Electronic Documentation/BMV Training
For
Nursing Students and Instructors

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Mission Statement

Madera Community Hospital is a not-for-profit community health resource, dedicated to actively promoting and maintaining the health and wellbeing of residents throughout the Central Valley. We are committed to identifying and serving our community's needs with compassion, concern, care, and safety for the individual.

Welcome Students/Instructors to MCH!

MCH staff pride themselves in facilitating an environment that is safe, collaborative, and beneficial to learning. The goal of this presentation is to provide students and instructors with the knowledge of electronic documentation and bedside medication verification (BMV), to ensure a successful and safe learning experience at MCH.

The following slides will identify safety rules, the process of logging into the Network and Meditech, documenting patient care, reviewing past documentation, and medication administration using BMV. Throughout the presentation, click the mouse or tap the downward arrow key to advance to the next slide.

Safety Rules

****All students must receive verbal permission from the patient to assist in their care, and document the permission****

- ✓ Access medical records on a **need to know basis** only
- ✓ **Never** leave an open screen unattended
- ✓ **Always** log off before walking away
- ✓ Remember to keep the WOW plugged in when not in use
- ✓ **NEVER** share your password with anyone
- ✓ All student documentation must be co-signed
- ✓ **NEVER** document interventions before carrying them out
- ✓ Record observations of behavior rather than your interpretation of the behavior

Logging into the Network

Enter your Network Username and temporary Password provided by MCH and click **OK**. You will be prompted to create a permanent password and asked to set up 5 security questions. The security questions are in place in case you forget your password when logging into the Network.

Logging into Meditech

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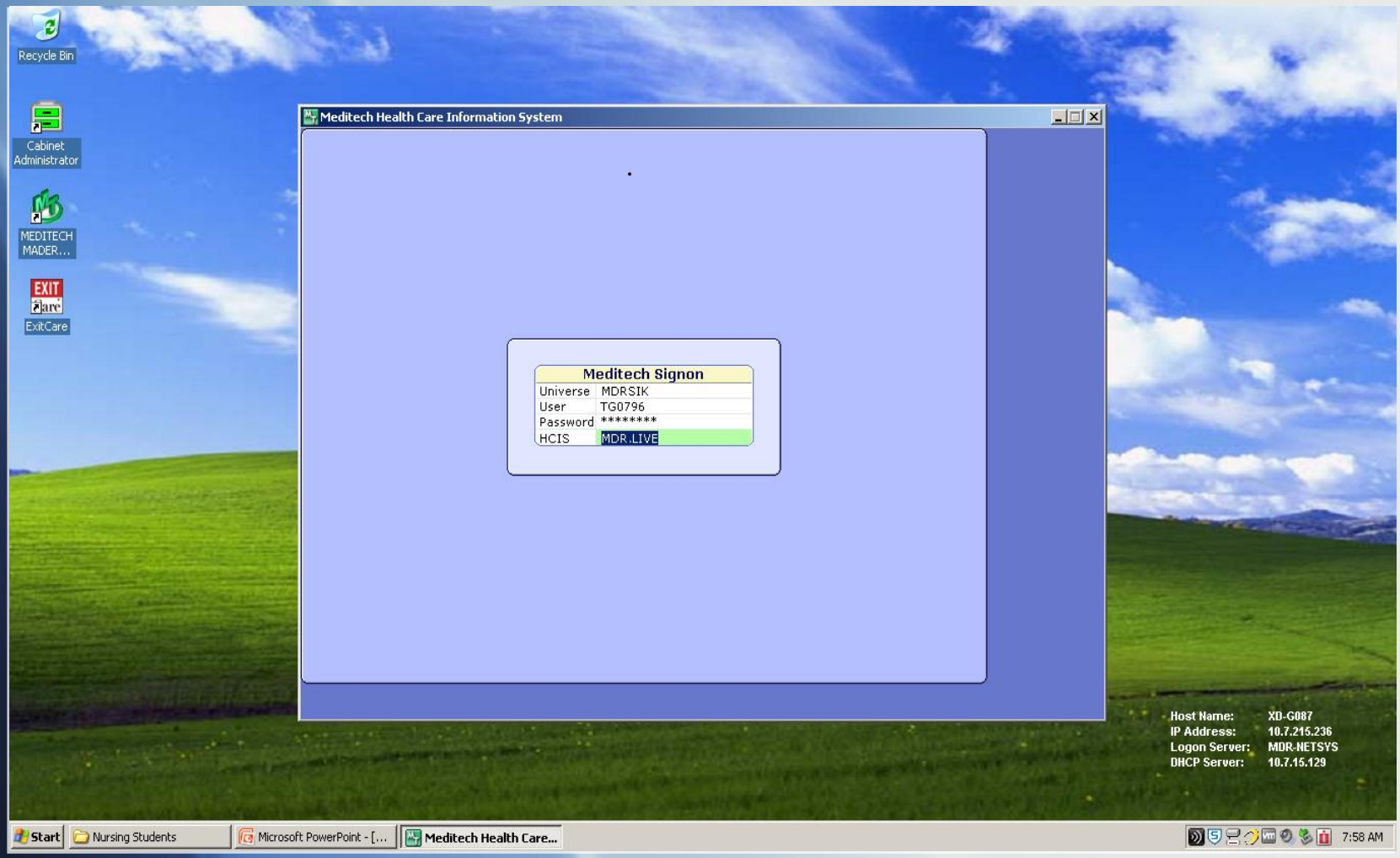
Meditech Sign-On

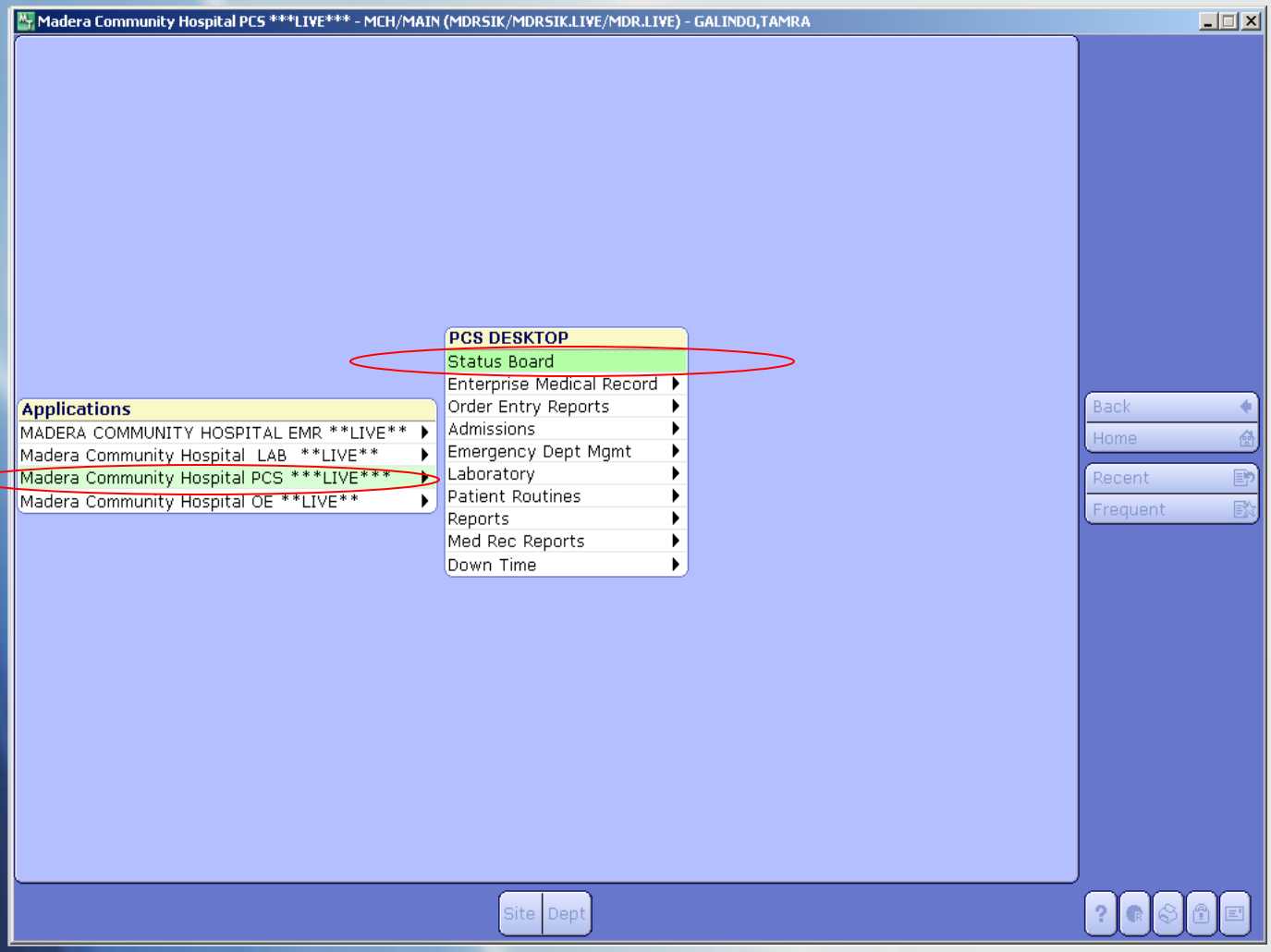
Type in your Meditech Username and Password provided by MCH

Tap the **Enter** key when done



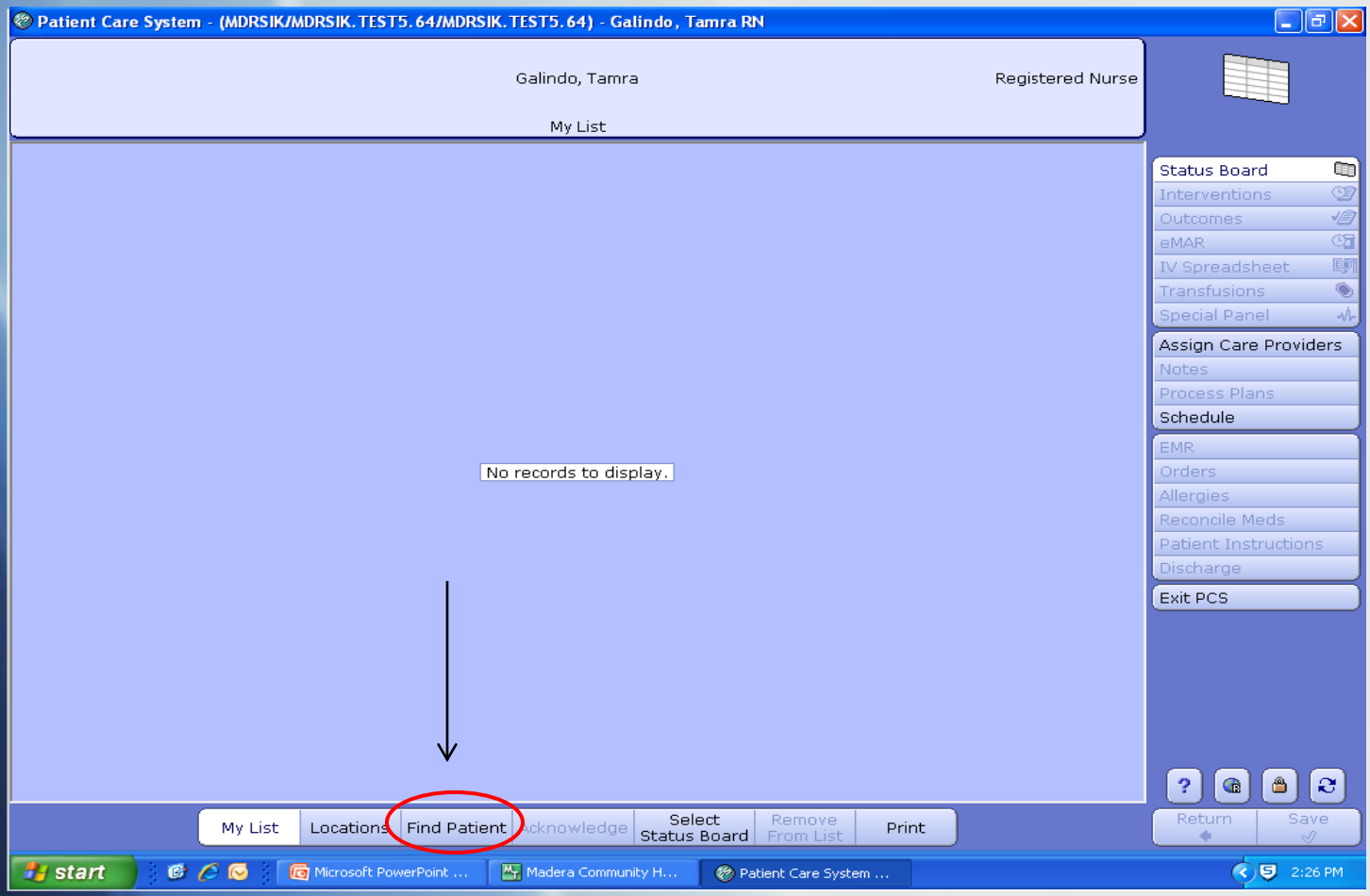
Logging into Patient Care Services (PCS)

Click on **PCS Live** and then on **Status Board**



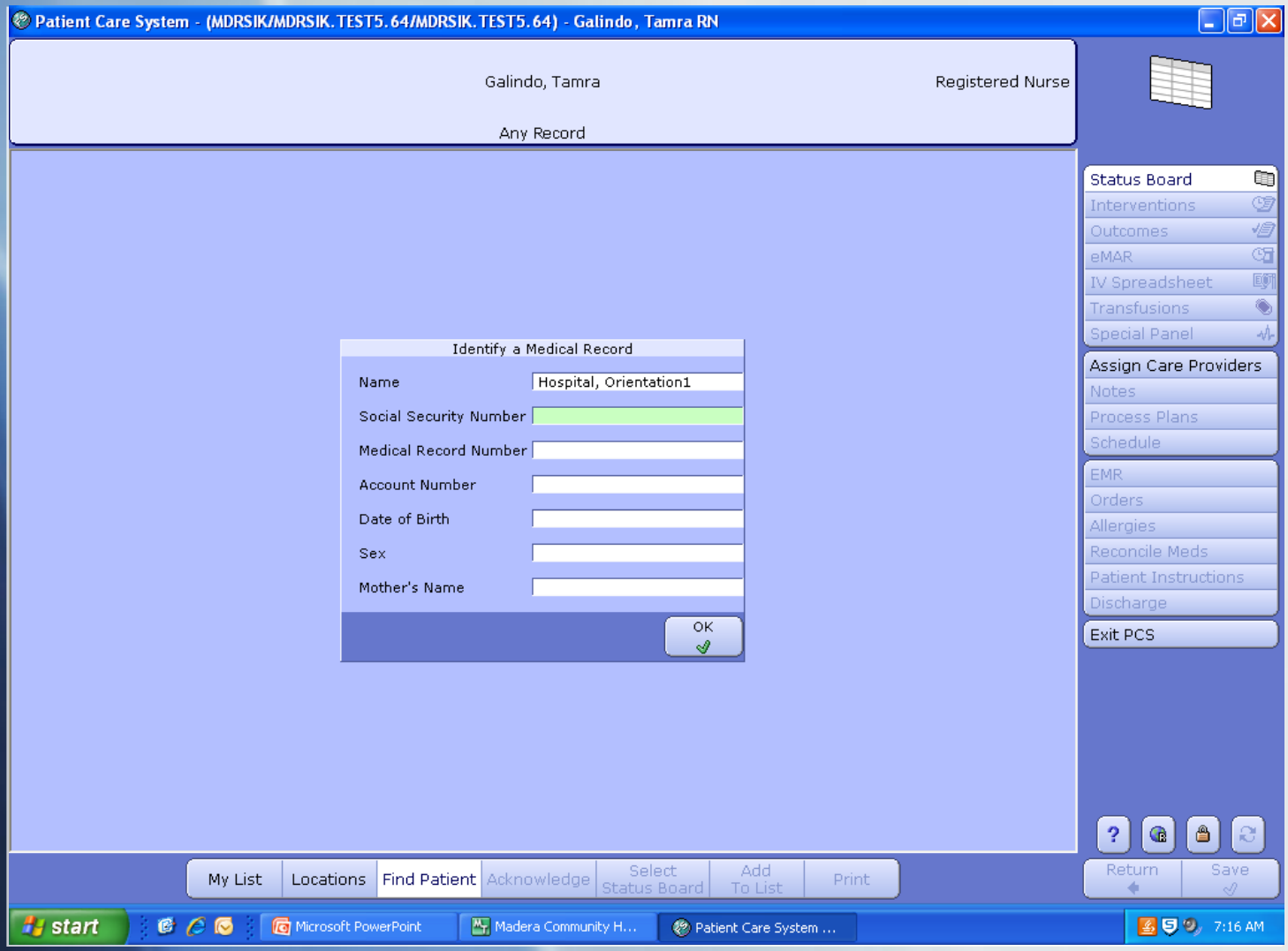
Creating Your Patient List

Click on **Find Patient**

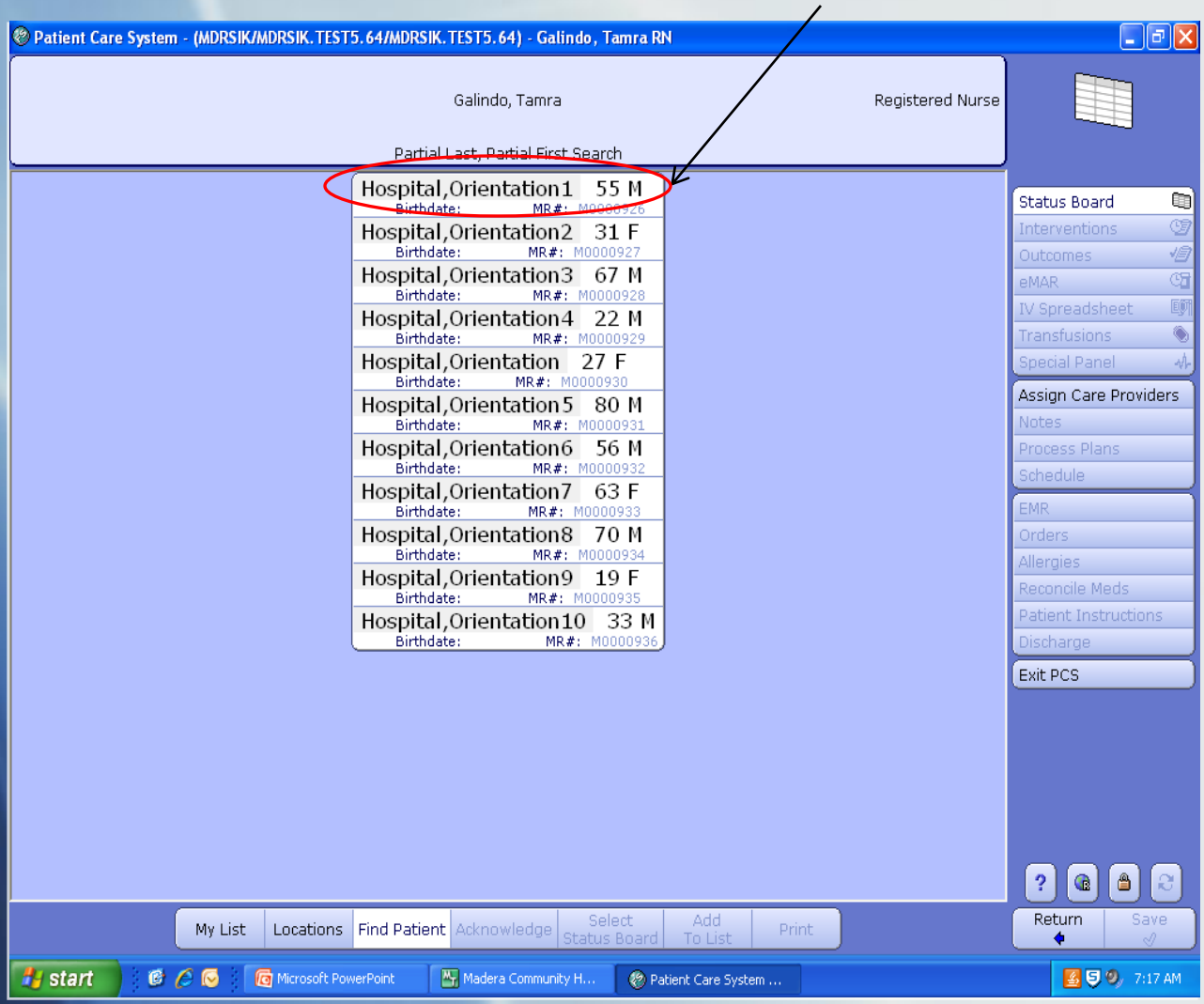


Patient Look Up

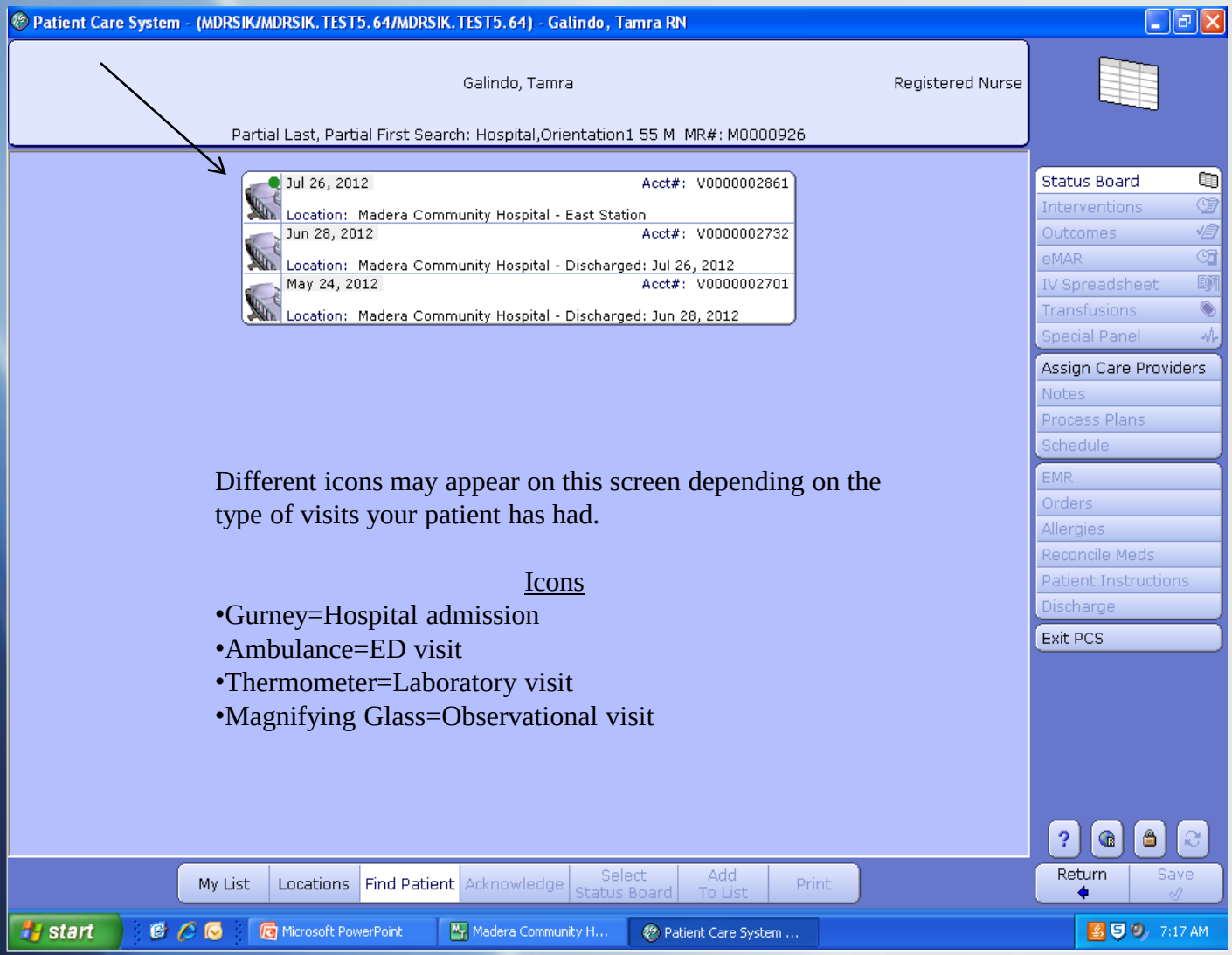
Enter the patient's last name first name, first name last.
Click **OK** when done.



Click on the Patient's Name



Click on the Visit with the Green Dot

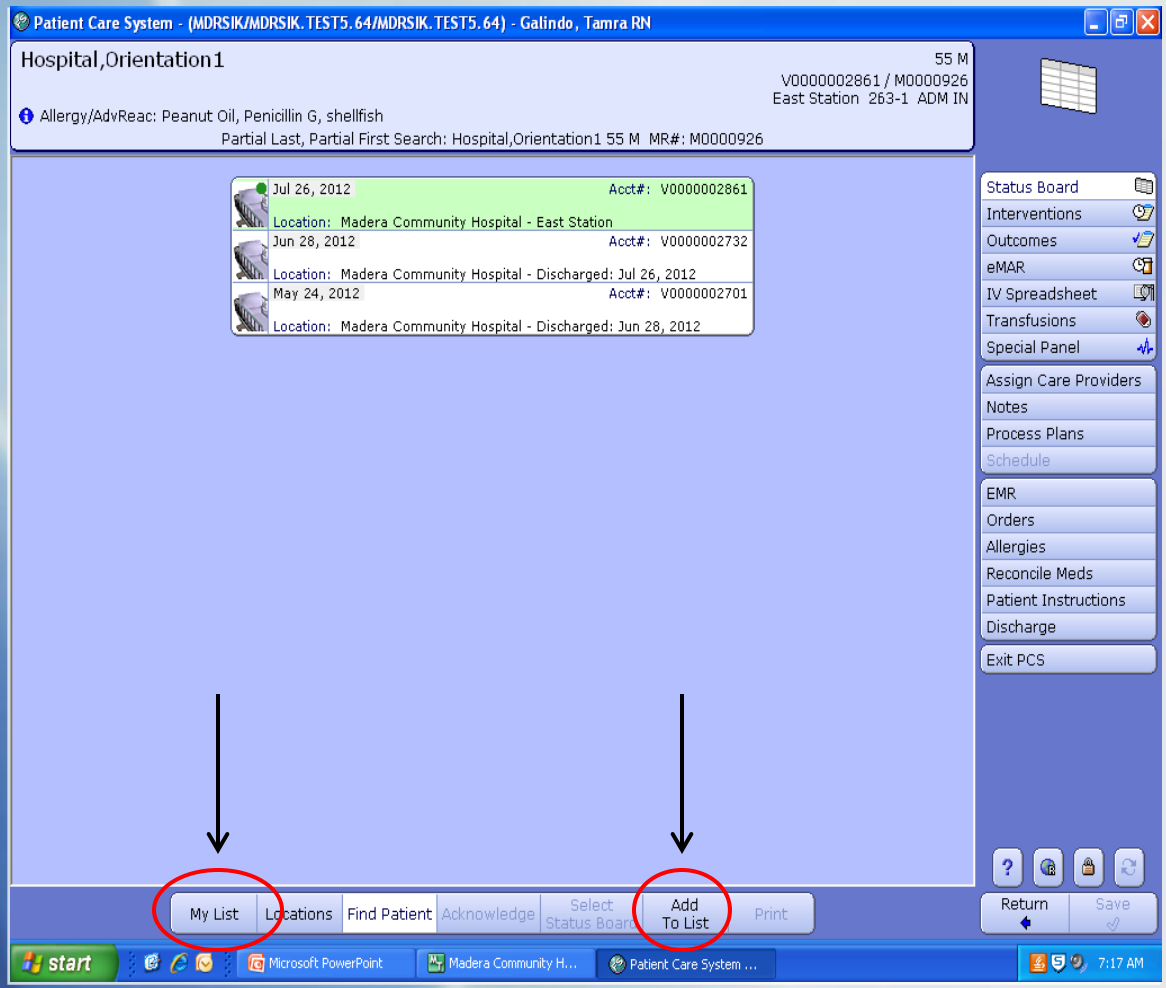


Different icons may appear on this screen depending on the type of visits your patient has had.

Icons

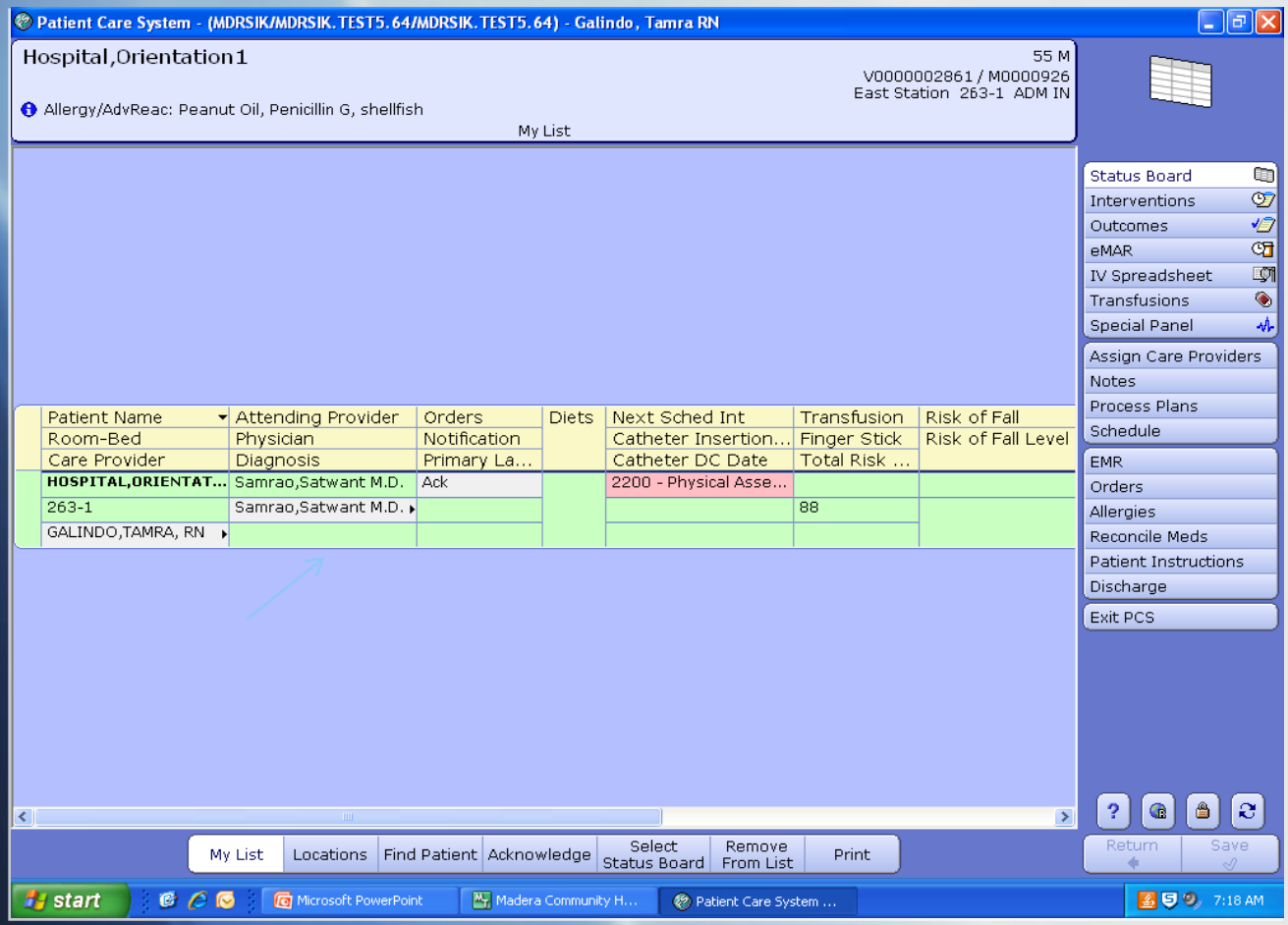
- Gurney=Hospital admission
- Ambulance=ED visit
- Thermometer=Laboratory visit
- Magnifying Glass=Observational visit

Click **Add to List** (1st) and **My List** (2nd)



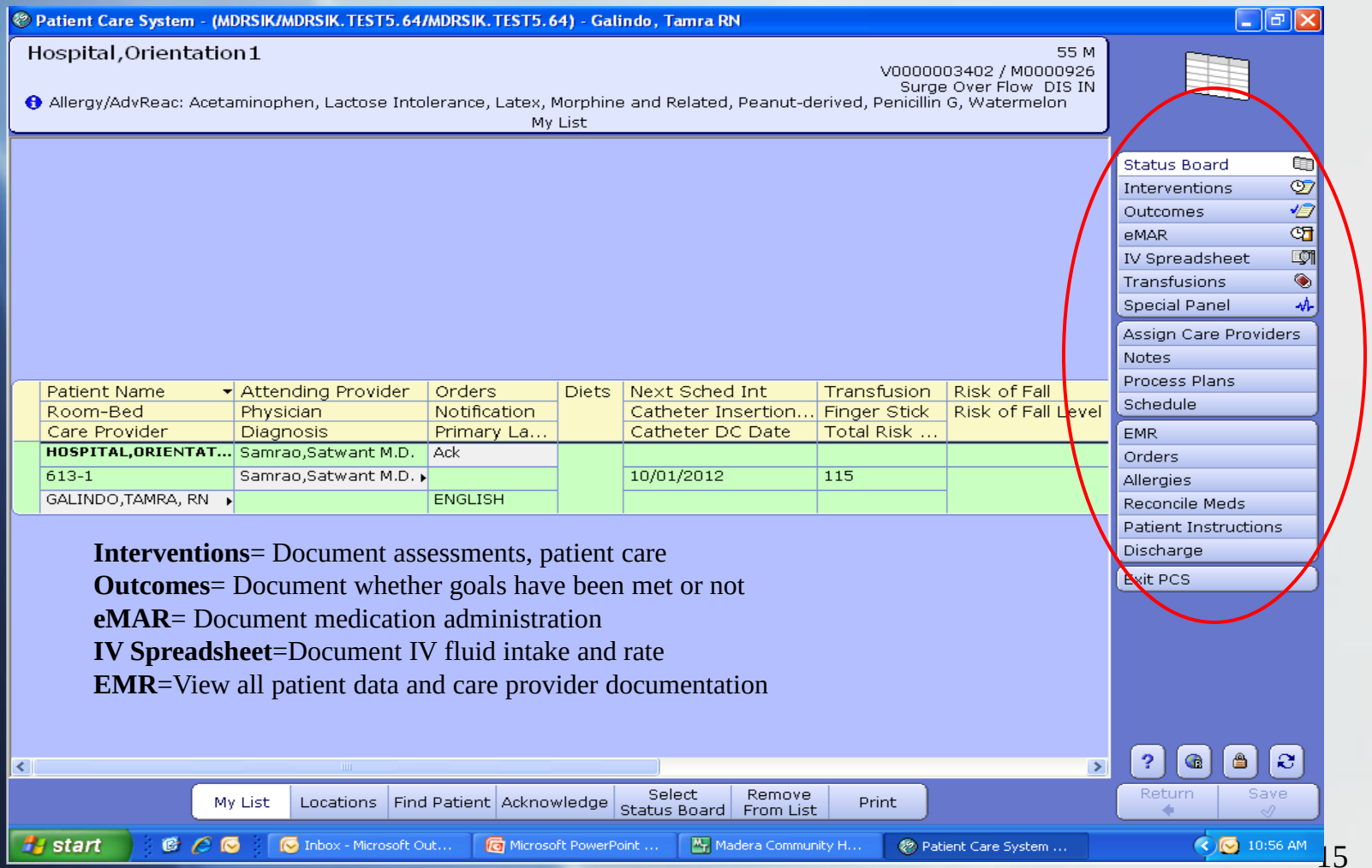
Status Board

Information available on the status board includes patient name, room number, physician name(s), diagnosis, and items continually monitored (e.g. orders, fingersticks, tele, fall risk, isolation, etc.)



Integrated Desk Top

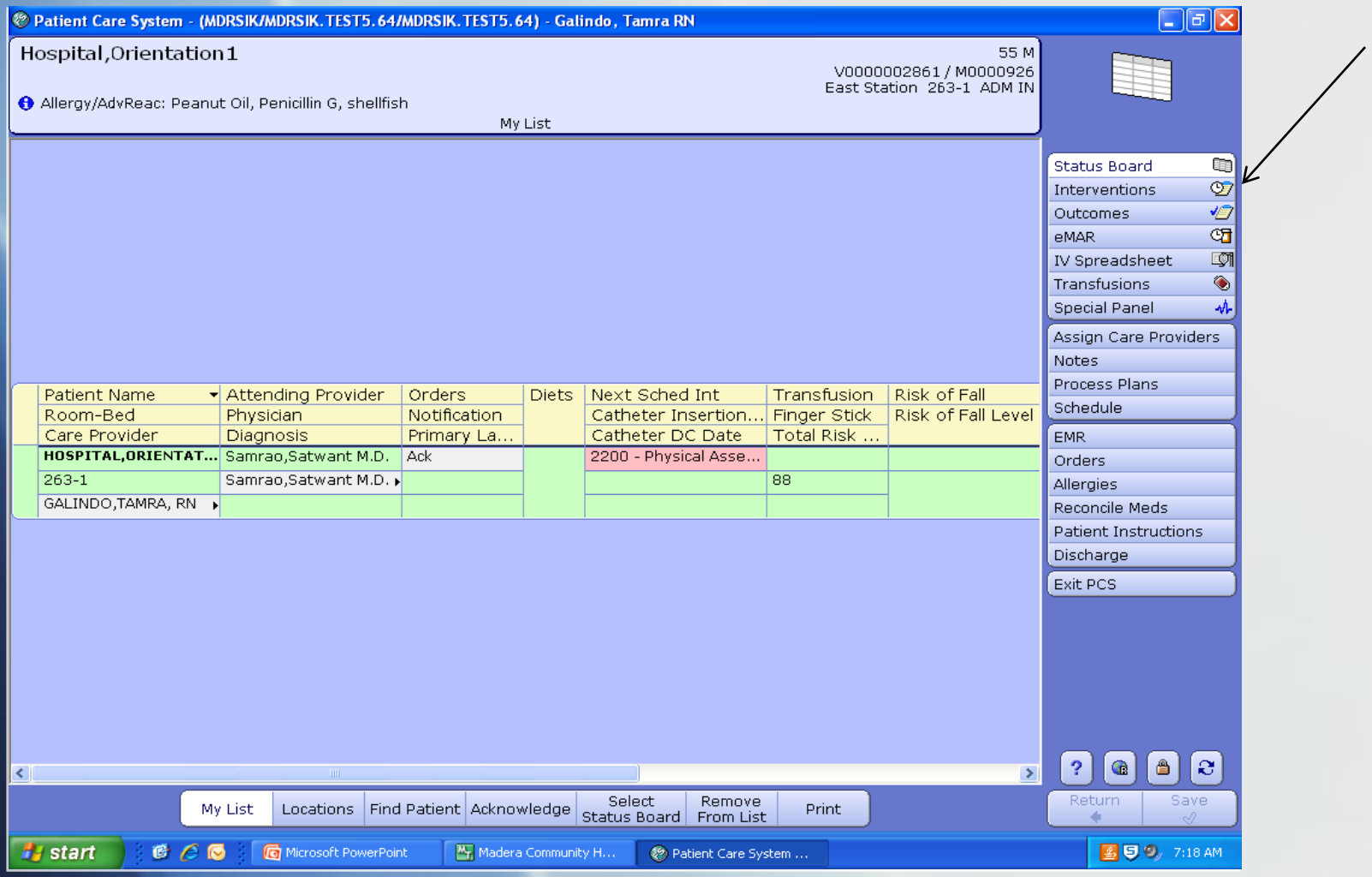
The integrated desk top (column to the right) contains tabs that allow you to document interventions, view results, and view what has been documented



Interventions= Document assessments, patient care
Outcomes= Document whether goals have been met or not
eMAR= Document medication administration
IV Spreadsheet=Document IV fluid intake and rate
EMR=View all patient data and care provider documentation

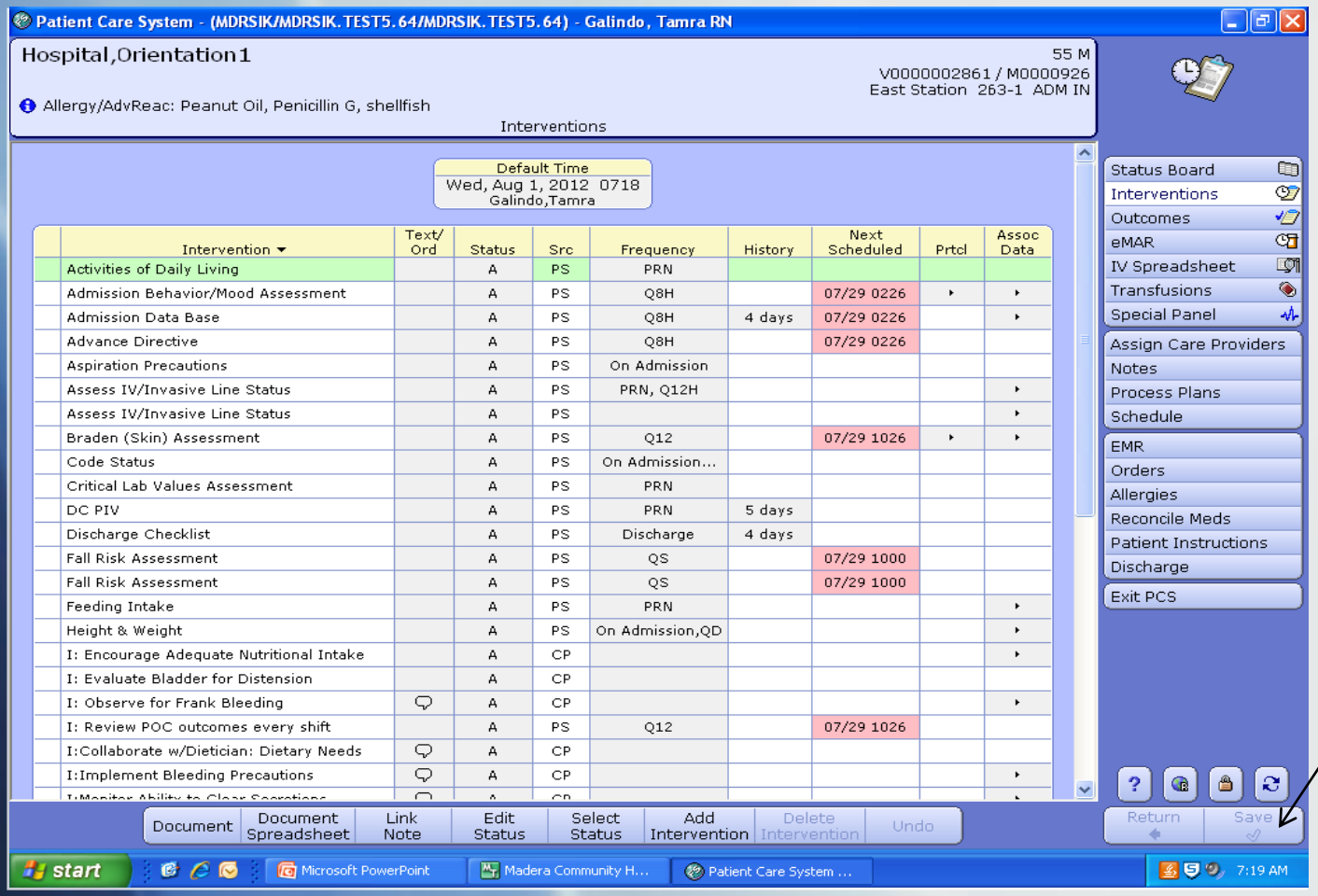
Patient Care Documentation

Click on the **Interventions** tab on the integrated desk top



Documentation is in "Real Time"

Double click the intervention you are wanting to document on (e.g. Activities of Daily Living). Document the intervention and click **Save**.



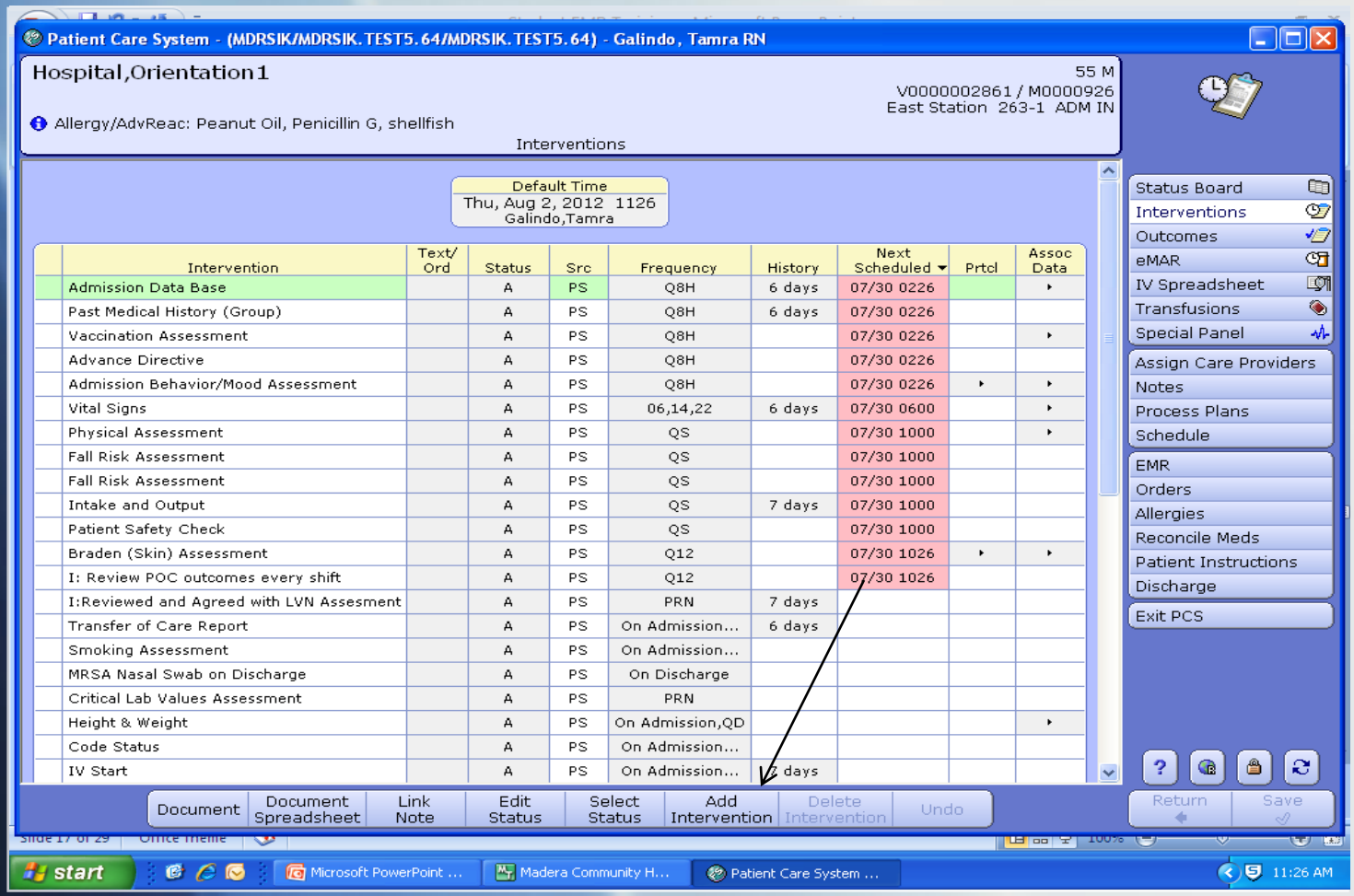
Interventions to Document

The interventions listed in red are how they appear on the intervention list

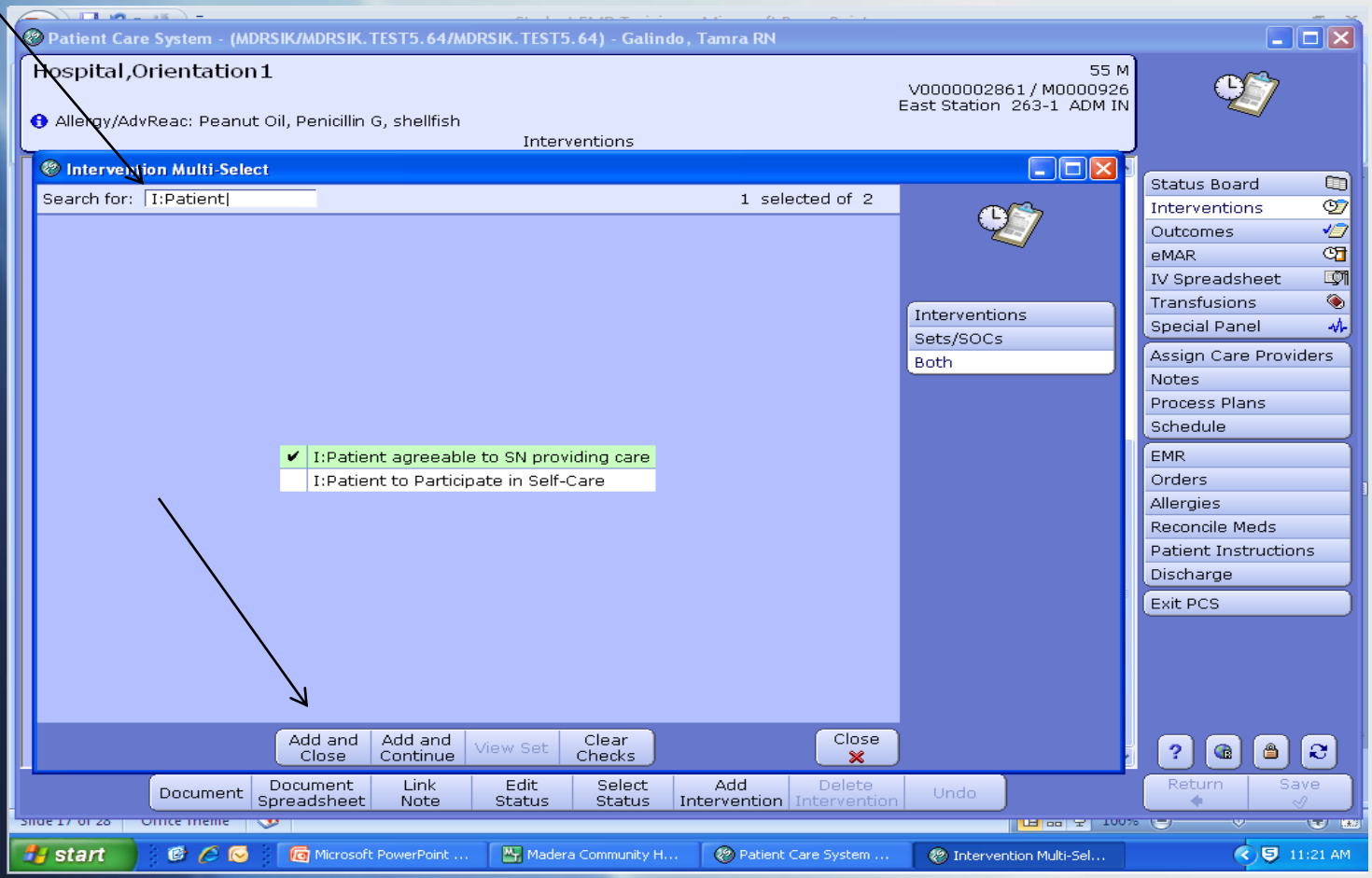
- Physical Assessment= physical assessment
- Braden (skin) Assessment= skin assessment
- Fall Risk Assessment= risk of fall assessment
- IV Start= inserting an IV
- DCIV/Invasive Line= discontinuing an IV
- Vital Signs= vital signs
- Pain assessment (stand alone)= pain
- Intake and Output= fluid intake and output
- Urinary Catheter Insertion/Assessment= inserting and assessing a urinary catheter
- Discontinue Urinary Catheter= urinary catheter removal
- Gastric Tube Insertion/Assessment= inserting, assessing, and removing a gastric tube (e.g. NGT)
- Feeding Intake= meal intake (breakfast, lunch, dinner, and supplements)
- Wound Assessment= wound assessments and dressing changes

Students must receive verbal permission from the patient to assist in their care, and document the permission.

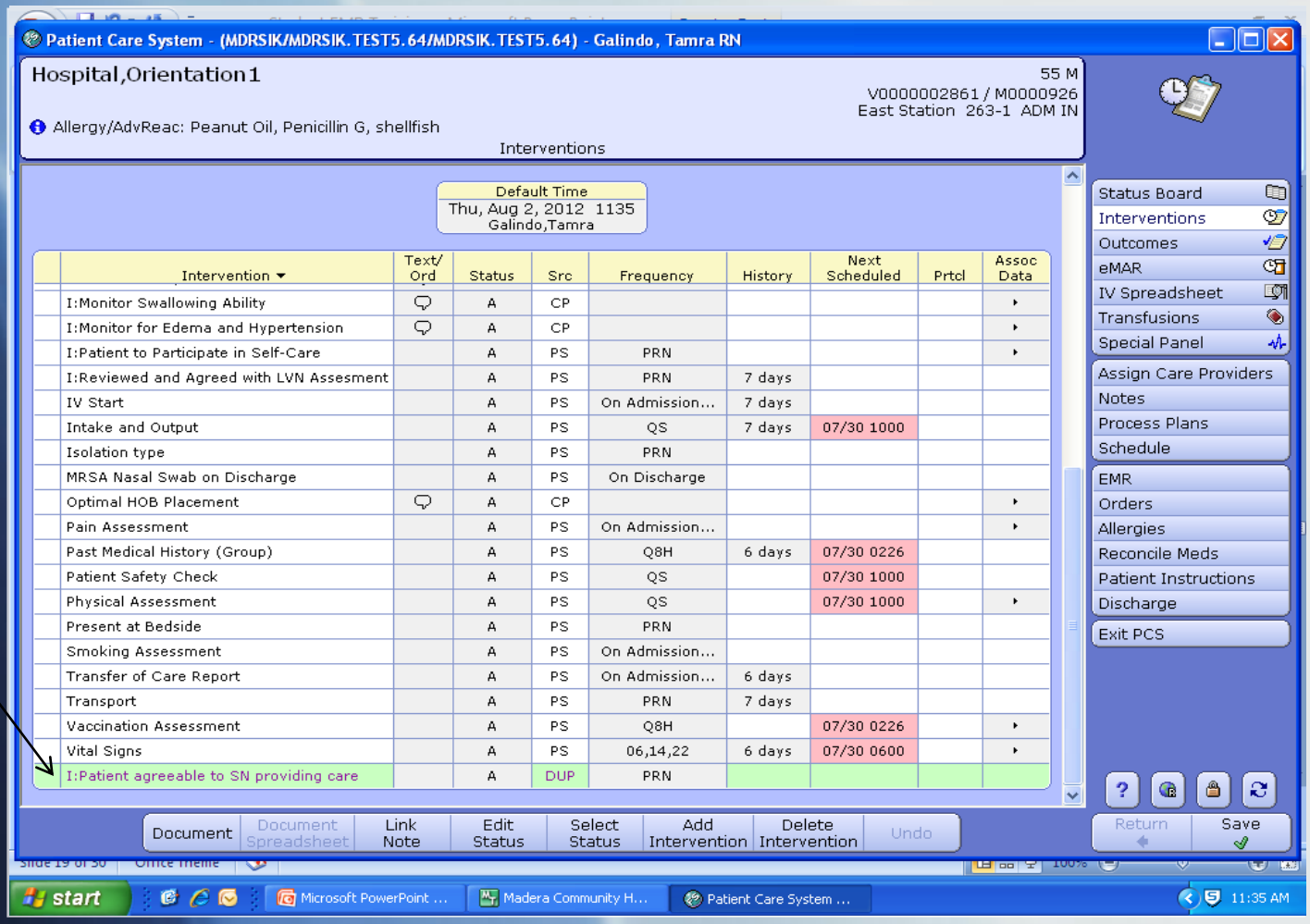
Click on **Add Intervention**



Type **I: Patient** in the search box. Click on the square to the left of the **I:Patient agreeable to SN providing care** intervention, a check mark will be placed. Click on **Add and Close** button.

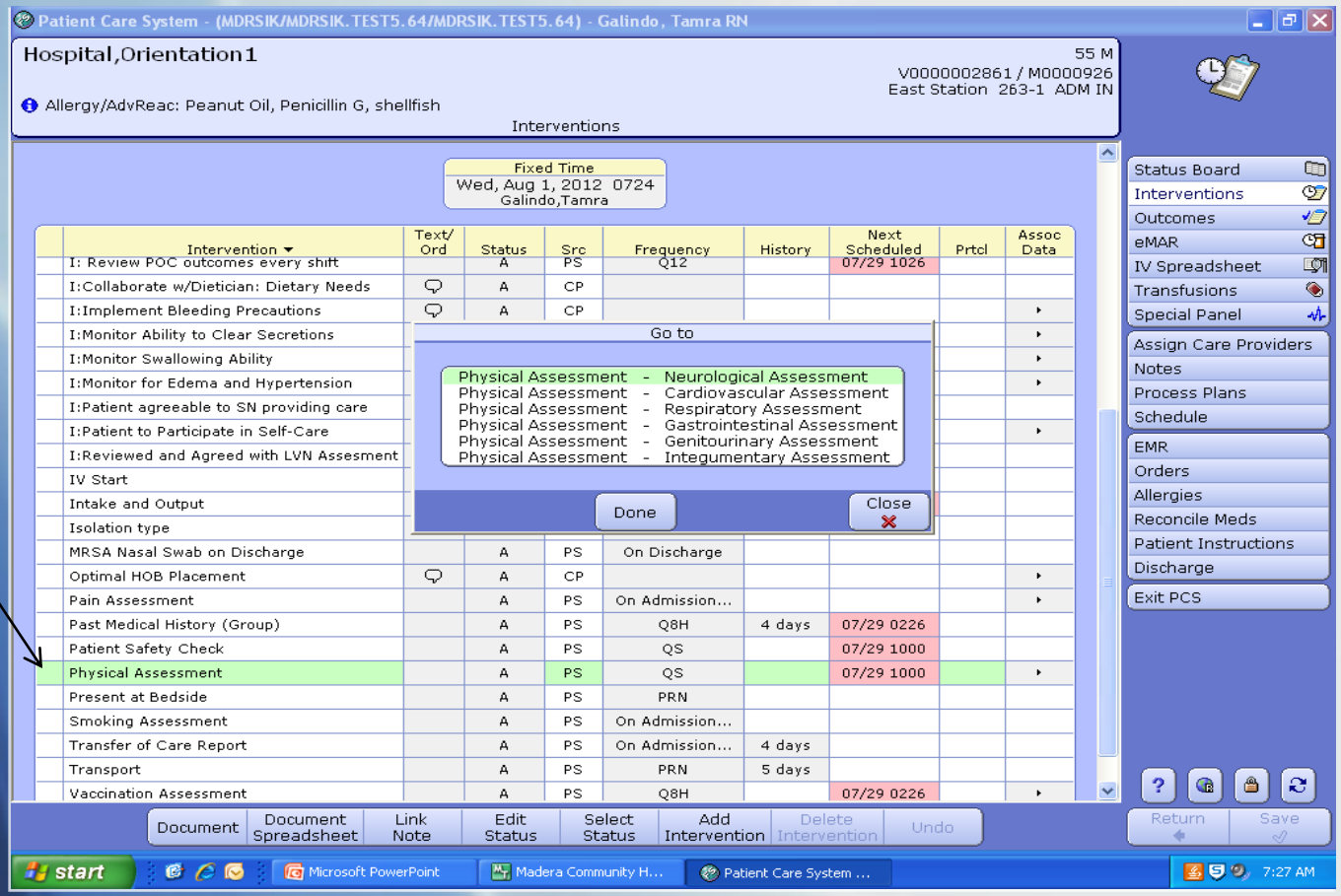


The **I:Patient agreeable to SN providing care** intervention will appear in purple on the intervention list. Double click the intervention and click Save.



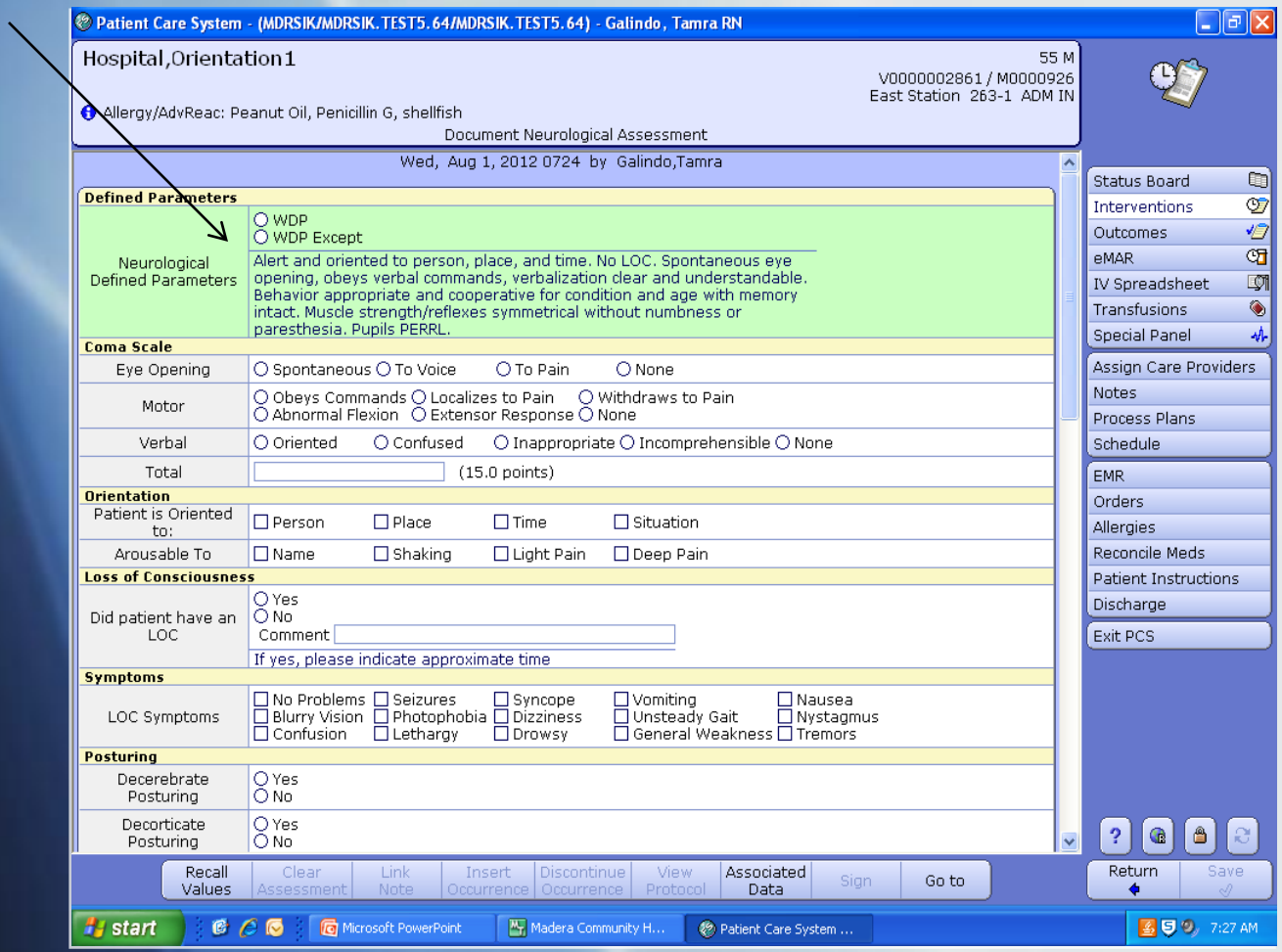
Documenting a Physical Assessment

Double click on **Physical Assessment**, each body system is listed individually



Charting by Exception on Physical Assessments

Click **WDP** (Within Defined Parameters) if the patient assessment matches the defined parameters listed. Click **WDP Except** if the patient assessment does NOT match the defined parameters listed.

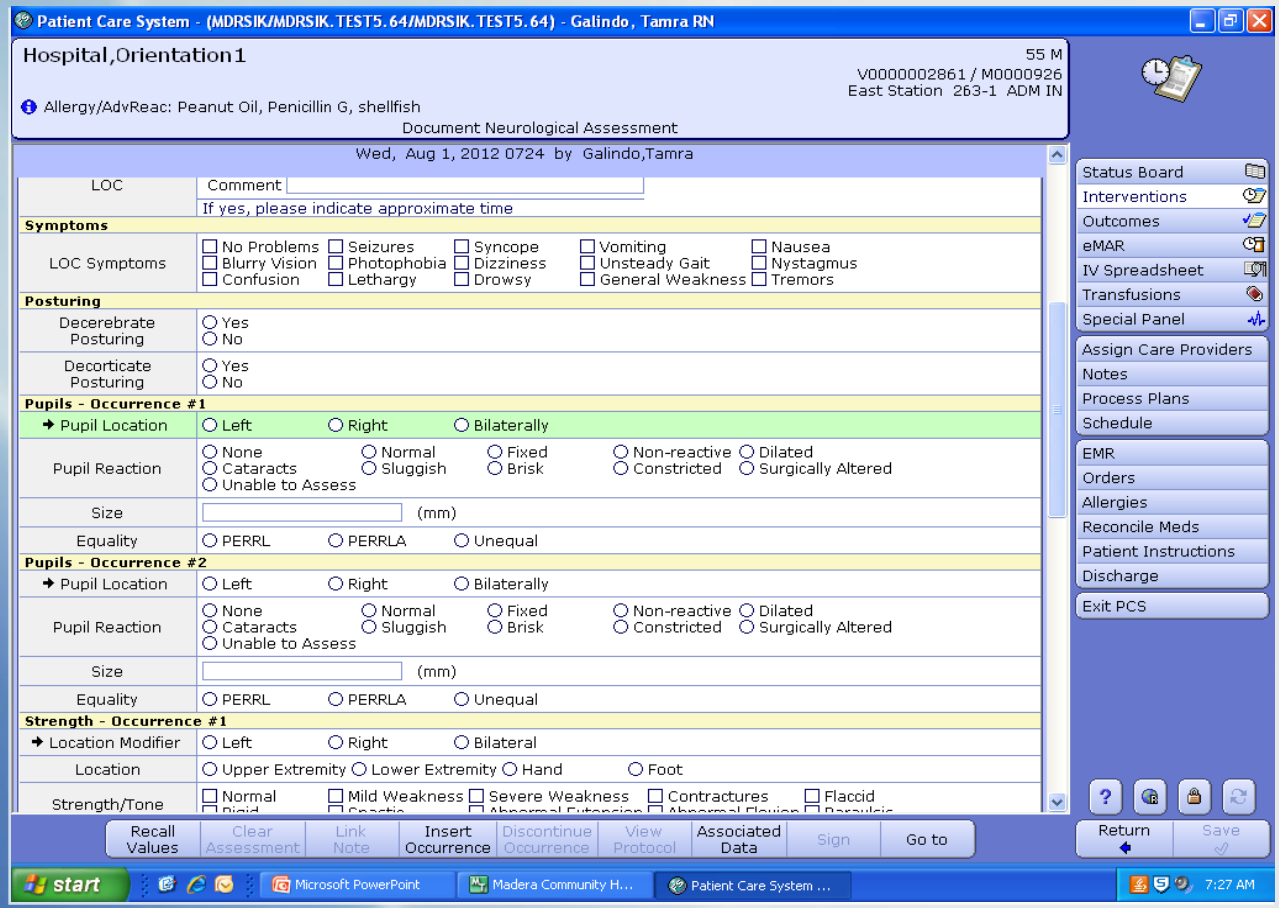


If you click WDP Except, only document the area(s) that are **NOT** within the defined parameters

Documenting a Repeatable Assessment/Intervention

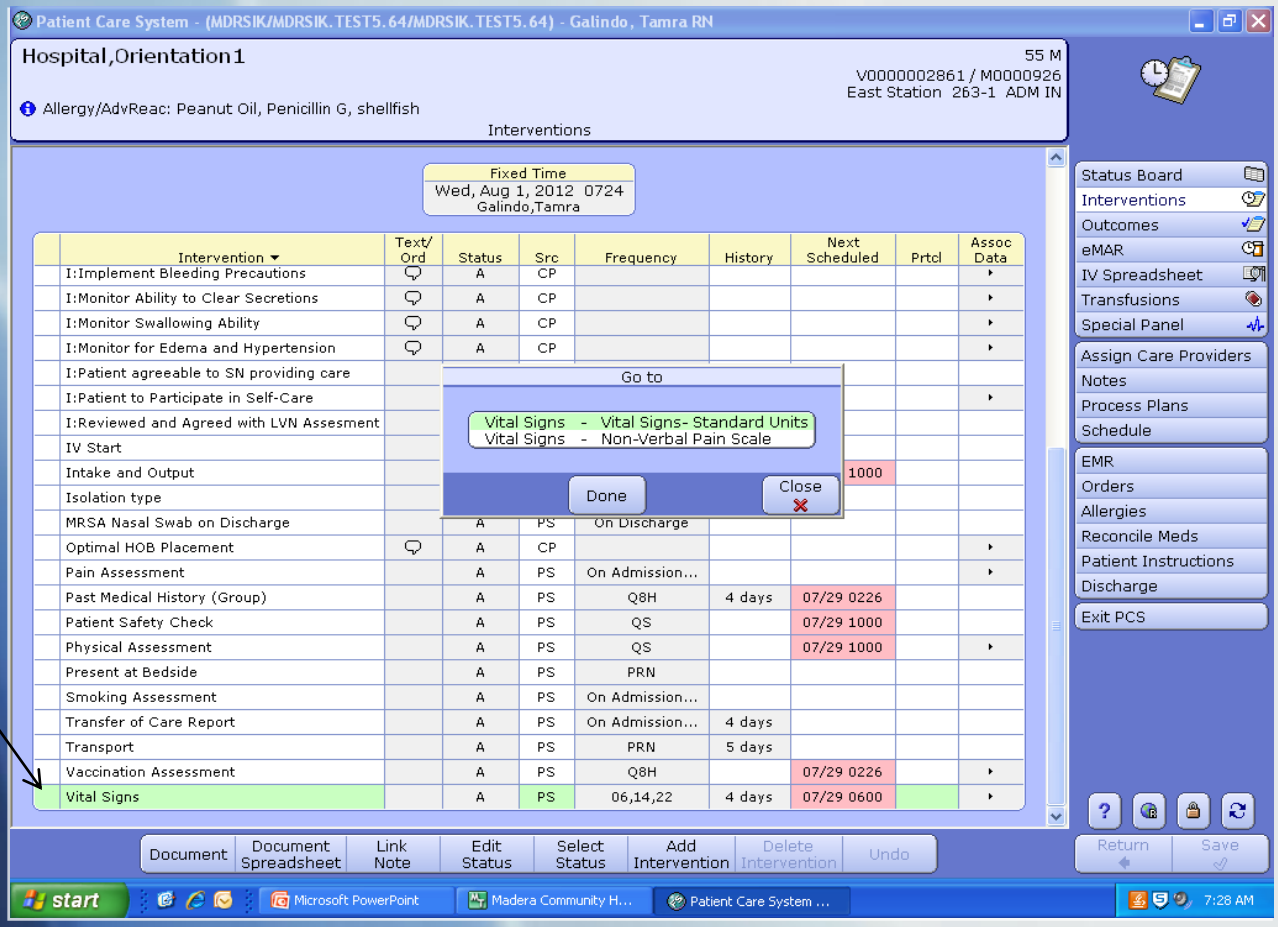
To document repeatable items; e.g. IV's, pupils, pulses, teaching, etc. Click on **Insert Occurrence** (footer button) and Occurrence #2, #3, etc. will appear.

For example: Pupils- Occurrence #2 has been added



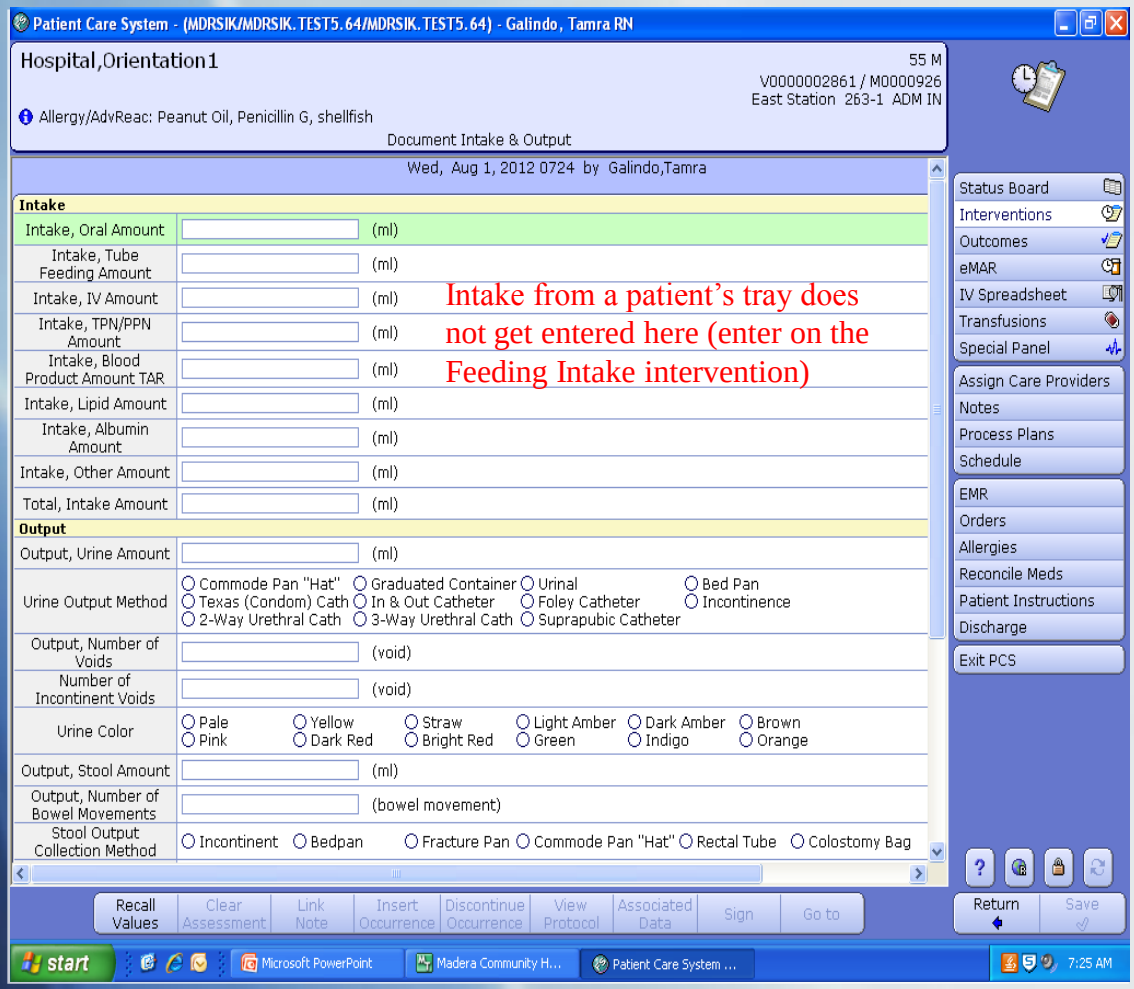
Documenting Vital Signs

Double click **Vital Signs** intervention, click Vital Signs-Standard Units, and click ***Save*** when done.



Documenting Intake & Output

Double click on the **Intake and Output** intervention and enter the patient's Intake and/or Output. Click **Save** when done.



The Intake and/or Output entered automatically transfers to the I & O in the EMR

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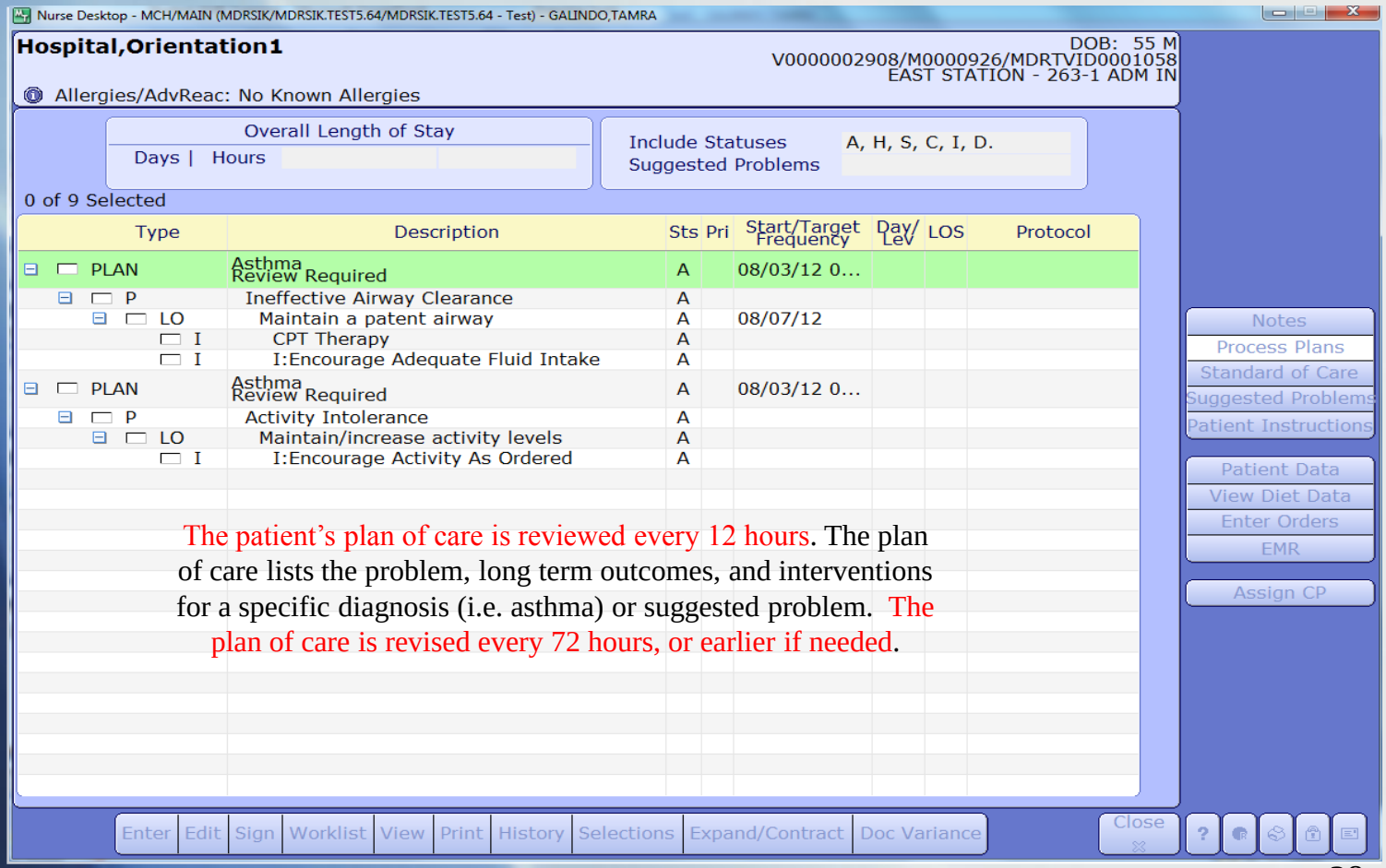
Charging for Supplies

- Please charge for new supplies as they are used.
- Charges are built into each intervention.

Ask for assistance from your instructor or RN Team Leader if you have questions about chargeable items

Care Plan

To view the Plan of Care (POC) click on **Process Plans** or **Outcomes** on the integrated desk top



The patient's plan of care is reviewed every 12 hours. The plan of care lists the problem, long term outcomes, and interventions for a specific diagnosis (i.e. asthma) or suggested problem. The plan of care is revised every 72 hours, or earlier if needed.

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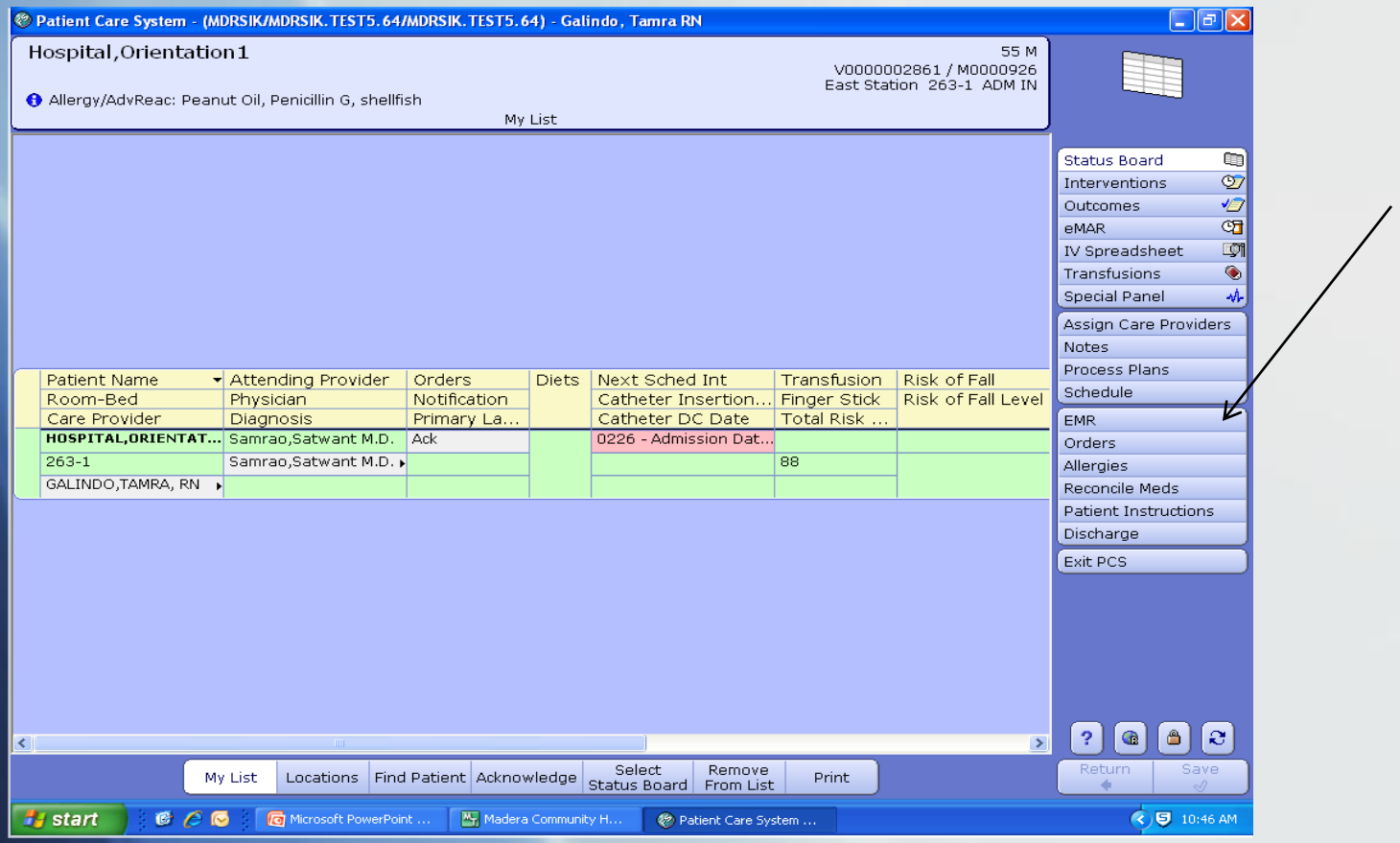
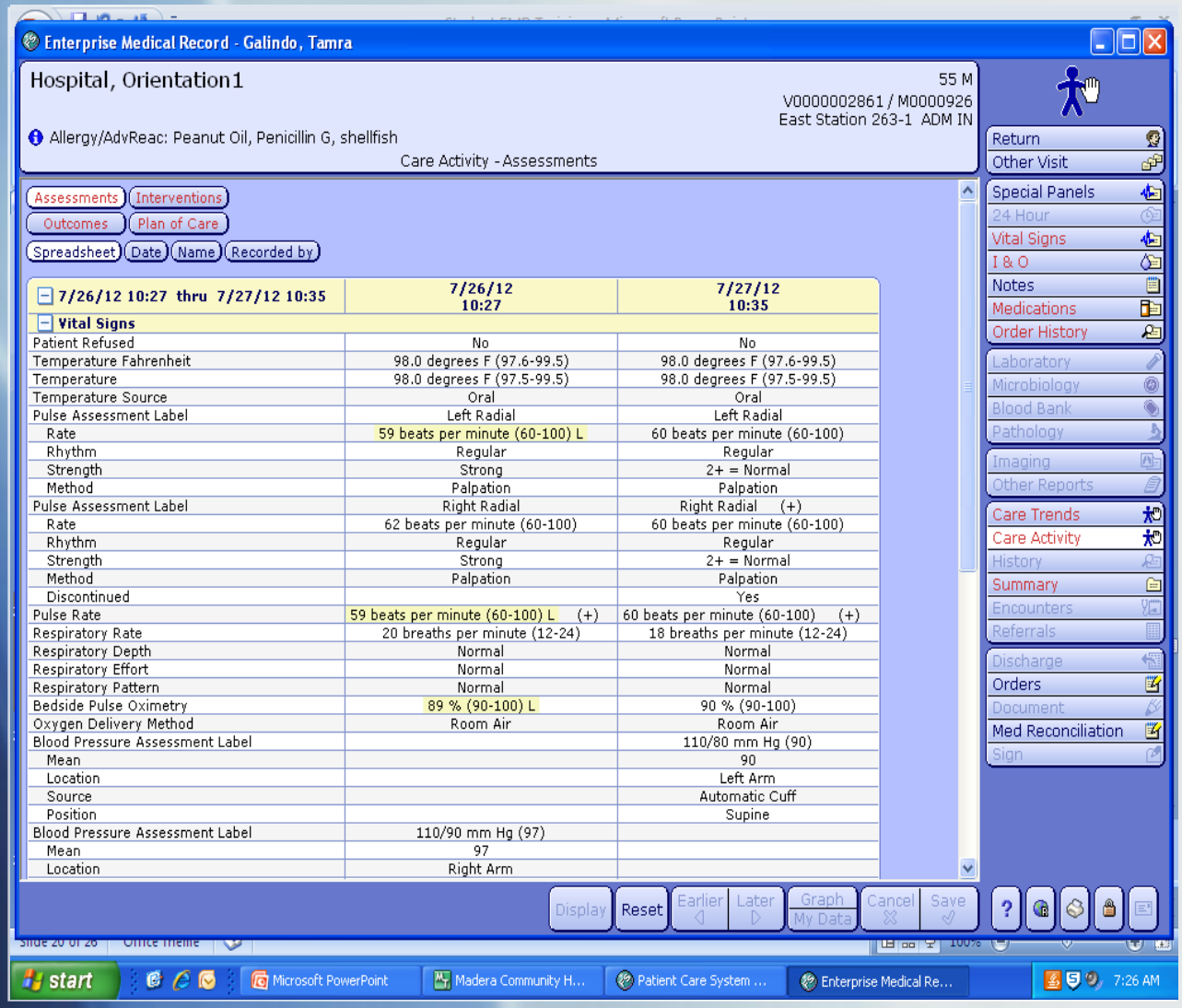
EMR (Enterprise Medical Record)

Click on **EMR** to "view only" patient VS, I & O, medications, order history, lab, microbiology, blood bank, pathology, imaging, ER notes, history and physical, care trends, and medication reconciliation.



Click on **Care Activity** tab to view a summary of the care documented during hospitalization.



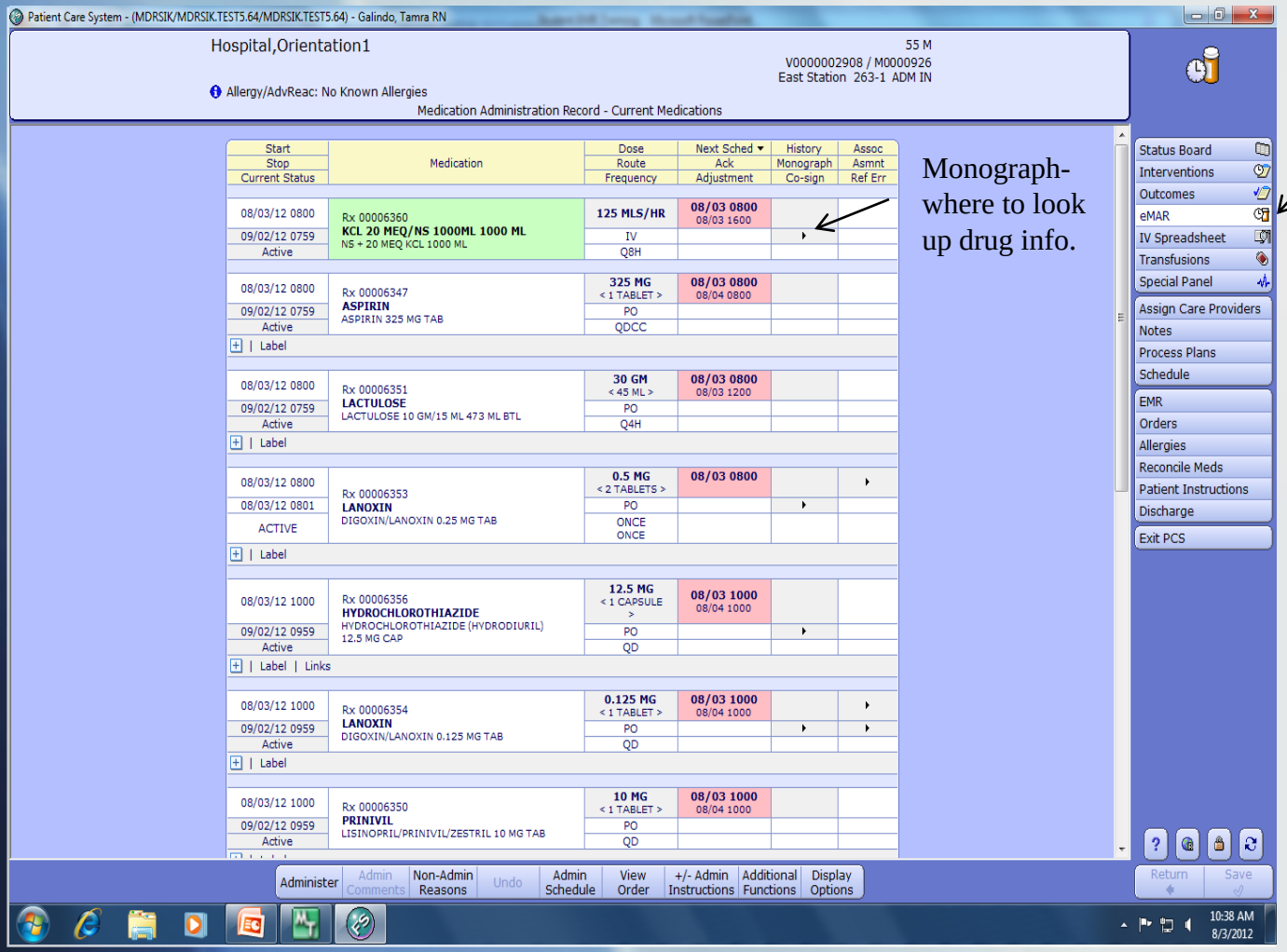
7/26/12 10:27 thru 7/27/12 10:35	7/26/12 10:27	7/27/12 10:35
Vital Signs		
Patient Refused	No	No
Temperature Fahrenheit	98.0 degrees F (97.6-99.5)	98.0 degrees F (97.6-99.5)
Temperature	98.0 degrees F (97.5-99.5)	98.0 degrees F (97.5-99.5)
Temperature Source	Oral	Oral
Pulse Assessment Label	Left Radial	Left Radial
Rate	59 beats per minute (60-100) L	60 beats per minute (60-100)
Rhythm	Regular	Regular
Strength	Strong	2+ = Normal
Method	Palpation	Palpation
Pulse Assessment Label	Right Radial	Right Radial (+)
Rate	62 beats per minute (60-100)	60 beats per minute (60-100)
Rhythm	Regular	Regular
Strength	Strong	2+ = Normal
Method	Palpation	Palpation
Discontinued		Yes
Pulse Rate	59 beats per minute (60-100) L (+)	60 beats per minute (60-100) (+)
Respiratory Rate	20 breaths per minute (12-24)	18 breaths per minute (12-24)
Respiratory Depth	Normal	Normal
Respiratory Effort	Normal	Normal
Respiratory Pattern	Normal	Normal
Bedside Pulse Oximetry	89 % (90-100) L	90 % (90-100)
Oxygen Delivery Method	Room Air	Room Air
Blood Pressure Assessment Label		110/80 mm Hg (90)
Mean		90
Location		Left Arm
Source		Automatic Cuff
Position		Supine
Blood Pressure Assessment Label	110/90 mm Hg (97)	
Mean	97	
Location	Right Arm	

This is a great tool for hand-off report. Remember to use SBAR

Bedside Medication Verification (BMV)

Always follow the 6 Rights of Medication Administration

Click on ***eMAR*** from the integrated desk top. You will use a hand held scanner attached to the WOW to scan your patient's wrist band and medications.



6 Rights of Med. Admin.

1. Right patient

2. Right med.

3.Right dose

4. Right route

5. Right time

6.Right to refuse

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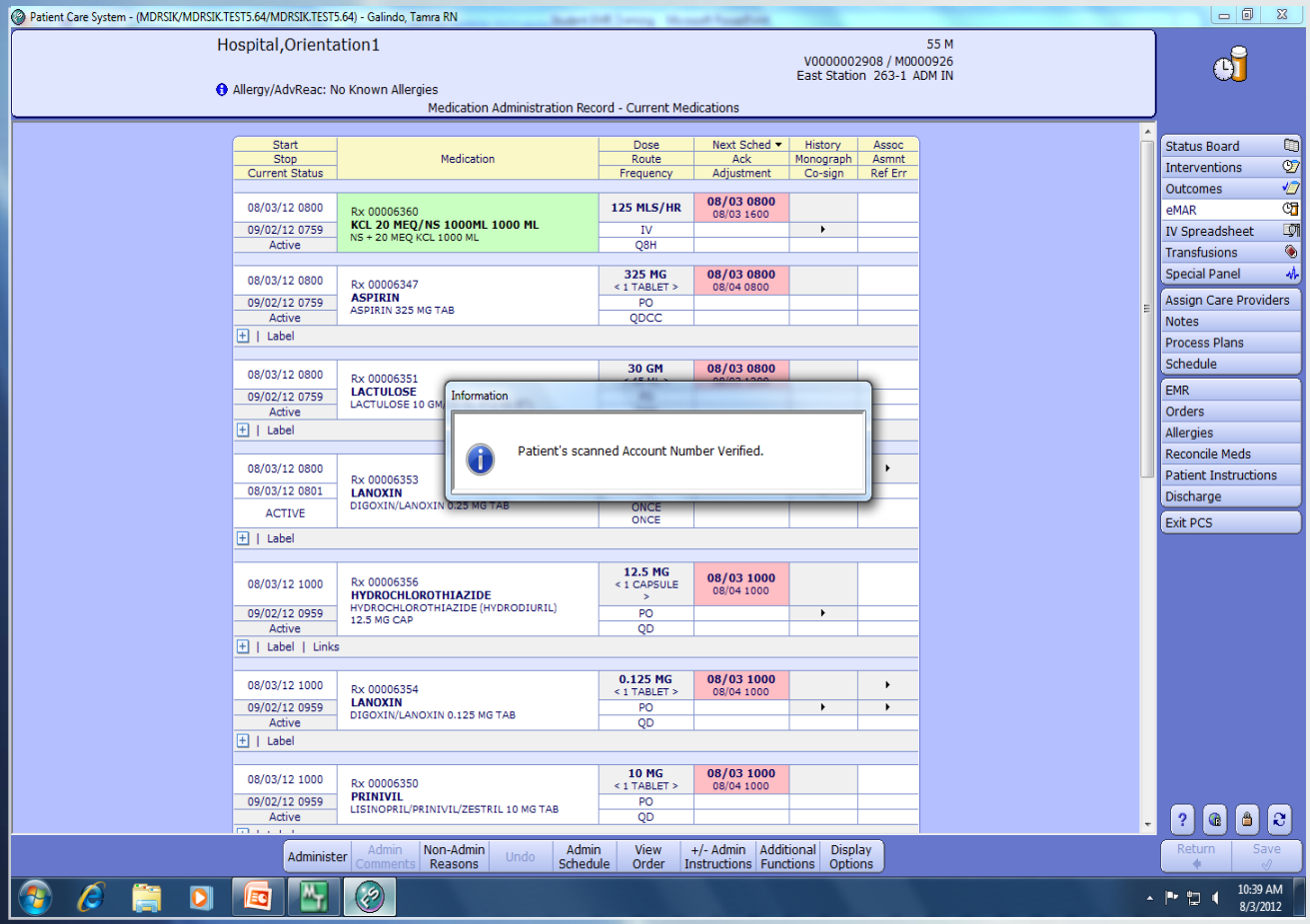
Bedside Medication Verification (BMV)

With your instructor or RN Team Leader at bedside scan the patient's wrist band with the hand held scanner, compare the patient's name and medical record number from the wristband against the eMAR, check for allergies, and medication expiration date. A confirmation box will appear in the middle of the screen.



Always tell the patient

- ✓ **Name of Medication**
- ✓ **What it is used for**
- ✓ **Why he or she is receiving it**
- ✓ **Possible side effects**

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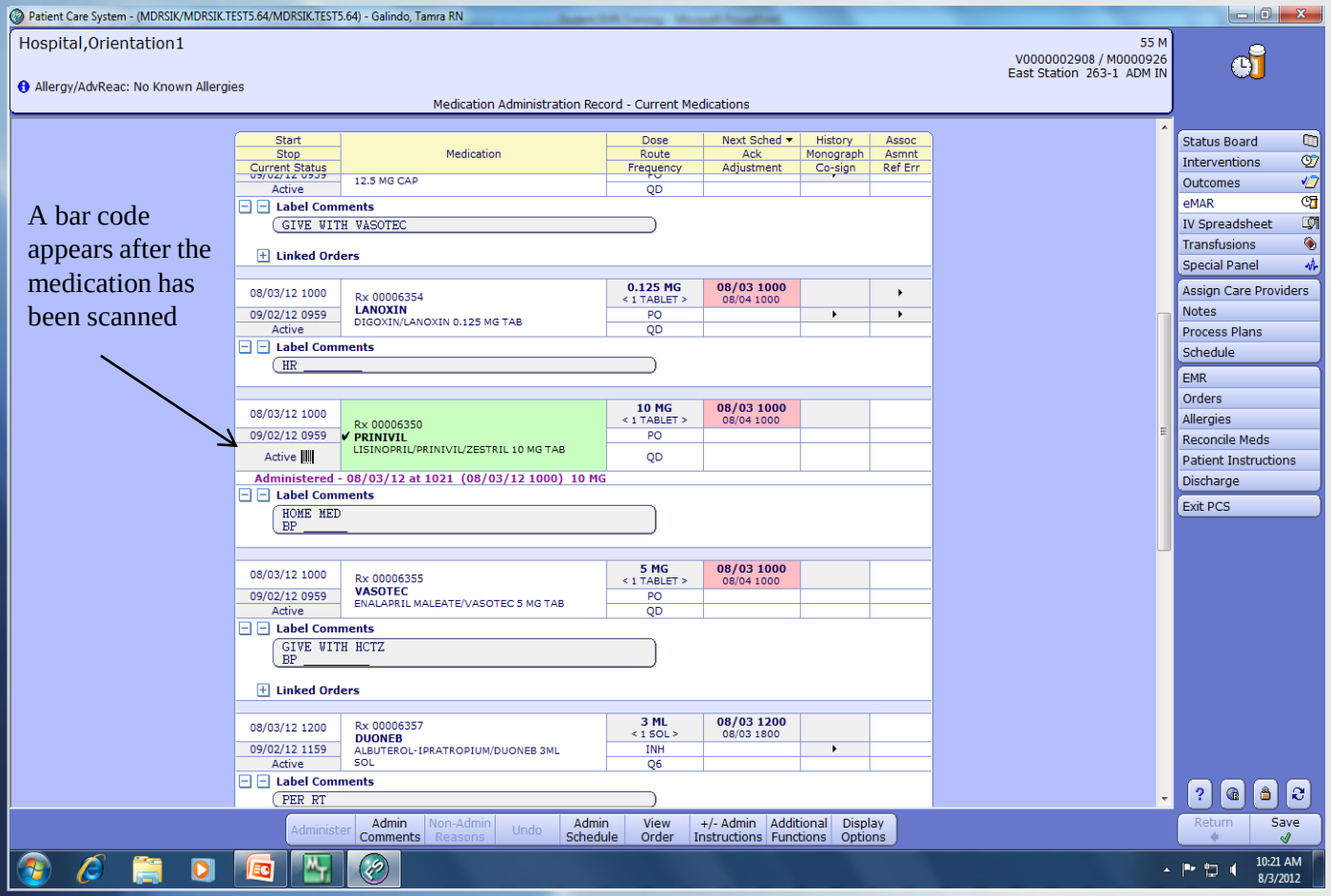
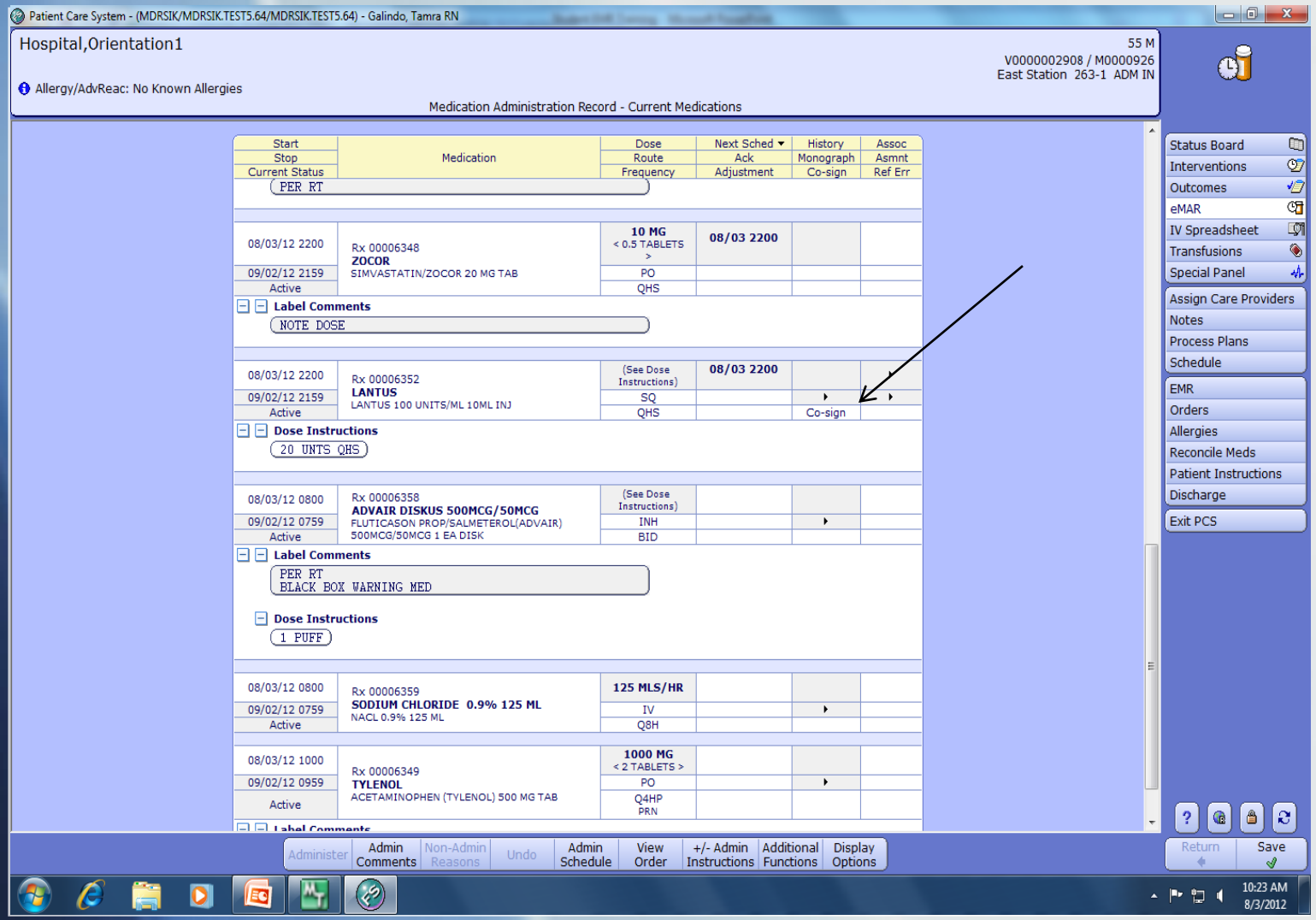
Double check the patient's name, name of the medication, dose, route, and scheduled time of the medication before scanning it. Administered-date, time, amount will appear below in purple. Click **Save** when done.

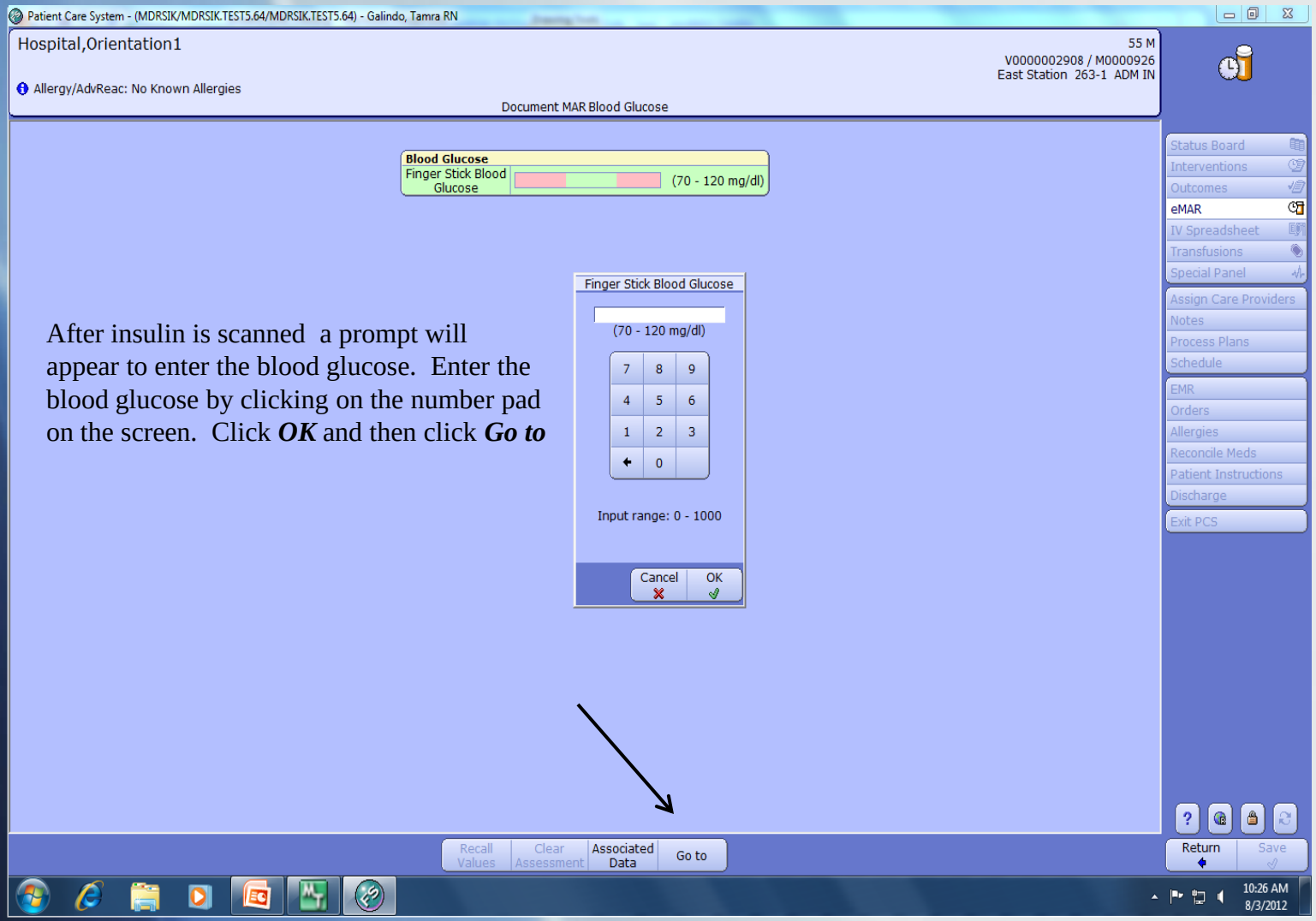


High-Risk Meds Require a Co-Signer

Insulin is an example of a high-risk med and the word Co-sign appears

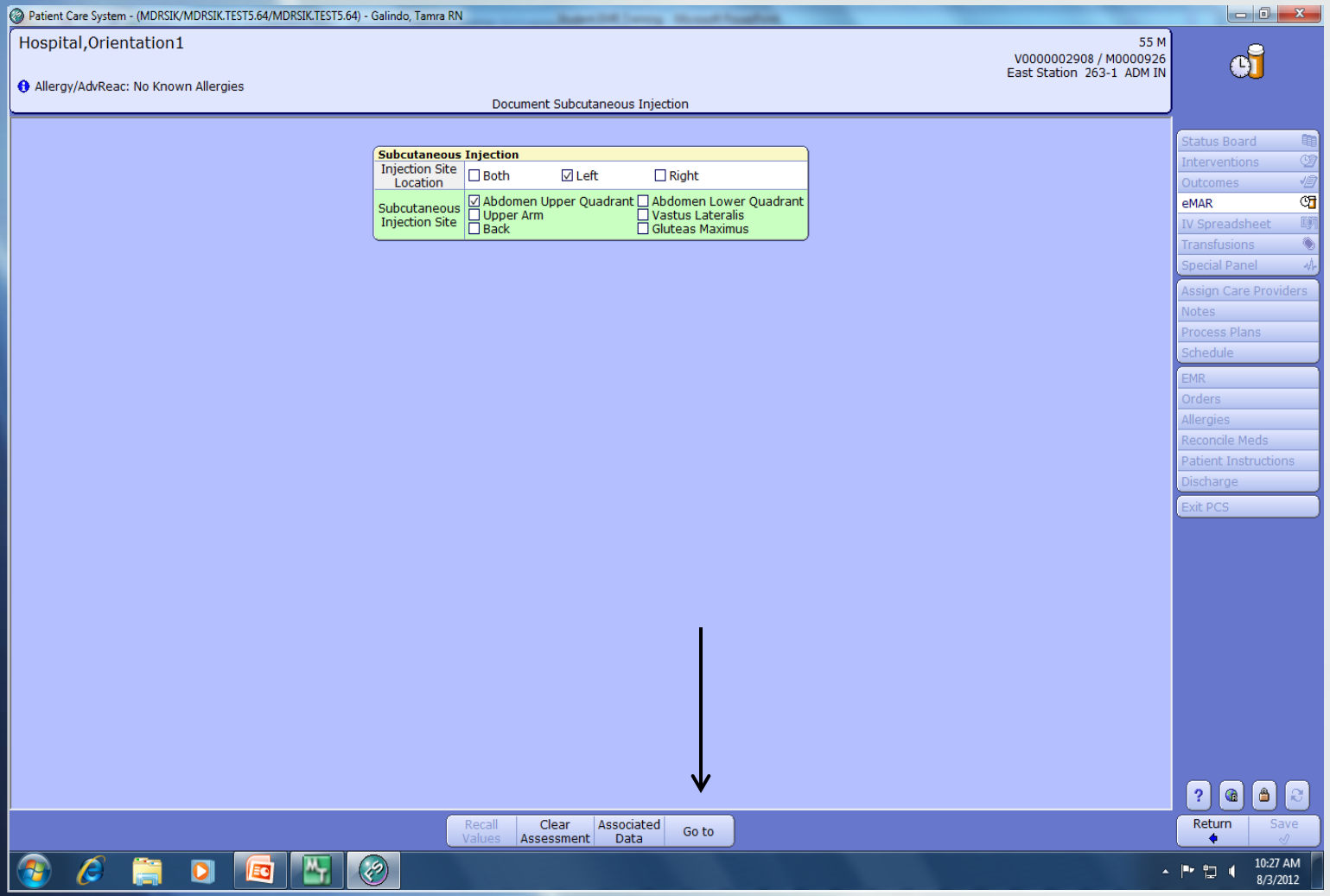


Documenting Blood Glucose

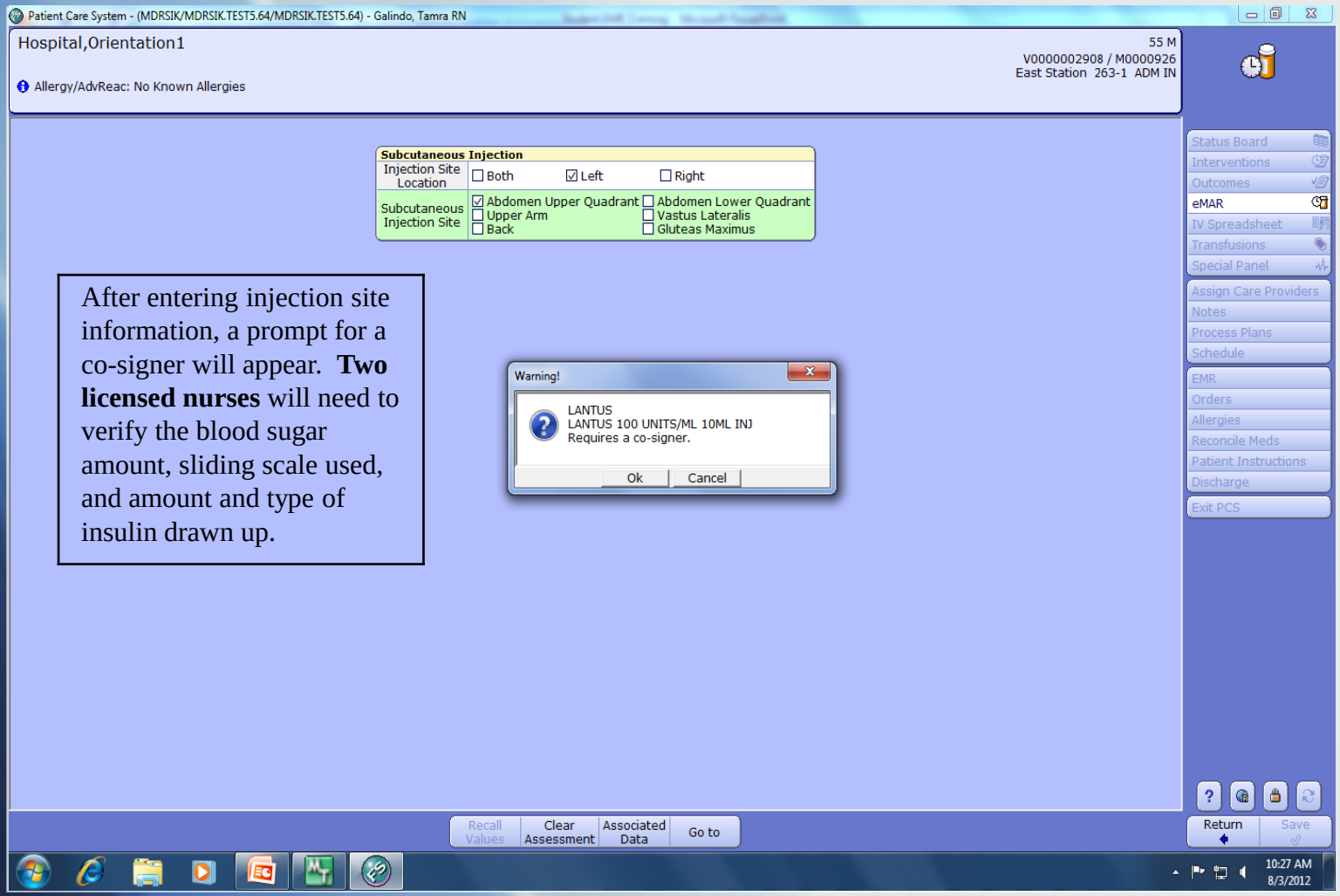


After insulin is scanned a prompt will appear to enter the blood glucose. Enter the blood glucose by clicking on the number pad on the screen. Click ***OK*** and then click ***Go to***

Click on the site location and site selected for injection. When finished, click ***Go to.***



Documenting Insulin Administration



After entering injection site information, a prompt for a co-signer will appear. **Two licensed nurses** will need to verify the blood sugar amount, sliding scale used, and amount and type of insulin drawn up.

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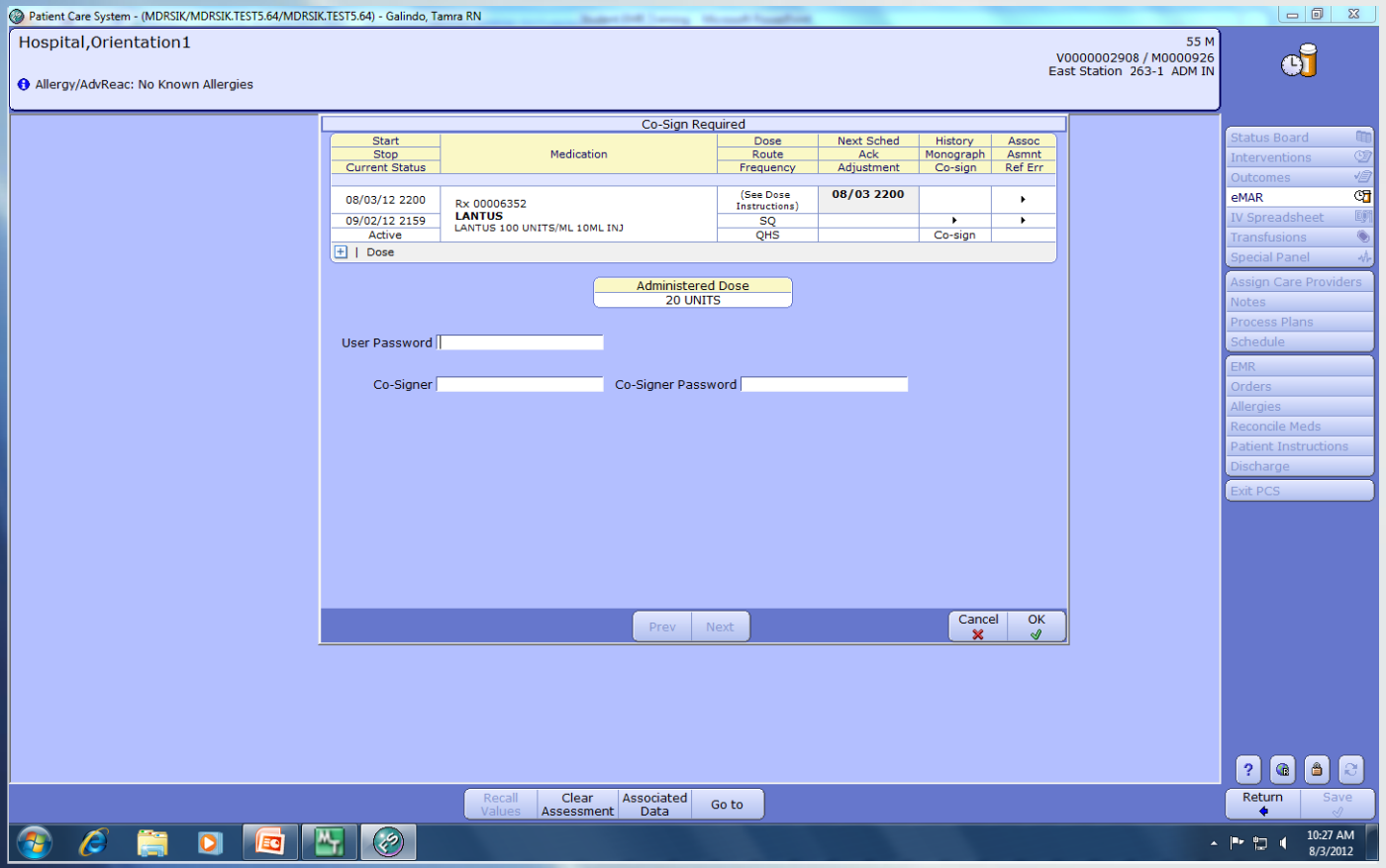
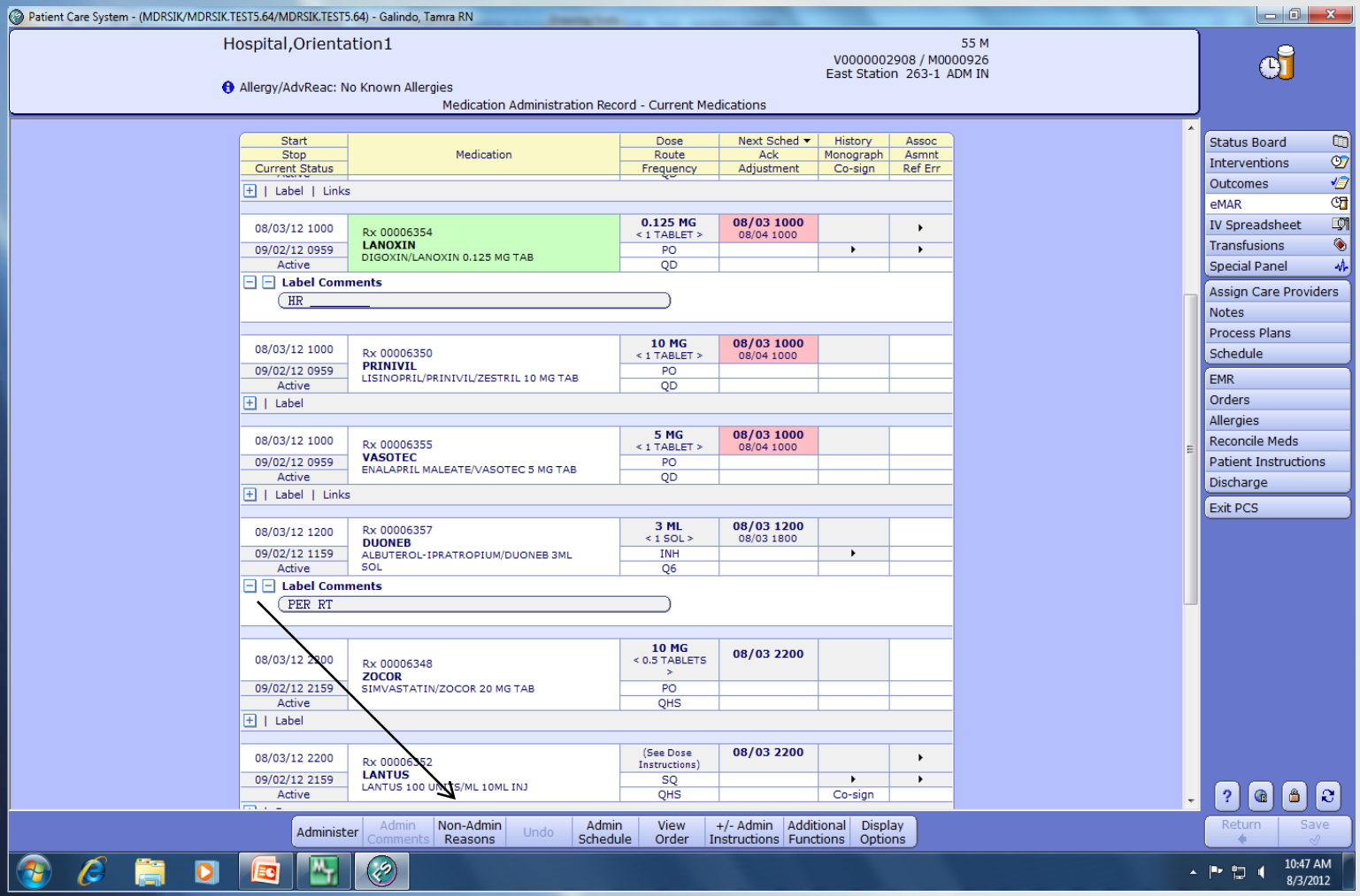
Co-Signer

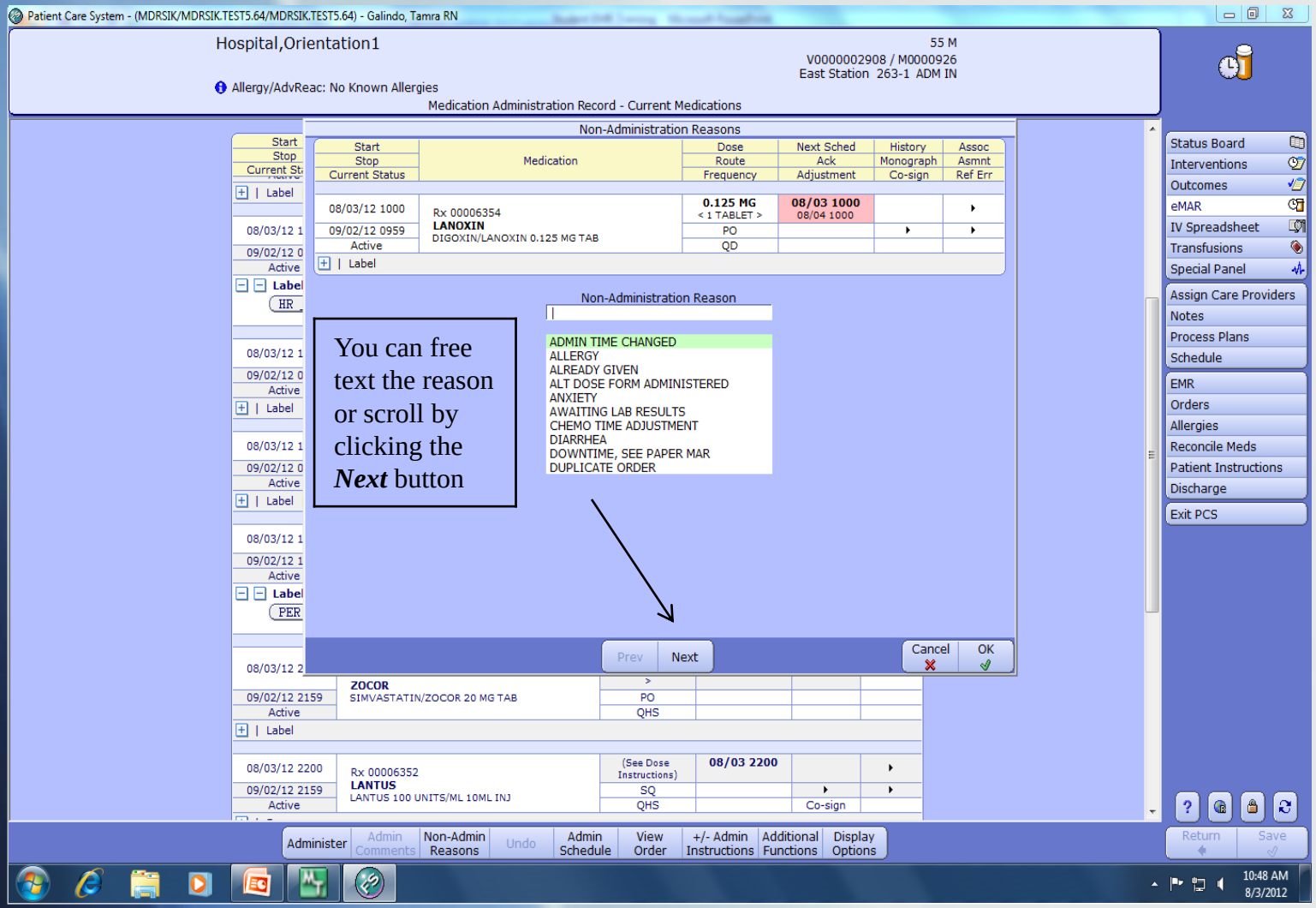
The RN/instructor administering the insulin with the student enters his or her User Password in the top box. The licensed co-signer enters his or her User Name and Password in the Co-Signer boxes.



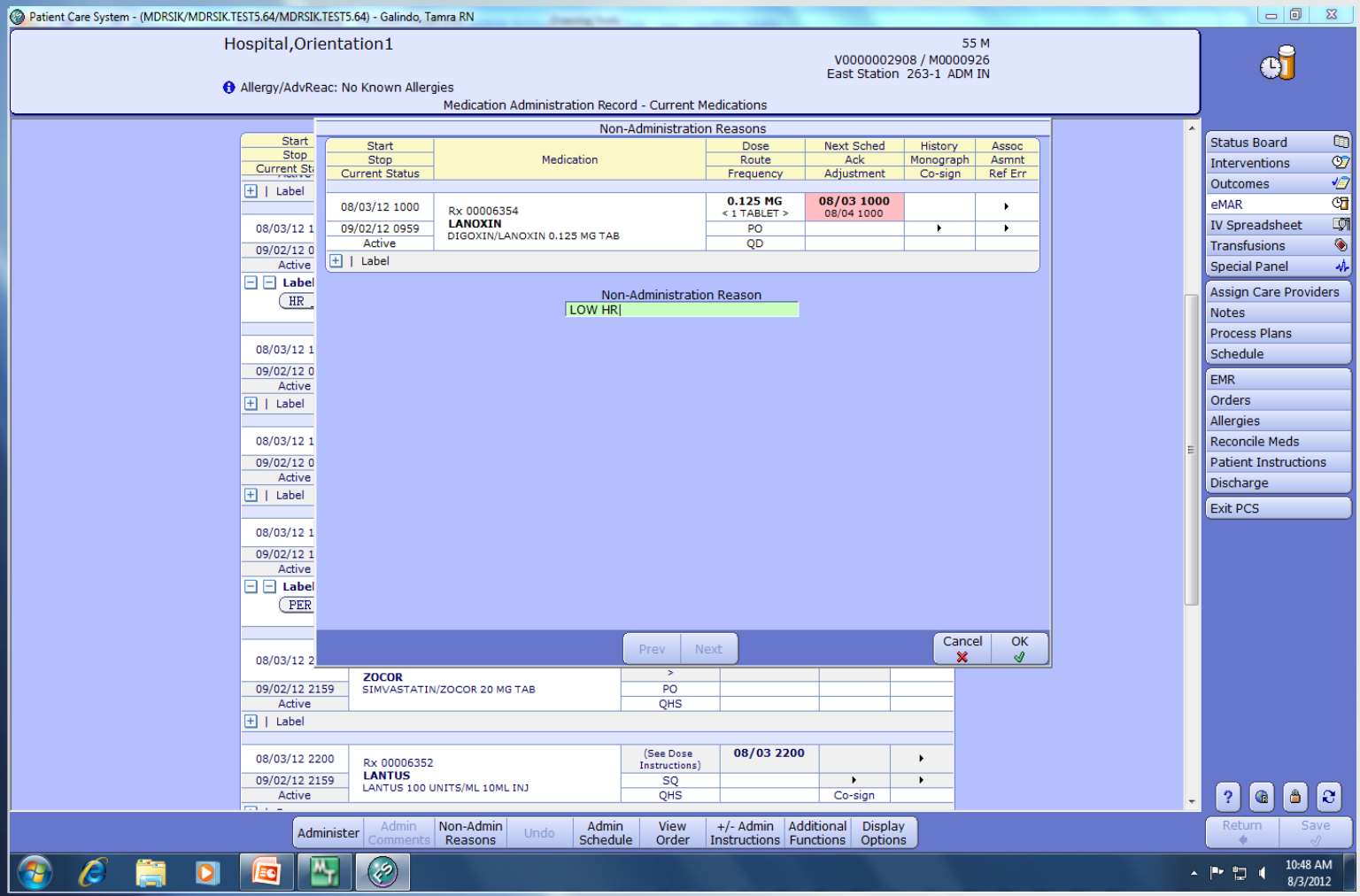
When a scheduled medication is not going to be given, click on ***Non-Admin Reasons*** to document



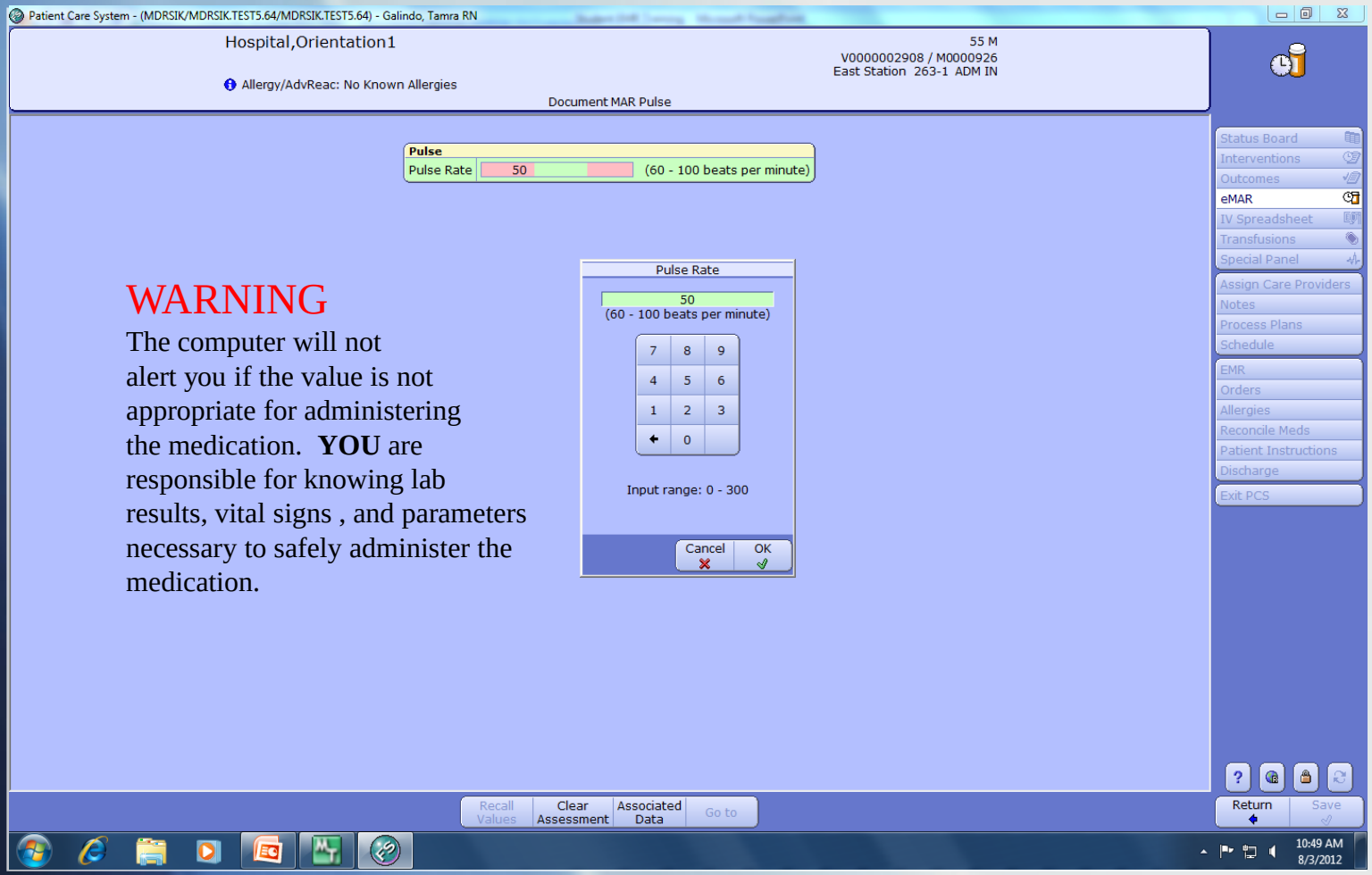
This screen will appear after clicking the **Non-Admin Reasons** button



Select from the list of Non-Admin Reasons for why the medication was not given



Enter additional information if needed/prompted to support why the medication was not administered

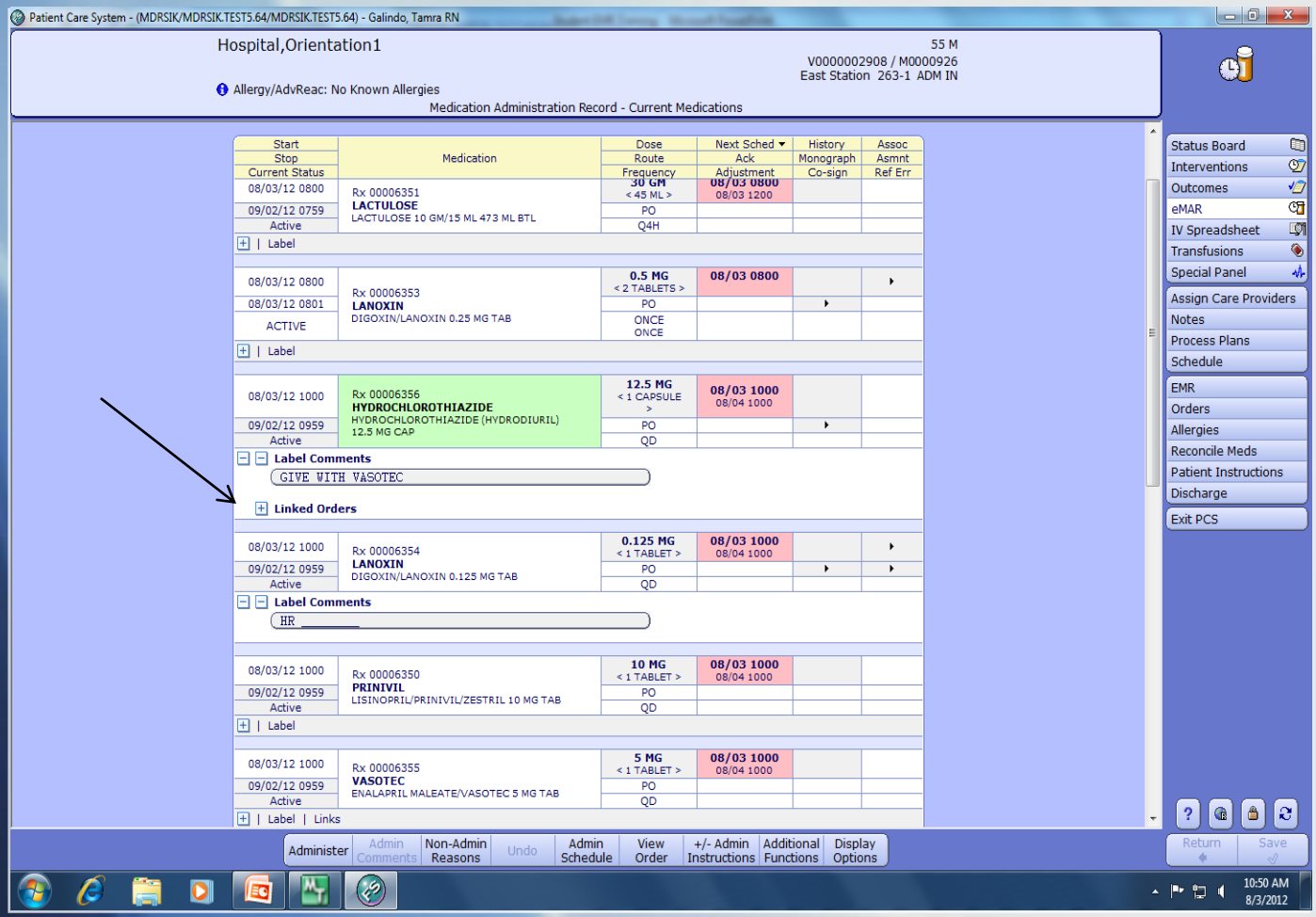


WARNING

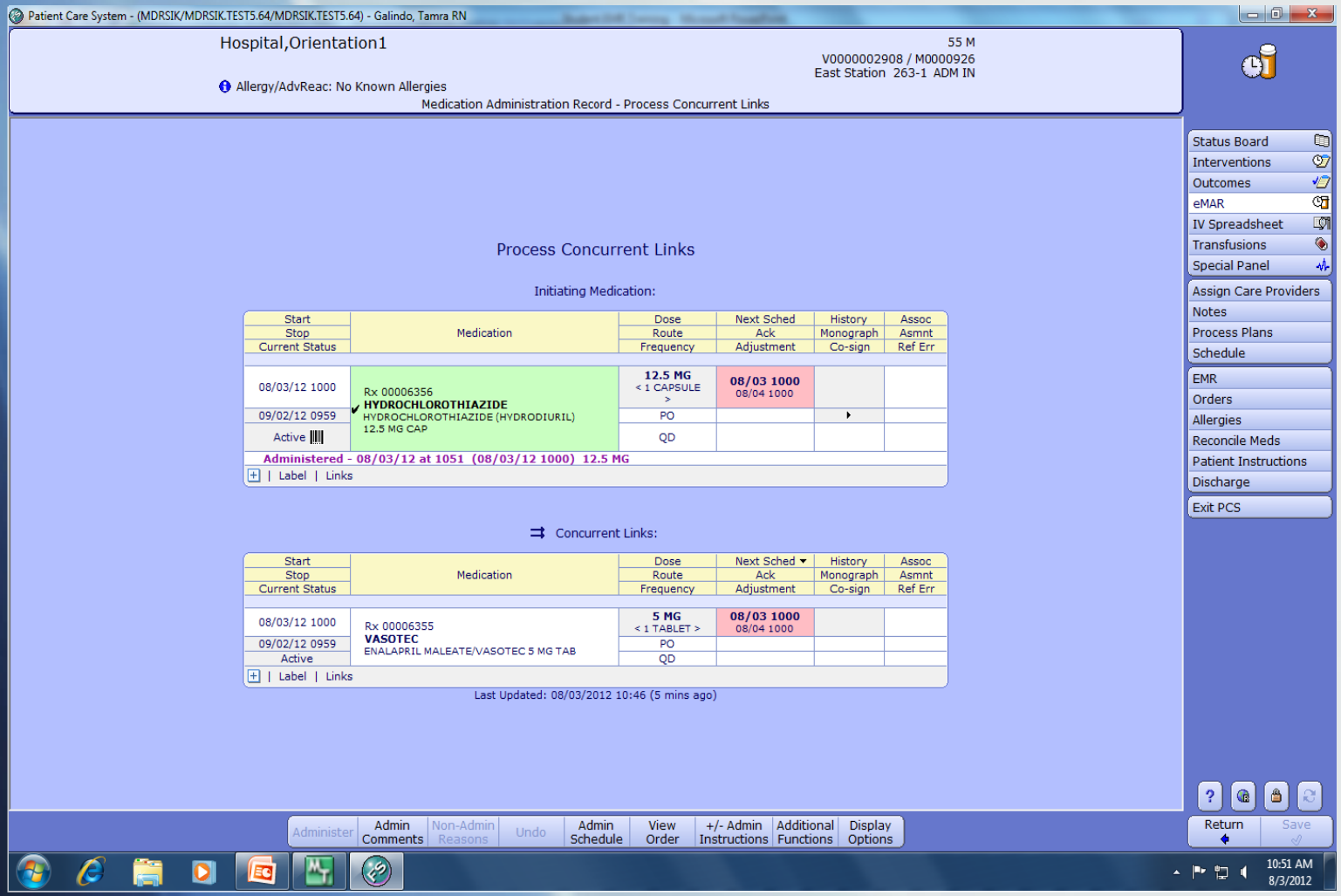
The computer will not alert you if the value is not appropriate for administering the medication. **YOU** are responsible for knowing lab results, vital signs , and parameters necessary to safely administer the medication.

Linked Medications

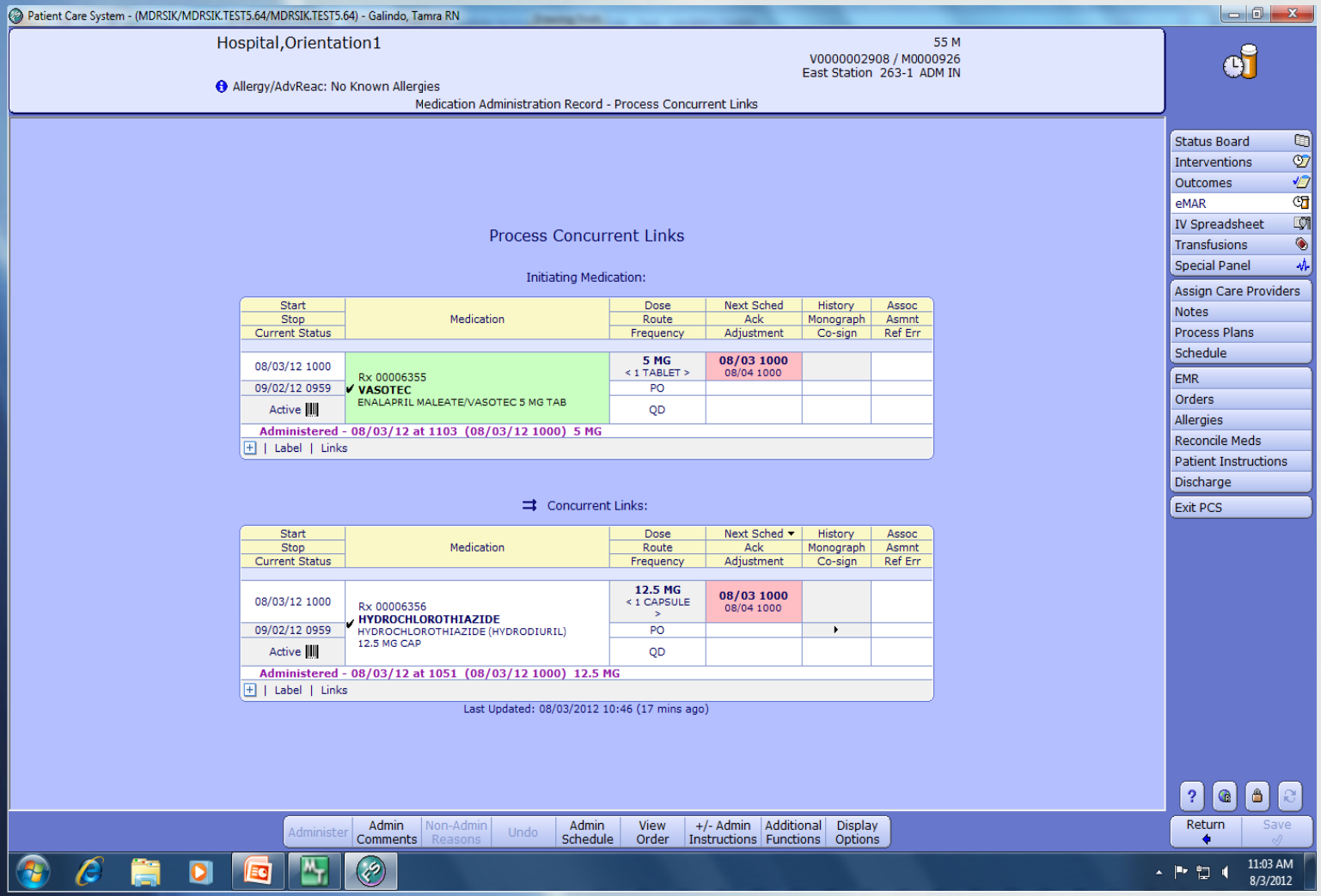
Medications that are to be given together will have the words **Linked Orders** by **Label Comments**.



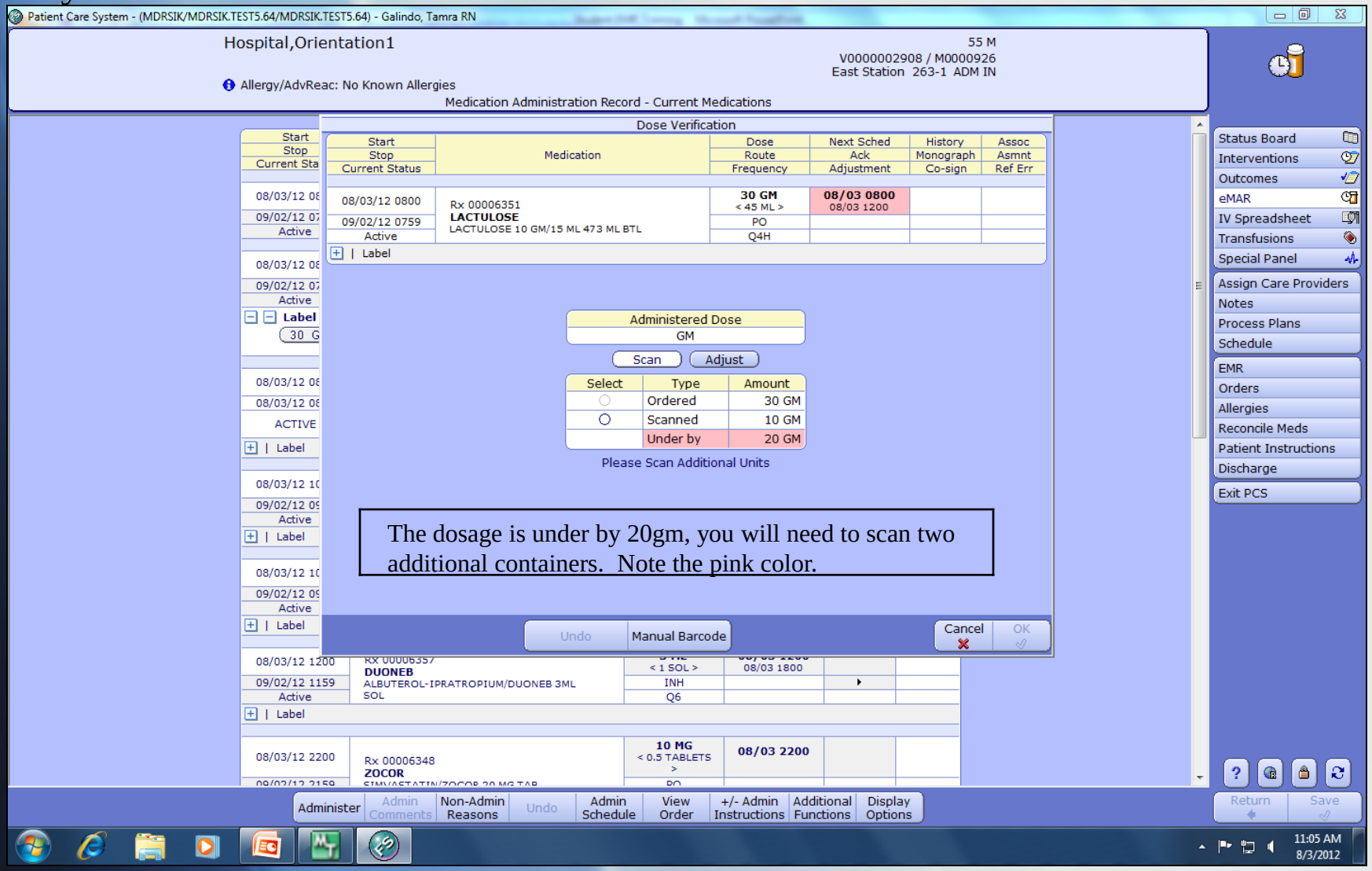
When the linked medication is scanned, the other medication it is linked to will appear below it.



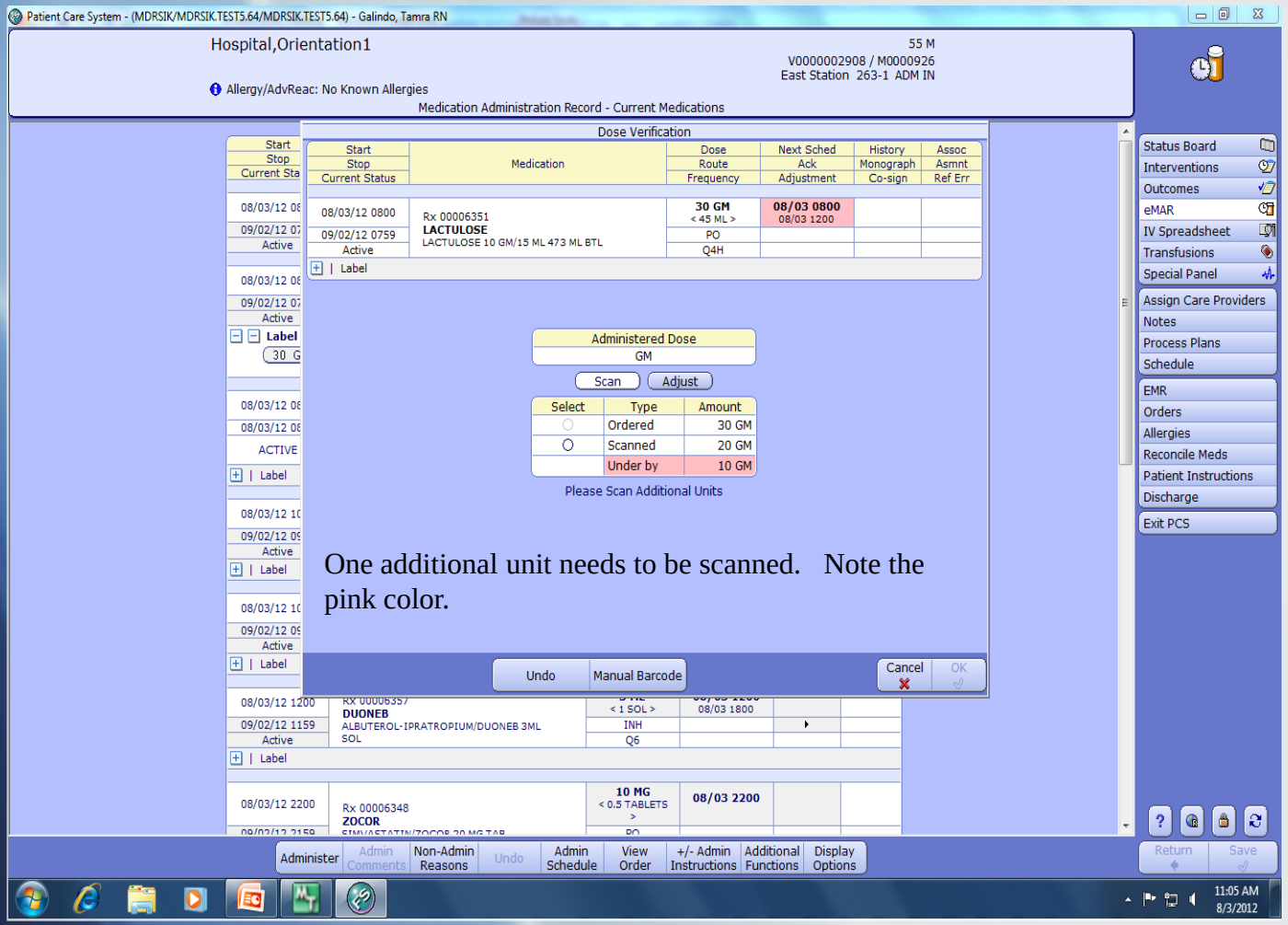
This screen appears after the second linked medication is scanned. Click **Return** to return to the eMAR.



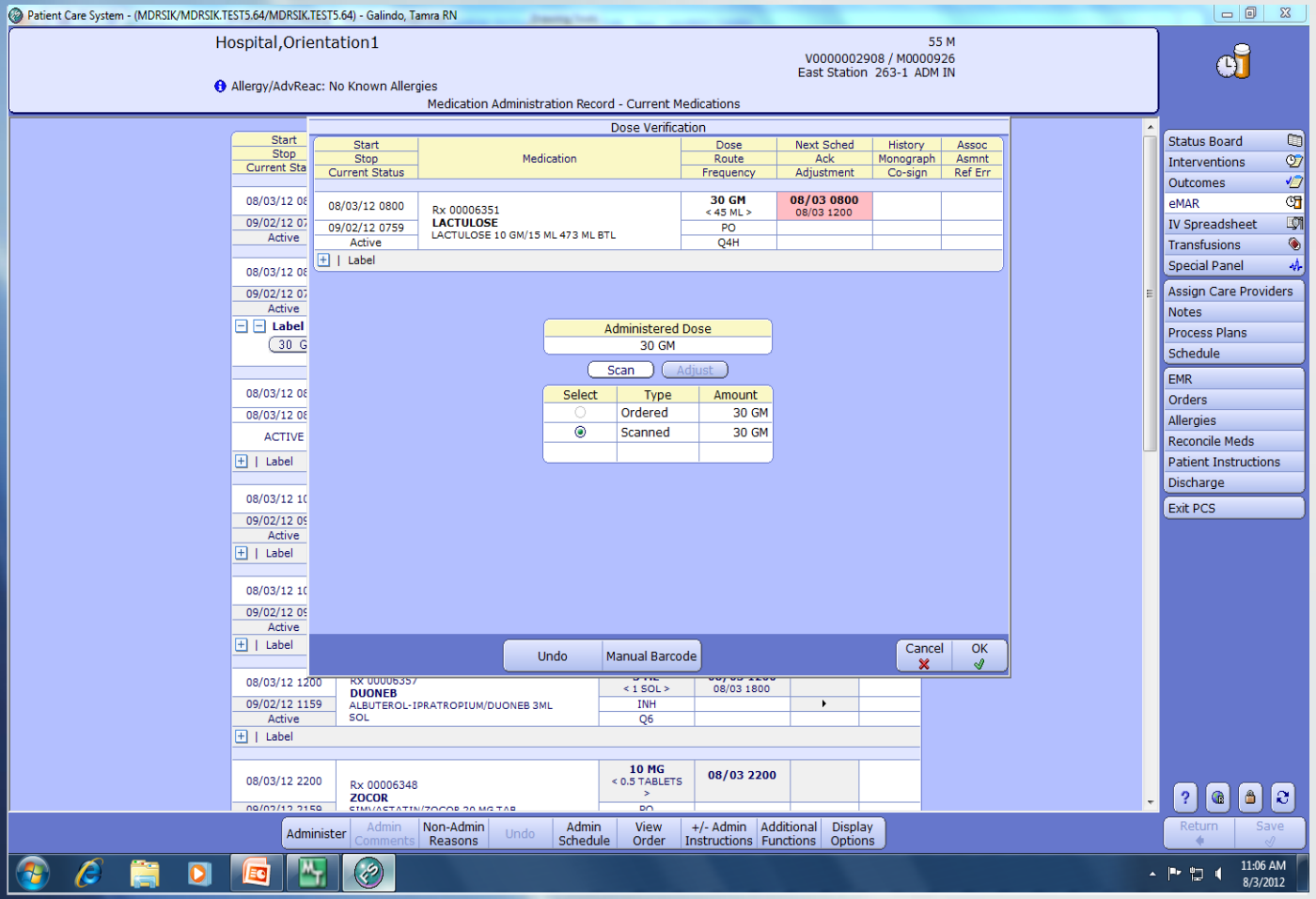
This screen appears when the dosage of the medication scanned is less or more than the ordered dose. The order is for Lactulose 30gm and the medication available is 10gm/15ml. You must scan 3 separate containers, you cannot scan one container 3 times.



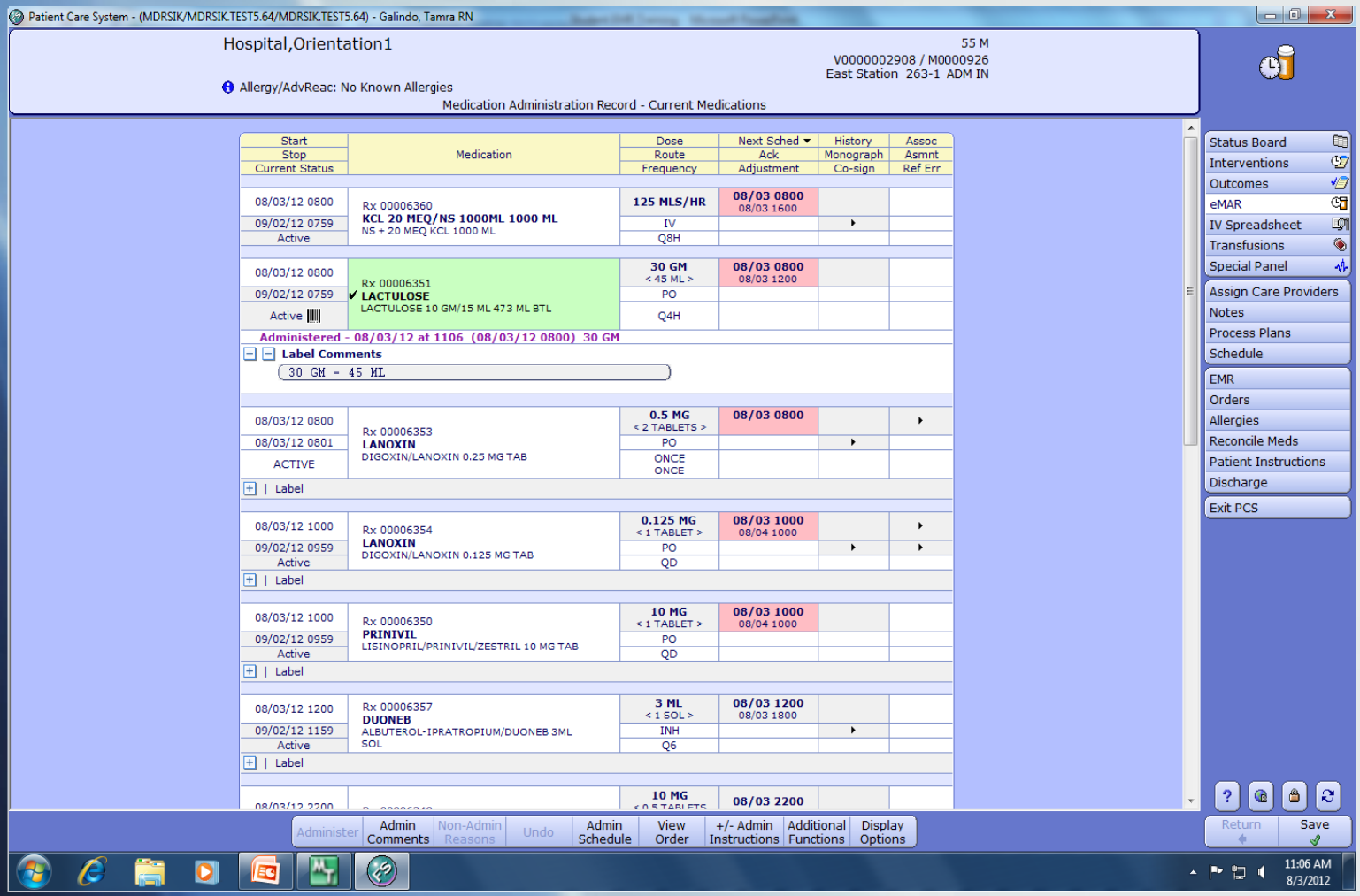
This screen shows the medication has been rescanned



After rescanning the medication two additional times the ordered dose of 30gm has been achieved. Note-the pink color is gone.



The total amount scanned (30gm) appears in purple along with date and time of administration. Click ***Save*** when done.



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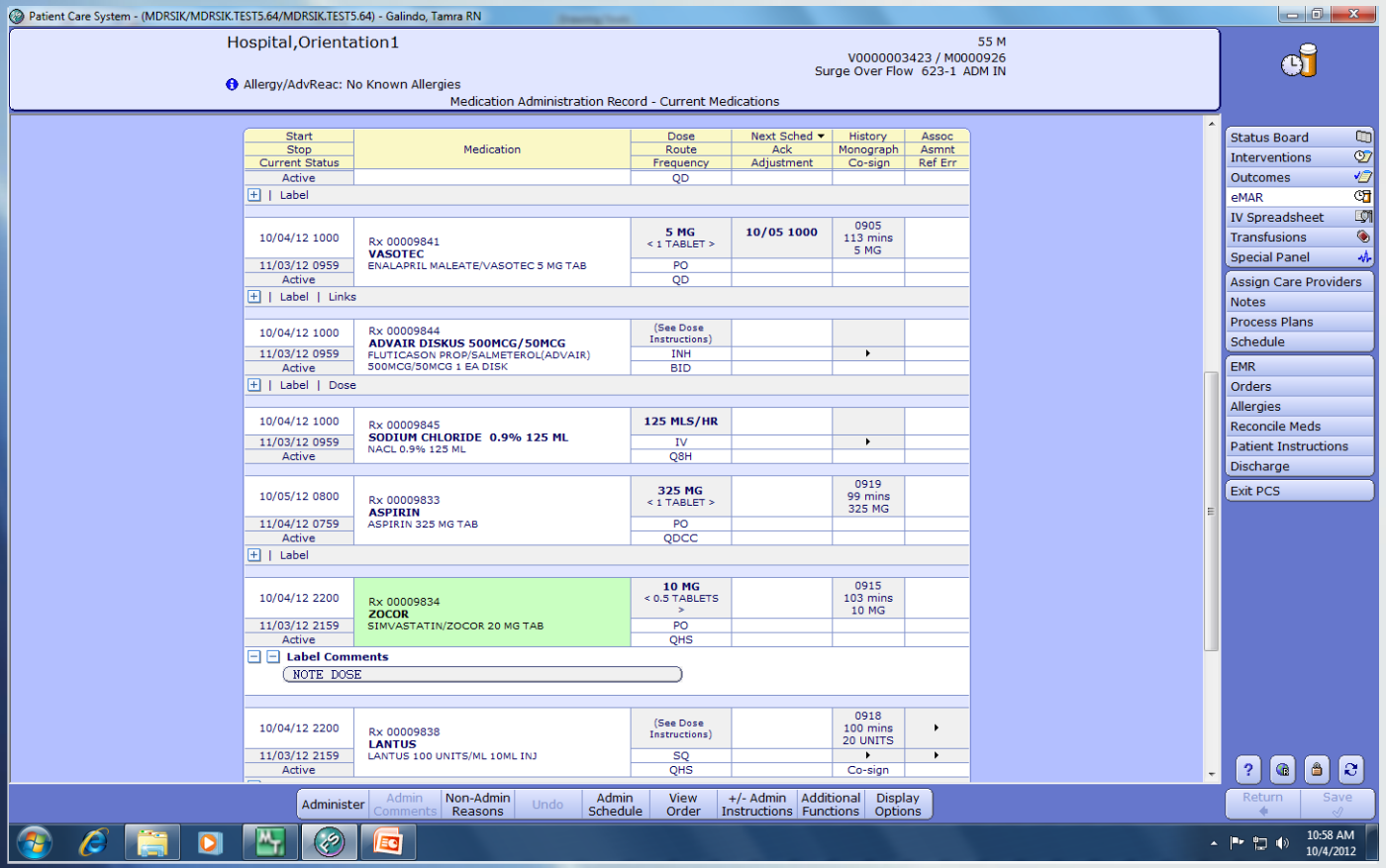
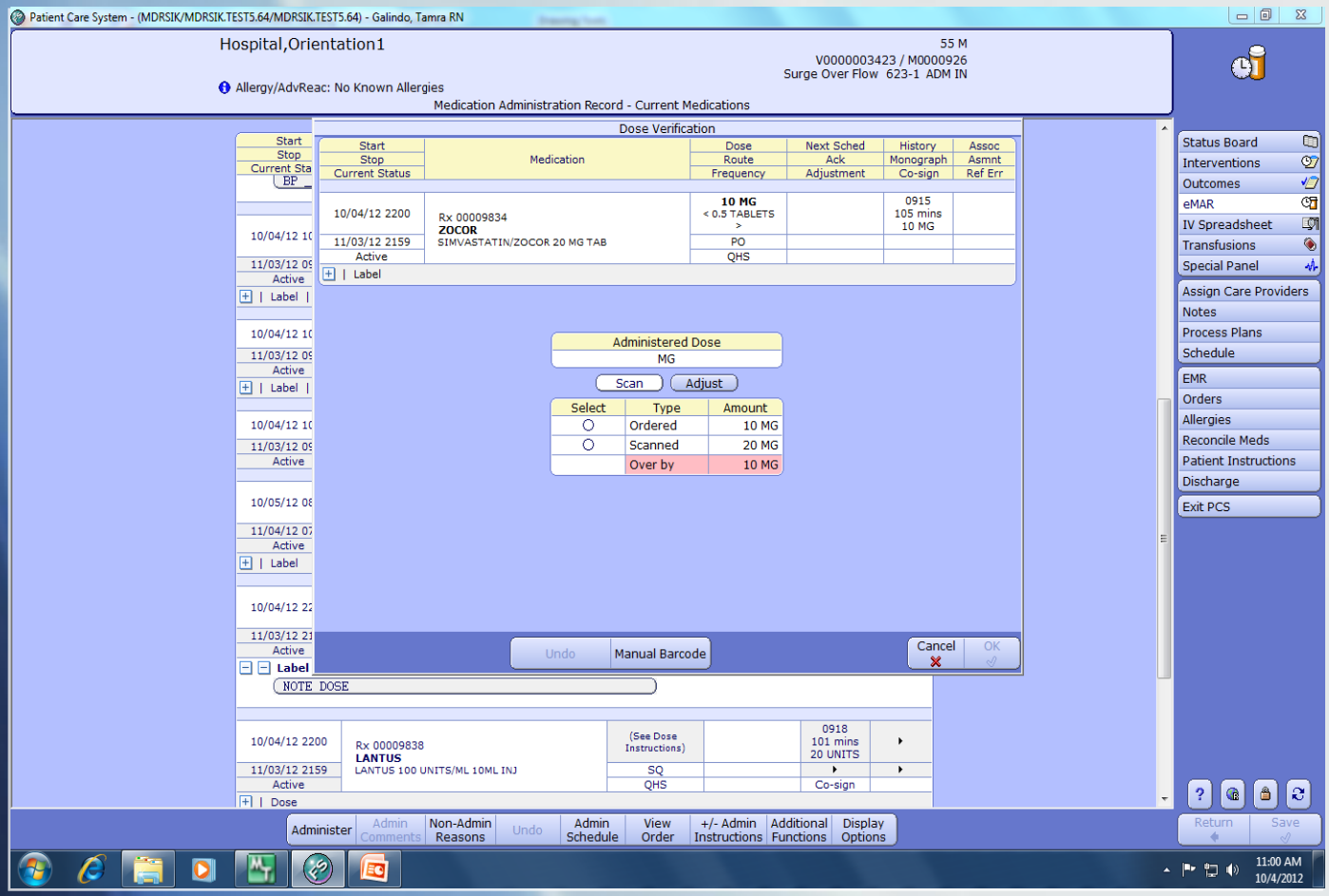
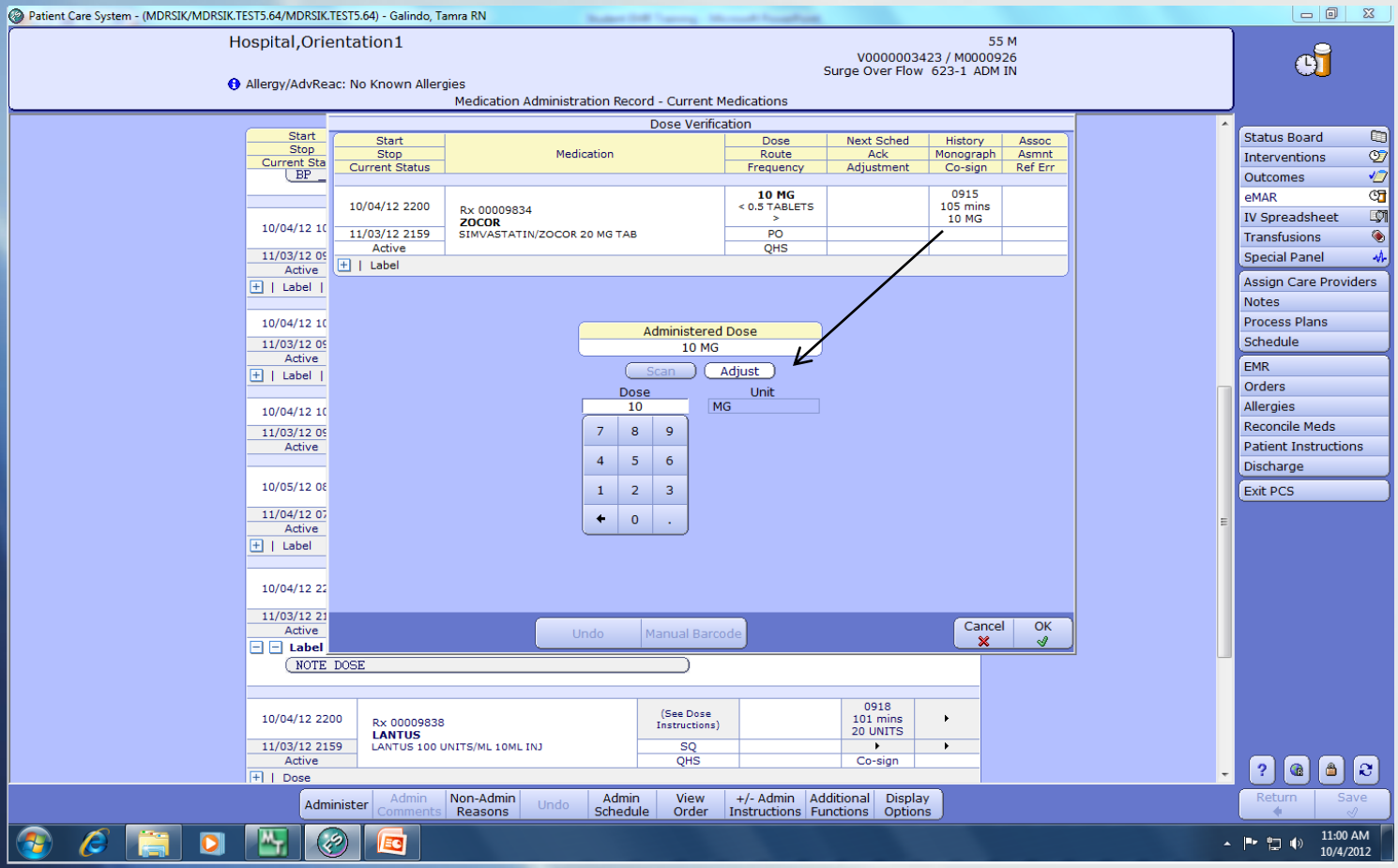
Some medications may need to be halved because the dosage ordered is less than what is available. The order is for Zocor 10mg PO and Zocor 20mg PO is available.



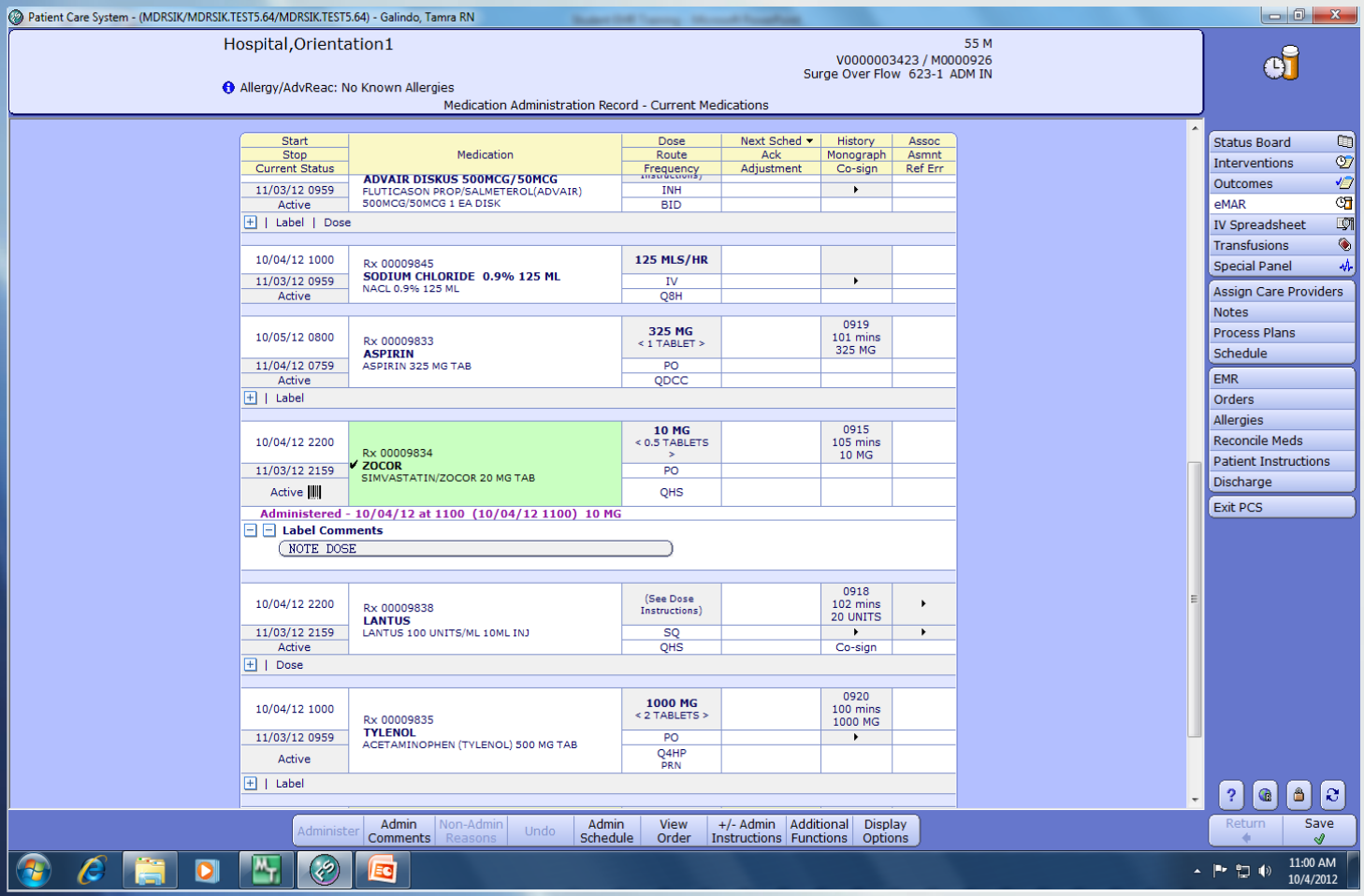
Once Zocor is scanned, a prompt stating the dosage scanned is over by 10mg (note the pink color).



Click **Adjust** and enter 10 and click **OK**.



Zocor 10mg is documented as administered.



This concludes **Electronic Documentation/BMV Training For Nursing Students and Instructors**

Documentation is very important in health care. Patient safety, including confidentiality must be maintained at all times. Documenting factual, objective information in a timely manner is key to successful documentation.

For questions regarding information in this presentation, please contact

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