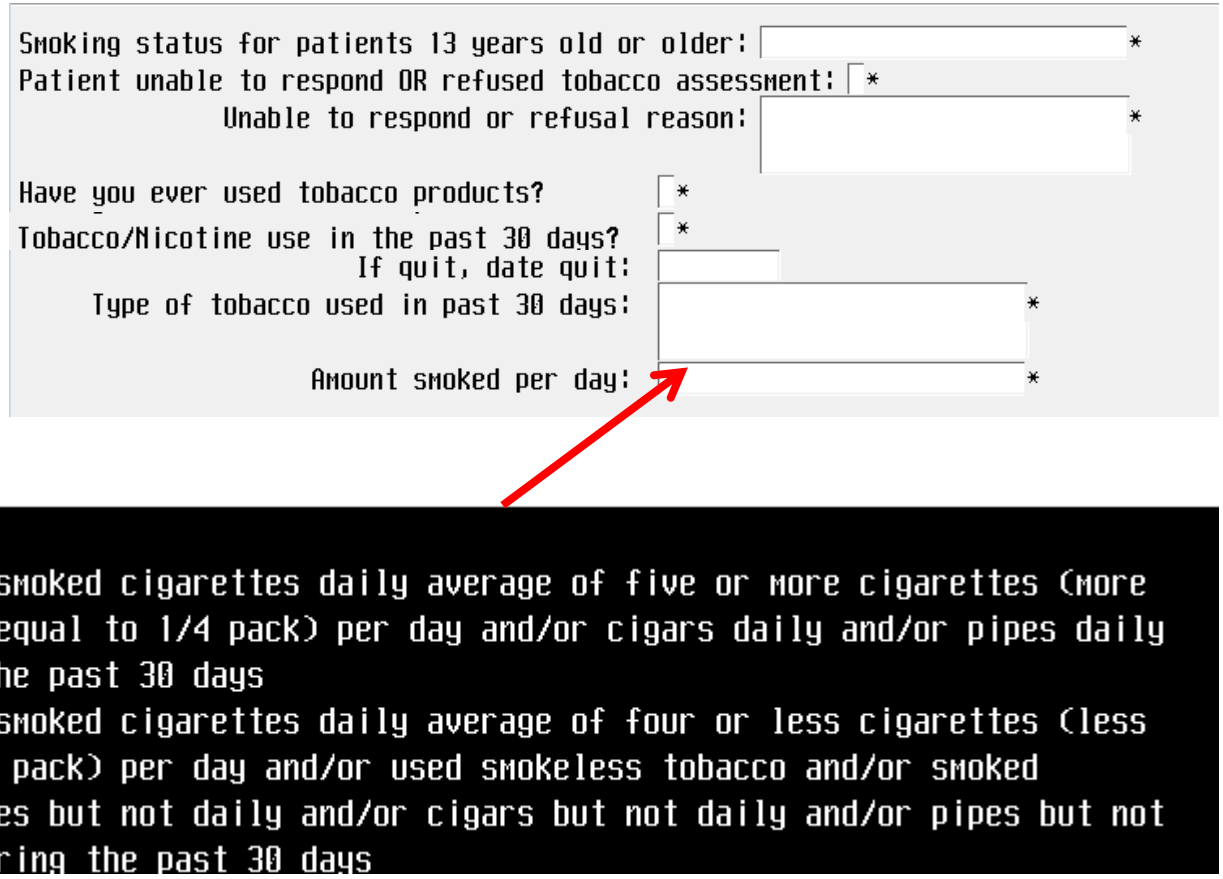
Smoking screening assessment must be completed on admission. If the patient is unresponsive, and no family is present, a follow-up assessment must be completed in the first 3 days of admission and as soon as possible once the patient regains consciousness or family presents.



You will not be required to complete this field if the patient is able to respond, and does not refuse the assessment.

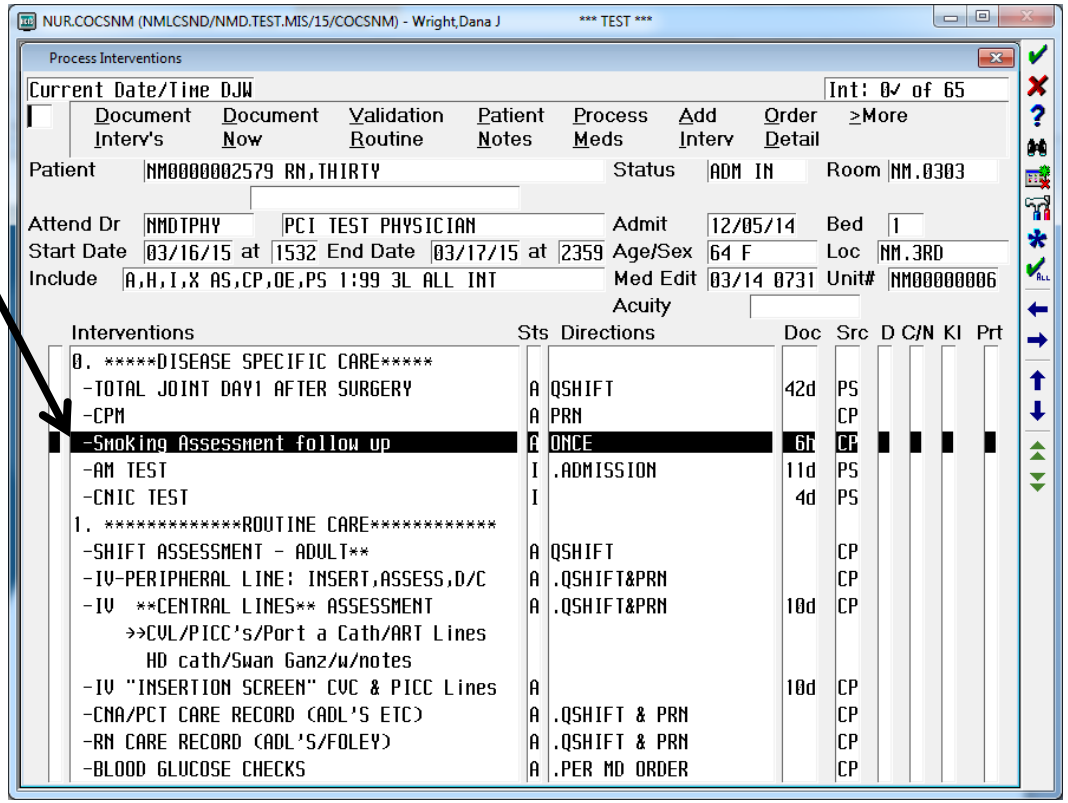





These responses are standardized by CMS and must be completed based on the amount of tobacco used by the patient. Please do not ask if they are a “Heavy or Light” smoker; instead ask “How many cigarettes do you smoke per day?” etc. and choose accordingly.

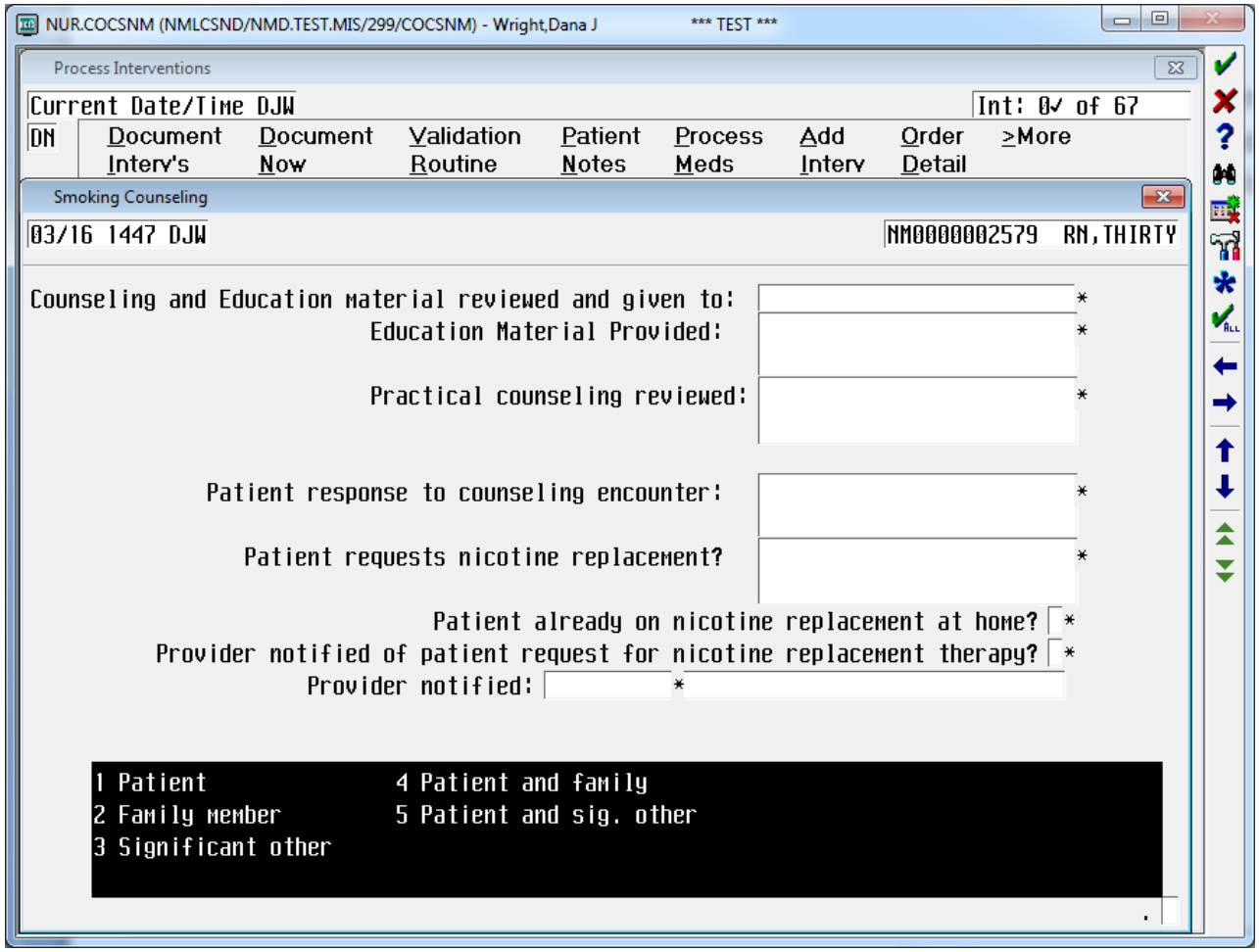
If the smoking assessment cannot be completed at admission, an additional intervention will be added to the Process Intervention list.

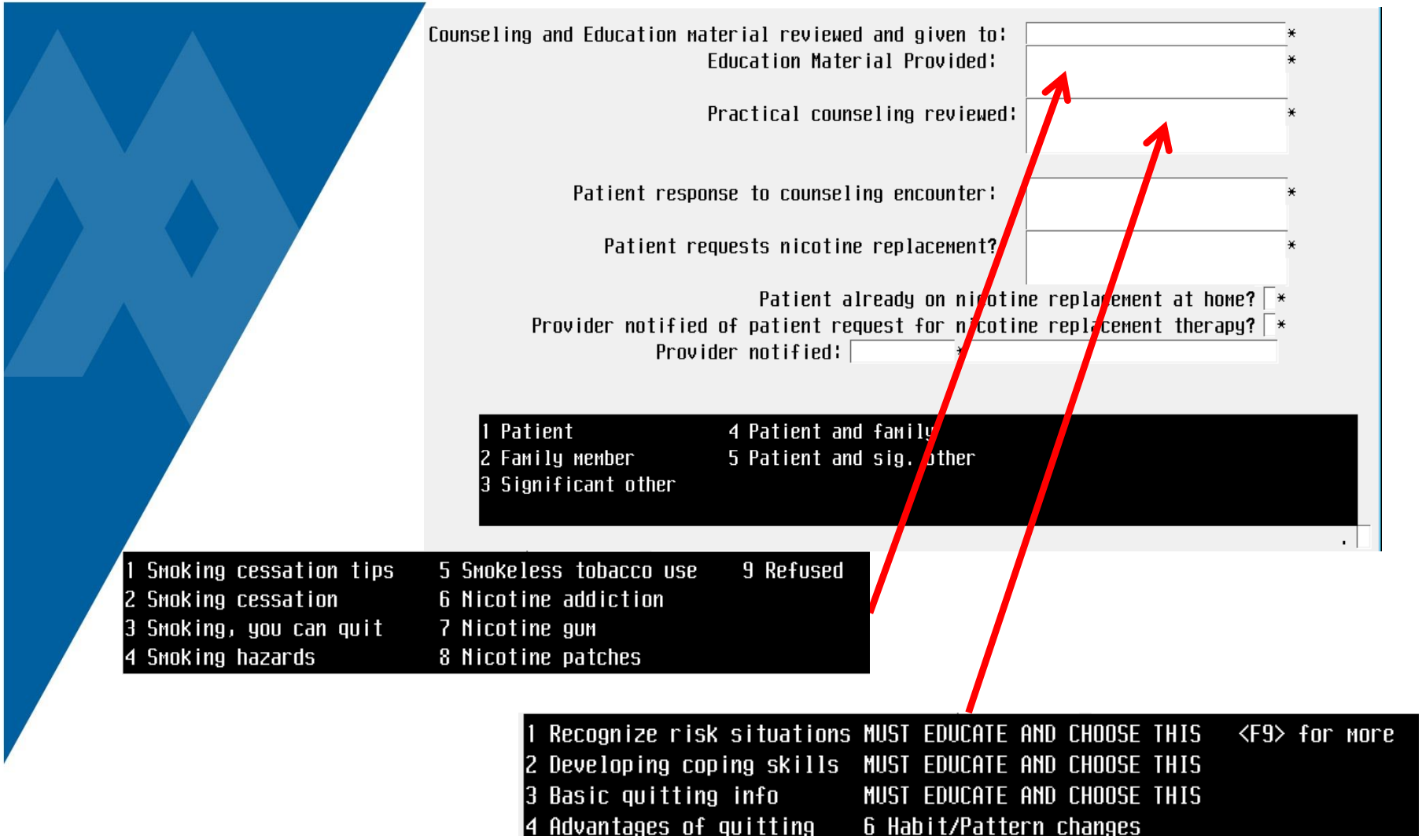


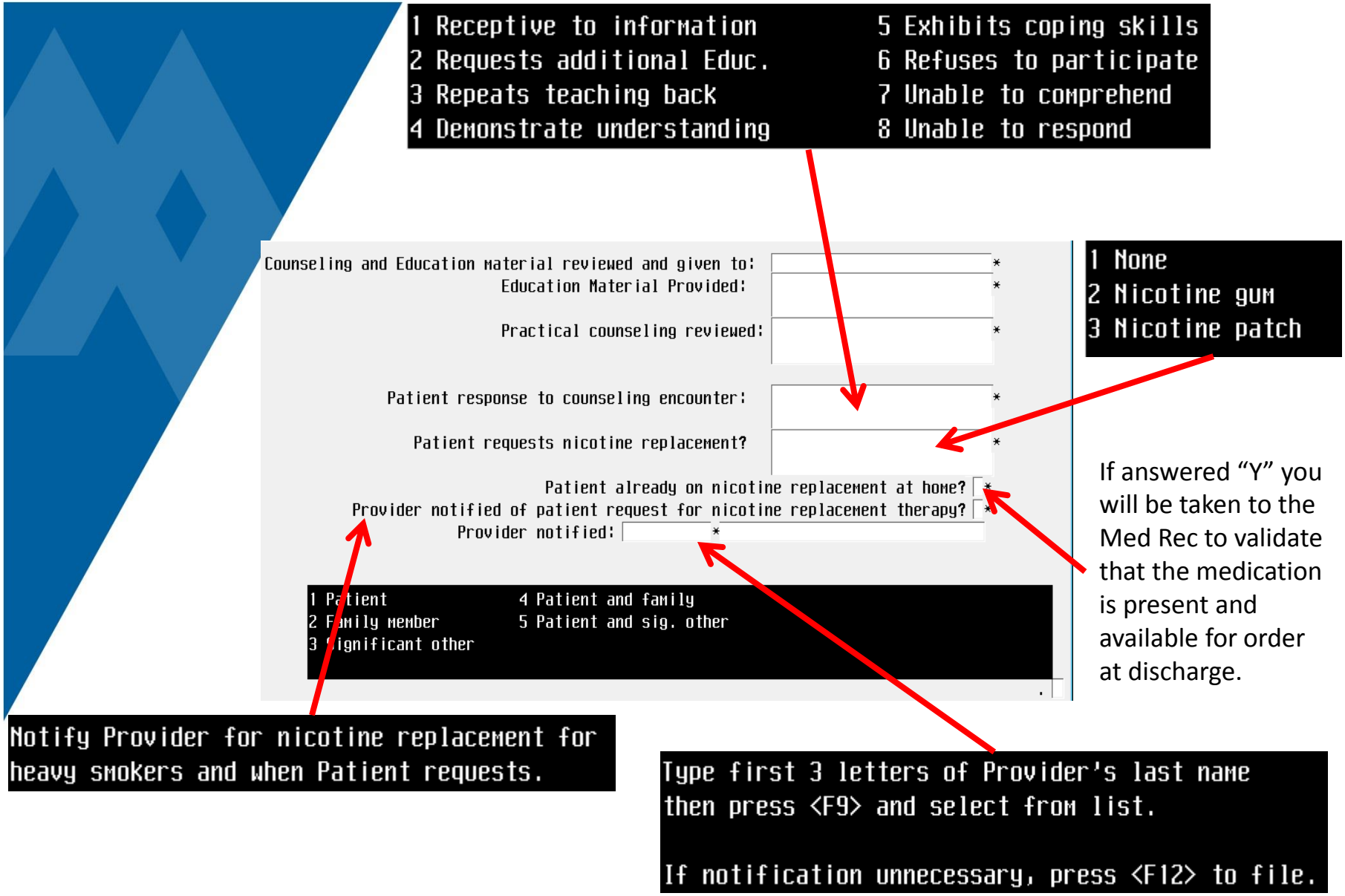

This assessment is identical to the admission assessment and will only be added if the original is not completed.

# Smoking Cessation: Counseling Intervention

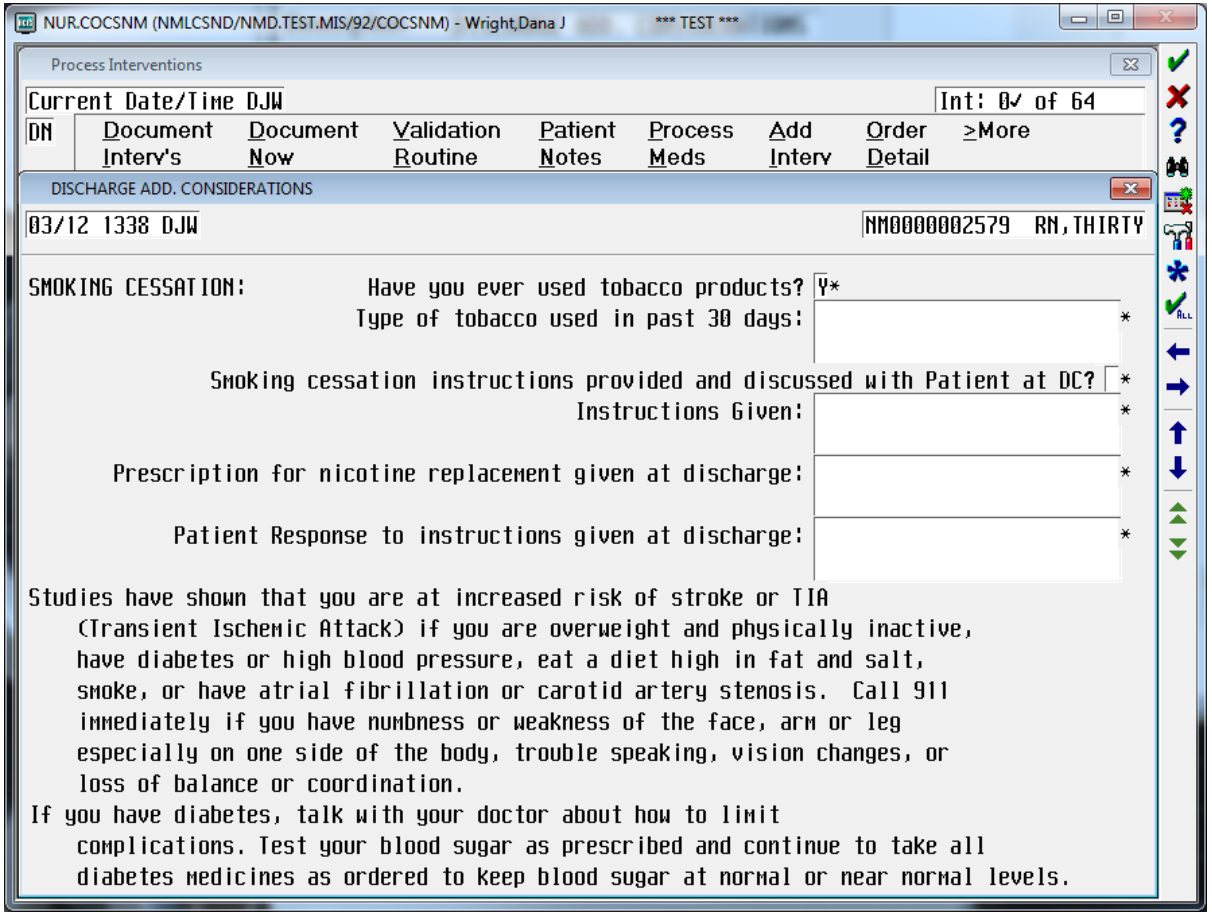
Smoking Cessation counseling must be completed in the first 3 days of admission. This intervention will activate based on the responses documented on the Nursing Admission History.



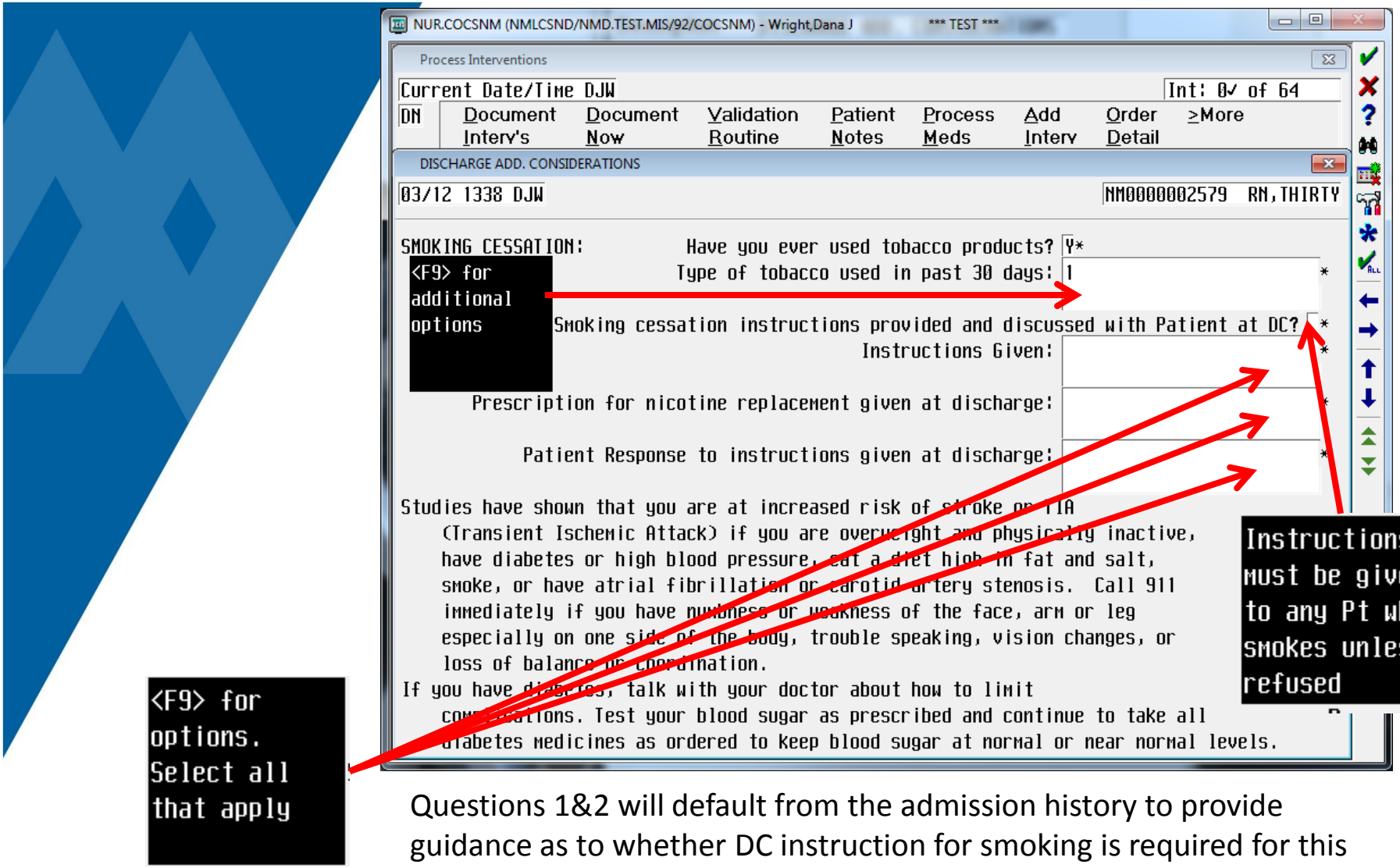

Counseling and Education material reviewed and given to:
Education Material Provided:
Practical counseling reviewed:
Patient response to counseling encounter:
Patient requests nicotine replacement?
Patient already on nicotine replacement at home?
Provider notified of patient request for nicotine replacement therapy?
Provider notified:
1 Patient
2 Family member
3 Significant other
4 Patient and family
5 Patient and sig. other
1 Smoking cessation tips
2 Smoking cessation
3 Smoking, you can quit
4 Smoking hazards
5 Smokeless tobacco use
6 Nicotine addiction
7 Nicotine gum
8 Nicotine patches
9 Refused
1 Recognize risk situations MUST EDUCATE AND CHOOSE THIS
2 Developing coping skills MUST EDUCATE AND CHOOSE THIS
3 Basic quitting info MUST EDUCATE AND CHOOSE THIS
4 Advantages of quitting
6 Habit/Pattern changes
<F9> for more


1 Receptive to information
2 Requests additional Educ.
3 Repeats teaching back
4 Demonstrate understanding
5 Exhibits coping skills
6 Refuses to participate
7 Unable to comprehend
8 Unable to respond
Counseling and Education material reviewed and given to:
Education Material Provided:
Practical counseling reviewed:
Patient response to counseling encounter:
Patient requests nicotine replacement?
Patient already on nicotine replacement at home?
Provider notified of patient request for nicotine replacement therapy?
Provider notified:
1 None
2 Nicotine gum
3 Nicotine patch
1 Patient
2 Family member
3 Significant other
4 Patient and family
5 Patient and sig. other
If answered "Y" you will be taken to the Med Rec to validate that the medication is present and available for order at discharge.
Notify Provider for nicotine replacement for heavy smokers and when Patient requests.
Type first 3 letters of Provider's last name then press <F9> and select from list.
If notification unnecessary, press <F12> to file.

# Smoking Cessation: Discharge Requirements

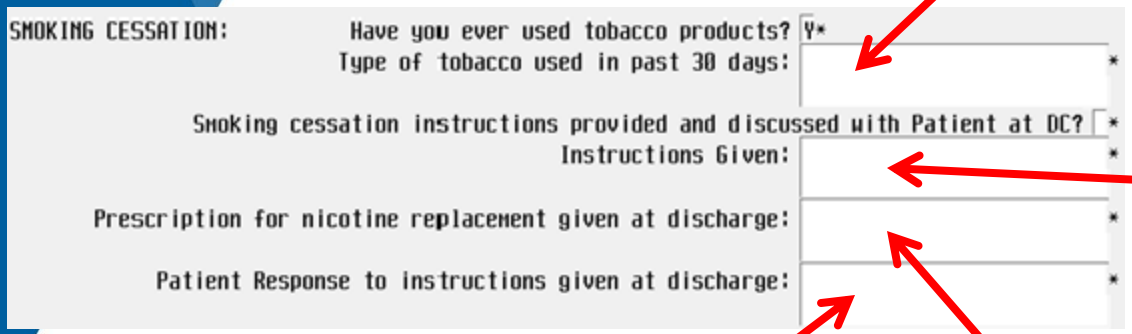



The “DC Additional Health Considerations” screen has been updated with the new required elements for smoking cessation. This intervention MUST be completed for ALL discharges regardless of smoking history.




Questions 1&2 will default from the admission history to provide guidance as to whether DC instruction for smoking is required for this patient. Complete the remaining fields appropriately.

Responses for each field can be accessed by pressing <F9>. **Instructions MUST include the [www.smokefree.gov](http://www.smokefree.gov) website address.**




| | |
|---|---|
| 1 | Cigarettes |
| 2 | Pipe |
| 3 | Cigars |
| 4 | Chewing Tobacco |
| 5 | Snuff |
| 6 | Smokeless Tobacco |
| 7 | E-Cigarette with nicotine |
| 8 | Hookah with nicotine |
| 9 | Other |

| | |
|---|---|
| 1 | www.smokefree.gov |
| 2 | Smoking cessation |
| 3 | Smoking, you can quit |
| 4 | Smoking cessation Tips |
| 5 | Smokeless tobacco use |
| 6 | Nicotine addiction |
| 7 | Nicotine chewing gum |
| 8 | Nicotine patches |
| 9 | Nicotine lozenges |
| 10 | Referral to clinic/class |
| 11 | Refused |

| | |
|---|---|
| 1 | Receptive to information |
| 2 | Requests additional Educ. |
| 3 | Repeats teaching back |
| 4 | Demonstrate understanding |
| 5 | Exhibits coping skills |
| 6 | Refuses to participate |
| 7 | Unable to comprehend |
| 8 | Review with family or SO |

| | |
|---|---|
| 1 | Nicotine patch |
| 2 | Nicotine gum |
| 3 | Nicotine lozenges |
| 4 | Nicotine nasal spray |
| 5 | Nicotine inhaler |
| 6 | Other |
| 7 | Refused |