



Pharmacy User Guide

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Chapter 1 Introduction

1.1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability Program certified products, recommended processes, and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications, and vendor specifications provided by CMS, ONC, and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bears no responsibility for attestation information submitted by the client.

Chapter 2 Overview

Information on the Pharmacy application will include selecting a patient, placing orders, clinical monitoring, reports, ad hoc reporting, charging, and printing labels. While the screens may appear to be point and click, the keyboard can still be used. A combination of the Alt key and the underlined letter of the function will allow for the use of the keyboard in the Pharmacy application.

NOTE: *TruBridge EHR Clinical software is being converted to new maps. Some of these new maps may be seen throughout this User Guide. When new maps are released for an application, TruBridge will add those new maps to the next set of manuals that are published.*

NOTE: *Facilities outside of the United States may choose a date format of MMDDYY, DDMMYY, or YYMMDD to be used on Pharmacy reports. Whichever date format is selected will be reflected on date-pickers, the report Date header, and the Run Date on the reports. A TruBridge Representative will need to be contacted in order for the date format to be changed.*

NOTE: *Facilities outside of the United States may choose to display the patient's height/weight in metric units throughout the Pharmacy application. A TruBridge Representative will need to be contacted in order for height/weight to default to metric units on certain Pharmacy screens and reports.*

Chapter 3 System Log On

3.1 Overview

This chapter will cover logging into ClientWare as well as employee sign on.

3.2 Employee Sign On

Login using Thrive UX

To access Pharmacy, the user must first access Thrive UX. The access point for employees is



the desktop link. The login screen will open and the user will enter the appropriate login information; then select **Thrive UX** from the application drop-down.



1. Select the icon from the desktop. Enter User-based Login information.

Select **Login > Enter login information > Application > Thrive UX**

The screenshot shows the 'Evident' login dialog box. The 'Application' dropdown menu is open, displaying a list of options: 'Thrive', 'Thrive Patient Care Portal', 'Thrive UX' (which is highlighted with a red box), and 'Thrive UX Patient Care Portal'. The 'Thrive UX' option is the one to be selected according to the instructions. Other fields in the dialog include 'Session' set to 'Evident Community Hospital', 'Host' set to '10.0.1.59', 'User' set to 'crb3426', and 'Password' masked with dots. There are also checkboxes for 'Default' and 'Remember'. On the right side, there are buttons for 'Connect', 'Save', 'Delete', 'Change Password', 'Send', 'About', and 'Exit'.

Thrive UX Login

2. After login information is entered and **Thrive UX** is selected, select **Connect**.

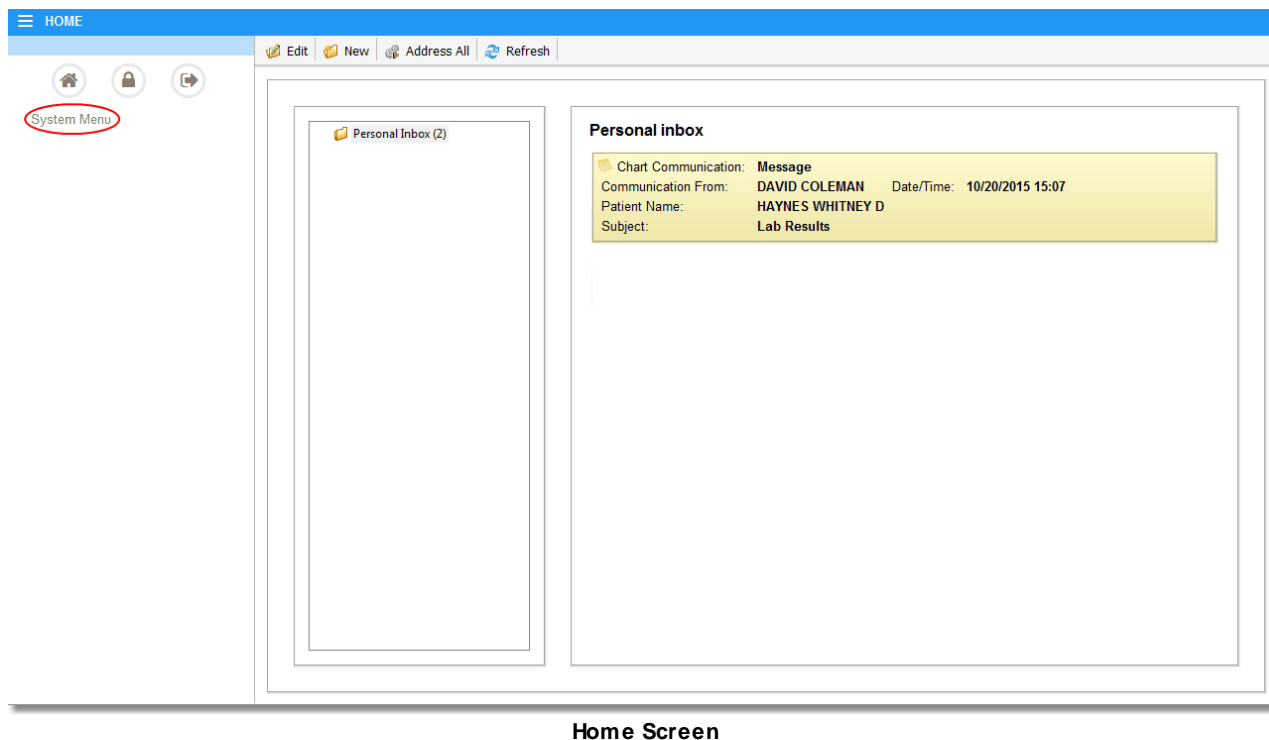
3. This will launch the [Home Screen](#) ¹²

Chapter 4 Home Screen

The **Home Screen** functions as a notification center for the user. Pharmacy users may receive chart-based communications. For more information, refer to the [Home Screen User Guide](#).

1. After logging into Thrive UX, the Home Screen will display.

Select **Login > Home Screen**



2. Select **System Menu** to access the [Hospital Base Menu](#)¹³.

NOTE: The screen Behavior “System Menu” is required to access the Hospital Base Menu from Home Screen.

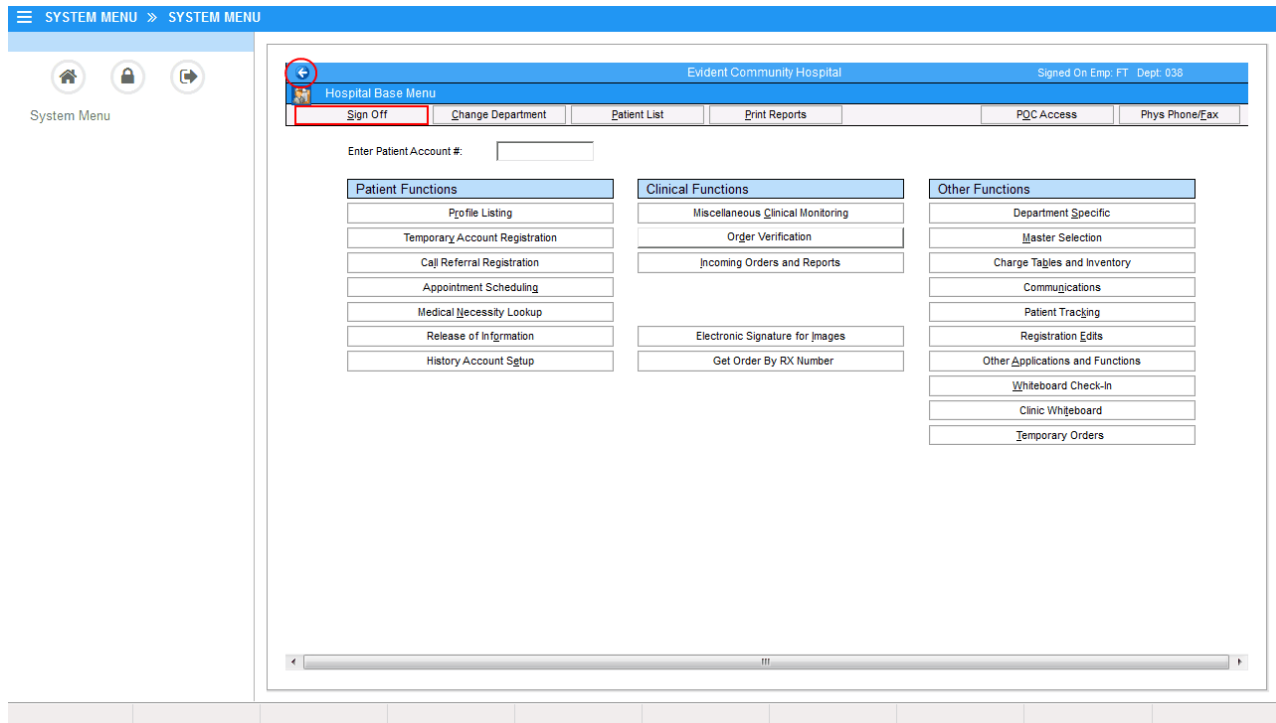
Chapter 5 Hospital Base Menu

The following options may be utilized from the Hospital Base Menu screen and will be discussed throughout this user guide.

- **Patient List:** access to patient search options which opens the patient functions screen (Pharmacy-Selection Screen)
- **Print Reports:** access to daily and miscellaneous pharmacy reports
- **POC Access:** access to Point of Care screens such as Med-Verify, Flowcharts, 24-Hour Electronic MAR, Diabetic Record, and PCA
- **Department Specific:** access to pharmacy tables
- **Master Selection:** access to Patient Charging, Rebuild Item Description Index, Regen NDC Index and Inventory Ad Hoc
- **Charge Tables and Inventory:** access to the hospital's formulary items
- **Order Verification:** access to verify temporary medication orders placed by physicians, nursing, and pharmacy technicians
- **Incoming Orders and Reports:** access to review completed laboratory results and signed transcriptions

Both the mouse and the keyboard may be used for order entry, medication selection, report printing, and table maintenance. To select a function using the keyboard, press **Alt** and the underscored coordinating letter.

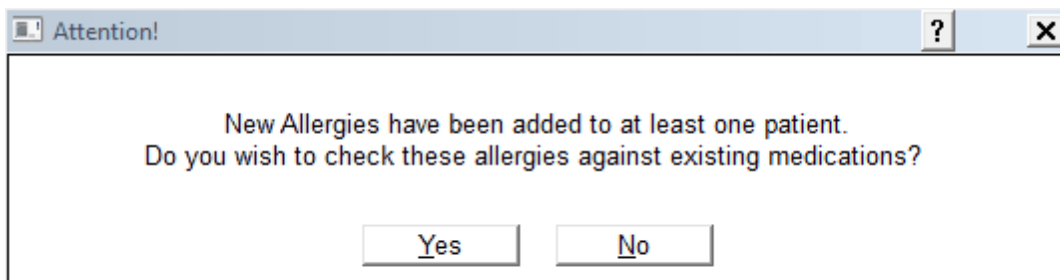
Select Home Screen > System Menu > Hospital Base Menu



Hospital Base Menu

1. Immediately after log in, a prompt will appear if new allergies have been added since last sign on. This displays if allergies have been entered on any patient visit by staff other than pharmacy employees.

Select **Hospital Base Menu** > **New Allergy Prompt**



New Allergy Prompt

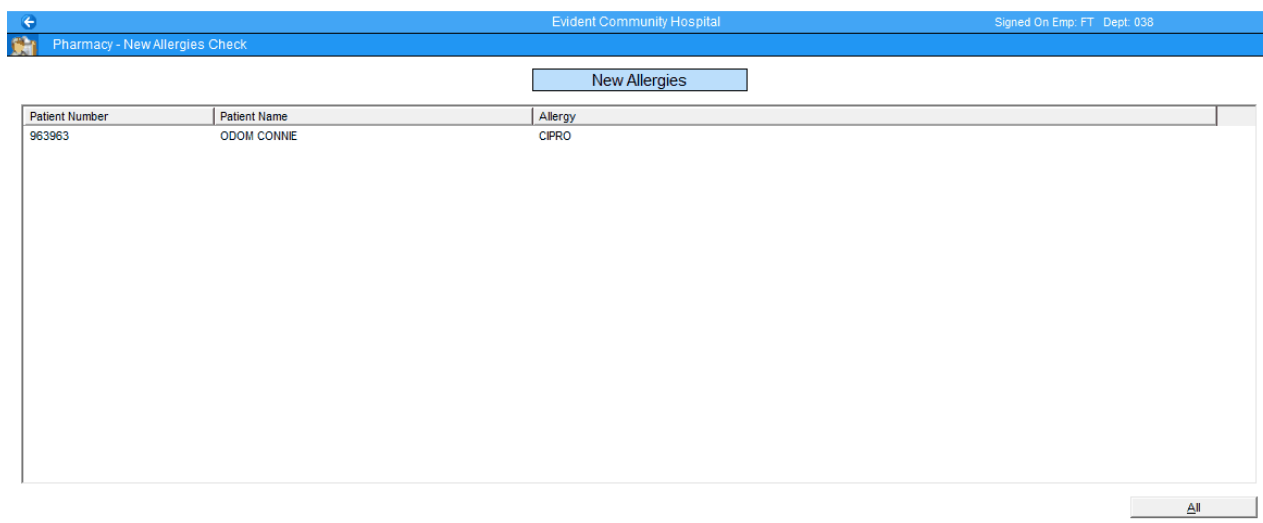
2. Select **Yes** to check the allergies against the patient's existing medication orders.
3. Select **No** to leave the allergy entries unaddressed and proceed with patient or pharmacy functions.

NOTE: Pharmacy employees will continue to receive the prompt when returning to the Hospital Base Menu until all new allergies have been addressed.

4. Select the Patient from the list and the software will perform drug-allergy checking.

NOTE: This will create a Clinical Monitoring trigger that will be recorded as audit-worthy events and may be viewable via the Patient Audit Log report.

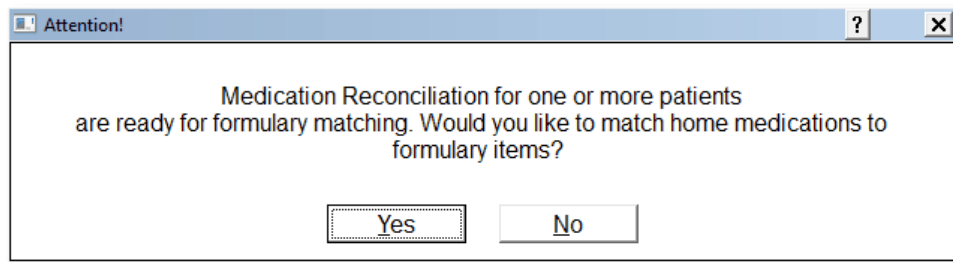
Select **Hospital Base Menu** > **New Allergy Prompt** > **Yes**



New Allergies Check

5. Immediately after log in, Pharmacy will receive a prompt that Formulary Matching is ready for one or more patients.

Select **Hospital Base Menu** > **Ready for Pharmacy Prompt**



6. Select **Yes** and the user will be taken into a list of patient's that were generated using the "Ready for Pharmacy" option.
7. Select **No** to close the prompt.

NOTE: The prompt will reappear the next time the Pharmacy Department is accessed as long as an Admission Reconciliation has not been performed for the patient prior to Pharmacy completing the Formulary Matching.

8. A list of patients ready for Formulary Matching will display. The Pharmacist may select a single patient, multiple patients, or all patients and initiate Formulary Matching by selecting 'Process.'

Select Hospital Base Menu > Ready for Pharmacy Prompt > Yes

CHARTS > PATIENTS WITH FORMULARY MATCHING > PATIENTS WITH FORMULARY MATCHING

Process Select All Delete

Formulary Matching

Date/Time	Patient Name	Account	Department	Room
01/09/2019 12:30	BUSHLEY BRYCE	369258	NS Medical-Surgical	300-2

Formulary Matching

Chapter 6 Patient List

Selecting a patient is the first step in the order entry process. Patients can be selected from the Patient List by various patient search functions. Patient Search categories include Current Patients, All Patients, My Patients, Master Patient Index and Patients with Held Chartlink Orders. After selecting the patient, specific patient functions can begin.

- When using sign-on security a **Column Maintenance** option is available. This can be selected to setup a default **Patient List** view per sign-on. The feature allows the user to define what columns are included and the order in which the columns are seen when using the **Patient List** as well as the default **Search** index that is in view when **Patient List** is selected.
- Setting the patient list option can be done at the department level via the Department Table, from page 1 select **Pat List** and this will allow display options for the following options during patient selection: All Patients, Current Patients, My Patients, Master Patient Index, and Patients w/ Held CL Orders.

Please refer to the [Patient List User Guide](#) for more information

Chapter 7 POC Access

This option requires a Point of Care license. POC Access allows pharmacy to access Med-Verify, 24-Hour Electronic MAR, Diabetic Record and PCA. For more information refer to the [POC Pharmacy User Guide](#).

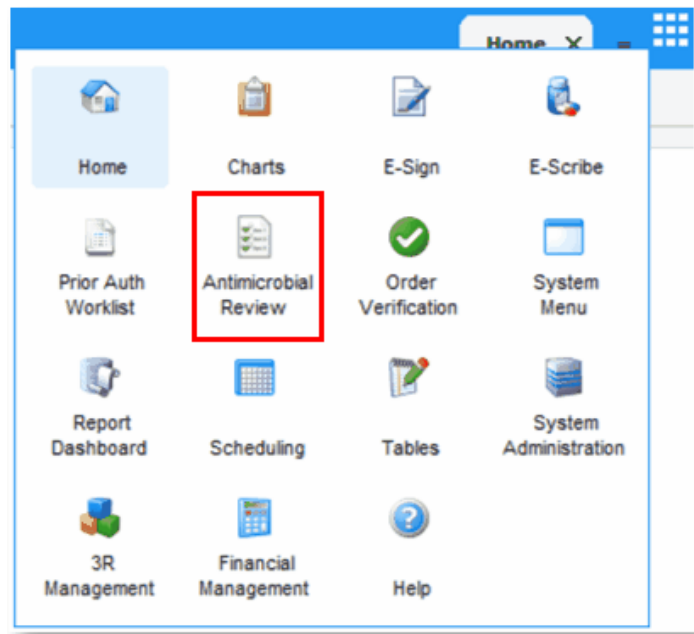
Chapter 8 Antimicrobial Review

Antimicrobial Stewardship is a coordinated program that promotes the appropriate use of antimicrobials (including antibiotics), improves patient outcomes, reduces microbial resistance, and decreases the spread of infections caused by multidrug-resistant organisms.

The Stewardship refers to a set of coordinated strategies to improve the use of antimicrobial medications with the goal of enhancing patient health outcomes, reducing resistance to antibiotics, and decreasing unnecessary costs.

As part of Antibiotic Stewardship, TruBridge has added the ability to view and review all antimicrobial medication orders.

An **Antimicrobial Review** launch point is included in the TruBridge EHR.



Antimicrobial Review

This launch point will take the user to an Antibiotic List screen that displays all patients that have had an antimicrobial medication ordered. From this screen, users can do the following:

- Require an Indication reason on specific medications.
- Document 'Outcomes' from the Review process.
- See the Review history of an antimicrobial order.
- Generate a Medication Review Report.

8.1 Formulary Code

All antimicrobial medications must have their respective Formulary Code entered on Pharmacy Information, Page 1. The Formulary Code classifies the medication based on the American Hospital Formulary Service (AHFS) codes.

All Antimicrobial medications will have '08' in the first field. This alone identifies the medication as an Anti-Infective Agent (Antimicrobial).

Select **Thrive UX > Tables > Control > Item Master > Select Item > Pharmacy Information > Page 1**

The screenshot shows the 'PHARMACY ITEM INFORMATION' form for 'Facility 1 : EVIDENT COMMUNITY HOSPITAL'. The item is 'AMOXICILLIN CAP : 500MG' with item number '381034'. The form is divided into several sections:

- Page 1:** Contains fields for NDC (00781261301), NDC Unit, Manufacturer (Sandoz), As of (03/10/2016), Prior NDC (54569333507), DEA Class (0), Predefined Orders (2), Default Routes (ORAL), and Formulary Code (08, 12, 16, 00). The Formulary Code field is highlighted with a red box.
- Page 2:** Contains fields for Charge Meds at Administration, Chartcart Selectable, Formulary Item, Estimate Creatinine Clearance, and Creatinine Clearance/Message.
- Page 3:** Contains fields for Pediatric Crcl/Message and Use Overdue Med Response.
- Page 4:** Contains fields for Other Units, Strength, and Unit.
- Page 5:** Contains fields for Strength and Unit.
- Page 6:** Contains fields for Strength and Unit.

Pharmacy Item Information - Page 1

8.2 Indication Required

A checkbox for 'Indication Required' has been added to Page 2 of Pharmacy Information. When selected, it will require the user to select an Indication before the order may be placed within the Order Entry Application.

NOTE: If 'Indication Required' is not selected on the item, the user may still access the field in Order Entry to add an Indication.

Select **Thrive UX > Tables > Control > Item Master > Select Item > Pharmacy Information > Page 2**

The screenshot shows the 'PHARMACY ITEM INFORMATION' form for Item Number 381034 (AMOXICILLIN CAP : 500MG) at Facility 1: EVIDENT COMMUNITY HOSPITAL. The form is divided into several sections:

- PHARMACY INFORMATION:** Includes Mnemonic (AMOX5001), Pharmacy Instruction Desc, Pharmacy Expiration Day (0), Interaction Codes, Intervention/ADR (A-ADR, I-Intervention), Short Description, Medicaid Formulary (checked), Dosage Range Check (checked), Duplicate Therapy Check (checked), Create Pharmacy Order (checked), Prompt for NDC when Charging, Online Adjudication Transmit Mode (A-Auto, H-Hold, N-None), and **Indication Required (checked)**.
- LAB VALUES:** Two Lab Value fields.
- NDC:** A table with columns for NDC Numbers and 10-Digit NDC.

NDC Numbers	10-Digit NDC
00781261301	0781261301
54569333507	5456933357

Pharmacy Item Information - Page 2

8.3 Indication of Use Table

The Indication of Use table allows for indication reasons to be associated to the Formulary Code listed on Page 1 of Pharmacy Control Information in the Item Master. When the item is ordered, those indication reasons will display in the drop-down for selection.

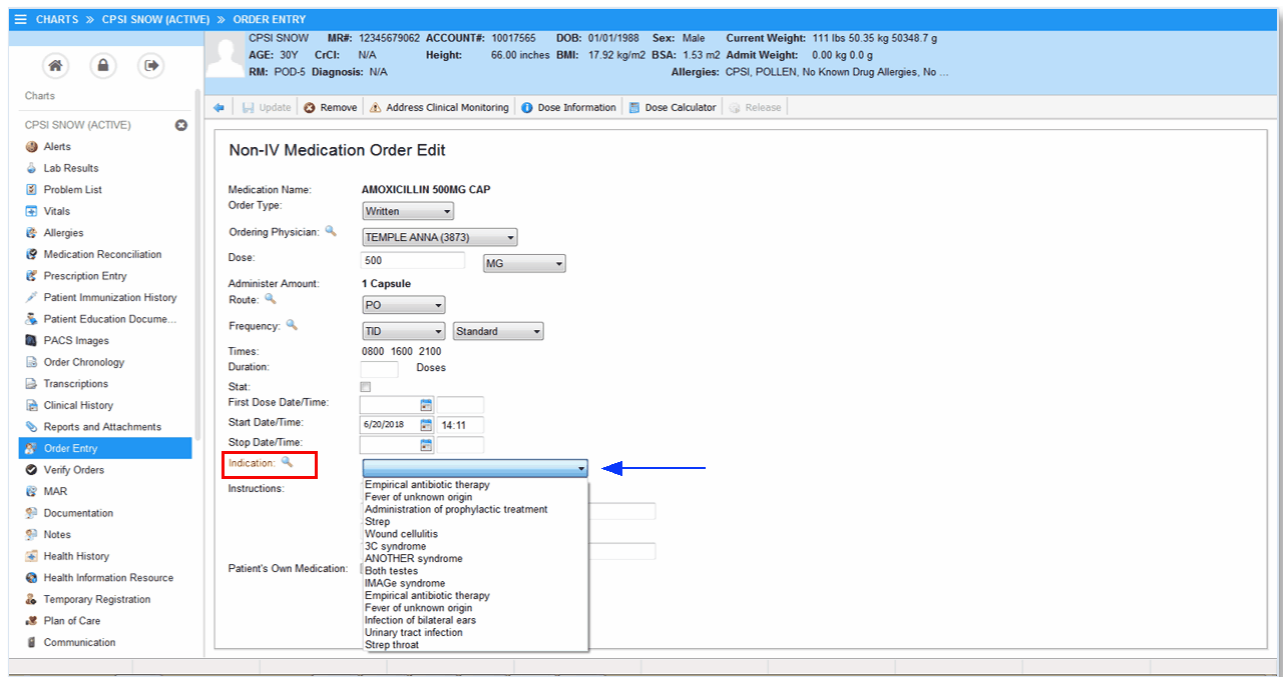
Please refer to the Pharmacy Control Chapter, Indications of Use section in the [Table Maintenance - Clinical User Guide](#) for steps to set up the Indication of Use Table.

8.4 Order Entry

If an antibiotic medication is ordered that has 'Indication Required' selected, the Indication field within the Order Entry Edit screen will highlight in red. A pre-defined drop-down list for the indication will appear during Order Entry if an Indication table exists for that item's formulary code. If the Indication needed is not listed in the pre-defined list, the user may select the magnifying glass option to select another codified reason.

NOTE: The Indication field will display on all medication orders and an indication may be added on a medication without the indication being required.

Select **Thrive UX > Charts > Select Patient > Order Entry**



Order Entry

8.5 Antimicrobial Review Application

The Antimicrobial Review application is accessible directly from the navigation panel in the TruBridge EHR and will allow users the ability to review all Antibiotic Medications that have been ordered.

NOTE: Only orders for medication items with Antimicrobial Formulary codes will pull to this application for review.

Select Thrive UX > Antimicrobial Review

Start Date/Time	Patient Name	Account	Location	Description	Duration	Admin Date/Time	Reviewer	Review Date/Time
01/19/2022 13:32	WALTON KYLE	357813	006-3	ANCEF 2 GM/D5W 100ML 100 ml/hr IVPB Q8H		01/19/2022 13:32	SHALANDA JENK...	02/24/2022 15:03
11/28/2016 09:49	PETERSEN ASHLYNN	357010	301-8	ANCEF 2 GM/D5W 100ML 100 ml/hr IVPB EVERY 8 HOURS		11/28/2016 16:37	SHALANDA JENK...	02/24/2022 15:31
03/22/2016 14:00	SIMS PHILLIP AND...	357929	500-7	LEVOFLOXICIN (LEVAQUIN) 500 MG PREMIX 100 ml/hr IV...		05/04/2016 09:00		
05/15/2015 09:00	JAMES JIM	357530	00714	LEVOFLOXICIN (LEVAQUIN) 500 MG PREMIX 100 ml/hr IV...		05/14/2015 11:14	SHALANDA JENK...	02/24/2022 15:31
08/03/2016 07:50	CHAPMAN COREY	357776	ER-6	CEFTRIAOXONE(ROCEPHIN) INJ 250 MG IM PRN		08/03/2016 07:51		
01/19/2022 08:53	ADAMS JIMMY	357004	ER-10	CEFTRIAOXONE(ROCEPHIN) INJ 100 MG IM Q24H		01/19/2022 08:54		
07/09/2019 07:58	HUTCH MATTHEW	357807	301-7	PENICILLIN VK TAB 250 MG PO QID		07/09/2019 08:00	Kerri B Williams	07/29/2019 08:54
07/29/2019 00:01	HUTCH MATTHEW	357807	301-7	PENICILLIN VK SUSPENSION 250 MG PO Q6H		07/29/2019 10:23	Kerri B Williams	08/06/2019 08:55
07/31/2019 08:27	HUTCH MATTHEW	357807	301-7	ANCEF 2 GM/D5W 100ML 100 ml/hr IVPB Q8H		08/05/2019 08:19		
10/08/2018 10:14	SMITH ELLA KATHE...	357351	ICU-2	ROCEPHIN/D5W IVPB 100 ml/hr IV Q24H		10/08/2018 10:17		

Antimicrobial Review

The List Options are as follows:

- **All Incomplete:** Displays all antimicrobial medication orders on all patients that has not been completed.
- **Pending:** Displays all antimicrobial medication orders pending a 'review' 48 hours after the first administration.
- **Complete:** Displays all medication orders that have been reviewed and marked as Complete.

Orders will no longer show on the Pending listing seven days after the patient has been discharged or seven days after the medication has been discontinued if the medication was not marked as completed.

NOTE: All radio buttons are sticky. Additional filters on the screen include a date range and search option.

A description of each column is listed below:

- **Start Date/Time:** The Start Date/Time of the medication order
- **Patient Name:** The patient's name.
- **Patient Account Number:** The patient's account/visit number.
- **Location:** Patient Room Number
- **Description:** Medication order with Dose and Frequency
- **Duration:** Number of doses for the Medication if entered
- **Admin Date/Time:** Displays the FIRST administration Date/Time for the medication order
- **Reviewer:** The last person to document an Outcome on the medication
- **Review Date/Time:** The last Date/Time an Outcome was documented
- **Outcome:** The last outcome documented
- **Indication of Use:** The Indication reason added during order entry

8.6 Reviewing Medications

Medication orders should be reviewed 48 hours from the first administration. Upon review, the user may select a pre-defined outcome that currently defines the status and/or progress of the antibiotic administrations. Comments may be added within the comment field if needed. Once the medication has been reviewed by all necessary personnel, it may be marked as 'Completed'.

NOTE: Outcomes will need to be set up in the user defined Medication Review Outcome table located in Clinical Table Maintenance, Pharmacy Control: Medication Review Outcome table. See [Table Maintenance - Clinical User Guide](#) for set up.

Select **Thrive UX > Antimicrobial Review > Select a Patient > Review**

The screenshot displays the 'ANTIMICROBIAL REVIEW' interface. At the top, there is a patient information bar with the following details: ADAMS JIMMY, MR#: 091173, ACCOUNT#: 357004, DOB: 09/02/1923, Birth Sex: Male, Admin Gender: UN, Current Weight: 135 lbs 61.24 kg 61235.0 g, AGE: 98Y, CrCl: N/A, Height: 60.00 inches, BMI: 26.37 kg/m2, BSA: 1.61 m2, Admit Weight: 0.00 kg 0.0 g, RM: ER-10, Diagnosis: N/A, CCM: N/A, and Allergies: ASPIRIN, SEAFOOD. Below this is an 'Update' button. The main section is titled 'ANTIMICROBIAL OUTCOMES' and shows a description: 'Description: CEFTRIAZONE(ROCEPHIN) INJ 100 MG IM Q24H'. There is a 'Comments:' field with a text input box. Below the comments is a 'Completed' checkbox. The 'Outcome' section lists several options: 'Continue medication, patient on correct antibiotic', 'Continue to monitor', 'Culture results back, change antibiotic', 'Discontinued', 'Modify Dose', 'Patient meets criteria for IV to PO switch', and 'Waiting for lab/culture results, continue current therapy'.

Antimicrobial Outcomes

Review History displays all users who have reviewed the medication along with the review date/time, the outcome, additional comments if entered, and the status of the outcome if removed.

Select Thrive UX > Antimicrobial Review > Select a Patient > Medication Review History

ANTIMICROBIAL REVIEW
Antimicrobial Review

WALTON KYLE MR#: 000281 ACCOUNT#: 357813 DOB: 01/27/1987 Birth Sex: Male Admin Gender: UN Current Weight: 180 lbs 81.65 kg 81646.6 g
AGE: 35Y CrCl: N/A Height: 68.00 inches BMI: 27.37 kg/m² BSA: 1.98 m² Admit Weight: 180 lbs 81.65 kg 81646.6 g
RM: 006-3 Diagnosis: Injury of knee CCM: N/A Allergies: No Known Drug Allergies

Remove

MEDICATION REVIEW HISTORY
Description: ANCEF 2 GM/D5W 100ML 100 ml/hr IVPB Q8H

Reviewer	Review Date/Time	Outcome	Comments	Status
SHALANDA JENKINS	02/24/2022 15:03	Continue to monitor		
MICHELLE MASON	02/25/2022 10:18	Continue medication, patient on correct antibiotic		

Medication Review History

8.7 Order Chronology

An Antimicrobial Orders filter has been added to the Order Chronology screen. Once the filter is selected, the user has the ability to review Antimicrobial orders specifically for that patient.

Using the Expanded View, the following review statuses could display for an antimicrobial medication order:

- **Needs Review:** Displays 48hrs after first administration Date/Time has been reached and the medication has not been reviewed.
- **Review Pending:** Displays 48hrs after the first administration Date/Time has been reached and the medication has been reviewed, but has not been marked as completed.
- **Review Completed:** Displays with a date/time stamp when the medication has been marked as completed.

Options on the action bar for Review and Review History have also been added to Order Chronology and Order Detail.

Select Thrive UX > Charts > Select Patient > Order Chronology

CHARTS > WHITESIDE KARA (ACTIVE) > ORDER CHRONOLOGY

WHITESIDE KARA MR#: 12345679058 ACCOUNT#: 10017992 DOB: 10/11/1952 Sex: Female Current Weight: 155 lbs 70.31 kg 70306.8 g
 AGE: 65Y CrCl: N/A Height: 72.00 inches BMI: 21.02 kg/m² BSA: 1.89 m² Admit Weight: 0.00 kg 0.0 g
 RM: 1304 Diagnosis: N/A Allergies: PENICILLINS (CLASS), LASIX

Order Chronology

Pharmacy: Renew Orders Antimicrobial Orders
 Ancillary: Exclude Standard Nursing Orders Nursing Stop Orders
 Order: Active All Search: Description Review Style: Expanded Sort: Description Ascending Descending

AMOXICILLIN 500MG CAP 500 MG PO BID (Order # 10)	Order Type: CPOE Pharmacy	Status: Active
Started: 05/15/2018 10:05	Last Given: 06/05/2018 14:50	Renew: 05/17/2018 10:05
Ordered: 04/23/2018 09:29 JAY HUBER		Review Completed: 06/14/2018 08:51
AMOXICILLIN 500MG CAP 500 MG PO DAILY (Order #..)	Order Type: Written Pharmacy	Status: Active
Started: 06/01/2018 07:44	Last Given: 06/01/2018 07:49	Renew: 06/09/2018 10:14
Ordered: 06/05/2018 07:44 DINSMORE JAMES		Review Completed: 06/14/2018 08:51
AMPICILLIN 1GM VIAL 1000 MG IM BID (Order # 27)	Order Type: Written Pharmacy	Status: Active
Started: 06/07/2018 10:14	Last Given: 06/07/2018 10:15	Renew: 06/09/2018 10:14
Ordered: 06/07/2018 10:14 DINSMORE JAMES		Review Completed: 06/11/2018 08:52
PENICILLIN VK SUSP 250 MG PO BID (Order # 15)	Order Type: CPOE Pharmacy	Status: Active
Started: 05/15/2018 11:21	Last Given: 06/05/2018 13:14	Renew: 05/17/2018 11:21
Ordered: 05/15/2018 11:21 JAY HUBER		Review Pending: 06/07/2018 16:58

Pending Actions:

Order Chronology

For more information, also refer to the Order Chronology chapter in the [Order Chronology User Guide](#).

8.8 Medication Review Report

The Medication Review Report provides a listing of all medication orders that have been reviewed within a specified time frame. The Report may be generated by Date, User, Visit Number, Department, and Formulary Code. The report may be setup to automatically generate via the Report Scheduler if needed.

Select **Thrive UX > Report Dashboard > Medication Review Report**

15:21		Medication Review Report		medication_review_report.template	
Medication Information					
TECH ORDERS	M	Account#: 03130531	Dept: QA SWEATHOG DEPARTMENT	DOB: 07/05/1975	
Medication:	AMOXICILLIN 500MG CAP		Doses Administered:	2	
Indication:	Fever of unknown origin				
Ordering Provider:	TIM OGLETREE				
Reviewed By	Date/Time	Outcome	Comment		
WHIDDEN GRAY	08/07/2018 16:19:18	CHANGE MEDICATION			
Medication Information					
WASTE ACCOUNT 2	M	Account#: 0313065B	Dept: QA SWEATHOG DEPARTMENT	DOB: 01/08/1975	
Medication:	ANCEF (CEFAZOLIN) 1GM VIAL		Doses Administered:	2	
Indication:					
Ordering Provider:	TIM OGLETREE				
Reviewed By	Date/Time	Outcome	Comment		
TIM OGLETREE	08/07/2018 16:09:57	CONTINUE MEDICATION			
Medication Information					
COUNTY CLAY	F	Account#: 10017546	Dept: Medical/Surgical	DOB:	
Medication:	CEFTRIAZONE(ROCEPHIN) TEST1000mg/NS 50ML		Doses Administered:	2	
Indication:					
Ordering Provider:	SAM CLAPPER				
Reviewed By	Date/Time	Outcome	Comment		
TIM OGLETREE	08/06/2018 14:38:56	CHANGE MEDICATION			
TIM OGLETREE	08/07/2018 10:37:40	DISCONTINUE			
Medication Information					
BAGGINS FRODO	M	Account#: 10017602	Dept: Medical/Surgical	DOB: 12/10/1988	
Medication:	CEFTRIAZONE(ROCEPHIN) TEST1000mg/NS 50ML		Doses Administered:	3	
Indication:					
Ordering Provider:	Evident Community Hospital				
Reviewed By	Date/Time	Outcome	Comment		
Candace Wilson	08/06/2018 14:22:35	CONTINUE MEDICATION			
Daniel Morrison	08/01/2018 10:07:31	TACO TUESDAY			

Medication Review Report

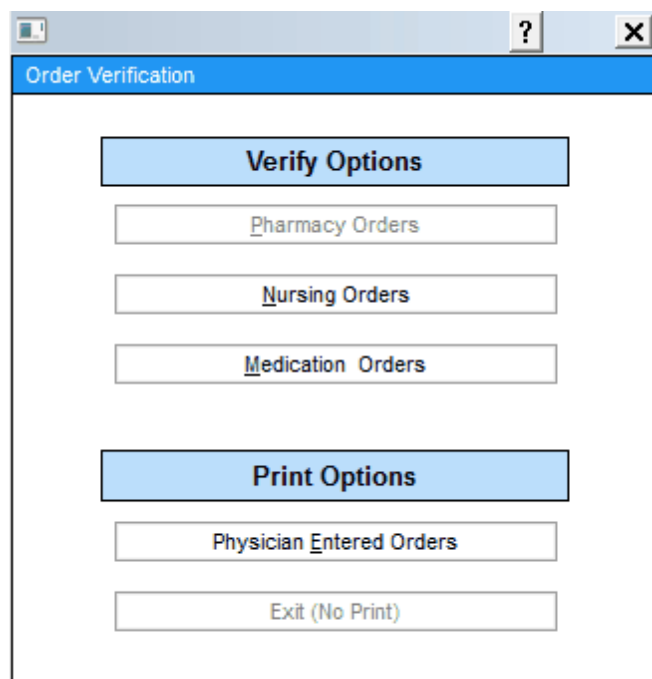
Chapter 9 Order Verification

All temporary orders, including technician, nursing, and physician orders, may be verified via the Order Verification Queue.

NOTE: The ability to verify orders is based on employee security.

1. Select **Order Verification** from the Hospital Base Menu to display the Verify Orders Menu. This menu has the following options:
 - **Pharmacy Orders:** This option is not used by the Pharmacy Department.
 - **Nursing Orders:** This option is not used by the Pharmacy Department.
 - **Medication Orders:** Displays the unverified CPOE, Pharmacy Technician, and Temporary Verbal and Phone orders.
 - **Physician Entered orders:** Prints orders generated by CPOE.
 - **Exit (No Print):** Returns user to previous screen.

Hospital Base Menu > Order Verification



Order Verification menu

2. Select **Medication Orders** to display the unverified medication orders screen.

Hospital Base Menu > Order Verification > Medication Orders

Priority	Patient Name	Order Description	Other Detail	Order Type	Order Set/List/Protocol	Pending Verification Reason
1	JOHNSON ROBERT LEVER	DIGOXIN (LANOXIN) 0.125MG TAB 125 MCG	XI ORAL	NS STAT		
2	ROTH OLIVER MICHAEL	FUROSEMIDE (LASIX) 20 MG TAB 20 MG	DAILY ORAL	NS ORDER		VERIFY DOSING WITH PROVIDER
3	AARON JEAN OPTIC	AMOXICILLIN CAP : 500MG 500 MG	TID ORAL	NS OR&DC		
3	AARON JEAN OPTIC	FUROSEMIDE (LASIX) TAB : 40 MG 40 MG	DAILY ORAL	NS ORDER	ADMISSION ORDER Set	
3	AARON JEAN OPTIC	HEPARIN INJ : 100 UNIT/ML 100 UN	Q8H IV PUSH	NS OR&DC		
3	BAKER JOHN	FUROSEMIDE (LASIX) 20 MG TAB 20 MG	DAILY ORAL	NS ORDER		
3	BAKER JOHN	METFORMIN (GLUCOPHAGE) 500MG TABLET 1000 MG	DAILY ORAL	SIG PD		
3	HUTCH MATTHEW	ACETAMINOPHEN (TYLENOL) 500MG TABLET 500 MG	PRNQ6H ORAL	SIG PD		
3	HUTCH MATTHEW	ANCEF 2 GM/D5 D5W 100 ML	IV PIGGY Q8H	UNSIG PO		
3	HUTCH MATTHEW	COUMADIN 2 MG TAB 2 MG	DAILY ORAL	UNSIG PO	ADMIT ORDERS Set	
3	HUTCH MATTHEW	DOPAMINE PREM	IV PIGGY CONTINUOUS	NS ORDER		
3	HUTCH MATTHEW	ROCEPHIN/DW5 D5W 50 ML	75 ML/HR	UNSIG PO	ADMIT ORDERS Set	
3	JOHNSON ROBERT LEVER	ASPIRIN 81MG TABLET 324 MG	XI ORAL	NS ORDER		
3	JONES RICHARD R	APAP/COD ELIX 12.5 ML	PRN Q4H ORAL	TEC TEMP		

Order Verification - Medication Orders

3. A list of orders will display with the following columns of information. The sort order can be changed by selecting any of the column headers.

NOTE: To filter the list to exclude discontinued orders, select the **Exclude Discontinue Orders** check box.

- **Priority:** System sort defaults
 - **Priority 1:** Stat orders (Red)
 - **Priority 2:** Pending Verification (Yellow)
 - **Priority 3:** Patient Name - Alphabetical
- **Patient Name:** Displays the name of the patient
- **Order Description:** Displays the Item Master Short Description for all orders with the exception of Chartlink orders, which display the Description.
- **Other Detail*:** Displays the dose and unit, the frequency, and the route of the order.
- **Order Type*:** Displays the type of order. Order Types are defined as follows:
 - **CL ORDER:** CPOE-entered order routed to nursing department first for verification
 - **CHARTLINK:** CPOE-entered order routed to pharmacy department first for verification
 - **NS ORDER:** Traditional (written) nursing order
 - **NS O&DC:** Traditional (written) nursing order & discontinue
 - **NS STAT:** Traditional (written) nursing stat order
 - **NS DC'D:** Traditional (written) nursing discontinued order
 - **SIG VD:** Signed discontinued verbal order
 - **UNSIG VD:** Unsigned discontinued verbal order
 - **UNSIG PO:** Unsigned phone order
 - **UNSIG PD:** Unsigned discontinued phone order
 - **UNSIG VO:** Unsigned verbal order
 - **UNSIG PR:** Unsigned protocol order
 - **TEC Temp:** Technician order or renew
 - **TEC DC:** Discontinued technician order
 - **TEC O&DC:** Technician order and discontinue

- **Order Set/List/Protocol:** Displays when an order was placed using an order set and identifies which order set was used.
- **Pending Verification Reason:** Displays the verification hold reason. When an order is pending verification, it is highlighted in yellow.

NOTE: Stat orders display in red.

***NOTE:** The **Other Detail** and **Order Type** columns may be replaced with **Order Date/Time** and **Location** if desired. Call TruBridge Support if you would like to use this alternate configuration.

- **Order Date/Time:** Displays the actual date and time that the order was entered.
- **Location:** Displays the patient's room number.

Patient Name	Order Description	Enter Date/Time	Room	Order Set/List/Protocol	Pending Verification Reason
HUTCH MATTHEW	HYDROCHLOROTHIAZIDE (HCTZ) 12.5 MG TAB 12.5 MG	12/03/2020 09:32	301-7		
HUTCH MATTHEW	FUROSEMIDE (LASIX) 20 MG TAB 20 MG	12/03/2020 09:32	301-7		
HUTCH MATTHEW	COUMADIN 2 MG TAB 2 MG	12/16/2020 15:19	301-7	ADMIT ORDERS Set	
HUTCH MATTHEW	ROCEPHIN/DW5 D5W 50 ML	12/16/2020 15:19	301-7	ADMIT ORDERS Set	
JOHNSON DOROTHY M	ESOMEPRAZOLE(Nexium) CAP:40 MG 20 MG	01/04/2018 09:42	028-1		
JOHNSON DOROTHY M	CITALOPRAM(CELEXA) TAB: 20 MG 20 MG	01/04/2018 09:42	028-1		

- To view the order, click the order and select **Look**. Select **Exit** to move back to the ChartLink order review screen.
- To verify the order, select the order and select **Verify**.
- To mark an order on verification hold, select **Pend Ver**. This will indicate that the order should not be reviewed until clarification is obtained from the provider or other caregivers.
 - After selecting the **Pend Ver** button, a free-text field becomes available to enter the Pending Verification Reason. Type the reason and select **Save**.
 - While a medication is on verification hold, the **Verify** button is disabled and the **Pend Ver** button changes to an **Edit Pend Ver** button. Select this button to edit the hold reason, if necessary.
 - To release the verification hold on a medication, select it from the queue and select the **Release** button. Enter the reason for release in the free-text field and select **Save**. The **Verify** button will then be enabled.
- To change the item of an order, select **Change Item**. Selecting **Change Item** will only be functional for any unverified CPOE order and will launch the Alternative Medication Selection screen.
 - The **Original Medication** should reflect the originally signed order's description along with dose and unit.
 - Once a medication is selected from the alternative list (or from using the Formulary option), the user should be taken into a new **Medication Edit** screen to make necessary changes to the order. When **Update** is selected from the **Medication Edit** screen, the user will be taken to pharmacy order entry to verify the order.
 - **Chartlink Order:** Will display the original order signed by the physician.
 - **Order History:** Will display the **Item Changed**.

Select Hospital Base Menu > Order Verification > Medication Orders > Alternative Medication Selection

SMITH JAMES MR#: 091173 ACCOUNT#: 357004 DOB: 09/02/1923 Birth Sex: Male Admin Gender: UN Current Weight: 135 lbs 61.24 kg 61235.0 g
 AGE: 98Y CrCl: N/A Height: 58.00 inches BMI: 28.21 kg/m2 BSA: 1.58 m2 Admit Weight: 0.00 kg 0.0 g
 RM: N/A Diagnosis: N/A CCM: N/A Allergies: PENICILLINS (CLASS), ASPIRIN, SEAFOOD

Formulary

ALTERNATIVE MEDICATION SELECTION

Original Medication: LISINOPRIL (PRINIVIL) 10 MG TAB: 10 MG ORAL DAILY Processing: 1 of 1
 Medication Type: All Exact Match Therapeutic Alternative

Description	Alternative Type	Match %
LISINOPRIL (PRINIVIL) 10 MG TAB	Exact Match	100
CAPTROPRI (CAPOTEN) TAB : 25 MG	Therapeutic Alternative	100
ENALAPRIL(VASOTEC)TAB: 10 MG	Therapeutic Alternative	100
ENALAPRIL(VASOTEC)TAB: 5MG	Therapeutic Alternative	100
LISINOPRIL (PRINIVIL) 2.5 MG TABLET	Therapeutic Alternative	100
LISINOPRIL(ZESTRIL,PRINIVIL)TAB.20MG	Therapeutic Alternative	100
LISINOPRIL(ZESTRIL,PRINIVIL)TAB.40MG	Therapeutic Alternative	100
QUINAPRIL(ACCUPRIL) TAB : 10 MG	Therapeutic Alternative	100

Order Verification - Alternative Medication Selection

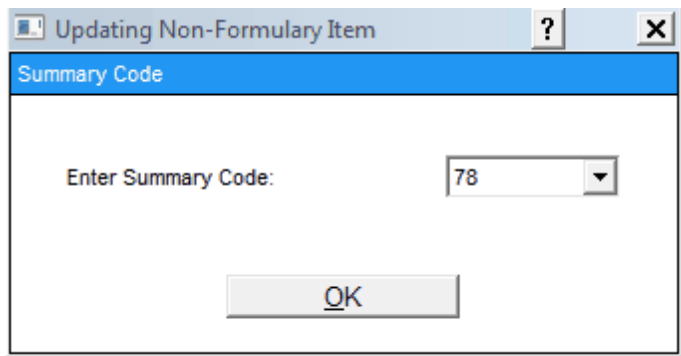
Update Copy Dose Copy Frequency Copy Duration Copy Instructions

MEDICATION EDIT

Original Medication: LISINOPRIL (PRINIVIL) 10 MG TAB Selected Medication: LISINOPRIL (PRINIVIL) 10 MG TAB
 Dose: 10 MG Dose: 10 MG
 Administer Amount: 1 Tablet Administer Amount: 1 Tablet
 Route: ORAL Route: ORAL
 Frequency: DAILY Frequency: DAILY Standard
 Times: 0900 Times: 0900
 Duration: 5 Duration: 5 doses
 Stat: Stat:
 First Dose Date/Time: Start Date/Time: 1/19/2022 13:18 First Dose Date/Time: 1/19/2022 13:18
 Stop Date/Time: 01/24/2022 09:00 Stop Date/Time: 1/24/2022 09:00
 Indication: N/A Instructions:
 Patient's Own Medication: Patient's Own Medication:

Order Verification - Medication Edit

NOTE: If the order being verified is a new Non-Formulary medication, pharmacy will be prompted to select the correct insurance summary code. This includes Non-Formulary orders entered via EDIS software. If EDIS orders do not go to pharmacy for verification, a default insurance summary code of 78 is automatically assigned. Non-Formulary items created via TruBridgeProvider EHR order entry will default to insurance summary code 78 since these orders are auto-verified.



Non-Formulary Summary Code Prompt

8. The software will perform Clinical Monitoring and alerts will be displayed.

9. Then the pharmacist may make any needed changes.

NOTE: If the order has been administered prior to verification, the frequency fields, including standard and non-standard times, will be disabled and may not be changed.

10. A 1st Time Quantity may be entered and labels requested.

11. If the Dose Calculator was utilized during order entry, the **Dose Calc** option will be enabled.

- When accessed, the Dose Calculator screen will be view only.
- If a pharmacist makes a change to the Dose, Unit, Frequency, Scheduled Date/Times, Hours between Doses, Days of the Week field after the order has been verified, the following warning prompt will occur, "Dose calculator was used for this order. Changing (this field) will clear the dose calculation information. Would you like to continue? Yes; No" If **Yes** is selected, the field will change on the order, but the Dose Calculator will remain the same. If **No** is selected, the order will not change and the Dose Calculator record will remain the same.

Select **Hospital Base Menu > Order Verification > Medication Orders > Order > Verify**

Pharmacy - Non-IV Order (NEW ORDER) Evident Community Hospital Signed On Emp: FT Dept: 038

Save Save & Exit Delete Restore ChartLink Order

SIMS PHILLIP ANDREW 357929 Age: 10M Sex: M Height: 30.00 in. Weight: 17 lbs CrCl: N/A Room: 500-7

Medication | RX Information | Clinical Monitoring | Stop History | RX Charge History | NDC History | Profile | Order History

Description: ACETAMINOPHEN ELIXIR (TYLENOL):160MG/5ML Item Number: 382012 RX Price:

Dose: 116 Unit: MG Route: PO Frequency: PRN Q4H Duration: Doses: Priority: Routine

Brand: TYLENOL Dose Unit/Dose = 0.3625 Standard

1st Time Quantity: Labels: 1 Alt Printer: Non-Standard

Resupply Quantity: Labels: Days: 1 Times

1st Dose Date: Start Date: 03/17/16 Time: 13:54 Initials: FT Days of the Week

Stop Date: Instructions: FOR TEMP > 101 OR PAIN Date: 03/17/16 Time: 13:54 Initials: FT

Physician: BARNETT R Treatment: Patient's Own NF Price POC Verified: NS 004 APAP160MG/5ML BAL =

Ready. Dose Calc Dose Info

Dose Calc

←
Update
Clear
Dose Information

Dose Calculator

Medication Name: **ACETAMINOPHEN ELIXIR (TYLENOL):160MG/5ML**

Dose:

Frequency:

Concentration: **160MG/5ML**

Rounding Option:

CALCULATION

Administer Dose: **116 MG**

Override Administer Dose:

Administer Amount: **4 ML Elixir**

FORMULAS

Administered Dose (MG) = Dose (mg/kg/DOSE) x Weight (kg)

Dose (mg/kg/DOSE) x Weight (kg)

Administered Amount (ML) = $\frac{\text{-----}}{\text{Concentration (mg/ml)}}$

Dose Calculator screen

12. To view the patient's pharmacy profile, select the patient from the listing and choose **View Profile**.
13. To select the patient, choose **Select Patient**.

9.1 Positive ID Authentication

If Positive Identification (Positive ID) is selected for the Pharmacy department, user authentication is required when verifying medication orders. The prompt will display when **Save & Exit** is selected. For more information on Positive ID, refer to the Pharmacy Set Up User Guide.

Select **Hospital Base Menu > Order Verification > Medication Orders > Order > Verify > Save & Exit**

The screenshot displays the 'Pharmacy - Non-IV Order (NEW ORDER)' window for patient AINSWORTH MARTHA COZEN. The medication is FUROSEMIDE (LASIX): 20 MG TAB. A modal dialog box titled 'POSITIVE ID' is overlaid on the screen, asking 'What was your first toy?' with an input field and 'Ok' and 'Refresh' buttons. The background interface includes fields for patient demographics, medication details, and a 'Ready' status bar.

User Authentication prompt

Enter the answer to the question and then select **OK**. If a new question is desired, select **Refresh**.

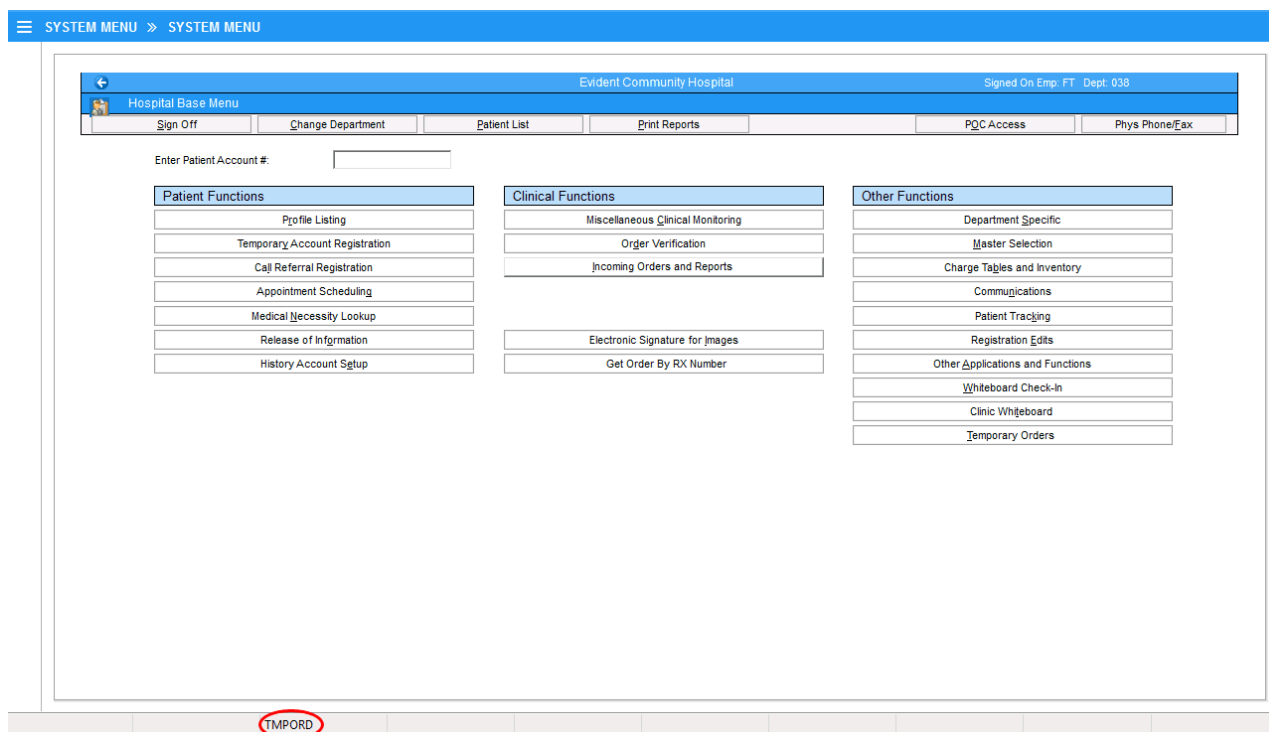
If the question is answered correctly, the user will be prompted with another until all required questions are answered.

If the questions are not answered correctly, the order will not be verified.

9.2 Temporary Order Notification

Pharmacists may receive notification when temporary orders are entered on a patient's profile. A temporary order is defined as a medication order placed by any clinician other than a pharmacist. This includes technician orders, nursing orders, Verbal or Phone orders and ChartLink orders. The notification can be in the form of a flash, a pop-up box, a sound or any combination of these three options. To ensure notifications function properly, setup must be complete. See [Pharmacy Setup User Guide](#) Temporary Order Notification section for more information.

Select Hospital Base Menu



Temporary Order Flash

- The Pharmacy department will receive the **CLORD** flash for CPOE entered medication orders and **CLSTAT** for CPOE entered stat medication orders.
- A **TMPORD** flash will be generated for any other temporary medication order with the exception of temporary stat orders which will generate a **TMPSTAT** flash.

9.3 Print Physician Entered Orders

1. To print physician orders from Order Verification, select **Physician Entered Orders** from the Print options.
2. The report will default to **All Patients**. To run the report by individual patients, deselect the All Patients option then enter up to a maximum of 50 accounts or use the magnifying glass to search for patients.
3. Key in the Acknowledged Beginning Date or use the drop down arrow to choose a date from the popup calendar.
4. Key in the Acknowledged Beginning Time.
5. Key in the Acknowledged Ending Date or use the drop down arrow to choose a date from the popup calendar.
6. Key in the Acknowledged Ending Time.
7. Key in the Acknowledged Employees Initials.
8. Select **Print**.

Select **Hospital Base Menu > Order Verification > Physician Entered Orders**

Patient Name	Number
AINSWORTH MARTHA COZEN	357823

Acknowledged Beginning Date: 111615
Acknowledged Beginning Time: 0001
Acknowledged Ending Date: 111715
Acknowledged Ending Time: 841
Acknowledged Employee Initials: FT

Print

Order Verification Print Physician Entered Orders

Chapter 10 Incoming Orders and Reports

The Pharmacy department may receive completed laboratory results and signed transcriptions by automatic printing or manually retrieving the reports. Laboratory must use the TruBridge EHR Laboratory application.

For more information on Incoming Orders and Reports, please refer to the [Incoming Orders and Reports](#) User Guide

Chapter 11 Pharmacy - Selection Screen

Patient specific functions are performed from the Pharmacy - Selection Screen.

11.1 Accessing the Pharmacy - Selection Screen

The Pharmacy-Selection Screen may be accessed via the following paths:

- Enter the **Patient Account #**
- Select **Patient List**

Select **System Menu > Hospital Base Menu**

The screenshot displays the 'Hospital Base Menu' interface. At the top, there is a blue header with 'SYSTEM MENU >> SYSTEM MENU' on the left and 'Evident Community Hospital' and 'Signed On Emp: FT Dept: 038' on the right. Below the header, there is a navigation bar with buttons for 'Sign Off', 'Change Department', 'Patient List' (highlighted with a red box), 'Print Reports', 'PQC Access', and 'Phys Phone/Fax'. Below the navigation bar, there is a text input field labeled 'Enter Patient Account #' with a blue arrow pointing to it. The main content area is divided into three columns of function buttons: 'Patient Functions', 'Clinical Functions', and 'Other Functions'. The 'Patient Functions' column includes buttons for Profile Listing, Temporary Account Registration, Call Referral Registration, Appointment Scheduling, Medical Necessity Lookup, Release of Information, and History Account Setup. The 'Clinical Functions' column includes buttons for Miscellaneous Clinical Monitoring, Order Verification, Incoming Orders and Reports, Electronic Signature for Images, and Get Order By RX Number. The 'Other Functions' column includes buttons for Department Specific, Master Selection, Charge Tables and Inventory, Communications, Patient Tracking, Registration Edits, Other Applications and Functions, Whiteboard Check-In, Clinic Whiteboard, and Temporary Orders. On the left side of the interface, there is a vertical menu with icons for Home, Lock, and Logout, and a list of menu items: System Menu, Charts, E-Sign, Reports, E-Scribe, Scheduling, and System Management.

Hospital Base Menu

11.2 Navigation Bar

Navigating to other areas of the Pharmacy application is quickly and easily accomplished using the Menu options available on the Pharmacy - Selection Screen. When exiting these areas, the user is returned to the patient account.

Options available from the Navigation Bar are as follows:

- Patient List
- Control Tables
- Item Master
- Print Reports
- Order Number
- RX (Prescription) Number
- Medication Reconciliation
- 24-Hour EMAR

Patient List

The Patient List may be accessed directly from the Pharmacy - Selection Screen. This is the same information that may be accessed from the Hospital Base Menu.

From the Pharmacy - Selection Screen, select **Patient List**.

Select Pharmacy - Selection Screen > Patient List

The screenshot shows the Pharmacy - Selection Screen with the Patient List window open. The Patient List window has a search bar and a table of patients. The search criteria are set to 'Nursing Station' and '003 NS Medical-Surgical'. The table lists the following patients:

Patient Name	Room	Acct. #	Admit Date
GARLAND REBECCA	010-1	357023	5/13/2003
SMITH ELLA KATHERINE	010-2	357388	6/08/2011
PETERSON MEGAN ELAIN	010-3	321654	10/26/2007
MAJURE TREY RALPH	010-4	357365	1/14/2011
DURDEN KELLY	010-5	357307	8/02/2010
BONINE BEVERLY	012-1	355274	7/12/2001
ROBERTS ESTELLE	012-2	356012	7/12/2001
ODOM CONNIE	014-1	963963	3/12/2001
CHAMBLISS STEPHEN	014-2	356787	7/06/2001
WALSH KIERNAN	016-1	356504	7/09/2001
SMITH GUS B	016-2	358694	12/10/2014
CORBITT JANICE	018-1	357444	1/12/2012
JONES RICHARD R	018-2	358422	11/11/2014
PHYS DOC ACCOUNT	020-1	123465	5/07/2013
WALSH KIERNAN	020-2	357896	3/03/2014

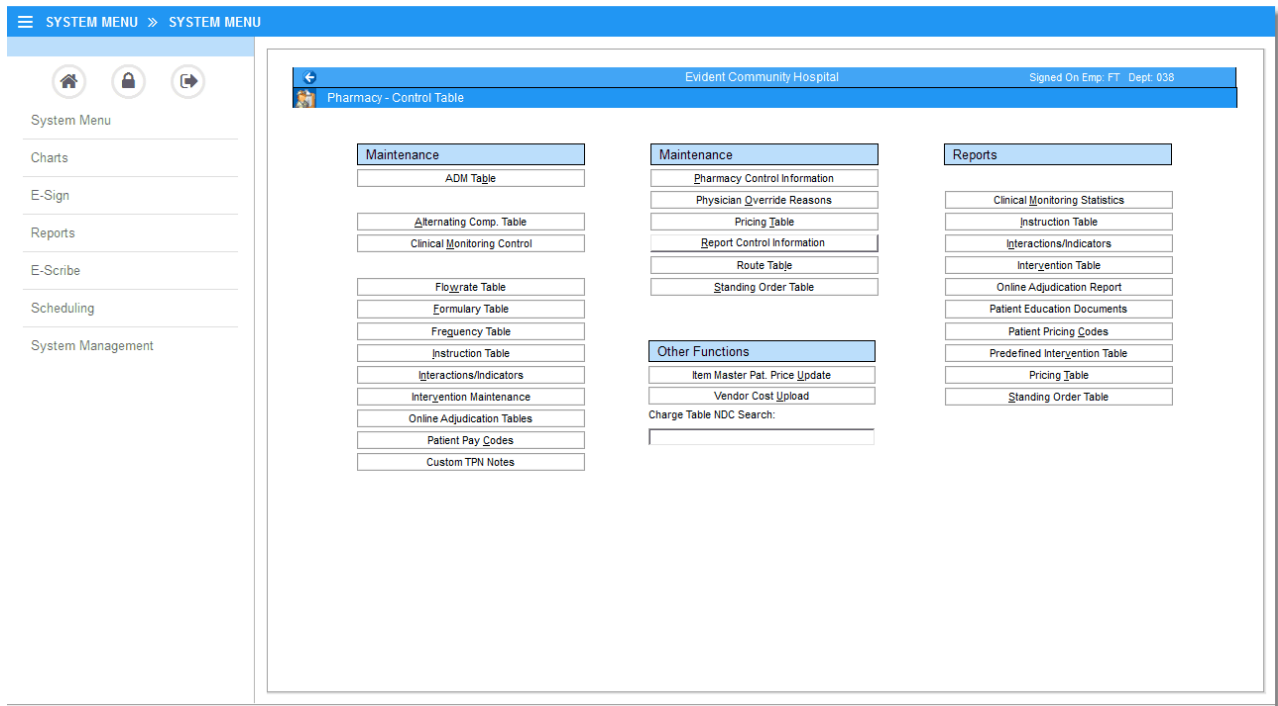
Patient List

Control Tables

The Pharmacy - Control Tables may be accessed directly from the Pharmacy - Selection Screen. These same tables may be accessed from the Hospital Base Menu, Department Specific path. Refer to [Pharmacy Setup](#) for information on these tables.

From the Pharmacy - Selection Screen, select **Control Tables**.

Select Pharmacy - Selection Screen > Control Tables



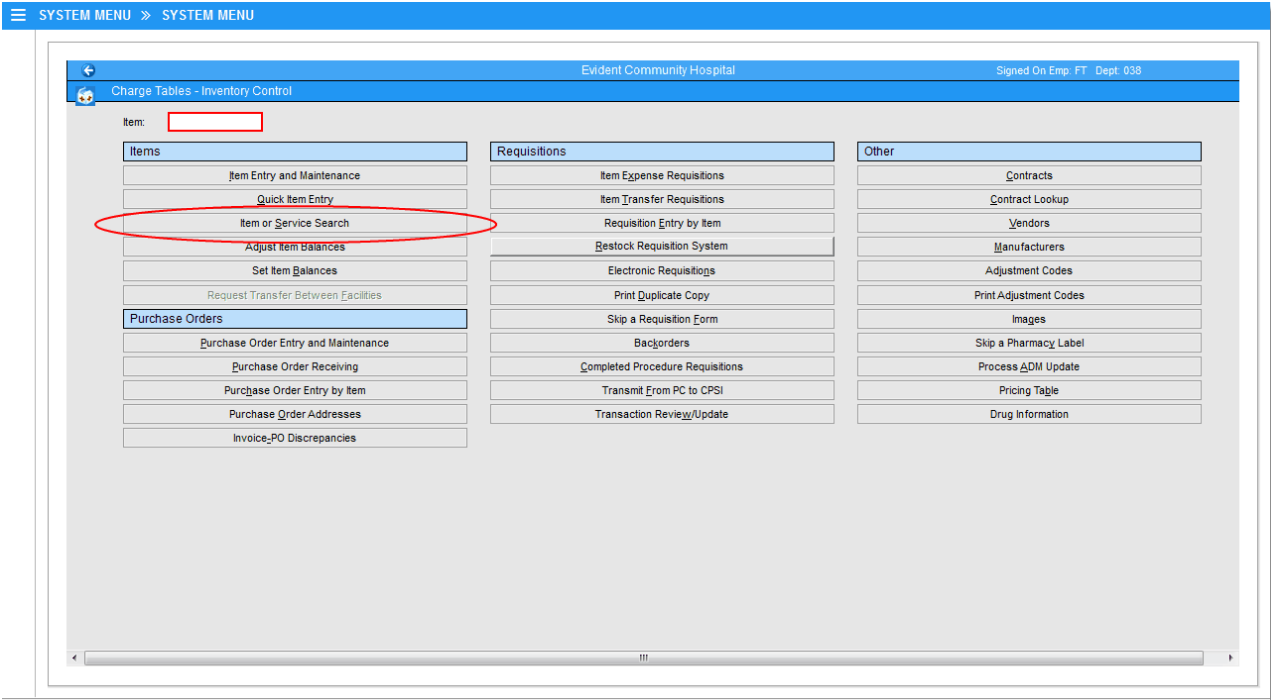
Control Tables

Item Master

The Item Master may be accessed directly from the Pharmacy - Selection Screen. The formulary list that may also be accessed from the Hospital Base Menu, Charge Tables and Inventory path. Refer to [Pharmacy Setup](#) for information.

From the Pharmacy - Selection Screen, select **Item Master**.

Select **Pharmacy - Selection Screen > Item Master**



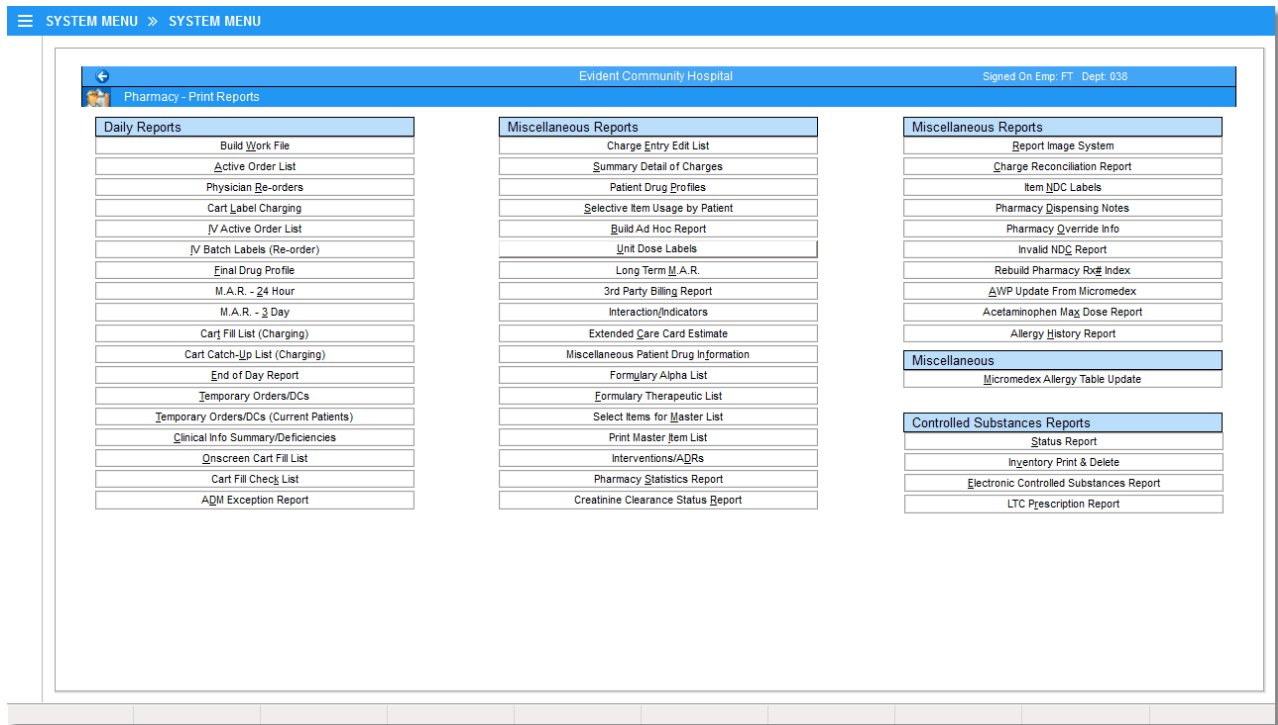
Charge Tables - Inventory

Print Reports

The Pharmacy Print Report menu may be accessed directly from the Pharmacy - Selection Screen. This is the same report list that may be accessed from the Hospital Base Menu, Print Reports path. Refer to the Daily Reports and Miscellaneous Reports for more information.

From the Pharmacy - Selection Screen, select **Print Reports**.

Select **Pharmacy - Selection Screen > Print Reports**



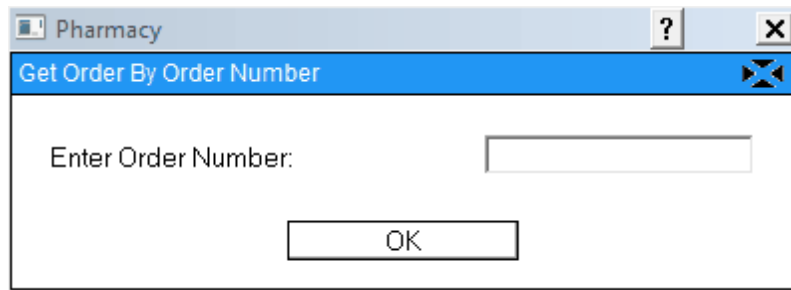
Print Reports

Order Number

Existing orders can be displayed without the need to search the Pharmacy Profile. The order number, if known, can be entered for instant access to the order.

1. From the Pharmacy-Selection Screen, select **Order Number**.
2. Enter the order number and select **OK** to display the order maintenance screen.

Select **Hospital Base Menu > Patient > Order Number**

A screenshot of a software dialog box titled "Pharmacy" with a subtitle "Get Order By Order Number". The dialog box has a blue header bar with the title and a close button (X) on the right. Below the header, there is a text label "Enter Order Number:" followed by a white rectangular input field. Below the input field is a rectangular button labeled "OK". The dialog box has a standard Windows-style border with a question mark icon and a close button (X) in the top right corner.

Pharmacy Selection Screen

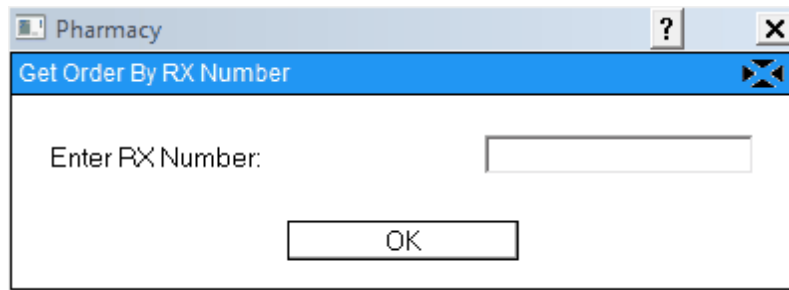
3. To exit without entering an order number, select the **X** in the upper right-hand corner of the display.

RX (Prescription) Number

Existing prescription orders can be displayed without the need to search the Pharmacy Profile. The prescription number, if known, can be entered for instant access to the order.

1. From the Pharmacy Selection Screen, select **Rx#**.
2. Enter the prescription number and select **OK** to display the order maintenance screen.

Select **Hospital Base Menu > Patient > Rx#**

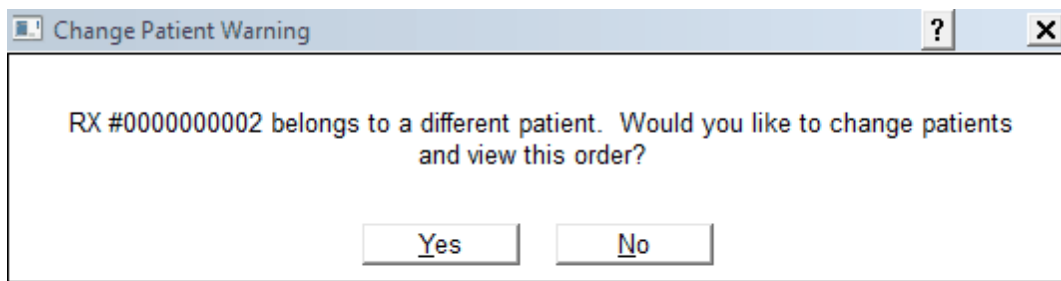


Pharmacy Selection Screen

3. To exit without entering a prescription number, select the **X** in the upper right-hand corner of the display.

NOTE: A warning will display if a prescription number is entered that does not belong to the selected patient. The prompt will allow that order number to be accessed.

Select **Hospital Base Menu > Patient > Rx# > OK**



Change Patient Warning Dialogue

Med Reconciliation

An option to access Medication Reconciliation is available from the Pharmacy - Selection Screen. For more information, refer to the [Updated Medication Reconciliation User Guide](#).

From Pharmacy - Selection Screen, Select **Med Reconciliation**.

Select **Hospital Base Menu > Patient Account # > Pharmacy Selection Screen**

CHARTS > AINSWORTH MARTHA COZEN (357823) > MEDICATION RECONCILIATION

AINSWORTH MARTHA COZEN MR#: 000307 ACCOUNT#: 357823 DOB: 12/10/1934 Sex: F Current Weight: 120 lbs 54.43 kg 54431.10 g
 AGE: 80 CrCl: 31.87 ml/min Height: 60.00 inches BMI: 23.44 kg/m2 BSA: 1.52 m2 Admit Weight: 120 lbs 54.43 kg 54431.10 g
 RM: 300-9 Diagnosis: Allergies: CODEINE

System Menu
 Charts
 AINSWORTH MARTHA CO...
 Alerts
 Lab Results
 Problem List
 Vitals
 Allergies
Medication Reconciliation
 Prescription Entry
 Patient Immunization History
 Patient Education Docume...
 PACS Images
 Order Chronology
 Transcriptions
 Clinical History
 Reports and Attachments
 Order Entry
 MAR
 Documentation
 Health History

New Home Med Associate Selected Remove Association Edit Home Review Active Remove Confirm Reviewed History


Medication Reconciliation Destination: [Dropdown]

Display Options: Show Removed Home Include DC'd Medications Sort: Home Ascending Descending
 Select Options: Select All Home Select All Active Selected Rows: 0

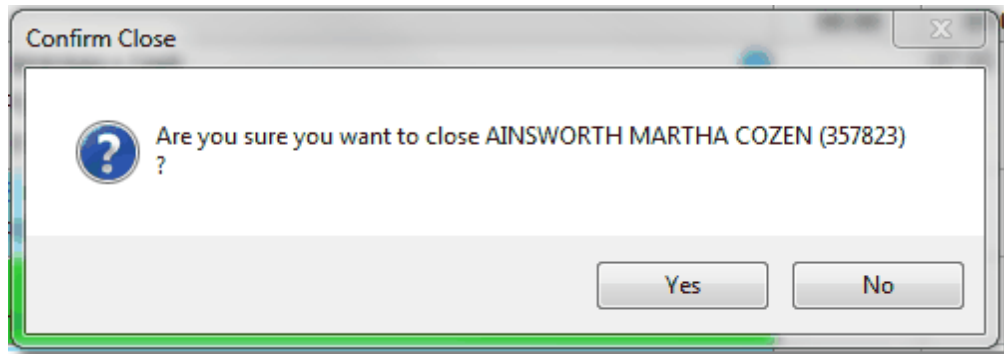
Home Meds	Active Meds	Pending Actions
Coumadin 7.5MG Oral Tablet 7.5 MILLIGRAMS ORAL Daily	WARFARIN (COUMADIN) 2.5 MG TAB 2.5000 MG PO DAILY	
	WARFARIN (COUMADIN) 5 MG TAB 5 MG PO DAILY	
Ibuprofen 200MG Oral Tablet 200 MILLIGRAMS ORAL AS NEEDED	IBUPROFEN (MOTRIN) TAB 200 MG ORALLY PRNQ6H (AS NEEDED)	
Lasix 20MG Oral Tablet 20 MILLIGRAMS ORAL Daily	FUROSEMIDE (LASIX) 20 MILLIGRAMS PO DAILY	
	ALBUTEROL INH SOL .083% 3ML 3 ML UPDRAFT QID	

Pending Actions: 0, 473 Total: 8

Medication Reconciliation screen

- Select  to exit the MAR and return to the Pharmacy - Selection Screen.

- The following prompt will display:



Confirmation Prompt

- Select **Yes** to close the chart and return to the Pharmacy - Selection Screen.
- Select **No** to remain in Medication Reconciliation.

24-Hour EMAR

An option to jet to the Point of Care 24-hour electronic MAR is available from the Pharmacy - Selection Screen. Select **24-Hour EMAR** option to view the EMAR used by nursing staff. The options to sort the MAR Display and view administration details are available to Pharmacy staff. For more information see [Medication Administration Record \(MAR\)](#) in the Updated EMAR/MedVerify User Guide or [Electronic Medication Administration Record](#) in the POC Pharmacy User Guide.

Select Hospital Base Menu > Patient Account # > Pharmacy Selection Screen

Pharmacy - Selection Screen

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 31.87 Room: 300-9

Order Entry	Clinical Review	Other	P.	Allergies	Reaction(s)
New Orders	Pharmacy Profile	Clinical Information Changes	1	Codeine	Itching; Blisters
Standing Orders	Interventions / ADR	Allergy Review			
Long Term Care / Prescriptions	Temporary Orders	Estimate Creatinine Clearance			
Stop ALL Active Orders	IV Orders	Clinical Monitoring			
Transfer Orders	Ancillary Orders	Misc. Clinical Monitoring			
		Patient Education			
		Interventions			
		Adverse Drug Reactions			
		Image/Signature Store/Retrieve			
		Electronic Forms			
		Rx Diagnoses			

Change to Account #:

Ready.

Pharmacy Selection Screen

Select Hospital Base Menu > Patient Account # > 24-Hour EMAR

AINS WORTH MARTHA COZEN MR#: 000307 ACCOUNT#: 357823 DOB: 12/10/1934 Sex: F Current Weight: 120 lbs 54.43 kg 54431.10 g

AGE: 80 CrCl: 31.87 ml/min Height: 60.00 inches BMI: 23.44 kg/m² BSA: 1.52 m² Admit Weight: 120 lbs 54.43 kg 54431.10 g

RM: 300-9 Diagnosis: Allergies: CODEINE

Update All Pending Remove All Pending Date View Change Date/Time Medication Report Color Legend Clinical Monitoring

Medication Administration Record Current Date and Time

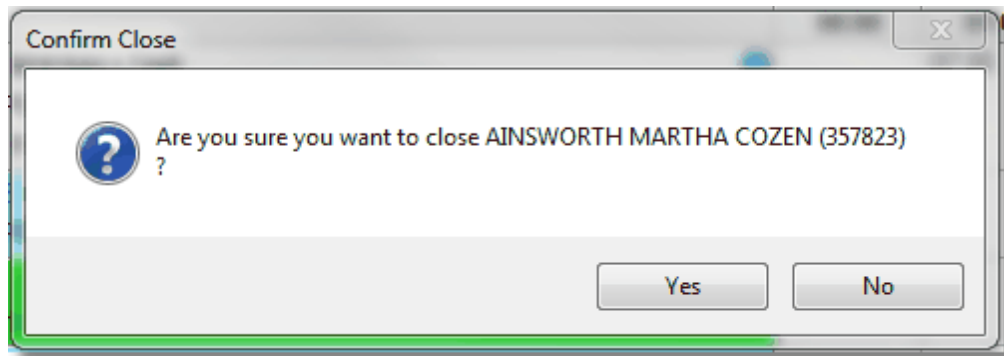
MAR Display: All Include Discontinued Medications Date range: 10/11/2015 17:00 - 10/16/2015 07:00

	10/16/2015 07:00	10/15/2015 20:00	10/15/2015 17:00	10/15/2015 16:00	10/15/2015 12:00	10/15/2015 10:00	1
PROPRANOLOL (INDERAL) TAB Dose: 20 MG TID PO CHECK PULSE BEFORE ADMINISTRATION IF < 50 HOLD AND CALL MD	07:00		17:00		12:00		Give
ALBUTEROL INH SOL .083% 3ML Dose: 3 ML QID UPDRAFT		20:00		16:00	12:00		
ROCEPHIN IVPB Flowrate: 100 ml/hr Q24H IVPB						10:00	
NORMAL SALINE 1000 ML Flowrate: 125 ml/hr CONTINUOUS IV							

Updated EMAR



- Select **X** to exit the MAR and return to the Pharmacy - Selection Screen.
- The following prompt will display:



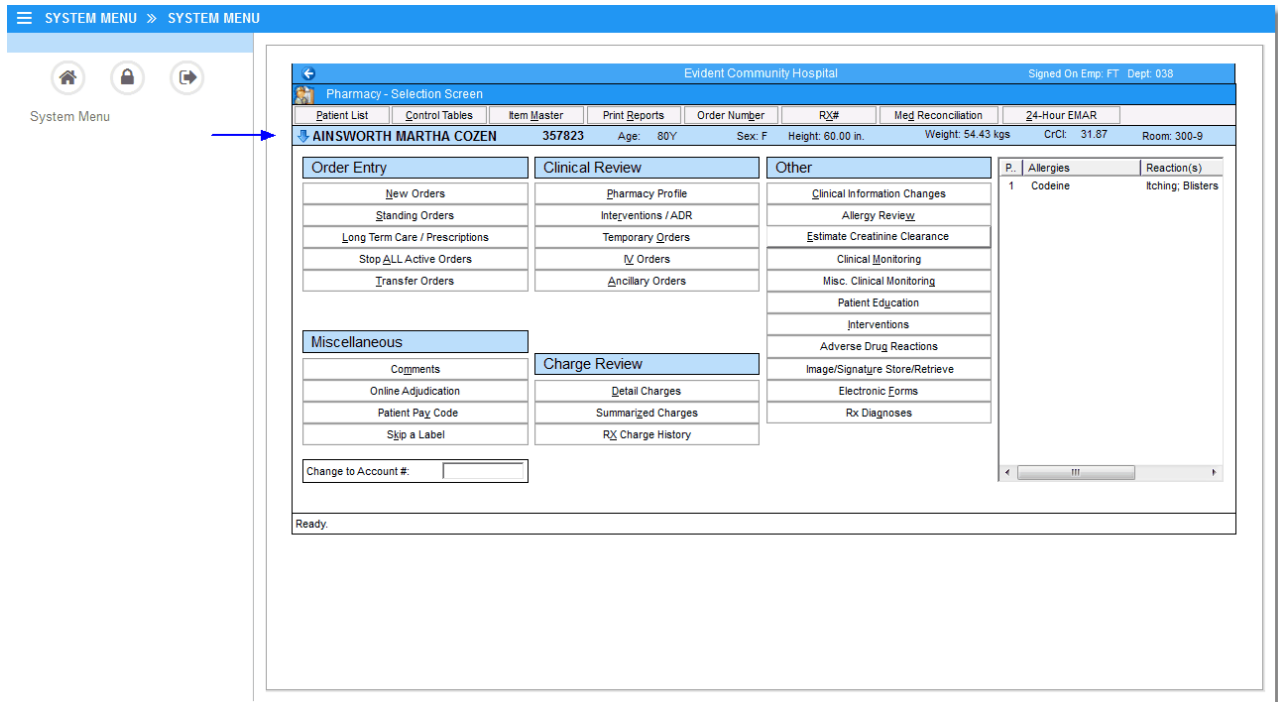
Confirmation Prompt

- Select **Yes** to close the chart and return to the Pharmacy - Selection Screen.
- Select **No** to remain in Medication Reconciliation.

11.3 Patient Demographic Bar

Patient Demographics will display on the majority of screens in the pharmacy application. The patient name, account number, age, sex, height weight, and room number display. Creatinine Clearance will display if age, height, weight and serum creatinine are available. Additional patient demographic information can be displayed by placing the mouse over the downward arrow located next to the patient name. If the patient is a pediatric patient, fewer than 14 years old, the highlighted age will show in the demographic header. The demographic box will display the word 'Pediatric' in red under the warnings section.

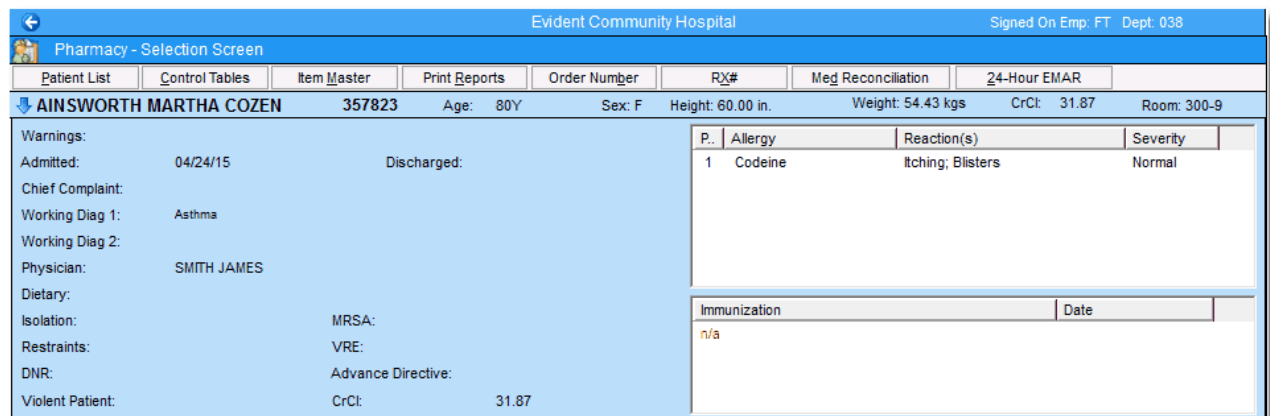
Select Hospital Base Menu > Patient List > Select Patient



Pharmacy-Selection Screen

Creatinine Clearance, when below the level defined in the Pharmacy Control Table, and patient warnings will display in red. Patient drug allergies and reactions will also display on the right of the screen.

Select Hospital Base Menu > Select Patient > Demographics



Patient Demographics

Creatinine Clearance

Overview

The TruBridge EHR provides support for renal function monitoring by allowing access to laboratory parameters. Serum Creatinine values for renally compromised patients can be reviewed with minimal effort. With access to serum Creatinine values, the software will calculate Creatinine clearance.

11.4 Order Entry

Overview

This section will cover placing new IV and non-IV orders, placing standing orders, long term care orders, how to stop all active orders, transfer orders, verify orders, and cover incoming orders.

New Orders

Both IV and Non-IV orders may be entered via **New Orders**. Default Routes (Pharmacy Information Page 1) determine whether the IV or Non-IV order entry screen will default. For this reason, all possible Default Routes should be entered for all items. Refer to [Pharmacy Setup](#) for additional information.

Non-IV Order Entry

1. From the Pharmacy Selection Screen, select **New Orders**.

Select **Hospital Base Menu > Patient > Pharmacy - Selection Screen > New Orders**

Evident Community Hospital Signed On Emp: FT Dept: 038

Pharmacy - New Order

Patient List Pharmacy Profile R_X Charge History

AINSWORTH MARTHA COZEN 357823 Age: 82Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: N/A Room: 300-9

All meds (by description) All meds (by mnemonic) My meds Non Formulary meds

Lookup Starting Point:

Description	Item Number	Primary Unit	NDC Number
***DO NOT USE	00389995	CONSULT	EA 99999-9999-99
-----ANCILLARY DEPARTMENTS-----	00389999		
0.45 NS 1000 ML	03814530	SOLN	EA 00338-0043-04
1/2 NS 1000 ML	03814530	SOLN	EA 00338-0043-04
1/2 NS 1000 ML BAG	00210211	1000 ML BAG	EA 00264-4021-55
1/2 NS 500 ML BAG	00210203	500ML BAG	EA 00338-0043-03
1000 ML NORMAL SALINE	03814505	100ML BAG	EA 00338-0049-04
>>>1. INITIAL OF 0.5-1 mU/MIN (3-6ML/HR)	38387282		EA 99999-9999-99
>>>2. AT 30-60 MIN INCREMENTS INCREASE	38387276		EA 99999-9999-99
>>>3. WHEN DILATATION REACHES 5-6 CM	38387279		EA 99999-9999-99
>>>4. DOSES OF 9 mU/MIN (54 ML/HR) RARE	38387275		EA 99999-9999-99
ABILIFY (ARIPIPIRAZOLE) 10 MG TAB	03814531	TAB	EA 54868-5202-00
ACCUPRIL 10 MG TAB	38381242	TAB	EA 00071-0530-23
ACETAMINOPHEN 650MG ORAL SOL 20.3ML	03814584		EA 49999-0211-04
ACETAMINOPHEN (TYLENOL) 325 MG TABLET	00381010	TAB	EA 50580-0496-60
ACETAMINOPHEN (TYLENOL) 500MG TABLET	00381604	TABLET	EA 50580-0710-51
ACETAMINOPHEN ELIXIR (TYLENOL):160MG/5ML	00382012	SML DOSE	EA 54868-1791-00
ACETAMINOPHEN ORAL SOLUTION 160MG/5ML	03814581		EA 00121-0657-21
ACETAMINOPHEN SUPP (TYLENOL) : 120 MG	00386070	1 SUPP	EA 51672-2115-04
ACETAMINOPHEN SUPP (TYLENOL) : 650 MG	00386072	1 SUPP	EA 00536-1260-12

* = Non-formulary item

Add to My Meds

Pharmacy-New Order Screen

The Pharmacy-New Order screen is comprised of the following components:

- **Navigation Bar**
 - **Patient Demographics**
 - **Search Options:**
 - **All meds (by description):** This is the default option when searching for a medication
 - **All meds (by mnemonic):** Select this option to search for medication using a facility created mnemonic. This option may be selected as the default in the Pharmacy Control Information table. Refer to [Pharmacy Setup](#) for additional information.
 - **My meds:** Select this option to search for a custom list of medications that was previously saved using the **Add to My Meds** option at the bottom of the screen
 - **Non Formulary meds:** Select this option to search for a medication that is not listed in the hospital item master (formulary). The Micromedex Lookup screen will display an alphabetic listing of medications.
2. Enter the medication description or mnemonic and press <Enter>.
 - The lookup screen lists the Item Description, Item Number, Primary Description and Unit, and NDC Number.

3. Double click on the desired item.

NOTE: If allergies, height or weight have not been entered, the Clinical Information Screen will display and require entry to continue order processing. This feature is controlled by switches located in the Pharmacy Control Information table. Refer to [Pharmacy Setup](#) for additional information.

Select **Hospital Base Menu > Patient > New Orders**

Evident Community Hospital Signed On Emp: FT Dept: 038

Pharmacy - New Order

Patient List Pharmacy Profile R_X Charge History

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 31.87 Room: 300-9

All meds (by description) All meds (by mnemonic) My meds Non Formulary meds

Lookup Starting Point:

Description	Item Number	Primary Unit	NDC Number
ABILIFY (ARIPIPRAZOLE) 10 MG TAB	03814531	TAB	EA 54868-5202-00
ACCUPRIL 10 MG TAB	38381242	TAB	EA 00071-0530-23
ACETAMINOPHEN (TYLENOL) 325 MG TABLET	00381010	TAB	EA 50580-0496-60
ACETAMINOPHEN (TYLENOL) 500MG TABLET	00381604	TABLET	EA 50580-0710-51
ACETAMINOPHEN ELIXIR (TYLENOL):160MG/5ML	00382012	SML DOSE	EA 54868-1791-00
ACETAMINOPHEN ORAL SOLUTION 160MG/5ML	03814581		EA 00121-0657-21
ACETAMINOPHEN SUPP (TYLENOL) : 120 MG	00386070	1 SUPP	EA 00182-1662-11
ACETAMINOPHEN SUPP (TYLENOL) : 650 MG	00386072	1 SUPP	EA 00536-1260-12
ACETAMINOPHEN W/ COD ELIXIR :30MG/12.5ML	00382018	12. SML (30MG) UD	EA 00045-0513-60
ACETAMINOPHEN W/COD (TYLENOL #3) 30/300MG	00381012	TAB	EA
ACETAMINOPHEN/CODEINE 300MG/30MG TAB	03814529		EA 54868-0364-01
ACETAZOLAMIDE (DIAMOX) : 250 MG	00381014	TAB	EA 51672-4023-01
ACTIVASE 50 MG INJ	00386106	50ML INJ	EA 50242-0044-13
ACTOS	00065890	TAB	EA
ACYCLOVIR (ZOVIRAX) PO : 800 MG	00381591	TAB	EA 13411-0183-06
ADMIXTURE FEE	03814527		EA 99999-9999-99
ADRIAMYCIN PFS 2MG/ML 100 ML VL	00003810	100 ML VIAL	EA 55390-0238-01*
ADVIL 400MG TABLET	00381200	TAB	EA 62584-0746-01
ADVIL 800MG TAB	03814582		EA 58864-0026-30
ADVIL SUSP 100MG/5ML	00382237	SML DOSE	EA 24385-0905-26

* = Non-formulary item

Add to My Meds

Medication Selection screen

4. Clinical Monitoring checks will be performed once the item is selected.
- If a Clinical Monitoring check is flagged, the **Clinical Monitoring** tab will be displayed first.
 - Once the clinical information has been viewed, select the **Medication** tab to continue.

Select Hospital Base Menu > Patient > New Orders > Order

Pharmacy - Non-IV Order (NEW ORDER) Evident Community Hospital Signed On Emp: SC Dept: 038

ALEXANDER BETTY L 358259 Age: 32Y Sex: F Ht: 08.00 in. Wt: 61.23 kg (135 lbs) CrCl: N/A Rm: 302-8

Save Save & Exit Copy Delete Restore Online Adjudication

Medication | RX Information | Clinical Monitoring | Stop History | RX Charge History | NDC History | Profile | Order History | Pend Ver History

Type	Partial Description	Override
DRUG INTERACTION	WARFARIN (COMADIN) 3MG TAB FLU VACCINE (FLUSSOR)	Major (n/a)
DRUG INTERACTION	WARFARIN (COMADIN) 3MG TAB FLU VACCINE (FLUSSOR)	Major (n/a)
DRUG INTERACTION	WARFARIN (COMADIN) 3MG TAB LEVOPLOXIN (LEVAQUIN) PREMI	Major (n/a)
FOOD INTERACTION	WARFARIN (COMADIN) 3MG TAB CRANBERRY JUICE	Major (n/a)
FOOD INTERACTION	WARFARIN (COMADIN) 3MG TAB FOSHEPHALATE	Major (n/a)
INTERVENTION/ADR	WARFARIN (COMADIN) 3MG TAB Possible Clinical Intervention	(n/a)
MISC. CHECK	WARFARIN (COMADIN) 3MG TAB Discontinued NDC number	(n/a)
REF. RANGE CHECK	Reference Range INR Unavailable	(n/a)
REF. RANGE CHECK	Reference Range PROTIME Unavailable	(n/a)

Sensitivity

Ready. Dose Calc Dose Info Check PSD

Clinical Monitoring

- Complete the order by clicking in the required field(s). Use the mouse clicker or <Tab> key to move from one field to the other. Each field will be described in detail on the following pages.

NOTE: Items that display fully or partially complete have been predefined. Required information will be listed in the bottom left-hand portion of the screen. Once all required fields have been completed, "Ready" will display.

Medication

Select Hospital Base Menu > Patient > New Orders > Order > Medication

The screenshot displays the 'Pharmacy - Non-IV Order (NEW ORDER)' interface for patient ALEXANDER BETTY L. The medication selected is WARFARN (COUMADIN) 3MG TAB. Key fields include:

- Medication Description:** WARFARN (COUMADIN) 3MG TAB
- Dose:** 3
- Unit:** MG
- Route:** ORAL
- Frequency:** DAILY
- Start Date:** 02/27/24
- Stop Date:** 02/28/24
- Physician:** ZETTS D
- Procedure Charge:** 0900
- POC Verified:** NS 003 COUMADIN 3MG BAL =

Non-IV Medication

- **Indication**

- If a PRN frequency is used, this will display the PRN Reason/Indication selected during Nursing or Physician Order Entry.
- If applicable, any Indication entered during Nursing or Physician Order Entry will display.

- **Dose**

- Default: Blank
- Options: 1 - 99999
- Usage: Dose denotes the strength of dose. Information should be entered exactly as the physician order reads. This information does not affect the amount charged.
 - Multiple or partial doses of an item should be entered as strength of dose. Further distinctions are made in the Instruction lines of the order.
 - Drugs with multiple ingredients or strengths are entered as the number of primary units to send in the *Dose* field.
 - Liquids are changed to the Dose to be dispensed and ML in the dosage unit.
 - When using the computer generated MAR, it is important to change the *Dose* and *Unit* to reflect the correct dosage. This is especially true if the dispensed unit is different from the dosage unit.
 - When this information is changed and the long description of the item has a colon, the information in *Dose* and *Unit* replaces the information after the colon in the description on the MAR.

EXAMPLE: Lasix 80MG, pharmacy only stocks Lasix 40MG. Lasix 40MG is selected and the dose of 80 is entered in the Dose field.

- **Unit**

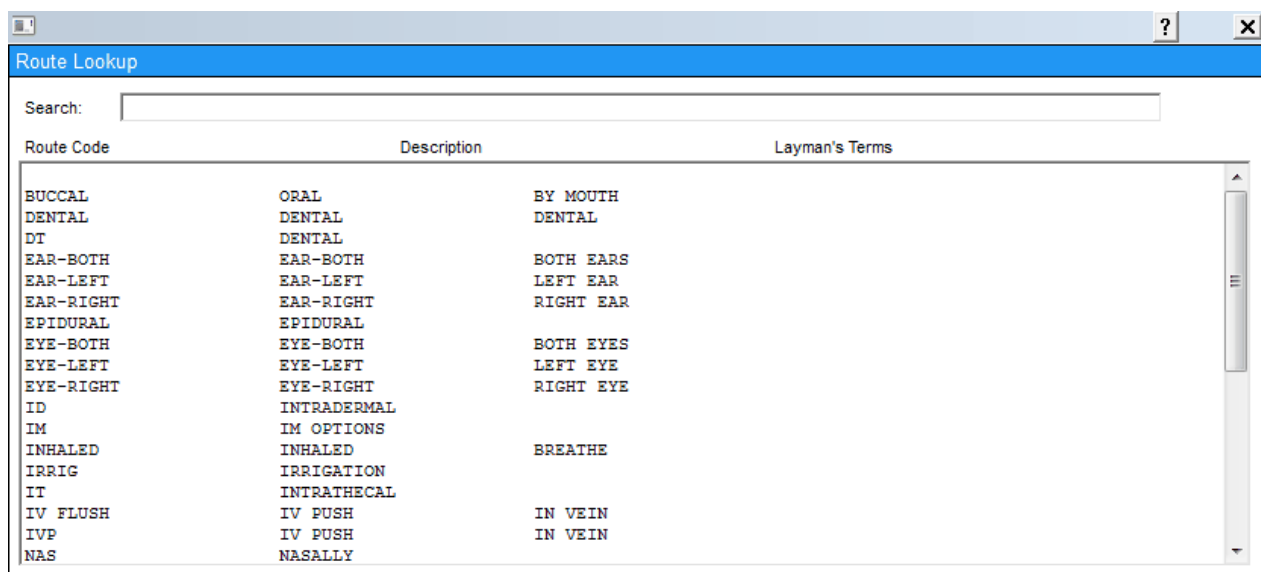
- Default: Blank
- Options: The Unit field accepts up to 20 alpha characters
- Usage: Unit denotes the dosage unit of the medication. Information should be entered exactly as the physician order reads. This information does not affect the amount charged.

- **Route**

- Default: Blank
- Options: Select a route from the Route Table.
- Usage: The Route field is a required entry field.
 - If a default route has been added to the Item Master, it will display in the *Route* field. Additional default routes are accessible by selecting the drop-down arrow.
 - The route table is accessible by selecting the drop-down arrow.
 - To search for a route in the table, enter a starting description and select **GO**. Double click the required route.
 - If the route needed does not appear, exit the Route Table. Add the route needed to the Route Table.

See [Pharmacy Setup](#) for further information on Route Table maintenance.

Select **Hospital Base Menu > Patient > New Orders > Order > Medication > Route > Route Table**



The screenshot shows a window titled "Route Lookup" with a search bar and a table. The table has three columns: "Route Code", "Description", and "Layman's Terms".

Route Code	Description	Layman's Terms
BUCCAL	ORAL	BY MOUTH
DENTAL	DENTAL	DENTAL
DT	DENTAL	
EAR-BOTH	EAR-BOTH	BOTH EARS
EAR-LEFT	EAR-LEFT	LEFT EAR
EAR-RIGHT	EAR-RIGHT	RIGHT EAR
EPIDURAL	EPIDURAL	
EYE-BOTH	EYE-BOTH	BOTH EYES
EYE-LEFT	EYE-LEFT	LEFT EYE
EYE-RIGHT	EYE-RIGHT	RIGHT EYE
ID	INTRADERMAL	
IM	IM OPTIONS	
INHALED	INHALED	BREATHE
IRRIG	IRRIGATION	
IT	INTRATHECAL	
IV FLUSH	IV PUSH	IN VEIN
IVP	IV PUSH	IN VEIN
NAS	NASALLY	

Route Lookup

- **Frequency**

- Default: Blank
- Options: Select a valid frequency from the Frequency Table.
- Usage: Denotes how often a medication can or should be administered.
 - Alternate frequencies are accessible by selecting the drop-down arrow.
 - The frequency table is accessible by selecting the drop-down arrow.

- To search for a frequency in the table, enter a starting description and select **GO**. Double click the required frequency.
 - If the frequency needed does not appear, exit the Frequency Table. Add the frequency needed to the Frequency Table.
 - Frequencies can be added or changed in the Frequency Table as needed. See [Pharmacy Setup](#) for further information.

NOTE: If the frequency is not clearly defined, more specific instructions should be entered in the instruction section of order maintenance.

- **Duration**

- Default: Doses
- Options: Number of Doses
- Usage: If not accessed, no particular duration will be assigned to the order.
 - This option can be utilized to specify if a medication is to be given only for a certain number of doses. The number of doses should be entered into the blank box.
 - The STOP Date and Time will calculate based on the Frequency and will update the Stop date and time field with a stop code of M. If using the Duration field with a PRN Frequency they system will count the number of administrations and when those match the number in the duration field once the last dose is administered via Patient Documentation the system will apply a STOP Date and Time with a stop code of D in the Stop date and time field. At that time the medication will turn BLACK on the eMar.

- **Priority**

- Default: Routine
- Options: Routine or STAT
- Usage: If STAT is selected, an additional X1 order will automatically be created. Upon selecting Save and Exit, two orders are created: the scheduled order and a X1 order.

- **Set Charge**

- Default: Blank
- Options: Item number of the set charge.
- Usage: Set Charge is only completed if the pharmacy charges an administration fee or charge for supplies. The line is left blank otherwise. A quick reference code can be set up in the Pharmacy Control Table to automatically pull a set charge into an order. (See [Pharmacy Setup](#) for further information.)

- **Procedure Charge**

- Default: Blank
- Options: Enter the item number for an administration fee or charge for supply charge, if applicable.
- Usage: Allows the pharmacy to charge a procedure fee. The line is left blank if the pharmacy does not charge a fee.

- **Brand**

- Default: Displays the short description of the item from the Item Master page 1.
- Options: If the brand name is appropriate, do not access the field.
- Usage: Change this line if the physician ordered a different brand by typing in the correct brand name.

- If the item has the short description switch set to "Y" in the Item Master, the brand description appears on the Review Active Orders screen and on some pharmacy reports.

- **1st Time Quantity**

- Default: Blank
- Options: Enter charge quantity or display last quantity charged
- Usage: The first time quantity is the amount needed before cart exchange or until the next cart fill. The first time quantity can include the amount taken from the pharmacy by a nurse (after hours) plus the amount needed before cart exchange.
 - The quantity in this line is the amount initially charged when the order is completed.
 - This amount, like the re-supply quantity, must be entered in primary units.
 - If the order is for a liquid that is charged by the ounce and a 4-ounce bottle is being dispensed, the first time quantity is 4. This amount prints on the label as the quantity issued. If the liquid is being charged by ML, the 1st time quantity is 120.

- **1st Time Labels**

- Default: Blank or default from Report Control Table
- Options: 1-99
- Usage: Default number of labels needed for OE and Employee prescriptions. The label prints to the designated printer after order completion. A label does not automatically print unless a charge is made. If more than one label is needed, enter the number of first time labels needed. For more information, refer to [Inpatient Labels](#)³¹².
 - If a charge is made, but a label is not needed, press the <Delete> key to remove the entry.
 - If a label is needed, but no charge is made, a quantity can be entered to cause a label to print without charging.

- **Resupply Quantity**

- Default: Blank
- Options: System calculates the supply quantity needed for a 24-hour cart refill.
- Usage: Resupply quantity indicates the quantity to be charged for and resupply in the medication carts for a 24-hour period. Quantities are entered and charged as primary units.
 - If an order is for 2 tabs TID, the resupply amount is 6. One tablet is the primary unit and six tablets need to be charged to provide the total daily dosage.
 - When printing the Cart Fill or Catch-Up List, the system asks for the number of days to charge Cart Fill.
 - The number of days entered is multiplied by the resupply quantity in **Resupply Quantity**.
 - Entering a daily supply in **Resupply Quantity** of the order allows carts to be filled for varying resupply days.
 - For PRN and multiple dose orders, the resupply quantity field is blank.
 - The amount in **Resupply Quantity** charges every time the Charging Cart Fill List is printed.

NOTE: When using the Hours Between Doses or Days of the Week administration times, the re-supply quantity is calculated as the quantity per dose, not the quantity per cart fill.

- **1st Dose Date / Time**

- Default: Blank
- Options: 6-digit date and 4-digit military time
- Usage: Allows the date and time that the first dose should be given to be entered. Used when the scheduled time has passed but the dose needs to be scheduled for the current day.

- Make sure the date and time reflect the actual time the first dose is to be given whether or not it is before or after the time the order is being placed.
- Select the drop-down arrow to display a calendar with the current month. Click on the desired start date. Use the left and right arrows to advance to the next month(s) or back up to previous month(s).

EXAMPLE: The current time is 1100 and the order being entered has a DAILY frequency for 0900. The scheduled time has passed, so the order will not be scheduled on the MAR until 0900 the following day. The current date and 0900 can be entered in field 1st **Dose Date / Time** so that the order will display on the MAR for today.

- **Start Date / Time / Initials**

- Default: Current Date / Time
- Options: Enter to accept default date/time or enter future date, time and initials.
- Usage: This field is used to indicate the Start Date and Time of an order and the initials of the person entering the order. Future dates on orders can be reflected here also. Sites using Point of Care should not back date orders because the Electronic MAR will indicate a missed dose by nursing.
 - If the start date and time is correct, press <Enter> through this field. System defaults to the current date and time.
 - Select the drop-down arrow to display a calendar with the current month. Click on the desired start date. Use the left and right arrows to advance to the next month(s) or back up to previous month(s).
 - Initials pull automatically if Employee Sign-on is switched to Y in the Pharmacy Control Table. If switched to N, enter 3 initials. Initials print on the label and remain as a permanent part of the order.

- **Stop Date / Time / Initials / Code**

- Default: Blank
- Options: Enter stop date/time, initials and stop code.
- Usage: This field is used to reflect the date an order has been stopped or will stop and the initials of the person entering the stop information. Stop codes indicate the reason an order has been or will be stopped.
 - Select the drop-down arrow to display a calendar with the current month. Click on the desired start date. Use the left and right arrows to advance to the next month(s) or back up to previous month(s).
 - Acceptable stop codes and their definition are as follows.

C = Copied Forward

D = Discontinue

E = Error

A = Physician Re-order

T = Take Home

1 = One Time

X = Transfer

M = Max (Max dose)

- **Instructions**

- Default: Blank
- Options: Both lines are a total of 65 characters - 25 characters in the first portion and 40 in the second.
- Usage: Allows detailed instructions of an order. Some routes of administration, such as PO, IM, or IVP orders, usually require detailed instructions. Decreasing dose orders normally require further instructions.

- Use this line to clarify the order, dose, or drug name.
 - To edit one instruction line, click in the desired line and over type, or press the <Delete> key to remove all information in the line.
 - The label breaks the line at the same place where it is broken on the screen.
- **Physician**
 - Default: Admitting Physician
 - Options: Enter prescribing physician.
 - Usage: Allows the ability to track prescribing physician. The admitting physician will display by default. To enter the prescribing physician, click in the **Physician** field and type the name using the keyboard. You can also click the lookup option and select the physician from the Physician's table.
 - **Standard Times**
 - Default: Blank
 - Options: Yes (✓) or No (Blank)
 - Usage: If the frequency is defined, standard times are the default and the appropriate administration time(s) are pulled into the order.
 - **Non-Standard Times**
 - Default: Blank
 - Options: Yes (✓) or No (Blank)
 - Usage: If the frequency is defined, but standard time(s) are not appropriate for the order, non-standard times can be entered. Up to 24 dosage times can be entered in military format.
 - **Hours Between Doses**
 - Default: Blank
 - Options: Yes (✓) or No (Blank)
 - Usage: Used for IV orders to define the hours between doses. The system calculates the next administration time based on the first dose date / time and the number of hours between doses. The system can accommodate frequencies greater than 7 days; for example, 10 days would be 240 hours.
 - **Days of the Week**
 - Default: Blank
 - Options: Yes (✓) or No (Blank)
 - Usage: Used for orders that are to be given on a specific day or days of the week. Click on each day of the week to select. Click again to deselect.

NOTE: When the Days of the Week or the Hours Between Doses option is chosen, the administration time is based on the start date and time. For this reason, it is imperative that the start date and time information be entered correctly.

Select **Hospital Base Menu > Patient > New Orders > Select the medication > Medication > Dose Info**

The screenshot displays the Pharmacy Selection Screen for Warfarin (Coumadin) 3MG TAB. The interface includes a top navigation bar with 'Thrive UX', 'Help', and 'CPSI System'. The patient information section shows 'ALEXANDER BETTY L' with ID 358259, Age 32Y, Sex F, Height 68.00 in, Weight 61.23 kg (135 lbs), CrCl: N/A, and Room 302-8. The medication details section shows 'WARFARIN (COUMADIN) 3MG TAB' with Item Number 3814567. The 'Dose Info' button is highlighted in red at the bottom right of the screen.

Dose Info

- The Date/Time/Initials of the staff entering the order will display in the lower right-hand portion of the screen.
- For facilities using the Point of Care application, the Date/Time/Initials of the staff verifying the order will also display in the lower right-hand.
- For facilities that have purchased an interface for an Automated Dispensing Machine, the nursing station balance will display.
- **Dose Info:** Select this option to view dosing information via the Micromedex® Website for the selected medication.

NOTE: IV orders with multiple components display dosing information for the first component of the IV.

[See entire document](#)

Warfarin Sodium

DrugPoint® Summary

[View Detailed information in DRUGDEX](#)

Dosing & Indications

Adult Dosing

[View Detailed information in DRUGDEX](#)

- in general, the recommended target INR is 2.5 (range, 2 to 3), according to the American College of Chest Physicians guidelines^[4]; an INR greater than 4 does not provide greater efficacy in most patients and increases the risk of bleeding^[5]
- Atrial fibrillation - Thromboembolic disorder: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day^[6]
- Atrial fibrillation - Thromboembolic disorder; Prophylaxis: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day^[6]
- Myocardial reinfarction; Prophylaxis: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day^[6]
- Percutaneous transluminal coronary angioplasty: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day
- Prosthetic cardiac valve component embolism: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day^[6]
- Prosthetic cardiac valve component embolism; Prophylaxis: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day^[6]
- Prosthetic cardiac valve component embolism; Prophylaxis: (bioprosthetic mitral valve) target INR 2.5 (range, 2 to 3) for the first 3 months after valve insertion (ACCP guidelines)^[7]
- Prosthetic cardiac valve component embolism; Prophylaxis: (mechanical heart aortic valves) target INR of 2.5 (range 2 to 3) (ACCP guidelines)^[7]
- Prosthetic cardiac valve component embolism; Prophylaxis: (mechanical mitral valve, mechanical heart valves, or both, caged ball or caged disk valves) target INR of 3 (range 2.5 to 3.5)^{[7][8]}
- Pulmonary embolism: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day^[6]
- Pulmonary embolism; Prophylaxis: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day^[6]
- Thrombosis, Post myocardial infarction; Prophylaxis: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day^[6]
- Venous thromboembolism: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day^[6]
- Venous thromboembolism; Prophylaxis: initial, 2 to 5 mg ORALLY/IV once a day; adjust dose based on the results of INR; usual maintenance, 2 to 10 mg ORALLY/IV once a day^[6]

Micromedex Dosing Screen

- **Dose Calc:** Select this option to launch the dose calculator. See [Dose Calculator](#)^[64] for more information.

The following options will display on the action bar at the top of the screen:

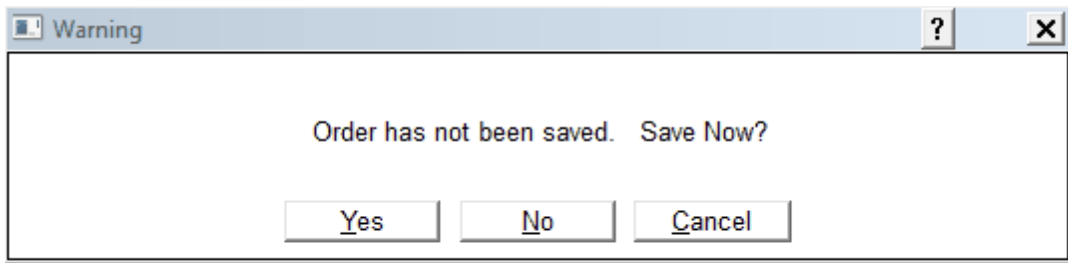
- Once the order is completed, **Save** may be selected without exiting the order.
 - The order will become a part of the patient's Pharmacy Profile.
 - 1st Time Quantity charges will be processed.
 - The requested number of Labels will print.

NOTE: This option is useful for facilities utilizing Online Adjudication as a charge may be posted to the account without exiting the order. The claim may then be transmitted to a third-party vendor.

- After all required fields have been addressed, select **Save & Exit** to process the order and return to the pharmacy formulary lookup screen.
 - The order will become a part of the patient's Pharmacy Profile.
 - 1st Time Quantity charges will be processed.
 - The requested number of Labels will print.
- If changes need to be made to an order, select **Copy** to discontinue the order and create a new duplicate order that may be modified.
- If the order was entered in error, select **Delete** to remove the order. This may only be used prior to saving the order.

- **Restore** may be selected to restore an order to its original condition.
- If an attempt is made to exit the order without saving or deleting, a warning will display.
 - Select **Yes** to save and exit the order.
 - Select **No** to exit without saving the order.
 - Select **Cancel** to remain on the current screen.

Select **Hospital Base Menu** > **Select Patient** > **Pharmacy Selection Screen** > **New Orders** > select **order** > **Medication Tab** > **Exit** > **Save Warning**



Order Save Warning

Dose Calculator

NOTE: The Order Entry application is required to access Dose Calculator. Order Entry is a default application for the Pharmacy Role. Please refer to the [Identity Management User Guide](#) for more information.

The Dose Calculator may be used to calculate the administer dose and administer amount for non-IV medications using a mg/kg formula.

NOTE: An item must be set up with a valid NDC and MG (in Other Units on Pharmacy Information Page 1) for the Dose Calculator to be enabled. The Dose Calculator may not be utilized with combination medications such as Norco.

Select Hospital Base Menu > Patient > New Orders > Medication

The screenshot shows the 'Pharmacy - Non-IV Order (NEW ORDER)' interface. At the top, it identifies the patient as SIMS PHILLIP ANDREW, 5 years old, male, 30.00 inches tall, and 7.71 kg (17 lbs) weight. The medication being ordered is ACETAMINOPHEN ELIXIR (TYLENOL) 160MG/5ML, with an item number of 382012. The order is for a PO (oral) route with a frequency of PRN Q4H. The 'Dose Calc' button is highlighted in red at the bottom right of the screen.

Dose Calculator

Select **Dose Calc** to launch the Dose Calculator screen. If the patient's weight is missing, the Vital Signs screen will open.

Select Hospital Base Menu > Patient > New Orders > Medication > Dose Calc

Vital Signs/Height/Weight/O2 Therapy Entry
Date/Time: 03/15/2016 10:11

Vital Signs
 Temperature: Fahrenheit Site:
 Celsius
 Pulse: Site:
 Respiration:
 Blood Pressure
 Systolic: Position:
 Diastolic: Site:
 Pain Scale:

Height/Weight
 Height/Length: Inches
 Centimeters
 Weight: Pounds
 Ounces
 Kilograms
 Grams
 Scale:

Miscellaneous
 Glucose Level: Level: Low High No BG Not Addressed
 Type:
 Method:


O2 Therapy
 O2 Sat: %
 O2 Method:
 O2 L/M:
 FIO2:

BMI:
 BSA:
 Head Circumference: Centimeters
 Inches

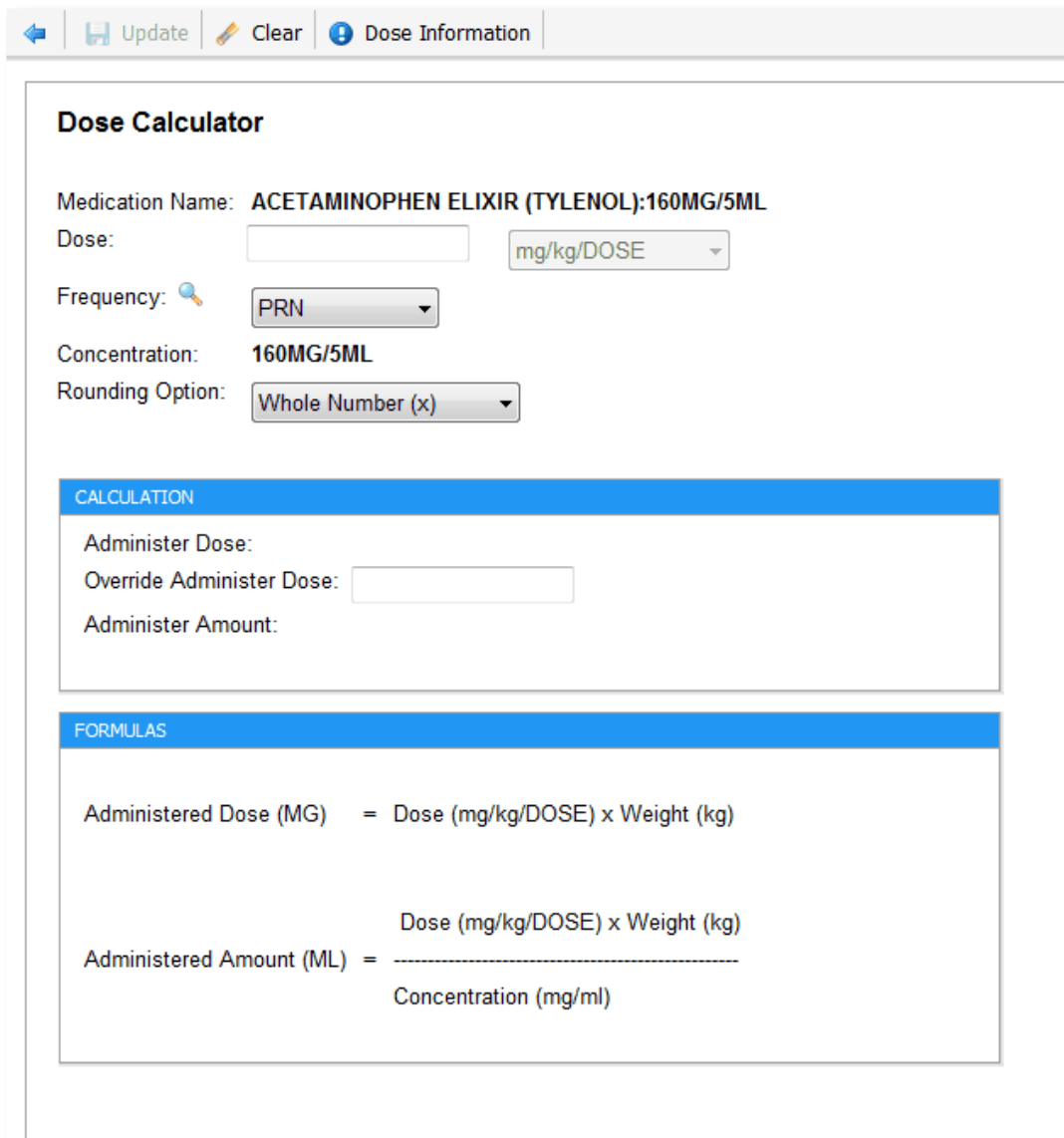
Vitals screen

Weight and scale must be entered in order to utilize the Dose Calculator. If weight is not known,



select  (beside the patient's name) to exit the screen and return to order entry. The dose must be manually entered. Select **Update** to save the information and proceed to the Dose Calculator screen.

Select **Hospital Base Menu > Patient > New Orders > Medication > Dose Calc > Enter weight and scale > Update**



Dose Calculator

Medication Name: **ACETAMINOPHEN ELIXIR (TYLENOL):160MG/5ML**

Dose: mg/kg/DOSE

Frequency: PRN

Concentration: **160MG/5ML**

Rounding Option: Whole Number (x)

CALCULATION

Administer Dose:

Override Administer Dose:

Administer Amount:

FORMULAS

Administered Dose (MG) = Dose (mg/kg/DOSE) x Weight (kg)

Administered Amount (ML) = $\frac{\text{Dose (mg/kg/DOSE)} \times \text{Weight (kg)}}{\text{Concentration (mg/ml)}}$

Dose Calculator

The Dose Calculator screen displays with the following:

- **Medication Name:** This field displays the Item Master **Description** for the ordered medication.
- **Dose:** Enter the formula in mg/kg that will be used to calculate the dose. The default unit is mg/kg/DOSE if the frequency is X1 or PRN and mg/kg/day for all other frequencies.
- **Frequency:** This field will default to the frequency predefined on the item. Other options include:
 - The magnifying glass icon may be selected to choose from the frequency table.
 - The drop-down menu may be used to select one of the Acceptable Frequencies available on the item.

- **Concentration:** This field displays the amount of medication per volume provided by Truven® and is based on the NDC number on page 1 of Pharmacy Information.
- **Rounding Option:** This field defaults to whole number. Other options are one decimal (x.x) place and two decimal (x.xx) places.

The **Administer Dose** and **Administer Amount** fields will display the calculated Dosage/Unit of the medication.

The screenshot shows a web-based "Dose Calculator" interface. At the top, there are navigation buttons: a back arrow, "Update", "Clear", and "Dose Information". The main content area is titled "Dose Calculator" and contains the following fields:

- Medication Name:** ACETAMINOPHEN ELIXIR (TYLENOL):160MG/5ML
- Dose:** 1 (input field) with a dropdown menu set to "mg/kg/DOSE"
- Frequency:** PRN (dropdown menu)
- Concentration:** 160MG/5ML
- Rounding Option:** Whole Number (x) (dropdown menu)

Below the input fields, there are two sections:

- CALCULATION:**
 - Administer Dose: 8 MG
 - Override Administer Dose: (empty input field)
 - Administer Amount: 0 ML Elixir
- FORMULAS:**
 - Administered Dose (MG) = Dose (mg/kg/DOSE) x Weight (kg)
 - Administered Amount (ML) = $\frac{\text{Dose (mg/kg/DOSE) x Weight (kg)}}{\text{Concentration (mg/ml)}}$

A red error message is displayed next to the Administer Amount: "Administer amount must be greater than 0."

Dose Calculator

If the Administer Amount is less than zero, a message will display, "Administer amount must be greater than 0." In this case, the Rounding Option may be adjusted to display more digits to the right of the decimal point.

The **Override Administer Dose** field defaults to blank and may be edited to enter a different dose from the calculated Administer Dose field above. The dose value may be entered in **MG** with the format xxxx.xxxx in numeric characters.

The Formulas section will display the formula that is being used to calculate the dose. The Formula box will change based on the selected units from the drop-down.

If the units selected are mg/kg/day:

$$\text{Administer Dose (MG)} = \frac{\text{Dose(mg/kg/day)} \times \text{Weight (kg)}}{\text{Frequency}}$$

$$\text{Administer Amount (ML)} = \frac{\text{Dose(mg/kg/day)} \times \text{Weight (kg)}}{\text{Concentration (mg/ml)} \times \text{Frequency}}$$

If the units selected are mg/kg/DOSE:

$$\text{Administer Dose (MG)} = \text{Dose(mg/kg/DOSE)} \times \text{Weight (kg)}$$

$$\text{Administer Amount (ML)} = \frac{\text{Dose(mg/kg/DOSE)} \times \text{Weight (kg)}}{\text{Concentration (mg/ml)}}$$

← Update Clear Dose Information

Dose Calculator

Medication Name: ACETAMINOPHEN ELIXIR (TYLENOL):160MG/5ML

Dose:

Frequency:

Concentration: 160MG/5ML

Rounding Option:

CALCULATION

Administer Dose: 77 MG

Override Administer Dose:

Administer Amount: 2 ML Elixir

FORMULAS

Administered Dose (MG) = Dose (mg/kg/DOSE) x Weight (kg)

Administered Amount (ML) = $\frac{\text{Dose (mg/kg/DOSE) x Weight (kg)}}{\text{Concentration (mg/ml)}}$

Dose Calculator

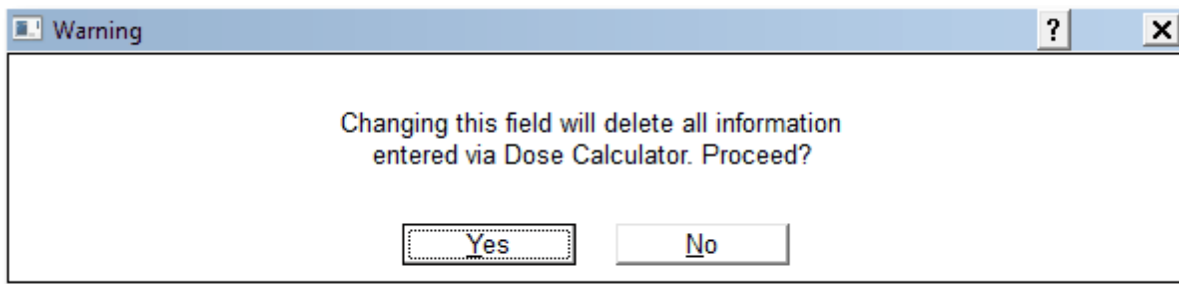
Once all information has been entered and **Update** is selected, the Non-IV Order screen will display.

Non-IV Order Dose Calc

The Dose and Unit fields will be updated with the calculated Administer Dose. If an Override Administer Dose was entered, the Dose/Unit will be updated with the Override Administer Dose.

The Frequency field will be updated with the frequency entered via the Dose Calculator and the appropriate Standard times. If the Dose Calculator was used, the Priority drop-down will be disabled as STAT may not be used with the Dose Calculator feature.

If a change is made to the Dose, Unit, Frequency, Scheduled Date/Times, Hours between Doses or Days of the Week fields, a warning prompt will display with the message, "Changing this field will delete all information entered via Dose Calculator. Proceed? Yes; No". If **Yes** is selected, the information in the Dose Calculator will be cleared. If **No** is selected, the order will not change and the Dose Calculator record will remain.



Warning

The calculated Administer Amount will display for nursing via the Updated EMAR Order Detail screen. See [Updated EMAR/MedVerify User Guide](#) for more information.

Rx Information

Medication orders on a patient profile can be labeled for home use.

1. From the Pharmacy Selection Screen, select **Pharmacy Profile**.

2. Select the medication order that is to be sent home.
3. Address the stop date and time.

NOTE: Enter a (.) period to set the date and time to the current date and time.

4. Type capital **T** for the Take Home stop code and press <Enter>.
 - The user is automatically taken to the RX Information tab.
 - An **RX Number** is automatically assigned.

Select **Hospital Base Menu > Patient Account# > Pharmacy Profile > Order**

The screenshot shows the 'Pharmacy - Non-IV Order (Order #11) (Modified)' window for patient AINSWORTH MARTHA COZEN. The medication is COMBIVENT MDI (Item Number 3866679). The 'Stop Date' field is highlighted in red, showing '11/19/15' and '09:21'. The 'Code' field contains 'T'. The 'Dose' is 2 PUFFS, inhaled, PRN EVERY 6 HOURS. The 'Brand' is COMBIVENT INH. The 'Physician' is SMITH JAME. The 'Entered' date and time are 11/19/15 09:19. The 'POC Verified' field shows 'NS 003 COMBIVENT INH BAL ='. The 'Ready' button is at the bottom left, and the 'Dose Info' button is at the bottom right.

Take Home medication

5. Complete any other required fields.
 - The label will print in the outpatient label format.

Select Hospital Base Menu > Patient > New Orders > Order > RX Information

RX Information

NOTE: Instructions on how to complete prescription information will be discussed later in this chapter. Refer to the Long Term Care / Prescription section of this chapter for further details.

Clinical Monitoring

TruBridge has contracted with Truven Health Analytics/Micromedex® Solutions for clinical monitoring. Updates will be automatically transmitted each month. The clinical monitoring files will then automatically load with the next backup unless Change Management is utilized. This transmission will go to all facilities that have purchased clinical monitoring.

Clinical monitoring is based on the NDC number and is performed on all medication orders. If one or more clinical monitoring checks are found, the Clinical Monitoring screen will display first. This will create a Clinical Monitoring trigger that will be recorded as audit-worthy events and may be viewable via the Patient Audit Log report. The following clinical monitoring checks may be performed based on the set up in the Clinical Monitoring Control Tables:

Allergy Checks, Duplicate Therapy Checks, Drug-Disease Interactions, Drug Interaction Checks, IV Compatibility Checks, Food Interaction Checks, Intervention / Adverse Drug Reaction Checks, Reference Range Checks, General Precaution Checks, Patient Specific Dosing Checks, and Miscellaneous Checks.

1. Double-click on the desired clinical monitoring check to display additional information.

NOTE: To bypass clinical monitoring and continue the order entry process, select the Medication tab.

Select Hospital Base Menu > Patient > New Orders > Select Order > Clinical Monitoring

Type	Partial Description	
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : Asthma	High Risk/Relative C
DRUG DISEASE	ALBUTEROL INH SOL .083% 3ML PROPRANOLOL (INDERAL) TAB :	*High Risk/Relative C
DRUG DISEASE	ALBUTEROL INH SOL .083% 3ML PROPRANOLOL (INDERAL) TAB :	*High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : HYDROMORPHONE (DILAUDID) INJ:	*High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : NORCO 7.5MG - 325MG TAB	*High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : ALBUTEROL INH SOL .083% 3ML	*High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : NORMAL SALINE 1000 ML	*High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : ALBUTEROL INH SOL .083% 3ML	*High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : ALBUTEROL INH SOL .083% 3ML	*High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : ALBUTEROL INH SOL .083% 3ML	*High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : ALBUTEROL INH SOL .083% 3ML	*High Risk/Relative C
DRUG DISEASE	Insulin REG (Humulin R) 100U PROPRANOLOL (INDERAL) TAB :	*High Risk/Relative C
DRUG INTERACTION	ALBUTEROL INH SOL .083% 3ML PROPRANOLOL (INDERAL) TAB :	Major
DRUG INTERACTION	Insulin REG (Humulin R) 100U PROPRANOLOL (INDERAL) TAB :	Moderate

Clinical Monitoring

NOTE: Allergy Checks and **Major Drug Interaction Checks** will be highlighted red. **Abnormal Reference Range Checks** will be highlighted in yellow.

- Some clinical monitoring checks will provide monographs that contain even more clinical data. A hard copy of this information can be obtained by selecting **Print Monograph**. To view the information on screen, select **View Monograph**.

Select Hospital Base Menu > Patient > New Orders > Order > Clinical Monitoring > Interaction

DRUG - DRUG

54569-3899-00 Albuterol Sulfate [ALBUTEROL INH SOL .083% 3ML]

54868-1442-02 Propranolol Hydrochloride [PROPRANOLOL (INDERAL) TAB : 20 MG]

ONSET: Not specified SEVERITY: Major DOCUMENTATION: Fair

Concurrent use of BETA-ADRENERGIC BLOCKERS and BETA-2 AGONISTS may result in severe bronchospasm and decreased effectiveness of the beta-2 agonist.

Buttons: Quit, ADR, Intervention, Print Monograph, View Monograph, OK

Clinical Monitoring

The following options are available:

- **Quit:** To cancel the order entry process.

- **ADR:** To document an Adverse Drug Reaction for this medication.
- **Intervention:** To document a Clinical Intervention performed in relation to the medication ordered.
- **Print Monograph:** Allows printing of a personalized patient drug monograph.
 - **NOTE:** *The monograph will default to the Drug Info printer loaded in the Pharmacy Control Table. Refer to [Pharmacy Setup](#).*
- **View Monograph:** Allows viewing of the drug monograph
- **OK:** To return to order entry not acting on the warning.

Clinical Monitoring updates are transmitted monthly to facilities' servers via auto-distribution. The clinical monitoring files will automatically load with the next backup.

NOTE: *Clinical monitoring checking is controlled by switches located in the [Clinical Monitoring Control Table](#).*

Clinical monitoring is automatically performed at order entry and order verification. Allergy, Drug Interaction and Reference Range checks are hard-coded and may not be disabled. Duplicate Therapy, Food Interaction, Disease Interaction, General Precaution, IV Compatibility (utilizing Trissels IV compatibility), and Patient Specific Dosing checks are available if desired. If an order is processed, the clinical monitoring checks are saved and accessible at any time via **Clinical Monitoring**.

Allergy Checks

Allergy checking occurs at time of order entry. For Allergy Checks to be performed, items must have a valid NDC number entered via Pharmacy Information. Allergy checks are performed using the NDC number or an Allergen Code pulled from Micromedex. See the [Pharmacy Setup](#) User Guide for more information on adding an NDC number to an item.

The allergy checking mechanism looks at the patient account and checks the selected medication against existing allergies. If there are no allergies listed on the account, na will display in red.

To enter an allergy on a patient:

1. From the Pharmacy Selection screen, select **Clinical Information Changes or Allergy Review**.
2. Select the **Allergies** tab.
3. Enter the first few characters of an allergy and press <Enter>.
 - An allergy lookup displays:
 - Scroll up or down to find the correct allergy.
 - Double click the allergy to accept the first allergy in the list.
 - All Clinical Monitoring checks detected for a patient are displayed under the Clinical Monitoring screen.

Select Hospital Base Menu > Patient > Clinical Information Changes > Allergies

The screenshot shows a software interface for 'Pharmacy - Clinical Information' at Evident Community Hospital. The patient is AINSWORTH MARTHA COZEN, ID 357823, aged 80Y, female, 60.00 in tall, 54.43 kgs weight, CrCl 39.84, Room 300-9. The 'Allergies' tab is active, displaying a table with the following data:

Priority	Allergy	Reaction(s)	Severity	Type	Added	Entered By
1	Codeine	Itching; Blisters	Normal	DRUG	10/06/2015 10:38:42	FT
2	Eggs	swelling	Major	CLASS	11/04/2015 09:39:09	FT
3	Peanuts	Anaphylaxis	Major	FOOD	11/04/2015 09:39:40	FT

Buttons for 'Add Allergy Data', 'Allergy History', and 'Remove Allergy' are visible at the bottom of the window.

Clinical Information - Allergies

4. Select the Clinical Monitoring check to view from the list. Allergy checks and major interactions will appear highlighted red.

Select Hospital Base Menu > Patient > Clinical Monitoring

Type	Partial Description
ALLERGY CHECK	NORCO 7.5MG - 325MG TAB CODEINE
DRUG DISEASE	NORCO 7.5MG - 325MG TAB Asthma Contraindication
DRUG DISEASE	NORCO 7.5MG - 325MG TAB Chronic Obstructive Pulmonar Contraindication
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : NORCO 7.5MG - 325MG TAB *High Risk/Relative C
DRUG INTERACTION	HYDROMORPHONE (DILAUID) INJ: NORCO 7.5MG - 325MG TAB Major
MISC. CHECK	NORCO 7.5MG - 325MG TAB Discontinued NDC number

Clinical Monitoring Checks

5. To select the Clinical Monitoring information, double click the appropriate line.

Select Hospital Base Menu > Patient > Clinical Monitoring > Type

DRUG - ALLERGY

52544-0729-01 Hydrocodone Bitartrate [NORCO 7.5MG - 325MG TAB]

ALLERGY: Allergen 7700100 - CODEINE

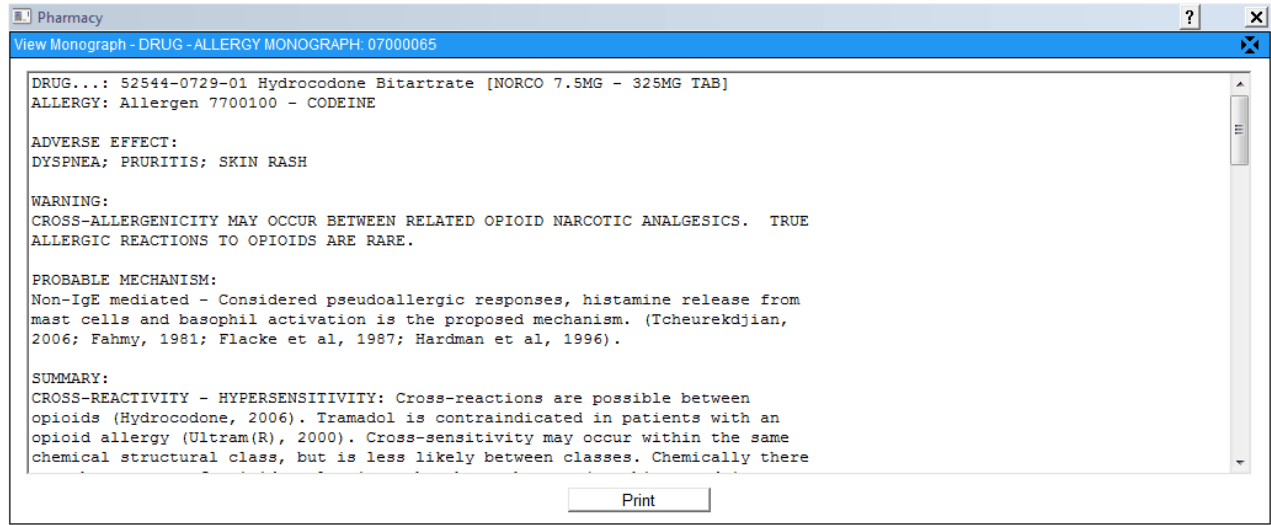
CROSS-ALLERGENICITY MAY OCCUR BETWEEN RELATED OPIOID NARCOTIC ANALGESICS. TRUE
ALLERGIC REACTIONS TO OPIOIDS ARE RARE.

Prior Adverse Reaction:
Itching
Blisters

Clinical Monitoring Checks

6. To display or print clinical information pertaining to the allergy, select **View Monograph**.

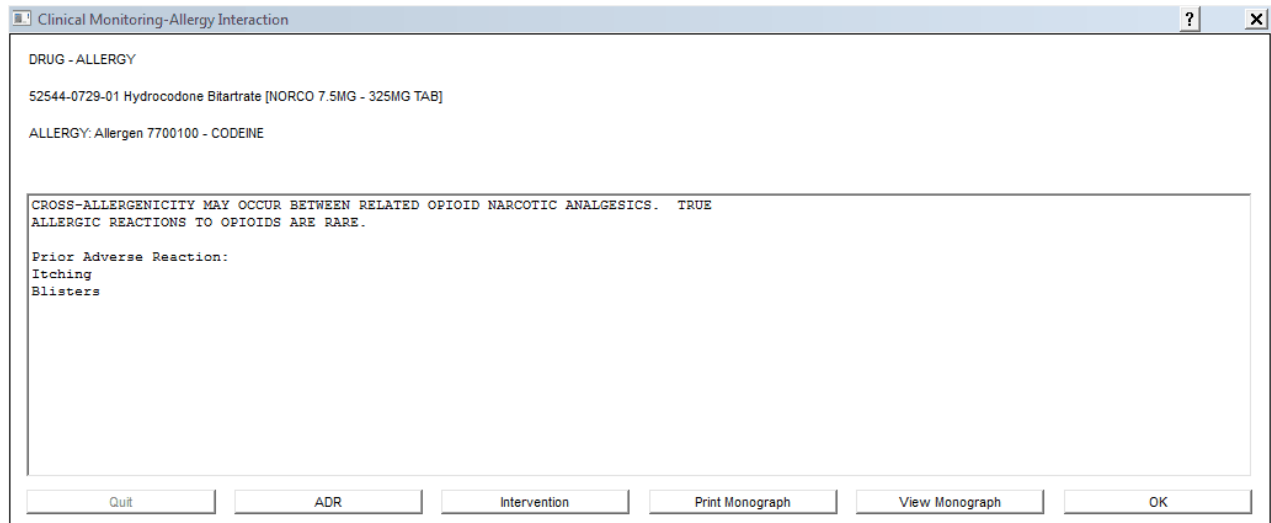
Select Hospital Base Menu > Patient > Clinical Monitoring > Drug Allergy > View Monograph



Monograph

7. Select **Print** and the monograph information will print to the default printer for the device.
8. Select the "X" in the top right to close out the monograph information

Select Hospital Base Menu > Patient > Clinical Monitoring > Drug Allergy



Allergy Monograph Display

Other options are as follows:

- **"X" / Exit:** Return to order entry without acting on the warning.
- **Quit:** Cancel the order.

- **ADR:** Document an Adverse Drug Reaction for this medication.
- **Intervention:** Document a Clinical Intervention performed in relation to the medication ordered.
- **Print Monograph:** Print the drug monograph information.
- **OK:** Return to the Clinical Monitoring display.

NOTE: When an order is placed for an item containing a combination of drugs, each active ingredient is checked against patient allergies.

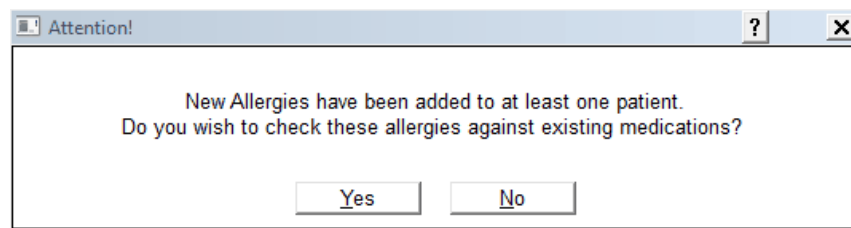
EXAMPLE: The system checks both Acetaminophen and Hydrocodone when an order is placed for Norco®.

Allergy Checking Messages

If new allergies are added to a patient profile from another department, such as nursing services, a notification will display via the Hospital Base Menu. This notification displays once a pharmacy employee signs on, or when returning to the Hospital Base Menu. This notification will only display for patients assigned to a room and that have existing pharmacy orders.

NOTE: This notification will not display if allergies are entered from the Pharmacy department.

Select **Hospital Base Menu** > **New Allergy Message**



Allergy Checking

1. Select **Yes** to check new allergies against existing medications. If **No** is selected, the new allergies are not reviewed.
 - It is important to note that this message continues to appear until these allergies (and any allergies added thereafter) have been reviewed.
 - It is required that the pharmacy review all allergies entered on a patient.
 - This feature is a critical step to ensuring that the pharmacy is aware of all patient allergies.
2. Select **Yes** to view the newly added allergies.
 - Displays patients with their newly added allergies.
 - Each patient and allergy appears on a single line with a corresponding sequence number.
3. Allergies can be checked one at a time by selecting the corresponding sequence number or select "**A**" to check for all patients at one time.

- Options are as follows:
 - Back Arrow:** Stops the review process. The new allergy message will continue to display.
 - PgDn:** Displays the next page of allergies if more than 20 new allergies have been added.
 - “A”II:** To check patient profiles and compare existing medication orders against new allergies for all displayed patients.

Select **Hospital Base Menu > New Allergy Message > Yes**

Patient Number	Patient Name	Allergy
356012	ROBERTS ESTELLE	PRILOSEC
963963	ODOM CONNIE	CIPRO

Allergy Checking

- If an allergy is detected the Clinical Monitoring Checks screen displays.
 - Allergies are checked for both active and discontinued medications.
 - The order for the medication in question displays.
 - Allows any necessary action to be taken on the medication order.

NOTE: The process is different for patients who do not have an order for a medication that corresponds to a newly added allergy. Selecting the sequence number of the allergy removes it from the list. Performing this step acknowledges that pharmacy has reviewed the allergies.

Drug Interaction Checks

The Pharmacy Drug Interaction Module detects drug-drug interactions. Micromedex® provides the drug interaction database along with monthly updates. Interaction checks are performed based upon item NDC number. The interaction monographs provided can be viewed and printed as needed. The system uses NDC numbers to perform drug interaction checks. All items in the Item Master must have their correct NDC number for the Drug Interaction Module to function optimally. The medication name and the message, “Unknown NDC Number Entered”, appears if the NDC number is missing or is incorrect. This message appears under Miscellaneous Checks on the Clinical Monitoring Checks screen.

NOTE: See [Pharmacy Setup](#) for more information on adding an NDC number to an item.

Drug Interactions

Drug interaction checks are provided during Non-IV and IV Order Entry. The Clinical Monitoring Checks screen appears when the medication is chosen. All Clinical Monitoring Checks are performed at this time.

NOTE: Medications discontinued within the preceding 24 hours are checked for drug interactions.

1. Select **Drug Interaction** by double clicking on the appropriate line to view drug interactions. Allergy checks and major interactions will display highlighted red.

Select Hospital Base Menu > Patient > Clinical Monitoring

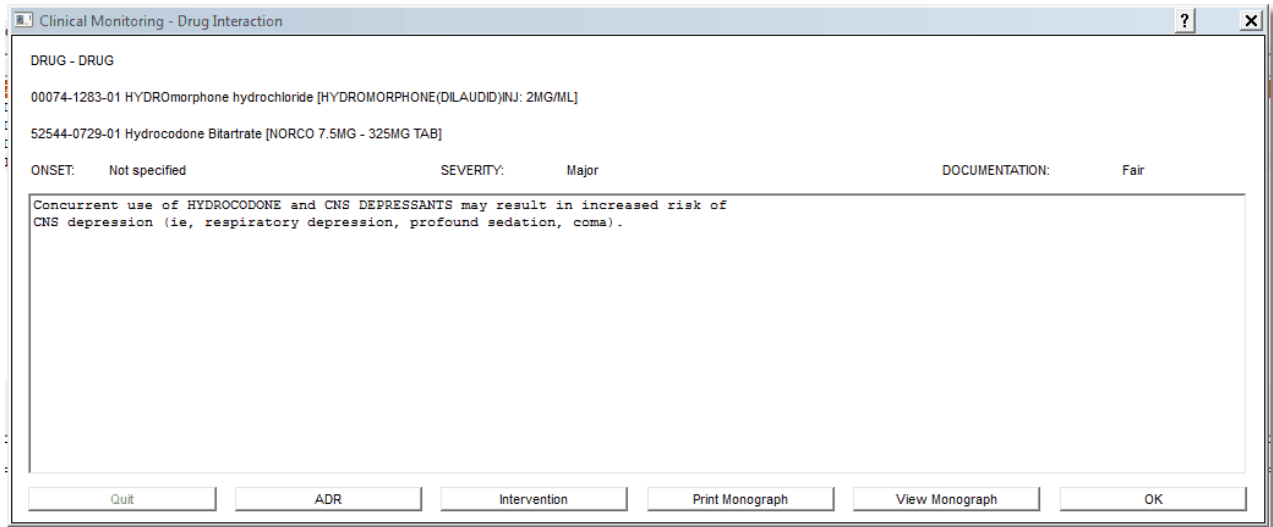
The screenshot displays the 'Clinical Monitoring' tab for patient AINSWORTH MARTHA COZEN. The patient's demographic information is shown at the top: 357823, Age: 80Y, Sex: F, Height: 60.00 in., Weight: 54.43 kgs, CrCl: 39.84, Room: 300-9. The 'Clinical Monitoring' section contains a table with the following data:

Type	Partial Description
ALLERGY CHECK	HYDROMORPHONE (DILAUDID) INJ: CODEINE
DRUG DISEASE	HYDROMORPHONE (DILAUDID) INJ: Asthma Contraindication
DRUG DISEASE	HYDROMORPHONE (DILAUDID) INJ: Chronic Obstructive Pulmonar Contraindication
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB : HYDROMORPHONE (DILAUDID) INJ: *High Risk/Relative C
DRUG INTERACTION	HYDROMORPHONE (DILAUDID) INJ: NORCO 7.5MG - 325MG TAB Major
MISC. CHECK	HYDROMORPHONE (DILAUDID) INJ: Discontinued NDC number

The 'ALLERGY CHECK' and 'DRUG INTERACTION' rows are highlighted in red. A 'Sensitivity' button is located below the table. The status bar at the bottom shows 'Ready' and a 'Dose Info' button.

Clinical Monitoring Checks

Select Hospital Base Menu > Patient > Clinical Monitoring > Interaction



Drug Interaction Checks

2. To display or print clinical information pertaining to the drug interaction, select **View Monograph**.
 - Other options are as follows:
 - **“X” / Exit** : To return to order entry not acting on the warning.
 - **Quit**: To cancel order entry.
 - **ADR**: To document an Adverse Drug Reaction for this medication on the patient.
 - **Intervention**: To document a Clinical Intervention performed in relation to the medication ordered.
 - **Print Monograph**: To print the monograph.
 - **OK**: To return to the Clinical Monitoring display.

Printer Setup For Drug Interaction Information

Drug interaction monographs print to the printer specified on the Pharmacy Control Information screen. Monographs printed to a workstation or a line printer must be printed on plain paper.

1. From the Hospital Base Menu, select **Dept Specific**.
2. Select **Pharmacy Control Information**.
3. Select **Drug Intr/Alg Printer**.
 - Enter the Line Printer number for a line printer.
 - Enter <S> for a Workstation printer.

Duplicate Therapy

The TruBridge EHR automatically screens new orders for duplication of therapy. The system reviews the current patient orders and warns if the patient is receiving a similar medication. Both IV and Non-IV orders are checked for duplicate therapy. The duplicate therapy check is based upon the NDC number. All items must have a valid NDC number entered on the Pharmacy Information screen.

NOTE: The Pharmacy Control Table contains a switch to enable or disable Duplicate Therapy Checking. Duplicate Therapy Checking may also be disabled per item. See [Pharmacy Setup](#) for more information.

Duplicate Therapy detected for a patient is displayed under **Duplicate Therapy** on the Clinical Monitoring Checks screen.

Select **Duplicate Therapy** by double clicking on the appropriate line to view duplicate therapy.

Select **Hospital Base Menu > Patient > Clinical Monitoring**

The screenshot displays the 'Clinical Monitoring Checks' window for patient AINSWORTH MARTHA COZEN. The window includes a menu bar with options like 'Medication', 'RX Information', 'Clinical Monitoring', etc. Below the menu is a table of clinical monitoring checks. One row is highlighted in yellow, indicating a duplicate therapy warning:

Type	Partial Description	Override
DRUG DISEASE	HYDROCHLOROTHIAZIDE (HCTZ) TAB NORMAL SALINE 1000 ML	*Contraindication {n/a}
DRUG DISEASE	HYDROCHLOROTHIAZIDE (HCTZ) TAB NORMAL SALINE 1000 ML	*High Risk/Relative C {n/a}
DRUG DISEASE	Insulin REG (Humulin R) 100U HYDROCHLOROTHIAZIDE (HCTZ) TAB	*Possible Risk {n/a}
DRUG INTERACTION	HYDROCHLOROTHIAZIDE (HCTZ) TAB Insulin REG (Humulin R) 100U	Moderate {n/a}
DRUG INTERACTION	HYDROCHLOROTHIAZIDE (HCTZ) TAB PROPRANOLOL (INDERAL) TAB :	Moderate {n/a}
DUPLICATE THERAPY	HYDROCHLOROTHIAZIDE (HCTZ) TAB Diuretic	{n/a}
MISC. CHECK	HYDROCHLOROTHIAZIDE (HCTZ) TAB Discontinued NDC number	{n/a}
REF. RANGE CHECK	POTASSIUM = 7.0000 HC ON 10/20/15	{n/a}

Clinical Monitoring Checks

The medications and order number of the medications flagged as duplicate therapy will display.

Select Hospital Base Menu > Patient > Clinical Monitoring > Duplicate Therapy

THERAPEUTIC CLASS DUPLICATION

Override Reason:

51655-0193-26 FUROSEMIDE (LASIX) : 20 MG TAB	[Order #10]
00223-1069-02 HYDROCHLOROTHIAZIDE (HCTZ) TAB:25MG	[New Order]

A therapeutic class duplication has occurred. The duplication exists between FUROSEMIDE (LASIX): 20 MG TAB and HYDROCHLOROTHIAZIDE(HCTZ)TAB:25MG of therapeutic class Diuretic.

Quit ADR Intervention Print Monograph View Monograph OK

Duplicate Therapy Checks

Other options are as follows:

- **“X” / Exit** - To return to order entry not acting on the warning.
- **Quit** - To cancel order entry.
- **ADR** - To document an Adverse Drug Reaction for this medication on the patient.
- **Intervention** - To document a Clinical Intervention performed in relation to the medication ordered.
- **OK** - To return to the Clinical Monitoring display.

Food Interaction Checks

The Pharmacy Food Interaction Module detects food-drug interactions. Micromedex® provides the food-drug interaction database along with monthly updates. Interaction checks are performed based upon item NDC number. The interaction monographs provided can be viewed and printed as needed. The system uses NDC numbers to perform food-drug interaction checks. All items in the Item Master must have their correct NDC number for the Drug Interaction Module to function optimally.

NOTE: See the [Pharmacy Setup](#) for more information on adding an NDC number to an item.

Food Interactions

Food interaction checks are provided during Non-IV and IV Order Entry. The Clinical Monitoring Checks screen appears when the medication is chosen. All Clinical Monitoring Checks are performed at this time.

1. Select **Food Interaction** to view food-drug interactions.

Select Hospital Base Menu > Patient Account # > Clinical Monitoring

Pharmacy - Non-IV Order (NEW ORDER)

Evident Community Hospital Signed On Emp: FT Dept: 038

Save Save & Exit Copy Delete Restore Save & Link Online Adjudication

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 39.84 Room: 300-9

Medication RX Information Clinical Monitoring Stop History RX Charge History NDC History Profile Order History

Type	Partial Description	Override
DRUG INTERACTION	WARFARIN (COUMADIN) 3MG TAB ceFTRIAXone (ROCEPHIN) INJ : Moderate	{n/a}
DRUG INTERACTION	WARFARIN (COUMADIN) 3MG TAB NORCO 7.5MG - 325MG TAB Moderate	{n/a}
DRUG INTERACTION	WARFARIN (COUMADIN) 3MG TAB ACETAMINOPHEN (TYLENOL) 325 Moderate	{n/a}
DRUG INTERACTION	WARFARIN (COUMADIN) 3MG TAB PROPRANLOLOL (INDERAL) TAB : Moderate	{n/a}
FOOD INTERACTION	WARFARIN (COUMADIN) 3MG TAB Pomegranate Major	{n/a}
FOOD INTERACTION	WARFARIN (COUMADIN) 3MG TAB Cranberry Juice Major	{n/a}
FOOD INTERACTION	WARFARIN (COUMADIN) 3MG TAB Noni Juice Moderate	{n/a}
FOOD INTERACTION	WARFARIN (COUMADIN) 3MG TAB High Protein Food Moderate	{n/a}
FOOD INTERACTION	WARFARIN (COUMADIN) 3MG TAB Vitamin K Containing Food Moderate	{n/a}
FOOD INTERACTION	WARFARIN (COUMADIN) 3MG TAB Enteral Nutrition Moderate	{n/a}
INTERVENTION/ADR	WARFARIN (COUMADIN) 3MG TAB Possible Clinical Intervention	{n/a}
REF. RANGE CHECK	Reference Range INR Unavailable	{n/a}
REF. RANGE CHECK	Reference Range PROTIME Unavailable	{n/a}

Sensitivity

Ready. Dose Info

Clinical Monitoring Checks

2. Select the appropriate line by double clicking.
3. To display or print clinical information pertaining to the drug interaction, select **View Monograph**.

Select Hospital Base Menu > Patient > Clinical Monitoring > Food Interaction > View Monograph

Pharmacy

View Monograph - DRUG - FOOD MONOGRAPH: 02200312

DRUG...: 66267-0631-00 Warfarin Sodium [WARFARIN (COUMADIN) 3MG TAB]

FOOD...: High Protein Food

WARNING:
Concurrent use of WARFARIN and HIGH-PROTEIN DIET may result in reduced warfarin anticoagulant effectiveness.

CLINICAL MANAGEMENT:
In patients receiving oral anticoagulant therapy with warfarin, closely monitor the international normalized ratio (INR) whenever a patient begins or withdraws from a high-protein diet. Coagulation parameters should be reassessed periodically during concurrent therapy. Adjustments of the warfarin dose may be required in order to maintain the desired level of anticoagulation when a high-protein diet is initiated or when the diet is discontinued (Beatty et al, 2005).

ONSET:
Delayed

SEVERITY:
.....

Print

Food Interaction

4. Select **Print** to print the Food Interaction Monograph.
 - Other options are as follows:
 - **"X"/Exit** - To return to the Clinical Monitoring Checks screen.
 - **Print Monograph** - To print a hard copy of the monograph.

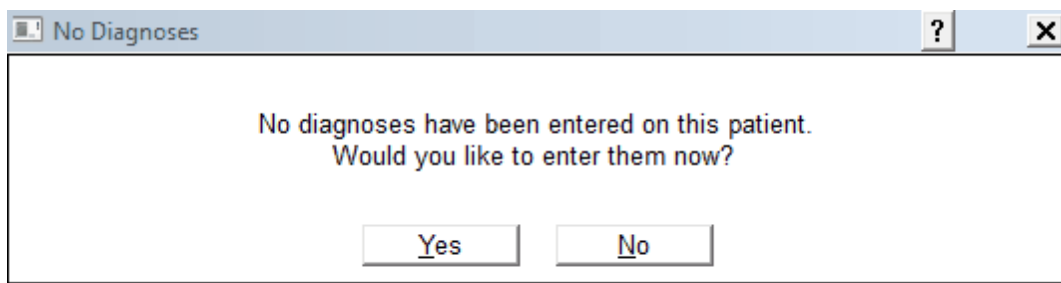
- **OK** - To return to Clinical Monitoring display

Drug - Disease Contraindications

Drug - Disease contraindication checks will be performed during medication order entry if the **Disease Interaction** switch is enabled in the Pharmacy Clinical Monitoring table. The check will ensure the drug ordered does not interfere with any diagnoses charted in the Physician Problem List, the Grouper or the RX Diagnoses menu.

1. A warning will prompt if the patient has no diagnoses entered when selecting **New Orders**.

Select **Hospital Base Menu > Patient Account # > New Orders**



No Diagnoses Prompt

2. If **No** is selected, the software will require a reason be entered.



Override Prompt

NOTE: Drug-Disease checking will not occur if **No** is selected.

3. If **Yes** is selected, the Pharmacy Diagnoses screen will open allowing a diagnosis to be entered. For more information on entering diagnoses, refer to [RX Diagnoses](#)¹⁸⁶.
4. After entering the diagnoses, select **New Orders**. If an order is placed that generates a disease interaction check the Clinical Monitoring screen will display.

Select Hospital Base Menu > Patient Account # > New Orders > Clinical Monitoring

Evident Community Hospital Signed On Emp: FT Dept: 038

Pharmacy - Non-IV Order (NEW ORDER)

Save Save & Exit Copy Delete Restore Save & Link Online Adjudication

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 39.84 Room: 300-9

Medication RX Information Clinical Monitoring Stop History RX Charge History NDC History Profile Order History

Type	Partial Description	Override
DRUG DISEASE	ASPIRIN 325 MG TAB	{n/a}
DRUG DISEASE	FUROSEMIDE (LASIX) : 20 MG TA	High Risk/Relative C
DRUG DISEASE	ASPIRIN 325 MG TAB	*High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB :	ASPIRIN 325 MG TAB *High Risk/Relative C
DRUG DISEASE	ASPIRIN 325 MG TAB	*Possible Risk
DRUG DISEASE	ASPIRIN 325 MC TAB	FUROSEMIDE (LASIX) : 20 MG TA *Possible Risk
DRUG INTERACTION	ASPIRIN 325 MG TAB	PROPRANOLOL (INDERAL) TAB : Moderate
DRUG INTERACTION	ASPIRIN 325 MG TAB	FUROSEMIDE (LASIX) : 20 MG TA Moderate
DRUG INTERACTION	DOCUSATE (COLACE) CAP:100 MG	ASPIRIN 325 MG TAB Moderate
DRUG INTERACTION	ASPIRIN 325 MG TAB	NORCO 7.5MG - 325MG TAB Moderate
DRUG INTERACTION	PROPRANOLOL (INDERAL) TAB :	ASPIRIN 325 MG TAB Moderate
DRUG INTERACTION	ASPIRIN 325 MG TAB	NORCO 7.5MG - 325MG TAB Moderate
DRUG INTERACTION	ASPIRIN 325 MG TAB	Insulin REG (Humulin R) 100U Moderate
DRUG INTERACTION	ASPIRIN 325 MG TAB	PROPRANOLOL (INDERAL) TAB : Moderate
DRUG INTERACTION	ASPIRIN 325 MG TAB	FUROSEMIDE (LASIX) : 20 MG TA Moderate
DRUG INTERACTION	NORCO 7.5MG - 325MG TAB	ASPIRIN 325 MG TAB Moderate
DUPLICATE THERAPY	ACETAMINOPHEN (TYLENOL) 325	Antipyretic

Sensitivity

Ready. Dose Info

Clinical Monitoring

5. To view the interaction, double click **Drug Disease**.

Select Hospital Base Menu > Patient Account # > New Orders > Clinical Monitoring > Drug Disease

Drug - Disease Contraindication

7. Select the drop-down menu to enter an **Override Reason**, then select **OK** to continue with the order entry process.
 - Other options are as follows:
 - **"X"/Exit:** To return to the Clinical Monitoring Checks screen.
 - **Quit:** To cancel order entry.
 - **ADR:** To document an Adverse Drug Reaction for this medication on the patient.
 - **Intervention:** To document a Clinical Intervention performed in relation to the medication ordered.

IV Compatibility Checks

Clinical Monitoring detects IV incompatibility if **IV Compatibility Checking** is enabled in the Pharmacy Clinical Monitoring Control table. IV Compatibility checks are performed based upon item NDC number.

NOTE: See [Pharmacy Setup](#) for more information on adding an NDC number to an item.

IV Compatibility checks are provided during Non-IV and IV Order Entry. The Clinical Monitoring Checks screen appears when the medication is chosen. IV Compatibility will utilize Trissels™ 2 IV compatibility checks.

1. Select **IV Compatibility** to view results for IV medications.
 - Clinical monitoring results will display generic medication names instead of item descriptions.
2. If the Clinical Monitoring Control table Drug Interaction Filtering for IV Compatibility is set to:
 - 1 - Show Incompatible Only: the results will include Incompatible and Caution: Variable.

- 2 - Show Incompatible or Unavailable: the results will include Incompatible Caution: Variable, See Study Detail, Not Tested, and Uncertain.
- 3 - Show All Checks: the results will include Incompatible, Caution: Variable, See Study Detail, Not Tested, Uncertain, and Compatible.

Select Hospital Base Menu > Patient Account # > New Orders > Clinical Monitoring

Type	Partial Description	Override
ALLERGY CHECK	CEPOTETAN (CEPOTAN): 2GM/50M PENICILLIN G	{n/a}
DUPLICATE THERAPY	NS : 50 ML - 2B1307F IV SO CLASS: 001393	{n/a}
DUPLICATE THERAPY	NACL 0.45% SOLN 1000 ML Sodium Chloride	{n/a}
IV COMPATIBILITY	Insulin, regular - Cefoxitin	Incompatible
IV COMPATIBILITY	Morphine sulfate - Normal saline- Sodium chloride 0.9%	Caution: Variable
IV COMPATIBILITY	Insulin, regular - Normal saline- Sodium chloride 0.9%	Caution: Variable
IV COMPATIBILITY	Morphine sulfate - Normal saline- Sodium chloride 0.9%	Caution: Variable
IV COMPATIBILITY	Morphine sulfate - Cefoxitin	Compatible
IV COMPATIBILITY	Furosemide - Cefoxitin	Compatible
IV COMPATIBILITY	Morphine sulfate - Cefoxitin	Compatible
IV COMPATIBILITY	Furosemide - Normal saline- Sodium chloride 0.9%	Compatible
IV COMPATIBILITY	Cefoxitin - D5W-Dextrose 5%	Compatible
IV COMPATIBILITY	Cefoxitin - Normal saline- Sodium chloride 0.9%	Compatible
IV COMPATIBILITY	Cefoxitin - Normal saline- Sodium chloride 0.9%	Compatible
IV COMPATIBILITY	Cefoxitin - Sodium chloride 0.45%	Unknown
IV COMPATIBILITY	Normal saline- Sodium chloride 0.9% - Sodium chloride 0.9%	Unknown
IV COMPATIBILITY	Normal saline- Sodium chloride 0.9% - D5W-Dextrose 5%	Unknown
IV COMPATIBILITY	Normal saline- Sodium chloride 0.9% - Normal saline- So...	Unknown

Ready. Dose Info Check PSD

Clinical Monitoring Checks

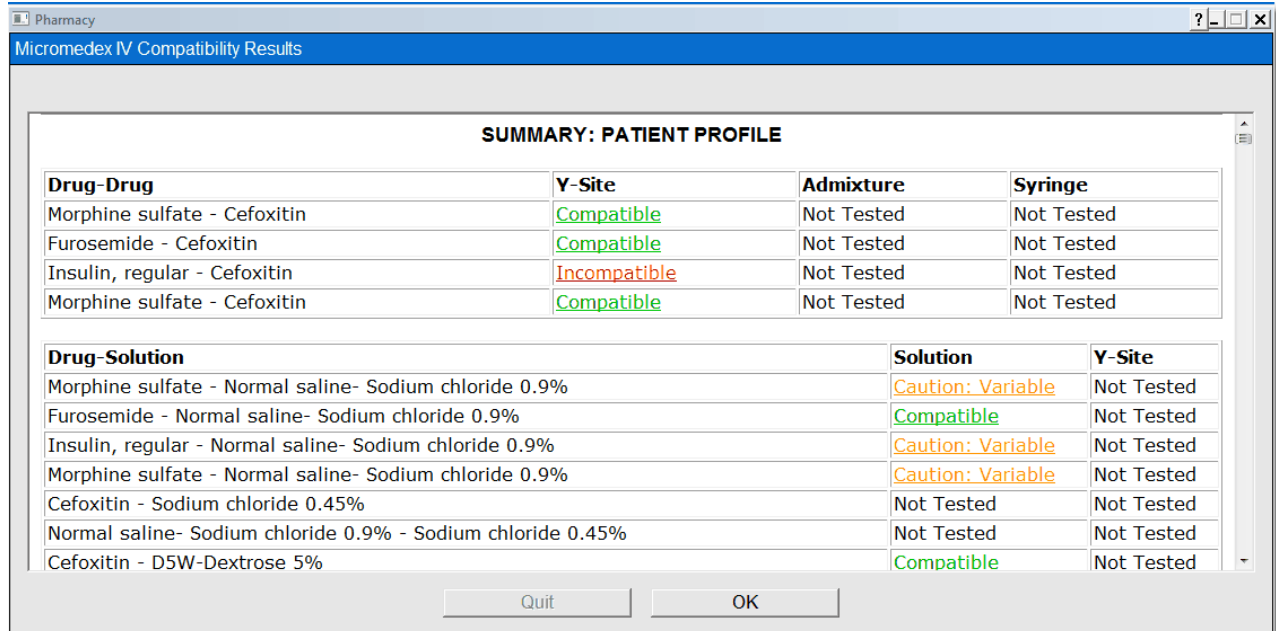
Select Hospital Base Menu > Patient Account # > New Orders > Clinical Monitoring > IV Compatibility

Pharmacy		Override Reason:
Insulin, regular - Cefoxitin Back to Top		
Cefoxitin	450mg/mL in D5W-Dextrose 5% Merck and Co.	
Insulin, regular	50units/mL in D5W-Dextrose 5% Novo Nordisk Pharmaceuticals Inc.	
Incompatible	This testing performed with human insulin, regular.	
	Physical Compatibility: Physically incompatible. An increase in measured haze or turbidity, particulates, and/or a color change was found. Storage: Ambient room temperature near 23 °C exposed to normal fluorescent light.	Reference: 8872 Study Period: 4 hours. Method: Visual observation and electronic assessment. Container: Simulated Y-site administration using glass test tubes.
Cefoxitin	450mg/mL in Normal saline- Sodium chloride 0.9% Merck and Co.	
Insulin, regular	50units/mL in Normal saline- Sodium chloride 0.9% Novo Nordisk Pharmaceuticals Inc.	
Incompatible	This testing performed with human insulin, regular.	

Quit OK

IV Compatibility Checks

3. Select the drop-down menu to select an **Override Reason**.
 - Other options are as follows:
 - **“X” / -Exit:** To return to order entry not acting on the warning.
 - **OK:** Returns to Clinical Monitoring display.



Caution: Variable

Patient Specific Dosing Version 2

Dosing recommendations are incorporated into the clinical monitoring checks when ordering a medication. Dosing recommendations takes into account such factors as the patient's age, BSA, weight, gender, Creatinine Clearance (for Renal dosing), diagnoses (for indication dosing considerations), medication dose, unit, and frequency to give a recommendation if any of the above factors are out of the normal range. Patient Specific Dosing V2 includes FDA approved indication based dosing using ICD10 and SNOMED codes, supports a larger quantity of drugs (chemo and Narrow Therapeutic Index (NTI)), suggested Dose and Infusion duration, lifetime maximum dosing, and has an expanded Pediatric Age Range now supporting 120 days through 17 years.

1. Select **New Order** from the Pharmacy Selection Screen.
2. Enter the medication to be ordered.
3. Select the medication to be ordered.
4. Clinical Monitoring checks will be performed.
5. Patient Specific Dosing will not be performed until the order is complete and Save and exit is selected
6. The patient specific dosing information will be accessible prior to selecting save and exit by selecting the **Check PSD** box.

Select **Hospital Base Menu > Patient > Order**


Check PSD

Patient Specific Dosing

7. When dosing is outside the normal limits, one of the following prompts may appear:
- **Warning: OVERDOSE** - this prompt will be followed by recommended maximum dosage information.
 - **Warning: SUBTHERAPEUTIC** - this prompt will be followed by minimal dosage information.
 - **Information_Plus:** This prompt will be followed by dosage recommendations.

Select **Hospital Base Menu > Patient > Order > Check PSD**

Patient Specific Dosing

8. To choose a specific diagnosis on the patient, select the drop down **Additional Diagnosis** and choose one of the existing diagnosis on the patient.
9. If the diagnosis has not been used for PSD, select the diagnosis and then choose the add icon .
10. Select **Reload** to run PSD again against the new diagnosis.
11. Select **Print** to print the PSD information.
12. Select **Change** to go back to the medication order and perform maintenance based on the PSD data.

13. Select **Intervention** to access the Clinical Intervention Data form.

14. Select **ADR** to access and complete the Adverse Drug Reaction form.

15. Select **Quit** to exit out of the order completely.

Reference Range Checks

The TruBridge EHR Pharmacy Application has the capability of linking laboratory tests/values to medications.

- Reference Range Checking allows review of medication related laboratory values.
- Laboratory value must be set up in the Pharmacy Order Entry Information screen. See [Pharmacy Setup](#) for further information.

Reference Range Checking

1. Select **Clinical Monitoring** to view the reference range lab values.

NOTE: Critical values will display highlighted yellow.

Select Hospital Base Menu > Patient > **Clinical Monitoring**

Pharmacy - Non-IV Order (Order #9) (Modified)

Save Save & Exit Copy View Protocol Error DC Print Drug Info. Online Adjudication

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 39.84 Room: 300-9

Medication RX Information Clinical Monitoring Stop History RX Charge History NDC History Profile Order History

Type	Partial Description
DRUG DISEASE	Insulin REG (Humulin R) 100U PROPRANOLOL (INDERAL) TAB : *High Risk/Relative C
DRUG DISEASE	Insulin REG (Humulin R) 100U FUROSEMIDE (LASIX) : 20 MG TA *Possible Risk
DRUG INTERACTION	ALBUTEROL INH SOL .083% 3ML Insulin REG (Humulin R) 100U Moderate
DRUG INTERACTION	COMBIVENT MDI Insulin REG (Humulin R) 100U Moderate
DRUG INTERACTION	Insulin REG (Humulin R) 100U PROPRANOLOL (INDERAL) TAB : Moderate
DRUG INTERACTION	Insulin REG (Humulin R) 100U FUROSEMIDE (LASIX) : 20 MG TA Moderate
REF. RANGE CHECK	GLUCOSE = 200.0000 H ON 11/04/15
REF. RANGE CHECK	GLUCOSE = 96.0000 ON 10/20/15

Sensitivity

Ready. Dose info

Clinical Monitoring Checks

2. Labs values will list in the Reference Range area of Clinical Monitoring

Other Clinical Monitoring Checks

The following sections will cover other types of clinical monitoring checks.

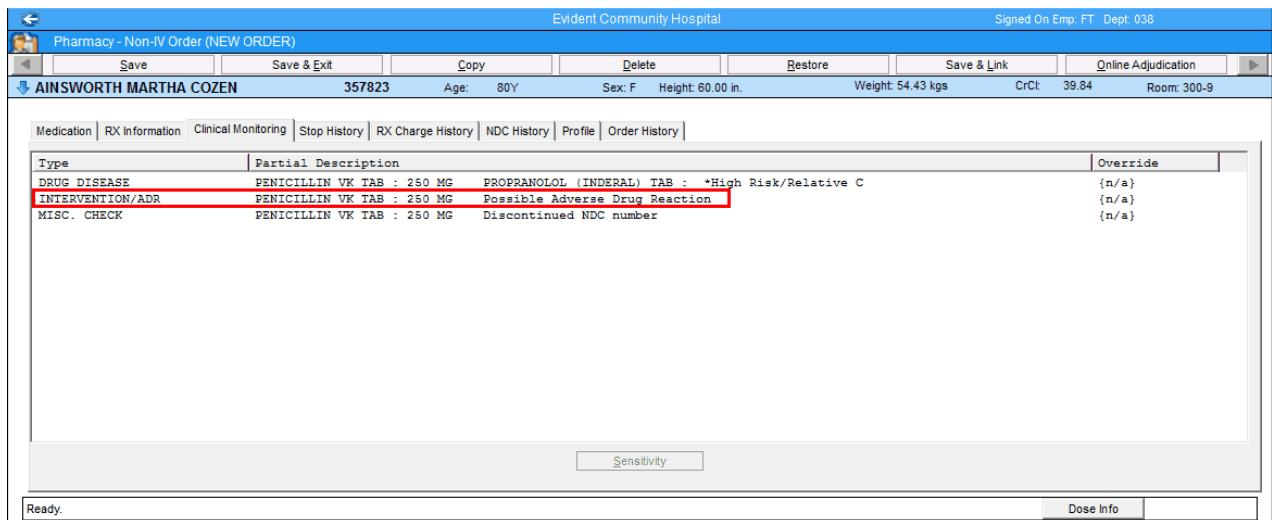
INT / ADR Checks

Clinical Monitoring can be set to flag for a possible Intervention or Adverse Drug Reaction. A switch in Pharmacy Information enables pharmacy to flag for an Intervention or Adverse Drug Reaction each time the medication is entered on a patient.

NOTE: Refer to [Pharmacy Setup](#) for further instructions on setting items to flag for Interventions or Adverse Drug Reactions.

Select **Interventions/ADR** to enter the Intervention or Adverse Drug Reaction.

Select **Hospital Base Menu > Patient Account # > New Orders > Clinical Monitoring**



Intervention/ADR

Select Hospital Base Menu > Patient Account # > New Orders > Clinical Monitoring > Intervention/ADR

Adverse Drug Reaction Data screen

Miscellaneous Checks

Miscellaneous checking is intended solely for the addition of NDC numbers to items that have unknown (invalid) or discontinued NDC numbers. The information can be added to items via Clinical Monitoring.

1. Select **Misc. Checks**.

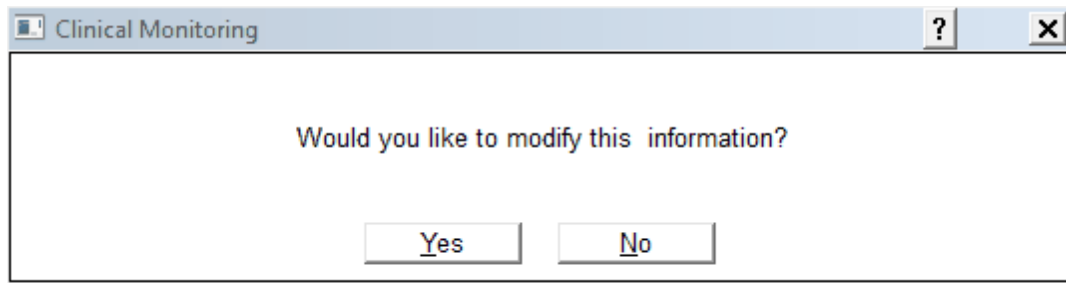
Select Hospital Base Menu > Patient > Clinical Monitoring

Type	Partial Description	
DRUG INTERACTION	Insulin REG (Humulin R) 100U	FUROSEMIDE (LASIX) : 20 MG TA Moderate
DRUG INTERACTION	PROPRANOLOL (INDERAL) TAB :	FUROSEMIDE (LASIX) : 20 MG TA Moderate
REF RANGE CHECK	GLUCOSE =	200.0000 H ON 11/04/15
REF RANGE CHECK	GLUCOSE =	96.0000 ON 10/20/15
REF RANGE CHECK	POTASSIUM =	7.0000 HC ON 10/20/15
DRUG DISEASE	HYDROMORPHONE (DILAUDID) INJ:	Asthma Contraindication
DRUG DISEASE	NORCO 7.5MG - 325MG TAB	Asthma Contraindication
DRUG DISEASE	HYDROMORPHONE (DILAUDID) INJ:	Chronic Obstructive Pulmonar Contraindication
DRUG DISEASE	NORCO 7.5MG - 325MG TAB	Chronic Obstructive Pulmonar Contraindication
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB :	Asthma High Risk/Relative C
DRUG DISEASE	FUROSEMIDE (LASIX) : 20 MG TA	NORMAL SALINE 1000 ML *Contraindication
DRUG DISEASE	FUROSEMIDE (LASIX) : 20 MG TA	NORMAL SALINE 1000 ML *High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB :	FUROSEMIDE (LASIX) : 20 MG TA *High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB :	HYDROMORPHONE (DILAUDID) INJ: *High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB :	NORCO 7.5MG - 325MG TAB *High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB :	NORMAL SALINE 1000 ML *High Risk/Relative C
DRUG DISEASE	Insulin REG (Humulin R) 100U	PROPRANOLOL (INDERAL) TAB : *High Risk/Relative C
DRUG DISEASE	PROPRANOLOL (INDERAL) TAB :	FUROSEMIDE (LASIX) : 20 MG TA *Possible Risk
DRUG DISEASE	Insulin REG (Humulin R) 100U	FUROSEMIDE (LASIX) : 20 MG TA *Possible Risk
MISC. CHECK	NS :100 ML 2B1302P IV	Unknown NDC number
MISC. CHECK	HYDROMORPHONE (DILAUDID) INJ:	Discontinued NDC number
MISC. CHECK	FUROSEMIDE (LASIX) : 20 MG TA	Discontinued NDC number
MISC. CHECK	NORCO 7.5MG - 325MG TAB	Discontinued NDC number

Clinical Monitoring Checks

2. Select the item with the Unknown or Discontinued NDC number by double clicking the appropriate item.

Select **Hospital Base Menu > Patient > Clinical Monitoring > Misc. Check**



Miscellaneous Checks

3. Select **No** to return to order entry without acting on the notification.
4. Select **Yes** to enter the NDC number.

Select **Hospital Base Menu > Patient > Clinical Monitoring > Misc. Check > Yes**

Pharmacy Information Page 1

5. Enter the desired **NDC**.
6. Select the **Back Arrow** to return to order entry. Clinical monitoring will be performed using the new NDC number.

Sensitivity

The TruBridge EHR has the capability to show when a sensitivity to a medication being ordered is present. This feature works in conjunction with Pharmacy Information Page 3, please refer to [Pharmacy Setup](#) for details in setting this feature up.

1. When a medication that has information in the **Sensitivity** field is ordered and the patient has microbiology results, the Sensitivity option will be enabled on the Clinical Monitoring screen.

Select **Hospital Base Menu > Patient Account #> New Orders > Clinical Monitoring**

Evident Community Hospital Signed On Emp: FT Dept: 038

Pharmacy - Non-IV Order (NEW ORDER)

Save Save & Exit Copy Delete Restore Save & Link Online Adjudication

AINSWORTH MARTHA COZEN 357447 Age: 40Y Sex: F Height: 62.00 in. Weight: 65.77 kgs CrCl: N/A Room:

Medication | RX Information | Clinical Monitoring | Stop History | RX Charge History | NDC History | Profile | Order History |

Type	Partial Description	Override
------	---------------------	----------

Sensitivity

Frequency Incomplete. Dose Info

Sensitivity

2. Select **Sensitivity** and the microbiology section of the laboratory cumulative vertical report will open in Adobe Acrobat.

MICROBIOLOGY REPORT ** FINAL **

----- Antimicrobial Susceptibility and Organism Identification Report -----

Isolate 01 Enterococcus faecalis

Enterococcus faecalis	
DRUG	MIC Sys. Urine
Ampicillin	2 S
Ciprofloxacin	<=1 S
Nitrofurantoin	<=32 S
Levofloxacin	<=2 S
Linezolid	<=2 S
Norfloxacin	<=4 S
Penicillin	2 S
Tetracycline	<=4 S
Vancomycin	<=2 S

S = Susceptible CC = Cost Code N/R = Not Reported BLac = Beta Lactamase Positive
 I = Intermediate MIC = mcg/ml (mg/L) --- = Not Tested TFG = Thymidine-dependent Strain
 R = Resistant Blank= Data not available, or drug not advisable or tested

For Blood and CSF Isolates, a Beta-Lactamase test is recommended for Enterococcus species.

IB appears in place of S, I (S), +, ++, or +++ with species known to possess inducible B-lactamases; potentially they may become resistant to all B-lactam drugs. Monitoring of patients during/after therapy is recommended. Avoid other/combined B-lactam drugs.

(a) Use maximum doses of drug with an aminoglycoside for P. aeruginosa in patients with granulocytopenia or serious infections.
 (b) Breakpoints based on parenteral dose. For cefuroxime Axetil (PO) use <8=S, 8-16=I, >16=R.
 (c) For streptococci (including enterococci), Micrococcus species, and Listeria species, refer to the Ampicillin interpretation. If Ampicillin results are unavailable, refer to Penicillin. If Pen result is resistant, test Ampicillin using an alternate method.

Interpretations based on NOCLS M7-A3. Pip/Tazo for streptococci and enterococci based on manufacturer's breakpoints.

Tech : _____ Source : URINE ID # : 357447 ** FINAL **
 Report Date : / / : Collected : 06/02/13 18:54

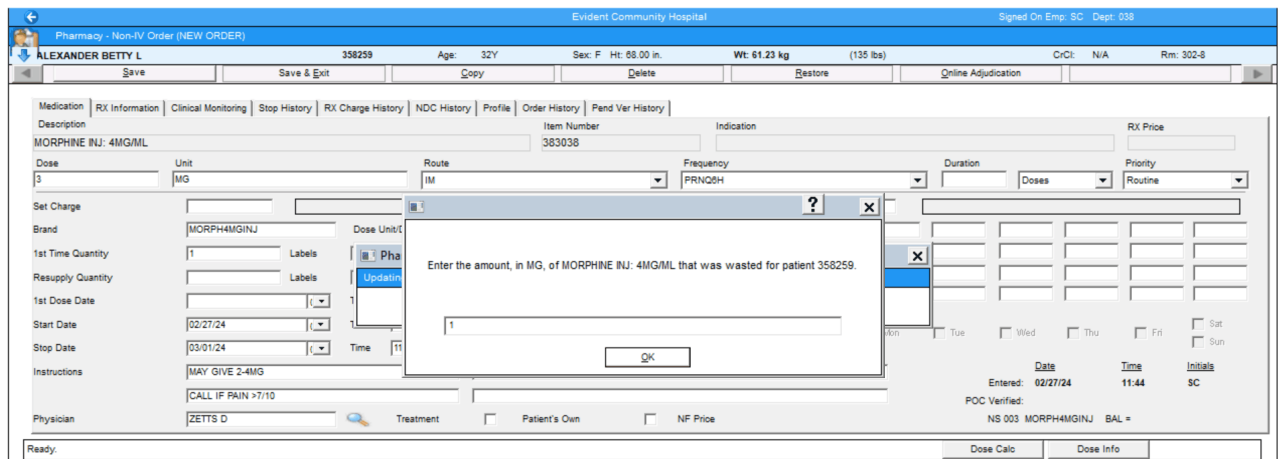
Microbiology Report

Capturing Medication Waste

Medication Waste may be captured via Pharmacy Order Entry, or order verification at the time of the charge, if the item is set up in Pharmacy Information Page 1 to capture waste and is not set to Charge Upon Administration. Specific items may be set up to automatically capture the amount wasted or to prompt to capture the amount wasted. Please refer to the [Pharmacy Setup](#) User Guide for more information.

The following example shows a non-IV order that is set up to prompt to capture waste. The prompt will display when Save & Exit is selected.

Select Hospital Base Menu > Patient > Pharmacy - Selection Screen > New Orders



Non-IV Order - Waste Prompt

There will be no prompt during order entry for waste if the non-IV item is set to automatically capture waste. The software will calculate the wasted amount by comparing the ordered dose to the Other Units listed on the item.

The following example shows an IV order that is set up to prompt to capture waste. The software will check the additives on the order and prompt for waste for each individual component, one after the other, if more than one component is set to capture waste. The prompt will display when Save & Exit is selected.

Select Hospital Base Menu > Patient > Pharmacy - Selection Screen > New Orders

The screenshot displays the 'Pharmacy - IV Order (NEW ORDER)' interface for patient ALEXANDER BETTY L. The main form includes fields for Route (IVPB), Frequency (Q24H), Flow Rate (100 ml/hr), Infusion Period (30 min), Duration, Doses, Priority (Routine), and As of Date (02/27/24). A modal dialog box is open, titled 'Enter the amount, in GM, of ceftRiAxone (Rocephin) 1GM INJ that was wasted for patient 358259.' with an 'Update' button and an 'OK' button. The background form also shows '1st Time Quantity' (1), 'Resupply Qty/Day' (1), 'Next IV Qty' (1), '1st Dose Date' (02/27/24), 'Start Date' (02/27/24), 'Stop Date' (03/05/24), 'IV Qty Issued', and 'Physician' (ZETTS D).

IV Order - Waste Prompt

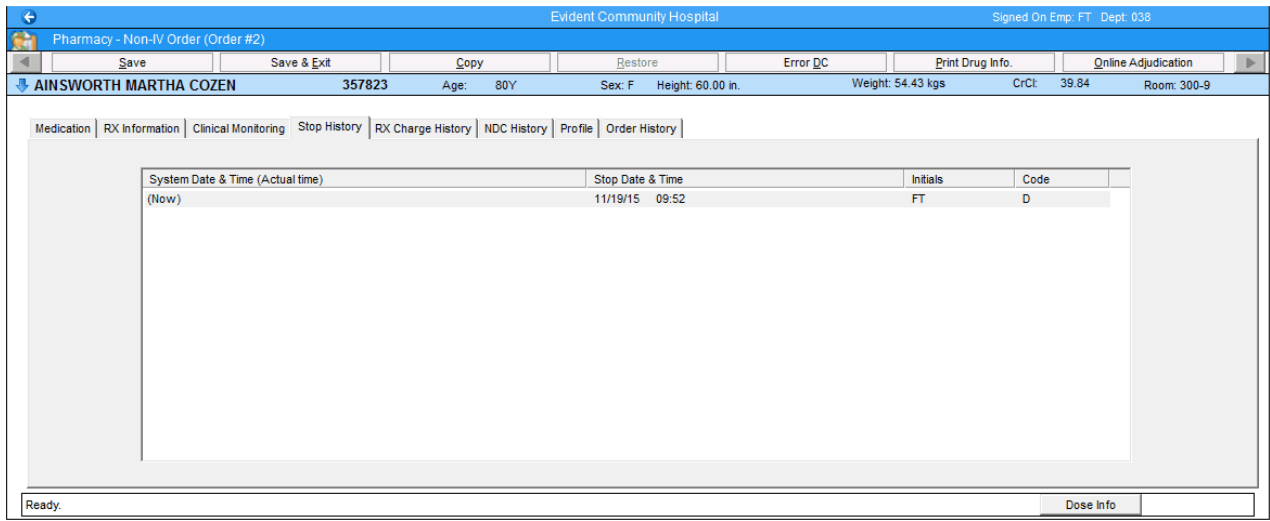
There will be no prompt for waste during order entry if the IV item is set to automatically capture waste. The software will calculate the wasted amount by comparing the ordered dose to the Other Units listed on the item.

Stop History

Stop History provides the ability to track the stop information entered on all orders. As the stop code is entered or changed on an order, it is logged in the Stop history screen.

Select the **Stop History** tab to display a reverse chronological listing of all stop code entries or changes.

Select Hospital Base Menu > Patient Account# > Pharmacy Profile > Order > Stop History



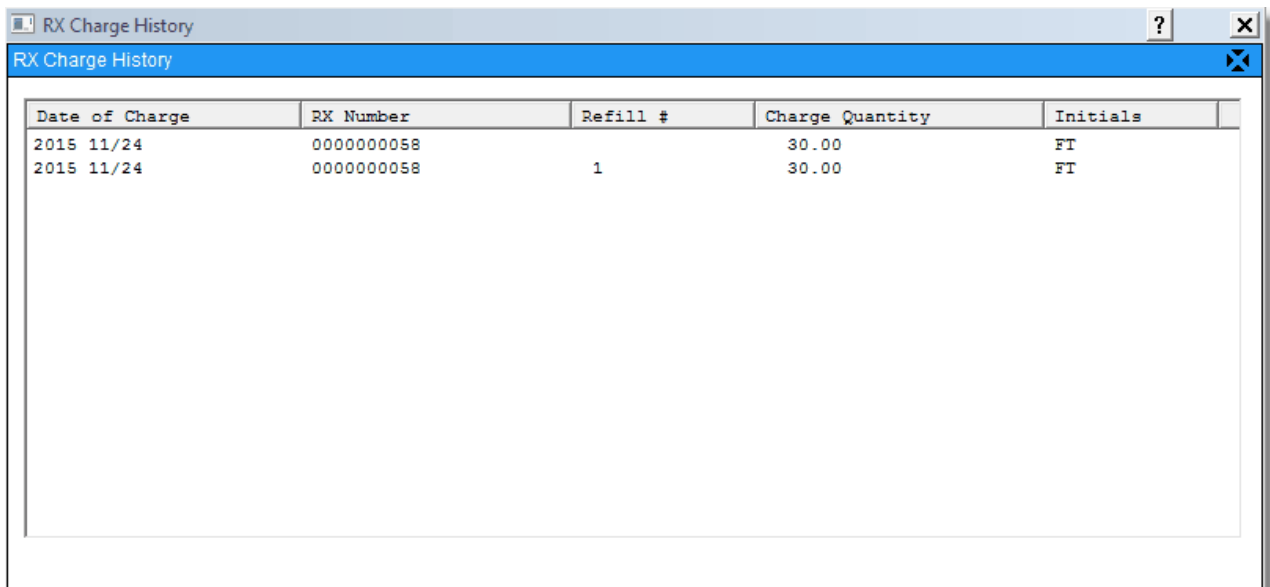
Stop History

Rx Charge History

RX Charge History maintains a record of all prescriptions charged for the selected account.

Rx Charge History displays the Date of Charge, RX Number, Refill Number, Amount Dispensed and Initials of staff entering the prescription into the system.

Select Hospital Base Menu > Patient Account # > Pharmacy Profile > RX Charge History



RX Charge History

NOTE: RX Charge History may also be accessed from the Pharmacy-Selection Screen.

NDC History

If a medication has a new NDC number assigned, it will be tracked from the NDC History tab.

NOTE: If the NDC number of a medication is changed after it has been ordered, the new NDC number will update on existing Long Term Care and Employee prescriptions.

1. Select the NDC History tab.
2. The Change Date, Change Time, RX Number, and NDC Number will display. The screen can be sorted by each of these options by clicking on the header of each column.

Select **Hospital Base Menu > Patient Account # > Pharmacy Profile > Order > NDC History**

Change Date	Change Time	RX Number	NDC Number
2015 11/24	15:43	0000000058	51079027820
2015 11/24	15:43	0000000058	54868144202
2015 11/24	15:37	0000000058	54868144202

NDC History

Profile

Profile is a review screen for all the selected patient's medication orders. The pharmacy profile can be accessed at any time during order entry for use as a reference. Orders can also be credited, charged, discontinued, renewed, or edited from the pharmacy profile. Labels can be requested from the profile as well. The Profile can also be accessed from the Pharmacy Selection Screen via Pharmacy Profile.

Select Hospital Base Menu > Select Patient > Pharmacy Profile

Order	Start Date	Stop Date	Time	Code	Description	Dose	Unit	Route	Notes	Pending Actions
1	10/07/15		10:39		PROPRANOLOL (INDERAL) TAB 20 MG	20 MG		PO	TID	
3	10/15/15		09:01		NORMAL SALINE 1000 ML 125 ml/hr			IV	CONTINUOUS	
4	10/15/15		10:00		ROCEPHIN IVPB : 500MG/100ML NS 100 ml/hr			IV	Q24H	
5	11/05/15		14:29		HYDROMORPHONE (DILAUDID) INJ 2MG/ML					

Pharmacy Profile

- **Sort Sequence**
 - The default Sort Sequence for the profile is determined by a switch located in the Pharmacy Control Table.
 - Radio buttons allow easy transition between, Chronological, Alphabetical or By Frequency.
- **Filter**
 - The system default is to display Current Orders. **Current orders** are those orders considered active.
 - Radio buttons allow All Orders to be displayed. **All Orders** consist of active and inactive orders. Use this option to access orders that have been stopped.
 - **New Orders** will display all orders entered prior to exiting to the Pharmacy Selection Screen.
- **Order Types**
 - The system default is to display all Order Types.
 - By removing the check marks the display of Order Types can be changed.

- **Edit**
 - To make a change to an order, highlight the order and select **Edit**. The order screen will display.
 - An order can also be accessed by double clicking using the mouse.
 - If changes are made to any portion of the order, select **Save and Exit** and the following prompt will display: *Require NS to reverify?* For facilities using the Point of Care application, answering **YES** will force nursing to reverify the order.

- **Charge**
 - To enter a charge for an order, highlight the order and select **Charge**
 - The Charge Quantity screen will display. Enter the number to charge and select **OK**.
 - The Number of Labels screen will display. Enter the number to labels to print and select **OK**.
 - If a Critical Access Hospital is charging/crediting there will be drop downs to select the patients stay type and service code.
 - Once the charge has been entered, it can be removed by selecting **Undo**.
 - **NOTE:** *Charges and Credits entered will display in the Pending Actions column. Pending Actions will be highlighted in red to denote an action was taken.*
 - To process the credit, select the **←** (Back Arrow) in the upper right-hand portion of the screen.
 - Select **Yes** to process the action(s). Selecting **No** will exit out and the pending action(s) will be deleted.
 - Select **Review** to return to the Profile screen to view pending actions.

Order History

Changes to the order and Dose Calculator utilization will be tracked on the Order History tab.

1. Select the **Order History** tab.
2. The Order History tab will contain the following columns: System Date and Time, Description of the modification or action including the Original Value and the New Value and the Employee that made the change. For transferred orders it will include the account the orders were transferred from.
 - A new line will be added if the Dose Calculator feature was used during order entry and will include: Date/Time, a description of Dose Calculator, and the Employee who accessed the Dose Calculator. The Original and New Value fields will be blank.

Select Hospital Base Menu > Patient Account # > Pharmacy Profile > Order > Order History

Pharmacy - Non-IV Order (Order #6)

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 39.84 Room: 300-9

Medication | RX Information | Clinical Monitoring | Stop History | RX Charge History | NDC History | Profile | Order History

Date/Time	Description	Original Value	New Value	Employee
11/09/15 08:20:28	New Order			FELICIA THOMAS
11/09/15 08:22:34	POC Verified Date/Time/Init		11/09/2015 08:22 FT	FELICIA THOMAS
11/24/15 15:47:21	Frequency	PRNQ6H (AS NEEDED)	PRNQ6H	FELICIA THOMAS

Ready. Dose Info

Order History

Pend Ver History

If an order is marked as a verification hold, the pending verification history will show on the **Pend Ver History** tab. This tab will contain the following:

- **Date/Time:** The date and time when the Pending Verification Reason was entered.
- **Pending Verification Reason:** The reason the order was placed on verification hold.
- **Release Reason:** The reason the order was released after being placed on verification hold.
- **Employee:** The person who placed the order on verification hold and/or entered the Release Reason and released the order.

While an order is on a verification hold, the **Edit Pend Ver** button allows you to edit the hold reason, if necessary.

Select the **Release** button to release the verification hold on an order. Enter the reason for release in the free-text field and select **Save**.

NOTE: An order cannot be verified while it has a verification hold. It must be released first and then it can be verified.

Select Hospital Base Menu > Patient Account # > Pharmacy Profile > Order > **Pend Ver History**

Date/Time	Pending Verification Reason	Release Reason	Employee
01/31/2024 07:50:47	AWAITING MD DOSE CONFIRMATION		SHALANDA JENKINS

Pend Ver History

IV Order Entry

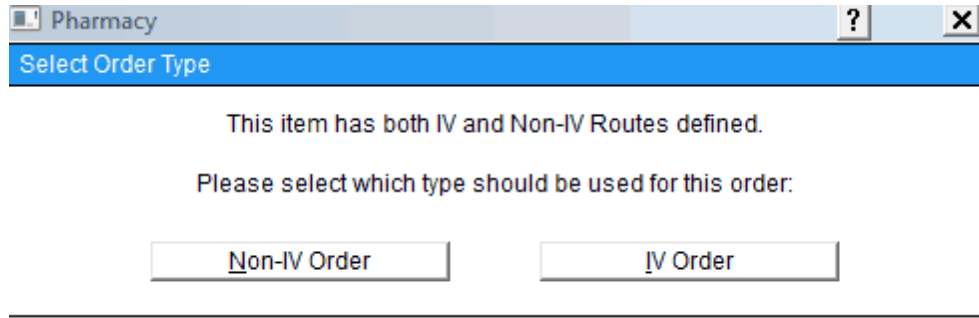
1. From the Pharmacy Selection Screen, select **New Orders**.

NOTE: The default for the Formulary Screen displays All meds (by description). The lookup display can be changed by selecting the All meds (by mnemonic) or My meds option.

2. Enter starting medication description and select **GO** or press <Enter>.
 - The formulary lookup screen lists the Item Description, Item Number, Primary Unit, and NDC Number.
3. Double click on the desired item. The default route will determine the order entry screen. The default route is set on page 1B of the Pharmacy Information for the item.
 - If the desired item is not displayed, re-key the partial description in the *Lookup Starting Point* field.

NOTE: If allergies, height or weight have not been entered, the Clinical Information Screen will display and require entry to continue order processing. This feature is controlled by a switch located in the Pharmacy Control Table. Refer to [Pharmacy Setup](#) for additional information.

Select Hospital Base Menu > Patient Account # > New Orders > Medication



Order Type Prompt

4. If the item has both IV and Non-IV routes set in Pharmacy Information, a prompt will display “This item has both IV & Non-IV Routes defined. Please select which type should be used for this order.” Non-IV Order or IV Order are the selectable options.

NOTE: This prompt is only available via the Pharmacy application.

5. Clinical Monitoring checks will be performed once the item is selected. If a Clinical Monitoring check is flagged, the **Clinical Monitoring** tab will be displayed first.
6. Once the clinical information has been viewed, select the **Additives** tab to continue.
7. Select the **Order Detail** tab. Complete the order by clicking in the required field(s). Use the mouse clicker or <Tab> key to move from one field to the other. Each field will be described in detail on the following pages.

NOTE: Items that display fully or partially complete have been predefined. Required information will be listed in the bottom left-hand portion of the screen. Once all required fields have been completed, Ready will display. Refer to [Pharmacy Setup](#) for more information on predefineding items.

Additives

The Additives screen lists the components that are required for the IV or IVPB order. Additives can be added or deleted from the order.

Select Hospital Base Menu > New Orders > Item > Additives

The screenshot shows the 'Additives Tab' in a software interface. At the top, it displays patient information: ALEXANDER BETTY L, 358259, Age: 32Y, Sex: F, Ht: 68.00 in., Wt: 61.23 kg (135 lbs), CrCl: N/A, Rm: 302-8. Below this is a navigation bar with tabs: Additives, Order Detail, RX Information, Clinical Monitoring, Stop History, Flow Rate History, RX Charge History, Profile, Order History, and Pend Ver History. The 'Additives' tab is active. The main area shows a table with the following data:

Item Number	Description	Quantity	Unit	Charge Qty
03814505	NORMAL SALINE 0.9% IV 1000 ML	1000	ML	1

Buttons for 'New Additive', 'Update', and 'Delete' are visible. The status bar at the bottom shows 'Ready' and 'Dose Info'.

Additives Tab

- To add an additive to an order, select **New Additive**. The formulary screen will display.
- Enter starting medication description and select **GO** or press <Enter>.
 - The formulary lookup screen lists the Item Description, Item Number, Primary Unit, and NDC Number.
- Double click on the desired item.
 - Quantity**
 - Default: 1
 - Options: 1 - 9999999
 - Usage: The dose will default from the Strength field from Pharmacy Information Page 1 or enter the total dose amount that will be required to complete the order. For example, the order is Gentamicin 60MG, the dose quantity is 60.
 - Unit**
 - Default: EACH
 - Options: Entry of an acceptable dosage unit
 - Usage: The unit will default from the Unit field from Pharmacy Information Page 1 or enter the dose unit such as MG, Each, GM, ML, MEQ, Units, Etc....
 - Charge Qty**
 - Default: 1
 - Options: 1-999
 - Usage: Charge quantity indicates the total number of item charges that will be required to create the IV order. For example, the order calls for Heparin 25000 Units in NS 500ML. The largest dose of Heparin in the formulary is 5000 Units. The Charge Quantity will be 5.

Select **Hospital Base Menu > Patient > Item > Additives > New Additive**

Pharmacy - IV Order (NEW ORDER) Evident Community Hospital Signed On Emp: SC Dept: 038

ALEXANDER BETTY L 358259 Age: 32Y Sex: F Ht: 68.00 in. Wt: 61.23 kg (135 lbs) CrCl: N/A Rm: 302-8

Save Save & Exit Copy Delete Restore Alternating IV Online Adjudication

Additives | Order Detail | RX Information | Clinical Monitoring | Stop History | Flow Rate History | RX Charge History | Profile | Order History | Pend Ver History

Item Description: NORMAL SALINE 0.9% IV 1000 ML

Description: KCL IV : 40 MEQ/20 ML Quantity: 40 Unit: MEQ Charge Qty: 1

New Additive Update Delete

Item Number	Description	Quantity	Unit	Charge Qty
03814505	NORMAL SALINE 0.9% IV 1000 ML	1000	ML	1

Ready Dose Info

New Additive

- Once complete, select **Update** to add the additive to the IV order. Repeat this process to add additional components.
 - To change an existing component, first highlight the component and then make adjustments to Quantity, Unit or Charge Quantity as necessary. Once changes have been made, select **Update**.
 - To remove an existing component, highlight the component and then select **Delete**.

Select **Hospital Base Menu > Patient > Item > Additives > New Additive > Update**

Pharmacy - IV Order (NEW ORDER) Evident Community Hospital Signed On Emp: SC Dept: 038

ALEXANDER BETTY L 358259 Age: 32Y Sex: F Ht: 68.00 in. Wt: 61.23 kg (135 lbs) CrCl: N/A Rm: 302-8

Save Save & Exit Copy Delete Restore Alternating IV Alternating Comp.

Additives | Order Detail | RX Information | Clinical Monitoring | Stop History | Flow Rate History | RX Charge History | Profile | Order History | Pend Ver History

Item Description: NORMAL SALINE 0.9% IV 1000 ML

Description: KCL IV : 40 MEQ/20 ML Quantity: 40 Unit: MEQ Charge Qty: 1

New Additive Update Delete

Item Number	Description	Quantity	Unit	Charge Qty
03814505	NORMAL SALINE 0.9% IV 1000 ML	1000	ML	1
00387217	KCL IV : 40 MEQ/20 ML	40	MEQ	1

Ready Dose Info Check PSD

Update Additive

NOTE: If a component is added, Clinical Monitoring will again be performed upon exiting the Additive screen.

Order Detail

Select **Hospital Base Menu > Patient > New Orders > Item**

Order Detail

• Indication

- If a PRN frequency is used, this will display the PRN Reason/Indication selected during Nursing or Physician Order Entry.
- If applicable, any Indication entered during Nursing or Physician Order Entry will display.

• Route

- Default: The default route will display in the order
- Options: Entry of an alternate route
- Usage: Defines the route by which the order is to be administered.
 - If a change in the ordered route is needed, the drop-down menu can be selected to display alternate routes.
 - Select **Route Table** from the drop-down menu to display a lookup of routes to choose from.

NOTE: Alternate routes default from Pharmacy Information Page 1 Default Routes field.

• Flow Rate

- Default: Blank
- Options: Entry of a flow rate from a drop-down menu
- Usage: Using the drop-down menu, select the ordered flow rate for the IV. Flow Rates default from the Flowrate Table or may be free-text by selecting the "Other" option. This flow rate can be changed as needed. The system keeps a log of all rate changes in Flow Rate History.

• Total Volume

- Default: Blank
- Options: Automatically calculates based on quantity and unit of the additive(s).
- Usage: Indicates the total fluid volume of the order in milliliters.

• Remaining Volume

- Default: Blank
- Options: Manual entry of remaining IV volume
- Usage: Indicates the total fluid volume remaining in milliliters.

• Duration

- Default: Doses
- Options: Number of Doses
- Usage: If not accessed, no particular duration will be assigned to the order. This option can be utilized to specify if a medication is to be given only for a certain number of doses. The number of doses should be entered into the blank box.

• Priority

- Default: Routine
- Options: Routine or Now
- Usage: Can be changed to NOW to specify that the order is to be given as stat. If NOW is selected, the order will become a X1 order automatically.

• Pump Dosage

- Default: Blank
- Options: This is a free text field where the pharmacist will key in the dose/units/kg/min information.
- Usage: This information will print on the Braum IV Pump label.

• Set Charge

- Default: Blank
- Options: Item number of the set, if known, is entered. If the item number is unknown, enter a (?) question mark and press <Enter> to display the formulary.
- Usage: Set Charge is only completed if the pharmacy charges for IV administration sets. The line is left blank, otherwise. A quick reference code can be set up in the Pharmacy Control Table to automatically pull a set charge into an order. (See [Pharmacy Setup](#) for further information)

• Procedure Charge

- Default: Blank
- Options: Enter item number for a procedure fee. If the item number is unknown, enter a (?) question mark and press <Enter> to display the formulary.
- Usage: Allows the pharmacy to charge a fee for sterile procedures or for IV admixing. The system charges one fee for each IV charged. The line is left blank if the pharmacy does not charge a fee.

• Resupply Qty / Day

- Default: The system will automatically calculate the number of IV bags needed over a 24-hour period. If an IV order reads Q6H, the resupply quantity is four.
- Options: This number can be changed manually if needed.
- Usage: Determines the number of IVs to be charged and labels printed when the IV Batch is generated. The system will consider the time frame entered on the IV Batch.
 - For large volume fluids, the resupply quantity is estimated based upon the flow rate.
 - Resupply quantities may be adjusted daily using the IV Active Order List.
 - If no resupply quantity is entered, a charge quantity must be entered manually each day.
 - For X1 frequency orders, an <N> is automatically populated in the resupply quantity field and the order will not be charged on the next IV Batch.
 - If the pharmacy dispenses IV administration sets, a Sets field prompts for the number of sets needed on resupply. Enter the appropriate number.

- **Next IV Qty**

- Default: Blank
- Options: The field is left blank during initial order entry.
- Usage: Displays the next IV quantity to charge for when the IV batch labels are printed. The number in this field usually matches the resupply IV quantity.
 - This next IV quantity is most often used in conjunction with the IV Active Order list to determine the number of IVs to dispense in a 24-hour period.
 - The number is changed when a patient does not need the number of IV's designated in **Resupply Qty**.
 - If dispensing IV administration sets, a Sets field prompts for the number of sets needed. Enter the appropriate number.

- **1st Time Quantity**

- Default: Blank
- Options: Enter the number of IV bags/bottles needed as a first time quantity
- Usage: Denotes the number of doses the patient needs until the next batch printing of the IV labels for a 24-hour period. The number entered in this field charges for IVs at the completion of the initial order. Enter the number of initial labels that will be needed. If dispensing IV administration sets, a Sets field prompts for the number of sets needed. Enter the appropriate number.

- **Labels**

- Default: Blank
- Options: Enter the number of initial IV labels needed
- Usage: Denotes the number of labels needed until the next batch printing of the IV labels. The number of labels entered in this field print at the completion of the initial order. If dispensing IV administration sets, a Sets field prompts for the number of sets needed. Enter the appropriate number.

- **1st Dose Date / Time**

- Default: Current Date /Time
- Options: 6-digit date and 4-digit military time
- Usage: Allows the date and time that the first dose should be given to be entered. Used when the scheduled time has passed but the dose needs to be scheduled for the current day. Make sure the date and time reflect the actual time the first dose is to be given. Select the drop-down arrow to display a calendar with the current month. Click on the desired start date. Use the left and right arrows to advance to the next month(s) or back up to previous month(s).

- **Start Date / Time / Initials**

- Default: Current Date / Time
- Options: Enter to accept default date/time or enter future date, time and initials.
- Usage: This field is used to indicate the Start Date and Time of an order and the initials of the person entering the order. Future dates on orders can be reflected here also. Sites using Point of Care should not back date orders because the Electronic MAR will indicate a missed dose by nursing.
 - If the start date and time is correct, press <Enter> through this field. System defaults to the current date and time.
 - Select the drop-down arrow to display a calendar with the current month. Click on the desired start date. Use the left and right arrows to advance to the next month(s) or back up to previous month(s).
 - Initials pull automatically if Employee Sign-on is switched to Y in the Pharmacy Control Table. If switched to N, enter 3 initials. Initials print on the label and remain as a permanent part of the order.

- **Stop Date / Time / Initials / Code**

- Default: Blank
- Options: Enter stop date/time, initials and stop code.
- Usage: This field is used to reflect the date an order has been stopped or will stop and the initials of the person entering the stop information. Stop codes indicate the reason an order has been or will be stopped.
 - Select the drop-down arrow to display a calendar with the current month. Click on the desired start date. Use the left and right arrows to advance to the next month(s) or back up to previous month(s).

- **IV Qty Issued**

- Default: Blank
- Options: The software tracks the total quantity of bags charged.
- Usage: Displays the running total of IV fluids charged or credited to the patient. This field is updated each time the IV Label Charging (Reorder) labels are run to provide doses for a 24-hour time period. This field is updated when charges or credits are applied to the patient account.

- **Physician**

- Default: Admitting Physician
- Options: Enter prescribing physician.
- Usage: Allows the ability to track prescribing physician. The admitting physician will display by default. To enter the prescribing physician, click in the **Physician** field and type the name using the keyboard.

- **Comments**

- Default: Blank
- Options: Two comment lines that allow for free text typing of up to 25 characters.
- Usage: The comment fields are used to document specific administration instructions. Both comment lines print on IV labels and all pharmacy reports that display IV orders.

- **Standard Times**

- Default: Blank
- Options: Yes (✓) or No (Blank)
- Usage: If the frequency is defined, standard times are the default and the appropriate administration time(s) are pulled into the order.

- **Non-Standard Times**

- Default: Blank
- Options: Yes (✓) or No (Blank)
- Usage: If the frequency is defined, but standard time(s) are not appropriate for the order, non-standard times can be entered. Up to 24 dosage times can be entered in military format.

- **Hours Between Doses**

- Default: Blank
- Options: Yes (✓) or No (Blank)
- Usage: Used for IV orders to define the hours between doses. The system calculates the next administration time based on the first dose date / time and the number of hours between doses. The system can accommodate frequencies greater than 7 days; for example, 10 days would be 240 hours.

- **Days of the Week**

- Default: Blank
- Options: Yes (✓) or No (Blank)
- Usage: Used for orders that are to be given on a specific day or days of the week. Click on each day of the week to select. Click again to deselect.


NOTE: When the Days of the Week or the Hours Between Doses option is chosen, the administration time is based on the start date and time.

Once all required fields have been addressed, select **Save** to process the order. Select **Save & Exit** to process the order and return to the pharmacy formulary lookup screen.

- The order will become a part of the patient's Pharmacy Profile.
- 1st Time Quantity charges will be processed.
- The Date / Time / Initials of the staff entering the order will display in the lower right-hand portion of the screen.
- For facilities using the Point of Care application, the Date / Time / Initials of the staff verifying the order will also display in the lower right-hand

Alternating IV

Alternating IV orders includes 2 or more IV's. These orders must each have a frequency of

"Continuous" and a numeric flow rate. Alternating IV's will display with a  icon on the Electronic Medication Administration Record.

1. Complete the Order Detail information for the first IV in the alternating set.
2. To create the alternating IV order, select **Alternating IV** rather than **Save and Exit**.

Select **Hospital Base Menu > Patient > New Orders > Item > Alternating IV**

Alternating IV

3. This will allow for the second IV order to be placed. Selecting the **Alternating IV** button again will allow another IV order to be added.
4. When finished placing orders for all IV's, select **Save & Alt**.

Select Hospital Base Menu > New Order > Select IV Medication > Alternating IV

Pharmacy - IV Order (NEW ALTERNATING IV ORDER) Evident Community Hospital Signed On Emp: SC Dept: 038

ALEXANDER BETTY L 358259 Age: 32Y Sex: F Ht: 55.00 in Wt: 61.23 kg (135 lbs) C-Cl: N/A Rm: 302-8

Save & Alt. Copy Delete Restore Alternating IV Alternating Comp. Online Adjudication

Item Description: NS W/KCL 20 MEQ 1L

Route: IV Frequency: CONTINUOUS Flow Rate: 125 ml/hr Infusion Period: 8.1 hr Duration: Doses: Priority: Routine

Pump Dosage: As of Date: 02/27/24 Time: 12:31

Set Charge: Procedure Charge: Standard Times

1st Time Quantity: Labels: Sets: Set Labels: Alt. Printer: Non-Standard

Resupply Qty/Day: 3 Sets: Times

Next IV Qty: 3 Sets: Hours Between Doses

1st Dose Date: 02/27/24 Time: 12:10 Days of the Week

Start Date: 02/27/24 Time: 12:10 Initials: SC

Stop Date: Time: Initials: Code: Mon Tue Wed Thu Fri Sat Sun

IV Qty Issued: Total Volume: 1010 Remaining Volume: 0

Physician: ZETTS D POC Verified: Entered: 02/27/24 12:10 Initials: SC

Comments: Treatment Patient's Own NF Price

Ready: Dose Info

Save and Alt

5. Select the IV from the left hand column, select the arrow pointing to the right hand column and place it in the right hand column in the sequence the IV's will be administered. Select the IV from the right hand column and choose the arrow pointing to the left hand column and the IV is removed from the alternating pattern.


Alternating IV Setup



Medications to Alternate	
Medication	Order
NORMAL SALINE 1000 ML	16
KCL 20 MEQ IN NS 1000ML	17

Alternating Medications				
Bag	Medication	Order	Start Date	Start Time
1	NORMAL SALINE 1000 ML	16	None	Issued
2	NORMAL SALINE 1000 ML	16	None	Issued
3	KCL 20 MEQ IN NS 1000ML	17	None	Issued

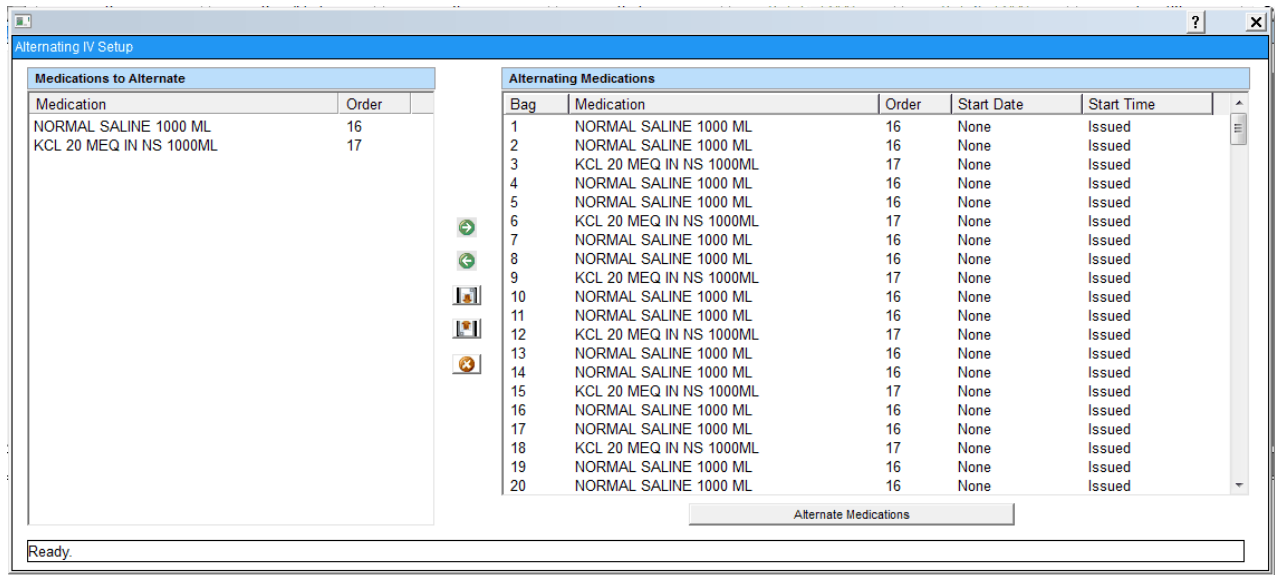
Ready:

Alternating IV Setup

6. To clear the list select the  icon and a prompt "Are you sure that you want to clear this list?" will appear. Select Yes to clear the alternating list, select No to return to the alternating IV order setup.

7. Select **Alternate Medications** and the system will set the pattern after it has been established for the first round of alternating IV administrations.
8. To insert an IV at any point in the alternating IV set, select the  icon to insert after the selected med or  to insert before the selected IV in the right hand column.

Select **Hospital Base Menu > Patient > New Orders > Select IV Medication > Alternating IV > Select 2nd IV Medication > Save & Alt > Alternate Medications**



Alternating IV Setup

9. "X"/Exit out and select **Save and Exit** to complete the order.

Diabetic Record

This section will explain placing Diabetic Record orders via the Pharmacy application. The Diabetic Record is used to document sliding scale insulin administrations, scheduled diabetic medications and insulins, blood glucose levels and carbohydrate counts.

Protocol Orders

1. From the Pharmacy Selection Screen, select **New Orders**.
2. If there is more than one route selected in the **Pull to Diabetic Record** section on the item, a box will display prompting the user to select the route for this diabetic medication order.

NOTE: Items are marked to be utilized in the Diabetic Record via switches on [Pharmacy Information Page 3](#).

Select Hospital Base Menu > Patient Account # > New Orders > select the medication > **Order Type**

Pharmacy - New Order

Evident Community Hospital Signed On Emp: FT Dept: 038

Patient List Pharmacy Profile RX Charge History

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 31.87 Room: 300-9

All meds (by description) All meds (by mnemonic) My meds Non Formulary meds

Lookup Starting Point: humulin

Description	Item Number	Primary Unit	NDC Number
HUMULIN 70/30 INSULIN	00386067	1 INJ	EA 00002-8715-01
HUMULIN LENTE 100 UN/ML	00386061	1 INJ	EA 00088-2220-33
HUMULIN NPH U100 INSULIN	00386060	1 INJ	EA 00677-1769-01
HUMULIN R U100 INSULIN			EA 0619-00
HYDRALAZINE (APRESOLINE) INJ:20MG/ML			0901-25
hydrALAZINE (APRESOLINE) INJ:20MG/ML			0901-25
HYDRALAZINE (APRESOLINE) TAB : 10MG			0029-01
hydrALAZINE (APRESOLINE) TAB:10MG			0029-01
HYDROCHLOROTHIAZIDE (HCTZ) TAB:25MG			1069-02
HYDROCODONE/APAP (LORTAB) TAB 5/500MG			0387-05
hydrocORTisone CREAM 1%			9899-99
HYDRODIURIL 25 MG TAB			1069-02
Hydromorphone PCA IV			0161-41
HYDROMORPHONE (DILAUDID) TAB:2MG			0452-01
HYDROMORPHONE (DILAUDID) INJ: 2MG/ML			1283-01
hydrOXYzine (ATARAX) TAB : 25 MG			0048-60
HYDROXYZINE (ATARAX) TAB: 25 MG	00381196	TAB	EA 88864-0048-60
HYDROXYZINE 50 MG INJ	00387115	1ML INJ	EA 00517-4201-25
hydrOXYzine INJ (VISTARIL) : 50 MG/ML	00387115	1ML INJ	EA 00517-4201-25

* = Non-formulary item

Add to My Meds

Medication Selection screen

The correct order screen will display.

Select Hospital Base Menu > Patient Account # > New Orders

The screenshot shows the 'Pharmacy - Non-IV Order (NEW ORDER)' interface for patient AINSWORTH MARTHA COZEN. The medication is Humulin R 100U/10ml. The order details include a dose of 1 unit, route of SUB Q, and a frequency of PRN Q6H. The screen also shows patient demographics, physician information (SMITH JAME), and a 'Frequency Incomplete' warning at the bottom.

New Order screen

- **Dose** and **Unit** do not need to be addressed for protocol orders and will be grayed out (disabled) after the protocol has been added.

NOTE: The correct Dose will display for nursing depending upon the blood glucose level.

3. Select the **Frequency** that will be used for blood glucose checks from the drop-down menu. These administrations times will display on the EMAR under the "Diabetic Intervention" order.

NOTE: Once the protocol has been selected, the Item Frequency is grayed out and defaults to PRN. This is now the frequency for the medication order, which will be given as needed based on the results of the BG level or carbohydrate count checks.

4. Select **Add Protocol**.

Select Hospital Base Menu > Patient Account # > New Orders > Add Protocol

The screenshot displays the 'New Orders' screen for a patient named AINSWORTH MARTHA COZEN. The medication being ordered is Humulin R 100U/10ml. The frequency dropdown menu is highlighted with a red box and contains the text 'ACHS'. The screen includes various fields for dose, unit, route, frequency, duration, and priority, as well as a section for instructions and physician information.

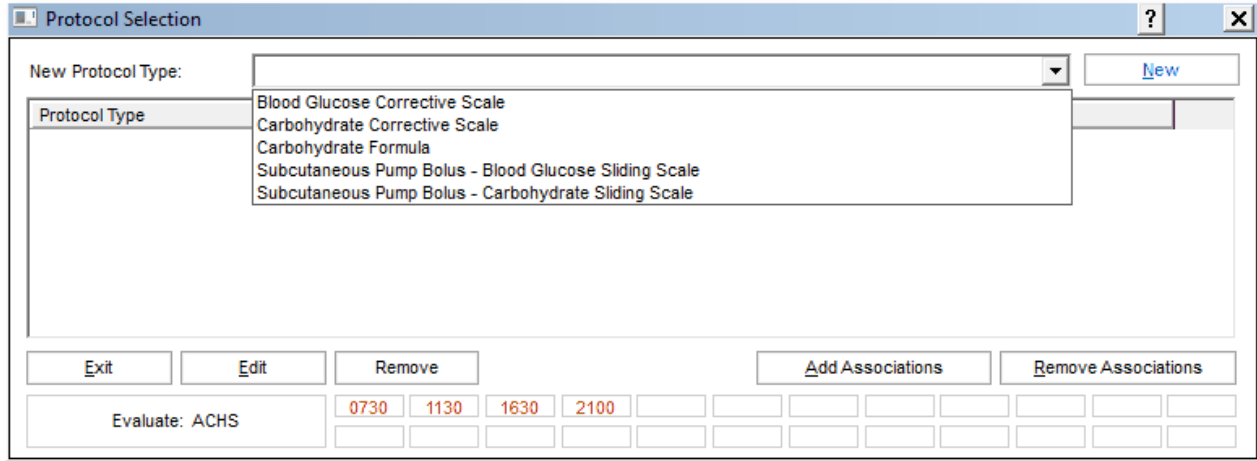
New Orders screen

The Protocol Selection screen will display.

5. Select the drop-down menu to select the Protocol Type and select **New**

- Available protocol types are based on the type of order that is placed (SubQ, IV, etc.) and may include any of the following:
 - **Blood Glucose Sliding Scale** - options for subcutaneous and IV
 - **Carbohydrate Sliding Scale** - options for subcutaneous and IV
 - **Carbohydrate Formula** - based on the amount of carbohydrates consumed at meal and snack times; options for subcutaneous and IV
 - **SQ Pump Bolus BG Sliding Scale** - subcutaneous insulin pump orders based on patient's blood glucose level - allows entry of bolus insulin
 - **SQ Pump Bolus Carbohydrate Sliding Scale** - subcutaneous insulin pump orders based on patient's carbohydrate intake - allows entry of bolus insulin
 - **CIV Bolus BG Sliding Scale** - continuous IV orders based on patient's blood glucose level - allows entry of bolus insulin
 - **CIV Bolus Carbohydrate Sliding Scale** - continuous IV orders based on patient's carbohydrate intake - allows entry of bolus insulin

NOTE: Descriptions on all protocol types are facility-defined. Reference the POC Setup Reference user guide for more information.

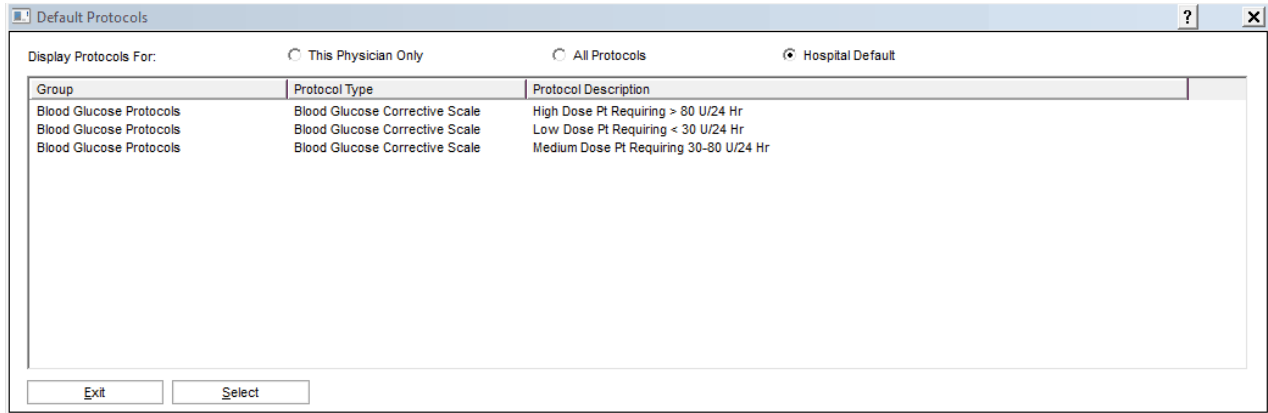


Protocol Type

Default Protocols will display.

Sliding scale entry offers several different protocol types, as well as many more user-defined protocol options. For more detailed setup information, please refer to the [POC Setup User Guide](#).

6. Select the desired Protocol. Protocol selection options are This Physician Only, All Protocols and Hospital Default. Multiple sliding scales may be available for each.



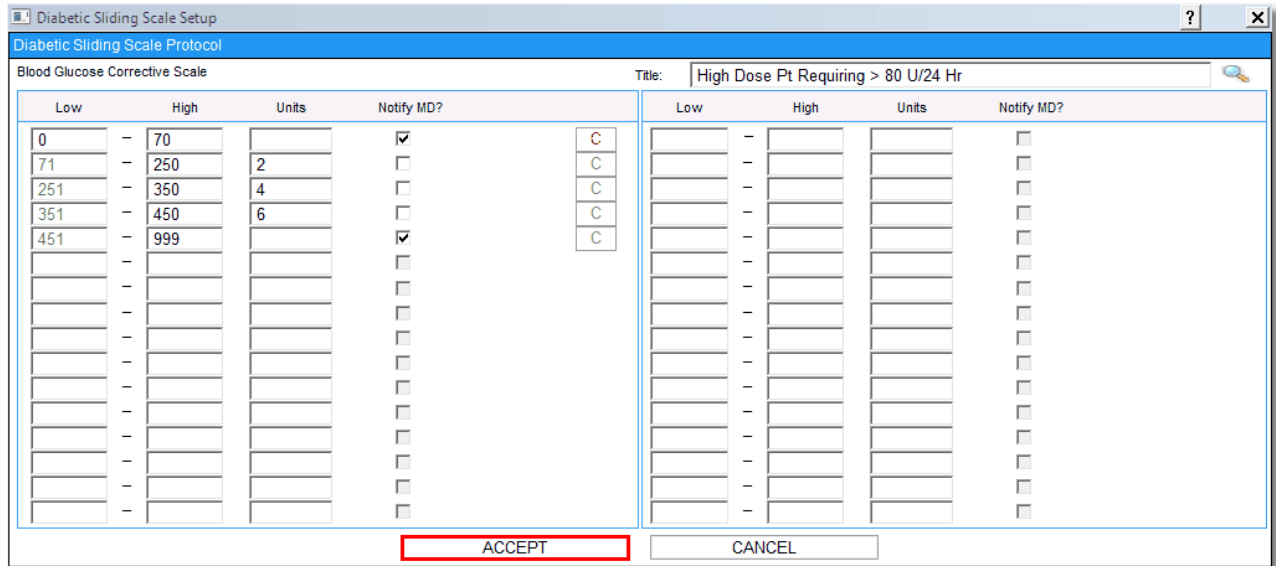
Protocol Defaults

The default scale will display but may be modified as needed.

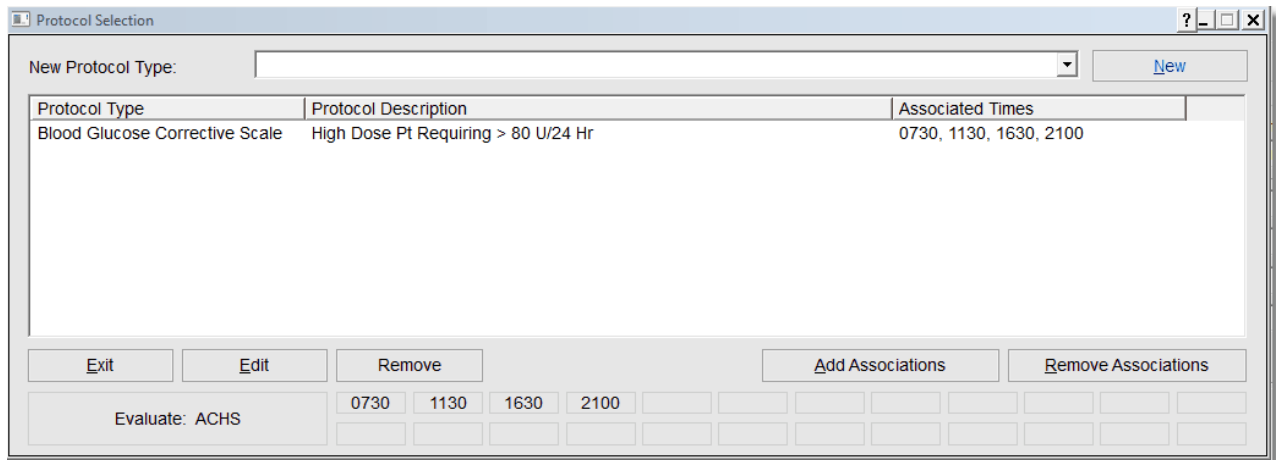
- Blood Glucose Sliding Scales should be addressed as follows:
 - Blood Glucose sliding scales will start with a low value of 0 and end with a high value of 999.
 - Each line is a BG level range between a low value and a high value.
 - When the highest value on the ordered scale has been entered, type a 999 in the final high value field to indicate that the sliding scale is complete.

- Comments may be added to each line of the scale. To enter a comment for a specific range, select the button labeled C. Type the comments into the text field and select Update to save or Cancel to exit without saving. A red C indicates that comments are present for a particular range.
- Carbohydrate Sliding Scales are set up the same way as Blood Glucose scales except the user should be aware that the low and high values pertain to number of grams of carbohydrates rather than blood glucose levels.
- Bolus scales function the same way as standard sliding scales but allow entry of bolus units to be entered for each range:

7. Select **ACCEPT**



Sliding Scale Protocol



Protocol Selection Screen

8. Select **Exit** to return to the order.

- After the protocol has been added, Dose and Unit will be disabled. The correct dose will display for nursing based on the blood glucose level entered.
- The frequency for the order will revert to PRN after the protocol is added. The frequency selected will be utilized for the blood glucose checks and display on the EMAR as "Diabetic Intervention".

Select **Hospital Base Menu > Patient Account # > New Orders > Add Protocol > Exit**

The screenshot displays the 'Pharmacy - Non-IV Order (NEW ORDER)' interface for patient AINSWORTH MARTHA COZEN. The medication is Humulin R 100U/10ml. The 'Dose' field is disabled and contains 'Unit(s)'. The 'Frequency' dropdown is set to 'PRN'. The 'Brand' is REGU-100HUMAN. The 'Route' is SUB Q. The 'Physician' is SMITH JAME. The 'Start Date' is 10/19/15 and the 'Time' is 15:23. The 'Initials' are FT. The 'Date' entered is 10/19/15 and the 'Time' is 15:23. The 'Initials' are FT. The 'POC Verified' is NS 003 REGU-100HUMAN BAL =. The 'Ready' button is visible at the bottom left, and the 'Dose Info' and 'Check PSD' buttons are at the bottom right.

Medication Tab

9. Select **Save & Exit** to complete the order.

Standing Orders

Standing orders allows recurring physician orders to be entered once and recalled as desired. Standing orders can be a combination of Non-IV, Routine, PRN, or IV Orders. Standing orders are created and maintained in the Standing Orders Table. See [Pharmacy Setup](#) for more information on Standing Orders or [Table Maintenance](#) for information on Order Sets.

Standing Orders

1. From the Pharmacy Selection Screen, select **Standing Orders**.
2. Enter starting standing order description and select **GO** or press <Enter> to start the display at the beginning.
3. Using the mouse, click once on the Standing Order.

Select **Hospital Base Menu > Patient Account # > Standing Orders**

Pharmacy - Standing Orders

Patent List

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 39.84 Room: 300-9

Starting Description: GO

Standing Order Description

- ADMIT ORDER
- ADMIT: STROKE CPOE
- Activase (TPA) Protocol
- Alcohol W/D Care Map
- Alcohol Withdrawal Pathway
- CHF-Admission Protocol
- CORONARY CARE PROTOCOL 69
- Cardiac CP-Day 1
- Cerebral Vascular Admit SO
- Chest Pain Protocol
- Complicated Pneumonia Pathway
- Detox Orders
- Detox Standing Orders
- Dr Baxter Abdominal Pain Admit Orders
- Dr Baxter ICU Admit
- Dr Baxter Labor Admission
- Dr Baxter NICU Admit Orders
- Dr Baxter Vag Delivery
- Dr Baxter: General Admission Orders
- Dr Graff's CAPs Protocol

Standing Orders

4. To process all of the selected Standing Orders, select **Process**.
 - Orders that do not need to be processed can be removed from the list prior to processing.
 - Using the mouse, highlight one or more orders and select **Remove**.

Select Hospital Base Menu > Patient Account # > Standing Orders > Select Standing Order

Selected Standing Order

5. Select Process to send the orders. Clinical Monitoring will be performed and each order will display for maintenance if necessary.
6. Once the order has been checked for accuracy and completeness, select **Next Standing Order** to display the next order.
 - Repeat until all orders have been processed.

Select Hospital Base Menu > Patient Account # > Standing Orders > Process

Medication Tab

Long Term Care / Prescriptions

The TruBridge EHR Pharmacy software has the capability to process Employee, Outpatient, and Long Term Care prescription orders.

- Long Term Care / Prescription orders will automatically be assigned a prescription number.
 - The prescription number is generated from the Pharmacy Control Information Table.
 - Non-Scheduled and Schedule 3-5 medication prescription numbers are assigned from the **Primary RX#** counter.
 - Schedule 2 medication prescription numbers are assigned from the **Secondary RX#** counter.

1. From the Pharmacy Selection Screen, select **Long Term Care / Prescriptions**.

NOTE: *The default for the Formulary Screen displays All meds (by description). The lookup display can be changed by selecting the All meds (by mnemonic) or My meds option.*

2. Enter starting medication description and select **GO** or press <Enter>.
 - The formulary lookup screen lists the Item Description, Item Number, Primary Unit, and NDC Number.
3. Double click on the desired item.
 - If the desired item is not displayed, re-key the partial description in the *Lookup Starting Point* field.

NOTE: *If allergies, height or weight have not been entered, the Clinical Information Screen will display and require entry to continue order processing. This feature is controlled by a switch located in the Pharmacy Control Table. Refer to [Pharmacy Setup](#) for additional information.*

4. Clinical Monitoring checks will be performed once the item is selected.
 - If a Clinical Monitoring check is flagged, the **Clinical Monitoring** tab will be displayed first.
 - Once the clinical information has been viewed, select the **Medication** tab to continue.

Select Hospital Base Menu > Patient > Item > Medication tab

The screenshot displays the 'Pharmacy - Non-IV Order (NEW ORDER)' interface for patient ALEXANDER BETTY L. The medication is QUINAPRIL (ACCUPRIL) TAB 10 MG. The 'Treatment' checkbox is highlighted with a red box. The screen includes fields for patient information, medication details, and order management options.

LTC Medication

5. Complete the order by clicking in the required field(s). Use the mouse clicker or <Tab> key to move from one field to the other. Refer to previous sections of this chapter for details on completing order entry. The information entered in dose, route, and frequency will also pull to the Long Term Care MAR.
 - **Treatment**
 - Default: Blank
 - Options: No – Blank or Yes - ✓
 - Usage: Indicates the LTC order is a treatment. Treatments can be printed to a separate Treatment Administration Record (TAR) rather than occupy space on the Medication Administration Record (MAR).
6. If the order has been credited back and there are no refills on the order, the order can still be charged when it is entered.

Rx Information

Once Medication information is complete, select the **RX Information** tab.

Select **Hospital Base Menu > Patient > LTC / Prescriptions > Item > RX Information**

The screenshot shows the 'RX Information' tab selected. The form contains the following fields and values:

Field	Value
Physician	TOLBERT JK
Rx Expiration Date	
Date Written	06/10/16
Days Supply	30
Print Drug Info.	N
Hard Copy Label	0
Override Paycode	
Alt. Practitioner	
NDC Number	00071 0530 23
NDC on Label	<input checked="" type="checkbox"/>
Payment Method	- None
Manufacturer	Pfizer Inc.
Pharmacist	FT
RX Number	000000060 #
Lot Number	RT568947
Lot Expiration Date	12/31/2024 (MMDDYYYY)
DEA	
DPS	
NPI	- None
DAW Code	0 - No Product Selection Indicated
Compound	<input type="checkbox"/>
No. of Refills	2 x Refill Qty 60 = 120
Refills issued	1 for 60
Serial No.	
Pill Desc.	Brown Solid Triangle 10 PD 530

RX Information

- **Physician**
 - Default: Admitting physician
 - Options: Entry of ordering physician
 - Usage: Prints the physician to the prescription label.
- **Rx Expiration Date**
 - Default: Blank
 - Options: 6-digit date
 - Usage: Enter the date the medication is set to expire in MMDDYY format. The system will automatically insert slashes in the date.
- **Date Written**
 - Default: Current Date
 - Options: 6-digit date
 - Usage: The current date will automatically display. The date can be changed to reflect the actual date the order was written if necessary. Enter the date in MMDDYY format. The system will automatically insert slashes in the date.
- **Days Supply**
 - Default: Blank
 - Options: 1 - 999
 - Usage: Describes the number of days the LTC or prescription order will supply.
- **Print Drug Info**
 - Default: N (No)

- Options: N (No) or Y (Yes)
- Usage: Set to Y (Yes) if a drug monograph is needed. The monograph will print following completion of the order.

- **Hard Copy Label**

- Default: 0 (Zero)
- Options: 1 - 9
- Usage: If a hard copy label of the prescription is needed, enter the amount. Hard copy labels are for outpatient prescriptions and can include the NDC number.

- **Override Paycode**

- Default: Blank, unless the patient has existing Patient Paycode
- Options: Entry of an alternate paycode.
- Usage: Patients Paycodes can be established to determine charges for prescriptions. Override Paycode allows the previously established Paycode to be overridden for the selected order.

NOTE: The **RX Number Only** field may be selected when setting up Paycodes for employee or outpatient prescriptions to conceal medication description viewing from any department other than Pharmacy.

NOTE: If the visit is registered with a Service Code of a dollar sign (\$) or a plus sign (+), the medication description will not display for any department other than Pharmacy.

- **Alternate Practitioner**

- Default: Blank
- Options: Up to a 15-character alternate practitioner
- Usage: Used to list an alternate practitioner, if required. The alternate practitioner will print to the prescription label.

- **NDC Number**

- Default: Current NDC for the item
- Options: 10-digit or 11-digit NDC
- Usage: Lists the National Drug Code (NDC). The NDC pulls automatically from Pharmacy Information in the Item Master. The NDC can be manually keyed if necessary.

NOTE: If the NDC number of a medication is changed after it has been ordered, the new NDC number will update on existing Long Term Care and Employee prescriptions.

- **Pharmacist**

- Default: Initials of the Pharmacist that is signed-on
- Options: Will accept up to a 26 characters for Pharmacist name or initials
- Usage: Attaches the initials or name of the entering pharmacist to the prescription and causes an outpatient label to print if a label is requested. The initials will display in RX Charge History and on the Order History tab.

- **RX Number**

- Default: Next numerical prescription number.
- Options: Select the # icon to generate the next available number.
- Usage: The RX Number is automatically generated by the system.

- **Lot Number**
 - Default: Blank
 - Options: Lot number of the medication.
 - Usage: Allows the medication lot number to print to the prescription label.

- **Lot Expiration Date**
 - Default: Blank
 - Options: Lot expiration date.
 - Usage: The lot expiration date must be entered in a MMDDYYYY format.

- **DEA**
 - Default: The admitting physician's DEA number
 - Options: Up to a 9-digit DEA number
 - Usage: The physician DEA number will automatically pull from the physician table. The DEA number will NOT print to the prescription label.

- **RX Origin Code:**
 - The RX Origin Code was created for Electronic Controlled Substance Reporting for the state of Alabama. This field indicates how the pharmacy received the prescription. The drop-down box displays the following options:
 - 01 Written Prescription
 - 02 Telephone Prescription
 - 03 Telephone Emergency Prescription
 - 04 Fax Prescription
 - 05 Electronic Prescription
 - 99 Other

- **DPS**
 - Default: Blank or DPS as entered in the Pharmacy Control table
 - Options: Up to a 10-digit DPS Number
 - Usage: List the Department of Public Safety (DPS) number if required. If required, the DPS should be listed in the Pharmacy Control Table.

- **Opioid Treatment Type**
 - Default: None
 - Options: Drop-down options that pull from the Opioid Treatment Type Table in Table Maintenance.
 - Usage: Explain the reason for the opioid prescription. If the prescription is not for an opioid, this field should not be used.

- **NPI**
 - Default: The prescribing physician's NPI number will display, providing the physician has an NPI number associated with their profile
 - Options: If the NPI number displays incorrectly or does not pull over, it can manually be keyed in.
 - Usage: Some states may require this information for outpatient prescriptions.

- **DAW Code**
 - Default: Blank

- Options: 1 - 9
- Usage: Lists the Dispense as Written (DAW) code for use with the Online Adjudication application.

- **Compound**
 - Default: Blank
 - Options: No – Blank or Yes - ✓
 - Usage: Indicates whether or not the selected medication is a compound drug.

- **No. of Refills**
 - Default: Blank
 - Options: 1 - 99
 - Usage: Indicates the number refills available for the order.

- **x Refill Qty**
 - Default: Blank
 - Options: 1 - 99999
 - Usage: Indicates the quantity of units available for each refill. The system will calculate the total number of units based on the number of refills times the refill quantity.

- **Refills Issued for**
 - Default: Blank
 - Options: 1 - 99999
 - Usage: This field will give the number of refills and the total number of pills given.

- **Serial Number**
 - Default: This is an 8 character field that will pull to the controlled substance report
 - Options: This is field will hold the serial number for the medication. No dashes, periods, commas, brackets, lower-case characters, asterisks, mathematical signs, or other signs or symbols should be entered in this field
 - Usage: The serial number will pull to the controlled substance report, some states may mandate this information be included on the report.

Stop All Active Orders

Stop All Active Orders allows all active orders to be stopped. This feature is useful when a patient goes to surgery or has extensive medication order changes.

1. From the Pharmacy Selection Screen, select **Stop ALL Active Orders**.

Select **Hospital Base Menu > Patient Account# > Pharmacy - Selection Screen**

Stop All Active Orders

2. Enter a valid stop code. The most commonly used stop codes for this option are as follows:
 - D – Discontinue
 - S – Surgery
 - H – Hold
3. Enter initials.
4. Enter Y (Yes) or ✓ (Check Mark) in **Require nursing to re-verify**. (Allows nursing to review and verify the stop information.)
5. Click **OK** to finalize the request.
 - If this option is accessed in error, click the **X** in the upper right hand corner to close.

NOTE: Do not use a stop code of <1> One Time Order or <A> Autostop.

Transfer Orders

Transfer Orders allows pharmacy to move orders from an old account number to a new account number quickly and easily. The following are all cases when patients could be given new account numbers:

-
- A patient is given a new account number when moved to a new room.
 - A patient moves from an acute care hospital room to a hospital owned rehab unit (or the reverse).
 - A patient remains in the same room but their status changes from acute care to swing-bed status.
1. From the Pharmacy Selection Screen, select **Transfer Orders**.
 2. Current patient account information will display. Enter the old account from which the orders need to transfer from.
 3. The initials of the staff signed-on will auto display.
 4. To process the transfer, select **OK**. To exit, select **Cancel**.

Select Hospital Base Menu > Patient > Transfer Orders

Pharmacy

Transfer Active Orders

From Account Num:

From Account Name:

To Account Num: 357823

To Account Name: AINSWORTH MARTHA COZEN

Initials:

OK Cancel

Transfer Active Orders screen

- The active orders on the original account are discontinued with a stop code of "X". The orders on the new account have a start date/time of the time the orders were transferred.

NOTE: If the Dose Calculator was utilized on the original order, the Dose Calculator screen will be blank when the new order is created. **Dose Calc** will need to be selected to recalculate the administer dose and amount.

NOTE: If the Diabetic Record item being transferred has a protocol / sliding scale attached, the new order will need to have the same protocol / sliding scale added back to the item manually. Otherwise, the diabetic record item will need to be recreated for the new account.

11.5 Miscellaneous Pharmacy Functions

Overview

This section will cover miscellaneous functions in the pharmacy application. Functions covered are Comments, Online Adjudication, Patient Pay Codes, and Skip A Label.

Comments

This function allows the pharmacy personnel to communicate with each other regarding any pertinent information relating to a patient profile. It is viewed only by the pharmacy and does not display anywhere else in the system.

1. From the Pharmacy Selection screen, select **Comments**.

Select **Hospital Base Menu > Patient Account # > Pharmacy-Selection Screen**

The screenshot shows the 'Pharmacy - Selection Screen' for patient AINSWORTH MARTHA COZEN (Account # 357823). The interface includes a top navigation bar with 'Patient List', 'Control Tables', 'Item Master', 'Print Reports', 'Order Number', 'RX#', 'Med Reconciliation', and '24-Hour EMAR'. Below this, patient demographics are displayed: Age: 80Y, Sex: F, Height: 60.00 in., Weight: 54.43 kgs, CrCl: 39.84, Room: 300-9.

The main area is divided into several functional panels:

- Order Entry:** New Orders, Standing Orders, Long Term Care / Prescriptions, Stop ALL Active Orders, Transfer Orders.
- Clinical Review:** Pharmacy Profile, Interventions / ADR, Temporary Orders, IV Orders, Ancillary Orders.
- Other:** Clinical Information Changes, Allergy Review, Estimate Creatinine Clearance, Clinical Monitoring, Misc. Clinical Monitoring, Patient Education, Interventions, Adverse Drug Reactions, Image/Signature Store/Retrieve, Electronic Forms, Rx Diagnoses.
- Miscellaneous:** **Comments** (highlighted), Online Adjudication, Patient Pay Code, Skip a Label.
- Charge Review:** Detail Charges, Summarized Charges, RX Charge History.

At the bottom left, there is a 'Change to Account #' field. The status bar at the very bottom indicates 'Ready'.

Pharmacy Selection Screen

2. Comments provides six lines to enter or change free text.
3. Select a line to enter or change information on that line only, use <TAB> to go to the next line.
4. To delete a line of comments click and drag across the line and select the <DELETE> key on the keyboard.
5. Select **Save** to save the comments.
6. Select **Cancel** to exit back to Pharmacy Selection screen.

NOTE: In the warning section of patient demographics, the word "Comment" and the date the last comment was entered or edited is displayed. If the Comment screen is reviewed, but no changes are made, the comment date does not change.

Select **Hospital Base Menu > Patient Account # > Comments**

The screenshot displays the 'Pharmacy - Comments' interface for patient AINSWORTH MARTHA COZEN. At the top, there are 'Save' and 'Cancel' buttons. Below the patient name, a 'Comments' button is visible. The main area contains a text input field with the text 'Patient has shown sensitivity to narcotics.' and several empty lines for additional comments. The patient's demographics are listed at the top: 357823, Age: 80Y, Sex: F, Height: 60.00 in., Weight: 54.43 kgs, CrCl: 39.84, Room: 300-9.

Comments Screen

NOTE: The Comments screen can be set to automatically display upon accessing order entry. A switch located in the Pharmacy Control Information Table controls this option. Refer to [Pharmacy Control Information Table/ Clinical](#) for further information.

Online Adjudication

Please call TruBridge for more information on Online Adjudication.

Patient Pay Codes

This option allows a Patient Pay Code to be attached to the patient profile for use with all prescription orders.

1. From the Pharmacy Selection screen, select **Patient Pay Code** and select the desired pay code.

Select Hospital Base Menu > Patient > Patient Pay Code

Pay Code	Description
EMP20	EMPLOYEE
OTC	OTC MARKUP
THOME	TAKE HOME MED

Patient Pay Code Lookup Window

2. The selected Pay Code will display next to **Currently Selected Paycode**.
3. To search for a new Pay Code select either **Search by Pay Code** or **Search by Description**.
4. Enter the beginning description and Enter.
5. Double click the appropriate Pay Code.
6. The selected Pay Code will then display next to Patient Pay Code.

Skip A Label

Selecting **Skip a Label** from the Pharmacy Selection screen causes the printer to form feed exactly one label forward. Using this option may help maintain the label alignment.

11.6 Clinical Review

Overview

This section will cover accessing the patient's Pharmacy Profile, viewing existing orders by order number, viewing existing prescriptions by the prescription number, and viewing existing Interventions / ADR will be covered as well as. Also covered is viewing temporary orders and the process of OK'ing these orders. Viewing IV orders and ancillary orders is covered as well.

Pharmacy Profile

Pharmacy Profile is a review screen for all the selected patient's medication orders. The pharmacy profile can be accessed at any time during order entry for use as a reference. Orders can be credited, charged, discontinued, renewed, or edited from the pharmacy profile.

Stop Codes

A Stop Code is the letter or number after the stop date and time on a medication order. Stop codes indicate the reason an order has been or will be discontinued. The TruBridge EHR automatically generates the following Stop Codes: A, C, D, E, M, T, X, 1. No other codes should be used. Any other code will be treated as a hard stop.

- **A (Physician Re-Order):** This is the only soft Stop Code and **orders with this code will remain active until discontinued**. Orders with this Stop Code will print to the Physician Re-Order Report or alert the physician via the Order Chronology that the medication needs to be renewed or discontinued. This code will automatically pull in the initials XXX. It should not be manually added or changed.
- **C (Copy Forward):** The Copy function will discontinue the original order and create a new identical order which may be modified. This is an efficient method to make changes to frequency or flow rate. The copy function cannot be utilized if the strength of the medication needs to be changed. If Dose Calculator was used on the original order, Dose Calc will need to be selected to recalculate the administer dose and amount on the new order.
- **D (Discontinue):** Medications with this stop code will turn black on the EMAR when the stop date and time is met. This stop code may be manually updated.
- **E (Error Discontinue):** Orders that are Error DC'd turn black on the EMAR, as do other discontinued orders. TruBridge recommends this function be used for the following reasons: order entered on the wrong patient, wrong medication ordered, or the order entered as non-IV instead of IV or the reverse.
- **M (Max Dose):** The "M" is auto assigned by the TruBridge EHR when the Duration field is utilized to enter a maximum number of doses. The software will track the number of doses administered via the Patient Documentation application. If the number of doses has not been met, the order will remain active past the stop date and time. A setting in the POC Control Maintenance table controls whether omissions count toward the max dose. This stop code should never be

manually added or changed. If a Max Dose order is copied, the Duration information does NOT copy forward to the new order.

- **T (Take Home):** Entering this code on an existing inpatient order will automatically assign a prescription number and the Pharmacist initials. The user will be taken to the Rx Information Tab to enter any other necessary information. If a label is requested, the software will generate an outpatient label to be placed on the medication being sent home with the patient.
- **X (Transfer):** When active orders are transferred to a patient's new account, all transferred orders will display an "X" in the stop code field on the original account.
- **1 (One Time):** One-time orders must have a frequency of X1. These orders have the same Start Date\Time and Stop Date\Time. X1 orders discontinue immediately on the Pharmacy Profile and must be viewed using the All Orders option.
- **PRNX1:** PRNX1 orders are discontinued as other X1 orders and do not need a dose in the Duration field. These orders have no **Stop** information until the medication is administered. After nursing administers the dose, the order is automatically discontinued on the EMAR and the **Stop Date/Time, initials and code** populate. The order is sent to the Order Verification queue as a NS D'C order.
- **PRN Duration (PRNXx):** As needed orders with a maximum number of doses must have a number in the Duration field. These orders have no **Stop** information until the medication is administered. When the number of doses specified in Duration is given, the order is automatically discontinued on the EMAR and the **Stop Date/Time, initials and code** populate. The order is sent to the Order Verification queue as a NS D'C order.

NOTE: *If a frequency is changed on an order, the Stop Code should be readdressed.*

Sort Sequence

The default Sort Sequence for the profile is determined by a switch located in the Pharmacy Control Table.

Radio buttons allow easy transition between Chronological, Alphabetical, or By Frequency.

Filter

The system default is to display Current Orders. **Current orders** are those orders considered active.

- Radio buttons allow All Orders to be displayed. **All Orders** consist of active and inactive orders. Use this option to access orders that have been stopped.
- **New Orders** will display all orders entered prior to exiting to the Pharmacy-Selection Screen.

Select Hospital Base Menu > Patient > Pharmacy Profile

Pharmacy - Medication Profile

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 39.84 Room: 300-9

Sort Sequence: Chronological Alphabetical Frequency Status: All Orders Current Orders

Order Type(s): Non-IVs Large Volume IVs Other IVs

Order	Start Date	Stop Date	Time	Code	Description	Dose	Unit	Route	Notes	Pending Actions
1	10/07/15	10:39			PROPRANOLOL (INDERAL) TAB 20 MG	20 MG		PO	TID	
2	10/15/15	08:38			ALBUTEROL INH SOL .083% 3ML 3 ML			UPDRAFT	QID	
3	10/15/15	09:01			NORMAL SALINE 1000 ML 125 ml/hr			IV	CONTINUOUS	
4	10/15/15	10:00			ROCEPHIN IVPB : 500MG/100ML NS 100 ml/hr 500MG			IV	Q24H	
					cefTRIAxone (ROCEPHIN) INJ 1 GM					

Medication	Dose	Route	Freq/Rate	Duration	Start Date/Time	Stop Date/Time

Buttons: Renew, DC, UnDC, Charge, Credit, Edit, Labels, Select All

Pharmacy Selection Screen

Edit

To make a change to an order, highlight the order and select **Edit**.

- An order can also be accessed by double clicking using the mouse.
- If the order is copied forward, the original order will be discontinued and the order information will copy forward to the new order.

NOTE: If the Dose Calculator was utilized on the original order, the Dose Calculator screen will be blank when the new order is created. **Dose Calc** will need to be selected to recalculate the administer dose and amount.

- If changes are made to any portion of the order, select **Save and Exit** and the following prompt will display: *Require NS to reverify?* For facilities using the Point of Care application, answering **YES** will force nursing to reverify the order.

Select Hospital Base Menu > Patient > Pharmacy Profile > Order > Edit

POC Verification

Require NS to reverify?

Yes No

Reverify Prompt

Charge

- To enter a charge for an order, highlight the order and select **Charge**.
 - The Charge Quantity screen will display. Enter the number to charge and select **OK**.
 - The Number of Labels screen will display. Enter the number to labels to print and select **OK**.
 - Once the charge has been entered, it can be removed by selecting **Undo**.

Select **Hospital Base Menu > Patient > Pharmacy Profile > Order > Charge**

The screenshot shows a dialog box titled "Non IV - Charge" with a blue header bar containing "PROPRANOLOL (INDERAL) TAB : 20 MG". The main area contains the following fields and controls:

- Service Date: 11/30/15 (dropdown menu)
- Charge Quantity: [text input field]
- Charge by Component: [button]
- Dispense Quantity: [text input field]
- Number of Labels: [text input field]
- Alternate Printer: [text input field]
- Number of Sets: [text input field]
- Number of Set Labels: [text input field]
- Stay Type: [dropdown menu]
- Service Code: [text input field]

At the bottom of the dialog box are three buttons: "Cancel", "Apply to All", and "OK".

Charge Quantity Prompt

NOTE: Charges and Credits entered will display in the Pending Actions column. Pending Actions will be highlighted in red to denote an action was taken.

- To process the charge, select the Back Arrow in the upper right-hand portion of the screen.
 - If charges/credits are entered on an account that has not been admitted or has been discharged the user will receive this warning prompt:
"Warning Outside Service Date XX/XX/XX-XX/XX/XX PROCEED YES/NO?"
 - If charges/credits are entered on a patient with a Pre-Admit account the user will receive this warning prompt:
"Warning: PRE-ADMIT-----PROCEED? Yes/No"

NOTE: Actions can be performed on multiple orders prior to processing pending actions.

Credit

- To enter a credit for an order, highlight the order and select **Credit**.
 - The Credit Quantity screen will display. Enter the number to credit and select **OK**.
 - Once the credit has been entered, it can be removed by selecting **Undo**.

Select **Hospital Base Menu > Patient > Pharmacy Profile > Order > Credit**

The screenshot shows a dialog box titled "Non IV - Credit" with a blue header bar that reads "PROPRANOLOL (INDERAL) TAB - 20 MG". The dialog contains the following fields and controls:

- Service Date:** A dropdown menu showing "11/30/15".
- Credit Quantity:** A text input field.
- Max Credits:** A label showing "61".
- Credit by Component:** A text input field.
- Number of Sets:** A text input field.
- Stay Type:** A dropdown menu.
- Service Code:** A text input field with a small key icon to its right.

At the bottom of the dialog are three buttons: "Cancel", "Apply to All", and "OK".

Credit Quantity Prompt

NOTE: Charges and Credits entered will display in the Pending Actions column. Pending Actions will be highlighted in red to denote an action was taken.

- To process the credit, select the Back Arrow in the upper right-hand portion of the screen.

NOTE: Actions can be performed on multiple orders prior to processing pending actions.

Renew

Only orders with a stop code of A may be renewed. Refer to [Pharmacy Information Page 1](#) for more information.

- To renew an order from the Profile screen, highlight the order and select **Renew**.
 - The stop date will be advanced using the reorder days listed on Pharmacy Information Page 1.
 - The following prompt will display: *Require NS to reverify?* For facilities using the Point of Care application, answering **YES** will force nursing to reverify the order.
- To process the renewed order, select the ← (Back Arrow) in the upper right-hand portion of the screen.

NOTE: Actions can be performed on multiple orders prior to processing pending actions.

Discontinue

1. To discontinue an order from the Profile screen, first highlight the order. The order will display in a box at the bottom of the screen.
 - If a future discontinue date is required, use the drop-down arrow in the Stop Date/Time field to select a discontinue date and then select **DC**.
 - The following prompt will display: *Require NS to reverify?* For facilities using the Point of Care application, answering **YES** will force nursing to reverify the order.
2. To process the discontinued order, select the Back Arrow in the upper right-hand portion of the screen.

NOTE: *Actions can be performed on multiple orders prior to processing pending actions.*

UnDc

1. To UnDC an order from the Profile screen, first select All Orders. Next, highlight the order and select **UnDC**.
 - The following prompt will display: *Require NS to reverify?* For facilities using the Point of Care application, answering **YES** will force nursing to reverify the order.
2. To process the UnDC order, select the Back Arrow in the upper right-hand portion of the screen.

NOTE: *Actions can be performed on multiple orders prior to processing pending actions.*

24-Hour EMAR

An option to access the 24-hour electronic MAR is available from the Pharmacy Profile as well as the Pharmacy - Selection Screen. Select **24-HOUR EMAR** option to view the EMAR used by nursing staff displaying all current medications and scheduled administration times. The options to sort medication list display and chart administration details available to nursing staff are also available to Pharmacy staff. For more information see [Medication Administration Record \(MAR\)](#) in the Updated EMAR/MedVerify User Guide or [Electronic Medication Administration Record](#) in the POC Pharmacy User Guide.

Select Hospital Base Menu > Patient Account # > Pharmacy Selection Screen

The screenshot shows the 'Pharmacy - Selection Screen' for patient AINSWORTH MARTHA COZEN (357823). The patient's age is 80Y, sex is F, height is 60.00 in, weight is 54.43 kgs, and room is 300-9. The '24-Hour EMAR' option is highlighted in the top right. The main area contains several menu categories: Order Entry (New Orders, Standing Orders, Long Term Care / Prescriptions, Stop ALL Active Orders, Transfer Orders), Clinical Review (Pharmacy Profile, Interventions / ADR, Temporary Orders, IV Orders, Ancillary Orders), Other (Clinical Information Changes, Allergy Review, Estimate Creatinine Clearance, Clinical Monitoring, Misc. Clinical Monitoring, Patient Education, Interventions, Adverse Drug Reactions, Image/Signature Store/Retrieve, Electronic Forms, Rx Diagnoses), and Miscellaneous (Comments, Online Adjudication, Patient Pay Code, Slip a Label, Charge Review, Detail Charges, Summarized Charges, RX Charge History). There is also a 'Change to Account #' field and a 'Ready.' status at the bottom.

Pharmacy Selection Screen

Select Hospital Base Menu > Patient Account # > Pharmacy Selection Screen > 24-Hour EMAR

The screenshot shows the 'Medication Administration Record - Current Date and Time' for patient AINSWORTH MARTHA COZEN (357823). The patient's MR# is 000307, DOB is 12/10/1934, sex is F, and current weight is 120 lbs 54.43 kg. The MAR display is set to 'All' and includes discontinued medications. The date range is from 10/11/2015 17:00 to 10/16/2015 07:00. The table shows medication administration times for 10/16/2015, 10/15/2015, and 10/16/2015. Medications listed include PROPRANOLOL (INDERAL) TAB, ALBUTEROL INH SOL .083% 3ML, ROCEPHIN IVPB, and NORMAL SALINE 1000 ML.

	10/16/2015 07:00	10/15/2015 20:00	10/15/2015 17:00	10/15/2015 16:00	10/15/2015 12:00	10/15/2015 10:00	1
PROPRANOLOL (INDERAL) TAB Dose: 20 MG TID PO CHECK PULSE BEFOREADMINISTRATION IF < 50 HOLD AND CALL MD	07:00		17:00		12:00		Give
ALBUTEROL INH SOL .083% 3ML Dose: 3 ML QID UPDRAFT		20:00		16:00	12:00		
ROCEPHIN IVPB Flowrate: 100 ml/hr Q24H IVPB						10:00	
NORMAL SALINE 1000 ML Flowrate: 125 ml/hr CONTINUOUS IV							

Updated EMAR

Acetaminophen Total

Once an Acetaminophen order has been administered on a patient via the Electronic MAR, a display option will appear on the top right of pharmacy profile screen called Acetaminophen Total. See [Pharmacy Setup](#) for information on enabling this feature.

Pharmacy - Medication Profile

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 39.84 Room: 300-9

Sort Sequence: Chronological Alphabetical Frequency

Status: All Orders Current Orders

Order Type(s): Non-IVs Large Volume IVs Other IVs

Order	Start Date Stop Date	Time Time	Description Code	Dose	Unit	Route	Notes	Pending Actions Frequency
1	10/07/15	10:39	PROPRANOLOL (INDERAL) TAB 20 MG	20 MG		PO		TID
4	10/15/15	10:00	ROCEPHIN IVPB : 500MG/100ML NS 100 ml/hr 500MG 100ML			IV	cefTRIAXone (ROCEPHIN) INJ 1 GM NS 100 ML 2B1302P IV SOL	Q24H
5	11/05/15 11/12/15	14:29 14:29 A	HYDROMORPHONE (DILAUDID) INJ 2 MG	2MG/ML		IVP		PRN Q6H
6	11/09/15	08:20	NORCO 7.5MG - 325MG TAB 1 TAB			PO		PRN Q8H

Medication Dose Route Freq/Rate Duration Start Date/Time Stop Date/Time

Buttons: Renew, DC, UnDC, Charge, Credit, Edit, Labels, Select All

Acetaminophen Total

This selection contains the following: The dose given, by whom, date and time, and the total milligrams of acetaminophen given in the current 24-hr period. The system calculates and accounts for any medication containing Acetaminophen based on the NDC This also works for any combination tablets or elixirs.

Administrations for AINSWORTH MARTHA COZ

Date	Time	Initials	Medication Description	Acetaminophen
11/30/15	10:15	FT	ACETAMINOPHEN (TYLENOL) 325 MG TABLET	650 MG
11/30/15	10:16	FT	NORCO 7.5MG - 325MG TAB	325 MG

[24 hour max dose: 3000 MG] 24 hour total: 975 MG

Acetaminophen Total Detail

Interventions / ADR

The Interventions and the Adverse Drug Reaction options allow previously entered Interventions and/or Adverse Drug Reactions to be reviewed.

1. From Pharmacy Selection Screen, select **Interventions** or **Adverse Drug Reaction**.
2. Choose the sequence number of the Intervention / ADR description to display and/or update.

Select **Hospital Base Menu > Patient > Intervention / ADR**

Description	Outcome	Date	IA	Intervention Type Status
==> NORCO 7.5MG - 325MG TAB CRITICAL	MORE APPROP. REGIMEN	11/30/15	Int	RECOMMEND MONITORING INCOMPLETE
==> PROPRANOLOL (INDERAL) TAB : 20 MG Intervention Required		11/30/15	ADR	

Review Intervention/ADR

Select **Hospital Base Menu > Patient > Intervention / ADR > select Intervention**

Clinical Intervention Data

Date: 11/30/15 Time: 1038 Physician: [] Drug: NORCO 7.5/325

Intervention Type: 19 - RECOMMEND MONITORING Suspected Outcome without Intervention: 01 - CRITICAL

Intervention Description: Recommend pt be monitored for respiratory distress due to multiple narcotics.

Outcome Due to Intervention: 01 - MORE APPROP. REGIMEN Intervention Status: 03 - INCOMPLETE

Time Involved: [] min(s) Cost Savings (\$): [] RPh: FT Pending/Complete: Pending

Comments: []

Intervention Maintenance

- **Time Involved** must be entered before the status can be Complete. A Pending Intervention will display "Intervention" in red on the Pharmacy-Selection Screen to alert pharmacy employees that there is an incomplete Intervention on the account.

Select Hospital Base Menu > Patient Account # > Pharmacy-Selection Screen

The screenshot displays the Pharmacy - Selection Screen for patient AINSWORTH MARTHA COZEN (Account # 357823). The patient's age is 80Y, sex is F, height is 60.00 in, weight is 54.43 kgs, CrCl is 39.84, and room is 300-9. The screen is divided into several sections:

- Order Entry:** New Orders, Standing Orders, Long Term Care / Prescriptions, Stop ALL Active Orders, Transfer Orders.
- Clinical Review:** Pharmacy Profile, Interventions / ADR, Temporary Orders, IV Orders, Ancillary Orders.
- Other:** Clinical Information Changes, Allergy Review, Estimate Creatinine Clearance, Clinical Monitoring, Misc. Clinical Monitoring, Patient Education, Interventions, Adverse Drug Reactions, Image/Signature Store/Retrieve, Electronic Forms, Rx Diagnoses.
- Miscellaneous:** Comments, Online Adjudication, Patient Pay Code, Skip a Label.
- Charge Review:** Detail Charges, Summarized Charges, RX Charge History.

At the bottom right, the status "INTERVENTION" is displayed in red. The bottom left shows "Ready." and a "Change to Account #" field.

Pending Intervention

Temporary Orders

Temporary orders must be reviewed and OK'd by a pharmacist before becoming permanent on a patient medication profile. Orders entered by providers, pharmacy technicians or nursing via Point of Care are considered temporary in the TruBridge EHR and will not print on any Pharmacy Reports. Temporary orders can also be reviewed by the pharmacist from the patient's Pharmacy Profile.

NOTE: Employee security designating the employee as a pharmacist must be enabled to use temporary orders. Contact a TruBridge Pharmacy Support Representative with questions regarding activation of employee security.

1. From the Pharmacy Selection Screen, select **Temporary Orders**.
2. Select **OK Temp. Order** located in the top portion of the screen. Clinical Monitoring will be performed.
 - If a Clinical Monitoring Check is flagged, it will be necessary to select the **Medication** tab to complete the review process.
 - Review the order, enter order information as required.

Select Hospital Base Menu > Patient > Temporary Orders

Pharmacy - Non-IV Order (Order #8) 'TEMPORARY ORDER*'

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 39.84 Room: 300-9

Medication Description: DOCUSATE(COLACE) CAP: 100 MG Item Number: 381999

Dose: 100 Unit: MG Route: PO Frequency: PRN Duration: 1 Doses: 1 Priority: Routine

Brand: COLACE 100 MG Dose Unit/Dose = 1 Standard

1st Time Quantity: Labels: Alt. Printer: Resupply Quantity: 2 Labels: Days: 1 Non-Standard

1st Dose Date: Start Date: 11/09/15 Time: 08:40 Initials: RBB Hours Between Doses: Days of the Week: Mon, Tue, Wed, Thu, Fri, Sat, Sun

Instructions: Physician: SMITH JAME Treatment: Patient's Own: NF Price: NS 003 COLACE 100 MG BAL =

Entered: 11/09/15 08:41 RBB
POC Verified: 11/09/15 08:41 RBB

Ready. Dose info

Medication

3. Select **Next Temp. Order** to advance to the next order for review.
 - Select **Save & Exit** when complete.
 - The following prompt will display: *Require NS to reverify?* For facilities using the Point of Care application, answering **YES** will force nursing to reverify the order.

IV Orders

IV Order review displays only IV Orders. This option is useful if only needing to modify or review IV orders. It is recommended that a patient profile always be reviewed before entering new orders on a patient. Reviewing the profile prevents reordering of existing medications and potential duplicate therapy conflicts.

1. From the Pharmacy Selection Screen, under the Clinical Review portion of the screen, select **IV Orders**.
2. To access an order for modification or additional information, select the order
 - Administration times will display on the IV Orders screen.
3. If the order is an IV Sliding Scale, select **View Protocol** to see the sliding scale.

Select Hospital Base Menu > Patient > IV Orders

IV Order Review Screen

Ancillary Orders

Ancillary Orders (Laboratory, Radiology, Respiratory Therapy, etc.) can be reviewed from Pharmacy.

Select System Menu > enter Patient Account # > Ancillary Orders

	11/08/22 10:12	10/18/22 09:01	09/07/21 11:28	09/07/21 11:27	05/25/21 20:00	05/25/21 08:00	05/24/21 20:00	05/20/21 10:00	03/23/21 13:24
SODIUM (L=136 H=146) mmol/L					139	140	140	140	138
POTASSIUM (L=3.3 H=5.3) mmol/L					3.0 (L)	4.2	4.0	4.0	4.3
CHLORIDE (L=99 H=110) mmol/L					100	101	100	100	101
CO2 (L=22 H=33) mmol/L					30	29	30	25	25
ANION GAP (L=7 H=16)					9	10	10	15	12
GLUCOSE (L=65 H=100) mg/dl					69	75	85	87	85
BUN (L=5 H=20) mg/dl					10	13	10	9	8
CREATININE (L=0.6 H=1.5) mg/dl					1.0	0.9	1.2	1.0	0.9
GFR AFR AMER (L=0.0 H=60.0) mL/min					102.9 (H)	116.2 (H)	83.4 (H)	102.9 (H)	116.2 (H)
GFR NON AFR AMER (L=0.0 H=60.0) mL/min					85.0 (H)	96.0 (H)	68.9 (H)	85.0 (H)	96.0 (H)
BUN/CREAT					10	14	8	9	9
CALCIUM (L=8.30 H=10.00) mg/dl					8.60	8.90	8.40	9.00	9.30
AGE yrs					35	35	35	35	35
BASIC METABOLIC PROFILE							PENDING		
Hematology									
WBC (L=4.8 H=10.8) cumm	6.0	5.0							
RBC (L=4.40 H=6.10) m/cumm	5.00	5.00							
HEMOGLOBIN (L=13.5 H=16.5) g/dl	13.6	14.5							
HEMATOCRIT (L=40 H=49) %	45	42							
MCV (L=86 H=97) fl	88	90							

Ancillary Order- Lab Results

Pharmacy Order History

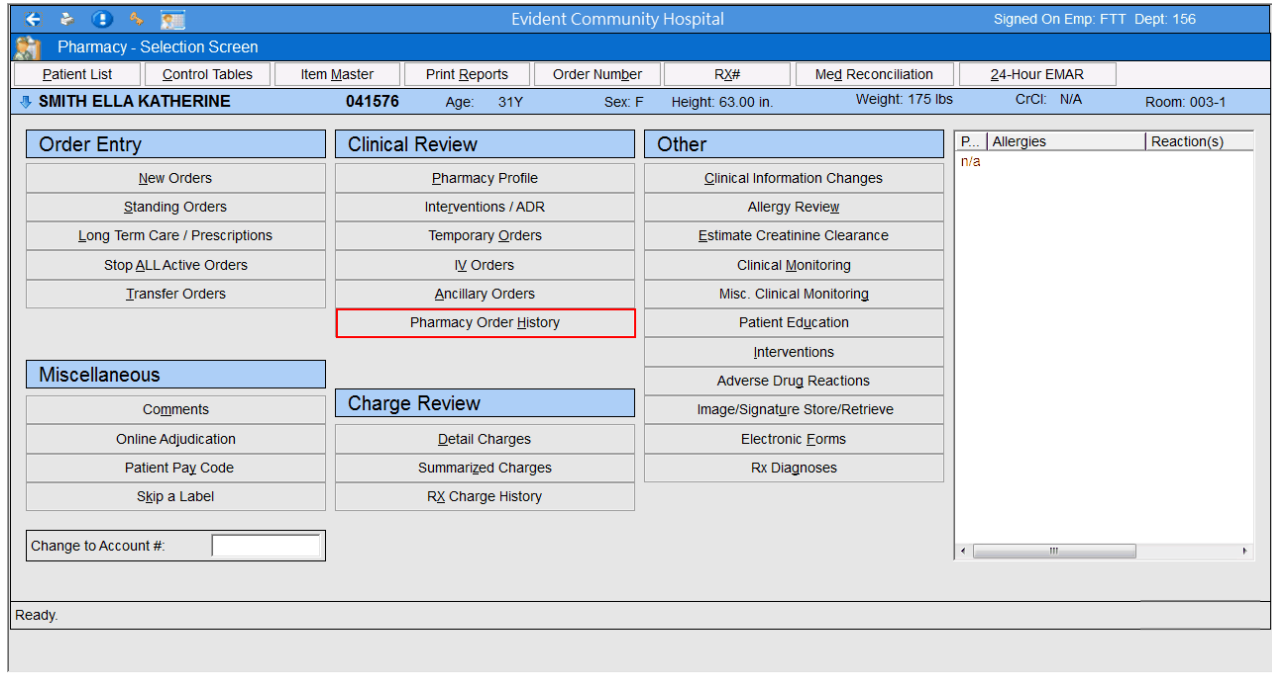
This section will cover Pharmacy orders moving to a history file and accessing this information.

Pharmacy Order History

After a patient is discharged, medication orders will move to Pharmacy Order history based on the number of days loaded in the Days to Keep Orders field in the Pharmacy Control Table. Once purged from the system, Pharmacy orders move to Pharmacy Order History and are available through two options.

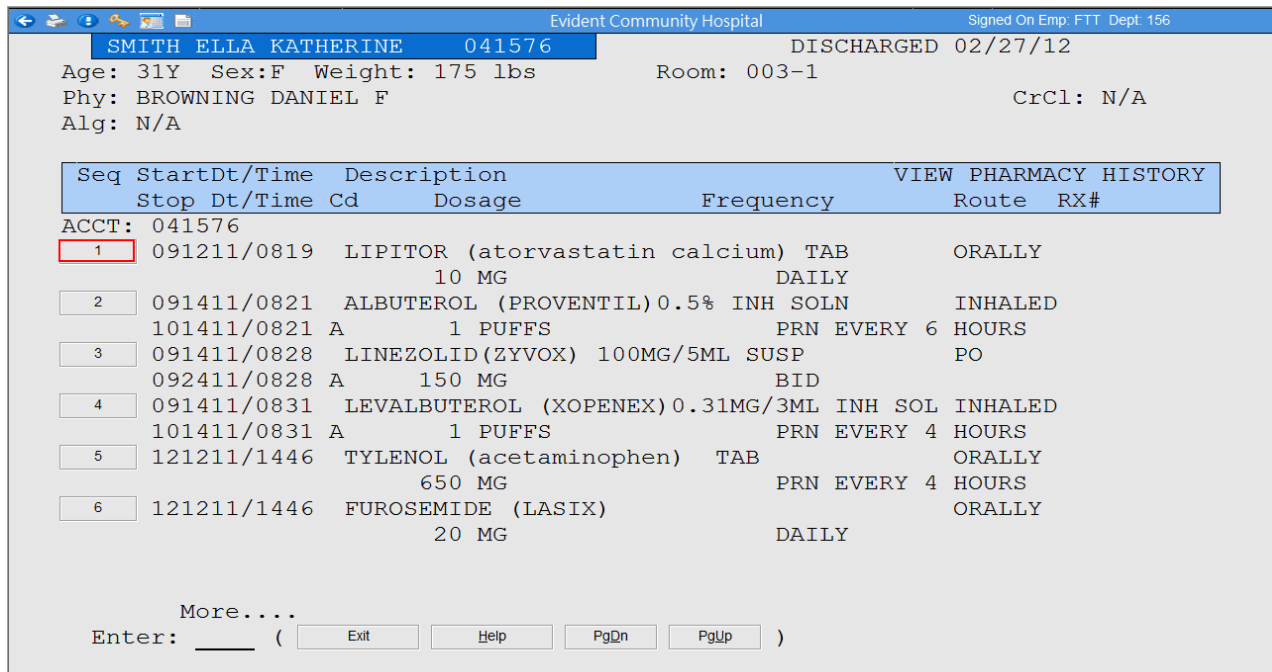
- Purged medication orders may be reviewed via the Pharmacy Selection Screen. A Pharmacy Order History option will appear for patients who have been discharged for the number of days equal to the number loaded in the Pharmacy Control Table.

Select Hospital Base Menu > Enter Patient Account > Pharmacy Order History



Pharmacy Order History

- Select **Pharmacy Order History** to view all archived medication orders.
- Select the number of the order to review.



Pharmacy Order History screen

Evident Community Hospital Signed On Emp: FTT Dept: 156

SMITH ELLA KATHERINE 041576 DISCHARGED 02/27/12

Age: 31Y Sex:F Weight: 175 lbs Room: 003-1

Phy: BROWNING DANIEL F CrCl: N/A

Alg: N/A

Pharmacy Order History: Non-IV Order

Item.: 381026 ALPRAZOLAM (XANAX) PO
 Brand: XANAX 0.5MG
 Dose Qty: 0.50 Unit: MG
 Frequency: PRN TID Route: PO

In structions

Manufacturer Name: Pharmacia Corpo

Pre scribing Physician: WILSON D Rx #:

Start Date: 121211 Time: 1447 Init: DLS
 Stop Date: 121911 Time: 1447 Init: XXX Code: A

Enter:

Pharmacy Order Detail

- The following information, if available, is retained for each order: item number, item description, brand, dose quantity and unit, route, frequency, instructions, start date/time and initials, stop date/time and initials, stop code, flow rate, prescription number and physician.
- A clinical ad hoc may also be utilized to retrieve information for purged medication orders.
- The following data is accessible via the Pharmacy Database.

Select Hospital Base Menu > Print Reports > Build Ad Hoc Report > Patient, Item, Pharmacy Order, Patient Clinical Data, and Hospital Defined > Pharmacy Order Data

All Orders		IV Orders		Non-IV Orders	
Order Number :	<input type="checkbox"/> ORDNUM	Flow Rate :	<input type="checkbox"/> IPBFLOWRATE	Item No. & Description :	<input type="checkbox"/> IPATEM
Start Date :	<input type="checkbox"/> IPASTARTDT	Comment Line 1 :	<input type="checkbox"/> IPBDESC1	Brand Name :	<input type="checkbox"/> IPABRAND
Start Time :	<input type="checkbox"/> IPASTARTTM	Comment Line 2 :	<input type="checkbox"/> IPBDESC2	Prescription Number :	<input type="checkbox"/> IPARXNUM
Start Initials :	<input type="checkbox"/> IPASTARTINIT	Item No. & Description :	<input type="checkbox"/> IPBITEM	Quantity :	<input type="checkbox"/> IPAQTY
Stop Date :	<input type="checkbox"/> IPASTOPDT	Quantity :	<input type="checkbox"/> IPBQTY	Units :	<input type="checkbox"/> IPAUNIT
Stop Time :	<input type="checkbox"/> IPASTOPTM	Units :	<input type="checkbox"/> IPBUNIT	Route :	<input type="checkbox"/> IPAROUTE
Stop Initials :	<input type="checkbox"/> IPASTOPINIT			Instruction Line 1 :	<input type="checkbox"/> IPAINSTR1
Stop Code :	<input type="checkbox"/> IPASTOPCODE			Instruction Line 2 :	<input type="checkbox"/> IPAINSTR2
Prescribing Physician :	<input type="checkbox"/> IPAPHY			Pay Code :	<input type="checkbox"/> IPAPPCODE
Frequency :	<input type="checkbox"/> IPAFREQ				
Lot # :	<input type="checkbox"/> IPALOT				
Lot Exp. Date:	<input type="checkbox"/> IPALOTEXP				
Manufacturer:	<input type="checkbox"/> IPAMANUFACTURER				

Pharmacy Order Data Element Selection

- Pharmacy order information, current and archived, is accessible via Pharmacy Database. The system will not distinguish purged orders and active orders.

11.7 Charge Review

Overview

This section will cover the charges on a patient's account. The types of charges are: Detail Charges: all pharmacy charges in chronological order, Summarized Charges: all charges and credits for a specific item number, and RX Charge History: lists all non-IV prescription charges.

Detail Charges

Detail Charges lists all pharmacy charges in chronological order. Each charge displays as one line on the Detail Charges screen. Example, if the same item is charged 14 times on a given day, 14 lines of charges display for that item. Review charges by start date or review all charges from beginning of stay.

1. From the Pharmacy Selection Screen, select **Detail Charges**.
2. Press **GO** or the <Enter> key to start display at the beginning.
 - To start the display for at a specific date, select the drop-down arrow to display a calendar with the current month. Click on the desired start date. Use the left and right arrows to advance to the next month(s) or back up to previous month(s).

Select **Hospital Base Menu > Patient > Detail Charges**

Date	Order	Item Number	Quantity	Price	Description	ST	SC
11/09/15	6	3814534	1	3.00	NORCO 7.5MG - 325MG TAB	1	M
11/10/15	7	381010	2	.80	ACETAMINOPHEN (TYLENOL) 325 MG TABLET	1	M
11/10/15	6	3814534	1	3.00	NORCO 7.5MG - 325MG TAB	1	M
11/19/15	4	387058	1	107.40	cefTRIAxone (ROCEPHIN) INJ : 1 GM	1	M
11/19/15	4	210559	1	6.80	NS :100 ML 2B1302P IV SOL	1	M

Detail Charges

3. To exit Detail Charges, select the Back Arrow in the upper right-hand portion of the screen.

Medication Waste

1. Documentation of wasted medications can be viewed, edited, deleted or printed via the **Medication Waste** option.

NOTE: To Edit the user will need the Charge Entry Behavior Control labeled **Allow Editing of Drug Waste**. To Delete the user will need the Charge Entry Behavior Control labeled **Allow Deletion of Drug Waste**.

Select Thrive UX > Chart > Select Patient > Detail Charges > Medication Waste

CHARTS » AINSWORTH MARTHA COZEN (ACTIVE) » WASTE ITEM LIST SCREEN

AINSWORTH MARTHA COZEN MR#: 000307 ACCOUNT#: 357823 DOB: 10/10/1945 Sex: Female Current Weight: 120 lbs 54.43 kg 54431.1 g
 AGE: 72Y CrCl: N/A Height: 60.00 inches BMI: 23.44 kg/m2 BSA: 1.52 m2 Admit Weight: 120 lbs 54.43 kg 54431.1 g
 RM: 300-9 Diagnosis: Asthma Allergies: CODEINE, CODEINE, PENICILLIN G

Edit Delete Medication Waste Report

Medication Waste

Date Recorded	Order #	Item #	Item Description	Min.Dispensable Qty	Qty Given	Qty Wasted	Init
2017-03-26	19	383038	MORPHINE INJ: 4MG/...	4.00 MG	3.00 MG	1.00 MG	FT

Medication Waste screen

The following information will display:

- Date the waste was documented
- Order number
- Item number and description of the wasted medication
- Available medication dose listed in **Other Units**
- Dose given
- Quantity wasted
- Initials of the employee who recorded the information

2. The report can be printed by selecting **Medication Waste Report**. When selected, this report displays information as seen on the Medication waste screen in PDF format.

NOTE: The **Medication Waste** option is also available via **Summarized Charges and Report Dashboard**

Select **Thrive UX > Hospital Base Menu > Patient > Detail Charges > Medication Waste > Medication Waste Report**

Evident		EVIDENT COMMUNITY HOSPITAL		CHARITY HUNTER	
		Medication Waste		08/19/2018	
		Document was generated by the Thrive EHR Software		10:41	
Patient Name: AINSWORTH MARTHA COZEN		Visit Number: 357823	MR Number: 000307		
Date: 03/26/2017	Item #: 383038	Order #: 19	Medication: MORPHINE INJ: 4MG/ML		
User: FT	Min Disp Qty: 4.00 MG	Qty Given: 3.00 MG	Qty Wasted: 1.00 MG		

Medication Waste Report

Summarized Charges

The Summarized Charges screen lists all charges and credits for a given item number together on a single line. This occurs even if the charges/credits were made via different order numbers or through the batch charge system. The Summarized Charges Review screen gives the following information:

- Order Number
- Item Number

- Item Description
- Charge Quantity and Amount (Patient Price)
- Credit Quantity and Amount (Patient Price)

If the item was ONLY entered through batch charging, the order number will be zero (0) and must be credited through batch charging. However, if the order was entered through pharmacy order entry and was charged via the Batch Charging, Summarized Charges displays the order number and total quantity charged. This occurs whether the charges were made through the order, through batch charging, or both.

1. From the Pharmacy Selection Screen, select **Summarized Charges**.
2. Summarized Charges lists the Order Number, Item Number, Description, Charge Quantity, Charge Amount, Credit Quantity, and Credit Amount.

Select **Hospital Base Menu > Patient > Summarized Charges**

Evident Community Hospital							
Signed On Emp: FT Dept: 038							
Pharmacy - Summarized Charges							
Patient List		Medication Waste					
AINSWORTH MARTHA COZEN		357823	Age: 80Y	Sex: F	Height: 60.00 in.	Weight: 54.43 kgs	CrCl: 39.84 Room: 300-9
Order	Item Number	Description	Charge Qty	Charge Amount	Credit Qty	Credit Amc	
6	3814534	NORCO 7.5MG - 325MG TAB	3	9.00			
7	381010	ACETAMINOPHEN (TYLENOL) 325	4	1.60			
4	387058	ceftriaXone (ROCEPHIN) INJ :	1	107.40			
4	210559	NS :100 ML 2B1302P IV	1	6.80			
12	3814589	CUBICIN 500MG IV	0.64	.00			
13	381371	PROPRANOLOL (INDERAL) TAB :	61	122.00	20	40.00	

Summarized Charges

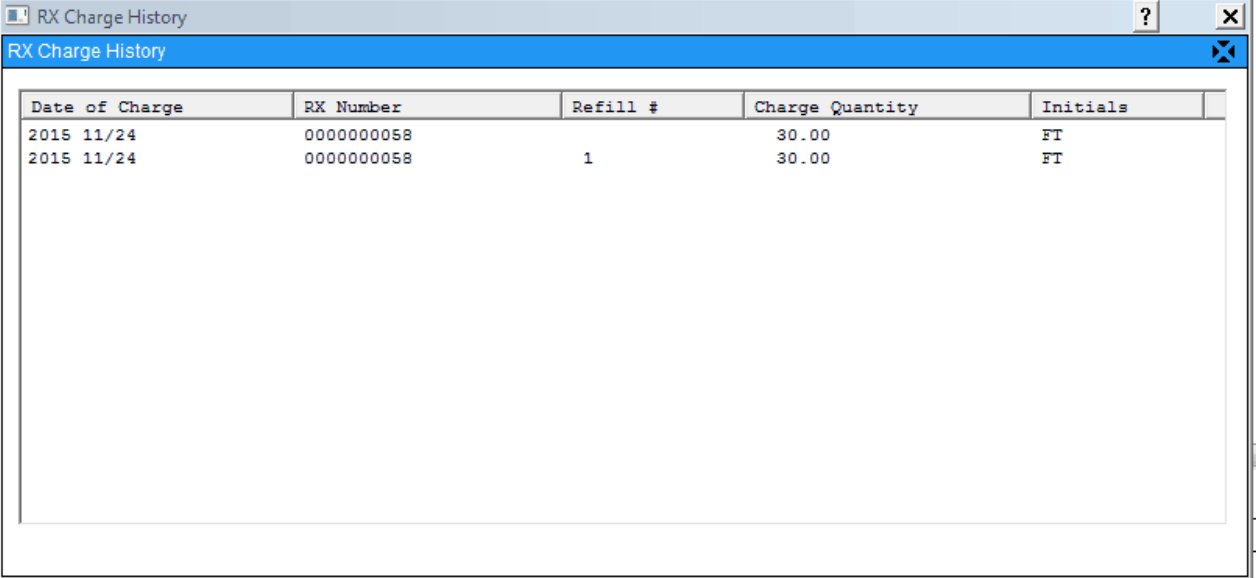
3. To exit Summarized Charges, select the ← (Back Arrow) in the upper right-hand portion of the screen.

RX Charge History

RX Charge History lists all Non-IV prescription charges. RX Charge History displays the *Date of Charge*, *Rx Number*, *Refill Number*, *Charge Quantity*, and *Initials* of staff completing the order.

1. From the Pharmacy Selection Screen, select **RX Charge History**.
2. To exit RX Charge History, select the **X** in the upper right-hand portion of the screen.

Select **Hospital Base Menu > Select Patient > Pharmacy Selection Screen > RX Charge History**



Date of Charge	RX Number	Refill #	Charge Quantity	Initials
2015 11/24	0000000058		30.00	FT
2015 11/24	0000000058	1	30.00	FT

RX Charge History

11.8 Other

This section explains all options under the Other section of the Pharmacy-Selection Screen.

Clinical Information Changes

Overview

This section will cover accessing and reviewing/changing Clinical Information on a patient.

Dietary / Height / Weight

Select **Hospital Base Menu > Patient > Clinical Information Changes**

The screenshot displays the 'Pharmacy - Clinical Information' interface for patient AINSWORTH MARTHA COZEN (ID: 357823). The patient's age is 80Y, sex is F, height is 60.00 in, weight is 54.43 kgs, CrCl is 39.84, and room is 300-9. The 'Dietary/Height/Weight' section is active, showing fields for Diet, Special Instructions, Food Dislikes, and checkboxes for Diabetic, Fluid Restriction, Sodium Restriction, Pregnant, and Breast Feeding. Below this, the 'Height/Length and Weight' section shows Admit Weight (120 lbs), Weight (120 lbs), Height/Length (60.00 in / 5'0"), and BMI (23.44 kg/m²). Metric values for weight (54.43 kg) and height (152 cm) are also displayed.

Clinical Information-Dietary/Height/Weight

Dietary

• Diet

- Default: Diet orders placed via nursing or dietary order entry.
- Options: N/A: The diet ordered via nursing or dietary will display.
- Usage: Displays the diet that has been ordered for a patient.
 - This field is updated from dietary orders and cannot be changed from this menu.

• Special Inst

- Default: Special Instruction orders placed via nursing or dietary order entry.
- Options: N/A: Special Instructions placed via nursing or dietary will display.
- Usage: Displays special instructions orders, for example, NPO or Hold orders that have been ordered for a patient.
 - This field is updated from special instruction orders and cannot be changed from this menu.

- **Food Dislikes**

- Default: Blank, or no entry
- Options: Ability to type in a patient's food dislikes.
- Usage: Allows the ability to type in and display any foods a patient may dislike.

- **Diabetic**

- Default: Blank, or no entry
- Options: Yes, ✓ (check mark), or blank (no)
- Usage: Allows the ability to indicate a patient is diabetic.
 - Yes or a "✓" (check mark) will indicate that the patient is diabetic.
 - Blank (no) will indicate that the patient is not a diabetic.

- **Fluid Restriction**

- Default: Blank, or no entry
- Options: Yes, ✓ (check mark), or blank (no)
- Usage: Allows the ability to indicate a patient is on fluid restriction.
 - Yes or a "✓" (check mark) will flag that the patient is on fluid restriction.
 - Blank (no) will indicate that the patient is not on fluid restriction.

- **Sodium Restriction**

- Default: Blank, or no entry
- Options: Yes, ✓ (check mark), or blank (no)
- Usage: Allows the ability to indicate a patient is on sodium restriction.
 - Yes or a "✓" (check mark) will indicate that the patient is on sodium restriction.
 - Blank (no) will indicate that the patient is not on fluid restriction.

- **Pregnant**

- Default: Blank, or no entry
- Options: Yes, ✓ (check mark), or blank (no)
- Usage: Allows the ability to indicate a patient is pregnant.

- **Breast Feeding**

- Default: Blank, or no entry
- Options: Yes, ✓ (check mark), or blank (no)
- Usage: Allows the ability to indicate a patient is breast feeding.

Height and Weight

- **Admit Weight**

- Default: Blank, or will display a weight if entered during patient registration
- Options: Ability to enter a patient's admitting weight.
- Usage: Allows the ability to enter a patient's admit weight in pounds, kilograms or grams.
 - The admit weight will pull from page 5, field 4, of patient registration if entered during patient registration.
 - The admit weight that is entered will automatically display in the patient header throughout the system. Once a weight is entered in field 19-Weight, that will be the weight, which will display in the patient header throughout the system.
 - When the admit weight is entered, the system will automatically convert the weight to metric weight. Field 18-Metric will display the metric weight value in (KG) kilograms and (GM) grams.

- **Metric**

- Default: Blank, or will display a patient's metric weight value if the standard weight value was entered in field 17.
- Options: Ability to enter a patient's admitting metric weight.
- Usage: Allows the ability to enter a patient's admitting metric weight.
 - If a patient's standard weight value is entered in field 17, the system will convert the value to metric weight and it will display in this field.
 - If a patient's admitting weight is entered as a metric value first, the system will convert the value to a standard weight value and will display in field 17.
 - The standard weight value in field 17 will automatically display in the patient header throughout the system. Once a weight is entered in field 19-Weight, that will be the weight, which will display in the patient header throughout the system.

- **Weight**

- Default: Blank, or no entry
- Options: Ability to enter a patient's weight.
- Usage: Allows the ability to enter a patient's weight in pounds, kilograms or grams.
 - The weight that is entered will automatically display in the patient header throughout the system.
 - When the admit weight is entered, the system will automatically convert the weight to metric weight. Field 20-Metric will display the metric weight value in (KG) kilograms and (GM) grams.

- **Metric**

- Default: Blank, or will display a patient's metric weight value if the standard weight value was entered in field 16.
- Options: Ability to enter a patient's metric weight, i.e., daily weights.
- Usage: Allows the ability to enter a patient's metric weight.
 - If a patient's standard weight value is entered in field 19, the system will convert the value to metric weight and it will display in this field.
 - If a patient's weight is entered as a metric value first, the system will convert the value to a standard weight value and will display in field 19.
 - The standard weight value in field 19 will automatically display in the patient header throughout the system.

- **Height / Length**

- Default: Blank, or no entry
- Options: Ability to enter a patient's height in inches.
- Usage: Allows the ability to enter a patient's height.
 - When the height is entered, the system will automatically convert the height to metric height. Field 19-Metric will display the metric height value.

- **Metric**

- Default: Blank, or will display a patient's metric height value if the standard height value was entered in field 18.
- Options: Ability to enter a patient's metric height in centimeters.
- Usage: Allows the ability to enter a patient's metric height in centimeters.
 - If a patient's standard height value is entered in field 18, the system will convert the value to metric height and it will display in this field.

- If a patient's height is entered as a metric value first, the system will convert the value to a standard height value and will display in field 18.

Miscellaneous Clinical Information

Select **Hospital Base Menu > Patient > Clinical Information Changes > Miscellaneous**

The screenshot shows the 'Miscellaneous' tab in the 'Pharmacy - Clinical Information' window for patient AINSWORTH MARTHA COZEN (ID: 357823). The patient's age is 80Y, sex is F, height is 60.00 in, weight is 54.43 kgs, CrCl is 39.84, and room is 300-9. The 'Miscellaneous' tab contains the following fields:

Field	Value
Condition	F - FAIR
Smokeless Tobacco User	4 Never chewed tobacco
Emergency	
Isolation	<input type="checkbox"/>
Smoker	4
Relation	
Advanced Directive	
Smoker Status	Never smoker
Home Phone	
Care Level	1
Smoker Start Date	
Work Phone	
Violent Patient	<input type="checkbox"/>
Smoker Stop Date	
Ethnicity	N
MRSA	<input type="checkbox"/>
DNR	<input type="checkbox"/>
Language	
VRE	<input type="checkbox"/>
Restrains	<input type="checkbox"/>
Terminally Ill/LTC	<input type="checkbox"/>
Risk for Falls	<input type="checkbox"/>

There is also a 'Family Health History' button at the bottom right of the tab.

Clinical Information-Miscellaneous Tab

- **Condition**
 - Default: Blank, or will display the condition code if entered during patient registration.
 - Options: G (Good), F (Fair), P (Poor), C (Critical), E (Expired)
 - Usage: Allows the ability to indicate a patient's condition.
 - The condition status will pull from page 4, field 7, of patient registration if entered during patient registration.
 - If the field is blank, enter a "?" in the field to display the facility's condition table. Choose the appropriate condition by selecting the sequence number next to it.
- **Isolation**
 - Default: Blank, or will display the isolation status if entered during patient registration.
 - Options: Y (yes) or N (no)
 - Usage: Allows the ability to indicate a patient's isolation status.
 - The isolation status will pull from page 5, field 2, of patient registration if entered during patient registration.
 - "Y" to indicate a patient is in isolation.
 - "N" to indicate a patient is not in isolation.

NOTE: If patient had an isolation status on previous admission, the system will prompt with a (?) question mark as to the patient's current isolation status.

- **Advanced Directive**

- Default: Blank, or will display a "Y" (yes) or "N" (no) answer if entered during patient registration.
- Options: Y (yes) or N (no)
- Usage: Allows the ability to indicate the status of a patient's advanced directive.
 - The advance directive status will pull from page 1, field 21, of patient registration if entered during patient registration.
 - "Y" to indicate a patient has an advanced directive.
 - "N" to indicate a patient has no advanced directive.

- **Care Level**

- Default: Blank
- Options: 1 - 5
- Usage: This field can be used to enter/modify the patient's care level.

- **Violent Patient**

- Default: Blank
- Options: Yes or No
- Usage: This field can be used to enter/modify change a patient's status as a violent patient.

- **MRSA**

- Default: Blank
- Options: Yes or No
- Usage: This field is used to enter/modify a patient's Multi Resistant Staph Aureus status

- **VRE**

- Default: Blank
- Options: Yes or No
- Usage: This field is used to enter/modify a patient's Vancomycin Resistant Enzyme status.

- **Smoker**

- Default: Blank, or will display a "√" (check mark), yes or blank (no) answer, if entered during patient registration.
- Options: Y (yes), √ (check mark), or N (no)
- Usage: Allows the ability to indicate a patient 's smoking status.
 - The smoking status will pull from page 1, field 20, of patient registration if entered during patient registration.
 - Yes or a "√"(check mark) will indicate that the patient does smoke.
 - Blank or no will indicate that the patient does not smoke.

- **DNR**

- Default: Blank, or will display a "√" (check mark), yes or blank (no) answer, if entered during patient registration.
- Options: Yes, √ (check mark), or blank (no)
- Usage: Allows the ability to indicate a patient 's DNR status.
 - The DNR status will pull from page 4, field 26, of patient registration if entered during patient registration.
 - Yes or a "√"(check mark) will indicate that the patient does have a DNR order.

- Blank or no will indicate that the patient does not have a DNR order.
- **Restraints**
 - Default: Blank, or will display a “√”(check mark), yes, or blank (no) answer, if entered during patient registration.
 - Options: Yes, √ (check mark), or blank (no)
 - Usage: Allows the ability to indicate a patient ‘s restraints status.
 - The restraints status will pull from page 4, field 27, of patient registration if entered during patient registration.
 - Yes or “√”(check mark) will indicate that the patient does have a restraints order.
 - Blank or no will indicate that the patient does not have a restraints order.
- **Terminally Ill / LTC Y/N**
 - Default: Blank
 - Options: Yes, √ (check mark), or blank (no)
 - Usage: Allows the ability to document the patient as terminally ill or as a long term care patient
 - Yes “√”(check mark) will indicate patient is either terminally ill or is a long term care patient
 - Blank (no) will indicate patient is not terminally ill or a long term care patient
- **Emergency**
 - Default: This field will default to the name entered at time of patient registration.
 - Options: If the field is not populated, a name can be entered via free text.
 - Usage: This field list the emergency contact for the patient
- **Relation**
 - Default: This field will default to the information entered at time of patient registration
 - Options: If this field is not populated, information can be entered via free text
 - Usage: This field list the relation of the emergency contact to the patient
- **Home Phone**
 - Default: This field will default to the information entered at time of patient registration
 - Options: If this field is not populated, information can be entered via free text
 - Usage: This field list the emergency contact home phone number
- **Work Phone**
 - Default: This field will default to the information entered at time of patient registration
 - Options: If this field is not populated, information can be entered via free text
 - Usage: This field list the work phone for the emergency contact
- **Ethnicity**
 - Default: This field will default to the information entered at time of patient registration
 - Options: If this field is not populated, the patient's ethnicity can be entered via free text
 - Usage: This field will display the patient's ethnicity
- **Language**
 - Default: This field will default to the information entered at time of patient registration
 - Options: If this field is not populated, the patient's language can be entered via free text
 - Usage: This field will display the patient's language preference

Diagnoses/Physician

Select Hospital Base Menu > Patient > Clinical Information Changes > Diagnosis/Physicians

Pharmacy - Clinical Information

Evident Community Hospital Signed On Emp: FT Dept: 038

Save Cancel Immunizations

AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 39.84 Room: 300-9

Dietary/Height/Weight Miscellaneous Diagnoses/Physicians Allergies

Diagnoses

Chief Complaint: Asthma

Working 1:

Working 2:

Physicians

Attending: SMITH JAMES

Second:

Primary Care:

Consulting 1:

Consulting 2:

Consulting 3:

Consulting 4:

Consulting 5:

Other Consulting Physicians:

Name	Number

Add

Delete

Clinical Information-Diagnoses/Physicians

Diagnoses / Physicians

- **Chief Complaint**
 - Default: Blank, or will display a diagnosis if entered during patient registration
 - Options: Ability to enter a patient's diagnosis
 - Usage: Allows the ability to enter a patient's diagnosis
- **Working 1, Working 2**
 - Default: Blank, or no entry
 - Options: Ability to enter a co-morbidity diagnosis
 - Usage: Allows the ability to enter a co-morbidity diagnosis by the facility's Medical Records department in order to do concurrent coding.

Physicians

• **Admitting, Second, Family**

- Default: Blank, or will display the admitting, second and family physician if entered during patient registration.
- Options: Ability to enter a patient's admitting, second, family physician.
- Usage: Allows the ability to enter a patient's admitting, second, family physician.
 - The admitting, second, and family physicians name will pull from page 4, fields 15, 16, and 17, of patient registration if entered during patient registration.
 - If either the admitting, second or family physician fields have been completed during patient registration, nursing cannot change them.
 - To enter either the admitting, second, or family physician, perform the following steps:
 - Enter the desired field number.
 - When the cursor is in the chosen field, choose the magnifying glass to access the lookup table.
 - Enter the first three letters of the physicians name or select the magnifying glass to display the facility's staff physician lookup table.
 - Select the sequence number beside the desired physician's name.
 - If the physician is a non-staff physician, select the option **Non-staff**, to display the non-staff physician lookup table.
 - If a physician's name cannot be located in either the staff physician or non-staff physician's lookup tables, it is recommended that the medical records department be notified.

• **Consulting**

- Default: Blank, or will display the admitting, second and family physician if entered during patient registration.
- Options: Ability to enter a patient's admitting, second, family physician.
- Usage: Allows the ability to enter a patient's consulting physicians.
 - To enter either a consulting physician, perform the following steps:
 - Enter the desired field number.
 - When the cursor is in the chosen field, select the magnifying glass to display the facility's staff physician lookup table.
 - Enter the first three letters of the physicians name or select the magnifying glass to display the facility's staff physician lookup table.
 - Select the sequence number beside the desired physician's name.
 - If the physician is a non-staff physician, select the option **Non-staff**, to display the non-staff physician lookup table.
 - If a physician's name cannot be located in either the staff physician or non-staff physician's lookup tables, it is recommended that the medical records department be notified.

Allergies

Drug, environmental and food allergies can be reviewed/modified from this screen along with their corresponding priorities, reactions and severities. Types, entry dates and entry employee's initials display also. This is an unlimited field in the number of entries that it can accommodate.

Select **Hospital Base Menu > Patient > Clinical Information Changes > Allergies**

Priority	Allergy	Reaction(s)	Severity	Type	Added	Entered By
1	Codeine	Itching; Blisters	Normal	DRUG	10/06/2015 10:38:42	FT
2	Eggs	swelling	Major	CLASS	11/04/2015 09:39:09	FT
3	Peanuts	Anaphylaxis	Major	FOOD	11/04/2015 09:39:40	FT

Clinical Information - Allergies

1. If the patient does not have any allergy data entered, select **Add Allergy Data**: Select this field to search the list of available drug, environmental and food allergies.
2. Type the first few letters of the allergen or the complete name to sort the list alphabetically beginning with the search criteria. Double click the allergen to add it.
3. Select **Other** to add an allergy that is not on the selection list. A warning will appear: Clinical Monitoring is unavailable for free text entries. Proceed? Select **YES** to proceed. Select **No** to return to the Allergy Entry screen. If yes is selected, select the field to free text the name of the allergy, then select **OK**. Allergies entered using the OTHER option will display Highlighted Yellow.
4. If a patient reports no allergies select the appropriate option: **No Known Allergies, No Known Env. Allergies, No Known Drug Allergy** or **No Known Food Allergies**.

NOTE: No Known Drug Allergies must be selected to meet Meaningful Use requirements. No Known Allergies does not meet the objective.

5. When allergies are added the Priority defaults to the next number in line, the Reaction defaults to blank and the Severity defaults to blank.

6. To modify the Priority, Reaction or Severity of an existing allergy, select the field you wish to modify.
- **Priority:** Select this field to enter/modify the allergy's priority. The priority affects the order in which the allergy will display in the patient's demographics. This is a free text field. The delete or backspace key can be used to remove existing information.
 - **Reaction:** Select the drop down arrow in this field to enter/modify the patient's reaction to the allergy. Select the appropriate reaction from the drop down list, select **Other** to free text a reaction, or select **Clear** to remove all reactions.
 - **Severity:** Select the drop-down menu in this field to enter/modify the patient's severity of reaction to the allergy. Select the appropriate severity from the list. Severity is not a required field.
 - To add an allergy select **Add Allergy Data**.
 - Select **Stop Adding** when all additional allergies have been added.
 - Select the allergy name then **Remove Allergy** to remove an allergy.
 - Select **Allergy History** to display when allergy data was added, removed or verified.

Select Hospital Base Menu > Patient > Clinical Information Changes > Allergies > Allergy History

Added	Entered By	Action
04/24/2015 10:16:53	FT	No Known Drug Allergies allergy added.
10/06/2015 10:38:42	FT	No Known Drug Allergies allergy removed.
10/06/2015 10:38:42	FT	Codeine allergy added.
10/06/2015 10:38:49	FT	Itching reaction added to Codeine allergy.
10/06/2015 10:38:58	FT	Blisters reaction added to Codeine allergy.
11/04/2015 09:39:09	FT	Eggs allergy added.
11/04/2015 09:39:20	FT	swelling reaction added to Eggs allergy.
11/04/2015 09:39:40	FT	Peanuts allergy added.
11/04/2015 09:39:45	FT	Anaphylaxis reaction added to Peanuts allergy.

Allergy History

- Allergy History contains fields for added information, employee and action and is color coded in the following way:
 - Blue text: entered allergy
 - Black text: entered reaction
 - Red text: removed allergy/reaction
 - Aquamarine text: verified allergy/reaction
 - Green text: all allergies verified

The screenshot shows a software interface for a pharmacy. At the top, it says "Evident Community Hospital" and "Signed On Emp: FT Dept: 038". Below that is a "Pharmacy - Clinical Information" header with buttons for "Save", "Cancel", and "Immunizations". A patient's name "AINSWORTH MARTHA COZEN" and ID "357823" are displayed, along with other demographic information: "Age: 80Y", "Sex: F", "Height: 60.00 in.", "Weight: 54.43 kgs", "CrCl: 39.84", and "Room: 300-9".

The main window is titled "Pharmacy - Allergy History" and contains a sub-window titled "Removed Allergy History". This sub-window has a table with the following data:

Added	Entered By	Action
10/06/2015 10:38:42	FT	No Known Drug Allergies allergy removed.

At the bottom left of the sub-window, there is a checkbox labeled "Show removed allergies only" which is checked. At the top right of the sub-window, there are icons for help (?) and close (X).

Allergy History Removed Allergies Only

8. Select the check box **Show removed allergies only** at the bottom to display only those allergies that have been removed.
9. Select the black **X** in the upper right-hand corner to exit Allergy History. Select **Save** to save the allergy information and exit. Select **Cancel** to exit without saving the changes.

Immunizations

The TruBridge EHR will display recorded immunizations, the date the immunizations were received, the date the information was charted, and the employee who documented the data. Each entry will also display the VFC Status and indicate if the immunization was publicly supplied.

Select **Hospital Base Menu > Patient > Clinical Information Changes**

The screenshot displays the 'Clinical Information Changes' interface for patient AINSWORTH MARTHA COZEN (ID: 357823). The patient's age is 80Y, sex is F, height is 60.00 in., weight is 54.43 kgs, CrCl is 39.84, and room is 300-9. The 'Immunizations' tab is highlighted in red. Below the patient information, there are tabs for 'Dietary/Height/Weight', 'Miscellaneous', 'Diagnoses/Physicians', and 'Allergies'. The 'Dietary' section includes fields for Diet, Special Instructions, and Food Dislikes, along with checkboxes for Diabetic, Fluid Restriction, Sodium Restriction, Pregnant, and Breast Feeding. The 'Height/Length and Weight' section shows the following data:

Height/Length and Weight					
Admit Weight:	120	lbs.		oz.	Metric: 54.43 kg 54431.1 gm
Weight:	120	lbs.		oz.	Metric: 54.43 kg 54431.1 gm
Height/Length:	60.00	in.	(5'0")		Metric: 152 cm
BMI:	23.44		kg / m ²		

Clinical Information Changes

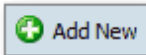
- Options on this screen include the abilities to add and delete historical immunizations, review changes to the patient's immunizations list via Removed Immunizations and display information for the current visit or all visits.

Select Hospital Base Menu > Patient > Clinical Information Changes > Immunizations

Description	Date Administered	Current	Date/Time Added	Entered By	Publicly Supplied	VFC Status
pneumococcal	07/15/2014	Y	07/15/2014 09:54	JOSHUA SHANE	N	

Clinical Information - Immunizations



1. To enter new immunization, select the  option at the lower left part of the immunization screen. Select this field to search the list of available immunizations. Type the first few letters of the immunization or the complete name to sort the list alphabetically beginning with the search criteria.

Select Hospital Base Menu > Patient > Clinical Information Changes > Immunizations > Add New

Search by Vaccine Description:

Short Description	Full Vaccine Name	CVX	Active
pneumococcal polysaccharide PPV23	pneumococcal polysaccharide vaccine, 23 valent	33	Y
pneumococcal conjugate PCV 7	pneumococcal conjugate vaccine, 7 valent	100	N
pneumococcal, unspecified formulation	pneumococcal vaccine, unspecified formulation	109	N
Pneumococcal conjugate PCV 13	pneumococcal conjugate vaccine, 13 valent	133	Y
Pneumococcal Conjugate, unspecified...	Pneumococcal Conjugate, unspecified formulation	152	N

Clinical Information - Immunizations

2. Select the appropriate immunization. Select the field for Date Received and free text the date in the MMDDYY format (the system will add the slashes) or use the drop-down button to select the date from the calendar. If the date is unknown, enter UNKNOWN. Select Add to add the immunization to the patient's account.

IMMUNIZATION MAINTENANCE

Immunization Source:

Immunization:

CVX Code:

Status:

Administered Amount:

Lot Number:

Lot Expiration:

Manufacturer Name:

Administered By:

Date Received:

Time Received:

Route:

Administration Site:

VFC Status:

Publicly Supplied?

Vaccine Statement Reviewed: Date:

Vaccine Statement Version Date:

Immunization Maintenance

- Options on this screen are as follows:
 - **Immunization Source:** Options to list immunization as new or specify source of immunization information are available from a drop-down menu
 - **Immunization:** Displays the immunization name; grayed out so it cannot be changed
 - **Status:** Active or Inactive; grayed out so it cannot be changed
 - **Administered Amount:** Grayed out so it cannot be changed during historical entry. When immunizations are provided while the patient is in the facility, this value pulls over from MedVerify and/or the EMAR.
 - **Lot Number:** Grayed out so it cannot be changed during historical entry
 - **Lot Expiration:** Grayed out so it cannot be changed during historical entry
 - **Manufacturer Name:** Grayed out so it cannot be changed during historical entry
 - **Administered By:** Grayed out so it cannot be changed during historical entry
 - **Date Received:** Accepts dates in MMDDYY or MMDDYYYY format or UNKNOWN
 - **Time Received:** Accepts times in HHMM format but is not required
 - **Route:** Options are selectable from a drop-down menu, but this field is not required.
 - **Administration Site:** Options are selectable from a drop-down menu, but this field is not required. The field is accessible when needed to define specific sites for certain routes, such as intramuscular.
 - **VFC Status:** If the immunization was provided to a child and the status is known, Vaccine for Children Eligibility may be addressed here using a drop-down menu.
 - **Publicly Supplied?:** This field is a check box used to indicate whether the vaccine was publicly supplied; checked means Yes while unchecked means No or unknown.
 - **Evidence of Immunity:** If a patient refuses a vaccine and there is evidence of their immunity, address this field by selecting the **lookup icon** to search immunity information by SNOMED code or description.
 - **Vaccine Information Statement Reviewed:** Displays whether certain vaccines administered in the hospital had their Vaccine Information Statement (VIS) reviewed by the patient and/or their parent, followed by the review date
 - **Vaccine Information Statement Version Date:** Allows the user to input the version date of the VIS shared with the patient
- Select **Save** from the Action Bar to add to the patient's immunizations list.
- Select **Delete** from the Action Bar to remove the vaccine from the patient's immunizations list.
- Select the **back arrow** from the Action Bar to exit without saving changes. If changes have been made prior to selecting this option, the system prompts, "You have not saved changes. Do you wish to continue?" Options are Yes to exit without saving, or No to return to the Immunization Maintenance screen.
- Users may choose to add Immunization information to a chart after that visit has been discharged. When the user selects **Add New** in this situation, the system displays a pop-up message asking "Entered Immunizations information will be updated on the Person Profile and will not update discharged accounts. Continue?" with choices Yes and No. Users should select **Yes** to continue adding these immunization records or **No** to stop. This means these immunizations will only display on visits that occur during or after the date the immunizations were received.

NOTE: Immunizations that are received during the patient's hospital stay should not be manually keyed in this area. Instead, they should be recorded via Medication Verification Administration or the Medication Given options in the Point of Care Pharmacy application. Please refer to the [POC Pharmacy](#) and [MedVerify](#) user guides for additional information about administering vaccinations.

The immunizations that display in this area default to **Current Visit**, which pulls all immunizations that have been entered through the account's discharge date. To see immunizations that are added to the patient's profile after the discharge date, the user may choose **All Visits**.

To print the Current Visit or All Visits list of immunizations or display them using Adobe Reader, select **Print / View**.

Allergy Review

Overview

Patient allergies and reactions can be reviewed via Allergy Review. New allergies and/or reactions can also be added to the patient's profile.

Allergy Review

1. From the Pharmacy Selection Screen, select **Allergy Review**.
2. To add a new allergy, select **Add Allergy Data** and enter the starting description of the allergy.

From **Hospital Base Menu > Patient > Allergy Review**

Priority	Allergy	Reaction(s)	Severity	Type	Added	Entered By
1	Codeine	Itching; Blisters	Normal	DRUG	10/06/2015 10:38:42	FT
2	Eggs	swelling	Major	CLASS	11/04/2015 09:39:09	FT
3	Peanuts	Anaphylaxis	Major	FOOD	11/04/2015 09:39:40	FT

Pharmacy Allergy Review

3. Using the mouse, double click the needed allergy.

From Hopsital Base Menu > Patient > Allergy Review > Add New

Priority	Allergy	Reaction(s)	Severity	Type	Added	Entered By
1	Codeine	Itching; Blisters	Normal	DRUG	10/06/2015 10:38:42	FT
2	Eggs	swelling	Major	CLASS	11/04/2015 09:39:09	FT
3	Peanuts	Anaphylaxis	Major	FOOD	11/04/2015 09:39:40	FT

Allergy Picklist

4. To enter an allergy not listed in the Allergy Lookup, select **Other** and key in the allergy description. Allergies entered with the **Other** option will display highlighted Yellow. Allergies entered via the **Other** option will not received Clinical Monitoring.
5. When allergies are added the priority defaults to the next number in line, the reaction defaults to blank and the severity defaults to blank. To change the priority, reaction or severity, click on the line to change, then click under the column that needs modification.
6. If a patient reports no allergies select the appropriate option: **No Known Allergies**, **No Known Env. Allergies**, **No Known Drug Allergy** or **No Known Food Allergies**.
 - Select **Stop Adding** when all additional allergies have been added.
 - Select the allergy name then **Remove Allergy** to remove an allergy.
 - Select **Allergy History** to display when allergy data was added, removed or verified. Select the black **X** in the upper right-hand corner to exit Allergy History. The allergy history contains fields for added information, employee and action and is color coded in the following way:
 - Blue text: entered allergy
 - Black text: entered reaction
 - Red text: removed allergy/reaction
 - Aquamarine text: verified allergy/reaction
 - Green text: all allergies verified
7. To Exit the Allergy Review screen, select **SAVE** at the top.

Estimate Creatinine Clearance

See Estimate Creatinine Clearance.

Clinical Monitoring

Clinical Monitoring may be selected to review clinical monitoring checks received on all orders on the account. From the Pharmacy Selection Screen, select **Clinical Monitoring**.

Select Hospital Base Menu > Patient Account # > Clinical Monitoring

The screenshot shows the 'Pharmacy - Selection Screen' for patient AINSWORTH MARTHA COZEN. The 'Clinical Monitoring' option is highlighted with a red box in the 'Other' section. The patient's demographic information is displayed at the top: Age: 80Y, Sex: F, Height: 60.00 in., Weight: 54.43 kgs, CrCl: 39.84, Room: 300-9. A table of allergies is visible on the right side of the screen.

P...	Allergies	Reaction(s)
1	Codeine	Itching, Blisters
2	Eggs	swelling
3	Peanuts	Anaphylaxis

Pharmacy-Selection Screen - Clinical Monitoring

Select Hospital Base Menu > Patient Account # > Clinical Monitoring

The screenshot shows the 'Pharmacy - Clinical Monitoring' screen for patient AINSWORTH MARTHA COZEN. It displays a list of clinical monitoring checks with columns for Type and Partial Description. Several items are highlighted in red, indicating significant interactions or checks.

Type	Partial Description
ALLERGY CHECK	HYDROMORPHONE (DILAUDID) INJ: CODEINE
ALLERGY CHECK	NORCO 7.5MG - 325MG TAB CODEINE
DUPLICATE THERAPY	PROPRANOLOL (INDERAL) TAB : Duplicate Item
DUPLICATE THERAPY	NORCO 7.5MG - 325MG TAB Acetaminophen Duplicate Ingredient
DRUG INTERACTION	KCL 20 MEQ IN NS 1000ML QUINAPRIL (ACCUAPRIL) TAB : 1 Major
DRUG INTERACTION	HYDROMORPHONE (DILAUDID) INJ: NORCO 7.5MG - 325MG TAB Major
DRUG INTERACTION	QUINAPRIL (ACCUAPRIL) TAB : 1 NORCO 7.5MG - 325MG TAB Moderate
DRUG INTERACTION	QUINAPRIL (ACCUAPRIL) TAB : 1 Insulin REG (Humulin R) 100U Moderate
DRUG INTERACTION	QUINAPRIL (ACCUAPRIL) TAB : 1 FUROSEMIDE (LASIX) : 20 MG TA Moderate
DRUG INTERACTION	Insulin REG (Humulin R) 100U PROPRANOLOL (INDERAL) TAB : Moderate
DRUG INTERACTION	Insulin REG (Humulin R) 100U PROPRANOLOL (INDERAL) TAB : Moderate
DRUG INTERACTION	Insulin REG (Humulin R) 100U FUROSEMIDE (LASIX) : 20 MG TA Moderate
DRUG INTERACTION	PROPRANOLOL (INDERAL) TAB : FUROSEMIDE (LASIX) : 20 MG TA Moderate
DRUG INTERACTION	PROPRANOLOL (INDERAL) TAB : FUROSEMIDE (LASIX) : 20 MG TA Moderate
REF. RANGE CHECK	GLUCOSE = 200.0000 H ON 11/04/15
REF. RANGE CHECK	GLUCOSE = 96.0000 ON 10/20/15
REF. RANGE CHECK	POTASSIUM = 7.0000 HC ON 10/20/15
MISC. CHECK	NS :100 ML 2B1302P IV Unknown NDC number
MISC. CHECK	HYDROMORPHONE (DILAUDID) INJ: Discontinued NDC number
MISC. CHECK	FUROSEMIDE (LASIX) : 20 MG TA Discontinued NDC number
MISC. CHECK	NORCO 7.5MG - 325MG TAB Discontinued NDC number

Clinical Monitoring

Miscellaneous Clinical Monitoring

Clinical Monitoring checks can be performed on items without accessing order entry. Miscellaneous Clinical Monitoring allows up to six medications to be selected and checked for Drug Interactions, Duplicate Therapy and Miscellaneous (missing NDC). Miscellaneous Clinical Monitoring can be accessed from Pharmacy, as well as any nursing station.

1. From the Pharmacy Selection Screen, select **Miscellaneous Clinical Monitoring**.
2. Enter the first few characters of the desired drug name and select **Go** or press <Enter> to begin the lookup.
3. Select the desired item by clicking on the name of the medication. Up to 6 medications can be selected.
4. To view medications selected select **MEDS SELECTED**.
5. Select **Process** to begin clinical monitoring process.

Select Hospital Base Menu > Patient > Misc. Clinical Monitoring

The screenshot displays the Pharmacy application interface for Evident Community Hospital. The patient information section shows: AINSWORTH MARTHA COZEN, ID 357823, Age 80Y, Sex F, Height 60.00 in., Weight 54.43 kgs, CrCl: 39.84, Room: 300-9. The 'Process' button is highlighted in red. Below the patient information, there are radio buttons for 'All meds (by description)', 'All meds (by mnemonic)', and 'My meds'. A 'Lookup Starting Point' field is present. The main area shows a list of medications with columns for Description, Item Number, Primary Unit, and NDC Number. The first medication, ACCURIP 10 MG TAB, is highlighted in blue. A 'MEDS SELECTED' button shows '(1) MEDS SELECTED'. At the bottom, there is a note: '* = Non-formulary item'.

Description	Item Number	Primary Unit	NDC Number
ABILIFY (ARIPIPRAZOLE) 10 MG TAB	03814531	TAB	EA 54868-5202-00
ACCURIP 10 MG TAB	3881747	TAB	EA 00071-0530-23
ACETAMINOPHEN (TYLENOL) 325 MG TABLET	00381010	TAB	EA 50580-0496-60
ACETAMINOPHEN (TYLENOL) 500MG TABLET	00381604	TABLET	EA 50590-0710-51
ACETAMINOPHEN ELIXIR (TYLENOL):160MG/SML	00382012	SML DOSE	EA 54868-1791-00
ACETAMINOPHEN ORAL SOLUTION 160MG/SML	03814581	EA	00121-0657-21
ACETAMINOPHEN SUPP (TYLENOL) : 120 MG	00386070	1 SUPP	EA 00182-1662-11
ACETAMINOPHEN SUPP (TYLENOL) : 650 MG	00386072	1 SUPP	EA 00536-1260-12
ACETAMINOPHEN W/ COD ELIXIR :30MG/12.5ML	00382018	12.5ML(30MG)UD	EA 00045-0513-60
ACETAMINOPHEN W/COD(TYLENOL #3) 30/300MG	00381012	TAB	EA
ACETAMINOPHEN/CODEINE 300MG/30MG TAB	03814529	EA	54868-0364-01
ACETAZOLAMIDE (DIAMOX) : 250 MG	00381014	TAB	EA 51672-4023-01
ACTIVASE 50 MG INJ	00386106	50ML INJ	EA 50242-0044-13
ACTOS	00065890	TAB	EA
ACYCLOVIR (ZOVIRAX) PO : 800 MG	00381591	TAB	EA 13411-0183-06
ADMIXTURE FEE	03814527	EA	99999-9999-99
ADRIAMYCIN PFS 2MG/ML 100 ML VL	00003810	100 ML VIAL	EA 55390-0238-01*
ADVIL 400MG TABLET	00381200	TAB	EA 62584-0746-01
ADVIL 800MG TAB	03814582	EA	58864-0026-30
ADVIL SUSP 100MG/SML	00382237	SML DOSE	EA 24385-0905-26

Clinical Monitoring Checks screen

Select **Hospital Base Menu > Patient > Misc. Clinical Monitoring > Process**

Evident Community Hospital		Signed On Emp: FT Dept: 038	
Pharmacy - Clinical Monitoring			
AINSWORTH MARTHA COZEN 357823 Age: 80Y Sex: F Height: 60.00 in. Weight: 54.43 kgs CrCl: 39.84 Room: 300-9			
Type	Partial Description		
ALLERGY CHECK	HYDROMORPHONE (DILAUDID) INJ: CODEINE		
ALLERGY CHECK	NORCO 7.5MG - 325MG TAB CODEINE		
DUPLICATE THERAPY	PROPRANOLOL (INDERAL) TAB :		
DUPLICATE THERAPY	QUINAPRIL (ACCUPRIL) TAB : 1 Duplicate Item		
DUPLICATE THERAPY	NORCO 7.5MG - 325MG TAB Acetaminophen Duplicate Ingredient		
DRUG INTERACTION	KCL 20 MEQ IN NS 1000ML QUINAPRIL (ACCUPRIL) TAB : 1 Major		
DRUG INTERACTION	KCL 20 MEQ IN NS 1000ML QUINAPRIL (ACCUPRIL) TAB : 1 Major		
DRUG INTERACTION	HYDROMORPHONE (DILAUDID) INJ: NORCO 7.5MG - 325MG TAB Major		
DRUG INTERACTION	QUINAPRIL (ACCUPRIL) TAB : 1 NORCO 7.5MG - 325MG TAB Moderate		
DRUG INTERACTION	QUINAPRIL (ACCUPRIL) TAB : 1 NORCO 7.5MG - 325MG TAB Moderate		
DRUG INTERACTION	QUINAPRIL (ACCUPRIL) TAB : 1 Insulin REG (Humulin R) 100U Moderate		
DRUG INTERACTION	QUINAPRIL (ACCUPRIL) TAB : 1 Insulin REG (Humulin R) 100U Moderate		
DRUG INTERACTION	QUINAPRIL (ACCUPRIL) TAB : 1 FUROSEMIDE (LASIX) : 20 MG TA Moderate		
DRUG INTERACTION	QUINAPRIL (ACCUPRIL) TAB : 1 FUROSEMIDE (LASIX) : 20 MG TA Moderate		
DRUG INTERACTION	Insulin REG (Humulin R) 100U PROPRANOLOL (INDERAL) TAB : Moderate		
DRUG INTERACTION	Insulin REG (Humulin R) 100U PROPRANOLOL (INDERAL) TAB : Moderate		
DRUG INTERACTION	Insulin REG (Humulin R) 100U FUROSEMIDE (LASIX) : 20 MG TA Moderate		
DRUG INTERACTION	PROPRANOLOL (INDERAL) TAB : FUROSEMIDE (LASIX) : 20 MG TA Moderate		
DRUG INTERACTION	PROPRANOLOL (INDERAL) TAB : FUROSEMIDE (LASIX) : 20 MG TA Moderate		
REF. RANGE CHECK	POTASSIUM	=	7.0000 HC ON 10/20/15
REF. RANGE CHECK	GLUCOSE	=	200.0000 H ON 11/04/15
REF. RANGE CHECK	GLUCOSE	=	96.0000 ON 10/20/15
MISC. CHECK	NS :100 ML 2B1302P IV Unknown NDC number		

Miscellaneous Monitoring Checks screen

Patient Education

Please refer to the [Patient Education Documents User Guide](#) for more information.

Interventions and Adverse Drug Reactions (ADRs)

Overview

There are separate data entry screens for documentation of both Interventions and ADRs. The system allows review of documented Interventions and ADRs with display and maintenance functions. Interventions are hospital defined according to set up in the Intervention Table.

Interventions and ADRs can be entered:

- Individually on a case-by-case basis.
- During order entry, when clinical monitoring is performed by the system. An allergy, drug interaction, duplicate therapy, or reference range check must be found by the system to allow Intervention/ADR entry.
 - Reference Range Checking allows Intervention documentation only.
 - See Clinical Monitoring for further information.
- Through automatic linkage of an item to Intervention/ADR entry.

Performing an Intervention

From the Pharmacy-Selection Screen, select **Interventions**.

Select **Hospital Base Menu > Patient Account# > Interventions**

The screenshot shows the 'Pharmacy - Intervention Maintenance' window for patient AINSWORTH MARTHA COZEN (ID: 357823). The patient's demographic information is displayed at the top: Age: 80Y, Sex: F, Height: 60.00 in., Weight: 54.43 kgs, CrCl: 39.84, Room: 300-9. The main form is titled 'Clinical Intervention Data' and contains the following fields:

- Date:** 12/01/15 (with a back arrow icon)
- Time:** 1033
- Physician:** (with a magnifying glass icon)
- Drug:** PREDNISON 1 (with a magnifying glass icon)
- Intervention Type:** (dropdown menu)
- Suspected Outcome without Intervention:** (dropdown menu)
- Intervention Description:** (text area)
- Outcome Due to Intervention:** (dropdown menu)
- Intervention Status:** (dropdown menu)
- Time Involved:** 5 min(s)
- Cost Savings (\$):** 5.00
- RPh:** FT
- Pending/Complete:** Pending (dropdown menu)
- Comments:** (text area)

At the bottom of the form, there is a legend: Drug Needed, Int. Type Needed, Outcome w/o Int. Needed, Outcome Due to Int. Needed, Int. Status Needed.

Clinical Intervention Data

- **Date**
 - Default: Current date.
 - Options: Overtyping date in MMDDYY format if desired.
 - Usage: Displays the date for which the intervention was performed. Select the back arrow to exit back to the Pharmacy Base Screen.
- **Time**
 - Default: Current time.
 - Options: Overtyping time in military format if desired.
 - Usage: Displays the time for which the intervention was performed.
- **Physician**
 - Default: Admitting physician for the patient.
 - Options: Select the magnifying glass to access the physician lookup.
 - Usage: Lists the ordering physician.
- **Drug**
 - Default: Blank
 - Options: Type the first few letters of the drug name and press <Enter>.
 - Usage: Lists the drug for which an intervention is required.

- **Intervention Type**
 - Default: Blank
 - Options: Select intervention type from look up menu.
 - Usage: There can be as many as 36 different Intervention types. Select **Other** to use an Intervention Type that is not setup or to use an unlisted Intervention Type.

- **Suspected Outcome Without Intervention**
 - Default: Blank
 - Options: Select suspected outcome from look up menu.
 - Usage: There can be as many as 12 Outcomes Without Interventions. Select **99-Other** to use an unlisted Outcome Without Intervention.

- **Intervention Description**
 - Default: Blank
 - Options: Allows four lines of text describing intervention performed.
 - Usage: Description is especially important if using the **99-Other** option for Intervention Type.

- **Outcome Due to Intervention**
 - Default: Blank
 - Options: Select outcome due to intervention from look up menu.
 - Usage: Select **99-Other** to use an unlisted Outcome Due to Intervention. There can be as many as 12 Outcomes Due to an Intervention.

- **Intervention Status**
 - Default: Blank
 - Options: Select intervention status from look up menu.
 - Usage: Select **99-Other** to use an unlisted Intervention Status.

- **Time Involved**
 - Default: Defaults to the number of minutes previously set up in the Intervention Table.
 - Options: Overtyping number of minutes if necessary.
 - Usage: Enter the number of minutes spent by the pharmacist on the intervention. Time is set up as a default in the Intervention Table (See [Pharmacy Setup](#) for further information). Overtyping number of minutes if necessary.

- **Cost Savings**
 - Default: Cost Savings is set up as a default in the Intervention Table
 - Options: Amount of cost savings can be overtyped if necessary.
 - Usage: If a dollar figure is applicable to intervention performed, Cost Savings is set up as a default in the Intervention Table (See [Pharmacy Setup](#) for further information).

- **RPh**
 - Default: The three initials of the pharmacist performing the intervention.
 - Options: Cannot be accessed or changed.
 - Usage: Displays the initials of the Pharmacist performing the intervention. Initials pull from sign-on.

- **Status**
 - Default: Pending
 - Options: Pending or Complete

- Usage: Allows incomplete, or pending, interventions to flash on the Pharmacy Selection screen. *Intervention* flashes in the lower right hand corner of the screen. Upon completion of all required fields of the intervention, the status will automatically change to Complete.

- **Comments**

- Default: Blank
- Options: Up to three lines of free text
- Usage: Allows up to three lines of additional information to be entered. The Comments field is free text.

Options available after completion are as follows:

- Select **Save** to save the Intervention.
- Select **Medwatch** to print the Intervention on a Medwatch report form.
 - Requires the use of a special Medwatch form printed on a postscript printer.
- Select **Print** to print the intervention.
- Select **Cancel** to cancel the intervention before completion.

Documenting an ADR

From the Pharmacy Selection screen, select **Adverse Drug Reactions**.

Select **Hospital Base Menu > Patient > Adverse Drug Reactions**

The screenshot displays the 'Adverse Drug Reaction Data' form within the 'Pharmacy-ADR Maintenance' application. The patient information at the top includes the name 'AINSWORTH MARTHA COZEN' and ID '357823'. The form contains several input fields and checkboxes for recording an adverse drug reaction, such as 'Date', 'Time', 'Physician', 'Drug', 'Dose', 'Frequency', 'Route', 'Lot', 'Expiration', and 'Therapy Dates'. It also includes checkboxes for 'Event Abated After D/C, Reduced Dose' and 'Event Recurred After Reintroduction', and a section for 'Outcomes Attributed to Adverse Event' with checkboxes for 'Death', 'Life-Threatening', 'Hospitalization', 'Congenital', 'Disability', 'Intervention Required', and 'Other'. There are also text areas for 'Description of Events', 'Relevant Test/Laboratory Data, Including Dates', and 'Other Relevant Information'. At the bottom, there are fields for 'RPh' (FT) and 'Title'.

Adverse Drug Reaction Data screen

- **Date**

- Default: Current date.
- Options: Overtyping date in MMDDYY format if desired. Select drop down to access a calendar to choose date.

- Usage: The date the ADR occurred. Select the back arrow to exit.
- **Time**
 - Default: Current time.
 - Options: Overtime time in military format if desired.
 - Usage: Displays the time for which the ADR occurred.
- **Physician**
 - Default: Admitting physician for the patient.
 - Options: Select the magnifying glass to display a physician look up.
 - Usage: Lists the ordering physician.
- **Drug**
 - Default: Blank
 - Options: Type the first few letters of the drug name and press <Enter>. Select drug by double clicking.
 - Usage: Lists the drug for which an ADR occurred.
- **Dose**
 - Default: Blank.
 - Options: 10-digit alphanumeric field.
 - Usage: Type the dosage quantity and unit of the medication and press <Enter>.
- **Frequency**
 - Default: Blank.
 - Options: 8-digit alphanumeric field.
 - Usage: Enter the frequency of the medication order and press <Enter>.
- **Route**
 - Default: Blank.
 - Options: Enter the route or enter the beginning description of the route and select the appropriate route from the route lookup.
 - Usage: Enter route of administration.
- **Lot**
 - Default: Blank.
 - Options: 9-digit alphanumeric field
 - Usage: Enter lot number of medication. This is very important if the ADR involves administration of a recalled medication.
- **Expiration Date**
 - Default: Blank.
 - Options: 6-digit numeric date field. Enter MMDDYY format. Select a date from the calendar by selecting the drop down arrow.
 - Usage: Provides expiration date information for the drug in which the adverse reaction occurred.
- **Therapy Dates**
 - Default: Blank.
 - Options: Two 6-digit numeric date fields. Enter MMDDYY format. Select a date from the calendar by selecting the drop down arrow.

- Usage: Enter the beginning and ending dates of this medication therapy for this patient.
- **Indication**
 - Default: Blank.
 - Options: Free format entry of indication for medication therapy.
 - Usage: Provides information as to what medication therapy is indicated for the selected patient.
- **Event Abated After D/C, Reduced Dose**
 - Default: Blank.
 - Options: Yes, No, or N/A (Not Applicable)
 - Usage: Enter Yes if reducing or discontinuing the dose abated reaction. Enter No if reaction continued to occur after reducing or discontinuing dose.
- **Event Recurred After Reintroduction**
 - Default: Blank.
 - Options: Yes, No, or N/A (Not Applicable)
 - Usage: Answering Yes denotes another reaction occurred once patient was reintroduced to the medication. Answering No denotes no further reaction occurred.
- **Outcomes Attributed to Adverse Event**
 - Default: Blank.
 - Options: Check all fields that apply. Leave fields that do not apply blank.
 - Usage: Check all fields that apply. If selecting the "Other" field, enter an up to 21-character free format outcome.
- **Description of Event**
 - Default: Blank.
 - Options: A free format entry describing the ADR.
 - Usage: Details the events that occurred prompting the initiation of the ADR.
- **Relevant Test/Laboratory Data, Including Dates**
 - Default: Blank.
 - Options: A free format entry of data.
 - Usage: Provides information regarding the selected patient's relevant lab data.
- **Other Relevant History**
 - Default: Blank.
 - Options: A free format entry of data.
 - Usage: Provides information regarding the selected patient's medical history.
- **Initials**
 - Default: Blank.
 - Options: Three initials of the person documenting ADR.
 - Usage: Initials of person documenting ADR.
- **Title**
 - Default: Blank.
 - Options: Enter the title of the person documenting the ADR (i.e. Pharmacist).
 - Usage: Title of person documenting ADR.

Options available after completion are as follows:

- Select **Save** to save the ADR.
- Select **Medwatch** to print the ADR on a Medwatch report form.
 - Requires the use of a special Medwatch form printed on a postscript printer.
- Select **Print** to print the ADR.
- Select **Cancel** to cancel the ADR before completion.

Linking a Drug to an Intervention / ADR During Order Entry

Some medications by the nature of their indications and usage are more likely to have Interventions/ADRs associated with them. Such medications can be automatically linked to an Intervention or ADR entry through the Pharmacy Information Screen.

1. From the Hospital Base menu, select **Charge Tables/Inventory**.
2. Search for an item by **Description** or **Item Number**.
3. Enter the first few alphabetic characters of the item or enter the item number and press **Go**.
4. Select appropriate item by double clicking.
5. Select **Pharmacy Information Page 2**
6. Select the drop-down menu option for **Intervention/ADR** and select **Intervention** or **ADR**.

Select **Hospital Base Menu > Charge Tables and Inventory > Item > Pharmacy Information > Page 2**

Pharmacy Information Page 2

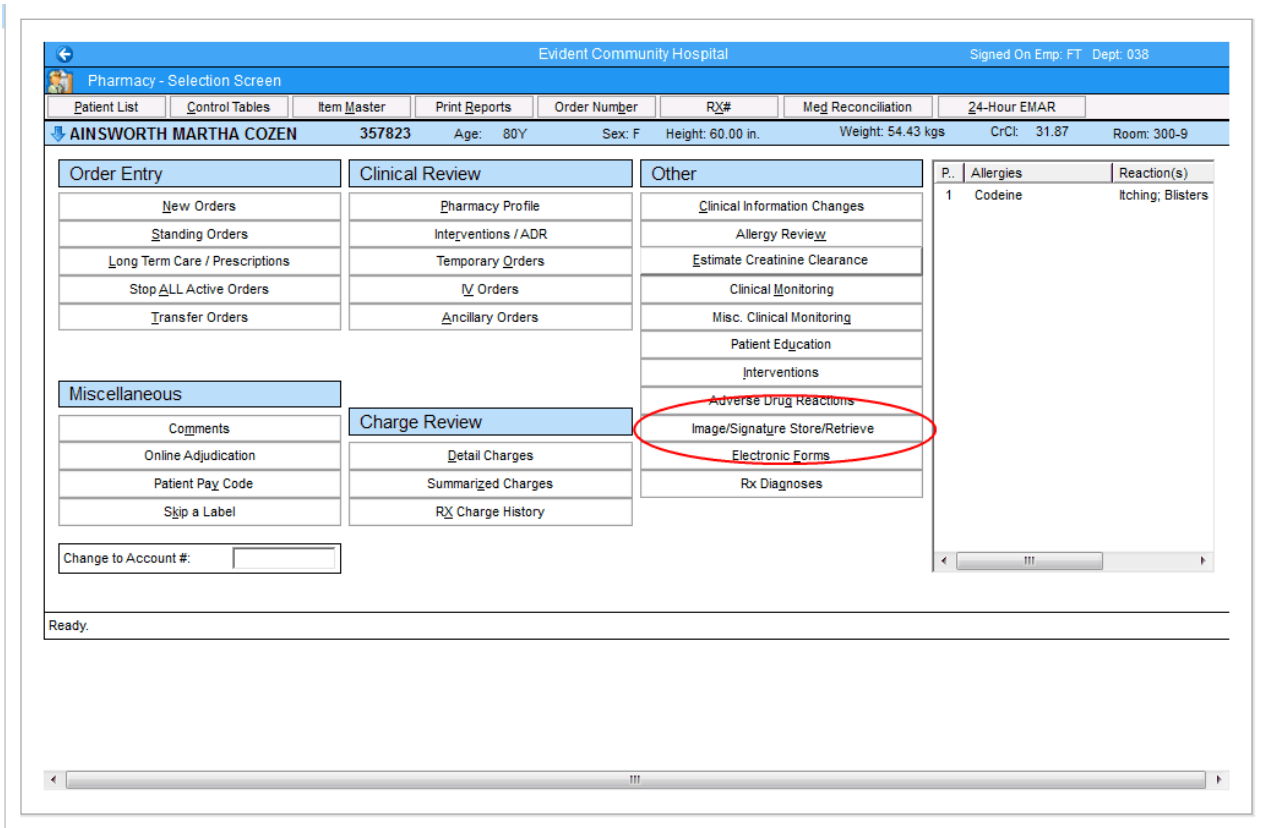
After linkage of an item to an Intervention/ADR through the Pharmacy Information screen, the software prompts for Possible Intervention/ADR documentation during the order entry process.

Image/Signature Store/Retrieve

Electronic File Management is a separately purchased application. Contact your TruBridge Account Manager for more information.

Scanned images may be accessed from the Pharmacy - Selection Screen. See [Electronic File Management](#).

Select Hospital Base Menu > Patient Account # > **Image/Signature Store/ Retrieve**



Image/Signature Store/Retrieve

Electronic Forms

Electronic Forms is a separately purchased application. Contact your TruBridge Account Manager for more information.

Electronic Forms may be accessed from the Pharmacy - Selection Screen. Refer to the [Electronic Forms User Guide](#) for more information.

Select **Hospital Base Menu > Patient Account # > Electronic Forms**

The screenshot shows the 'Pharmacy - Selection Screen' for patient AINSWORTH MARTHA COZEN (ID: 357823). The patient's age is 80Y, sex is F, height is 60.00 in, and weight is 54.43 kgs. The screen is divided into several menu sections:

- Order Entry:** New Orders, Standing Orders, Long Term Care / Prescriptions, Stop ALL Active Orders, Transfer Orders.
- Clinical Review:** Pharmacy Profile, Interventions / ADR, Temporary Orders, IV Orders, Ancillary Orders.
- Other:** Clinical Information Changes, Allergy Review, Estimate Creatinine Clearance, Clinical Monitoring, Misc. Clinical Monitoring, Patient Education, Interventions, Adverse Drug Reactions, Image/Signature Store/Retrieve, **Electronic Forms** (highlighted in red), Rx Diagnoses.
- Miscellaneous:** Comments, Online Adjudication, Patient Pay Code, Skip a Label.
- Charge Review:** Detail Charges, Summarized Charges, RX Charge History.

On the right side, there is a table for allergies:

P.	Allergies	Reaction(s)
1	Codeine	Itching; Blisters

At the bottom left, there is a 'Change to Account #' field and a 'Ready.' status indicator.

Electronic Forms

Electronic Forms for AINSWORTH MARTHA COZEN

Refresh Post Superbill Show Deleted

Previously Selected Forms

Title	Last Updated On/By	Created On	...	Locked On/By
-------	--------------------	------------	-----	--------------

Available Forms

Category	Title	Version
Inpatient Nursing	Quality Measures 2014	1
IRF-PAI	IRF PAI FORM2	1
Occupational Therapy	EVIDENT OT Evaluation	1
Occupational Therapy	EVIDENT OT Progress Note	1
Operating Room	EVIDENT Consent for Anesthesia Services	1
Operating Room	EVIDENT OR General Surgery	1
Operating Room	EVIDENT OR Initial Interview	1
Operating Room	EVIDENT OR PACU	1
Operating Room	EVIDENT OR Post-Op Phone Call	1
Physical Therapy	EVIDENT PT Evaluation	1
Physical Therapy	EVIDENT PT Progress Note	1
Physical Therapy	EVIDENT PT Progress Report	1

Ready

Electronic Forms List

RX Diagnoses

Overview

Diagnoses may be entered via the Pharmacy Application for the purpose of Drug-Disease Interaction checking. If **Disease Interaction Checking** is enabled in the [Pharmacy Clinical Monitoring Table](#), the software will check for Admitting Diagnosis, Patient Diagnoses, and diagnoses on the Physician Problem List. If there are no diagnoses listed, the pharmacist will be prompted to enter an RX Diagnoses.

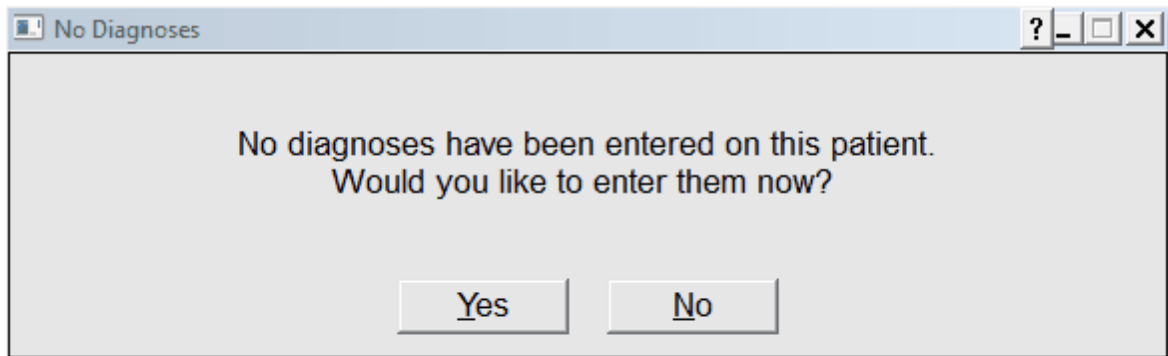
Employees in the Pharmacy Role will automatically be assigned default Behavior Controls **Coding by Pharmacy, Code by HIM, and Non-HIM Diagnoses and Procedure Information**. This security allows access to the RX Diagnoses screen where existing diagnoses may be viewed or new diagnoses may be entered.

NOTE: Diagnoses entered via RX Diagnoses will not update the Problem List or the Medical Records Group.

RX Diagnoses

If Disease Interaction Checking is enabled and no diagnoses are listed for the visit, a prompt will display.

Select **Hospital Base Menu > Patient Account # > RX Diagnoses**



No Diagnoses Prompt

If **Yes** is selected, the RX Diagnoses screen will be launched so a diagnosis may be entered and drug-disease checking will be performed. If **No** is selected, an override reason must be entered and drug-disease checking will not occur.

Select **Hospital Base Menu > Patient Account # > RX Diagnoses**

Diagnoses Screen

The screen defaults to Pharmacy but other drop-down menu options are available. **Diagnoses** may be selected to view all existing diagnosis codes, **Admitting Diagnosis** may be selected to view admitting diagnosis codes and **Reason for Visit** may be selected to view reason for visit diagnosis codes.

To add a new diagnosis code from the Diagnoses screen, select **New Diagnosis** on the action bar.

The screenshot shows the 'Pharmacy Diagnoses' screen for patient AINSWORTH MARTHA COZEN (357823). The patient's demographic and clinical information is displayed at the top, including account number, sex, date of birth, age, MR#, attending physician, service code, financial class, service dates, BMI, BSA, and admit weight. The 'Diagnoses' section features a dropdown menu currently set to 'Pharmacy' and an empty table with the following columns: Rank, ICD9 Code, ICD10 Code, Description, POA, Admitting, Reason for Visit, Code Class, and MCE. An action bar at the top of the table includes buttons for 'New Diagnosis', 'Edit', 'Delete', 'Compute', 'Finish', 'Insert Problems', and 'PDF'.

Pharmacy Diagnoses screen

The **Diagnosis List** screen will display. The Filter gives the ability to search for the diagnosis code by Description, ICD-9 or ICD-10. Once the search criteria is entered in the **Search** field, the search results will display the ICD-9, ICD-10, Snomed and Diagnosis Description. Double-click the desired code to move it to the Selected Diagnosis portion of the screen until all desired codes have been added. Select **Update** on the action bar to place the codes on the account and return to the previous screen.

CHARTS » AINSWORTH MARTHA COZEN (357823) » DIAGNOSIS

AINSWORTH MARTHA COZEN Account: 357823 Sex: F DOB: 12/10/1934 Age: 80 MR#: 000307 Attending Phy: SMITH J
 Pt Type: 1 10 Service Code: M Financial Class: Service Dates: 04/24/2015 - Disc Cd:
 BMI: 23.44 kg/m2 BSA: 1.52 m2 Admit Weight: 120 lbs 54.43 kg 54431.10 g

System Menu

Charts

AINSWORTH MARTHA CO... ✕

- Patient Summary
- Diagnosis**
- Procedures
- Edits
- Chief Complaint
- Problem List
- PACS Images
- Transcriptions
- Clinical History
- Reports and Attachments
- MAR
- Documentation
- Health History
- Plan of Care
- Physician Query
- Order Chronology
- Demographics
- Medical Necessity

Update

Diagnosis List

New Diagnosis
Billing Code Set: ICD-9

Filter: Description ICD9 ICD10 Search:

DIAGNOSIS LOOKUP LIST			
ICD9	ICD10	SNOMED	Diagnosis Description

SELECTED DIAGNOSIS			
ICD9	ICD10	SNOMED	Diagnosis Description
49390	J45909	195967001	ASTHMA
496.5198	J440	196001008	COPD W/ ACUTE LRTI

Diagnosis List screen

The selected diagnosis codes will list in the assigned ranking order on the Diagnoses screen.

Select Hospital Base Menu > Patient Account # > RX Diagnoses > Pharmacy

CHARTS >> AINSWORTH MARTHA COZEN (357823) >> DIAGNOSIS

AINSWORTH MARTHA COZEN Account: 357823 Sex: F DOB: 12/10/1934 Age: 80 MR#: 000307 Attending Phy: SMITH J
 Pt Type: 1 10 Service Code: M Financial Class: Service Dates: 04/24/2015 - Disc Cd:
 BMI: 23.44 kg/m2 BSA: 1.52 m2 Admit Weight: 120 lbs 54.43 kg 54431.10 g

System Menu Charts AINSWORTH MARTHA CO... Patient Summary Diagnosis Procedures Edits Chief Complaint Problem List PACS Images Transcriptions Clinical History Reports and Attachments MAR Documentation Health History Plan of Care Physician Query Order Chronology Demographics Medical Necessity

Diagnoses

Pharmacy

Rank	ICD9 Code	ICD10 Code	Description	POA	Admitting	Reason for Visit	Code Class	MCE
PRIN	49390	J45909	Asthma					
2	496.5198	J440	COPD w/ acute LRTI					A,


Diagnoses screen


The following information displays on the Pharmacy Diagnoses screen:

- **Rank:** Gives the ability to define the order in which the diagnosis codes will display on the Diagnoses screen. The Rank field defaults to the order in which the diagnosis code is entered but may be changed. The diagnosis code with a ranking of one will be considered the Principal Diagnosis (PRIN).
- **ICD-9:** Displays the ICD-9 code selected from the Diagnosis List screen
- **ICD-10:** Displays the ICD-10 code selected from the Diagnosis List screen
- **Description:** Displays the diagnosis code description selected from the Diagnosis List screen
- **POA:** Present On Admission: Specifies whether or not the illness was present at the time of admission. The default options are **Yes**, **No** or **Blank**.
- **Admitting:** Specifies whether or not the illness was present when the patient was admitted. There can only be only one Admitting Diagnosis.
- **Reason for Visit:** Specifies whether or not the illness was the reason for the visit. This is only used for unscheduled outpatient visits.
- **Code Class:** Displays applicable indicators of **C** for Complication or Comorbidity (CC), **H** for Hospital Acquired Condition (HAC), and **M** for Major Complication or Comorbidity (MCC).

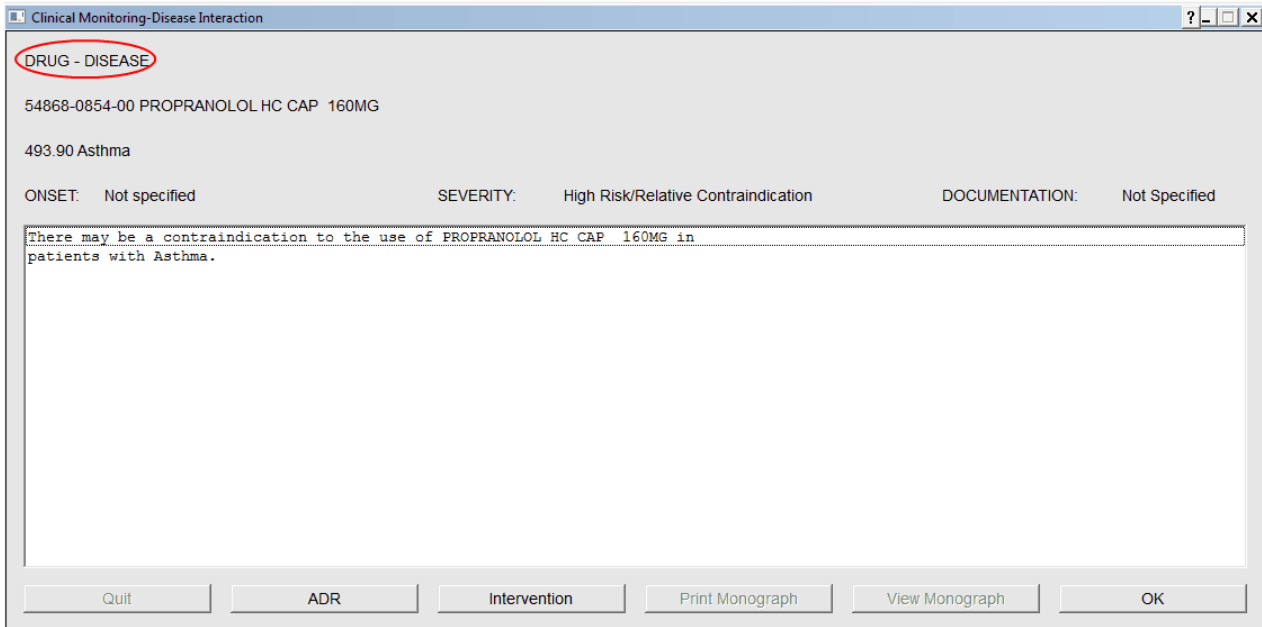
- **MCE's:** Displays any applicable Medicare Code Edits

To remove a diagnosis code, highlight the code and select **Delete** on the action bar.

AINSWORTH MARTHA CO... 

To exit the Diagnoses screen, select  **X**. Clinical monitoring will be performed and all checks, including Drug - Disease checks, will display.

Select **Hospital Base Menu > Patient Account # > RX Diagnoses > X to exit the Diagnoses screen > Clinical Monitoring > Drug-Disease**



The screenshot shows a window titled "Clinical Monitoring-Disease Interaction". At the top left, "DRUG - DISEASE" is circled in red. Below this, the text reads: "54868-0854-00 PROPRANOLOL HC CAP 160MG" and "493.90 Asthma". Further down, it displays "ONSET: Not specified", "SEVERITY: High Risk/Relative Contraindication", and "DOCUMENTATION: Not Specified". A text box contains the message: "There may be a contraindication to the use of PROPRANOLOL HC CAP 160MG in patients with Asthma." At the bottom of the window, there are several buttons: "Quit", "ADR", "Intervention", "Print Monograph", "View Monograph", and "OK".

Drug-Disease screen

Physician Problem List

The Physician Problem List is accessible via the Pharmacy Application. When any ClientWare 5 application is selected, other applications are available via the Navigation Panel. Select **RX Diagnoses** from the Pharmacy Selection screen then **Problem List** to view the Problem Display screen. For more information, please refer to the [Physician Problem List User Guide](#).

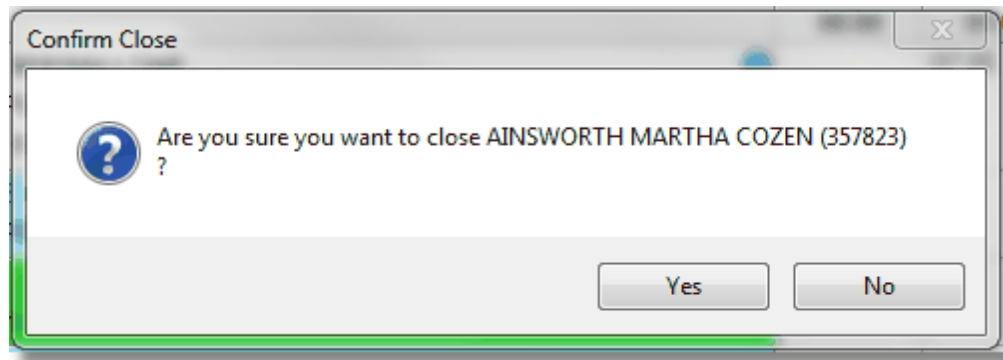
Select **Hospital Base Menu > Patient Account # > RX Diagnoses > Problem List**

Problem List

NOTE: Additional security is required in order to edit the Problem List.

AINSWORTH MARTHA CO...

- Select to exit the MAR and return to the Pharmacy - Selection Screen.
- The following prompt will display:



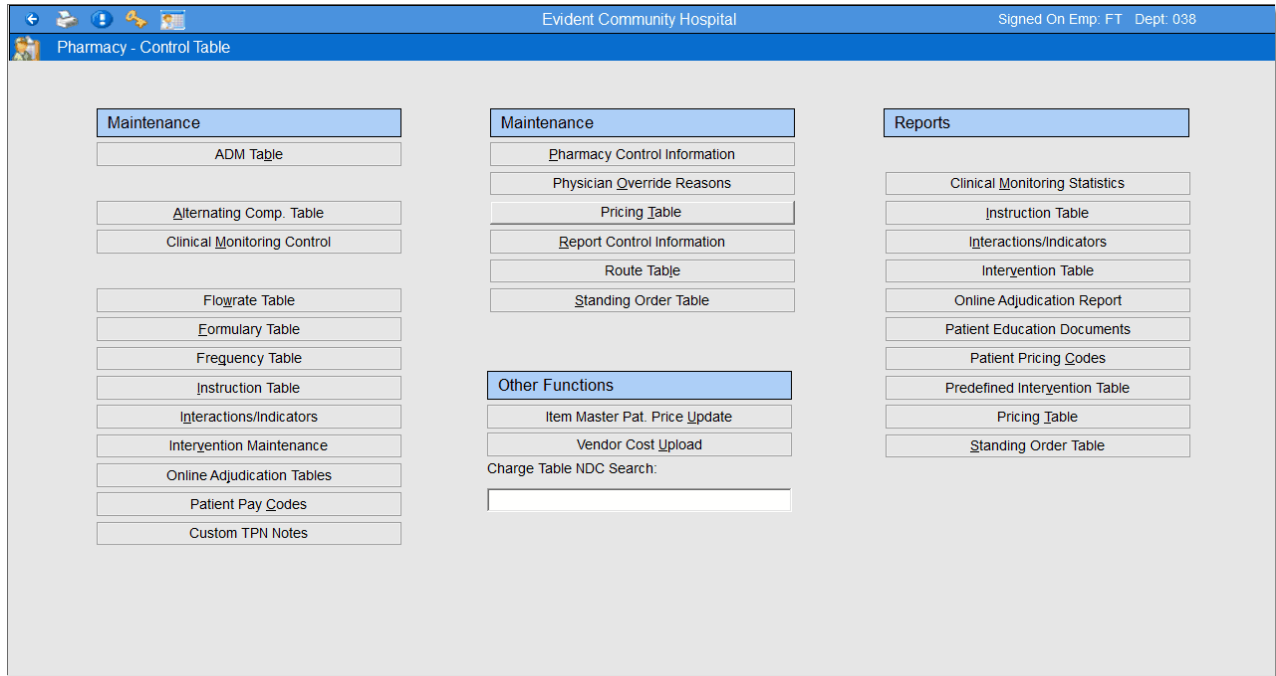
Confirmation Prompt

- Select **Yes** to close the chart and return to the Pharmacy - Selection Screen.
- Select **No** to remain in Problem List.

Chapter 12 Department Specific

Department Specific presents access to the pharmacy table set up options that control many aspects of pharmacy functionality.. Refer to [Pharmacy Setup \(Department Specific section\)](#) for more information.

Select **Hospital Base Menu > Department Specific**



Department Specific

Chapter 13 Charge Tables and Inventory

Charge Tables and Inventory presents access to the hospital formulary. Refer to the [Pharmacy Setup User Guide](#) Item Master and Pharmacy Information sections for more information.

Select **Hospital Base Menu > Charge Tables and Inventory**

Charge Tables - Inventory Control

Item:

Items	Requisitions	Other
Item Entry and Maintenance	Item Expense Requisitions	Contracts
Quick Item Entry	Item Transfer Requisitions	Contract Lookup
Item or Service Search	Requisition Entry by Item	Vendors
Adjust Item Balances	Restock Requisition System	Manufacturers
Set Item Balances	Electronic Requisitions	Adjustment Codes
Request Transfer Between Facilities	Print Duplicate Copy	Print Adjustment Codes
Purchase Orders	Skip a Requisition Form	Images
Purchase Order Entry and Maintenance	Backorders	Skip a Pharmacy Label
Purchase Order Receiving	Completed Procedure Requisitions	Process ADM Update
Purchase Order Entry by Item	Transmit From PC to CPSI	Pricing Table
Purchase Order Addresses	Transaction Review/Update	Drug Information
Invoice_PO Discrepancies		

Charge Tables and Inventory

13.1 Master Selection Functions

This chapter will cover pharmacy functions performed via Master Selection.

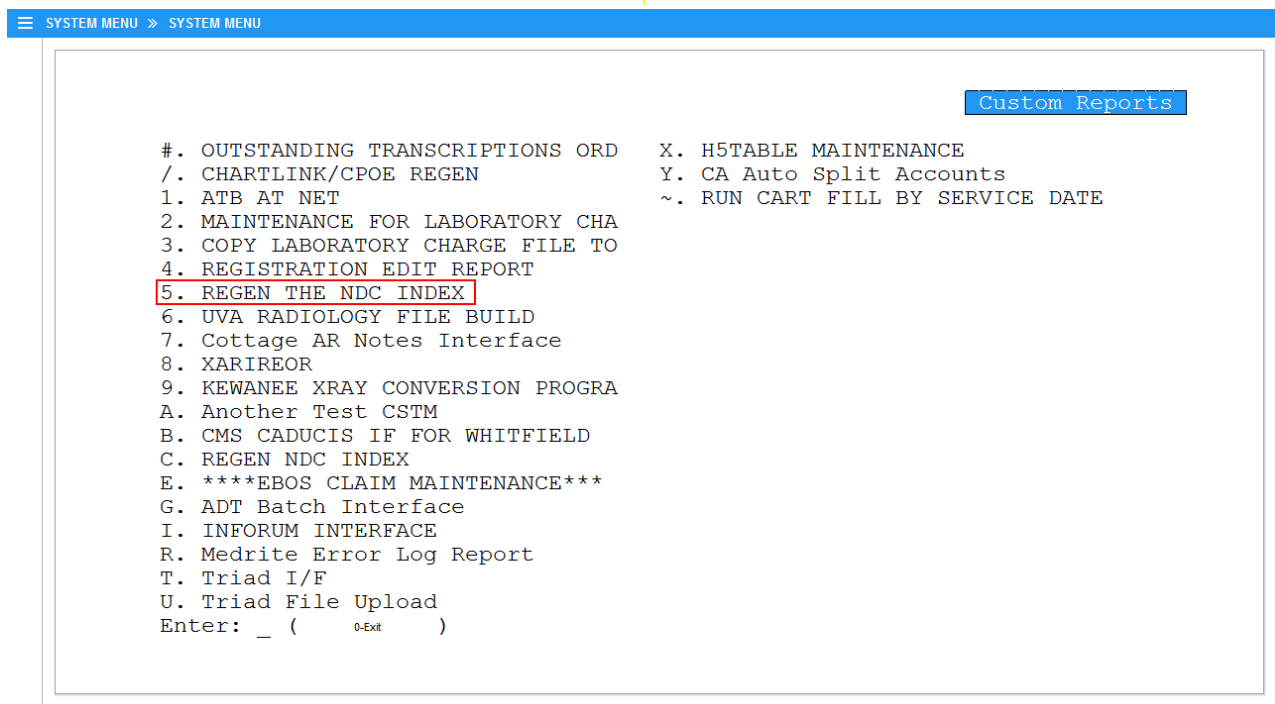
Custom Reports

Regen NDC Index

After NDC numbers are added or modified on Pharmacy Information Page 1 or Page 2, it is good practice to "regen" or rebuild the NDC index file.

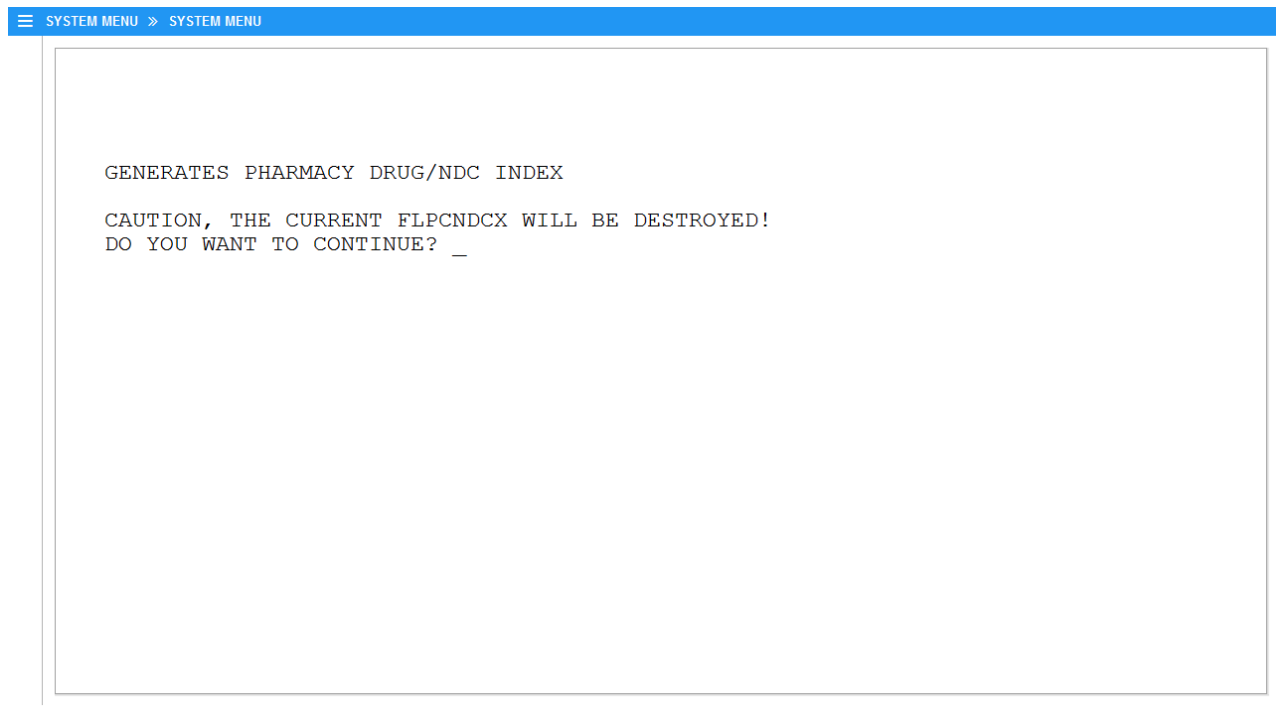
1. Enter the alpha or numeric character for **Regen the NDC Index**.

Select **Hospital Base Menu > select Master Selection > Print Reports > Custom Reports > Regen the NDC Index**



Custom Reports

The following warning will appear:



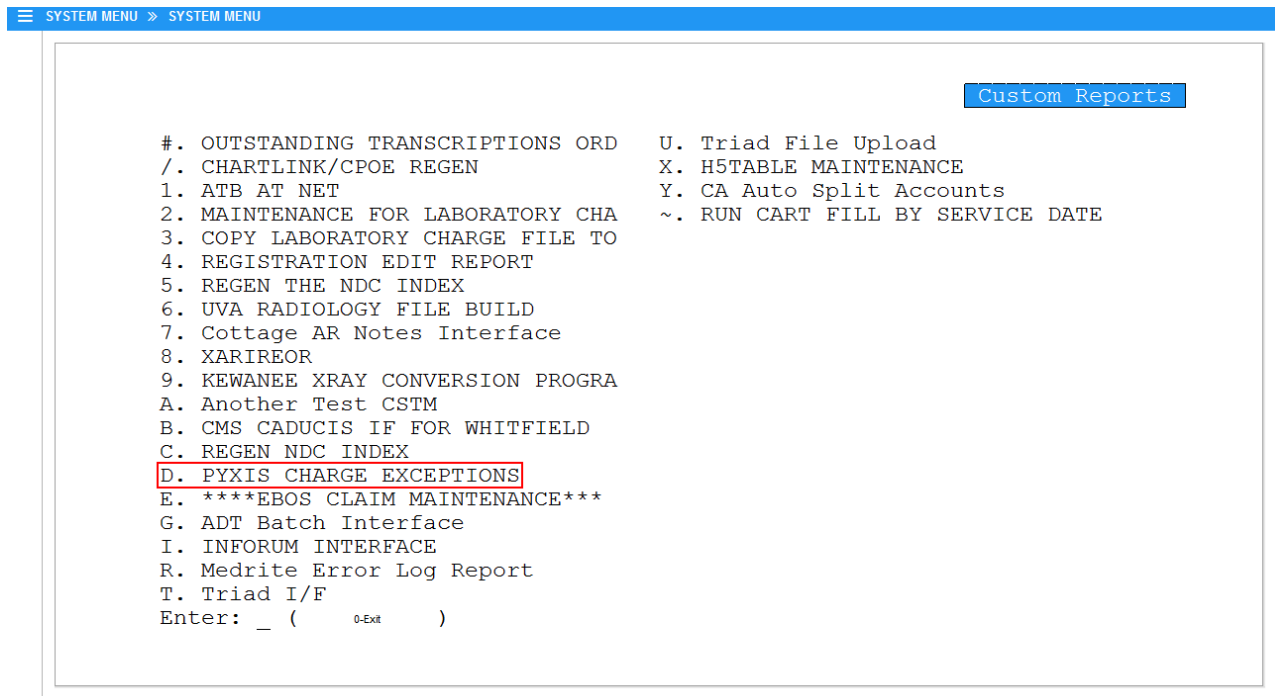
NDC File Warning

2. Enter "Y"es to generate the file.
 - The message "Generation in Progress" will display.
 - The user will be returned to the Hospital Base Menu when the process is complete.
3. Enter "N"o to cancel the process and return to the Hospital Base Menu.

Charge Exception Report

The Charge Exception Report may be generated to review medications removed from an Automated Dispensing Machine (ADM) which did not charge due to an invalid patient account number or invalid item number.

1. Select the Charge Exception report created for your facility. The title will reflect the type of ADM machine at the facility.

Select Hospital Base Menu > Master Selection > Print Reports > Custom Reports

Custom Report screen

2. Enter the **Start Date** and **End Date**.
3. Enter "Y"es to generate the report
 - "N"o to change the date range.
 - 0 to exit the report and return to the Hospital Base Menu

Select Hospital Base Menu > Master Selection > Print Reports > Custom Reports > Pyxis Charge Exceptions

Signed On Emp: FTT Dept: 156

PRINT CHARGE EXCEPTIONS FOR PYXIS PHARMACY INTERFACE

START DATE (CNYMMDD):20151005 (RETURN FOR ALL)
 END DATE (CNYMMDD):20151105 (RETURN FOR ALL)
 OKAY Y/N/0?

Charge Exception Parameters

Charge Exception Report

DATE/TIME	ACCT #	NUM RECEIVED	DEPT	ORD #	ITEM #	QTY	SERV DATE/TIME	MESSAGE ID
	PATIENT NAME			PRICE			REASON FOR EXCEPTION	

NO EXCEPTIONS IN DATE RANGE.								

RUN DATE: 11/05/15
 TIME: 09:19

PYXIS PHARMACY INTERFACE
 CHARGE EXCEPTIONS
 10/05/15 - 11/05/15

PAGE 1
 LAIPRTCHGLOG

Inventory Ad Hoc Report

For use of the Inventory Ad Hoc report, please refer to the [Materials Management \(Inventory\)](#) section of the Ad Hoc Reporting User Guide

Patient (Batch) Charging

Overview

OR or Floor stock charges are often entered through batch charging instead of order entry. The Patient Charging System or "batch" entry allows charges and credits to be processed without an order. The pharmacy must decide which method is better for charge/credit entry. No more than 60 lines of charge items can be entered at one time when batch charging. Each group of charges is called a batch.

The TruBridge Inventory System allows tracking of floor stock usage and lost charges in a given hospital department using Patient Charge Entry. Batch Charge Entry is also a more efficient way of processing large numbers of charges.

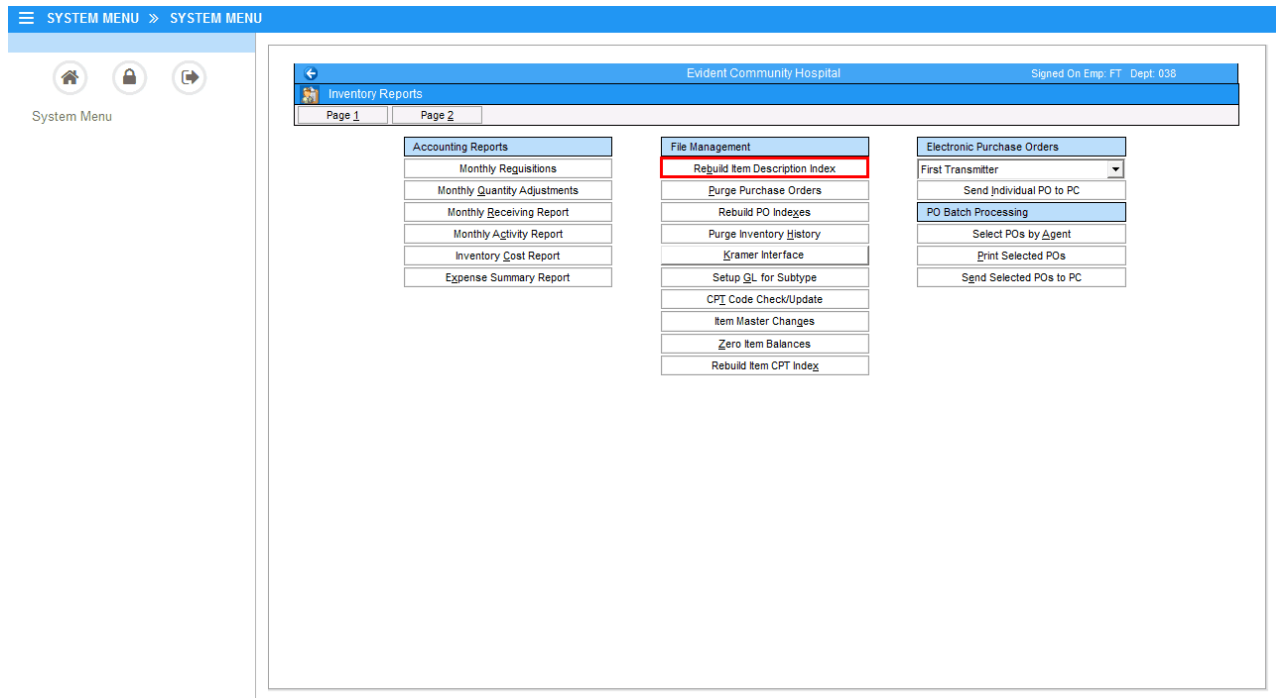
Refer to the [Charging/Item Master User Guide](#) for more information.

Rebuild Item Description Index

Certain changes may not display immediately in the Item Master alphabetical lookup. The user may need to "regen" or rebuild the item description file. This process removes hidden and deleted items and also updates Descriptions and Alternate Names which have been modified.

1. Select **Rebuild Item Description Index**.

Select **Hospital Base Menu > select Master Selection > Print Reports > Inventory > Page 2 > Rebuild Item Description Index**



Inventory Reports screen

2. The user is returned to the Hospital Base Menu when the process is complete.

13.2 Drug Information Lookup

Drug information lookup, while accessible in multiple areas of ClientWare, is also accessible via **Drug Information** listed under the "Other" column in Charge Tables and Inventory.

Select **Hospital Base Menu > Charge Tables and Inventory > Drug Information**

Facility 1 : EVIDENT COMMUNITY HOSPITAL

Search: NDC Active Only

Description	Strength	Dose	Quantity	Unit	Package	NDC	Status
Amyvid Intravenous Solution No Strength		Solution	1.000	EA	Vial	00002120001	Active
quiNIDine Gluconate Injection 80MG/ML	80MG/1ML	Solution	10.000	ML	Vial	00002140701	Active
Axiron Topical Solution 30MG/1.5ML	30MG/1.5ML	Solution	90.000	ML	Bottle	00002197590	Active
PROzac Weekly Capsule 90MG	90MG	Capsule, Delayed Re...	4.000	EA	Strip	00002300475	Active
Strattera Oral Capsule 10MG	10MG	Capsule	30.000	EA	Bottle	00002322730	Active
Strattera Oral Capsule 25MG	25MG	Capsule	30.000	EA	Bottle	00002322830	Active
Strattera Oral Capsule 40MG	40MG	Capsule	30.000	EA	Bottle	00002322930	Active
Symbyax Oral Capsule 3MG-25MG	3MG-25MG	Capsule	30.000	EA	Bottle	00002323030	Active
Symbyax Capsule 6MG-25MG	6MG-25MG	Capsule	30.000	EA	Bottle	00002323130	Active
Symbyax Capsule 6MG-25MG	6MG-25MG	Capsule	100.000	EA	Strip	00002323133	Active
Symbyax Capsule 12MG-25MG	12MG-25MG	Capsule	30.000	EA	Bottle	00002323230	Active
Symbyax Capsule 6MG-50MG	6MG-50MG	Capsule	1.000	EA	Strip	00002323301	Active
Symbyax Capsule 6MG-50MG	6MG-50MG	Capsule	30.000	EA	Bottle	00002323330	Active
Symbyax Capsule 6MG-50MG	6MG-50MG	Capsule	100.000	EA	Strip	00002323333	Active
Symbyax Capsule 12MG-50MG	12MG-50MG	Capsule	1.000	EA	Strip	00002323401	Active
Symbyax Capsule 12MG-50MG	12MG-50MG	Capsule	30.000	EA	Bottle	00002323430	Active
Symbyax Capsule 12MG-50MG	12MG-50MG	Capsule	100.000	EA	Strip	00002323433	Active
Cymbalta Capsule, Delayed Release 20MG	20MG	Capsule, Delayed Re...	60.000	EA	Bottle	00002323560	Active
Strattera Capsule 18MG	18MG	Capsule	30.000	EA	Bottle	00002323830	Active
Strattera Oral Capsule 60MG	60MG	Capsule	30.000	EA	Bottle	00002323930	Active
Cymbalta Delayed-Release Capsule 30MG	30MG	Capsule, Delayed Re...	1.000	EA	Strip	00002324001	Active
Cymbalta Capsule, Delayed Release 30MG	30MG	Capsule, Delayed Re...	30.000	EA	Bottle	00002324030	Active
Cymbalta Delayed-Release Capsule 30MG	30MG	Capsule, Delayed Re...	90.000	EA	Bottle	00002324090	Active
Strattera Oral Capsule 80MG	80MG	Capsule	30.000	EA	Bottle	00002325030	Active
Strattera Oral Capsule 100MG	100MG	Capsule	30.000	EA	Bottle	00002325130	Active
Cymbalta Delayed-Release Capsule 60MG	60MG	Capsule, Delayed Re...	1.000	EA	Strip	00002327001	Active
Cymbalta Delayed-Release Capsule 60MG	60MG	Capsule, Delayed Re...	1000.000	EA	Bottle	00002327004	Active

Drug Information Lookup

From the Drug Information lookup menu, a search may be performed through Micromedex database by not only medication description, but we can now search a medication by NDC under the search dropdown. As search criteria is keyed, the database will retrieve results immediately via smart search. Search data can be further refined to display just active NDCs by selecting the Active only option. The initial search will include drug specific info such as strength, dose and package information to insure the correct medication is selected.

Double click a listed item OR select an item and select "Info" at bottom left to display drug details.



Drug Selection

Micromedex provides drug detail specific to Package-Product Information, UltiMedex/Company Info, Ingredients, Class Information and Patient Specific Dosing.

Medication: **Morphine Sulfate Oral Cap ER 20MG**
 NDC Number: **49884083301**

Drug Notes
 Package-Product Information
 UltiMedex/Company Information
 Ingredients
 Class Information
 Patient Specific Dosing

Drug Notes

Morphine, Slow Release (By mouth)
 Morphine (MOR-feen)
 Treats moderate to severe pain. This medicine is a narcotic analgesic.
 Brand Name(s): Avinza, Kadian, MS Contin
 There may be other brand names for this medicine.

When This Medicine Should Not Be Used:
 Do not use this medicine if you have had an allergic reaction to morphine, codeine, hydrocodone, dihydrocodeine, oxycodone, Tylenol(R) No. 3, Tylox(R), or Vicodin(R). Do not use this medicine if you have severe lung or breathing problems (such as severe asthma) or paralytic ileus.

How to Use This Medicine:
 Long Acting Capsule, 24 Hour Capsule, Long Acting Tablet

- * Your doctor will tell you how much of this medicine to use and how often. Your dose may need to be changed several times in order to find out what works best for you. Do not use more medicine or use it more often than your doctor tells you to.
- * Take this medicine at the same time each day.
- * Swallow the extended-release tablet whole. Do not crush, break, or chew it. Do not take any tablet that has been chipped or broken. If you take a broken tablet, the medicine can be released into your blood too quickly, which could be dangerous.
- * While taking the extended-release form of this medicine, part of the tablet may pass into your stools. This is normal and is nothing to worry about.
- * Swallow the extended-release capsule whole. Do not crush, break, or chew it.
- * If you cannot swallow the extended-release capsule, you may open it and pour the medicine into a small amount of soft food such as pudding, yogurt, or applesauce. Stir this mixture well and swallow it without chewing. You should not receive this medicine through a feeding tube.
- * You may take this medicine with food or milk if it upsets your stomach. Drink plenty of water and get plenty of exercise to avoid constipation.
- * Morphine extended-release capsules work differently from the regular morphine tablets, even at the same dose. Do not switch from one form to the

Page: 1 / 3 Zoom: 100% PORTRAIT

Drug Information

Patient Specific Dosing will display Low to High Ages in days, months and years.

NDC Lookup

Medication: **Morphine Sulfate Oral Cap ER 20MG**
 NDC Number: **49884083301**

Drug Notes
 Package-Product Information
 UltiMedex/Company Information
 Ingredients
 Class Information
 Patient Specific Dosing

Patient Specific Dosing

Route	Dose Form	Dose Type	Age Low	Age High	Sugg. Dose	Period	Norm/Over	Minimum	Maximum	Method
Oral	Capsule, Exte...	Maintenance	18 years	130 years	30 mg	Dose	Normal	30 mg	120 mg	Flat
					24 hr	Override			unit/kg	
					24 hr	Normal		1600 mg	Flat	
Oral	Capsule	Maintenance	30 days	18 years	0.2 mg	Dose	Normal		0.5 mg	unit/kg
					4 hr	Override		30 mg	Flat	
					24 hr	Normal		3 mg	unit/kg	
Oral	Capsule	Maintenance	18 years	130 years	10 mg	Dose	Normal		30 mg	Flat
					4 hr	Override			unit/kg	
					24 hr	Normal		180 mg	Flat	
Oral	Capsule, Exte...	Maintenance	18 years	130 years	15 mg	Dose	Normal	15 mg	30 mg	Flat
					8 hr	Override			unit/kg	
					24 hr	Normal		90 mg	Flat	
Oral	Capsule, Dela...	Maintenance	18 years	130 years	15 mg	Dose	Normal	15 mg	30 mg	Flat
					8 hr	Override			unit/kg	
					24 hr	Normal		90 mg	Flat	
Oral	Solution	Maintenance	30 days	18 years	0.2 mg	Dose	Normal		0.5 mg	unit/kg
					4 hr	Override		30 mg	Flat	
					24 hr	Normal		3 mg	unit/kg	
						Override		180 mg	Flat	

Patient Specific Dosing

Chapter 14 Print Reports

This chapter covers all standard pharmacy reports.

14.1 Daily Reports

Overview

This section will cover all of the daily reports necessary for the Pharmacy Application.

Printer Types

The pharmacy departments are equipped with workstation printers and line (or system) printers. These printers vary in type and function differently based upon connections.

Workstation Printers

These printers are so named because they are dedicated to a given terminal. Workstation printers can only be printed to from a specific terminal; a cable connects this printer to the terminal. Workstation print is necessary for Controlled Substance labels, which print automatically when the three initials are keyed.

Workstation printers can also be used to print reports and other batch functions, which are selected through the pharmacy and other report screens. After selecting the report or batch labels to be printed, the screen will display:

Enter Printer Number: ____ or (S-Spool, W-Workstation) B-Backup

If printing to a workstation printer, enter <W>. When printing reports or batch labels to a workstation printer, the printer "number" is always W. The system automatically "spools" any reports printed to a workstation printer (spooling involves printing the report to a file in the system called the spool file). This allows reprinting of report/labels, if necessary, or printing several copies of the report/labels.

If the wrong report is chosen, enter (Backup) to return to the Hospital Base menu. Using <Q> (Quit) is not recommended.

After entering the printer number <W> workstation, the system displays the following:

1. # of Copies: 1
 - Press <Enter> or overwrite with correct quantity.
2. Build a Work File?, press <Y>.
3. Press <Enter> to select All Patient Types.
4. Press <Enter> to select All Nursing Stations

5. Okay?, press <Y> to generate the newest information to the report.
6. Orders generate.
7. Printing in Progress.
8. Enter Character per Inch code: _ (1=10CPI, 2=16CPI, 3=Default).
 - Typically, the choice is to enter <2> for reports and labels.
9. If the printer power and select lights are on, the report begins printing.

All printers have a small memory called a "buffer" which allows them to hold and print information after the cursor has returned to the menu screen. In the case of the workstation printer, when all information has been sent to the printer the Spooled Report Options appears.

1. If the report printed correctly, press <0> to delete the spooled report. The system prompts, "Are You Sure?" Answer <Y> to delete report.
2. The Report Image System is used when a report cannot be easily reprinted, as is the case with the IV Label Charging (Reorder) report. Press <1> to retain spooled report. This allows access to the report through the Report Image System for reprinting.

Printing from Report Imaging (Spool File)

To reprint a report/label from the Report Imaging System, use the following procedures:

1. From Hospital Base menu, select **Print Reports**.
2. Select **Report Image System**.
3. Select the report to print by a Current Reports option.
 - Example, select **By Date**.
 - Enter the date the report was spooled.
 - Select report to print by sequence number.
 - Press <Enter> to search the next page for a spooled report.
4. Select option **Select A Printer**.
 - Select a designated line printer by printer number.
 - Select **Workstation** to print to a workstation printer
5. After returning to Report Image System screen, select **Print All**.
6. "Are You Sure?" reply <Y> (Yes).
7. Labels or Reports print to specified printer.
8. "Do you want to remove the spool files? Y/N"
9. If the print process concluded properly, answer <Y> (Yes).

- 10.If the print process did not conclude properly, answer <N> (No).
- Correct the problem and repeat process beginning with **Print All**.
- 11.Enter <0> (zero) to exit the Selected Report screen.
- 12.Enter <0> (zero) to exit the Current Reports screen.
- 13.Enter <0> (zero) to exit the Report Image system.

Select Base Menu > Print Reports > Report Image System

Report Image System

Report Image System

Select Base Menu > Print Reports > Report Image System > Report Image > Enter Date

Report Description	Date and Time	CPSI Number	Application Code	Form	Report ID	Curr/Archive	Status	Memo
PHARMACY M.A.R. REPORT	07/17/00 21:33	542	PH	PC	YM	Current	C	
PRINT LIST OF ACTIVE I.V.	07/18/00 17:42	542	PH	PH	Y5	Current	C	
PRINT LIST OF ACTIVE I. V.	07/18/00 17:43	542	PH	PH	Y5	Current	C	
PRINT LIST OF ACTIVE I.V.	07/18/00 17:45	542	PH	PH	Y5	Current	C	
RE-ORDER LABEL OF I.V.	07/18/00 20:36	542	PH	1W	Y6	Current	C	
RE-ORDER LABEL OF I.V.	07/18/00 20:47	542	PH	1W	Y6	Current	C	
PATIENT I.D. LABELS FOR PHARMACY	07/19/00 13:35	144	PH	1W	Y4	Current	C	
PATIENT I.D. LABELS FOR PHARMACY	07/19/00 13:37	144	PH	1W	Y4	Current	C	
PATIENT I.D. LABELS FOR PHARMACY	07/19/00 13:41	144	PH	1W	Y4	Current	C	
PHARMACY M.A.R. REPORT	07/19/00 15:01	634	PH	PC	YM	Current	C	
PATIENT I.D. LABELS FOR PHARMACY	07/19/00 16:30	288	PH	1W	Y4	Current	C	CART FILL
PATIENT I.D. LABELS FOR PHARMACY	07/19/00 16:41	650	PH	1W	Y4	Current	C	
PATIENT I.D. LABELS FOR PHARMACY	07/19/00 16:44	650	PH	RT	Y4	Current	C	LABEL TEST
PRINT SELECTED PHARMACY CHARGES/NBR	07/19/00 16:46	650	PH	PH	YX	Current	C	

Report Image System-Current Reports

Report Image System-Current Reports

Select Base Menu > Print Reports > Report Image System > Report Image > Enter Date > Select Report

Report Image System

Stopping and Pausing the Print

If the workstation printer is turned off while printing, the report will be lost. When the printer is off, the terminal continues to send information, but without power, the printer cannot store data. To pause the printer temporarily, without losing data, press the select button (light goes off). This allows the option to re-align the form or add paper without losing portions of the report.

Line Printers

A line printer is not a different model of printer. The same model of printer used as a workstation printer can be converted to a line printer. A line or system printer is connected directly to the network server instead of to a specific terminal.

The advantages of the line printer are:

1. Control is returned to the terminal quickly.
2. Print process is easier.
3. Printer can be used from any terminal (in the pharmacy or the hospital).
4. Reports can be continuously "queued" to the printer. The printer is never "busy", so reports can be printed in sequence, and the printer stores each report and begins printing the next one when the first is finished.
5. Unlike the workstation printer, report information is never lost. Even if the printer is turned off, the report prints when the printer is turned back on. (Although, information that was in the printer buffer when the power is switched off will be lost.)

The limitations of a line printer are:

1. Reports are not automatically retained in a spool file; therefore, copies cannot be reprinted.
 - When generating a report, there is the option to spool the report first.
 - If spooled first, the report can be sent back to the line printer.
2. On a spooling line printer (the type used by pharmacy), if a report is printed accidentally, it must complete the print before it can begin the next report. The hospital data processing department can interrupt this process, but turning the printer off does not cause the report to be deleted.

Printing to a Line Printer

Each line printer is given a number (workstation printers are all indicated by a “W”). Line printers allow the option to print to a specific printer number in the hospital. Printer numbers can range from one (1) to 500, although normally a hospital has far fewer.

When printing to a line printer, after selecting the report or batch labels to be printed, the screen displays:

"Enter Printer Number: ____ or (W-Workstation, S-Spool), B-Backup"

Enter the printer number for the pharmacy printer (this number is assigned when the printer is initially installed). If the wrong report has been chosen, enter (Backup) to return to the Hospital Base menu. Entering <Q> (Quit) is not recommended. The print routine for this particular report now begins. If the line printer is a non-spooling printer, one must complete all steps of the report process, and in some cases, press <0> to zero out before the printing starts. Spooling printers free up the system faster than other printers, allowing the option to continue working while the report is printing.

How and When to Use the Restart Feature

At some point it can become necessary to restart the Cart Fill List or the IV labels without recharging the patients previously charged. This could occur for several reasons, the most common being an invalid item number, a power failure, or the system going down. Use this procedure to charge patients who have not yet been charged. Call a TruBridge Pharmacy Support Representative before using this feature.

While the report is generating, the system charges as the numbers flash on the bottom of the screen. An error in charging is indicated by either the receipt of an error message or any change in normal operation before the system prompts for the character per inch code (e.g., terminal "hangs up" before the report finishes).

1. If report was printed to a workstation printer, the system asks, "Reprint Report Yes or No?"
2. Select **Yes** to reprint report.
 - If answering No, see "PRINTING FROM REPORT IMAGING" previously detailed in this chapter.
3. The report prints up to the point where charging stopped.

4. Check the last order printed and correct any problems.
5. Hospital Base menu, select **Print Reports**.
6. Select **Cart Fill List** or **IV Labels Charging**.
7. Select **Workstation** or enter line printer number.
8. "Generate Charges Yes or No". Answer **Yes**.
9. "IS THIS RESTART Yes or No". Answer **Yes**.
10. "ENTER LAST PATIENT NUMBER".
 - Enter the last patient number that was printed on the spooled report.
11. "ENTER THE LAST ORDER NUMBER".
 - Enter the last order number that was printed on the spooled report.
12. The Cart Fill List or IV Label Charging report resumes printing and charging beginning with the entered patient and order number.
13. The cart can be filled using the reprinted spool report and the restarted report or a non-charged cart fill list can be run.

NOTE: *If a new non-charged Cart Fill List is desired, do not rebuild the work file.*

Pharmacy Reports Menu

The Print Report menu is where most pharmacy reports are located. The menu is divided into three sections:

- Daily reports
- Miscellaneous reports
- Controlled Substance reports

The following sections will review each option from the Print Report menu.

Select Hospital Base Menu > Print Reports

Pharmacy - Print Reports		
Daily Reports	Miscellaneous Reports	Miscellaneous Reports
Build <u>W</u> ork File	Charge <u>E</u> ntry Edit List	Report Image System
<u>A</u> ctive Order List	<u>S</u> ummary Detail of Charges	<u>C</u> harge Reconciliation Report
Physician <u>R</u> e-orders	Patient Drug <u>P</u> rofiles	Item <u>N</u> DC Labels
Cart <u>L</u> abel Charging	<u>S</u> elective Item Usage by Patient	Pharmacy <u>D</u> ispensing Notes
<u>I</u> V Active Order List	<u>B</u> uild Ad Hoc Report	Pharmacy <u>O</u> verride Info
<u>I</u> V Batch Labels (Re-order)	<u>U</u> nit Dose Labels	Invalid <u>N</u> DC Report
<u>F</u> inal Drug Profile	Long Term <u>M</u> .A.R.	Rebuild Pharmacy <u>R</u> x# Index
M.A.R. - <u>2</u> 4 Hour	3rd Party <u>B</u> illing Report	<u>A</u> WP Update From Micromedex
M.A.R. - <u>3</u> Day	Interaction/ <u>I</u> ndicators	Acetaminophen <u>M</u> ax Dose Report
Cart <u>F</u> ill List (Charging)	Extended <u>C</u> are Card Estimate	Allergy <u>H</u> istory Report
Cart <u>C</u> atch- <u>U</u> p List (Charging)	Miscellaneous Patient Drug <u>I</u> nformation	Miscellaneous
<u>E</u> nd of Day Report	Formulary <u>A</u> lpha List	<u>M</u> icromedex Allergy Table Update
<u>T</u> emporary Orders/DCs	<u>F</u> ormulary Therapeutic List	Controlled Substances Reports
<u>T</u> emporary Orders/DCs (Current Patients)	Select Items for <u>M</u> aster List	<u>S</u> tatus Report
<u>C</u> linical Info Summary/Deficiencies	Print Master <u>I</u> tem List	<u>I</u> nventory Print & Delete
<u>O</u> nscreen Cart Fill List	Interventions/ <u>A</u> DRs	<u>E</u> lectronic Controlled Substances Report
Cart <u>F</u> ill Check List	Pharmacy <u>S</u> tatistics Report	LTC Prescription Report
<u>A</u> DM Exception Report	Creatinine Clearance <u>S</u> tatus Report	

Print Report menu

Build Work File

The “Build the Work File” prompt is added into all of the daily pharmacy reports. It is not necessary to build a file before generating a report.

How to Build a Work File

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Build Work File**.
3. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).

Select **Hospital Base Menu > Print Reports > Build Work File**

Pharmacy

Order File Generator

Patient Types: 1 - I/P 4 - NH
 2 - O/P 5 - OPEN
 3 - E.R.

Nursing Stations: 003 - MED/SURG

Include Clinic:

OK Cancel

Order File Generation Screen

4. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
5. Select **OK** to process the report.

How often should this file be built?

- This file should be built as necessary throughout the day.

Who should build this file?

- The Pharmacy Department from the terminal that will print subsequent reports.

What is the Description and Usage?

- The Work File captures a moment in time. The Work File is terminal specific. This means that a work file will only affect reports printed from the terminal where the work file was built. The Work File only builds for patients with room numbers. Emergency Department patients in rooms with a status of **lower case t** will be included if the ER stay type is chosen. Outpatients are included in the Work File build only if they are admitted to a room. The Work File will display an option to include pharmacy items associated with a clinic department on pharmacy reports. The **Include Clinic** check-box will default unchecked.

NOTE: The **Include Clinic** check-box will only appear for facilities that have clinics set up as departments of the hospital.

Active Order List

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Active Order List**.
3. Select a printer number, **Spool to File** or **Print to Workstation**.
4. The system prompts “BUILD A WORK FILE Y/N?” Answer Y.
5. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).

Select **Hospital Base Menu > Print Reports > Active Order List > Spool to File or Print to Workstation**

Order File Generator Screen

6. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.

Physician Re-orders

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Physician Re-Orders**.
3. Select a printer number, **Spool to File** or **Print to Workstation**.
4. System defaults to current date.
5. System prompts "BUILD A WORK FILE?" Yes or No, answer Yes.
6. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
7. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
8. Select **OK** to process the report.

How often should this Report be printed?

- This report should be printed daily.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Copy sent to the appropriate Nursing Unit.

What is the Description and Usage?

- The Physician Reorder List displays all orders with an <A> in the stop code and a reorder date one day older than the current date. In other words, all orders with a reorder date of tomorrow or before will print today.

The default sort for the Physician Reorder List is by nursing station, and then within nursing station by physician. In order for the message to the physician to print, the sort must be Patient Name and then Physician Name. The primary and secondary sorts can be changed via:

1. From the Pharmacy Selection Screen, **Control Tables**.
2. Select **10-Report Control Information**.
3. Select **1-Physician Reorder Report**.

This list should be printed daily and sent to the affected nursing stations to serve as a reminder to the nurse and/or the physician to reorder medications which have expired or expiring reorder dates. The last page of the report summarizes the auto stops for all nursing stations and should be kept in the pharmacy for review.

Floor stock narcotics do not print on this report unless they have been entered on the patient profile. If all orders (including floor stock) are entered on the patient profile, then a more accurate report is generated.

IV Active Order List

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **IV Active Order List**.
3. Select a printer number, **Spool to File** or **Print to Workstation**.
4. System defaults to current date.
5. System prompts “BUILD A WORK FILE?” Yes or No, answer Yes.
6. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
7. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
8. Select **OK** to process the report.

How often should this Report be printed?

- This report should be printed as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- **IV Active Order List** prints all active IV orders in order by nursing station. The report provides an area to record changes and adjustments in IV Therapy.

The IV Active Order List lists all the active IV Orders in nursing station order. Within the nursing station, patients are listed in order by room number. The report includes basic patient demographic data such as diagnosis, age, and weight, along with start and stop dates, order number, drug name and resupply amount (if any).

NOTE: *The Diagnosis will print according to the following hierarchy: Principal (Grouper) diagnosis, if no Principal Diagnosis, use the first Working Diagnosis; if no first Working Diagnosis, use Chief Complaint.*

IV Active Order List (Sample)

RUN DATE: 12/01/15 TIME: 14:53	Evident Community Hospital IV SOLUTIONS N.S.= NS Medical-Surgical	ADMINS FROM: 12/01/15 11:00 TO: 12/02/15 10:59	PAGE 1 PCIV
-----------------------------------	---	---	----------------

ROOM	PATIENT NAME (NUMBER)	STOP DATE-CODE	ORD NUM	RESUPPLY IV/SET	NEXT IV/SET	--DOSAGE-- QTY UNIT	IV DESCRIPTION	VOLUME (ML)
010-2	SMITH ELLA KATHERINE(357388) Eggs, Mineral oil 72 F SMITHDANIE	12/11/13-A	97/...		ROCEPHIN/DWS IVPB 50 ml/hr 1 GM cefTRIAxone (ROCEPHIN) IN 50 ML D5W (5% DEXTROSE IN WATER)		0 50 50ML*
						FREQUENCY: CONTINUOUS ADMIN TIMES: ** Non-Scheduled IV **	STANDARD TIMES?: Y	TOTAL
		11/22/14-A	106	3...../...		NACL 0.45% SOLN 1000 ML 100 ml/hr 1000 ML NACL 0.45% SOLN 1000 ML		1000 1000ML
						FREQUENCY: CONTINUOUS ADMIN TIMES: ** Non-Scheduled IV **	STANDARD TIMES?: Y	TOTAL
		8/13/15-A	111	2...../...		ROCEPHIN/D5W IVPB 100 ml/hr 1 GM cefTRIAxone (ROCEPHIN) IN 50 ML D5W (5% DEXTROSE IN WATER)		0 50 50ML*
						FREQUENCY: Q12H ADMIN TIMES: 12/01-12:00 12/02-00:00	STANDARD TIMES?: Y	TOTAL
010-4	MAJURE TREY RALPH (357365) Demerol, No Known Environmental Allergies, No Known Food Allergies, ASDF 30 M BAXTER J	8/06/15-A	2/...		D5W 500ML/HEPARIN 25,000 UNITS TITRATE 1000 ML D5W 25000 UNITS HEPARIN INJ		1000 5 1005ML
						FREQUENCY: CONTINUOUS ADMIN TIMES: ** Non-Scheduled IV ** COMMENTS: D5W 1 L/HEPARIN 25,000 UN	STANDARD TIMES?: Y	TOTAL
			6	3...../...		NORMAL SALINE 1000 ML 125 ml/hr 1000 ML NORMAL SALINE 1000 ML		1000 1000ML
						FREQUENCY: CONTINUOUS ADMIN TIMES: ** Non-Scheduled IV **	STANDARD TIMES?: Y	TOTAL

IV Batch Labels

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **IV Batch Labels**.
3. Select a printer number, **Spool** or **Workstation**.
4. System prompts "BUILD A WORK FILE?" Yes or No, answer Yes.
5. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
6. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
7. Select **Generate Charges** if charging via the IV Batch.
8. Select **Oder Type**. System defaults to All The options are Scheduled or Non-scheduled.
9. Enter **Begin Date/Time** and **End Date/Time**.
10. **Print**

NOTE: *If the IV Batch was interrupted during printing you can choose the Restart option and enter the last patient and order that generated.*

11. Enter initials and select **OK**.

How often should this Report be printed?

- This report should be run daily after the new IV orders have been entered and the IVs have been checked against the IV Active Order list.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal Department Use.

What is the Description and Usage?

- **6-IV Label Charging** prints labels and charges for all IV orders entered through the IV order entry.

NOTE: *If this report is run at a Critical Access Hospital, the patient level of care, patient stay type, and service code will be captured in Account Detail.*

Pharmacy Print Report

IV Label Charging(Re-order)

Last Batch Charged

Scheduled IVs From: To:

Non-Scheduled IVs From: To:

Batch Options

Generate Charges:

IV Order Type: All

IV Label Range:

Begin Date: 12/02/15 Begin Time: 00:00

End Date: 12/02/15 End Time: 00:00

Restart: Last Patient: Last Order:

Ready

Last Batch Print

Pharmacy Print Report

IV Labels Charging (Reorder) Sample

BOLTZ CAROLYN ROOM: 590-1
355959 MED SURGE
ORDER: ..13 05/10 11:44
CEFAZOLIN 1GM/50ML D5W
KEEP REFRIGERATED
100ML/HR
50 ML D5W
1 GM CEFAZOLIN (ANCEF) INJ
EXP AFTER: 05/13/00
HANG-05/10/00 12:00 Q 8 H BAG# 1

BOLTZ CAROLYN ROOM: 590-1
355959 MED SURGE
ORDER: ..13 05/10 11:44
CEFAZOLIN 1GM/50ML D5W
KEEP REFRIGERATED
100ML/HR
50 ML D5W
1 GM CEFAZOLIN (ANCEF) INJ
EXP AFTER: 05/13/00
HANG-05/10/00 20:00 Q 8 H BAG# 2

BOLTZ CAROLYN ROOM: 590-1
355959 MED SURGE
ORDER: ..13 05/10 11:44
CEFAZOLIN 1GM/50ML D5W
KEEP REFRIGERATED
100ML/HR
50 ML D5W
1 GM CEFAZOLIN (ANCEF) INJ
EXP AFTER: 05/13/00
HANG-05/11/00 04:00 Q 8 H BAG# 3

BOLTZ CAROLYN ROOM: 590-1
355959 MED SURGE
ORDER: ..15 05/10 11:44
D5 1/2NS 1000ML + 40MEQ
KEEP REFRIGERATED
100ML/HR
1000 ML D5 1/2NS
40 MEQ KCL IV
EXP AFTER: 05/17/00

BOLTZ CAROLYN ROOM: 590-1
355959 MED SURGE
ORDER: ..15 05/10 11:44
D5 1/2NS 1000ML + 40MEQ
KEEP REFRIGERATED
100ML/HR
1000 ML D5 1/2NS
40 MEQ KCL IV
EXP AFTER: 05/17/00

BOLTZ CAROLYN ROOM: 590-1
355959 MED SURGE
ORDER: ..15 05/10 11:44
D5 1/2NS 1000ML + 40MEQ
KEEP REFRIGERATED
100ML/HR
1000 ML D5 1/2NS
40 MEQ KCL IV
EXP AFTER: 05/17/00

Final Drug Profile

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Final Drug Profile**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Select patients by:
 - Discharges for a given date (MMDDYY). The default is current date. Select the drop down arrow to display a calendar from which a start date can be selected.
 - Select account numbers; enter up to 50 account numbers.
 - In-house accounts (from work file).
5. After selecting the options above, select **Print**.

How often should this Report be printed?

- Should be printed daily if maintaining a hard copy profile for discharged patients, or using to match against MAR charges. Otherwise, print as needed.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal Department use. If approved, Medical Records can place a copy on patient chart as part of the permanent record.

What is the Description and Usage?

- The Final Drug Profile provides demographic data, start date, stop date, stop code, order number, medical record number, drug description, dosage, quantity charged, quantity credited, total quantity used, and usage instructions. The profile includes both active and discontinued orders. Any miscellaneous charges (not charged/credited through an order) are displayed, along with any Clinical Interventions and Adverse Drug Reactions performed.

Final Drug Profile (Sample)

RUN DATE: 12/02/15 TIME: 09:47	Evident Community Hospital FINAL PATIENT DRUG PROFILE	PAGE 1 PCPDF
PATIENT...357823 AINSWORTH MARTHA COZEN	ADMIT DATE... 4/24/15 BIRTH DATE...12/10/1934 AGE... 80 ROOM...300-9	
	DISC DATE.... M/R #.....000307	
DOCTOR..SMITH JAMES DOC ADDR..	SERVICE..M MEDICAL WEIGHT..120lbs ALLERGIES..Codeine, Eggs, Peanuts	
-----D I A G N O S I S-----		
Asthma	-----TREATMENT THERAPY ORDERS-----	

-----R O U T I N E O R D E R S-----		
START DT ORDER	DESCRIPTION/PREScribing PHYS	
STOP DT CODE	INSTRUCTIONS	DOSAGE

		STOP CHARGE CREDIT QTY
		RPh/INIT QTY QTY USED

10/07/15 1	PROPRANOLOL (INDERAL) TAB : 20 MG	20 MG PO TID
	PHY: SMITH JAMES	FT / 1 20 -19
	CHECK PULSE BEFORE	
	ADMINISTRATION IP < 50 HOLD AND CALL MD	
10/15/15 2	ALBUTEROL INH SOL .083% 3ML	3 ML UPDRAFT QID
11/19/15 D		FT /FT
	PHY: SMITH JAMES	
4/24/15 10	FUROSEMIDE (LASIX) : 20 MG TAB	20 MG PO DAILY
		FT /
	PHY: SMITH JAMES	
11/24/15 13	PROPRANOLOL (INDERAL) TAB : 20 MG	20 MG PO TID
5/24/17 D		FT /XXX 60 60
	PHY: SMITH JAMES	
11/30/15 18	QUINAPRIL (ACCUPRIL) TAB : 10 MG	10 MG PO BID
5/31/17 D		FT /XXX

M.A.R. 24 HR

1. From the Pharmacy-Selection Screen, select **Print Reports**.
2. Select **M.A.R. – 24 Hr**.
3. Select a printer number, **Spool To File**, or **Print to Workstation**.
4. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
5. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
6. Select **OK**.
7. Select patients by:
 - In-house Accounts (from Work File) - this option requires that a current work file for the desired patient parameters be available.
 - Select Account Numbers - enter up to 50 account numbers. Select **Print** after last account number entered.
8. Select the drop down arrow to display a calendar from a start date and end date can be selected.

How often should the Report be printed?

- This report should be printed daily for sites using Pharmacy generated MARs.

Who should print this Report?

- Pharmacy.

Who should get copies of this Report?

- Nursing.

What is the Description and Usage?

- The MAR (Medication Administration Record) is used to chart medications given to a patient. It is used to track when medications are given, and by whom. Once the MAR is completed, it becomes a legal portion of the patient chart. The MAR is formatted in 3 sections:
 - Routine medications
 - The routine section has at least 4 blank lines below the printed medications.
 - IVs
 - The IVs section has at least 7 blank lines below the printed medications.
 - PRN/One-Time and Stat orders.
 - The PRN, One-Time, and Stat Medications section has at least 7 blank lines below the printed medications.
 - If all PRNs cannot print on the first page of the MAR, they are split out to the second page.
 - One-time orders (Orders with X1 in the frequency) print at the end of the PRN section.

The Medication Administration Record is divided into 4 sections:

1. The right half of the MAR contains the administration times for the medication.
 - When a medication is given, the nurse should slash through the time and initial beneath it.
 - If a medication is not given, circle the time and initial.
 - The reason not given can be recorded on the back of the MAR, or in the nursing notes.
 - PRNs do not print times. The nurse writes in the time and initials.
2. The left half of the MAR contains the following order information:
 - Drug Name
 - Dosage
 - Frequency
 - Special Instructions
 - Start and Stop dates
 - Stop dates are coded to indicate why the drug is being stopped.
3. The bottom of the MAR contains space for each shift to sign and initial.
 - If there is not enough space for all the nurses who administered medication to this patient, the back of the MAR can be used.
4. The following patient information is printed at the bottom of the page:
 - Name
 - Date of Birth
 - Account Number
 - Room
 - Age
 - Sex
 - Physician
 - Weight
 - Allergies
 - Medical Record Number
 - Chief Complaint

If a patient has too many medications to print on one MAR page, the bottom of the page says, "CONTINUED ON NEXT PAGE".

- More pages print for that patient.

The MARs use a work file to determine patient room numbers.

- The work file is only built for patients currently admitted to a room.
- The MAR uses the information to read patient files to determine active orders, future orders, discontinued orders, etc.
- Orders entered after the work file is built will appear on the printed MAR.
- Admissions, discharges, or room transfers occurring between the time of the work file build and the MAR print are not reflected by the printed MAR.

NOTE: For information on setting up and printing MARs, see [Pharmacy Setup](#).

Acute M.A.R. - Plain Paper (Sample)

<i>Evident Community Hospital</i>		AINSWORTH MARTHA COZ ROOM: 300-9	
M.A.R.		AGE: 80	
FROM: 12/09/15 07:00 TO: 12/10/15 06:59 Page 1 of 3		SMITH JAMES	
(REPORT RUN TIME) 12/09/15 09:52		DOB: 12/10/1934	
		ALLERGIES: Codeine Eggs	
		M/R#: 000307	
		Peanuts	
		CHIEF COMPLAINT: Asthma	
ROUTINE MEDICATION	7 - 3	3 - 11	11 - 7
	7 8 9 10 11 12 13 14	15 16 17 18 19 20 21 22	23 0 1 2 3 4 5 6
Start: 04/24/15			
FUROSEMIDE {LASIX}			
20 MG PO DAILY			
Start: 11/24/15 Stop: 05/24/17 D	12	17	
PROPRANOLOL {INDERAL} TAB			
20 MG PO TID			
Start: 11/30/15 Stop: 05/31/17 D	21		
QUINAPRIL {ACCUPRIL} TAB			
10 MG PO BID			
PRN, ONE TIME AND STAT MEDICATION	7 - 3	3 - 11	11 - 7
	7 8 9 10 11 12 13 14	15 16 17 18 19 20 21 22	23 0 1 2 3 4 5 6
Start: 11/05/15 Stop: 11/12/15 A			
HYDROMORPHONE{DILAUDID} INJ			
2 MG IVP PRN Q6H			

M.A.R. 3 Day

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **M.A.R. – 3 Day**.
3. Select a printer number, **Spool To File**, or **Print to Workstation**.
4. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
5. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
6. Select **OK**.

7. Select patients by:

- In-house Accounts (from Work File) - this option requires that a current work file for the desired patient parameters be available.
- Select Account Numbers - enter up to 50 account numbers. Select **Print** after last account number entered.
- Select the drop down arrow to display a calendar from a start date and end date can be selected.

How often should the Report be printed?

- This report should be printed daily for sites using the Pharmacy generated M.A.R.

Who should print this Report?

- Pharmacy.

Who should get copies of this Report?

- Nursing.

What is the Description and Usage?

- The M.A.R. – 3 Day is used to chart medications given to a patient. It is used to track when medications are given, and by whom. Once the M.A.R. is completed, it becomes a legal portion of the patient chart. The M.A.R. is formatted in 3 sections:
 1. Routine medications
 2. IVs
 3. PRN/One-Time and Stat orders.

The Medication Administration Record is divided into 4 sections:

1. The right half of the MAR contains the administration times for the medication.
 - When a medication is given, the nurse should slash through the time and initial beneath it.
 - If a medication is not given, circle the time and initial.
 - The reason not given can be recorded on the back of the MAR, or in the nursing notes.
 - PRNs do not print times. The nurse writes in the time and initials.
2. The left half of the MAR contains the following order information:
 - Drug Name
 - Dosage
 - Route
 - Frequency
 - Special Instructions
 - Start and Stop dates
 - Stop dates are coded to indicate why the drug is being stopped.
3. The bottom of the MAR contains space for each shift to sign and initial.
 - If there is not enough space for all the nurses who administered medication to this patient, the back of the MAR can be used.
4. The following patient information is printed on the report:
 - Name
 - Date of Birth

-
- Account Number
 - Room
 - Age
 - Sex
 - Physician
 - Weight
 - Allergies
 - Medical Record Number
 - Chief Complaint

The M.A.R. uses a work file to determine patient room numbers.

- The work file is only built for patients currently admitted to a room.
- The M.A.R uses the information to read patient files to determine active orders, future orders, discontinued orders, etc.
- Orders entered after the work file is built will appear on the printed M.A.R.
- Admissions, discharges, or room transfers occurring between the time of the work file build and the M.A.R. print are not reflected by the printed M.A.R.

M.A.R. 3 Day (Sample)

<i>Evident Community Hospital</i> 3 Day M.A.R. FROM: 12/09/15 07:00 TO: 12/12/15 06:99 Page 1 of 3 (REPORT RUN TIME) 12/09/15 09:54		AINSWORTH MARTHA COZ ROOM: 300-9 SMITH JAMES AGE: 80 DOB: 12/10/1934 WT: 54.43KG ALLERGIES: Codeine Eggs M/R#: 000307 Peanuts CHIEF COMPLAINT: Asthma			
ROUTINE MEDICATION	Wednesday 12/09/15	Thursday 12/10/15	Friday 12/11/15	Saturday 12/12/15	
Start: 04/24/15 FUROSEMIDE {LASIX} 20 MG PO DAILY		09:00	09:00		
Start: 11/24/15 Stop: 05/24/17 D PROPRANOLOL {INDERAL} TAB 20 MG PO TID	12:00 17:00	07:00 12:00 17:00	07:00 12:00 17:00	07:00	
Start: 11/30/15 Stop: 05/31/17 D QUINAPRIL {ACCUPRIL} TAB 10 MG PO BID	21:00	09:00 21:00	09:00 21:00		
PRN, ONE TIME AND STAT MEDICATION	Wednesday 12/09/15	Thursday 12/10/15	Friday 12/11/15	Saturday 12/12/15	
Start: 11/05/15 Stop: 11/12/15 A HYDROMORPHONE {DILAUDID} INJ 2 MG IVP PRN Q6H					

Cart Fill List (Charging)

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Cart Fill List (Charging)**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
5. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
6. Select **OK**.

7. Enter Number Of Days____ (Depress Return for 1 Day).
- Enter the number of days desired or press <Enter> for one day resupply.
 - Example, if the normal resupply amount is for one day and the cart is to be filled for a one-day period, simply press <Enter>.
 - If the carts are to be filled for a three-day period (to cover a weekend or holiday), enter <3>.

Note: the **Restart Patient #** and **Restart Order #** can only be utilized if a Charging Cartfill is used.

How often should this Report be printed?

- This report must be printed prior to the Cart Exchange Time set in the Pharmacy Control Table.

NOTE: *If the Cart Fill List is not generated prior to the Cart Exchange Time, a TruBridge Pharmacy Support Representative can change the report set up to generate this report by Service Date. Contact TruBridge for more information.*

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal Department Use.

What is the Description and Usage?

- The Cart Fill List provides a charging document for use in filling medication carts. Non-IV Orders with an entry in **Re-supply Quantity** have a quantity in the resupply column of the Cart Fill List. This indicates the amount to put in the patient drawer and the amount charged. A column has been provided to list charges and credits. This column can be used to credit returned items or to charge items that need to be resupplied. Some items that need to be resupplied will not have a charge generated by running the cart fill. These include orders such as PRNs and Multi-Dose Items, e.g. Nitrol ointment.

The Cart Fill List lists all the active Non-IV Orders in nursing station order. Within the nursing station, patients are listed in order by room number. The report includes basic patient demographic data such as diagnosis, age, and weight, along with start and stop dates, order number, drug name, resupply amount (if any), primary unit, item number, and a space to list charges or credits for items to the patient account.

NOTE: *If this report is run at a Critical Access Hospital, the patient level of care, patient stay type, and service code will be captured in Account Detail.*

NOTE: *The Diagnosis will print according to the following hierarchy: Principal (Grouper) diagnosis, if no Principal Diagnosis, use the first Working Diagnosis; if no first Working Diagnosis, use Chief Complaint.*

Cart Fill List Charging (Sample)

RUN DATE: 03/22/16 TIME: 15:25		Evident Community Hospital CHARGE/FILL LIST FOR PHARMACY		NURSING STATION: 003 GENERATING CHARGES		PAGE 15 PRACT2	
FOR CART FILL FROM: 03/23/16 AT 15:00 THROUGH: 03/24/16 AT 14:59							
ROOM	PATIENT NAME	PAT. NUMBER	START-DT	ORD STOP-DT CD	NUM DESCRIPTION	---RESUPPLY---	ITEM# CHARGES/CREDITS
300-8	SCAVULO CLAIRE X 132.00lbs 54 F TAYLOR J	356626				ALLERGIES: Penicillin, Sulfa (sulfonamide), Tetracycline, Cefaclor, Peanuts	
			8/16/02	49	PROPOXYPHENE/APAP 100/650 (DARVCT N-100)	EA	381369
			6/30/09 A		1 EA		
				PO	PRN Q4H FOR MILD LOW BACK PAIN		____/____
			8/16/02	56	Insulin REG (Humulin R) 100U/ML	EA	381719
					1 EA		
				SUB Q	PRN >120-150 2 UN; 151-200 3 UN; 201-250 4 UN; 251-300 5 UN; 301-350 6 UN; >350 CALL MD		____/____
			11/03/05	71	MEPERIDINE INJ: 50MG/ML		383027
			11/06/05 A		50 MG		
				LINK	INTRAMUSCULARLY PRN EVERY 4 HOURS PROMETHAZINE (PHENERGAN) INJ : 50MG/ML	*NOTE* POC CHARGED ITEM	____/____
					50 MG		387828
					INTRAMUSCULARLY		____/____
300-9	AINSWORTH MARTHA COZEN 120.00lbs 81 F BARNETT R	357823				ALLERGIES: Codeine, Penicillin g	
					DIAGNOSIS: Asthma		
			11/20/15	1	cefTRIAxone (ROCEPHIN) INJ : 1 GM	1 EA	387058
			11/27/15 A		1 GM		
				IM	Q24H		____/____
				FIRST DOSE:	11/20/15 12:00		
			1/12/16	3	ACETAMINOPHEN ELIXIR (TYLENOL):160MG/5ML	.17 EA	382012
					18 MG		
				PO	TID FOR TEMP > 101 OR PAIN		____/____
				ADMIN TIMES:	0700 1200 1700		

Cart Catch-Up List (Charging)

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Cart Catch-Up List (Charging)**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.

How often should this Report be printed?

This report should be printed whenever necessary to update the medication carts before the cart exchange. The Catch Up List will only generate new information entered since the printing of the previous Cart Fill List or Catch Up List. The Cart Catch-Up can only be utilized if a "charging" Cart Fill is done.

Who should print this Report?

The Pharmacy department.

Who should get copies of this Report?

Internal Department Use.

What is the Description and Usage?

The Catch-Up List is part of the cart fill procedure. This report prints all changes that occur between printing the Cart Fill List and the Catch-Up List. The Catch-Up List looks for changes and charges/credits appropriately for each change. The Catch-Up List indicates if the order is new, old, or discontinued. It also indicates patient transfers or discharged patients. The list prints the word DISCHARGED next to the orders of the discharged patient. This is to facilitate pulling all medications from the patient drawer. The list also prints TRANS. TO. and TRANS. FROM. to facilitate the transfer of medications from drawer to drawer or cart to cart. A frequency change is indicated by QTY HAS CHANGED. The Catch-Up List will print only new information entered between each Catch Up List printed or between the Cart Fill List and the first Catch Up List.

The report includes basic patient demographic data such as diagnosis, age, and weight, along with start and stop dates, order number, drug name, resupply amount (if any), primary unit, item number, and a space to list charges or credits for items to the patient account.

NOTE: *If this report is run at a Critical Access Hospital, the patient level of care, patient stay type, and service code will be captured in Account Detail.*

NOTE: *The Diagnosis will print according to the following hierarchy: Principal (Grouper) diagnosis, if no Principal Diagnosis, use the first Working Diagnosis; if no first Working Diagnosis, use Chief Complaint.*

Catch Up List Charging (Sample)

RUN DATE: 12/09/15 TIME: 11:17		Evident Community Hospital CATCH-UP LIST FOR PHARMACY		NURSING STATION: 003 GENERATING CHARGES		PAGE 1 PCCATUP		
ROOM	PATIENT NAME	PAT. NUMBER	START-DT STOP-DT	ORD CD	DESCRIPTION	---RESUPPLY---	ITEM#	CHARGES/CREDITS

010-4	MAJURE TREY RALPH 245.00 30 M BAXTER J	357365			ALLERGIES:Demerol, No Known Environmental Allergies, No Known Food Allergies, ASDF			
	OLD ORDER		7/30/15	5	ACETAMINOPHEN (TYLENOL) 325 MG TABLET	EA	381010	
	NOTE POC CHARGED ITEM		12/09/15 D		650 MG ORALLY	PRN EVERY SIX HOURS		____/____

300-2	SMITH ELLA KATHERINE 114.00 72 F KEW	357411			ALLERGIES:Eggs, Mineral oil DIAGNOSIS: Skin rash			
	QTY. HAS CHANGED		12/10/14	1	ATORVASTATIN (LIPITOR) 10 MG TAB	1 EA	38381614	
					10 MG PO	EVERY OTHER DAY		____/____
					PERFORM LFT PRIOR TO INITIATION			
			FIRST DOSE:		12/10/14 10:11			

300-9	AINSWORTH MARTHA COZEN 120.00 80 F	357823			ALLERGIES:Codeine, Eggs, Peanuts			
	NEW ORDER		12/09/15	21	hydroxyzine (ATARAX) TAB : 25 MG	1 EA	381196	
					25 MG PO	BEDTIME		____/____
			ADMIN TIMES:		2100			
	NEW ORDER		12/09/15	22	COMBIVENT INHALER 14.7G	EA	38199046	
	NOTE POC CHARGED ITEM				1 PUFF INHALED	DAILY		____/____
			ADMIN TIMES:		0900			

End of Day Report

The End of Day Report does not require a work file to be built. However, the End of Day Report is generated from the Accounts Receivable temporary file. This requires that the End of Day Report be run before the Business Office closes the day (runs the daily edit) and does the backup.

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **End of Day Report**.
3. Select a printer number, **Spool to File** or **Print to Workstation**.
4. The default print date is current date. Select the drop-down arrow to display a calendar from which a print date can be selected.

How often should this Report be printed?

- This report should be printed daily at the end of the day or the next morning at the beginning of the day for the previous day. Normally, a day is closed by the business office a day late. For example, Monday will be closed on Tuesday, etc. If the report is not printed before the closed day is backed up, the information will be purged. Once the information is purged, the report cannot be reprinted.

NOTE: It is important that this report be printed on a daily basis. This report is a compilation of all activity (charges/credits) in pharmacy for that day.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal Department Use.

What is the Description and Usage?

- The End of Day Report prints in three sections.
 - The first section is a summarization of the daily patient charges.
 - This section contains the patient account number, patient name, drug name, prescription number, refills, quantity dispensed, patient price, and the dispensing pharmacist's initials. Charges without initials are generated by batch charging. Charges with XXX are generated by the system (i.e. Cart Fill, IV Labels, etc.).
 - The end of the first section gives a total quantity of charges, a charge dollar total, a total quantity of credits, a credit dollar total, and a net quantity and dollar total. This section can be printed for all patients, or printed by patient stay type. If the person chooses the latter method, this section groups the charges for patients of the same stay type (e.g., inpatients, outpatients, ER patients). This format prints sub-totals for the number and dollar amount of charges, credits, and net.
 - The end of this section contains grand totals for all patient stay types regardless of which print format is chosen.
 - Call TruBridge Pharmacy Support for assistance in implementing the report format.
 - The second section of the End of Day Report is a summary recap.
 - This recap lists a summary of revenue amounts and quantity issued for Insurance Summary Codes. The default codes are 78 (Pharmacy drugs), 79 (Pharmacy injectables), 47 (IV sterile procedures), 45 (IV fluids), and 44 (Misc IV charges).
 - If Insurance Summary Codes other than the defaults are used, then all the codes that will be listed on the End of Day Report must be entered in **EOD Report Summary Charge Codes** in the Pharmacy Control Table.
 - If patient charges are grouped by stay type, there will be a sub-total Insurance Summary Code recap for each stay type in addition to the grand total recap.
 - The third section of the End of Day Report is a Pharmacy Controlled Substances Report.
 - This section lists the drug class, drug name, item number, quantity, patient name, patient number, initials of the dispensing pharmacist, and prescription number.
 - This section recognizes narcotics and the classification from **DEA Class** on the Pharmacy Order Entry Information screen. If this line is incomplete, the Pharmacy Controlled Substances Report will not be accurate. The report sorts and prints the controlled substances by class number (II, III, IV, V).
- The report summarizes charges for similar items.

End Of Day Report (Sample)

RUN DATE: 12/03/15 TIME: 08:46		Evident Community Hospital PHARMACY END-OF-DAY REPORT FOR Thursday 12/03/15				PAGE 1 PCB00P	
PAT#	PATIENT NAME/ADDRESS	DRUG NAME START DATE	RX #	REFILLS USED	QTY	PRICE RPh/TECH/RN	PHYSICIAN/ ADDRESS/DEA#
357823	AINSWORTH MARTHA COZEN	AMITRIPTYLINE(ELAVIL) TAB: 25 MG 12/03/15			1	1.10 FT	SMITH JAME
		DOCUSATE(COLACE) CAP:100 MG			1	.40	
		HYDROMORPHONE(DILAUDID) INJ: 2MG/ML 11/05/15			1	14.70 FT	SMITH JAME
		Insulin RBG {Humulin R} 100U/ML 11/13/15			1	7.40 FT	SMITH JAME
		KCL 20 MEQ IN NS 1000ML 11/27/15			2	.00 FT	SMITH JAME
		NORMAL SALINE 1000 ML 11/27/15			3	44.40 FT	SMITH JAME
		NS :100 ML 2B1302P IV SOL 10/15/15			2	13.60 FT	SMITH JAME
		cefTRIAxone {ROCEPHIN} INJ : 1 GM 10/15/15			2	214.80 FT	SMITH JAME
357257	BOLTZ CAROLYN RR 1 BOX 4266 SARALAND AL	HUMULIN NPH U100 INSULIN 02/26/13			1	7.40 RBB/FT	
355274	BONINE BEVERLY RFD 1 BOX 3120 THEODORE AL	D5W {5% DEXTROSE IN WATER}: 50 ML 01/22/15			2	29.60 FT	DEXTER R 900 Springhil Mobile DEA# AL394858
		IV ADMIXTURE FEE 01/22/15			2	10.00 FT	DEXTER R 900 Springhil Mobile DEA# AL394858
		cefTRIAxone {ROCEPHIN} INJ : 1 GM 01/22/15			4	429.60 FT	DEXTER R 900 Springhil Mobile DEA# AL394858

Controlled Substance Section (Sample)

CLASS DRUG NAME	ITEM#	QTY	PATIENT NAME	NUMBER	RPh/TECH/RN RX #	PHYSICIAN
2 HYDROMORPHONE{DILAUDID}INJ: 2MG/ML	383062	1	AINSWORTH MARTHA COZEN	357823	PT	SMITH JAME
	TOTAL	1				

Temporary Orders / DC's

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Temporary Orders / DCs**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.

How often should this Report be printed?

- This report should be printed as necessary. Contact a TruBridge Pharmacy Support Representative to get this report set to automatically print every morning to a specified printer.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- Medication orders entered by any employee other than a Pharmacist are considered Temporary Orders. Temporary Orders will not print to any Pharmacy reports other than the Temporary Orders Reports. Pharmacy can print temporary orders throughout the day for all patients. This includes all patients whether they are currently assigned to a room or not.

Temporary Orders / DC's (Sample)

RUN DATE: 12/03/15		Evident Community Hospital			PAGE 5		
TIME: 08:50		PHARMACY TEMPORARY ORDERS/DC's			PCTMPORD		
PATIENT NUMBER & NAME	ROOM	ORDER#	DRUG NAME	TEMP/DC	START DATE	STOP DATE	INIT
357810	PETERSEN ASHLYNN	177-8	3 AMBIEN 5 MG	CL ORDER	10/28/14	11/02/14	BS
357810	PETERSEN ASHLYNN	177-8	4 NORCO	CL ORDER	10/28/14		BS
357814	SMITH ELLA KATHERINE	300-7	1 ATENOLOL 50MG	CL ORDER	06/24/14		EL3
357814	SMITH ELLA KATHERINE	300-7	2 GLUCOPHAGE500	CL ORDER	06/24/14		EL3
357814	SMITH ELLA KATHERINE	300-7	3 XANAX 0.5MG	CL ORDER	06/24/14	07/24/14	EL3
357814	SMITH ELLA KATHERINE	300-7	4 CRESTOR	CL ORDER	06/24/14		EL3
357814	SMITH ELLA KATHERINE	300-7	5 AMBIEN 5 MG	CL ORDER	07/17/14	07/17/14	EL3
357814	SMITH ELLA KATHERINE	300-7	6 D5W 1000 ML	CL ORDER	07/17/14	07/24/14	EL3
			HEPARIN10000U				
357814	SMITH ELLA KATHERINE	300-7	8 MSPCA 1MG/ML	CL ORDER	07/18/14	07/21/14	BS
357814	SMITH ELLA KATHERINE	300-7	9 TYLENOL325MG	CL ORDER	07/21/14		BS
357814	SMITH ELLA KATHERINE	300-7	10 NOVOLOG INJEC	UNSIG PR	08/08/14	08/08/14	CTJ
357814	SMITH ELLA KATHERINE	300-7	11 NOVOLOG INJEC	CL ORDER	08/08/14		CTJ
357814	SMITH ELLA KATHERINE	300-7	12 METOPROLOL50	CL ORDER	09/24/14		KWW
357816	JONES BOB	WAIT	1 KEPZOL1GM INJ D5W 100 ML	UNSIG VO	04/09/15	04/09/15	DT
357823	AINSWORTH MARTHA COZEN	300-9	8 COLACE 100 MG	NS ORDER	11/09/15		RBB
357826	EDWARD JAMES MILLER	103-1	1 MORPHINE INJ:	UNSIG VO	05/14/15	05/14/15	JC
357826	EDWARD JAMES MILLER	103-1	2 NORMAL SALINE	UNSIG VO	05/14/15	05/14/15	JC
357826	EDWARD JAMES MILLER	103-1	3 ONDANSETRON(Z	UNSIG VO	05/14/15	05/14/15	JC
357833	MOORE WILLIAM T	WAIT	1 MORPH2MGINJ	NS ORDER	08/03/15	08/06/15	KBW
357833	MOORE WILLIAM T	WAIT	2 BENADRYL ELIX	NS ORDER	08/03/15		KBW
357833	MOORE WILLIAM T	WAIT	3 IASIX 20MG TB	NS ORDER	09/22/15		KBW
357833	MOORE WILLIAM T	WAIT	4 REG Insulin U	NS ORDER	09/22/15		KBW
357833	MOORE WILLIAM T	WAIT	5 D5 1/2NS+KCL	NS ORDER	09/22/15		KBW

Temporary Orders / DC's (Current Patients)

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Temporary Orders / DCs for Current Patients**.
3. Select a printer number, **Spool to File** or **Print to Workstation**.
4. The current date displays and prints orders still considered to be in temporary status for that date.

How often should this Report be printed?

- This report should be printed as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- Pharmacy can print temporary orders for current patients throughout the day. This report only prints temporary orders for those patients currently occupying a room. Outpatients do not print on this report (unless admitted to a room).

Temporary Orders / DC's for Current Patients (Sample)

RUN DATE: 12/01/15 TIME: 14:49		Evident Community Hospital PHARMACY TEMPORARY ORDERS/DC's FOR CURRENT PATIENTS				PAGE 1 H5PCTOCUR	
PATIENT NUMBER & NAME	ROOM	ORDER#	DRUG NAME	TEMP/DC	START DATE	STOP DATE	INIT
357823	AINSWORTH MARTHA COZEN	300-9	8 COLACE 100 MG	NS ORDER	11/09/15		RBB
357351	SMITH ELLA KATHERINE	302-1	3 TYLENOL325MG	CL ORDER	01/21/15		PLL
357351	SMITH ELLA KATHERINE	302-1	4 AMBIEN 5 MG	NS ORDER	03/10/15	03/15/15	N
357351	SMITH ELLA KATHERINE	302-1	5 LIPITOR	NS ORDER	03/10/15		N
357004	ADAMS JIMMY		2 LASIX 20MG TB	NS ORDER	05/21/15		MAA
357004	ADAMS JIMMY		3 LASIX 20MG TB	NS ORDER	05/26/15		KBW
357861	BOWDEN CAUSEY ANNE	302-5	1 NF-Fondaparin	NS ORDER	06/15/15		CEK
357861	BOWDEN CAUSEY ANNE	302-5	3 VALSARTAN(DIO	NS ORDER	06/15/15		CEK
357861	BOWDEN CAUSEY ANNE	302-5	4 ACETAMINOPHEN	NS OR&DC	06/15/15	06/15/15	CEK
357861	BOWDEN CAUSEY ANNE	302-5	5 MSPCA 1MG/ML	NS ORDER	06/29/15	07/02/15	CEK
357861	BOWDEN CAUSEY ANNE	302-5	7 MEPERIDINE PC	NS ORDER	08/04/15	08/07/15	CEK
357861	BOWDEN CAUSEY ANNE	302-5	8 REGU-100ANIMA	NS ORDER	08/31/15		CEK

Clinical Info Summary/Deficiencies

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Clinical Info Summary / Deficiencies**.
3. Enter a printer number, **Spool to File**, or **Print to Workstation**.
4. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
5. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
6. Select **OK**.
7. Select **All Patients** or **Patients with missing clinical info**
8. Display Diagnosis Codes/Descriptions (Yes or No)
 - Answer Yes to include patients missing a diagnosis.
 - Answer No to not include patients missing a diagnosis.

NOTE: ICD-10 Diagnoses Codes will print according to the following hierarchy:

- *Principal (Grouper) diagnoses if available*
- *If no Principal Diagnoses, use the first Working Diagnosis*
- *If no first Working Diagnosis, use Chief Complaint*

How often should this Report be printed?

- This report should be printed on a daily basis as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- A copy is often sent to Nursing.

What is the Description and Usage?

- To alert the Pharmacy to deficiencies in Patient Clinical Information. Patients missing Heights, Weights, Allergies or a Diagnosis will pull to the report. This report prints two copies; one copy for each Nursing Station and one master copy of all Nursing Stations for Pharmacy. **Select All Patients** can be printed and used as a daily census for pharmacy.

Clinical Information Summary All Nursing Stations (Sample)

PATIENT NAME DIAGNOSIS CODES	ROOM	PAT. #	ALLERGIES	WEIGHT	HEIGHT
RUN DATE: 12/09/15 TIME: 09:56					
Evident Community Hospital CLINICAL INFORMATION SUMMARY ALL NURSING STATIONS					
PAGE 1 PCDEPREP1					
GARLAND REBECCA	010-1	357023	No Known Drug Allergies, No Known Environmental Allergies, No Known Food Allergies	175 POUNDS 79.38 KG 79378.7 GM	.0 OZ 55.00 INCHES
SMITH ELLA KATHERINE	010-2	357388	Eggs, Mineral oil	175 POUNDS 79.38 KG 79378.6 GM	.0 OZ 66.00 INCHES
PETERSON MEGAN ELAIN S0990 Head injury	010-3	321654	No Known Drug Allergies	150 POUNDS 68.04 KG 68038.9 GM	.0 OZ 65.00 INCHES
MAJURE TREY RALPH	010-4	357365	Demerol, No Known Environmental Allergies, No Known Food Allergies, ASDF	245 POUNDS 111.13 KG 111130.1 GM	.0 OZ 75.00 INCHES
DURDEN KELLY	010-5	357307	No Known Drug Allergies	125 POUNDS 56.70 KG 56699.0 GM	.0 OZ 60.00 INCHES
BONINE BEVERLY	012-1	355274	Eggs, Egg yolk, Egg albumin	123 POUNDS 55.79 KG 55791.9 GM	.0 OZ 66.00 INCHES
ODOM CONNIE	014-1	963963	Penicillin, Strawberries, Cipro	45 POUNDS 20.41 KG .0 GM	.0 OZ 65.00 INCHES
CHAMBLISS STEPHEN	014-2	356787	No Known Drug Allergies	120 POUNDS 54.43 KG 54431.1 GM	.0 OZ 52.00 INCHES

On Screen Cart Fill List

The On-Screen Cart Fill is a paperless method of filling medication carts. The application replaces the Cart Fill and Catch-Up List paper report system. This is a procedure that allows charging and crediting to occur on-screen.

The system operates in three different modes. The modes are listed below in order of occurrence:

1. Cart Fill (First time Cart Fill option selected).
2. Catch up (Each additional time Cart Fill option selected).
3. Release Cart (Option to produce final Cart Fill list and process charges).

Each mode performs a particular function in On Screen Cart Fill.

1. In Cart Fill mode, the following options are available:
 - Entry of resupply quantity for charge or credit.
 - Orders can be marked with an <X> to bring forward to the next Catch Up.
2. Each additional time Cart Fill option is selected, the following information is retrieved:
 - Patients transferred (since first Cart Fill was run)
 - Patients discharged (since first Cart Fill was run)
 - New orders entered (since first Cart Fill was run)
 - Order changes (since first Cart Fill was run)
 - Options include:
 - Pull all orders marked with <X> during Cart Fill mode.
 - Charge or credit resupply quantities
3. Release Mode is the final step in the On Screen Cart Fill process. Once this has been selected, the system resets for a new Cart Fill to be run and the patients are charged or credited the appropriate amounts set in the resupply field.

Using On Screen Cart Fill

The steps to using the On Screen Cart Fill are as follows:

1. Hospital Base menu, select **Print Reports menu**.
2. Select **On Screen Cart Fill**.
3. Select the nursing station to fill by typing the department number.
 - An asterisk <*> appears next to the nursing station to be filled.
 - More than one nursing station at a time can be selected by holding the Ctrl key and left click on the department.
 - Deselect a nursing station option is available while still on the select nursing station screen, this can be done single clicking on another department name. The new department is now selected and the first department is deselected
4. Select **Proceed** to process list.
5. The Pharmacy Fill List screen creates a work file. From this screen:
 - Select **OK** to accept all patient types or deselect an individual patient type.
 - Select **OK** to fill for one day or enter the number of days needed to fill.
 - Select **OK** if all information is okay.
6. The Cart Fill screen indicates the resupply quantity for each order.
 - To fill for the designated re-supply quantity, press <Enter> and the resupply quantity defaults to the set amount.
 - To change the charge quantity, enter the number to charge.
 - Press <0> to charge zero.
 - To credit, enter a negative number to charge.
 - If the item the order is for is unavailable, press <X> for the charge quantity. This brings the order forward for the next Catch-Up List.

- Discontinued orders will show on the cart fill list once for two consecutive Cart Fill periods. This gives the ability to credit any items that were not used by the patient. The date the order was discontinued will appear in a blue flashing box.
- Prior to zeroing out the following options are available:
 - To re-access a patient's orders, select the sequence number.
 - If a patient has more than one page of orders, use the <Page Up> or <Page Down> to access all orders.
 - Patient orders *cannot be re-accessed* after zeroing off the patient's account.
 - Select option <Q> to quit the Cart Fill process. The next time the Cart Fill is run, the system picks up at the next patient following where <Q> was entered.
 - To Release Cart Fill, select option <n> On Screen Cart Fill.
 - Select the nursing stations with Last Run dates. An <*> will be to the right of the department number after department has been selected.
 - Select Release Cart from the bottom of the screen.
 - Releasing the Cart will generate the Last Fill list. <X> is not available for use to move an order forward when in Release Cart mode.
 - Releasing the cart generates the charges for everything that is in the patient's drawer.
 - If there are no changes to orders between the last Cart Fill and the Release Cart Fill, the screen moves to the Hospital Base menu. If changes are made, those orders appear for charging and crediting.

Select Hospital Base Menu > Print Reports > On Screen Cart Fill List > Select Nursing Station(s) > OK > Charge Quantity

Order	Description	Start	Stop	Code	Dose	Route	Cart Fill List	Charge
7	WARFARIN (COUMADIN) : 03/24/98 03/31/98 MG PO	03/24/98	03/31/98	A	2 MG	EVERY DAY		1
9	LISINOPRIL (ZESTRIL, PRINIVIL) TAB : 10MG 08/25/98 MG	08/25/98			10	EVERY DAY		
15	DIGOXIN (LANOXIN) : 0.125 MG TAB 03/03/03 03/03/03 MG	03/03/03	03/03/03	A	0.5	EVERY DAY		1

Enter: _____ (0-Exit PgDn PgUp *Quit)

On-Screen Cart Fill

Cart Fill Check List

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Cart Fill Check List**.

How often should this Report be printed?

- This report should be printed on a daily basis as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal use only.

What is the Description and Usage?

- The Cart Fill Check List indicates all medications that should be in the patient drawer according to the last Onscreen Cart Fill. It is a good idea to run this after each Onscreen Cart Fill as a checking mechanism. This report also shows items that did not have a resupply quantity, but were charged.
- The report includes basic patient demographic data such as diagnosis, age, and weight, along with start and stop dates, order number, drug name, resupply amount (if any) and charges that were applied to the patient account.

NOTE: *The Diagnosis will print according to the following hierarchy: Principal (Grouper) diagnosis, if no Principal Diagnosis, use the first Working Diagnosis; if no first Working Diagnosis, use Chief Complaint.*

Cart Fill Check List (Sample)

RUN DATE: 12/04/15		Evident Community Hospital		NURSING STATION: 003		PAGE 1	
TIME: 13:58		CART CHECK LIST FOR PHARMACY				PCCKLST	
FOR CART FILL FROM: 12/04/15 AT 15:00 THROUGH: 12/05/15 AT 1459							
ROOM	PATIENT NAME	NUMBER	WEIGHT	AGE	SEX.	PHYSICIAN	DIAGNOSIS
ORDER	START-DT	STOP-DT	CD	DESCRIPTION	DOSE		QUANTITY
			UNIT		ROUTE		RESUP
							CHRG

010-1	GARLAND REBECCA	357023	175	46Y	F	BAXTER JAMES	
	ALLERGIES: CODEI ANAPR PCN ALPR						
No Active Orders for This Patient							

010-2	SMITH ELLA KATHERINE	357388	175	72Y	F	DANIEL E SMI	
	ALLERGIES: NONE ENTERED						
27	02/23/12			LORAZEPAM(ATIVAN) TAB : 0.5MG		0.5	
				MG	PO	PRN TID	
	ADMIN TIMES:						
32	03/19/12			TRAMADOL(ULTRAM) TAB: 50 MG		50	
				MG	PO	PRN Q4H	
	MAX OF 400MG/D						
	ADMIN TIMES:						
81	02/27/13			IBUPROFEN(ADVIL) SUSP :100MG/5ML		100	
				5 mL	ORALLY	PRN	3 3
	GIVE 5-10mg/kg						
	GIVE WITH FOOD						
	ADMIN TIMES:						
84	02/27/13			ACETAMINOPHEN (TYLENOL) 325 MG TABLET		650	
				MG	ORALLY	PRN EVERY 4 HOURS	
	FOR PAIN OR TEMP>100.0						
	ADMIN TIMES:						
88	06/11/13			LEVAQUIN/ D5 : 250 ML/100ML		250	
				ML	IV PIGGYBACK	Q12H	2
	FIRST DOSE: 6/11/13 09:29						

ADM Exception Report

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **ADM Exception Report**.
3. Enter a printer number, **Spool to File**, or **Print to Workstation**.
4. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
5. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
6. Select **OK**.

How often should this Report be printed?

- This report should be printed on a daily basis as necessary. Print this report prior to running a Cart Fill List-Charging to ensure that all medications not supplied by the ADM are charged by the Cart Fill List.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal use only.

What is the Description and Usage?

- This report is used by sites that supply routine medications through an Automated Dispensing Machine (ADM). The report list all orders for patients that have either no resupply qty or are also not supplied on the ADM, and all orders which both have a resupply qty and supplied by the ADM.

ADM Exception Report (Sample)

ROOM	PATIENT NAME	NUMBER		QUANTITY
ORDER ITEM NUM.	DESCRIPTION		FREQ.	RESUPPLY ADM

010-1	GARLAND REBECCA	357023		
7	381711 ZOLPIDEM (AMBIEN) 5 MG TAB		PRN BEDTIME	

010-2	SMITH ELLA KATHERINE	357388		
27	381247 LORAZEPAM (ATIVAN) TAB : 0.5MG		PRN TID	
32	387506 TRAMADOL (ULTRAM) TAB: 50 MG		PRN Q4H	
84	381010 ACETAMINOPHEN (TYLENOL) 325 MG TABLET		PRN EVERY 4 HOURS	
99	381483 WARFARIN (COUMADIN) 2.5 MG TAB		NIGHTLY	
100	381485 WARFARIN (COUMADIN) 5 MG TAB		NIGHTLY	
102	38381311 ESOMEPRAZOLE (NEXIUM) CAP:40 MG		EVERY DAY	
107	381711 ZOLPIDEM (AMBIEN) 5 MG TAB		PRN BEDTIME	
108	3814561 MEPERIDINE (DEMEROL) INJ: 25MG/ML		PRNQ4H (AS NEEDED)	
109	3814534 NORCO 7.5MG - 325MG TAB		PRNQ6H (AS NEEDED)	
110	301457 NITROGLYCERINE 0.4MG SL TAB (NITROSTAT)		PRN Q5MIN X3	

010-3	PETERSON MEGAN ELAIN	321654		
15	381369 PROPOXYPHENE/APAP 100/650 (DARVCT N-100)		PRN Q4H	
20	381261 METOCLOPRAMIDE (REGLAN) TAB:10MG		FOUR TIMES BEF MEALS	
22	381181 LASIX 40MG TB		DAILY	
24	387825 KETOROLAC (TORADOL) INJ : 30 MG		PRN Q6H	
26	381719 Insulin REG (Humulin R) 100U/ML		PRN	

010-4	MAJURE TREY RALPH	357365		
5	381010 ACETAMINOPHEN (TYLENOL) 325 MG TABLET		PRN EVERY SIX HOURS	
9	381483 WARFARIN (COUMADIN) 2.5 MG TAB		Q12H	

010-5	DURDEN KELLY	357307		
1	370056 ACETAMINOPHEN		2 TIMES DAILY (BID)	

014-1	ODOM CONNIE	963963		
18	381604 ACETAMINOPHEN (TYLENOL) 500MG TABLET		PRNQ8H (AS NEEDED)	

014-2	CHAMBLISS STEPHEN	356787		
12	381010 ACETAMINOPHEN (TYLENOL) 325 MG TABLET		PRN EVERY SIX HOURS	
15	3814531 ABILIFY (ARIPIPRAZOLE) 10 MG TAB		DAILY	

14.2 Miscellaneous Reports

Overview

This section will cover reports that will be printed in the pharmacy but not necessarily on a daily basis.

Charge Edit Entry

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Charge Entry Edit List**.
3. Select a printer number, **Spool to File** or **Print to Workstation**.
4. Enter Terminal Number, select **Add More** so that multiple terminal numbers can be entered, or leave blank for all terminals.
5. The default is current date. Select the drop down arrow to display a calendar from which a start date can be selected.
6. "Group Charges By Department?" Always answer Yes.
7. Select the drop down arrow to select Posted, Unposted, or Both.

How often should this Report be printed?

- This report should be printed as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- The Charge Edit Entry List prints an edit list for Pharmacy charges entered through the batch patient charging screen (Hospital Base menu, Master Selection, Patient Charging, Charge Entry). Print charges entered on a specific terminal or all terminals and print unposted, posted, or both types of charges. The unposted charges are useful for checking hash totals while the posted charges recap the total days charging for audit or review purposes.

The Charge Edit Entry List lists the following information:

- Selected Terminal Number
- Selected Charges
- Patient Number

- Patient Name
- A/R Date
- Service Date
- Department
- Initials of person who keyed the charge/credit
- Item Number
- Quantity
- Charge Amount
- Description
- Physician Number
- Physician Amount

The report summarizes the number of transactions, the charge dollar amount, the quantity totals, the hash total - patient numbers, and the hash total - item numbers. The report concludes with an Initials section. This summarizes the number of transactions and the dollar amount associated with the initials of the individual that created batch charges and/or credits.

Charge Entry Edit List (Sample)

RUN DATE: 02/08/13 TIME: 14:22		Evident Community Hospital CHARGE EDIT LIST FOR TERM=ALL				ALL CHARGES		PAGE 1 AREBIT		
NUMBER	NAME	A/R DATE	SERV DATE	DEPT	INIT	ITEM NUM.	QTY	CHARGE AMOUNT	DESCRIPTION	----PHYSICIAN----
										NUMBER AMOUNT
357257	BOLTZ CAROLYN	02/08/13		038	RBB	381010	2	.80	ACETAMINOPHEN (TYLENOL) : 32	
357257	BOLTZ CAROLYN	02/08/13		038	RBB	210195	1	14.80	NS :1000 ML 2B1324 IV	
# OF TRANSACTIONS-----:				2						
CHARGE \$ AMOUNT-----:				15.60						
QUANTITY TOTALS-----:				3						
HASH TOTAL-PATIENT NUMBERS:		714514		357257						
HASH TOTAL-ITEM NUMBERS---		591205								
-----INITIALS-----										
INITIALS		COUNT		DOLLARS						
RBB		2		15.60						
		-----		-----						
		2		15.60						

Summary Detail of Charges

The Summary Detail of Charges can be run for individual patient numbers or from a work file.

1. From the Pharmacy Selection Screen, **Print Reports**.
2. Select **Summary Detail of Charges**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Enter Patient Numbers.
5. Select the drop down arrow to display a calendar from which a start date can be selected.
6. Select the drop down arrow to display a calendar from which an end date can be selected.
7. Select **Print**.

How often should this Report be printed?

- This report should be printed as necessary.

Who should print this Report?

- The Pharmacy department or anyone requiring detail of the pharmacy charges.

Who should get copies of this Report?

- Anyone needing a summary of charges for individual patients.

What is the Description and Usage?

- The Summary Detail of Charges prints the information from **Summarized Charges** of the Pharmacy Selection screen. This report can be printed for either individual accounts or from a work file. The report can be further refined to print for only a selected date range, such as one month of charges for Long Term Care patients, or print the entire stay of the selected accounts.
- The Summary Detail of Charges lists the selected date range, patient demographic information, stay information, order number, item number, item description, charge quantity and amount, credit quantity and amount, total quantity used, and summarized totals of the quantitative fields. The charge quantities include charges entered through the batch charging function regardless from which department the item was charged.
- The Summary Detail of Charges is especially useful for audits. The summarized information is available for two years after patient discharge.

Summary Detail Of Charges (Sample)

12/09/15		Evident Community Hospital		PAGE 1			
09:59 Wednesday		PHARMACY ACCOUNT DETAIL (ALL)		H5PCSDET			
PATIENT-----			STAY INFORMATION-----				
1	NUM/NAME--:	357823 AINSWORTH MARTHA COZEN	5	STAY TYPE--:	1 IN-PATIENT		
2	SEX-----:	F	6	ADM DATE---	4/24/15		
3	BIRTH----	12/10/1934	7	DIS DATE---			
4	DOCTOR---	003426					
ORD	ITEM		-----CHARGE-----		-----CREDIT-----	QTY	
NUM	NUMBER	DESCRIPTION	QUAN	AMOUNT	QUAN	AMOUNT	USED
6	3814534	NORCO 7.5MG - 325MG TAB	3	9.00		.00	3
7	381010	ACETAMINOPHEN (TYLENOL) 325 MG TABLET	4	1.60		.00	4
4	387058	cefTRIAXone (ROCEPHIN) INJ : 1 GM	4	429.60		.00	4
4	210559	NS :100 ML 2B1302P IV SOL	4	27.20		.00	4
12	3814589	CUBICIN 500MG IV		.64		.00	.64
13	381371	PROPRANOLOL (INDERAL) TAB : 20 MG	61	122.00	-20	40.00	41
16	3814505	NORMAL SALINE 1000 ML	5	74.00		.00	5
17	38387716	KCL 20 MEQ IN NS 1000ML	3	.00		.00	3
5	383062	HYDROMORPHONE(DILAUDID)INJ: 2MG/ML	1	14.70		.00	1
8	381999	DOCUSATE(COLACE) CAP:100 MG	1	.40		.00	1
9	381719	Insulin REG (Humilin R) 100U/ML	100	740.00		.00	100
19	381033	AMITRIPTYLINE(ELAVIL) TAB: 25 MG	1	1.10		.00	1
10	381179	FUROSEMIDE (LASIX): 20 MG TAB	1	.40		.00	1
***** T O T A L S *****			188.64	1420.00	-20	40.00	168.64

Patient Drug Profiles

1. From the Pharmacy Selection Screen, **Print Reports**.
2. Select **Patient Drug Profiles**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
5. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
6. Select **OK** to process the report.
7. Select patients by:
 - In-house accounts (from Work File) - this option requires that a current work file for the desired patient parameters be available.
 - Select account numbers - up to 50 account numbers can be entered.
8. Select **Print** after the last selected account number is entered.

How often should this Report be printed?

- This report should be printed as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Anyone who needs to review the current drug therapy of the patient.

What is the Description and Usage?

- The Patient Drug Profile provides a current drug profile for a patient. Along with demographic data, this current profile includes the start date, order number, drug description, dosage, quantity charged, quantity credited, total quantity used, and usage instructions. The dosage and usage instructions print together at the end of each line.

NOTE: *If demographic data includes Diagnoses, ICD-10 Diagnoses Codes will print according to the following hierarchy:*

- *Principal (Grouper) diagnoses if available*
- *If no Principal Diagnoses, use the first Working Diagnosis*
- *If no first Working Diagnosis, use Chief Complaint*

This profile is suitable for drug therapy review at any time. This profile is a compilation of all patients active orders - Routine, I.V., and PRN.

The charged quantities on the Patient Drug Profile can differ from the charged quantities listed on the Summary Detail of Charges Report, Review Summarized Charges or Review Detailed Charges. The quantity charged includes quantities charged through batch charging. The item appears regardless of whether the charge was generated from the pharmacy or other department.

Patient Drug Profile (Sample)

RUN DATE: 12/07/15		Evident Community Hospital		PAGE 1		
TIME: 10:27		PATIENT DRUG PROFILE AS OF 12/07/15		PCPDP		
PATIENT..357823	AINSWORTH MARTHA COZEN	ADMIT DATE.. 4/24/15	BIRTH DATE.. 12/10/1934	AGE.. 80	ROOM..300-9	
DOCTOR..	SERVICE..M MEDICAL	WEIGHT..120lbs	ALLERGIES..Codeine, Eggs, Peanuts			
-----D I A G N O S I S-----			-----TREATMENT THERAPY ORDERS-----			
Asthma						
-----R O U T I N E O R D E R S-----						
START DT	ORDER	DESCRIPTION	DOSAGE	CHARGE QTY	CREDIT QTY	QTY USED
STOP DT	CODE	INSTRUCTIONS				
4/24/15	10	FUROSEMIDE (LASIX): 20 MG TAB	20 MG PO			
						DAILY
11/24/15	13	PROPRANOLOL (INDERAL) TAB : 20 MG	20 MG PO	61	20	41
5/24/17	D					TID
11/30/15	18	QUINAPRIL (ACUPRIL) TAB : 10 MG	10 MG PO			
5/31/17	D					BID
-----P R N O R D E R S-----						
START DT	ORDER	DESCRIPTION	DOSAGE	CHARGE QTY	CREDIT QTY	QTY USED
STOP DT	CODE	INSTRUCTIONS				
11/05/15	5	HYDROMORPHONE (DILAUDID) INJ: 2MG/ML	2 MG IVP	1		1
11/12/15	A					PRN Q6H
11/09/15	7	ACETAMINOPHEN (TYLENOL) 325 MG TABLET	650 MG ORALLY	4		4
						PRN EVERY SIX HOURS

Selective Item Usage By Patient

1. From the Pharmacy Selection Screen, **Print Reports**.
2. Select **Selective Item Usage by Patient**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Enter the beginning and ending account range, or leave blank for all accounts.
5. Select the drop down arrow to display a calendar from which a start date can be selected.
6. Select the drop down arrow to display a calendar from which an end date can be selected.
7. Enter desired patient stay types, or leave blank for all patient types.

8. Enter up to 50 charge numbers.

9. Select **Print** to process report.

How often should this Report be printed?

- This report should be printed as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Anyone who needs to review drug usage by patient.

What is the Description and Usage?

- The Selective Item Usage Report is used to find all patients who have been charged for a selected drug(s) over a specified period of time.
- This is useful when doing D.U.E. studies.
 - Example, a study on Tagamet® for the last three months.
 - Generate the report for the last three months and enter all Tagamet® item numbers.
 - The report prints all patients who were on the drug, for how long, and the quantity each patient received.
- This report takes a while to build. It must read all patients who have ever been in the hospital.
 - To decrease the build time, insert a starting patient number.
 - Example, if building the file for a two month period, and approximate patient numbers that were being used at the beginning of that period (or even in the month prior) are known.
 - Key in the range of patient numbers, the system has fewer accounts to search, and the file build is shorter.

The selective item usage report contains patient demographic data including name, number, age, sex, admission date, discharge date, patient type, and admitting physician. The medication information consists of charge date, charge number, quantity, and description.

Select Item Use By Patient (Sample)

```

RUN DATE: 12/07/15          Evident Community Hospital          PAGE: 1
TIME: 10:36                SELECTED CHARGES                               HSPCSELP

--SERVICE--
PATIENT NAME      NUMBER AGE SEX FROM   TO   TYPE   DATE   CHARGE  QTY DESCRIPTION          ADMIT PHYSICIAN
-----
SMITH GUS B       358694  39Y M 12/10/14      I/P  12/07/15 00381371  1.00  PROPRANOLOL (INDERAL  WILLIAMS KATHERINE
RHEUM AORTIC DIS NEC NOS

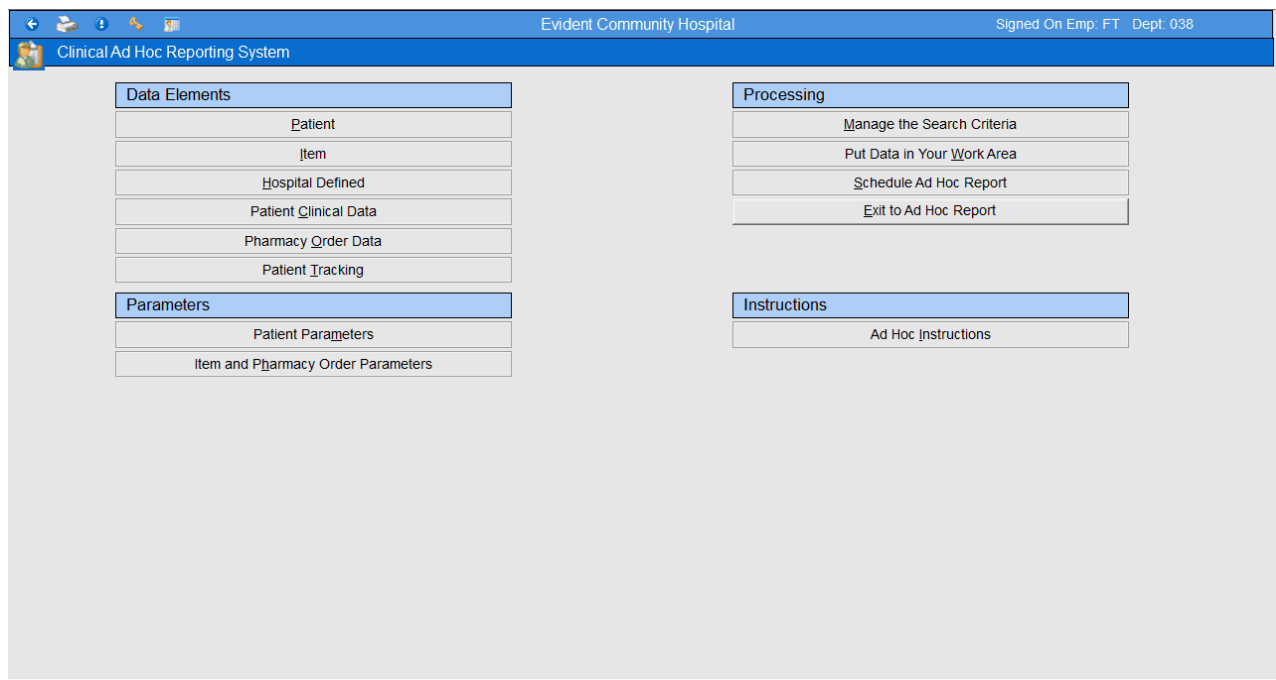
WALSH KIERNAN    357896  29Y F 03/03/14      I/P  12/03/15 00381371  4.00  PROPRANOLOL (INDERAL  JOHN K TOLBERT
                                12/03/15 00381371  4.00  PROPRANOLOL (INDERAL

TOTAL PATIENTS =      2
```

Build Ad Hoc Report

This option allows access to the Pharmacy Database. Please refer to [Clinical Ad Hoc Database User Guide](#) for detailed information on the Pharmacy Database.

Select **Hospital Base Menu > Print Reports > Build Ad Hoc Report > Patient, Item, Pharmacy Order, Patient Clinical Data, and Hospital Defined >**



Build Pharmacy Ad Hoc Report

Unit Dose Labels

The unit dose label printing program is designed to operate with labels which measure 1 23/32 inches by 1 inch. The labels print in a continuous two across strip.

1. From the Pharmacy Selection Screen, **Print Reports**.
2. Select **Unit Dose Labels**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. From the Department Printer Functions menu, select **Label 1 23/32 x 1**.
5. Type the desired information to print on the unit dose labels.
 - Up to 27 characters per line and 8 lines per label can be entered.
 - To print a barcode, type the command: \128S\ and the 10-digit NDC Number (with no spaces and no hypens)
 - Example: \128S\0409610204

6. When label entry is complete, select **Print**.
7. The system prompts for the number of labels to print.
 - Enter from 1 to 99 labels.
 - If an odd-numbered response is entered, the system rounds up and print the next even number of labels (if 3 labels are entered, the system prints 4).

If the labels print too large, check to make certain the select light is not blinking. If it is blinking, turn the printer off and back on, then try again.

Unit Dose Labels (Sample)

The screenshot shows a software window titled "Unit Dose Labels" with a blue header bar. Below the header, there are three buttons: "Load Predefined", "Save Predefined", and "Delete Predefined". A status bar at the top of the main area displays printer configurations: "3 1/2 x 7/16", "3 1/2 x 15/16", "4 x 1 15/16", "1 23/32 x 1", "1 11/16 x 1 3/16 (okidata only)", and "Standard Pharmacy". The main area contains a label template with a blue header bar that says "<-27 Positions->". The label text is as follows:

METRONIDAZOLE TAB 500MG
(FLAGYL)
LOT: 12356
EXP: 12/25

\\128S\5011133401

At the bottom left of the window, it says "Ready". At the bottom right, there is a "Print" button.

Long Term M.A.R.'s

1. From the Pharmacy Selection Screen, **Print Reports**.
2. Select **Long Term M.A.R.**
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
5. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
6. Select **OK** to process the report.
7. Select patients by:

- **From Work File.** Build a Work File prior to selecting this option.
 - **Account Numbers.** Enter up to 50 account numbers.
8. Select the drop down arrow to display a calendar from which a start date can be selected.
 9. Select the drop down arrow to display a calendar from which an end date can be selected.
 10. Select **Print** to process report.
 11. To print a T.A.R (Treatment Administration Record), answer Yes to the prompt: Print TREATMENT orders on separate TREATMENT ADMINISTRATION RECORD?: (Yes or No)

How often should this Report be printed?

- This report should be printed bimonthly or monthly depending on the forms in use.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- The affected Nursing Units.

What is the Description and Usage?

- Used to chart medications given to a patient, when they were given, and by whom. Once the MAR is completed, it becomes a legal part of the chart.

The MAR is printed in 3 sections: Routine medications, PRNs/one-time, and IVs orders.

The left half of the MAR contains order information including, drug name, dosage, route, frequency, and instructions from of the order entry screen.

The central column contains the dosage time for each drug. The dosing time can be left blank for formatting in standard (AM/PM) or military times. Contact a TruBridge Pharmacy Representative for assistance in changing the format.

The right half of the MAR contains columns corresponding to the days of the charting period. As the medication for that time period is given (by row), the nurse initials the proper block.

The following patient information is printed at the bottom of the page:

- Name
- Account number
- Room
- Age
- Sex
- Physician
- Weight
- Allergies
- Diagnosis
- Diet

NOTE: The Diagnosis will print according to the following hierarchy: Principal (Grouper) diagnosis, if no Principal Diagnosis, use the first Working Diagnosis; if no first Working Diagnosis, use Chief Complaint.

If a patient has the maximum number of medications that will print on one MAR page, the bottom of the page states: CONTINUED ON NEXT PAGE and a second page for that patient prints.

Portions of the Long Term Care MAR form are custom printed for each site. Areas that can be customized include the entire back of the form, the number of days per charting period (typically 1-31 or 1-16 and 17-31), and the area between the "charting from" line and the "account number" line.

Physician medical orders can be printed on the right side of the MAR. This requires a two-part MAR form.

The Long Term Care MARs are numbered, in print order, sequentially in the upper right corner of the form.

Treatment Administration Record (TAR)

The T.A.R. is used to document treatments such as wound care, catheter care and other non-medicinal procedures. The TAR will decrease documentation time by listing all procedural orders on a single record rather than have them mixed with medications on the MAR.

T.A.R.s may be printed at the same time and on the same form as the Long Term M.A.R. A separate page will print with the words TREATMENT ADMINISTRATION RECORD at the top of the form.

The following patient information is printed at the bottom of the page:

- Name
- Account number
- Room
- Age
- Sex
- Physician
- Weight
- Allergies
- Diagnosis
- Diet

NOTE: The Diagnosis will print according to the following hierarchy: Principal (Grouper) diagnosis, if no Principal Diagnosis, use the first Working Diagnosis; if no first Working Diagnosis, use Chief Complaint.

3rd Party Billing Report

The 3rd Party Billing Report can be generated using either individual patient numbers or from a work file.

1. From the Pharmacy Selection Screen, **Print Reports**
2. Select **3rd Party Billing Report**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Select patients by:
 - **Use Work File**
 - Requires that a current work file for the desired patient parameters.
 - **Specific Patients**
 - Enter up to 50 account numbers.
 - As each account number is entered, the completed number disappears.
 - Enter the next number in the same place.
 - **All Patients**
 - Enter Patient Type(s). Leave blank for all.
 - Enter Service Type(s). Leave blank for all.
5. Select the drop down arrow to choose to print either a Summary or a Detail Report.
 - The Summary Report reports a summary of the total quantity dispensed and charged. It is useful if long-term prescriptions are filled more frequently than monthly.
 - The Detail Report is useful for employee prescriptions (insurance purposes) and when long-term prescriptions are filled on a monthly basis.
6. Select the drop down arrow to display a calendar from which a start date can be selected.
7. Select the drop down arrow to display a calendar from which an end date can be selected.
8. Select **Print** to process the report.

How often should this Report be printed?

- This report should be printed as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Whoever needs pharmacy charging information to provide to a third party.

What is the Description and Usage?

- This report is used to provide an insurance report for employee prescriptions and to provide a report with all information needed for third party billing of retail/nursing home charges.

The Third Party Billing Report includes the patient name, medicaid number, birthdate, sex, account number, RX number, start date, stop date, drug name, drug NDC number, administration instructions, refill number, charge date charge quantity, charge dollar amount, prescribing physician, and dispensing pharmacist.

NOTE: *In order for the Pharmacist's initials to be changed after the original prescription is filled, the initials must be manually changed on the RX Information tab and the refill charge has to be posted the day the refill is done. If more than one refill is done in a day for the same order, the Pharmacist listed when the last refill was charged will display on the report.*

The drugs are listed in RX number order, within the RX number, charges are printed in chronological order, listing subsequent occurrences as refills. If there is no RX number, the drugs are sorted by order number. Charges entered through Batch Charging orders will not have numbers. These are listed separately at the end of the report.

The Third Party Billing Report includes a subtotal for each prescription. The subtotals are totaled to provide a grand total for the report.

Third Party Billing Report - Summary (Sample)

12/07/15 10:49 Monday		Evident Community Hospital PHARMACY 3RD PARTY BILLING CHARGES FOR: 11/01/15 - 12/07/15				DETAIL		PAGE 2 PCDET		
PATIENT NAME		CONTRACT		BIRTHDATE		SEX		ACCT #		
PATIENT ADDRESS								PATIENT PHONE		
RX #	DRUG NAME			NDC NUMBER	START	STOP	MANUFACTURER			
REFILL #	DOSE	QTY DISP	CHG DATE	QTY	CHARGE	INSTRUCTIONS	PHYSICIAN	DEA#	PHARMACIST	CHARGED BY
CLAIM #						ADDRESS1			CO-PAY AMOUNT	
						ADDRESS2				
						CITY,	STATE	ZIP		

AINSWORTH MARTHA COZEN				12/10/1934		F		357823		
								SUBTOTAL 1.60		
								Physicians Tota		
of 0	DOCUSATE (COLACE) 100 MG PO PRN	CAP:100 MG		1	.40	54868-2337-00	SMITH JAME		11/09/15	FT
								SUBTOTAL 0.40		
								Physicians Tota		
of 0	Insulin REG (Humulin R) 0 Unit(s)SUBCUTANEPRN	100U/ML		1	7.40	54868-3619-00	SMITH JAME		11/13/15	FT
of 0			12/03/15	99	732.60		SMITH JAME			FT
								SUBTOTAL 740.00		
								Pharma Pac A Se		
0000000058	PROPRANOLOL (INDERAL) 20 MG PO TID	TAB : 20 MG		30	60.00	52959-0212-50	SMITH JAME	FT	11/24/15	05/24/17
0 of 6			11/24/15	30	60.00		SMITH JAME	FT		FT
1 of 6			11/24/15	30	60.00		SMITH JAME	FT		FT

Interactions / Indications

1. From the Pharmacy Selection Screen, **Print Reports**.
2. Select **Interactions/Indicators**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. The system will default to selecting all Patient Types. Use the mouse to deselect unwanted Patient Type(s).
5. Enter the desired (up to 10 different) nursing station(s) or All nursing stations.
6. Select **OK** to process the report.

7. The system default is to print *All Interaction Types*.
8. The report can be printed by:
 - Specific Interaction code(s) (i.e., F for FOOD).
 - Enter the Interaction Code (A-Z).
 - The letter entered disappears.
 - Enter the next interaction code.
9. Enter meds discontinued _ days. Leave blank for current meds only.

How often should this Report be printed?

- This report should be printed as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- This report information can be printed on dietary cards in Dietary department, if so desired.

What is the Description and Usage?

- The Interactions/Indicators report is designed to flag Dietary, Nursing, and Pharmacy as to any possible adverse effects from certain foods digested while taking particular medications. This report can also be used to flag Pharmacy and Lab as to patients on particular medications that require peak/trough levels. The report can also be used to find medications administered for Adverse Drug Reactions to assist in identifying ADRs. This report can be defined to track or flag anything the department deems necessary.

Note: Orders will continue to pull to this report for 24 Hours after the order has been Discontinued.

Interactions / Indicators Report (Sample)

ROOM#	PAT. #	PATIENT NAME	ORD. #	DESCRIPTION	TITLE
START	STOP	CD	COMMENTS		

010-2	357388	SMITH ELLA KATHERINE	65	FUROSEMIDE (LASIX): 20 MG TAB 11/14/12	DIURETICS-POTASSIUM DEPLETING AVOID -Monosodium Glutamate (MSG) i.e. -Seasoned Salts, Meat Tenderizers, Frozen Vegetables, Oriental Cuisine. BECAUSE-MSG & Diuretics both act to remove excess water from body tissue. May deplete water soluble vitamins.
			65	FUROSEMIDE (LASIX): 20 MG TAB 11/14/12	DIURETIC-POTASSIUM PATIENT IS ON A DIURETIC WHICH CAUSES POTASSIUM LOSS. SUPPLEMENT DIET WITH POTASSIUM RICH FOODS SUCH AS ORANGE JUICE AND BANANAS.

010-3	321654	PETERSON MEGAN ELAIN	22	FUROSEMIDE (LASIX) PO : 40 MG TAB 05/06/09	DIURETICS-POTASSIUM DEPLETING AVOID -Monosodium Glutamate (MSG) i.e. -Seasoned Salts, Meat Tenderizers, Frozen Vegetables, Oriental Cuisine. BECAUSE-MSG & Diuretics both act to remove excess water from body tissue. May deplete water soluble vitamins.

Extended Care Estimates

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Extended Care Card Estimate**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. The system will default to printing all Patient Types. Leave blank for All Patient Type(s).
5. Enter the desired (up to 10 different) nursing station(s) or leave blank for All nursing stations.
6. Select **OK** to process the report.

How often should this Report be printed?

- Monthly prior to the long term care medication resupply.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- To estimate the resupply for long-term care medications.

Misc. Patient Drug Information

Miscellaneous Patient Drug Monographs print in a non-patient specific format.

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Miscellaneous Patient Drug Information**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Type drug name and double click the medication to select.
 - Up to six drugs can be selected.
5. Select one of three options:
 - Select the back arrow icon to exit and not print.
 - Select **Process** to begin printing.
 - Select **Print Spanish** to print monograph in Spanish.

How often should this Report be printed?

- Print monographs as often as necessary.

Who should print this Report?

- Pharmacy, Nursing and Point of Care print these monographs.

Who should get copies of this Report?

- Copies of these monographs can be distributed to anyone the hospital feels needs medication information.

What is the Description and Usage?

- Patient Drug Information Monographs are included in the Clinical Monitoring Package. The monographs are supplied by Micromedex® and are updated quarterly. Monographs can be printed for individual patients, and includes basic demographic information. All monographs provide spaces for handwritten notes. Hospital specific information, counseling checklists, notes for procedures, or outpatient surgery, etc, can be linked to any medication. The linked information prints with the monograph.

Miscellaneous Patient Drug Information (Sample)

Evident Community Hospital

Patient Drug Information

As of 12/07/15 16:21

ALBUTEROL/IPRATROPIUM (DUONEB) 3MG/3ML

Ipratropium (By breathing)

Ipratropium (ip-ra-TROE-pee-um)

Treats chronic obstructive pulmonary disease (COPD). Also prevents asthma attacks.

Brand Name(s): Atrovent HFA

There may be other brand names for this medicine.

When This Medicine Should Not Be Used:

You should not use this medicine if you have had an allergic reaction to ipratropium or to other medicines like ipratropium (such as atropine, scopolamine, or hyoscyamine). This medicine is not to be used during an asthma attack.

How to Use This Medicine:

Aerosol

- * Your doctor will tell you how much medicine to use. Do not use more than directed.
- * You will use this medicine with a device called a metered-dose inhaler. The inhaler fits on the medicine canister and turns the medicine into a fine spray that you breathe in through your mouth and to your lungs. You may be told to use a spacer, which is a tube that is placed between the

Formulary Alpha List

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Formulary Alpha List**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.

How often should this Report be printed?

- This report should be printed as often as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- The Alphabetical Formulary Listing provides a quick reference to search for medications by name. It also provides the short descriptions that some hospitals use to list the generic or brand medication name. It is more concise than a department Item Master listing.

Formulary Alpha List (Sample)

RUN DATE: 02/11/13 TIME: 12:02		Evident Community Hospital ALPHABETICAL FORMULARY LISTING		PAGE 1 H5PCFORMA	
ITEM #	LONG DESCRIPTION	SHORT DESCRIPT	ITEM #	LONG DESCRIPTION	SHORT DESCRIPT
381012	ACETAMINOPHEN	ACETAMINOPHEN	38387114	ARGATROBAN (NOVASTAN) INJ: 100MG/ML	ARGATROBAN IN
381010	ACETAMINOPHEN (TYLENOL) : 325 MG TAB *	TYLENOL325MG	38384445	ARTIFICIAL TEARS DROPS	TEAR DROPS
382012	ACETAMINOPHEN ELIXIR (TYLENOL):160MG/5ML	APAP160MG/5ML	381044	ASPIRIN (BABY) PO 81 MG	ASA 81MG TAB
386070	ACETAMINOPHEN SUPP (TYLENOL) : 120 MG	APAP120MGSUPP	387171	ASPIRIN 325 MG TAB	ASA 325 MG
386072	ACETAMINOPHEN SUPP (TYLENOL) : 650 MG	APAP650MG SUP	381045	ASPIRIN EC (ECOTRIN) : 325 MG TAB **	ECOTRIN 325MG
382018	ACETAMINOPHEN W/ COD ELIXIR :30MG/12.5ML	APAP/COD ELIX	386068	ASPIRIN SUPP : 600 MG	ASA SUPP 10GR
381604	ACETAMINOPHEN(TYLENOL) ES CAPLET: 500MG	APAP 500MG TB	381047	ATENOLOL (TENORMIN) PO : 50 MG	ATENOLOL 50MG
381014	ACETAZOLAMIDE (DIAMOX) : 250 MG	DIAMOX250MGTB	381243	ATIVAN INFUSION	ATIVAN INFUSI
65890	ACTOS	ACTOS	38381614	ATORVASTATIN(LIPITOR) TAB:10 MG	LIPITOR 10MG
381591	ACYCLOVIR (ZOVIRAX) PO : 800 MG	ZOVIRAX800MG	386111	ATRACURIUM (TRACRIUM) IV : 10MG/ML 5 ML	TRACRIUM 5ML
389052	AEROBID-M MDI	MDI TX	389512	ATROPINE : 1MG SYRINGE 10 ML	ATROP1MG5YR
1100002	AEROCHAMBER	AEROCHAMBER	387024	ATROPINE INJ : 0.4MG/ML	ATROP1MG/MLIN
389010	ALBUTEROL INH SOL .083% 3ML	ALBUTEROLSOLN	300498	AURALGAN OTIC DROPS	AURALGAN OTIC
382022	ALBUTEROL SYRUP (PROVENTIL) : 2MG/5ML	ALBUTEROL SYR	381700	AZITHROMYCIN(ZITHROMAX) INJ:500 MG VIAL	ZITHROMAX INJ
381018	ALBUTEROL (PROVENTIL)REPETABS:4MG	PROV-SR4MGTAB	38381615	AZITHROMYCIN(ZITHROMAX) TAB:250 MG	ZITHROMAX250
389013	ALBUTEROL (VENTOLIN) MDI:90MCG/SPRAY	ALBUTEROL INH	99003	BALANCE TRANSFER	BALANCE TRANS
3814503	ALBUTEROL/IPRATROPIUM (DUONEB) 3MG/3ML	ALBUTEROL/IPR	389018	BECLMETHASONE INH.(VANCERIL,BECCLOVENT)	BECLMETHINH
381288	ALFALFA TAB: 520 MG	ALFALFA TAB	384010	BENZON TINC. COMPOUND TOP SOLN	BENZON TINC.
383052	ALFENTANIL(ALFENTA) INJ:500MCG	ALFENTA INJ	381051	BENZTROPINE MES((COGENTIN) TAB :2MG	COGENT2MG TAB
381020	ALLOPURINOL (ZYLOPRIM) PO : 100 MG	ZYLOPRIM100MG	386098	BISACODYL(DULCOLAX) SUPP:10MG	BISACODYL SUP
381022	ALLOPURINOL (ZYLOPRIM) PO : 300 MG	ZYLOPRIM300MG	381055	BISACODYL(DULCOLAX) TAB:5MG	BISACODYL TAB

Formulary Therapeutic List

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Formulary Therapeutic List**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.

How often should this Report be printed?

- This report should be printed as often as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- The Therapeutic Formulary Listing serves a dual purpose. It displays the current pharmacy formulary with the correct therapeutic classification for medications. It can provide the pharmacy with much useful information. This report lists any items that do not have AHFS codes, or items with invalid AHFS code attached in the Item Master. However, it is much easier to find missing AHFS codes through a database rather than printing this report. Correcting missing or invalid AHFS codes are a beneficial byproduct of this report.

Formulary Therapeutic List (Sample)

RUN DATE: 02/11/13 TIME: 12:05	Evident Community Hospital THERAPEUTIC FORMULARY LISTING	Page: 1 H5PCFORMT
<hr/>		
00:00 NEW	NITROGLYCERINE 5MG(0.2MG/HR)PATCH	NTG5MGPATCH
<hr/>		
04:00 ANTIHISTAMINE DRUGS	CETIRIZINE(ZYRTEC) LIQ: 5MG/5ML	ZYRTEC LIQ
	CETIRIZINE(ZYRTEC) TAB: 10 MG	ZYRTEC: 10 MG
	CYPROHEPTADINE(PERIACTIN) TAB : 4 MG	PERIACTIN 4MG
	DIPHENHYDRAMINE EL 12.5MG/5ML(BENADRYL)	BENADRYL ELIX
	DIPHENHYDRAMINE (BENADRYL) CAP:50MG	DIPHEN50MGCAP
	diphenhydrAMINE (BENADRYL) INJ:50MG/ML	DIPHEN50MGINJ
	FEXOFENADINE (ALLEGRA) TAB : 180 MG	ALLEGRA: 180
	PROMETHAZINE (PHENERGAN) INJ : 50MG/ML	PHENERG 50 IJ
<hr/>		
08:00 ANTI-INFECTIVE AGENTS		
08:04 00		
08:12 ANTIBIOTICS		
08:12.02 AMINOGLYCOSIDES		
	GENTAMICIN IV : 80 MG/2ML	GENT 80MG INJ
	NEOMYCIN SULFATE TAB:500MG	NEOMY500MGTAB
	TOBRAMYCIN (NEBCIN) INJ : 80MG/2ML	TOBRA 80MGINJ

Select Items for Master List

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Select Items for Master List**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. The Inventory Selection screen will display.
5. Choose the parameters required for the Item Master list needed.
6. Select **Print**.

How often should this File be generated?

- This report should be printed as often as necessary.

Who should generate this File?

- The Pharmacy department.

What is the Description and Usage?

- This file is used to define the type of items desired for an Item Master List.

Select **Hospital Base Menu > Print Reports > Select Items for Master List**

	Low	High	Seq		Low	High	Seq
Inv GL#:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>	Rev GL1:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Desc:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>	Rev GL2:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Exp GL#:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>	Rev GL3:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Supplier:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>	Rev GL4:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Switch 1:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="0"/>	Rev GL5:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Switch 2:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="0"/>	Price 1:	<input type="text" value="+0.00"/>	<input type="text" value="+0.00"/>	<input type="text" value="0"/>
Switch 3:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="0"/>	Price 2:	<input type="text" value="+0.00"/>	<input type="text" value="+0.00"/>	<input type="text" value="0"/>
Switch 4:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="0"/>	Price 3:	<input type="text" value="+0.00"/>	<input type="text" value="+0.00"/>	<input type="text" value="0"/>
Switch 5:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="0"/>	Price 4:	<input type="text" value="+0.00"/>	<input type="text" value="+0.00"/>	<input type="text" value="0"/>
Switch 6:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="0"/>	Price 5:	<input type="text" value="+0.00"/>	<input type="text" value="+0.00"/>	<input type="text" value="0"/>
Switch 7:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="0"/>	Form-Cdt:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>
Switch 8:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="0"/>				
Switch 9:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="0"/>				
Switch 10:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text" value="0"/>				
Generic#:	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>				
Ins Sum Cdt:	<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>				
Item Cost:	<input type="text" value="+0.00"/>	<input type="text" value="+0.00"/>	<input type="text" value="0"/>				
Item Num:	<input type="text" value="0"/>	<input type="text" value="0"/>	<input type="text" value="0"/>	Dept:	<input type="text"/>		

Ready Print

Inventory Selection screen

Print Master Item List

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Print Master Item List**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Enter the desired file for the Item Master list:
 - From Selected File (Access I-Select Items for Master List prior to selecting).
 - From Description Index (Enter beginning and ending department number range).
 - From Item Number Index (Enter beginning and ending Item Numbers).
5. Use the drop down arrow to select the types of Items wanted from the following:
 - 1-Print Service Items Only.
 - 2-Print Inventory Items Only.
 - 3-Print all Item Types.

6. Select **Print** to process the report.

How often should this Report be printed?

- This report should be printed as often as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- This report is used as a reference for all available pharmacy information pertaining to the Item Master. It is also used to identify deficiencies in certain required pharmacy fields.

Master Item List (Sample)

RUN DATE: 02/11/13		Evident Community Hospital		PAGE 4	
TIME: 13:29		ITEM MASTER LIST		H5PCREP1	
381045			PT.PRICE	REV.GL	INSTRUCTION ALLERGY
ASPIRIN EC (ECOTRIN) : 325 MG TAB **	COST=	.02	.40	30000038	
ECOTRIN 325MG EA =TAB	AWP=	0.00	.00	30100038	I/I=
P NDC=62107002801	CPT=		.00	00000000	I/I=
28080400 Y SER=N PTCHRG=Y	ISC=78		.00	00000000	I/I=
REORD DAYS= EXP DAYS= CC=Y IV=2	GENERIC#=		.00	00000000	
381047			PT.PRICE	REV.GL	INSTRUCTION ALLERGY
ATENOLOL (TENORMIN) PO : 50 MG	COST=	.21	1.10	30000038	
ATENOLOL 50MG EA =TAB	AWP=	0.00	.00	30100038	I/I=
P NDC=54868070100	CPT=		.00	00000000	I/I=
24040000 Y SER=N PTCHRG=Y	ISC=78		.00	00000000	I/I=
REORD DAYS= EXP DAYS= CC=Y IV=2	GENERIC#=		.00	00000000	
381049			PT.PRICE	REV.GL	INSTRUCTION ALLERGY
ETOPOSIDE 20MG/1ML INJ (CHEMO)	COST=	.35	1.70	30000038	
EA =TAB	AWP=	0.00	.00	30100038	I/I=
N3 NDC=55390029301	CPT=		.00	00000000	I/I=
28080400 Y SER=N PTCHRG=Y	ISC=78		.00	00000000	I/I=
REORD DAYS= EXP DAYS= CC=Y IV=	GENERIC#=		.00	00000000	
381051			PT.PRICE	REV.GL	INSTRUCTION ALLERGY
BENZTROPINE MES((COGENTIN) TAB :2MG	COST=	.05	2.00	30000038	
COGENT2MG TAB EA =TAB	AWP=	0.00	.00	30100038	I/I=
P NDC=00832108200	CPT=		.00	00000000	I/I=
12080400 Y SER=N PTCHRG=Y	ISC=78		.00	00000000	I/I=
REORD DAYS= EXP DAYS= CC=Y IV=2	GENERIC#=		.00	00000000	

Intervention / ADRs

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Intervention/ADRs**.

3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Select **Intervention/ADR Statistics** or **Intervention/ADR Detail**.
5. Select the drop down arrow to display a calendar from which a start date can be selected.
6. Select the drop down arrow to display a calendar from which an end date can be selected.
7. Select **Print** to process report.

How often should this Report be printed?

- This report should be printed as often as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- This report is used to track Interventions and/or Adverse Drug Reactions entered into the system during a specified time period. This report can be detailed or statistical in format.

Interventions / ADRs Detail (Sample)

RUN DATE 07/22/16	Evident Community Hospital	PAGE 2	
RUN TIME 11:34	6600 WALL ST MOBILE, AL 3669		PCADPRINTP
	DETAIL INTERVENTIONS & ADRS REPORT		
	From 01/01/16 To 07/22/16		
ADVERSE DRUG REACTIONS			
PATIENT NUMBER	PATIENT NAME	ROOM DATE	DESCRIPTION
357667	MADISON FIN	034-2 031416	AMITRIPTYLINE(ELAVIL) TAB: 25 MG
		PHYSICIAN	ADR OUTCOME
		BAXTER J	

Interventions / ADRs Statistics (Sample)

RUN DATE 07/22/16	Evident Community Hospital	PAGE 3
RUN TIME 11:30	6600 WALL ST MOBILE, AL 3669	PCADRINTP
	ADVERSE DRUG REACTION STATISTICS	
	From 01/01/16 To 07/22/16	
<u>ADR MEDICATION</u>	<u>QUANTITY</u>	
AMITRIPTYLINE (ELAVIL) TAB: 25 MG	1	
TOTAL	1	
<u>OUTCOME ATTRIBUTED TO ADR</u>	<u>QUANTITY</u>	
1. Death		
2. Life-threatening		
3. Hospitalization		
4. Congenital		
5. Disability		
6. Intervention Req	1	
7. Other		
<u>PHARMACIST</u>	<u>QUANTITY</u>	
FT	1	
<u>PHYSICIAN</u>	<u>QUANTITY</u>	
010000	1	

Pharmacy Statistics Report

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Pharmacy Statistics Report**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Select the drop down arrow to display a calendar from which a start date can be selected.
5. Select the drop down arrow to display a calendar from which an end date can be selected.
6. Select **Print** to process report.

How often should this Report be printed?

- This report should be printed as often as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- Use this report to track pharmacy productivity parameters for a specified time period. This report will also break down orders entered per individual pharmacist and technicians and further divide those orders into IV vs. Non-IV.

Pharmacy Statistics Report (Sample)

INSURANCE		LINE			UNIT			REVENUE		
SUMMARY	TYPE	CHARGES	CREDITS	NET	CHARGES	CREDITS	NET	CHARGES	CREDITS	NET
PHARMACY		112	1	111	609	20	589	9,540.80	40.00	9,500.80
DRUGS/OTHER		0	0	0	0	0	0	.00	.00	.00
CENTRAL SUPPLY STERILE		0	0	0	0	0	0	.00	.00	.00
IV SOLUTIONS		42	0	42	114	0	114	1,633.00	.00	1,633.00
IV THERAPY		6	0	6	15	0	15	40.00	.00	40.00
TOTAL:		160	1	159	738	20	718	11,213.80	40.00	11,173.80

INTERVENTION TYPE	QUANTITY	TIME
1. TRANSCRIBING ERROR		
2. PRESCRIBING ERROR	1	
3. ILLEGIBLE WRITING		
4. NONFORMULARY REQUEST		
5. DUPLICATE THERAPY		
6. C & S STREAMLINING		
7. RENAL DOSE ADJUSTMEN		
8. PT EDUCATION		
9. DRUG INFORMATION		
10. DUE- CEPHALOSPORINS		
11. DUE- QUINOLONES		
12. DRUG INTERACTIONS		
13. ALLERGY		

RUN DATE: 12/07/15
TIME: 16:07

Evident Community Hospital
PHARMACY STATISTICS REPORT FOR 11/01/15 THRU 12/07/15

PAGE 4
PCSTATP

IV THERAPY

IV TYPE	LINE			UNIT		
	CHARGES	CREDITS	NET	CHARGES	CREDITS	NET
Non-compounded LVP	0	0	0	0	0	0
Compounded LVP	0	0	0	0	0	0
IVPB	3	0	3	8	0	8
TEN	0	0	0	0	0	0
Chemotherapy	0	0	0	0	0	0

RUN DATE: 12/07/15
TIME: 16:07

Evident Community Hospital
PHARMACY STATISTICS REPORT FOR 11/01/15 THRU 12/07/15

PAGE 5
PCSTATP

RPh		Permanent Orders		Total
		IV Orders	Non-IV Orders	
DCJ	Entered	0	3	3
	OK'd	0	0	0
Total		0	3	3
PT	Entered	5	9	14
	OK'd	0	3	3
Total		5	12	17
Grand	Entered	5	12	17
	OK'd	0	3	3
Total		5	15	20

Creatinine Clearance Status Report

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Creatinine Clearance Status Report**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Select **Print** to process report.
5. The report prints to the printer specified in the CrCl printer set up in Page 1 of the Pharmacy Control Table if it is set up to run automatically every day.

How often should this Report be printed?

- This report should be printed as often as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- The Creatinine Clearance Status Report prints the estimated Creatinine Clearance, if available, or prints N/A if unavailable. As the report builds, it searches for more recent Serum Creatinine values and re-calculates Creatinine Clearance. Recalculation is performed even if no new serum creatinine values are found, because height and weight can change as well. The report sorts by patient name.

Creatinine Clearance Report (Sample)

Run Date: 12/07/15 Time: 15:59		Evident Community Hospital Creatinine Clearance Status Report For Nursing Station 003				NS = 003	Page 1	P00000P
Pat. #	Patient Name	Room	Adm. Date	Age	Weight LB /KG	Height IN /CM	Serum Date	Creatinine Date Clearance
357023	GARLAND REBECCA	010-1	05/13/03	46	175/ 79	55.00/139		* NA *
357388	SMITH ELLA KATHERINE	010-2	06/08/11	72	175/ 79	66.00/167	1.00 10/23/14	47.20
321654	PETERSON MEGAN ELAIN	010-3	10/26/07	38	150/ 68	65.00/165	1.20 11/01/07	56.69
357365	MAJURE TREY RALPH	010-4	01/14/11	30	245/111	75.00/190	6.00 07/30/15	21.51
357307	DURDEN KELLY	010-5	08/02/10	96	125/ 56	60.00/152		* NA *
355274	BONINE BEVERLY	012-1	07/12/01	76	123/ 55	66.00/167	1.20 03/29/05	35.12
356012	ROBERTS ESTELLE	012-2	07/12/01	43	154/ 69	65.00/165		* NA *
963963	ODOM CONNIE	014-1	03/12/01	2	45/ 20	65.00/165	2.10 01/20/97	* NA *
356787	CHAMBLISS STEPHEN	014-2	07/06/01	58	120/ 54	52.00/132	1.80 03/14/06	31.63
356504	WALSH KIERNAN	016-1	07/09/01	30	52/ 23	7.00/ 17		* NA *
358694	SMITH GUS B	016-2	12/10/14	40	185/ 83	72.00/182	1.00 09/30/14	107.77
357444	CORBITT JANICE	018-1	01/12/12	60	150/ 68	65.00/165		* NA *
358422	JONES RICHARD R	018-2	11/11/14	46	205/ 92	73.00/185		* NA *
123465	PHYS DOC ACCOUNT	020-1	05/07/13	4	125/ 56	71.00/180		* NA *
357896	WALSH KIERNAN	020-2	03/03/14	30	189/ 85	72.00/182		* NA *
356626	SCAVULO CLAIRE X	300-8	06/19/12	54	132/ 59	62.00/157	1.30 11/03/02	38.73
357823	AINSWORTH MARTHA COZEN	300-9	04/24/15	80	120/ 54	60.00/152	.80 11/17/15	39.84
357801	SMITH BETTY	301-1	12/30/13	43				* NA *
357802	WALKER JEFFREY	301-2	12/30/13	65				* NA *
357803	LEWIS DAVID	301-3	12/30/13	38				* NA *
357804	PARKER JENNIFER	301-4	12/30/13	36				* NA *
357805	OWENS JOSEPH	301-5	12/30/13	47				* NA *
357806	CORDERO LAUREN	301-6	12/30/13	32				* NA *
357807	HUTCH MATTHEW	301-7	12/30/13	22				* NA *
357808	CARLISLE SAMANTHA	301-8	12/30/13	28				* NA *

Report Image System

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Report Image System**.
3. Select or enter any desired **Delimiters** (Status, Date, Form Code, etc.).
4. Select Application Code **PH**.
5. Select **Begin Display**.
6. Locate your desired report in the list and select.
7. You now have the option to Print, View, or Delete the report, etc.

How often should this be used?

- This option should be used as often as necessary.

Who should use this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- Any Daily or Miscellaneous Pharmacy report that were set to **Spool to File** will be accessed here.

Description	Date Time	CS/Logname	App Code	Form Code	Report ID	Location	Status	Memo
Patients with deactivated alle	09/14/2025 04:44	001	PH	1W		Live	C	/usr3/f
PHARMACY ACTIVE ORDER LIST	10/17/2025 10:32	stc1737	PH	PH	Y2	Live	C	
PHARMACY END OF DAY REPORT	09/13/2018 06:32	stc1737	PH	PC	YP	Live	C	

Charge Reconciliation Report

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Charge Reconciliation Report**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.

4. Select the drop down arrow to display a calendar from which a start date can be selected.
5. Select the drop down arrow to display a calendar from which an end date can be selected.
6. Select **Print** to process the report.

How often should this Report be printed?

- This report should be printed as often as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- The Charge Reconciliation Report displays a list of all orders that have charges posted for the selected date/time range along with the resupply quantity for the order. Charges are posted via Point of Care when the Charge at Administration feature is being utilized.

Charge Reconciliation Report (Sample)

Room	Patient	Order	Item/IV Components	Chg Date	Time	Init	Ns Adm	Dose	Freq	Resupply	Chg Qty
Run Date: 12/07/15 Evident Community Hospital Page 1 Time: 15:54 Pharmacy Medication Charge Reconciliation Report POCRR NS 003 NS Medical-Surgical From 12/01/15 00:01 to 12/07/15 15:54											
300-9	357823	AINSWORTH MARTHA COZEN									
5	00383062 HYDROMORPHONE (DILAUDID) INJ: 2MG/ML		12/03/15		08:45	FT			PRN Q6H		1
Total:											1
8	00381999 DOCUSATE (COLACE) CAP:100 MG		12/03/15		08:45	FT			PRN		2
Total:											1
9	00381719 Insulin REG (Humulin R) 100U/ML		12/03/15		08:45	FT			PRN		1
											99
Total:											100
10	00381179 FUROSEMIDE (LASIX): 20 MG TAB		12/07/15		14:37	FT	Y	20MG	DAILY		1
Total:											1

Pharmacy Dispensing Notes

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Pharmacy Dispensing Notes**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.

How often should this Report be printed?

- This report should be printed as often as necessary.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- The Pharmacy Dispensing Notes report list all dispensing notes currently entered in the system. Included in the report is the drug item number and description along with the dispensing note.

Pharmacy Dispensing Notes Report (Sample)

Run Date: 12/07/15 Evident Community Hospital Page 1
Time: 11:04 Pharmacy Dispensing Notes PCNPP

DRUG: 301390 DIPHTHERIA/TETANUS TOXOID(ADULT):INJ
STORE IN REFRIGERATOR

DRUG: 301648 EPINEPHRINE INJ : 1MG/ML*
POTENTIAL ADR
Document in clinical intervention as ADR Investigation #27.

If an ADR has occurred; fill out MedWatch form.

DRUG: 301993 ROCEPHIN 1 GM /D5W 50ML
After blood cultures

DRUG: 381010 ACETAMINOPHEN (TYLENOL) 325 MG TABLET

DRUG: 381093 CIPROFLOXACIN (CIPRO) TAB: 500 MG

DRUG: 381246 LORAZEPAM (ATIVAN) INJ :2MG/ML 10ML VIAL
STORED IN REFRIGERATOR

DRUG: 381483 WARFARIN (COUMADIN) 2.5 MG TAB
***ALTERNATE ITEM: 381485 WARFARIN (COUMADIN) 5 MG TAB
PRODUCT SHORTAGE PROBLEM. IF NOT AVAILABLE USE 5 MG WARFARIN.

DRUG: 381485 WARFARIN (COUMADIN) 5 MG TAB
***ALTERNATE ITEM: 381714 ENOXAPARIN(LOVENOX) INJ: 60 MG
PREGNANCY WARNING: PER MEDICAL STAFF PROTOCOL CHANGE TO ENOXAPARIN. CALL VERBAL
ORDER TO FLOOR

PHARMACIST INTERVENTION REQUIRED:

- 1) INR ORDERED OR AVAILABLE
 - *IF HOME MED AT LEAST ONE CHECK
 - *IF HOME MED AND MEDICATIONS ARE ADDED THEN ROUTINE INR IS INDICATED
 - *IF NEW DRUG THE PHYSICIAN IS FOLLOWING PROGRESS OF ANTICOAGULATION

Pharmacy Override Info

The Pharmacy Override Info report lists override reasons entered by nursing and/or physicians during order entry for the selected date range.

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Pharmacy Override Info**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Select to print Nursing and/or Physician overrides.
5. Select the drop down arrow to display a calendar from which a start date can be selected.
6. Select the drop down arrow to display a calendar from which an end date can be selected.

7. Select **Print** to process the report.

Pharmacy Override Reasons Report (Sample)

PATIENT NAME CM CHECK MEDICATION	NUMBER	OE INIT.	VER INIT.	OVERRIDES
*****NURSING OVERRIDES*****				
CUNNINGHAM CAROLINE LO	B01129	DCJ	DCJ	
MISCELLANEOUS CHECKS Discontinued NDC number				N ot True Allergy
CUNNINGHAM CAROLINE LO	B01138	DCJ	DCJ	
MISCELLANEOUS CHECKS Missing NDC number				M onitoring pt
CUNNINGHAM CAROLINE LO	B01140	DCJ	DCJ	
MISCELLANEOUS CHECKS Discontinued NDC number				D uplicate Tx Req
GENERAL PRECAUTIONS CL INFLUENZA 0.5ML (5ML: Moderate)				D uplicate Tx Req
SUBTOTAL:	3			
SMITH ELLA KATHERINE	B01110	DCJ	DCJ	
GENERAL PRECAUTIONS CL PHENERGAN 25MG/1ML C: Moderate				N ot True Allergy
MISCELLANEOUS CHECKS Discontinued NDC number				N ot True Allergy
GENERAL PRECAUTIONS CL PNEUMONIA(PNEUMOVAX: Major)				N on-Spec Rxn
MISCELLANEOUS CHECKS				

Invalid NDC Report

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. Select **Invalid NDC Report**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Enter department number or leave blank for All departments.
5. Select **Print** to process report.

How often should this Report be printed?

- This report should be printed as often as necessary. This report will automatically print each time the Clinical Monitoring tape is loaded.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- The Invalid NDC report lists all items from the Pharmacy item master that have missing or invalid NDC numbers. The report also includes discontinued items. Included in the report is the drug item number and description along with the current NDC#, if available, and the status of the item.

Invalid NDC Report (Sample)

ITEM#	DESCRIPTION	NDC#	STATUS
	-----ANCILLARY DEPARTMENTS-----		
389999	ACETAMINOPHEN (TYLENOL) 500MG TABLET	50580071051	Discontinued
381604	ACETAMINOPHEN SUPP (TYLENOL) : 120 MG	00182166211	Discontinued
386070	ACETAMINOPHEN SUPP (TYLENOL) : 650 MG	00536126012	Discontinued
382018	ACETAMINOPHEN W/ COD ELIXIR :30MG/12.5ML	00045051360	Discontinued
381012	ACETAMINOPHEN W/COD(TYLENOL #3) 30/300MG		
3814529	ACETAMINOPHEN/CODEINE 300MG/30MG TAB	54868036401	Discontinued
65890	ACTOS		
389052	AEROBID-M MDI	00456067299	Discontinued
1100002	AEROCHAMBER	00456067299	Discontinued
383052	ALFENTANIL (ALFENTA) INJ:500MCG	11098006002	Discontinued
382139	ALUMINUM/MAGNESIUM HYDROX SUSP(MAALOX)	00067033644	Discontinued
381033	AMITRIPTYLINE (ELAVIL) TAB: 25 MG	60429001690	Discontinued
1	AMOX/CLAVULAN (AUGMENTIN) SUSP: 250MG/5ML		
382037	AMOX/CLAVULAN (AUGMENTIN) SUSP: 250MG/5ML	00029609023	Discontinued
381531	AMOX/CLAVULANATE (AUGMENTIN) TAB:500MG	00029608012	Discontinued
301481	AMOXICILLIN SUSP:250MG/5ML (POLYMOX)	55045120003	Discontinued
38381034	AMOXICILLIN (AMOXIL) TAB: 875 MG	65862001505	Discontinued
387021	AMPICILLIN ADDV : 2 GM	00015740520	Discontinued
387017	AMPICILLIN ADDV : 500 MG	00015740320	Discontinued
387018	AMPICILLIN INJ : 1 GM	00015740418	Discontinued
386111	ATRACURIUM (TRACRIUM) IV : 10MG/ML 5 ML	10019000205	Discontinued
389512	ATROPINE : 1MG SYRINGE 10 ML	00548203900	Discontinued
99003	BALANCE TRANSFER		
389018	BECLMETHASONE INH. (VANCERIL,BECLOVENT)	58016620701	Discontinued
387038	BUPIVACAINE INJ (MDV) 0.5%	00186103501	Discontinued
387032	BUPIVACAINE-MPF INJ:0.25%	00186103012	Discontinued
381994	BUTORPHANOL (STADOL) 2 MG INJ	00015564620	Discontinued
300798	CALCIUM CHL 10% 10ML	00074490818	Discontinued
381063	CAPTOPRIL (CAPOTEN) TAB : 12.5 MG	60505000306	Discontinued
382234	CEFADROXIL (DURICEF) SUSP:250MG/5ML	55045351901	Discontinued
387045	CEFAZOLIN (KEFZOL,ANCEF) INJ : 1 GM	00069031220	Discontinued
387810	CEFOTETAN (CEFOTAN): 2GM/50ML	63323034220	Discontinued
3866691	CEFOTETAN INJ 1GM	54868384700	Discontinued
301150	CEPACOL LOZENGES	11509020818	Discontinued

AWP Update from Micromedex

The AWP Update from Micromedex provides the ability to update an item's AWP based on a matching NDC number in Micromedex. Call a TruBridge Pharmacy Representative before generating this report.

The two available options are:

- **Edit Run:** Provides a report that allows the user to view the changes that will be made to the item's AWP but will not execute these changes unless the Update Run is generated
- **Update Run:** Updates the item's AWP and provides a report that displays the prior AWP and new AWP.

NOTE: *This update does NOT consider the Purchase Unit Conversion field. The AWP from Micromedex updates based on the Micromedex unit and may not match the purchase unit from the facilities' vendor.*

1. From the Pharmacy Hospital Base Menu, select **Print Reports**.
2. Select **AWP Update from Micromedex**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Select **Edit Run** or **Update Run**
5. Select **Print** to process report.

AWP Update from Micromedex (Sample)

Item #	NDC #	Item Description	Prior AWP	New AWP
00381020	65483-0991-10	ALLOPURINOL (ZYLOPRIM) PO : 100 MG	.0000	1.8574
00381022	65483-0993-10	ALLOPURINOL (ZYLOPRIM) PO : 300 MG	.0000	5.0873
00381024	00009-0029-01	ALPRAZolan (XANAX) 0.25 mG	.0000	3.2702
00381026	00378-5023-91	XANAX (ALPRAZOLAM) 2 MG TABLET	.0000	3.5483
00381032	55289-0730-01	AMITRIPTYLINE (ELAVIL) : 25 MG	.3635	1.6862
00381034	00781-2613-01	AMOXICILLIN CAP : 500MG	.0000	.4341
00381035	00093-2275-34	AMOXICILLIN/CLAV(AUGMENTIN) TAB:875MG	.0000	5.0515
00381044	24385-0535-76	ASPIRIN (CHILDREN LOW STRENGTH) PO 81 MG	.0000	.0344
00381045	62107-0028-01	ASPIRIN EC (ECOTRIN) : 325 MG TAB **	.0000	.0290
00381047	62584-0467-01	ATENOLOL (TENORMIN) 50 MG TAB	.0000	1.1302
00381051	00832-1082-00	BENZTROPINE MES ((COGENTIN) TAB :2MG	.0000	.5189
00381061	00766-7390-70	CALCIUM CARBONATE(TUMS) TAB:750MG	.0000	.0495
00381065	54868-3724-03	CAPTOPRIL(CAPOTEN) TAB : 25 MG	.6166	.0954
00381067	54868-0147-04	CARBAMAZEPINE (TEGRETOL) TAB: 200MG	.0000	.3530
00381071	54868-3742-01	CEFADROXIL (DURICEF) CAP : 500 MG	20200.0152	2.2425
00381084	54569-4700-00	CLOPIDOGREL(PLAVIX) 75 MG TABLET	.0000	7.7333
00381095	00009-0395-14	CLINDAMYCIN (CLIROCIN)CAP:150MG	20200.0152	15.2789
00381097	00597-0006-01	CLONIDINE (CATAPRES) : 0.1 MG TAB	.4577	2.6855
00381099	00597-0007-01	CLONIDINE (CATAPRES) : 0.2 MG TAB	.0000	4.1086
00381100	00093-0833-01	CLONAZEPAM (KLONOPIN)TAB:1MG	.0000	.8550
00381108	00054-4184-25	DEXAMETHASONE (DECADRON) TAB :4 MG	1.6770	.6425
00381110	00140-0004-01	DIAZEPAM (VALIUM)TAB: 2MG	.0000	3.8858
00381112	00140-0005-01	DIAZEPAM (VALIUM)TAB:5MG	.0000	6.0436
00381118	57664-0437-88	DIGOXIN (LANOXIN) 0.125MG TAB	.0000	1.4220

AWP Update Changes Report

Listed below is an explanation of each field.

- **Item #:** Displays the item number

- **NDC #:** Displays the NDC number
- **Item Description:** Displays the description of the item
- **Prior AWP:** Displays the AWP of the item prior to the update
- **New AWP:** Displays the new AWP

Acetaminophen Max Dose Report

The Acetaminophen Max Dose Report is a document that includes a list of patients that have received more than the 24-HR maximum dose of acetaminophen as defined in the Pharmacy Control Table. The report may be generated by specific date range and/or by a single patient or all patients.

1. From the Pharmacy Hospital Base Menu, select **Print Reports**.
2. Select **Acetaminophen Max Dose Report**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. **All** defaults as the selection for all patients or enter a specific patient account number.
5. Enter **Date** Range or select **All** for all dates of stay if a specific patient was selected
6. Select **Print** to process report.

Acetaminophen Max Dose Report (Sample)

```

DATE: 06/16/16                Acetaminophen Max Dose Report                PAGE #1
                               24 Hour Max Dose = 3000 MG
TIME: 07:44                    01/01/16 THRU 06/16/16                XNSACETRPT
=====
PATIENT NAME                    NUMBER
DATE      TIME    INIT  ORD#  MEDICATION                    OVERRIDE
-----
PACIENT TOTAL
=====
BOWDEN CAUSEY ANNE              357881
02/08/16 13:52  FT    4    ACETAMINOPHEN (TYLENOL) 500MG
02/08/16 13:53  FT    4    ACETAMINOPHEN (TYLENOL) 500MG
02/08/16 13:58  FT    4    ACETAMINOPHEN (TYLENOL) 500MG  limit is 4000
24 Hour Total: 3000 MG
-----
ALLISON MARY D                  357696
03/10/16 12:48  KBW   10   ACETAMINOPHEN (TYLENOL) 500MG  MD ORDER
24 Hour Total: 4000 MG
-----

```

Acetaminophen Max Dose Report

Listed below is an explanation of each field.

- **Date/Time:** Displays the Date and Time the report was generated
- **24 Hour Max Dose:** Displays the maximum dose of acetaminophen to be given in a 24-hour period as defined in the Pharmacy Control Information Table.
- **Date:** Displays the date range for which the report was generated
- **Patient Name:** Displays the patient name
- **Number:** Displays the patient account number
- **Date/Time:** Displays the Date and Time the Max Dose warning was received.
- **Initials:** Displays the initials of employee signed on when the Max Dose warning was received
- **Ord#:** Displays the pharmacy order number
- **Medication:** displays the description of the medication that was administered
- **Override** displays the override reason given when the Max Dose warning was received

Allergy History Report

The Allergy History Report is an audit report for allergy information. The report may be generated for one patient or for all patients in a date range.

1. From the Pharmacy Hospital Base Menu, select **Print Reports**.
2. Select **Allergy History Report**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. **All** defaults as the selection for all patients or enter a specific patient account number.
5. Enter **Date** Range or select **All** for all dates of stay if a specific patient was selected.
6. Select **Print** to process report.

Allergy History Report (Sample)

SSN/Pat#	Date	Time	Employee Name	Allergy History Report		Page #
				Init	Action	
100000544	02/16/2023	11:10:47	SHALANDA CARR	SC	No Known Drug Allergies allergy added.	1
100000587	02/16/2023	10:34:10	JENNIFER JENKINS	JJ	No Known Drug Allergies allergy added.	
357280	02/16/2023	11:10:49	SHALANDA CARR	SC	All allergy information verified.	

Allergy History Report

Listed below is an explanation of each field.

- **SSN/Pat#:** Lists the patient's Social Security or Profile number.
- **Date and Time:** Displays the Date and Time of the allergy information changes.
- **Employee Name and Init:** Displays the name and initials of the employee that modified the information.
- **Action:** Displays the action taken.

14.3 Pharmacy Controlled Substance Reports

Overview

This section will cover printing the Controlled Substance Inventory and Status reports, the Electronic Controlled Substance Report and the LTC Prescription Report.

Controlled Substance Status Report

1. The Control Substances Status Report does not require a work file.
2. Hospital Base menu, select **Print Report menu**.
3. Select **Status Report**.
4. Select a printer number, **S-Spool**, or **W-Workstation**.

How often should this Report be printed?

- This report should be printed daily.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- This report gives an accounting of all outstanding controlled substance sign out sheets in the hospital. Each sheet is listed in order by control number. This information includes:
 - Control number
 - Department issued to
 - Drug item number
 - Drug description
 - Drug unit
 - Date issued
 - Time issued
 - Issuer
 - Requisition number
 - Number issued

Each entry also includes a detailed breakdown of usage including date used, patient number, patient name, and quantity used. The ending balance and date are also included. If an item has a zero balance, then the balance is listed as "COMPLETE."

The hospital must be installed on the Controlled Substance Program to utilize this report.

Controlled Substance System

Controlled Substances are tracked using the inventory portion of TruBridge EHR. The perpetual inventory system tracks:

1. Charges
2. Purchases
3. Adjustments

Narcotics are tracked as totals within:

1. Specified hospital departments
2. Nursing stations

Narcotics are transferred to the floor and charged through batch charging.

The system satisfies state requirements for narcotic record keeping. Physical counts are still used to reconcile the computer inventory. A TruBridge Pharmacy Support Representative should be consulted before implementing the narcotic inventory system.

The Controlled Substance program:

1. Assigns an individual control number to the narcotic as it is dispensed to the floor.
2. Provides a more accurate and detailed method for tracking narcotic inventory.
3. Requires that the hospital have a system of dispensing narcotics with a control number, such as shingle sheet form.
4. Works with the inventory system to keep a perpetual inventory in each nursing station.
5. Tracks controlled substances for each floor by narcotic control number.
6. Subtracts each narcotic charged from that control number.

When all charges are received for a narcotic control number, the following procedures should be followed:

1. System prints a completed narcotic sheet with all the charges against that number and the dates the charges were entered.
2. Original narcotic form can be filed numerically by control number.
3. Computer sheet can be filed by either:
 - Medication name
 - Nursing station

The narcotic system works by:

1. Using a control number to keep track of each issued narcotic.
 - Pharmacist or technician assigns a control number to the narcotic when it is transferred to the floor.
 - The control number should be the same as the number on the actual narcotic sign-out form.
 - The control number is already stamped on each shingle sheet (charge form) on the narcotic sign-out form.
2. Charges are entered using this control number when shingle sheets are returned to pharmacy.
 - System subtracts one unit from the amount signed out on that control number.

DEA Class Setup

The first step for implementing the narcotic program is to assign the DEA classification to a drug:

1. From the Hospital Base menu, select **Charge Tables / Inventory**.
2. Select **Item or Service Search**.
3. Select option **Description** or **Item Number**.
4. Choose appropriate drug.
5. Select **Pharmacy Information**.
6. Select **DEA Class**.
7. Enter DEA Class, <2>, <3>, <4>, or <5>.
 - DEA Class affects items differently during:
 - Transferring.
 - Charging.
 - Reporting.
8. Only items with a DEA Class are prompted for a control number during transfer.
 - The control number captures charges during charge entry.

Issuing Departments

Issuing departments are assigned to items in the following manner:

1. From the Hospital Base menu, select **Charge Tables / Inventory**.
2. Select **Item or Service Search**
3. Select option **Description** or **Item Number**.
4. Choose appropriate drug by sequence number.
5. Select **Item Master**.

6. Select **Issuing Department** and press <Enter>. Enter an issuing department in the next available space.
 - Departments that stock and dispense controlled substances must be listed as an issuing department.
 - If an issuing department is unlisted, a narcotic cannot be transferred to that station, floor, or department.

Cut-off Time

1. Establish a cut-off time for converting to the Controlled Substance system.
2. Charge all narcotics through the cut-off time and set all floor narcotic balances to zero (0).
 - Set the floor balances to zero (0) by transferring the stock back to pharmacy if the pharmacy is already on the inventory system.
3. Consult a TruBridge Pharmacy Support Representative before implementing the Controlled Substance system.

Counting And Transferring

1. Count all signed out narcotics for each station.
2. Make a list of each of the following:
 - Control numbers
 - Station numbers
 - Narcotic counts
3. Transfer narcotics in the computer from pharmacy to the floors.
4. All charges after the cut-off time are entered using the narcotic control number.

Setting The Balances

1. After transfers are finished, count and set the narcotic inventory in the pharmacy department.
2. Print a Control Substance Status report.
3. The Control Substance Status report is checked against the manual list of floor narcotic counts.
4. The Materials Management Inventory Status report is checked against the pharmacy narcotic inventory count.
5. Check the Materials Management Inventory Status report against the Control Substance Status report to make sure the floor inventory counts are the same on both reports.

Entering Charges

1. Enter charges for control drugs with the control number from the charge ticket or shingle sheet.

2. Charges must have the correct department number and control number.
 - If incorrect or missing, the system does not recognize or make the correct charge entry to the Control Status report.
3. Make sure to batch charge and compare to hash totals.

Printing The Reports

Print the Control Substance Status report daily.

1. From the Hospital Base menu, select **Print Report menu**.
2. Select **Status Report**.
3. The Controlled Substance Status report lists:
 - All signed out narcotics.
 - Current balances for each control sheet.
 - Charges against each control number.

Print the Inventory Print and Delete report daily, as well.

1. From the Hospital Base menu, select **Print Report menu**.
2. Select **Inventory Print and Delete**.
3. The Inventory Print and Delete report:
 - Clears out the control numbers that have been completed.
 - Prints a separate page for each completed control number.
4. Charges against the completed control number.
5. Compare printout to the actual narcotic form when it is returned from the floor.
6. Staple the printout to the narcotic form and keep on file as a permanent record.

Correcting Errors

A transfer can be reversed if a control number is used:

1. In error.
2. For the incorrect drug.
3. For the incorrect nursing station.

The system does not allow you to re-enter that control number until the following reports are reprinted:

1. The Controlled Substance Status Report.

2. Inventory Print and Delete Report.

To correct errors:

1. Perform the transfer again using a new control sheet and number.
2. After the Controlled Substance reports are printed the next day, the control number is cleared out and can be used again.

If charges are entered on the control number before the error is caught:

1. Transfer the balance of narcotics back to Pharmacy.
2. Re-issue using a new sheet and new number.
3. The old sheet number cannot be used until the reports are completed the next day.

Issuing Narcotics

1. From the Hospital Base menu, select **Charge Tables / Inventory**.
2. Enter **Item Transfer Requisitions**.
3. Press <Enter> at department from. Defaults to pharmacy department.
4. System automatically pulls in the next control number in sequence.
 - Listed above the pharmacy department on this screen.
5. Enter the department number that is being issued the controlled substance.
6. Current date displays.
 - If the date is incorrect, overtype with the correct date or select the dropdown arrow next to the date field and a calendar will appear allowing the correct date to be selected.
7. Enter the name or initials of the person requesting the controlled substance.
8. If the name does not completely fill the line, press <Enter> to advance to the next line.
9. Select Add New Items.
10. Enter the item number or beginning description.
 - A menu of items appears on the screen.
11. Select the desired item by clicking one time on the item.
12. If the desired item does not display:
 - Select More to advance to the next page of items.
 - Scroll up to return to previous page.
 - If an item is still not found, enter another item description to begin a new search.
13. After item selection, the system prompts: Enter a Narcotic Control #.

- Enter the number from the shingle sheet.
14. The cursor moves to the UN (units) field. Cost per primary unit appears in the primary column to the right of the units field. Press <Enter>.
 15. Enter the amount to transfer in the quantity field.
 16. If an item has a negative balance, the following message appears: WARNING—STOCK OUT – ITEM BALANCE (-NUMBER) STILL WISH TO TRANSFER IT? YES or NO.
 - Select NO and cursor returns to the previous line for new item selection.
 - Select YES and the quantity entered moves into the primary column and the extend column reflects the total cost of the quantity transferred.
 - An item should not be transferred if it has a negative balance. An adjustment to the item balance is necessary.
 17. Repeat for the next controlled substance to be issued to the same department.
 18. If all information is correct, select **Update**.
 19. Select the back arrow in the top left before updating to cancel the transaction.
 20. If any information is incorrect, select the field to correct.
 21. When the transaction is confirmed, the system asks “Print form”. Press <Enter> to answer Yes or select No to not print the form.
 22. After selecting Yes, enter R for requisition or N for Narcotic.
 23. After entering initials, a label prints. Place this label on the box or package of the controlled substance.

Select Hospital Base Menu > Charge Tables Inventory > Item Transfer Requisitions

Item	Description	Catalog #
03503610	CODEINE (PROMETHAZINE) SR : 10-6.2	1185370
07600662	CODEINE (PROMETHAZINE) SR : 10-6.2	3332962
00321654	CODEINE (TYLENOL) ELIX :	1131044
03504098	CODEINE (TYLENOL) TB : 60-300	1379700
07600862	CODEINE TB : 15MG	1285451
07602018	CODEINE TB : 30MG	333815
56791198	CODEINE TB : 30MG	1168822
03502506	CODIMAL 10 SR	1466853
03502504	CODITUSS 10 SR	2715274
56707727	COGNEX (TACRINE) CAPS:30MG	1985548
71722931	COLACE (DOCUSATE SOD)	
56707132	COLACE 100MG CP	3508686

Item Transfer Requisition screen

Reversing an Issue - Returning Narcotics to the Pharmacy

When a narcotic is returned to pharmacy or entered incorrectly, the transfer needs to be reversed. Use the following procedure for returning narcotics to pharmacy:

1. From the Hospital Base menu, select **Charge Tables / Inventory**.
2. Select **Item Transfer Requisitions**.
3. Press <Enter> at department from. Defaults to pharmacy department.
4. System automatically pulls in the next control number in sequence.
 - Listed above the pharmacy department on this screen.
5. Enter the department number that is being issued the controlled substance.
6. Current date displays.
 - If the date is correct, press <Enter>.
 - If the date is incorrect, overtype with the correct date or select the dropdown arrow next to the date field and a calendar will appear allowing the correct date to be selected.
7. Enter the name or initials of the person requesting the controlled substance.
8. If the name does not completely fill the line, press <Enter> to advance to the next line.

9. Select Add New Items. If the item number of the narcotic to be issued is known, enter the item number.
10. If the item number is unknown, type the first few characters of the item name and press <Enter>.
 - A menu of items appears on the screen.
11. Select the desired item by clicking one time on the item.
12. If the desired item does not display:
 - Select More to advance to the next page of items.
 - Scroll up to return to previous page.
 - If an item is still not found, enter another item description to begin a new search.
13. After item selection, the system prompts – Enter a Narcotic Control #.
 - Enter the number from the shingle sheet.
14. The cursor moves to the UN (units) field. Cost per primary unit appears in the primary column to the right of the units field. Press <Enter>.
15. Enter the amount to credit. This must be a “negative” number.
16. If an item has a negative balance, the following message appears: WARNING—STOCK OUT – ITEM BALANCE (-NUMBER) STILL WISH TO TRANSFER IT? YES or NO.
17. Type NO and the system returns for new item selection.
18. Type YES and the quantity entered moves into the primary column and the extend column reflects the total credit of the quantity returned to pharmacy.
 - An item should not be transferred if it has a negative balance. An adjustment to the item balance is necessary.
19. Repeat for the next controlled substance to credit from the same department.
20. If no other controlled substances are to be credited from this department, select Update.
21. If all information is correct, enter initials to confirm.
22. Select Delete before entering initials to cancel the transaction.
23. If any information is incorrect, enter the sequence number of the line to correct.
24. When the transaction is confirmed, the system asks “Print requisition form?” Press <Enter> to answer no.
25. After entering initials, a label prints. Place this label on the shingle sheet to document credit.

Select Hospital Base Menu > Charge Table/Inventory > Item Transfer Requisitions

Item	Description	ET	To GL#	Quantity	Un	Primary Qty	Ext Cost
3502702	FENTANYL (DURAGESIC) AP : 100MCG (078945)	T	10000002	-20.00	EA	-20.00	-932.640

Returning Narcotics to Pharmacy

Charging Narcotics

Enter narcotic charges through patient batch charging. When the TruBridge EHR Controlled Substance System is installed, the entry of narcotics through the patient batch charging screen causes the subtraction of the charged narcotics from the narcotic sign-out sheet or control number.

Charging Narcotics Through Batch Charging

1. From the Hospital Base menu, select **Master Selection**.
2. Select **Patient Charging**.
3. Select **Charge Entry**.
4. Enter the narcotic control number stamped on each narcotic charge slip instead of the item number.
5. The narcotic control number must be prefixed with a <N> to let the system know this is a control number and not a regular item number.
 - If the control number is 000222, enter <N0000222>.
6. The control number must be seven digits.
7. The first digit (following the N) must be <0>.
 - If the control sheet number is 1234, enter <N0001234> for the item number.

8. The system will reject this number:
 - If the department entered on the charge line does not match the department that the control sheet was issued to.
 - If the control number entered does not exist.
9. If everything is correct, the name of the narcotic and the control number appear in the description area. The item number appears in the item number field.

Select **Base Menu > Master Selection Patient Charging > Charge Entry**

Pat#	Service Dt	Stay Type	Serv CD	Dept	Item #	Quantity	Amount	Description	Phy #	Phy Amt	Del
356959	09/28/06	5	01	156	N012345		00	BOLTZ CAROLYN			
							00				
							00				
							00				
							00				
							00				
							00				
							00				
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Charging Narcotics Through Batch Charging

Wastage of Narcotics

If a controlled substance is wasted or out-of-date, the item must be returned to pharmacy before adjusting the balance. The only exception would be if the hospital registers a fictitious patient for the sole purpose of absorbing narcotic wastage. A TruBridge pharmacy representative should be consulted before implementing this method.

When the item is returned to pharmacy, the following steps remove it from pharmacy inventory.

1. From the Hospital Base menu, select **Charge Tables/Inventory**.
2. Select **Adjust Item Balances**.
3. Press <Enter> through Department Number (defaults to pharmacy department).
4. Enter the item number and press <Enter>.

5. The system pulls in item description.
6. Adjust as of Date: MMDDYY.
 - If the date is incorrect overtype with the correct date. Selecting the drop down will allow a calendar to appear.
7. Reason code. Enter <W> for wasted, or enter another appropriate reason code.
8. Primary quantity.
 - Enter the number to remove from inventory.
 - Must be entered as a negative number.
9. Purchase quantity. Press <Enter> to bypass this field.
10. Other quantity. Press <Enter> to bypass this field.
11. Select **Update**. Enter initials to confirm.
12. If the information is incorrect:
 - Select the field to correct.
 - Select the back arrow in the top left to cancel the transaction.

Select **Hospital Base Menu > Charge Table/Inventory > Adjust Item Balances > Wastage of Narcotics**

	Primary	Purchase	Other
Unit:	EA	BX	
Quantity:	-10	10	
Unit:	EA	BX	
Packing:	CARPUJECT		
Conv:		10	
Cost:	63	6.30	
Qty on Hand:			

Adjust Item Balance

Purchase of narcotics

To ensure an accurate inventory, narcotics are received and added to pharmacy inventory. Pharmacies on the Inventory System (Materials Management) do this through the purchase order system. If the pharmacy does not use the inventory system, but does wish to keep an accurate pharmacy narcotic inventory, the adjust feature is used to add narcotics to inventory. This allows keeping of a correct perpetual inventory.

Follow the procedure below to adjust item balances:

1. From the Hospital Base menu, select **Charge Tables/Inventory** and press.
2. Select **Adjust Item Balances**.
3. Department defaults to pharmacy. Press <Enter>.
4. Enter the item number and press <Enter>.
5. The system fills in the item description.
6. Adjust as of Date: MMDDYY. Defaults to current date.
 - If the date is incorrect overtype the correct date. Selecting the dropdown arrow next to the date and a calendar will appear allowing the proper date to be selected.
7. Enter <P> for purchased in the Reason Code field.
8. Enter the number purchased in the primary quantity field.
 - This must be a positive number.
9. Press <Enter> to bypass the purchase quantity field.
10. Press <Enter> to bypass the other quantity field.
11. Select **Update**. Enter initials to confirm.
12. If the information is incorrect:
 - Select the field to correct.
 - Select the back arrow in the top left to cancel the transaction.

Select **Hospital Base Menu > Charge Tables Inventory > Adjust Item Balances > Purchase of Narcotics**

	Primary	Purchase	Other
Unit:	EA	BX	
Quantity:	50		
Unit:	EA	BX	
Packing:	CARPWJECT		
Conv.:		10	
Cost:	63	6.30	
Qty on Hand:			

Adjust Item Balance

Inventory Print and Delete Report

1. The Inventory Print and Delete does not require a work file.
2. The Control Substances Status Report must be run prior to printing Inventory Print and Delete.
3. From the Pharmacy Selection Screen, select **Print Reports**.
4. Select **Inventory Print & Delete**.
5. Select a printer number, **Spool to File**, or **Print to Workstation**.

How often should this Report be printed?

- This report should be printed daily.

Who should print this Report?

- The Pharmacy department.

Who should get copies of this Report?

- Internal department use.

What is the Description and Usage?

- This report should be run immediately after the Control Substance Status Report. The Inventory Print and Delete Report clears the completed narcotic numbers so that they no longer appear on the Control Substances Status Report. If a control number is entered in error, the transfer can be reversed, but the control number cannot be used again until the Inventory Print and Delete Report has been run to clear the completed control numbers.

- This report prints a list of all charges on each completed control number. This list can be compared to the original narcotic form and then stapled to the original form to serve as an audit trail. Alternatively, this report can be filed by another criteria such as drug name or issue department to provide a cross-reference.

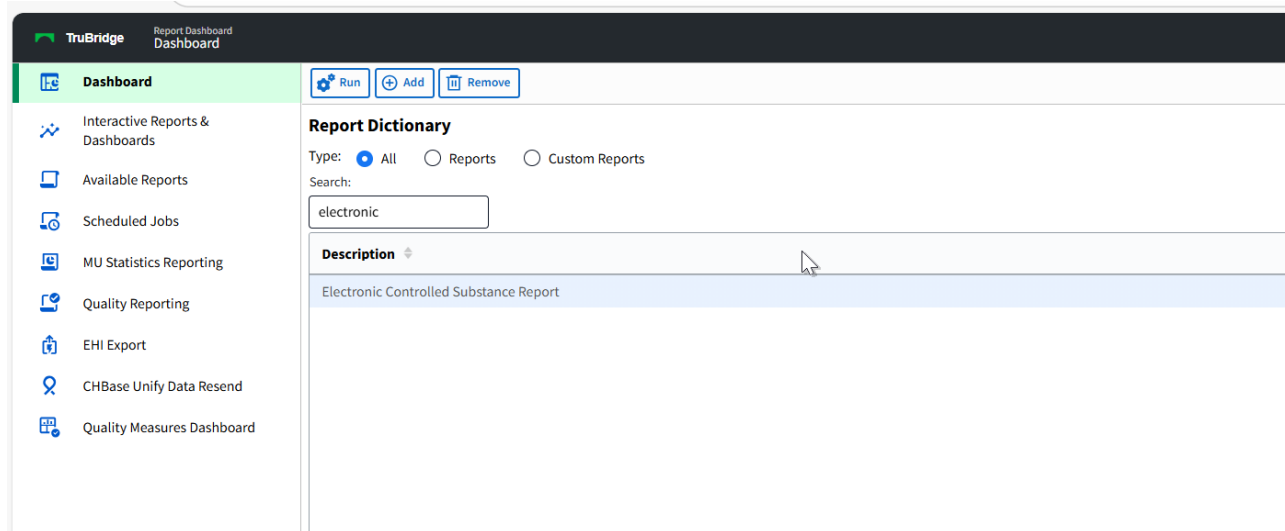
Electronic CS Report

Electronic submission of controlled substances is available for pharmacies in states for which this is required. Information generated and file format will vary by state.

Electronic Controlled Substance Report

1. From the Application Drawer, select Report Dashboard
2. From the Report Dashboard select **Electronic Controlled Substance Report**.

Select Application Draw > Report Dashboard > Electronic Controlled Substance Report



Print Report Menu

3. Select the desired date range using the drop-down menu and enter the **ASAP Format** required by the state and then select Run Report.

TruBridge Report Dashboard
Electronic Controlled Substance Report

Electronic Controlled Substance Report [Run Report] [Reset]

Electronic Controlled Substances Report Parameters

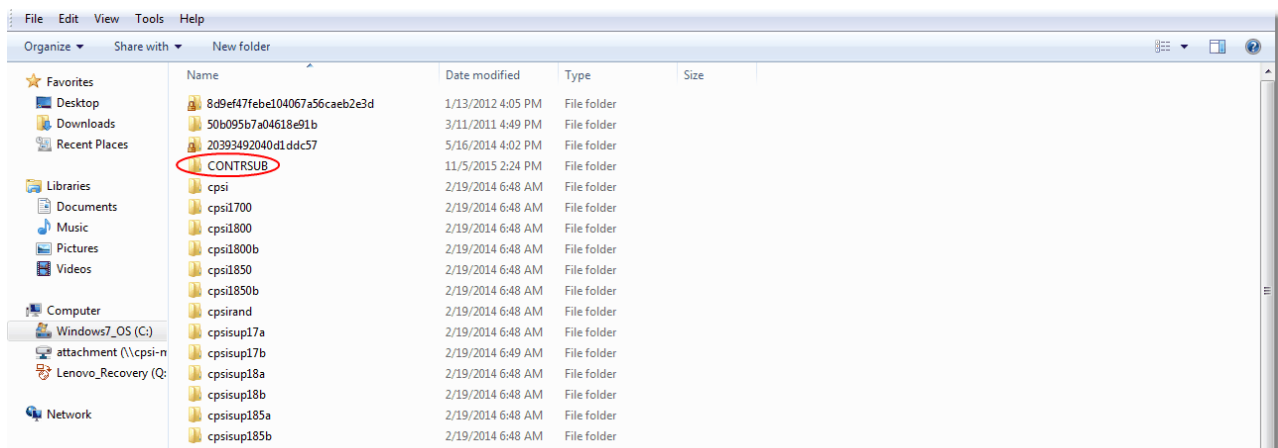
Date Range: 12/17/2025 - 12/17/2025

ASAP format:

- 4.0
- 4.1
- 4.2
- 4.2A
- 4.2B
- 5.0

Electronic Controlled Substance prompt

The report will write to the CONTRSUB folder on the C drive in the file format required by the state and may be emailed to the proper agency.



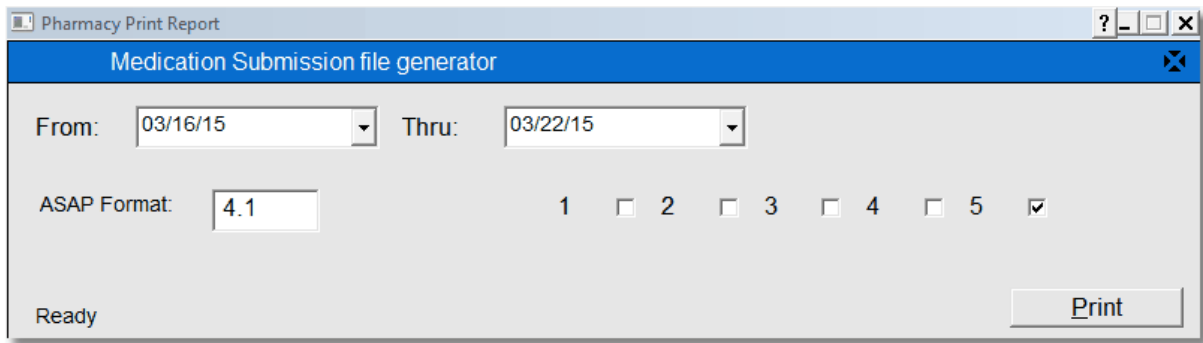
Controlled Substance Folder

LTC Prescription Report

The Illinois Department of Human Services has put in place Mandatory Pharmacotherapy Reporting in Illinois Long Term Care Facilities. These facilities are required to send an electronic transmission of medications in the ASAP 4.1 format for their long term care patients on a weekly basis. TruBridge has created the LTC Prescription Report to meet this mandate.

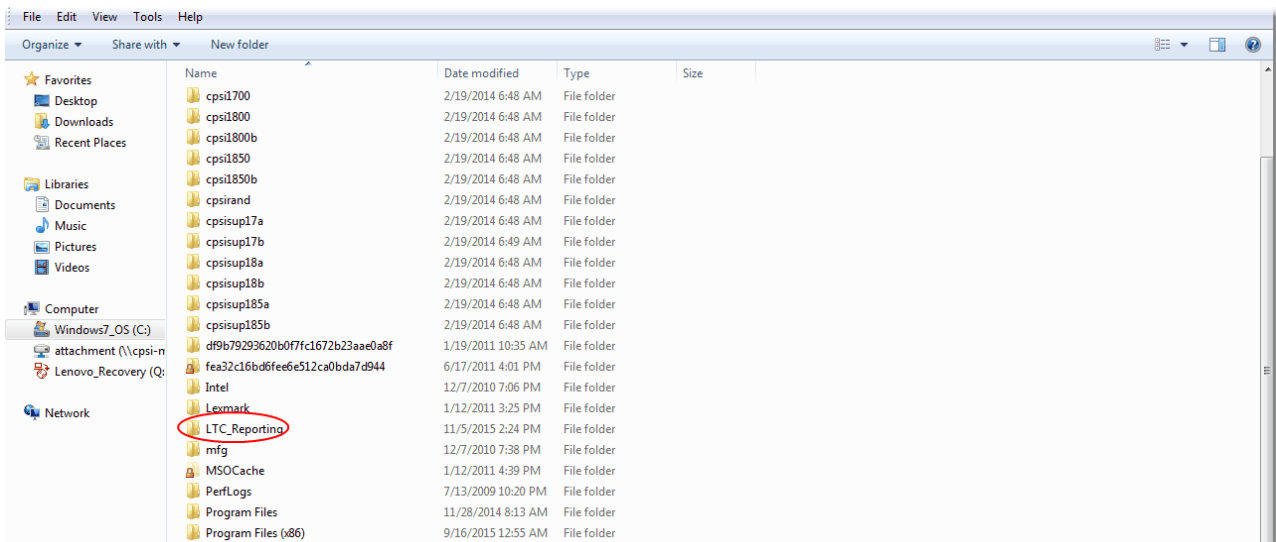
LTC Prescription Report

1. From the Hospital Base Menu, select **Print Reports**.
2. From the Print Report Menu, select **LTC Prescription Report**.
3. Select the desired date range using the drop-down menu and enter the required ASAP Format.
4. Select the Long Term Care Stay Type used by your facility.



LTC Prescription Report File Generator

5. The report is generated to the LTC_REPORTING folder on the C drive.



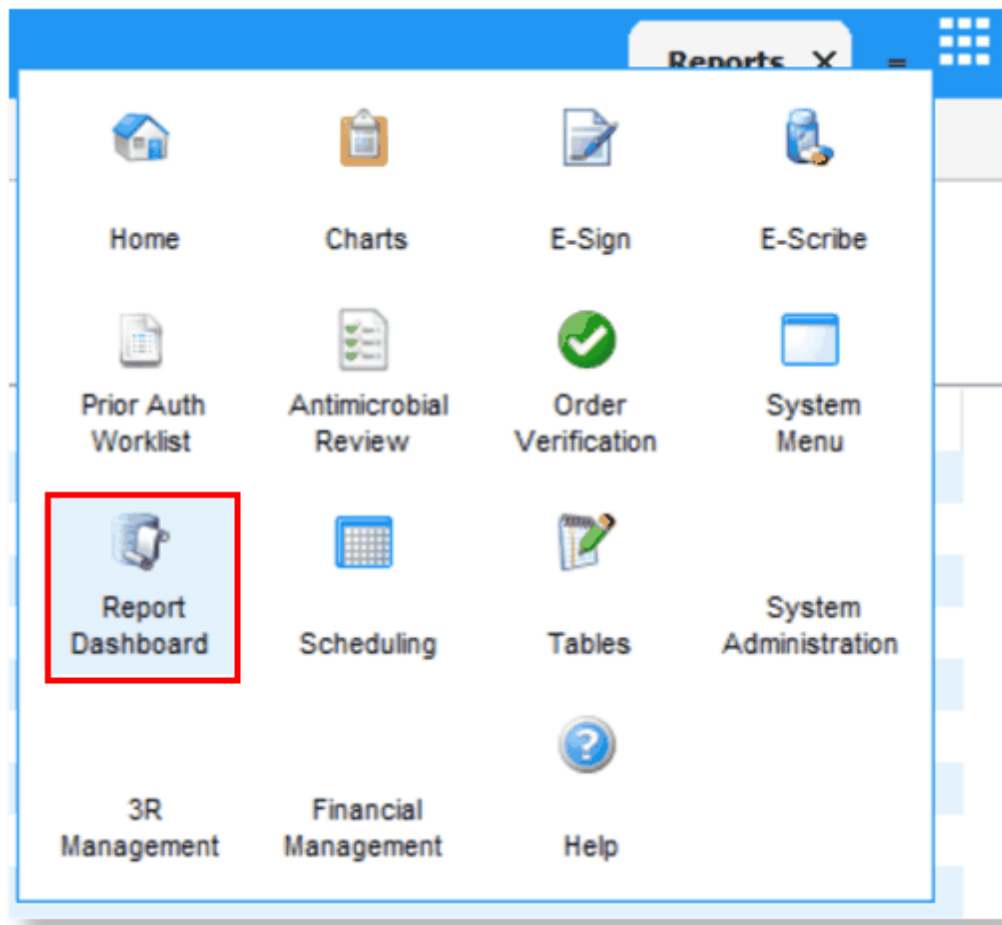
LTC Reporting Folder

Chapter 15 Report Dashboard

15.1 Overview

This section details Pharmacy Reports available in the Report Dashboard.

Select **Thrive UX Navigation Panel > Report Dashboard > Add > Type the name of report > Insert > Select Report > Run**



Thrive UX Navigation Panel- Report Dashboard

15.2 Pharmacy Controlled Substance Report

The Pharmacy Controlled Substance Report will allow facilities to generate the Pharmacy End of Day report for Controlled Substances by Sub Types.

1. From Report Dashboard, select **Pharmacy Controlled Substances**.
2. Choose the desired parameters, which includes:

- Date Range
- DEA Class
- Sub Type
- Service Code
- Visit ID
- Option to Exclude Grand Total Quantity
- Level of Detail
- Option to Include Cover Sheet
- Option for Safe Mode
- Output Format

3. After selecting the desired options above, select **Run Report**.

How often should this Report be printed?

- Should be printed as necessary.

Who should print this Report?

- The Pharmacy Department.

What is the Description and Usage?

- The Pharmacy Controlled Substance Report allows the facility to generate the Pharmacy End of Day report for Controlled Substances by Sub Types.
- The report recognizes narcotics and the classification from the **DEA Class** on the Pharmacy Information, page 1 screen. If this field is incomplete, the Pharmacy Controlled Substances Report will not be accurate. The report sorts and prints the controlled substances by class number (II, III, IV, V).
- The report lists the drug class, drug name, item number, quantity, patient name, patient number, initials of the dispensing pharmacist, prescription number, and the physician.

Pharmacy Controlled Substances

Class	Drug Name	Item Number	Quantity	Patient Name	Account Number	Charged By	Prescription#	Physician
2	MEPERIDINE INJ: 25MG/ML	383023	1	FAULKNER JEFF	357059	SC		BAXTER J
2	OXYCODONE/APAP (PERCOCET) TAB 5/325MG	383045	1	FAULKNER JEFF	357059	SC		
		Class 2 Total:	2					
Class	Drug Name	Item Number	Quantity	Patient Name	Account Number	Charged By	Prescription#	Physician
3	ACETAMIN W/COD(TYLENOL #3) TAB 300/30MG	381012	1	THOMPSON DALE	357902	SC		
		Class 3 Total:	1					
Class	Drug Name	Item Number	Quantity	Patient Name	Account Number	Charged By	Prescription#	Physician
4	QUINAPRIL(ACCUPRIL) TAB : 10 MG	38381242	1	THOMPSON DALE	357902	SC		WILLIAMS K
		Class 4 Total:	1					
		Grand Total:	4.00					

Pharmacy Controlled Substance Report (PDF Output Format) Sample

15.3 Medication Waste Report

1. The Medication Waste Report displays information as seen on the Medication waste screen in PDF format in the **Report Dashboard**.

Select **Thrive UX > Report > Report Dashboard > Medication Waste**

REPORT DASHBOARD >> MEDICATION WASTE >> REPORT WRITER REPORT SCREEN

Run Report Advanced Sort Load Save Spool Reset

Medication Waste

Parameters

Facility: 0002 EVIDENT COMMUNITY HOSPITAL

Date Range: 01/01/2018 - 06/19/2018

Visit ID:

Miscellaneous

Include Cover Sheet:

Safe Mode:

Output Format: HTML

- PDF
- XML
- CSV
- HTML
- MAPLIST
- TXT

Medication Waste Report Parameters

Select Thrive UX > Report > Report Dashboard > Medication Report > Run Report

06/19/2018 11:02	EVIDENT COMMUNITY HOSPITAL			1
	Medication Waste			pharmacy_waste_capture.template
	Document was generated by the Thrive EHR Software			
	01/01/2018 - 06/19/2018			
Patient Name:	BARTLETT JOSIAH C	Visit Number:	358691	MR Number:
Date:	02/09/2018	Item #:	2290573	Order #: 0
User:	RSB	Min Disp Qty:	10.00 MG	Medication: MORPHINE INJ:10MG/1ML VIAL
		Qty Given:	6.00 MG	Qty Wasted: 4.00 MG
Date:	02/09/2018	Item #:	300558	Order #: 0
User:	RSB	Min Disp Qty:	10.00 MG	Medication: MORPHINE INJ: 10MG/ML
		Qty Given:	3.00 MG	Qty Wasted: 7.00 MG
Patient Name:	COLEMAN JENNIFER SWEEN	Visit Number:	20001213	MR Number: 970695
Date:	02/27/2018	Item #:	2501953	Order #: 0
User:	JCC	Min Disp Qty:	200.00 MG	Medication: PROPOFOL 200MG/20ML VIAL
		Qty Given:	50.00 MG	Qty Wasted: 150.00 MG
Patient Name:	COLEMAN JENNIFER SWEEN	Visit Number:	20001215	MR Number: 970695
Date:	02/27/2018	Item #:	2501955	Order #: 0
User:	JCC	Min Disp Qty:	150.00 MG	Medication: PROPOFOL 150MG
		Qty Given:	375.00 MG	Qty Wasted: 75.00 MG
Date:	02/27/2018	Item #:	2501954	Order #: 0
User:	JCC	Min Disp Qty:	100.00 MG	Medication: PROPOFOL 100MG
		Qty Given:	75.00 MG	Qty Wasted: 25.00 MG
Date:	02/27/2018	Item #:	2501954	Order #: 0
User:	JCC	Min Disp Qty:	100.00 MG	Medication: PROPOFOL 100MG
		Qty Given:	75.00 MG	Qty Wasted: 25.00 MG
Date:	02/27/2018	Item #:	2501955	Order #: 0
User:	JCC	Min Disp Qty:	150.00 MG	Medication: PROPOFOL 150MG
		Qty Given:	200.00 MG	Qty Wasted: 100.00 MG
Patient Name:	COLEMAN JENNIFER SWEEN	Visit Number:	20001216	MR Number: 970695
Date:	02/27/2018	Item #:	2501956	Order #: 0
User:	JCC	Min Disp Qty:	3.50 MG	Medication: PROPOFOL 3.5MG
		Qty Given:	5.00 MG	Qty Wasted: 2.00 MG
Date:	02/27/2018	Item #:	2501956	Order #: 0
User:	JCC	Min Disp Qty:	3.50 MG	Medication: PROPOFOL 3.5MG
		Qty Given:	3.00 MG	Qty Wasted: 0.50 MG

Medication Waste Report

15.4 Pharmacy Order Exceptions Report

The Pharmacy Order Exceptions Report allows users to generate a list of pharmacy order exceptions stemming from inbound pharmacy orders from pipeline.

Select **Thrive UX > Report Dashboard > Pharmacy Order Exceptions**

Pharmacy Order Exceptions

- Once the list is generated, the information that is available may be maintained. If there is information that is no longer needed, highlight the row of data and select **Remove** to remove the documentation from the generated list.
- Selecting **PDF** will pull the information into a PDF format exactly as it's shown on the screen.

15.5 Antimicrobial Use, Pharmacy Option (AUP) Summary Report

The Antimicrobial Use, Pharmacy Option (AUP) Summary Report was developed by TruBridge to allow facilities to submit data to the National Healthcare Safety Network (NHSN). This report allows users to track and report the number of days patients were on antimicrobial medications, the number of admissions, and the number of days each medication was given. Manual data entry is not available. This report was developed with an Export option.

For more information on Antimicrobial Use reporting, visit the CDC website to view the FAQ's for Antimicrobial Use (AU) Option at <https://www.cdc.gov/nhsn/faqs/faq-au.html>.

Some setup of Pharmacy tables and Pharmacy items must be put in place to populate data on the report. Setup includes:

- Registering with the NHSN to receive OID and NHSN Facility codes
- Adding the RxNorm Class to medications in Item Maintenance
- Adding a SNOMED code in Route Table Maintenance
- Facility Reporting Populations
- Associating the Location Code to the Department Table
- Security to access the report

Registration with NHSN

Each facility will need to register with NHSN to be able to submit data. This NHSN Facility ID and the Object Identifier (OID) must be entered in the Lab Control Table to run the report. These codes will be received when the facility registers. Facilities must then provide these codes to TruBridge, and a TruBridge representative must enter the codes into the table.

- Step 1: Register with NHSN at <https://www.cdc.gov/nhsn/enrollment/index.html>
- Step 2: Provide NHSN Facility Code and OID code to a TruBridge Representative via a support situation. TruBridge will add the codes to the Lab Control Table.

Add the RxNorm Class to Medications

Path: UX > Tables > Control > Item Master > Select Item > Pharmacy Information > Page 1 > Select RxNorm > Add > Search for appropriate RxNorm Class > Save

NOTE: The RxNorm Class table is generated from the CDC.

The screenshot shows the 'Pharmacy Item Information' form for Item Number 7022020, Ciprofloxacin 400MG/200ML. The 'RxNorm' tab is selected in the top navigation. The form is divided into several sections:

- PHARMACY ITEM INFORMATION:** Facility 58 : #10 MPEMR IN HOSPITAL, Item Number: 7022020, CIPROFLOXACIN 400MG/200ML.
- Page 1:**
 - NDC: 00781324009
 - NDC Unit: []
 - Manufacturer: Sandoz
 - As of: 07/02/2020
 - Prior NDC: []
 - DEA Class: 0
 - Predefined Orders: 1
 - Default Routes: IV PIGGYBACK
 - Formulary Code: [] [] [] []
 - Reorder Days: 00
- Page 2:**
 - Charge Meds at Administration:
 - Chartcart Selectable:
 - Formulary Item:
 - Estimate Creatinine Clearance:
 - Creaitine Clearance/Message: 0.00
 - Pediatric Crcl/Message: 0.00
 - Use Overdue Med Response:
 - Other Units: Example: 1EA = 500MG or 10 ML
 - Strength: 400.0000, 200.0000, 0.0000, 0.0000, 0.0000
 - Unit: MG, ML
 - Rounding Options: Next Whole Unit

Pharmacy Item Information, Page 1

TABLES
Item Master Pharmacy: 7022020

← | Save | Remove

RXNORM CLASS EDIT

Facility 58 : f10 MPEMR IN HOSPITAL

Item: 7022020 CIPROFLOXACIN 400MG/200ML

RxNorm Class: 🔍 **Ciprofloxacin**

Active Date: 📅

Inactive Date: 📅

Pharmacy Item Information, RxNorm Class Edit

Add a SNOMED Code to Routes

A SNOMED code must be associated with any route used on the medication orders to populate the medication to the report. The CDC has a list of SNOMED codes that may be applied. SNOMED codes commonly used are:

- Respiratory tract route (includes inhaled and nebulized antimicrobials): 447694001
- Intramuscular route (IM): 78421000
- Intravascular route (IV):
 - Intravenous route: 47625008
 - Intravenous central route: 418114005
 - Intravenous peripheral route: 419993007
- Digestive tract route (Oral): 26643006

Path: UX > Tables > Clinical > Under Pharmacy Control, select Route Table > Select Route > Enter SNOMED code > Save

PHARMACY ROUTE TABLE EDIT
Facility 58 : f10 MPEMR IN HOSPITAL

Route: PO

Description: BY MOUTH

Layman's Description:

Label Description:

Type: N

I - IV
N - Non-IV
P - Piggyback IV

MDS Route: 1

1 - By Mouth
2 - Sub-Lingual
3 - Intramuscular
4 - Intravenous
5 - Subcutaneous
6 - Rectal
7 - Topical
8 - Inhalation
9 - Enteral Tube
10 - Other

HL7 Code: PO

SNOMED Code: 26643006

NCIT Code: C38288 ORAL

Pharmacy Route Table Edit

Facility Reporting Populations

The Facility Reporting Population must be setup in Table Maintenance to indicate the Patient Type being reported. The patient type must be associated with the Antimicrobial Reporting Type and the appropriate Location code. This allows the defined patient type to be included in the report parameters.

Path: Thrive UX > Tables > Control > Facility Reporting Population > Add > Select Patient Population from the stay type drop down > Select Antimicrobial from the Reporting Type dropdown > Use lookup icon and select the appropriate Healthcare Service Location > Save

NOTE: Make a note of the Location Code. This will need to be tied to the corresponding department in the Department Table.

FACILITY REPORTING POPULATION EDIT
f10 MPEMR IN HOSPITAL

Patient Population: Inpatient

Reporting Type: Antimicrobial

Healthcare Service Location: 1061-1 Medical-Surgical Ward

Facility Reporting Population Edit

TABLES Control			
← Add Remove			
FACILITY REPORTING POPULATIONS			
f10 MPEMR IN HOSPITAL			
Patient Population: All		Reporting Type: All	
Patient Population	Reporting Type	Location Code	Description
Inpatient	Antimicrobial	1058-7	Labor and Delivery Ward
Inpatient	Antimicrobial	1061-1	Medical-Surgical Ward
Inpatient	Antimicrobial	1081-9	Pediatric Medical-Surgical Ward
Inpatient	Antimicrobial	1220-3	Long Term Acute Care Intensive Care Unit
Critical Care		1025-6	Trauma Critical Care
Critical Care		1026-4	Burn Critical Care
Critical Care		1027-2	Medical Critical Care

Facility Reporting Populations

NOTE: The Patient Population may be any stay type, but must be Inpatient to be included in the FacWideIn default report option. Assigning an alternate stay type allows the facility to report the stay type separately from the population as a whole.

Add the Location Code to the Department Table

This will allow any patient of the specified stay type, admitted to the department, to populate on the report.

Path: Thrive UX > Tables > Control > Department Table > Select the nursing station (Example: MED SURG) > Page 5 > Enter the Healthcare Service Location > Save

TABLES Department Edit : 003		Tables	Department Table List	Department Edit X
← Show Shared Print Delete Save Refresh				
Facility 58 : f10 MPEMR IN HOSPITAL				
DEPARTMENT TABLE				
Department Number: 003				
Page 1 Page 2 Page 3 Page 4 Page 5				
Schedule Auto Refresh:	<input type="checkbox"/>			
Schedule Auto Refresh Interval:	30			
Alt Whiteboard Departments:	007 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Clinic Code:	<input type="text"/>			
Default Location	<input type="text"/>			
Auto Consolidate:	<input type="checkbox"/>			
Schedule for All Dates:	<input checked="" type="checkbox"/>			
Healthcare Service Location:	1061-1 Medical-Surgical Ward			
Use CCDA HTML View:	<input checked="" type="checkbox"/>			
Send Scanned Images with Ancillary Orders	<input type="checkbox"/>			

Department Table, Page 5

Setting Report Parameters

- The Antimicrobial Use, Pharmacy Option (AUP) Summary Report is located in the Report Dashboard. To include all applicable patients, allow the Reporting Location to default to FacWideIn > Select Reporting Month > Run Report.
- The report will display the Number of Patient Days, the Number of Admissions, and each Antimicrobial Medication that has been ordered. For each medication, the report will include the Rx Norm Code, Total Therapy Days, IV Days, IM Days, Digestive Days or Respiratory Days.
- Once the report has populated, users will have the option to select additional Output formats of PDF, CSV, or Export to allow submission to NHSN.
- The Application Code (MI) Antimicrobial Reporting is needed for a user to access this report.

Path: Thrive UX > System Administration > Logins or Roles > New > Application code is **Application Code** > Allow > Select bold **Application Code** > Add > Select Antimicrobial Reporting > Back Arrow > Save > Assign rule description > Back Arrow.

REPORT DASHBOARD
Antimicrobial Use, Pharmacy Option Report Screen

Export PDF CSV

ANTIMICROBIAL USE, PHARMACY OPTION (AUP) SUMMARY REPORT

Facility: #10 MPEMR IN HOSPITAL
Reporting Month: 06/2020
Patient Location: FacWideIn

Number of Patient Days: 1829
Number of Admissions: 13

Antimicrobial Agent	Rx Norm Code	Total Therapy Days	IV Days	IM Days	Digestive Days	Respiratory Days
Amantadine	620	0	0	0	0	0
Amikacin	641	0	0	0	0	0
AMIKLIP - Amikacin Liposome	2059180	0	0	0	0	0
Amoxicillin	723	0	0	0	0	0
Amoxicillin / Clavulanate	19711	0	0	0	0	0

Antimicrobial Use, Pharmacy Option Summary Report

Chapter 16 Labels

16.1 Overview

The TruBridge Pharmacy System utilizes the following five types of labels:

1. Inpatient
2. Outpatient
3. IV
4. Unit Dose
5. Nursing Medication Cart Labels

Each label type provides different information based on the application and patient type. Whether an inpatient or outpatient label prints depends on the setup in the Pharmacy Control Table.

16.2 Pharmacy Labels

Inpatient Labels

This label is used for inpatient stay types defined in the Pharmacy Control Table. The inpatient label normally prints when the order is first processed. It is used to label the medication for distribution to the appropriate nursing station. The label is designed to provide the following information:

1. Patient location.
2. Patient information.
3. Order number.
4. Long and short description of the medication.
5. Complete instructions based on information in lines 1 through 6 of the order.
6. Quantity charged.
7. Order entry initials.
8. Up to six Standard/Non-Standard Administration Times. For more than five administration times, "five" prints along with the word "more."

Outpatient Labels

This label is attached to on medication dispensed directly to the patient. The first two lines of the label identify the pharmacy. These lines are defined in the Pharmacy Control Table. The first line of the label and the ingredients print in bold.

The outpatient label is designed to provide all necessary information for the following:

1. Outpatient prescriptions
2. Employee prescriptions
3. Long Term Care prescriptions

IV Labels

The IV label format is used in both:

1. Initial order entry of the order.
2. IV batch labels.

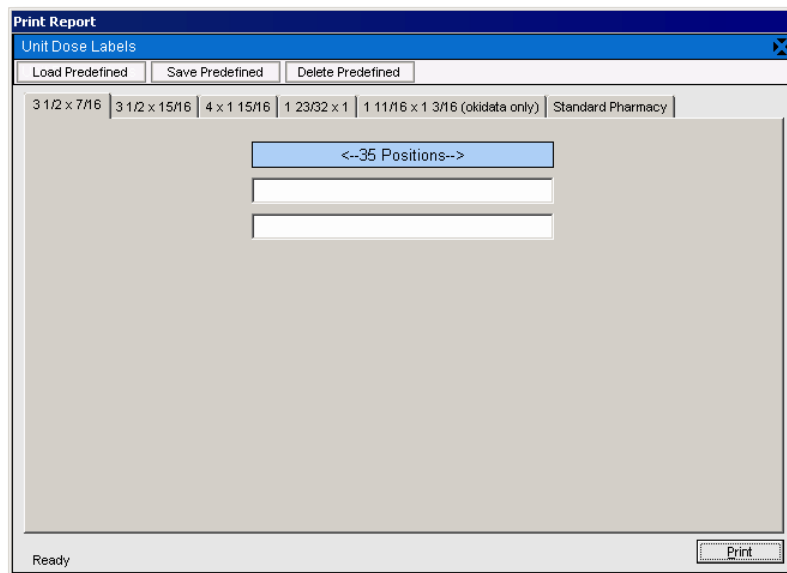
The format of the label is as follows:

1. The first two lines are for patient demographic information.
2. The fourth line is the Comment Line.
3. The fifth line is the Flow Rate from line 2 of the IV order.
4. The sixth through tenth lines print the ingredients of the IV.
 - More than five components, the last line on label displays "Continued on Next Label."
5. The eleventh line displays EXP AFTER: MMDDYY.
 - This date indicates the expiration date of this IV based on the current date plus the IV expiration date.
 - The IV expiration date for each individual additive is established via the Pharmacy Information screen.
6. The Start Date/Time of the order displays on the third line of the label (First Dose 10/27/02 0900).
7. The Frequency appears in between the Hang Time and Bag Number.
8. The last line on the IV label includes the hang date and time, the IV frequency and the bag number.

Unit Dose Labels

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. From the Pharmacy Reports menu, select **Unit dose Labels**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.

Select **Hospital Base Menu > Print Reports > Unit Dose Labels**



Unit Dose Labels

4. Select **1 23/32 x 1** for unit dose labels.
 - Used to create labels for strip-packing medications.

Select Hospital Base Menu > Print Reports > Unit Dose Labels > 1 23/32 x 1

Label 1 23/32 x 1 maintenance screen

5. Select Print to generate the label.
 - **Load Predefined** Allows a previously created label to be loaded to for printing or modification.
 - **Delete Predefined** Allows a created label to be permanently deleted.
 - **Save Predefined** Allows a created label to be saved under a unique filename for reprinting.

Free Form Labels

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. From the Pharmacy Reports menu, select **Unit dose Labels**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. Select **Standard Pharmacy**.
5. An auxiliary label can be printed if, during order entry, an extra label is needed for additional medication usage instructions.
6. Once a label has been created, the following options are available:
 - **Load Predefined:** Allows a previously created label to be loaded to for printing or modification.
 - **Delete Predefined:** Allows a created label to be permanently deleted.
 - **Save Predefined:** Allows a created label to be saved under a unique filename for reprinting.

Predefined Labels

Once a label has been created, it can be given a filename and saved. The saved label can be retrieved at a later time to reprint. Changes can also be made to predefined labels.

1. From the Pharmacy Selection Screen, select **Print Reports**.
2. From the Pharmacy Reports menu, select **Unit dose Labels**.
3. Select a printer number, **Spool to File**, or **Print to Workstation**.
4. From the Department Printer Functions screen, select **Load Predefined**.
5. Select label from list for printing or modification.
 - **Load Predefined:** Allows a previously created label to be loaded to for printing or modification.
 - **Delete Predefined:** Allows a created label to be permanently deleted.
 - **Save Predefined:** Allows a created label to be saved under a unique filename for reprinting.

16.3 User Defined Labels

User defined labels can be created allowing choice of font size, bold text, free text and patient information not available on the traditional labels.

1. From the Pharmacy Hospital Base Menu, select **Master Selection**.
2. From the Master Selection Screen, select **Business Office Tables**.
3. From the Business Office Tables, select **Maintenance Menu**.
4. From the Business Office Table Maintenance Menu, select **Udef Label**.
5. The User Defined Forms screen will be displayed. This screen includes existing forms (labels and requisitions), the TTY number (of the terminal that generates the form) and the status (active or inactive) of each. Active forms are currently in use. Inactive forms are under construction or are not being used at the current time. The following options can be selected:
 - The sequence number to the left of the existing form
 - **0-Exit**: To return to the previous menu
 - **N-New**: To create a new label
 - **PgDn**: To advance to the next page of existing forms
 - **PgUp**: To return to the previous page of existing forms
 - **D-Delete**: To delete an existing form

Select **Base Menu > Master Selection > Business Office Tables > Maintenance Menu > Udef Label**

Department: PHARMACY DEPARTMENT

Seq	Name	TTY	Status
1	IPNIVLABEL	001	INACTIVE
2	IPNIVLABEL	046	INACTIVE
3	OPNIVLABEL	257	ACTIVE
4	IVLABEL	294	ACTIVE
5	BATCHLABEL	630	ACTIVE
6	IVLABEL	630	INACTIVE
7	IVLABEL	630	ACTIVE
8	IPNIVLABEL	630	INACTIVE
9	IPNIVLABEL	630	ACTIVE
10	OPNIVLABEL	630	INACTIVE
11	OPRCTLABEL	630	INACTIVE
12	IVLABEL	736	ACTIVE

Enter: ___ (Seq#, 0-Exit, "N"ew, PgDn, PgUp)
 "D"eleate "R'eport

User Defined Forms

16.4 Creating a New Udef Label

NOTE: When creating a custom label, you must be logged into the pharmacy department.

1. From the User Defined Forms screen, select **N-New** and press <Enter>.

Select **Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Udef Labels**

Seq	Name	TTY	Status
1	IPNIVLABEL	13R	INACTIVE
2	IPNIVLABEL	13R	ACTIVE
3	IPNIVLABEL	A70	INACTIVE

Enter: ___ (Seq#,)

0-Exit *N*ew PgDn PgUp
*D*elete *R*eport

User Defined Forms

2. The User Defined forms Setup menu will be displayed. Select the appropriate type of label.

NOTE: The mnemonics that are available are different based on the type of label being created.

Select Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Udef Labels > "N"ew

CPSI Community Health System Signed On Emp: RBB Dept: 038

CPSI Community Health System User Defined forms Setup

Pharmacy

Select an Application

- 1 Inpatient Non-IV Labels
- 2 Inpatient IV Labels
- 3 IV Batch Labels
- 4 LTC Labels
- 5 Cart Labels
- 6 Outpatient Non-IV Labels
- 7 Outpatient Non-IV Receipt

Enter: _ (0-Exit)

User Defined Forms

Defining the Basic Format of Each Label

Once the appropriate application has been selected, the User Defined Forms Maintenance table will be displayed. The basic format of the label is defined in this table.

Select Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Udef Labels > "N"ew > Select Label Type

CPSI Community Health System Signed On Emp: RBB Dept: 038

CPSI Community Health System User Defined Forms Maintenance

Pharmacy

Form Definition

Name : IPNIVLABEL

1. Active Form (Y/N).....: N
2. Total Number of Pages..: 1
3. Form Width (Max = 132)..: 132 (Characters)
4. Export for TTY.....: 13R

Enter: _ (0-Exit "S"etup "P"rint)

User Defined Forms Maintenance

The name displayed is a result of the application selected.

1. Active Form (Y/N):

- Default:
- Options: Y (yes) or N (no)
- Usage: Controls whether the label is currently in use. If there are 2 labels defined for the same tty in which one is active and the other inactive, in order to activate the inactive label, the prompt "Selecting "Y" will OVERWRITE the existing active label. ARE YOU SURE (Y/N)?" will be displayed. If answered Y (yes), the system will copy the format over the active label and that label will no longer exist. The existing active form can be saved by changing the tty number to a bogus number. Contact Information Services for an available bogus tty number.
 - Y: Currently in use.
 - N: Under construction or not in use.

2. Total Number of Pages:

- Default: 1
- Options: 1-9
- Usage: Defines the total number of pages defined for the label. Each label is considered one page.

3. Form Width (Max = 132):

- Default: 80
- Options: 01-132
- Usage: Defines the width of the label. The average page of paper accommodates 80 characters at 12PI. The page will accommodate 132 characters at 16PI.

4. Export for TTY#:

- Default: Blank
- Options: The TTY number of the terminal that will generate the label.
- Usage: Defines the terminal that will generate the form. Labels are assigned to CSNUM's as they are in CS.COPY. This will allow multiple exports to be setup for a program, but allows ONLY ONE export for this program for a TTY. Exports entered on page 2 field 9 of Order Entry Information will override custom-defined forms. The following options can be selected:
 - **Seq#:** Accesses the selected sequence number.
 - **0-Exit:** Returns to the previous menu.
 - **S-Setup:** Advances to the Page Definition screen where the format of each page of the label is defined.
 - **P-Print:** Allows the form to be printed/previewed.

Defining the Basic Format of Each Page

Once the basic format of the label has been defined, select **S-Setup** to define the basic format of each page of the label. The Page Definition screen for the first page will be displayed.

Select **Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Udef Labels > "N"ew > Select Label Type > S**

CPSI Community Health System Signed On Emp: RBB Dept. 038

CPSI Community Health System **User Defined Forms Maintenance**

Pharmacy

Page Definition Page 1

Name : IPNIVLABEL

1. Form Feed Only (Y/N)...: N

2. Number of Lines: 11

3. Lines per Inch (6/8)...: 6

4. Top Margin: 00 Lines

5. Bottom Margin: 00 Lines

6. Landscape Orientation : N (Zebras Only)

Enter: ___ ()

Page Definition

1. Form Feed Only:

- Default: N
- Options: Y (yes) or N (no)
- Usage: Allows a blank page (or label) to feed between each page or label. This could also be used to skip a page (or label) between each patient. This would be considered one page.

2. Number of Lines:

- Default: 01
- Options: 01-99
- Usage: Defines the number of lines the label will contain.

3. Lines per Inch (6/8):

- Default: 6
- Options: 6 or 8
- Usage: Defines the number of lines that will appear per inch.

4. Top Margin

- Default: 00
- Options: 01-98
- Usage: Defines the top margin. The system will insert a 3-character margin for the top, bottom and sides of the page even when the top margin is set to zero when printing to a post-script printer.

5. Bottom Margin:

- Default: 00
- Options: 01-98
- Usage: Defines the bottom margin. The system will insert a 3-character margin for the top, bottom and sides of the page even when the top margin is set to zero when printing to a post-script printer.

6. Landscape Orientation:

- Default: N
- Options: Y (yes) or N (no)
- Usage: Allows the label to be printed in Landscape Orientation (rotates the text 90 degrees). This option is only available for Zebra printers.

The following options can be selected:

- **Seq#:** Accesses the selected sequence number.
- **0-Exit:** Returns to the previous menu.
- **S-Setup:** Advances to User Defined Page 1 Setup where each field of each line of the label is defined.
- **PgDn:** Advances to the following page of the label as defined in the label definition table.
- **PgUp:** Returns to the previous page of the label as defined in the label definition table.

Defining Each Field of Each Line of the Label

Once the basic format of each page has been defined, select **S-Setup** to define each field of each line. The contents of each line are constructed by defining field names and field contents using mnemonics for system demographics. The available mnemonics vary based upon the type of label being created. Each line can have up to 30 fields. The system will automatically skip a space between fields and/or field names. Each field is defined in a separate table like the one below. For example, the screen below defines field 1 of the first line, on page one. It indicates that the patient name should print in the first field on line one, page one.

Select Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > UdefLabels > "N"ew > Select Label Type > S > S

User Defined Page 1 Setup

Definitions

- A. **Line Number:** The line you are currently creating.
- B. **Free Text Only (Y /N):** Defines whether the information on this line is free-text only. When set to Y (yes), allows access to the Text field to enter free text information.
- C. **Field Number:** The field number currently being defined. Depending on the characters per inch selected, as many as 30 fields per line can be entered. Each field can be a defined number of characters. Text greater than the field will be truncated.
- D. **Text:** Defines the free-text information. (The system will not indicate when the end of the line has been reached. This will need to be checked by manually viewing or printing the form.)
- E. **Mnemonic:** The mnemonic that corresponds to the patient information to be included on this line can be selected from a list by entering a question mark (?) or entered exactly. When selected, the system will display the maximum numbers of characters for that field. This can be adjusted manually if necessary. When working across one line, one field at a time, the system will calculate where the next column can begin. The space needed for the entered information will also be displayed

NOTE: The mnemonics that are available are different based on the type of label being created.

Select Hospital Base Menu > Master Selection > Business Office Tables > Maintenance Menu > Udef Labels > "N"ew > Select Label Type > S > S > E > ?

User Defined Forms Mnemonics					
Seq	Field Name	Seq	Field Name	Seq	Field Name
01	ACCOUNT NUMBER	21	DIAGNOSIS 2	41	FREQUENCY
02	ADMINISTER AMOUNT	22	DISCARD AFTER DATE	42	GENERIC FOR
03	ADMINISTRATION TIMES	23	DISPENSE QTY	43	INITIALS
04	ADMIT CODE	24	DNR	44	INSTRUCTIONS LINE 6A
05	ADMIT CONDITION	25	DOB/PAT# BC	45	INSTRUCTIONS LINE 6B
06	ADMIT DATE	26	DOB/XRAY# BC	46	INSTRUCTIONS LINE 7A
07	ADMIT PHYSICIAN NAME	27	DOSAGE QTY & UNIT	47	INSTRUCTIONS LINE 7B
08	ADMIT PHYSICIAN NUM	28	DRUG NAME	48	ISOLATION CODE
09	ADVANCED DIRECTIVE	29	DRUG NAME SHORT	49	IV RESUPPLY QTY
10	ALLERGY CODES	30	ETHNICITY	50	LANGUAGE
11	ALT. PRACTITIONER	31	EXPECT DATE	51	LOT Expiration
12	CHARGE QUANTITY	32	FAMILY PHYS NAME	52	LOT NUMBER
13	CHIEF COMPLAINT	33	FILL DATE	53	MANUFACTURER
14	CONTRACT CODE	34	FILLED BY	54	MED NEC DIAG Y/N
15	CONTRAST ALLERGY	35	FIRST DOSE DATE	55	NDC NUMBER
16	CPT CODE	36	FIRST DOSE TIME	56	NON-IV RESUPPLY QTY
17	CURRENT DATE	37	FLUID RESTRICTION	57	NOTIFY NAME
18	CURRENT TIME	38	FOOD ALLERGY	58	NOTIFY PHONE
19	DIABETIC Y/N	39	FOOD DISLIKES	59	NPI NUMBER
20	DIAGNOSIS 1	40	FREE TEXT	60	NUMBER OF LABELS

Enter: __ ()

Inpatient Non-IV User Defined Label Mnemonics

Select Hospital Base Menu > Master Selection > Business Office Tables > Maintenance > Udef Labels > "N"ew > Select Label Type > S > S > E > ? > Pg Dn

User Defined Forms Mnemonics					
Seq	Field Name	Seq	Field Name	Seq	Field Name
01	NURSES STATION	21	PATIENT SUBTYPE	41	START DATE
02	OP LABEL ID ADDR	22	PATIENT TYPE	42	START TIME
03	OP LABEL ID NAME	23	PATIENT WEIGHT	43	STOP DATE
04	PAT ADDRESS CITY	24	PERSON PROFILE NUMBE	44	TEMP ACCOUNT Y/N
05	PAT ADDRESS STATE	25	PILL DESCRIPTION	45	XRAY NUMBER FROM AR
06	PAT ADDRESS ZIPCODE	26	PRE-ADMIT Y/N		
07	PAT ADDRESS1 STREET	27	PRESCRIBING PHYS		
08	PAT ADDRESS2 STREET	28	PRESCRIPTION NUMBER		
09	PAT DOB 6 DIG B/CODE	29	REFILLS		
10	PATIENT ADMIT WEIGHT	30	REFILLS REMAINING		
11	PATIENT AGE	31	REPORT LOCATION		
12	PATIENT BIRTH DATE	32	RESTRAINTS		
13	PATIENT GENDER	33	ROOM NUMBER		
14	PATIENT HEIGHT	34	ROUTE		
15	PATIENT MR NUM	35	RX ORDER NUMBER		
16	PATIENT NAME	36	SECOND PHYSICIAN		
17	PATIENT PHONE	37	SECOND PHYSICIAN NUM		
18	PATIENT PRICE	38	SERVICE CODE		
19	PATIENT SPECIES	39	SODIUM RESTRICTION		
20	PATIENT SS NUMBER	40	SPECIAL INSTRUCTIONS		

Enter: ___ ()

User Defined Mnemonics Page 2

NOTE: Administer Amount has been added as a mnemonic.

- F. **Alternate 1:** The first choice of alternate information to be included when the requested patient information as indicated by the mnemonic is not available.
- G. **Alternate 2:** The second choice or alternate information to be included when the requested patient information as indicated by the mnemonic is not available.
- H. **Alternate 3:** The third choice or alternate information to be included when the requested patient information as indicated by the mnemonic is not available.
- I. **Begin Column:** Defines where each new field begins.
- J. **Length:** The length of this particular field. The system calculates the minimum amount of space required for each mnemonic. This field can be greater than or less than the suggested number. If the field is smaller than the suggested number, information will be truncated.
- K. **CPI (10/12/16):** Defines the size of print.
- L. **Bar Code (Y/N):** Defines whether a bar code will print. This will always start in position 1 on the line.

M. **Font: (B–Bold, I–Italics):** De-fines whether the text is to be printed in bold or italics. The default is regular font.

Options

N. **Field Name (Text Descriptions):** This field is used to add a description to the mnemonic selected. For example, if the mnemonic for patient name is selected, the description “Patient Name:” could also be included with the patient’s name. The system will automatically calculate the necessary space needed and apply the description before the mnemonic.

O. **Begin Column:** Defines the column where the above description will begin printing.

P. **Length:** Defines the length of the text description.

Q. **CPI (10/12/16):** Defines the size of font of the text description.

R. **Font (B – Bold, I – Italics):** Defines whether the text description will print in bold or italics.

Nursing Medication Cart Labels

Nursing Medication Cart labels are set up through:

1. Hospital Base menu, select **Print Report Menu**.
2. Select **Cart Label Charging**.
 - Prints information necessary to label carts for nursing.
 - The following information is provided on the label:
 - Patient name
 - Patient account number
 - Patient room number
3. Call a TruBridge Pharmacy Support Representative before using this option.

Nursing Medication Cart Labels (Sample)

BOLTZ CAROLYN	101999
ROOM..500	AGE..54 SEX..F

FREEMAN MAGGIE	012200
ROOM..501	AGE..35 SEX..M

JOHNSON LYLE	092297
ROOM..502	AGE..31 SEX..M

Label Sizes

The TruBridge EHR supports five sizes of order entry labels: 4 x 1 7/16, 3.5 x 1 15/16, 3.5 x 1 7/16 and 2.8 x 1 15/16 inches. The label size is controlled by the setting in the Pharmacy Control Table.

4 x 1 15/16 inches 10 CPI 6 LPI (example of an Inpatient NON - IV Label)

```

BOLTZ CAROLYN          ROOM: 590-1
355959 ORDER: ...2 MED SURGE
05/08/00 18:00 DR. BAXTER JAM
900 1800 -----CIPRO TAB
CIPROFLOXACIN (CIPRO) TAB : 500 MG
500 MG PD BID

QTY 2 EA INIT: APD 1 OF 1
  
```

4 x 1 15/16 inches 10 CPI 6 LPI (example of an Inpatient IV Label)

```

BOLTZ CAROLYN          ROOM: 590-1
355959 MED SURGE
ORDER: ..13.FIRST DOSE 05/10/00 12:00
CEFAZOLIN 1GM/50ML D5W
KEEP REFRIGERATED
1Q0ML/HR
50 ML D5W
1 GM CEFAZOLIN (ANCEF) INJ

EXP AFTER: 05/13/00
HANG-05/11/00 04:00 Q 8 H BAG# 3
  
```

4 x 1 15/16 inches 10 CPI 6 LPI (example of an Outpatient Label)

```

CPSI TRAINING HOSPITAL (334)639-8100
6600 WALL STREET MOBILE, AL 36695
RX 1000000353 DR BAXTER J 05/10/00
BOLTZ CAROLYN 355959 ORD# 16
TAKE ONE TABLET BY MOUTH
DAILY

LASIX TAB : 40MG
LOT#GH6754 DISCARD AFTER: 07/01/01
APD QTY 30 4 REF $3.00
  
```

3.5 x 1 15/16 inches 12 CPI 6 LPI (example of an Inpatient NON - IV Label)

```

BOLTZ CAROLYN          ROOM: 590-1
355959 ORDER: ...2 MED SURGE
05/08/00 18:00 DR. BAXTER JAM
900 1800 -----CIPRO TAB
CIPROFLOXACIN (CIPRO) TAB : 500 MG
500 MG PO BID

QTY 2 EA INIT: APD 1 OF 1

```

3.5 x 1 15/16 inches 12 CPI 6 LPI (example of an Inpatient IV Label)

```

BOLTZ CAROLYN          ROOM: 590-1
355959 MED SURGE
ORDER: ..13.FIRST DOSE 05/10/00 12:00
CEFAZOLIN 1GM/50ML DSW
KEEP REFRIGERATED
100ML/HR
50 ML DSW
1 GM CEFAZOLIN (ANCEF) INJ

EXP AFTER: 05/13/00
HANG-05/11/00 04:00 Q 8 H BAG# 3

```

3.5 x 1 15/16 inches 12 CPI 6 LPI (example of an Outpatient Label)

```

CPSI TRAINING HOSPITAL (334)639-8100
6600 WALL STREET MOBILE, AL 36695
RX 1000000353 DR BAXTER J 05/10/00
BOLTZ CAROLYN 355959 ORD# 16
TAKE ONE TABLET BY MOUTH
DAILY

LASIX TAB : 40MG
LOT#GH6754 DISCARD AFTER: 07/01/01
APD QTY 30 4 REF $3.00

```

3.5 x 1 7/16 inches 12 CPI 8 LPI (example of an Inpatient NON - IV Label)

BOLTZ CAROLYN ROOM: 590-1
355959 ORDER: ...2 MED SURGE
05/08/00 18:00 DR. BAXTER JAM
900 1800 -----CIPRO TAB
CIPROFLOXACIN (CIPRO) TAB : 500 MG
500 MG PO BID

QTY 2 EA INIT: APD 2 OF 2

3.5 x 1 7/16 inches 12 CPI 8 LPI (example of an Inpatient IV Label)

BOLTZ CAROLYN ROOM: 590-1
355959 MED SURGE
ORDER: ..13.FIRST DOSE 05/10/00 12:00
CEFAZOLIN 1GM/50ML DSW
KEEP REFRIGERATED
100ML/HR
50 ML DSW
1 GM CEFAZOLIN (ANCEF) INJ

EXP AFTER: 05/15/00
HANG-05/11/00 04:00 Q 8 H BAG# 3

3.5 x 1 7/16 inches 12 CPI 8 LPI (example of an Outpatient Label)

CPSI TRAINING HOSPITAL (334)639-0100
6600 WALL STREET MOBILE, AL 36695
RX 1000000353 DR BAXTER J 05/12/00
BOLTZ CAROLYN 355959 ORD# 16
TAKE ONE TABLET BY MOUTH
DAILY

LASIX TAB : 40MG
LOT#GH6754 DISCARD AFTER: 07/01/01
APD QTY 30 4 REF \$3.00

2.8 x 1 15/16 inches 16 CPI 6 LPI (example of an Inpatient NON - IV Label)

BOLTZ CAROLYN	ROOM: 590-1
355959 ORDER: ...2 MED SURGE	
05/08/00 18:00	DR. BAXTER JAM
900 1800	-----CIPRO TAB
CIPROFLOXACIN (CIPRO) TAB : 500 MG	
500 MG	PO BID
QTY 2 EA	INIT: APD 1 OF 1

2.8 x 1 15/16 inches 16 CPI 6 LPI (example of an Inpatient IV Label)

BOLTZ CAROLYN	ROOM: 590-1
355959	MED SURGE
ORDER: ..13.FIRST DOSE 05/10/00 12:00	
CEFAZOLIN 1GM/50ML DSW	
KEEP REFRIGERATED	
100ML/HR	
50 ML DSW	
1 GM	CEFAZOLIN (ANCEF) INJ
EXP AFTER: 05/13/00	
HANG-05/11/00 04:00	0 8 H BAG# 3

2.8 x 1 15/16 inches 16 CPI 6 LPI (example of an Outpatient Label)

CPSI TRAINING HOSPITAL (334)639-8100	
6600 WALL STREET MOBILE, AL 36695	
RX 1000000353 DR BAXTER J 05/10/00	
BOLTZ CAROLYN 355959 ORD# 16	
TAKE ONE TABLET BY MOUTH	
DAILY	
LASTX TAB : 40MG	
LOT#GH6754 DISCARD AFTER: 07/01/01	
APD QTY 30 4 REF \$3.00	

2.8 x 1 7/16 inches 16 CPI 6 LPI (this size is no longer available from CPSI)

Zebra Labels**3 x 2 inches 16CPI 6LPI (example of an Inpatient Non-IV label)**

BOLTZ CAROLYN	ROOM: 39003
356959 ORDER: ...4	ICU EAST WING
05/16/00 10:20	DR. BAXTER J
800 2000	-----CIPRO 500 MG
CIPROFLOXACIN (CIPRO) TAB : 500MG	
500 MG	PO BID
QTY 2 EA	INIT: XXX 1 OF 1

3 x 2 inches 16CPI 6LPI (example of an Inpatient IV Label)

BOLTZ CAROLYN	ROOM: 39003
356959	ICU EAST WING
ORDER: ...6.FIRST DOSE	05/16/00 12:00
GENTAMICIN 80MG/100ML D5W	
KEEP REFRIGERATED	
100 ML	D5W
80 MG	GENTAMICIN IV
EXP AFTER: 05/21/00	

3 x 2 inches 16CPI 6LPI (example of an Outpatient label)

Previewing User Defined Labels

1. From the User Defined Forms screen select “R”eport.

Select **Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > Udef Labels**

CPSI Community Health System Signed On Emp: RB6 Dept: 038
 CPSI Community Health System User Defined Forms

Department: Pharmacy

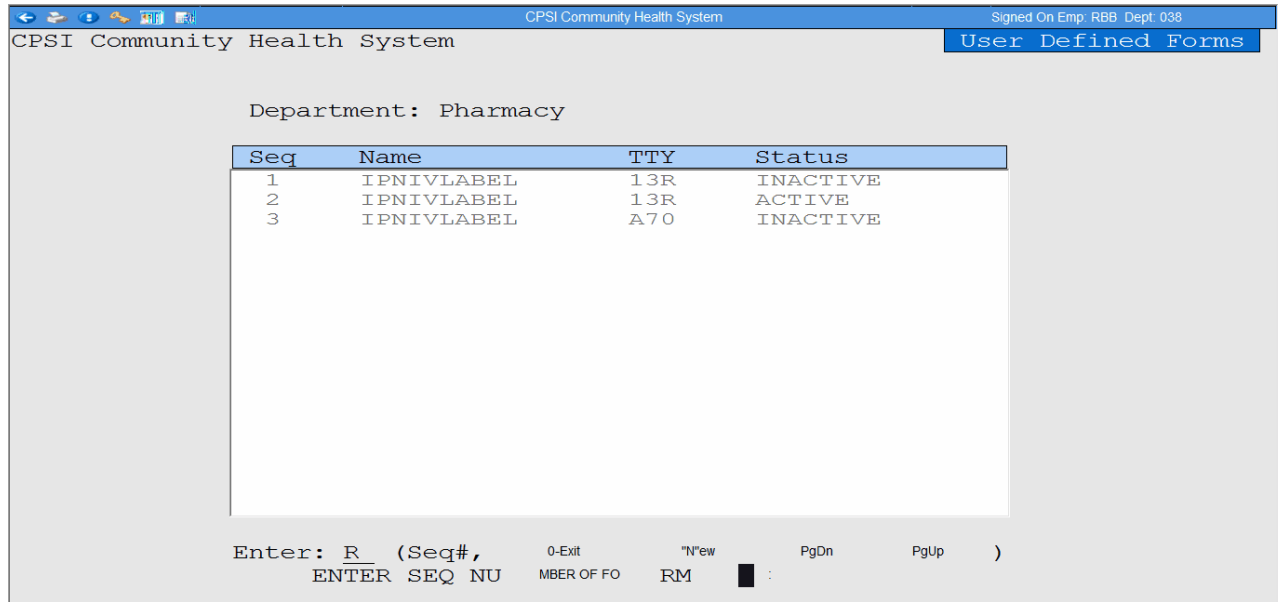
Seq	Name	TTY	Status
1	IPNIVLABEL	13R	INACTIVE
2	IPNIVLABEL	13R	ACTIVE
3	IPNIVLABEL	A70	INACTIVE

Enter: █ (Seq#, 0-Exit *N*ew PgDn PgUp)
 *D*elete *R*eport

Viewing User Defined Labels

2. Enter sequence number of form to view.

Select **Hospital Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance > Udef Labels > Report**



Viewing User Defined Labels

3. Select printer or to view label in Adobe Acrobat select **Windows**.