



PatientTouch® Care Interventions Module User Guide

June 2020

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Care Interventions Overview

Care Interventions Module

Overview

The Care Interventions Module provides caregivers with intervention execution guidance and allows them to collect patient vital signs, conduct assessments, and document patient care activity at the bedside with enhanced safety and efficiency. Data is documented in a configurable flowsheet and is available for interfacing with outside systems.

Care Interventions are configured using the Clinical Manager **Intervention/Prompt Setup** folder. Refer to the *Clinical Manager Configuration User Guide* for more information on prompt and intervention setup. Caregivers execute Care Interventions from the **Care** tab in the *Patient Context* on the PatientTouch handheld device. They may also document Care Interventions in the Clinical Manager.

The PatientTouch System can be configured two different ways for Care Interventions: Available or Scheduled. When the system is configured for Available only, caregivers choose when to document based on patient need. When the system has Scheduled Interventions enabled, additional features are included. Patients can have both available (as needed) interventions and ones with specific scheduled times. Schedules can be configured based on unit/facility needs and practices. Caregivers also have the ability to order and discontinue interventions for patients. Caregivers will see the scheduled interventions in their To Do list with the option to receive due/late reminders.

The following are examples of interventions that can be configured in the system:

- Vitals Collection — record data when collecting vital signs and document intake and output.
- Assessments — caregivers can be guided through clinical assessments, such as the Morse Fall Risk Assessment and the Braden Pressure Ulcer Risk Assessment, calculating assessment results where appropriate and documenting assessment results immediately.
- Care Procedures — receive procedural guidance on the iPhone device, with seamless documentation of compliance.
- Care and Patient Activity Documentation — quickly and easily document patient status and task completion, such as hourly rounds.
- Medication Follow-Ups — The facility can define the information that should be obtained after a medication is administered.

Professional Responsibility

The PatientTouch System when used as outlined in the user guides and training documentation can help prevent serious intervention collection errors. The PatientTouch System should always be used in conjunction with the caregiver's professional clinical judgment and is not a substitute for this. If the PatientTouch System is used in a manner outside of these parameters the potential for an intervention collection error can increase. Examples of system misuse include ignoring system

warnings or failing to positively identify the patient. These examples are for illustration only and are not intended to be a complete list.

Executing a Care Intervention on PatientTouch

Executing a care intervention launches a series of prompts for caregiver response. All interventions use a common set of data entry and workflow controls. The following workflow options are available during intervention execution:

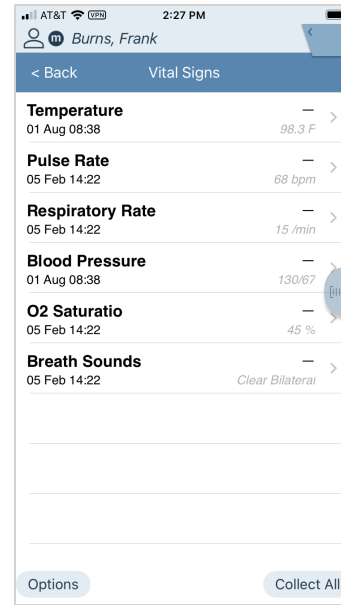
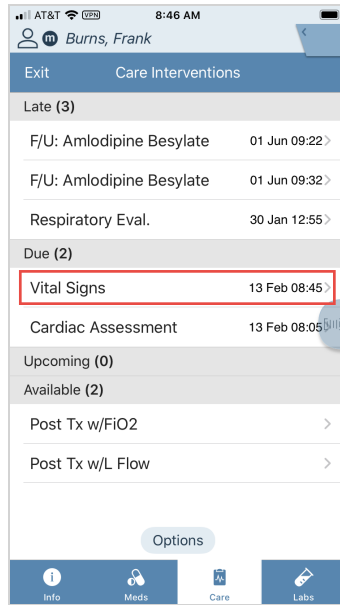
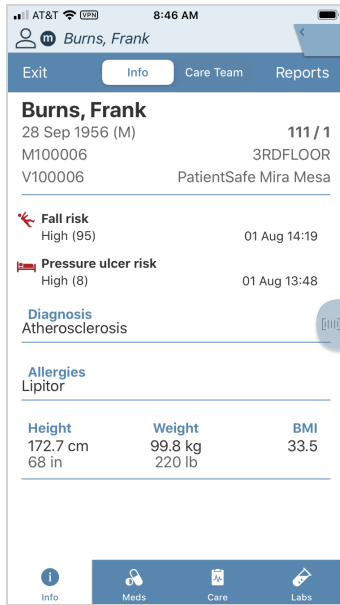
- Cancel:** Cancel the operation
- Accept:** Accept the operation
- Input Panel:** Allows data entry
- LastValue:** Allows you to select the last value documented for this intervention
- Skip:** Allows you to skip the question without answering
- Dismiss:** Dismisses the input panel
- Collect All:** Initiates collection of all questions in an intervention instead of the user selecting each individual question. If configured to do so, some questions can be skipped.
- Begin Collection :** Initiates collection of all questions in an intervention in which no questions can be skipped

Upon completing an intervention, you will need to scan your badge to document the care intervention. This saves the information to the system database. The results are then available for mView, Flowsheet display, and potentially for interfacing to other hospital systems. All values selected with the **Use Last Value** option will display on mView and Flowsheets as the new value with the current date/time.

As a configuration option, users may be required to scan the patient wristband prior to documenting an intervention.

Collect All/Last Value Workflow

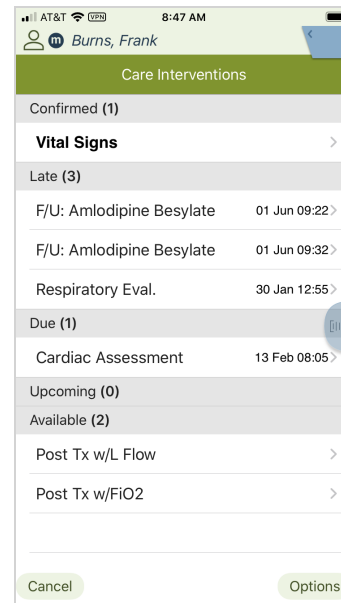
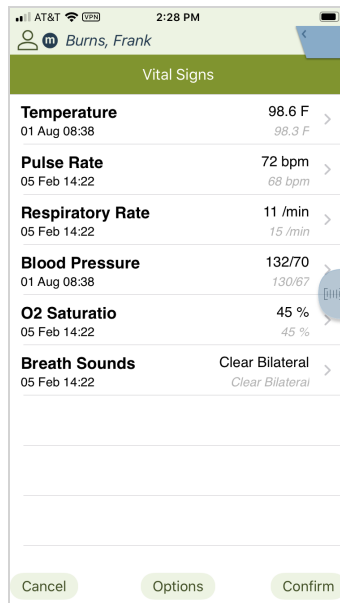
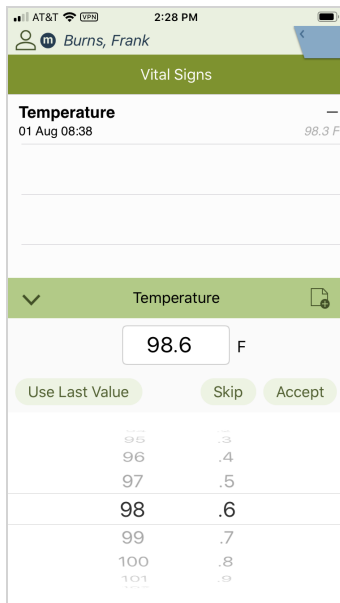
All Care Interventions display under the **Care** tab.



1. Access the Patient Info screen.
2. Touch the **Care** tab.

3. The *Care Interventions* screen displays interventions available for execution.
4. Touch **Vital Signs**.

5. If your facility is enabled, the last collected values may display for this intervention.
6. Touch **Collect All**.

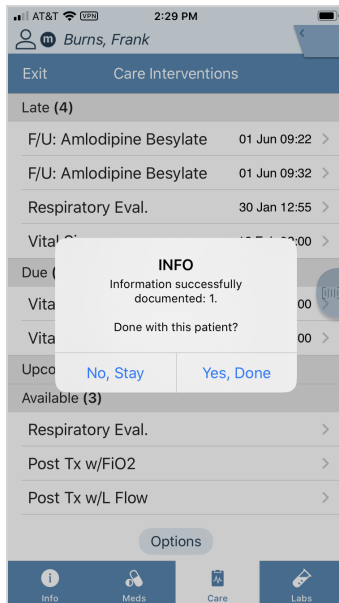


7. The last collected value displays in the upper right hand corner of the screen.
8. You can touch **Use Last Value** to document this Temperature reading as the current value.

10. After answering all of the prompts, the final *Vital Signs* screen displays the results.
11. Touch **Confirm**.

12. Scan your badge to document the intervention.

9. Or you can select a different value and touch **Accept**.



13. Touch **Yes, Done**.

Documenting Multi-Component Interventions

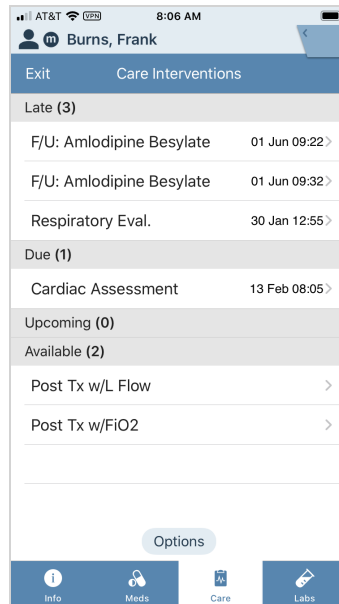
When you are documenting a long, multi-component intervention, before you confirm, you return to the place in the application where you left off, instead of returning to the top of the list. If you are documenting a nested multi-component intervention, you return to the previous level of the intervention at the point of entry.

Let's look at an example of a nested multi-component intervention.

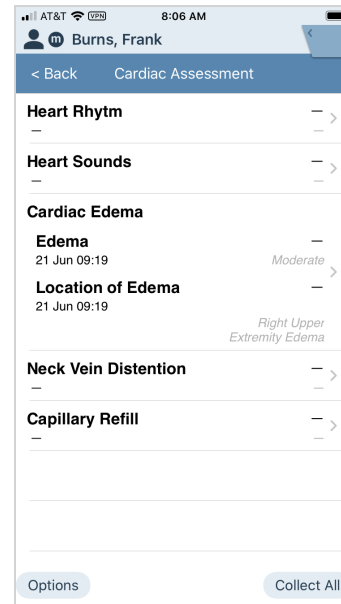
Nested Multi-Component Intervention



1. Access the Patient Info screen and touch the **Care** tab.

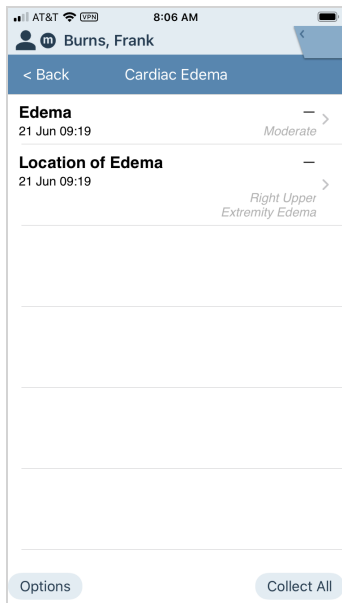


2. Touch **Cardiac Assessment**.

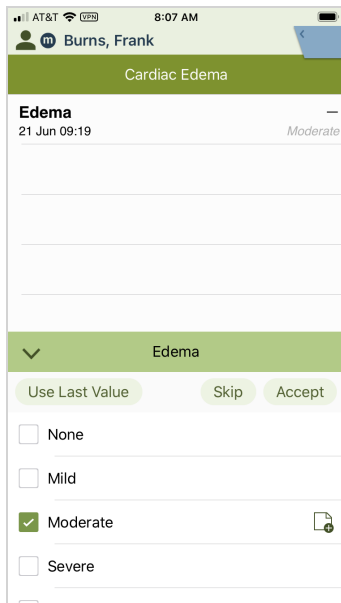


3. At this point, you can touch **Collect All**, which will take you through all of the components of the intervention. Or you can touch a specific part of the intervention, for example Cardiac Edema, to document only that section.

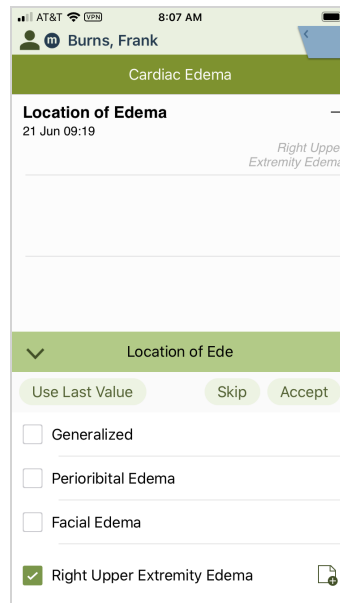
4. For this example, touch **Cardiac Edema**.



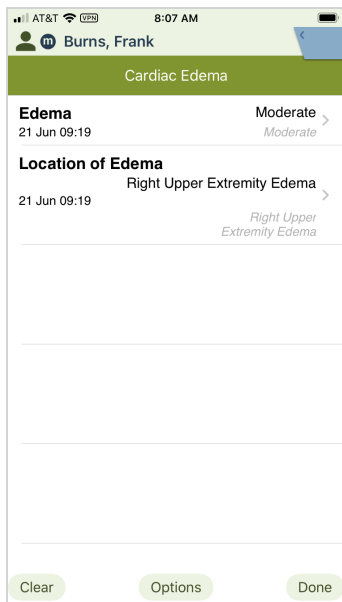
5. Touch **Collect All**.



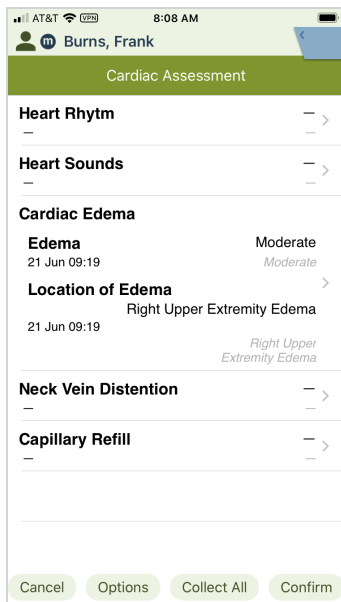
6. Select a value and touch **Accept**.



7. Select a value and touch **Accept**.

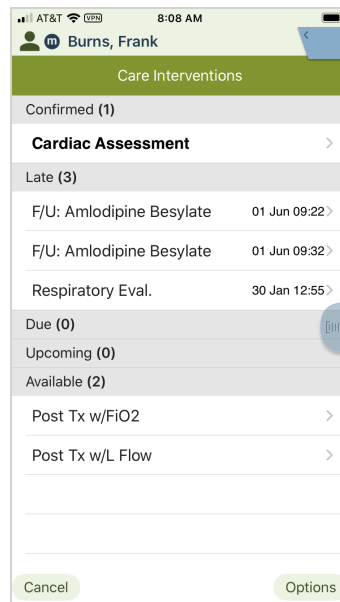


8. Touch **Done**.



9. At this point, you can:

- Touch **Collect All** to collect the remaining components
- Touch **Options** to add prompts or omit the intervention altogether
- Touch the right arrow to collect



10. After you confirm, scan your badge to document the intervention.

another single component
- Touch **Confirm**

Example Interventions


Some interventions and assessments will utilize a concept known as branching or conditional prompting. In these cases, questions will display to the user based on the response to a previous question.

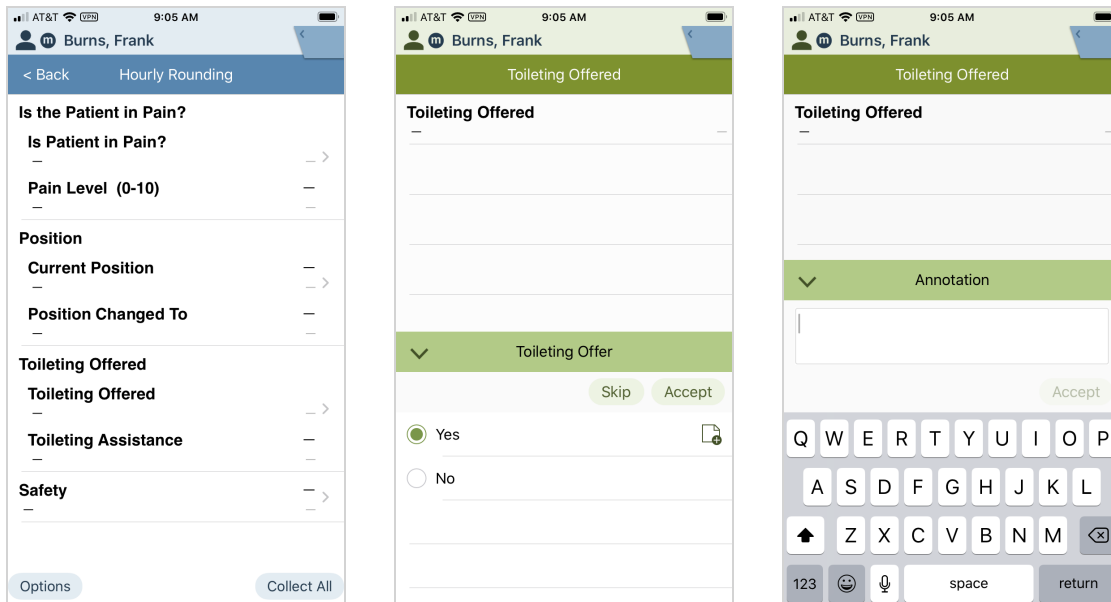
The examples in this section illustrate four types of interventions. These may not all be applicable to your facility and your facility may also have interventions that are not included here.

- 1. [Hourly Rounding](#)
- 2. [Patient Care](#)
- 3. [Morse Risk of Falling Assessment](#)
- 4. [Braden Ulcer Assessment](#)

Hourly Rounding Intervention

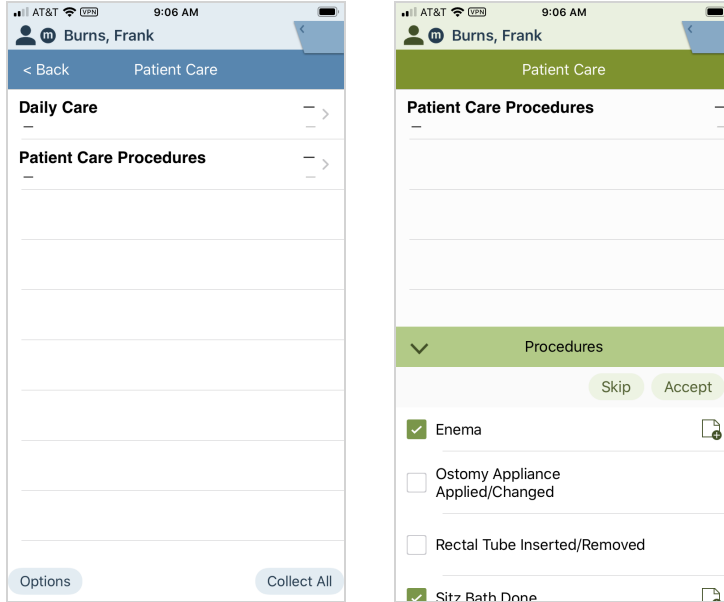
Below is an example of the Hourly Rounding Intervention. For some interventions, if configured in

Clinical Manager, caregivers can use free-text fields to enter specific information (indicated by the  icon). In addition, this intervention uses a keypad for entering data. However, an intervention may contain different entry panels including keypad, response list, etc.



Patient Care Intervention

A typical Patient Care intervention may include information similar to the following. This intervention provides an example of a list of options from which the caregiver can make multiple selections.

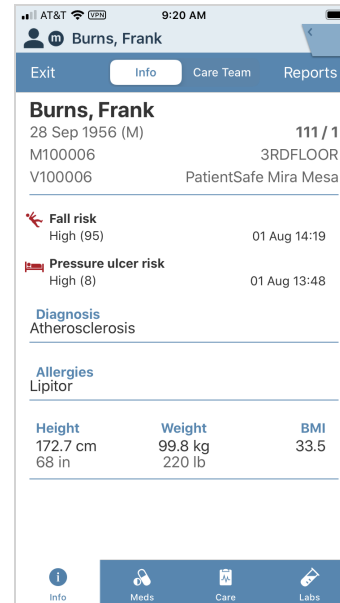
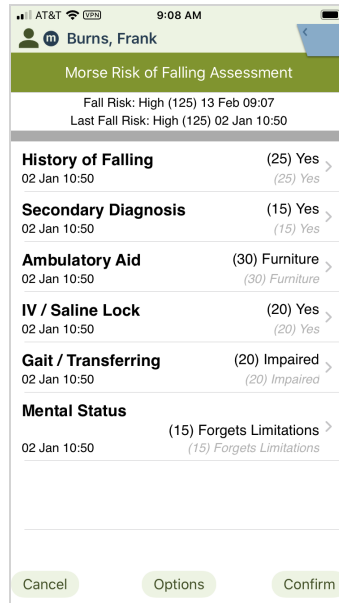
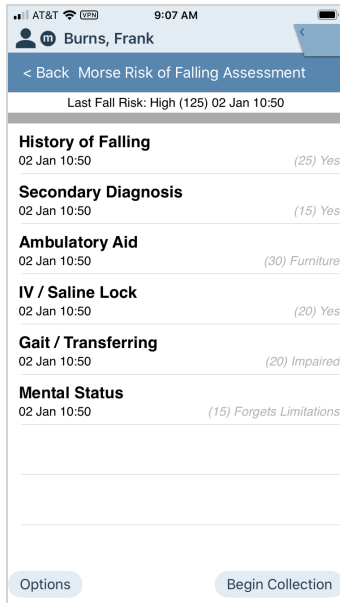


Morse Risk of Falling Assessment Intervention


Assessments may perform calculations in order to determine things such as a patient's risk level for a condition (for example, falling or developing pressure ulcers). The calculation is driven by the values the caregiver enters. If the patient's risk for the condition is calculated as high, an icon indicating the risk is displayed under the patient's name on the Patient Info screen.

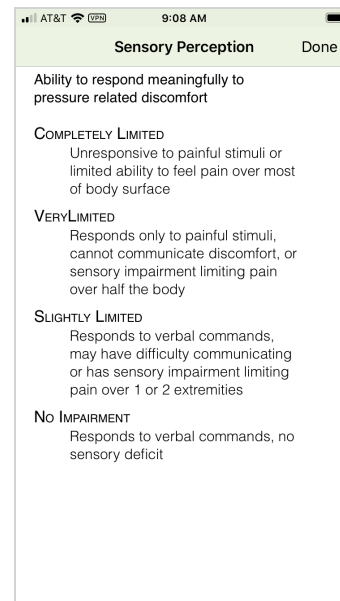
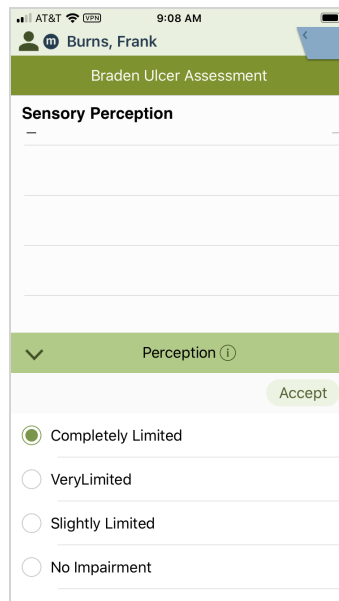
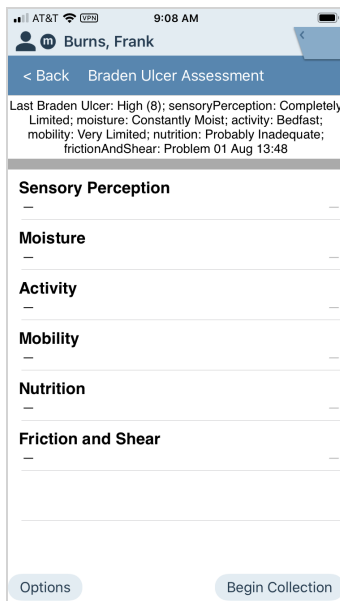


Assessments are among those interventions in which all questions require responses.



Braden® Ulcer Assessment Intervention

Below is an example of the Braden Ulcer Assessment. Under the Sensory Perception question, you can select the **Clinical Definitions** icon  to display further information that can guide you in responding to the intervention questions. The **Clinical Definitions** icon displays for all questions under the Braden Ulcer Assessment.



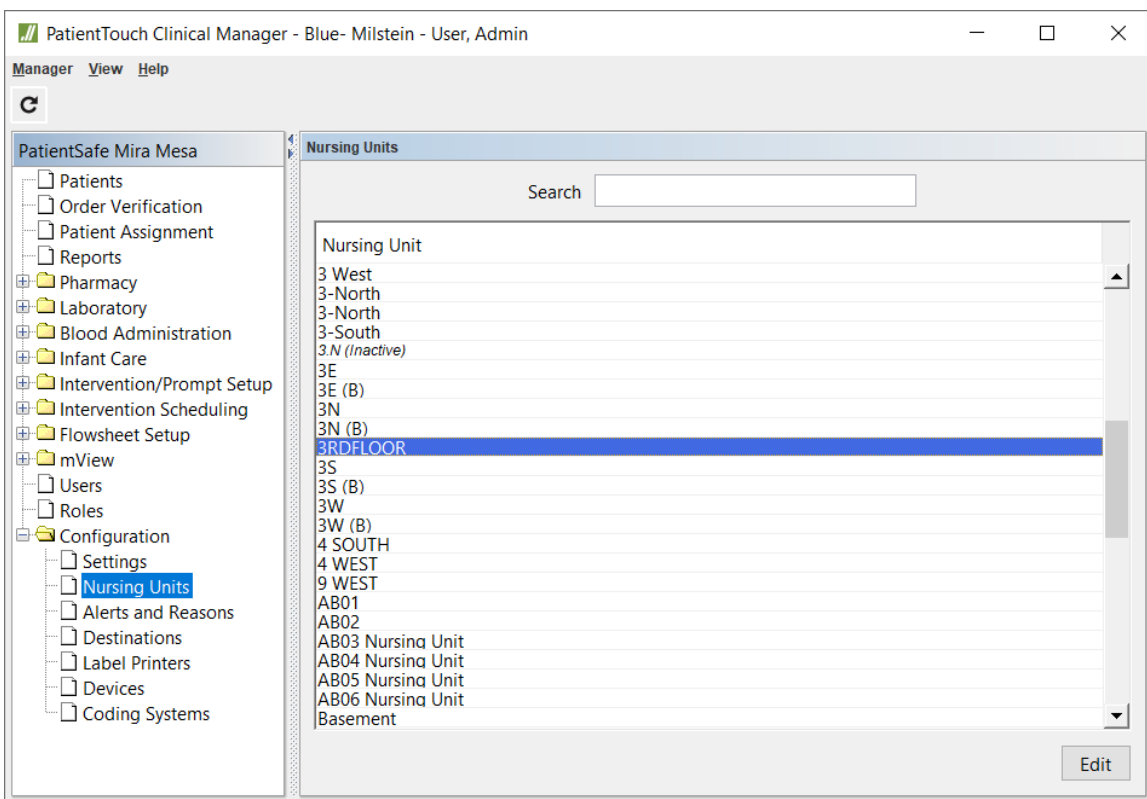
Nonscheduled Interventions

Non-scheduled interventions are made available for execution whenever the caregiver chooses to document based on patient need. Non-scheduled interventions must be made available to the caregiver by associating an intervention to a nursing unit. Then, interventions can be documented for specific patients.

If your facility does not have **Intervention Scheduling** enabled in the Clinical Manager, use the instructions below to make interventions available to the caregiver. The intervention won't have a specific "due" time, it will display on PatientTouch as "Available."

Making Interventions Available to the Caregiver

1. Select **Configuration>Nursing Units**.
2. Select the nursing unit for which you want to associate the intervention and click **Edit**, or just double-click the nursing unit.



3. Click the **Interventions** tab.

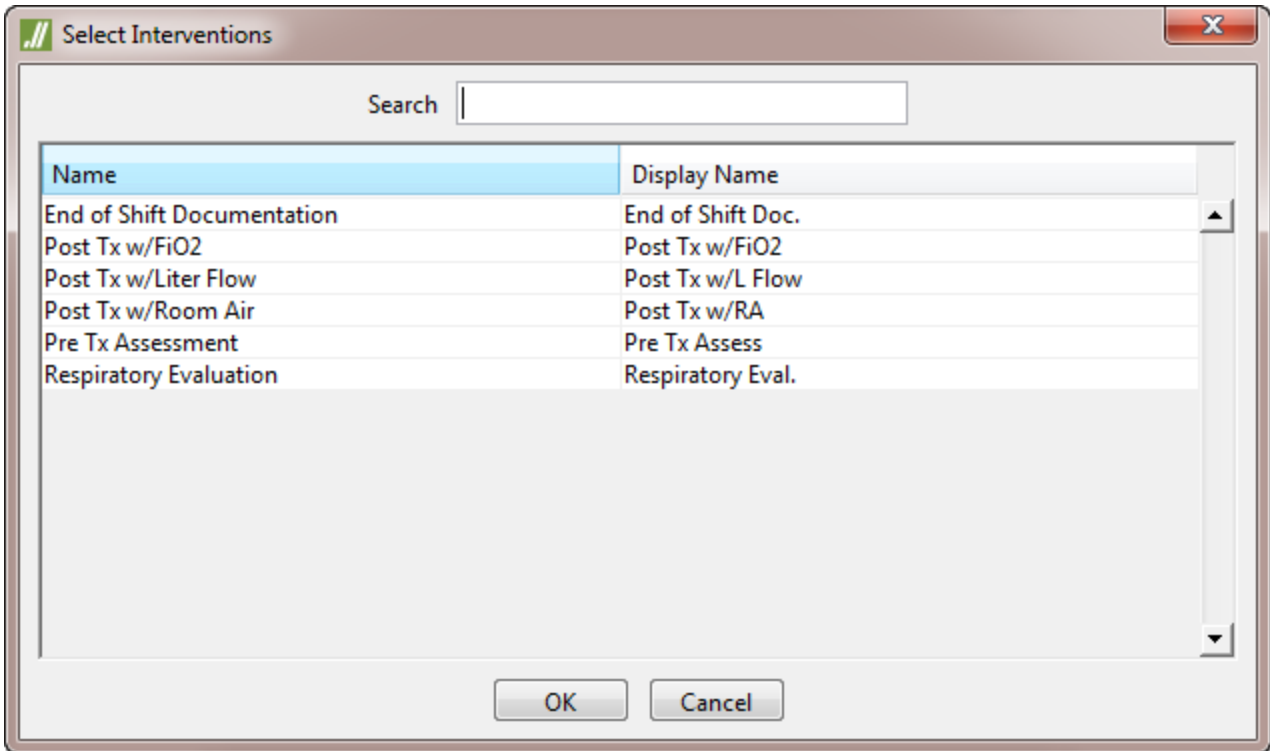
The screenshot shows a dialog box titled "Nursing Unit: 3RDFLOOR" with a close button in the top right corner. It has three tabs: "Unit", "Settings", and "Interventions". The "Interventions" tab is selected. The "Name:" field contains "3RDFLOOR" and is highlighted in yellow. Below it are two unchecked checkboxes: "Non-Profile Unit" and "Infant Care Unit". A "Rooms:" list box contains the following items: "41-223", "T11", "10011", "T31", "11021", and "T21-348". At the bottom are "OK", "Cancel", and "Apply" buttons.

4. Click **Add Intervention**.

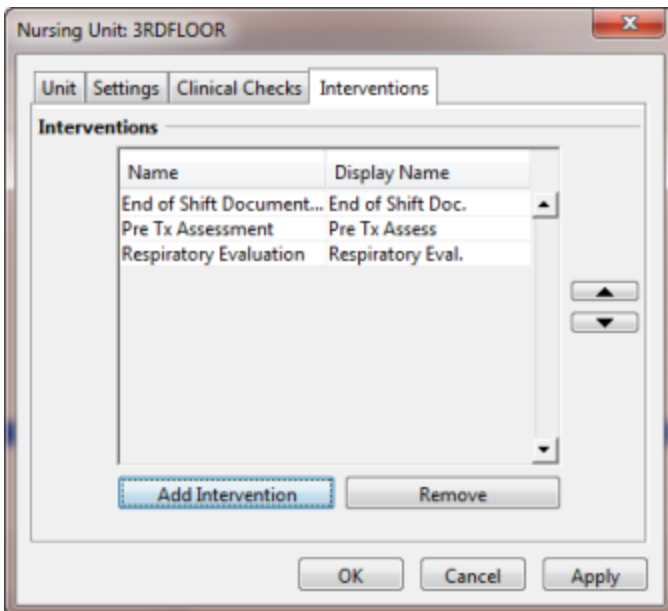
The screenshot shows the same dialog box, but now the "Interventions" tab is active and displays a list of interventions. The list has two columns: "Name" and "Display Name". The list is currently empty. To the right of the list are two arrow buttons for scrolling. Below the list are "Add Intervention" and "Remove" buttons. At the bottom are "OK", "Cancel", and "Apply" buttons.

The list of interventions displays.

5. Select the intervention(s) you want to add to the nursing unit and click **OK**.



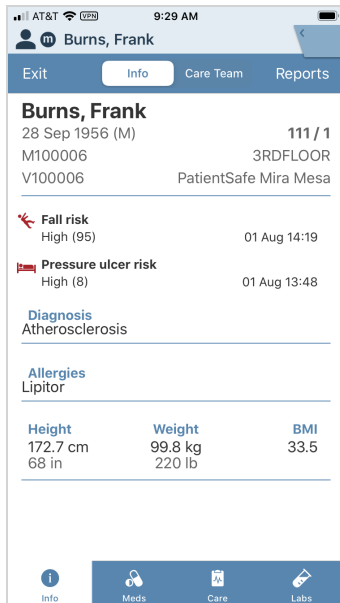
6. The order of the interventions displays on PatientTouch as listed on the **Interventions** tab. To change the order of the items in the list, use the up and down arrows on the right side of the window.
7. To remove an intervention, select it from the list and click **Remove**.



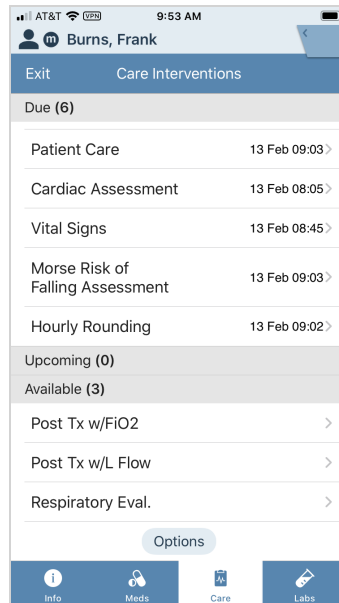
Documenting an Intervention on PatientTouch

After you have made the intervention available to the nursing unit (refer to the previous lesson, "Making Interventions Available to the Caregiver"), it displays on the Care tab of all patients assigned to that unit. Then you can document the intervention using the handheld.

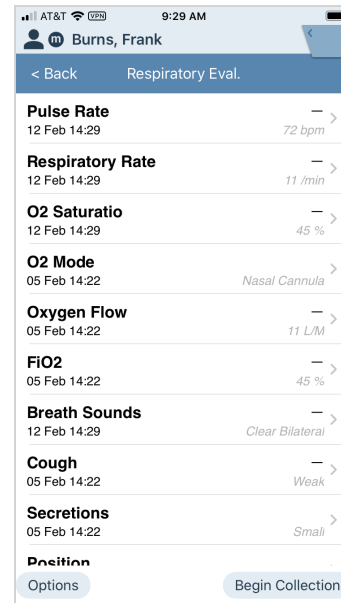
Let's look at an example.



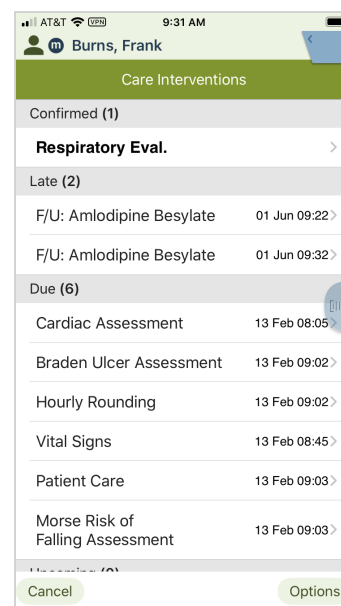
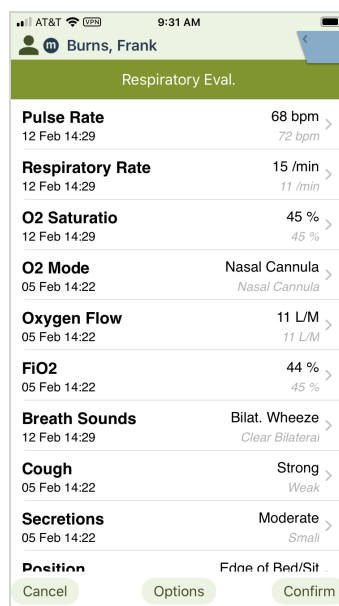
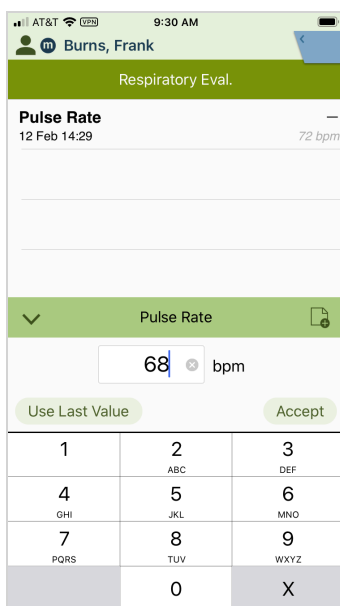
1. After you scan the patient wristband, touch the **Care** tab.



2. Touch **Respiratory Eval** listed under *Available* interventions.



3. Touch **Begin Collection** to start collecting data.



4. Enter the value for the first prompt and touch **Accept**.
5. Continue entering all values or select Use Last Value.
6. When you are done collecting, touch **Confirm**.
7. Scan your badge to document the intervention.

Scheduled Interventions

Overview

Scheduled interventions have explicit schedules/times/frequencies (e.g. every hour, every four hours, available/as needed, etc.). If configured, caregivers will be reminded to document interventions that have specific schedules.

If your facility has **Intervention Scheduling** enabled in your Clinical Manager, you must make interventions "orderable" in order to be assigned to a specific patient. Orderable interventions are configured in the Intervention Scheduling section of the Clinical Manager. Refer to the *Clinical Manager Configuration User Guide* for detailed information on making interventions "Orderable."

After you have made interventions "orderable" you can order patient specific interventions using one of the following two methods:

1. [Using the Clinical Manager](#)
2. [Using PatientTouch](#)

After the ordering has been completed, you can document the intervention using any of the following methods:

1. [From the Patient Detail Screen](#)
2. [From the Patient Flowsheet](#)

Please refer to the desired topic by clicking a link above.

Ordering a Patient Specific Intervention Using the Clinical Manager

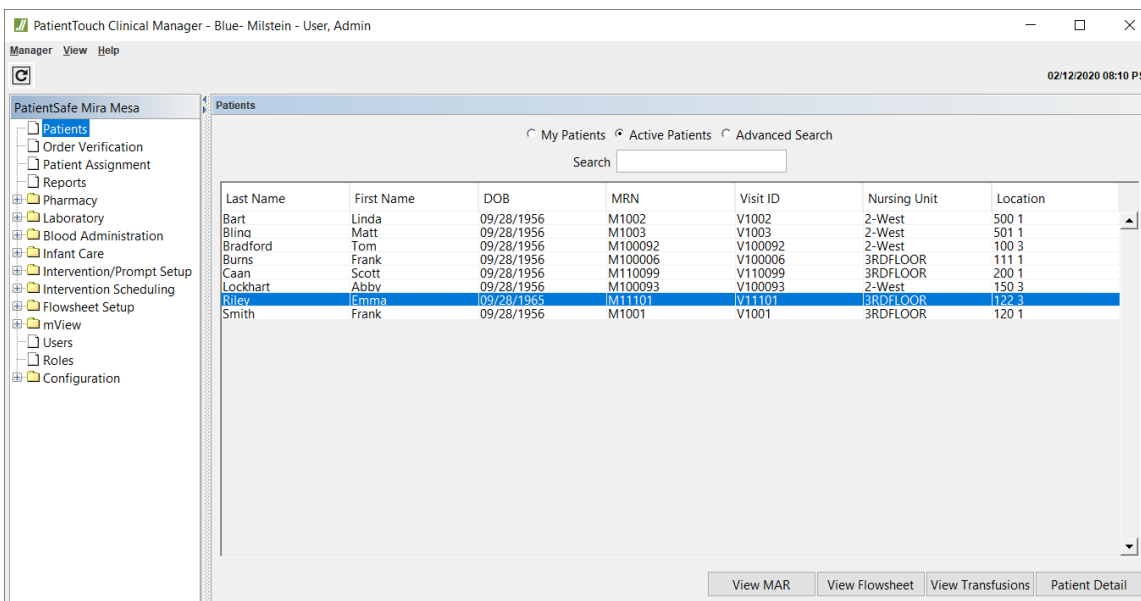
Orderable interventions require that only selected Care Roles order the intervention. So be certain you have the privileges to order a patient specific intervention before continuing.

Please follow the instructions below to order a patient specific intervention using the Clinical Manager.

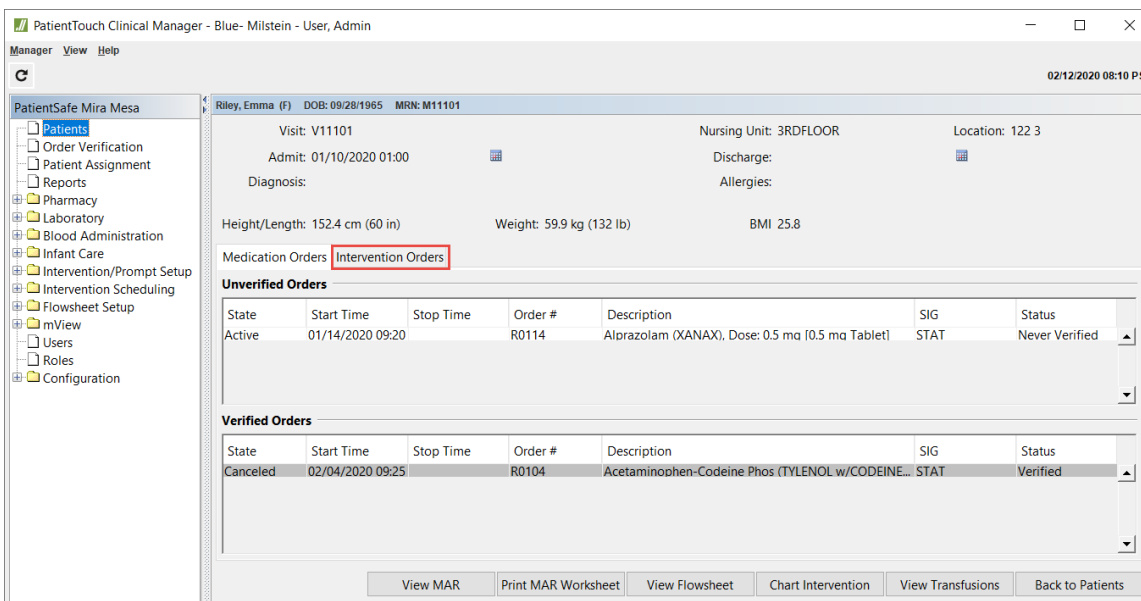
Patient Detail Screen

Caregivers can order a specific care intervention for a specific patient using the *Patient Detail* screen.

1. Select the patient from the list of Active Patients (or My Patients) and click **Patient Detail**. Or, just double-click the name of the patient.



2. Click the **Intervention Orders** tab.



3. Click **New Intervention Order**.

PatientSafe Mira Mesa

Riley, Emma (F) DOB: 09/28/1965 MRN: M11101

Visit: V11101 Nursing Unit: 3RDFLOOR Location: 122 3

Admit: 01/10/2020 01:00 Discharge:

Diagnosis: Allergies:

Height/Length: 152.4 cm (60 in) Weight: 59.9 kg (132 lb) BMI 25.8

| State | Start Time | Stop Time | Order # | Intervention | Due | Schedule |
|------------------|------------------|------------------|---------|-------------------|------------------|---------------|
| Active | 01/30/2020 12:53 | | | Post Tx w/FIO2 | | Available |
| Active | 01/30/2020 12:53 | | | Post Tx w/L Flow | | Available |
| Active | 01/30/2020 12:53 | | | Vital Sians | 02/12/2020 02:00 | Daily |
| Active | 01/30/2020 12:53 | | | Respiratory Eval. | 01/30/2020 12:53 | One Time |
| Active | 01/30/2020 12:53 | | | Vital Sians | 02/12/2020 02:00 | Every 4 Hours |
| Stopped | 01/19/2018 13:55 | 01/31/2018 00:00 | | Vital Sians | 01/30/2018 11:00 | Daily |
| Stopped | 01/04/2019 08:20 | 01/31/2018 00:00 | | Post Tx w/FIO2 | | Available |
| Stopped | 01/04/2019 08:20 | 01/31/2018 00:00 | | Post Tx w/L Flow | | Available |
| Stopped | 01/04/2019 08:20 | 01/31/2018 00:00 | | Vital Sians | | Daily |
| Stopped | 01/04/2019 08:20 | 01/31/2018 00:00 | | Respiratory Eval. | | One Time |
| Stopped | 01/04/2019 08:20 | 01/30/2020 06:00 | | Post Tx w/L Flow | | Available |
| Stopped | 01/04/2019 08:20 | 01/30/2020 06:00 | | Vital Sians | | Daily |
| DC'd @ 01/04/... | 01/19/2018 13:55 | 01/31/2018 00:00 | | Post Tx w/FIO2 | | Available |
| DC'd @ 01/04/... | 01/19/2018 13:55 | 01/31/2018 00:00 | | Post Tx w/L Flow | | Available |
| DC'd @ 03/04/... | 01/04/2019 08:20 | | | Post Tx w/FIO2 | | Available |
| DC'd @ 01/08/... | 01/04/2019 08:20 | | | Respiratory Eval. | | One Time |

New Intervention Order

View MAR Print MAR Worksheet View Flowsheet Chart Intervention View Transfusions Back to Patients

4. Click **Select** next to the Intervention field.

Order Intervention

Intervention: **Select**

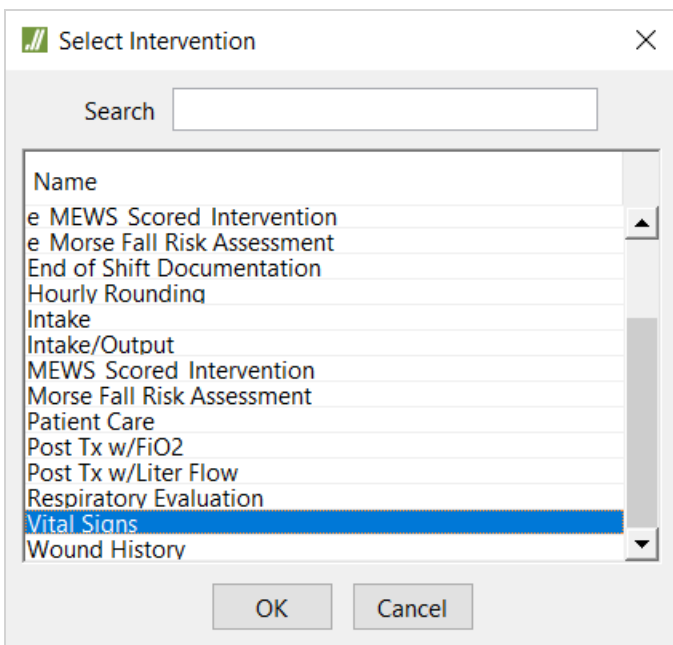
Schedule: **Select**

Start Date: **Select**

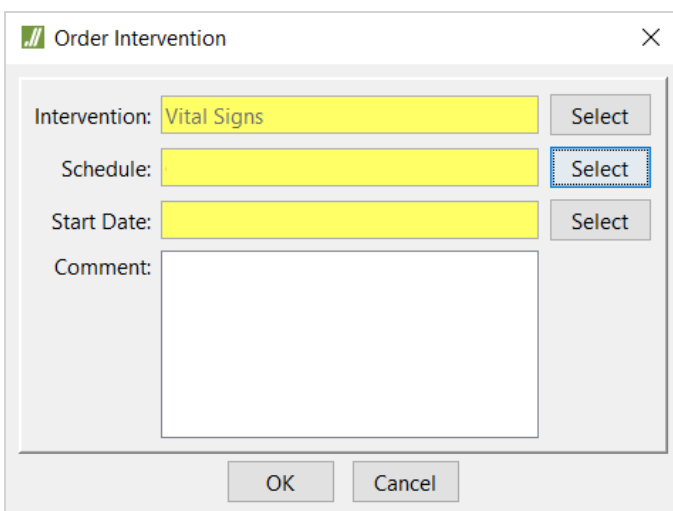
Comment:

OK Cancel

5. Select the intervention you want to assign to the patient and click **OK**.



6. Click **Select** next to the Schedule field.



7. Select the schedule for the intervention and click **OK**.

Select Schedule

Search

Name
Available
Daily
Every Other Hour Nurse
NOW
One Time
Q 4 Hour
Q 8 Hour

OK Cancel

8. Click **Select** next to the Start Date field.

Order Intervention

Intervention: Vital Signs Select

Schedule: Q 8 Hour Select

Start Date: Select

Comment:

OK Cancel

9. Select the start date and time.
10. Click OK.


Select Start Date and Time ✕

Date: ◀ 2020 ▶ ◀ February ▶

| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|-----|-----|-----|-----|-----|-----|-----|
| 26 | 27 | 28 | 29 | 30 | 31 | 1 |
| 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| 9 | 10 | 11 | 12 | 13 | 14 | 15 |
| 16 | 17 | 18 | 19 | 20 | 21 | 22 |
| 23 | 24 | 25 | 26 | 27 | 28 | 29 |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Time:

- Click **OK** on the *Order Intervention* window.

 Order Intervention ✕

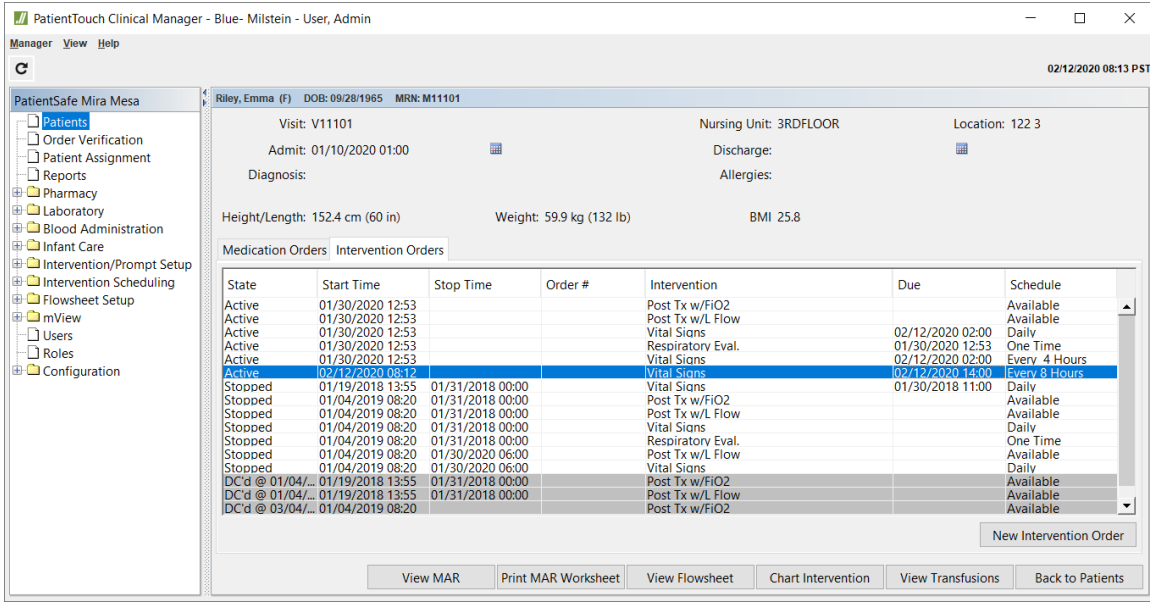
Intervention:

Schedule:

Start Date:

Comment:

The Vital Signs intervention now displays in the Patient Detail screen with a due date and time. This intervention also displays on the Care tab of the PatientTouch handheld.

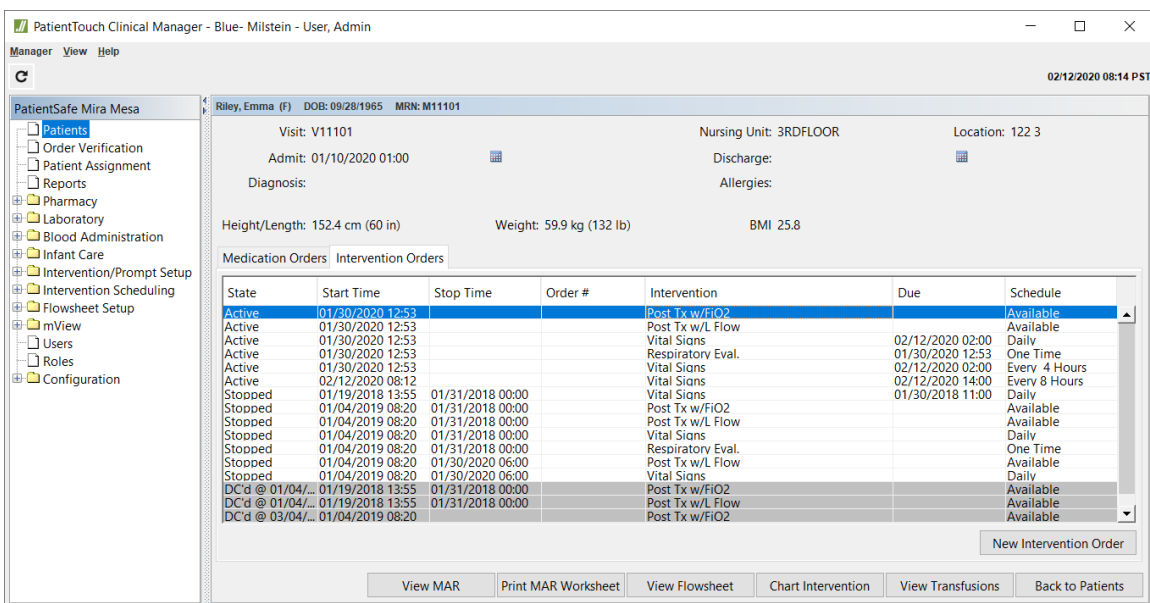


Discontinuing a Care Intervention

Refer to the Orderable Intervention section of the Clinical Manager to see which roles have the ability to discontinue an intervention.

When you discontinue a care intervention, it no longer displays on PatientTouch. However, it will display in the Clinical Manager as “discontinued.” If you have run a flowsheet against this intervention, the flowsheet information will continue to display on PatientTouch.

1. Double-click the intervention from the **Patient Detail>Intervention Orders** tab.



2. Click **Discontinue Order**.

Order Intervention
✕

Intervention:

Schedule:

Start Date:

Comment:

3. The order displays with a state of "DC'd".

PatientTouch Clinical Manager - Blue- Milstein - User, Admin
02/12/2020 08:14 PST

Manager View Help

C

PatientSafe Mira Mesa

- Patients
- Order Verification
- Patient Assignment
- Reports
- Pharmacy
- Laboratory
- Blood Administration
- Infant Care
- Intervention/Prompt Setup
- Intervention Scheduling
- Flowsheet Setup
- mView
- Users
- Roles
- Configuration

Riley, Emma (F) DOB: 09/28/1965 MRN: M11101

Visit: V11101 Nursing Unit: 3RDFLOOR Location: 122 3

Admit: 01/10/2020 01:00 Discharge:

Diagnosis: Allergies:

Height/Length: 152.4 cm (60 in) Weight: 59.9 kg (132 lb) BMI 25.8

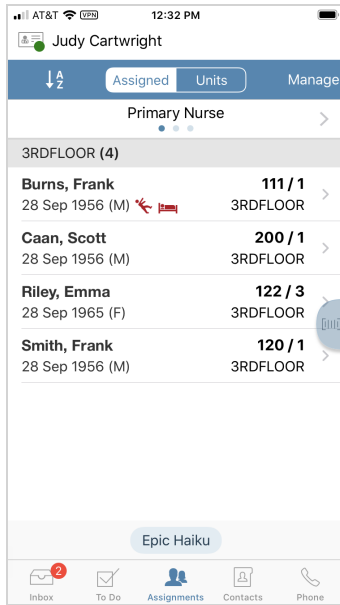
Medication Orders Intervention Orders

| State | Start Time | Stop Time | Order # | Intervention | Due | Schedule |
|-----------------------|------------------|------------------|---------|-------------------|------------------|---------------|
| DC'd @ 02/12/2020 ... | 01/30/2020 12:53 | | | Post Tx w/FiO2 | | Available |
| Active | 01/30/2020 12:53 | | | Post Tx w/L Flow | | Available |
| Active | 01/30/2020 12:53 | | | Vital Signs | 02/12/2020 02:00 | Daily |
| Active | 01/30/2020 12:53 | | | Respiratory Eval. | 01/30/2020 12:53 | One Time |
| Active | 01/30/2020 12:53 | | | Vital Signs | 02/12/2020 02:00 | Every 4 Hours |
| Active | 02/12/2020 08:12 | | | Vital Signs | 02/12/2020 14:00 | Every 8 Hours |
| Stopped | 01/19/2018 13:55 | 01/31/2018 00:00 | | Vital Signs | 01/30/2018 11:00 | Daily |
| Stopped | 01/04/2019 08:20 | 01/31/2018 00:00 | | Post Tx w/FiO2 | | Available |
| Stopped | 01/04/2019 08:20 | 01/31/2018 00:00 | | Post Tx w/L Flow | | Available |
| Stopped | 01/04/2019 08:20 | 01/31/2018 00:00 | | Vital Signs | | Daily |
| Stopped | 01/04/2019 08:20 | 01/31/2018 00:00 | | Respiratory Eval. | | One Time |
| Stopped | 01/04/2019 08:20 | 01/30/2020 06:00 | | Post Tx w/L Flow | | Available |
| Stopped | 01/04/2019 08:20 | 01/30/2020 06:00 | | Vital Signs | | Daily |
| DC'd @ 01/04/2019 ... | 01/19/2018 13:55 | 01/31/2018 00:00 | | Post Tx w/FiO2 | | Available |
| DC'd @ 01/04/2019 ... | 01/19/2018 13:55 | 01/31/2018 00:00 | | Post Tx w/L Flow | | Available |
| DC'd @ 03/04/2019 ... | 01/04/2019 08:20 | | | Post Tx w/FiO2 | | Available |

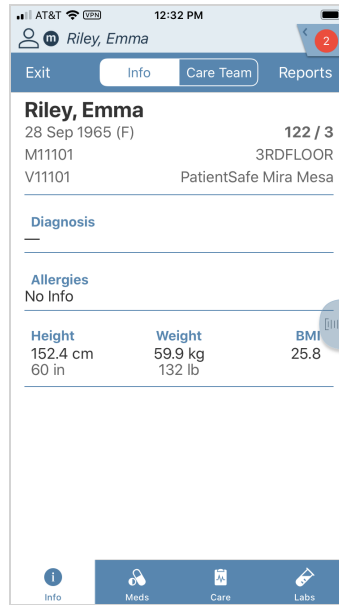
Ordering a Patient Specific Intervention Using PatientTouch

To order an intervention using the handheld, you must have your role listed under Roles for Ordering Intervention under Orderable Interventions of the Clinical Manager.

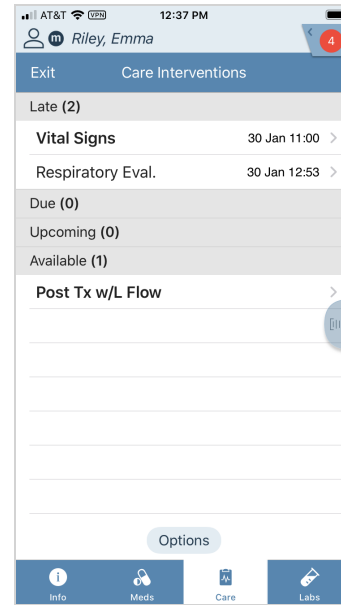
Follow the instructions below to order an intervention:



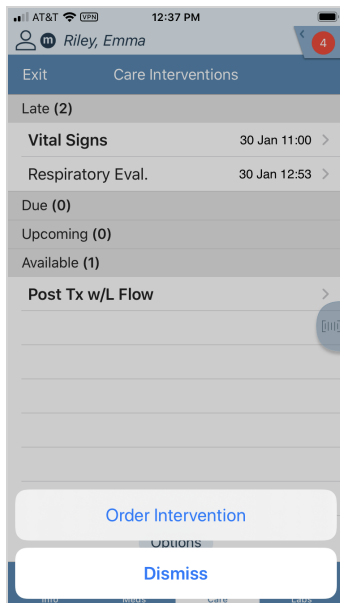
1. From the **Assignments** tab, touch the patient name.



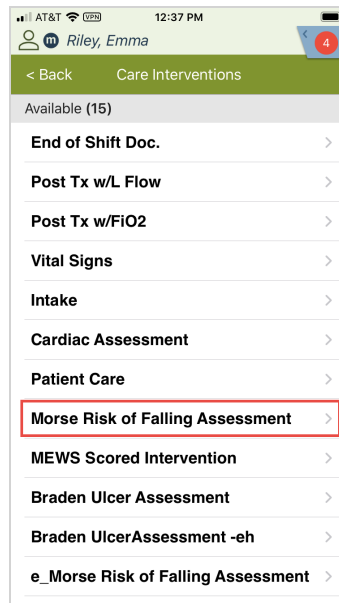
2. Touch the **Care** tab.



3. Touch **Options**.

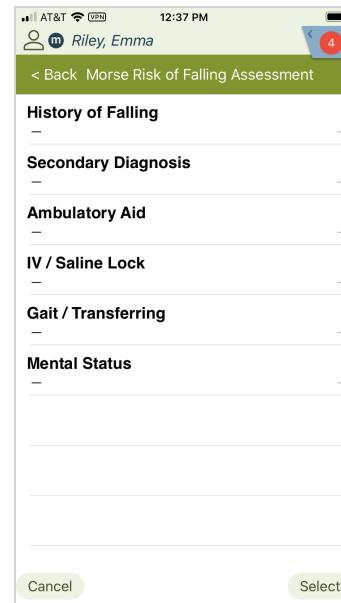


4. Touch **Order Intervention**.

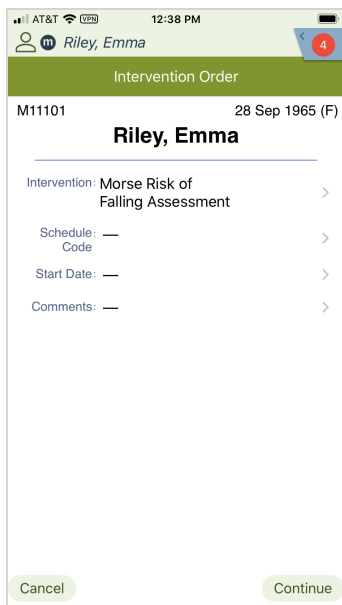


5. A list of Available Interventions displays.

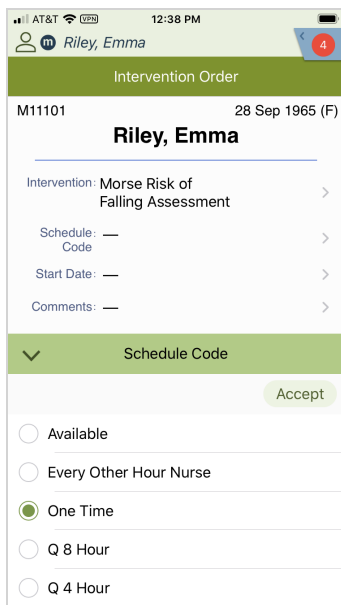
6. Select the intervention you want to order for the patient.



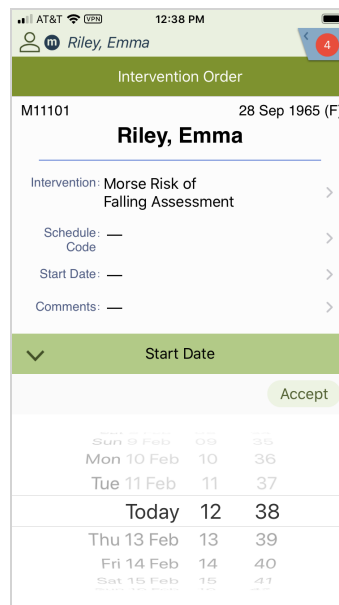
7. Touch **Select**.



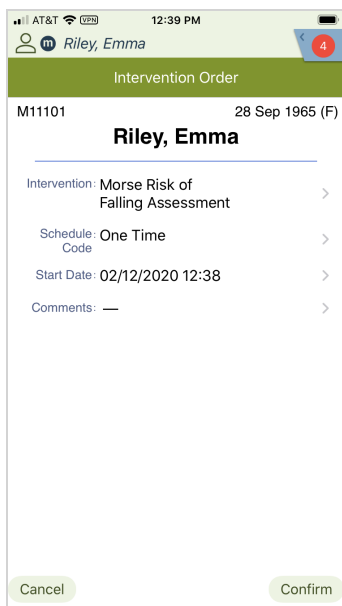
8. The intervention displays on the *Intervention Order* screen.
9. Touch **Continue**.



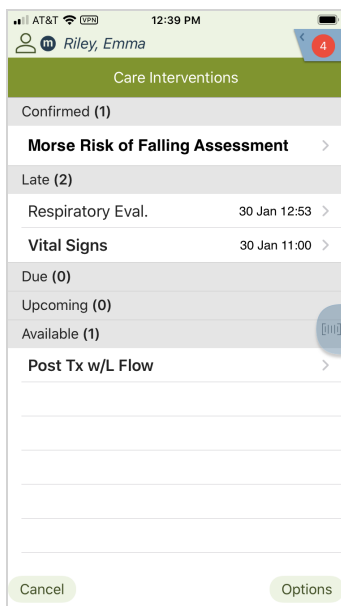
10. Select the desired schedule and touch **Accept**.



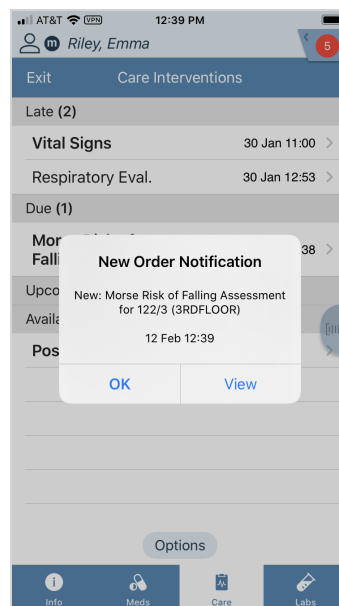
11. Select the date and touch **Accept**.



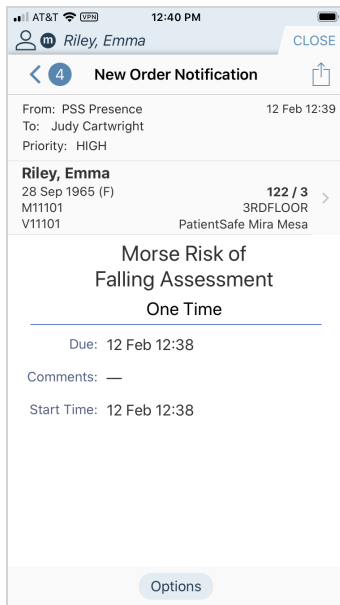
12. The Schedule displays on the *Intervention Order* screen.
13. Touch **Confirm**.



14. Scan your badge to document the workflow.



15. A New Order Notification displays.
16. Touch **View**.



17. Details of the intervention display for the patient.

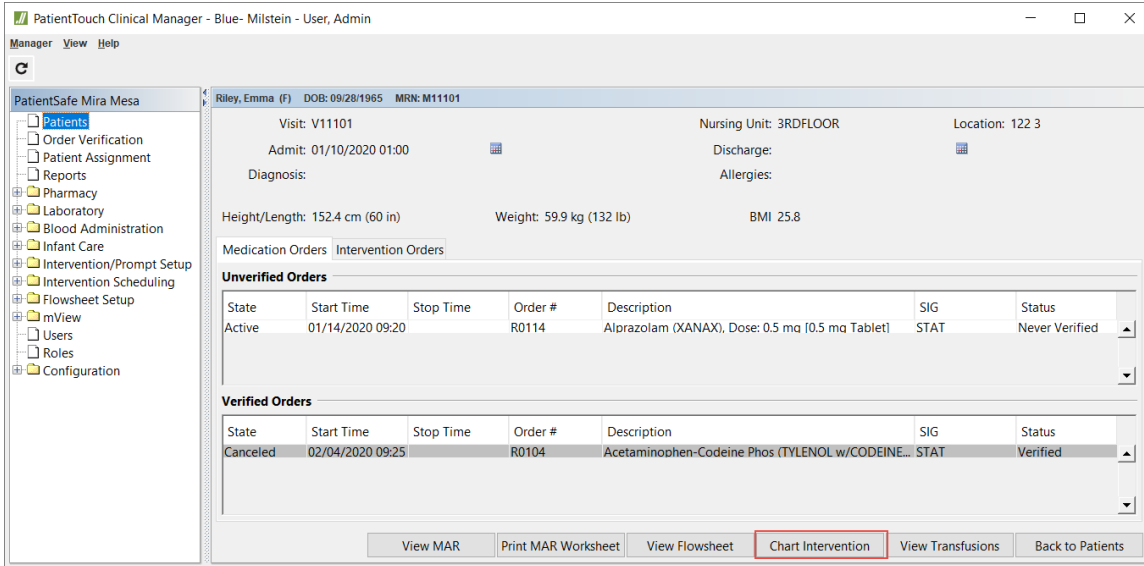
Documenting an Intervention from Patient Detail

In order to document an intervention from the patient detail, you must have your role listed under Care Roles for Executing Intervention Order under Orderable Interventions of the Clinical Manager.

You can document an intervention from the patient detail screen, which is described below. Or, you can document an intervention from the patient flowsheet, which is described in the next section “Documenting an Intervention from the Patient Flowsheet.”

Interventions must be “Orderable” in order to be selected and assigned to a specific patient. Refer to the Clinical Manager Configuration User Guide for detailed information on making interventions “Orderable.” These instructions assume you have an intervention assigned to a patient or a unit the patient is on.

1. Select a patient from the **Patients** tab.
2. Click **Patient Detail** (or just double-click the patient’s name).
3. Click **Chart Intervention**.

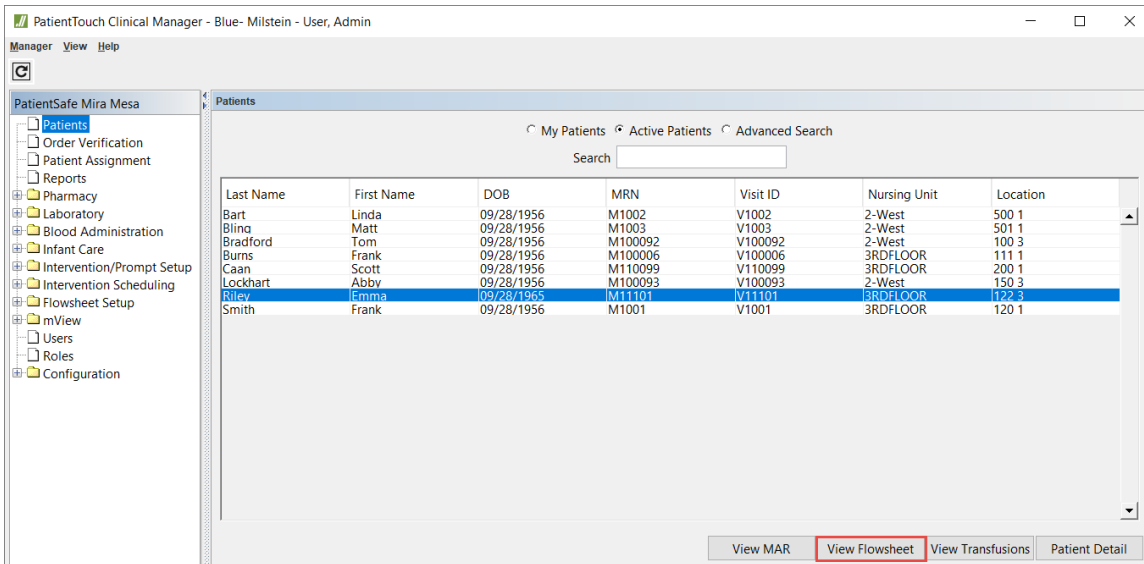


4. Follow the instructions in the next section on how to Document an Intervention from the Patient Flowsheet.

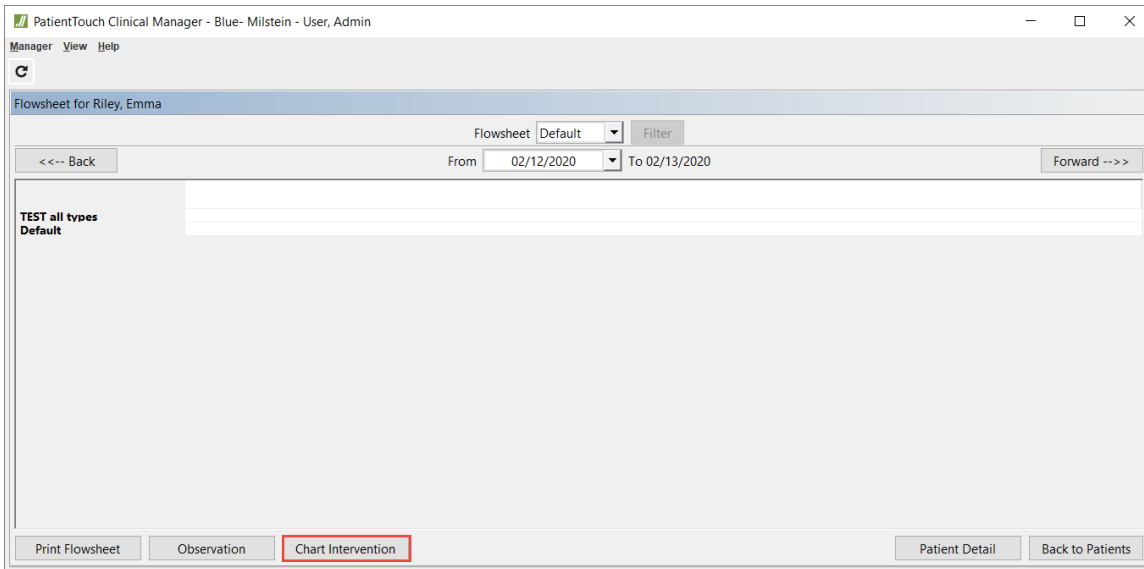
Documenting an Intervention from the Patient Flowsheet

In order to document an intervention from the patient detail, you must have your role listed under Care Roles for Executing Intervention Order under Orderable Interventions of the Clinical Manager.

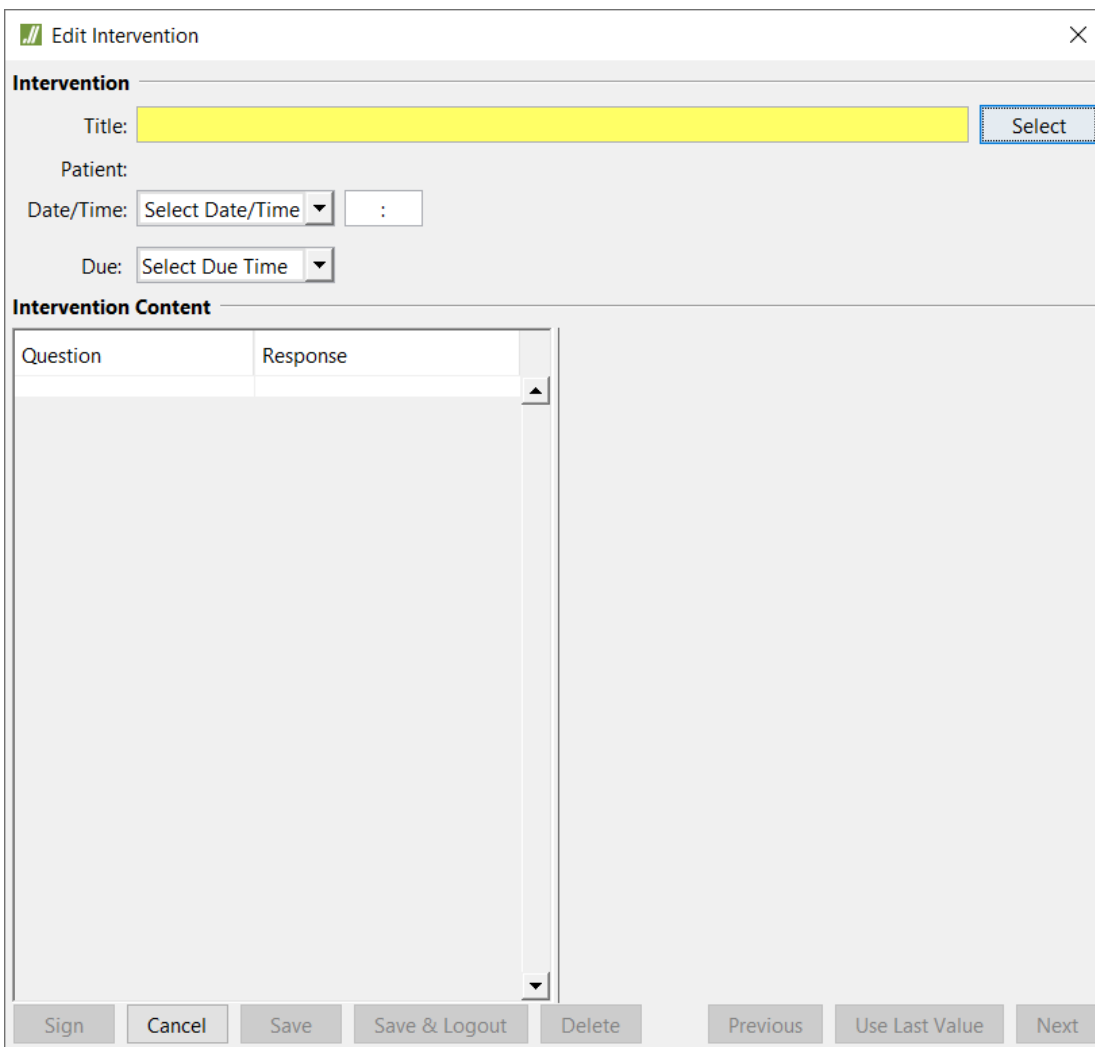
1. Select a patient from the **Patients** tab.
2. Click **View Flowsheet**.



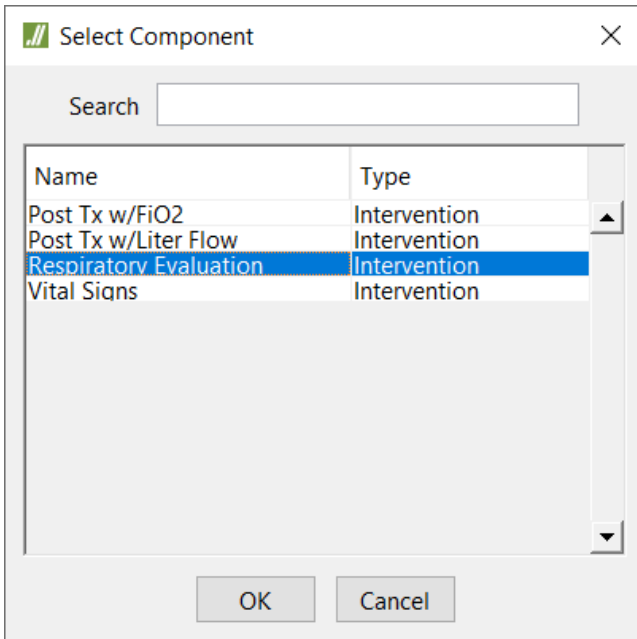
3. Click **Chart Intervention**.



4. Click **Select** next to the Title field and select the intervention you want to document.



- Only the interventions that have been assigned to the patient or unit the patient is on will display. In this example, we are selecting the Respiratory Evaluation.
- Click **OK**.



- The **Edit Intervention** window displays. The intervention components display on the left with required fields colored light purple. The color remains in the field until a value is entered. Select the appropriate response from the fields on the right and click **Next (F5 or Enter)**. Or, click **Use Last Value (F4)**.

Edit Intervention
✕

Intervention

Title: Select

Patient:

Date/Time:

Due:

Intervention Content

| Question | Response |
|------------------------------|----------|
| Respiratory Evaluation In... | |
| Respiratory Eval. | |
| Pulse Rate | 172 bpm |
| Respiratory Rate | 50 /min |
| O2 Saturatio | 50 % |
| O2 Mode | |
| Oxygen Flow | |
| FiO2 | |
| Breath Sounds | |
| Cough | |
| Secretions | |
| Position | |
| Med/Equip Ed | |

O2 Mode

Aerosol Mask

BIPAP

CPAP

Nasal Cannula

Non-Rebreather

Partial Non-Rebreather

Room Air

Simple Face Mask

Trach Collar

T-Piece

Ventilator

Venti Mask

Sign
Cancel
Save
Save & Logout
Delete
Previous
Use Last Value
Next



If a plus sign, or View User Text icon appears, enter any desired annotations. The annotations will appear on the flowsheet.

8. Click **Previous (F3 or Shift + Enter)** to return to the previous entry and make any adjustments as necessary. Your current entry will be saved.
9. If you need to stop documenting the intervention, click **Save** to save the intervention and remain in the Clinical Manager. The partially completed intervention is added to the unfinished interventions queue, however it is not documented to the patient flowsheet.
10. When you are ready to document the intervention, click **Sign**.

Edit Intervention
✕

Intervention

Title: Select

Patient: _____

Date/Time:

Due:

Intervention Content

| Question | Response |
|------------------------------|-----------------|
| Respiratory Evaluation In... | |
| Respiratory Eval. | |
| Pulse Rate | 172 bpm |
| Respiratory Rate | 50 /min |
| O2 Saturatio | 50 % |
| O2 Mode | CPAP |
| Oxvgen Flow | 12 L/M |
| FiO2 | 25 % |
| Breath Sounds | Exp. Wheeze L/R |
| Cough | Weak |
| Secretions | Scant |
| Position | Edge of Bed/Sit |
| Med/Equip Ed | Med Re-Ed. |

Med/Equip Ed

Initial Med Education

Initial Equip Use Education

Med Re-Education

Equip Use Re-Education

No Ed. Given

Sign
Cancel
Save
Save & Logout
Delete
Previous
Use Last Value
Next

Intervention Options

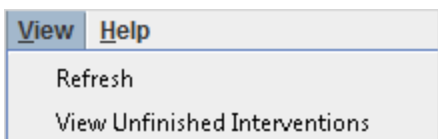
The table below provides descriptions of each of the buttons located on the Edit Intervention window.

| Functionality | Description |
|---------------------------|---|
| Sign: | Clicking Sign publishes user documentation to the patient flowsheet and closes the Edit Intervention window. Users will typically use this button when the intervention is complete. |
| Cancel: | Clicking Cancel exits the Edit Intervention window without saving or publishing documentation. |
| Save: | Clicking Save adds in progress documentation to the Unfinished Interventions worklist and does not publish documentation to the flowsheet or interfaced systems. The user remains in the System Manager and is not logged out. |
| Save & Logout: | Clicking Save & Logout adds in progress documentation to the Unfinished |

| Functionality | Description |
|-----------------------|---|
| <p>Delete:</p> | <p>Interventions worklist and does not publish documentation to the flowsheet or interfaced systems. The user logged out of System Manager. All saved interventions are accessible from the System Manager>Unfinished Queue.</p> <p>Delete is available for saved and signed interventions. If the intervention is signed and published to the flowsheet, the user may delete the documentation. However, the deleted documentation is struck through on the printed flowsheet report and the deletion is indicated by an asterisk (*) on the online flowsheet.</p> <p>If the intervention is saved, the user may delete the documentation and this will remove it from their Unfinished Interventions worklist and will not be published to the flowsheet or interfaced systems.</p> |

Accessing Unfinished Interventions

1. To access any unfinished interventions, click the View menu>View Unfinished Interventions.



You can also log out and when you log back in you can select the intervention from the Unfinished Intervention queue.

Viewing Interventions from the Patient Flowsheet

Once you’ve completed the intervention and selected the appropriate flowsheet from the drop down menu, the intervention values automatically display. These values also display on the Care tab of the handheld and in mView.

PatientTouch Clinical Manager - Blue- Milstein - User, Admin

Manager View Help

Flowsheet for Riley, Emma

Flowsheet **Resp Eval** Filter

<<-- Back From 02/12/2020 To 02/13/2020 Forward -->>

| | 12:00 | Last Value |
|-------------------------|---|---|
| Respiratory Eval | | |
| Pulse Rate | Pulse Rate: 172 bpm (by adm) | Pulse Rate: 172 bpm (by adm) 12:00 |
| Respiratory Rate | Respiratory Rate: 50 /min (by adm) | Respiratory Rate: 50 /min (by adm) 12:00 |
| O2 Sat | O2 Saturation: 50 % (by adm) | O2 Saturation: 50 % (by adm) 12:00 |
| O2 Mode | O2 Mode: CPAP (by adm) | O2 Mode: CPAP (by adm) 12:00 |
| O2 Flow | Oxygen Flow: 12 L/M (by adm) | Oxygen Flow: 12 L/M (by adm) 12:00 |
| FiO2 | FiO2: 25 % (by adm) | FiO2: 25 % (by adm) 12:00 |
| Breath Sounds | Breath Sounds: Exp. Wheeze L/R (by adm) | Breath Sounds: Exp. Wheeze L/R (by adm) 12:00 |
| Cough | Cough: Weak (by adm) | Cough: Weak (by adm) 12:00 |
| Secretions | Secretions: Scant (by adm) | Secretions: Scant (by adm) 12:00 |
| Position | Edge of Bed/Sit (by adm) | Edge of Bed/Sit (by adm) 12:00 |
| RT Education | Med/Equip Ed: Med Re-Ed. (by adm) | Med/Equip Ed: Med Re-Ed. (by adm) 12:00 |

Print Flowsheet Observation Chart Intervention Patient Detail Back to Patients

Editing Values

The values on the intervention may be edited or you can select **Use Last Value** to maintain the last documented value.

1. Click inside any of the boxes under Last Value on the flowsheet.

PatientTouch Clinical Manager - Blue- Milstein - User, Admin

Manager View Help

Flowsheet for Riley, Emma

Flowsheet Resp Eval Filter

<<-- Back From 02/12/2020 To 02/13/2020 Forward -->>

| | 12:00 | Last Value |
|-------------------------|---|---|
| Respiratory Eval | | |
| Pulse Rate | Pulse Rate: 172 bpm (by adm) | Pulse Rate: 172 bpm (by adm) 12:00 |
| Respiratory Rate | Respiratory Rate: 50 /min (by adm) | Respiratory Rate: 50 /min (by adm) 12:00 |
| O2 Sat | O2 Saturation: 50 % (by adm) | O2 Saturation: 50 % (by adm) 12:00 |
| O2 Mode | O2 Mode: CPAP (by adm) | O2 Mode: CPAP (by adm) 12:00 |
| O2 Flow | Oxygen Flow: 12 L/M (by adm) | Oxygen Flow: 12 L/M (by adm) 12:00 |
| FiO2 | FiO2: 25 % (by adm) | FiO2: 25 % (by adm) 12:00 |
| Breath Sounds | Breath Sounds: Exp. Wheeze L/R (by adm) | Breath Sounds: Exp. Wheeze L/R (by adm) 12:00 |
| Cough | Cough: Weak (by adm) | Cough: Weak (by adm) 12:00 |
| Secretions | Secretions: Scant (by adm) | Secretions: Scant (by adm) 12:00 |
| Position | Edge of Bed/Sit (by adm) | Edge of Bed/Sit (by adm) 12:00 |
| RT Education | Med/Equip Ed: Med Re-Ed. (by adm) | Med/Equip Ed: Med Re-Ed. (by adm) 12:00 |

Print Flowsheet Observation Chart Intervention Patient Detail Back to Patients

2. The Response column is pre-populated with the last documented values for this intervention.
3. You can select to choose the last value documented by clicking **Use Last Value**.
4. Or you can edit a value and click **Next**.
5. Complete the modification of the intervention values as necessary.
6. Click **Sign** on the *Edit Intervention* window when done.

Edit Intervention
✕

Intervention

Title: Clinical Data Select

Patient: Patient: Riley, Emma MRN: M11101 Visit: V11101

Date/Time:

Due:

Intervention Content

| Question | Response |
|------------------------------|------------------------|
| Respiratory Evaluation In... | |
| Respiratory Eval. | |
| Pulse Rate | 168 bpm |
| Respiratory Rate | 50 /min |
| O2 Saturatio | 50 % |
| O2 Mode | CPAP |
| Oxygen Flow | 12 L/M |
| FiO2 | 25 % |
| Breath Sounds | Exp. Wheeze L/R |
| Cough | Strong, Non-productive |
| Secretions | Scant |
| Position | Edge of Bed/Sit |
| Med/Equip Ed | Med Re-Ed. |

Secretions

Last Value: Scant

None
 Scant
 Small
 Moderate
 Copious
 Loose
 Thin
 Thick
 Red
 Pink
 Tan
 White

Sign
Cancel
Save
Save & Logout
Delete
Previous
Use Last Value
Next

7. The edited values are documented on the flowsheet below and designated with an asterisk (*).

PatientTouch Clinical Manager - Blue- Milstein - User, Admin

Manager View Help

Flowsheet for Riley, Emma

Flowsheet Resp Eval Filter

<<-- Back From 02/12/2020 To 02/13/2020 Forward -->>

| | 12:00 | Last Value |
|-------------------------|---|---|
| Respiratory Eval | | |
| Pulse Rate | *Pulse Rate: 168 bpm (by adm) | *Pulse Rate: 168 bpm (by adm) 12:00 |
| Respiratory Rate | Respiratory Rate: 50 /min (by adm) | Respiratory Rate: 50 /min (by adm) 12:00 |
| O2 Sat | O2 Saturation: 50 % (by adm) | O2 Saturation: 50 % (by adm) 12:00 |
| O2 Mode | O2 Mode: CPAP (by adm) | O2 Mode: CPAP (by adm) 12:00 |
| O2 Flow | Oxygen Flow: 12 L/M (by adm) | Oxygen Flow: 12 L/M (by adm) 12:00 |
| FiO2 | FiO2: 25 % (by adm) | FiO2: 25 % (by adm) 12:00 |
| Breath Sounds | Breath Sounds: Exp. Wheeze L/R (by adm) | Breath Sounds: Exp. Wheeze L/R (by adm) 12:00 |
| Cough | *Cough: Strong Non-productive (by adm) | *Cough: Strong Non-productive (by adm) 12:00 |
| Secretions | Secretions: Scant (by adm) | Secretions: Scant (by adm) 12:00 |

Print Flowsheet Observation Chart Intervention Patient Detail Back to Patients