patienttouch system

# PatientTouch® Clinical Manager User Guide for Administrators

**June 2020**

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All patient names and medical histories depicted in these materials are fictitious. Any resemblance to an actual person or case is purely coincidental. All drugs, drug orders, and dosages depicted in screen shots, videos, diagrams, or other media are for illustrative purposes only. PatientSafe Solutions, Inc. makes no recommendation or representation about any treatment or dosage. These materials are subject to revision by PatientSafe Solutions, Inc. from time to time, at any time.



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# The Clinical Manager User Guide for Administrators

## Overview

The PatientTouch Clinical Manager runs in the pharmacy and on designated workstations in various care areas throughout the hospital where clinicians are using the system. Users can perform many activities, depending upon their individual roles and privileges within the system.

The PatientTouch Clinical Manager is used by various hospital personnel to perform the following tasks:

- Pharmacists have access to update the hospital formulary, maintain other pharmacy-related configurations and view patient information.
- Caregivers can chart medication administrations on the online MAR.
- Caregivers can view, edit, and print MARs.
- Management can run statistical reports and see system configurations.
- IT personnel can configure settings, prompts and interventions for all modules in the PatientTouch System.
- Lab personnel can collect lab orders and print specimen labels.
- Blood Bank Technicians assist laboratory and blood bank personnel in accurate matching of blood samples with correct blood products, and assist nurses in transfusing blood products to the correct patient.
- Caregivers can collect and label human milk from mothers to ensure that the correct human milk is matched and administered for feeding.
- Hospital staff can call or text one another using the fully integrated communications tool with or without VoIP capabilities.

## Professional Responsibility

The PatientTouch System when used as outlined in the user guides and training documentation can help prevent serious 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 errors 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.

# Migrating to the Enterprise Manager

Some of the functionality in the PatientTouch Clinical Manager (System Manager) has migrated to the Enterprise Manager. The table below outlines the application in which you will find each feature.

| Feature | Clinical Manager (System Manager) | Enterprise Manager |
|---|---|---|
| Patients | X | X |
| Order Verification | X | |
| Patient Assignment | X | X |
| Reports | X | |
| Pharmacy | X | |
| Laboratory | X | |
| Intervention/Prompt Setup | X | |
| Flowsheet Setup | X | |
| mView | X | |
| Users (Caregivers in Enterprise Manager) | | X |
| • Default Printer | X | |
| Roles | X | X |
| Configuration: | | |
| • Settings | | |
| Hospital Address | | X |
| Global Settings | X | |
| Notification Settings (System) | X | |
| Notification Settings (Text and VoIP) | X | X |
| User Security | | X |
| Respiratory Therapy | X | |
| • Nursing Units | X | X |
| • Alerts and Reasons | X | |
| • Destinations | X | |
| • Label Printers | X | |
| • Devices | | X |
| • Coding Systems | X | |
| • Communications | | X |

# PatientTouch System Components

Because each facility has unique clinical workflows and procedures, a PatientSafe Solutions project team works with the hospital to implement the PatientTouch System in each hospital environment. The team works with the hospital's clinical, pharmacy, laboratory, respiratory therapy, and information systems staff to ensure the necessary training, configurations, policies, and procedures are all in place.

## System Requirements

The PatientTouch Positive Patient Identification (PPID) Platform is required for all PPID modules and Vitals and consists of the following components:

- Clinical Manager (Optional with the installation of any clinical module)
- Platform/Interface Engine
- Enterprise Manager (Required for all 4.x Environments. Also a necessity for PatientTouch Communication applications)
- PatientTouch Handheld

- Clinical Manager Reporting Services
- PatientTouch Analytics

## PatientTouch Clinical Manager

The PatientTouch Clinical Manager runs in the pharmacy and on designated workstations in various care areas throughout the hospital where clinicians are using the system. Users can perform many activities, depending upon their individual roles and privileges within the system. The Clinical Manager is optional for those sites interested in installing any of the following clinical modules:

- Medication Administration
- Care Interventions
- Specimen Collection
- Infant Care
- Blood Product Administration
- Clinical Communications

The PatientTouch Clinical Manager is used by various hospital personnel to perform some of the following tasks:

- Pharmacists have access to update the hospital formulary, maintain other pharmacy-related configurations and view patient information.
- Caregivers can assign patients, run reports or chart medication administrations on the online MAR.
- Caregivers can view, edit, and print MARs.
- Management can run statistical reports, view patient information and see system configurations.
- IT personnel can configure settings, prompts and interventions for all modules in the PatientTouch System.
- Lab personnel can collect lab orders and print specimen labels.
- Blood Bank Technicians assist laboratory and blood bank personnel in accurate matching of blood samples with correct blood products, and assist nurses in transfusing blood products to the correct patient.
- Caregivers can collect and label human milk from mothers to ensure that the correct human milk is matched and administered for feeding.
- Hospital staff can call or text one another using the fully integrated communications tool with or without VoIP capabilities.

## Platform

The PatientTouch Platform is required for use on any of the system modules. The platform contains the PatientTouch Clinical Manager for centralized management of all clinical rules and content, management of core system configurations, and reporting services. The PatientTouch Platform contains both inbound and outbound interface engines.

## Enterprise Manager

The Enterprise Manager is a required application for all 4.x environments. It is a tool that provides greater flexibility in assigning caregivers and patients. You will use the Enterprise Manager to manage the relationship between the hospital, care role, and the patient.

The Enterprise Manager also allows you to:

1. Create and manage user information/permissions and contacts
2. Manage user extensions
3. Configure the organization structure, including organization types (i.e. unit) and organization units (i.e. 3rd Floor) across multiple facilities
4. Configure the clinical attributes, including care roles and clinical profiles
5. Manage settings for system security, messaging and voice
6. Manage devices
7. View patient information
8. Add multi-facility configuration

## PatientTouch Handheld

PatientTouch includes an Apple iPod touch® (16GB/32GB) or an iPhone. Please refer to the iOS Compatibility Matrix located on the client portal for recommended PatientTouch iOS devices.

### *Softscan*

PatientSafe Solutions is recommending our Softscan technology that enables the camera to scan badges and medications.

### *Handheld Workflow*

The PatientTouch System requires the caregiver to scan a unique user ID barcode (typically found on the caregiver's name badge) to log into the system, complete the med pass and/or other workflows for each patient, and document and “sign” the information, providing enhanced security and accountability for the process.

By scanning barcodes on patient wristbands, medications and caregiver badges, caregivers can quickly and easily check medication accuracy at the bedside; lab personnel can accurately scan specimens and document collection; caregivers can match infant formulas to the correct baby and more.

Caregivers can also document pertinent information, such as vital signs, IV rate flow, and reasons for alert overrides. The handheld wirelessly links to the PatientTouch server for real-time updates and charting.

### *PatientTouch Application Uses*

Depending on how the hospital sets up the PatientTouch System, it can streamline a variety of reporting and communication needs. For example, the PatientTouch application can:

- Initiate and document workflows
- Initiate vital readings and record vital patient data
- Document override reasons for deviations on a med pass
- Document injection sites
- Send messages to the pharmacy
- Print MARs or other reports for physicians and caregivers
- Assist phlebotomists with correct labeling of specimen collection tubes at the bedside
- Assist laboratory personnel in accurate matching of blood samples with correct blood

products

- Caregivers can perform patient care activities such as vitals, I/O, nursing hourly rounds, skin assessments, evaluating fall risk, capturing pain information, and more

# PatientTouch System Modules

## Medication Administration Module

Using an interface with the hospital information systems, the PatientTouch System receives patient medication orders, admitting data, and allergy information for example. The system is designed to help caregivers ensure the Seven Rights of medication administration at the point of care. To help ensure patient safety, the system also performs drug interaction, allergy checking and duplicative drug-therapy checking for medications administered when there is no order found in the system. An online medication orders list on the PatientTouch application allows the clinician to see STAT, late, due, scheduled, and PRN medications.

Clinical prompts can be associated with formulary items to allow the collection of patient data, such as temperature, blood pressure, blood glucose, and so on, at the time of administration. The alerting capabilities give clinicians visual indicators of potentially harmful events at the time of medication administration.

The Medication Administration module also includes a real-time reminder system to make the clinician aware of due administrations, late administrations, data collection follow-up, order status changes, and new orders.

Medication administration is documented on both hardcopy and online versions of a MAR, which can be viewed by all care team members. Additionally, the PatientTouch System provides interfaces with other vendors' MARs.

## Vitals Module

The Vitals module delivers user-definable interventions to the bedside for real-time documentation of patient's clinical status. Caregivers leverage the module to capture and document vitals signs, Input/Output (I/O)/dietary status, and other clinical observations at the point of care. All observations are documented in real time and may be presented to the care team via mView, Flowsheets, and as clinical decision values throughout clinical workflows, if configured to do so. Observations can also be sent via an outbound interface to other clinical systems.

Users can author Interventions using Clinical Manager, which can contain clinical prompts and other Interventions. All Interventions guide the caregiver through the collection process.

## Care Interventions Module

The Care Interventions module provides point-of-care workflows and clinical data entry support for performing patient care activities such as vitals, I/O, nursing hourly rounds, skin assessments, evaluating fall risk, capturing pain information, and more. Interventions can be configured to suit your

facility's point-of-care workflows, including clinical data collection, assessments, safety best practices, patient status, and care team clinical and activity documentation.

Care intervention orders can be scheduled and executed via the PatientTouch Clinical Manager and PatientTouch. They can be ordered and discontinued based on assigned roles and privileges.

Intervention results are seamlessly documented in real-time and can be made available for review in the mView display on caregiver handhelds, and/or in the patient's flowsheet(s) in the PatientTouch Clinical Manager.

Additionally, data captured using Care Interventions supports HL7 and Web Service-based integration with other hospital information systems.

## Specimen Collection Module

PatientTouch Specimen Collection workflows increase the safety, accuracy, and efficiency of lab order processing and fulfillment by combining the PatientTouch System with mobile label printing at the point-of-care.

PPID-based workflows coupled with the PatientTouch Mobile Orchestration Platform enable frontline caregivers to enforce patient identification and care verification, document in real time, and optimize care team workflows through order recruitment and escalation.

## Blood Product Administration Module

The PatientTouch Blood Product Administration (BPA) module is a point-of-care Transfusion Safety Management System intended to assist in positive patient identification for the transfusion of blood products.

In conjunction with the PatientTouch Specimen Collection module, which assists phlebotomists with correct labeling of specimen collection tubes at the bedside, BPA assists laboratory personnel in accurate matching of blood samples with correct blood products, and assists nurses in transfusing blood products to the correct patient.

## Infant Care Module

PatientTouch Infant Care helps ensure safe, high-quality infant care. PPID-based workflows support accurate mother and baby matching, accurate labeling of collected breast milk and safety of breast milk feedings.

## Clinical Communications Module

PatientTouch Clinical Communications is a fully integrated communications tool that improves care collaboration, safety, and patient satisfaction by allowing caregivers to stay connected with each other and the patient care process. The PatientTouch Platform eliminates the inefficiencies of carrying multiple devices and using disconnected applications by providing a single, mobile application for all communications and clinical workflow needs. This product is currently in Limited Commercial Release (LCR).

# Additional PatientTouch Services

## Professional Services Support

PatientSafe Solutions assists hospitals by supporting the full integration of the PatientTouch System with your EHR and other health information systems. Included in this is the ability to support nursing documentation and custom interventions and assessment workflows, as well as to support your organization's Meaningful Use Activities. This includes specific interoperability functionality to support Clinical Quality Measure (CQM) data capture and reporting. The Clinical Manager provides specific code fields to identify the element vocabulary (SNOMED-CT®, RxNorm, LOINC®, etc.) code, short description, and description for the following clinical information:

1. Interventions and Assessments
2. Formulary Items
3. Routes of Administration

Documentation performed at the bedside using PatientTouch will contain these codes, and may be optionally exported via the HL7 interface.

Please contact PatientSafe Solutions for further information on the services we can provide to support the set up and implementation of this functionality.

# Logging In and Out

An icon on the hospital workstation allows you to quickly access the PatientTouch Clinical Manager. Some facilities may provide a link on the intranet network from which users can access the application.

The system administrator sets your login name and you create your own unique password. You use the same password for the Clinical Manager, Enterprise Manager, and PatientTouch.

You may have access to one or more Hospitals through the optional feature: Campus support. When applicable you'll be offered the ability to choose a specific hospital at login, or "All" hospitals. The "All" hospital option will allow you to perform certain functionality that will apply to all hospitals within a campus.

## Logging In

To log in, perform the following steps.

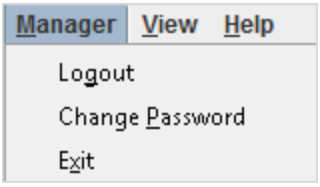
1. Double-click the **PatientTouch Clinical Manager** icon to launch the application. Or, select the link from the intranet.

2. Enter your login name and password and click **OK**. (Please note that the login name and password are case sensitive).
3. If your hospital is configured for Campus Support, select the facility for which you want to log in. Or, select <All>. **Note for Campus Support**: If your hospital is *not* configured for Campus Support, you will not be provided with the hospital selection field.
4. Click **Options** to change the domain name of the server to which the PatientTouch System is pointing.
5. Click **Exit** to quit the Patient Touch Clinical Manager.


## Logging Out

To log out of the PatientTouch Clinical Manager once you have logged in, select **Logout** from the **Manager** menu.

**Note for Campus Support**: If your hospital is configured for Campus Support, and you want to change views to a different hospital, you must log out and log back in and select that hospital.

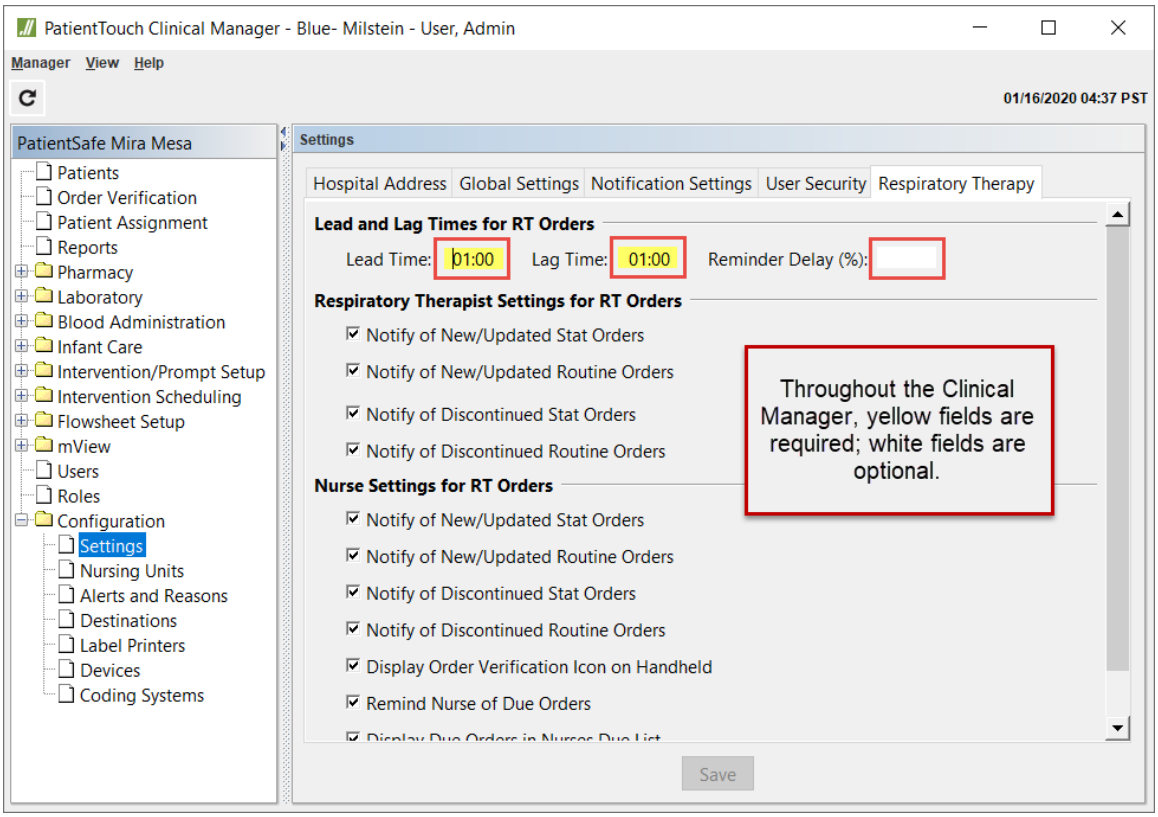


- To close the application, select **Exit** from the **Manager** menu.
- The system may also log you out automatically after a period of inactivity that is defined for your hospital to comply with hospital policies and HIPAA guidelines.

## Clinical Manager Navigation

Use the menu structured list of folders in the left pane of the main screen to open windows in the right pane of the main screen in which you can view and enter information.

The system time is displayed in the upper right corner of all Clinical Manager screens. The Clinical Manager uses the time zone of the server.




The system displays only the options available to you. This is based on the role and privileges you are assigned. The menus and options you see may be different from those illustrated in this guide.

For example, caregivers with the Nurse Manager role may see options that allow them to view and edit the online MAR, run reports, open patient charts, and assign patients. Pharmacists will have options that allow them to view the master drug file or to edit SIG codes.

- Click the Refresh icon or select **Refresh** from the View menu to update the information window with changes.
- To expand the information screen to the entire work area, click the left arrow between the two panes. To return to a dual-pane window, click the right arrow

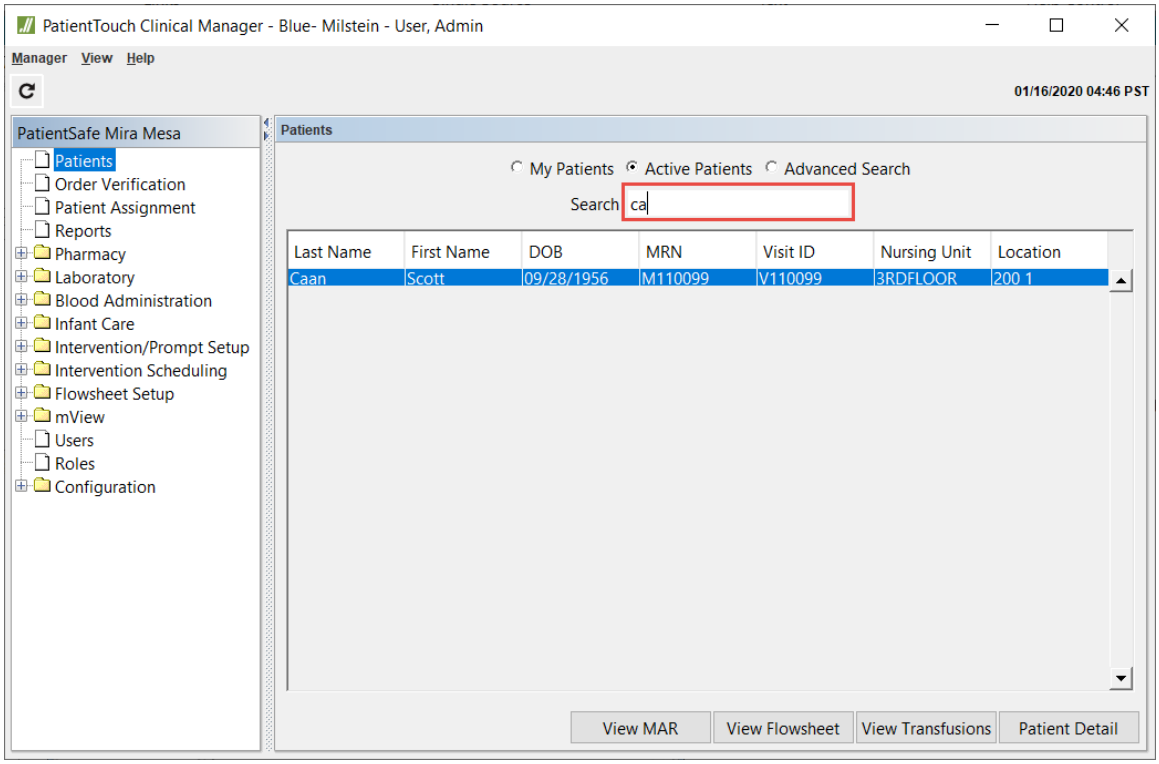
.

- Double-click folders to expand them and view or navigate to the options within.

## Searching the Database

The PatientTouch Clinical Manager database is searchable. The list of patients, medications, SIG codes, and additional information can be searched by entering a few characters of the item's name in the Search field. The Clinical Manager searches all columns for characters that appear in the same sequence.

**Note for Campus Support:** If your hospital is configured for Campus Support, the search will only look for patients in the selected hospital.




# Configuration

## Settings

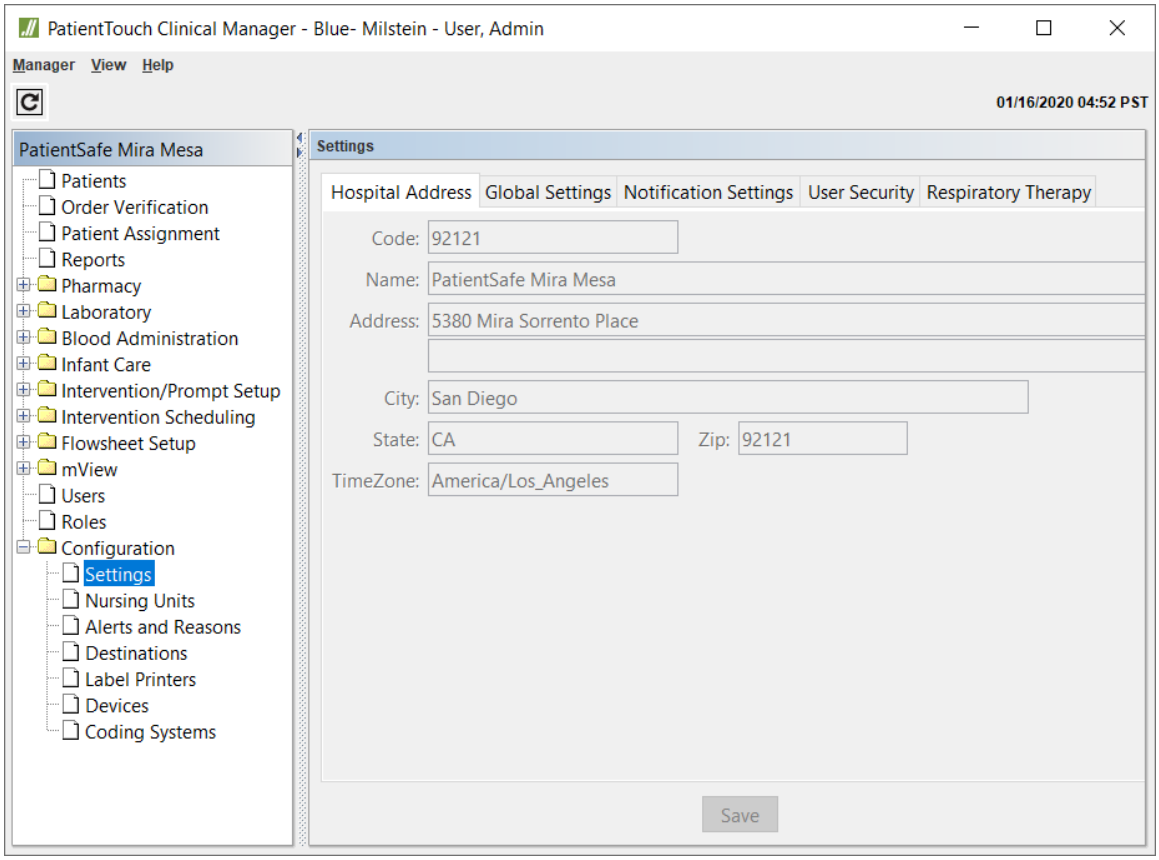
The Settings tab allows you to enter setup information for:

- Hospital Address
- Global Settings
- Notification Settings
- User Security
- Respiratory Therapists (optional)

This section explains how to configure these settings. Initially, your PatientSafe Solutions representative will help define these settings. However, the hospital's system administrator can edit these options and will do so after the initial setup in order to keep the configuration current.

## Hospital Address Tab

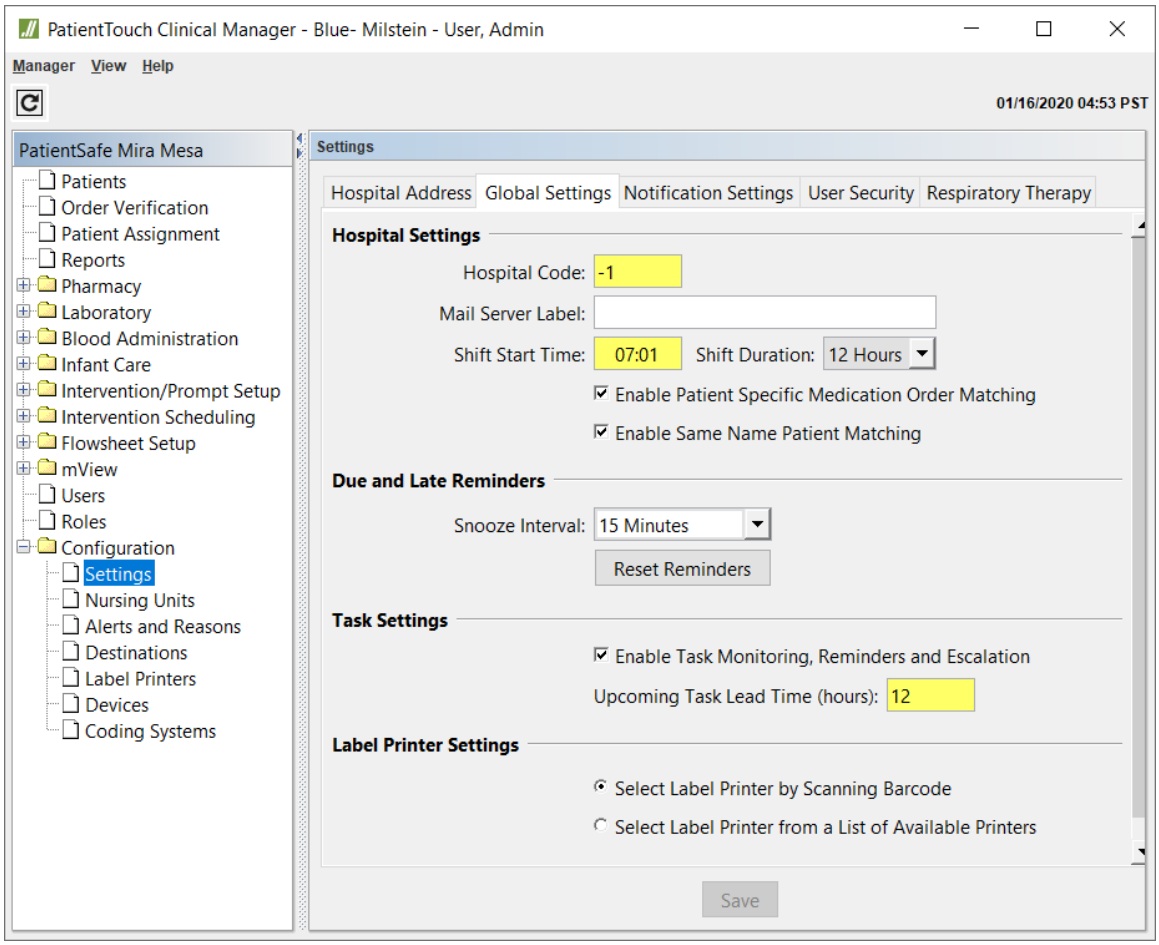
The Hospital Address and Time Zone are configured under the Organization Unit in the Enterprise Manager. They display here for your reference.




## Global Settings Tab

Global Settings configure basic options such as the shift start time and duration. To set up these options in the Clinical Manager, perform the steps below:

1. Select **Configuration > Settings**.
2. Click the **Global Settings** tab.




3. Select the following global settings.

| Hospital Settings: Hospital Code | Set for you by PatientSafe Solutions and cannot be changed. |
|---|---|
| Mail Server Label | The IP address of the hospital's e-mail server. It is used if you want e-mails to be sent through the hospital's mail server (recommended). If left blank, e-mails will be sent using a PatientSafe Solutions mail server. |
| Shift Start Time | Sets the start time for the first shift column displayed on the printed and online MARs. |
| **Shift Duration** | Determines whether the MAR shifts display as three 8-hour columns or two 12-hour columns. |
| **Enable Patient-Specific Medication Order Matching** | Select this checkbox if you want to reduce the number of patient-specific medications that must be re-labeled by the pharmacy when certain changes are made to an order but the medication and dose remain the same. If this feature is active and the pharmacy makes a change to an existing order such that it requires a new order and new patient-specific barcode label, the clinician can still scan the original patient-specific barcode on the medication until the pharmacy is able to provide the new label. This feature only works if the medication and dose match the new order for 24 hours after the original order is discontinued. |
| **Enable Same-NamePatient Matching** | Select this checkbox to display an icon next to the names of patients who have identical names. The icon only appears next to the names of patients who share both first and last names. |
| Due and Late Reminders: | Depending on how the system is configured, users can receive pop-up reminders about the items on the To Do tab: due and/or late medication doses, uncollected lab orders, due or late interventions, or |

| | |
|---|---|
| | number of unverified orders on the handheld. The reminder pop-up will display periodically until the task is complete. The Snooze Interval setting defines the length of time between the reminder pop-ups if the user selects Snooze. The Snooze Interval can be set to last from 5—60 minutes in 5-minute increments. In certain situations, you may want to reset reminders being sent to users about various activities (e.g. due and late medications). For example, the system may be down for a long period of time and backup procedures put in place. Once the system is back up, you do not want to remind users of activities for which they may have already addressed during the down time. Therefore, you can select "Reset Reminders" and specify the unit(s) for which the system will only remind users about activities from that point forward. |
| Task Settings | The Enable Task Monitoring, Reminders and Escalation setting determines whether or not users will receive reminder pop-ups and an incremental badge count for the To Do tab on the handheld. Additionally, if the Specimen Collection module is installed, this setting determines if the user will receive lab escalation messages. By default, this box is checked. However, during setup, the PatientSafe Solutions field team may uncheck this box so the new system easily loads without extraneous reminders and tasks. When you are ready to use the system, this checkbox must be selected for reminders and the To Do tab badge count to work. The Upcoming Tasks Lead Time defines the window of time for which to display upcoming orders in the Upcoming section of the caregiver's To Do list. For example, if this setting is defined for 12 hours, the system will show any "upcoming" orders within the next 12 hours. |
| Label Printer Settings | These settings are enabled with the installation of Specimen Collection or Infant Care Modules. A description of how to set this option is included in this user guide. |

4. Click **Save** to record your changes. Note that the **Save** button is only available if you have made changes in the tab settings.

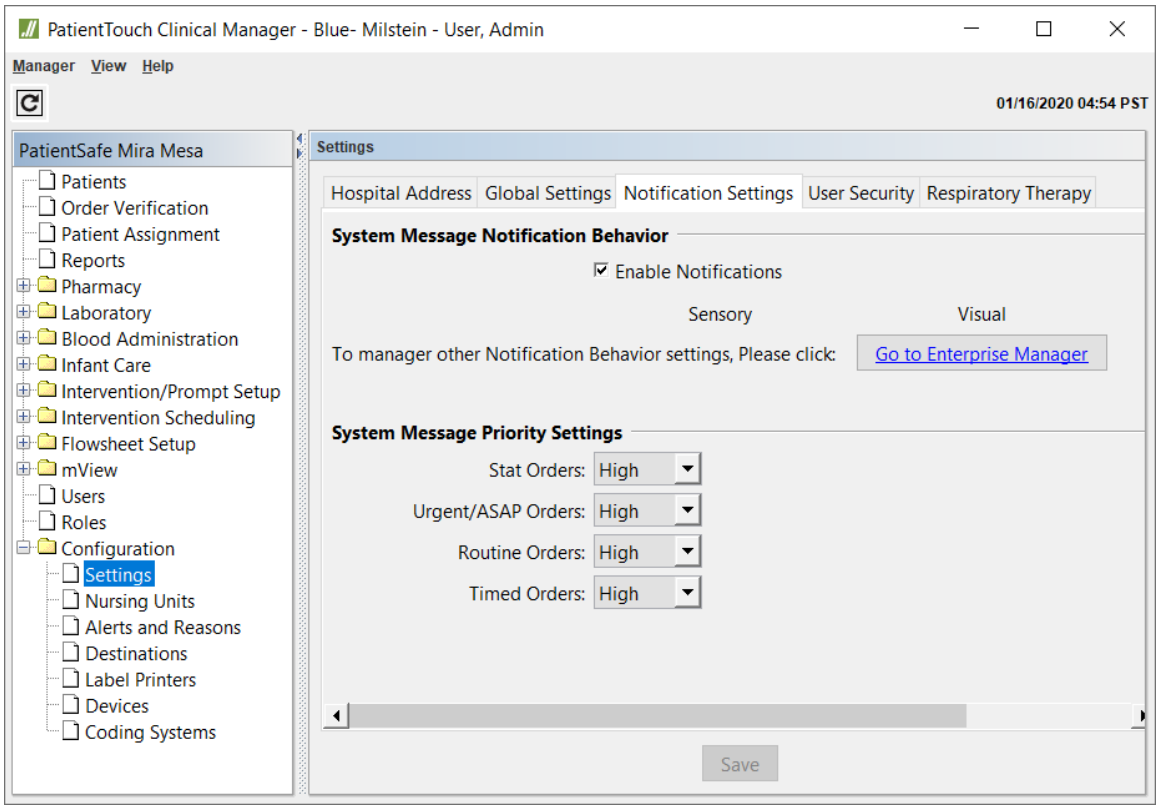
## Notification Settings Tab

The Notification Settings tab in the Clinical Manager allows you to enable notifications and configure the behavior of System Messages.

Notification settings for text messages, notification messages, clinical due and late reminders and voice calls are all configured in the Enterprise Manager.

1. Select **Configuration>Settings**.
2. Click the **Notification Settings** tab.

Use the descriptions below the screen image to complete the fields.




| | |
|---|---|
| System Message Notification Behavior | Click this checkbox to enable system notifications. |
| System Message Priority Settings | Set the message priority (High, Medium, or Low) for **Stat, Urgent, Routine** and **Timed** medication administration and specimen collection orders. Priority level determines the category of the message in the Inbox and the notification behavior initiated when order messages are received. |

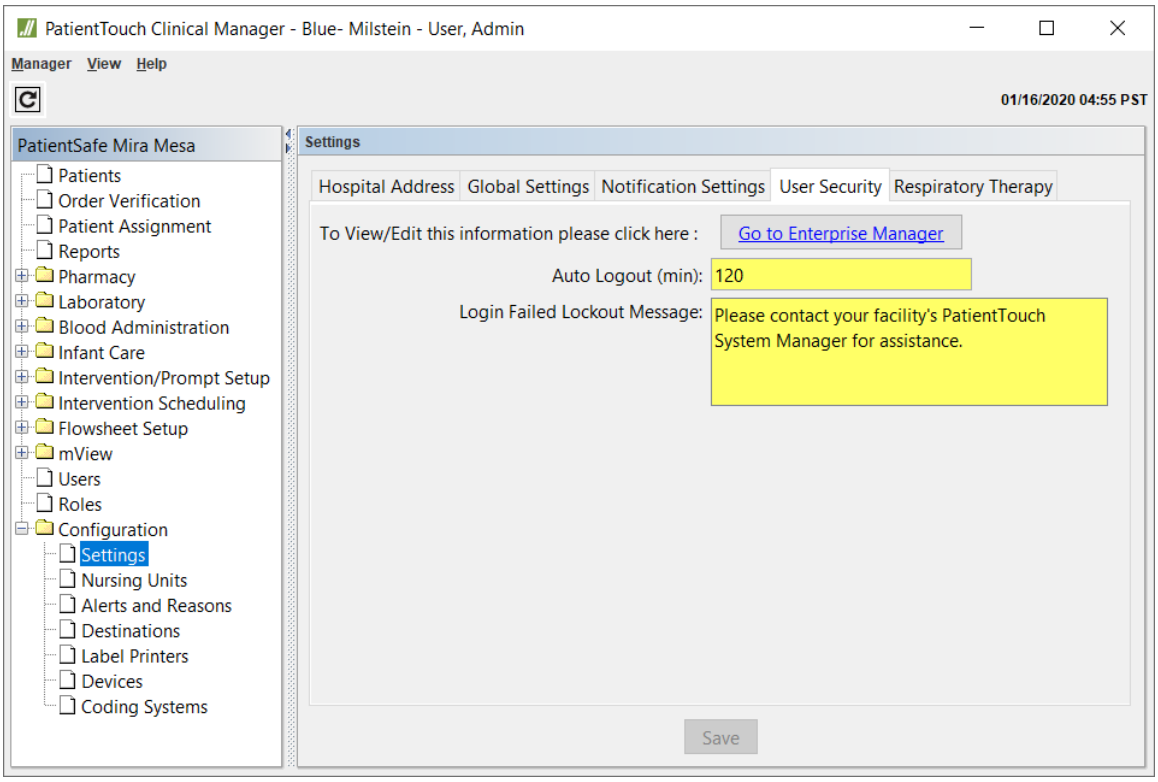
After defining the desired notification settings, click **Save** to record your changes. Note that the **Save** button is only available if you have made changes in the tab settings.

## User Security Tab

The User Security settings are now configured in the Enterprise Manager and a link is provided for your reference.

However, two settings remain specific to the Clinical Manager and need to be defined here. Auto Logout (min): This defines the amount of idle time before the user is automatically logged out of the Clinical Manager.

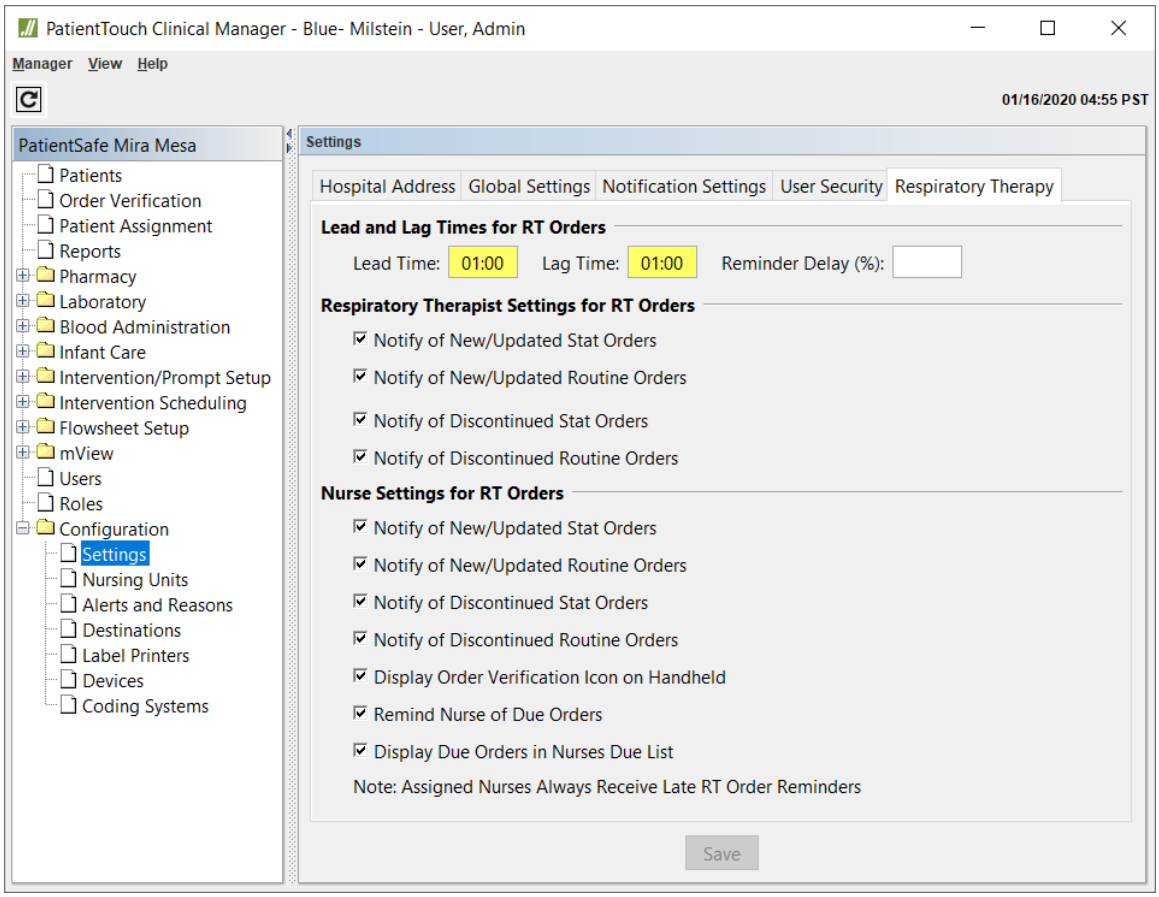
Login Failed Lockout Message: This is a custom message displayed to a user when they attempt to log into the Clinical Manager but have failed three times.




## Respiratory Therapy Tab (Optional)

For hospitals that have enabled the optional Respiratory Therapy (RT) module, these settings determine how the PatientTouch System manages orders designated as RT orders. To configure these options in the Clinical Manager:

1. Select **Configuration > Settings**.
2. Click the **Respiratory Therapy** tab.




3. Select the Lead and Lag Times for RT Orders, as follows:

| | |
|---|---|
| Lead Time Lag Time | The times you set here determine the lead time and lag time (RT orders only) when there is no lead or lag time set in the SIG Code. SIG Code lead or lag times always take precedence over these settings. These settings drive if/when an RT medication is considered to be early (too soon before the scheduled dose due time) or late (too long after the scheduled dose due time). |
| Reminder Delay (%) | This number is a percentage of the lag time before a "Dose Due" reminder for an RT medication displays on the handheld. For example: If the lag time is set by the hospital to 1 hour (01:00), enter:<br>**25%** to display a reminder 15 minutes after the RT med due time<br>**50%** to display a reminder 30 minutes after the RT med due time<br>**75%** to display a reminder 45 minutes after the RT order due time<br>**100%** to display a reminder only after the lag time (1 hour) elapses |

4. Define the Respiratory Therapist Settings for RT Orders:

| | |
|---|---|
| **Notify of New/Updated Stat and Routine Orders** | Select this option to notify RTs about new/updated and/or discontinued RT orders for assigned patients. You can choose one or both of these options. |
| **Notify of Discontinued Stat and Routine Orders** | If the hospital is utilizing the Order Verification features, be aware that users will receive this notification in their Inbox and a task in their To Do list to verify the order. |

5. Define the Nurse Settings for RT Orders:

| | |
|---|---|
| **Notify of New/Updated Stat and** | Select this option to notify nurses about new/updated and/or discontinued RT orders for |

| | |
|---|---|
| **Routine RT Orders** | patients assigned to them. You can choose one or both of these options. |
| **Notify of Discontinued Stat and Routine RT Orders** | If the hospital is utilizing the Order Verification features, be aware that users will receive this notification in their Inbox and a task in their To Do list to verify the order. |
| **Display Order Verification Icon on Handheld** | If your hospital has enabled order verification, the verification status is displayed on the handheld. |
| **Remind Nurse of Due Orders** | Select this option to alert nurses when RT-specific orders are due, based on the reminder delay defined above.<br>**Note**: *Regardless of the settings you select, nurses always receive reminders of late RT orders for patients assigned to them.* |
| **Display Due Orders in Nurses Med Due List** | Select this option to display RT-specific orders in the list of "Meds Due" after a nurse scans a patient. |

6. Click **Save** to record your changes. Note that the **Save** button is only available if you have made changes in the tab settings.

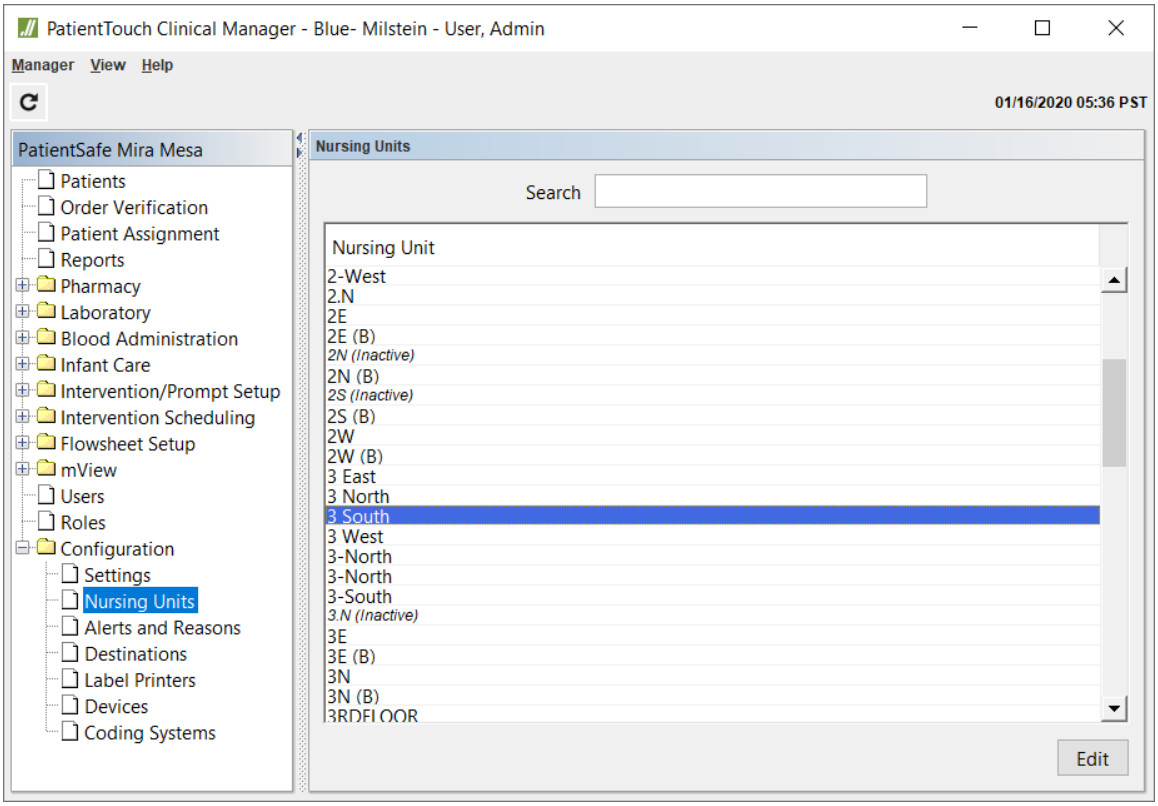
# Nursing Units

The PatientTouch System automatically creates nursing units, rooms and bed numbers based upon information received from the hospital's ADT (Admissions, Discharges and Transfers) system. Additionally, nursing unit information comes over from the Enterprise Manager>Organization Units.

**Nursing Units are made inactive via the Enterprise Manager.**

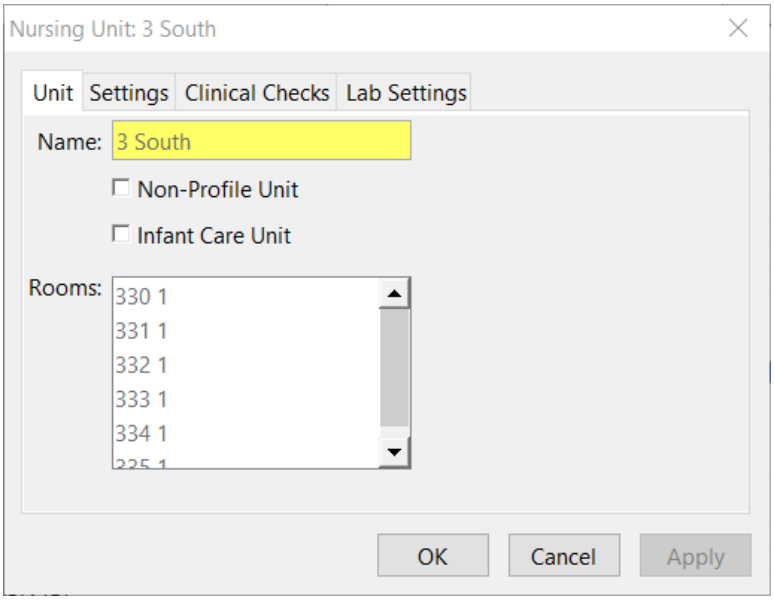
Use the Clinical Manager to view and edit the following nursing unit information:

## Edit a Nursing Unit



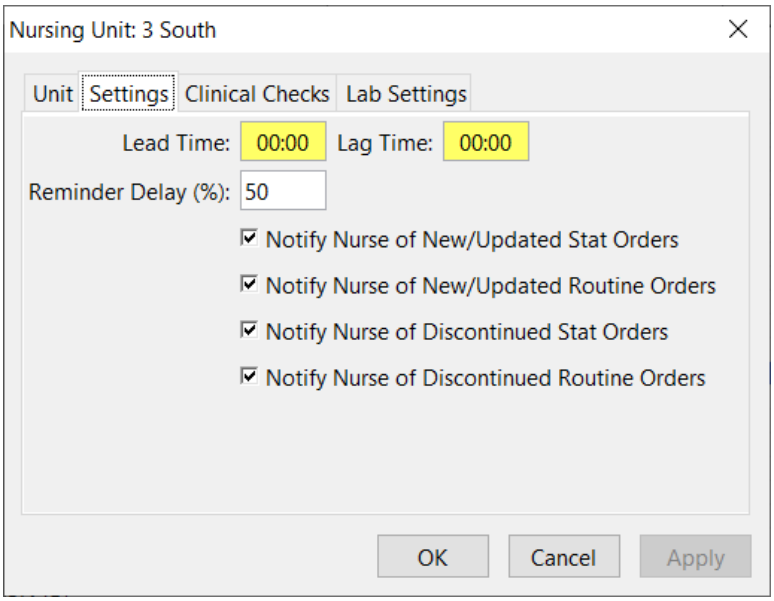
To edit a nursing unit, perform the following steps.

1. Select a unit and click **Edit**, or simply double-click the highlighted unit.
2. In the **Unit** tab, enter or change information as follows:




   - The **Name** field automatically populates according to what is sent from the hospital's ADT system or from the Enterprise Manager. You cannot edit this field. If it does not match the name from the ADT system, information will be incorrect and/or lost.
   - **Non-Profile Unit**: Select this check box for areas such as emergency rooms or other units where caregivers administer medications that are not routinely entered in the Pharmacy system. When this option is selected, users in these areas will still receive an Order Not Found in System alert when scanning medications. However, they will not have to provide an override reason and no order matching takes place.
   - **Infant Care Unit**: Select this check box if the unit is an Infant Care nursing unit
   - **Rooms** Numbers automatically populate according to what is sent from the hospital's ADT system or from the Enterprise Manager. Rooms are made active or inactive via the Enterprise Manager.
   - Click **Apply** to save nursing unit settings and remain in the *Nursing Unit* window to perform more edits. Or click **OK** to save changes and close the *Nursing Unit* window.

3. In the **Settings** tab, enter or change information as follows:

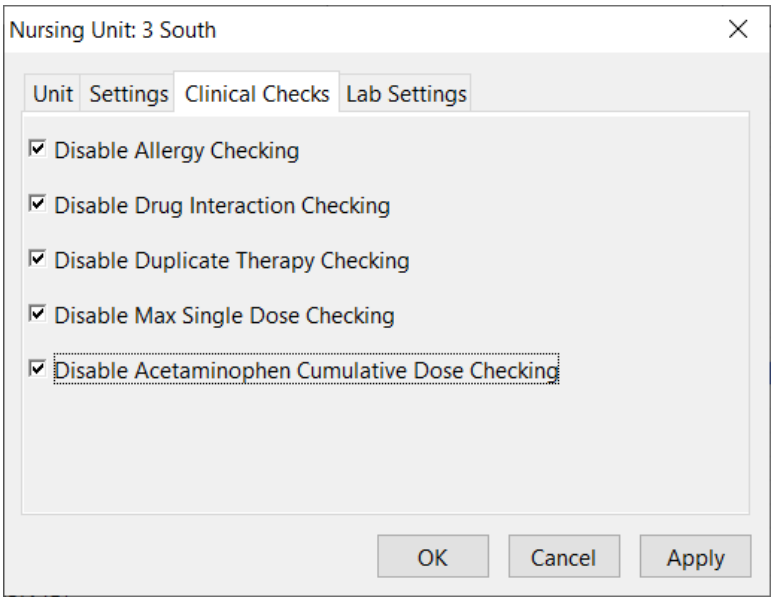



- Enter a Lead Time and Lag Time for the unit in hours:minutes format. (This option is not available for non-profile units.) The time you set here determines the lead time and lag time for medication administration only when there is no lead or lag time set in the SIG code or formulary item. The formulary and SIG code lead or lag times always take precedence. Example: you would enter 1:00 and 1:00 for one hour each for lead and lag time.
- Enter the Reminder Delay %. (This is not available for non-profile units.) This number is a percentage of the lag time before a med due reminder displays on the handheld. For example, if the lag time is set to 1 hour, then enter:
  - 25% to display a reminder 15 minutes after the med due time
  - 50% to display a reminder 30 minutes after the med due time
  - 75% to display a reminder 45 minutes after the med due time
  - 100% to display a reminder only after the lag time (1 hour) elapses

**If the hospital is utilizing the Order Verification features, be aware that users will receive the notifications below in their Inbox and a task in their To Do list to verify the order.**

- Click **Notify Nurse of New/Updated Stat Orders** to notify caregivers on the nursing unit specifically about new and updated STAT orders for their assigned patients. (This option is not available for non-profile units.)
- Click **Notify Nurse of New/Updated Routine Orders** to notify caregivers on the nursing unit specifically about new and updated routine (non-STAT) orders for their assigned patients. (This option is not available for non-profile units.)
- Click **Notify Nurse of Discontinued Stat Orders** to notify caregivers on the nursing unit about discontinued STAT orders for their assigned patients.
- Click **Notify Nurse on Discontinued Routine Orders** to notify caregivers on the nursing unit about discontinued routine (non-STAT) orders for their assigned patients.

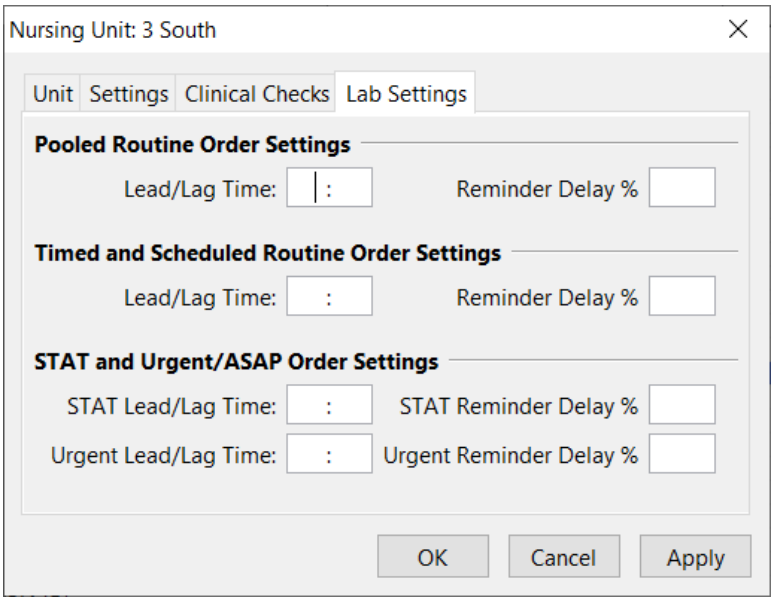
4. In the **Clinical Checks** tab, select options as follows:



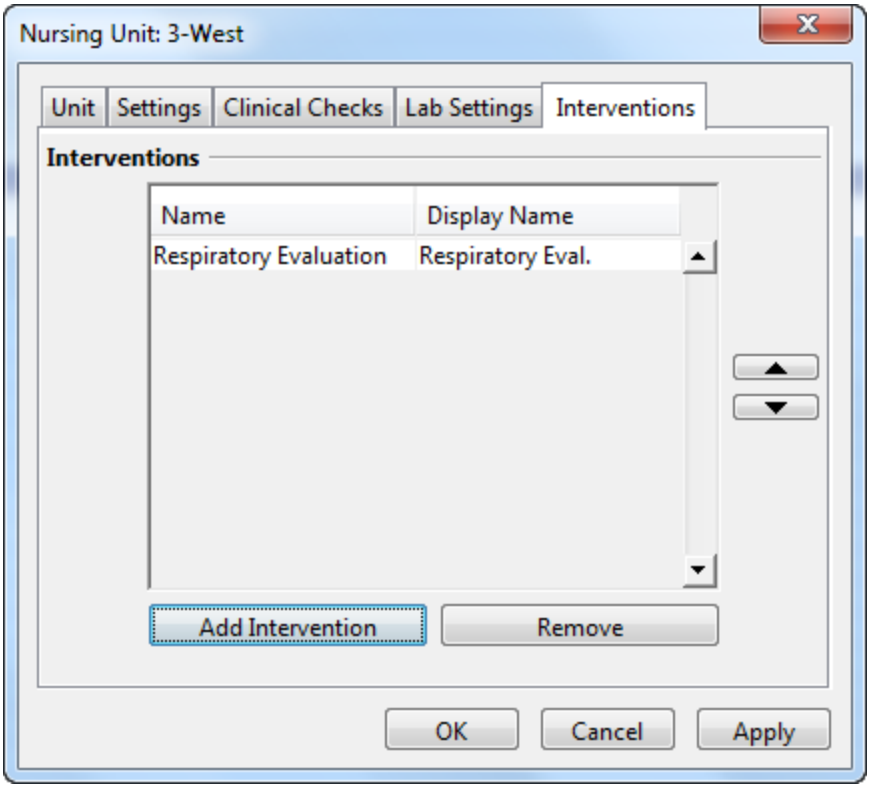

- Select **Disable Allergy Checking** to prevent this check from occurring.
- Select **Disable Drug Interaction Checking** to prevent this check from occurring.
- Select **Disable Duplicate Therapy Checking** to prevent this check from occurring for any patient in this nursing unit. This setting is only active when the Enable Duplicate Therapy Checking setting is selected.
- Select **Disable Max Single Dose Checking** to prevent this check from occurring.
- Select **Disable Acetaminophen Cumulative Dose Checking** to prevent this check from occurring.

**The options you set here will be valid for the selected nursing unit only.**

5. In the **Lab Settings** tab, enter the lead/lag times for each priority type (Pooled Routine, Timed and Scheduled, STAT and Urgent).



6. The **Interventions** tab displays if you do *not* have the **Intervention Scheduling Module** enabled.
   - Click **Add Intervention** to add a Care Intervention to the nursing unit.
   - Click **Remove** to remove a Care Intervention from the nursing unit.




## Alerts and Reasons

A fundamental design principle of the PatientTouch System is to give hospitals latitude in managing clinical process exceptions and to allow caregivers to exercise independent clinical judgment. And so, while the system may offer alerts concerning allergies, late dosing, wrong dosing, etc., caregivers always have the ability to do what they think is right in any situation. An example would be to override an alert saying a medication dose is early (in which case a reason for doing so is required).

The **Override Reasons** tab contains the master list of possible override reasons for all situations. This list serves as the “library” from which to choose what reasons are made available to the caregiver on the handheld. This “library” of reasons is customized to the hospital's preferences and policies. For example, reasons for a medication given late might include 'Patient occupied', ‘Pending IV start', ‘Clarifying physician order', etc.

The **Alert Reason Lists** tab contains the system-generated alert types requiring users to provide an override reason. For each alert type, you can build a logical list of appropriate override reasons using the reasons from the Override Reasons “library”. The handheld displays a list of these approved override reasons for the specific alert that the caregiver has received. For example, the handheld might display an alert when it detects that a patient may have an allergy to an un-ordered medication.

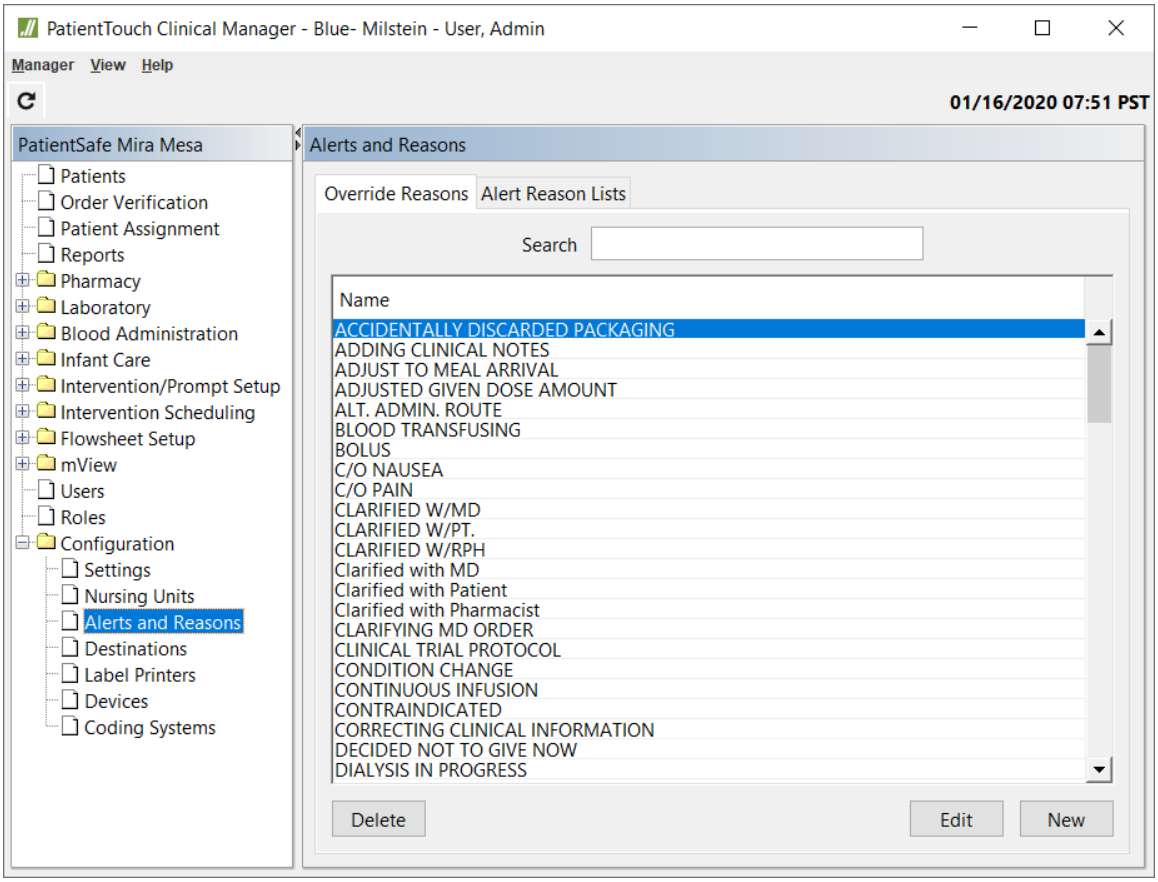
The clinician can override this alert and continue to administer the medication after they select a reason why they are choosing to continue the medication administration.

Given the required privileges (Manage Override Reasons), you can review and edit the override reasons library and the reasons for each alert type from **Alerts and Reasons** under the **Configuration** folder.

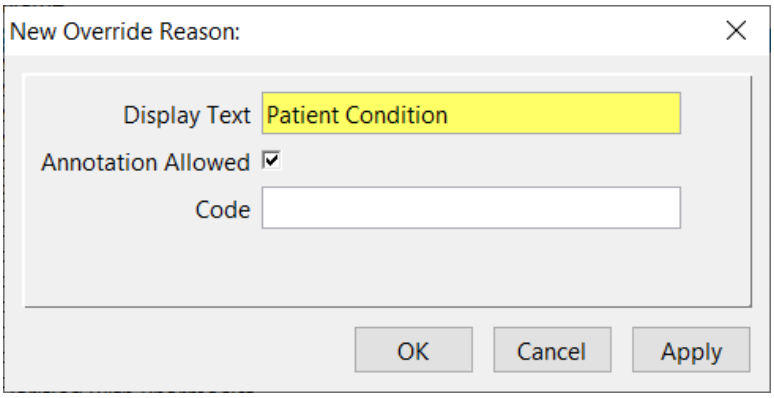
## Add an Override Reason

To add a reason to the Override Reasons list, follow the steps below.

1. Select **Configuration > Alerts and Reasons**.




2. Click **New**.
3. Enter a name for the new override reason in the Display Text field.

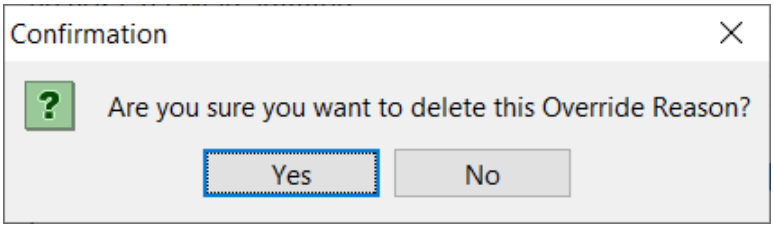



**Maintain abbreviated entries when possible. Text that is too long will not display properly on the handheld. When entering text, remain brief but clinically accurate for documentation.**

4. Select **Annotation Allowed** to display an icon on the handheld that allows free text entry when this override reason is selected. The annotation information displays on the patient's MAR, Flowsheets, and mView.
5. Code (Optional): Enter a code in the Code field.
6. Click **OK** to save the new reason and close the window.

## Delete an Override Reason

1. To delete an override reason, select the reason from the list and click **Delete**.
2. Click **OK** to confirm the deletion.




## Edit an Override Reason

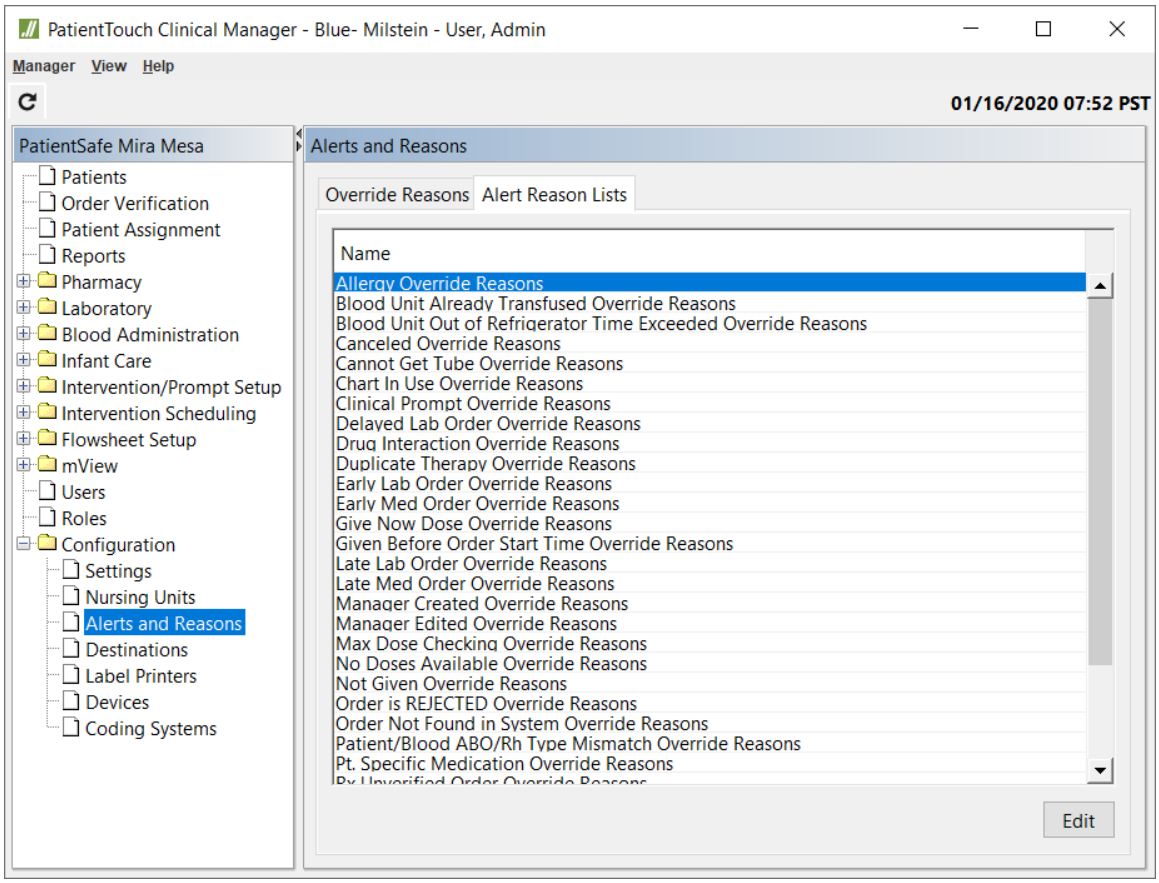
1. To edit an override reason, select the reason from the list and click **Edit** or simply double-click the highlighted reason.
2. Edit the Display Text field and click **OK** to save the changes.

## Alert Reasons Lists

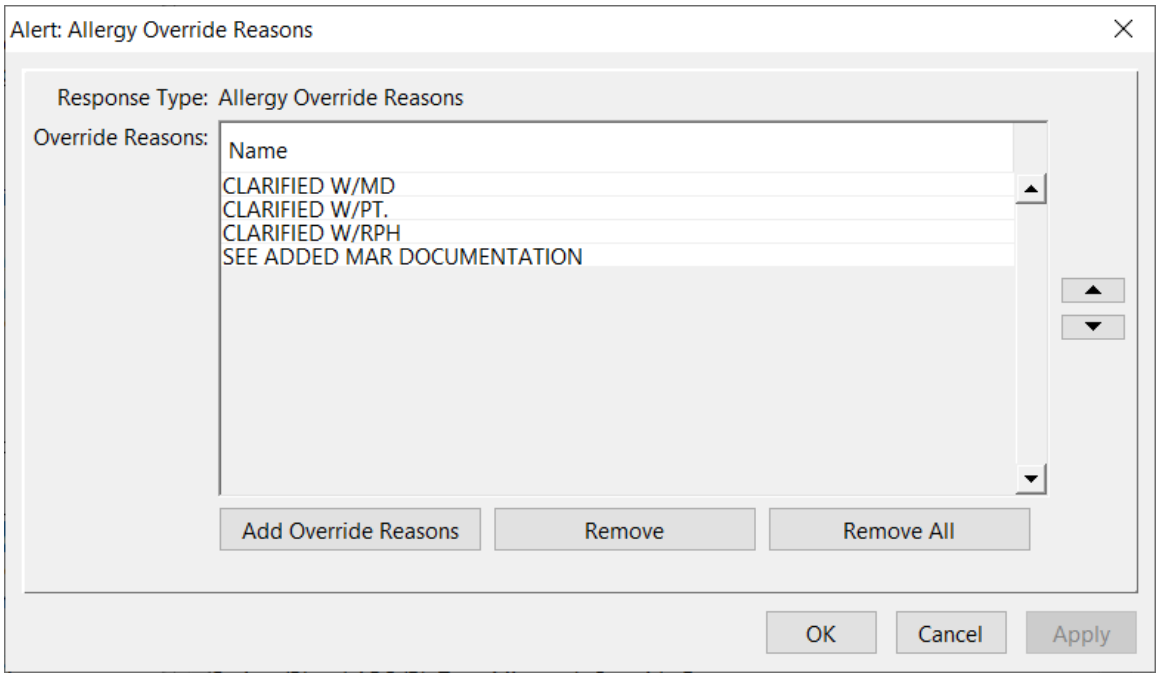
The Alert Reasons Lists can be viewed and edited by clicking the **Alert Reason Lists** tab. When the user receives one of these alert types on the handheld, the list of defined reasons for that particular alert is available for the user to select from when they decide to override. The list of alert types is not configurable. Only the override reasons for each alert from which the clinician can select can be configured.

## Edit Alert Reason List

1. Double-click an Alert Reason List to modify.




2. Click **Add Override Reasons** to add a new reason to the list, or select an existing reason in the list and click **Remove** to delete it. The reasons are displayed to the user in the order they are shown on this screen. You may change the display order by moving the reason up or down in the list.




3. Click **OK** to save your changes and close the window.

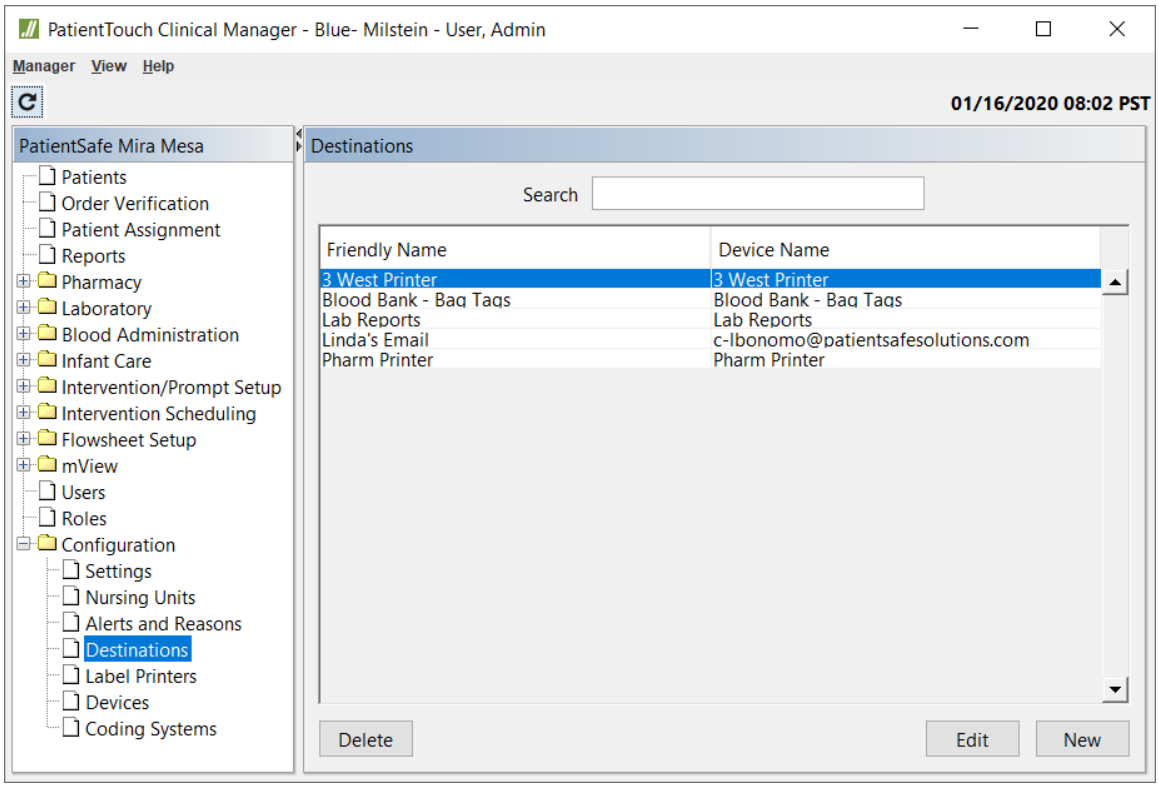
## Destinations

You can configure the PatientTouch System to use printers and other associated destinations available on your hospital network. PatientSafe Solutions recommends that you add at least one printer/destination per nursing unit and one printer for each area of the pharmacy.

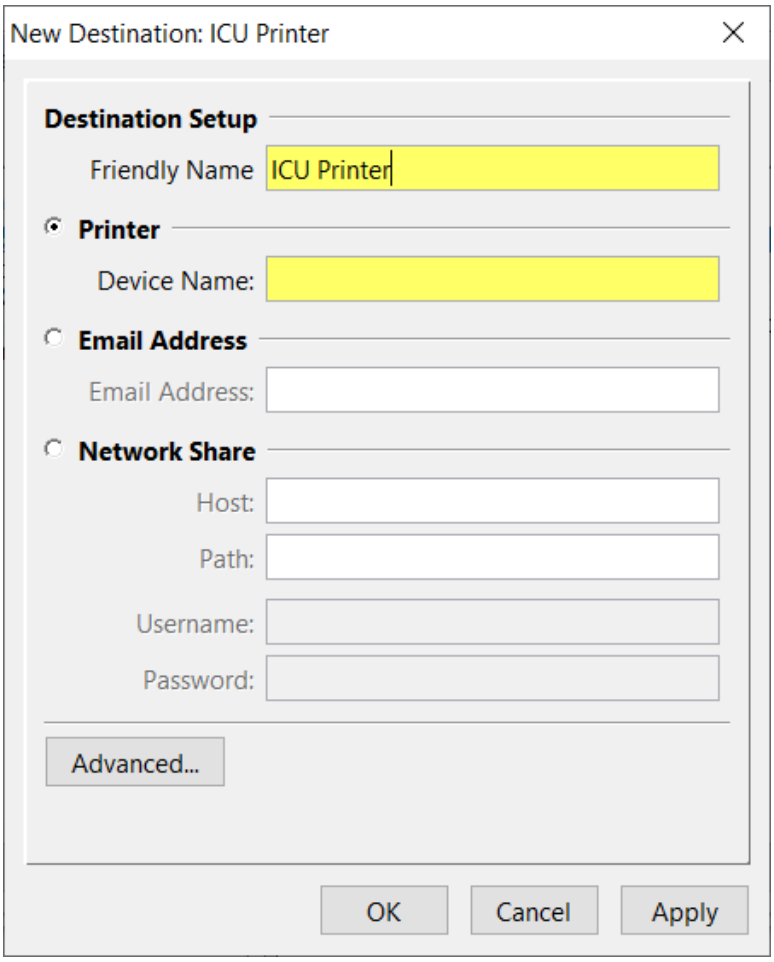
**Printers used with the Clinical Manager must be laser printers in order to print barcodes properly.**

To add a printer in the Clinical Manager, follow the steps below:

1. Select **Configuration > Destinations**.


PatientTouch Clinical Manager - Blue- Milstein - User, Admin
Manager View Help
01/16/2020 08:02 PST
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
Settings
Nursing Units
Alerts and Reasons
Destinations
Label Printers
Devices
Coding Systems
Destinations
Search
Friendly Name
Device Name
3 West Printer
3 West Printer
Blood Bank - Bag Tags
Blood Bank - Bag Tags
Lab Reports
Lab Reports
Linda's Email
c-lbonomo@patientsafesolutions.com
Pharm Printer
Pharm Printer
Delete
Edit
New

2. Click **New**.




3. Enter the **Friendly Name** that will be displayed when users select a printer/destination for reports. For example, “ICU Printer” or “ICU Director Email”, etc.. Be sure to enter a name that adequately indicates the location of the printer.
4. Click the **Printer** radio button and enter the Device Name of the printer. (This must be identical to the name assigned in the Common Unix Printing System [CUPS]) For more information on configuring CUPS, see Configure Printers in CUPS.

   -or-

   Click **Email Address** and enter the e-mail address where you want the information directed. For example, enter the Pharmacy e-mail address to send quarantined orders there.

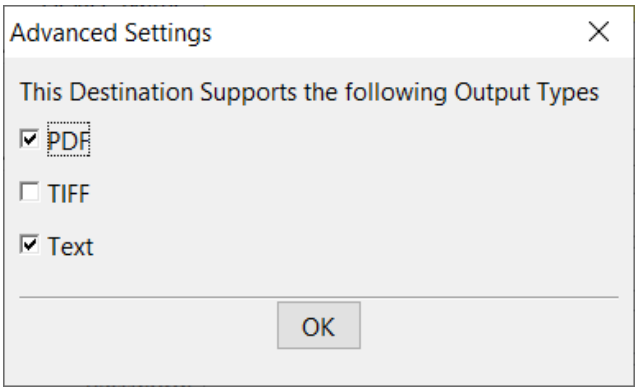
   -or-

   Click **Network Share** and enter the following details.

| | |
|---|---|
| Host | The host name of the workstation where the network share is located. |
| Path | The full pathname to the network share. |
| Username | The username for accessing the network share (if required). |

| | |
|---|---|
| Password | The user's password (if required for the username). |

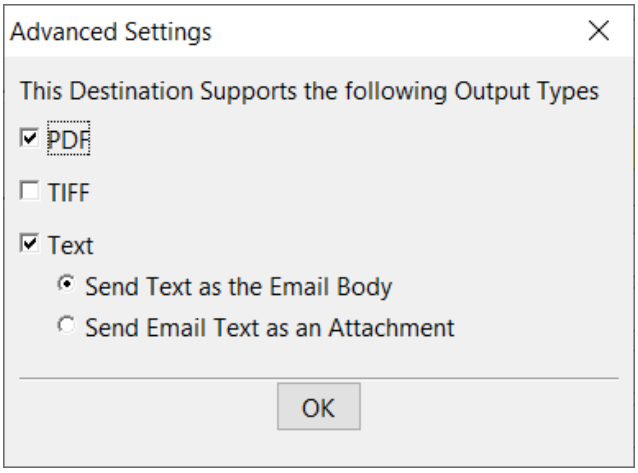
5. Click **Advanced** to change the file type(s) accepted by this printer destination. By default, output types PDF and Text are selected.




When you have the **Email Address** radio button selected, the Advanced Settings change and you have two choices under the Text option:

- Send Text as the Email Body.
- Send Email Text as an Attachment.

It is recommended that you send the email text as an attachment, especially if it is a CSV report.



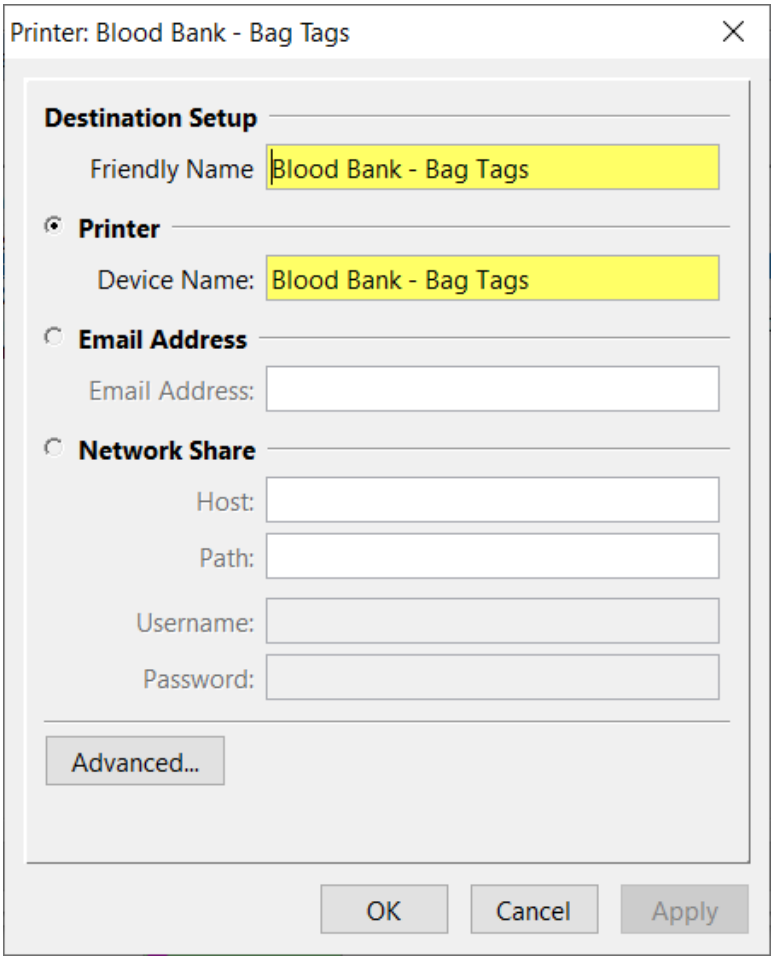

6. Select the file types accepted by this destination. For example, if you clear the checkbox for PDF and, instead, select TIFF, the Clinical Manager will automatically convert the report and send a TIFF file when the report is printed/created.

**You must select PDF or TIFF if you want the destination to accept formatted reports like the MAR. If you select Text, the destination will accept only the statistical CSV and text reports, and will reject other reports. (The Quarantine Order and Pharmacy Order Change Request are available in text.)**

7. Click **OK** to close the *Advanced Settings* window.
8. In the *New Destination* window, click **OK** to save the printer information. This printer is now available to all Clinical Manager Users.

## Change or Delete a Printer

To edit a printer's configuration, select it from the Printers list and click **Edit**. After you change the options as described above, click **OK** to close the *Edit Printer* window.




To delete a printer, select the target printer and click **Delete**. Click **Yes** to confirm the deletion.

## Configure Printers in CUPS

Printers configured in the Clinical Manager application must also be configured in CUPS (Common UNIX Printing System).

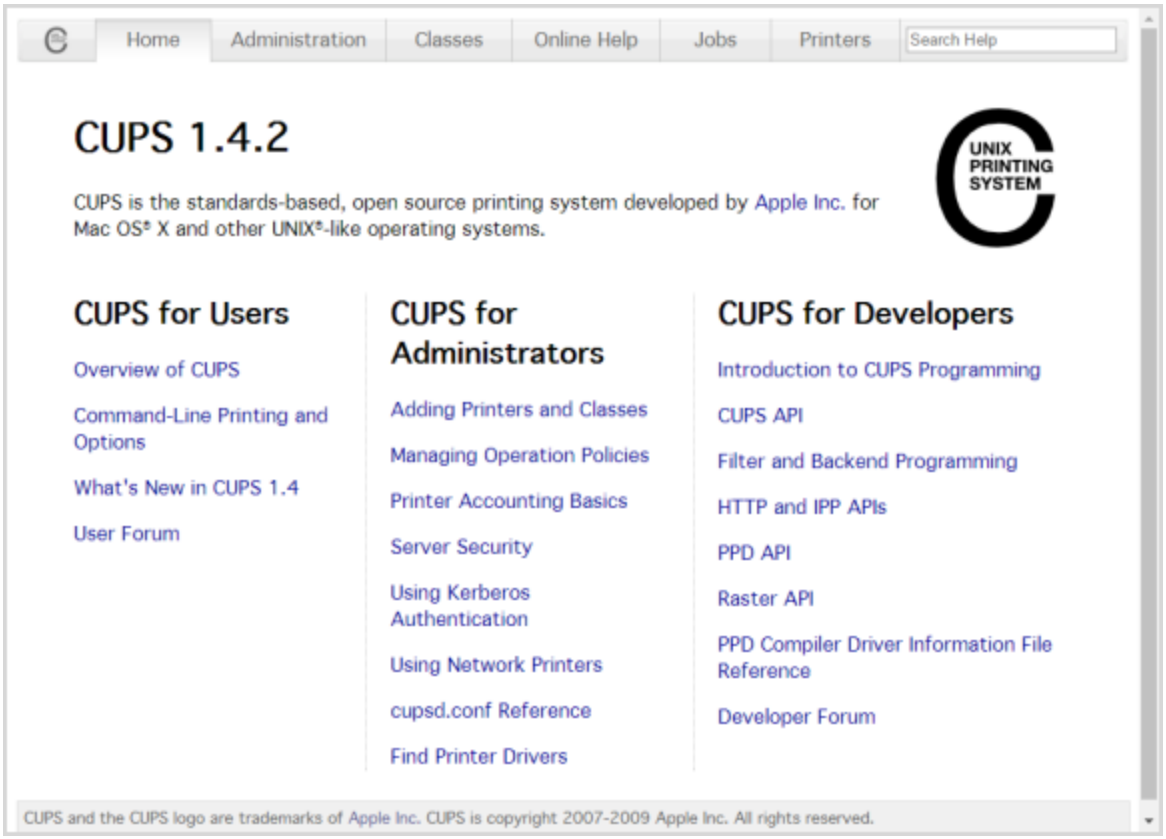
To configure a printer in CUPS:

1. Enter the following URL into a web browser: https://IPAddress:631

   where “IPAddress” is the IP address of the PatientTouch server.

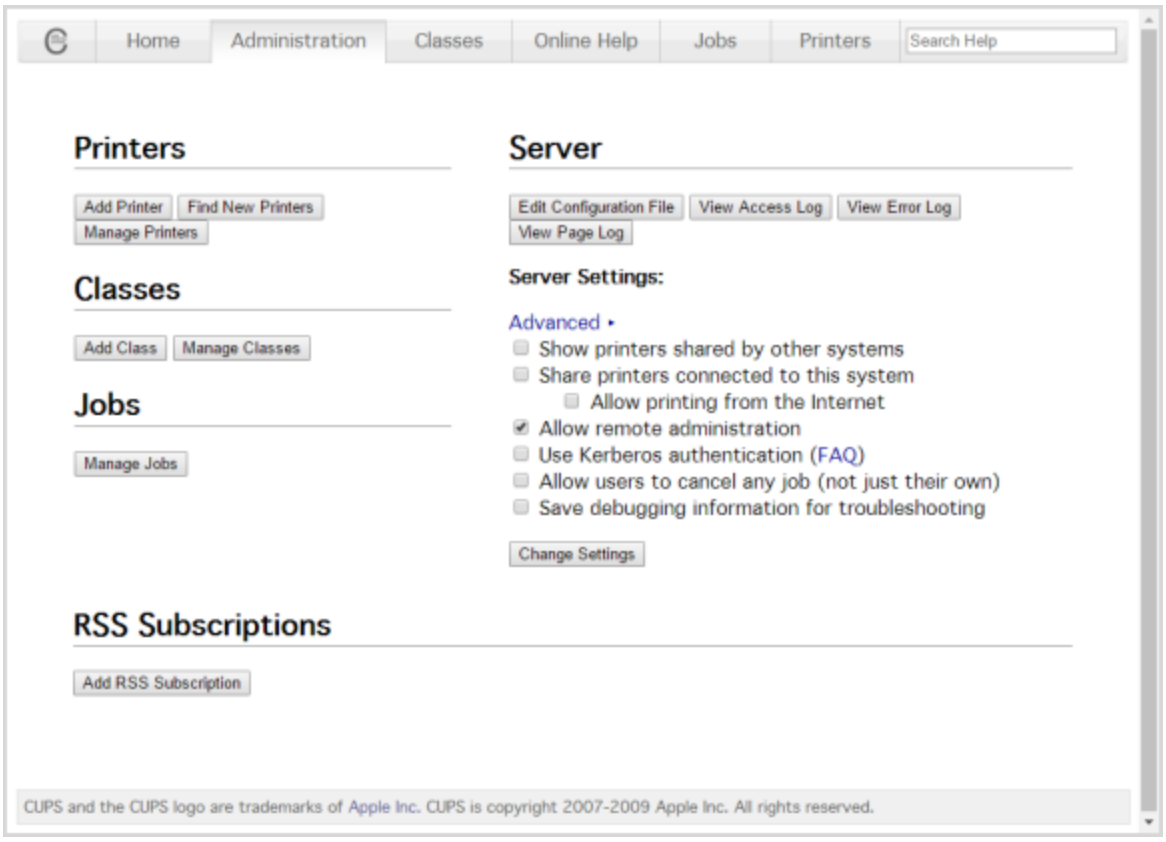
   For example: https://172.17.10.51:631

The CUPS 1.4.2 main screen displays.

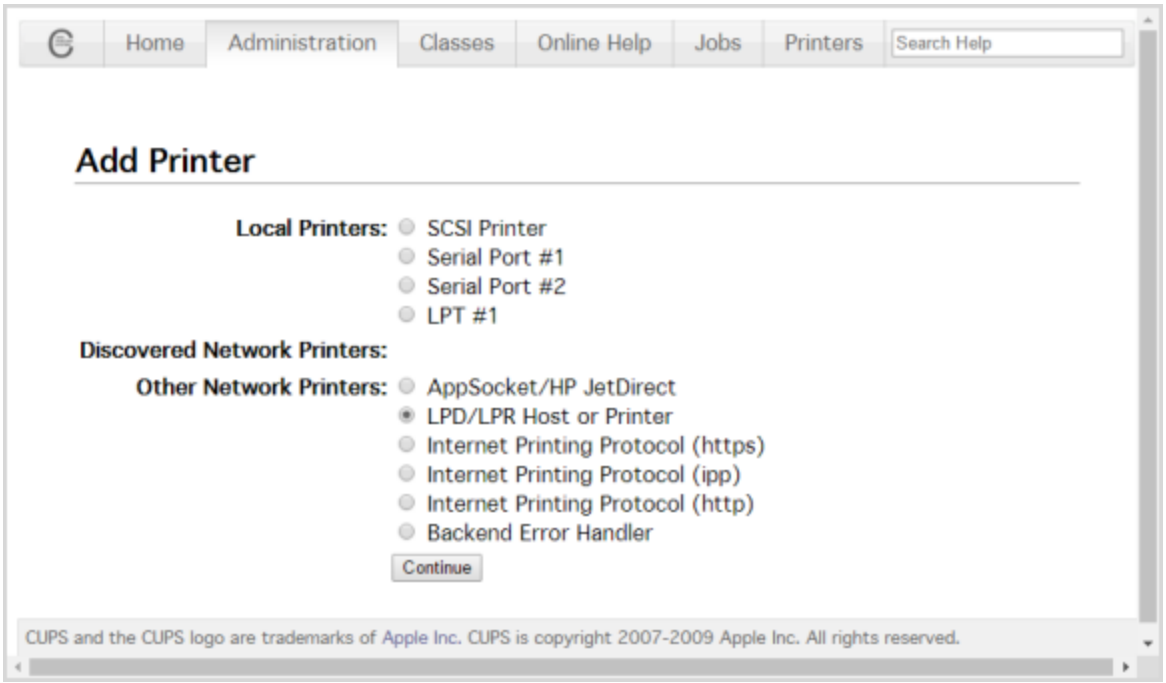



2. Under CUPS for Administrators, click **Adding Printers and Classes**.

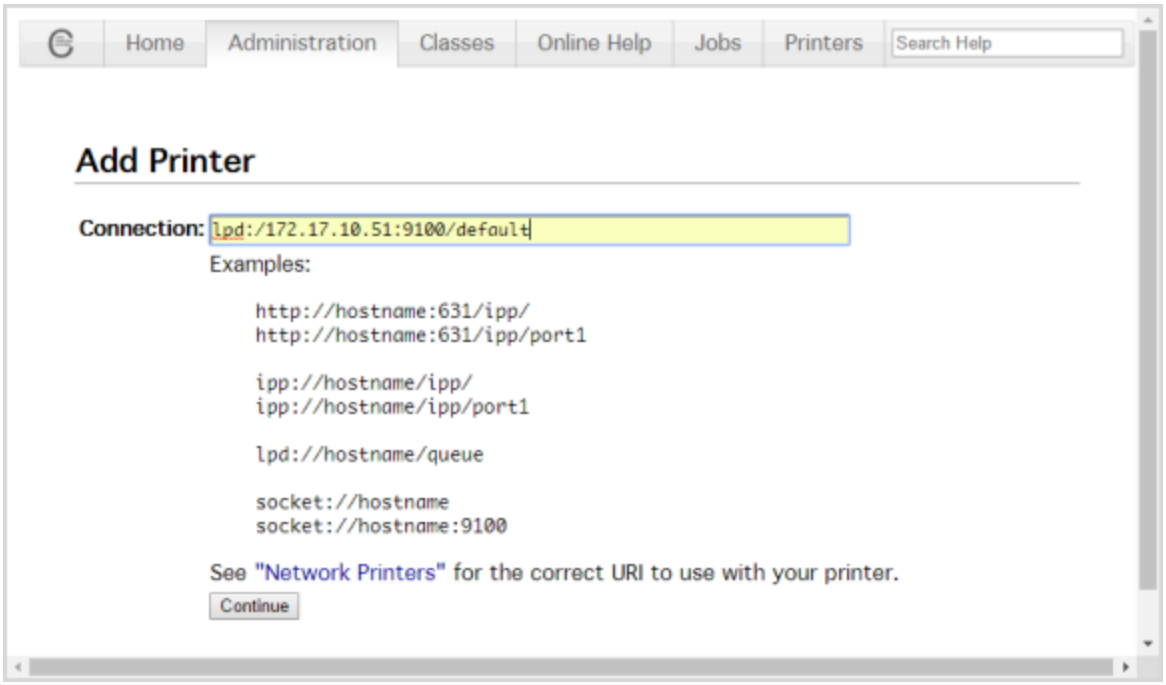
**You may be prompted to enter a username and password. Enter "cupsadmin" (without the quotation marks) as the user name and password.**



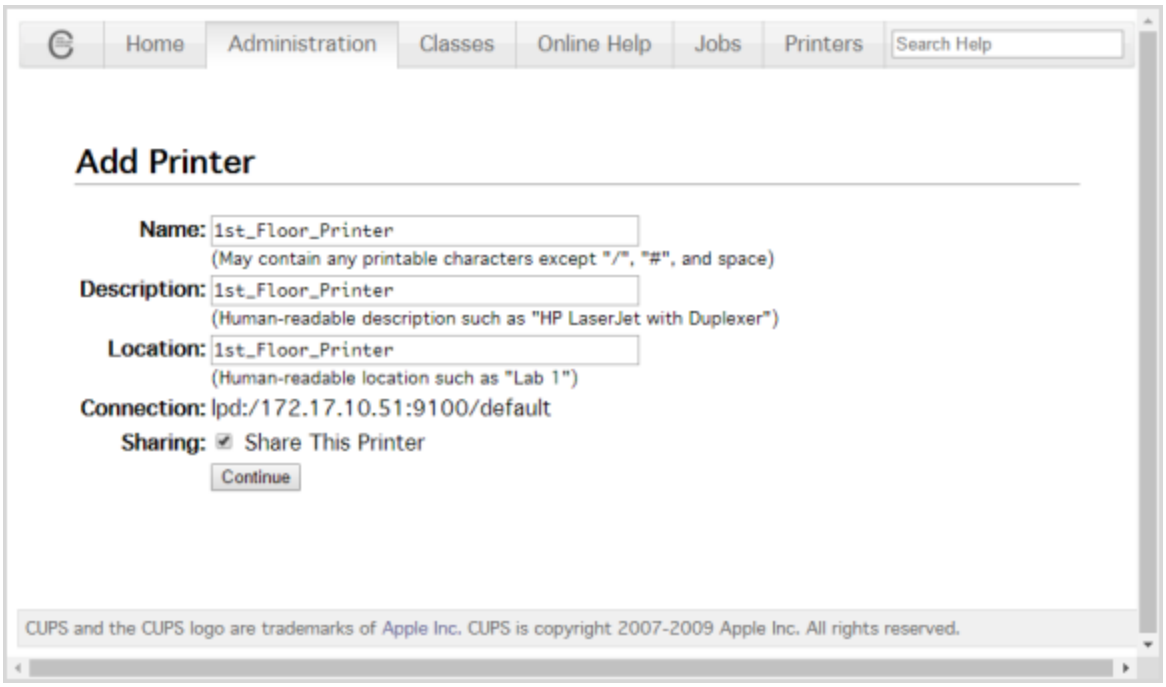

3. Click **Add Printer**.



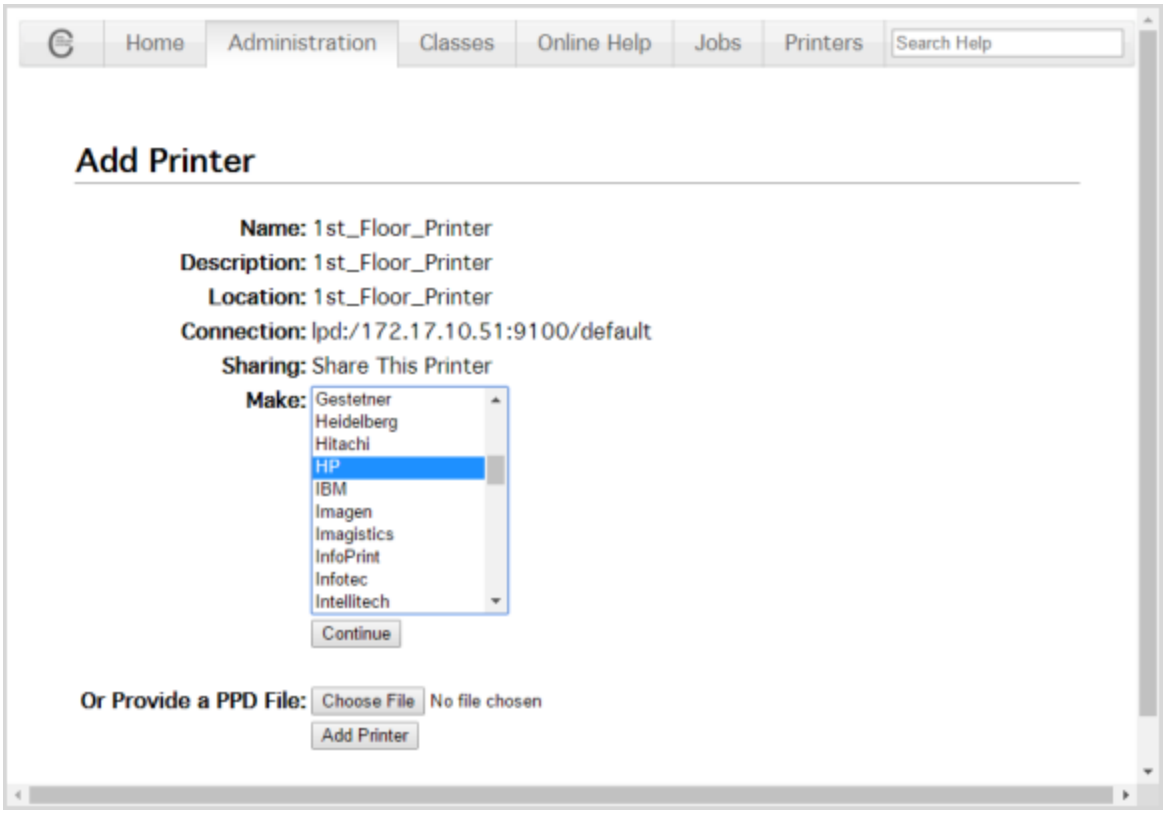
4. Click **LPD/LPR Host or Printer and click Continue.**
5. Enter lpd:/IPAddress/default in the Connection field, where “IPAddress” is the IP address of the printer. Example - lpd:/172.17.10.51:9100/default.
6. Click **Continue**.



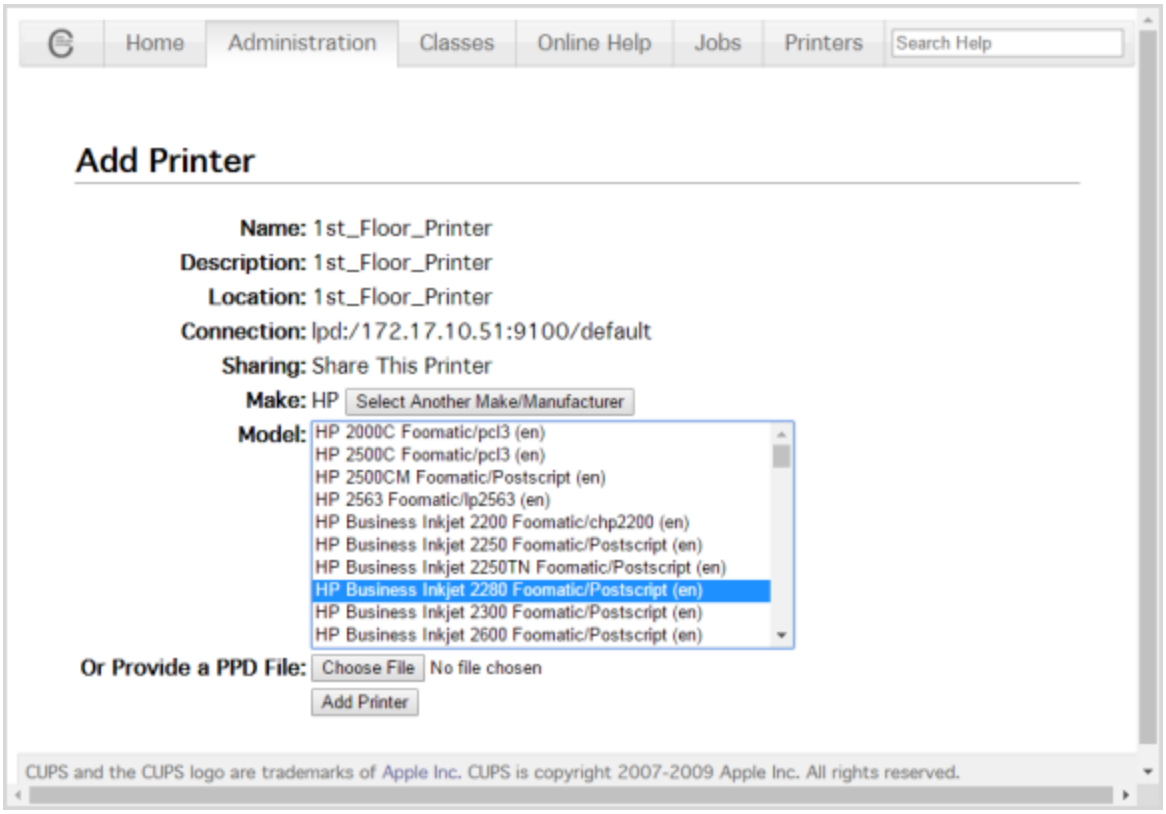

7. Complete the following fields:
   - **Name**: The name of the printer. This name must match the Device Name designated in the Clinical Manager. For example, “1st_Floor_Printer”. You cannot use spaces between words.
   - **Description**: An optional field that can be used to describe the printer in more detail. For example, you might enter the IP address or location of the printer, so you can have this when you need to edit or modify printer information.
   - **Location**: An optional field that describes the physical location of the printer such as “1st floor”.
   - **Sharing:** Select if you are going to share this printer.
8. Click **Continue**.



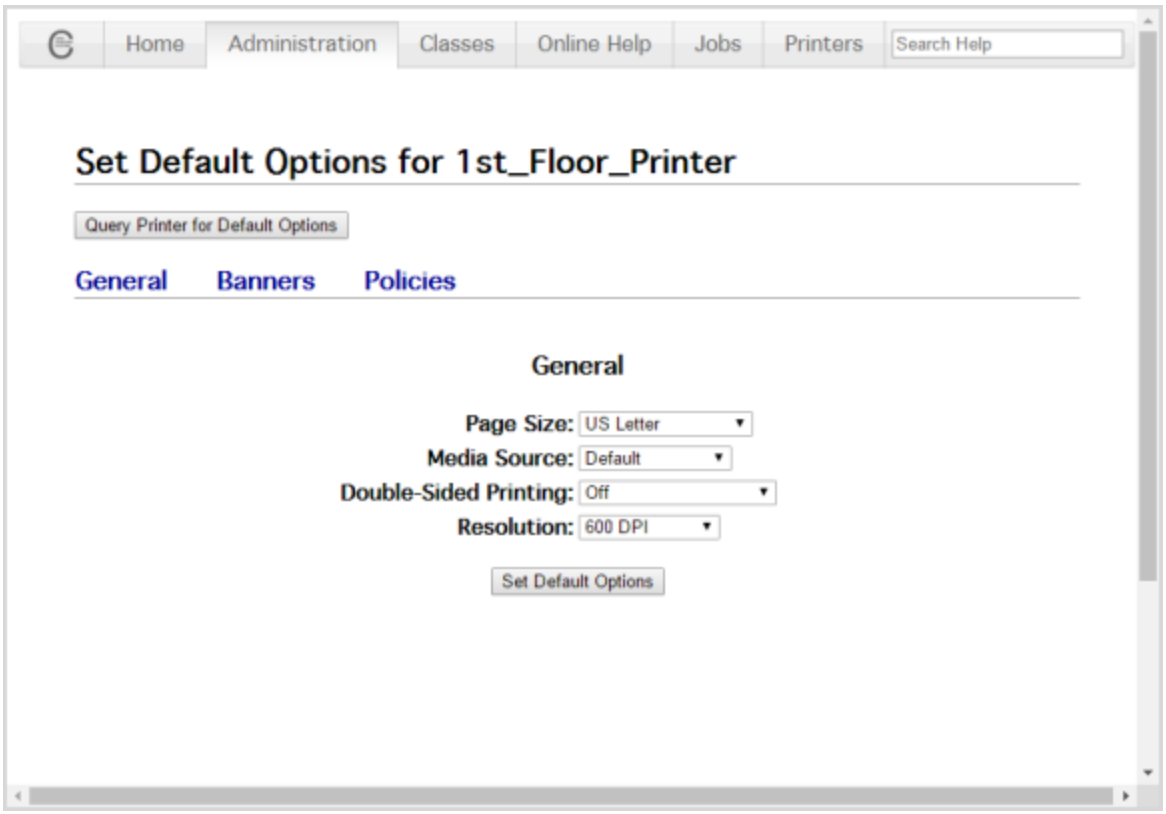

9. Select the printer manufacturer (HP in this example) from the list and click **Continue**.



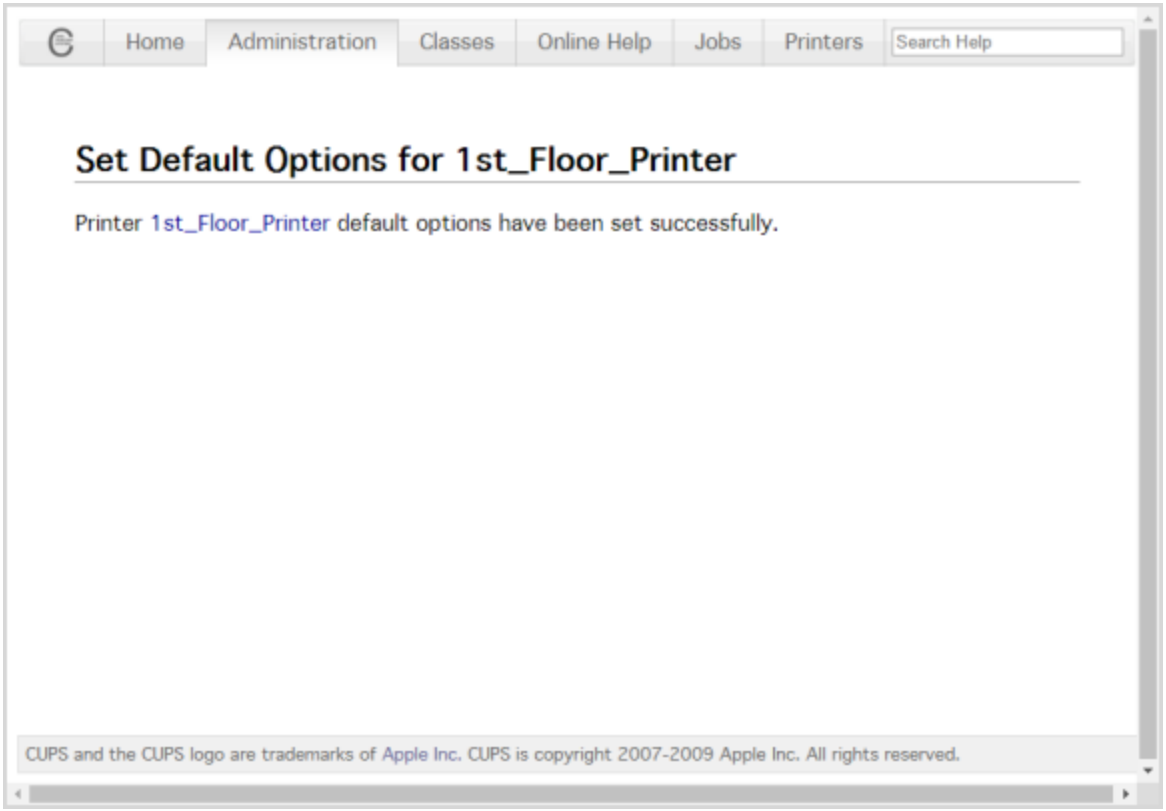
10. Select the Model of printer from the list (for example, the HP Business Inkjet 2280 Foomatic/Postscript) and click **Add Printer**.




11. Select the options for the printer or click Set Default Options.




12. The printer has been added successfully.

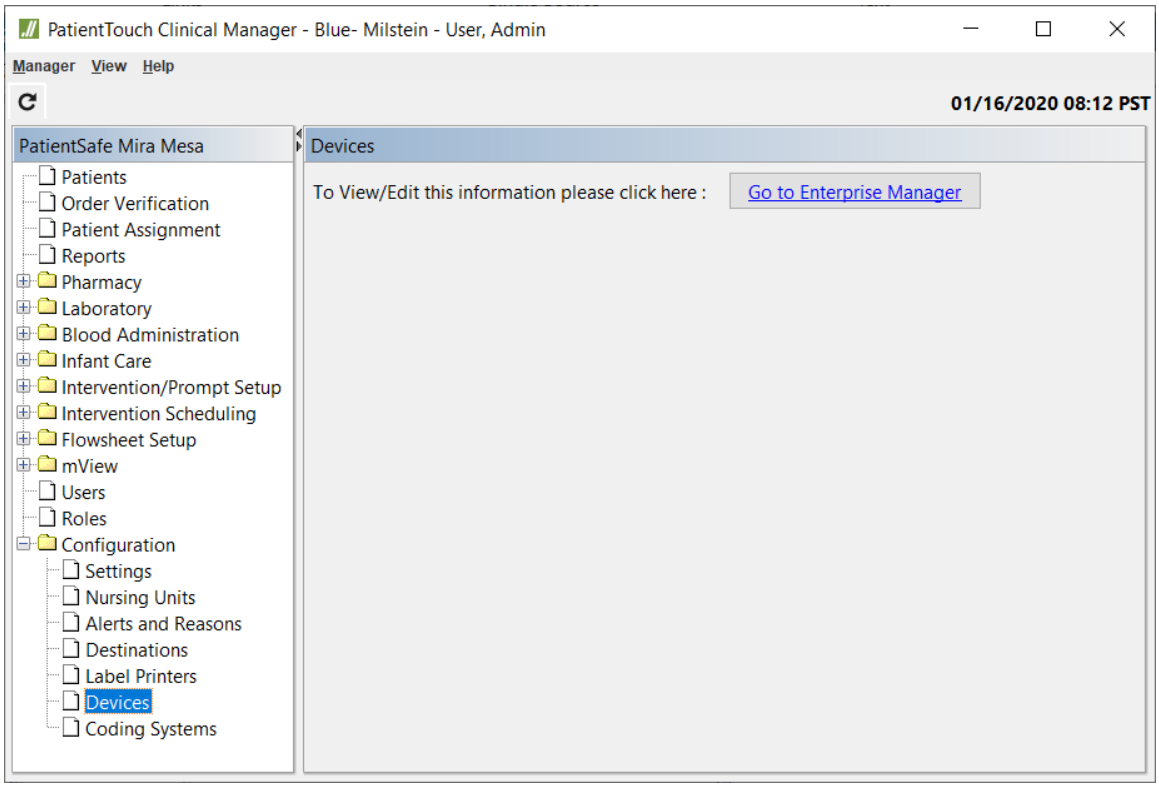


# Label Printers

Label Printers are only available if you have purchased the Specimen Collection or Infant Care Modules. To learn how to configure Label Printers, refer to the Configure Label Printer Selection Setting in the Specimen Collection Configuration section.

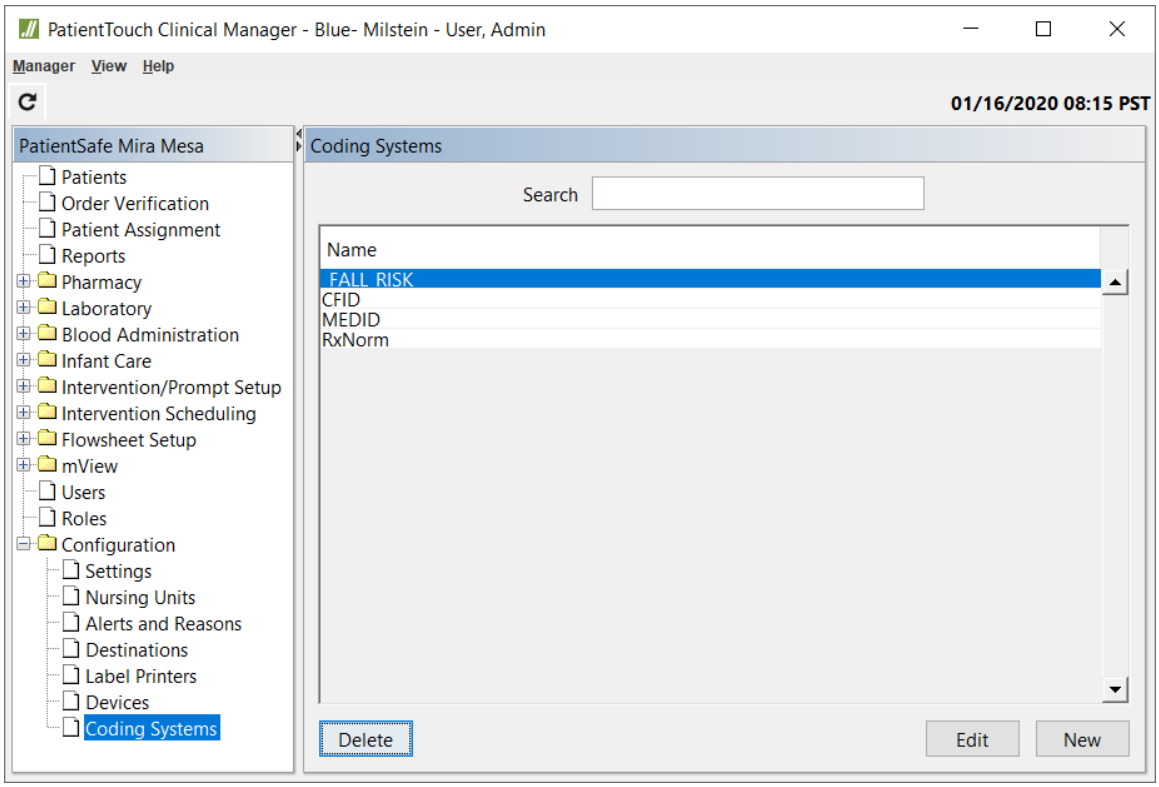
# Devices

Devices is now configured in the Enterprise Manager. A link is provided for your reference.

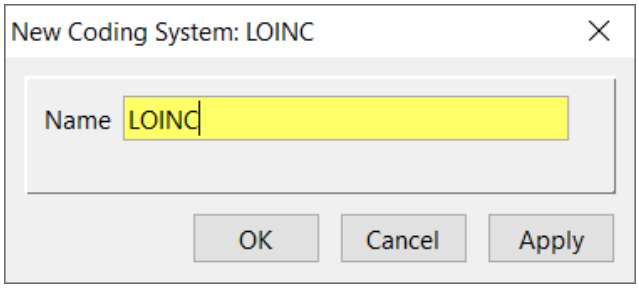



# Coding Systems

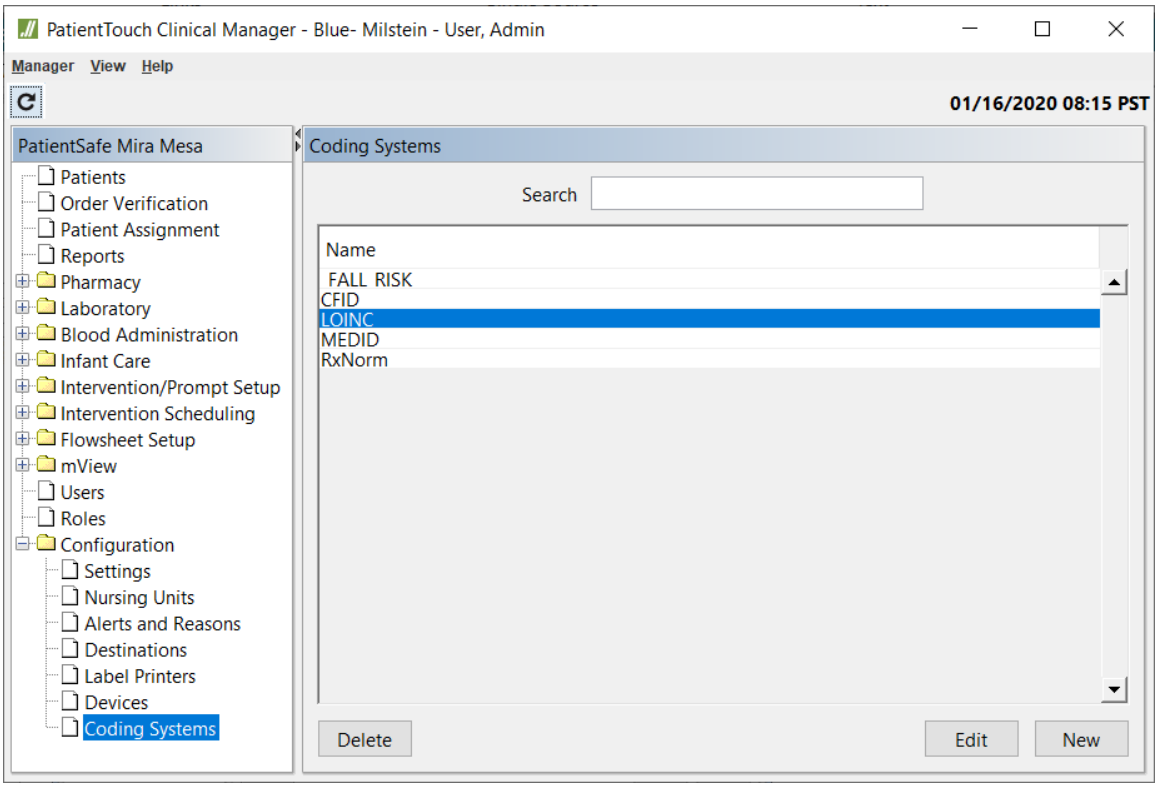
Coding Systems is a feature in the Clinical Manager that allows hospitals to enter vocabulary items, such as RxNorm, SNOMED-CT®, LOINC® and other vocabulary standards. These vocabularies can then be associated with interventions, formulary items, and routes of administration. Documentation performed at the bedside using PatientTouch will contain the codes for these items and may be optionally exported via the HL7 interface. Associating vocabulary items with interventions, formulary items, and routes of administration supports Interoperability, and assists in the process of Clinical Quality Measure Reporting.




1. To enter a Coding System, click **New**.



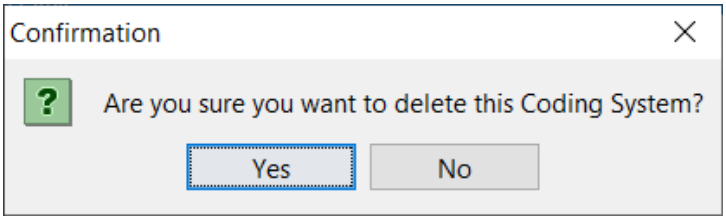

2. Enter the name and click **OK**.




The new vocabulary item displays in the list.

**Once you have defined a Coding System, you can associate it to interventions using Response Lists and Clinical Types. You can also associate a Coding System to formulary items.**

1. To edit a Coding System, select the item and click **Edit**.
2. To delete a Coding System, select the item and click **Delete**.




3. Click **Yes** on the confirmation window.

# Roles and Privileges

The Clinical Manager comes with a predefined set of privileges you can combine, as needed, to create roles that align with hospital policies. For example, you might create a Staff Nurse role with privileges to view and edit patient information, while a Pharmacist role would have privileges to edit the formulary and view the patient information, but not edit the MAR.

A description of all privileges is provided below.

# Description of Privileges

| Privilege | Description |
|---|---|
| **View Formulary** | View formulary, no editing allowed. |
| **Manage Formulary** | View and edit formulary. |
| **Manage Clinical Prompts and Flowsheets** | View and edit certain information within the following sections (if installed): Blood Administration, Infant Care, Intervention/Prompt Setup, Intervention Scheduling, Flowsheet Setup, mView. Additionally, this privilege allows the user to manage the clinical prompts associated to medication formulary items. |
| **Manage Users** | View and edit user information. However, to ensure security in the system, users with this privilege can only assign roles that have equal or lesser privileges than his or her assigned role. |
| **Access to All Patients** | Provides access to view all patients and all related information. Warning: Assign this privilege with care and limit user access to patient information in accordance with your hospital's security and confidentiality policies. |
| **View Patient Info** | View patient information, no editing allowed with this privilege. |
| **Manage Patient Info** | View patient information and edit the date and/or time of admission/discharge. Note that this is not connected to hospital's ADT system. |
| **Document/Edit Patient MAR** | View, edit, and add documentation to the online MAR in Clinical Manager. Without this privilege, users can only view the online MAR information. User must also have at least the View Patient Info privilege for this privilege to have any affect. |
| **Edit All Documentation** | Edit any user's documentation. Use caution when assigning this privilege. Most caregivers should only be able to edit their own documentation. |
| **Manage Nursing Units** | View and edit nursing unit information and settings. |
| **Manage Hospital Configuration** | View and edit Hospital configuration (address, global settings, user security, RT settings, printers, etc.). |
| **Manage User Roles** | View and edit privileges assigned to user roles. |
| **Manage SIG Codes** | View and edit SIG codes. |
| **View SIG Codes** | View SIG codes; no editing allowed. |
| **Manage Handheld Devices** | View and reset devices. |
| **View Override Reasons** | View Override Reasons; no editing allowed. |
| **Manage Override Reasons** | View and edit Override Reasons. |
| **Manage Reports** | View and edit Scheduled Reports. |
| **View Patient Assignment** (Managed in Enterprise Manager permissions) | View current Patient assignments. Automatically granted to users who have the Manage Patient Assignment, Manage RT Assignment or Manage Pharmacist Assignment privileges. |
| **Manage Patient Assignment** (Managed in Enterprise Manager permissions) | View and perform patient assignment in Clinical Manager and/or the PatientTouch application. |
| **Manage RT Assignment** | This privilege is used to check availability of Assign/Unassign button for a user on Clinical Manager. |

| Privilege | Description |
|---|---|
| **Manage Clinical Checks** | Edit Allergy and Drug Interaction settings, and modify Max Single Dose Checking and Acetaminophen Cumulative Dose Checking settings. |
| **Verify Orders** | Verify nursing medication orders using the Clinical Manager and, if Order Verification settings permit, using the PatientTouch application. (To verify orders, you must also have the Administer Meds privilege.) |
| **Quarantine Orders** | Quarantine nursing medication orders using the Clinical Manager and, if Order Verification settings permit, using the PatientTouch application. |
| **Un-quarantine Orders** | Un-quarantine an order in the Clinical Manager. |
| **Reset Dose Reminders** | Ability to reset medication dose due reminders for specific or all nursing units. |
| **Administer Meds** | Administer medications with the PatientTouch application, including RT orders, if applicable. |
| **Respiratory Therapy** | Administer only medications designated as RT medications (as determined by the SIG code of the order). |
| **Collect Observations** | Collect patient vital signs, patient care activities, etc., via interventions. |
| **Breast Milk Collection and Administration** | Collect breast milk and deliver infant feedings. |
| **Blood Bank** | Assign, check out, etc., blood bags and configure Blood Admin settings. |
| **Transfuse Blood** | Administer blood products at the bedside. |
| **Document/Edit Patient TAR** | Allows users to document and edit the patient TAR for their entries only. This is similar to the Document/Edit Patient MAR privilege that already exists. This privilege should be given to any role that will need to document and/or edit the patient TAR. |
| **Witness** | Ability to witness the preparation or administration of medications or other process such as blood product administration. |
| **Verify Respiratory Therapy Orders** | Perform order verification for orders designated as 'RT' based upon the SIG code. |
| **Quarantine Respiratory Therapy Orders** | Quarantine orders designated 'RT'. |
| **Manage Laboratory Configuration** | Configure Laboratory settings. This privilege is required to edit the Unable to Complete Transfusion Reason. |
| **Manage Phlebotomy Assignment** | Assign collection privileges to users from the Lab Dashboard (for users with Phlebotomist privilege). |
| **Manage Lab Orders** | View, edit and omit lab orders using Clinical Manager. |
| **Phlebotomist** | View and collect specimens for lab orders of this collector type. |
| **Collect Nurse Lab Orders** | View and collect specimens for lab orders of all (P, N, R) collector types. |
| **Collect RT Lab Orders** | View and collect specimens for lab orders of this collector type. |
| **Laboratory** | Perform Laboratory functions such as Receive/Reject Specimens, Add On Tests, and Print Aliquot Labels. |
| **Publish Notices** | Send a "text message" to all Handhelds currently in use/logged in. |

| Privilege | Description |
|---|---|
| **Mother-Infant Matching** | Verify correct infant link to inpatient mother or visitor, and link with crib. |
| **Pharmacist** | User with the Pharmacist privilege can be assigned as "pharmacist for a location". An assigned pharmacist will appear on the care team list of the patient located in that location. Only one pharmacist can be assigned to a location at a time. |
| **Manage Pharmacist Assignment** | Ability for User to manage assignment via the PatientTouch application or the Clinical Manager. |
| **Unit Secretary** | Allows the user to order and discontinue, but not execute, scheduled interventions. |

# Recommended Roles and Privileges

The following roles and associated privileges are recommended for the most common roles in a hospital environment. These default privileges and roles are part of the PatientTouch System's original configuration. You can use this list as a starting point and adapt the roles to fit any unique job descriptions. There is no limit to the number of roles you can define, and each one can have a unique set of privileges.

## Roles and Privileges

Click a link below to learn about the privileges typically assigned to each role:

- Nurses
- Pharmacists
- Lab
- System Administration

### *Nurses*

The following roles and privileges are recommended for nurses and nurse staff.

| Privilege | House Supervisor | Nurse Manager | Nurse Preceptor | Staff Nurse | Nurse Tech/CNA | Unit Secretary | RT Manager | Respiratory Therapist |
|---|---|---|---|---|---|---|---|---|
| View Formulary | X | X | X | | | | X | |
| Manage Clinical Prompts and Flowsheets | | | | | | | X | |
| Manage Users | X | X | | | | | X | |
| Access to All Patients | X | | | | | | | |
| View Patient Info | X | X | X | X | X | X | X | X |
| Manage Patient Info | X | X | X | | | | X | |
| Document/Edit Patient MAR | X | X | X | X | | | X | X |
| Edit All Documentation | X | X | | | | | X | |
| Manage Hospital Configuration | X | | | | | | | |

| Privilege | House Supervisor | Nurse Manager | Nurse Preceptor | Staff Nurse | Nurse Tech/CNA | Unit Secretary | RT Manager | Respiratory Therapist |
|---|---|---|---|---|---|---|---|---|
| View SIG Codes | X | X | | | | | X | |
| Manage Handheld Devices | X | | | | | | | |
| View Override Reasons | X | X | | | | | | |
| Manage Reports | X | X | | | | | X | |
| Manage RT Assignment | | | | | | | X | X |
| Verify Orders | X | X | X | X | | | | |
| Quarantine Orders | X | X | X | X | | | | |
| Reset Dose Due Reminders | X | | | | | | | |
| Administer Meds | X | X | X | X | | | | |
| Respiratory Therapy | X | X | X | X | | | X | X |
| Collect Observations | X | X | X | X | X | | X | X |
| Breast Milk Collection and Administration | X | X | X | X | X | | | |
| Transfuse Blood | X | X | X | X | | | | |
| Document/Edit Patient TAR | | X | | X | | | | |
| Witness | X | X | X | X | | | | |
| Verify Respiratory Therapy Orders | X | X | X | X | | | X | X |
| Quarantine Respiratory Therapy Orders | X | X | X | X | | | X | X |
| Collect Nurse Lab Orders | X | X | X | X | | | | |
| Collect RT Lab Orders | | | | | | | X | X |
| Publish Notices | X | | | | | | | |
| Mother Infant Matching | X | X | X | X | X | | | |
| Unit Secretary | | | | | | X | | |

## *Pharmacists*

The following roles and privileges are recommended for the pharmacy.

| Privilege | Pharmacy Manager | Pharmacist | Pharmacy Inventory Tech | Pharmacy Tech |
|---|---|---|---|---|
| View Formulary | X | X | X | X |
| Manage Formulary | X | X | X | |
| Manage Clinical Prompts and Flowsheets | X | | | |
| Manage Users | X | | | |
| Access to All Patients | X | X | | |
| View Patient Info | X | X | X | X |

| Privilege | Pharmacy Manager | Pharmacist | Pharmacy Inventory Tech | Pharmacy Tech |
|---|---|---|---|---|
| Manage SIG Codes | X | X | | |
| View SIG Codes | X | X | X | X |
| View Override Reasons | X | X | | |
| Manage Reports | X | | | |
| Manage Clinical Checks | X | X | | |
| Verify Orders | X | X | | |
| Quarantine Orders | X | X | | |
| Un-quarantine Orders | X | X | | |
| Verify Respiratory Therapy Orders | X | X | | |
| Quarantine Respiratory Therapy Orders | X | X | | |
| Pharmacist | X | X | | |
| Manage Pharmacist Assignment | X | X | | |

## Lab

The following roles and privileges are recommended for the laboratory.

| Privilege | Lab Manager | Lab Tech | Phlebotomist | Blood Bank Technologist |
|---|---|---|---|---|
| Manage Users | X | | | |
| View Patient Info | X | X | X | X |
| Manage Reports | X | | | |
| Blood Bank | | | | X |
| Manage Laboratory Configuration | X | | | |
| Manage Phlebotomy Assignment | X | X | X | |
| Manage Lab Orders | X | | | |
| Phlebotomist | | | X | |
| Laboratory | X | X | | |

## Administration

The following roles and privileges are recommended for system administrators and IT personnel.

| Privilege | System Administrators | IT Personell |
|---|---|---|
| View Formulary | X | |
| Manage Formulary | X | |
| Manage Clinical Prompts and Flowsheets | X | |
| Manage Users | X | X |
| Access to All Patients | X | |
| View Patient Info | X | |
| Manage Patient Info | X | |
| Document/Edit Patient MAR | X | |

| Privilege | System Administrators | IT Personell |
|---|---|---|
| Edit All Documentation | X | |
| Manage Nursing Units | X | |
| Manage Hospital Configuration | X | |
| Manage Users Roles | X | |
| View SIG Codes | X | |
| Manage Handheld Devices | X | X |
| View Override Reasons | X | |
| Manage Override Reasons | X | |
| Manage Reports | X | |
| Manage RT Assignment | X | |
| Verify Orders | X | |
| Quarantine Orders | X | |
| Reset Dose Due Reminders | X | |
| Administer Meds | X | |
| Respiratory Therapy | X | |
| Collect Observations | X | |
| Breast Milk Collection and Administration | X | |
| Transfuse Blood | X | |
| Witness | X | |
| Verify Respiratory Therapy Orders | X | |
| Quarantine Respiratory Therapy Orders | X | |
| Manage Laboratory Configuration | X | |
| Collect Nurse Lab Orders | X | |
| Publish Notices | X | X |
| Mother Infant Matching | X | X |

# Creating Roles

The system administrator, along with other's input, defines roles corresponding to job descriptions at your hospital and the way you manage responsibilities, privileges and security within the PatientTouch System.

Once the roles have been defined, each user is assigned to one of these roles. While rare, a user may have more than one role.

Once the roles are created in the Clinical Manager, they must be mapped to a Clinical Profile in the Enterprise Manager. If a mapped Clinical Profile is assigned to a user in the Enterprise Manager, the corresponding Role will be checked in the Clinical Manager. However, the update will not be in real time; the Clinical Manager will have to be refreshed to see any changes.

To see a table of Clinical Profiles from the Enterprise Manager that are associated to Roles in the Clinical Manager click here.

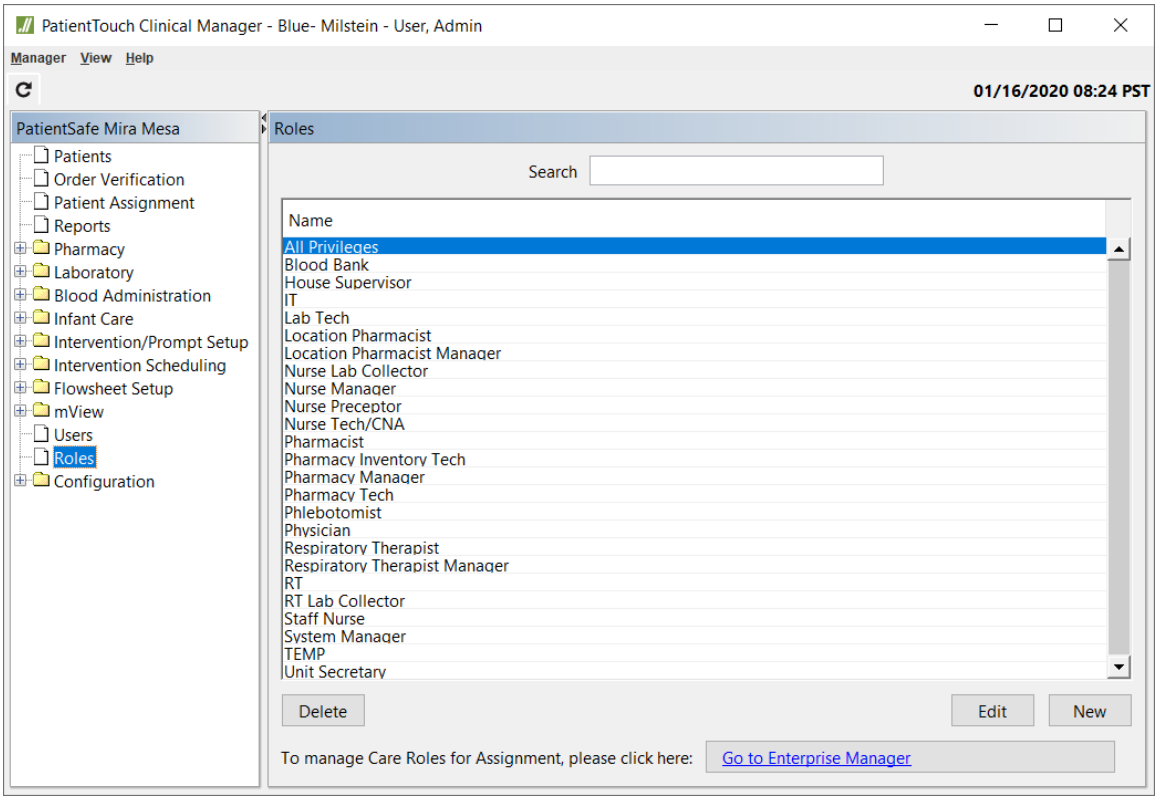
Roles must be defined before adding users.

You can define as many roles as necessary to reflect your staff titles and positions.

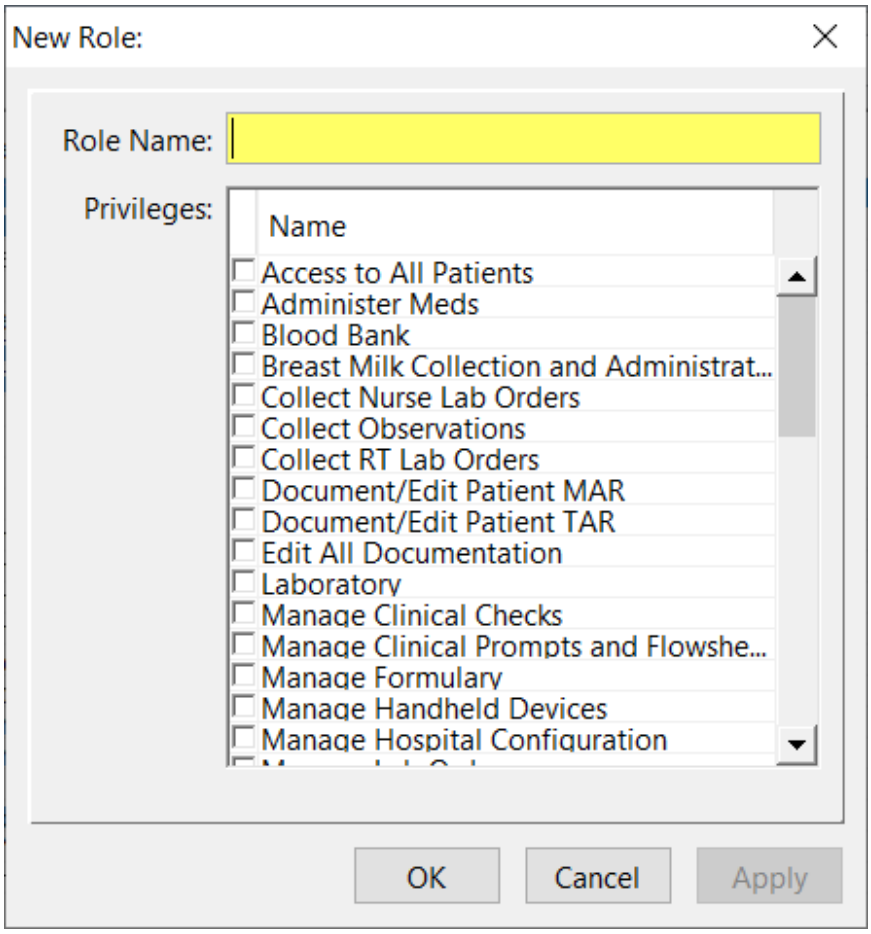
When you select a privilege that represents a "super" set of privileges, such as Manage Formulary, the system automatically selects the lesser privilege(s) as well, such as View Formulary.

To create roles, follow the steps below.

1. Click **Roles** from the Clinical Manager menu tree.




2. Click **New** to display the *New Role* window.

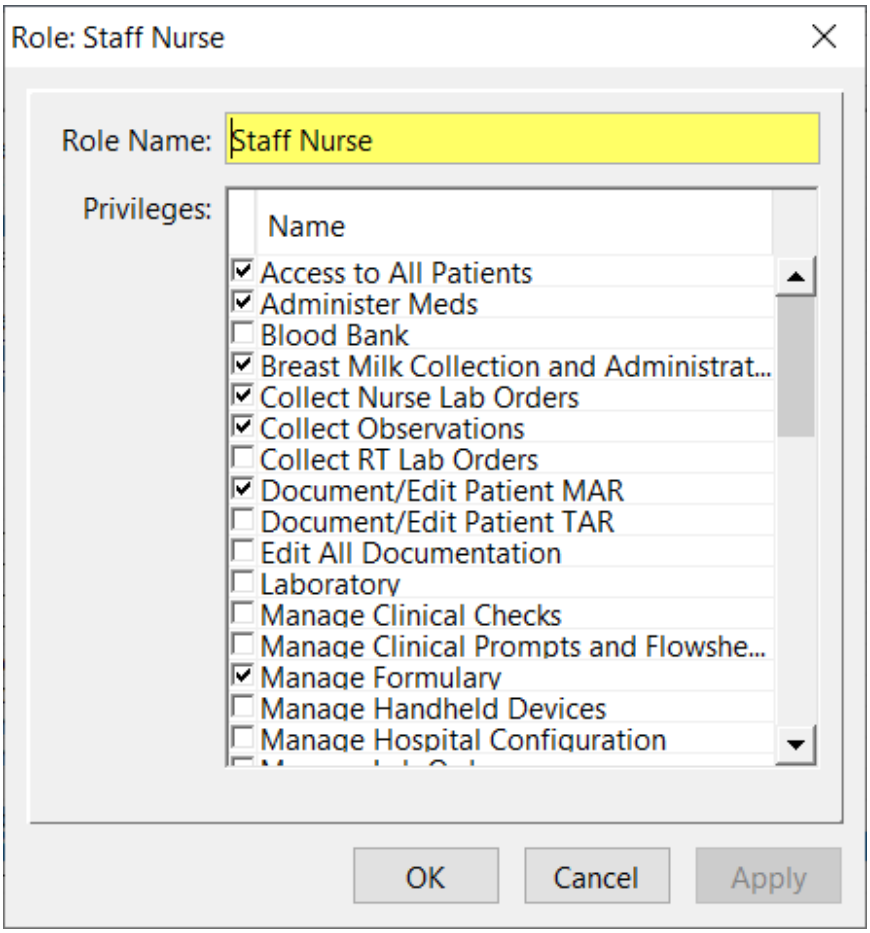



3. Enter a name in the Role Name field.
4. In the Privileges list, select the check boxes that correspond to privileges to associate with the role. The different privileges correspond to specific options in the Clinical Manager as described in the section above. Once the privileges are assigned, users in the system see only those options associated with the privileges assigned to their respective roles.
5. Click **OK** to save your changes.

## Editing a Role

To edit a role:

1. Select it from the list and click **Edit** (or simply double-click the highlighted role).
2. Modify the Role Name, if desired.
3. After you finish editing the privileges, click **OK** to save your changes.

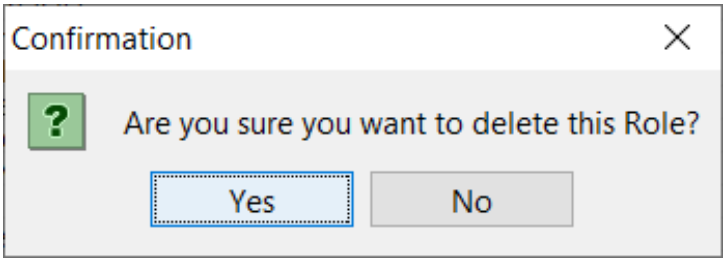



## Deleting a Role

To delete a role:

Select the role in the *Roles* window and click **Delete**. Click **Yes** to confirm deletion of the role.

**WARNING!** Deleting a role cannot be undone.



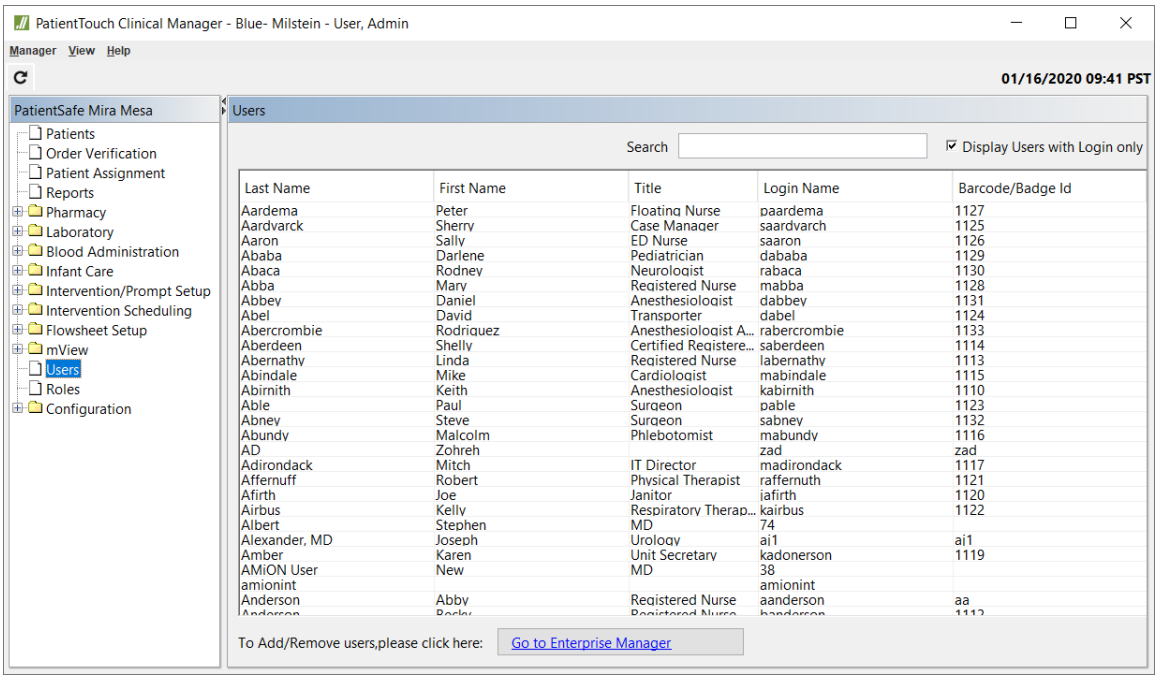

# Users

Creating new users is now done via the Enterprise Manager. A link is provided for your reference at the bottom of the Clinical Manager>Users screen. However, you can still modify user roles and the default printer using the Clinical Manager.

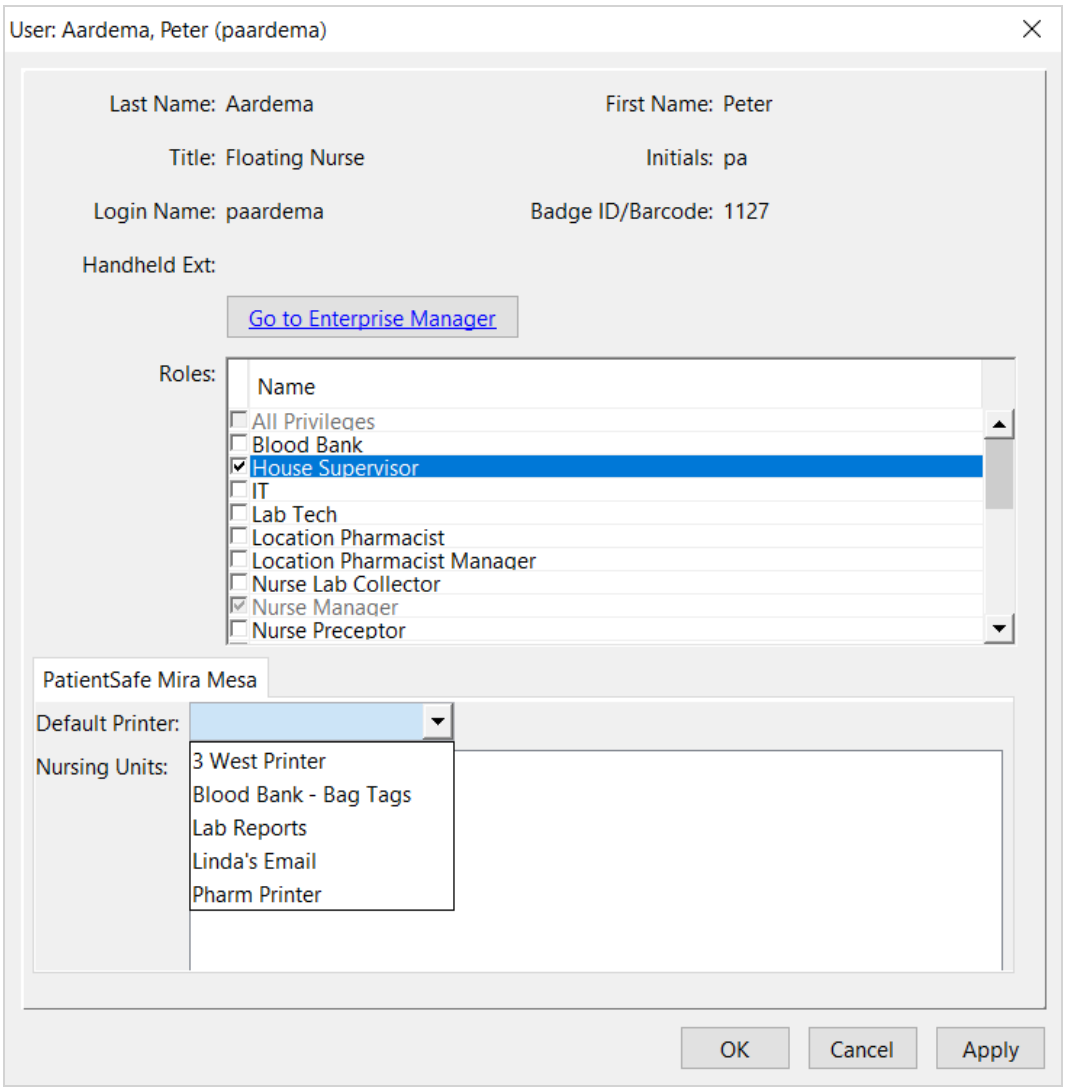
# Modify User Role and Default Printer

To modify a user, follow the steps below.

1. Select **Users** from the Clinical Manager menu tree.




2. Double-click the specific user name.




3. Add a role.

**Roles that are not grayed out are unmapped and applicable to the Clinical Manager only. They are available for selection. The roles that are grayed out are mapped to the Enterprise Manager and cannot be removed. To manage them, refer to the Enterprise Manager application.**

The table below lists several Clinical Profiles from the Enterprise Manager that are associated to Roles in the Clinical Manager. However, this may be configured for your facility and may be different than seen here.

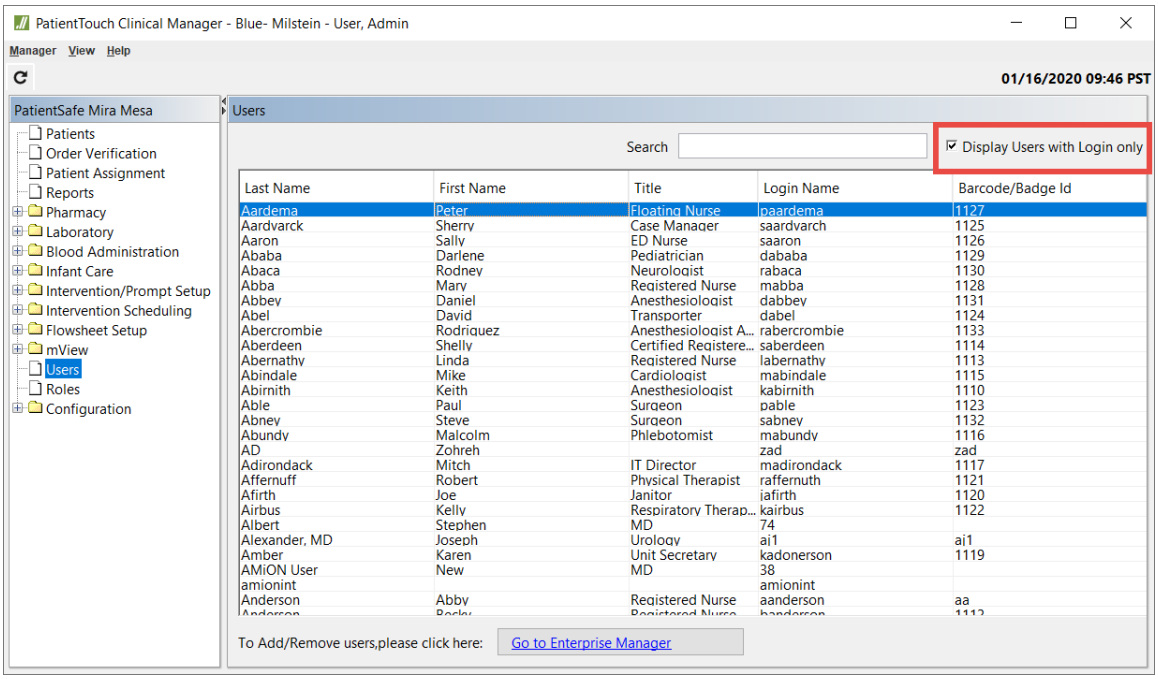
| Enterprise Manager Clinical Profiles | Clinical Manager Roles |
|---|---|
| Primary Nurse | Staff Nurse |
| Nurse Tech/CNA | Nurse Tech/CNA |
| Head Nurse | House Supervisor, Nurse Manager, Staff Nurse, Nurse Tech, CNA |
| Respiratory Therapist | Respiratory Therapist, RT |

| Enterprise Manager Clinical Profiles | Clinical Manager Roles |
|---|---|
| RT Lab Collector | RT Lab Collector |
| Technicians | Pharmacy Inventory Tech |
| Pharmacy Manager | Pharmacy Manager |
| Phlebotomist | Phlebotomist |
| Pharmacist | Pharmacist |
| Physician | Physician |

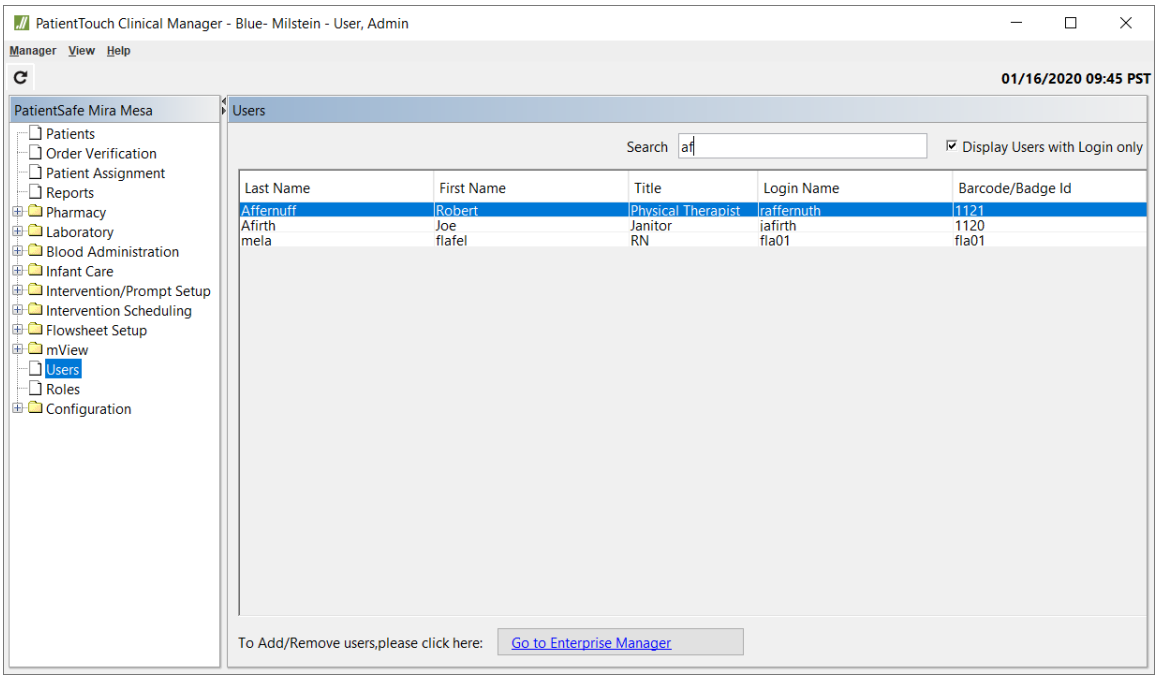
4. Select a default printer for this user from the **Default Printer** drop down list. This printer will be automatically selected when the user prints reports from the Clinical Manager or the PatientTouch application. However, the user can choose a different destination at the time of printing, as needed.
5. **Nursing Units** are read-only in the Clinical Manager. They are selected for each caregiver using the Enterprise Manager.
6. Click **Apply** to save the new user and remain in the *New User* window. Or, click **OK** to save the new user and close the *New User* window.

## Search for a User

1. Filter the list of users so only the users with login names appear by selecting the **Display Users with Login only** checkbox. This is the default view when you first launch the Clinical Manager.




2. Search for a specific user by entering the first few characters of the person's first or last name.
3. The list of filtered users displays in the Search panel.



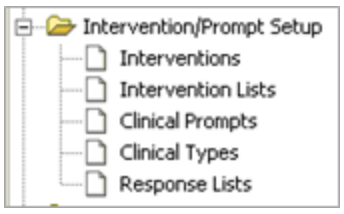

# Intervention/Prompt Setup

Interventions and clinical prompts can be associated with formulary items, used in clinical documentation, and used in vitals-type interventions.

Interventions 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.

Clinical prompts associated with formulary items are displayed during workflows in the PatientTouch application and during charting using the Online MAR in the Clinical Manager. The pharmacy team typically works with nursing staff to set up the required prompts and link them to specific formulary items. Clinical prompts used in clinical documentation and vitals interventions are collected when the intervention is executed within the PatientTouch application.

When setting up Interventions and Prompts, it is best to work from the bottom up on the Clinical Manager menu tree (start with Response Lists and finish with Interventions).




The following items are available for configuration (listed in order of set up). Click a link below or from the Contents tab on the left to learn more.

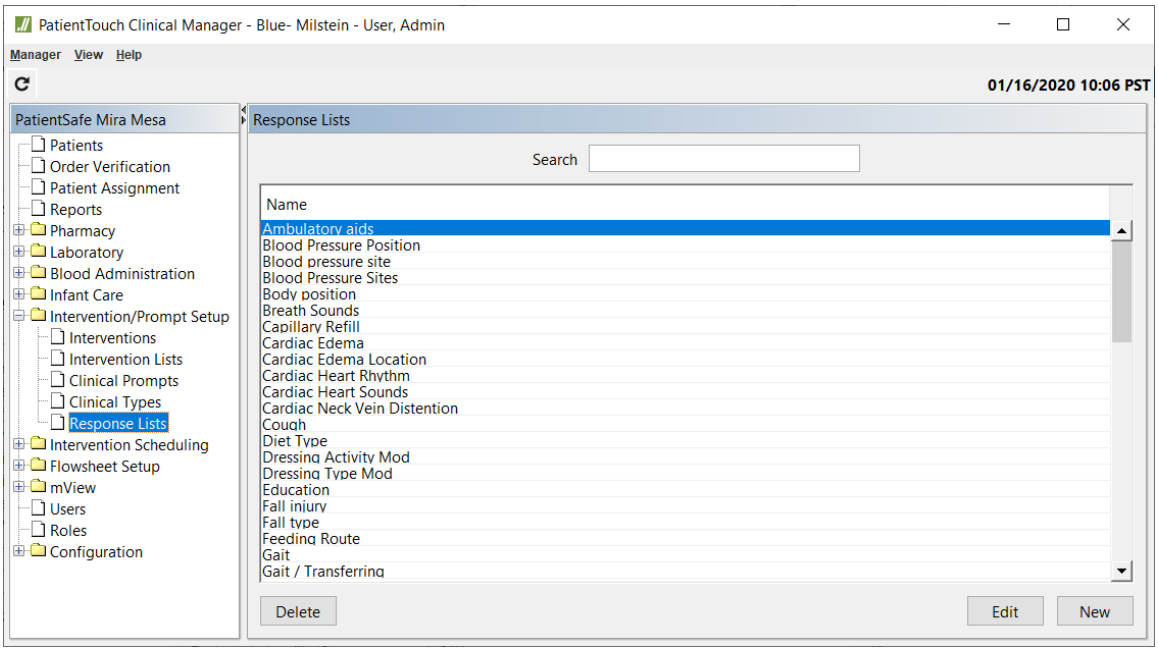
- **Response Lists** - This feature allows creation of custom descriptive answer lists. You can create as many lists as necessary to allow caregivers to provide answers to interventions and clinical prompts that are approved by your hospital policy. For example you might setup a response list for injection sites, temperature sites, pain descriptions, etc.
- **Clinical Types** - This feature is used to define clinical observation characteristics. Clinical types allow users to customize how information is interpreted by the system. For example, if it is important to distinguish a temperature value from more generic, "floating point" types of values, you may want to create a Temperature clinical type.
- **Clinical Prompts** - This feature allows selection of a clinical type to be collected by using the prompt, and can be configured to appear during medication preparation, at the bedside, or as follow-up reminders to appear at specific intervals after a med pass or other workflows. A prompt may be either informational only or may require the caregiver to enter clinical data.
- **Intervention Lists** - Individual interventions and clinical prompts are grouped together in an easy-to-use list so caregivers receive a seamless flow of procedural guidance and documentation opportunities rather than having to select individual prompts.
- **Interventions** - This feature allows for grouping individual clinical prompts together in a clinically meaningful way. Caregivers receive procedural guidance in the PatientTouch application, with seamless documentation of compliance. Caregivers can quickly and easily document patient status and assessments (such as hourly rounds and vital signs). Additionally, interventions can be configured to make calculations based on collected data, e.g. falls risk score, accumulated fluid intake and output, and so on. Interventions can be a grouping of multiple clinical prompts and other interventions.

The procedures in this section will guide you through creating and configuring the various types of prompts and interventions and associating them with patients and/or nursing units.

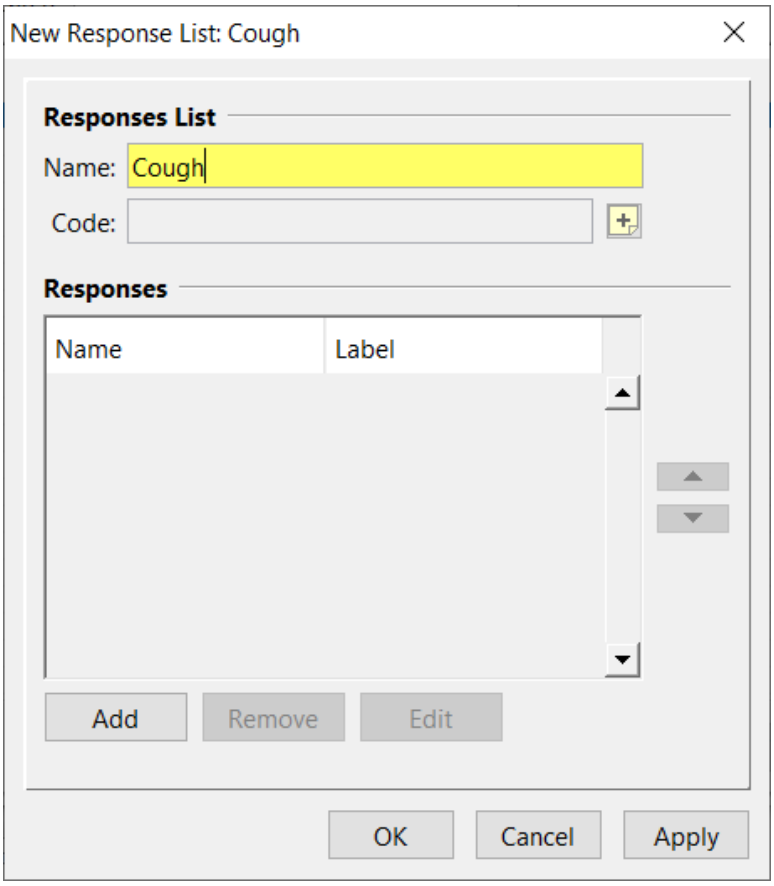
## Response Lists

To add or edit a response list:

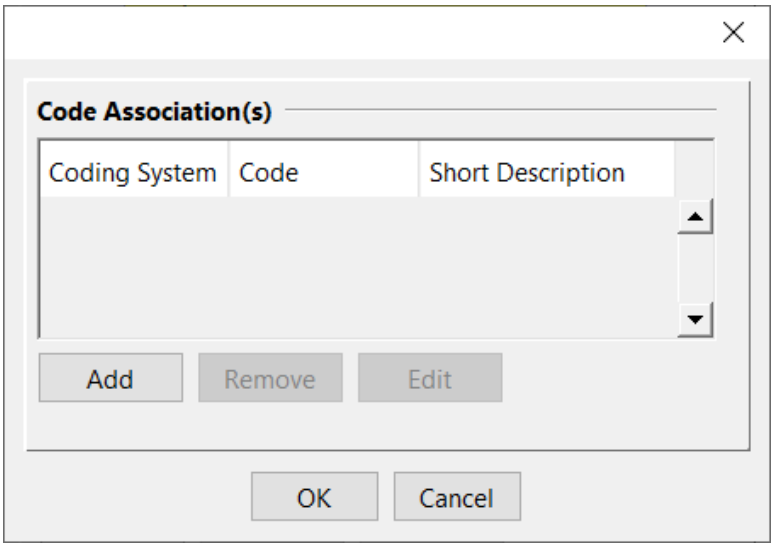
1. Select **Intervention/Prompt Setup > Response Lists**.



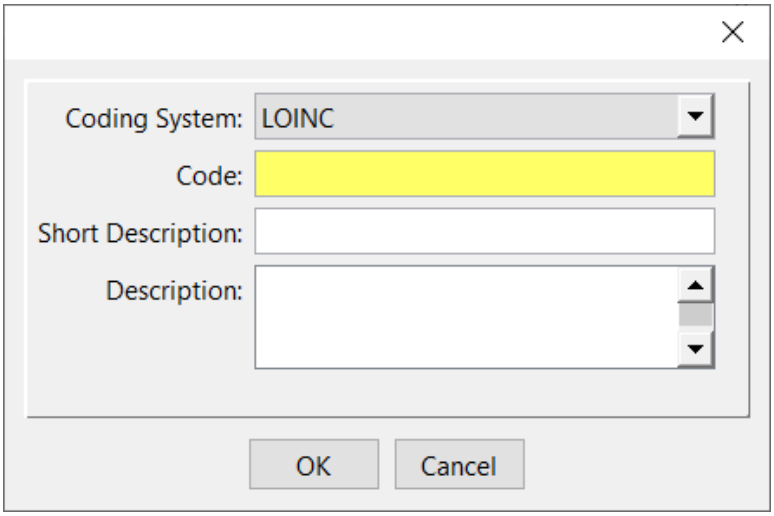

2. Do one of the following:
   - To create a new response list, click **New**.
   - To edit an existing response list, select the response and click **Edit**.
3. In the Name field, add or change the name of the response list.



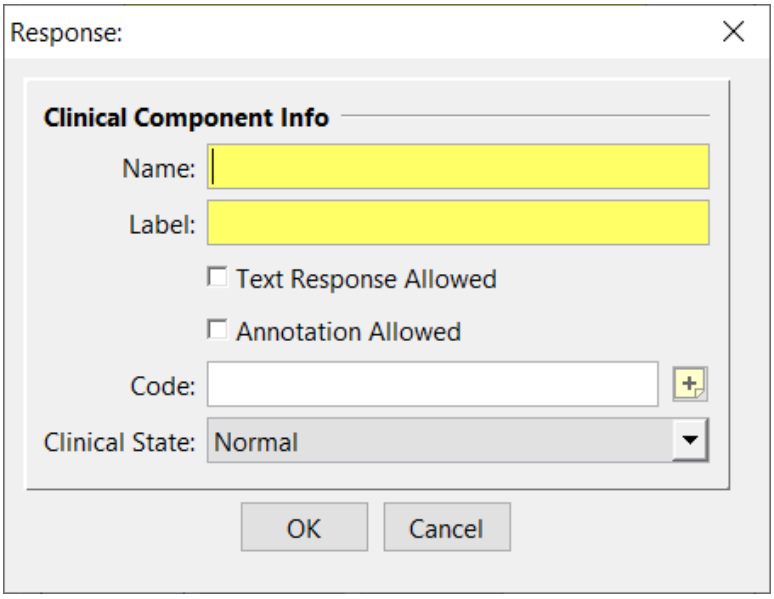

4. **Coding System (Plus Sign)**: You must have Coding Systems defined in the Clinical Manager to populate this field. To add a code to the response list or to a specific response on the list, click the plus sign .
5. Click **Add**.



6. Select a Coding System from the drop down menu.




7. Enter the Code, Short Description, and Description.
8. Click **OK**.
9. To add a new response to the response list, click **Add**.




10. Enter information for the desired response:
    - Name – enter a name for the response
    - Label –The label is how the response will appear in the PatientTouch application AND in documentation. For an example of the character length of the field, you should be able to enter “Calm and Cooperative” in both the Name and Label fields.
    - **Text Response Allowed** – If the option is checked, the user can use the PatientTouch application to optionally include 500+ characters of additional free text information along

with the pre-defined response. This may be useful if the user has more to describe than the selected response.

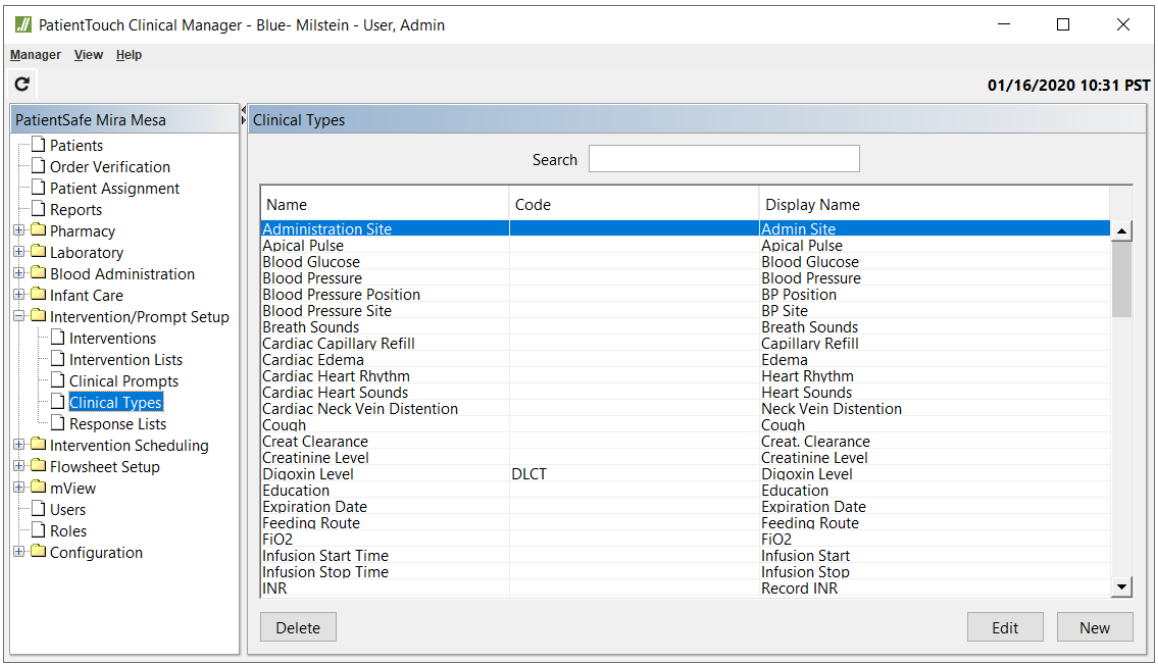
- **Annotation Allowed** – Similar to a text response, if this option is checked, the user will be given the option to include an annotation (note) along with the pre-defined response.
- **Coding System (Plus Sign)**: You must have Coding Systems set up in the Clinical Manager to populate this field. To add a code, click the plus sign , click **Add** on the *Coding Association* window and select a Coding System from the drop down list. Enter the Code, Description and Short Description.
- **Clinical State** – Each response can be identified as either "Normal ", "Abnormal" , or "Critical". For example, in a "Wound Description" response list, a response of "No redness/ooze" would have a "Normal" clinical state. On the other hand, a response of "Red & oozing" is likely considered "Abnormal". Both abnormal and critical settings will display in red font in the Flowsheet and mView.

11. Click **OK** once the desired text and settings are defined.
12. When finished adding all desired responses, click **OK** to save the new response list. The list is displayed in the Response Lists directory.

# Clinical Types

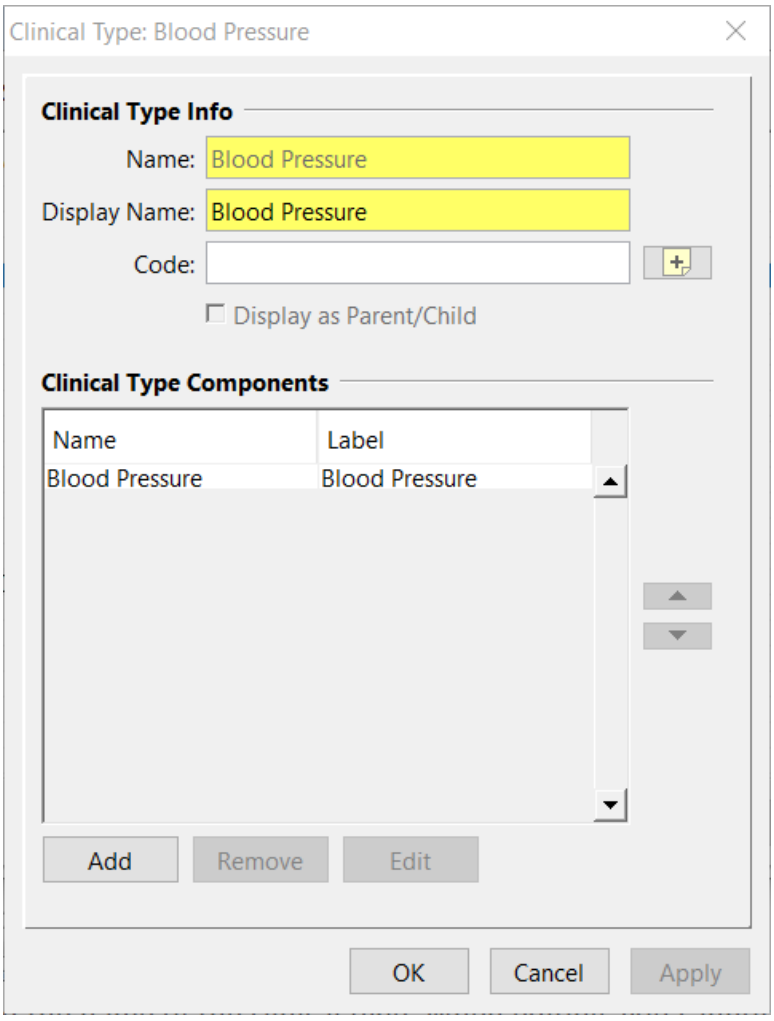
To add or edit a clinical type:

1. Select **Intervention/Prompt Setup > Clinical Types**.

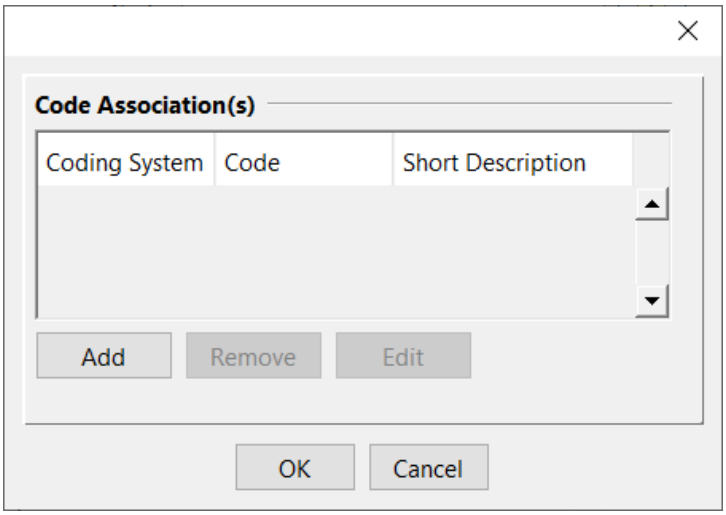



2. Do one of the following:

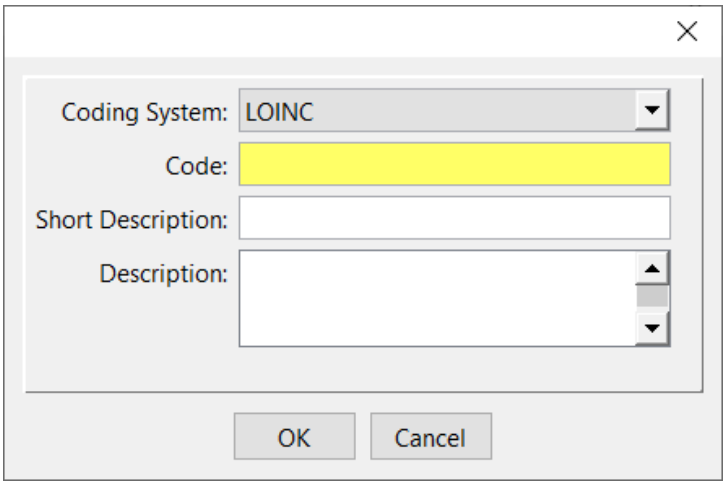
- To create a new clinical type, click **New**.
- To edit an existing clinical type, select the type and click **Edit**.



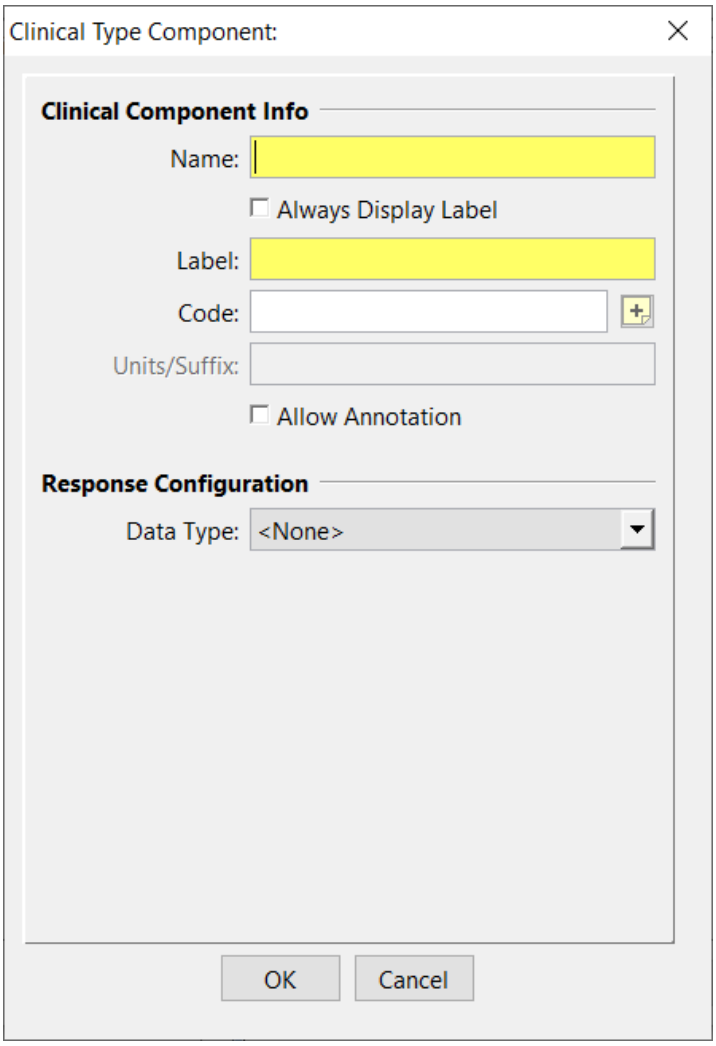

3. In the Name field, add the name of the clinical type. When editing, you cannot change the Name field once it has been set.
4. In the Display Name field, add or change the name that will appear on the PatientTouch application *Care Interventions* screen.
5. **Coding System (Plus Sign)**: You must have Coding Systems set up in the Clinical Manager to populate this field. To add a code, click the plus sign .




6. Click **Add**.




7. Select a **Coding System** from the drop down list.
8. Enter the Code, Short Description, and Description. Click **OK**.
9. Click **OK** on the *Code Association* window.
10. Select **Display as Parent-Child** to display the clinical type as a parent-child prompt. A parent-child prompt simply means there is a “relation” that links the clinical type components together. For example, you may create a Blood Pressure clinical type where Blood Pressure is the parent component and Blood Pressure Site is the child component. You would not want to prompt a user for just the Blood Pressure Site, so you make it a “child” of Blood Pressure.
11. To add components to the clinical type, click **Add**.




- In the Name field, enter the name of the component.
- Select **Always Display Label**, and enter the name that should be displayed in the Label field. This is the label that will display on any flowsheets.
- **Coding System (Plus Sign)**: You must have Coding Systems set up in the Clinical Manager to populate this field. To add a code, click the plus sign , click **Add** on the *Code Association* window and select a Coding System from the drop down list. Enter the Code, Short Description, and Description.
- Enter Unit/Suffix information. Based on the selected Data Type, enter any desired unit of measure/suffix (examples: pounds, kilograms, F, C, inches, mL/Hr, etc.).
- Select **Allow Annotation** to allow users access to a post-it note icon that opens a keyboard to enter free text to add additional notations when capturing this data.
- Under Response Configuration, select the appropriate **Data Type** for the component. Data types tell the system what kind of information is being captured by the component. The data type options include:

- **Alpha-numeric** (letter/number combination): Use for data that contains both letters and numbers. Example: medication lot numbe
- **Integer**: Use for data that is in whole numbers. Example: Blood Glucose.
- **Floating point**: Use for data that may contain a decimal value. Example: INR.
- **Height**: Use for clinical types/prompts that ask for height values. In order for the system to calculate BMI based on user-input data, this data type must be used for height.
- **Weight**: Use for clinical types/prompts that ask for weight values. In order for the system to calculate BMI based on user-input data, this data type must be used for weight.
- **Response list**: Use for data that requires descriptive answers. Example: Pain Scale Type.
- **Blood pressure**: Use for blood pressure clinical types.
- **Date**: Use for data that needs a date. Example: Expiration Date.
- **Date/time**: Use for data that needs both a date and a time. Example: IV Stop Time.

**When you create a clinical prompt with a clinical type that has a data type of Date/Time, a Specifies Time of Occurrence checkbox displays. If selected, this feature captures the date/time the action was taken, not the time the badge was scanned to document the action.**

- **Non-response**: Use for clinical types/prompts that do not require the user to input any data; it is a "reminder-only" clinical type/prompt. Example: Give with food.
- **Witness barcode**. Use for clinical types/prompts that require the user to scan a witness barcode. Example: Witness Required.

- Based upon the selected **Data Type**, fill in the required fields (in yellow) and any other desired response configuration fields, described below:

- Min Value: The minimum value field defines the lowest value that will be accepted to progress through the workflow. If users enter a value lower than what is defined here, they will be alerted and asked to enter a value within the defined range. This value is recommended but not required.
- Normal Min: The normal min field defines the lowest normal value for the clinical type (ex: normal min. value for potassium level). If users enter a value lower than what is defined here, they will be alerted. They will then have the option to edit the value or proceed with their originally entered value.
- Default Value: The default value field defines the first value that appears on the PatientTouch application without entering or changing the value. For example, when asking for a blood pressure value, the application will present two spin dials to the users. If you want each dial to have a starting point, such as 130 and 80, you would define them here as default values. This value is optional.
- Normal Max: The normal max field defines the highest normal value for the specific clinical type (ex: normal max. value for potassium level). If users enter a value greater than what is defined here, they will be alerted. They will then have the option to edit the value or proceed with their originally entered value.
- Max Value: The max value field defines the highest value that will be accepted to progress through the workflow. If users enter a value higher than what is defined here, they will be alerted and asked to enter a value within the defined range. This value is recommended but not required.
- Min Characters: The min characters field defines the minimum amount of characters the user must enter for an alpha-numeric response. This helps to prevent the user from accidentally entering incomplete data. For example, if a lot number always has a minimum amount of characters, you define that here to ensure the minimum length is met when the user enters the information using the PatientTouch application.
- Max Characters: The max characters field defines the maximum amount of characters the user

must enter for an alpha-numeric response. This helps to prevent the user from accidentally entering inaccurate data. For example, if a lot number always has a maximum amount of characters, you define that here to ensure the user does not enter more than the maximum number of characters.

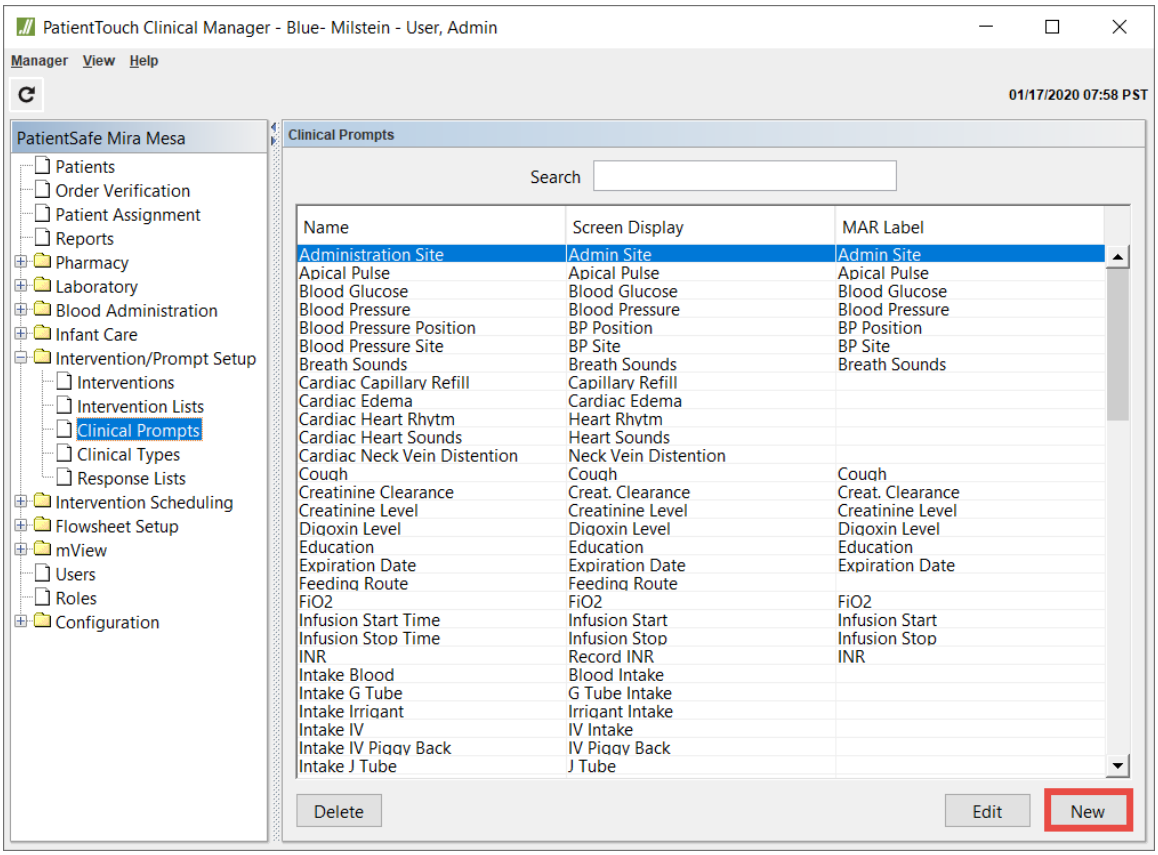
- Precision: The precision field defines how precise you want the entered value to be (how many numbers past the decimal point the value can go). For example, a potassium level value only has one decimal value (3.5) whereas a weight value may need to be more specific, like 9.25 kg. In the weight example, the precision value would be "2", to allow two values after the decimal point.

12. Click **OK**.
13. When finished, click **OK** on the *Clinical Type* window to save the new clinical type. The clinical type is displayed in the Clinical Types list.

# Clinical Prompts

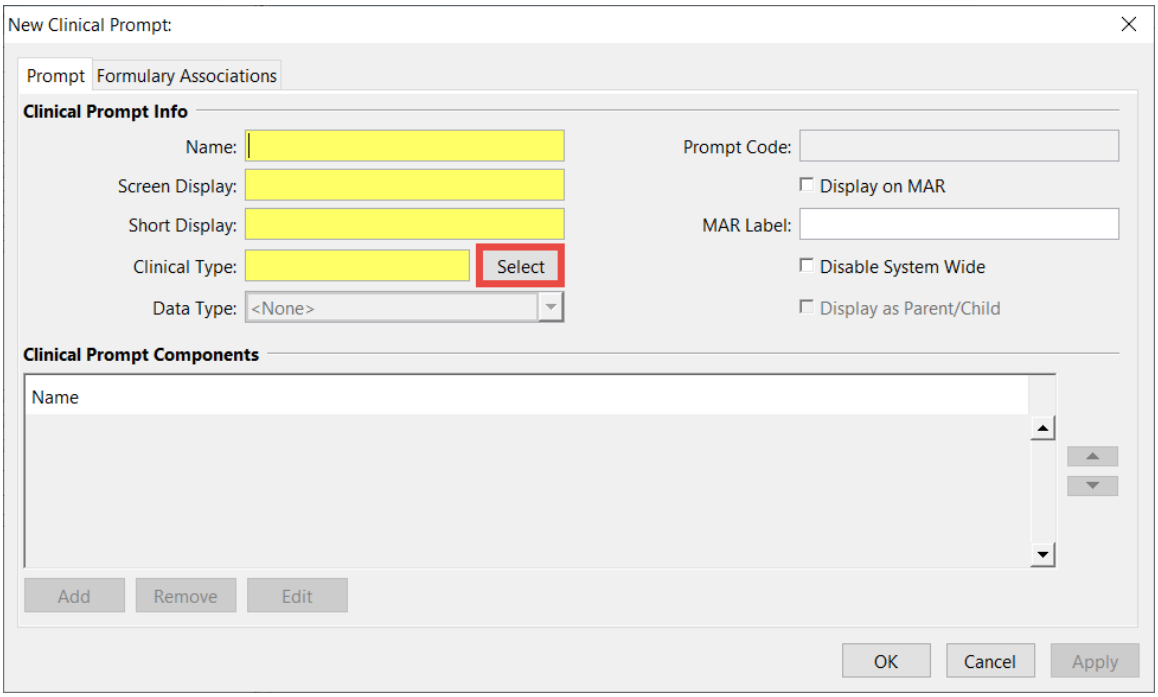
To add or edit a clinical prompt:

1. Select **Intervention/Prompt Setup > Clinical Prompts**.
2. Do one of the following:
   - To edit an existing clinical prompt, select the prompt and click **Edit** or just double-click it.
   - To create a new clinical prompt, click **New**.

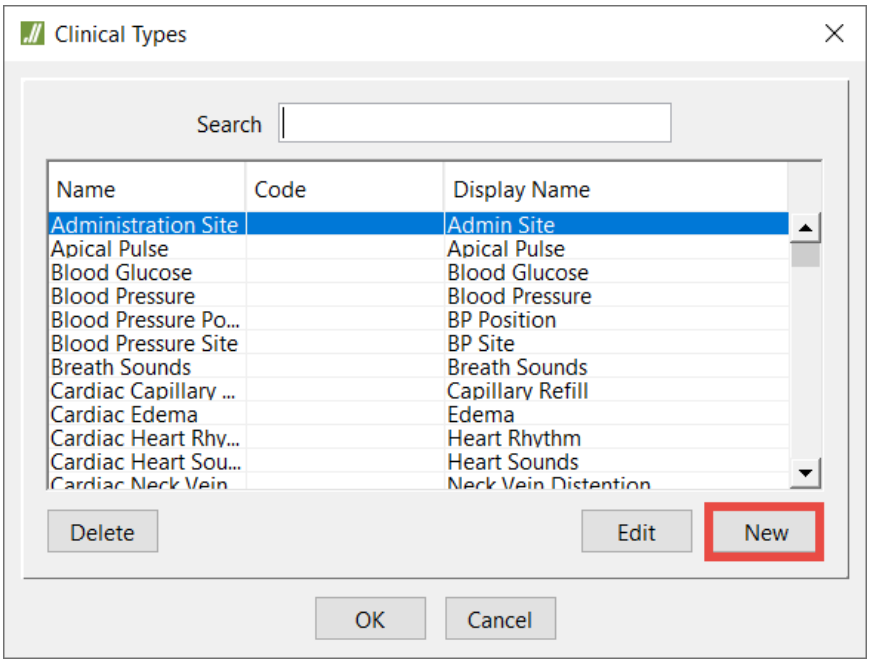


On the New Clinical Prompt screen, in the **Prompt** tab use the information below to complete the fields.

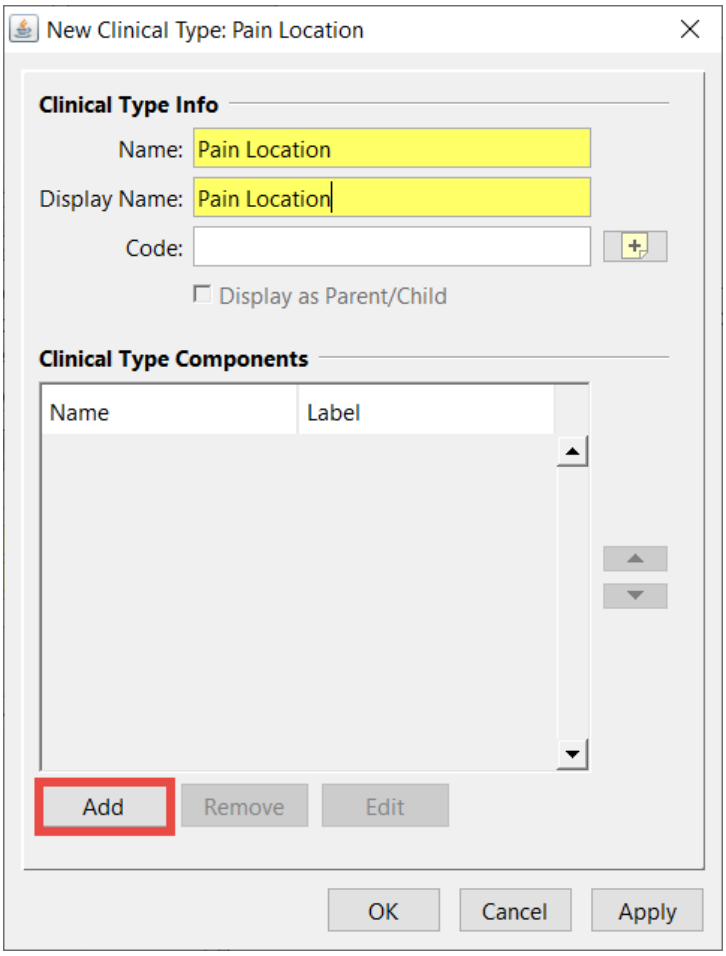
3. Name: add or change the name of the clinical prompt.
4. Screen Display: add or change the prompt name that will appear on the PatientTouch application *Care Interventions* screen.
5. Short Display: add or change the name that will appear on the data entry panel on the PatientTouch application when the users enter their response.
6. To the right of the Clinical Type field, click **Select**.



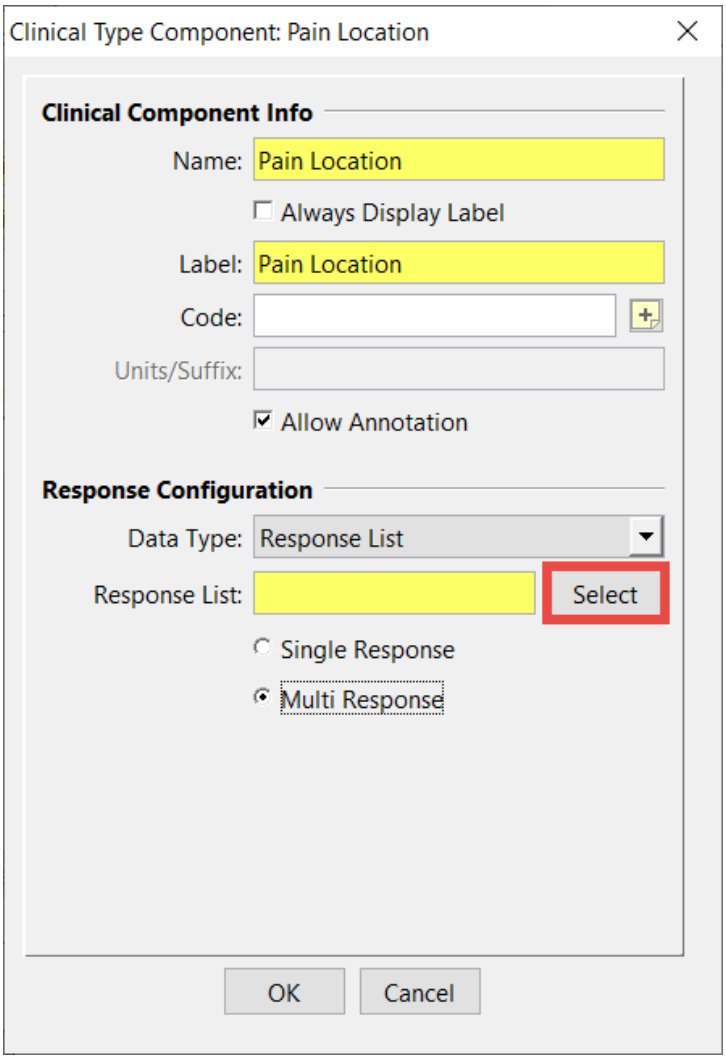

7. Select a Clinical Type from the list and click **OK**. In general, the clinical type corresponds to the clinical prompt name. For example, if you're creating a clinical prompt for blood pressure, the Clinical Prompt Name will be something like Blood Pressure and the Clinical Type will also be Blood Pressure.
8. If the desired Clinical Type does not display in the list, you can create a new clinical type by clicking **New**.



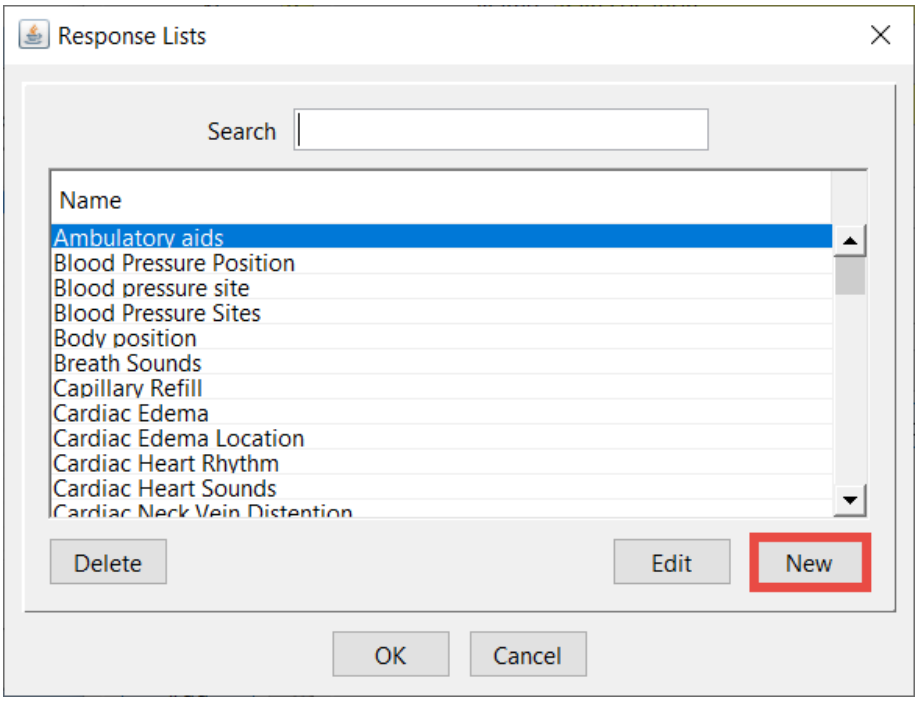

9. Name: Enter the name of the clinical type.
10. Display Name: Enter the name that will display on the PatientTouch application.
11. Click **Add** to add a clinical type component.



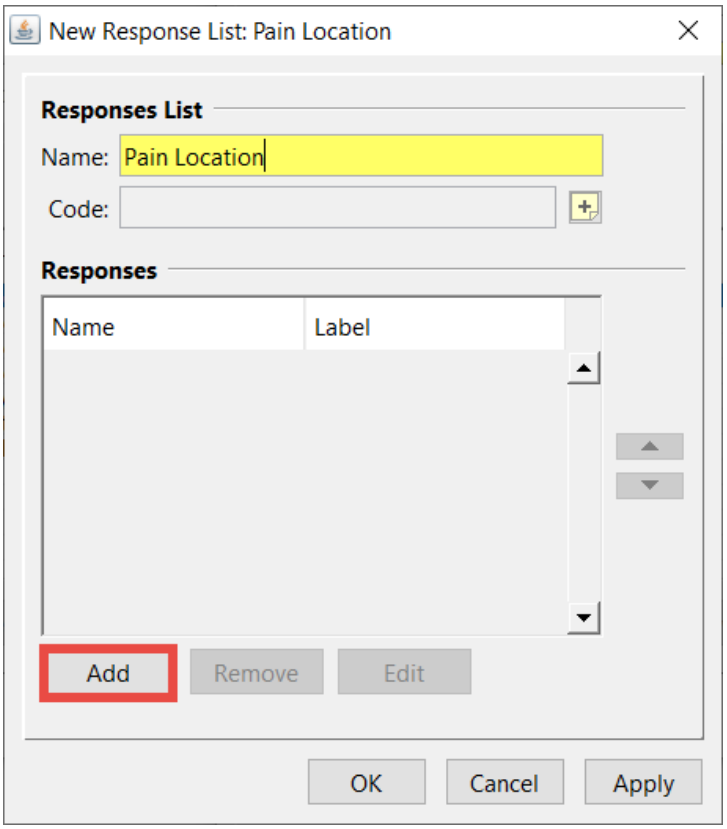

12. Name: Enter the name of the clinical component.
13. Label: Enter the name that will display on the PatientTouch application.
14. Select **Allow Annotation** to display a post-it note icon to add a text message when collecting prompt information.
15. Add a **Data Type**. In this example, we chose a response list data type.
16. Click **Select** to add the response list.



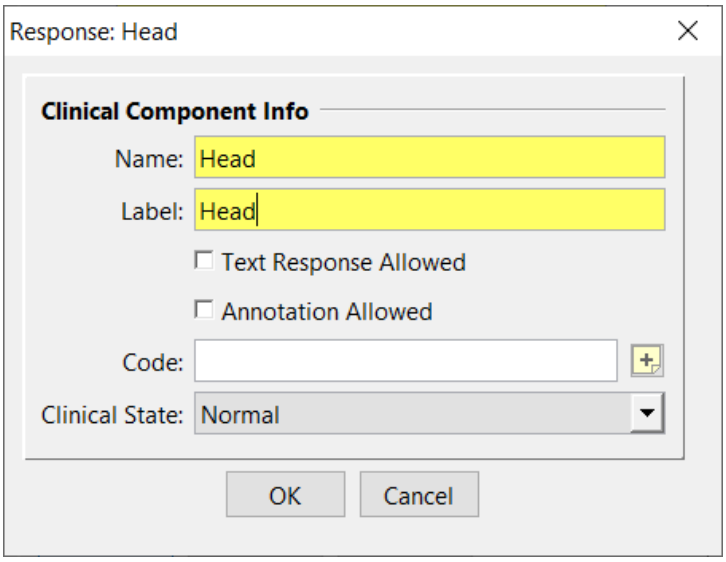

17. The *Response Lists* window displays. If the desired response list does not appear, click **New**.



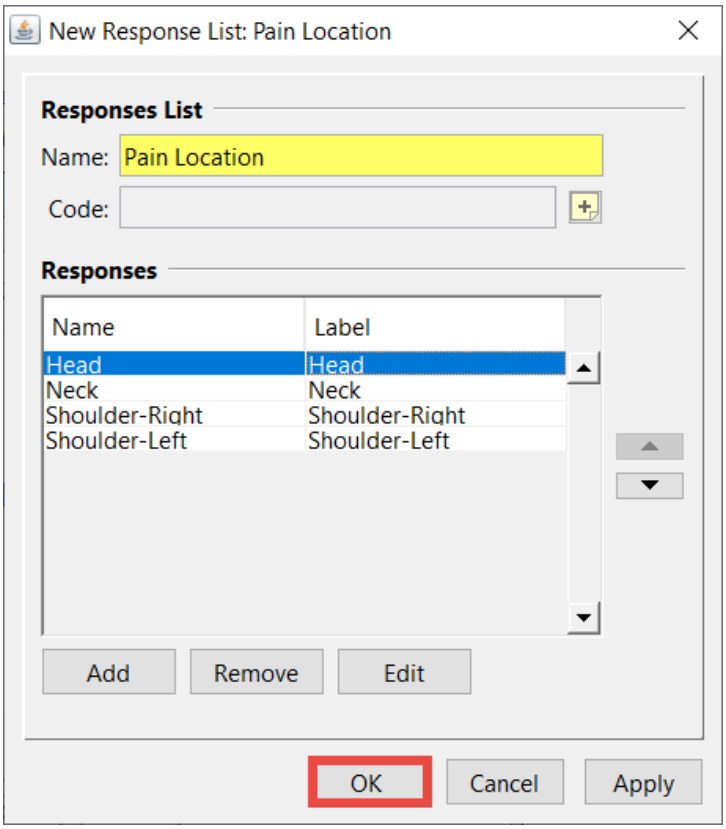

18. Enter the name of the new response list.
19. Click **Add** to start adding the responses to the response list.



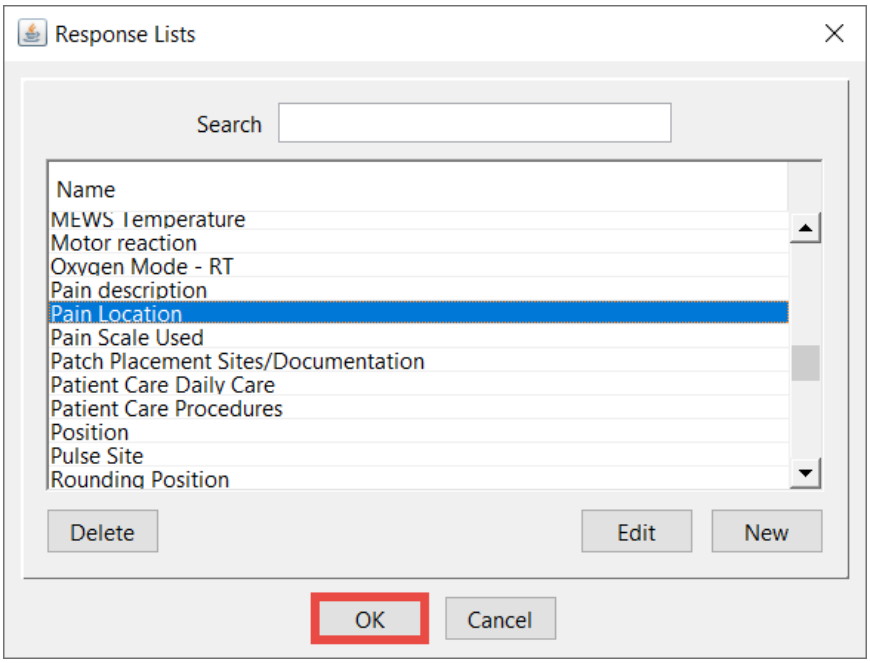
20. Enter the name and Label of the new response lists.
21. Click **OK**.



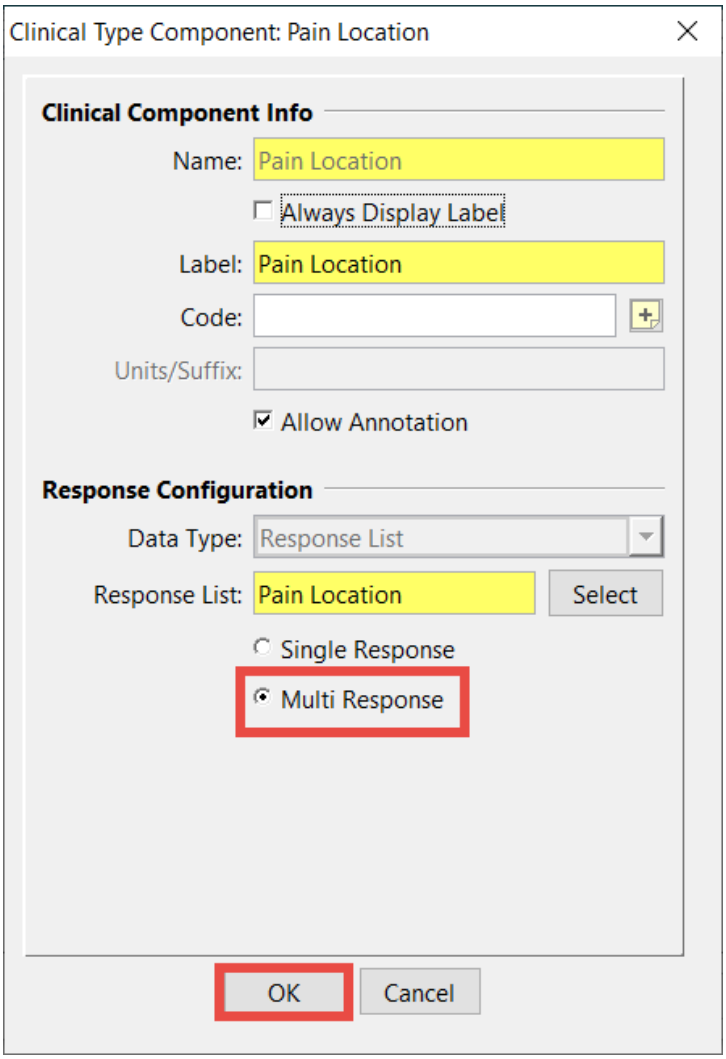

22. Continue adding response list items until your list is complete.
23. Click **OK.**



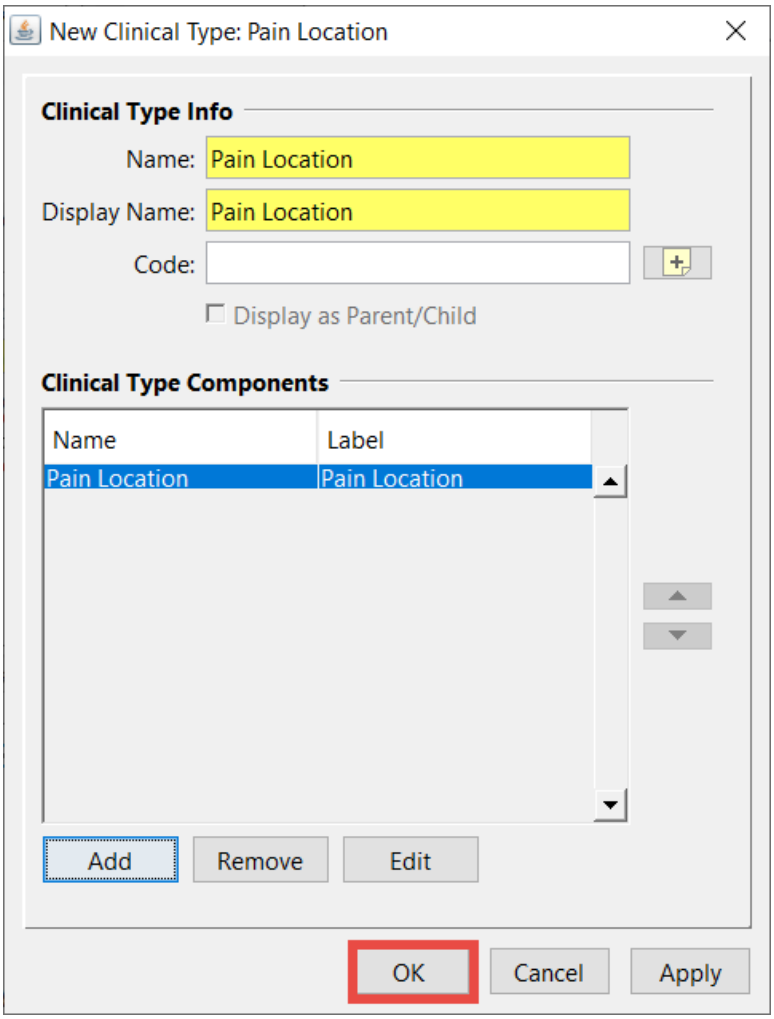

24. Select the response list and click **OK**.



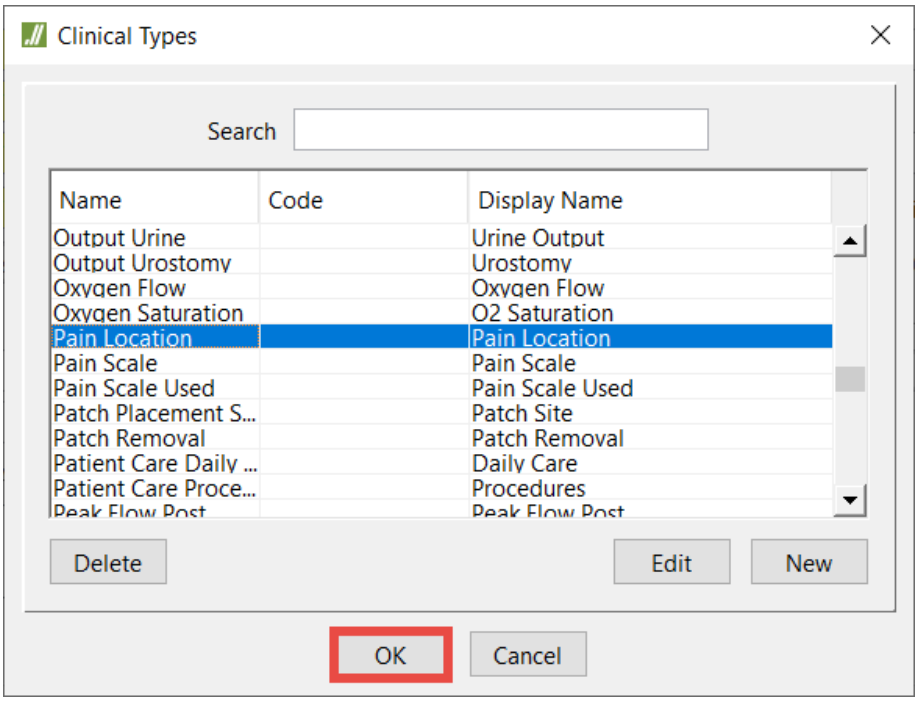

25. Click **Multi Reponse** when your list has more than one response.
26. Click **OK** on the *Clinical Type Component* window.




27. Click **OK** on the *New Clinical Type* window.



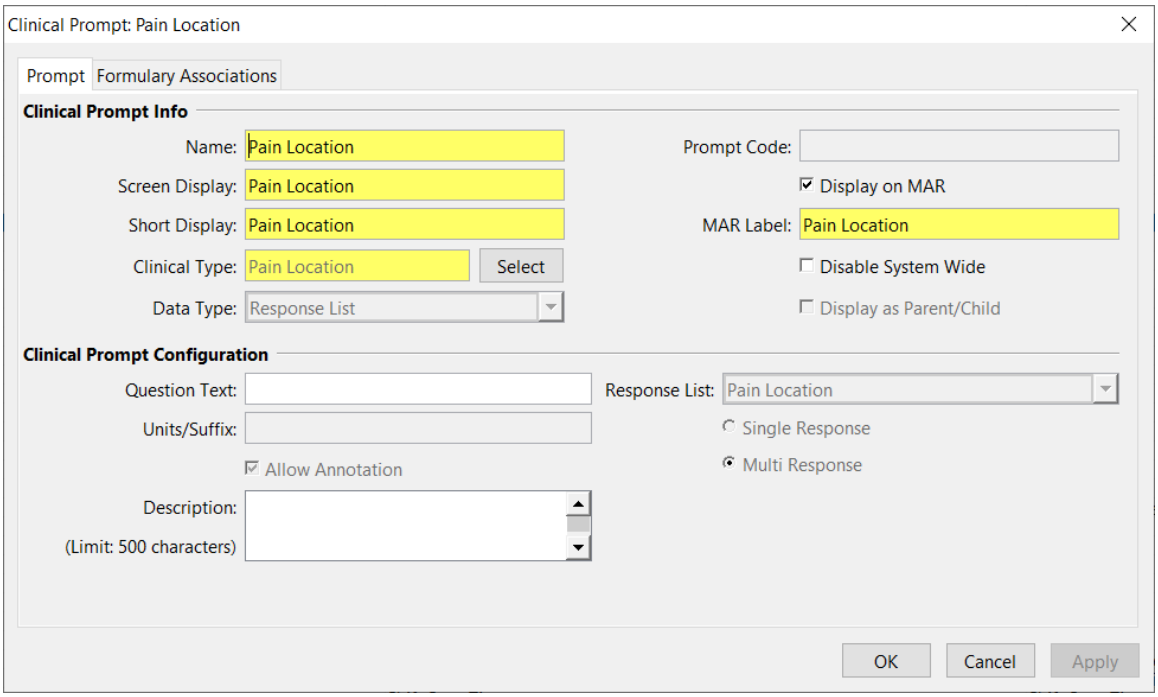

28. Select the clinical type from the *Clinical Types* window and click **OK**.




The new Clinical Type, Data Type, and Response List display.

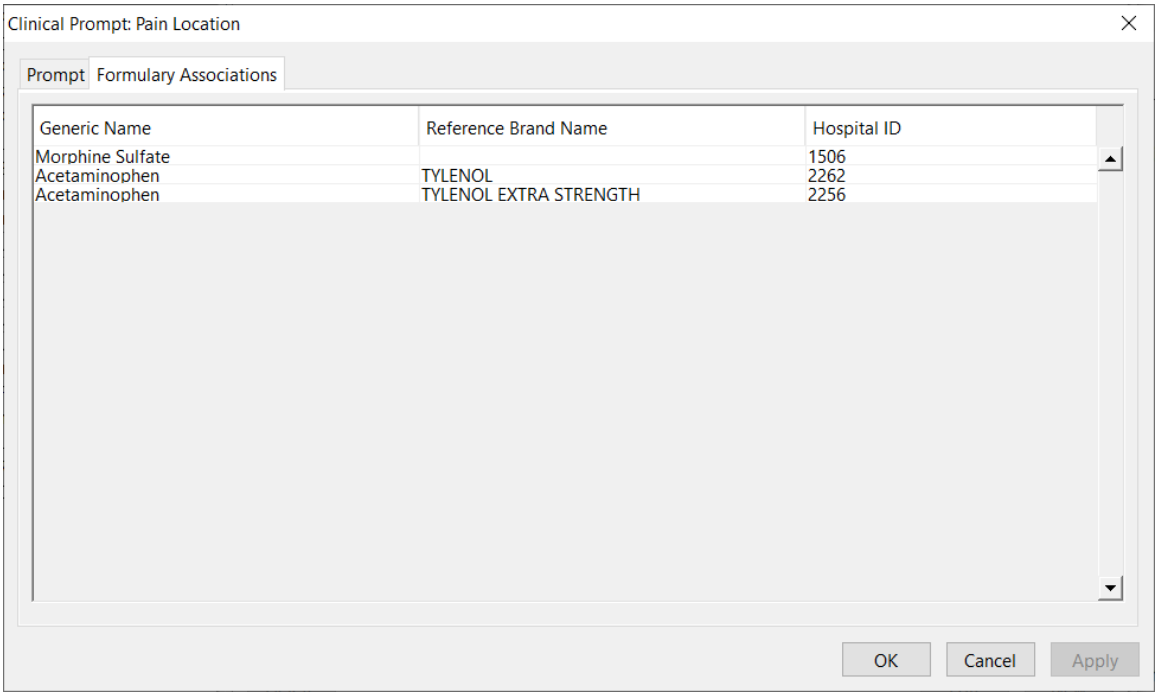
When you select a Clinical Type:

- The Data Type field is automatically populated

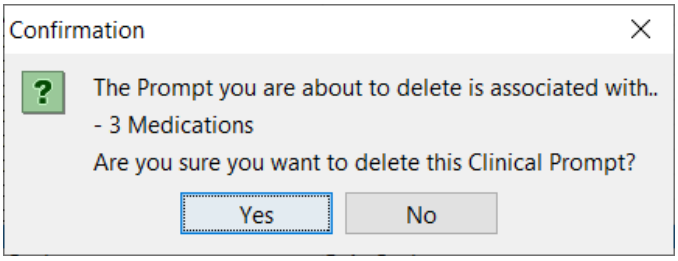



- Some of the fields under the Clinical Prompt Configuration area may change

29. To display the clinical prompt on the online MAR and printed MAR reports, select **Display onMAR**, and enter the name that should be displayed in the MAR Label field.
30. Enter a Prompt Code if the information collected from this prompt will also be sent to your EHR. Hospitals that use this option work with their IT department and the PatientSafe Solutions System Engineer to obtain the prompt code values.
31. Select **Disable System Wide** if you want to proactively create a prompt but don't want it seen by users. This is most frequently used when testing a new prompt and then wanting to educate staff prior to it displaying in their workflows.
32. Under the Clinical Prompt Configuration area, certain fields will be auto-populated from the configurations of the selected Clinical Type. Other fields can be configured here and include:
    - **Allow Annotation**: While this setting is determined by the configuration of the selected Clinical Type, you can change it here by either selecting or deselecting the checkbox.
    - **Require Password**: When the Data Type is set to Witness Barcode, this checkbox becomes enabled. When selected, users will have to enter a Witness password after scanning a Witness badge.
    - Description: If you think it will be helpful for users to access additional information about what this prompt is asking them, you can include a more detailed description in this field. For example, you may prompt the user to enter a sedation scale score. In order to help the user better determine what value to enter, you can include a description of the sedation scale values in this field. On the application, the user will be able to select an icon with a caduceus symbol to display this information.
33. If you want to see which formulary items currently have this prompt associated, click on the **Formulary Associations** tab. This table helps you determine if there are medications that still need to be associated or medications that no longer need to prompt for this information.



34. When you are finished defining the clinical prompt settings, click **OK** to save the new clinical prompt. The prompt is displayed in the Clinical Prompts list.
35. If you try to delete a prompt, and it is associated with formulary items and/or interventions, you will receive a message asking if you are sure you want to delete.



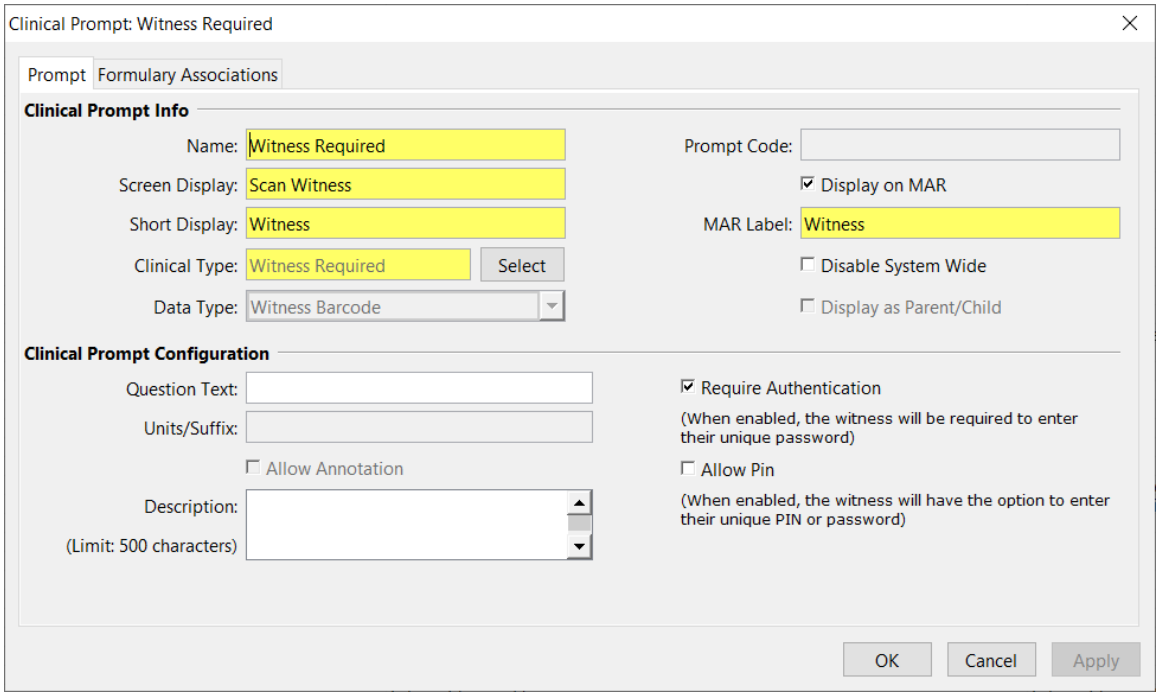

## Configuring the Witness Prompt

Please follow the instructions below to configure dual authentication for the witness prompt.

**Users may configure the Witness prompt without using dual authentication.**

1. If you want to require users to enter a password as part of the witness process, click **Require Authentication**.
2. If you want to also allow the user to have the alternative option of entering a PIN instead of a password, click **Allow PIN.**

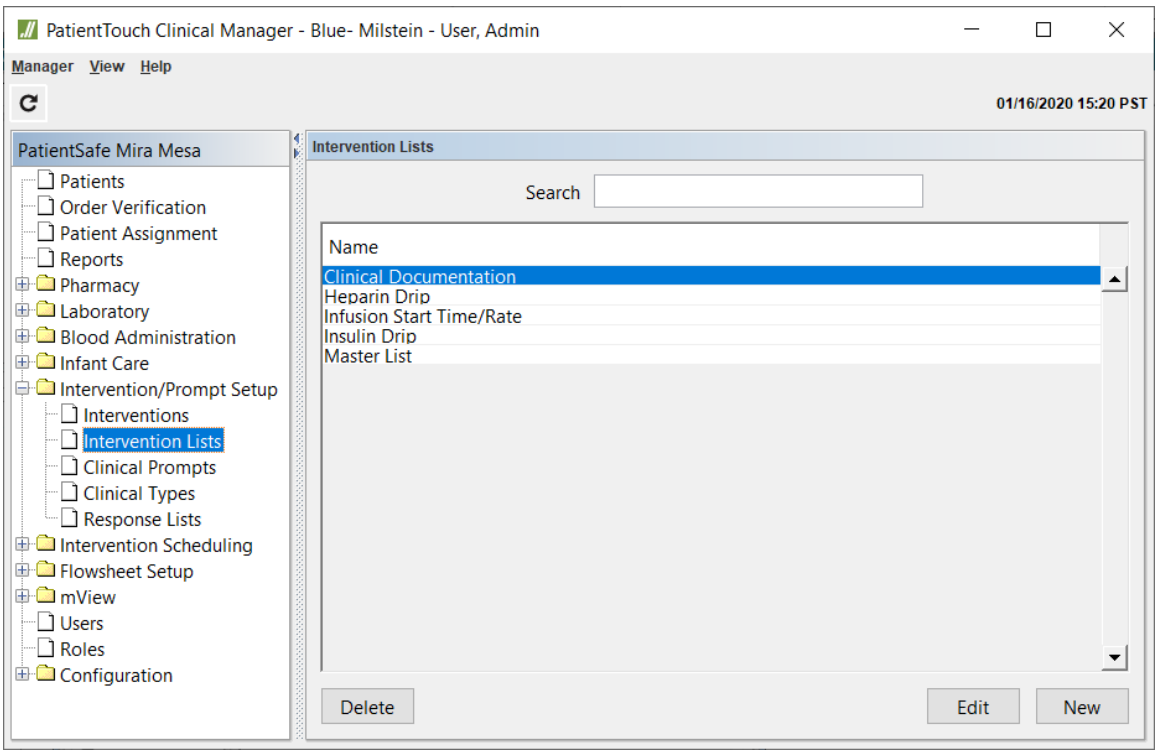
In order for users to enter a PIN, they must have a PIN configured in their caregiver profile in the Enterprise Manager. If the user does not have a PIN configured, he/she will only be able to enter a password.



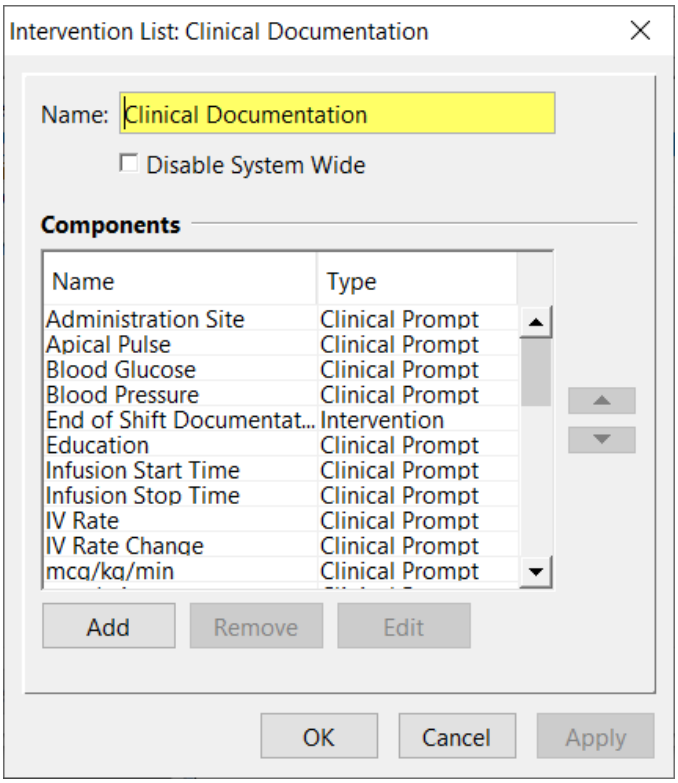

# Intervention Lists

To add or edit an Intervention List:

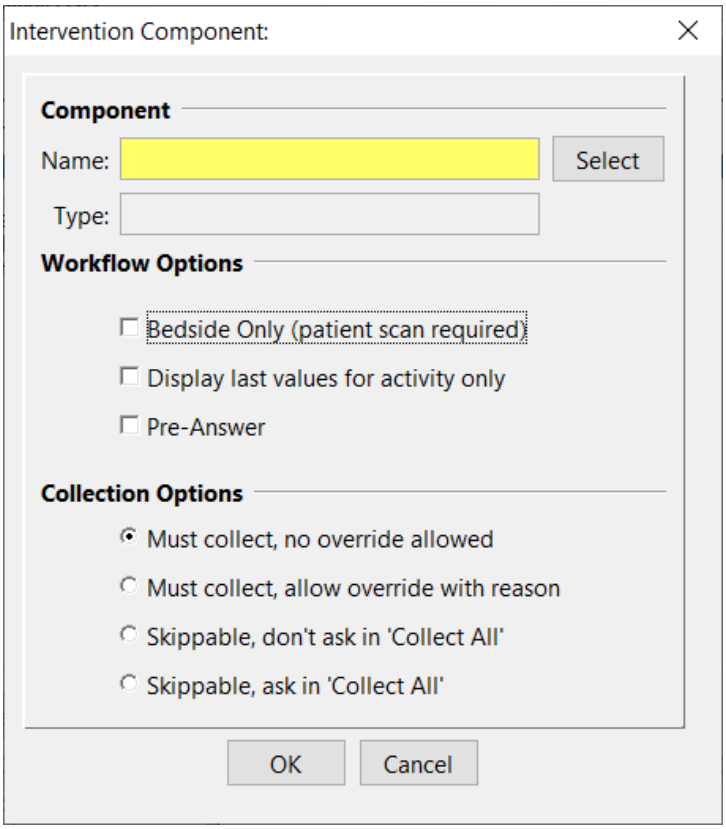
1. Select **Intervention/Prompt Setup > Intervention Lists.**



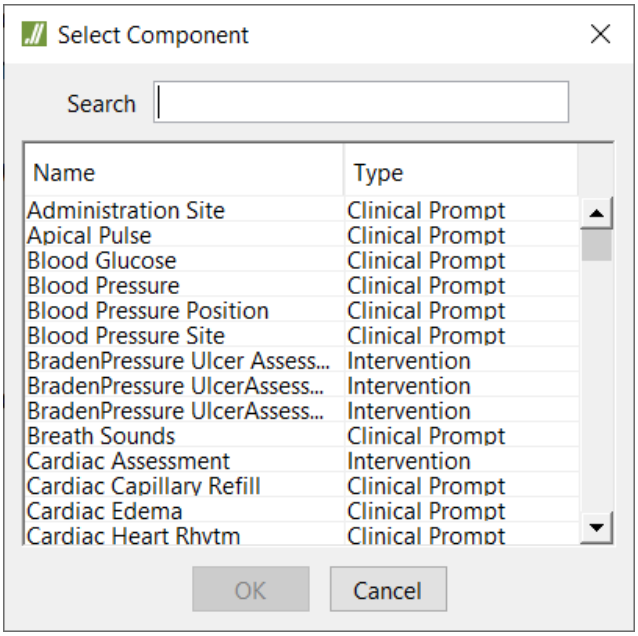

2. Do one of the following:
   - To create a new intervention list, click **New**.
   - To edit an existing intervention list, select the list and click **Edit** or double-click it.
3. In the Name field, add or change the name of the intervention.
4. To add components to the intervention, click **Add.**



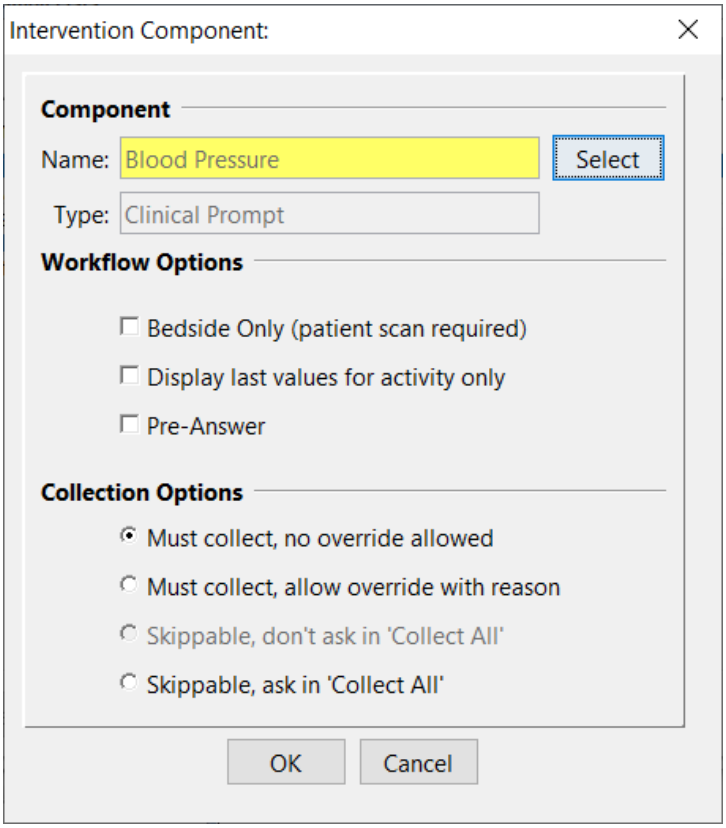

5. Click **Select**.



6. Select the desired component, and click **OK**.




7. Select the desired Workflow and Collection Options for this component.




Workflow Options:

- **Bedside Only** – Bedside only indicates that the prompt can only be documented after the patient is scanned. For example, you may want to set Administration Site to be Bedside Only to ensure the user does not document a site of administration until the point of administering the medication which requires that information.
- **Display last values for activity only** – The system will display the last entered value at the time the user is prompted to enter a new value. If you want the last value to be only from this activity as opposed to pulling the last value for the same prompt from a different activity, check this option.
- **Pre-Answer** - When selected, the user will not have to re-enter the same information for the same prompt that may be associated with multiple items throughout a single workflow. For example, during a medication administration workflow, the user may be giving multiple blood pressure medications requiring a blood pressure value. With this option checked the user will only be prompted for the value with the first medication and the system will automatically use the same value for any subsequent medications *withinthe same* workflow.

Collection Options:

- **Must collect, no override allowed** – The user must collect a value and cannot continue without doing so. An example of this might be prompting for a witness to a medication amount. If you want to require the user to capture this information prior to moving forward in the workflow, select this collection option.
- **Must collect, allow override with reason** – The user can override and bypass entering a value but must provide an override reason which will be documented. For example, if the user is prompted for a lab value which may not be available, you may consider selecting this option for that prompt so the user can either enter the value or provide a hospital-approved reason for overriding.
- **Skippable, don't ask in 'Collect All'** – If this option is selected, the prompt will not display as part of the list of prompts when the user "Begin Collection" to step through the list of prompts. No override reason is required.
- **Skippable, ask in 'Collect All'** – If this option is selected, the prompt will display as part of the list of prompts when the user "Begin Collection" to step through the list of prompts. However, the user can skip it and no override reason is required.

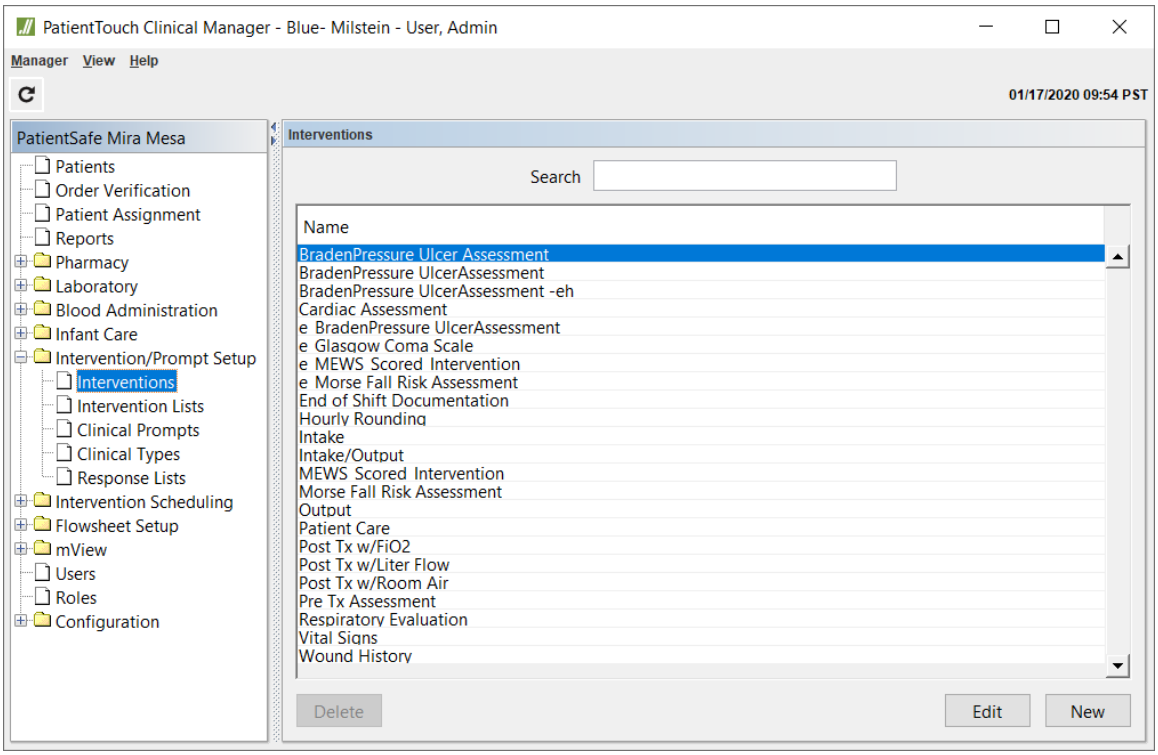
8. Once you have defined all the options, click **OK**.
9. Repeat these steps to add components, as necessary.
10. When finished adding components, click **OK** to save the new intervention list. The list is displayed in the Intervention Lists list.

# Interventions

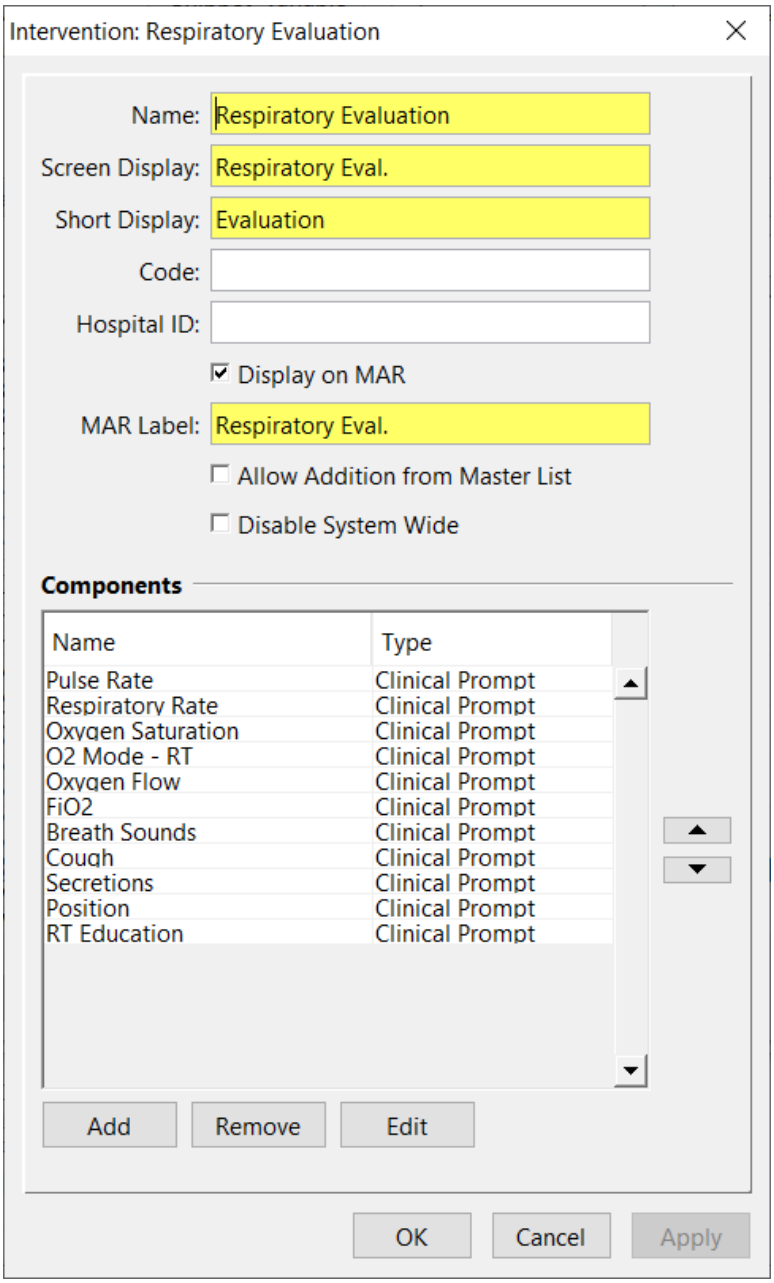
Interventions are created based on the clinical data types and prompts you have set up in Intervention/Prompt Setup>Clinical Prompts/Clinical Types.

To add or edit an intervention:

1. Select **Intervention/Prompt Setup > Interventions**.

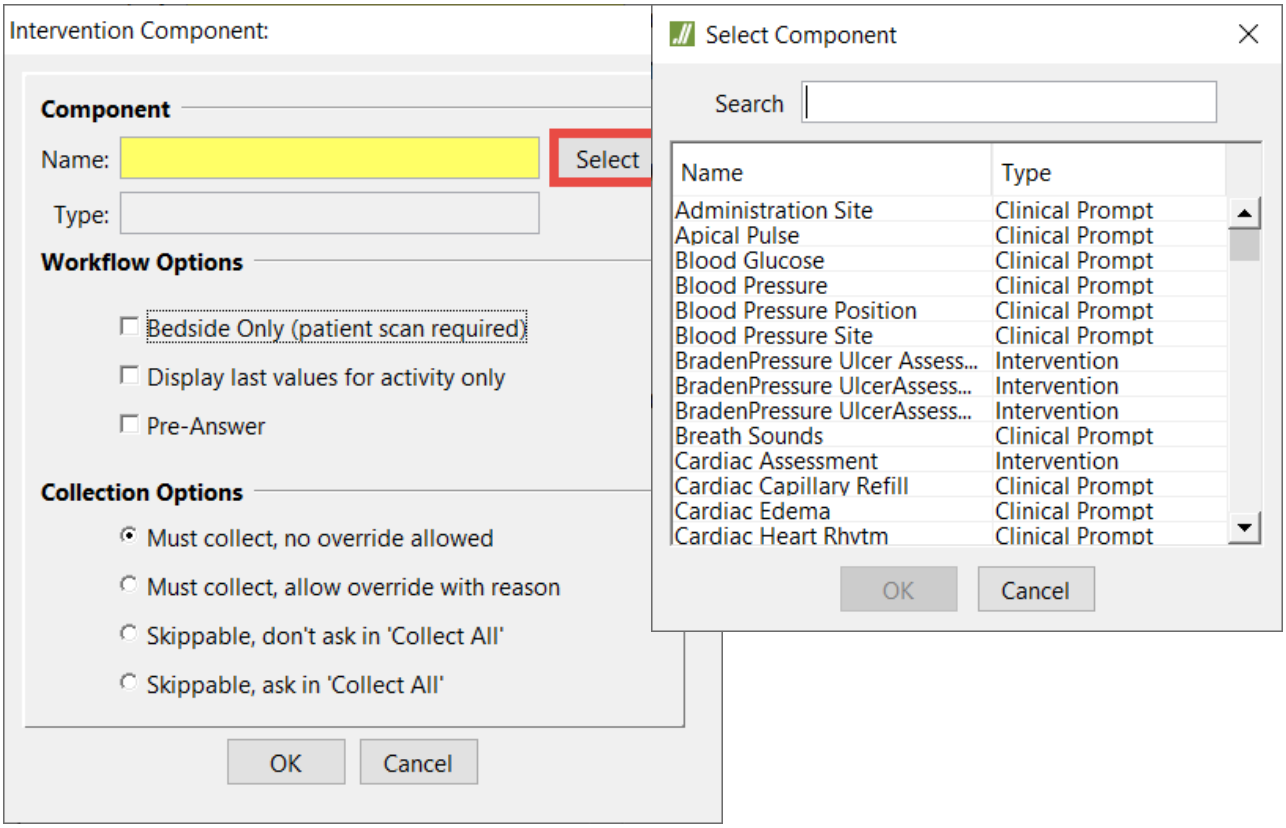



2. Do one of the following:
   - To create a new intervention, click **New**.
   - To edit an existing intervention, select the intervention and click **Edit** or double-click it.




3. In the Name field, add or change the name of the intervention.
4. In the Screen Display field, add or change the intervention name that will appear on the PatientTouch application Interventions screen.
5. In the Short Display field, add or change the intervention name that will appear where summary information is used.
6. Add the Hospital ID (optional)
7. Click **Display on MAR** to have the intervention display in the online MAR and printed MAR documents.

8. Enter the MAR Label, which will be the name of the intervention that displays in the online MAR.
9. Click **Allow Addition from Master List** to allow the user to add additional pieces of information from a "master list" of prompts accessible in the PatientTouch application.
10. Click **Disable System Wide** to prevent the intervention from displaying to the users in the PatientTouch application until the point in time you are ready for them to be prompted for, or use, the information.
11. To add components to the intervention, click **Add**, and then click **Select**.




12. Select the desired component and click **OK**.
13. Select the desired Workflow and Collection Options for this component and click **OK**. Refer to the Intervention Lists section for more detailed information on how to setup Workflow and Collection Options.
14. Repeat these steps to add components, as necessary.
15. When finished adding components, click **OK** to save the new intervention. The intervention is displayed in the Interventions list.

# Intervention Scheduling

Intervention Scheduling is only available if you have purchased the Intervention Scheduling Module. The following sections explain the Intervention Scheduling tab of the PatientTouch Clinical Manager.

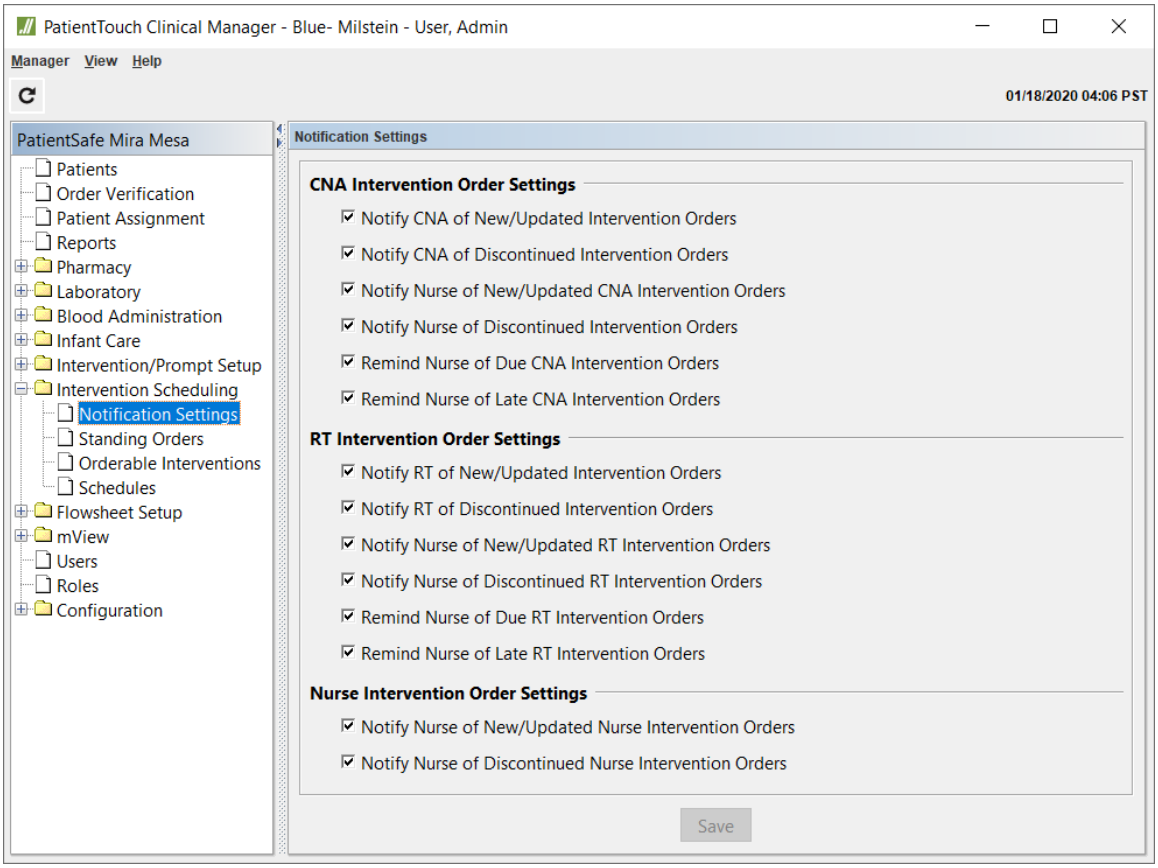
This user guide describes each of the tabs under the Intervention Scheduling folder. Click a link below or from the Contents tab on the left to learn more.

- Notification Settings
- Standing Orders
- Orderable Interventions
- Schedules

# Notification Settings

Notification Settings allows caregivers to select CNA, RT, and Nurse intervention order notification settings.

1. Select **Intervention Scheduling>Notification Settings**.




2. Select the options for this screen based on the following field definitions:

## CNA Intervention Order Settings

- **Notify CNA of New/Updated Intervention Orders:** Notify the CNA of any new or updated intervention orders.
- **Notify CNA of Discontinued Intervention Orders:** Notify the CNA of any discontinued

intervention orders.

- **Notify Nurse of New/Updated CNA Intervention Orders:** Notify the nurse of any new or updated CNA intervention orders.
- **Notify Nurse of Discontinued Intervention Orders:** Notify the nurse of any discontinued intervention orders.
- **Remind Nurse of Due CNA Intervention Orders:** Remind the nurse of any CNA intervention orders that are due.
- **Remind Nurse of Late CNA Intervention Orders:** Remind the nurse of any CNA intervention orders that are late.

### RT Intervention Order Settings

- **Notify RT of New/Updated Intervention Orders**: Notify the RT of any new or updated intervention orders.
- **Notify RT of Discontinued Intervention Orders**: Notify the RT of any discontinued intervention orders.
- **Notify Nurse of New/Updated RT Intervention Orders**: Notify the nurse of any new or updated RT intervention orders.
- **Notify Nurse of Discontinued RT Intervention Orders**: Notify the nurse of any discontinued RT intervention orders.
- **Remind Nurse of Due RT Intervention Orders**: Remind the nurse of any RT intervention orders that are due.
- **Remind Nurse of Late RT Intervention Orders**: Remind the nurse of any RT intervention orders that are late.

### Nurse Intervention Order Settings

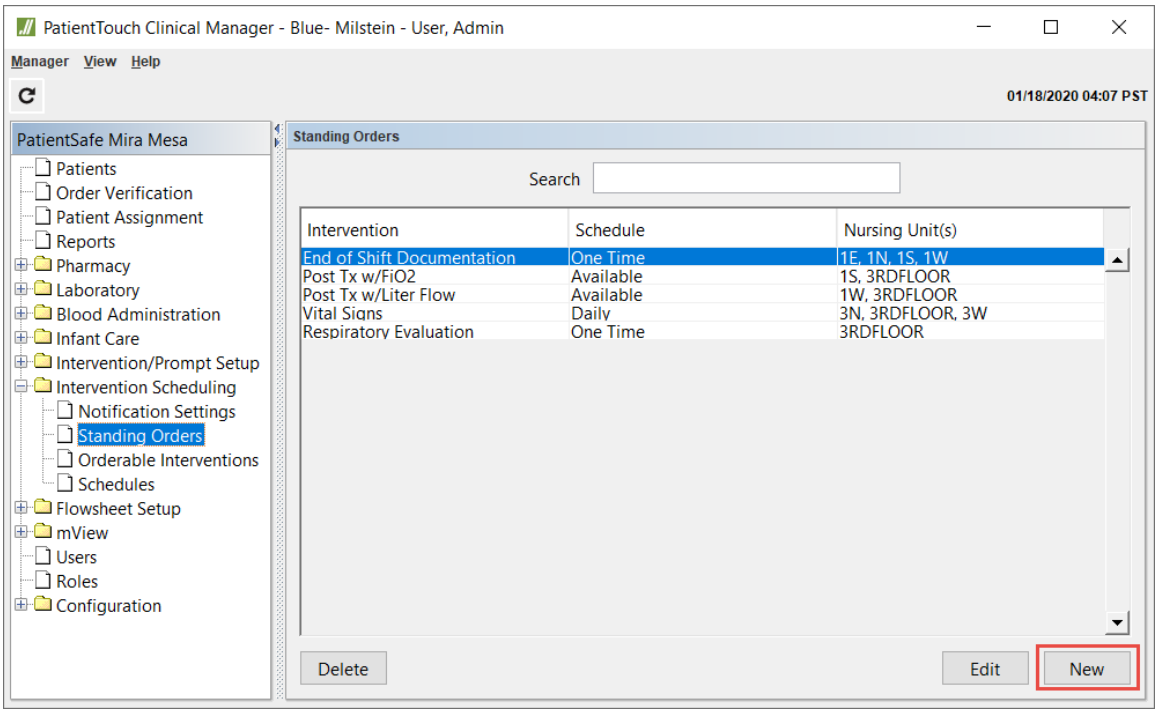
- **Notify Nurse of New/Updated Nurse Intervention Orders**: Notify the nurse of any new or updated nurse intervention orders.
- **Notify Nurse of Discontinued Nurse Intervention Orders**: Notify the nurse of any discontinued nurse intervention orders.

3. Click **Save** when you are done.

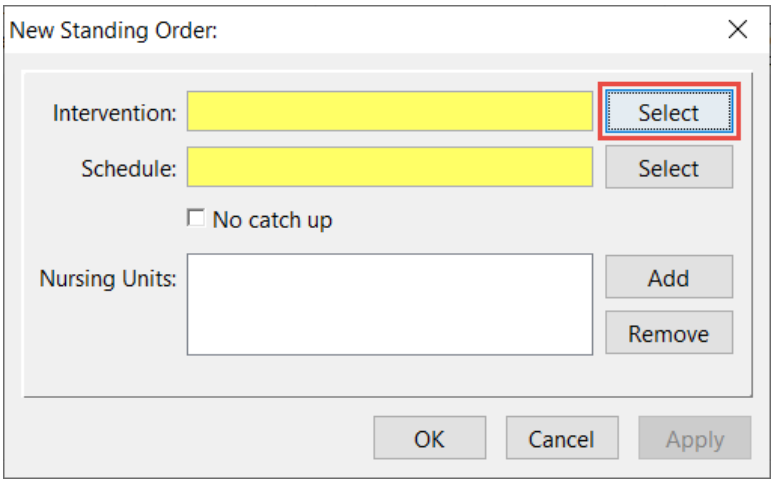
## Standing Orders

Interventions that are created as Standing Orders, are assigned to specific nursing units. They are available immediately for patients assigned to those nursing units.

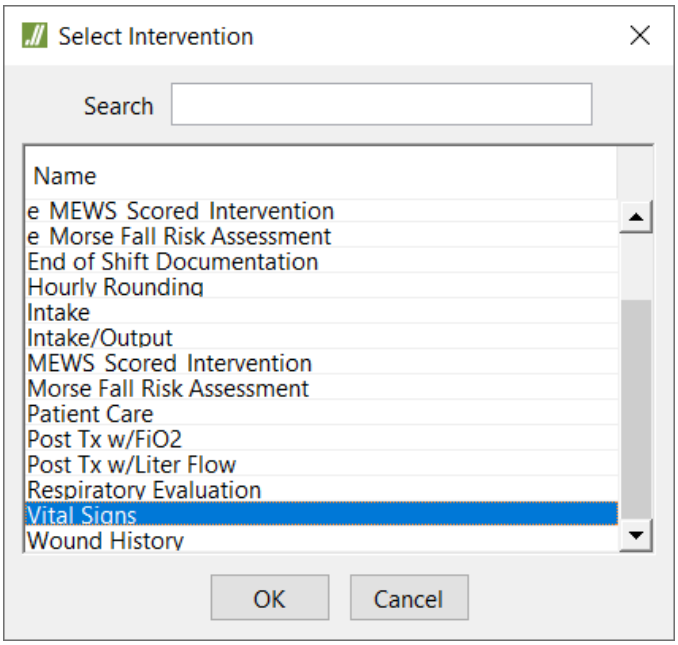
1. To configure a new Standing Order, select **Intervention Scheduling>Standing Orders** from the left.
2. Click **New**.



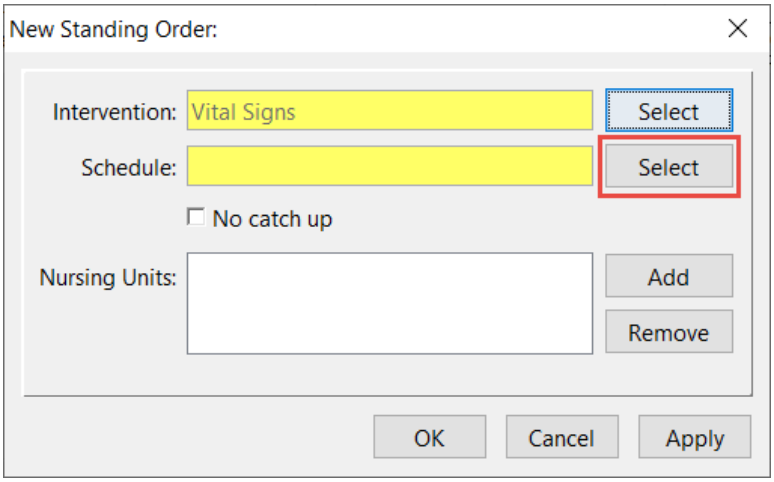

3. Click **Select** next to the Intervention field to display a list of interventions.



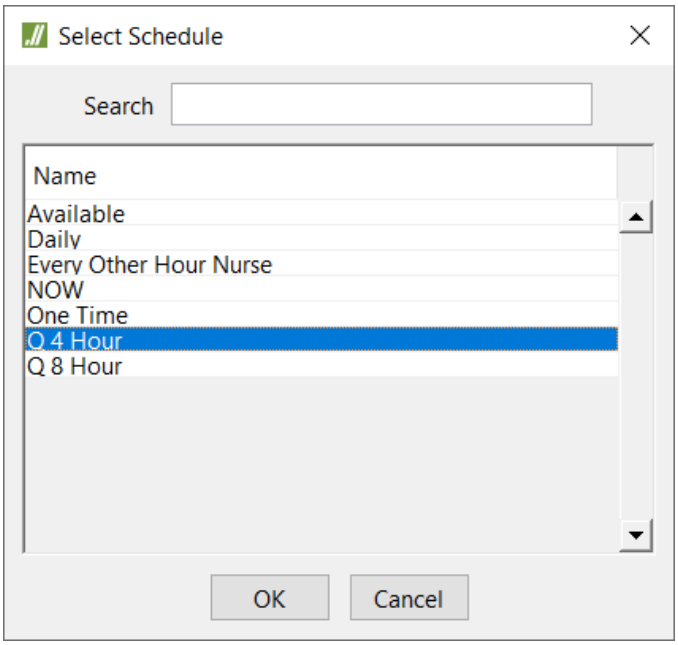

4. Select an intervention from the list.
5. Click **OK**.



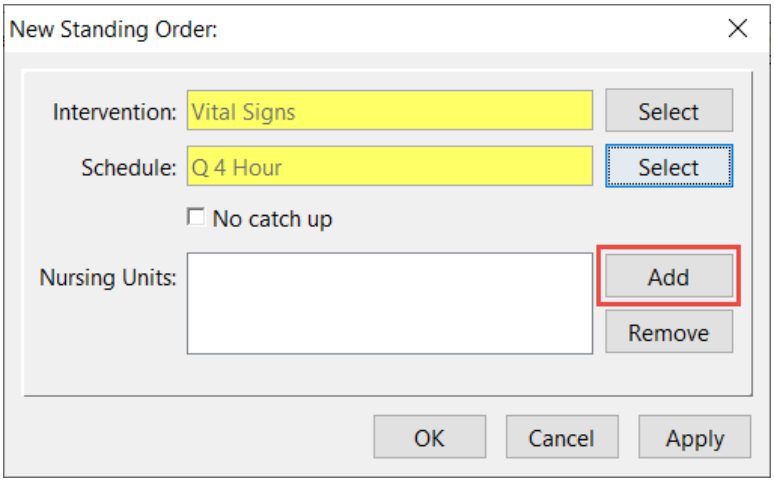

6. Click **Select** next to the Schedule field.



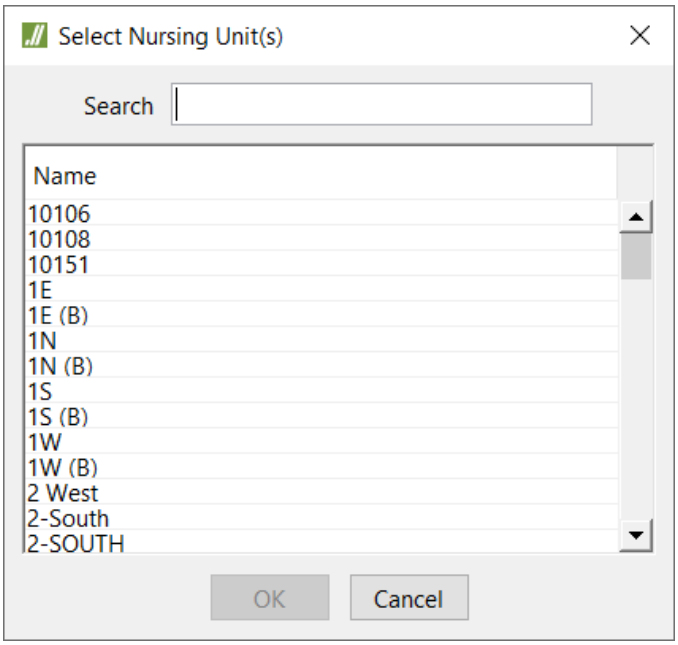

7. Select a Schedule from the list.
8. Click **OK**.



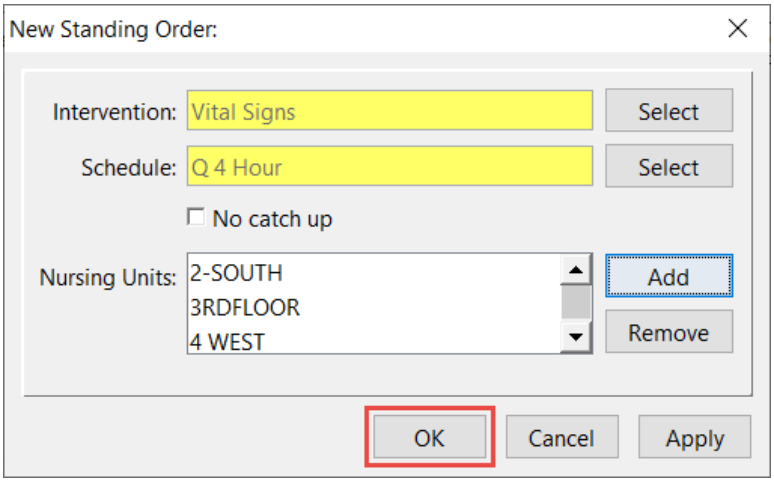

9. The **No catch up** check box is used for interventions that are scheduled to repeat: When checked, missed interventions would be removed from the To do List and Care tab at the earliest of:
   - The end of the missed intervention lag time
   - The beginning of the next intervention lead time
   - The mid point between the missed intervention due time and the next due time.
10. Click **Add** to the right of the Nursing Units field to display a list of Nursing Units.



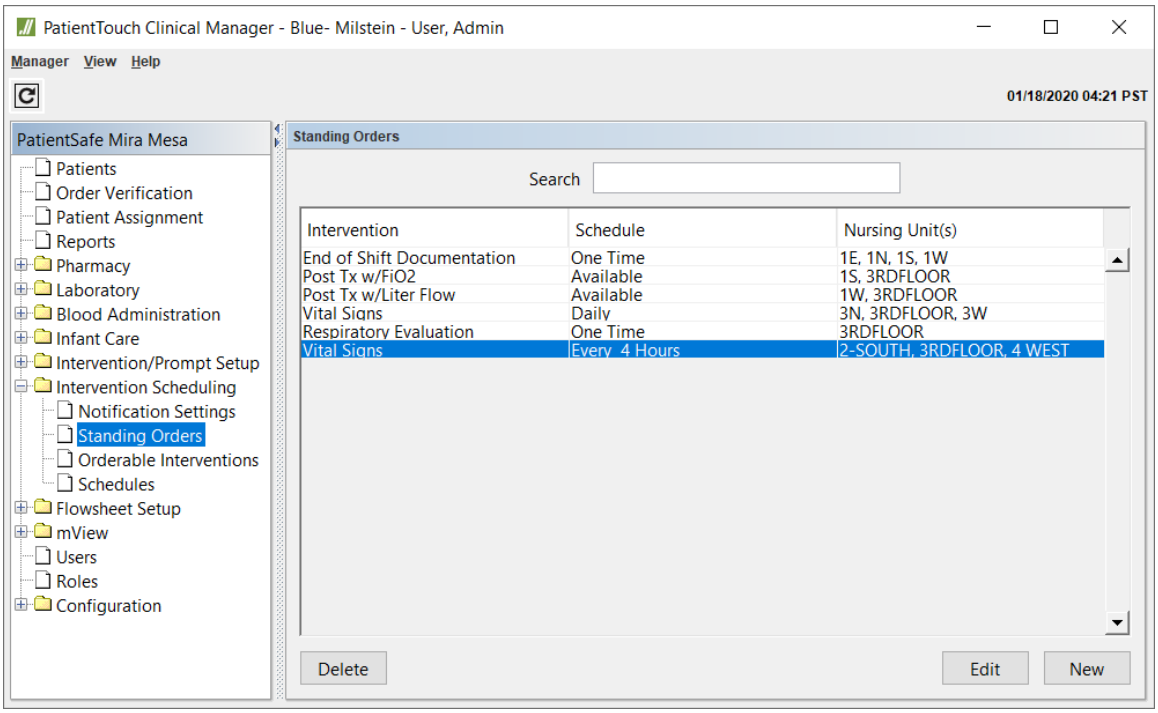

11. Select nursing unit(s) as required.
12. Click **OK**.




13. The *New Standing Order* window displays the selected configuration for this order.
14. Click **OK** to accept the configuration.



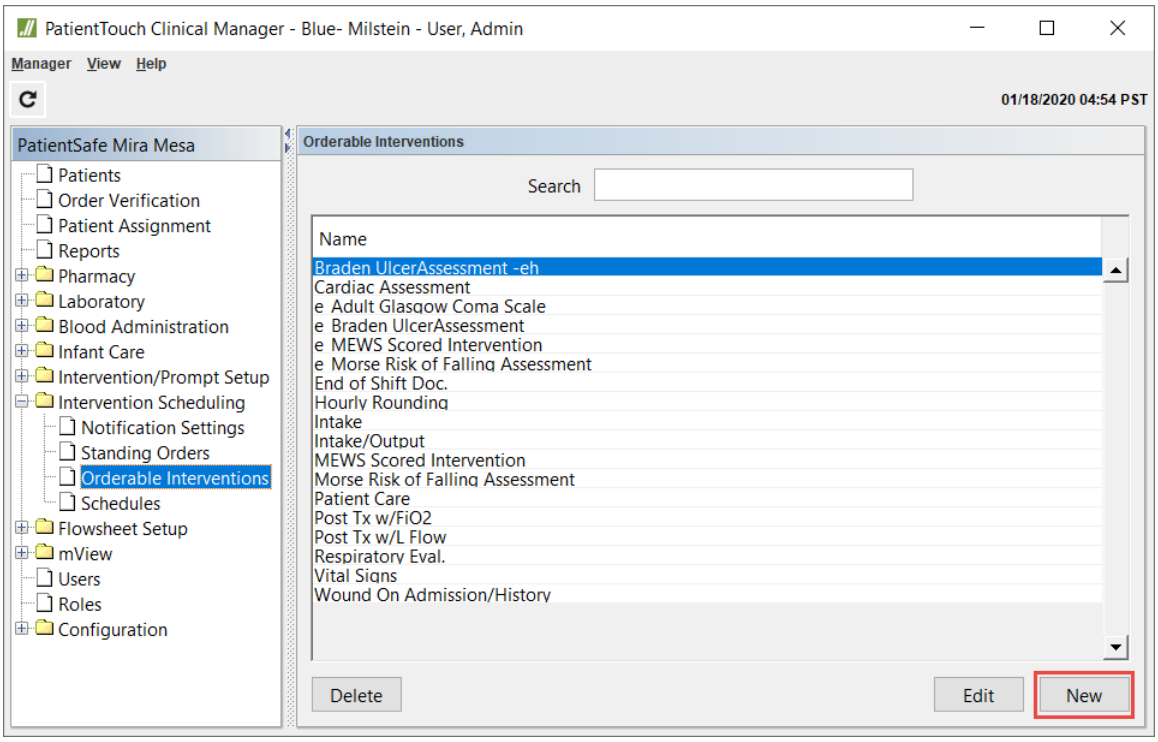

15. The new Intervention displays as a Standing Order.



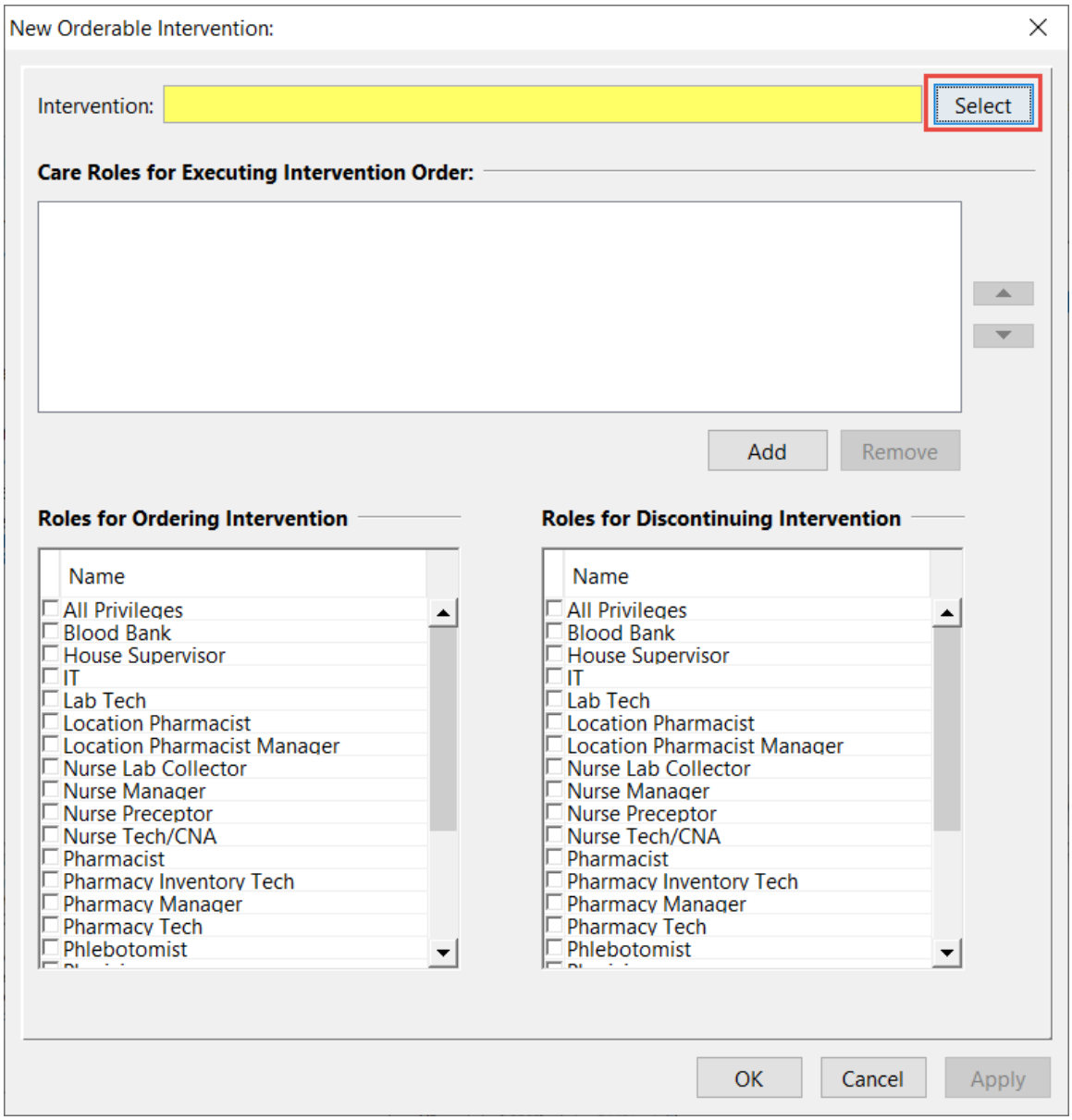

# Orderable Interventions

Select **Orderable Interventions** to configure which care roles (CNA, Nurse, RT) can execute interventions (document the intervention), and which user roles can order and discontinue interventions. In order to schedule an intervention for a specific patient or assign an intervention to a specific nursing unit, all interventions must be listed under the **Orderable Interventions** tab.

1. Select **Intervention Scheduling> Orderable Interventions**.
2. Click **New**.

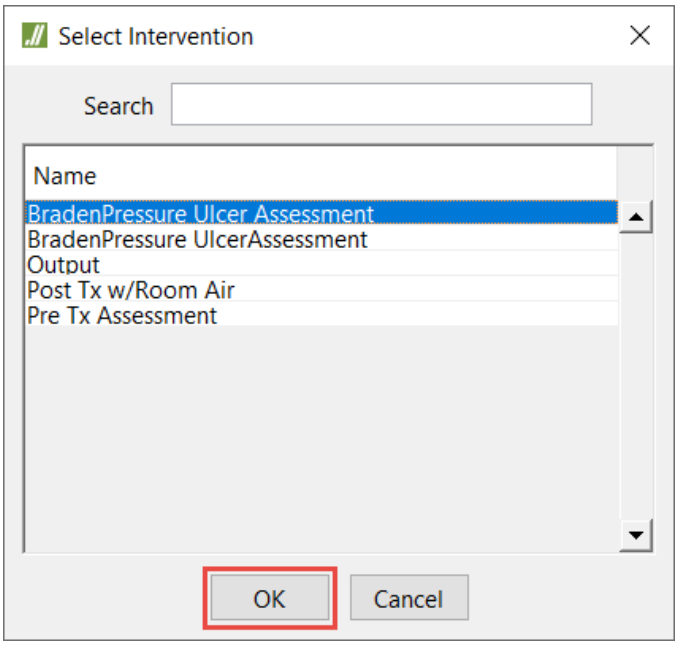



3. The *New Orderable Intervention* window displays.
4. Click **Select**.

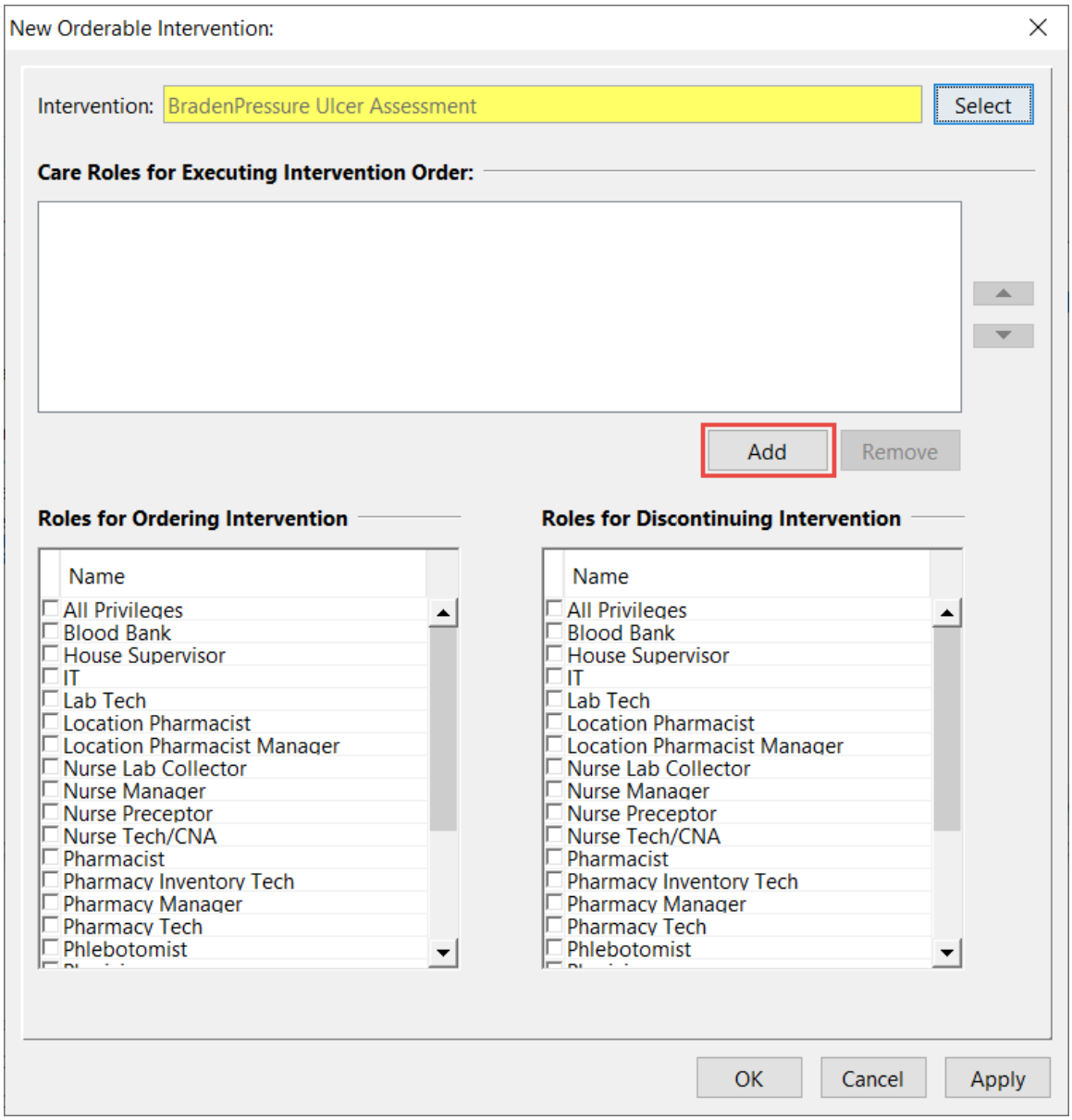



**When interventions are listed, use the arrows to change the priority order of the selected roles.**

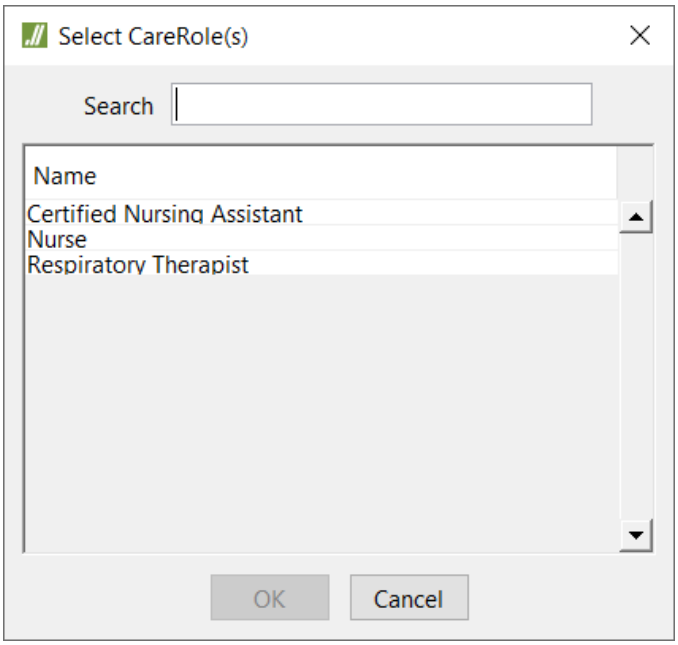
5. Select an Intervention from the list.
6. Click **OK**.



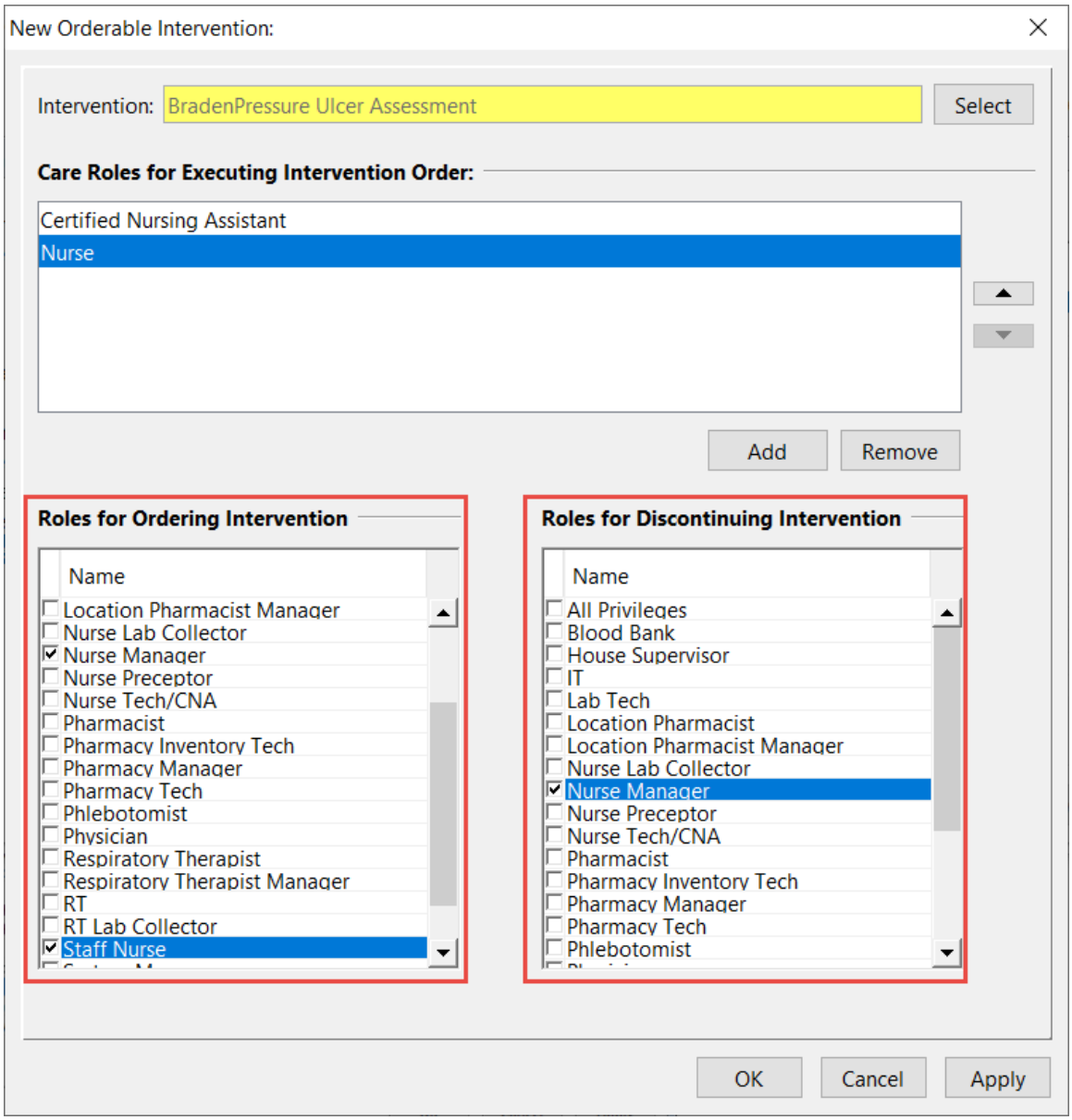

7. Click **Add** under Care Roles for Executing Intervention Order.



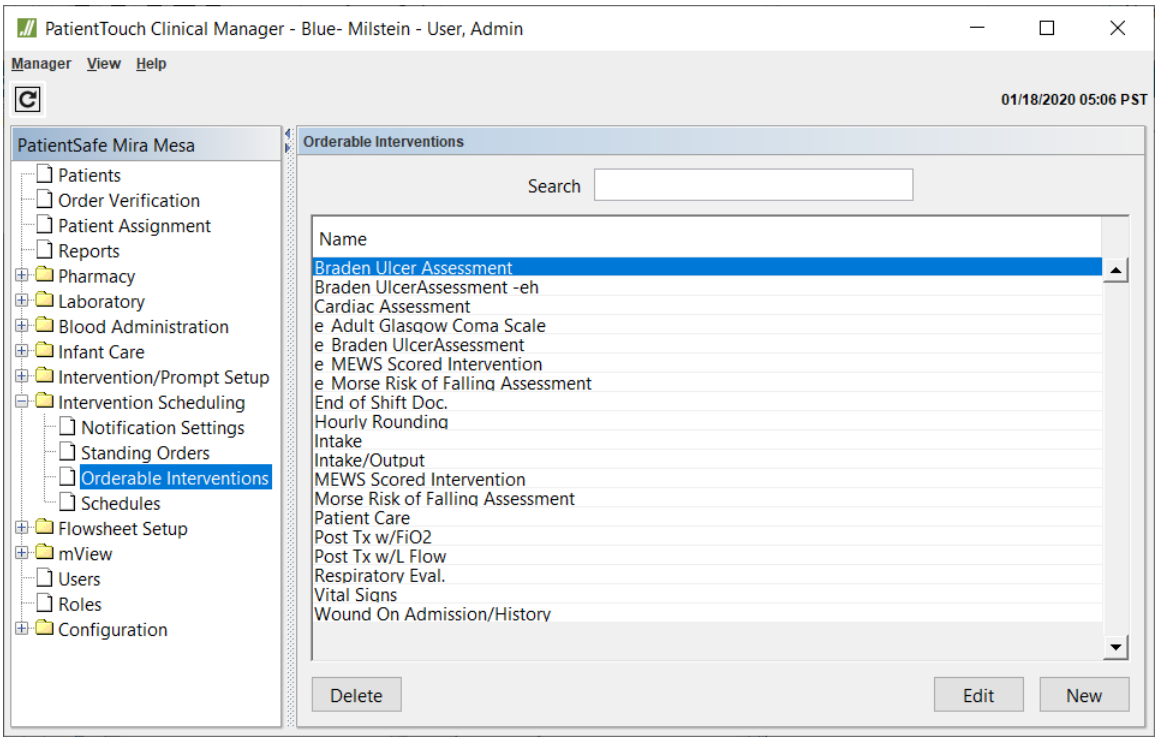

8. Select the Care Roles that will be executing this intervention order.
9. Click **OK**.




10. Select the user roles that can order this intervention.
11. Select the user roles that can discontinue this intervention.
12. Click **OK** to accept the input.




13. The new Orderable Intervention displays.



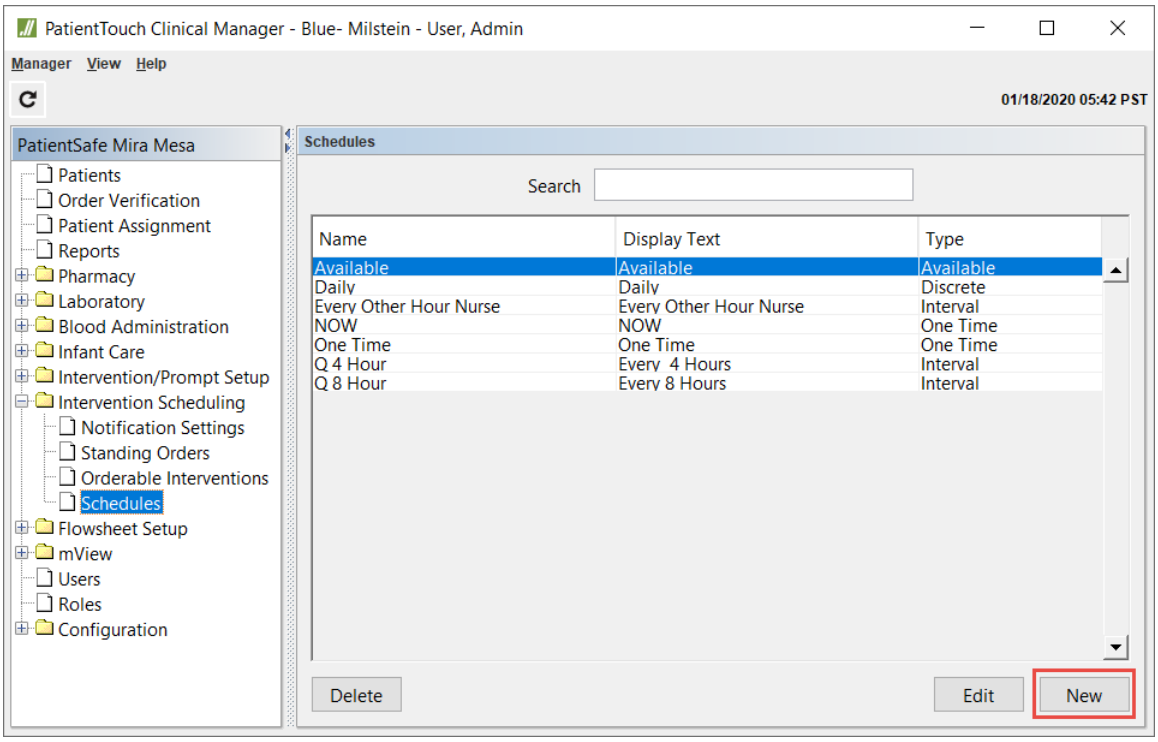

# Schedules

Schedules provide the ability to configure interventions based on:

- Discrete times
- Intervals
- One Time
- PRN

Interventions can be ordered from within Clinical Manager, in the PatientTouch application, from an external system, or as Standing Orders.

1. To begin the intervention scheduling configuration, click **Schedules** from the left.
2. Then, click **New** to create a new intervention schedule.



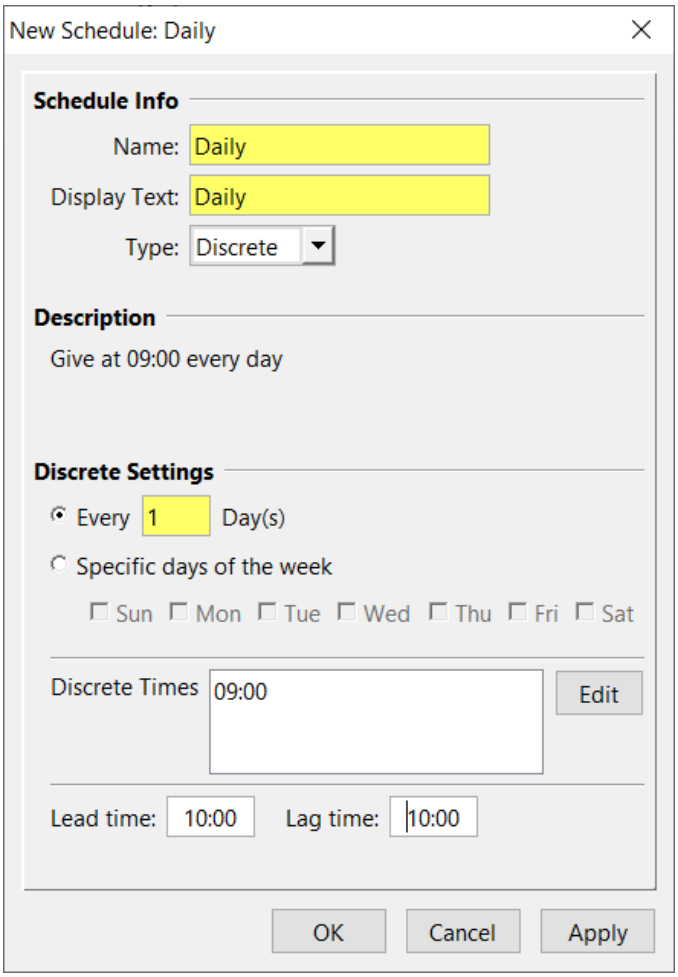

## Intervention Types

There are four intervention types that are available (**Discrete, Interval, One Time**, or **Available**). Each option offers a unique set of fields.

### *Discrete*

A **Discrete** intervention is scheduled to occur at a specific time(s). In this example, the intervention will occur at 9:00 each morning.

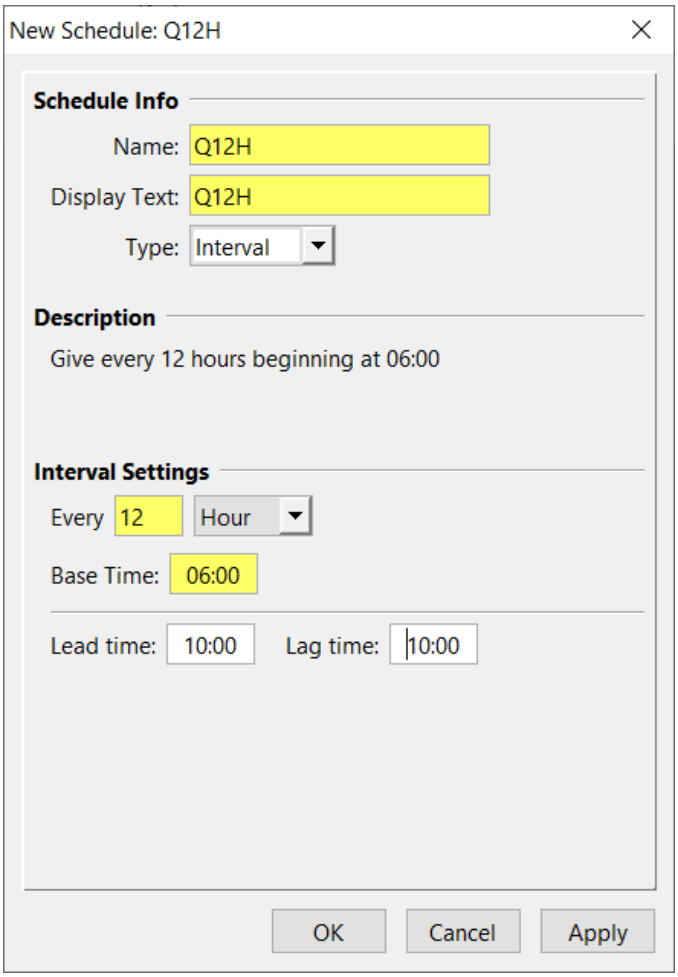
1. Add a name for the schedule.
2. Add a label (Display Text) to appear on the PatientTouch application.
3. Enter the Discrete Settings.
4. Click **Edit** to enter information in the Discrete Times field.
5. Enter Lead and Lag times if desired.
6. Click **OK** to accept the entries and return to the Schedules screen.




### *Interval*

An **Interval** intervention is scheduled to occur at designated time intervals. In this example, the intervention will occur every 4 hours, starting at 8:00 each morning.

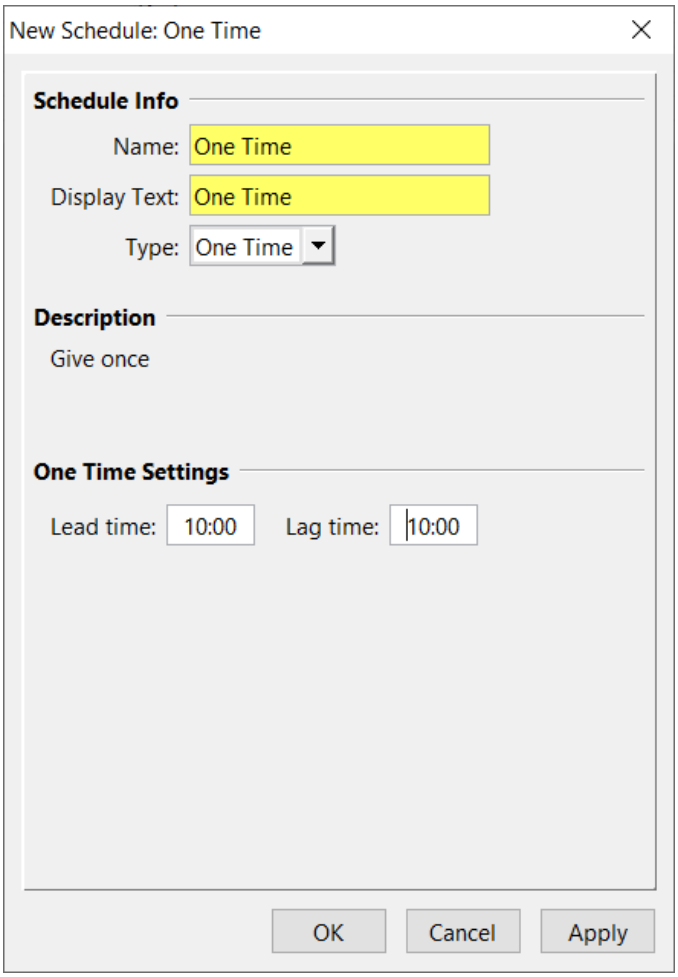
1. Add a name for the schedule.
2. Add a label (Display Text) to appear on the PatientTouch application.
3. Enter the Interval Settings.
4. Enter Lead and Lag times if desired.
5. Click **OK** to accept the entries and return to the *Schedules* screen.




### *One Time*

A **One Time** intervention is scheduled to occur once.

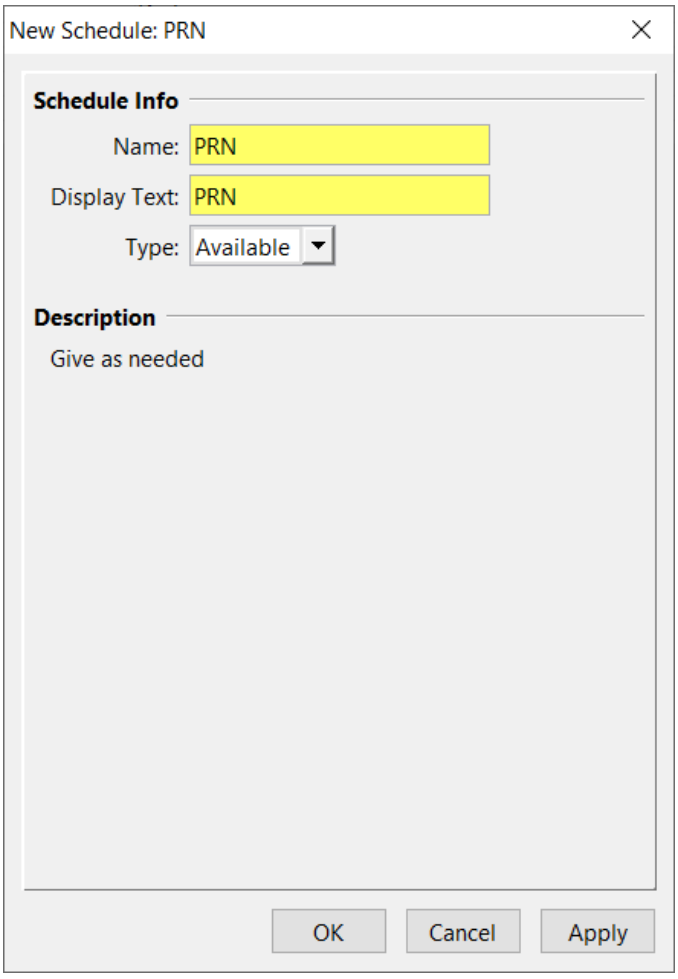
1. Add a name for the schedule.
2. Add a label (Display Text) to appear on the PatientTouch application.
3. Select **One Time** from the **Type** drop down list.
4. Enter Lead and Lag times if desired.
5. Click **OK** to accept the entries and return to the *Schedules* screen.




### *Available (PRN)*

An **Available** intervention can be scheduled as needed.

1. Add a name for the schedule.
2. Add a label (Display Text) to appear on the PatientTouch application.
3. Select **Available** from the **Type** drop down list.
4. Click **OK** to accept the entries and return to the *Schedules* screen.




# Configuring the Medication Administration Module

## General Settings

The Pharmacy tab of the PatientTouch Clinical Manager is used to configure basic settings for the Medication Administration Module. We begin with an overview of the Pharmacy Settings.

### Overview of Pharmacy Settings

Working with a PatientSafe Solutions representative, the hospital pharmacy performs initial setup for the Clinical Manager to import the pharmacy information system's hospital formulary list into the Clinical Manager. After the initial formulary items are in the system, the configuration process includes:

- Entering/uploading the NDC and barcodes present in pharmacy inventory and associating them with the corresponding formulary item.
- Selecting options for clinical checks—including drug interaction and allergy checking,

maximum single dose checking, and acetaminophen cumulative dose checking—to trigger the PatientTouch application to perform the necessary checks at the point of administration.

- Associating clinical prompts with formulary items.
- Entering/uploading SIG codes that correspond to those used in the pharmacy information system.
- Enabling Computerized Physician Order Entry (CPOE) settings, if CPOE is in use at the hospital.

**CPOE functionality must be activated by PatientSafe Solutions technical support prior to configuring the pharmacy settings.**

Physician medication orders are reviewed by the pharmacist and entered into the pharmacy information system. These medication orders are then sent to the PatientTouch Clinical Manager via an interface. Formulary and SIG codes must be custom configured for the hospital so the orders can be interpreted correctly by the PatientTouch Clinical Manager.

Because the iPhone device is designed to scan barcodes on medications at the patient bedside, the hospital pharmacy department is responsible for insuring that a barcode will be present on every item to be, both during system setup and as an ongoing process, and that these barcodes are in the Clinical Manager formulary.

Because several brands may satisfy a single formulary medication, multiple barcodes can be added to each formulary item.

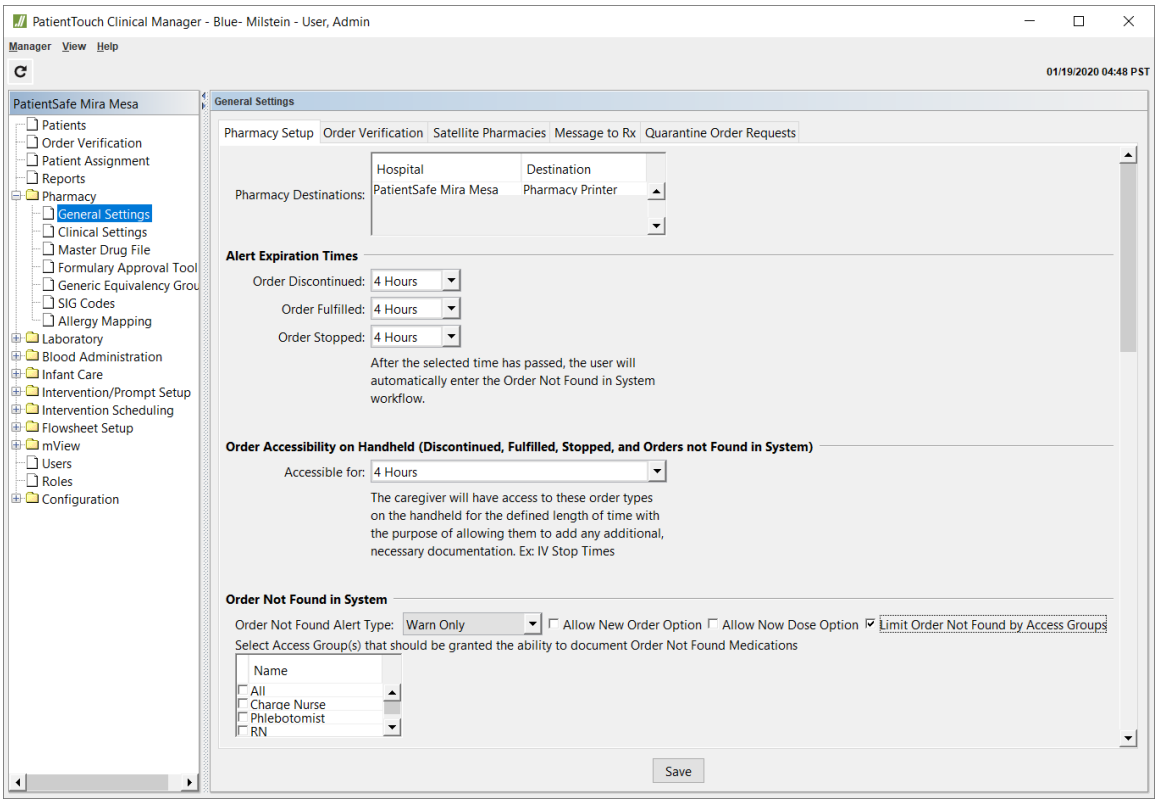
Click the links below to learn more about the General Settings tab:

- Pharmacy Setup
- Order Verification
- Satellite Pharmacies
- Message to Rx
- Quarantine Order Requests

## Pharmacy Setup Tab

The Pharmacy Setup options allow you to configure system preferences for your pharmacy, such as designating a default Pharmacy destination, specifying alert expiration times, specifying barcode packager settings, and configuring CPOE options.

To get started configuring pharmacy system preferences, select **Pharmacy>General Settings>Pharmacy Setup**.




## Pharmacy Destinations

**Pharmacy Destinations** is used to specify the default destination for messages sent from caregivers (for example, Quarantined Order Notifications Message to Rx). The Pharmacy Destination is defined in the Clinical Manager>Destinations as a physical printer, an email address or a shared drive. If your facility has more than one destination configured, click inside the Destination area to select one from the list.

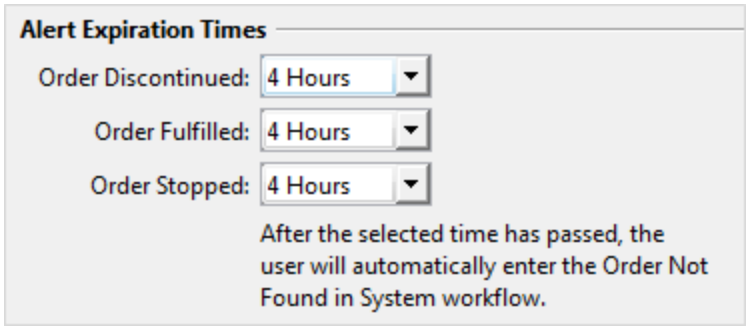
If your hospital is configured for Campus Support and you have selected <All> hospitals at login, you will see the various hospitals display in the Pharmacy Destinations field. The hospitals that display have been associated to a printer in the Destinations folder. Click the drop down menu under the Destination column to select a specific printer for each hospital.

## Set Alert Expiration Times

Alert expiration times can be configured to support your hospital's polices on how long caregivers will continue to receive notifications of an order's status when they scan a medication that has been discontinued, fulfilled, or stopped.

To select or change the alert expiration times:

- In the Alert Expiration Times area, use the drop-down lists to select expiration times for discontinued, fulfilled, and stopped orders.




Alerts can be overridden in the PatientTouch application, but require an override reason be entered. Overriding alerts invokes the *Order Not Found in System* workflow. After the Alert Expiration Times have been reached, the PatientTouch application invokes the *Order Not Found in the System* workflow without displaying notification of order status.

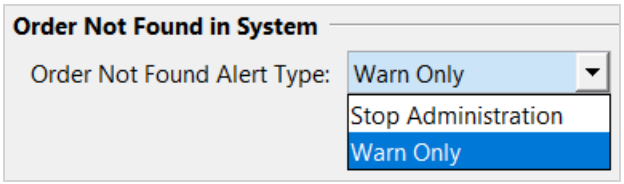
## Order Accessibility on Handheld

This option allows you to define the amount of time for which you want inactive orders to remain available on the handheld. In doing so, users are able to add additional MAR documentation (e.g. clinical documentation) against these orders from the handheld device.

## Order Not Found in System

Use the configurable *Order Not Found in System* alert to set the workflow to a hard stop or warn and proceed.

### Order Not Found Alert Type




#### Stop Administration

Select **Stop Administration** when you want to stop the administration of a medication. When you enter the Order Not Found in System workflow using the PatientTouch application, you will receive a *Stop Administration* alert and only have the option to cancel the workflow.

#### Warn Only

Select **Warn Only** so when you encounter the *Order Not Found in System* workflow, you will only receive the warning and you will be able to tap **Continue** and complete the workflow as necessary.

## Allow New Order Option

Users have the ability to configure the *New Order* workflow, which allows caregivers to administer a new order for the medication, different from the scheduled dose. The setting is on by default. When the setting is selected, or checked, users can enter the *New Order* workflow and will see the **New Order** option on the **Options** menu of the PatientTouch application. Deselect the **Allow New Order**

**Option** checkbox to disable the *New Order* workflow. If the *Order Not Found in System* alert is configured to be a hard stop (Stop Administration), the **New Order** option is automatically disabled.

### *Allow Now Dose Option*

Users have the ability to configure the *Now Dose* workflow, which allows caregivers to administer a medication now, as opposed to the regularly scheduled dose. The setting is on by default. When the setting is selected, users can enter the *Now Dose* workflow using the PatientTouch application. Deselect the **Allow Now Dose Option** checkbox to disable the *Now Dose* workflow.

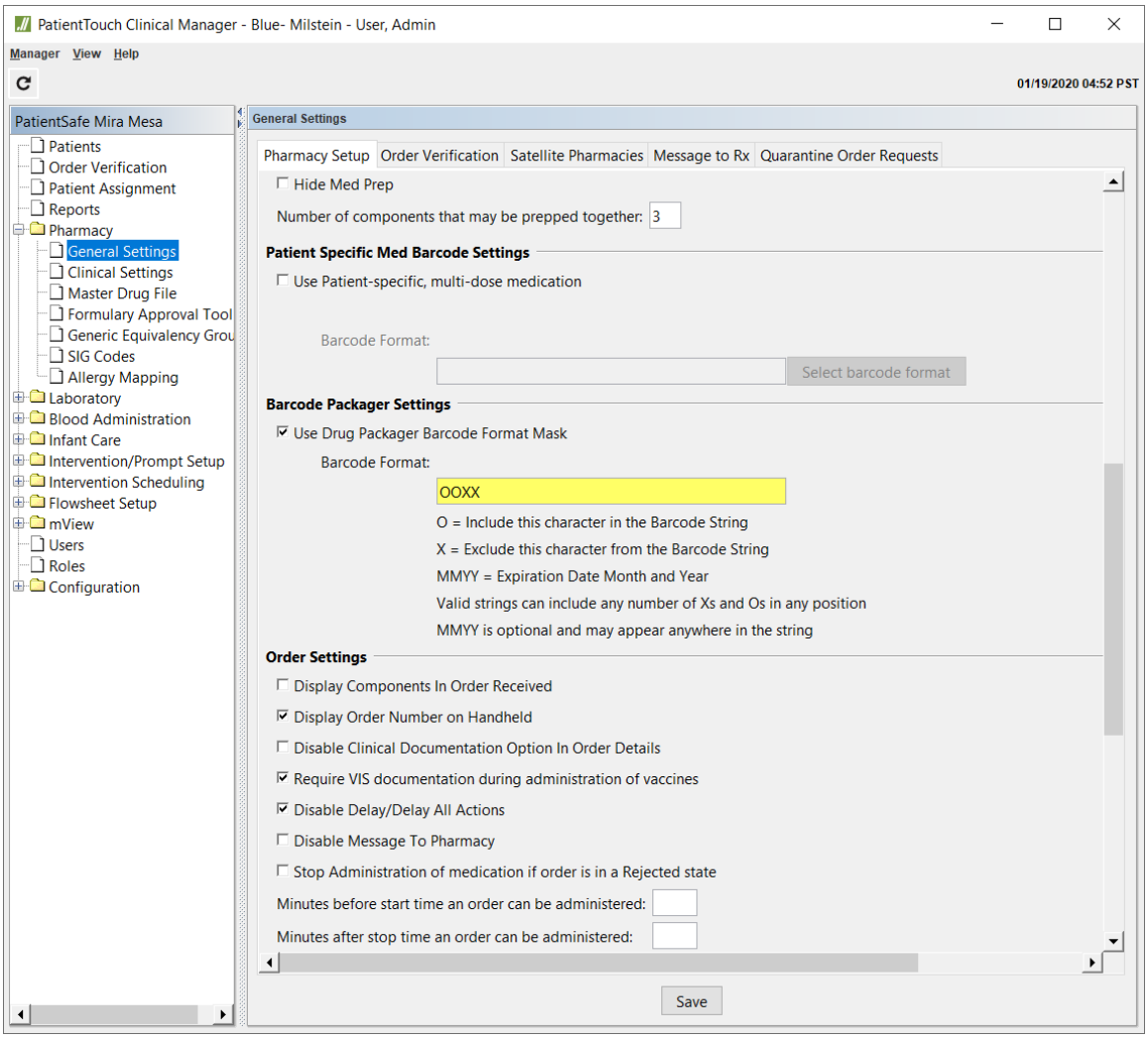
When users do not want to use the **Now Dose** option, the following workflows will change:

- *Order Not Started* – The alert screen will only show the first scheduled dose and the user will need to provide a reason for giving the medication before the order start time.
- *Early* – The alert screen will only show the early dose as the option and user will have to provide a reason for giving the dose early.

### *Limit Order Not Found by Access Groups*

If your facility has the ability to define Access Groups in the EHR, you will be able to configure certain PatientTouch features in the Clinical Manager based on the same Access Groups.

Access Groups can be configured for ONFS and CPOE orders.




## *Med Preparation*

### Hide Med Prep

For customers that do not need the med prep workflow, PatientSafe Solutions provides the option to disable this feature.

When enabled, caregivers will not see the Med Prep or Med Admin buttons on the handheld.

### Set the Number of Components that Can Be Prepped Together

Depending on a hospital's pharmacy service coverage and policies, the caregiver may need to prepare (compound or admix) a medication prior to taking the final preparation to the point of administration. This process is completed in the Med Prep workflow. To allow compliance with laws and policies, the PatientTouch System allows the facility to specify the total number of medication components that can be prepared by the caregiver using the Med Prep process. For IV admixtures, this number includes the base solution and additives. The number of components permitted is entered in the Number of components that may be prepped together field.

To select or change the number of components that can be prepped together:

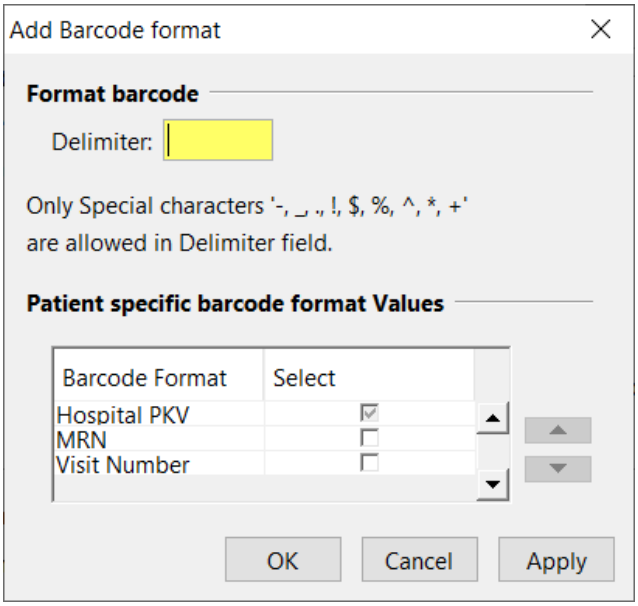
In the Order Not Found in System area, enter the number of components that can be prepped together in the field provided.

### *Patient-Specific Med Barcode Settings*

**Use Patient-Specific, Multi-Dose Medication** – Select to enable the patient-specific, multi-dose medication barcode format. This barcode will identify the medication being specific to a patient, similar to order-specific barcodes. However, the difference this barcode provides is the ability to be re-used even if the order changes. The pharmacy will need to be able to generate a barcode with the information defined here (patient visit number and/or MRN number plus the hospital ID/PKV).

**If the "Patient-Specific, Multi-Dose Medication" option is enabled, this barcode information is required.**

**Delimiter**: Select from one of the special characters listed on the screen.



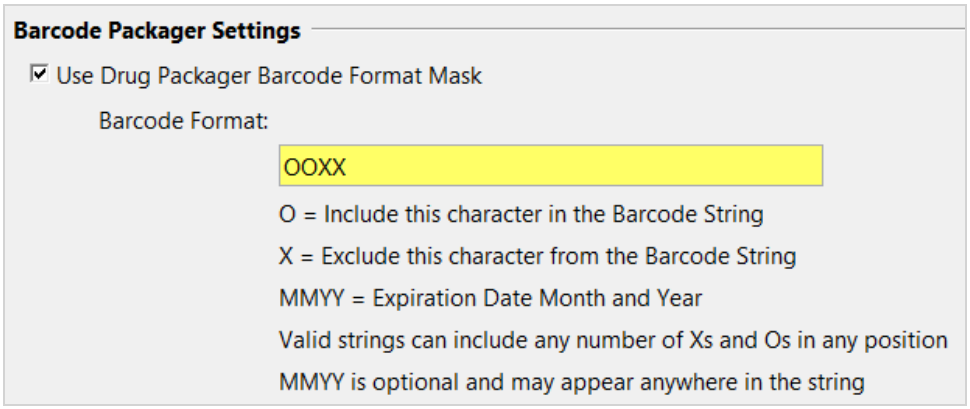

**MRN, Visit Number, Hospital PKV:** Select the MRN and/or Visit Number option, which will be used in conjunction with the Hospital PKV to define the barcode format. Use the up/down arrow to place each item in the sequence desired. Click **OK**.

### *Define the Drug Packager Barcode Format Mask*

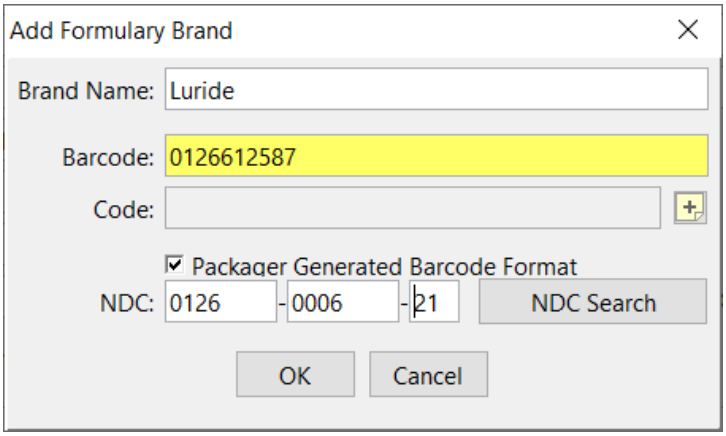
The Barcode Packager Settings is applicable when using a pharmacy-based packaging system that allows you to embed the expiration date in the barcode. By defining a global Barcode Format Mask, it is then possible to embed an expiration date in certain pharmacy-packaged barcodes as well as to ignore certain unneeded characters within the barcode. If the Barcode Format Mask is used with the position of MMYY specified, and if the barcode is flagged in the Clinical Manager formulary as using the mask format, the expiration date in the barcode will be checked when the medication is scanned prior to administration. Doses will be considered expired after the last day of the month specified by MMYY.

To define the Drug Packager Format Mask, perform the following steps:

1. In the Barcode Packager Settings area, select **Use Drug Packager Barcode Format Mask**.




2. Use Os, Xs, and MMYY to define the purpose of the characters within the barcode. Note in the example that the Barcode Format establishes the first 10 digits to be the product identifier, the next 8 characters to be ignored, and the last 4 characters as the month and year.
3. In the **Master Drug File** folder, choose a formulary item, click **Add Brand** and select the **Packager Generated Barcode Format** checkbox for barcodes in the formulary for which you want the Barcode Format Mask to be applied. Do not include the excluded characters or the MMYY characters in the barcode field.




## *Order Settings*

**Display Components in Order Received:** When selected, the MAR and PatientTouch application will display multi-component orders in the order received from the HL7 interface.

**Display Order Number on Handheld:** When selected, the PatientTouch application will display the order number.

**Disable Clinical Documentation Option in Order Details:** When selected, clinical documentation from the **Options** menu in the Order Details view will be suppressed. When the **Disable Clinical Documentation Option in Order Details** is selected, the **Observation** button on the patient's online MAR will be disabled.

**Require VIS documentation during administration of vaccines:** When selected, caregivers will need to print the Vaccine Information Sheet (VIS) for the patient before documenting the administration. The VIS shows up on eMar and printed MAR.

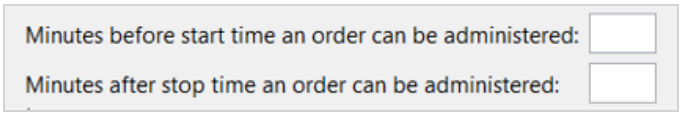
**Disable Delay/Delay All Actions:** The Delay and Delay All functions in PatientTouch are designed to suppress dose reminders longer than the global reminder setting. Due to some customers not wanting to utilize these functions and/or EHR systems not supporting them, the PatientTouch System now includes the option to disable them from the clinical application.

**Disable Message to Pharmacy:** Provides the option to remove Message to Rx from the Options menu of the handheld.

**Stop Administration of Medication if Order is in a Rejected State:** When selected, caregivers will not be able to administer medication orders that have been rejected by Pharmacy and thus placed in a rejected state. For example, pharmacists may need to investigate an order to determine the appropriateness of care for a patient. The pharmacist may then choose to reject a medication order in the Host EHR Pharmacy system to indicate the investigation in ongoing.

**Documentation Boundaries for Order Start and Stop Times**

These two optional settings allow you to further define when a user can document against an order before the start and/or after the order stop time. For example, you may want to limit the acceptable documentation time for doses being given prior to the order start time. Or, if there is a dose scheduled at the same time as the order stop time, customers may want the users to have up to a defined amount of time after that point to administer this last dose.

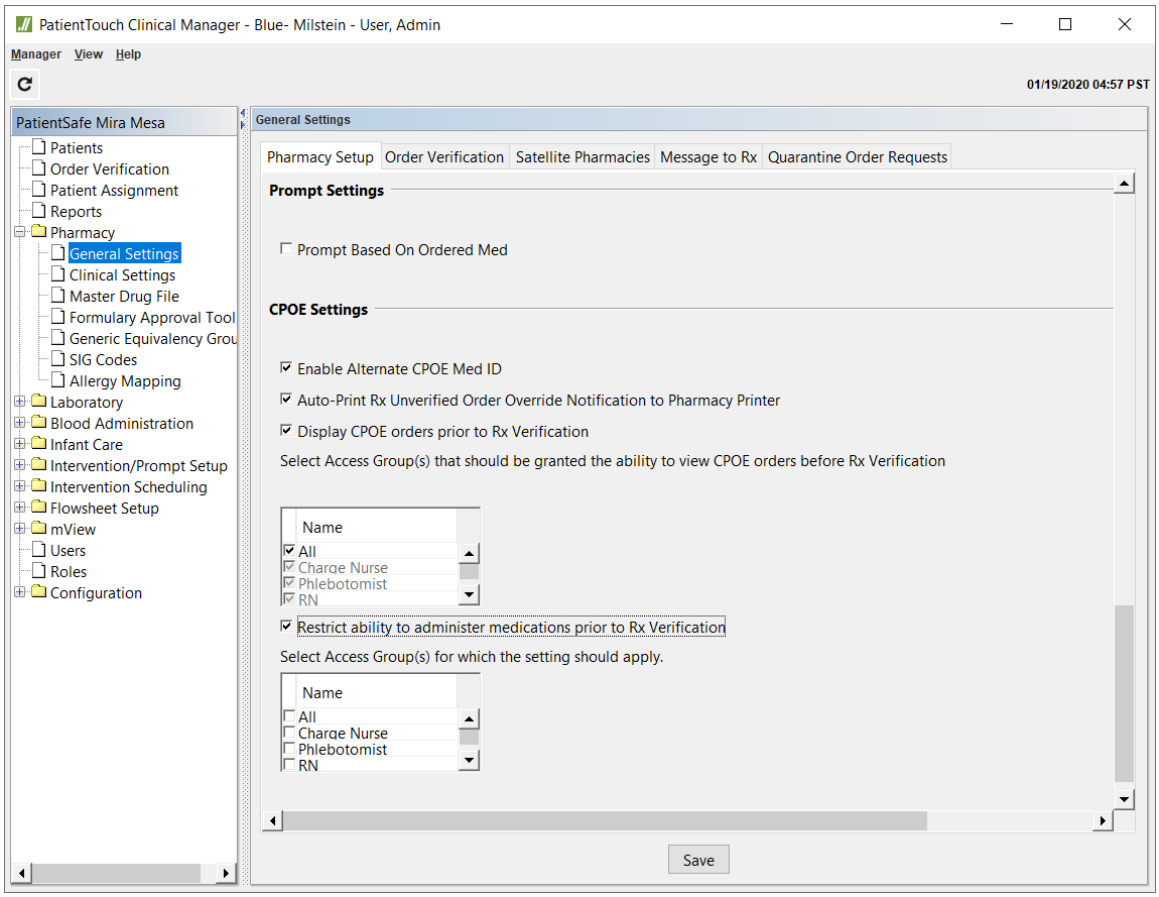



**These settings will take precedence over the defined lead and/or lag time set at the Formulary Item/Sig Code/Nursing Unit level. If you want those times to still be honored for order start and order stop times, make sure to set these new times to an equal or greater amount of time.**

To define the allowed amount of time for documentation before the order start and after the order stop time, perform the following steps:

1. In the Minutes before start time an order can be administered, define the number of minutes prior to order start time doses are able to be administered/documented.
2. In the Minutes after stop time an order can be administered, define the number of minutes after order stop time doses are able to be administered/documented.

**The recommendation is to set these times to equal or longer than the greatest defined lead/lag times. For example, if the longest lead and/or lag time setting at any level (med, sig code or nursing unit) is 60 minutes, set these times to at least 60 minutes.**




## *Prompt Settings*

**Prompt Based on Ordered Med:** Please contact your account manager for further information on this feature.

## *CPOE Settings*

If your hospital has the CPOE order matching feature enabled, the CPOE Settings options appear in the Pharmacy Setup tab.

To define the CPOE options, perform the following steps:

1. Select **Enable Alternate CPOE Med ID** to allow medications to be mapped to medication IDs in another formulary.
2. Select **Auto-Print Rx Unverified Order Override Notification to Pharmacy Printer** to send a notification to the Pharmacy printer that a CPOE order which pharmacy has not yet approved has been administered.
3. **Display CPOE orders prior to Rx Verification:** When this setting is enabled, the caregiver will be able to see the CPOE order in the PatientTouch System prior to pharmacy verification and prior to any administration. If the setting remains off, the caregiver will not see the CPOE order until either pharmacy has verified it or a dose has been documented in the PatientTouch System.

**Restrict ability to administer medications prior to Rx verification**: When enabled, caregivers who are within the selected access group(s) will be able to administer CPOE medications prior to pharmacy verification. However, users who are not within the selected access group try to administer a CPOE medication before pharmacy verifies, will receive an alert. If they choose, they may continue with an override reason.

**Remember to click the Save button after making changes to each tab under Pharmacy, General Settings.**

## Order Verification Tab

If Order Verification is enabled, caregivers are expected to verify orders entered by the pharmacy before administering the ordered medication. Orders may be verified via the PatientTouch application or at the Clinical Manager. If you choose to verify new orders (recommended), you may also indicate whether discontinued or updated orders will require verification and whether re-verification of orders following patient transfer will be required.

A caregiver who believes there is an issue with an order can choose to Quarantine the order at the Clinical Manager or using the PatientTouch application. While quarantined, the order is still displayed on the application and the caregiver can administer the medication but must provide a reason for bypassing the quarantine alert. The application will then enter the *Order Not Found in System* workflow.

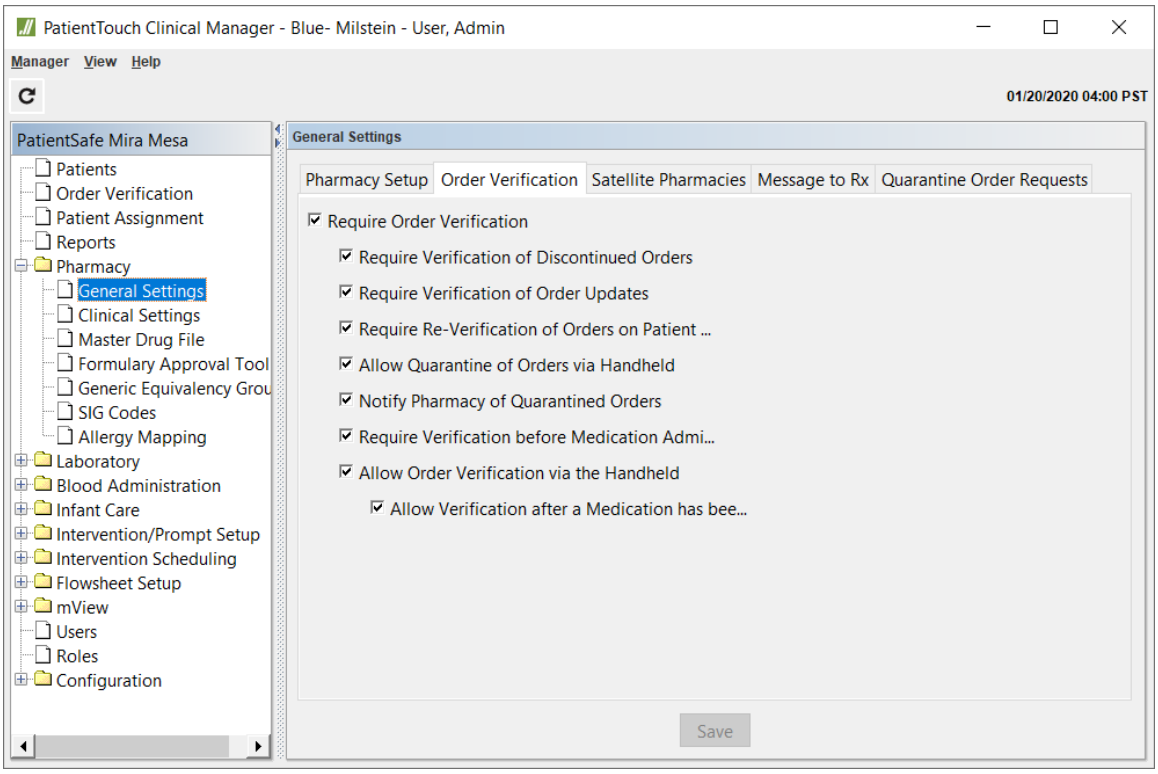
If Notify Pharmacy of Quarantined Orders is selected, the pharmacy receives notification of quarantined orders to the configured Pharmacy Default Printer, Pharmacy Satellite printer if applicable, or, if needed, another specified destination. The report includes the patient information, order details, and the reason the caregiver quarantined the order.

### *Configure Order Verification Options*

If Order Verification is enabled, only those users with the Verify Orders privilege can perform this task. The status of verified and unverified orders is visible to all users in the *Patient* window and on the PatientTouch application.

To change the Order Verification options, perform the following steps:

1. Select **Pharmacy>General Settings>Order Verification**.




2. Select, as needed, the following verification options:

   - **Require Order Verification**—Select to require order verification for all new orders.
   - **Require Verification of Discontinued Orders**—Select to require verification for all discontinued orders.
   - **Require Verification of Order Updates**—Select to require verification of all order updates.
   - **Require Re-Verification of Orders on Patient Transfer**—Select to require re-verification of active orders when a patient is transferred from one nursing unit to another. This helps hospitals to comply with Joint Commission requirements related to medication reconciliation.
   - **Allow Quarantine of Orders via Handheld**—Select to allow users with the Quarantine Orders privilege to quarantine an order using the PatientTouch application.

**If Allow Quarantine via the Handheld is enabled, the default reasons must be configured in the Clinical Manager under the Quarantine Order Requests tab.**

   - **Notify Pharmacy of Quarantined Orders**—Select to automatically notify the pharmacy when an order is quarantined. These notifications will be automatically sent to the default Pharmacy Printer or Satellite Pharmacy Printer as defined for the involved unit.
   - **Require Verification before Medication Administration** - Select to require that medications be verified before administration. After scanning an unverified medication, the caregiver will receive a message indicating the med has not been verified and therefore

cannot be administered.

**If Allow Verification after Medication has been Scanned is also enabled, users will be able to proceed with the verification and medication administration workflow.**

- **Allow Order Verification via Handheld**—Select to allow users to complete Order Verification using the PatientTouch application.
- **Allow Verification After Medication has been Scanned** - Select to require that when unverified medications are scanned, an alert displays stating that the medication is unverified and launches into a process to verify the med.

3. Click **Save** to record your changes.

## Satellite Pharmacies Tab

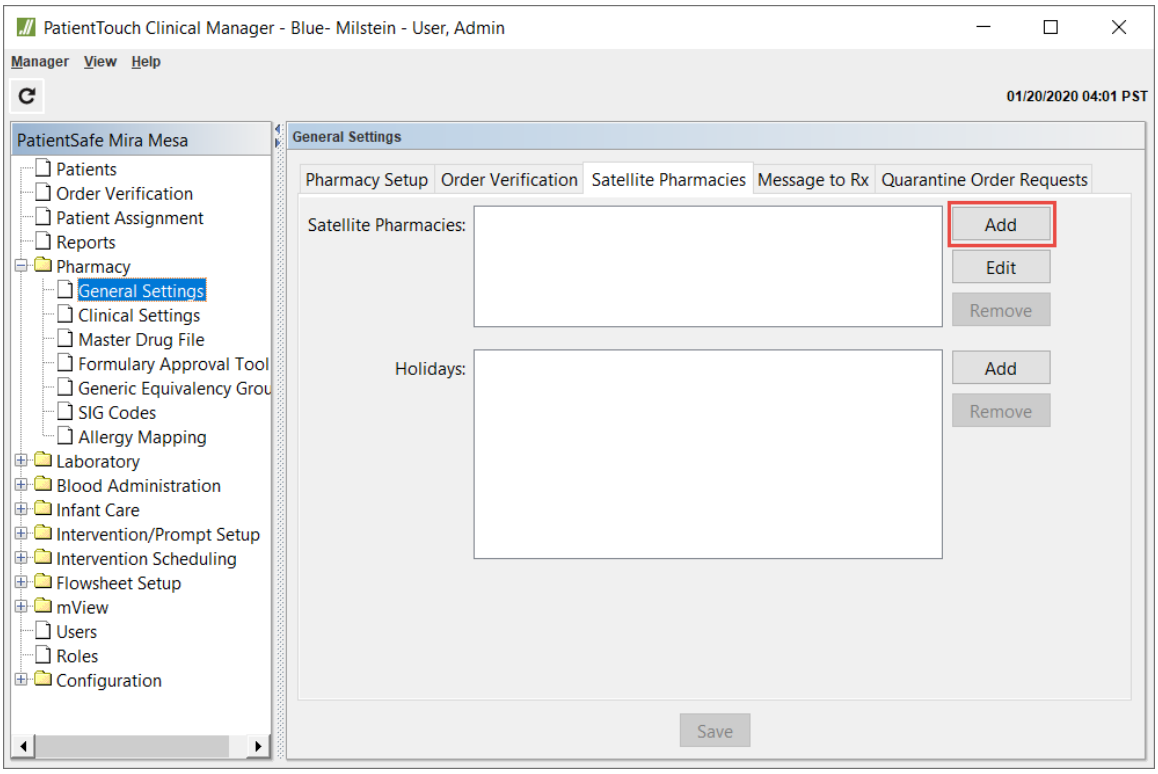
The hospital's Pharmacy Department often includes one or more satellite pharmacies to provide pharmacy services to various areas of the hospital. Hospitals that use satellite pharmacies can configure the Clinical Manager to route pharmacy reports to these pharmacy satellites based on a predefined schedule.

For example, if the NICU is serviced by a satellite pharmacy from 8PM to 7AM Monday through Friday, the Clinical Manager can send pharmacy reports and quarantined orders from the NICU to this satellite rather than the main pharmacy during those hours. The Clinical Manager can recognize holidays when defining satellite hours.

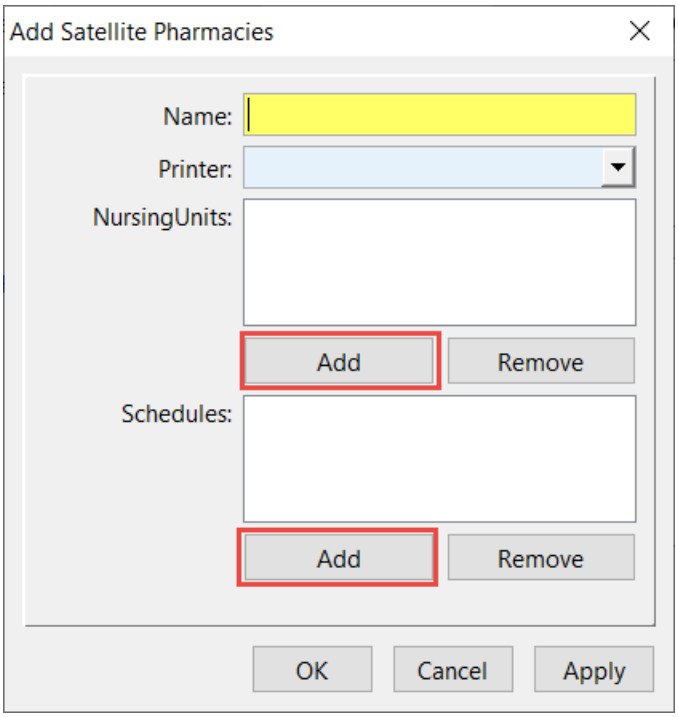
### *Set Up Satellite Pharmacies*

To set up a Satellite Pharmacy in the Clinical Manager:

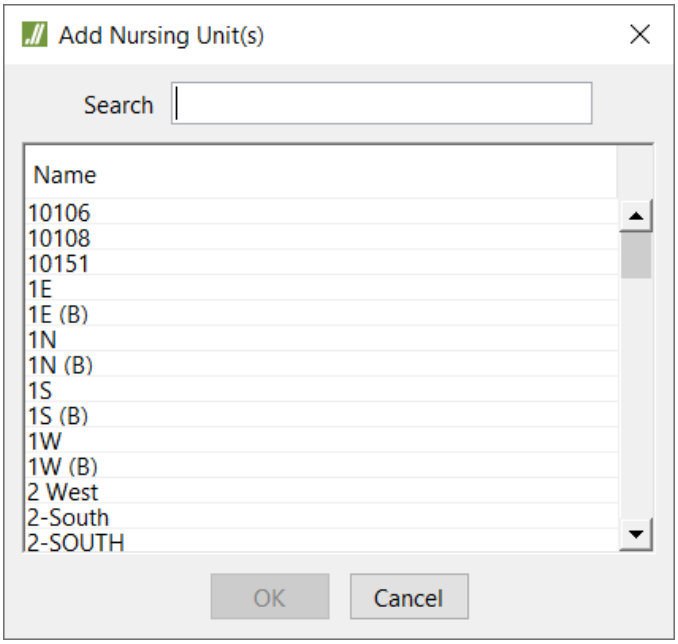
1. Select **Pharmacy>General Settings>Satellite Pharmacies**.




2. Click **Add** (directly to the right of the Satellite Pharmacies text box).
3. Enter a name for the satellite pharmacy.
4. Select a printer from the **Printer** drop-down list to which reports will be sent.
5. Click **Add** below the Nursing Units text box to add the nursing units that will use this Satellite Pharmacy when it is open.

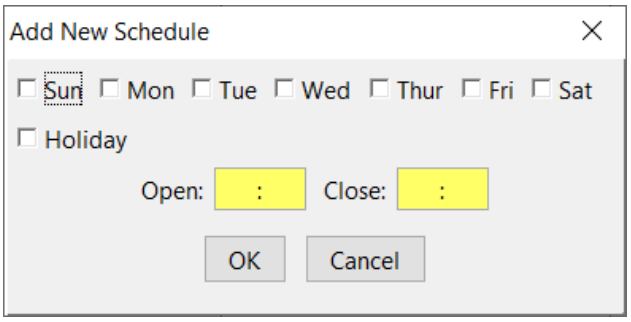



6. Select each nursing unit from the list or use the shift key to select a range of units.
7. Click **OK** to close the window.
8. Repeat this process if necessary until all of the desired nursing units have been added.
9. Click **OK**.




**Each nursing unit can only be assigned to one Satellite Pharmacy.**

10. Define the days that reports from these nursing units will be routed to this pharmacy satellite.
    - Click **Add** below the Schedules text box.




    - Select the box next to each day to be included in the schedule.
    - Select **Holiday** if the Satellite Pharmacy is open on holidays.
    - Enter the operating hours of this pharmacy satellite (for example, 08:00-19:00). Before and after these times, reports will be routed to the default pharmacy printer.

**You can create multiple schedules for each satellite. For example, the satellite may be open weekdays from 7 a.m. until 7 p.m. but on weekends and holidays from 7 a.m. to 3 p.m. Hours are in 24h format.**

11. Click **OK** to save.
12. Click **OK** on the *Add Satellite Pharmacies* window.
13. Click **Save** to save your changes.

### *Set Holiday Dates for the Satellite Pharmacy*

If a satellite pharmacy will be open on holidays, follow the steps below to specify the dates to be treated as holidays.

1. From the **Satellite Pharmacies** tab, click **Add** next to the Holidays text box.
2. Select the holiday date(s) from the window.
3. Click **OK** after selecting each holiday date.
4. Repeat steps to add more dates as needed.
5. Click **OK**.

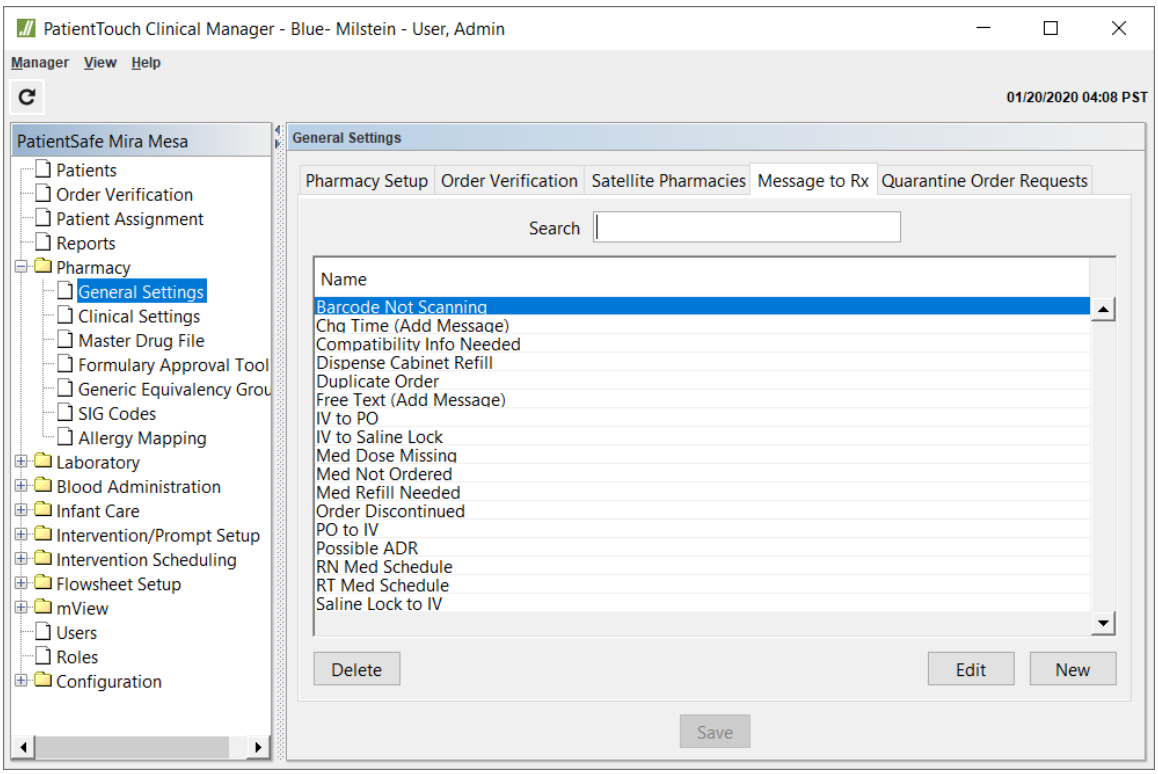
## Message to Rx Tab

You can create pre-configured messages that the caregiver can send to the pharmacy when an order change or other order-specific message needs to be sent. Caregivers see these as choices under the Messages to Rx function of the PatientTouch application. These messages are configured in the **General Settings > Message to Rx** tab.

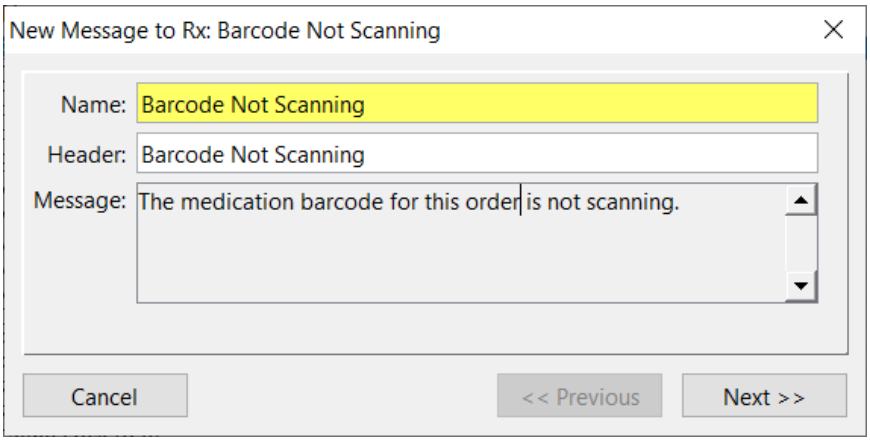
### *Set Up Message to Rx*

To configure pharmacy order change requests, perform the following steps:

1. Select **Pharmacy>General Settings>Message to Rx**.

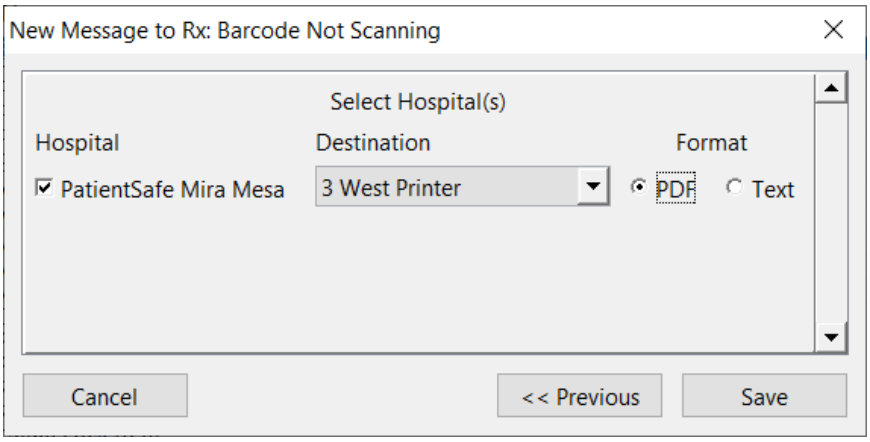



2. Do one of the following:
   - To create a new message, click **New**.
   - To edit an existing message, select the message and click **Edit**.




3. In the Name field, enter or edit the name of the message. This field is required.
4. In the Header field (optional), enter or edit the message's header (which will be printed at the top of the message.)

5. In the Message field, enter the message text you want to be sent to the pharmacy.
6. Click **Next**.




7. Place a check mark next to your hospital. The Destination field becomes active.
8. From the **Destination** drop-down list, select the printer to which the message should be sent. The printers displayed here have been configured in the Clinical Manager>Configuration>Destinations tab. This field is required once a hospital has been selected.
9. Select either **PDF** or **TEXT** format, depending on your pharmacy's preferences. This field is required once a hospital has been selected.
10. When finished, click **Save** to save the message and close the window.

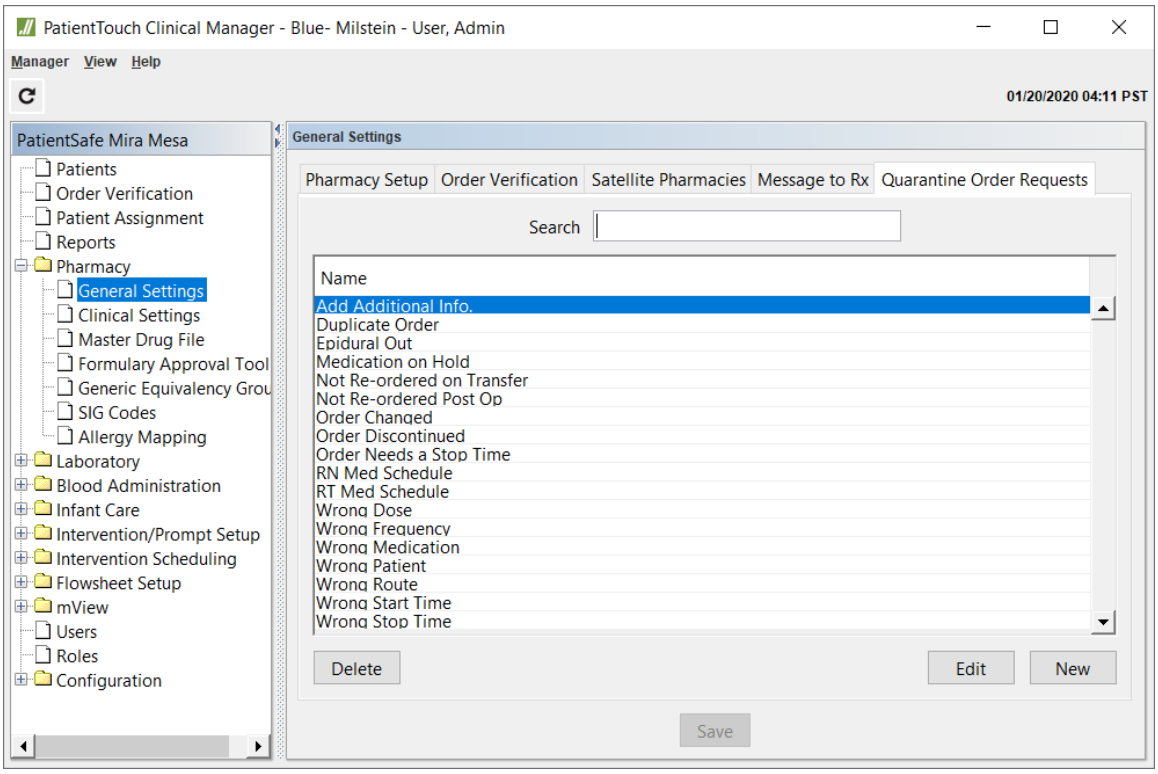
## Quarantine Order Requests Tab

You can create a list of quarantine reasons in the **General Settings > Quarantine Order Requests** tab. If the option to quarantine orders on the PatientTouch application is enabled, the quarantine reasons set up in Clinical Manager will be available for selection.

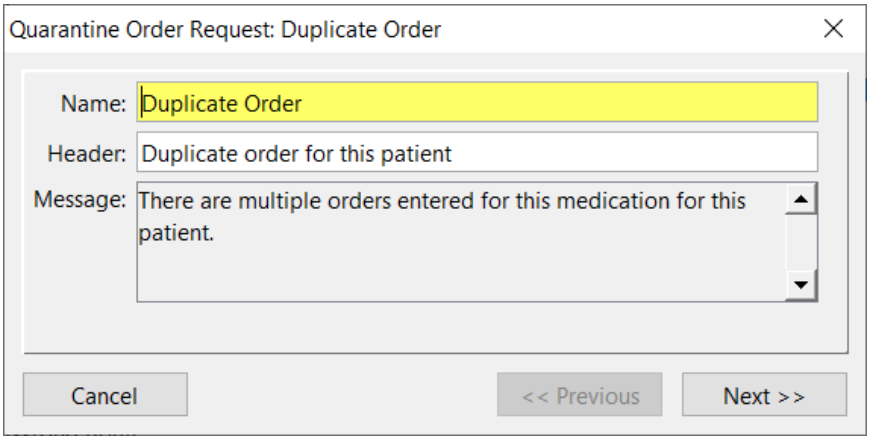
### *Set Up Quarantine Order Requests*

To configure quarantine order request reasons, perform the following steps:

1. Select **Pharmacy>General Settings>Quarantine Order Requests**.

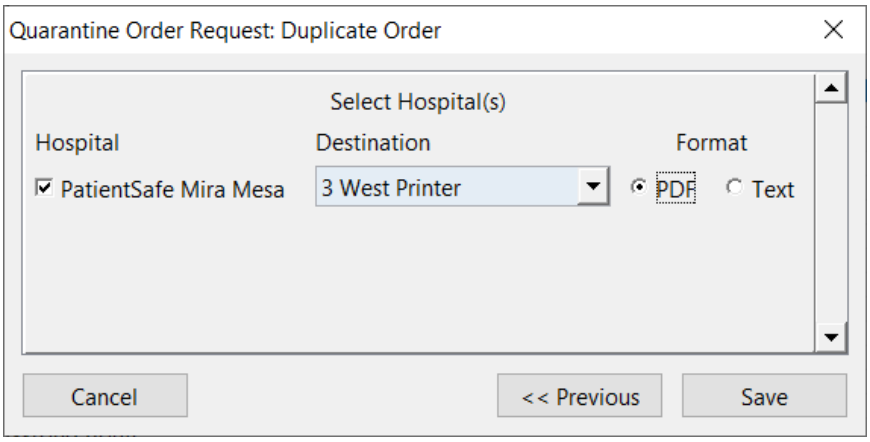



2. Do one of the following:
   - To create a new reason request, click **New**.
   - To edit an existing reason, select the quarantine order request reason and click **Edit**.




3. In the Name field, enter or edit the message's name. This will appear in the application in the list from which the caregiver can select a reason for the quarantine. This field is required and cannot be left blank.
4. In the Header field, enter or edit the message's header (which will be printed at the top of the message.) This field is optional and can be left blank, if desired.

5. In the Message field, enter the message text you want to be sent to the pharmacy.
6. Click **Next**.




7. Place a check mark next to your hospital. The Destination field becomes active.
8. From the **Destination** drop-down menu, select the printer to which the quarantine order request reason should be sent. The printers displayed here have been configured in the Clinical Manager>Configuration>Destinations tab. This field is required once a hospital has been selected.
9. Select either **PDF** or **TEXT** format, depending on your pharmacy's preferences. This field is required once a hospital has been selected.
10. When finished, click **Save** to save the quarantine order request reason and close the window.

# Clinical Settings

To set or change the settings for allergy and drug interaction checking, see the Clinical Check tab below.

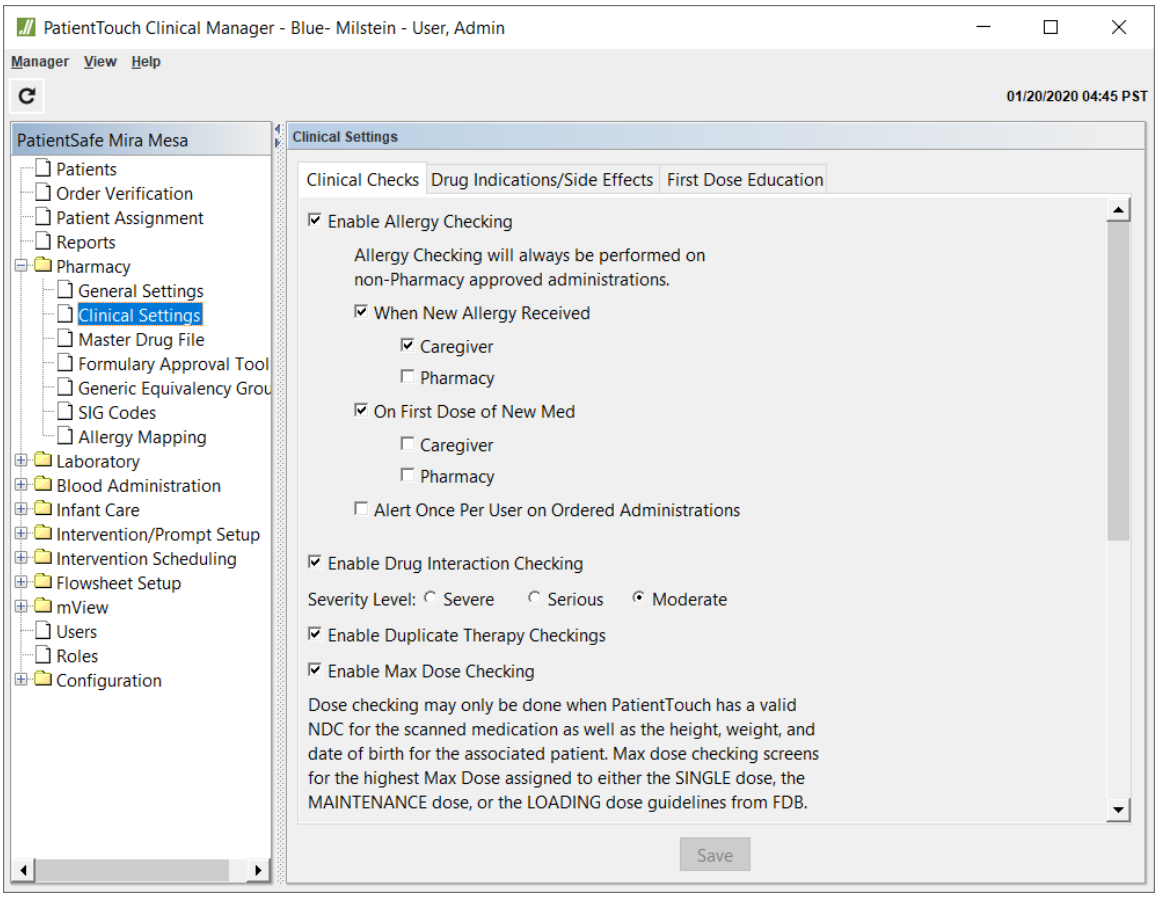
To set or change drug interactions/side effects or first dose education, select one of the following links:

Drug Indications/Side Effects

First Dose Education

## Clinical Checks Tab

1. Select Pharmacy > Clinical Settings
2. Click the Clinical Checks tab




Before setting clinical checks options for specific formulary items, you can choose whether to globally enable clinical checks. Clinical checks require that the medication being scanned has a valid NDC code in the PatientTouch System formulary and occur when medications are scanned prior to administration using in certain workflows.

By default, all formulary items are included in the clinical checks enabled in **General Settings > Clinical Checks**. For more information on clinical check settings for specific formulary items, refer to the Formulary Settings and Nursing Units sections of this guide.

The following clinical checks are available to be enabled:

- **Enable Allergy Checking**—The PatientTouch System uses patient allergy information received from the hospital information system (typically either the ADT or PIS) and the NDC codes for medications in the formulary to check for potential allergies using the FDB database. If this setting is enabled, the allergy check is done anytime a medication is scanned for which there is no pharmacy-approved order present in the System. Patient allergies are matched to FDB allergy codes using the PatientTouch Allergy Mapping table. Also, if enabled the following additional allergy checking options become available:
  - **When New Allergy Received** - If active, when a new allergy is received via interface, and medication orders are already present in PatientTouch, the new allergy will be checked against existing orders. If a potential allergy is found, the assigned caregiver will receive an Inbox message and the pharmacy will be notified via the pharmacy printer settings.

- **On First Dose of New Med** - Allergies will be checked when the first dose of a new medication order is scanned for administration. If a potential allergy is found, the assigned caregiver will receive an Inbox message and the pharmacy will be notified via the pharmacy printer settings.

- **Enable Drug Interaction Checking** – If enabled, the PatientTouch System uses the scanned item's NDC code in conjunction with FDB to perform drug-drug interaction checks anytime a medication is scanned for which there is no pharmacy-approved order present in the System.

  If you enabled drug interaction checking, select the severity options to deteremine what alerts caregivers see at the handheld, as follows:

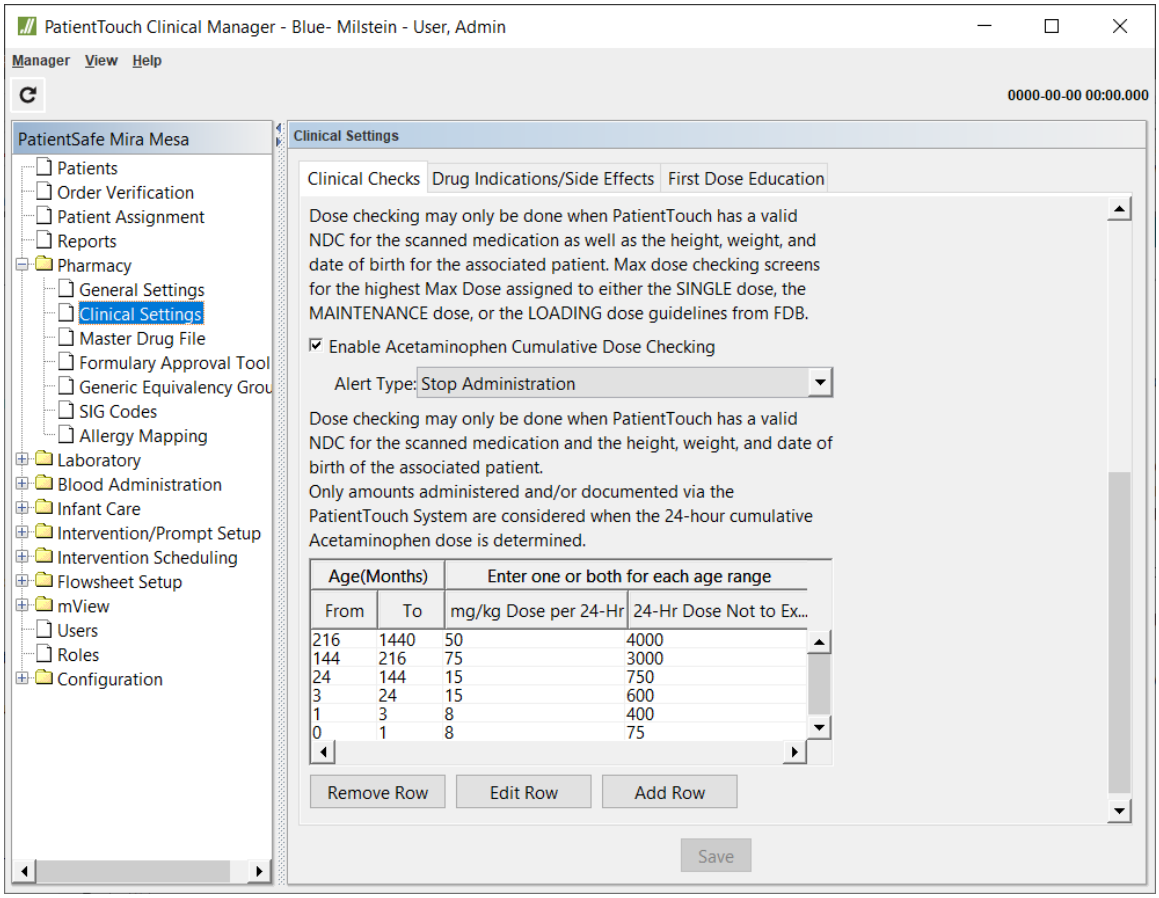
  - Select **Severe** to alert the caregiver of only those interactions with potentially life-threatening consequences.
  - Select **Serious** to alert the caregiver of severe interactions plus interactions that may cause the patient's condition to deteriorate or require additional care.
  - Select **Moderate** to alert the caregiver of Severe and Serious interaction plus those that are bothersome but not medically significant.

- **Enable Duplicate Therapy Checking** - When selected, the PatientTouch System will check for duplicate drug therapy when a medication is scanned for which there is no order. The default setting is false.
- **Enable Max Single Dose Checking** – If enabled, the PatientTouch System uses the scanned item's NDC code in conjunction with FDB to perform a check for recommended maximum single dose amount anytime a medication is scanned for which there is no pharmacy-approved order present in the System. Depending on the medication, the maximum dose amount based on patient height, weight, and age may vary for a Loading Dose, Single Dose, or Maintenance Dose.
- **Enable Acetaminophen Cumulative Dose Checking**—If enabled, the PatientTouch System will maintain a cumulative rolling 24-hour record of acetaminophen administered to each patient. When an acetaminophen-containing medication is scanned for a patient, the system sends a query to FDB to identify the amount of acetaminophen contained in the drug and verifies whether administering that amount will cause the patient to exceed the recommended daily limit. See Unlike the other Clinical Checks, which are part of the No Order Found in System workflow, the Acetaminophen Cumulative Dose Check is done for ALL administrations of drugs containing Acetaminophen. Therefore, a nurse could receive this alert when administering an ordered and pharmacy-approved medication.

  If the scanned amount of acetaminophen will exceed the hospital's established 24-hour dosing limits (see setup below), the caregiver will receive an alert. There are two globally-set **Alert Types** that can be selected from the drop-down list:

  - **Warn only**—Caregivers will see an alert showing the 24-hour cumulative amount of acetaminophen (including the scanned dose) for the patient while indicating that the patient's daily acetaminophen limit will be exceeded if the scanned medication is administered. The caregiver can then choose to either cancel the administration or continue with the administration after providing a reason for overriding the alert.
  - **Stop Administration**—Caregivers will see an alert showing the 24-hour cumulative amount of acetaminophen (including the scanned dose) for the patient while indicating that the medication should not be administered because the 24-hour acetaminophen limit for this patient will be exceeded. The administration can only be canceled, and the caregiver provides a reason for cancellation.

- If you enabled acetaminophen cumulative dose checking, fill in the associated table with your hospital's acetaminophen dosing guidelines. Alerts occur when either the mg/kg/24hr or the Not To Exceed 24hr limit is reached based on patient age.

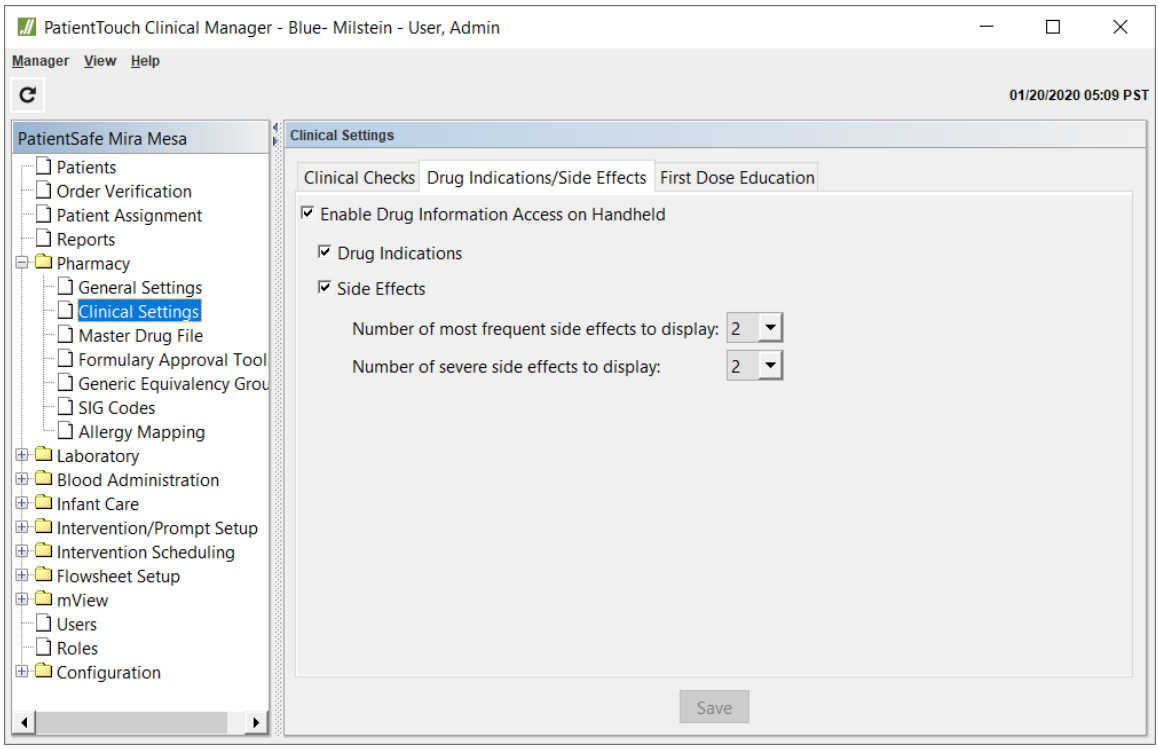



**The "From" setting is interpreted as > or =, and the "To" setting is interpreted as < the number of months entered.**

3. Click **Save** to save your changes.

## Drug Indications / Side Effects Tab

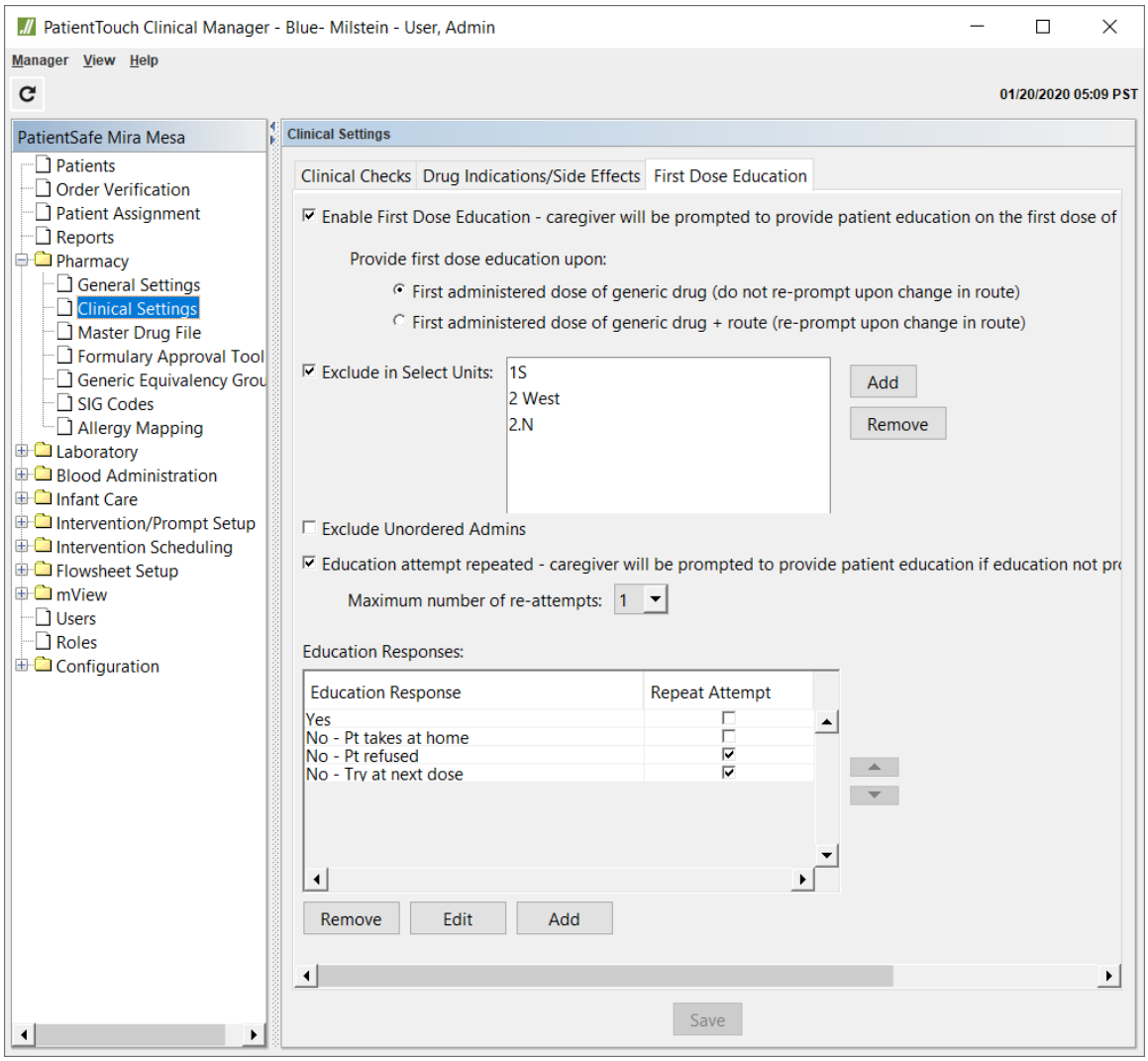
The PatientTouch Handheld can provide access to a limited number of key indications and side effects for ordered medications to be freely referenced by the caregiver. The availability of this information depends on the presence of a valid NDC in the PatientTouch formulary for the ordered drug.




- **Enable Drug Information Access on Handheld** – If enabled, PatientTouch will display a Drug Information screen for the selected medication when a valid NDC for that medication is available.
  - **Drug Indications** – If enabled, the indications for the medication will be displayed on the *Drug Information* screen as retrieved from FDB.
  - **Side Effects** – If enabled, side effects for the medication will be displayed on the *Drug Information* screen as retrieved from FDB.
    - **Number of most frequent side effects to display** – This setting determines the number of most frequent side effects (per FDB) that will be displayed.
    - **Number of severe side effects to display** – This setting determines the number of severe side effects (per FDB) that will be displayed.
- Click **Save** to save your changes.

## First Dose Education Tab

You can configure whether Drug Indications and Side Effects will automatically display the first time a formulary item is administered by using the settings on the **First Dose Education** tab. This feature is designed to help improve the hospital's HCAHPS scores and therefore its use is recommended.




The following settings are available:

- **Enable First Dose Education** – This setting globally enables the First Dose Education feature. If enabled, one of the following options must be chosen based on the hospital's patient education practices:
  - **First administered dose of generic drug** - If this setting is chosen, drug indications and side effects for the scanned drug will be presented to the caregiver during the administration workflow only the first time that a generic drug entity is scanned for administration to the patient. For example, the drug indications and side effects screen will appear for the caregiver when furosemide injection is first administered, and will not again be presented when a later dose of furosemide oral is scanned.
  - **First administered dose of generic drug + route** - If this setting is chosen, indications and side effects for the scanned drug will be presented to the caregiver during the administration workflow the first time that a generic drug is scanned for administration to the patient by a specific route. For example, the drug indications and side effects screen will appear for the caregiver when furosemide injection is first administered, and will again be presented when a later dose of furosemide oral is scanned.

– If First Dose Education cannot be completed due to patient's condition or other factors present at the time of the first dose, the caregiver can delay First Dose Education to the next dose. See Education attempt repeated below.

- **Exclude in Select Units** – This setting allows you to designate units in which First Dose Education is not required. Examples may be NICU and Pediatrics.
- **Exclude Unordered Admins** – If enabled, this setting indicates that the system will not display first dose education drug information to the caregiver when a dose is scanned prior to pharmacy approval of the order. Consult your hospital's First Dose Education policy on whether to enable this setting.
- **Education Attempt Repeated** – If enabled, this setting allows you to define the number of First Dose Education repeat attempts before the education is automatically and permanently considered incomplete.
- **Education Responses** – This allows you to define the acceptable caregiver responses when First Dose Education is presented during the medication administration workflow. These responses should comply with your hospital's First Dose Education policies.
  - **Add** - Allows you to add a new response and designate whether it should spawn a repeat attempt at education when the next dose occurs. Example responses are:
    – Yes
    – No: Patient takes at home
    – No: Patient refused the information
    – No: Try again at next dose [Repeat]
  - **Edit** – Allows you to edit an existing response.
  - **Remove** – Allows you to delete an existing response.
- Save your changes.

# Formulary Approval Tool (FAT)

**This feature is only applicable to Cerner sites.**

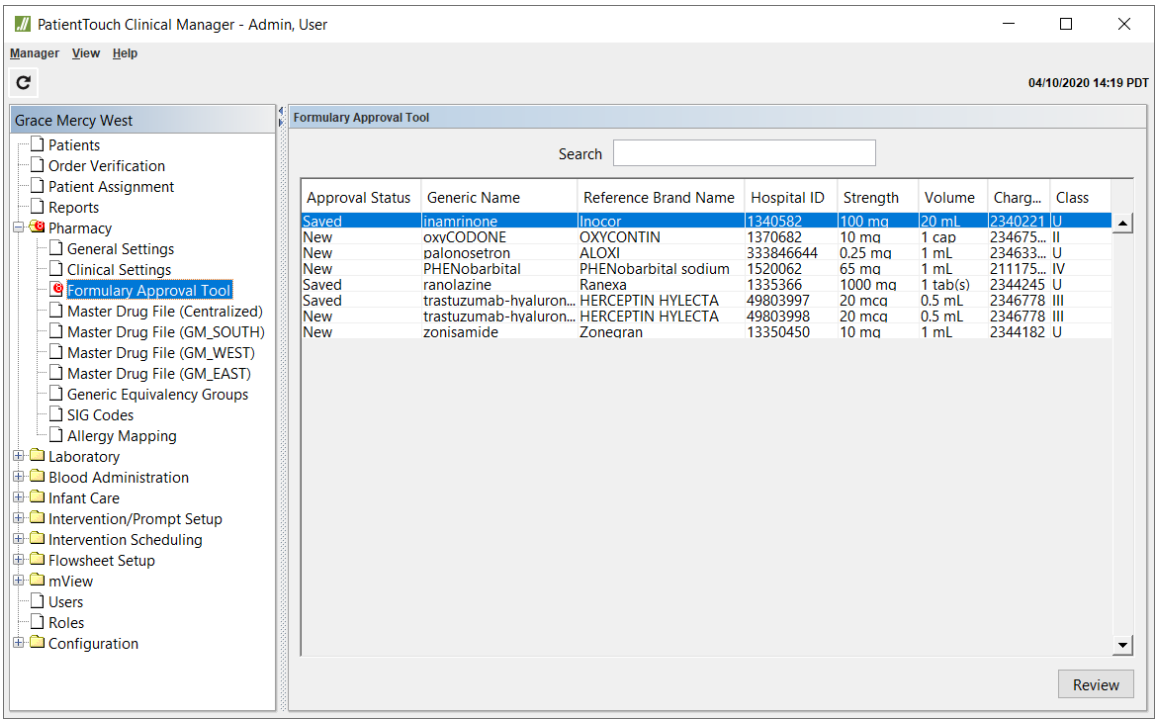
The Formulary Approval Tool provides a way for users to review and approve any newly added formulary items and make necessary updates that could not be populated via the interface. It provides for an external formulary and the PatientSafe formulary to be more in sync. Medications that are visible in the FAT will not qualify for use until they have been "Approved."

A badge count icon will be used at the folder level and again at the tool level to indicate how many new formulary items are awaiting review/approval.

**Users will need the Managed Centralized Formulary privilege to use the FAT.**

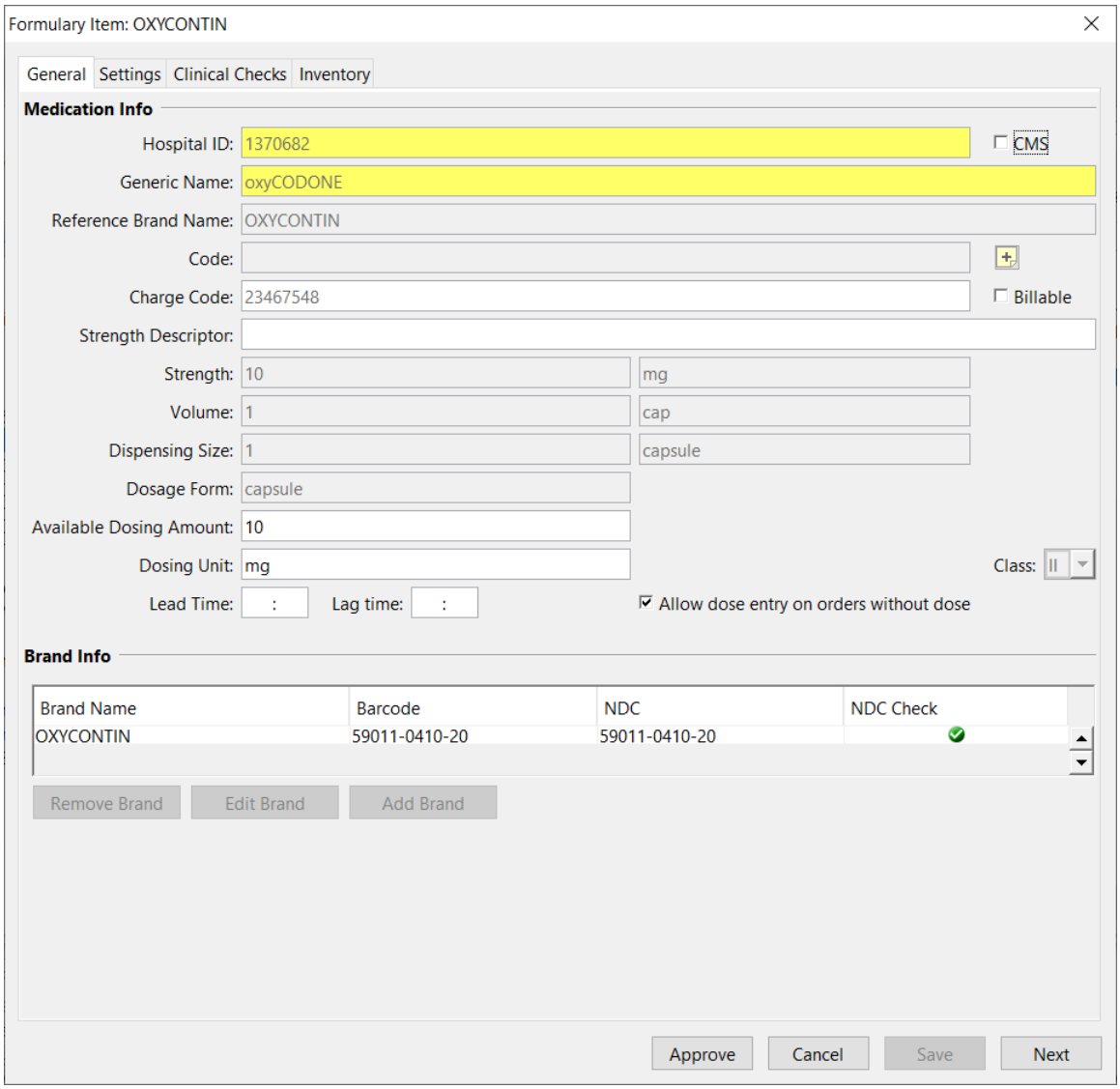
When you open the FAT you will see a queue of new medications waiting review/update/approval. A status column indicates if a formulary item is New (not yet reviewed/saved), or Saved.

1. Select a medication from the list by either double clicking the medication name , or, by selecting the medication and clicking **Review**.




2. You need to populate all required fields (if not already done) before you can approve any medication in the list. Review the button descriptions below for proper use:

   - **Approve** - If all required fields have been completed, clicking the Approve button will automatically release the medication for use and will display in the Master Drug File. If your site has multiple facilities, it will display in Master Drug File (Centralized) as well as the inventoried facility level Master Drug File(s).
   - **Save** - This will Save any modifications/edits to the medication (i.e. if you add/edit dosing unit), but will not approve the medication. Caregivers may approve the medication after saving.
   - **Cancel** - This will send the user back to the Formulary Approval Tool screen.
   - **Next** - This will send the user to the next medication in the list without approving.

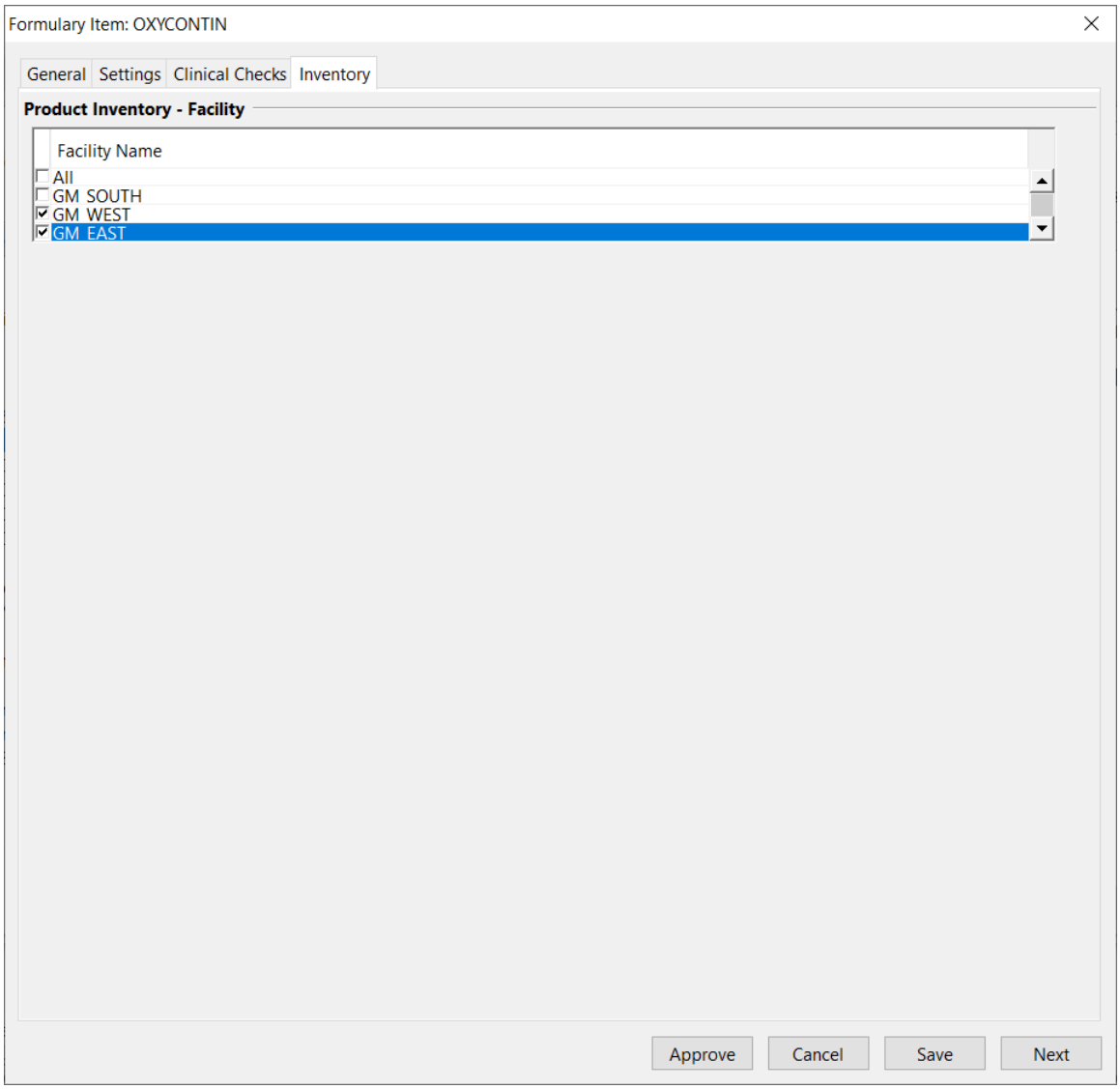



Modifications received through the interface will not require FAT review and approval. Modifications made through the interface will automatically update in the centralized formulary as well as the individual, site-specific formularies.

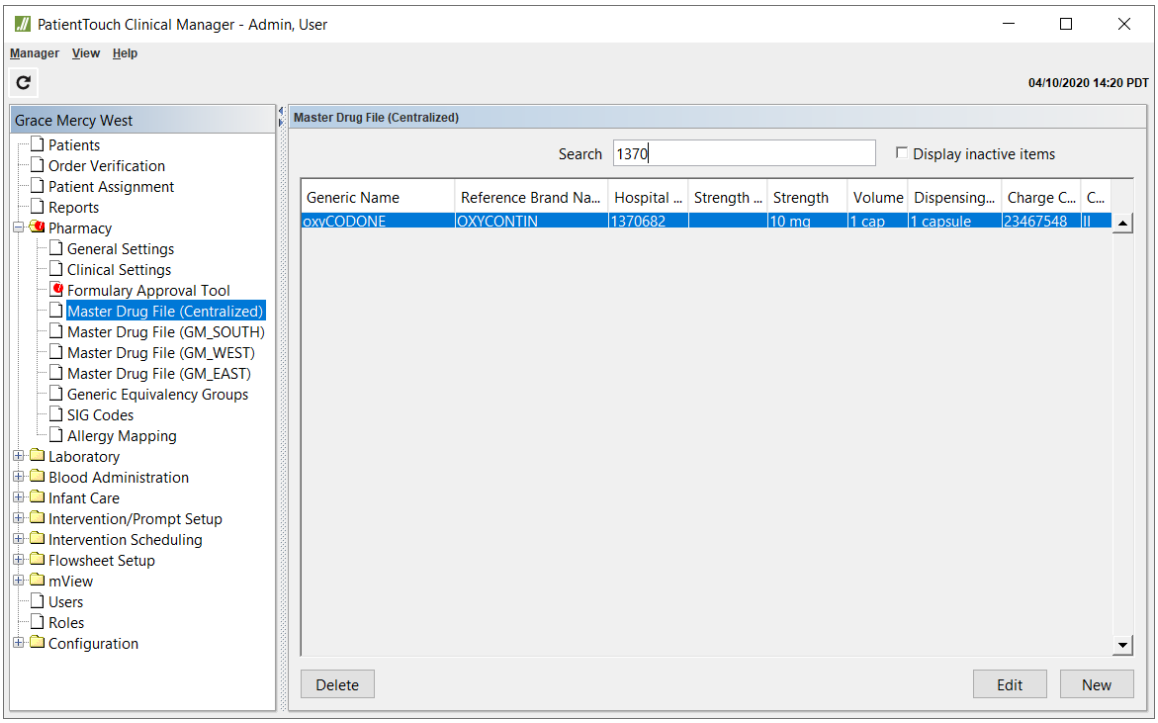
# Multi Facility

If your site has multiple facilities, the Inventory tab will display with those sites. Managing inventory is configurable to allow management through the PatientTouch System or via interface updates.

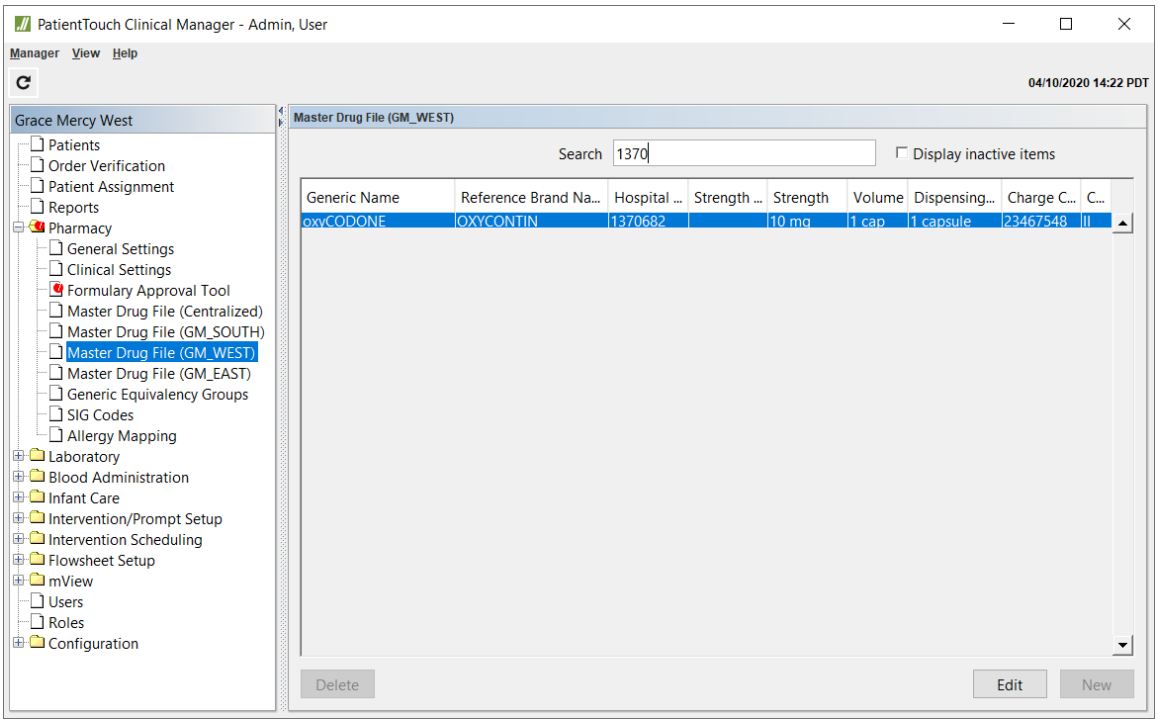
1. If managed through the PatientTouch System, select the facilities for which you want to distribute the medication.
2. Click **Approve**.



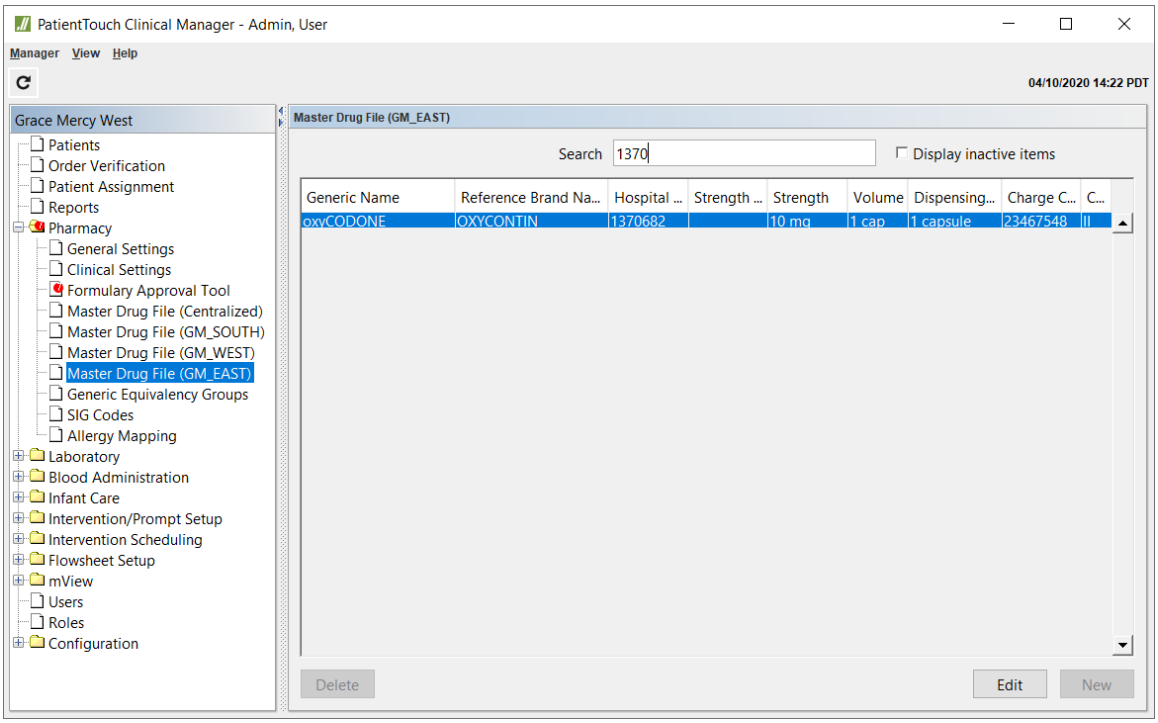

3. The approved medication now displays in the Master Drug File (Centralized). Any changes to the medication from the centralized formulary will also appear in the medications in the designated facilities (GM_EAST, GM_WEST in the example above). For example, you may approve a medication in Master Drug File (Centralized)>Inventory tab, which will distribute the medication to the designated facilities.




4. The approved medication displays in GM West….

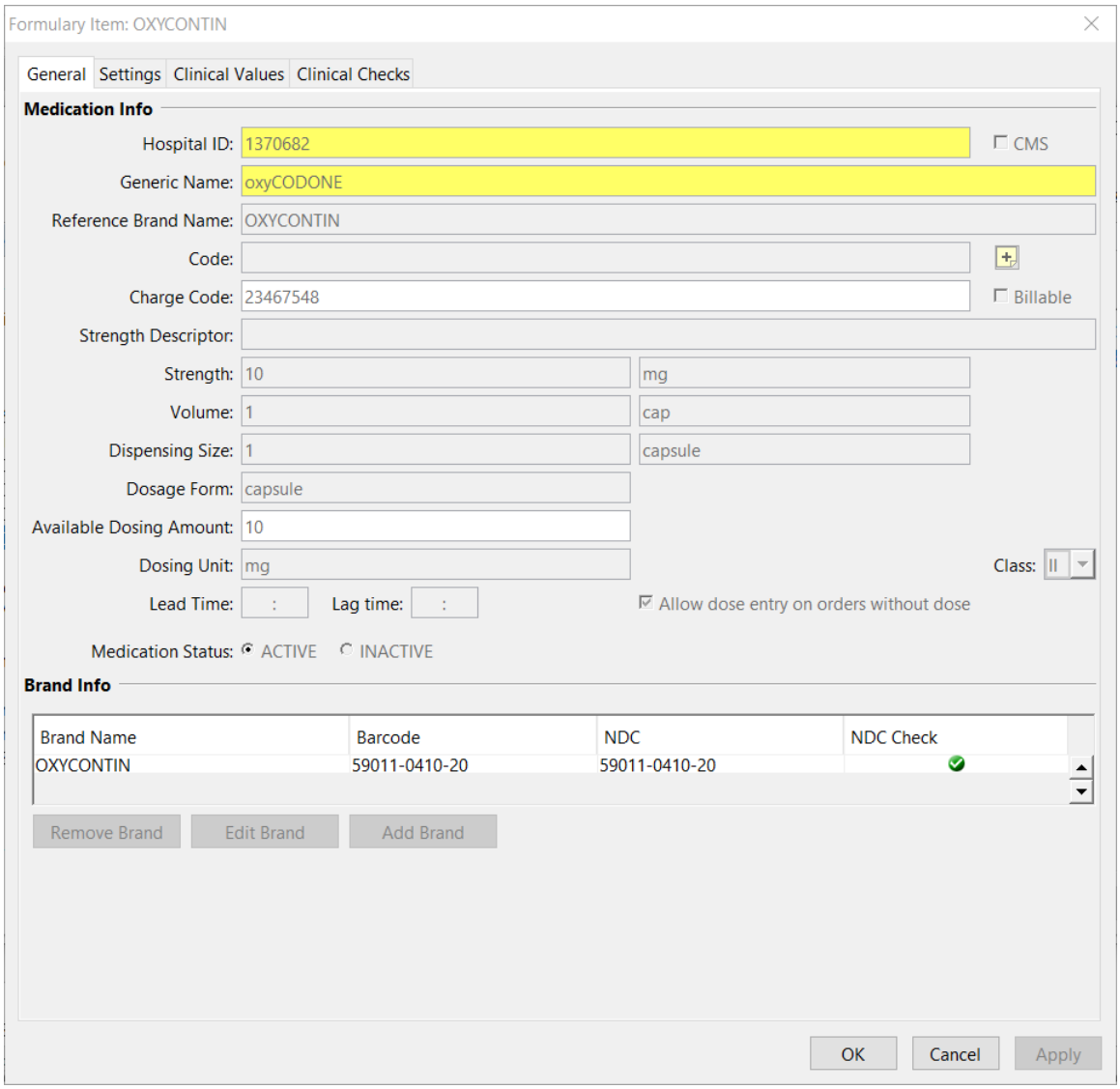



5. and GM East.




Depending on configuration, some centralized fields will be grayed out as you can only make changes to clinical prompting at the site level.

**Please contact PatientSafe Solutions Implementation Team during install or the PatientSafe Solutions Technical Support Team after install if you want any centralized fields active that are not currently made so.**




# Master Drug File

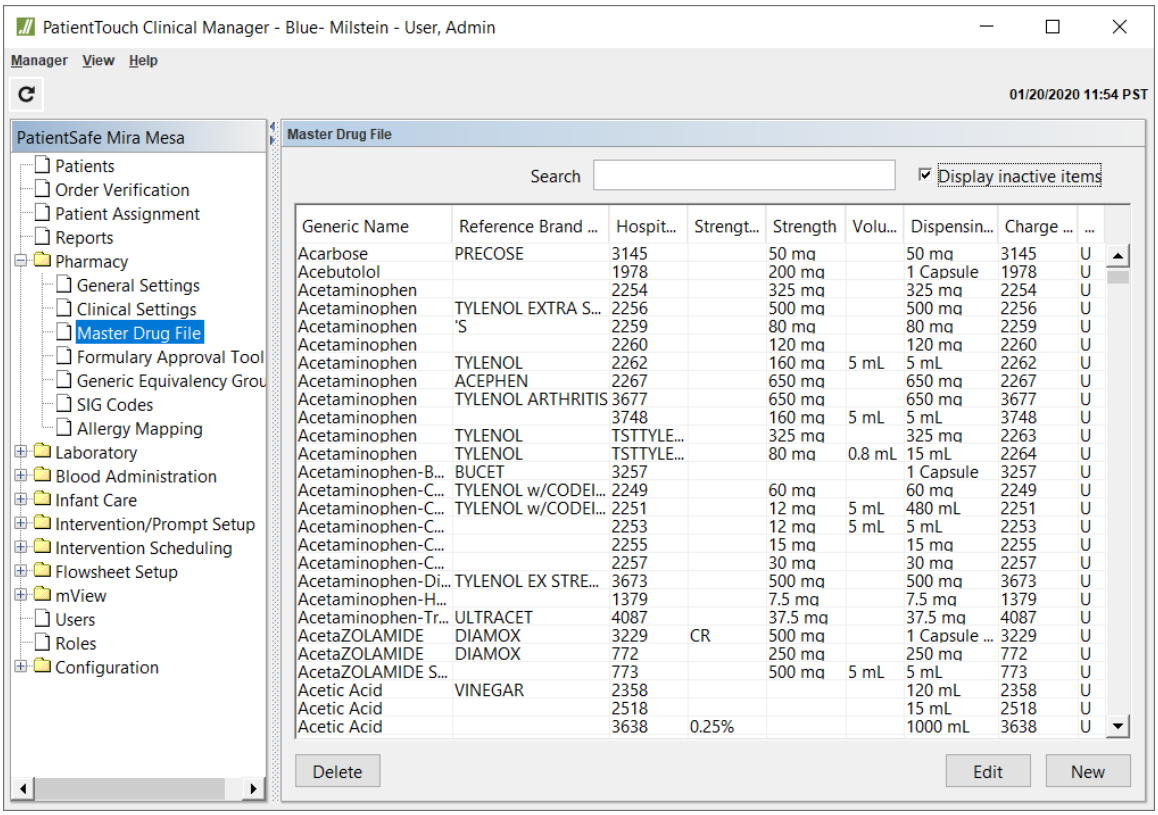
The PatientTouch System **Master Drug File** should mirror the Pharmacy Information System Formulary. It is also where barcodes, NDCs, clinical prompts assignments, and numerous functional and clinical settings are defined at the formulary item level.

## Search for Formulary/Master Drug Items

You can quickly locate an item in the **Master Drug File** list by entering the first few characters of the item's generic name, brand name, or identifier code (Hospital ID) into the search field. As you continue to type, the list on the *Master Drug File* screen is narrowed.

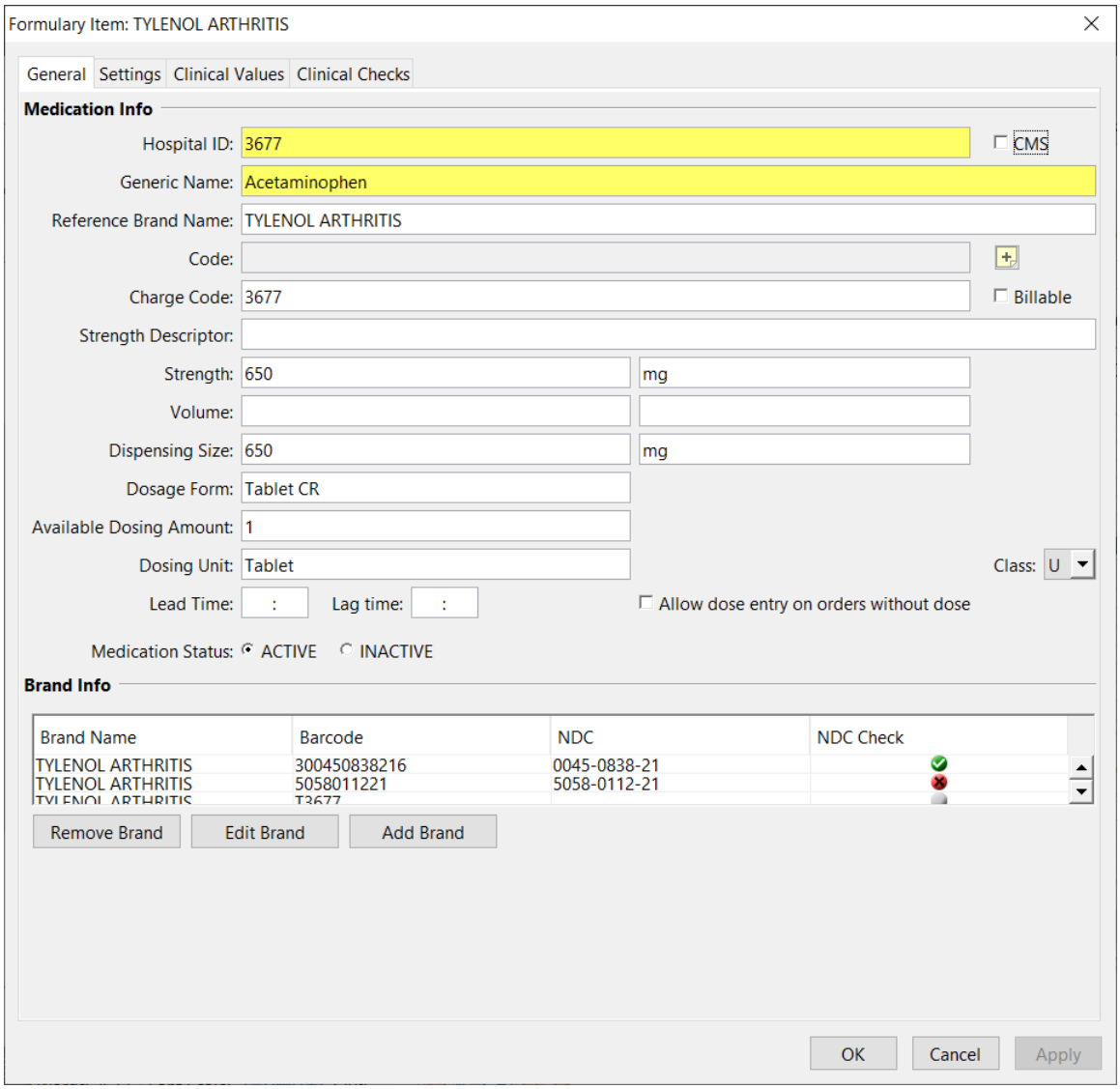
## Add/Edit Formulary Item

1. Select **Pharmacy > Master Drug File**.




2. Do one of the following:

   - **New** – Click to add a new formulary item
   - **Edit** – Click after selecting a formulary item to edit that item.
   - **Delete** - Click after selecting a formulary item to delete that item. (Caution: Deleting a formulary item that has been ordered and/or administered in the past is not recommended.)




## Formulary Setup Guidelines

We recommend that you adhere to the following general requirements when configuring formulary items in the PatientTouch **Master Drug File**.

- Never end a field with a period.
- Enter generic and brand names in specific letter case. Lower case is recommended for generic name and upper case for brand name. Use Tall-Man lettering where applicable (see http://www.ismp.org/Tools/tallmanletters.pdf)
- Remember that the letter case entered here appears throughout the system.

### *General Tab*

**Hospital ID field** - The Hospital ID is the hospital-specific code by which the item is ordered in the Pharmacy Information System.

**This is a required field, alphanumeric, with a maximum length of 16 characters.**

**Generic Name** - This field should contain only the generic or non-proprietary name of the product. If the item is not known by a generic or non-proprietary name, the brand name may be entered here instead and the Reference Brand Name field left blank. The generic name field should *not* contain strength, concentration, dosage form or any other information. This is a required field; entries must be- alphanumeric, with a maximum length of 60 characters.

| Correct | Incorrect |
|---|---|
| **Ibuprofen** | Motrin |
| **Hydrocortisone** | Hydrocortisone 10% |
| **Amoxicillin** | Amoxicillin Susp |
| **Furosemide** | Furosemide 40mg/2mL |
| **Mineral Oil** | Mineral Oil 30ml |

**Reference Brand Name** - This field should contain the one brand or proprietary name that is *most commonly* used at your hospital when this item is prescribed. If the item does not have a brand name (only known by generic name), this field may be left blank. This field should *not* contain strength, concentration, dosage form or any other information.

Optional: Alphanumeric and maximum length of 40 characters.

| Correct | Incorrect |
|---|---|
| **MOTRIN** | MOTRIN, ADVIL |
| **<blank> (brand name never used)** | Hydrocortisone |
| **LAROTID** | LAROTID Susp |
| **LASIX** | LASIX 40mg/2mL |

**Coding System (Plus Sign)**: You must have Coding Systems (e.g. RxNorm) defined in the Clinical Manager to populate this field. To add a vocabulary item for this formulary item, click the plus sign  , click **Add** on the *Code Association* window and select a Coding System from the drop down menu. Enter the Code, Short Description, and Description.

**The RxNorm code and associated information is automatically updated as necessary when the FDB updates are run for formulary items.**

**Charge Code** - This field should contain the code by which the item is billed by the hospital billing system. The Charge Code can be the same or different from the Hospital ID. Required if Billable Flag is checked. Alphanumeric characters and maximum length of 20 characters.

**Billable Flag** - This checkbox indicates whether the item is eligible to be billed when administered if an outbound billing interface is configured. When selected, the Charge Code and Available Dosing Amount fields change to become required.

For proper billing when a PatientTouch outbound billing interface is used, this box is typically not selected for:

- Multi-dose items (inhalers, ophthalmic drops, topicals, etc.)
- Items billed up front by pharmacy when compounded or mixed
- Items billed on dispense by another automated system

**Strength Descriptor** - This field should contain information that describes the strength or concentration of a product but does not fit appropriately in the Strength and Strength Unit fields (see below). It is used where strength or concentration is expressed as %, ratio (1:1000), or a combination of multiple ingredient strengths (25-250). For some items such as transdermal patches, the Strength Descriptor is a unit of dosing over a period of time (e.g. mg/Day). This field should not contain generic name, brand name, dosage form or any other information.

Placing this type of strength information in the Strength Descriptor field rather than in both the generic and brand name fields eliminates redundant entry.

Optional: Alphanumeric and maximum length of 80 characters.

| Correct | Incorrect |
|---|---|
| **5%** | 5mg |
| **1:1000** | 1mEq/ml |
| **25-250*** | Tab |
| **0.1mg/hr (5cm2)** | Patch |
| **SR** | |

*Example uses a dash in descriptions like 25-250 rather than 25/250 because ISMP recommends that / be avoided.

**Strength** - This field should contain the numeric strength of the product expressed in conjunction with Strength Unit as a weight or other non-volumetric unit of measure (mg, G, mEq, Units, and so on).

This field is required if Strength Unit is used. It should be numeric, whole numbers with up to 6 digits before and 4 digits after the decimal point.

**Strength Unit** - This field should contain the properly abbreviated unit by which the Strength is expressed. This field is required if the Strength field is used. It should be alphanumeric and a maximum length of 12 characters.

| Correct | Incorrect |
|---|---|
| **mg** | 5mg |
| **G** | Puffs |
| **Units** | cm2 |
| **mEq** | Tabs |
| | mg/hr |

**Volume** - This field should contain the numeric volume of the product that associates with the strength information to create a concentration (e.g. mg/mL). It should be expressed in conjunction with Volume Unit as a volumetric measure (most often mL). Entry in this field is required when Volume Unit is used. The entry should be numeric, whole numbers with up to 6 digits before and 4 digits after the decimal point.

**Volume Unit** - This field should contain the properly abbreviated unit by which the Volume field is expressed. This field is required when the Volume field is used. The entry should be alphanumeric and a maximum length of 12 characters.

| Correct | Incorrect |
|---|---|
| **mL** | Ml |
| **Ounces** | mg |
| **Liters** | Tabs |
| | $cm^2$ |
| | mg/Day |

**Dispensing Size** - This field should contain the numeric value used in conjunction with the Dispensing Unit to indicate the total size or volume of the package that the pharmacy dispenses. In many cases, this is different from the original package size.

**Dispensing Size and Dispensing Unit** are used by the handheld and report medication displays for descriptive purposes, such as when verifying pharmacy inventory items or scanning and documenting non-ordered items during administration. The Dispensing Size and Unit are not used to determine whether multiple units of the medication are needed to deliver a prescribed dose (see Available Dosing Amount).

The Dispensing Size is required if the Dispensing Unit is used. The type should be numeric, whole numbers with up to 6 digits before and 4 digits after the decimal point.

**Dispensing Unit** - This field should contain the properly abbreviated unit by which the Dispensing Size is expressed. Dispensing Unit may or may not be the same as the Strength Unit or Volume Unit.

This field is required if the Dispensing Size field is used. The entry should be alphanumeric with a maximum length 12 characters.

| Correct | Incorrect |
|---|---|
| **mL** | SL |
| **G** | Drops |
| **mg** | Sprays |
| **Tab (tablet with no strength)** | |

**Dosage Form** - This field should contain the properly abbreviated or full-length dosage form for the item if applicable. Spaces are permitted. The exact case entered here displays throughout the system. This field is optional; if entered, the entry should be alphanumeric and a maximum length of 20 characters.

| Correct | Incorrect |
|---|---|
| **Sublingual or Subl Tab** | Puffs |
| **Ointment or Oint** | 10 Gram |
| **Inhaler or Inh or Inhal** | |
| **Tablet or Tab** | CR (CR, XL, other part of generic and brand) |
| **IV Bag or Bag** | |
| **Ophth Drops** | Drops (more specific - Ophth Drops, Otic Drops, Oral Drops, or Nose Drops, is better) |
| **Nasal Spray** | Spray (more specific - Nasal Spray is better) |
| **Injection or Inj or Vial or Ampule** | |
| **Irrigation or Irrig** | |
| **Liquid or Liq** | |
| **Oral Soln** | |
| **Suspension or Susp** | |
| **Vaginal Crm or Vag Cream** | VCRM |
| **Vaginal Supp** | VSUPP |

**Available Dosing Amount** - This field is used by the Clinical Manager to check the ordered dose against the amount of drug in the scanned product to determine whether to prompt the user to scan multiple units, or in some cases to determine whether only a partial dose of the scanned medication should be administered. For example, if the ordered dose is 650 mg and the Available Dosing Amount/Unit of a tablet is 325 mg, the handheld prompts the caregiver to scan a second tablet to achieve the ordered dose. Therefore, where applicable, this numeric field should contain the total amount of drug in the scanned item as measured in terms of the Dosing Unit. In essence, this field defines the maximum dose that can be obtained from one unit or package of this item. If the Available Dosing Amount field is blank, the dose versus amount check is bypassed during administration.

This field is required if the **Billable Flag** checkbox is selected or if you want to use the dose versus amount check. The entry should be numeric, whole numbers with up to 6 digits before and 4 digits after the decimal point.

**Dosing Unit** - This field must be the same unit of measure used in the Pharmacy Information System when entering a prescribed dose amount for this item. It also indicates the unit of measure to use when prompting the caregiver to enter the dose being administered. In most cases, the Dosing Unit will be the same as the Strength Unit, Volume Unit, or Dosage Form. However, in some cases, the Dosing Unit will be a completely different unit of measure (for example, with puffs, drops, or sprays).

If the Available Dosing Unit is blank, the dose versus amount check is bypassed during administration and the handheld does not prompt for the specific dose to be given (applicable to an ointment, cream, or similar item where dose amount is not recorded).

This field is optional, but required in order to prompt for dose. The entry should be alphanumeric and a maximum length of 12 characters.

| Correct | Incorrect |
|---|---|
| **Tabs (if tablet has no strength)** | Tabs (if tablet has a strength) |
| **mg** | mL (if item has a strength) |
| **mL (for example, oral liquid)** | Teaspoonfuls |
| **Puffs** | 17 G |
| **Drops** | Ophth Drops |
| **Sprays** | Nasal Spray |
| **G** | Bottle |
| **mcg** | Vial |
| **mEq** | Can |

**Lead and Lag Time** - This field determines the acceptable times before and after the scheduled time of the drug that the administration of a dose is considered to be "on time."

Lead and Lag Times set at the formulary item level take precedence over lead/lag times set in the SIG code or nursing unit settings.

**Medication Status** - Select **Active/Inactive** to indicate the status of the medication. To see all inactive medications, click the **Display Inactive Items** from the top left of the Master Drug File screen. Users must have the Manage Formulary privilege to inactivate a medication.

**Allow dose entry on orders without dose** - In some cases, the PatientTouch System will receive a medication order with a dose amount of "0". In order to accommodate these order types, formulary items in the PatientTouch System can now be configured to allow the user to specify the dose amount.

**CMS** - This setting allows you to flag certain medication as CMS medications for reporting purposes.

**Class** – This setting allows you to indicate the control class (U, I, II, III, IV, V) for reporting purposes.

## Enter Barcodes and NDC Numbers

Each product received by the pharmacy must be checked to ensure that its barcode is in the **Master Drug File**. Perform this step using the *Verify Item* workflow.

- Any formulary items received without barcodes printed on them must be packaged or labeled with a barcode. Medications without barcodes cannot be scanned for safe use at the bedside.
- If a Medication is scanned but has a barcode that is not known to the system, the user can follow the Add Barcode routine on the handheld to search for the medication in the formulary and match it.

The NDC numbers and barcodes for formulary items are not imported from the pharmacy information system. These elements of information must be entered manually or by using a scanner connected directly to the hospital workstation running the PatientTouch Clinical Manager. For more information on this, refer to Adding Barcodes to Master Drug File.

## Maintain the Master Drug File

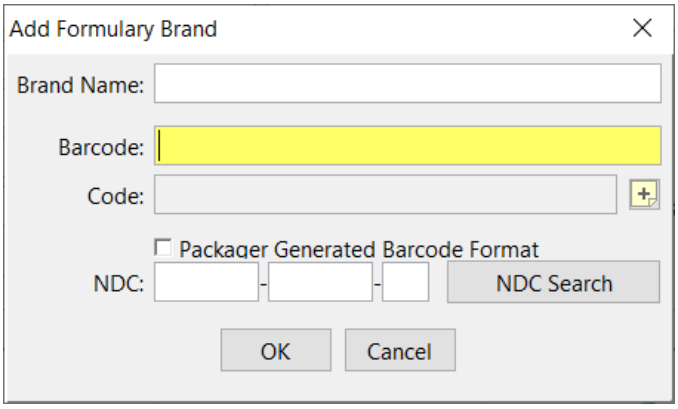
After the initial download of the formulary database, pharmacists maintain the **Master Drug File** by adding new formulary medications and adding new barcodes and corresponding NDCs.

### *Associate Barcodes with Formulary Items*

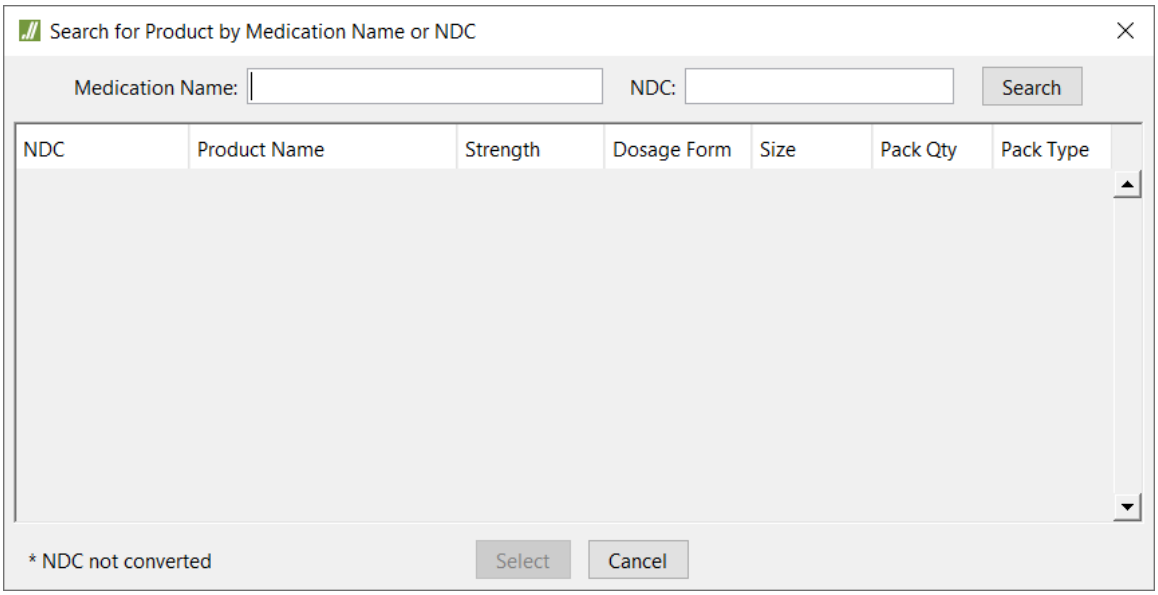
The recommended way to associate barcodes with formulary items is to capture the barcodes by scanning them into the Clinical Manager. A USB scanner connected directly to the Clinical Manager will serve this purpose. You can also type in the barcodes, but this is not recommended, as it is not as efficient or accurate as scanning.

To associate a brand barcode with a currently listed formulary item, perform the following steps:

1. Beneath the Brand Info list, click **Add Brand** to open the *Add Formulary Brand* window.




2. The cursor defaults to focus in the Barcode field. Scan the medication barcode to populate the Barcode field with the barcode value.
3. **Coding System (Plus Sign)**: You must have Coding Systems (e.g. RxNorm) defined in the Clinical Manager to populate this field. To add a vocabulary item for this formulary item, click the plus sign  , click **Add** on the *Code Association* window and select a **Coding System** from the drop down list. Enter the Code, Short Description, and Description.
4. Enter the product brand name in the Brand Name field. In many cases, the brand name for the barcode you are adding is a generic name. (This brand name is only seen by pharmacy when using the Lookup function. Its entry is optional and, if blank, the generic name will be displayed in its place during Lookup.)
5. Either enter the NDC number manually or click **NDC Search** to locate it. If you click **NDC Search**, the following window opens so you can enter the Medication name or enter the NDC number from the FDB database list:

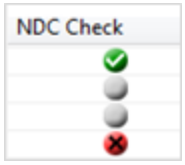



6. Click **Select** to choose the NDC number.
7. Click **OK** to accept the NDC number and return to the *Formulary Item* window.
8. Click **OK** to save the new entry and close the window or click **Apply** to save the newly entered information in the formulary and continue editing the item (repeat steps above).

## NDC Check

If you enter the NDC code manually, the system cross-references the number with the FDB database and indicates the results in the NDC Check field:

- A green circle with checkmark indicates the NDC is valid.




- A red circle with an “x” indicates the NDC is invalid (not in the current version of FDB). However, the NDC may still be the correct NDC for the product barcode that you are adding.
- A gray circle indicates that no NDC was entered for the brand and barcode.

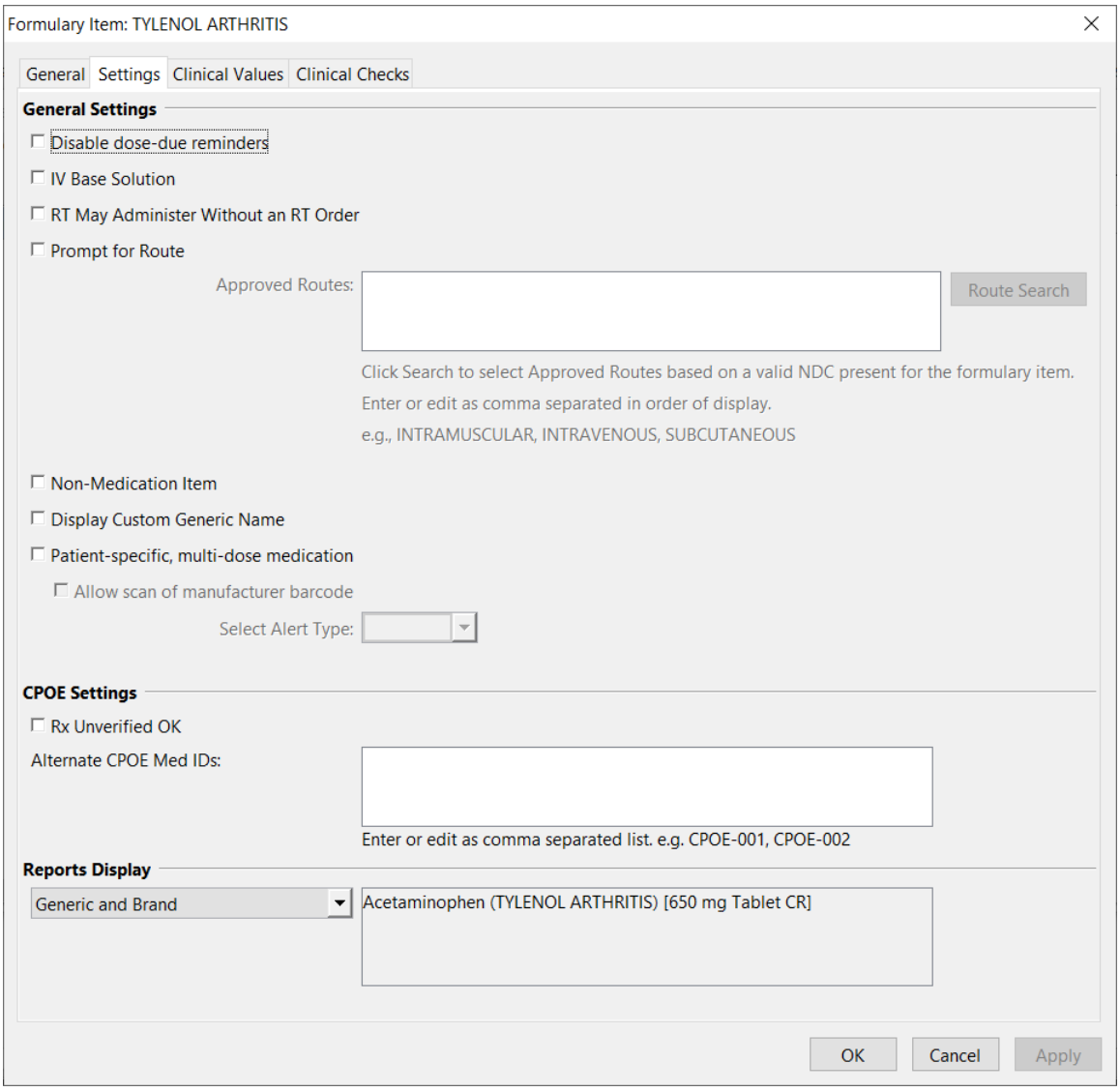
**Only one valid NDC is required for each parent formulary item for drug interaction and allergy checking to take place. The NDC check column only appears if allergy and/or drug interaction checking is enabled at the system and formulary item level.**

**MEDID(s) and CFID(s) from the FDB have been added to each formulary item based upon the NDC associated to the formulary item. Each valid NDC in the Brand Info that is**

**associated with the formulary item is associated with one MEDID and one CFID. All NDCs within the same formulary item should have the same MEDID; they may or may not have the same CFID.**

## *Settings tab*

Use the descriptions below to complete the fields on this tab.




**Disable dose-due reminders** - Select if you do not want the assigned caregiver to be reminded when this medication is due.

**IV Base Solution** – Select if, when the caregiver scans this item, you want to document the dose as "Infusion Started" on the PatientTouch MAR. In addition, only the rate designated in the order from the pharmacy will display on the MAR-related documents and on the handheld, and the dose will not be shown.

**Prompt for Route** - Select when you want the nurse to record the route of administration which will be used for administration when no pharmacy-approved order exists.

For medications being prepared or administered as a multi-component dose via the "Order Not Found in System" workflow that have common (matching) Approved Routes in the PatientTouch formulary:

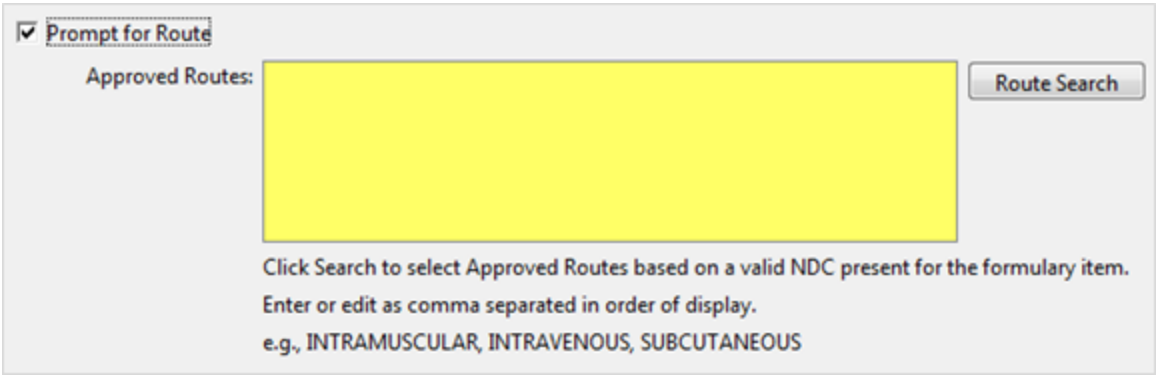
- If the involved medications have more than one common Approved Route, the handheld will present the caregiver with only the common route choices.
- If the involved medications have only one common Approved Route, that route will automatically be documented and the caregiver will not be prompted to select a route.

For medications being prepared or administered as multi-component doses via the "Order Not Found in System" workflow that do NOT have common (matching) Approved Routes in the PatientTouch formulary:

- The handheld will present the caregiver with route choices for the first medication scanned.
- If the first medication has only one Approved Route, that route will automatically be documented and the caregiver will not be prompted to select a route.

Recommendation to Pharmacy: Ensure that formulary medications that may potentially be administered together in a multi-component dose via the "Order Not Found in System" workflow have common and appropriate Approved Routes.

**When you select Prompt for Route, the text field changes to a required field. Click Route Search to select the appropriate route. The latest entry supersedes the previous entry.**




**Non-Medication Item** – Select to remove the item from statistical and MU reports.

**Display Custom Generic Name** – Select to display the custom generic name entered into the order comment field of the Pharmacy order. This is applicable for formulary items like Non-Formulary Medication and Patient's Own Medication.

Pharmacy can now identify medications as being patient-specific, multi-dose items to provide an additional layer of safety for medications that should not be shared between patients (ex: insulin pens). Additionally, to alleviate re-printing order barcodes when a dose amount changes for these items, pharmacy can configure a custom order barcode. See **Pharmacy>General Settings>Patient-Specific Med Barcode Settings** for more information on creating custom barcodes.

**Formulary items flagged as patient-specific, multi-dose medication cannot be added to Generic Equivalency Groups.**

**Patient-Specific, Multi-Dose Medication** – When selected, enables the identification of the patient-specific, multi-dose medication function.

**Allow Scan of Manufacturer Barcode** – When selected, enables the caregiver to still have the option of scanning the manufacturer barcode. When this setting is off or disabled, it provides you with the following options:

- A "soft stop" alert will display the following message on the handheld to the user, "Per hospital policy, this medication requires you to scan the pt. specific barcode. Please provide a reason for not scanning that barcode." The user can cancel or proceed. If the user proceeds, he or she must provide an override reason.
- A "hard stop" alert which will display the following message on the handheld to the user, "Per hospital policy, this medication requires you to scan the pt. specific barcode. If there is no pt. specific barcode on the item, please contact pharmacy." The user will only have the option to cancel out of the workflow.

**CPOE Settings**:

**Rx Unverified OK** - Select to allow the medication to match a CPOE order before it has been verified by Pharmacy. The caregiver will be alerted and prompted to enter a reason for administering the medication before Pharmacy verification.

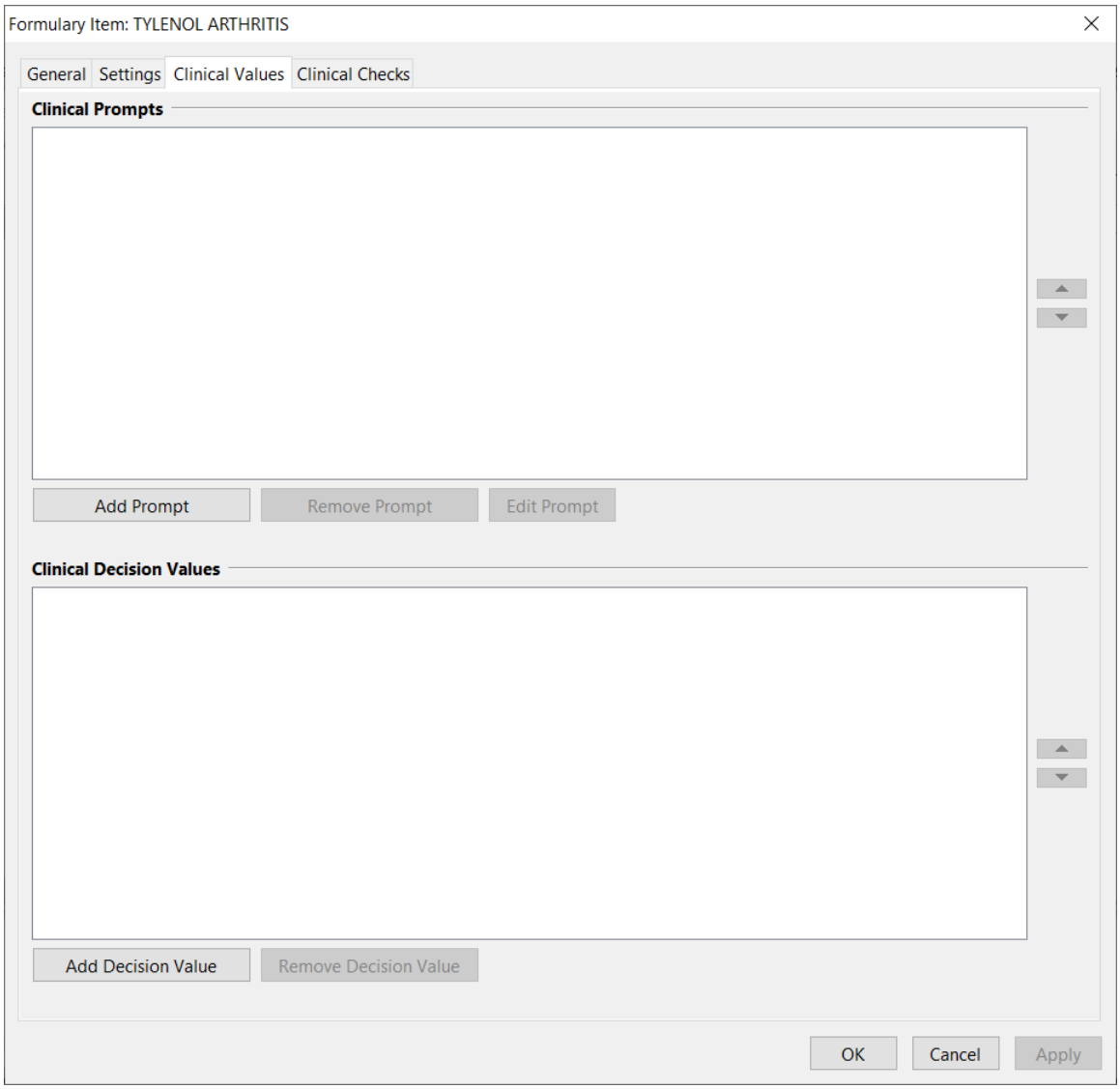
**Alternate CPOE Med IDs** - This field allows for more than one CPOE Alternate Med ID to be saved on each formulary item.

**Reports Display** - From the drop-down list select **Generic Only**, **Brand Only**, or **Generic and Brand,** depending on which medication name information you want to display on reports. Default is **Generic and Brand**.

Click **OK** to save your changes and exit the window, or click **Apply** to save these changes and continue to edit other settings.

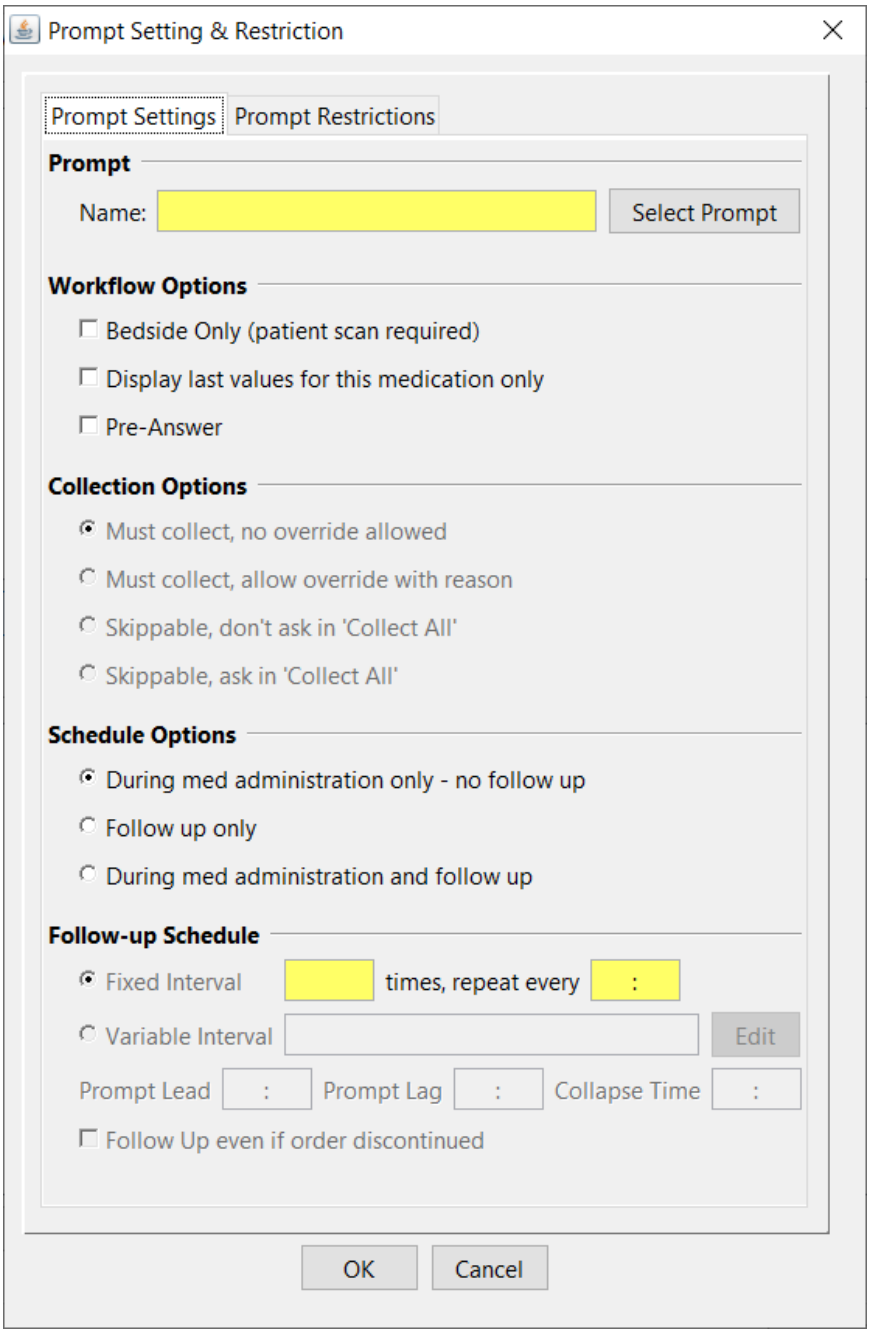
### *Clinical Values tab*

The **Clinical Values** tab provides a means to assign PatientTouch Clinical Prompts or Clinical Decision Values such as incoming lab values to the formulary item to be available during the administration process for the item.




## Clinical Prompts

1. In the Clinical Prompts section, click **Add Prompt.** The *Prompt Settings and Restriction* window appears.
2. Enter information into the following fields:




Name – required field. Click **Select Prompt** and select a prompt from the list that displays.

Select Workflow Options:

- **Bedside Only** – when selected, the prompt will not occur during the Prep Med process.
- **Display last values for this medication only** – when selected, the handheld prompt screen will display the last value collected (if any) for all subsequent administrations of the same medication.
- **Pre-Answer** – when selected, the caregiver will only need to enter this specific prompt

information once during a med pass session even if required by multiple medications within that session.

Select the Collection Options:

- **Must Collect, no override allowed** – The caregiver cannot proceed with the handheld workflow until the required data is entered.
- **Must collect, allow override with reason** – The caregiver may bypass the prompt but must provide a reason for doing so. This setting applies when administering a medication on the handheld and also when charting a dose using the Clinical Manager.
- **Skippable, don't ask in 'Collect All'** – The caregiver may bypass the prompt without specifying a reason.
- **Skippable, ask in 'Collect All'** - The caregiver may bypass the prompt but the data will be collected later.

Select Schedule Options as follows:

- **During med administration only – no follow up** – The caregiver will be prompted for this data only during the administration process.
- **Follow up only** – The caregiver will not be prompted for this data during the administration process but instead will be prompted when follow up is due.
- **During med administration and follow up** – The caregiver will be prompted for this data during the administration process and at the time of follow up.

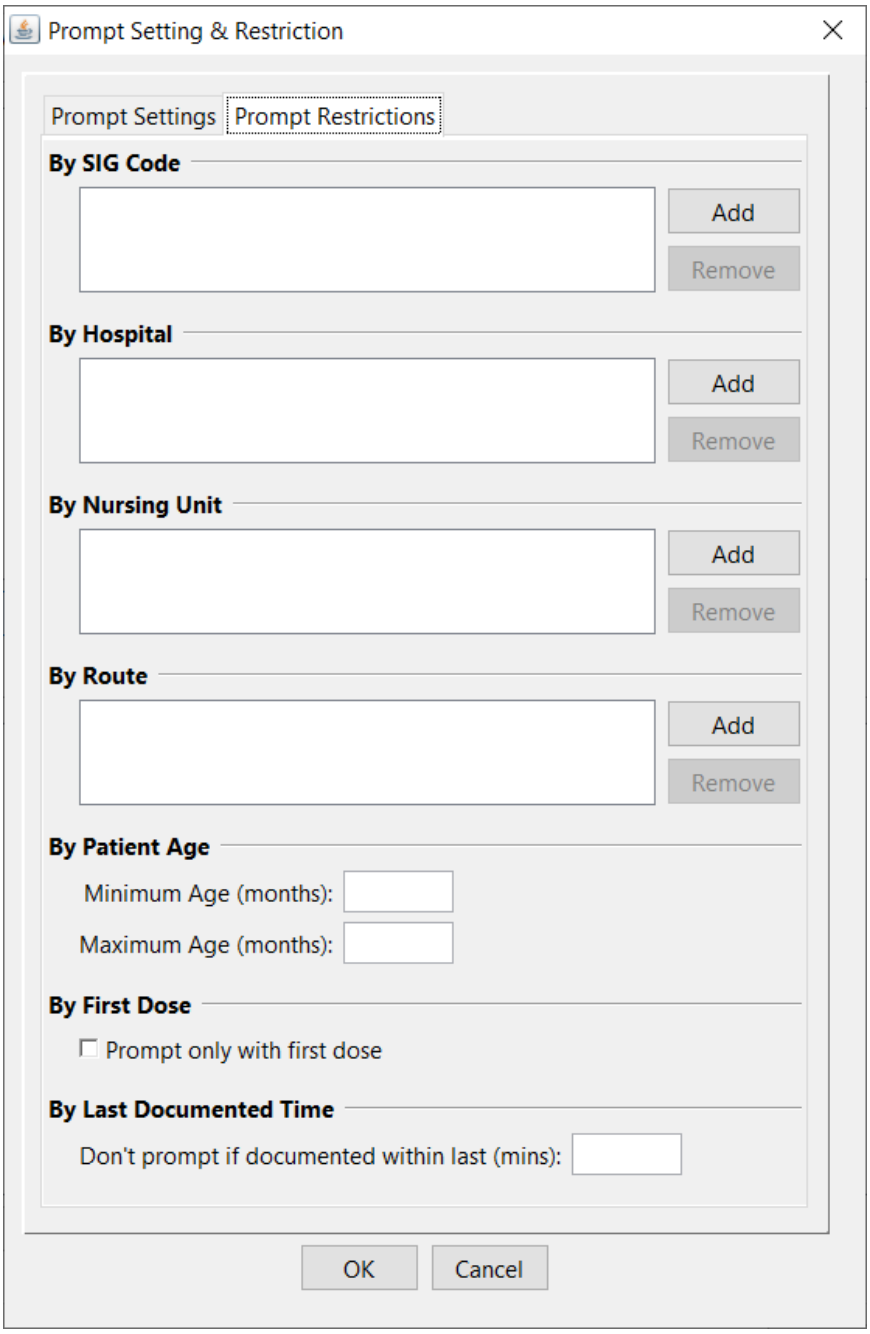
If applicable, indicate Follow Up Schedule options as follows:

- **Fixed Interval and Repeat Times** – Indicates the time interval between administration and follow up, and if desired, additional follow ups at the same time interval.
- **Variable Interval** – Allows the definition of varying time intervals for follow ups.
- **Prompt Lead** – Defines the time period before a follow up is due during which the follow up may be fulfilled.
- **Prompt Lag** - Defines the time period after a follow up is due during which the follow up may be fulfilled.
- **Collapse Time** – Defines the time period within which multiple follow ups for the same clinical data may be collapsed into one follow up event.
- **Follow Up even if order discontinued** – Allows you to indicate that follow ups due after the last dose of an order is given should continue to be due even if the order is subsequently discontinued.

Repeat these steps for each Clinical Prompt you want to add.

3. Click the **Prompt Restrictions** tab.

**Prompt restrictions are included with follow up prompts.**




Configure prompt restrictions by:

- By SIG Code – Only prompt when an order for this medication contains specific SIG code(s)
- By Hospital – Only prompt when an order for this medication is to be given within the selected hospital. The list displays in alphabetical order. Select one or more facilities. Please note that the prompt will only display if the following conditions are met:
  - The prompt has been assigned to the medication being scanned or documented at the Clinical Manager.

- The transaction is taking place for a patient located in a hospital that is defined in the "By Hospital" table in prompt restriction setup.

- By Nursing Unit – Only prompt when an order for this medication is for a patient in a specific unit(s).
- By Route – Only prompt when an order for this medication is for specific route(s) of administration.
- By Patient Age – Only prompt if the patient age is between the min and max age in months specified.
- By First Dose – Only prompt on first dose of this medication.
- By Last Documented Time - Don't prompt if documented within last "X" minutes. There may be times when caregivers do not need to document the same clinical information that has recently been documented. For example, you may generally require that a pain assessment be documented as part of a medication administration. However, if a pain assessment has been documented within the past 30 minutes, you may want to alleviate the caregiver from having to re-document it. This setting allows you to define a time parameter to determine if the caregiver is required to document the information at the time of the administration.

4. Click **OK**.

### Clinical Decision Values

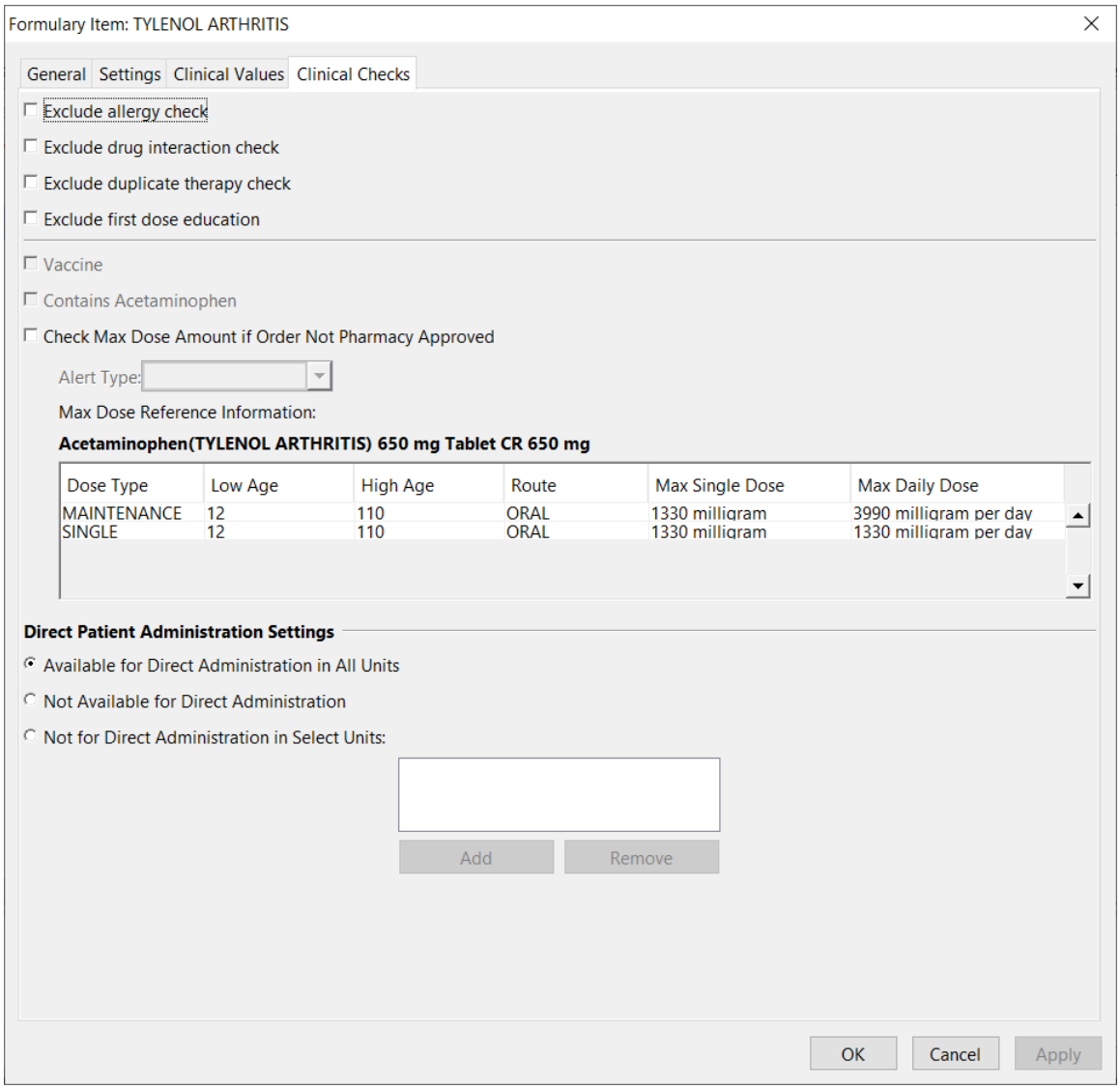
- The patient's lab values come to PatientTouch via an HL7 message from the Laboratory Information System. In order to display values, your hospital staff should work with PatientSafe Solutions Technical Support to establish this interface and verify that these messages are being passed from the LIS to the PatientTouch System.
- For medications to display these Clinical Decision Values during the administration workflow, the Clinical Decision Values must be assigned to the formulary line item.

To add clinical decision values:

1. In the Clinical Decision Values section, click **Add Decision Value** and select the decision values to associate with this formulary item.
2. Click **OK** to save your changes and exit the window, or click **Apply** to save these changes and continue to edit other settings.

### *Clinical Checks tab*

1. Select the **Clinical Checks** tab.




**Exclude allergy check** – Select to exclude this formulary item from allergy checking.

**Exclude drug interaction check** – Select to exclude this formulary item from drug interaction checking.

**Exclude duplicate therapy check** - When selected, the formulary item will be excluded from duplicate therapy checking. This setting is only active when the **Enable Duplicate Therapy Checking** setting is selected in **Clinical Settings**.

**Exclude first dose education** – Select to exclude educating the patient at the time of the first dose.

**Vaccine** – Medications that have a valid NDC and have been identified by FDB as a vaccine will display a grayed out checkbox.

**Contains Acetaminophen** – Note that any medication containing acetaminophen will be automatically identified by FDB, as shown in the grayed out section of the screen shot above.

**Check Max Single Dose Amount if Dose Not Pharmacy Approved** – Select to specify that the max single dose amount of this item based on patient parameters should be checked when being administered without a pharmacy approved order.

If the Check Max Single Dose options is selected, from the **Alert Type** drop-down list, select **Warn Only** if caregivers can continue medication administration after selecting an override reason, or select **Stop Administration** if caregivers must cancel the administration and document the reason.

Direct Patient Administration Settings:

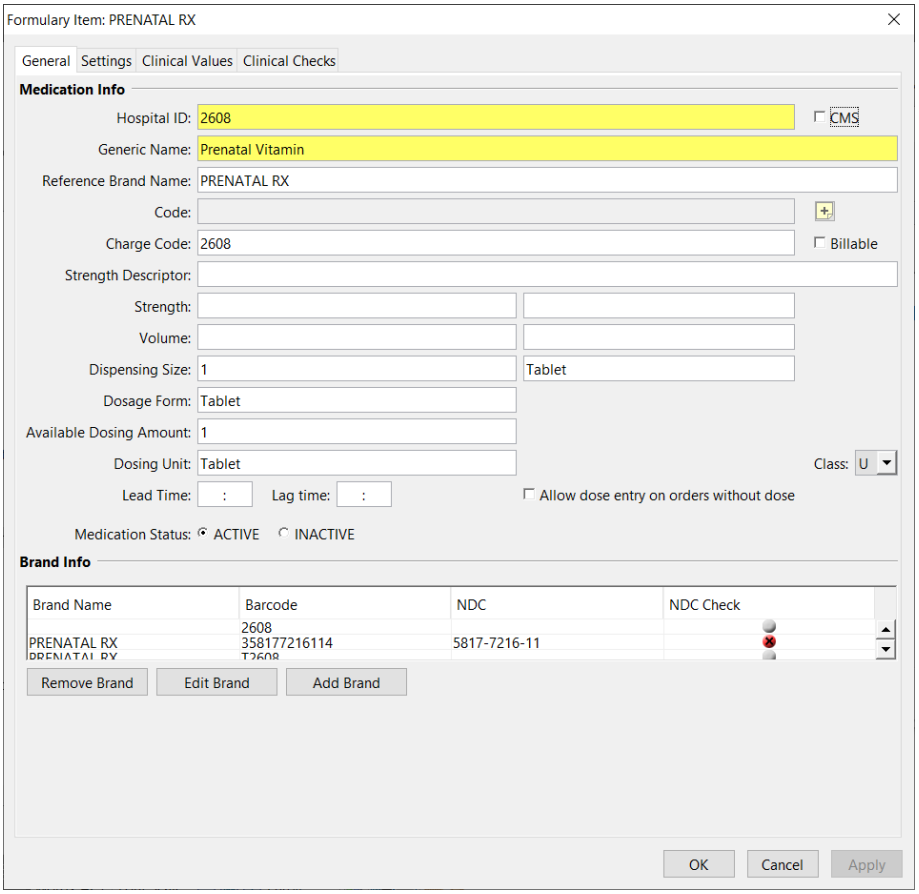
**Available for Direct Administration in All Units** – Indicates that this medication is approved for direct administration to a patient (e.g. without dilution) in all units of the hospital. [Default]

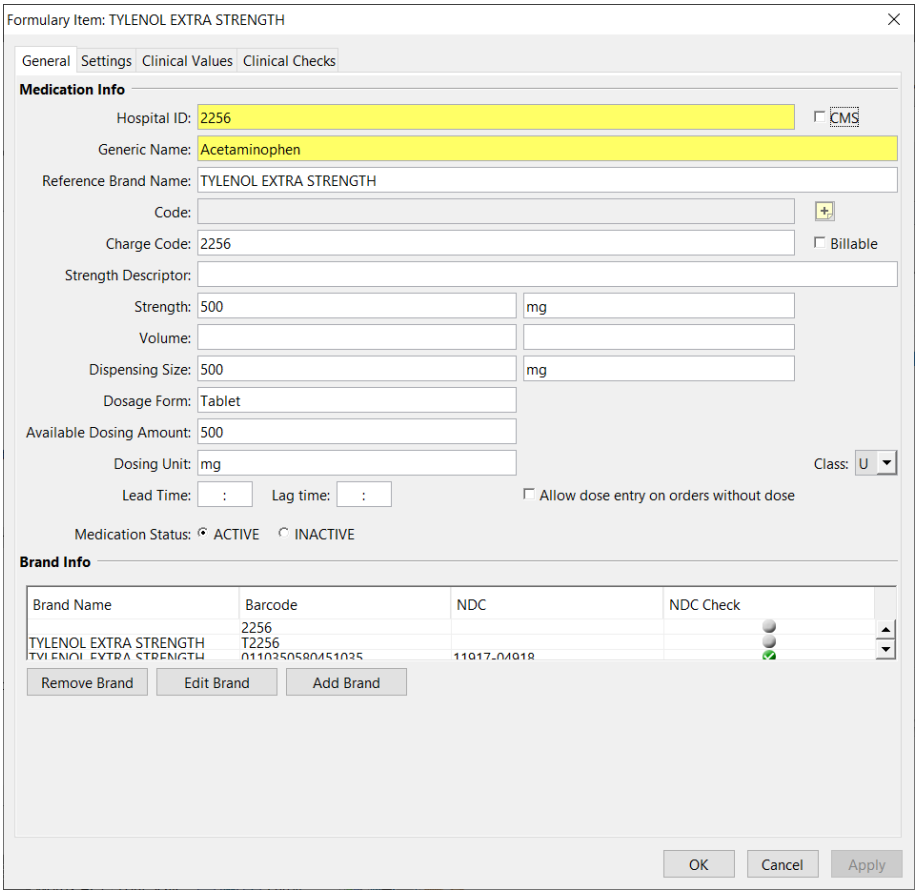
**Not Available for Direct Administration** - – Indicates that this medication is NOT approved for direct administration to a patient (e.g. without dilution) ANYWHERE in the hospital.

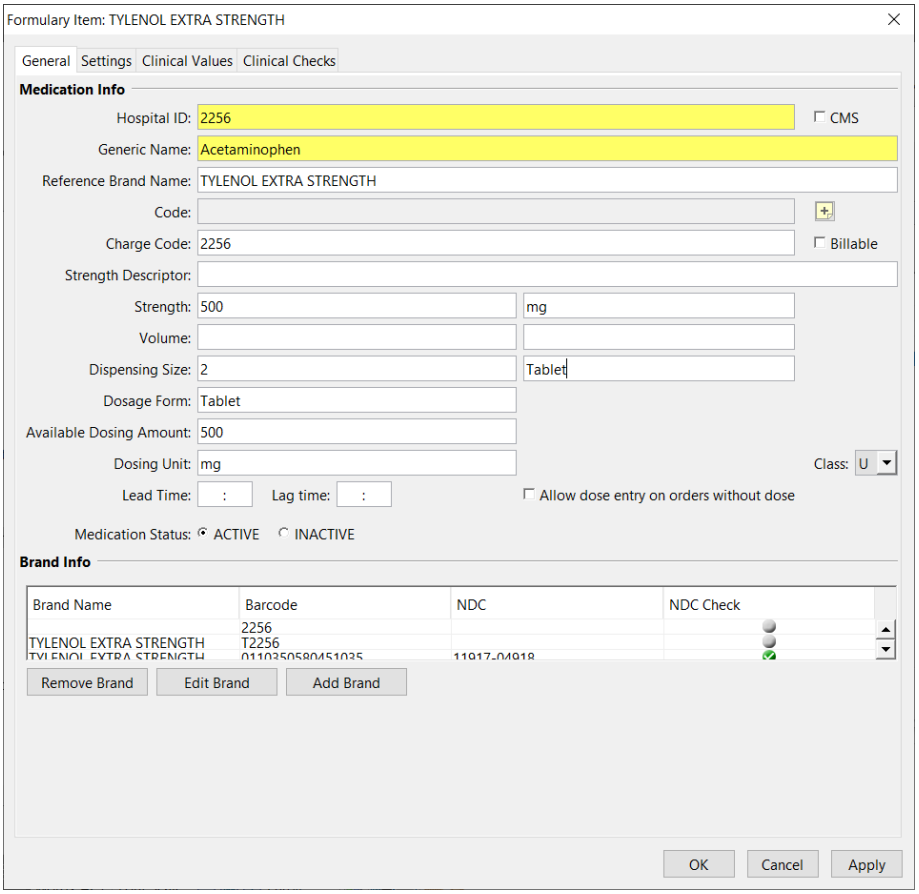
**Not for Direct Administration in Select Units** – Indicates that this medication is NOT approved for direct administration to a patient (e.g. without dilution) in SPECIFIED UNITS of the hospital (E.G. Heparin 10,000 Unit/mL in NICU).

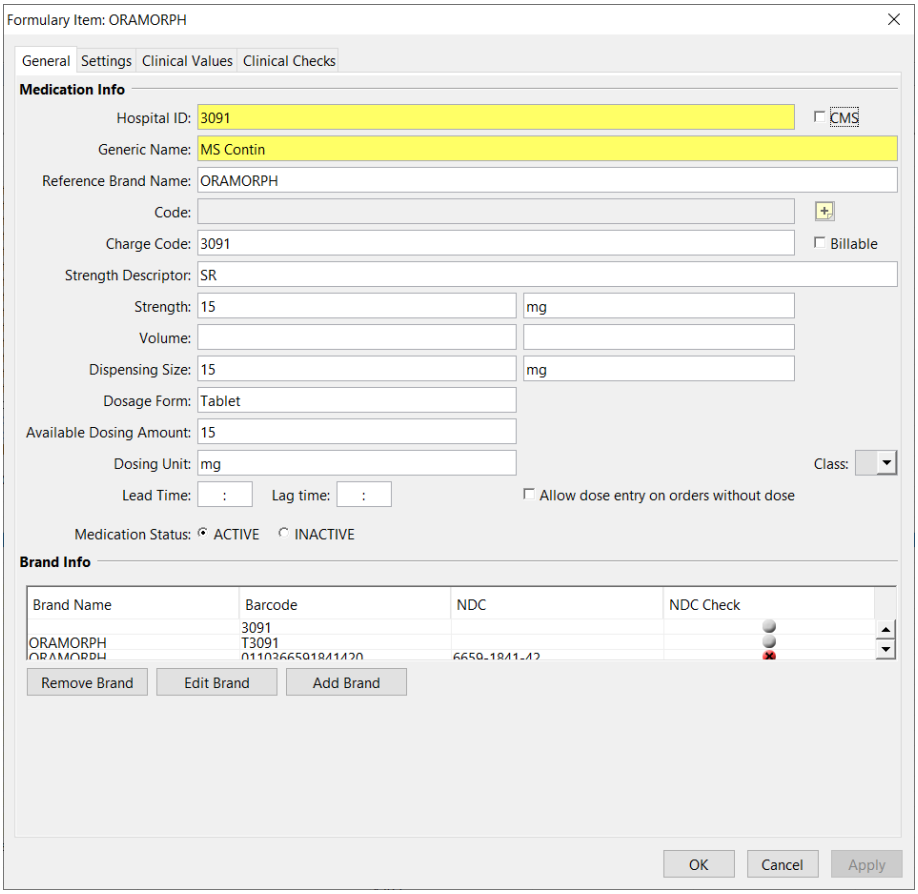
## Formulary Item Examples

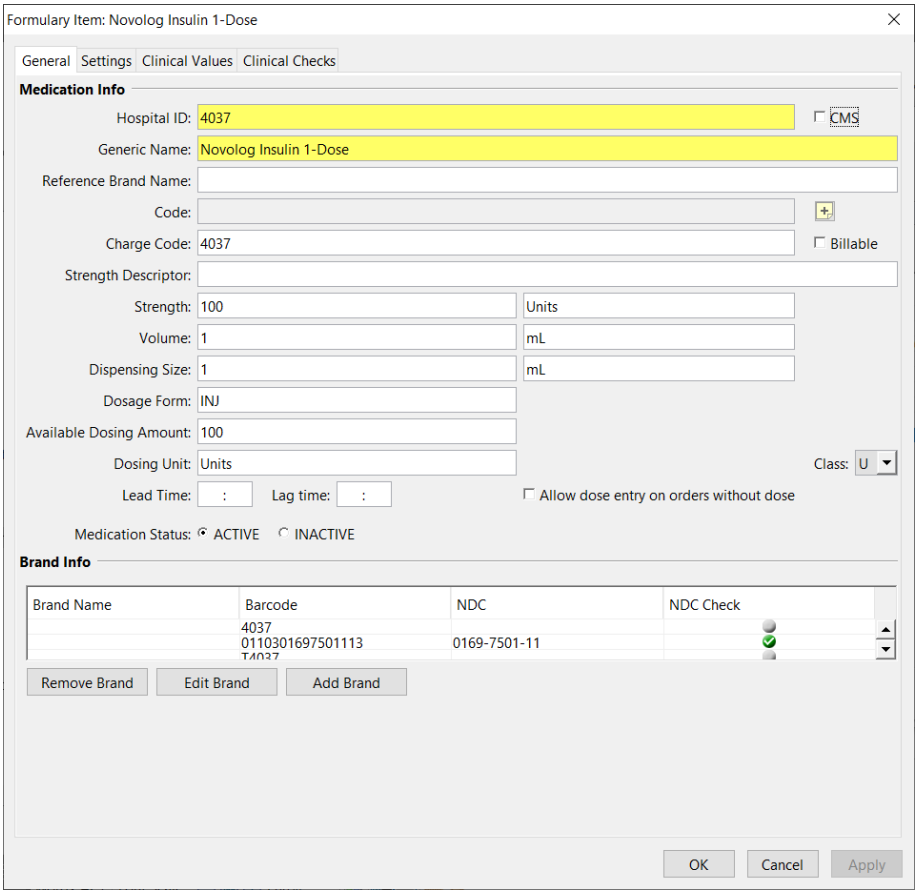
Refer to the following illustrations for an example of how to configure the most common formulary item types.

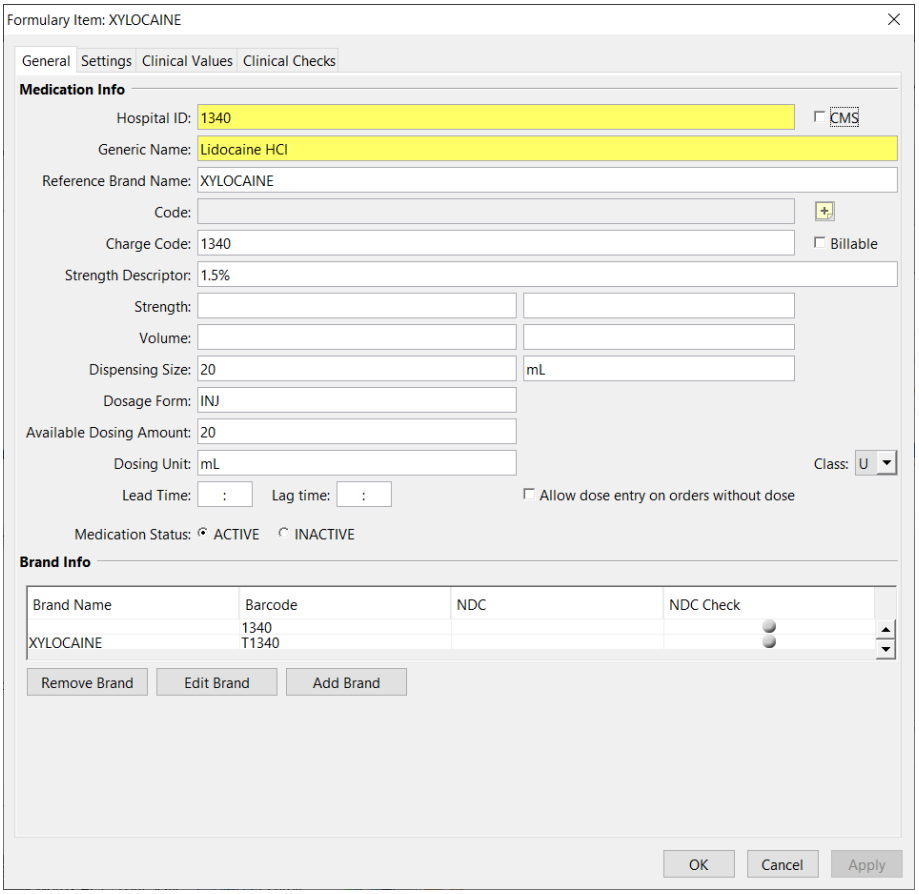
| Formulary Item | Example |
|---|---|
| Oral Solid - No Strength |  |

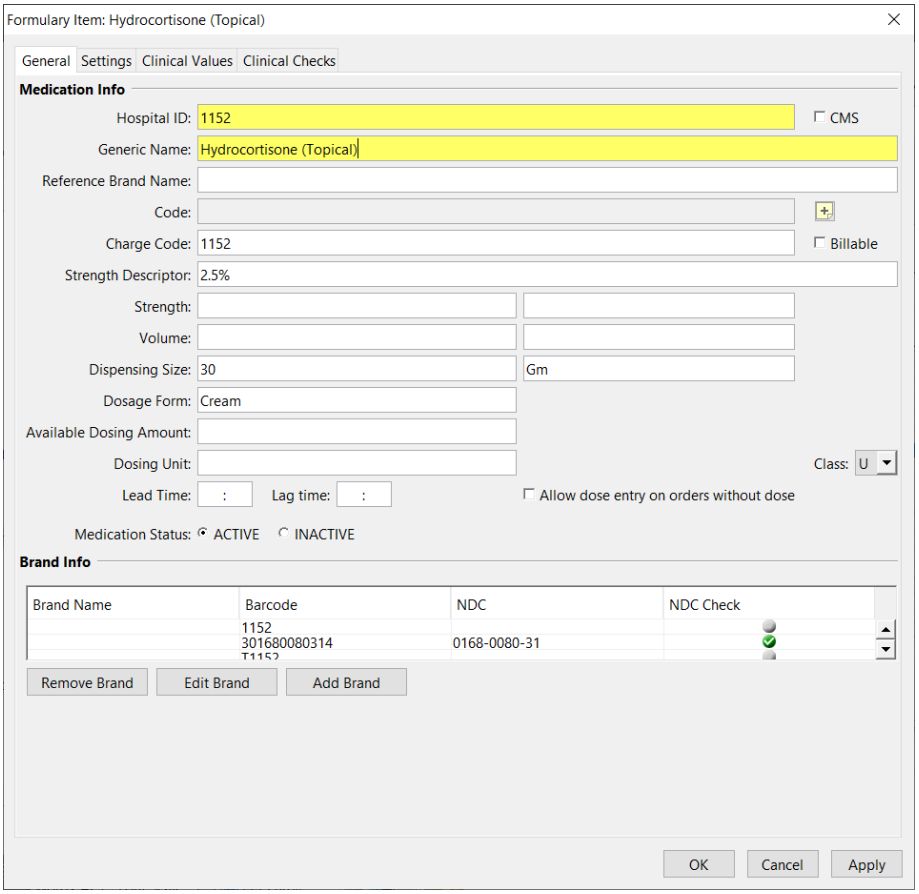
| Formulary Item | Example |
|---|---|
| Oral Solid - With Strength |  |

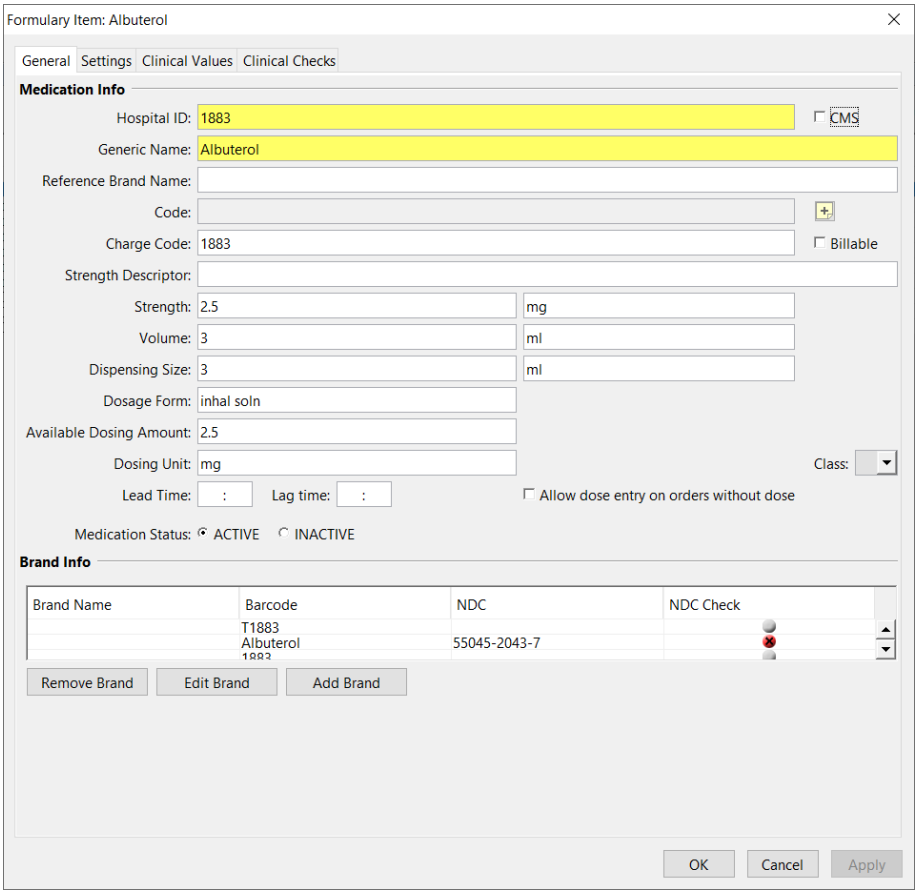
| Formulary Item | Example |
|---|---|
| Oral Solid - 2 Tab Packet |  |

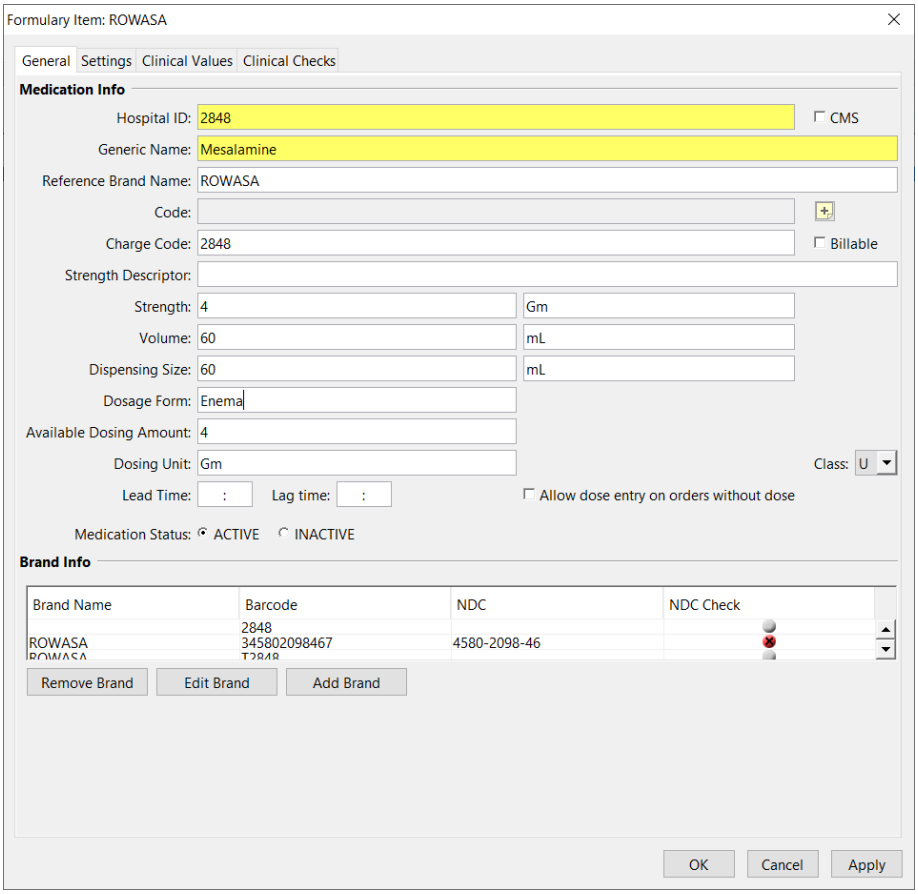
| Formulary Item | Example |
|---|---|
| Sustained Release Tab (LA, CR, XL) |  |

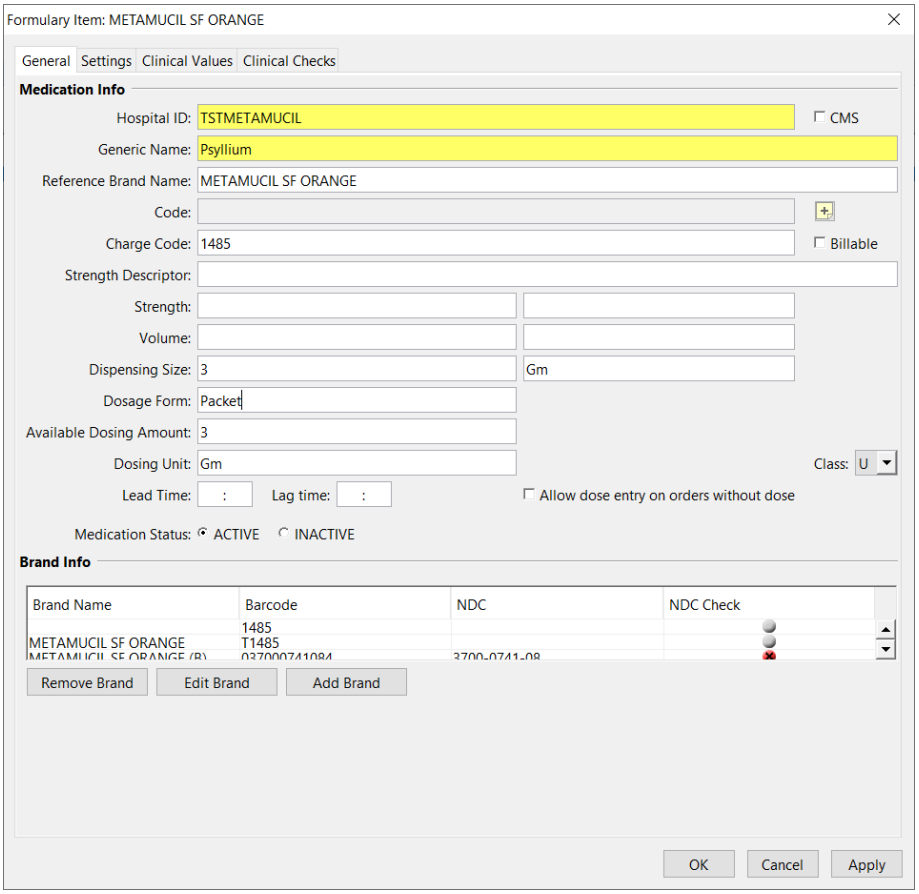
| Formulary Item | Example |
|---|---|
| Injectable - Single Dose |  |

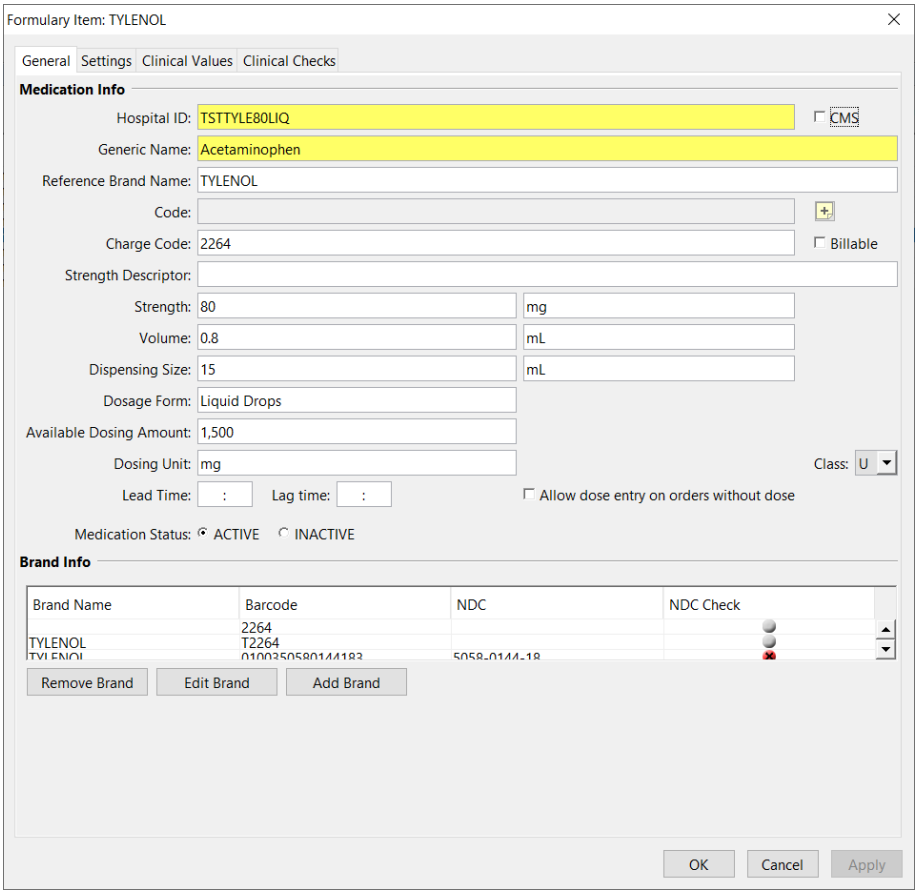
| Formulary Item | Example |
|---|---|
| Multi-Dose Floor Stock Injectable<br>With Strength |  |

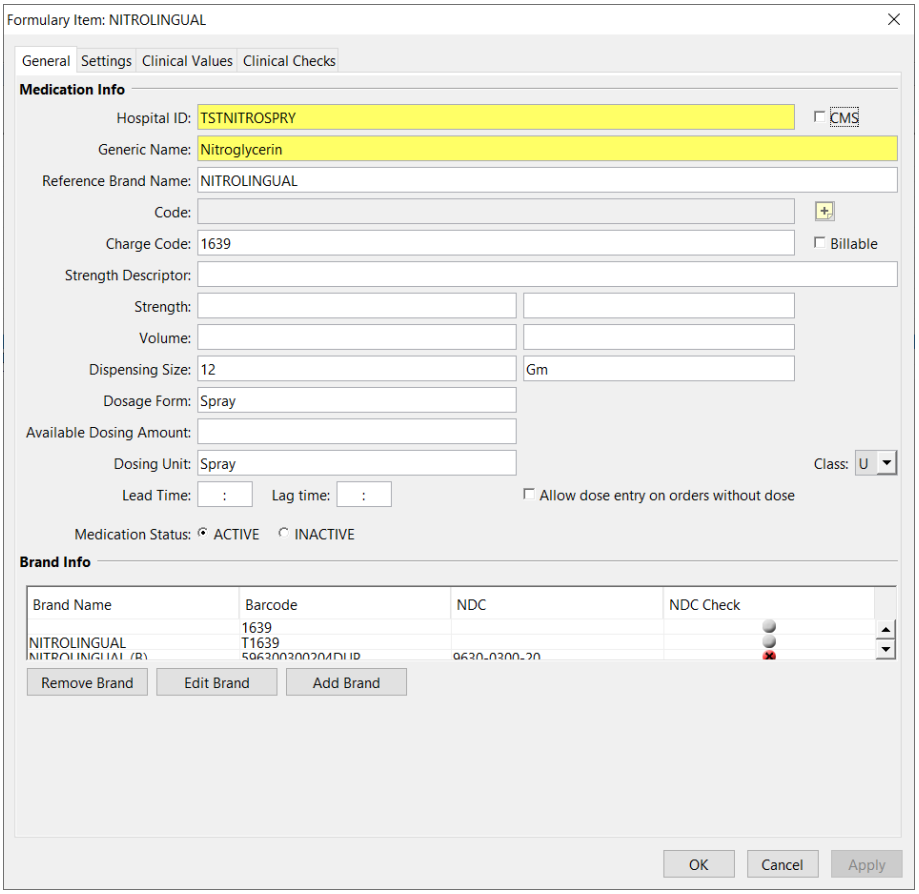
| Formulary Item | Example |
|---|---|
| Topical Cream/Ointment<br><br>Billed on Dispense |  |

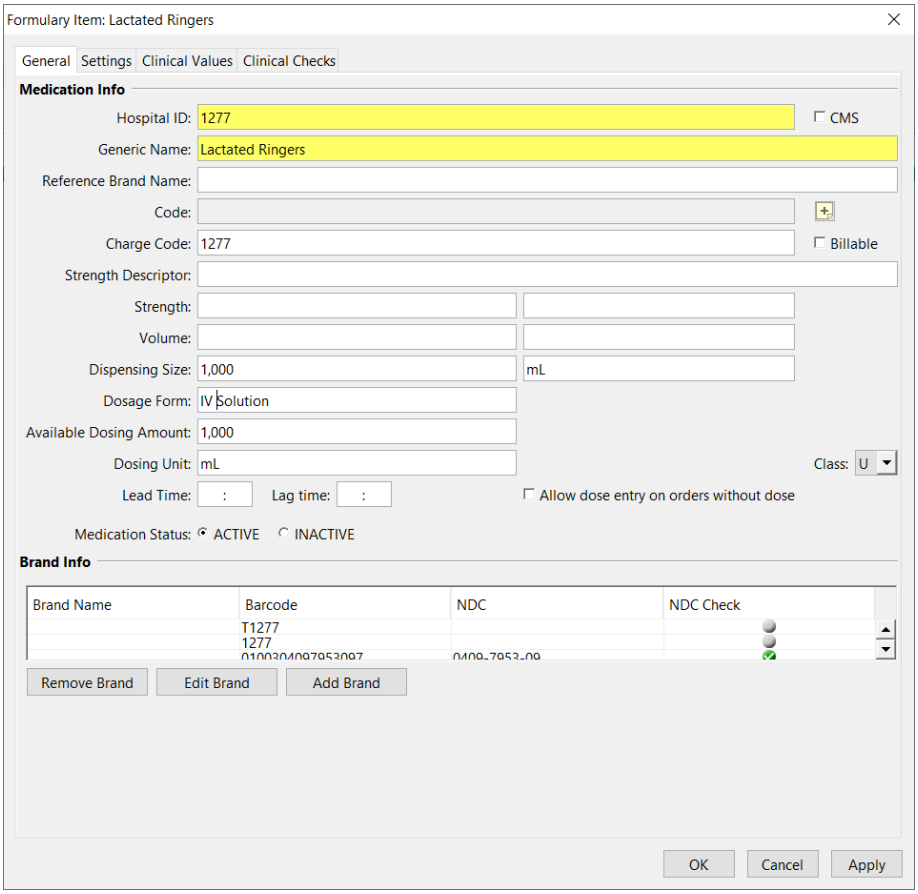
| Formulary Item | Example |
| --- | --- |
| Inhaler - Billed on Dispense |  |

| Formulary Item | Example |
|---|---|
| Enema |  |

| Formulary Item | Example |
|---|---|
| Powder Packet |  |

| Formulary Item | Example |
|---|---|
| Drops Billed on Dispense |  |

| Formulary Item | Example |
|---|---|
| Spray Billed on Dispense |  |

| Formulary Item | Example |
|---|---|
| IV Solution<br><br>Use the generic name field only, to avoid long and redundant display names. Use abbreviations cautiously. |  |



# Formulary Approval Tool (FAT)

**This feature is only applicable to Cerner sites.**

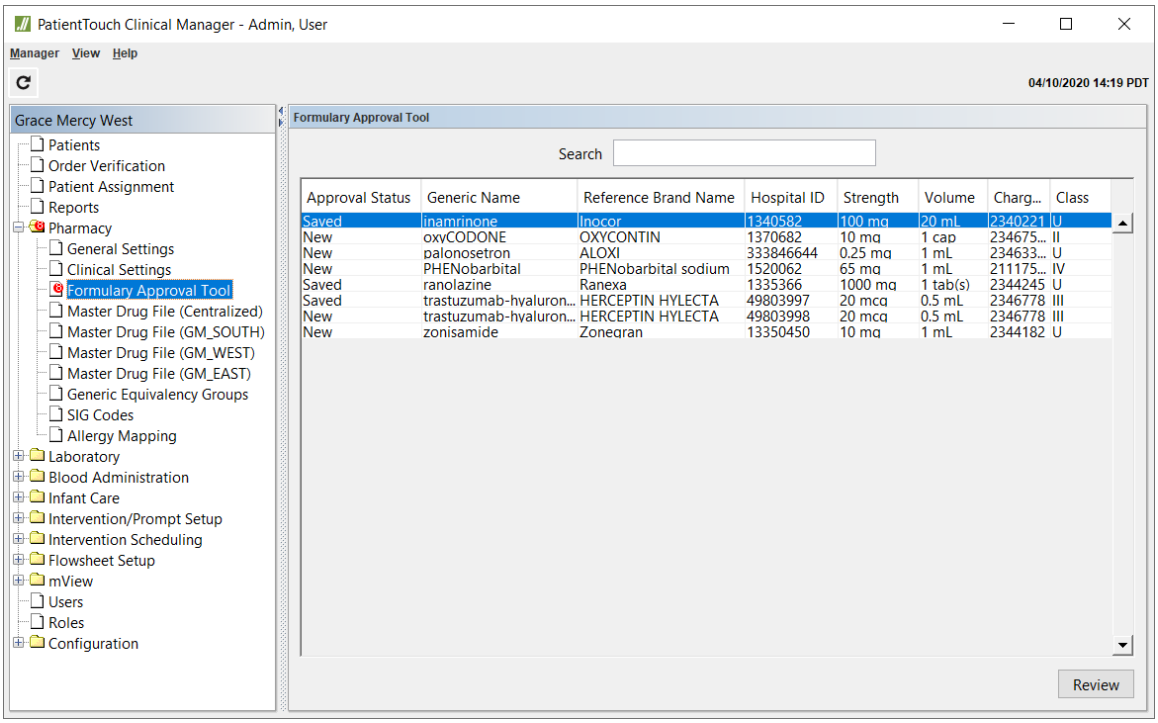
The Formulary Approval Tool provides a way for users to review and approve any newly added formulary items and make necessary updates that could not be populated via the interface. It provides for an external formulary and the PatientSafe formulary to be more in sync. Medications that are visible in the FAT will not qualify for use until they have been "Approved."

A badge count icon will be used at the folder level and again at the tool level to indicate how many new formulary items are awaiting review/approval.

**Users will need the Managed Centralized Formulary privilege to use the FAT.**

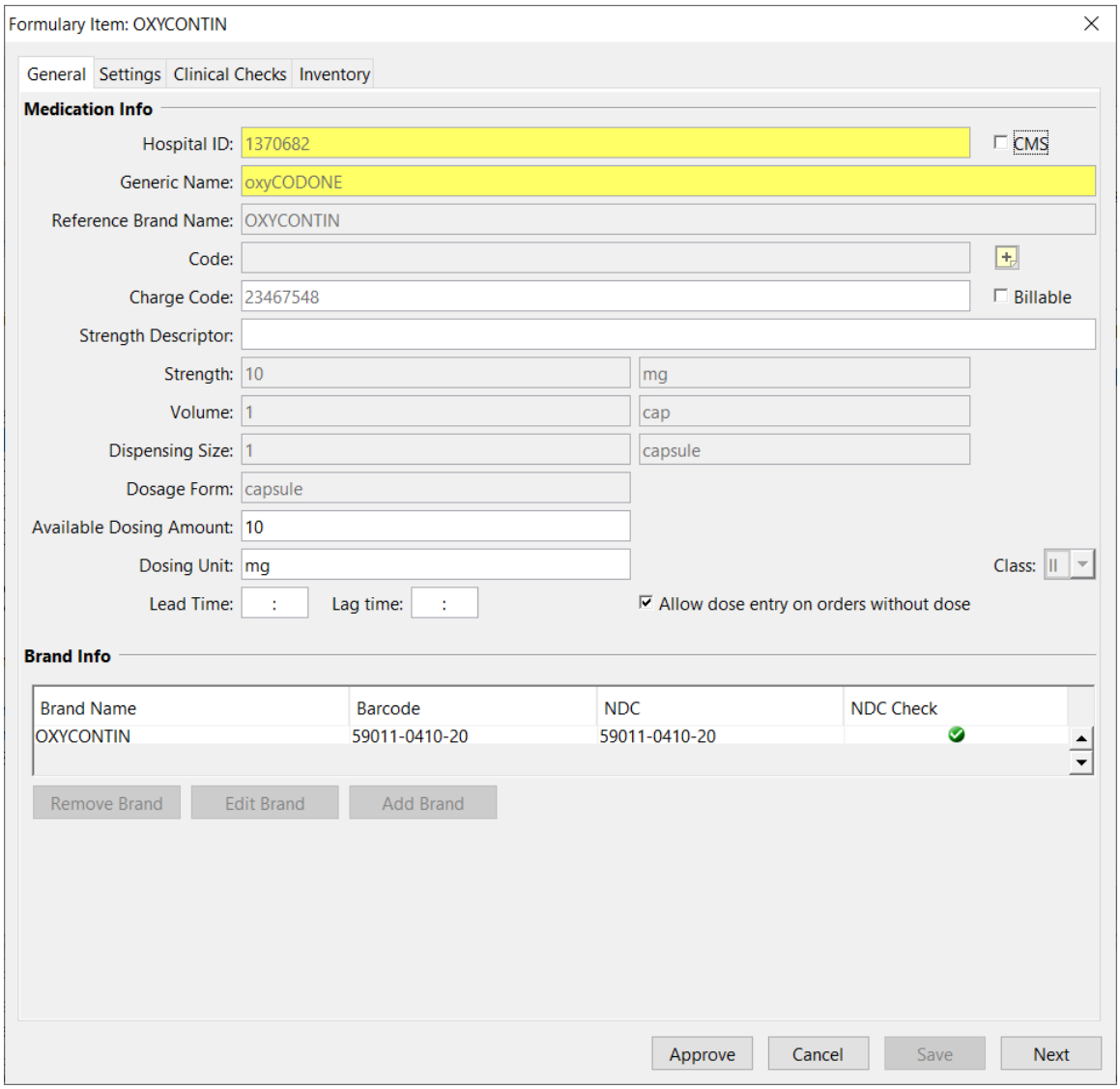
When you open the FAT you will see a queue of new medications waiting review/update/approval. A status column indicates if a formulary item is New (not yet reviewed/saved), or Saved.

1. Select a medication from the list by either double clicking the medication name , or, by selecting the medication and clicking **Review**.




2. You need to populate all required fields (if not already done) before you can approve any medication in the list. Review the button descriptions below for proper use:

   - **Approve** - If all required fields have been completed, clicking the Approve button will automatically release the medication for use and will display in the Master Drug File. If your site has multiple facilities, it will display in Master Drug File (Centralized) as well as the inventoried facility level Master Drug File(s).
   - **Save** - This will Save any modifications/edits to the medication (i.e. if you add/edit dosing unit), but will not approve the medication. Caregivers may approve the medication after saving.
   - **Cancel** - This will send the user back to the Formulary Approval Tool screen.
   - **Next** - This will send the user to the next medication in the list without approving.

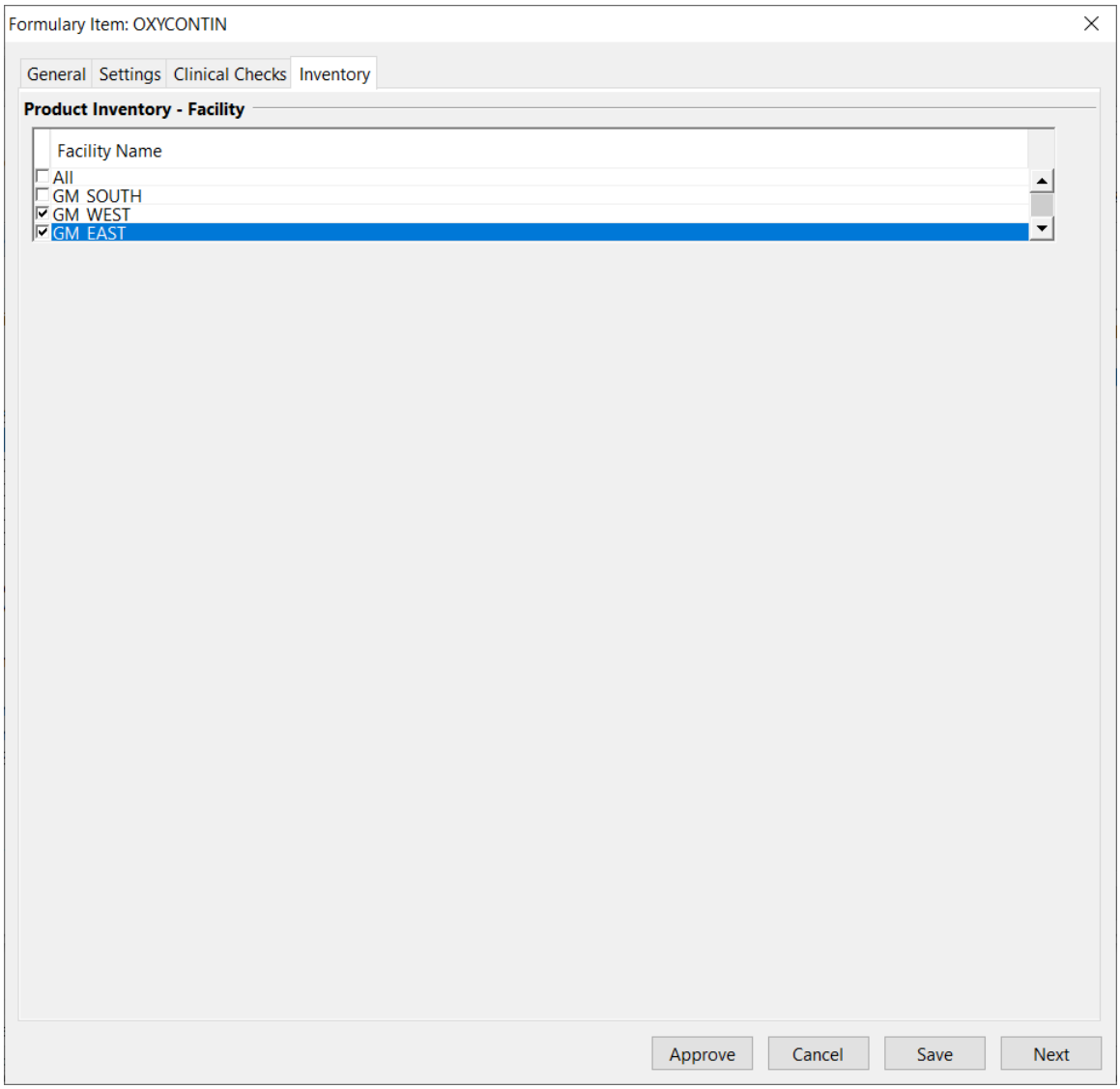



Modifications received through the interface will not require FAT review and approval. Modifications made through the interface will automatically update in the centralized formulary as well as the individual, site-specific formularies.

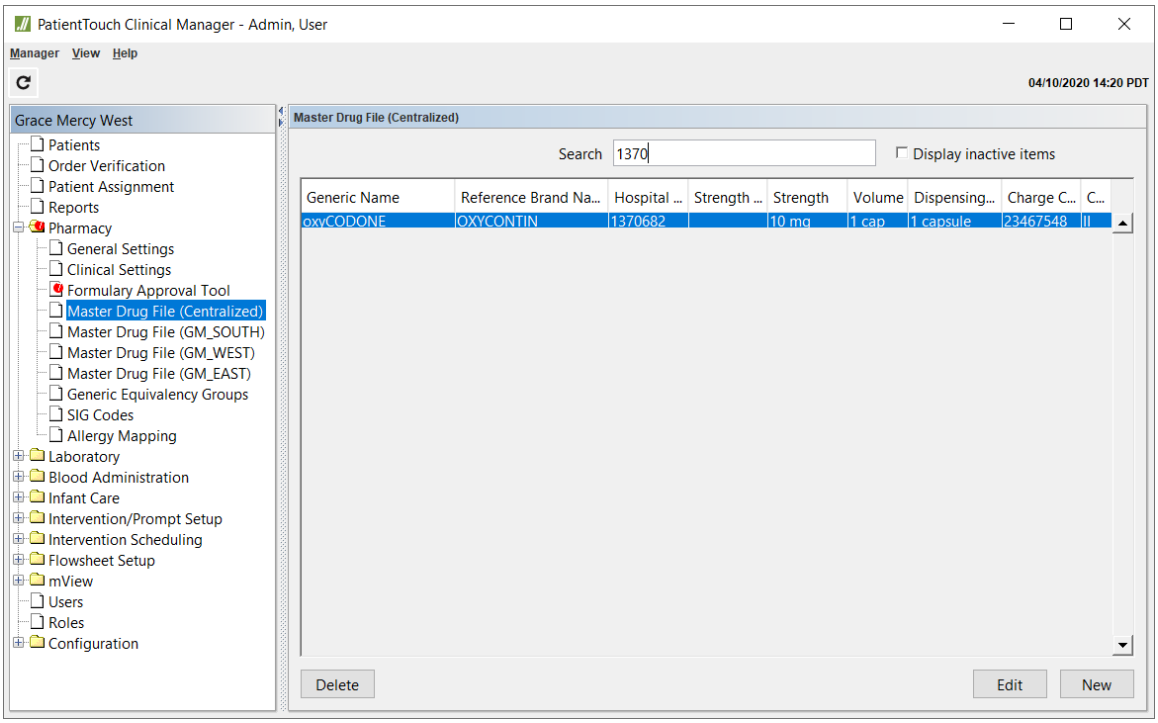
# Multi Facility

If your site has multiple facilities, the Inventory tab will display with those sites. Managing inventory is configurable to allow management through the PatientTouch System or via interface updates.

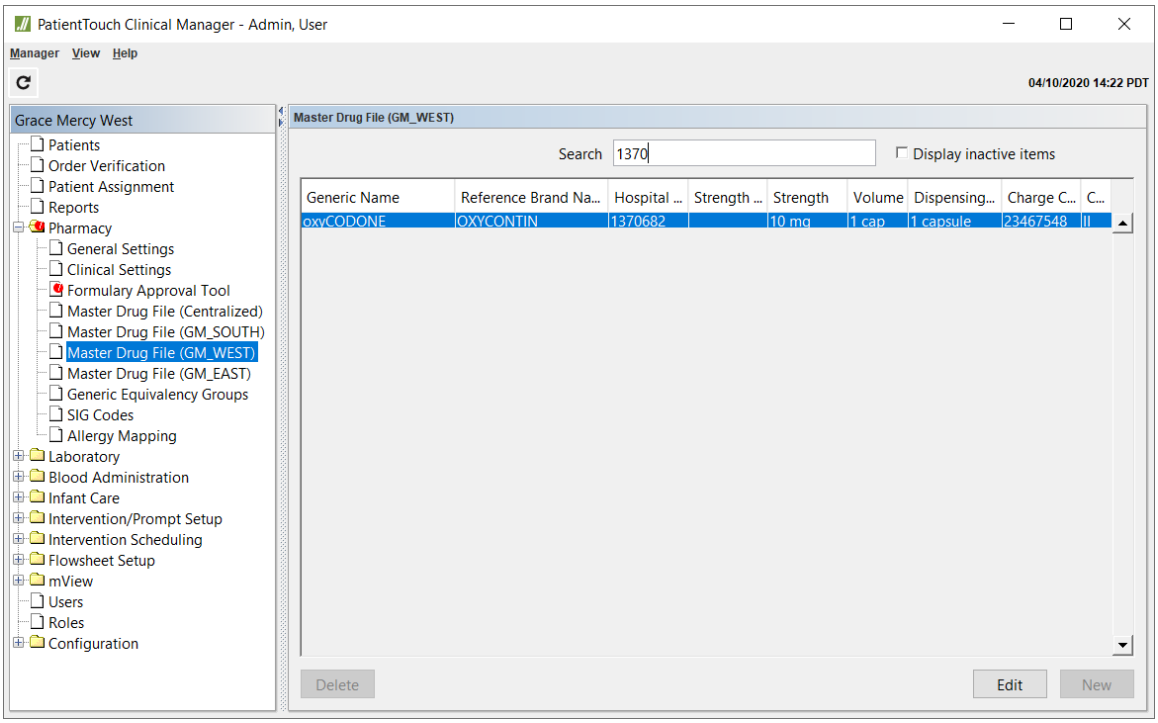
1. If managed through the PatientTouch System, select the facilities for which you want to distribute the medication.
2. Click **Approve**.



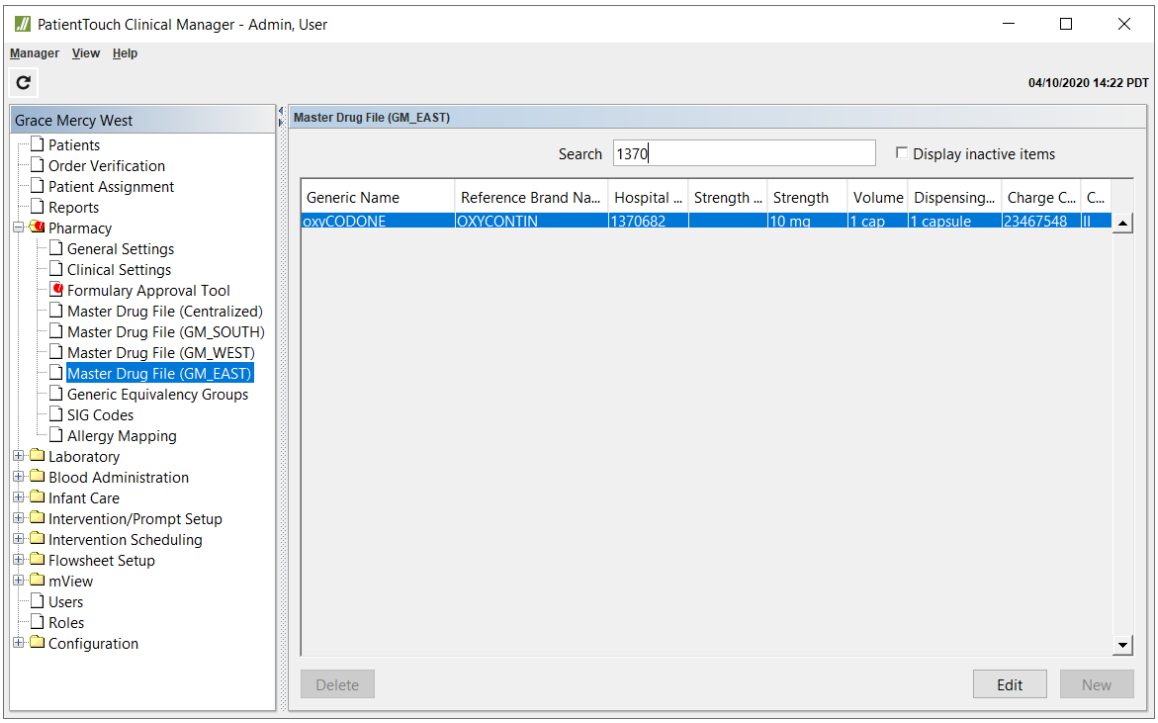

3. The approved medication now displays in the Master Drug File (Centralized). Any changes to the medication from the centralized formulary will also appear in the medications in the designated facilities (GM_EAST, GM_WEST in the example above). For example, you may approve a medication in Master Drug File (Centralized)>Inventory tab, which will distribute the medication to the designated facilities.




4. The approved medication displays in GM West….

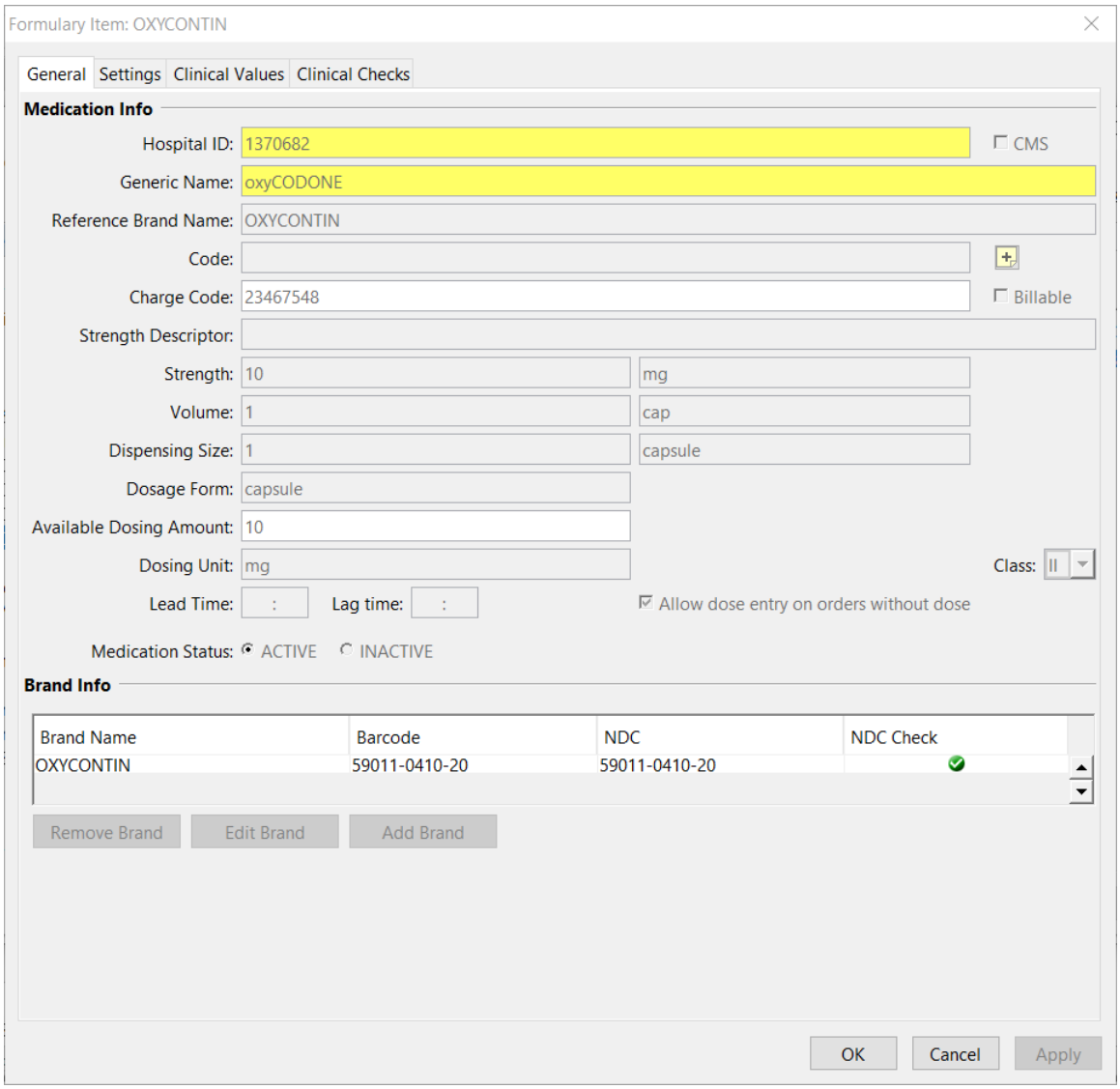



5. and GM East.




Depending on configuration, some centralized fields will be grayed out as you can only make changes to clinical prompting at the site level.

**Please contact PatientSafe Solutions Implementation Team during install or the PatientSafe Solutions Technical Support Team after install if you want any centralized fields active that are not currently made so.**




# Generic Equivalency Groups (GEG)

Situations sometimes occur where a caregiver needs to fulfill the dose of an ordered medication with a different strength of the same medication. For example, an order for Furosemide 40mg Tablet might be fulfilled by scanning two Furosemide 20mg tablets.

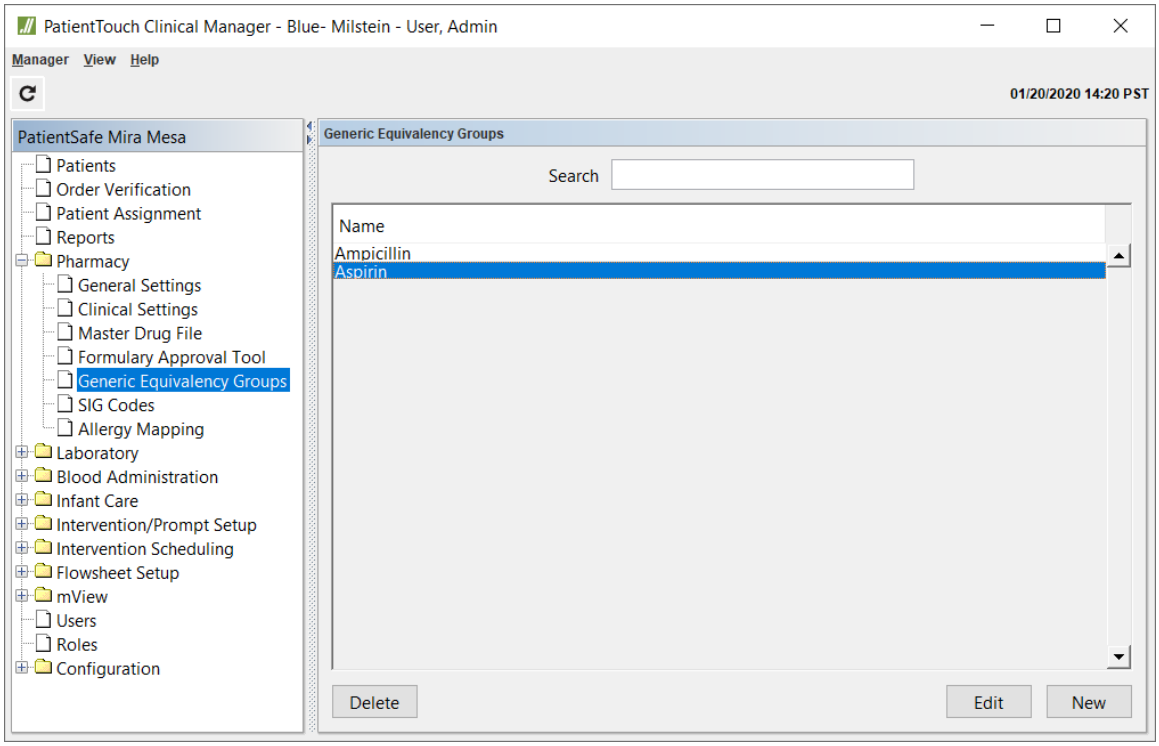
However, when scanned, the barcode on the 20mg tablets is not recognized as a match for the 40mg tablet order, so the nurse is prompted with an “Order Not Found in System” alert. Similarly, this would occur if a Pilocarpine 1% eye drop was ordered as the 5mL size but the 2mL size was dispensed and scanned. Generic Equivalency Groups allow you to anticipate these situations.

The PatientTouch System provides for two types of Generic Equivalency Groups: **Single Units of Measure** and **Multiple Units of Measure**. Use the instructions below for each method.

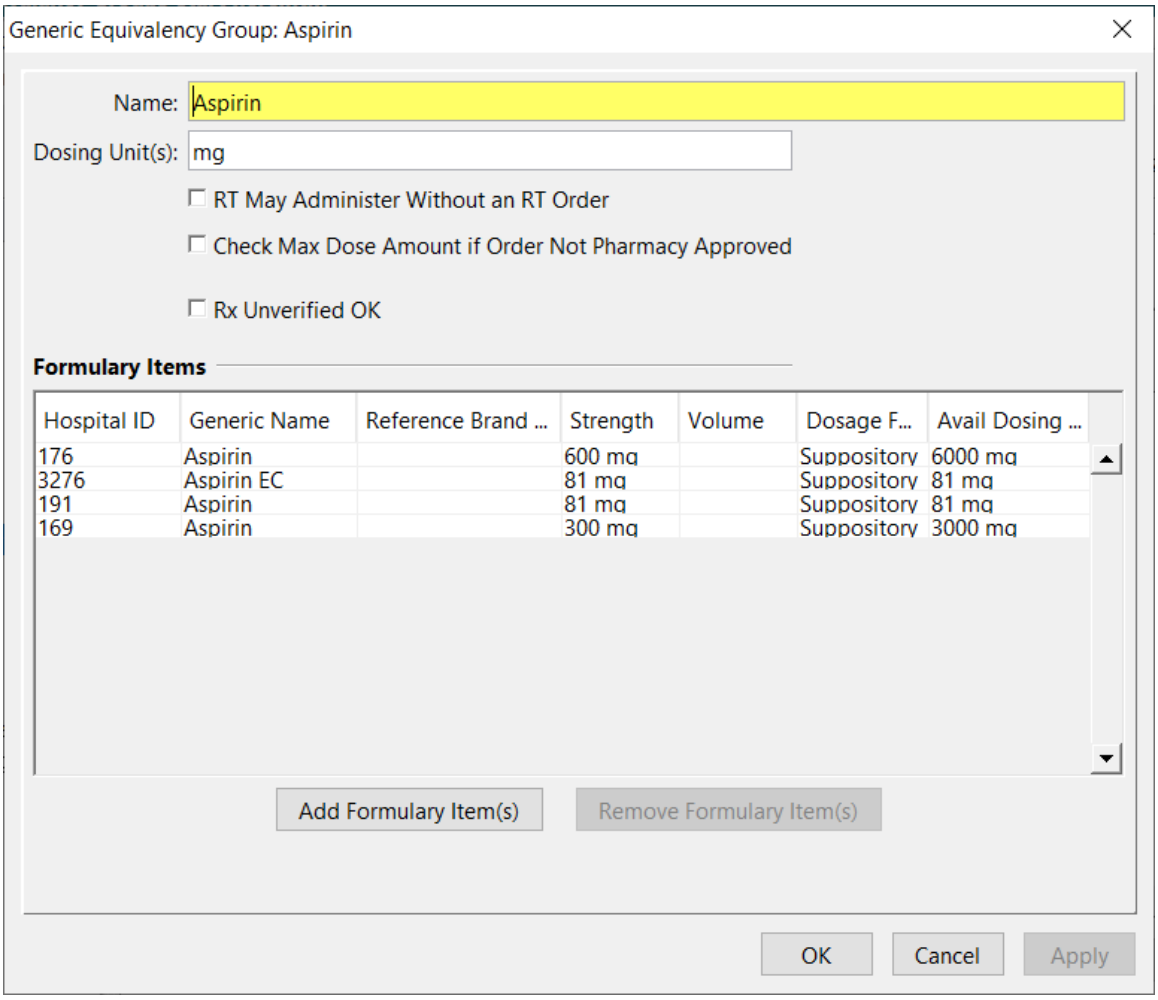
# Single Units of Measure

To create a new Generic Equivalency Group with formulary items of the same unit of measure:

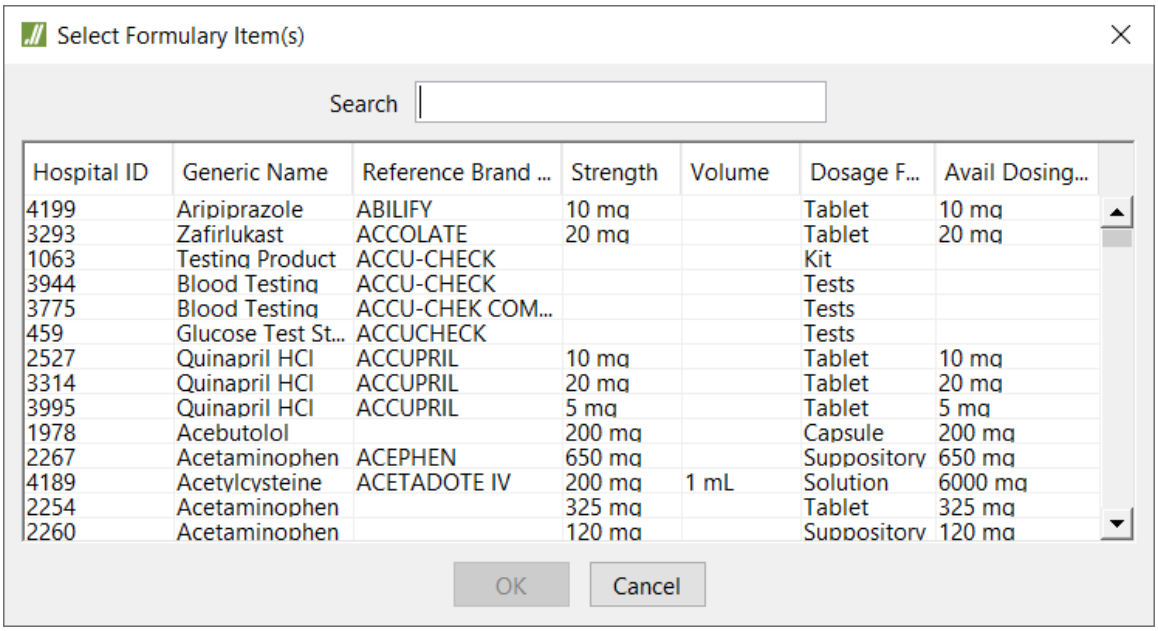
1. From the **Pharmacy** folder, select **Generic Equivalency Groups**.
2. Click **New** to display the window for the new group.




3. Enter a Name for the group. For example, Aspirin.
4. Define the settings for the group:
   - **Dosing Unit (e.g. mg)** – PatientTouch formulary dosing unit must be the same for all members of a group.
   - **RT May Administer Without an RT Order** – Setting must be the same for all members of the group.
   - **Check Max Single Dose Amount if Dose Not Pharmacy Approved** - The max single dose checking feature alerts the caregiver if he or she is going to exceed the recommended maximum dose amount for a single dose of the medication based on the patient's age, height and weight. The check will take place if the caregiver scans the medication prior to pharmacy entering/approving the order AND there is a valid NDC associated with the formulary item and the patient's demographics are available.
   - **RX Unverified OK** – This CPOE-related setting must be the same for all members of the group.
5. Click **Add Formulary Item(s).**




6. Select the formulary items to include in the group. To select multiple items at once, hold the Ctrl key down while selecting each item.
7. Click **OK** on the *Select Formulary Item* window.




8. Click **OK** again on the *New Generic Equivalency Group* window.

## Multiple Units of Measure

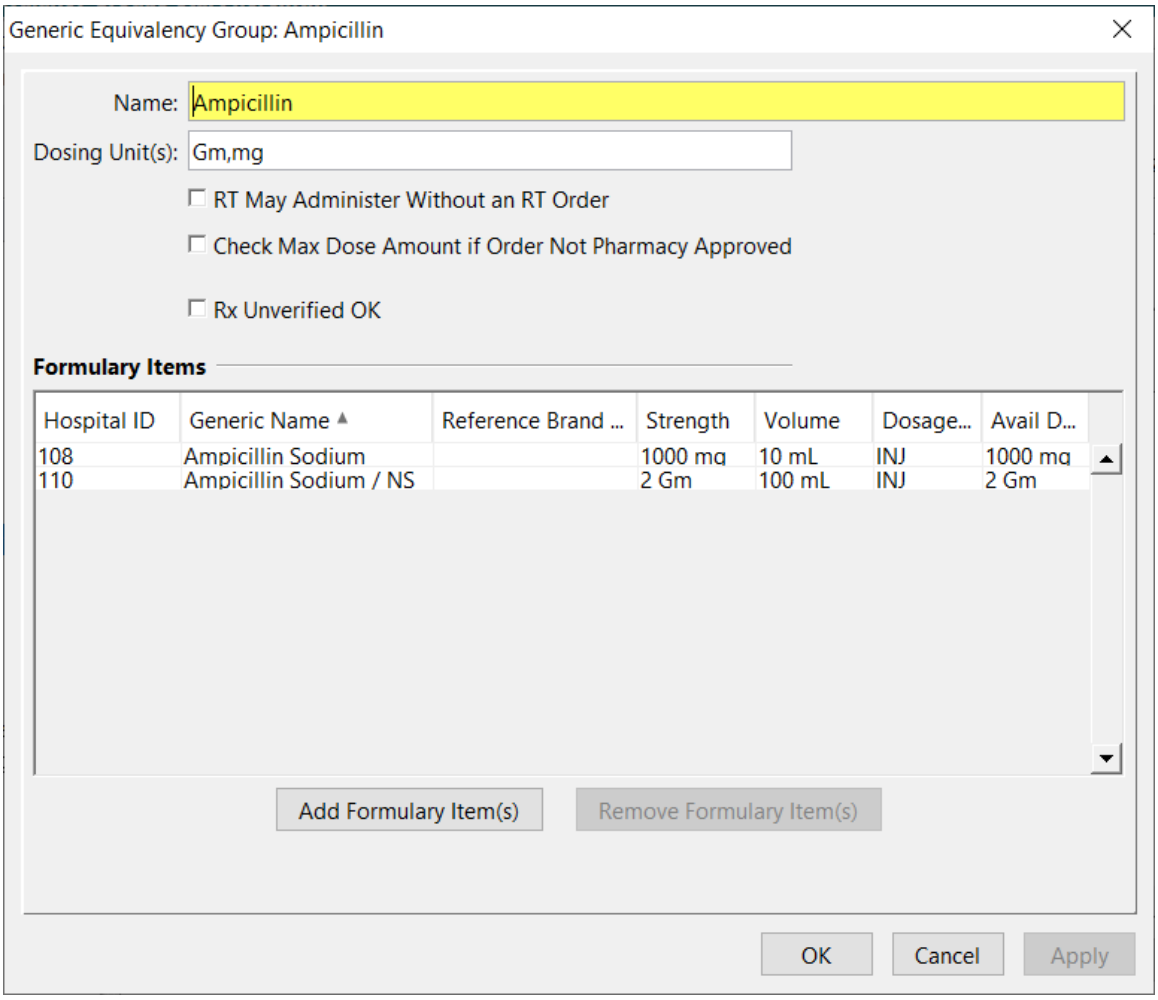
Clinicians may use certain units of measure interchangeably when ordering and/or administering medications. Therefore, Generic Equivalency Groups, allow for products of different, but equivalent, units of measure to exist within the same GEG.

The following unit types are recognized as equivalents in the GEG and allowed to be present in the same grouping:

- mL and L
- mcg, mg, and Gm
- milliunits and units

To create a new Generic Equivalency Group with formulary items of different units of measure:

Select formulary items within the same grouping. For example, Ampicillin may have mg's and Gm's as units of measure. Select each one for the same GEG.




# Generic Equivalency Group Warnings

Three types of warnings may display when you create or edit a group

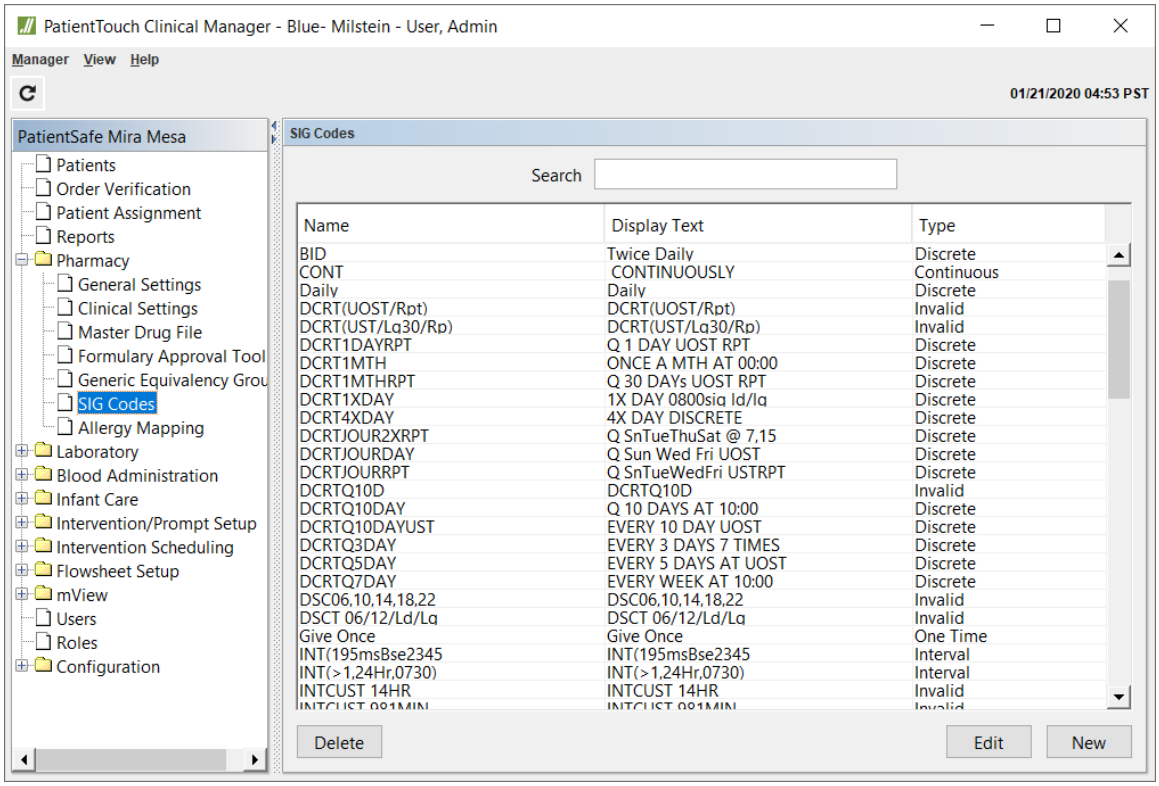
1. If the selected items do not have a defined Dosing Unit (such as mg, mL, mEq), do not have the same Dosing Unit (such as mg), or the Dosing Units are not compatible (Gm and units) in the formulary settings, the system displays an error message and returns you to the formulary item search window. A similar error message will occur if the **RT May Administer Without an RT Order, Check Max Single Dose Amount if Dose Not Pharmacy Approved**, or **RX Unverified OK** settings do not match.
2. If the Generic Names of one or more of the selected items are not consistent, the system displays a confirmation/warning message. If you want to save the equivalency group as is, click **OK**. If you want to make corrections to the group first, click **Cancel**.
3. If the Dosage Form of one or more of the selected items is not consistent with other items in the group (for example, Tablet LA versus Tablet), the system displays a confirmation/warning message. You can click **OK** to save the equivalency group as is or click **Cancel**.

# SIG Codes

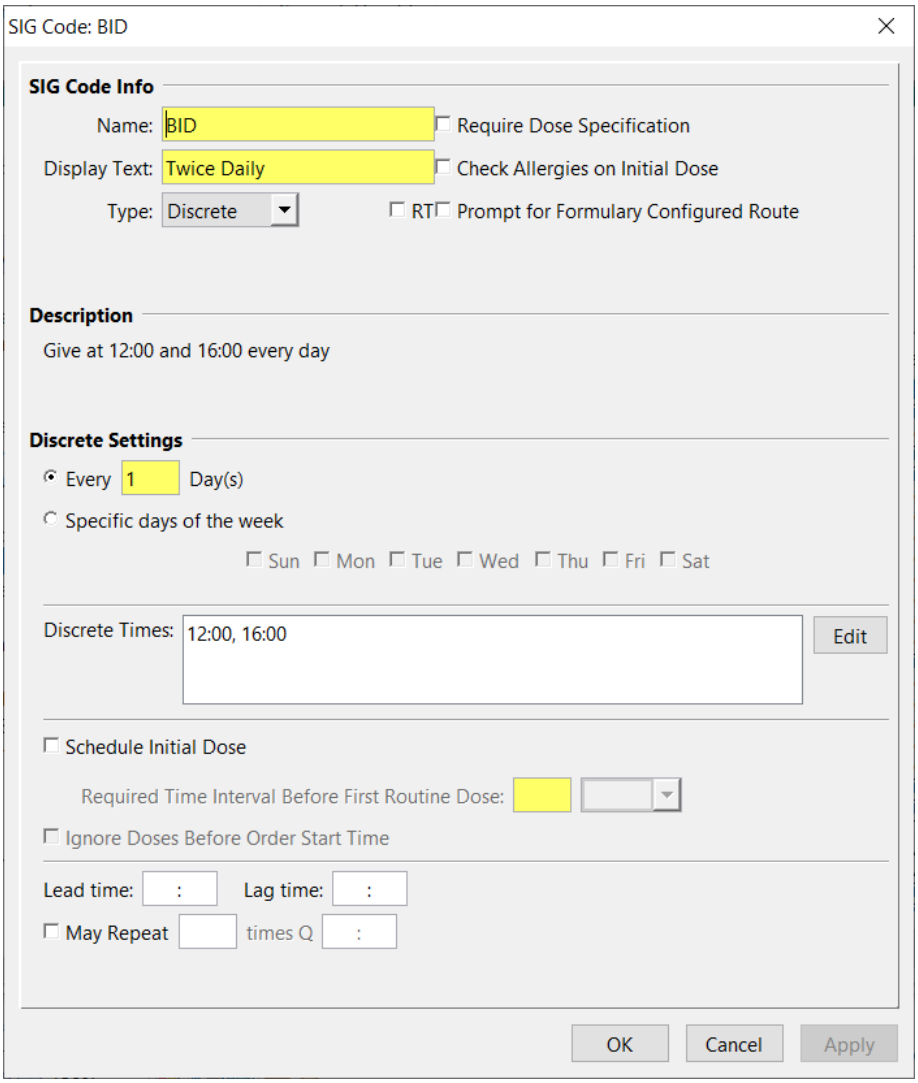
The Clinical Manager allows you to set up a unique SIG code to correspond with each SIG code in the pharmacy information system. The name of each SIG code in the Clinical Manager must be an exact match (including case) with the codes in the pharmacy information system.

## Create or Edit SIG Codes

1. Select **SIG Codes** from the Clinical Manager menu tree.
2. Click **New** to create a new SIG code.
3. Click **Edit** to modify an existing SIG code.




Every SIG code includes a Name (such as “BID”), which must match the name in the pharmacy system and Display Text, which is what appears on the handheld and on the MAR.




Selecting the **Type** of the SIG code determines what other options can be specified. The following types are available:

- **Discrete** for doses administered at specific times of the day
- **Interval** for SIG Codes with dose times at consistent time intervals
- **One Time** used for orders to be administered only once
- **PRN** for doses administered as needed
- **Continuous** for meds given routinely but without specific dose due times (for example, an IV infusion)

### *RT*

Check RT if you want users with the Respiratory Therapist privilege to see prompts and reminders for medication orders with this SIG code. If you check this option, the system also sends orders entered with this SIG code to the RT MAR Worksheet.

### Require Dose Specification

In some cases, the PatientTouch System will receive a medication order with a dose amount of “0” or with dosing units that do not match what is configured in the PatientTouch System. In order to accommodate these order types, sig codes in the PatientTouch System can now be configured to require the user to specify the dose amount.

### Check Allergies on Initial Dose

When this setting is enabled, allergy checks will occur on the initial dose of an order using this SIG code. The user will be informed/alerted only if there is an identified allergy. Note: This setting is subordinate to the global "Enable Allergy Checking" setting. If the global setting is off, this setting will not be functional.

### Prompt for Formulary Configured Route

When this setting is enabled, the user will be prompted for route using the formulary item's route settings, regardless of the route that is provided in the medication order. If the formulary item has only one route configured, the system will automatically use it and document against it. The route prompting will occur at admin details screens and the answer CAN trigger route based formulary prompting restrictions.

### Lead and Lag Times

Lead and lag times determine the window of time before and after a scheduled dose during which a dose can be administered and still be considered on time.

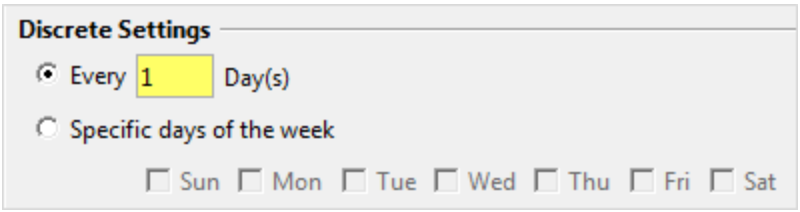
Setting lead and lag times for a SIG code is optional. If you do set a lead or lag time for a SIG code, these settings will take precedence over the times set for the nursing unit, but are superseded by the formulary lead and lag times.

### Discrete Dosing

For SIG codes that have hospital standard administration times, use the **SIG Type Discrete**.

To enter Discrete Dosing Times for a SIG code:

1. Choose the **SIG Type, Discrete**.
2. Check **RT** if you want users with the Respiratory Therapist privilege to see prompts and reminders for medication orders with this SIG code. If you check this option, the system also sends orders entered with this SIG code to the RT MAR Worksheet.
3. Enter the day interval. For example, enter 1 for a dose that occurs daily, 2 for every other day, etc.



If dosing for this SIG will occur only on select days of the week, click **Specific days of the week** and choose the appropriate weekdays.

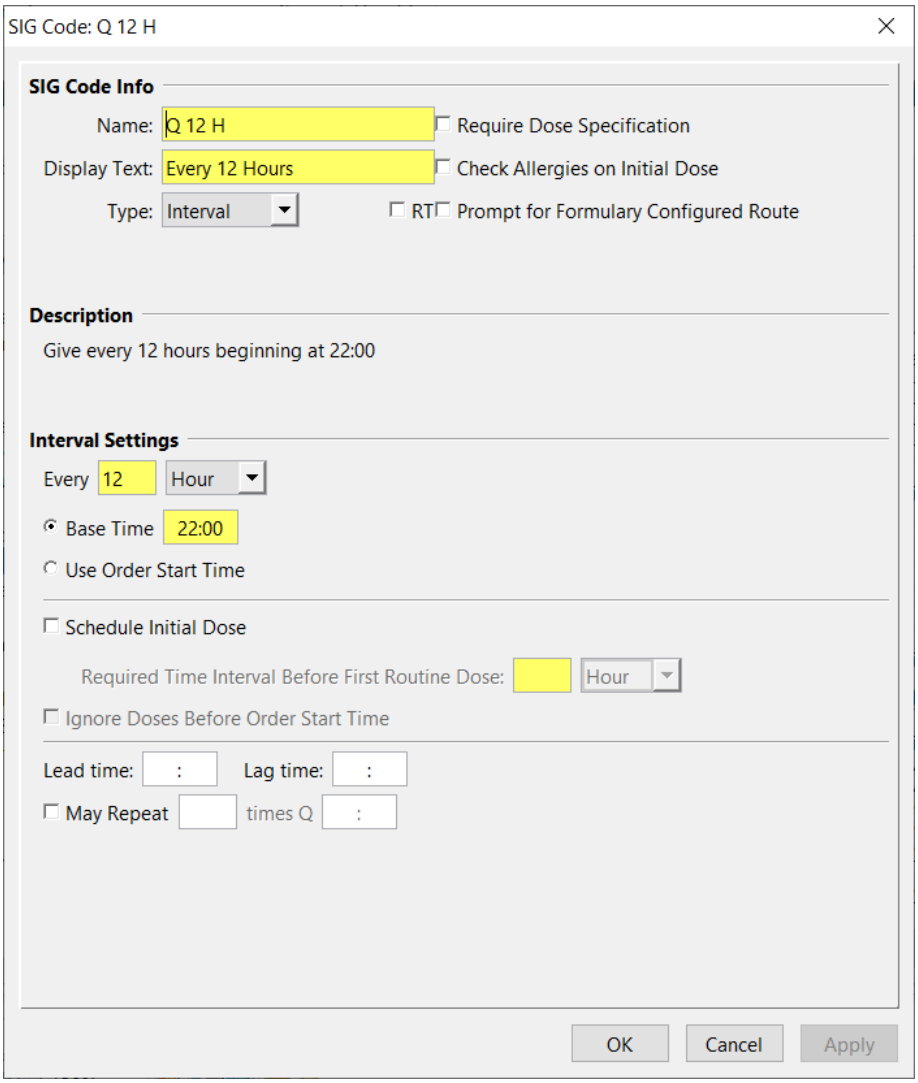
4. To select Discrete Dosing Times click **Edit** to enter the desired discrete times. Times can be indicated such as “0900, 1700” or just “9, 17”. Separate each time by a comma.
5. Select **Schedule Initial Dose** and enter a required time interval (minutes or hours) to have PatientTouch schedule an immediate dose if the length of time before the first scheduled dose will be due is longer than the time interval specified. For example, if discrete times for BID are 0900 and 2100 and an order is entered at 1300 for BID with Schedule Initial Dose enabled and time interval set at 6 hours, an initial dose will be scheduled. However, if the time interval were set at 9 hours, an initial dose would not be scheduled.
6. Enter Lead and Lag Times for doses on orders with this SIG code if desired.
7. If the order can be repeated, such as with HSMRx1i, select the **May Repeat** checkbox and enter the number of allowable repeat doses, and the required interval between each dose.
8. Click **OK** to save your changes.

### *Interval Dosing*

For SIG codes associated with scheduled time intervals in hours or minutes (such as Q 12 H), choose the **SIG Type Interval.**

To base the time of the first scheduled dose on the order start time, select the **Use Order Start Time** option. Otherwise, select the **Base Time** option, and enter a base time for calculating dosing times.

- Select **Schedule Initial Dose** and enter a required time interval (minutes or hours) to have PatientTouch schedule an immediate dose if the length of time before the first scheduled dose will be due is longer than the time interval specified. For example, if discrete times for BID are 0900 and 2100 and an order is entered at 1300 for BID with Schedule Initial Dose enabled and time interval set at 6 hours, and initial dose will be scheduled. However, if the time interval were set at 9 hours, an initial dose would not be scheduled
- Enter Lead and Lag Times for doses on orders with this SIG code if desired.




## One-Time Dosing

The **One Time SIG Type** designates a single dosing time and is based on the order's start time.

To create a one-time SIG code:

- Select **One Time** from the **SIG Type** drop-down list.
- Select the **Stat** checkbox if SIG code will always be used for STAT orders. This will cause the order to appear in the STAT category on the patient's medication order screen on the handheld.
- Select the **RT** checkbox if this is a Respiratory Therapy SIG Code, if needed.
- Enter specific lead and/or lag times as needed.

## As Needed Dosing

For SIG codes that may be given as needed, with or without an interval, select **PRN** as the **SIG Type** and, optionally, designate a PRN Setting interval in hours or minutes. To provide a "lead time" for PRN

dosing when a dosing interval is desired, use an interval that is slightly less than the actual dosing interval. This allows the nurse to be slightly early for a PRN dose without receiving a warning that the dose being given is early. For example, for “every four hours PRN” (Q4HP), use a PRN Setting interval of 220 minutes rather than 4 hours (240 minutes) to allow a PRN lead time of 20 minutes.

Select the **RT** checkbox if this is a Respiratory Therapy SIG Code, if needed.

### *Continuous Dosing*

If a routine SIG code is intended, but specific dose due times are not applicable, use the Continuous SIG type. For example, you may want to use this type of SIG Code for IV infusions. Orders with a Continuous SIG type will be listed on MAR reports and shown on the handheld with Scheduled meds even though specific dose times are not applied.

Select the **RT** checkbox if this is a Respiratory Therapy SIG Code, if needed.

## SIG Code Examples

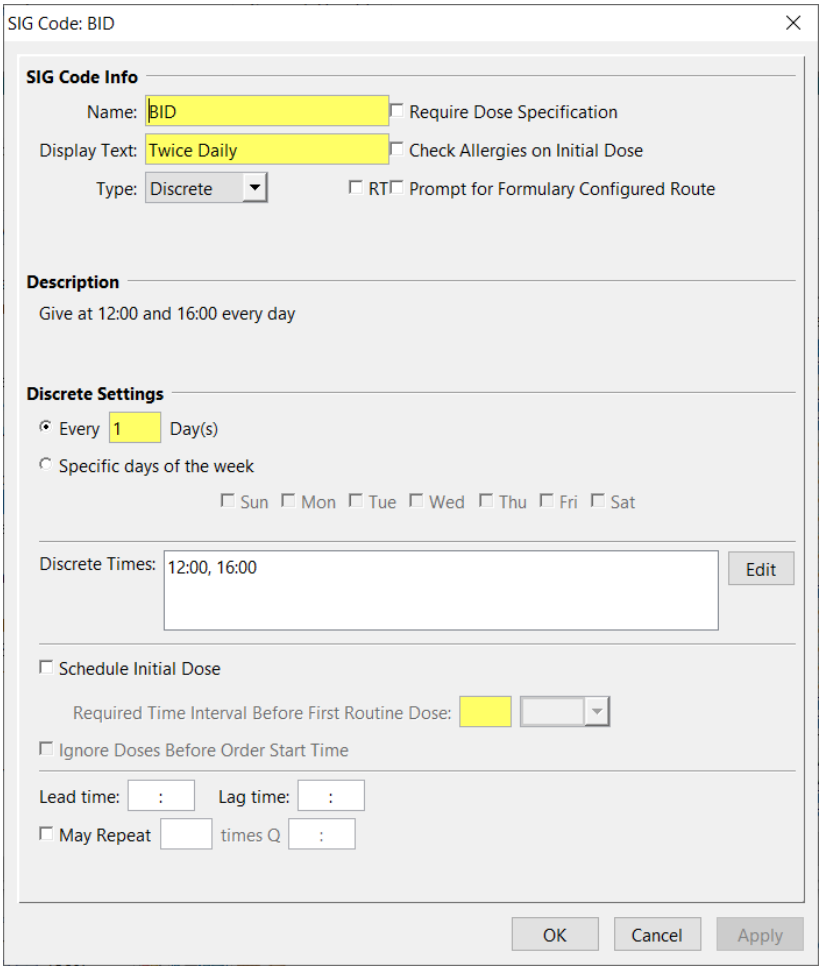
The following examples illustrate the settings for a variety of SIG codes.

### *Twice Daily (BID)*

A basic SIG code on a fixed schedule typically uses the hospital’s standard discrete dosing times. In addition to providing a name and display text for the SIG code, this example sets the following options:

**Every 1 Day** indicates this is a daily SIG code.

Discrete Dosing Times is selected, and the default times are used. In this case, those times are 09:00 and 21:00.



## *Every 4 Hours PRN (Q4HP)*

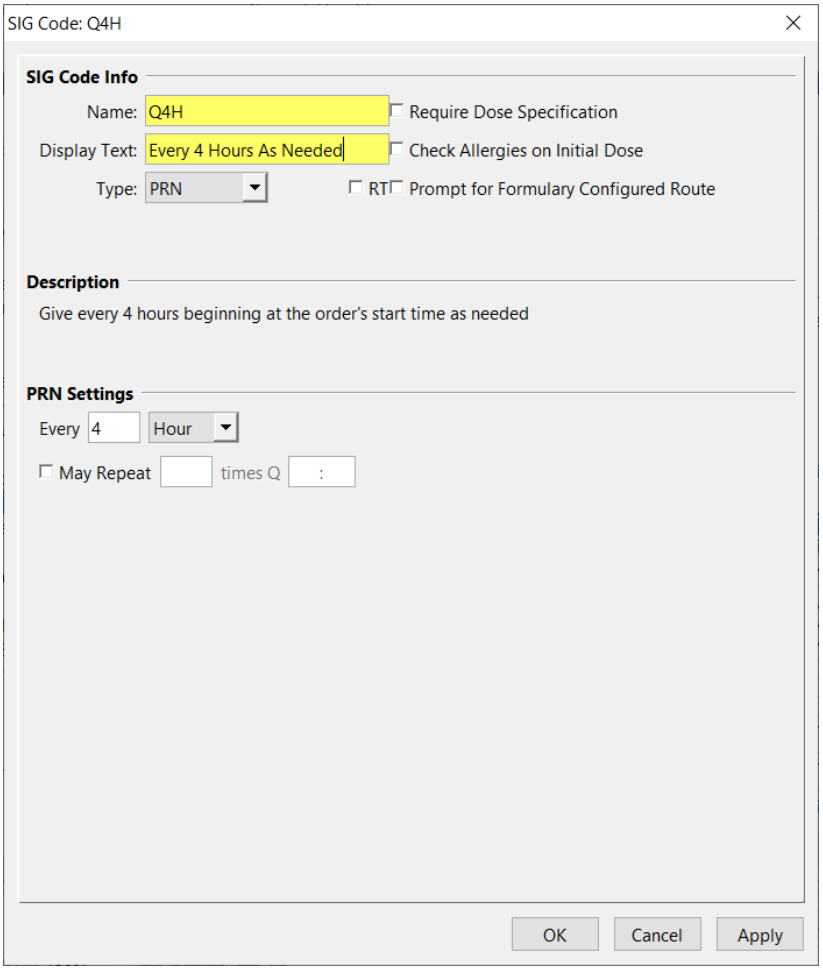
In this case, to enter a PRN SIG Code for every 4 hours, select **PRN** from the **SIG Type** list and select the Every 4 Hours interval. This example uses the following options:

**PRN** is used, so Discrete Dosing Times are disabled.

**Every 4 Hour** is the minimum time interval in which the PRN dose may be repeated. (To allow a lead time for the PRN Setting, see As Needed Dosing.)

Click **Apply** to add the SIG code to the list.

Click **OK** to close the New SIG code screen.



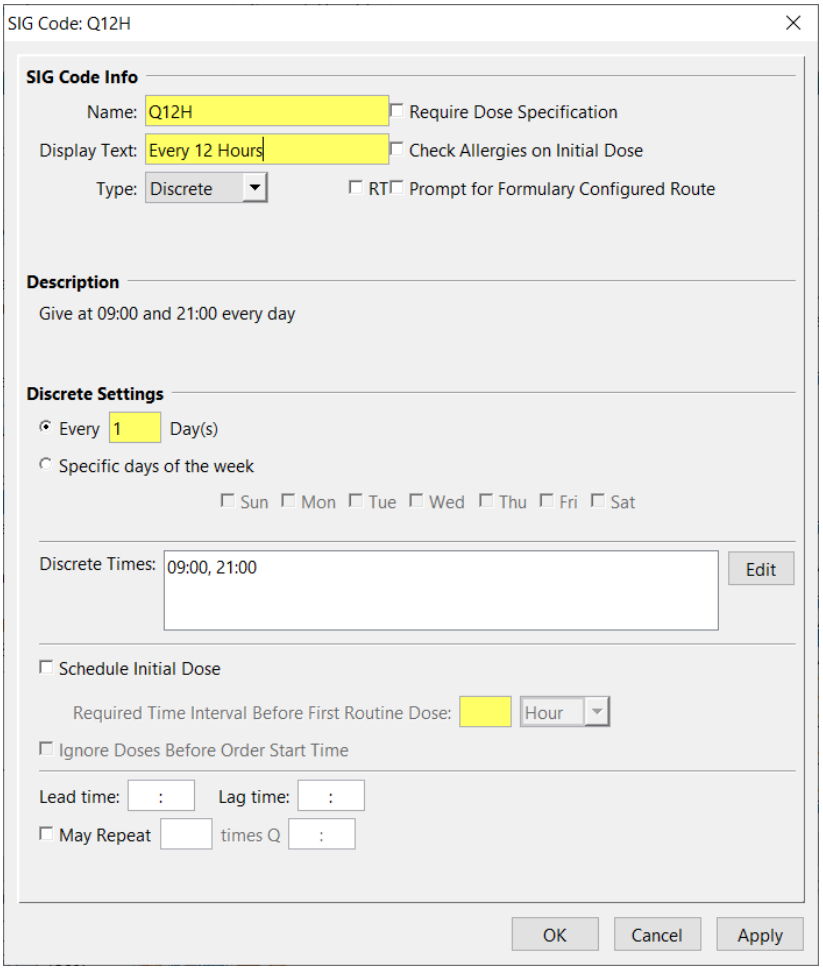
### *Every 12 Hours (Q12H)*

A SIG code with a daily dosing interval may be set up as a Discrete SIG and assigned specific dosing times. For example, even though a SIG Code of Q12H could be based on a 12-hour interval, discrete dosing times help caregiver's better schedule the med pass and ensure that dosing times are always consistent.

In addition to providing a name and display text for the SIG code, this example sets the following options:

**Every 1 Day** indicates this is a daily SIG code.

Discrete (Dosing) Times is selected, and the default times are used. In this case, those times are 09:00 and 21:00.



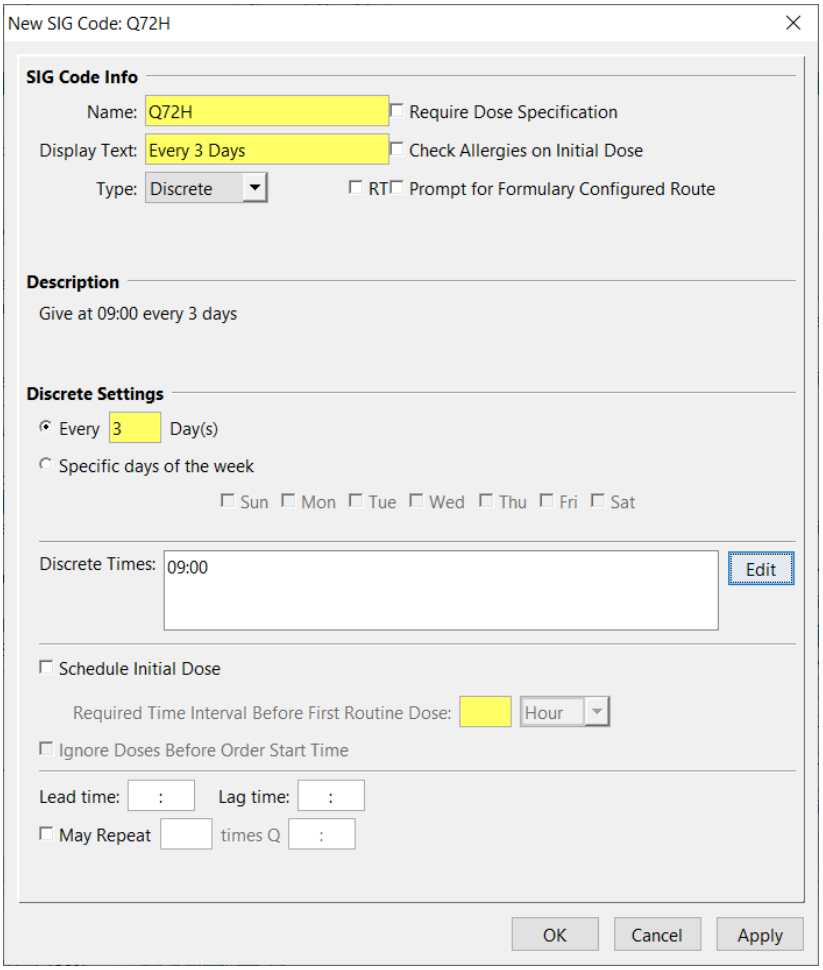
### *Every 3rd Day at Discrete Time (Q72H)*

A Q72H SIG code would use the following options:

**Discrete** is the **SIG Type**.

**Discrete Times** indicates 09:00 as the designated dosing time.

**Every 3 Days** indicates the time interval.



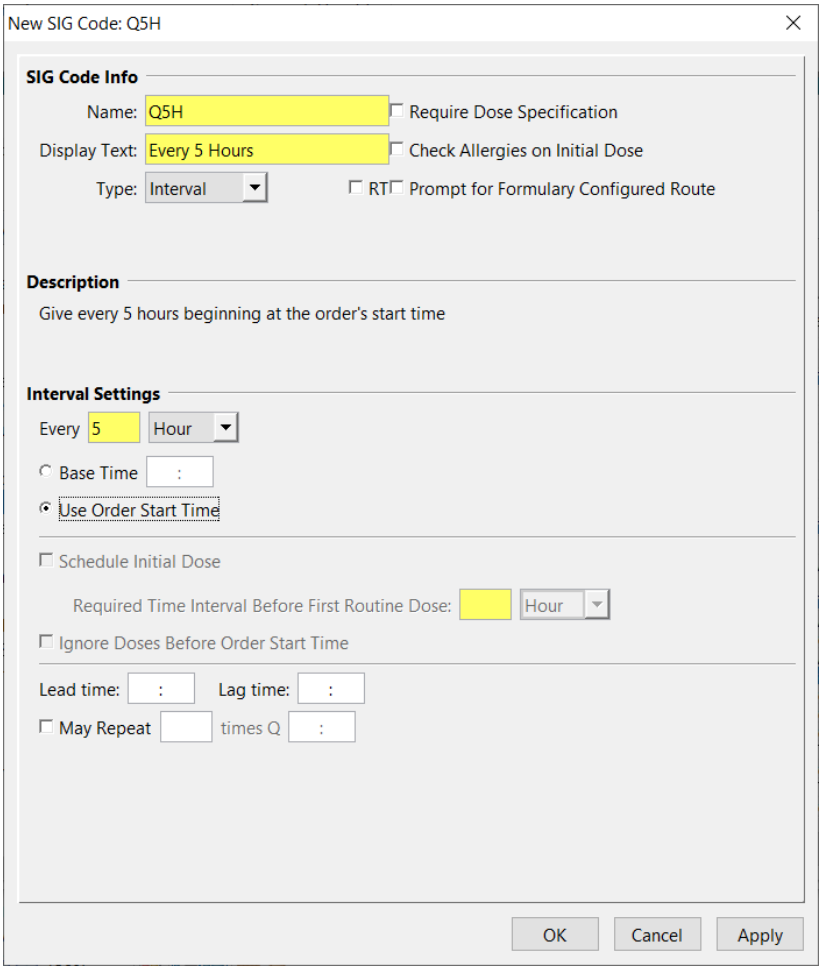
### *Every 5 Hours (Q5H)*

If the dosing schedule is not divisible in a 24-hour period, set up the SIG code according to the following Q5H example:

**Interval** indicates this is a specified interval SIG code.

**Every 5 Hours** indicates the scheduled frequency.

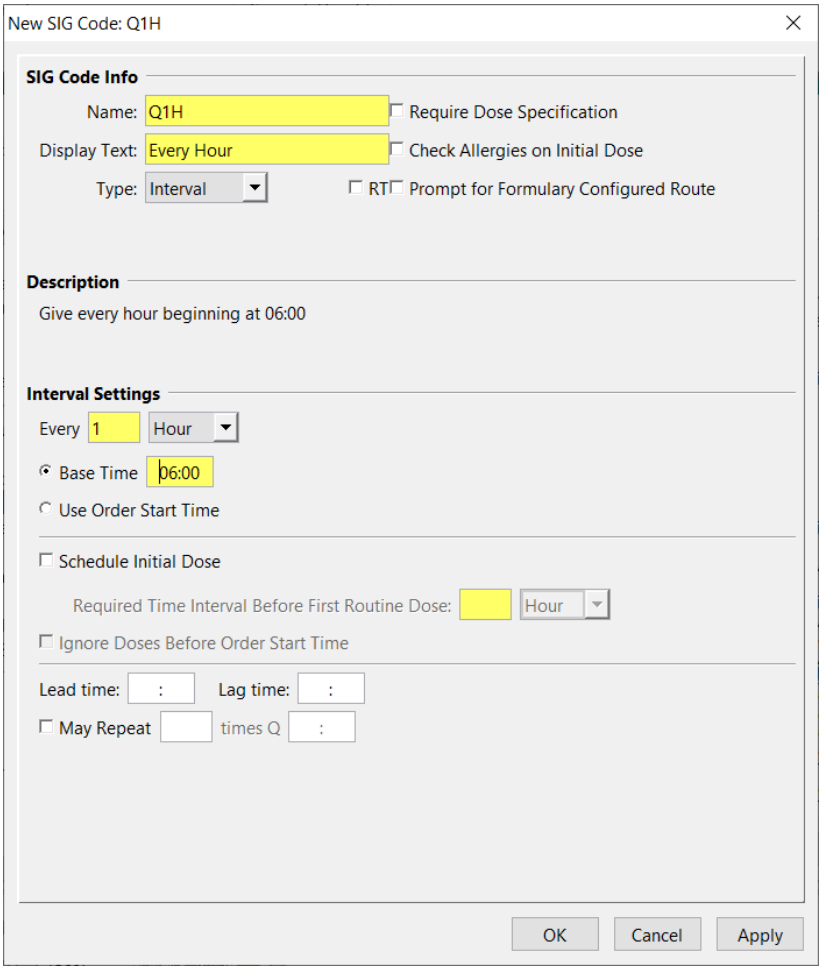
**Use Order Start Time** indicates when to start the dosing schedule.



### *Every Hour (Q1H)*

If a particular interval SIG code has a short time interval setting, you should consider shorter lead and lag times for this SIG code. In this example, the SIG code dosing time interval of 1 hour is the same or less than the hospital's standard lead and lag time of 60 minutes. The SIG lead and lag times can set at 30 minutes each to avoid overlapping the lead and lag period for consecutive doses.

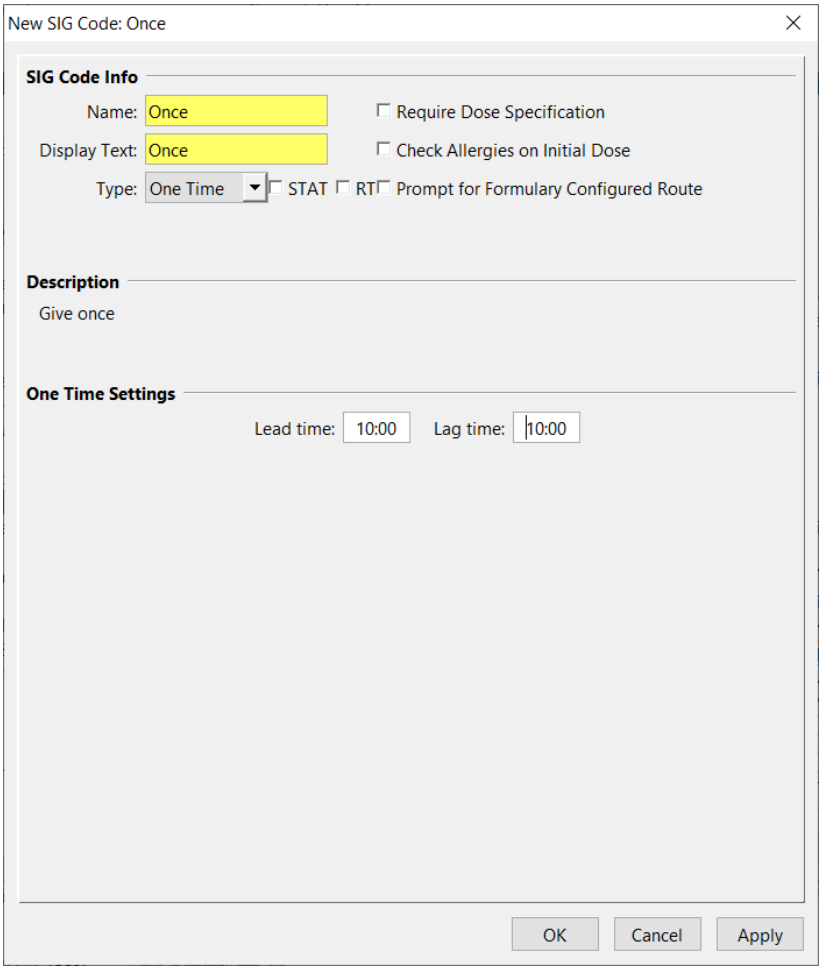
Use Order Start Time indicates that dose scheduling will begin at the Pharmacy order's start time.



### *One Time Only (Once)*

"Once" is an example of a one-time SIG Code. In this example, the dose time will be the particular order's start time and the lag time is set at 4 hours to allow the caregiver ample time in which to administer the dose.

A lead time and lag time can be designated for a One Time SIG code. However, if the SIG were only used for immediate One Time doses, only the lag time would apply.



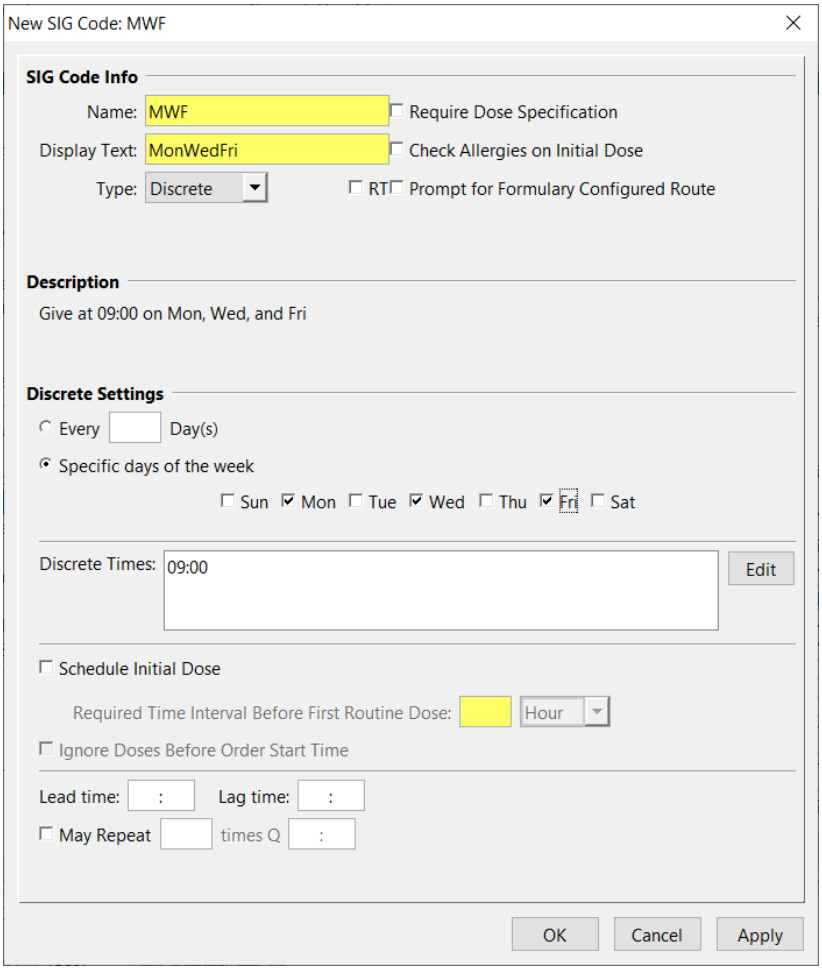
### *Specific Days of Week (MWF)*

It is common for some medications to be ordered for specific days of the week, as illustrated in the following MWF SIG Code. In this case, set the following options:

**Discrete** is the **Type**.

Discrete Times is specified as 09:00.

**Specific days of the week** is selected for Mon, Wed, and Fri.



### *May Repeat (KCLIV)*

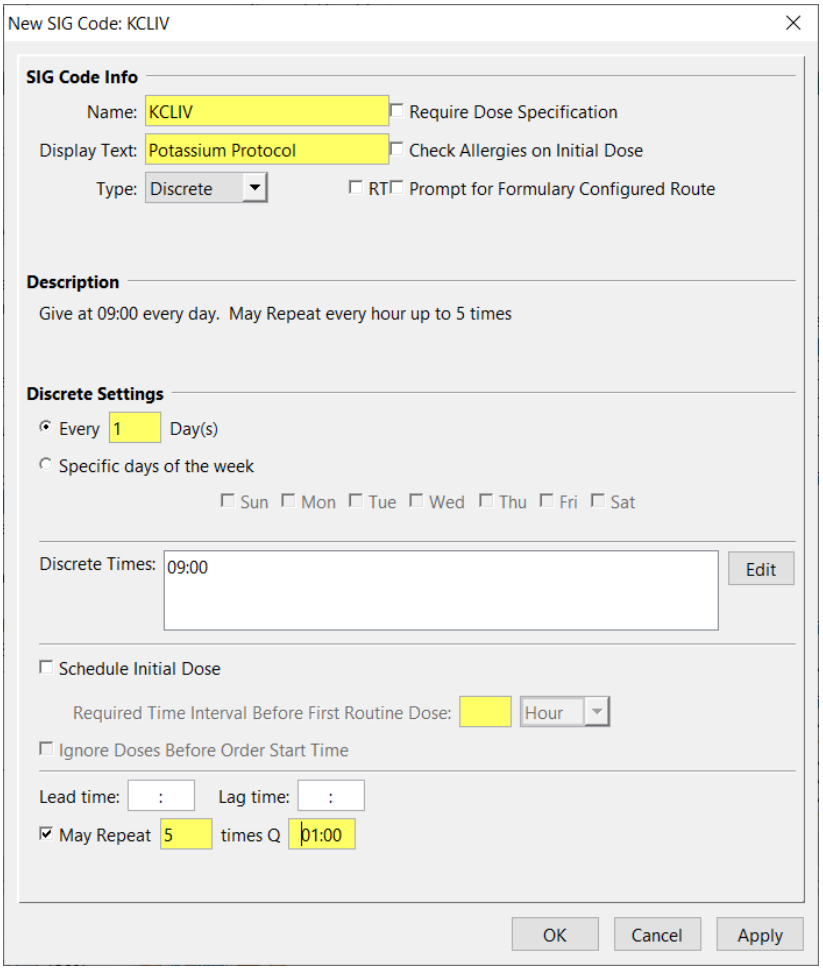
Some orders, such as a Potassium Chloride IV protocol, use a **May Repeat** option, so the dose may be divided as clinically indicated among several intervals. For KCLIV, the options are:

**Discrete** is the **SIG Type**.

Discrete Times with the time set to 09:00.

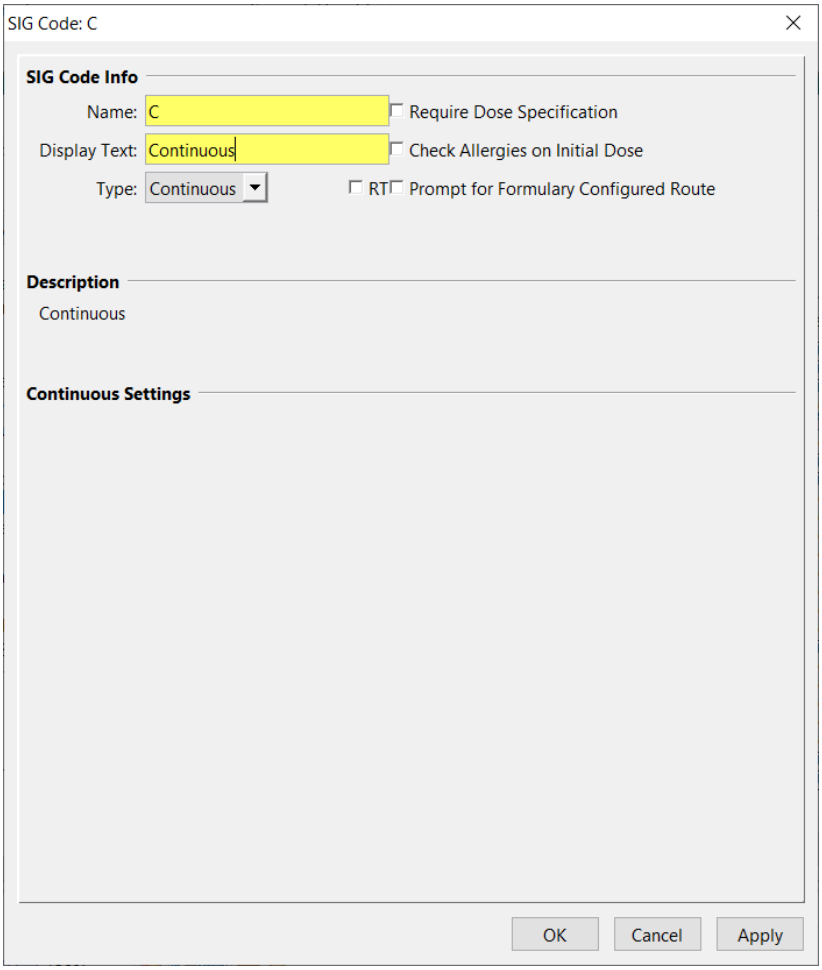
**Every 1 Day** indicates this is a daily SIG code.

**May Repeat** 5 times Q 01:00 indicates the interval at which the dose may be repeated.



### *Continuous*

Orders with this SIG Type appear in the scheduled medication section on the MAR Worksheet and MAR. There is no interval and no dose due times, so doses can be scanned and administered at any time. No alerts or warnings regarding dose times will occur. Select the **Continuous SIG Type**.

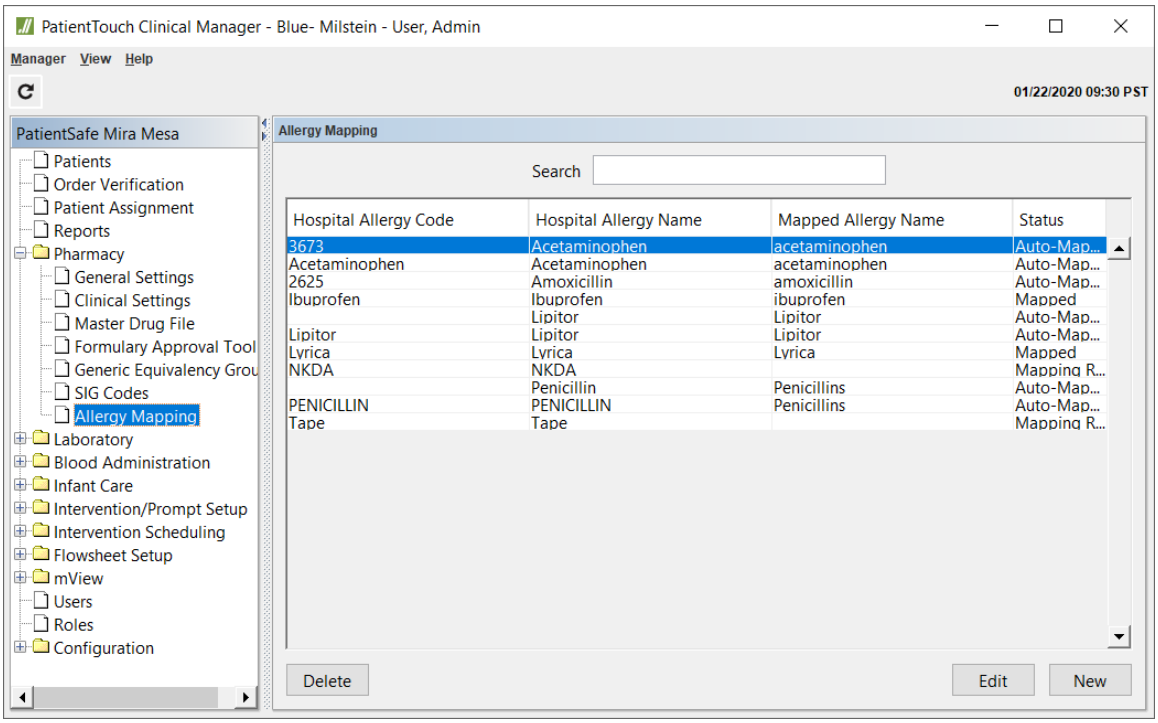



## Allergy Mapping

When a patient has an allergy, the allergy information is entered into the hospital's EHR system. The Clinical Manager receives this information through its interface to the EHR. Every allergy name and corresponding allergy code received is stored in the Allergy Mapping table. The table allows the hospital's allergy codes to be matched to the allergy codes used by FDB.

When an allergy name is received for the first time, the Clinical Manager looks for an exact match in the FDB Allergy table. If one is found, the allergy name is Auto-Mapped. If an exact match is not found, the allergy status is Mapping Required as it awaits manual mapping to a similar FDB allergy by the pharmacist. Until all of a patient's allergies are mapped to FDB in the **Allergy Mapping** table, the patient's allergies cannot be screened by the handheld.

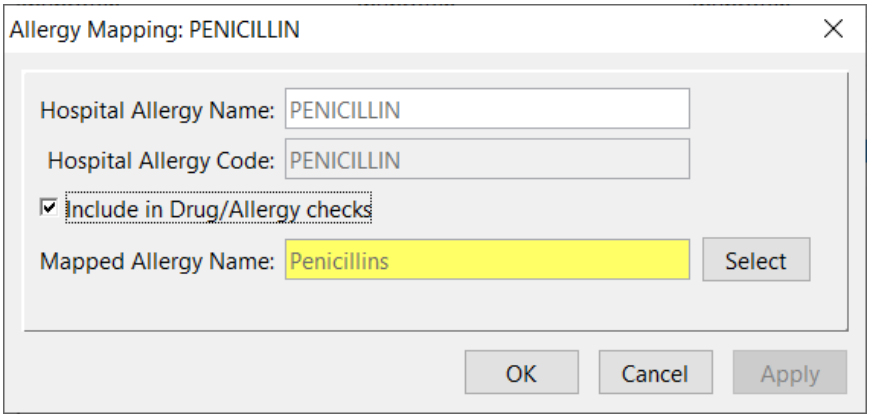
To map an allergy code to the corresponding code in FDB, select **Allergy Mapping** from the **Pharmacy** folder to open the *Allergy Mapping* screen.




## Allergy Code: Mapping Required

Allergies from the EHR that have not been Auto-Mapped or mapped manually are displayed in the table with a Mapping Required status.

1. To map or exclude the hospital allergy name and code, select the allergy from the list and click **Edit** to open the *Allergy Mapping* window.




By default, the option to **Include in Drug/Allergy Checks** is selected for each code. To exclude this particular code from the checking process (e.g. not a drug allergy), deselect the checkbox.

2. Click **Select** to display the FDB allergy code list.
3. To sort through and narrow the list of FDB Allergy Names, enter the name (or first part of name)

of the allergy in the Search field.

4. When you find the appropriate FDB Allergy name, highlight the name and click **OK** to select it.

**The FDB Allergy name is displayed with the corresponding hospital allergy name and code.**

5. Click **OK** to save the mapping and close the window. The hospital allergy is now displayed in the Allergy Mapping table with the associated FDB Allergy name and Mapped status.

## Map New Allergy Code

If an Allergy's name and code are not yet in the Hospital Allergy Code list, you can proactively add it from the *Allergy Mapping* window.

1. Select **Pharmacy > Allergy Mapping**.
2. Click **New**.
3. Enter the Hospital Allergy Name (required) and the Hospital Allergy Code (optional).
4. Retain the enabled **Include in Drug/Allergy checks** checkbox if you want the handheld to screen for this allergy.
5. Click **Select** and locate the corresponding FDB allergy.
6. Click **OK** to complete the entry and close the window.

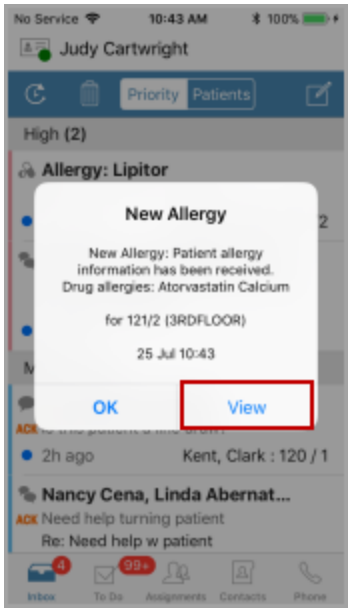
## Exclude an Allergy

If an allergy is listed in the Mapping table, but the **Include in Drug/Allergy Check** checkbox is not enabled, the status of that allergy will be Excluded and the specific allergy will NOT be included in the allergy checking process. There is no need to associate excluded allergies with a FDB allergy name.

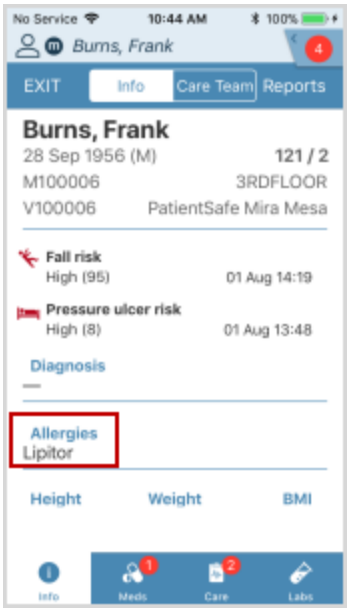
## Perform Allergy Checks on Pre-Existing Orders

When a new allergy is received from the Hospital's Admissions system, PatientTouch can now check all active orders for potential allergies to this medication. If an allergy is found, the administering caregiver, assigned caregiver (if different from the administering) and pharmacy will be notified.

- The administering/assigned caregiver will be notified via a notification and an Inbox message.
- Pharmacy will be notified via printed bulletin sent to the Pharmacy default printer.








Allergy checks can also be done on the administration of the first dose of ordered medications. If an existing allergy is found, the administering caregiver, assigned nurse, and pharmacy will be notified. See Pharmacy/Clinical Checks for information on configuring this type of allergy check.

- The administering/assigned caregiver will receive a standard allergy alert during the workflow.
- Pharmacy will be notified via printed bulletin sent to the Pharmacy default printer.

# Configuring the Specimen Collection Module

The Laboratory folder is only available if you have purchased the Specimen Collection Module .

The following sections explain how to configure the PatientTouch Specimen Collection Module, including the Laboratory folder of the PatientTouch Clinical Manager. We begin with an overview of the necessary roles and users.

## Setting Up User Roles and Privileges

Caregivers who will collect specimens and technicians who will process specimens in the lab must have the appropriate collector laboratory privileges before they can perform the related tasks.

The following system privileges are available in connection with specimen collector and lab users:

| Privilege | Description |
|---|---|
| **Phlebotomist** | View orders and collect lab specimens designated for this collector type. |
| **Collect Nurse Lab Orders** | View orders and collect lab specimens for all collector types. |
| **Collect RT Lab Orders** | View orders and collect lab specimens designated for this collector type. |

| Privilege | Description |
|---|---|
| **Laboratory** | Perform laboratory functions, such as receiving or rejecting specimens. |
| **Manage Laboratory Configuration** | Configure laboratory settings. |
| **Manage Phlebotomy Assignment** | Assign phlebotomists to nursing units from the Lab Dashboard in Clinical Manager. User with this privilege is also able to do unit assignment on the handheld. |
| **Manage Lab Orders** | Omit orders and change an order's collector type using the PatientTouch Clinical Manager. |

Refer to the Roles and Users section of this user guide for more information about defining roles and creating users.

# Getting Started

Before you can use the Specimen Collection module, you must have a tested and verified interface between your hospital's Laboratory Information System (LIS) and the PatientTouch System for laboratory orders.

You must also perform the following configuration tasks.

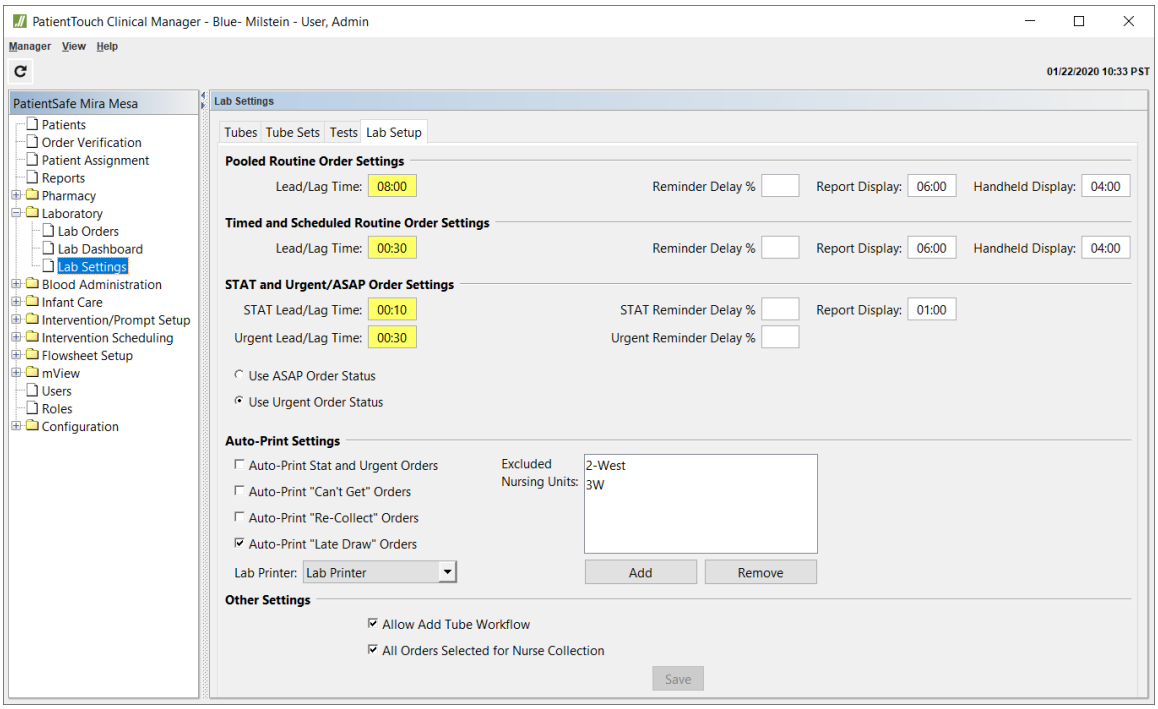
Click a link below to learn more:

- Configure Laboratory Settings
- Configure Label Printer Selection Setting
- Set Up Wireless Label Printers
- Designate Collector Types
- Create Clinical Prompts (optional)
- Configuring Tube and Test Types (optional)

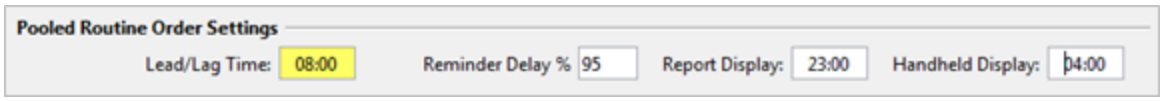
## Configure Laboratory Settings

To configure the Laboratory settings:

1. From the main screen, click **Laboratory, Lab Settings**, and then click the **Lab Setup** tab.




2. Configure the following Pooled Routine Order Settings:




- For Lead/Lag Time, enter the amount of time before or after the order due time when a pooled routine order can be collected without receiving an early or late warning on PatientTouch.

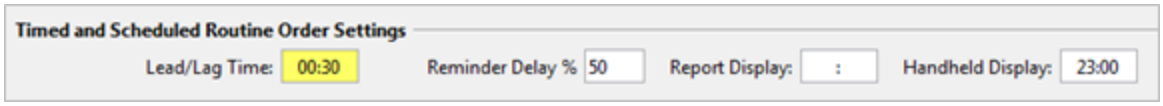
**Pooled routine orders are those that are received from the Laboratory Information System (LIS) without a specified due time (i.e., with only a due date, or with no due date/time at all). These orders are due at the date/time received (or at 00:00 if the due date is in the future). For example, if the Pooled Routine Order Lead/Lag Time setting is 08:00 (eight hours), an order received at 11:00 will be due immediately and will be considered late at 19:00.**

- For Reminder Delay %, enter the percentage of lag time that should elapse before the user who accepted assignment of a pooled routine order should be reminded with a popup. For example, if the Lead/Lag Time setting is 08:00 (eight hours) and the reminder delay is 95%, the assigned user would be reminded 95% of the way through the eight-hour lag time, or 24 minutes before the order becomes late. If this field is left blank, assigned users will not be reminded.
- For Report Display, enter the forward-looking window of time when pooled routine orders will print on the Draw List Report. For this option to apply, the pooled routine order must have a future due date (since these types of orders are considered due when received).

Note that any orders that have not been collected after the due date and time continue to print on the Draw List report until they are collected.

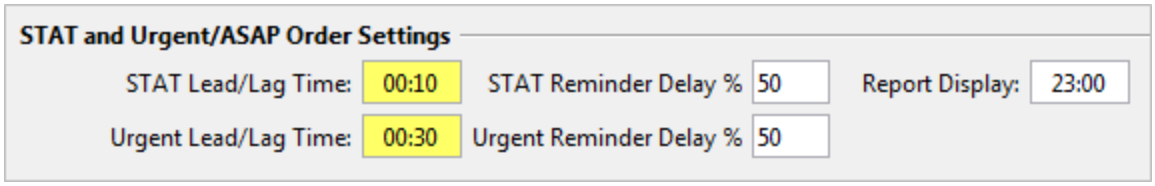
- For Handheld Display, enter the forward-looking window of time when pooled routine orders will display on PatientTouch in the To Do List and patient's **Lab Orders** tab. For this option to apply, the pooled routine order must have a future due date (since these types of orders are considered due when received). Note that any orders that have not been collected after the due date and time continue to display on PatientTouch until they are collected.

3. Configure the following Timed and Scheduled Routine Order Settings:




- For Lead/Lag Time, enter the amount of time before or after the scheduled collection time when a timed or scheduled routine order can be collected without receiving an early or late warning on PatientTouch.
- Enter the Reminder Delay % for this order type, similar to the setting for pooled routine orders.
- For Report Display, enter the forward looking window of time when scheduled orders will print on the Draw List Report. For example, if the Report Display is set to four hours, a scheduled order due at 06:00 will not display if the Draw List is printed at 01:00. However, if the report is printed at 04:00, the 06:00 scheduled order appears on the report. For this option to apply, the order must have a future due date and time. Any orders that have not been collected after the due date and time continue to display on the Draw List report until they are collected.
- For Handheld Display, enter the forward-looking window of time when scheduled orders will display on PatientTouch in the To Do List and patient's **Lab Orders** tab. Similar to the Report Display, if the handheld Display is set to 12 hours, a scheduled order due at 19:00 will not display on the handheld at 06:00, but will display at 07:00. For this option to apply, the order must have a future due date and time. Note that any orders that have not been collected after the due date and time continue to display on PatientTouch, and the users will receive late reminders for those uncollected orders after the defined lag time has expired.

4. Configure the following STAT and Urgent/ASAP Order Settings:



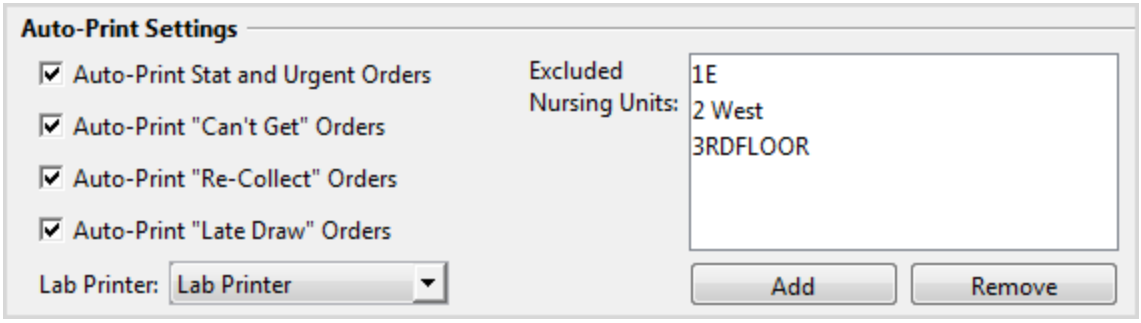

- For STAT Lead/Lag Time and Urgent/ASAP Order Lead/Lag Time, the interval you enter determines the amount of lag time the collector has, after the order due time, to collect the corresponding orders without receiving a late warning on PatientTouch. For example, if the

Lead/Lag Time is set to 15 minutes, the order is entered (or scheduled) at 16:00, and the patient is scanned at 16:16 or later, the draw would be late. All stat order specimens that are collected outside of this lead/lag time will appear on the early/late orders report.

**Normally, a STAT or Urgent/ASAP order is available immediately, with no lead time. However, if an order designated STAT or Urgent/ASAP is scheduled for a future date/time, it may be collected within the lead time of the order's scheduled due time without receiving an Early Lab Order alert.**

- Enter the Reminder Delay % for these order types, similar to the setting for pooled routine and scheduled orders.
- For Report Display, enter the forward looking window of time when scheduled draws will print on the Draw List Report. For this option to apply, the order must have a future due date and time. Any orders that have not been collected after the due date and time continue to display on the Draw List report until they are collected.
- Select either Use Urgent Order Status (the default) or Use ASAP Order Status to correspond with the terminology used by the laboratory.

5. Configure the following Auto-Print Settings:




- Enable **Auto-Print Stat and Urgent Orders** to automatically print a report on the designated Lab Printer when a Stat or Urgent order is received.
- Enable **Auto-Print "Can't Get" Orders** to automatically print a report on the designated Lab Printer when a collector cannot collect a specimen.
- Enable **Auto-Print "Re-Collect" Orders** to automatically print a report on the designated Lab Printer when the specimen is rejected and the laboratory requests a re¬collection.
- From the **Lab Printer** list, select the printer to use for the enabled auto-print reports.

**Note that the configured printer can be a desktop printer, an email address, or a network share.**

6. Select the **Allow Add Tube Workflow** checkbox to turn on the *Add Tubes* workflow. Deselect the checkbox to turn off the *Add Tubes* workflow. When the *Allow Add Tube* Workflow checkbox is selected, the Add Tubes option displays from the **Options** menu on the handheld, along with Nurse Line Draw and Dismiss. If the checkbox is deselected, the Add Tubes option does not display and the workflow is not available.

7. Select **All Orders Selected for Nurse Collection** so that all of the labs available to be collected will be pre-selected for collection on the handheld. If the nurse does not want to collect all tests, he/she will have to de-select the test he/she does not want to collect. If the checkbox is deselected, the nurse will have to select all lab tests she wants to collect.
8. Click **Save** to save the settings.

## Configure Label Printer Selection Setting-Specimen Collection

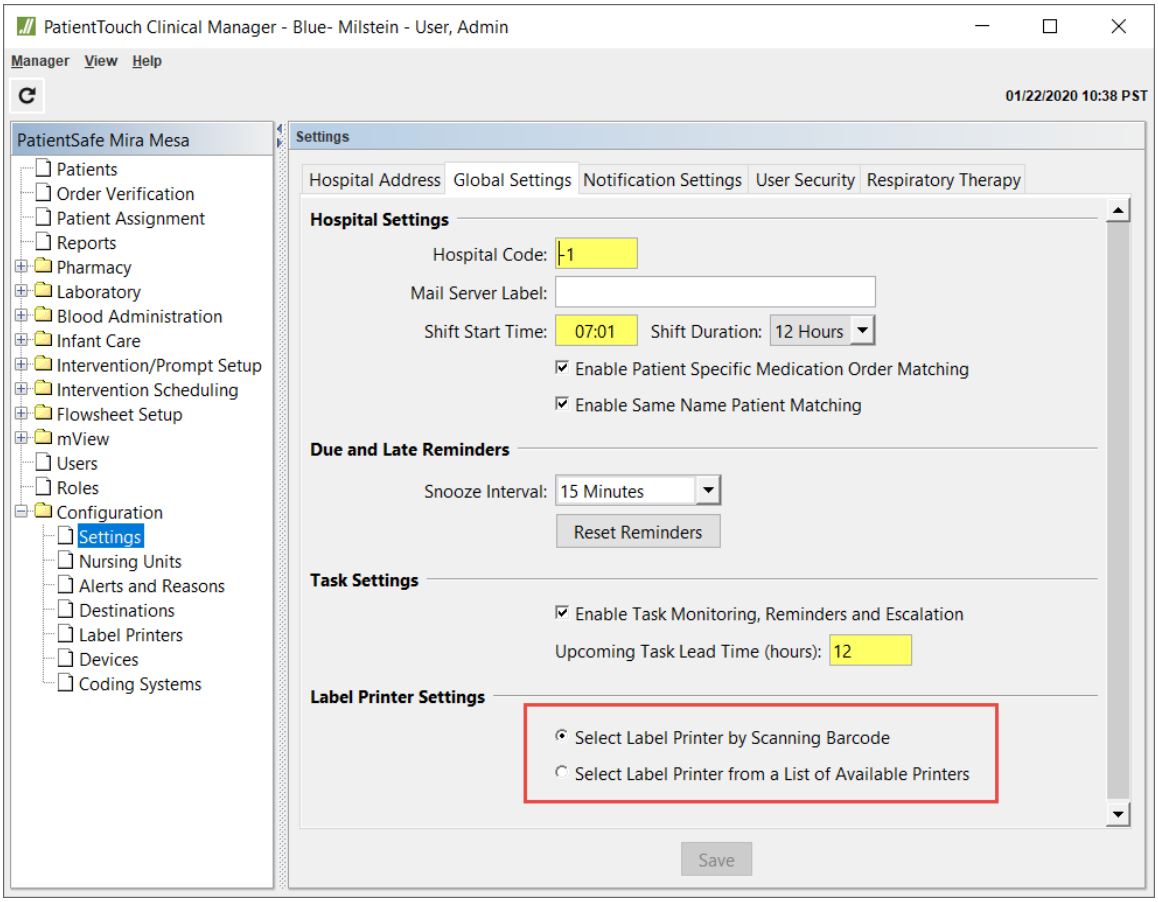
The PatientTouch System allows you to configure how handheld users select a label printer when printing specimen labels. The options include:

- The user selects the printer (by Friendly Name) from a list of label printers available in the system
- The user scans a barcode associated with (and affixed to) the printer to select it

**This option applies to workflows in which labels are printed in all installed PatientTouch modules, including Specimen Collection, Infant Care, and others as applicable.**

To configure the label printer selection setting in Clinical Manager:

1. From the **Configuration** folder, click **Settings**, and then click the **Global Settings** tab.



2. In the Label Printer Settings section, select the desired option.
3. If the **Select Label Printer by Scanning Barcode** option is selected, make sure that all label printers configured in the system are assigned a unique barcode that will be scanned when users print specimen labels. Refer to the Set Up Wireless Label Printers section below for more information.
4. Click **Save** to save the settings.

## Set Up Wireless Label Printers

Use the PatientTouch Clinical Manager to set up the wireless label printers that will be used to print specimen collection tube labels from the handheld. The supported printer models include:

- Zebra QLn
- Honeywell RP2
- O'Neil

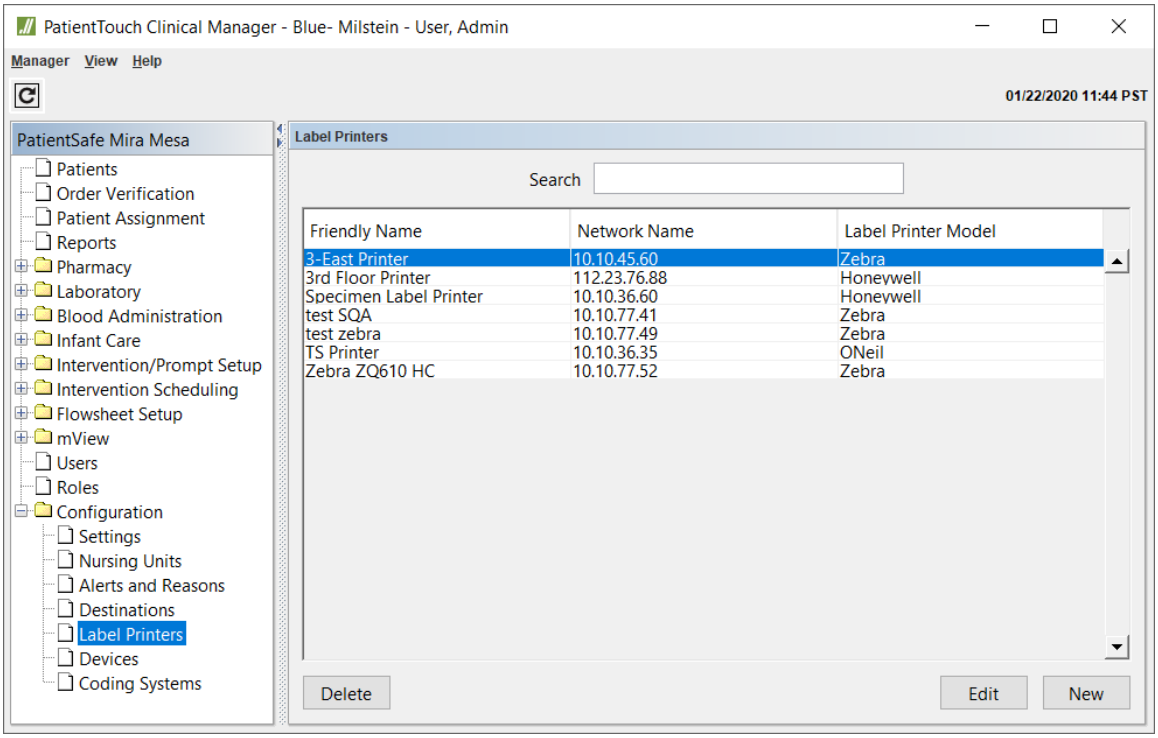
A PatientSafe Solutions implementation team member can assist your hospital's Information Systems department in determining the IP addresses and wireless configuration settings for the label printers.

### *Set Up a New Label Printer*

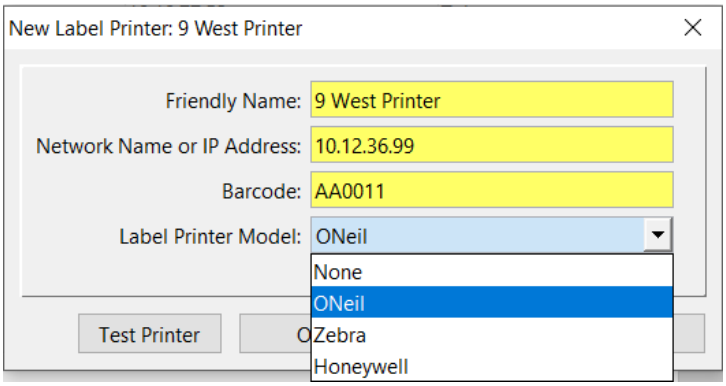
To configure a wireless label printer in Clinical Manager, use the instructions below.

If your hospital is configured for Campus Support, and you have selected <All> hospitals at login, a Hospital column displays on the Label Printers screen. Select the facility for which you want to view label printers.

1. From the **Configuration** folder, click **Label Printers**.



2. Click **New** to add a printer. The *New Label Printer* window is displayed.
3. If your hospital is configured for Campus Support, select the facility from the drop down menu. If your hospital is not configured for Campus Support, this field will not display.
4. Enter a Friendly Name that will appear in the label printer selection list on PatientTouch. If desired, the Friendly Name can be the same as the Network Name or IP address you enter, but both are required.
5. Enter the Network Name or IP Address of the label printer. The network name should be the same as the Station Name assigned to the printer when using DHCP.
6. Enter a Barcode value if the **Select Label Printer by Scanning Barcode** option is selected in the Label Printer Settings section of the *Configuration > Global Settings* screen in Clinical Manager. (Refer to Configure Label Printer Selection Setting for more information.)
7. Click the Label Printer Model drop down menu and select the desired printer model from the list (O'Neil, Zebra, or Honeywell).




**The barcode can be any value desired—for example, the printer's asset tag barcode, friendly name or IP address, manufacturer's serial number, etc.—but must be unique among the label printers configured in the system. Note that if you use a barcode value not already accessible on the printer (for example, the friendly name or IP address), you will need to generate and print the barcode, and then affix it to the printer so it can be scanned during specimen collection and other applicable handheld workflows.**

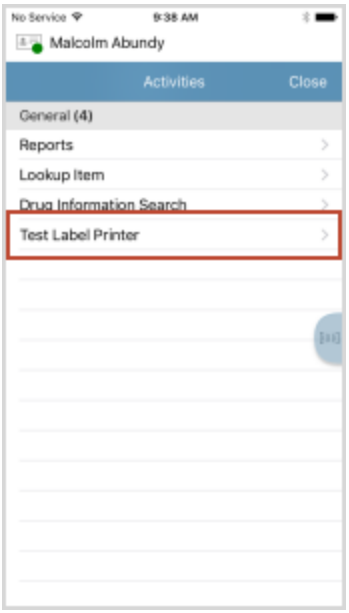
8. Click **Apply** to save the printer configuration. It now appears in the list of available printers.
9. Click **Test Printer** to print a test label and verify that the new printer is properly configured and working.
10. Click **OK** to save the information and close the dialog.

### *Select and Test a Label Printer on the Handheld*

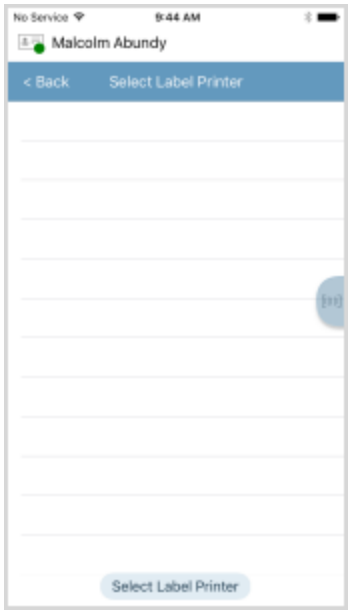
After you configure a wireless printer, you can test and confirm the connection:

1. Log in to a PatientTouch Handheld device. You will need to log in with someone who has a clinical profile of "Phlebotomist" or "Nurse Lab Collector" in order to see the "Test Label Printer" option.

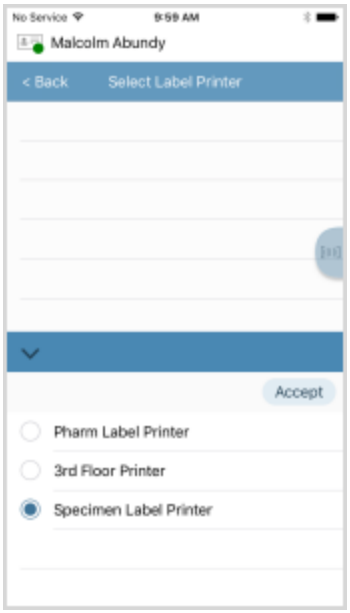
2. Tap the **To Do** tab.
3. Tap **Activities**.




Touch **Test Label Printer**.




Touch **Select Label Printer**.




If you have "Select Label Printer from a List of Available Printers" selected in the Configuration>Settings>Global Settings tab, select the desired printer from the list and touch **Accept**.

**If you have "Select Label Printer by Scanning Barcode" selected in the Configuration>Settings>Global Settings tab, scan the desired label printer.**


Touch **Yes, Test** to print a test label.


Scan the label barcode on the printer to test.

If the connection is successful, the printer will produce a test label. If not, no label will be printed and a message indicating the unsuccessful connection will display on the handheld.

### *Edit a Label Printer*

You can update an existing printer in the PatientTouch Clinical Manager.

To change a wireless label printer:

1. From the **Configuration** folder, click **Label Printers**.
2. Select the printer you want to edit.
3. Click **Edit** to change the friendly name or network address of the printer.
4. Click **OK** to save the changes and dismiss the dialog.

### *Delete a Label Printer*

You can also delete an existing printer in the PatientTouch Clinical Manager.

To remove a wireless label printer:

1. From the **Configuration** folder, click **Label Printers**.
2. Select the printer you want to delete.
3. Click **Delete**.
4. At the prompt, click **Yes** to confirm you want to delete the printer.

### *Customize Specimen Label Format*

Specimen labels may be customized for your hospital by PatientSafe Solutions. The labels generally include the following information:

- Unique barcode that identifies the specimen
- Order accession number
- Patient name, age, gender, date of birth, and room/bed number
- MRN and visit number
- Tube type
- Test name(s)
- Collection date and time
- Collector initials
- Location Code

You may also include additional fields which can be configured to display on Specimen Collection labels. These new fields must be configured to be received 1) via the interface from the Laboratory Information System and, 2) to be printed on the Specimen label by PatientSafe Solutions Technical Support. They include:

- Source
- Site
- Reporting Priority
- Service Resource
- Microbiology Additional Description
- Comments

Contact the PatientSafe Solutions Technical Support Team to discuss the interface and label configuration to add these new fields to your Specimen Collection Labels.

Separate label formats for ordered specimens, added tubes, add-on tests, and aliquot samples are available and can be configured by your PatientSafe Solutions implementation team.

## Designate Collector Types

Hospitals often have caregivers in several roles collecting specimens. Which caregiver is involved in collecting or managing specimens depends on the workflow and clinical conditions and hospital policies. An example of typical responsibilities might include:

- Central venous lines: exclusively collected by licensed registered nurses (RNs).
- Peripheral venipuncture: may be collected by either nurses or phlebotomists.
- Arterial puncture: may be collected by nurses or, in the case of blood gases (a common reason for arterial access), respiratory therapists.
- Non-blood specimens: may be collected by nurse technicians or practical nurses.

Occasionally, hospital blood drawing policy may be set by the level of care or by hospital geography.

For example:

- Intensive care units
- Labor and delivery units (can be exclusively RNs in some cases)
- Emergency departments

To implement the hospital policies and allow different types of caregivers to collect specimens based on the order type, the PatientTouch System has four distinct collector types:

- P: Phlebotomists
- N: Nurses
- R: Respiratory Therapists
- A: Add-On or Lab. This collector type applies exclusively to the "add-on-test" workflow.

**The Add-On collector type can be received across the interface associated with a lab order. The Lab collector type can also be designated in the Clinical Manager as a part of the add-on test workflow process.**

## *Designate Collector Types for Lab Orders*

You can designate collector types for each lab order in several ways.

- An order-specific designator may be entered into the laboratory system and then sent across the interface to the PatientTouch System.
- Collector type may be defined for a test type in the Lab Settings of the PatientTouch Clinical Manager. Note that when test-level settings are applied to an order that includes multiple tests, this may change the order's collector type. Refer to the Collector Type Hierarchy section below.
- Collector type may be selected for an individual patient order from the *Lab Orders* screen of PatientTouch Clinical Manager after the order is received from the laboratory system.

The rules respect the above hierarchy.

- An order-specific designator set in the Clinical Manager will take precedence over a collector type received through the interface.
- After the order is received, a patient-specific designator may be entered into the Clinical Manager and will take precedence.

## *Collector Type Hierarchy*

When the PatientTouch System determines which caregiver(s) collector types are to receive a collection order, the system uses the following methods:

- If the test specifies a single collector type, the collector type for that test is used.
- If there are multiple collector types for the associated tests of a given order, the order is:

1. Nurse
2. Phlebotomist

- If neither a test-associated collector nor an order collector type is received via the interface message from the LIS, the order's collector type is set to Phlebotomist.
- If a collector type is designated for the test in the PatientTouch Clinical Manager, this designation overrides the order collector type sent via the interface from the LIS.
- If the tests associated with a given order contain collector types for all defined groups—Nurse, Phlebotomist, and Respiratory Therapist—the collector type is treated as:

1. Nurse
2. Phlebotomist
3. Respiratory Therapist

- If an order has multiple tests and at least one test is designated Nurse Collector, the entire order is designated as the Nurse Collector type.
- If an order has multiple tests and at least one test is designated Phlebotomist and one or more test is designated Respiratory Therapist, the order becomes a Phlebotomist collector type.

The collector type for the order determines how orders are handled in the PatientTouch System for notifications and reminders, displaying tasks on the To Do List, filtering and sorting in the *Lab Orders* and *Lab Dashboard* screens in Clinical Manager, and other functions.

PatientSafe Solutions' implementation team will work with your facility to assure accurate setup of collector types.

## Create Clinical Prompts (optional)

Clinical prompts can be created and associated with a tube or test type to remind the caregiver to take a particular action (as instructions), or to capture documentation when collecting a specimen for the given tube or test.

You can create clinical prompts such as "Keep on Ice," "Fill to Line," or "Invert Tube 8-10 times." These clinical prompts are similar to special handling instructions that may be configured in the test dictionary of the Laboratory Information System.

You also can create prompts to collect documentation during a draw, such as temperature for an ABG or draw site for a blood culture.

Once created, you can associate a clinical prompt with a tube or test type. Clinical prompt creation and association with tubes and tests is optional. Refer to Configuring Tube and Test Types for more information.

**Instructions for tubes and tests may not need to be created if the special handling instructions can be sent to the PatientTouch System via the HL7 laboratory orders interface.**

## Configuring Tube and Test Types (optional)

Tubes and tests are automatically created in the PatientTouch System when a laboratory order is received via the HL7 interface with your Laboratory Information System. You can view this information in the PatientTouch Clinical Manager and associate one or more clinical prompts with each tube or test.

### *Configure Tubes*

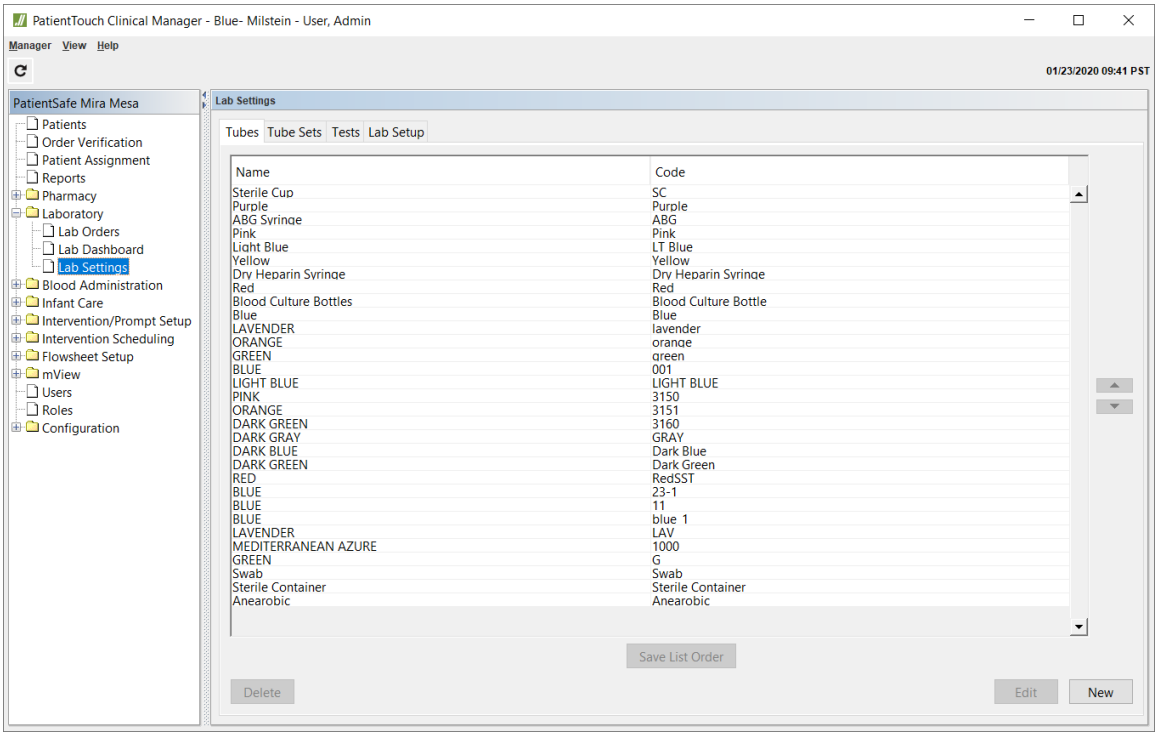
If you wish, you can create tubes manually in the PatientTouch Clinical Manager to represent the different tube types used to collect specimens.

You can also associate clinical prompts and instructions with specific tube types. These prompts display on the handheld immediately after the orders are displayed and prior to collection of the specimen.

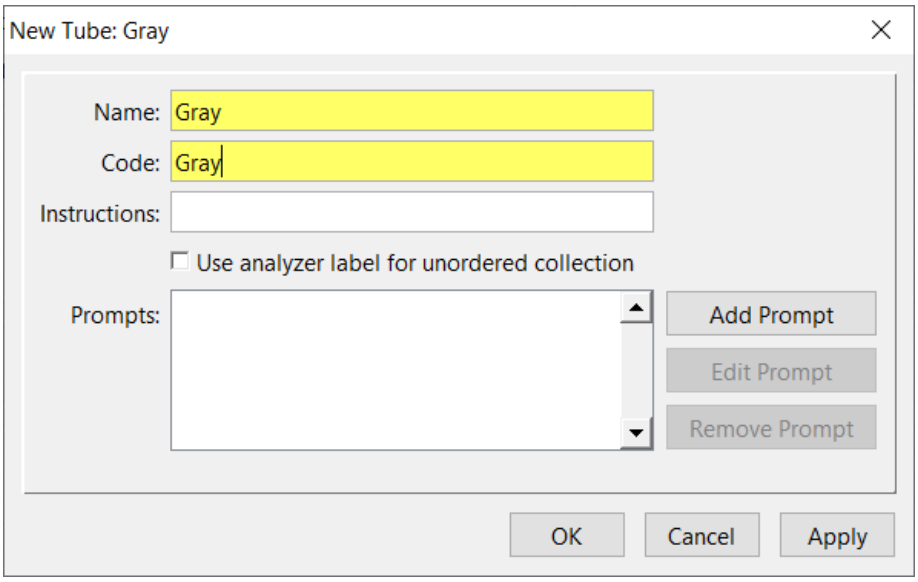
#### Create a Tube

To create a tube in Clinical Manager:

1. From the Laboratory folder, click **Lab Settings**, and then click the **Tubes** tab.

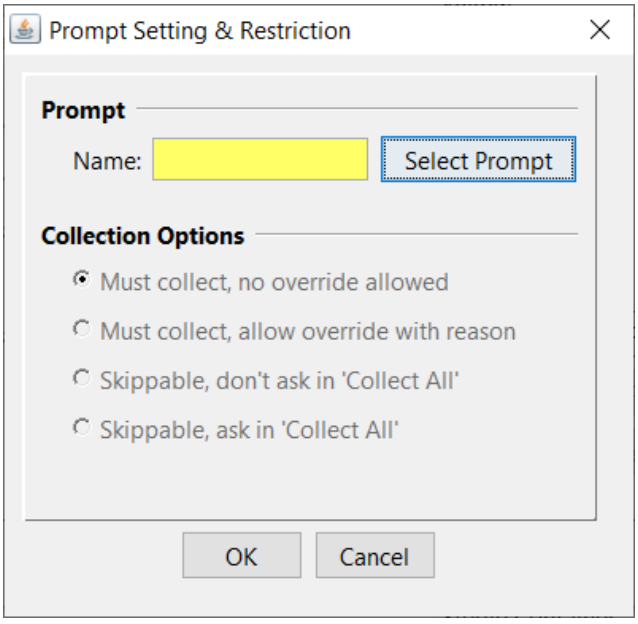



2. Click **New** to add a tube. The *New Tube* window appears.
3. Enter a name for the tube that will appear on the handheld and draw lists to identify the tube. For example, type "PURPLE" for the tube name.
4. Enter the tube code. This code must match the code received via the HL7 interface from the LIS. For example, enter "Gray" for the Gray tube code.

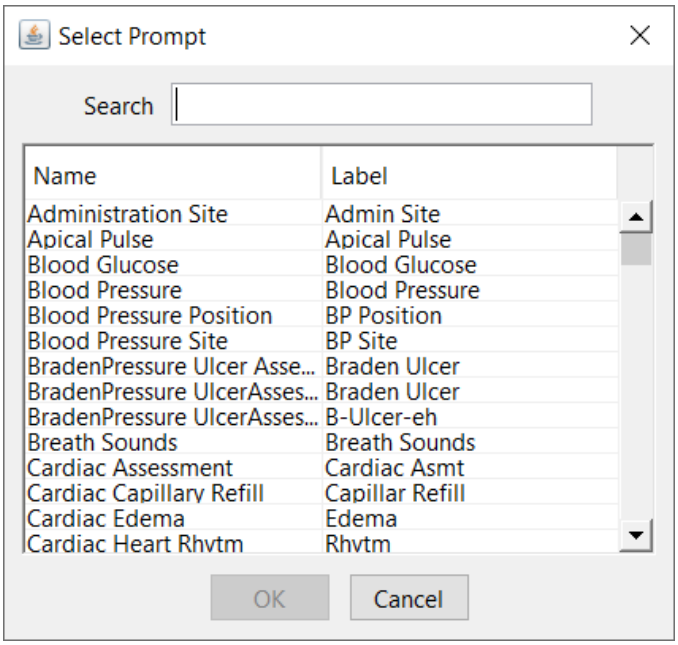



**When an order is received from the LIS, the ordered tubes are matched based on tube codes in the HL7 message, so a new tube with a different tube name that matches an existing tube code will be recognized as an order for the existing tube.**

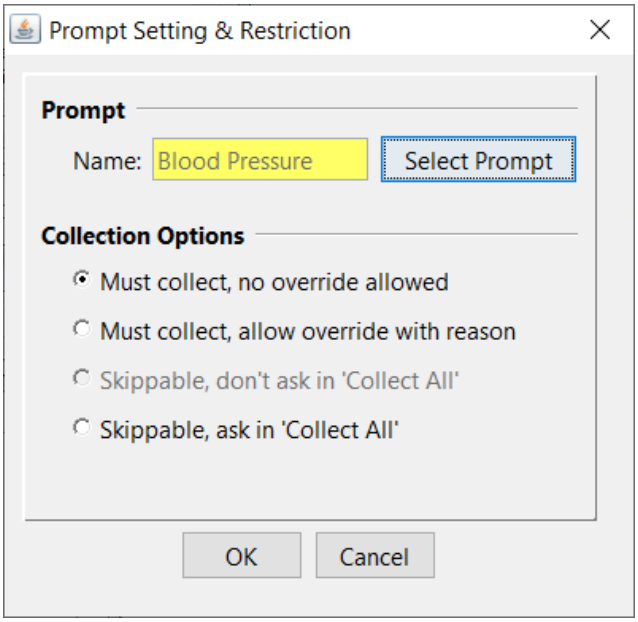
5. Optionally, add any standard Instructions for the tube (for example, “Keep on ice”, “Deliver to lab immediately”).
6. Optionally, click **Add Prompt** to select one or more clinical prompts or interventions to display with this tube type.




7. Click **Select Prompt** and select the prompt or intervention you want to display and click **OK**.




8. Select the appropriate Collection Options for the prompt or intervention and click **OK**.




- **Must collect, no override allowed** requires the collector to respond to the prompt or intervention before continuing with the specimen collection workflow.
- **Must collect, allow override with reason** requires the collector to either respond to the prompt or intervention, or select a reason for not providing a response before continuing with the specimen collection workflow.
- **Skippable, don't ask in 'Collect All'** allows the collector to either respond to the prompt or intervention, or skip responding to prompts individually.
- **Skippable, ask in 'Collect All'** allows the collector to either respond to the prompt or

intervention, skip responding to the entire intervention, or skip prompts in the intervention individually.

9. Repeat steps 6–8 to select additional prompts or interventions if desired.
10. Click **OK** in the *New Tube* window to save the tube definition.
11. After you have reviewed or created all the desired tubes, you can use the arrow buttons on the right side to change the order of the tubes in the list. The order of tubes in the list determines the draw sequence that displays on PatientTouch. When you are satisfied with the tube order, click **Save List Order**.

### Edit a Tube

To modify an existing tube, select the tube from the list that appears in the PatientTouch Clinical Manager and click **Edit**. Update as needed using the same options you use to create new tubes, and click **OK** to save your changes.

### Delete a Tube

To delete an existing tube, select the tube from the list that appears in the PatientTouch Clinical Manager and click **Delete**. When prompted to confirm, click **Yes**.

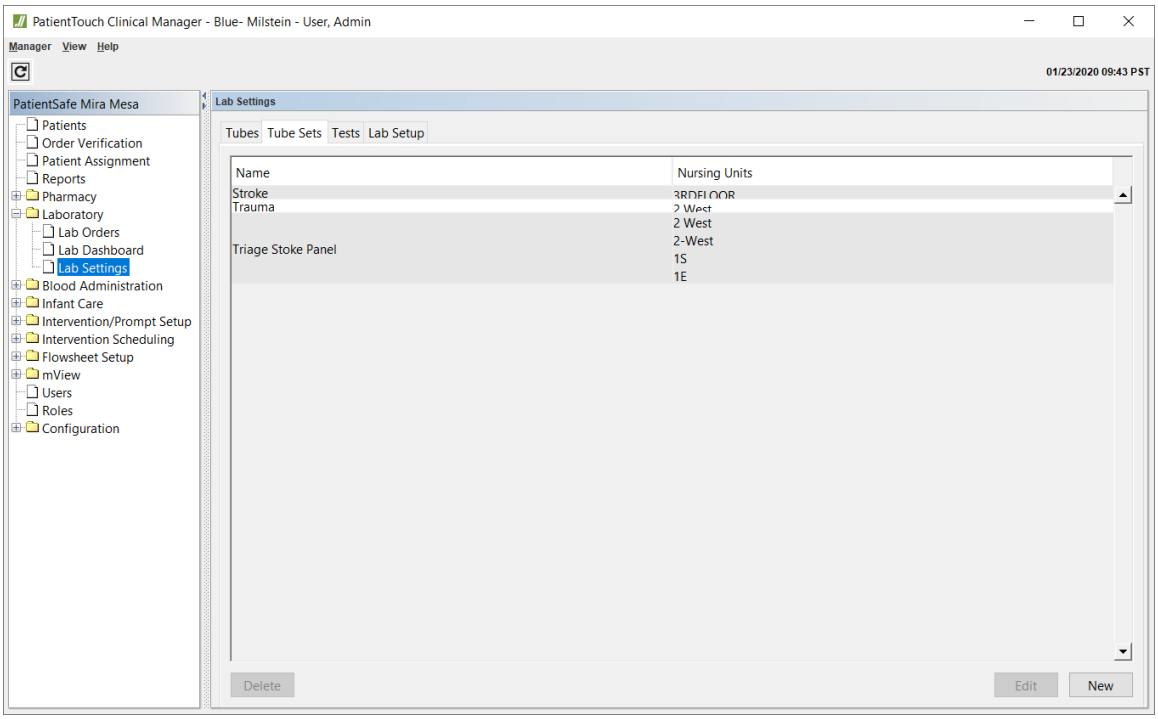
## *Configure Tube Sets*

If you wish, you can create tube sets in the PatientTouch Clinical Manager that comprise a standard set of multiple tubes that can be easily added to a blood draw, rather than requiring the tubes to be added individually. For example, you might create a “Chest Pain Panel” or “Trauma Panel” tube set to be used in the Emergency Department.

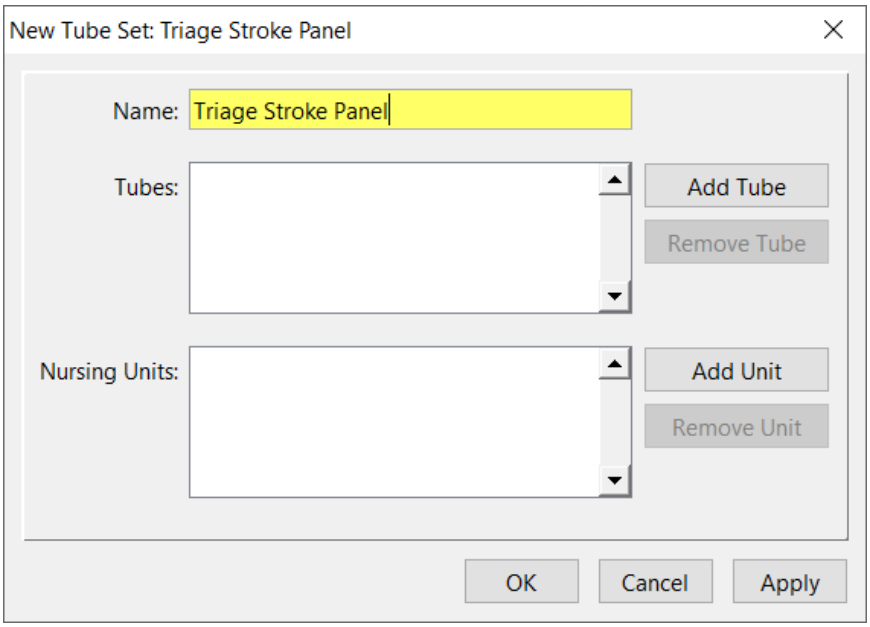
### Create a Tube Set

To create a tube set in Clinical Manager:

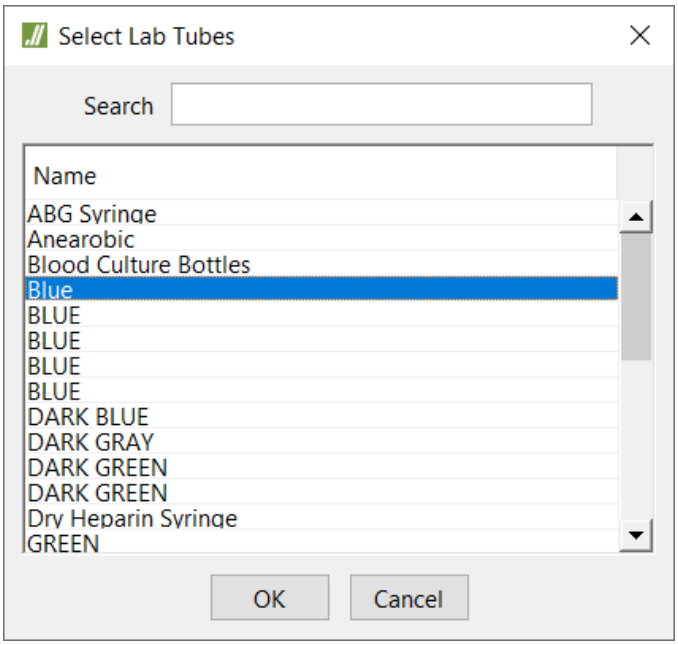
1. From the **Laboratory** folder, click **Lab Settings**, and then click the **Tube Sets** tab.



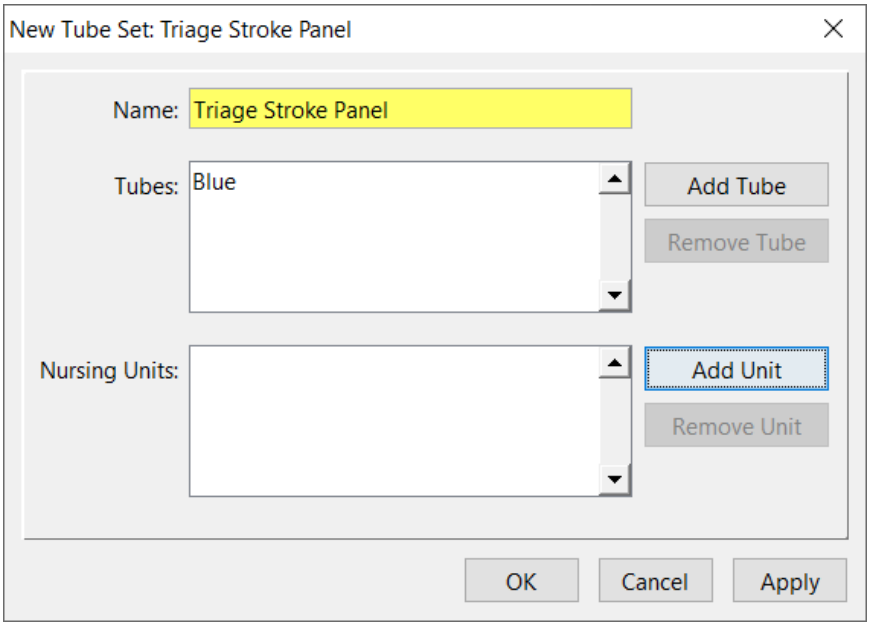

2. Click **New** to add a tube set. The following window appears:



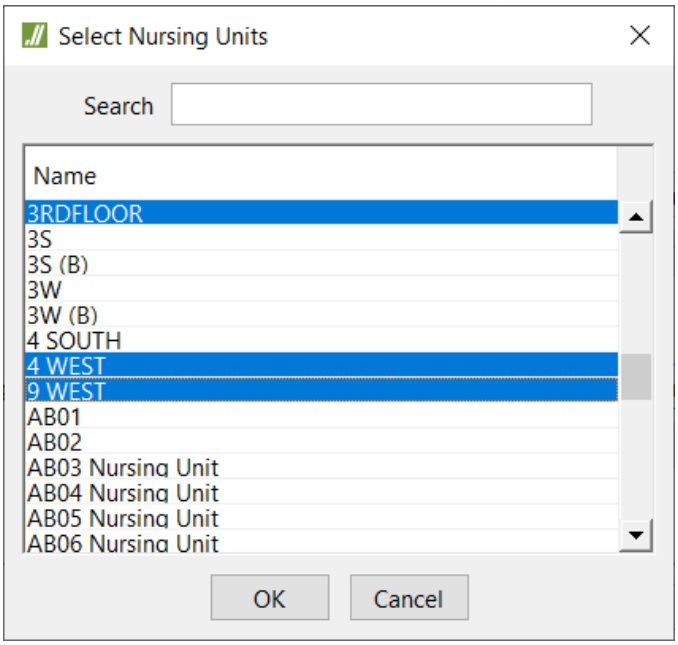

3. Enter a name for the tube set that will appear on the handheld to identify the collection of tubes. For example, type "Triage Stroke Panel".
4. Click **Add Tube** and select from existing tubes in the system to add to the tube set, and click **OK.** To select multiple tubes, hold down the Ctrl key (or Command key on Mac OS X).



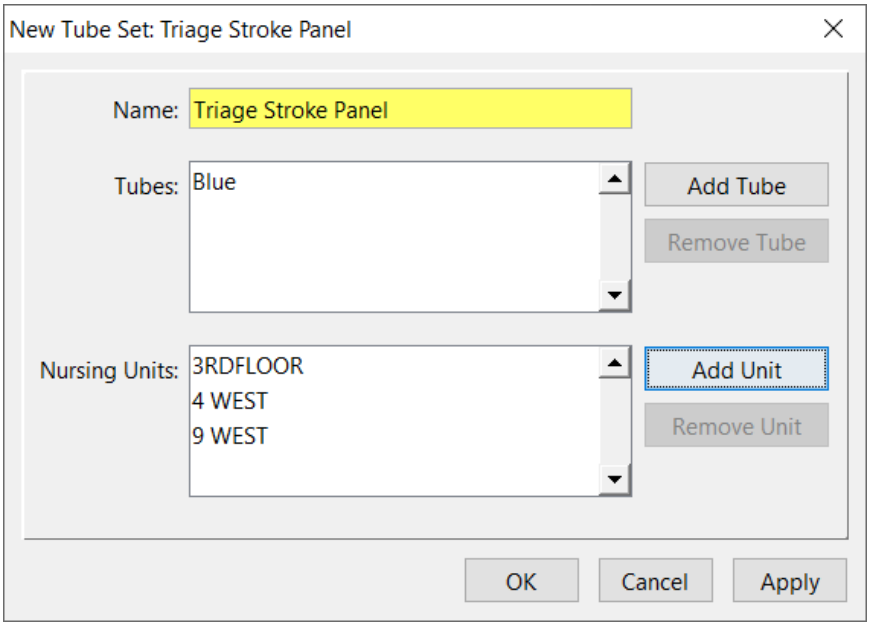

5. Click **Add Unit.**




6. Select from existing nursing units in the system where you want to make the tube set available for specimen collection, and click **OK**. To select multiple nursing units, hold down the Ctrl key (or Command key on Mac OS X).




7. Click **OK** in the *New Tube Set* window to save the tube set definition.




After you have reviewed or created all the desired tube sets, they will be available to collectors in the All Tube list displayed on PatientTouch when adding unordered tubes to a draw.

## Edit a Tube Set

To modify an existing tube set, select the tube set from the list that appears in the PatientTouch Clinical Manager and click **Edit**. Update as needed, using the same options you use to create a new tube set, and click **OK** to save your changes.

### Delete a Tube Set

To delete an existing tube set, select the tube set from the list that appears in the PatientTouch Clinical Manager and click **Delete**. When prompted to confirm, click **Yes**.

## *Configure Tests*

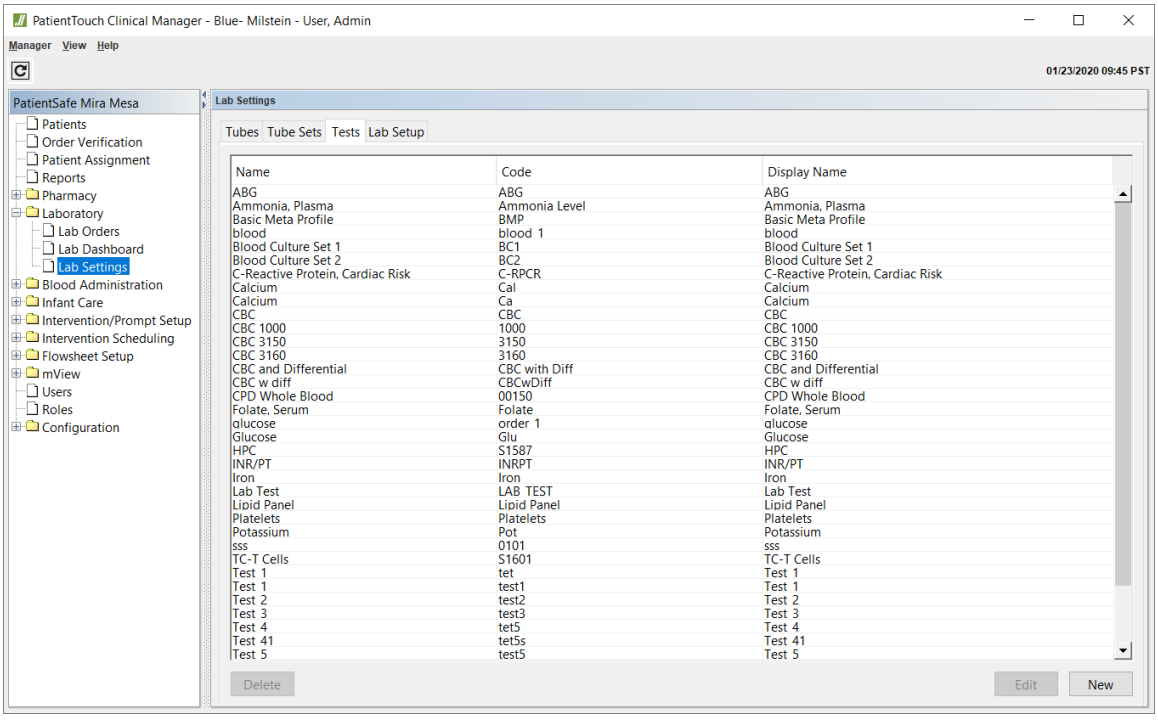
You can either create tests in the PatientTouch Clinical Manager or the tests are automatically created when the PatientTouch System receives lab orders for the tests from the Laboratory Information System.

Similar to how you configured tubes, you can associate clinical prompts and/or instructions with specific tests. During a blood draw workflow, these prompts display on the handheld before the specimen labels are printed.

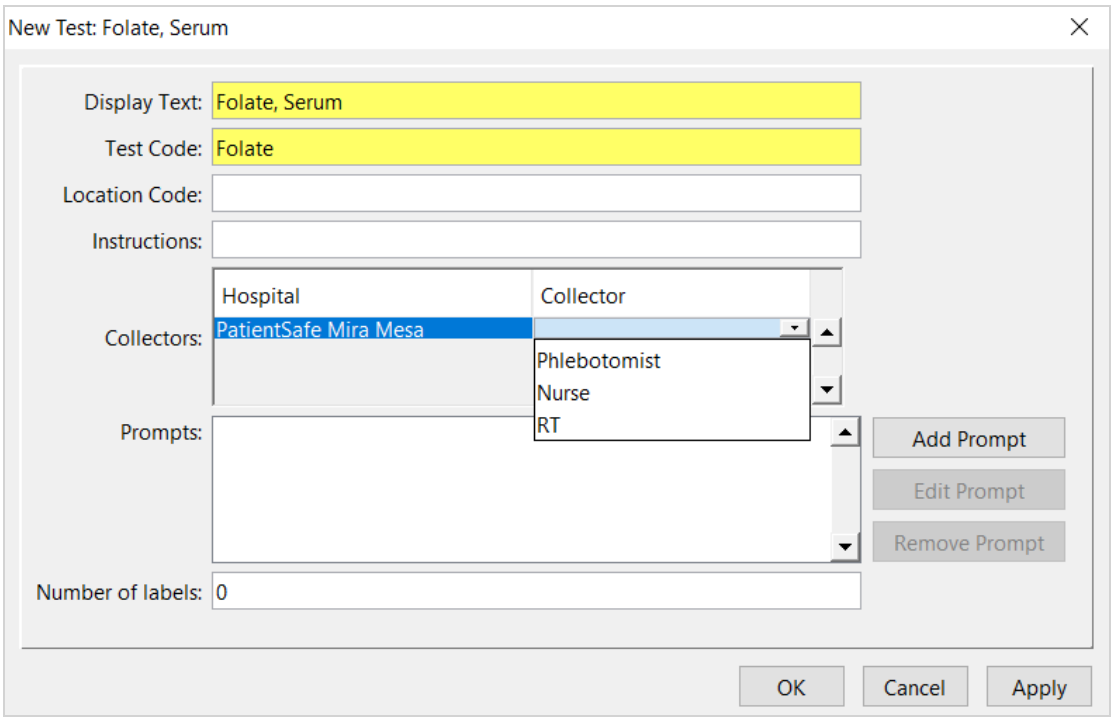
### Create a Test

To create a test in Clinical Manager:

1. From the **Laboratory** folder, click **Lab Settings**, and then click the **Tests** tab.




Click **New** to add a test. The following screen displays.




2. Enter a name for the test that will appear on the handheld and draw lists to identify the test.
3. Enter the test code. The code must exactly match the code received via the HL7 interface from the LIS.
4. Optionally, enter a location code to designate a specific area of the laboratory to which the specimens for this test should be routed. The Location Code can be configured to print on the specimen labels.
5. Optionally, add any standard instructions for the test.
6. If your hospital is configured for Campus Support, and you have selected <All> hospitals at login, all associated facilities will display under the Hospital column. Select a specific **Collector** type—**Phlebotomist, Nurse,** or **Respiratory Therapist**—for each hospital.

**Be sure these collector types match the types that are received from the LIS across the HL7 interface.**

**If different collector types are in different areas of the facility, you can define a test for each area. For example, you can define a test type "CBC-Med Surg" (with the Phlebotomist collector type) and "CBC-ICU" (with Nurse as the collector type). Note that defined test codes must match those used in the LIS.**

7. Optionally, click **Add Prompt** to select one or more clinical prompts to display with this test or tube type.
8. Click **Select Prompt** and select the prompt you want to display and click **OK**.
9. Select the appropriate Collection Options for the prompt or intervention and click **OK**.

10. Repeat steps 8–10 to select additional prompts if desired.
11. Enter the number of labels to print for the test.
12. Click **OK** in the *New Test* window to save the test definition.

### Edit a Test

To modify an existing test, select the test from the list that appears in the PatientTouch Clinical Manager and click **Edit**. Update as needed, using the same options you use to create new tests and click **OK** to save your changes.

### Delete a Test

To delete an existing test, select the test from the list that appears in the PatientTouch Clinical Manager and click **Delete**. When prompted to confirm, click **Yes**.

# Configuring the Blood Product Administration Module

The Blood Administration folder is only available if you have purchased the Blood Products Administration Module.

The following sections explain how to configure the PatientTouch Blood Product Administration Module, including the Blood Administration folder of the PatientTouch Clinical Manager. We begin with an overview of the necessary roles and users.

## Setting Up Roles and Users

Privileges must be added to the appropriate roles granted to those users before they can begin performing blood product administration tasks using the PatientTouch System.

| Privilege | Description |
|---|---|
| **Blood Bank** | Assign blood products, create blood bag tags, and distribute blood units. |
| **Transfuse Blood** | Administer blood products at the bedside. |
| **Document/Edit Patient TAR** | Edit Transfusion Record Elements from a transfusion initiated by the user. |
| **Manage Override Reasons** | View and edit Override Reasons and the Alert Reasons List for the *Unable to Complete Transfusion* workflow. |
| **Manage Laboratory Configuration** | Provides access to the Unable to Complete Transfusion Override Reasons Alert Reasons List. |

Refer to the Roles and Users section of this user guide for more information about defining roles and creating users.

## Getting Started

Before you can use the Blood Product Administration module, you must have a verified interface from your hospital's Laboratory Information System (LIS) to the PatientSafe Solutions system for laboratory

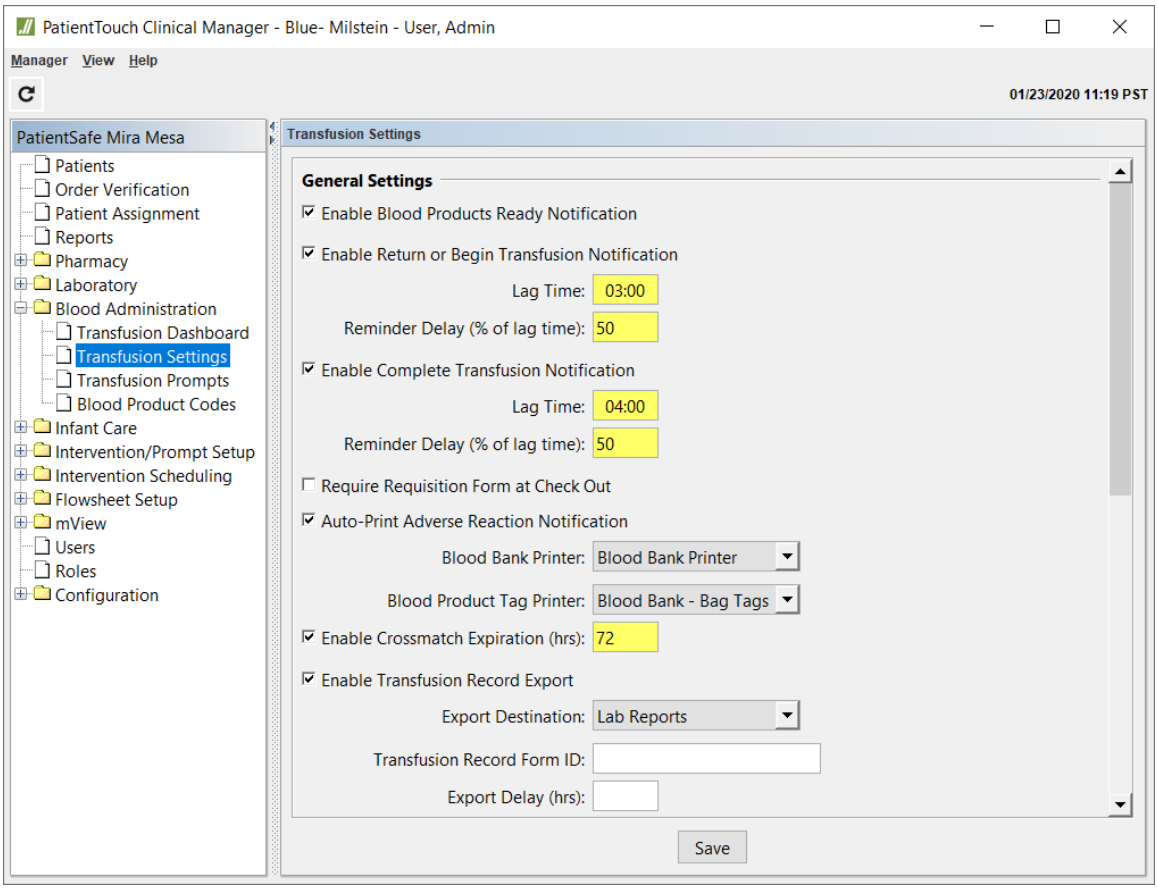
orders. You must also perform the following configuration tasks. Click a link below or from the Contents tab on the left to learn more.

- Configure Blood Product Administration Settings (optional step)
- Configure Clinical Prompts for Transfusions
- Manage Blood Product Codes
- Configure Alerts and Reasons

## Configure Blood Product Administration Settings

Configure your facility's preferred Blood Bank settings in the **Blood Administration** folder in PatientTouch Clinical Manager. To configure the Blood Transfusion settings:

1. From the **Blood Administration** folder, click **Transfusion Settings**.



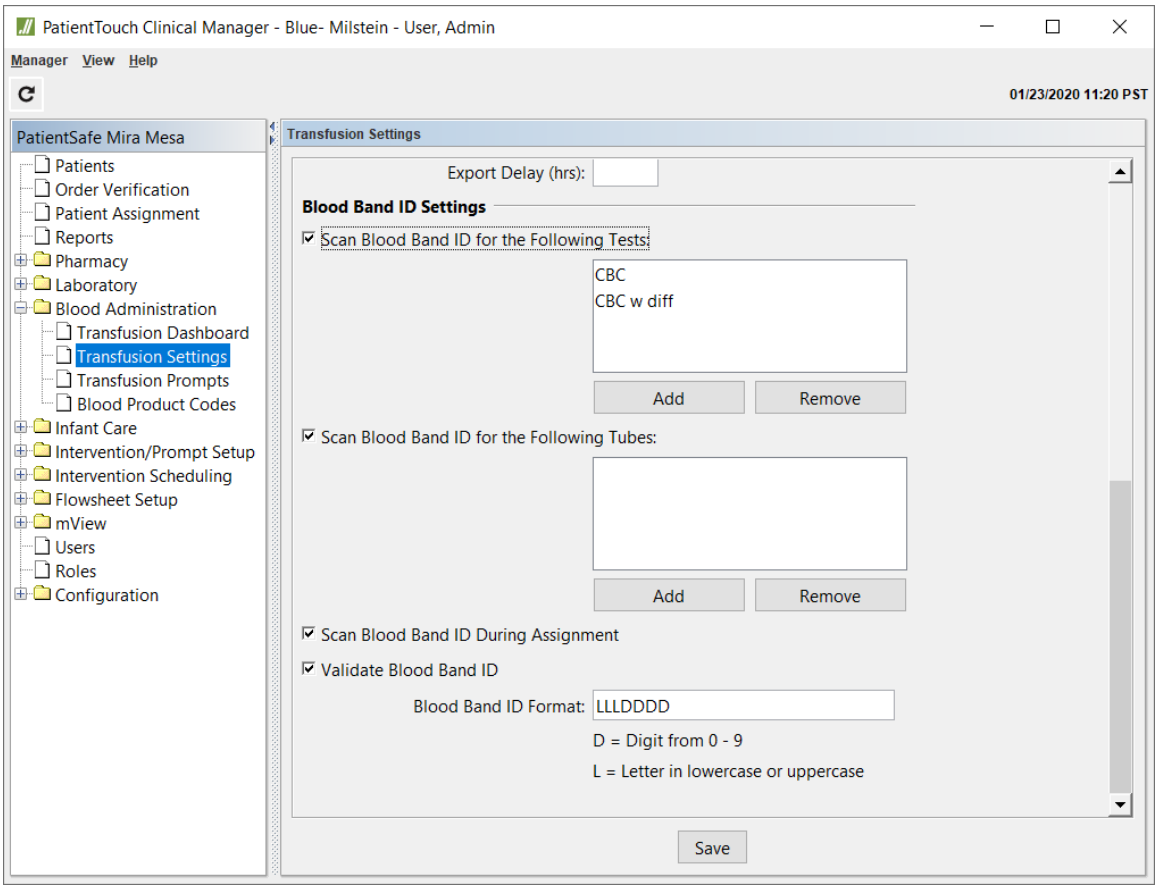

2. Enable the following General Settings for the facility, if desired:

   - Select **Enable Blood Products Ready Notification** if you want the system to notify the patient's assigned caregiver when blood products have been assigned and are ready for pickup. A notification message will be sent to the assigned caregiver's inbox each time a

new blood product is assigned to the patient. The caregiver must be logged in and have the patient assigned in order to receive these notifications.

- Select **Enable Return or Begin Transfusion Notification** to display a task on the To Do List of the assigned caregiver within the return grace period for checked out blood products. Use this option with Lag Time plus Reminder Delay to remind the assigned caregiver to return the blood product or begin the transfusion. For example, if the Lag Time is 30 minutes, and the Reminder Delay is 67%, the system reminds the caregiver if the transfusion has not been initiated 20 minutes after the blood product was checked out. The patient must be assigned to a caregiver and the *Check Out Blood* workflow must be completed in the Blood Bank to receive these notifications.
- Select **Enable Complete Transfusion Notification** to display a task on the To Do List of the assigned caregiver and remind the caregiver when the time to complete the transfusion is about to expire. Use this option with Lag Time plus Reminder Delay. For example, if the Lag Time is 4 hours and the Reminder Delay is 75%, the system reminds the user if the transfusion has not been completed within 3 hours of the blood being checked out. The patient must be assigned to a caregiver and the *Check Out Blood* workflow must be completed in the Blood Bank to receive these notifications.
- Select **Require Requisition Form at Check Out** to require that caregivers present a PatientTouch Blood Requisition Form in the Blood Bank in order to check out blood products. Note that if this option is not selected, you can still use the *Check Out Blood* workflow without using the requisition form. Instead of scanning the form, the blood bank user will be required to select the patient from a list of those to which the blood product is assigned.
- Select **Auto-Print Adverse Reaction Notification** and designate a printer if you want to automatically print the Transfusion Record when a transfusion with an adverse reaction is documented at the bedside.
- Select a **Blood Bank Printer** from the drop down list, where you want the Transfusion Record for Adverse Reaction notification to print.
- Select a **Blood Product Tag Printer** from the drop down list, where you want Blood Product Tags to print.
- Select **Enable Crossmatch Expiration (hrs)** to automatically expire the association between an assigned blood product and patient at the designated interval, based upon collection time of the specimen used for crossmatch. After a crossmatch expires, the blood unit cannot be checked out or transfused using the PatientTouch System.
- Select **Enable Transfusion Record Export** to export the transfusion record to a printer or network share drive. Select the export destination from the dropdown list. The Transfusion Record Form ID is included in the file name and in the transfusion record as a barcode. Enter an export delay in hours to allow time for additional documentation to be included with the record before export.

Enable the following Blood Band ID settings for the facility, if desired:




- Select **Scan Blood Band ID for the Following Tests** to enable scanning of the patient's blood band for selected tests during specimen collection.
  - To add tests, click **Add** to open the *Select Test* window and then click, ctrl+click, or shift+click on available tests to add tests to the list of selected tests. Click **OK** when done.
  - Select tests and click **Remove** to remove tests from the list of selected tests.
- Select **Scan Blood Band ID for the Following Tubes** to enable scanning of the patient's blood band for selected tubes during specimen collection. If this option is enabled, a tube must be selected.
  - To add tubes, click **Add** to open the *Select Tubes* window and then click, ctrl+click, or shift+click on available tubes to add tubes to the list of selected tests. Click **OK** when done.
  - Select tubes and click **Remove** to remove tubes from the list of selected tubes.
  - Only users with the Blood Bank privilege are able to edit this setting.
- Select **Scan Blood Band ID During Assignment** to require the patient's blood band ID to be scanned and validated during the blood assignment workflow.
- Select **Validate Blood Band ID** to validate the patient's blood band ID during the *Assign* and *BeginTransfusion* workflows.
- Enter the **Blood Band ID Format** to validate the blood band ID during the specimen collection, blood assignment, and blood transfusion process (if configured). If a user scans

the wrong Blood Band ID format, they will receive the following message: “Invalid Blood Band ID.”

The Blood Band ID Format consists of both numbers and upper or lowercase letters in any combination using an uppercase “D” for numbers, an uppercase “L” for letters. For example, “DDDLLLL” would indicate a format with 3 numbers and 4 letters.

**The PatientTouch System recognizes upper and lower case letters in the Blood Band ID format. For example, if a user scans a Blood Band ID with lower case letters during specimen collection and then scans a Blood Band ID with upper case letters during assignment, if configured, they will receive the “Invalid Blood Band ID” message.**

3. Click **Save** when done to save the transfusion settings.

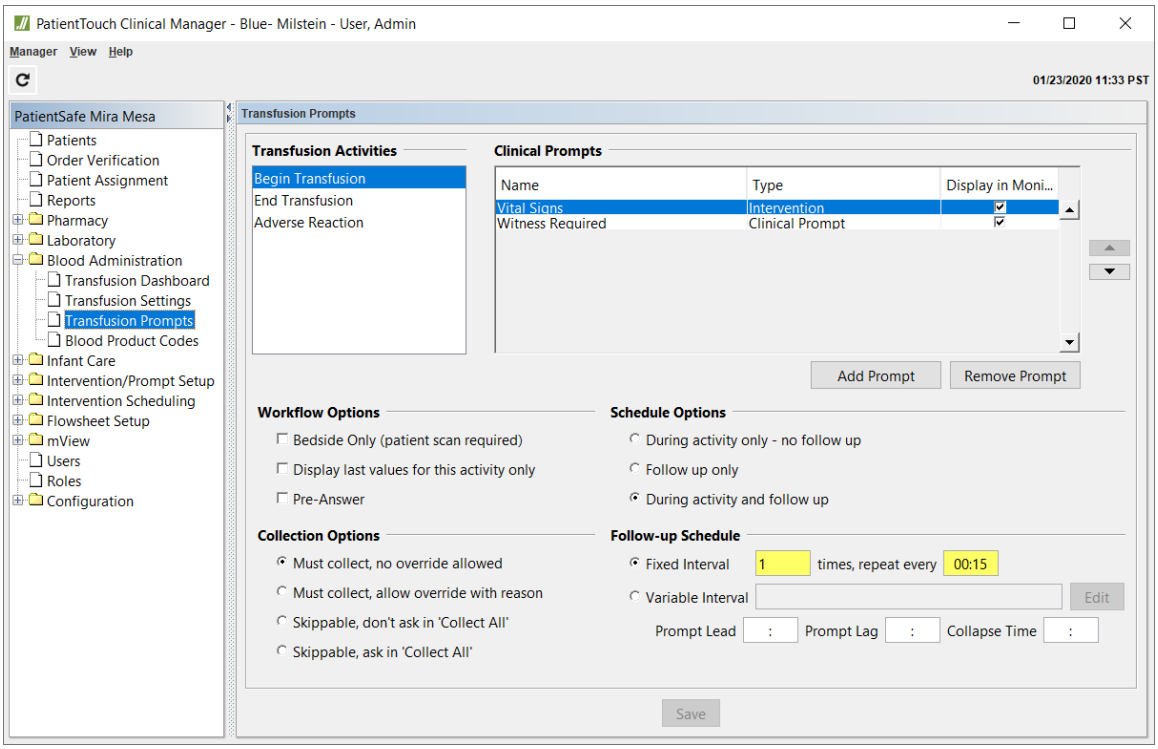
## Configure Clinical Prompts for Transfusions

Clinical prompts can be created and associated with *the Begin Transfusion, End Transfusion*, and *Adverse Reaction* workflows to remind the caregiver to take a particular action or to capture information when documenting a transfusion. You can create clinical prompts to capture clinical data associated with transfusions, such as vital signs, a witness, or signs of an adverse reaction. Creating and associating clinical prompts with transfusion activities is optional.

**The user must first create the desired clinical prompts before they are displayed in the selection list and are available for use with blood transfusion workflows. For more information about creating clinical prompts, refer to the appropriate section of this user guide.**

To configure the clinical data that you want to capture during transfusion procedures:

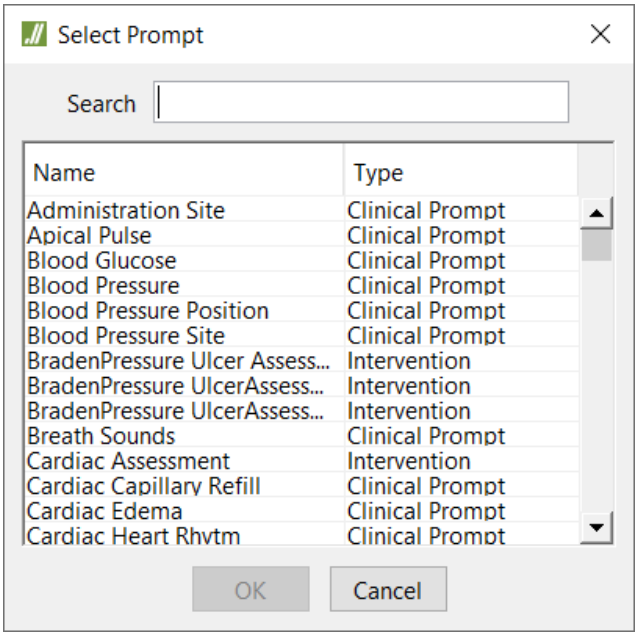
1. In the Clinical Manager, select the **Blood Administration** folder and click **Transfusion Prompts**.




2. Select a transfusion workflow (e.g. *Begin Transfusion*) for which you want to configure prompts from the list in the upper left of the window. The prompts that are associated with the selected activity are displayed in the list to the right.

   - Prompts associated with the Begin Transfusion activity will display on the handheld during the *Begin Transfusion* workflow. The prompts and collected responses will be displayed in the Transfusion Start section of the Transfusion Record or in the Transfusion Monitoring section of the Transfusion Record if the prompts have been configured in the **Blood Administration, Transfusion Prompts** settings in the Clinical Manager to **Display in Monitoring Table**.
   - Follow-up interventions for in-progress transfusion monitoring will be scheduled and displayed on PatientTouch while a transfusion is in progress for any associated prompts that have a follow-up schedule configured.
   - Prompts associated with the End Transfusion activity will display on the handheld during the *End Transfusion* workflow when the transfusion is ended normally (i.e., no adverse reaction recorded).
   - Follow-up interventions for post-transfusion monitoring will be scheduled and displayed on PatientTouch after a transfusion has been ended normally for any associated prompts that have a follow-up schedule configured.
   - Prompts associated with the Adverse Reaction activity will display on the handheld during the *End Transfusion* workflow when the transfusion is ended with an adverse reaction recorded.
   - Follow-up interventions for post-reaction monitoring will be scheduled and displayed on PatientTouch after a transfusion has been ended with an adverse reaction for any associated prompts that have a follow-up schedule configured.

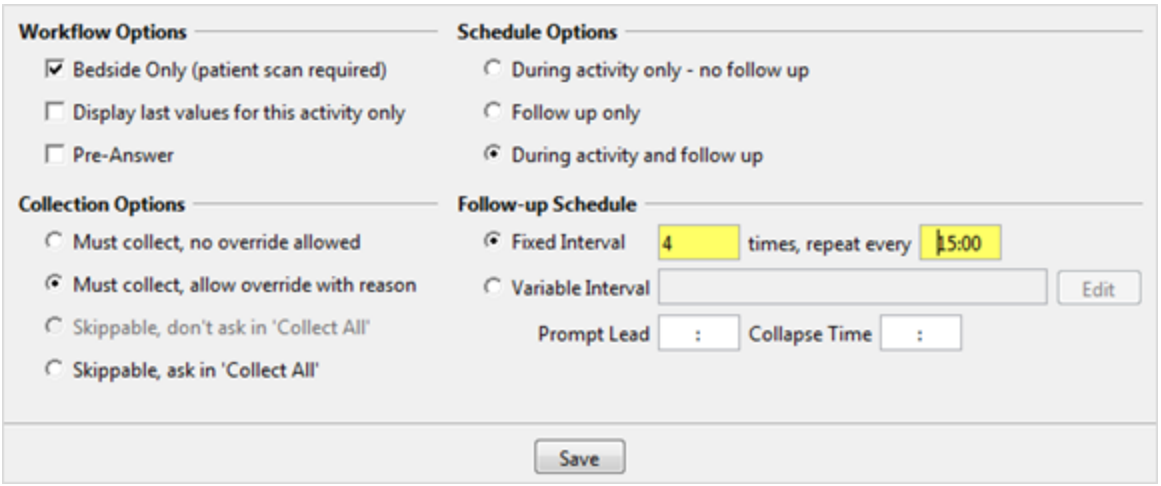
3. Click **Add Prompt** and select the desired clinical prompts and interventions to associate with the activity.




4. Click **OK**. To select multiple prompts, hold down the Ctrl key. You select prompts to associate from among those available in your system.

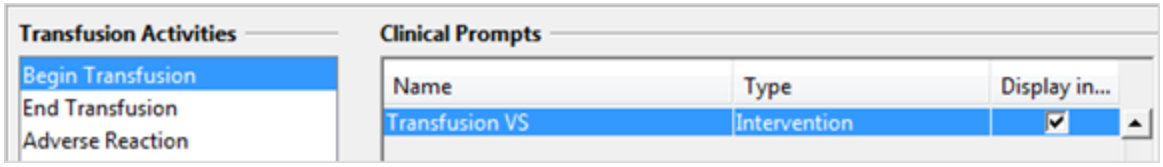
5. Use the vertical arrows to the right of the prompts list to change the order in which the prompts will be displayed when the selected activity workflow is performed on PatientTouch.

6. Select a prompt in the Clinical Prompts list and configure the options in the bottom pane, below the prompt list.




7. Click the **Display in Monitoring Table** checkbox for an associated prompt if you want to display the responses for that prompt in the Transfusion Monitoring table of the Transfusion Record. If you setup a prompt to **Display in MonitoringTable** in the *Begin Transfusion* workflow, the

same prompt will also be setup to **Display in Monitoring Table** in the *End Transfusion* workflow.




Prompts that are not selected to display in the Transfusion Monitoring table will be displayed in the corresponding sections of the Transfusion Record for the workflows in which they were documented.

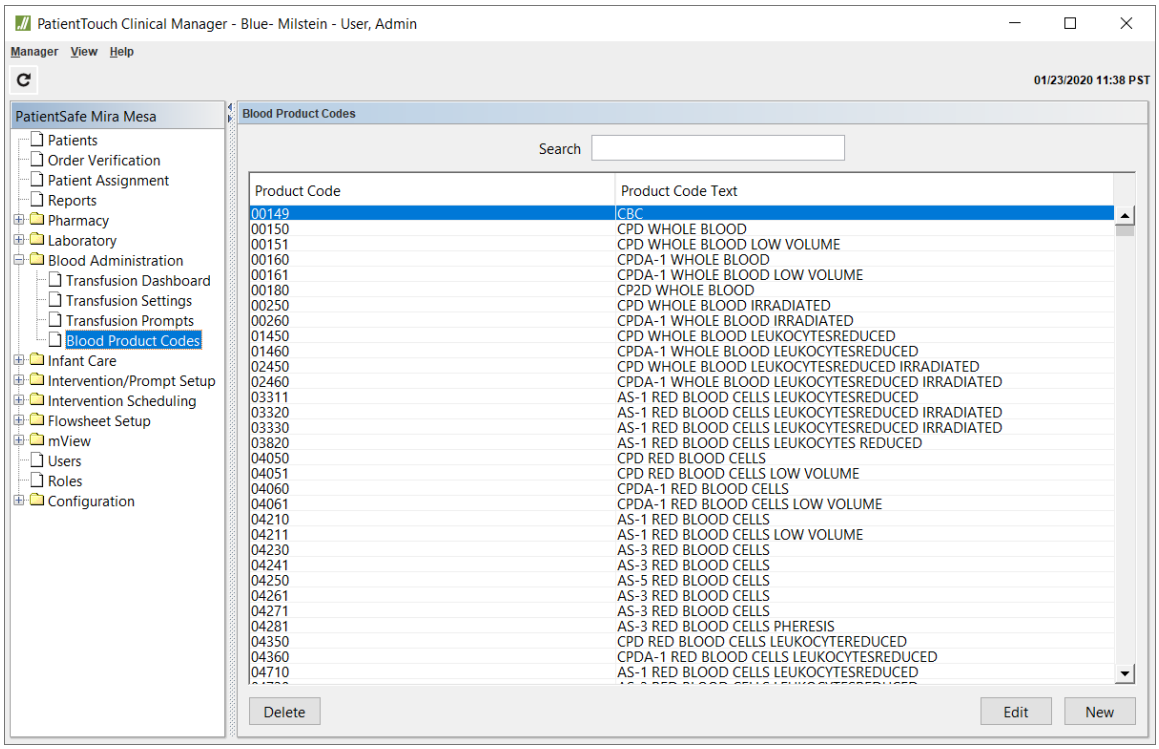
For example, prompts associated with the Begin Transfusion activity will display in the Transfusion Start section. Prompts associated with the End Transfusion and Adverse Reaction activities will display in the Transfusion Completion and Reaction sections respectively.

8. Repeat steps 6 and 7 for each prompt you add to the workflow.
9. Repeat steps 2 – 8 for the three transfusion workflows (i.e. *Begin Transfusion, End Transfusion*, and *Adverse Reaction*), as desired.
10. Click **Save** to save the configuration settings for all prompts associated with each of the available transfusion activities.

## Manage Blood Product Codes

Blood product codes provide a translation of blood bag product barcodes to blood product descriptions (for example, Whole Blood or Frozen Packed Plasma) when the blood bag product barcode is scanned. The PatientTouch System includes a standard database of ISBT Code 128 and Codabar blood product codes, and you may add blood product codes if desired.

To manage blood product codes that will be recognized when assigning blood product in the Blood Bank, select **Blood Product Codes** from the **Blood Administration** folder. The list of blood product codes in the system is displayed.




To add a new blood product code that will be translated into readable text to be displayed on PatientTouch and the printed blood product tag:

1. Click **New**.
2. Enter the Blood Product Code (the value of the barcode that will be scanned) and Blood Product Text to display in the designated fields, and click **OK**.
3. The new item will appear in the list.

To edit an existing blood product code:

1. Highlight the blood product code in the list.
2. Click **Edit**.

Editing a blood product code will not affect information for previously assigned blood units.

To remove an existing blood product code:

1. Highlight the blood product code in the list.
2. Click **Delete**.

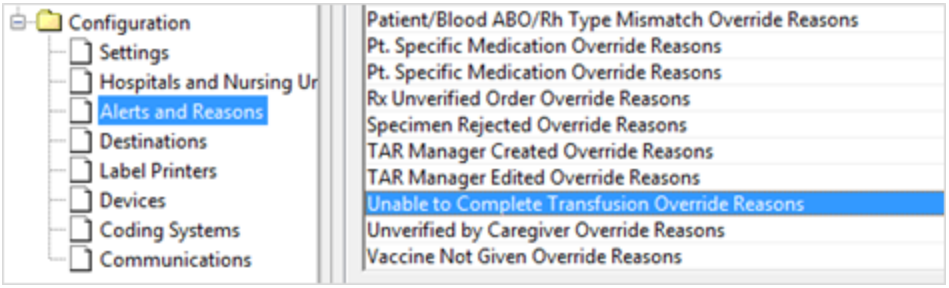
Deleting a blood product code will not affect information for previously assigned blood units.

## Configure Alerts and Reasons

The PatientTouch System comes with a default Alert Reason List “Unable to Complete Transfusion Override Reasons.” You must have the Manage Laboratory Configuration and the Manage Override

Reasons privileges to configure the override reasons list. Override reasons will differ from facility to facility but can include reasons such as patient expired or patient transferred out of hospital.

**Refer to the Configuration>Alerts and Reasons section of this user guide (Clinical Manager Configuration User Guide) for more information on how to create Override Reasons.**




# Configuring the Infant Care Module

The Infant Care folder is only available if you have purchased the Infant Care Module.

The following sections explain how to configure the PatientTouch Infant Care Module, including the Infant Care folder of the PatientTouch Clinical Manager. We begin with an overview of the necessary roles and users.

## Setting Up User Roles and Users

Caregivers who will care for infants in the facility must have appropriate privileges before they can perform the required tasks. The following system privileges are available in connection with the Infant Care module:

| Privilege | Description |
|---|---|
| **Breast Milk Collection and Administration** | Document the collection of breast milk from admitted mothers, print labels for home collection, receive and verify matching of bottles for storage, create labels for breast milk storage bins, and document the administration of correctly matched breast milk to infants. |
| **Mother-Infant Matching** | Verify that infants are correctly matched to inpatient or discharged mothers and other authorized visitors at the bedside, as well as matched to the correct cribs in the nursery. |

Refer to the Roles and Users section of this user guide for more information about defining roles and creating users.

## Getting Started

Once you have configured the Infant Care module in the PatientTouch Clinical Manager, the workflows for breast milk collection and management, infant feeding, and mother-infant matching are available on PatientTouch.

Before you can use the Infant Care module, you must perform the following configuration tasks. Click a link below or from the Contents tab on the left:

- Mother-Baby Link
- Configure Label Printer Selection Setting
- Set Up Wireless Label Printers
- Customize Breast Milk Bottle Label Format
- Add Infant Care Activities to Nursing Units
- Configure Clinical Prompts for Infant Care Workflows (optional)

## Mother-Baby Link

When both mother and baby are admitted to the hospital, the PatientTouch System links them using admission data provided by the hospital information system. To ensure that breast milk is properly labeled and retrieved for feeding, each container of milk collected from an inpatient mother is labeled with the mother's admission data, including MRN and account/visit number.

For home collection, the labels printed at the hospital identify the baby. When the mother uses these labels during home collection and returns the milk to the hospital for feeding, the caregiver who feeds the baby scans the label and the baby's wristband to ensure a match.

## Configure Label Printer Selection Setting - Infant Care

The PatientTouch System allows you to configure how handheld users select a label printer when printing breast milk bottle labels and bin labels.

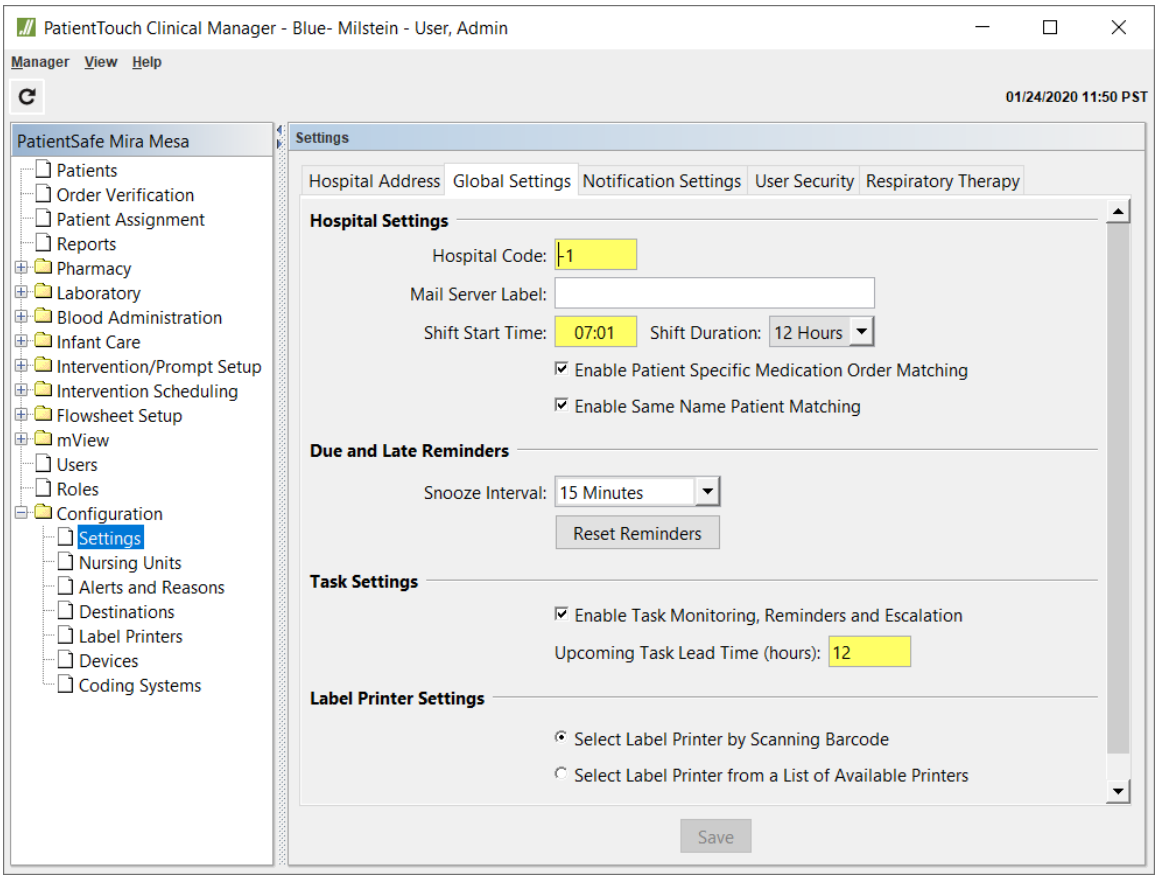
The options include:

- The user selects the printer (by friendly name) from a list of label printers available in the system.
- The user scans a barcode associated with (and affixed to) the printer to select it.

**This option applies to workflows in which labels are printed in all installed PatientTouch modules, including Infant Care, Specimen Collection, and others as applicable.**

To configure the label printer selection setting in Clinical Manager:

1. From the **Configuration** folder, click **Settings**, and then click the **Global Settings** tab.




2. In Label Printer Settings, select the desired option.
3. If the **Select Label Printer by Scanning Barcode** option is selected, make sure that all label printers configured in the system are assigned a unique barcode that will be scanned when users print labels. Refer to Set Up Wireless Label Printers below for more information.
4. Click **Save** to save the settings.

## Set Up Wireless Label Printers

You must set up the wireless label printers that will be used to print breast milk bottle labels and bin labels from the handheld in PatientTouch Clinical Manager.

A PatientSafe Solutions implementation team member can work with your hospital's Information Systems department to determine the IP addresses and wireless configuration settings for the label printers.

### *Set Up a New Label Printer*

Refer to the Configuring the Specimen Collection Module>Configure Label Printer Selection Setting section for details on how to set up and test a label printer.

## Customize Breast Milk Bottle Label Format

Labels for collected breast milk bottles may be customized for your hospital by PatientSafe Solutions. The labels typically include the following information:

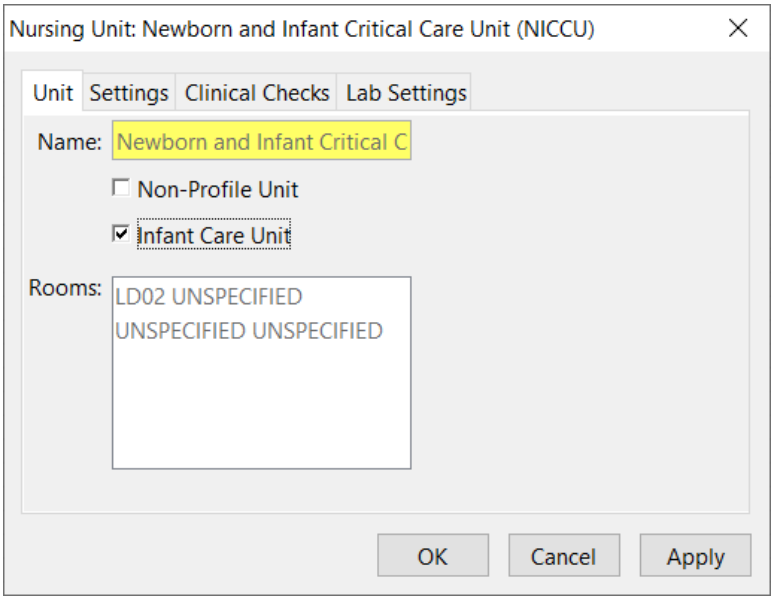
- Unique barcode that identifies the bottle.
- Patient name and room/bed number (for infant or mother, depending on collection method).
- Patient MRN and visit number.
- Patient date of birth.
- Collector's name.
- Collection date and time.

## Add Infant Care Activities to Nursing Units

Infant Care activities must be assigned to the desired nursing units in your facility—for example, Labor and Delivery, Nursery, or NICU—before they can be available for use by clinical staff. Each infant care workflow can be individually assigned to specific nursing units. Activities will only display in the PatientTouch application for users who have the privileges to perform them.

To set up the nursing unit for infant care, follow the instructions below.

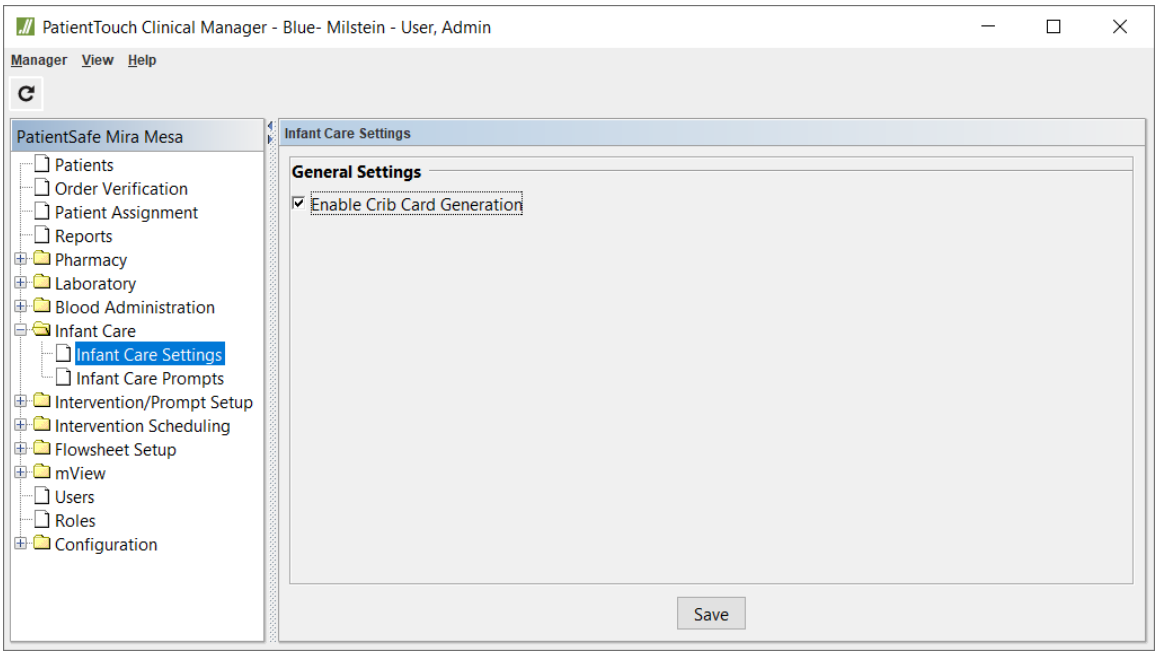
1. Select **Configuration>Hospitals and Nursing Units**.
2. Select the nursing unit and click **Edit**, or double-click it.
3. Click the **Infant Care Unit** checkbox.




## Configure Infant Care Settings

In order for caregivers to complete the Print a Crib Card workflow using PatientTouch, the Clinical Manager must have the following setting configured:

Infant Care Settings>Enable Crib Card Generation.



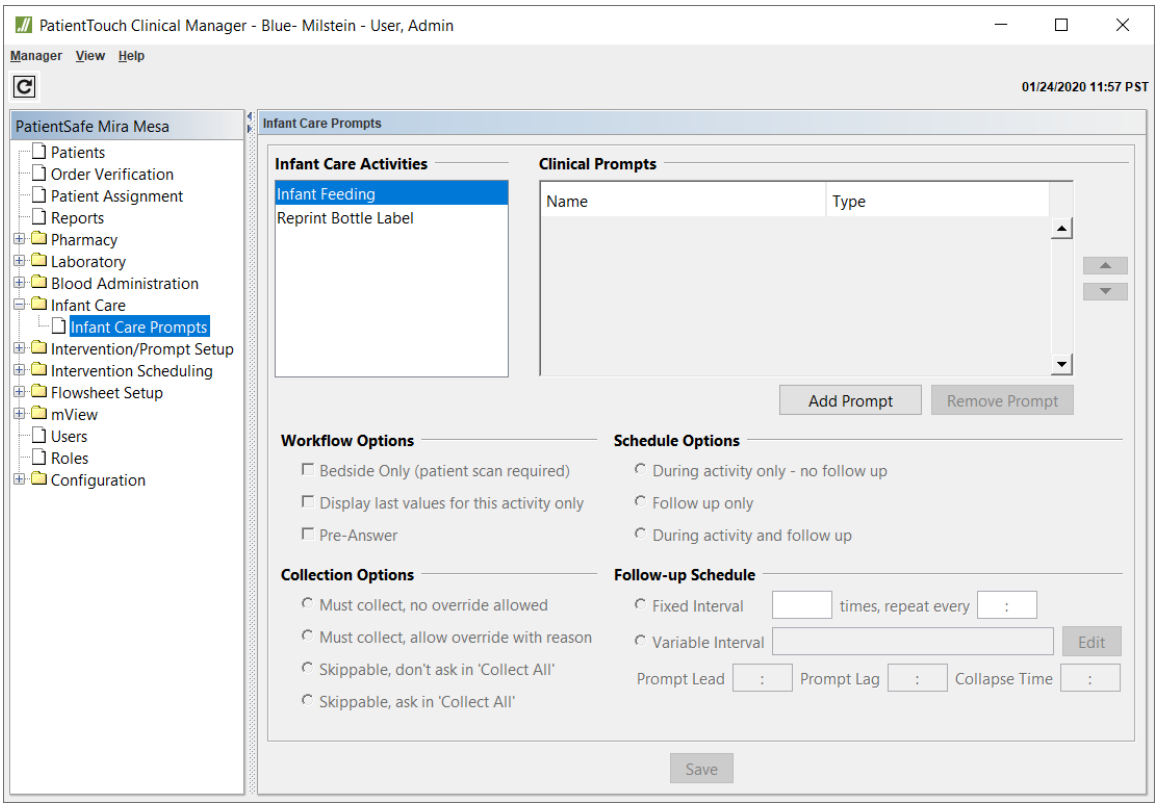

## Configure Clinical Prompts for Infant Care Workflows

Using the PatientTouch Clinical Manager, you can configure the clinical data that you want to capture for the following infant care activities:

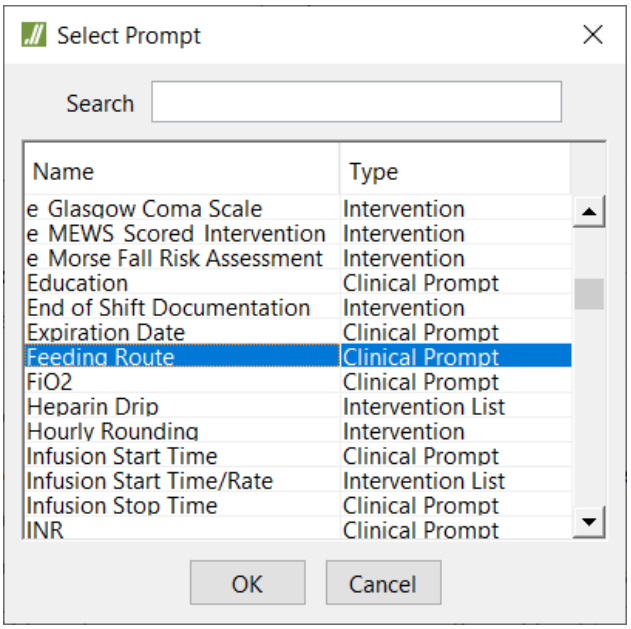
- Infant Feeding, for prompts to display during the feeding procedure and/or as post-feeding follow-ups.
- Reprint a Damaged Breast Milk Bottle Label for prompts to capture collection date, witness, and other information.

To configure prompts for these activities:

1. In the Clinical Manager, select the **Infant Care** folder and click **Infant Care Prompts**.



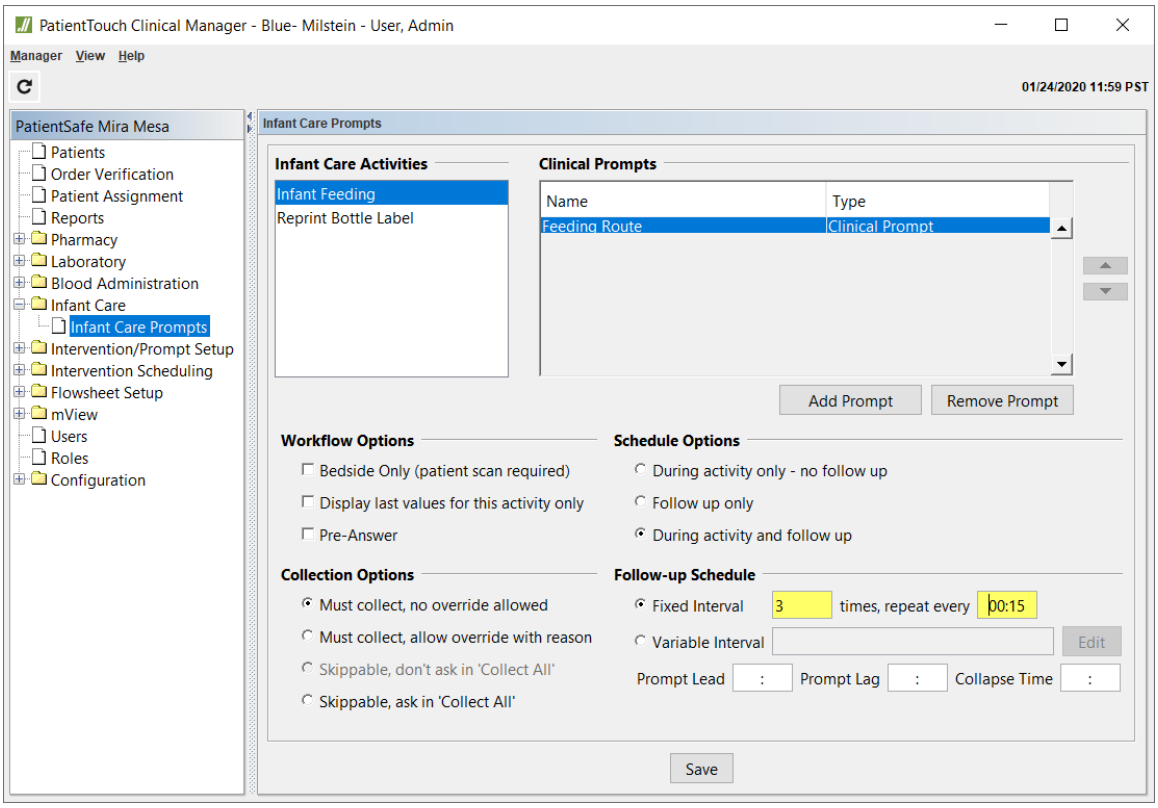

2. From the list in the upper left pane, select an activity (e.g. Infant Feeding) for which you want to configure prompts. The prompts associated with the selected activity are displayed in the list to the right.
3. Click **Add Prompt** and select the desired clinical prompts and interventions to associate with the activity.
4. Select one or more prompts or interventions to associate with the activity and click **OK**. To select multiple prompts, hold down the Ctrl key (or Command key on Mac OS X).




5. Use the vertical arrows to the right of the prompts list to change the order in which the prompts will be displayed when the selected activity workflow is performed on PatientTouch.
6. Select a prompt in the Clinical Prompts list and configure the options in the bottom pane, below the prompt list.
7. For Workflow Options, select whether the patient must be scanned to allow the prompt to be answered, and whether the caregiver should see last values for this infant care activity, or the last time it was collected for the patient during any activity.

For Collection Options, select the appropriate option:

- **Must collect, no override allowed** requires the collector to respond to the prompt or intervention before continuing with the workflow.
- **Must collect, allow override with reason** requires the collector to either respond to the prompt or intervention, or select a reason for not providing a response before continuing with the workflow.
- **Skippable, don't ask in 'Collect All'** means if the collector selects the 'Collect All' workflow, this particular prompt will not be asked as part of the 'Collect All' workflow.
- **Skippable, ask in 'Collect All'** means if the user selects the 'Collect All' workflow, allows the collector to either respond to the prompt or intervention, or skip responding to the prompt in the workflow.




For Schedule Options, select whether caregivers should respond to the prompt only while completing the infant care activity (workflow), only as a follow-up to the activity, or both. If you choose an option for follow-up, enter the desired schedule—either repeating one or more times at a fixed interval, or a variable series of follow-up times—in the Follow-Up Schedule section.

8. Repeat step 6 for each prompt you added to the activity.
9. Repeat steps 2 – 7 for each of the available infant care activities, as desired.
10. Click **Save** to save the configuration settings for all prompts associated with each of the available infant care activities.

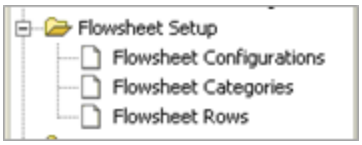
# Flowsheet Setup

Flowsheets and *mView* can display medications, vital signs, user-entered responses to prompts and interventions and data imported from external clinical systems such as lab results.

Flowsheets display all data collected for a shift, defaulting to display data collected over the current 24-hour period. You can scroll through previous days by clicking Back and Forward. You can view and print Flowsheets through the Clinical Manager.

The *mView* display on the handheld shows the last value collected for that component.

When setting up Flowsheets, it is best to work from the bottom up on the Clinical Manager menu tree (start with Flowsheet Rows and finish with Flowsheet Configurations).




Click a link below or from the Contents tab on the left to learn more.

Create a **Flowsheet** row

- The Flowsheet row defines the type of clinical data that will be displayed, such as blood pressure.

Create a **Flowsheet** category

- The Flowsheet category defines a group of Flowsheet rows that make sense to display together, such as vital signs, assessments, procedures, and lab values.

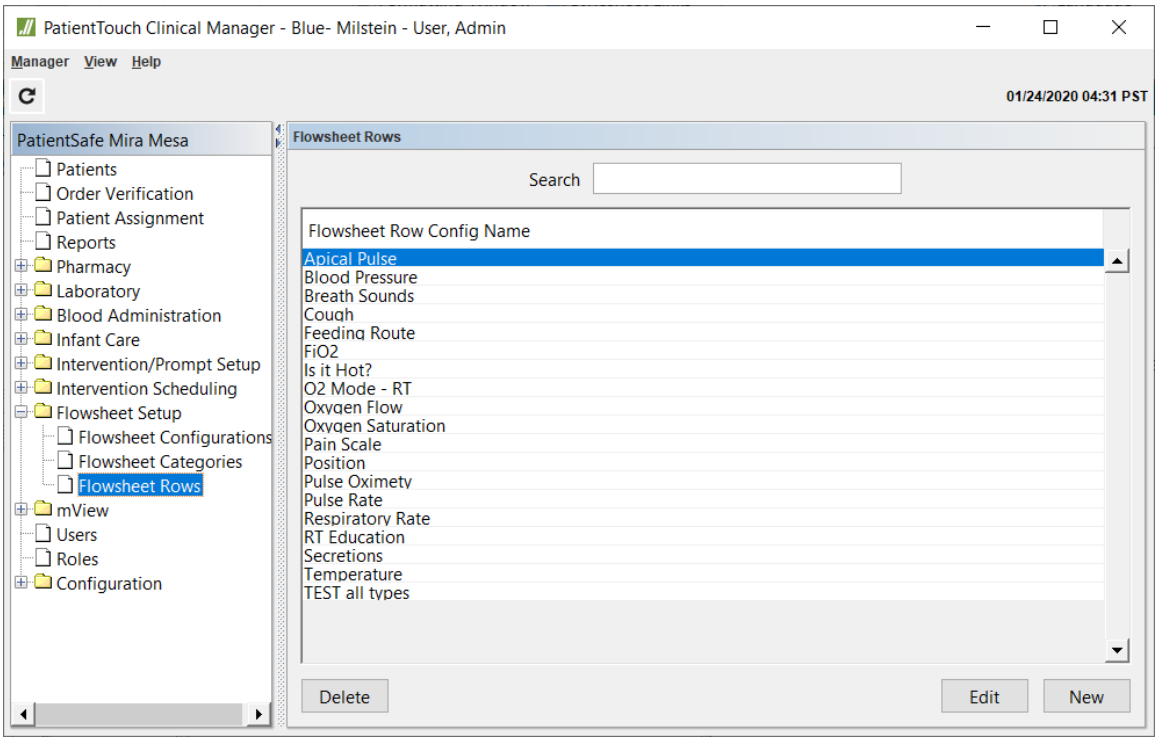
Create the **Flowsheet** configuration

- The Flowsheet configuration defines a collection of Flowsheet categories available for the nurse to select to display, such as insulin/blood sugar, antibiotic/temp/CBC.

# Creating a Flowsheet Row

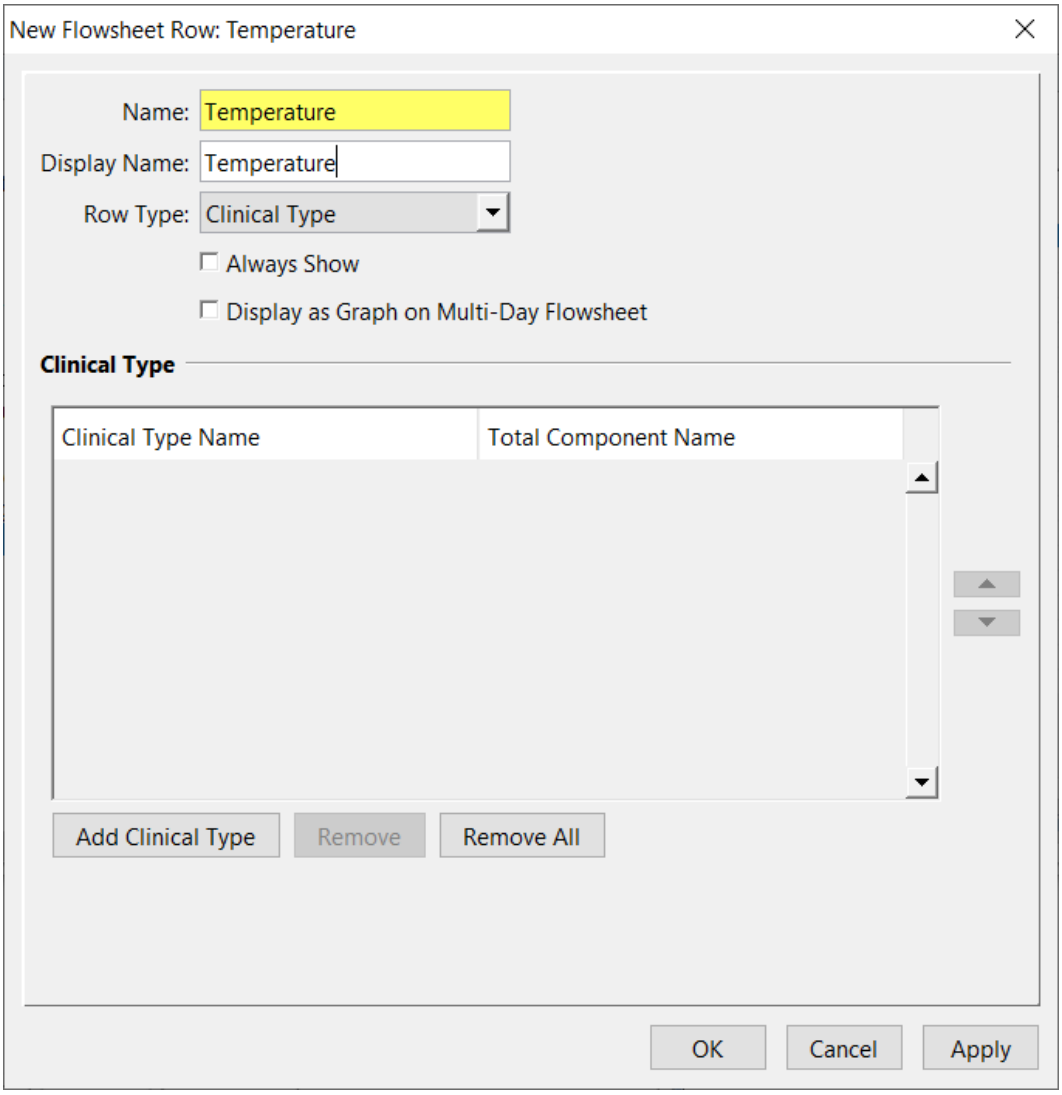
Flowsheet rows are created based on the clinical data types you set up in Intervention/Prompt Setup>Clinical Types.

1. In Clinical Manager, select **Flowsheet Setup > Flowsheet Rows**.

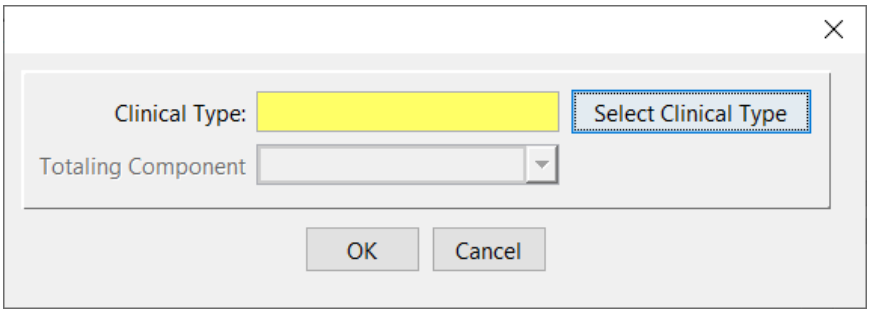


2. Click **New** to display the *New Flowsheet Row* window.
3. Enter a name for the row. In this example, we will create a Temperature row.
4. Select **Clinical Type** from the **Row Type** drop down list.

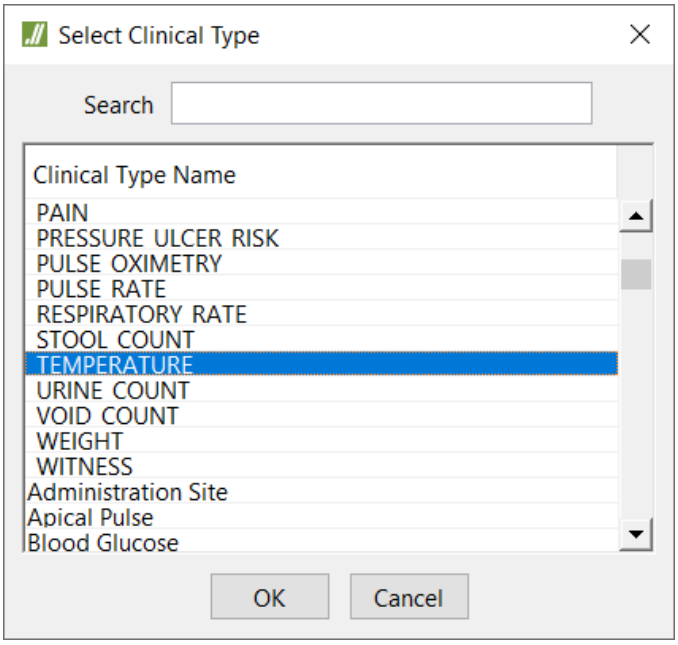
**If no display name is entered, the Flowsheet will display the Clinical Type name.**



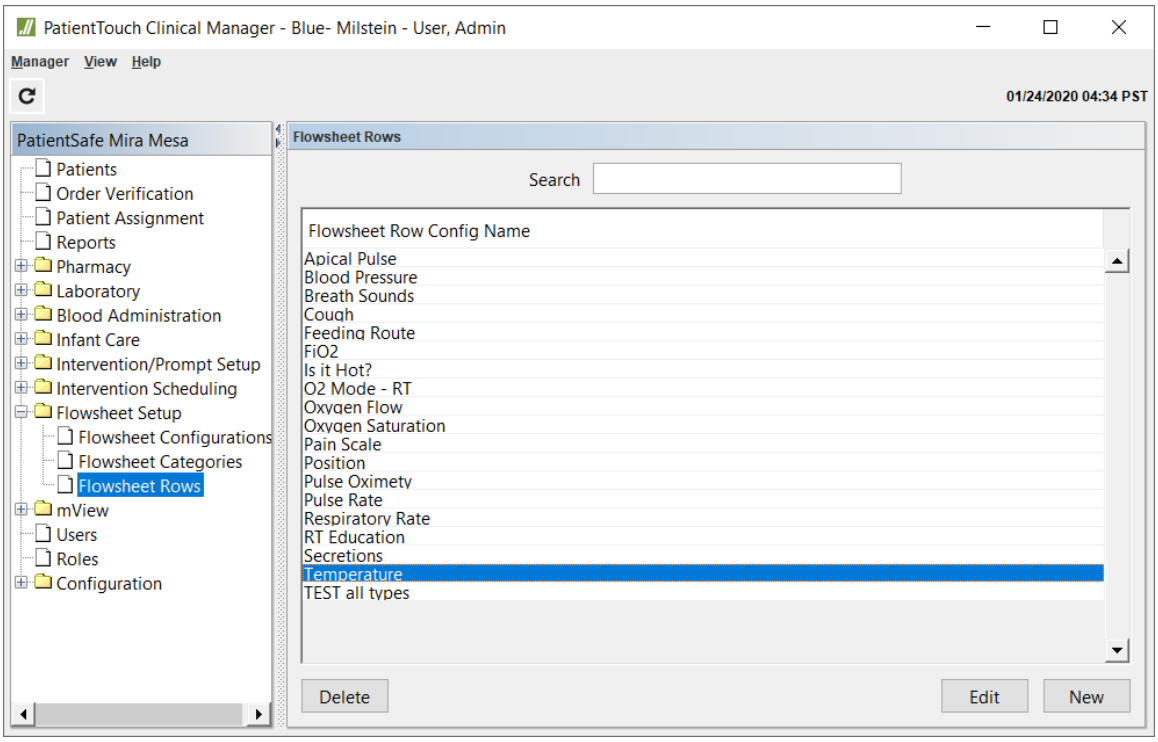

5. Click **Add Clinical Type** and then **Select Clinical Type**.




6. Select a Clinical Type.



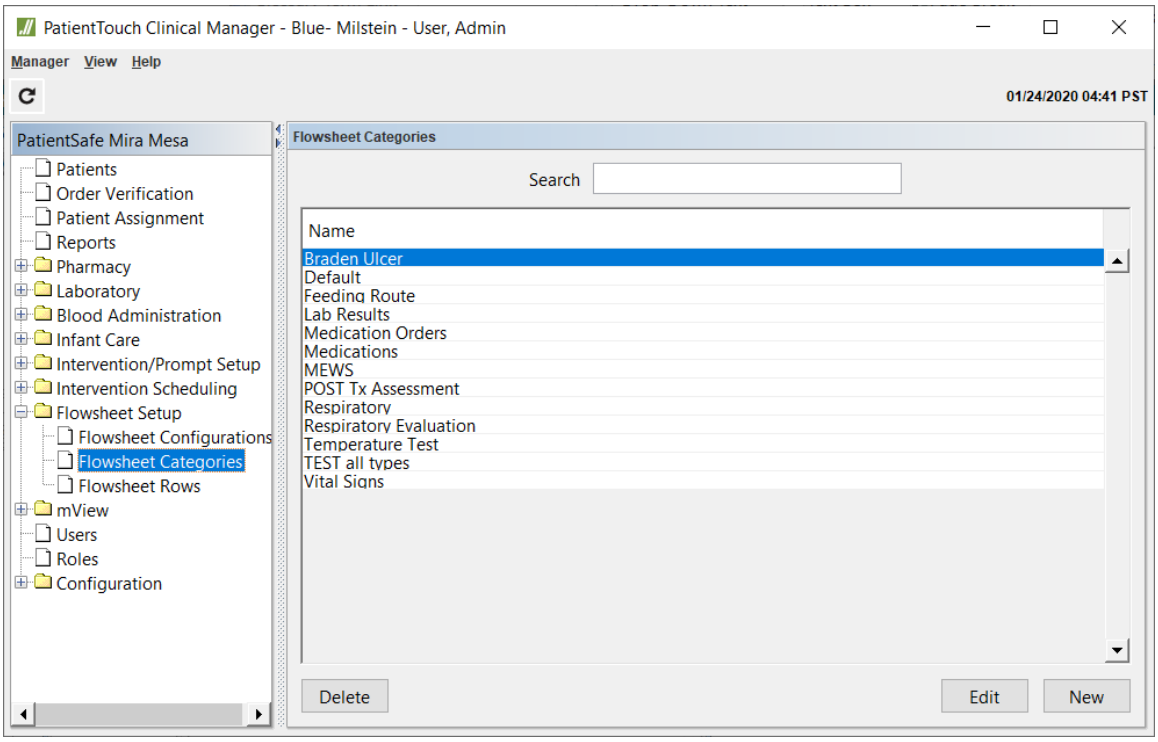

7. Click **OK** three times.
8. The new Flowsheet Row appears on the screen.
9. Repeat these steps for each new Flowsheet Row.



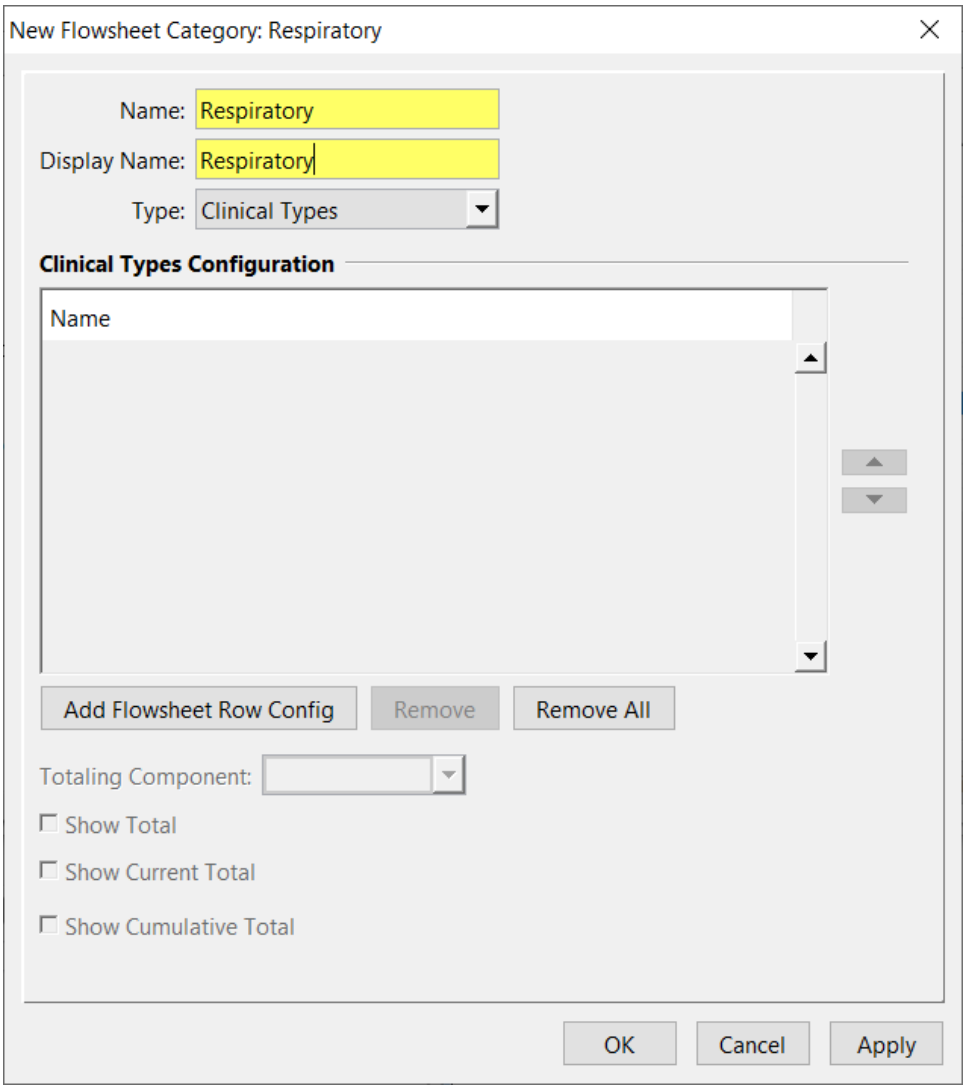

# Creating a Flowsheet Category

Flowsheet categories are created from the flowsheet rows you created in Flowsheet Setup>Flowsheet Rows.

1. Select **Flowsheet Setup > Flowsheet Categories** to display the *Flowsheet Categories* screen.




2. Click **New** to display the *New Flowsheet Category* window.
3. In the Name field, enter a unique name (mandatory).
4. In the Display Name field, enter the name that will display in the handheld (mandatory).

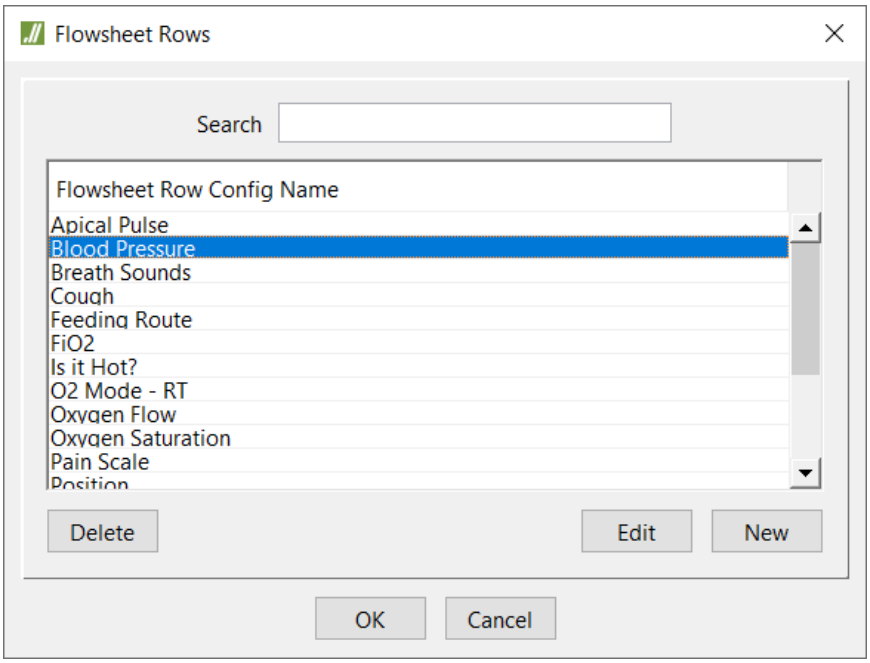



5. Select **Clinical Types** from the **Type** drop down list.

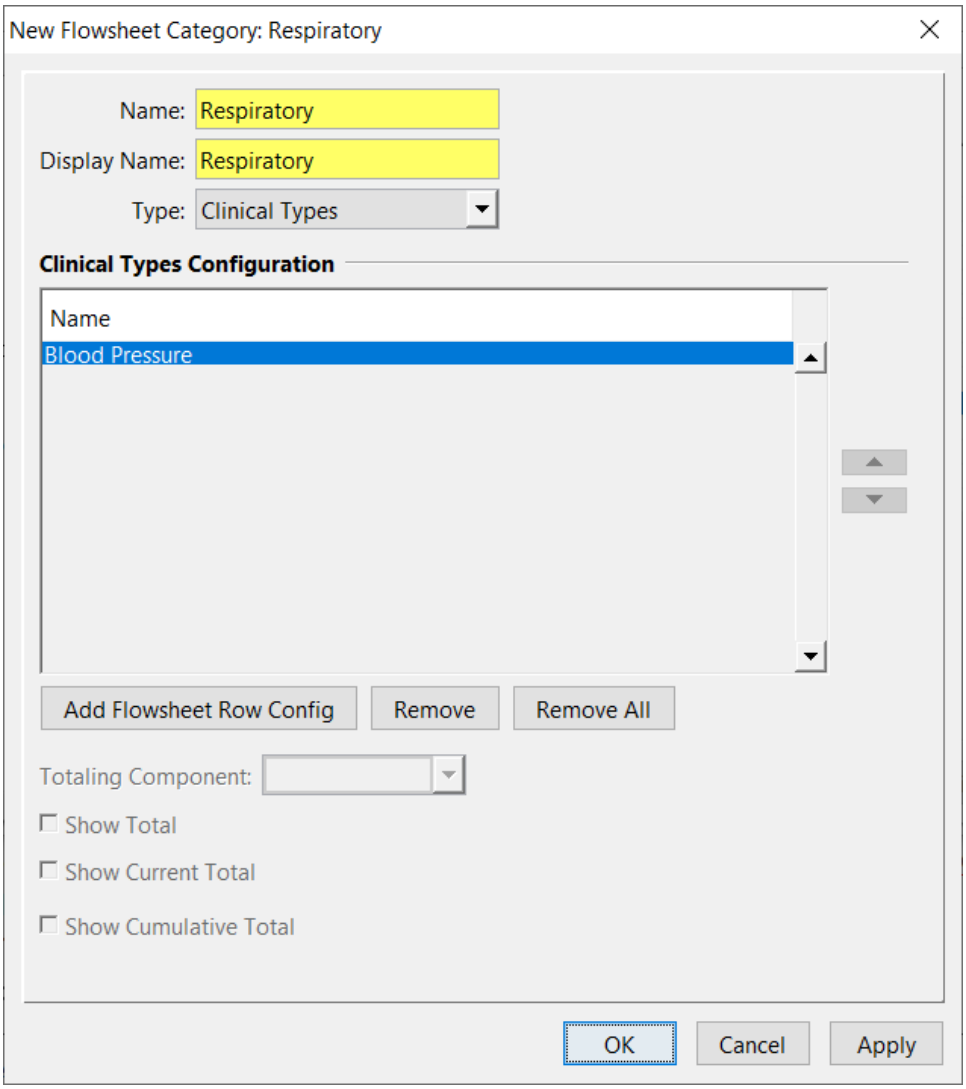
**Configurations will change based upon the selection from the Type drop down list.**

6. Click **Add Flowsheet Row Config**.
7. Select the row you want to add to this Flowsheet category.

**Rows can only be added one at a time.**


Flowsheet Rows
Search
Flowsheet Row Config Name
Apical Pulse
Blood Pressure
Breath Sounds
Cough
Feeding Route
FiO2
Is it Hot?
O2 Mode - RT
Oxygen Flow
Oxygen Saturation
Pain Scale
Position
Delete
Edit
New
OK
Cancel

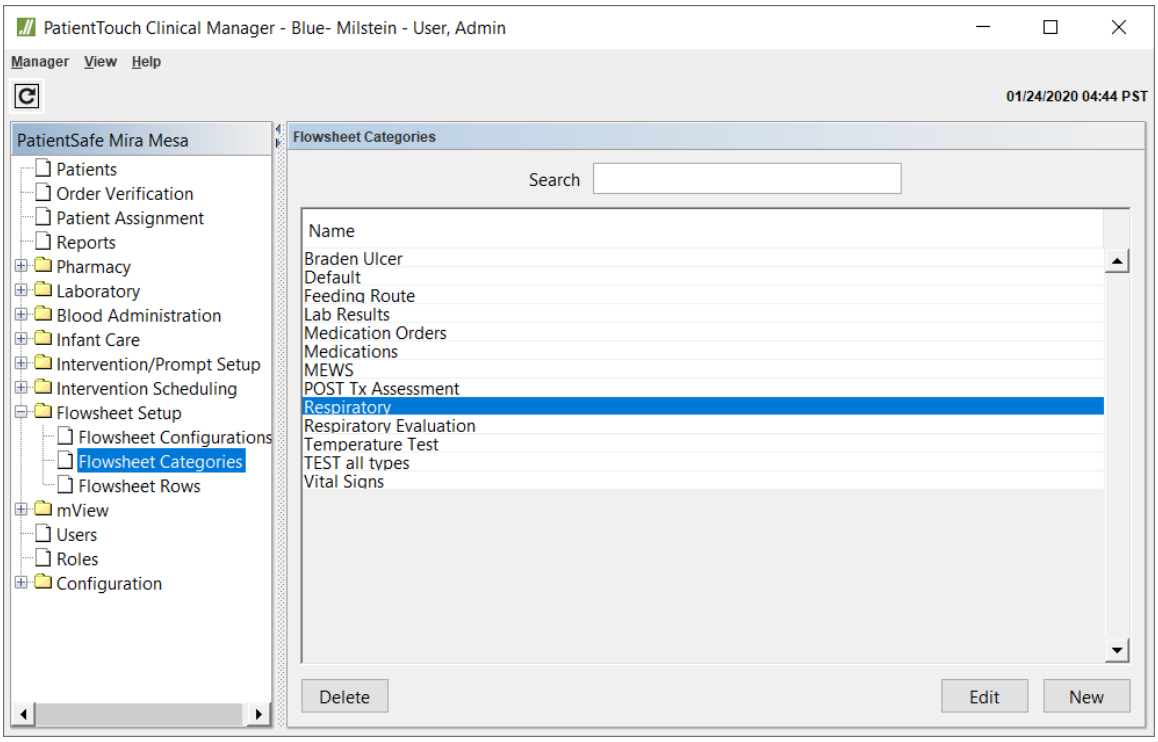
8. Click **OK**.




9. If the row you're adding prompts for a **Totaling Component**, select the appropriate checkbox for the desired behavior:
   - **Show Total** displays the current total for all rows in the category requiring totals.
   - **Show Current Total** displays the current total for the cell.
   - **Show Cumulative Total** displays the cumulative total for the row.

If necessary, change the order of the components by selecting a component and clicking the up or down arrow on the right to move the component to the desired location.

10. Click **OK**. The new category appears in the list of available categories.



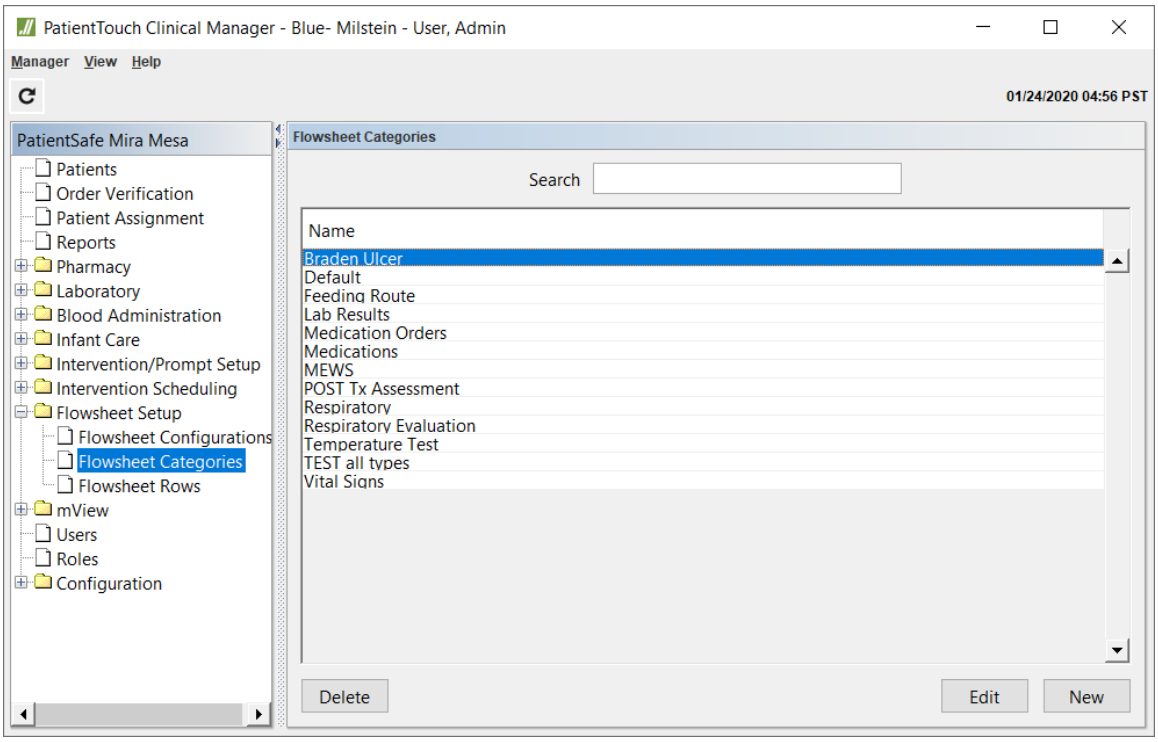

# Creating a Flowsheet Category for Medication Orders

Create a new flowsheet category for Medication Orders for mView to display a Medication Orders tab. The new mView tab will display the full list of medication orders that are currently profiled for a patient, regardless if the medication has been administered.

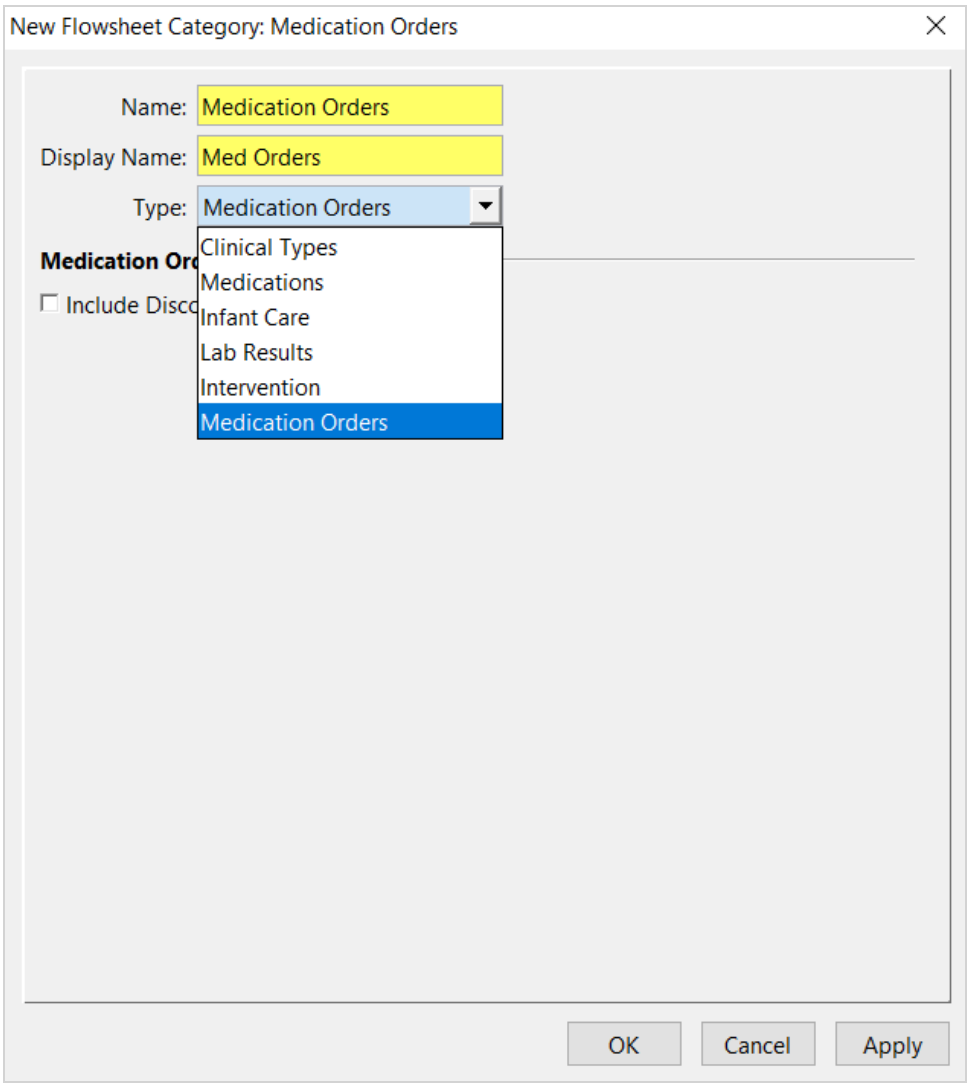
This tab does not show medication data details, it only shows medication orders.

This flowsheet category will not populate flowsheet data with medication orders, it will only allow users to create a tab in mView.

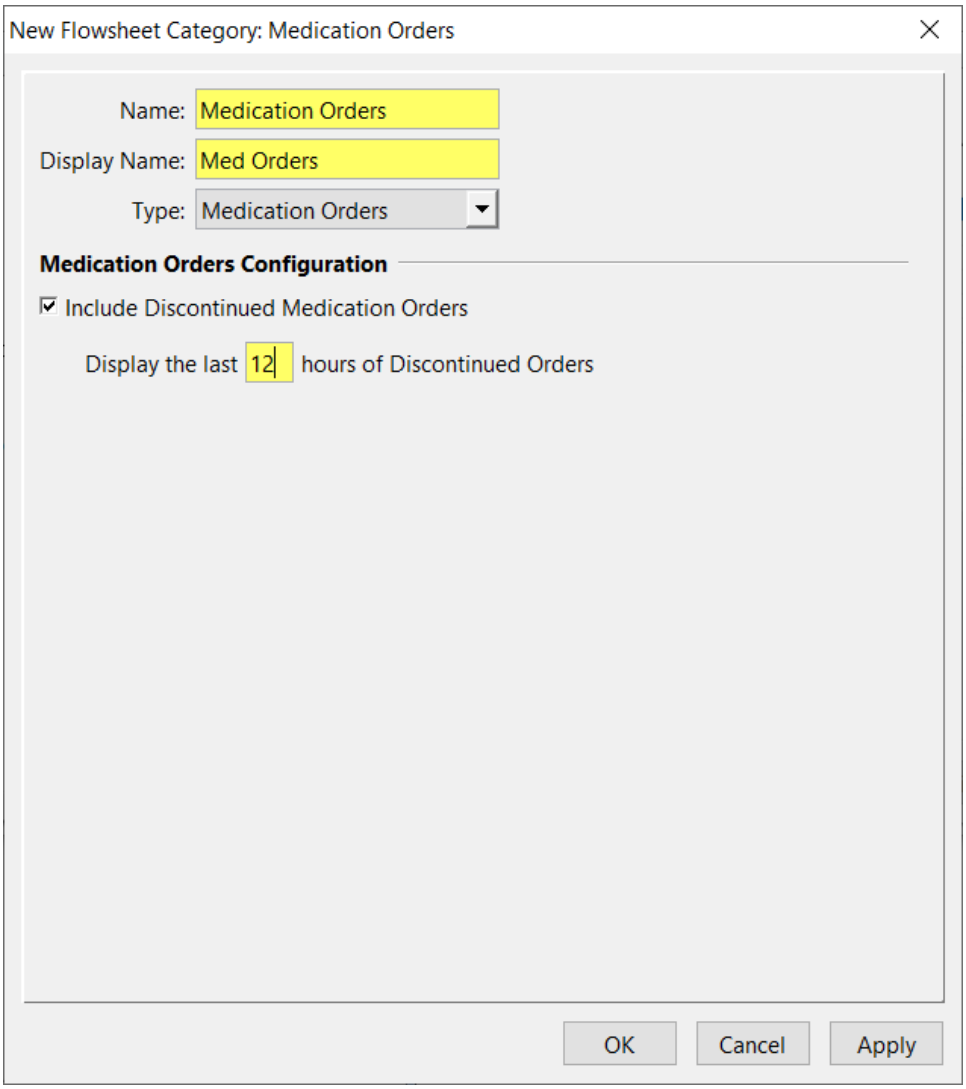
1. From the Flowsheet Categories tab, click **New**.



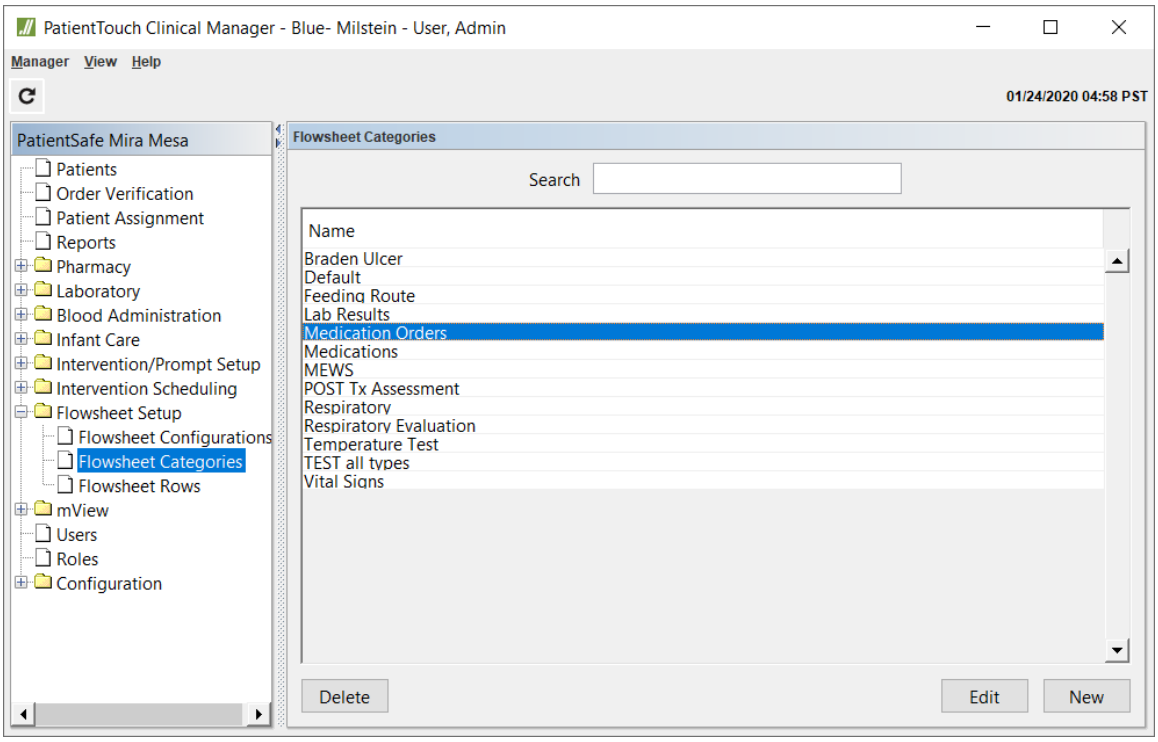

2. Enter the Name and Display Name as **Medication Orders**.
3. Select **Medication Orders** from the **Type** drop down menu.




4. Click **Include Discontinued Medication Orders**, if you want to include them in the mView tab.
5. Enter a value in the **Display the last _____ hours of Discontinued Orders.** The maximum is 12 hours.
6. Click **OK**.



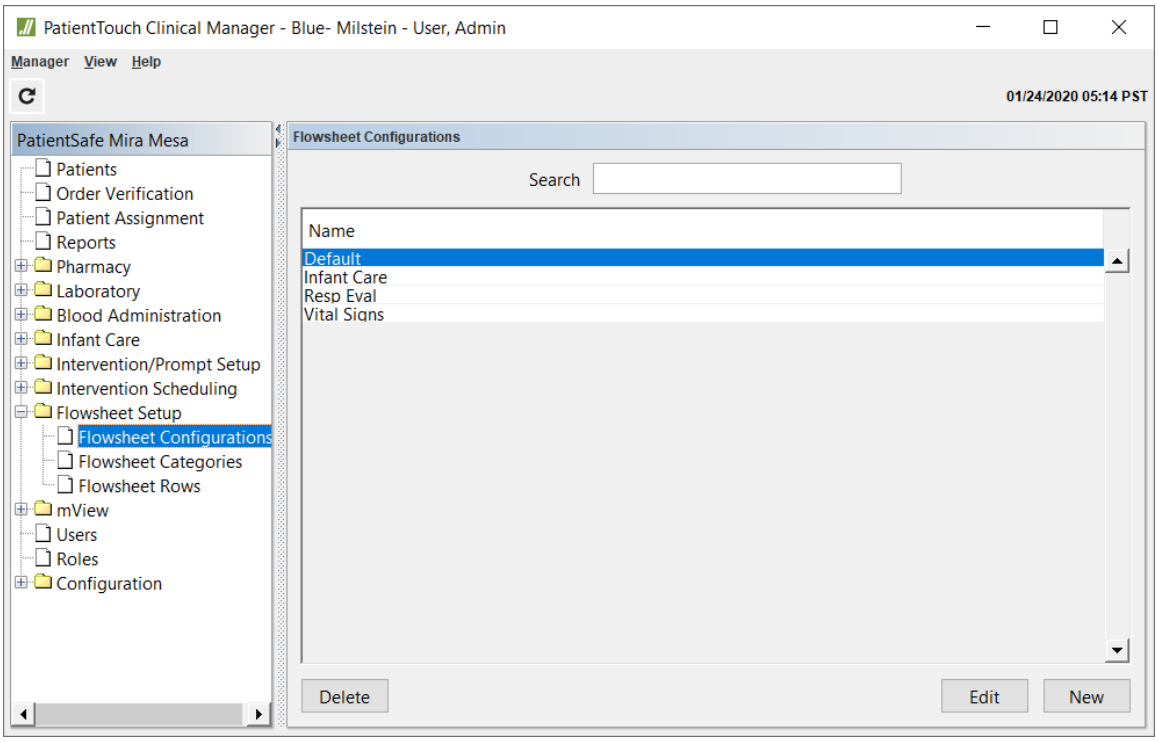

7. The new flowsheet category **Medication Orders** displays.
8. Next, you will need to add this flowsheet category as an mView Tab Group.



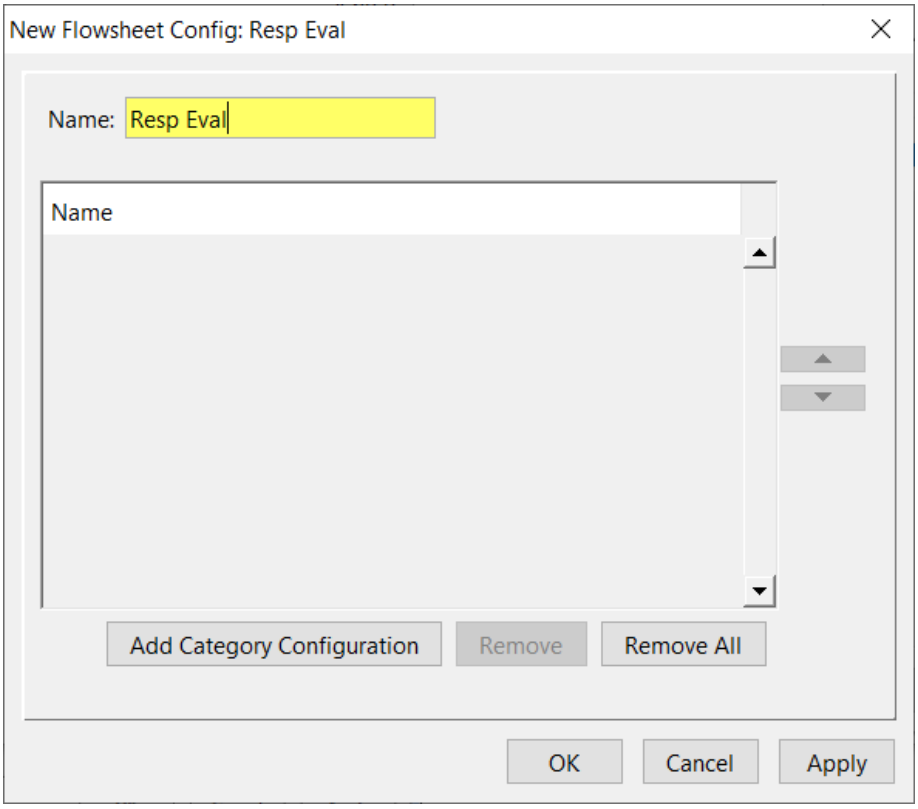

# Creating a Flowsheet Configuration

Flowsheet configurations are created from one or more flowsheet categories you created in Flowsheet Setup>Flowsheet Categories.

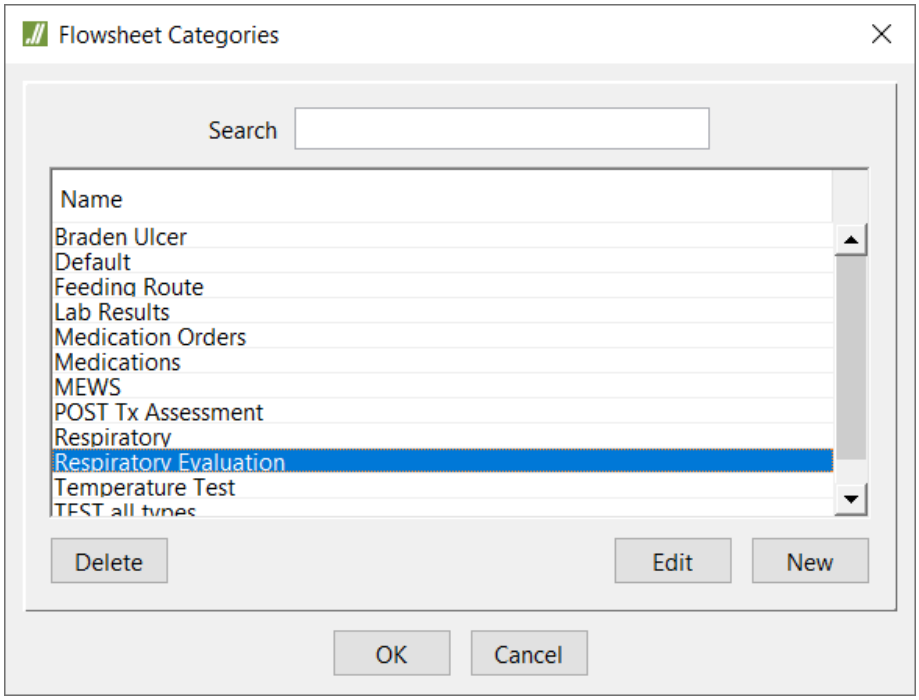
1. In Clinical Manager, select **Flowsheet Setup > Flowsheet Configurations**.



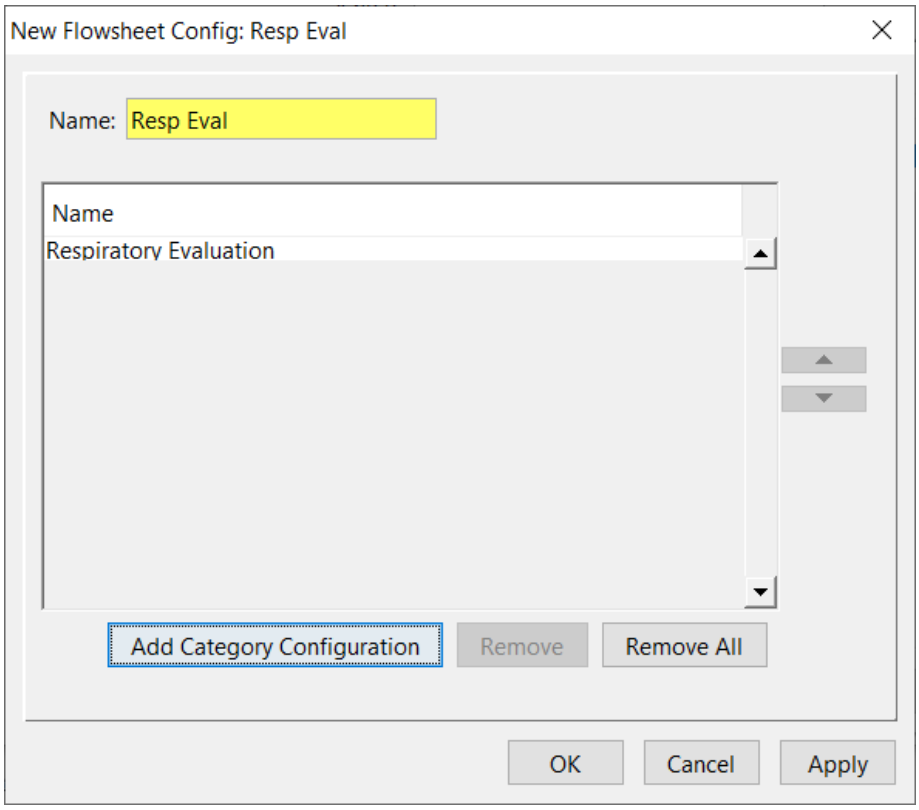

2. Click **New**.
3. In the Name field, enter a unique name (mandatory).



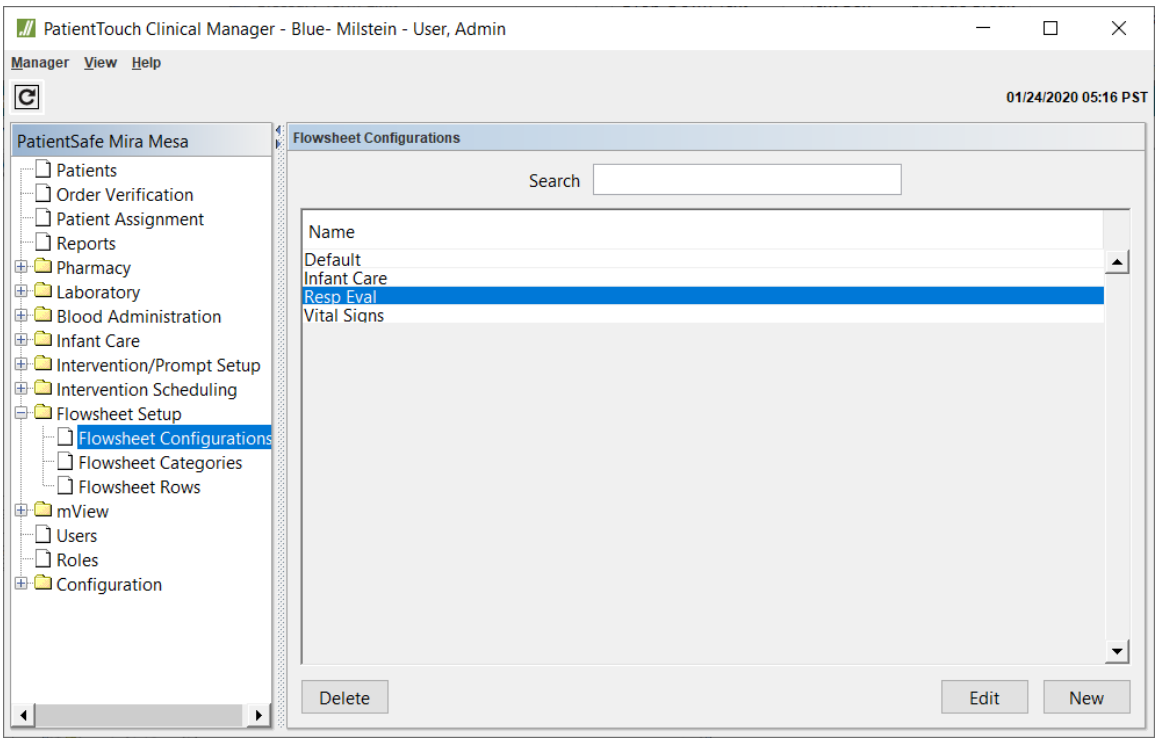
4. Click **Add Category Configuration**. Choose a category. Categories can only be added one at a time. Repeat these steps for each category you want to add.




5. Click **OK** to accept the entries.

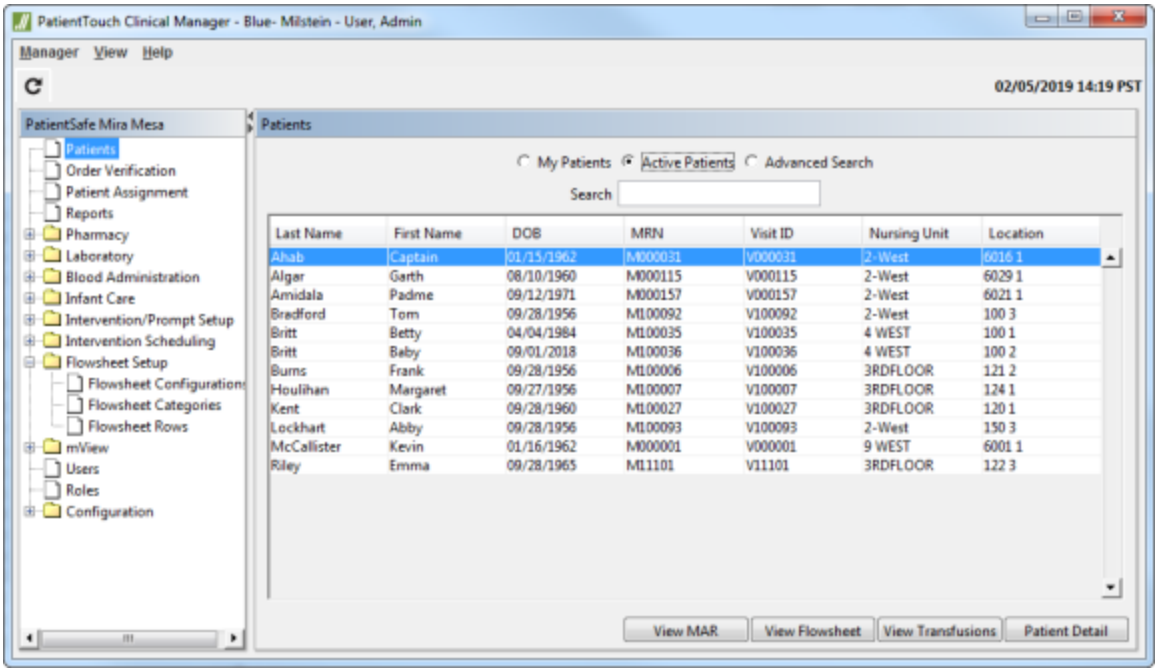


6. Click **OK** again to add this entry to the Flowsheet Configuration.

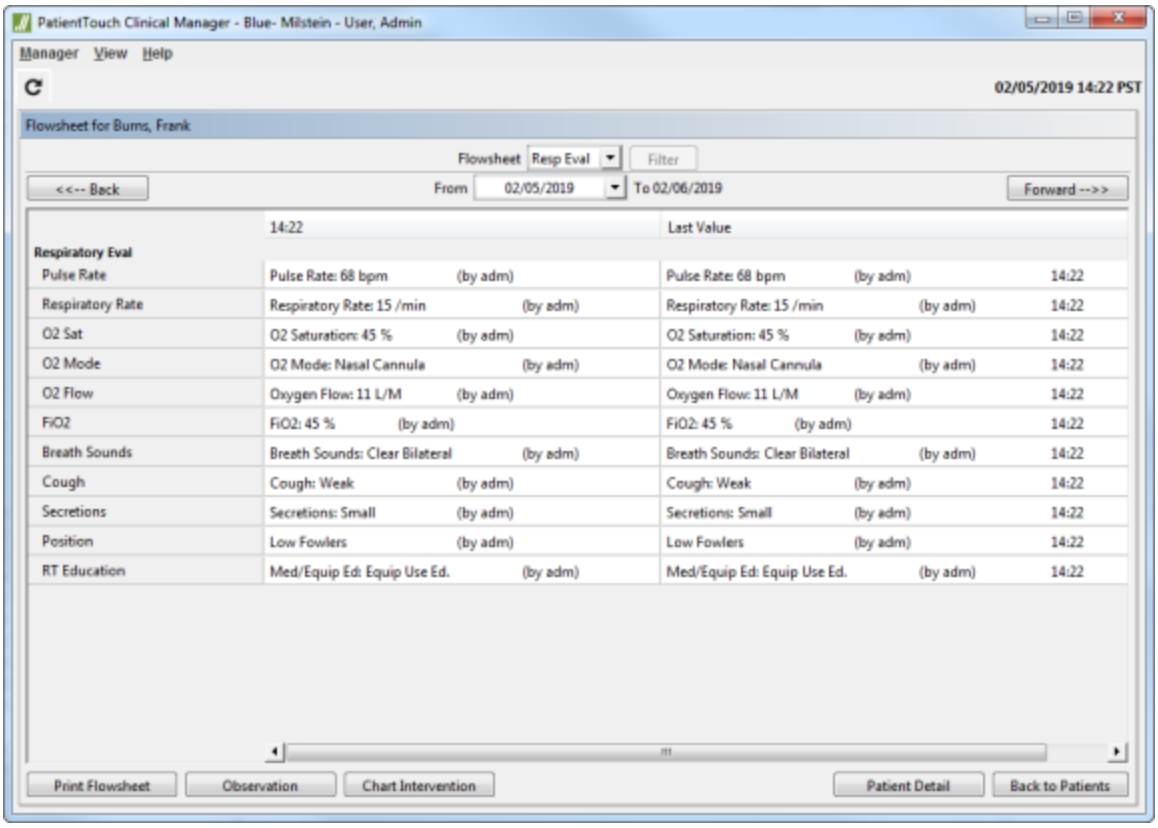



# Viewing Flowsheets

1. In Clinical Manager, select **Patients**.



2. Select the desired patient, and click **View Flowsheet**.
3. From the **Flowsheet** drop-down list select the new Flowsheet to display. In this case, it is the Resp Eval flowsheet.




# mView Overview

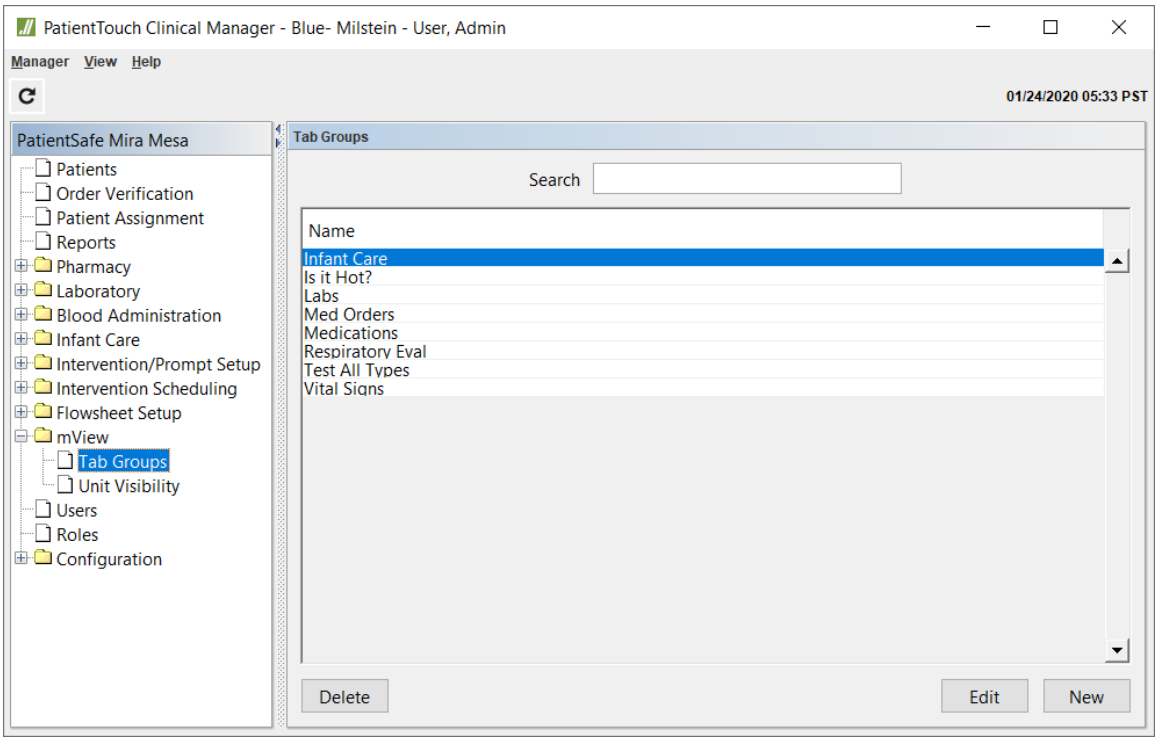
*mView*, which stands for mobile view, can be configured to display patient-specific clinical data to clinicians on the handheld. The power of *mView* is in bringing information to the user instead of the user having to go to various locations (computers, pieces of paper, another person, etc.). *mView* includes user-entered documentation including medication administrations, vital sign collection, interventions, assessments, and lab values. The information displays in tab groups as seen in the picture below (Resp, Vitals, Meds, Labs). Touch a Tab Group to see patient specific information.


# Adding Tab Groups

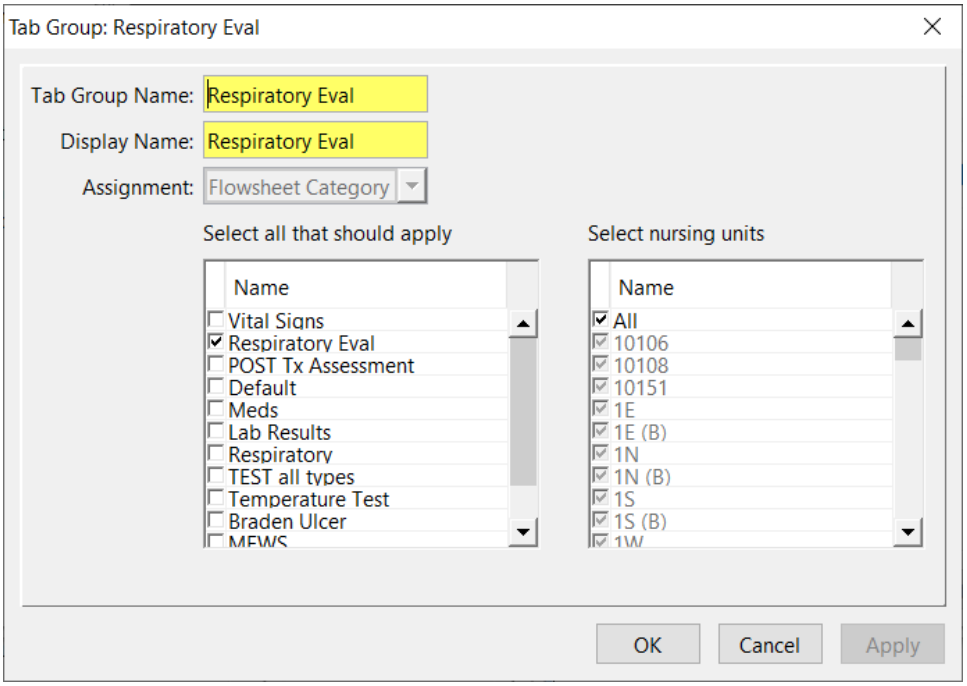
The information displayed in mView is highly configurable. To define what displays, Tab Groups are created to logically group data together. Tab groups may or may not be based on Flowsheet Categories. Another option, a plug-in, is also available for users to configure their mView tabs. However, users must contact the PatientSafe Solutions Technical Support Team for configuration.

To create Tab Groups:

1. From the menu tree, select **mView > Tab Groups** to display the *Tab Groups* screen.
2. Click **New**.

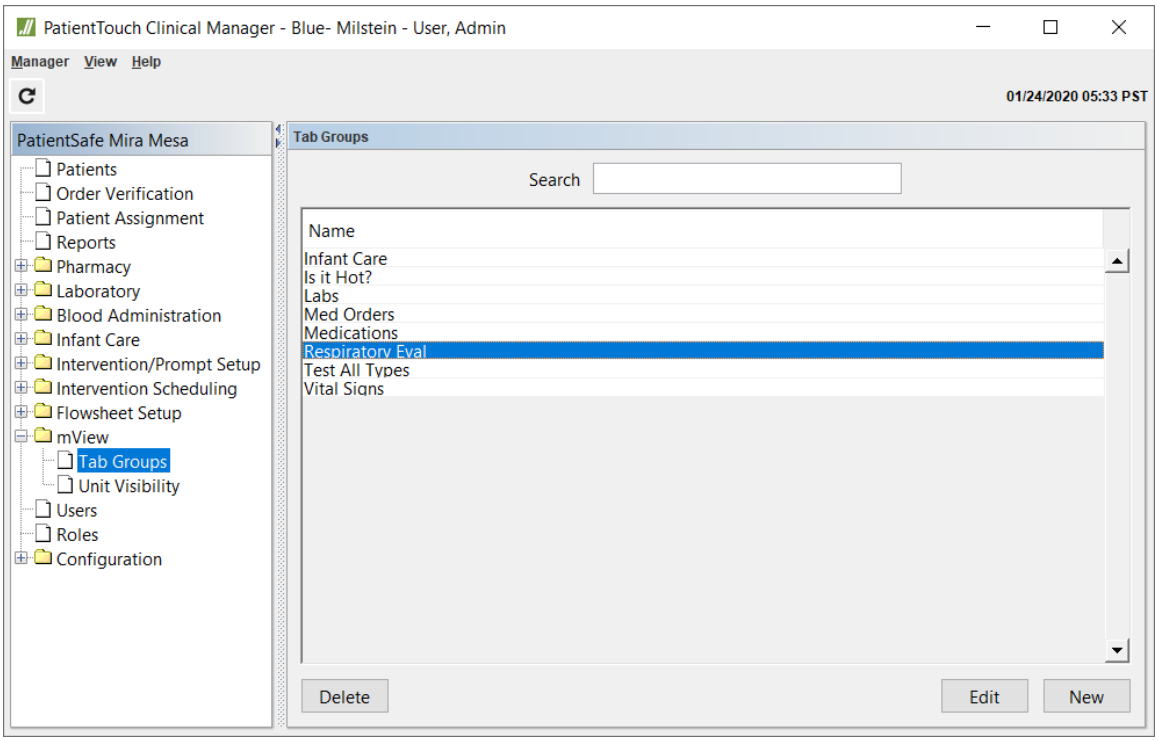



The *New Tab Group* window appears.




3. Enter a Tab Group Name.
4. Enter a Display Name. This is the tab name that will appear on mView of the handheld. It is best to keep this name short.

5. Select the Flowsheet category(s) that should appear in this tab. Flowsheet categories must be configured in order to create *mView* tab groups.
6. Select the Nursing unit(s) for which to display this tab.
7. Click **OK** to accept your entries.



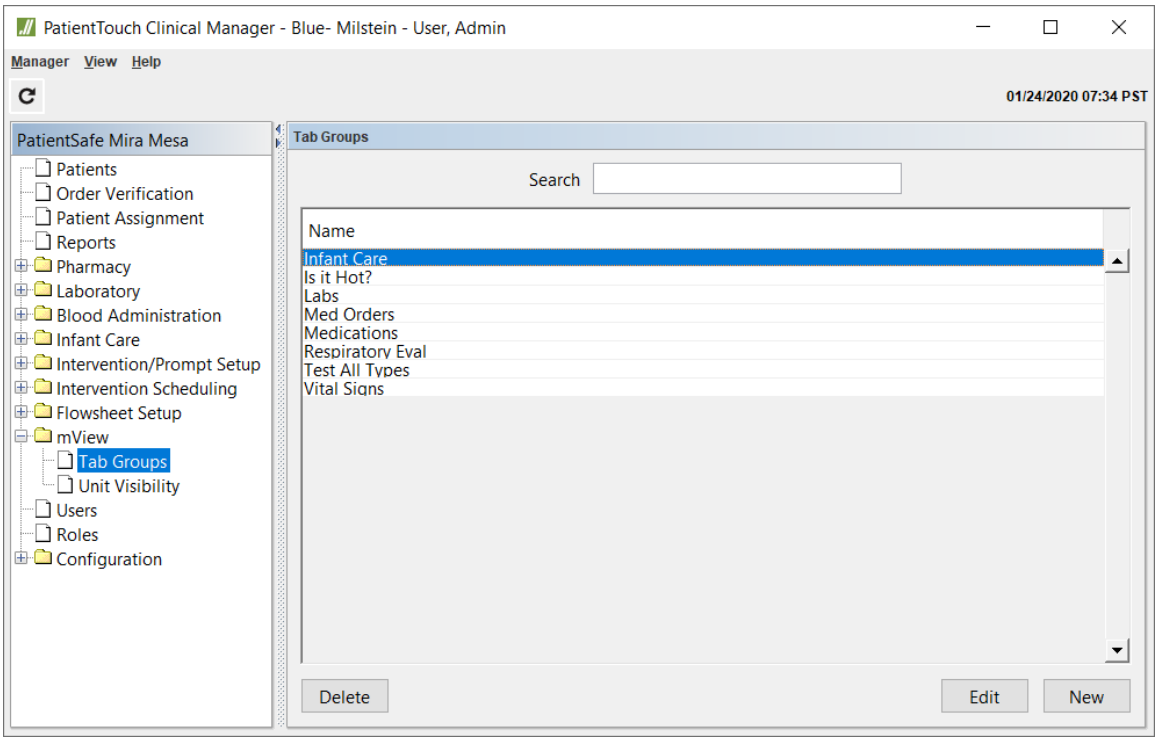

# Adding Medication Orders Tab Group

Users can create a new mView tab to display Medication Orders. The new tab will display the full list of medication orders that are currently profiled for a patient, regardless if the medication has been administered.

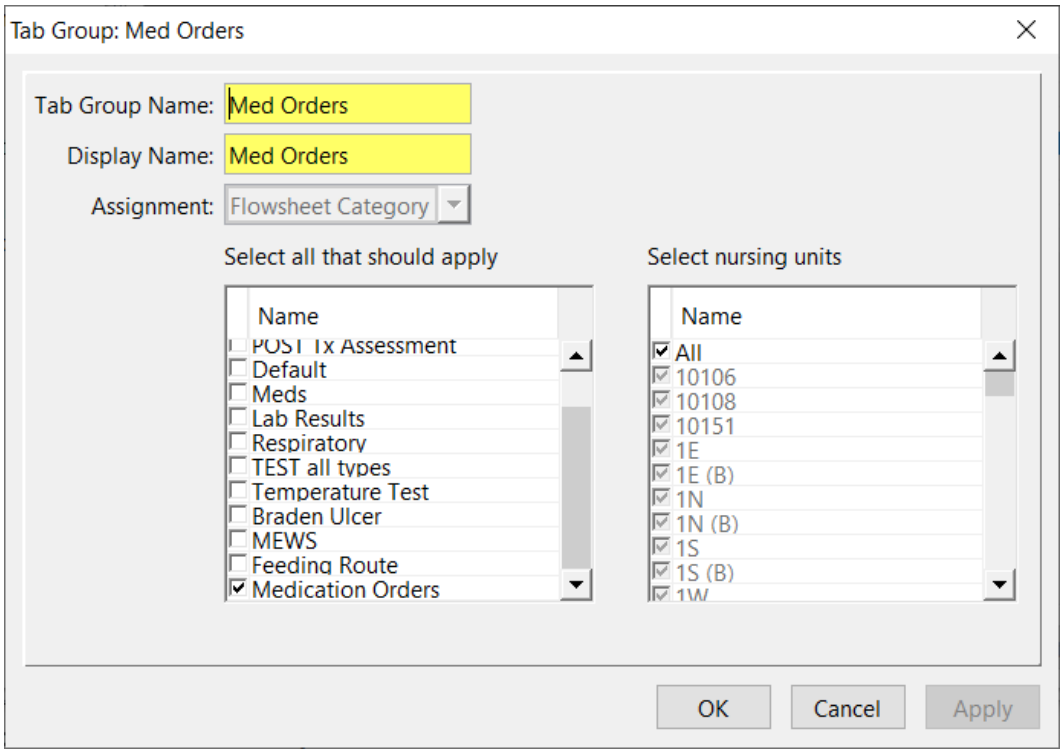
This tab does not show medication data details, it only shows medication orders.

You must have a Medication Orders Flowsheet Category created in order to add the mView tab.

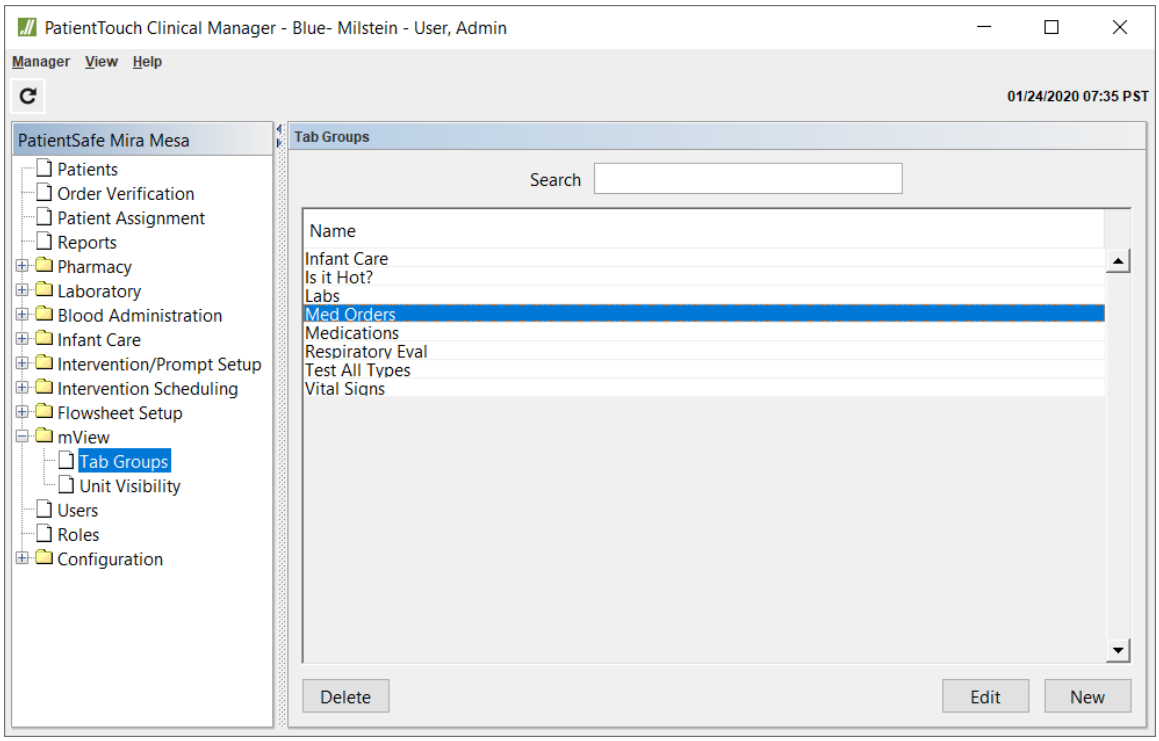
1. Select **mView>Tab Groups** from the menu tree.
2. Click **New.**




3. Enter a **Tab Group Name** of **Medication Orders**.
4. Enter the **Display Name** as **Med Orders** (shorten the name so it displays well on the mView tab list on handhelds).
5. Select the flowsheet category of **Medication Orders** from the list that displays.
6. Select the associated nursing units.
7. Click **OK.**



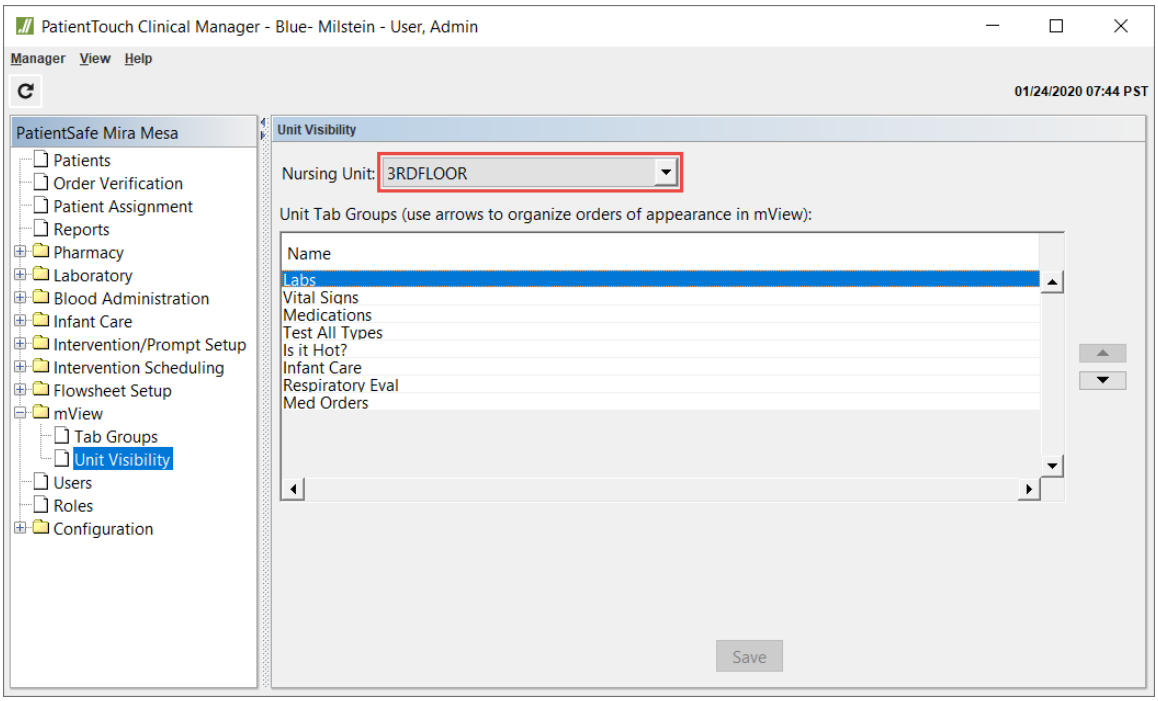

8. The **Medication Orders Tab Group** has now been entered as a new mView tab.



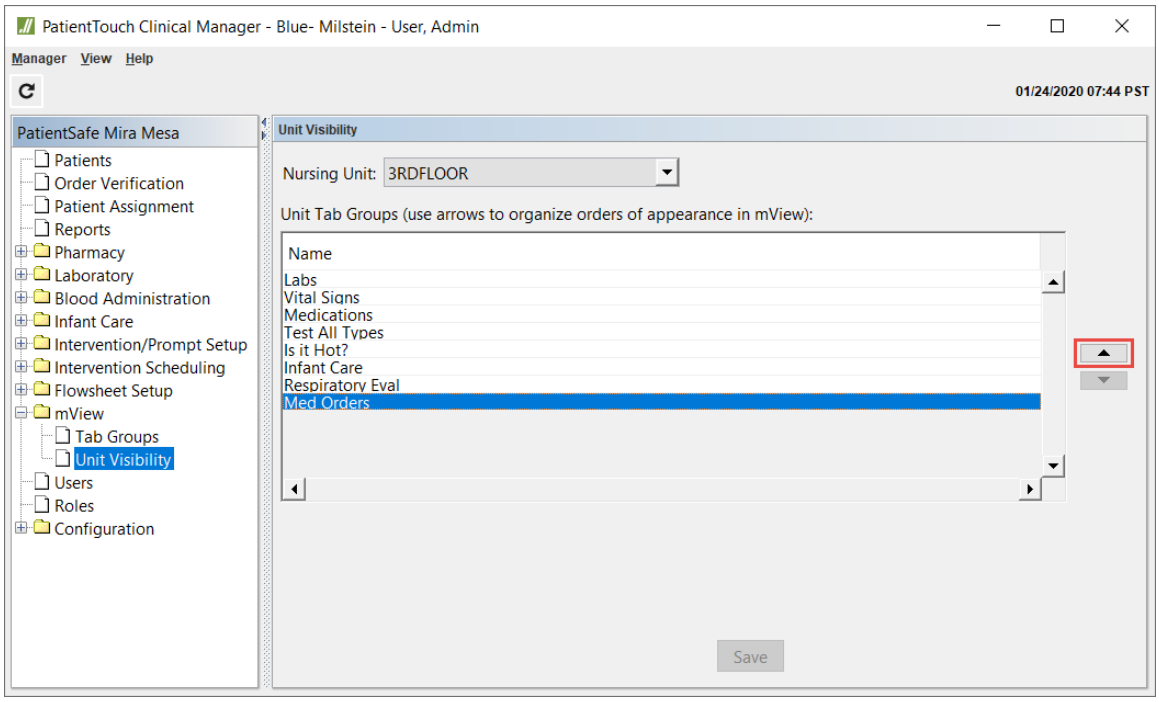
# Unit Visibility

Unit visibility controls the order (from left to right) in which each nursing unit will see the *mView* tabs on their handhelds.

1. Select **mView>Unit Visibility** from the menu tree.




2. Select a nursing unit from the **Nursing Unit** drop down list. The tab groups configured for this unit will be displayed.
3. Use the up/down arrows to select the order of the tab groups to display in *mView* on the handheld.
4. For example, to move Medication Orders to the top, select it from the list and click the up arrow until finished.




5. The **Medication Orders** tab group now displays on the top of the list, which means it will display first in the list of mView tabs on handhelds.