Table Maintenance - Clinical

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Table of Contents

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.

1.2 What's New

This section introduces the new features and improvements for **Table Maintenance - Clinical** for release Version 22. A brief summary of each enhancement is given referencing its particular location if applicable. As new branches of Version 22 are made available, the original enhancements will be moved to the Previous Work Requests section. The enhancements related to the most current branch available will be listed under the main What's New section.

Each enhancement includes the Work Request (WR) Number and the description. If further information is needed, please contact the **Client Services** Support.

Pharmacy Report Control MAR Report

DESCRIPTION: A chapter on the Pharmacy Report Control: MAR Report has been added.

DOCUMENTATION: See MAR Report 141

Chapter 2 Overview

This document describes Clinical tables maintained via Table Maintenance.

Select **Web Client** > **Tables** > **Clinical**

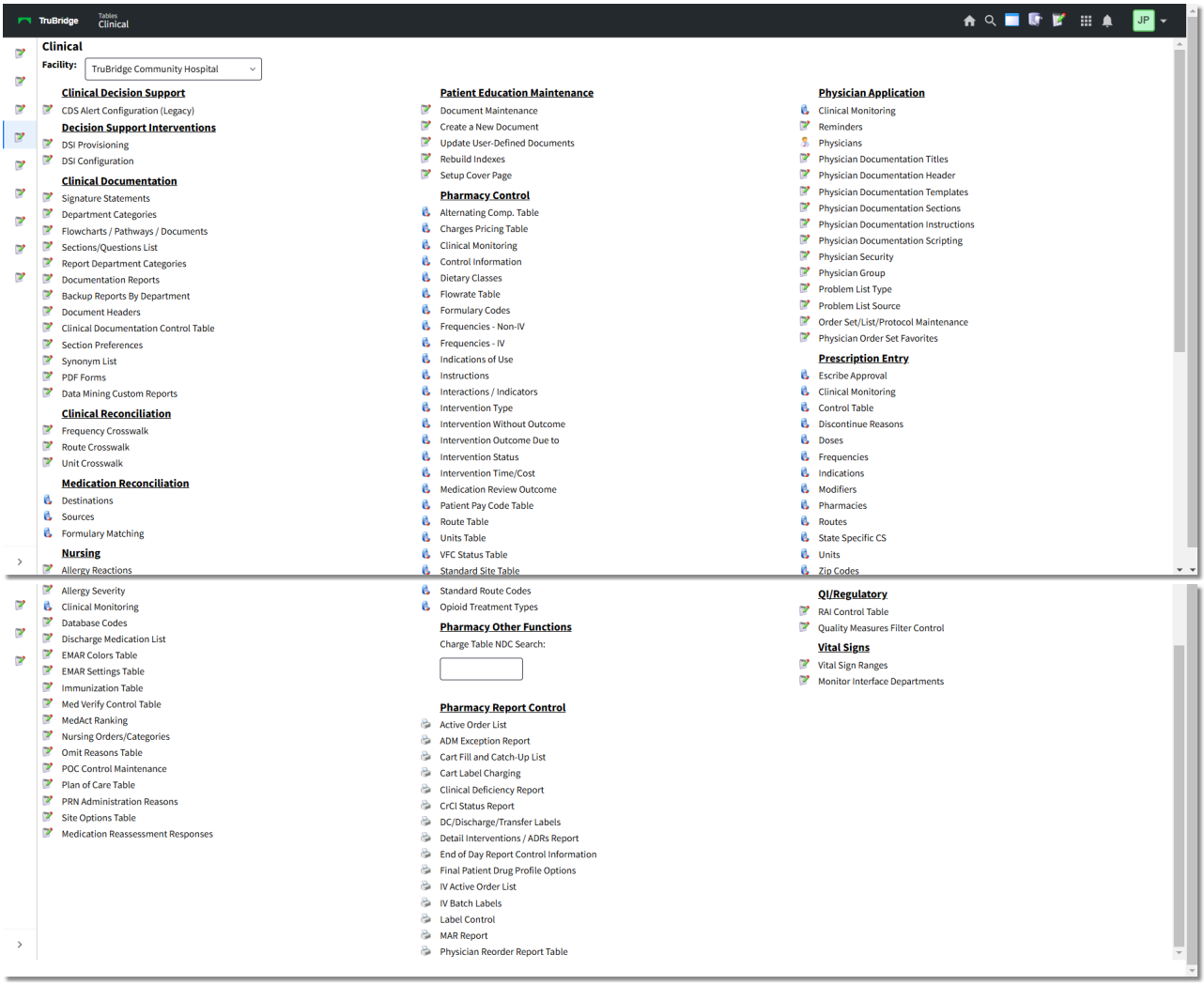


Table Maintenance - Clinical

NOTE: *Facilities outside of the United States may choose a date format of MMDDYY, DDMMYY, or YYMMDD to be used on all date fields in the Clinical tables. Where four-digit dates display, a date format of MMDD, DDMM, or MMDD, respectively, will be used. Whichever date format is selected will be reflected in all date fields and column displays throughout the tables. Contact a TruBridge Representative if you want the date format changed for your facility.*

Chapter 3 Clinical Decision Support

3.1 CDS Alert Configuration

TruBridge's Learning and Development Team will be updating documentation for this table in the future.

Chapter 4 Clinical Documentation

4.1 Signature Statements

Please see Signature Statements within the Documentation Setup User Guide.

4.2 Department Categories

Please see Department Categories within the Documentation Setup User Guide.

4.3 Flowcharts/Pathways/Documents

Please see Flowcharts/Pathways/Documents within the Documentation Setup User Guide.

4.4 Sections/Questions List

Please see Section/Questions List within the Documentation Setup User Guide.

4.5 Report Department Categories

Please see Report Department Categories within the Documentation Setup User Guide.

4.6 Documentation Reports

Please see Documentation Reports within the Documentation Setup User Guide.

4.7 Backup Reports By Department

Please see Backup Reports By Department within the Documentation Setup User Guide.

4.8 Document Headers

Please see Document Headers within the Documentation Setup User Guide.

4.9 Clinical Documentation Control Table

Please see Clinical Documentation Control Table within the Documentation Setup User Guide.

4.10 Section Preferences

Please see Section Preferences within the Documentation Setup User Guide.

4.11 PDF Forms

TruBridge Use Only

4.12 Data Mining Custom Reports

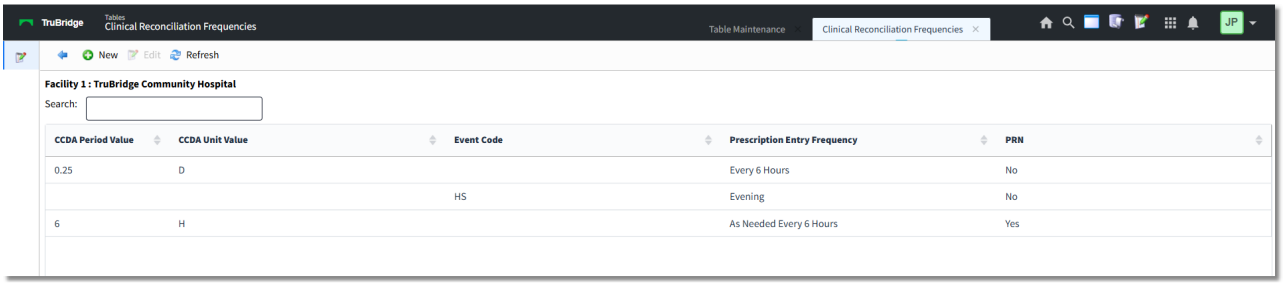
Please See Data Mining Custom Reports within the Data Mining Custom Reports User Guide.

Chapter 5 Clinical Reconciliation

5.1 Frequency Crosswalk

The Frequency Crosswalk table allows the facility to cross-reference frequencies from the CCDA to their prescription frequency table when importing medications during Clinical Information Reconciliation.

Select **Web Client** > **Tables** > **Clinical** > **Frequency Crosswalk**



Clinical Information Reconciliation Frequencies Crosswalk

The Frequency Crosswalk table displays information under the following column headers:

- **CCDA Period Value**
- **CCDA Unit Value**
- **Event Code**
- **Prescription Entry Frequency**
- **PRN**

The table may be sorted by column in ascending or descending order by selecting a column header. A smart search field is also available to search by description as displayed in the Prescription Entry Frequency column.

The Action Bar has the following options:

- **Back Arrow**: Returns to the Clinical table maintenance screen.
- **New**: Launches the Frequency Maintenance screen to enter a new CCDA value and associate a frequency. This option will be disabled if an existing row in the table is selected.
- **Edit**: Launches the Frequency Maintenance screen to modify an existing CCDA value and frequency association. This option is only available when an existing row in the table has been selected.
- **Refresh**: Reloads the Frequency Crosswalk table with all updated information.

Frequency Maintenance

The Frequency Maintenance screen provides the means to enter a new frequency association or edit an existing association. Once values are entered, then the appropriate prescription frequency may be associated to it.

Select **Web Client** > **Tables** > **Clinical** > **Frequency Crosswalk** > **New**

Clinical Information Reconciliation Frequency Maintenance

The following fields are available:

NOTE: *Not all fields necessarily need to be addressed depending on the frequency being entered or edited (i.e., period/unit values versus event code). However, it is possible to have a frequency with both period/units and an event code (e.g., 1H and PC for taking a medication one hour after meals).*

- **CCDA Period Value**: Maximum four digits. Allows the entering of a valid period value, e.g., 0.5, 1, 4, 6, 8, 12, etc.
- **CCDA Unit Value**: Maximum two characters. Allows the entering of a valid unit value, e.g., D, H, MO, WK, etc. Upper and lower case may be used.
- **Event Code**: Maximum three characters. Allows the entering of a valid event code, e.g., PC, AC, HS, ACM, ICD, etc.
- **Prescription Entry Frequency**: Select the magnifying glass icon to launch the Prescription Entry Frequencies table. Frequencies may be searched by Frequency, Hospital Frequency or Display Order. Double-click the desired frequency. The selected frequency will display to the right of the magnifying glass icon.
- **PRN**: Default is unchecked (No). Check the box (Yes) to designate the frequency as PRN. PRN medications have a special section in the CCDA indicating the frequency is PRN instead of standard. Records must be created for the standard frequency and the PRN frequency separately (i.e., a frequency of "Four times a day" could be represented by 6H, and a frequency of "Four times a day as needed" could be represented by 6H with the PRN box checked).

NOTE*: The period of time (period and unit values) may be represented by a decimal up to two decimal places instead of a whole number, i.e., .5D or 12H may both be utilized for a medication to be taken twice a day.*

When attempting to save a record for an association that already exists, users will be prompted with the message, "This setup (Period, Unit, Event, PRN) is already associated to an existing frequency."

The Action Bar has the following options:

- **Back Arrow**: Returns to the Frequency Crosswalk table. If unsaved information exists when the Back Arrow is selected, users will be prompted with the message, "Are you sure you wish to exit without saving?" with "Yes" and "No" options. Selecting "Yes" will return to the Frequency Crosswalk table without saving the entered information. Selecting "No" will return to the maintenance screen so that the entered information may be saved.

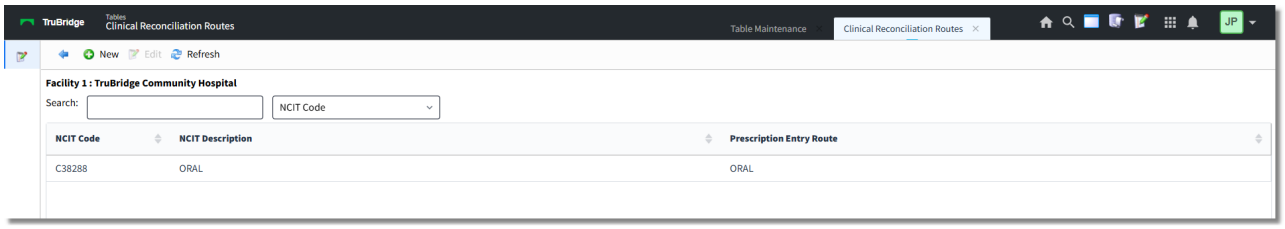
- **Update**: Saves the current information and exits back to the Frequency Crosswalk table. This option will become available when new information has been entered.

- **Delete**: Prompts the user with the message, "Are you sure you wish to remove this record?" with "Yes" and "No" options. Selecting "Yes" will remove the record from the Frequency Crosswalk table. Selecting "No" will return to the maintenance screen. This option will become available when editing an existing record.

5.2 Route Crosswalk

The Route Crosswalk table allows the facility to cross-reference routes from the CCDA to their prescription route table when importing medications during Clinical Information Reconciliation.

Select **Web Client** > **Tables** > **Clinical** > **Route Crosswalk**



Clinical Information Reconciliation Route Crosswalk

The Route Crosswalk table displays information under the following column headers:
- **NCIT Code**
- **NCIT Description**
- **Prescription Entry Route**

The table may be sorted by column in ascending or descending order by selecting a column header. A smart search field is available to search routes by NCIT Code, NCIT Description or Route as selected from the drop-down selection filter.

The Action Bar has the following options:

- **Back Arrow**: Returns to the Clinical table maintenance screen.

- **New**: Launches the Route Maintenance screen to enter a new NCIT code and associate a route. This option will be disabled if an existing row in the table is selected.

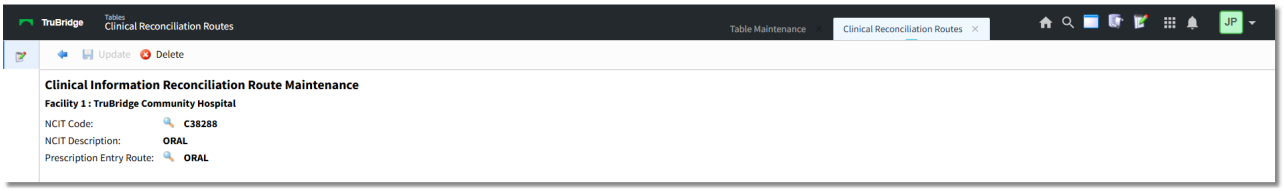
- **Edit**: Launches the Route Maintenance screen to modify an existing NCIT code and route association. This option is only available when an existing row in the table has been selected.

- **Refresh**: Reloads the Route Crosswalk table with all updated information.

Route Maintenance

The Route Maintenance screen provides the means to enter a new route association or edit an existing association. Once a NCIT code is selected, then the appropriate prescription route may be associated to it.

Select **Web Client** > **Tables** > **Clinical** > **Route Crosswalk** > **New**



Clinical Information Reconciliation Route Maintenance

The following fields are available:

- **NCIT Code**: Select the magnifying glass icon to launch the NCI Thesaurus List. NCIT codes may be searched by Description or Code. Either double-click the desired code or select the desired code and then select **OK**. The selected code will display to the right of the magnifying glass icon.

- **NCIT Description**: Displays the description of the selected NCIT code.

- **Prescription Entry Route**: Select the magnifying glass icon to launch the Prescription Entry Routes table. Routes may be searched by Route, Prefix, Hospital Route or Display Order. Either double-click the desired route or select the desired route and then select **OK**. The selected route will display to the right of the magnifying glass icon.

NOTE: *If a Prescription Entry Route that has already been associated is selected before selecting a NCIT code, the NCIT code association will automatically display.*

When attempting to associate a NCIT code for an association that already exists, users will be prompted with the message, "The selected NCIT code is already attached to another route."

The Action Bar has the following options:

- **Back Arrow**: Returns to the Route Crosswalk table. If unsaved information exists when the Back Arrow is selected, users will be prompted with the message, "Are you sure you wish to exit without saving?" with "Yes" and "No" options. Selecting "Yes" will return to the Route Crosswalk

table without saving the entered information. Selecting "No" will return to the maintenance screen so that the entered information may be saved.

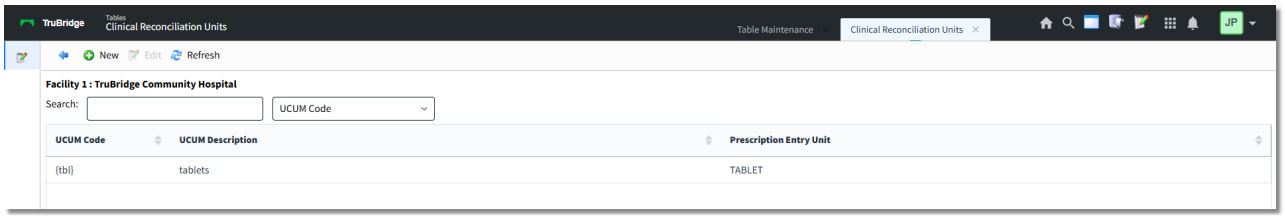
- **Update**: Saves the current information and exits back to the Route Crosswalk table. This option will become available when new information has been entered.

- **Delete**: Prompts the user with the message, "Are you sure you wish to remove this record?" with "Yes" and "No" options. Selecting "Yes" will remove the record from the Route Crosswalk table. Selecting "No" will return to the maintenance screen. This option will become available when editing an existing record.

5.3 Unit Crosswalk

The Unit Crosswalk table allows the facility to cross-reference units from the CCDA to their prescription unit table when importing medications during Clinical Information Reconciliation.

Select **Web Client** > **Tables** > **Clinical** > **Unit Crosswalk**



Clinical Information Reconciliation Unit Crosswalk

The Unit Crosswalk table displays information under the following column headers:
- **UCUM Code**
- **UCUM Description**
- **Prescription Entry Unit**

The table may be sorted by column in ascending or descending order by selecting a column header. A smart search field is available to search units by UCUM code, UCUM Description or Unit as selected from the drop-down selection filter.

The Action Bar has the following options:

- **Back Arrow**: Returns to the Clinical table maintenance screen.

- **New**: Launches the Unit Maintenance screen to enter a new UCUM code and associate a unit. This option will be disabled if an existing row in the table is selected.

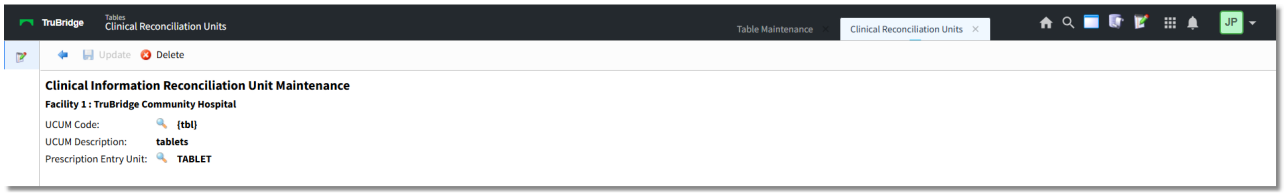
- **Edit**: Launches the Unit Maintenance screen to modify an existing UCUM code and unit association. This option is only available when an existing row in the table has been selected.

- **Refresh**: Reloads the Unit Crosswalk table with all updated information.

Unit Maintenance

The Unit Maintenance screen provides the means to enter a new unit association or edit an existing association. Once a UCUM code is selected, then the appropriate prescription unit may be associated to it.

Select **Web Client** > **Tables** > **Clinical** > **Unit Crosswalk** > **New**



Clinical Information Reconciliation Unit Maintenance

The following fields are available:

- **UCUM Code:** Select the magnifying glass icon to launch the UCUM Code table. UCUM codes may be searched by Code or Description. Either double-click the desired code or select the desired code and then select **OK**. The selected code will display to the right of the magnifying glass icon.

- **UCUM Description:** Displays the description of the selected UCUM code.

- **Prescription Entry Unit:** Select the magnifying glass icon to launch the Prescription Entry Units table. Units may be searched by Units, Hospital Unit or Display Order. Either double-click the desired unit or select the desired unit and then select **OK**. The selected unit will display to the right of the magnifying glass icon.

NOTE: *If a Prescription Entry Unit that has already been associated is selected before selecting a UCUM code, the UCUM code association will automatically display.*

When attempting to associate a UCUM code for an association that already exists, users will be prompted with the message, "The selected UCUM code is already attached to another unit."

The Action Bar has the following options:

- **Back Arrow:** Returns to the Unit Crosswalk table. If unsaved information exists when the Back Arrow is selected, users will be prompted with the message, "Are you sure you wish to exit without saving?" with "Yes" and "No" options. Selecting "Yes" will return to the Unit Crosswalk table without saving the entered information. Selecting "No" will return to the maintenance screen so that the entered information may be saved.

- **Update:** Saves the current information and exits back to the Unit Crosswalk table. This option will become available when new information has been entered.

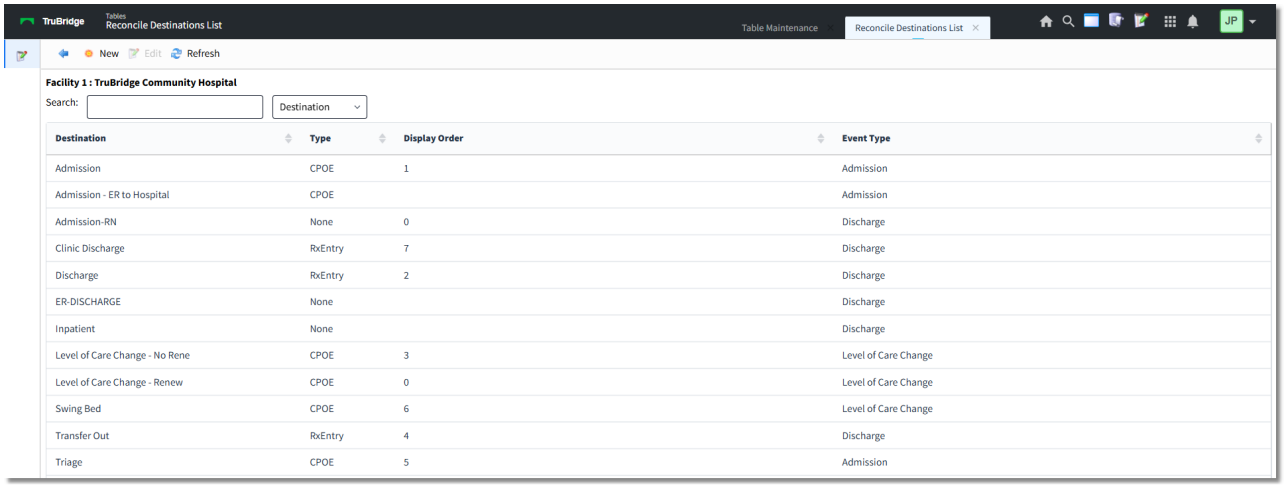
- **Delete:** Prompts the user with the message, "Are you sure you wish to remove this record?" with "Yes" and "No" options. Selecting "Yes" will remove the record from the Unit Crosswalk table. Selecting "No" will return to the maintenance screen. This option will become available when editing an existing record.

Chapter 6 Medication Reconciliation

6.1 Destinations

Destinations are used to denote the point in a patient's stay for which reconciliation is occurring. Destination setup also determines the functionality of the application at each juncture in the patient's stay. The **Destinations** table is selected to create a facility-defined listing of the Destinations that will display in the drop-down menu in Medication Reconciliation (e.g. Admission, Level of Care Change, and Discharge).

Select **Web Client** > **Tables** > **Clinical** > **Medication Reconciliation** > **Destinations**



Destination	Type	Display Order	Event Type
Admission	CPOE	1	Admission
Admission - ER to Hospital	CPOE		Admission
Admission-RN	None	0	Discharge
Clinic Discharge	RxEntry	7	Discharge
Discharge	RxEntry	2	Discharge
ER-DISCHARGE	None		Discharge
Inpatient	None		Discharge
Level of Care Change - No Rene	CPOE	3	Level of Care Change
Level of Care Change - Renew	CPOE	0	Level of Care Change
Swing Bed	CPOE	6	Level of Care Change
Transfer Out	RxEntry	4	Discharge
Triage	CPOE	5	Admission

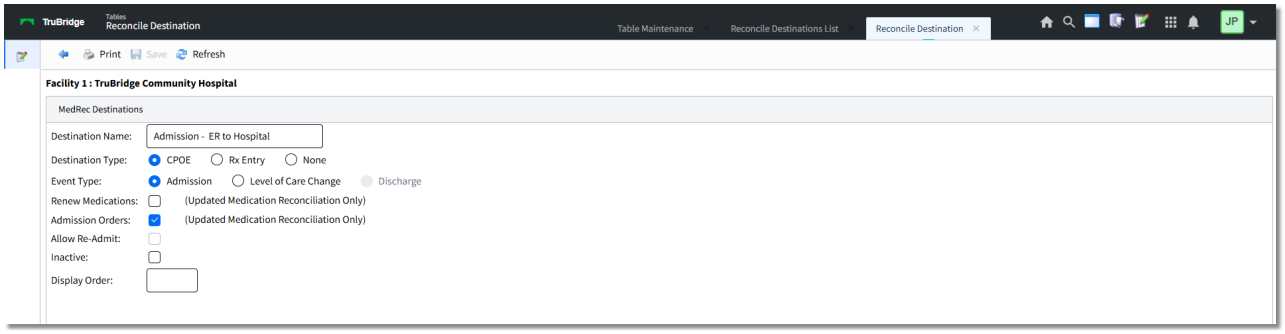
Destinations table

Existing Destinations will display including their Description, Type, Display Order and Event Type. The columns may be sorted by selecting the header.

To modify an existing Destination, select the Destination then **Edit**. Select **Refresh** to immediately apply any changes made to the Destination. Select **Back Arrow** to return to the previous screen.

Select **New** to create a new Destination.

Select **Web Client** > **Tables** > **Clinical** > **Medication Reconciliation** > **Destinations** > **New**



Admission Destination Setup

The following setup options are available:

- **Destination Name:** This is the description that will display in the **Destination** drop-down and in the Med Rec **History**.

- **Destination Type:** This option determines where the user will be launched upon selecting **Reconcile**.
  - **CPOE:** When a reconciliation is performed for this Destination Type, the TruBridge EHR launches Physician Order Entry so that new orders may be placed. CPOE is most commonly associated with Admission Event Types or Level of Care Changes when new orders are needed.
  - **Rx Entry:** When a reconciliation is performed for this Destination Type, the TruBridge EHR launches Prescription Writer so discharge medications may be documented. Rx Entry is most commonly associated with Discharge Event Types.
  - **None:** This Destination Type is used when no new orders or prescriptions are needed. **None** is most commonly associated with Level of Care Change Event Types where the patient changes account numbers.

- **Event Type:** This option defines how the reconciliation will be counted for Meaningful Use statistics and will also list in the Med Rec **History**.

- **Renew Medications:** If selected, this field allows physicians to renew medications in Updated Medication Reconciliation when performing a Level of Care Change**.** The provider selects **Continue Active** and is launched into CPOE where medications may be reviewed and signed without having to address each medication. This option is only enabled if the Destination Type is CPOE.

- **Admission Orders**: When the provider performs an Admission Reconciliation with this option selected, the orders will be flagged as Admission Orders and will have a 'Pending Admit' status. Once the patient is fully admitted, these orders will be automatically released to the verification queues. The Admission Orders option is only enabled if the facility has purchased EDIS and the Destination Type is set to CPOE.

- **Allow Re-Admit:** This option allows the user to reverse a discharge reconciliation. This is most commonly associated with Discharge Event Types. This field is retroactive, so it can be turned on/off as needed.
- **Inactive:** Destinations cannot be deleted. However, Destinations that are no longer used should be hidden so they will not display in the Destination drop-down.
- **Display Order:** Determines the order in which the destination will appear in the **Destination** drop-down.

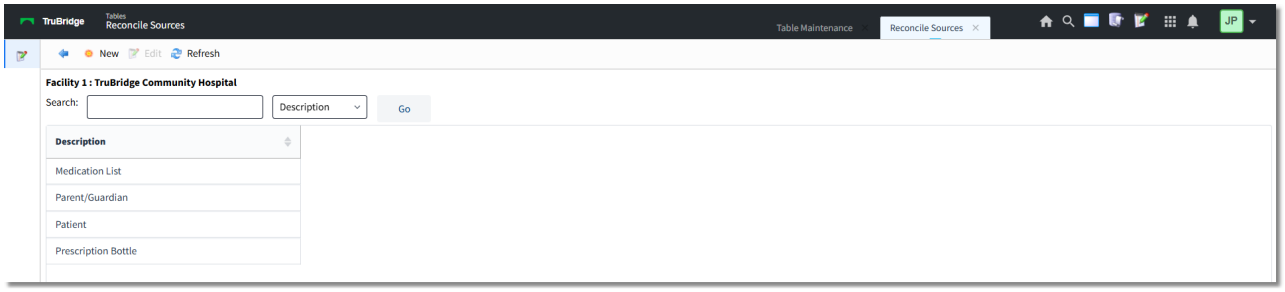
After setup is complete, the following options are available:

- **Print**: Select this option to print setup.
- **Save**: Select this option to save modifications.
- **Refresh**: Select this option to apply any changes made to the setup before the system completes an automatic refresh.
- **Back Arrow**: Select this option to return to the previous screen.

6.2 Sources

The **Sources** table is used to create a facility-defined listing of the sources that provide the patient's medication list. The source is selected from a drop-down menu when adding Home Meds during the Medication Reconciliation process.

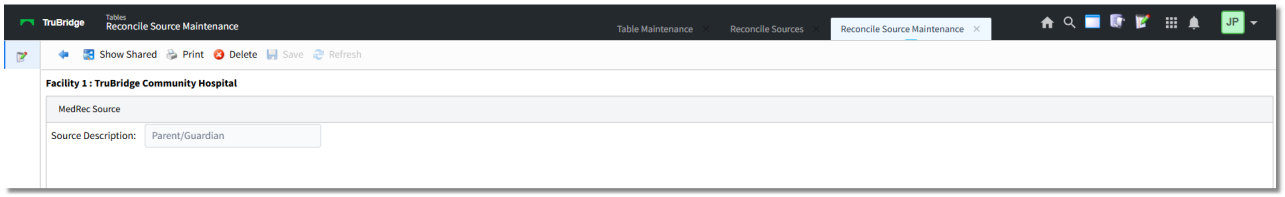
Select **Web Client** > **Tables** > **Clinical** > **Medication Reconciliation** > **Sources**



Sources Table

Select **New** to create a new source or choose an existing source and select **Edit**.

Select **Web Client** > **Tables** > **Clinical** > **Medication Reconciliation** > **Sources** > **New**



New Source

- **Source Description:** Enter the description.

The following options are available on the action bar:

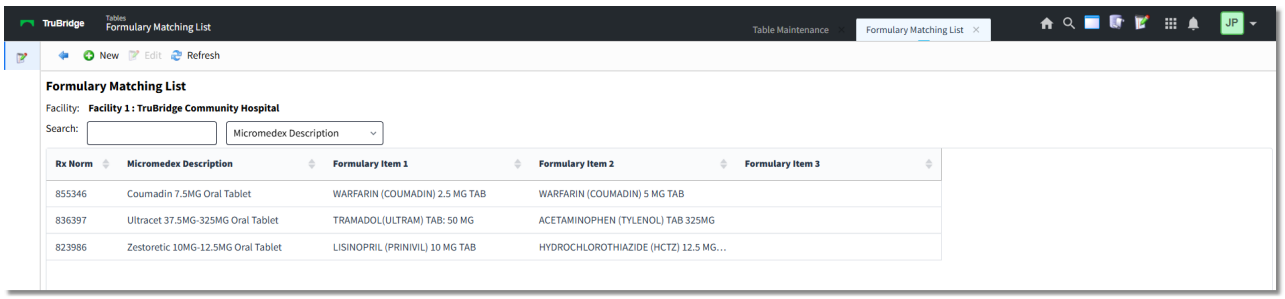
- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.
- **Print**: Displays the table settings in a pdf document.
- **Delete**: Deletes the selected entry.
- **Save**: Saves changes made to the table.
- **Refresh**: Allows changes to show immediately in the **Source** list.

Select the **Back Arrow** to return to the previous screen.

6.3 Formulary Matching

The Formulary Matching table allows the facility to cross-reference medications from the Micromedex® database to their hospital formulary. Up to three formulary medications may be matched to one Micromedex® combination medication. Name Brand medications may be matched to Generic medications. This table is intended to improve the process of continuing Home Meds during Admission Reconciliation by matching non-formulary Home Meds to what is available within the hospital's formulary.

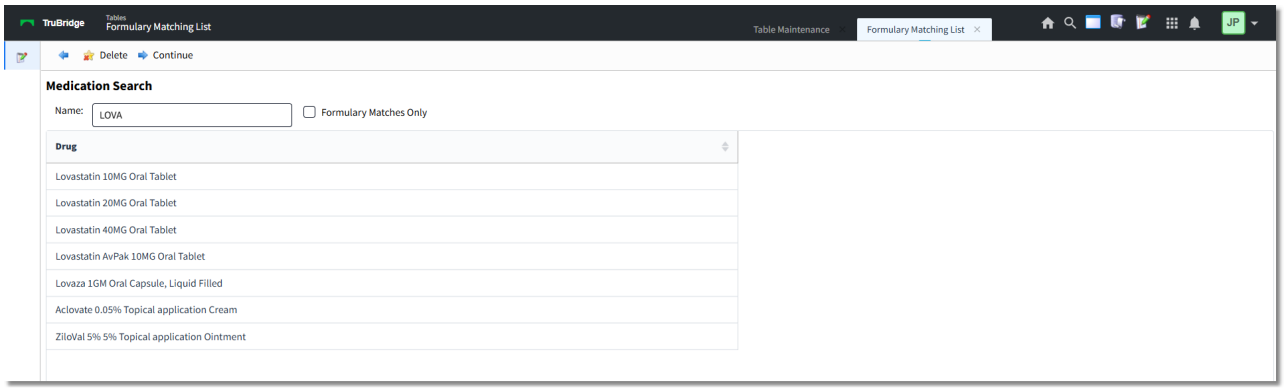
Select **Web Client** > **Tables** > **Clinical** > **Medication Reconciliation** > **Formulary Matching**



Formulary Matching Table

Select **New** to begin searching for a medication or choose an existing match and select **Edit**.

Select **Web Client > Tables > Clinical > Medication Reconciliation > Formulary Matching > New**

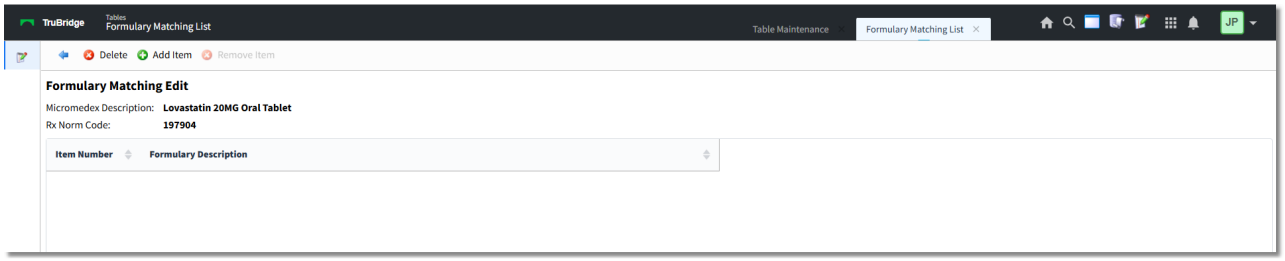


New Formulary Match

Enter a few characters of the medication description to search the Micromedex® database or select the **Formulary Matches Only** checkbox to search for formulary medications that may be matched to Micromedex® medications.

Double-click or select the medication then select **Continue** to cross-reference the selected medication.

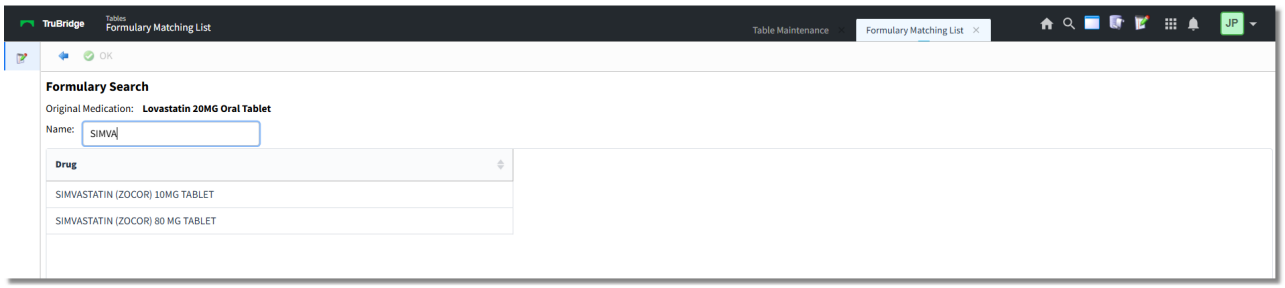
Select **Web Client > Tables > Clinical > Medication Reconciliation > Formulary Matching > New > select Med > Continue**



Formulary Matching Edit

Select **Add Item** to begin searching for the medication to be cross-referenced with the original selected medication. Enter a few characters of the medication description to search the hospital formulary (Item Master).

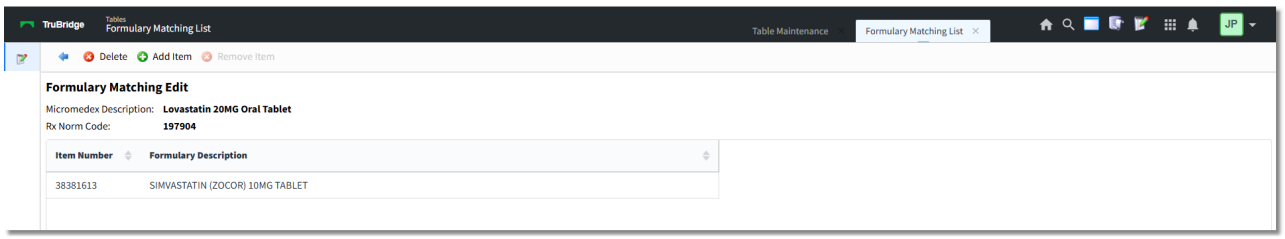
Select **Web Client** > **Tables** > **Clinical** > **Medication Reconciliation** > **Formulary Matching** > **New** > **select Med** > **Continue** > **Add Item**



Formulary Search screen

Double click or select the appropriate medication then select **OK.**

Select **Web Client** > **Tables** > **Clinical** > **Medication Reconciliation** > **Formulary Matching** > **New** > **select Med** > **Continue** > **Add Item**

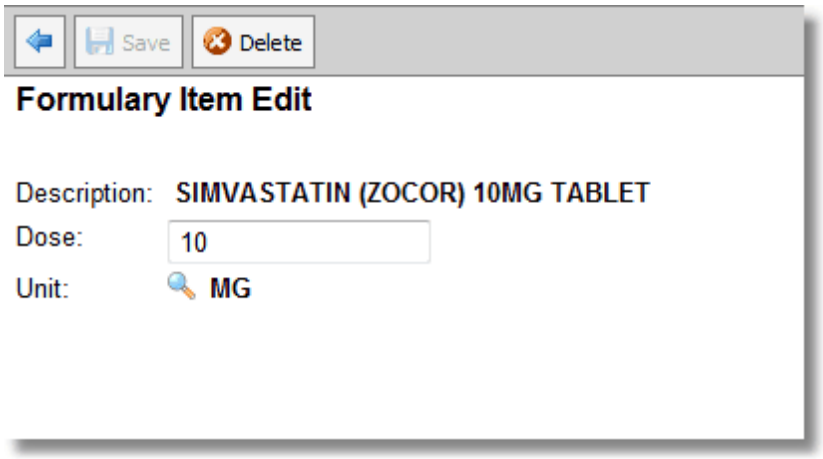


Add Item

Double-click or select the medication then select **Edit Item** if the dose and unit need to be edited for this item.

NOTE: *If a predefined Dose and* Unit (*from Pharmacy Information Page 1) exists, the TruBridge EHR will use this information and skip the Formulary Item Edit screen. If predefined information does not exist on the selected formulary item, the system will display the Formulary Item Edit screen for* ***Dose*** *and* ***Unit*** *entry.*

Select **Web Client** > **Tables** > **Clinical** > **Medication Reconciliation** > **Formulary Matching** > **New** > **select Med** > **Continue** > **Add Item** > **Select item** > **Edit Item**



Formulary Item Edit

- Enter the dose of the medication.
- Select the magnifying lens to select the unit.
- Select **Save** to save the changes.
- Select **Delete** to remove the item.

Select **Web Client** > **Tables** > **Clinical** > **Medication Reconciliation** > **Formulary Matching** > **New** > **select Med** > **Continue** > **Add Item** > **Select item** > **Edit Item** > **Save**

Formulary Matching Edit

Select **Add Item** to attach another formulary medication or select the **Back Arrow** to return to the previous screen.

The non-formulary medication has been matched to the formulary medication and will display in the Alternative Medication Screen during Admission Reconciliation.

NOTE: *Additional security is available to allow the user to bypass the Alternative Medication Screen and launch directly to order entry for the "matched" medication.*

Select  **Back Arrow** to exit.

The following options are available on the action bar:

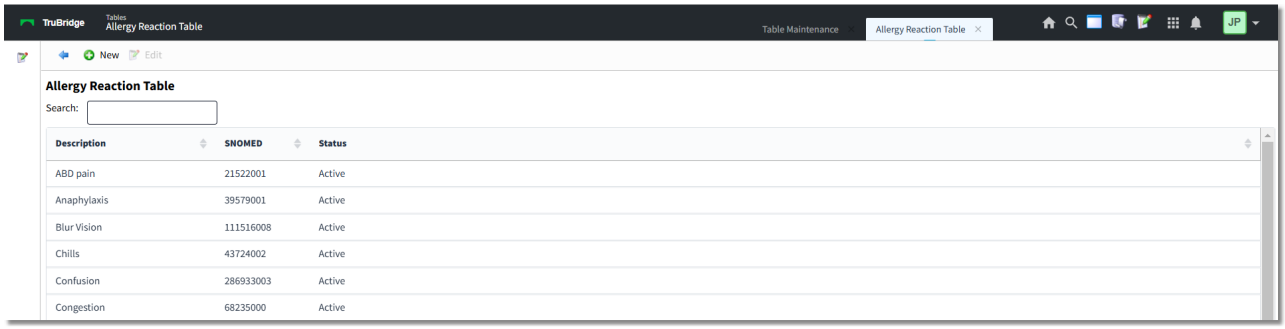
- **Edit**: Select the medication then select **Edit.** This allows the item to be edited or deleted.
- **Refresh**: Allows changes to show immediately.

Chapter 7 Nursing

7.1 Allergy Reactions

The Allergy Reaction Table lists the reactions that display when charting a patient's allergies. Reactions may be added, edited, and inactivated in this table.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Allergy Reactions**



Allergy Reaction Table

The table displays the following information:

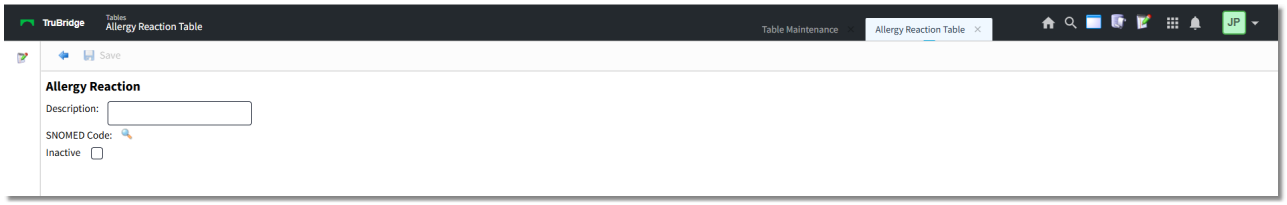
- **Description:** Displays the description of the allergy reaction.
- **SNOMED:** Displays the SNOMED code associated with the allergy reaction.
- **Status:** Displays the status of the allergy reaction (**Active** or **Inactive**).

Action Bar Options

- **Blue back arrow:** Select to return to the previous screen.
- **New:** Select to create a new allergy reaction.
- **Edit:** Select to edit the selected allergy reaction.

To Add a New Allergy Reaction

1. Select **New**. The **Allergy Reaction** screen displays.



Allergy Reaction - New

2. In the **Description** field, enter a description for the allergy reaction.
3. In the **SNOMED Code** field, use the lookup icon to search for and select the appropriate SNOMED code.
4. The **Inactive** check box defaults to unchecked, indicating the reaction is active and available for use in the system. If you do not want the reaction available, select the check box.
5. Select **Save**.
6. Select the **blue back arrow** to return to the **Allergy Reaction Table**.

To Edit an Allergy Reaction

1. On the **Allergy Reaction Table**, select the reaction entry you want to edit.
2. Select **Edit**.
3. Make the necessary edits.
4. Select **Save**.
5. Select the **blue back arrow** to return to the **Allergy Reaction Table**.

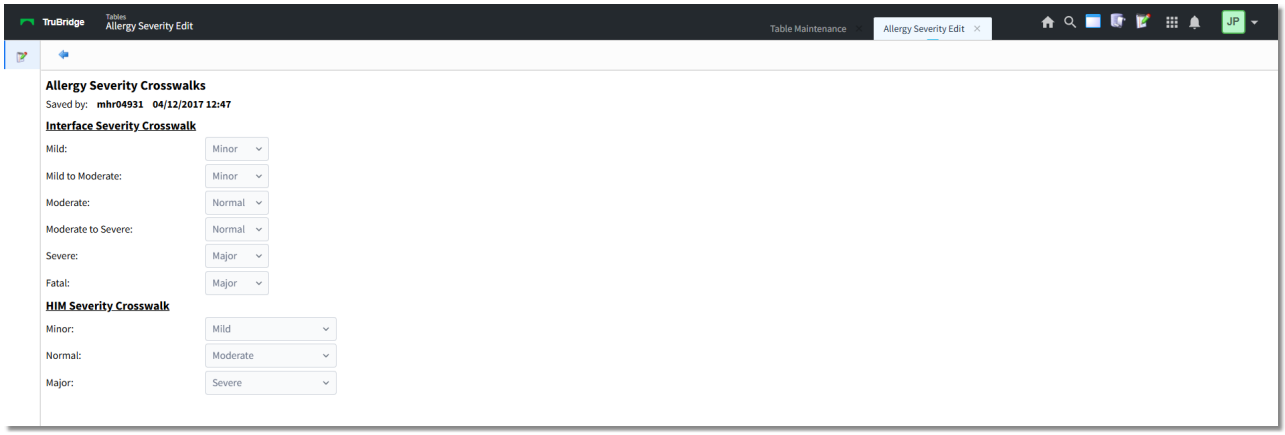
NOTE: *Existing allergy reactions cannot be deleted. Selecting the* ***Inactive*** *check box will remove the reaction from the drop-down list in the Allergy application.*

7.2 Allergy Severity

The Allergy Severity table creates a crosswalk to convert existing Allergy Severities (Minor, Normal, Major) to standard Allergy Severities (Mild, Mild to Moderate, Moderate, Moderate to Severe, Severe, and Fatal).

NOTE: *This table may only be updated one time. After* ***Save*** *is selected, all fields will be disabled.*

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Allergy Severity**



Allergy Severity Crosswalk

In the **Interface Severity Crosswalk** section, select the drop-down for each of the standard severities (**Mild**, **Mild to Moderate**, **Moderate**, **Moderate to Severe**, **Severe**, and **Fatal**) and map to the existing severities (**Minor**, **Normal**, **Major**).

NOTE: *The crosswalk is used for interface transmission purposes. The crosswalk must be completed in order to save a new severity or edit an existing severity on an allergy reaction.*

In the **HIM Severity Crosswalk** section, select the drop-down and map the new severities to existing severities. A new severity must be selected for each existing severity.

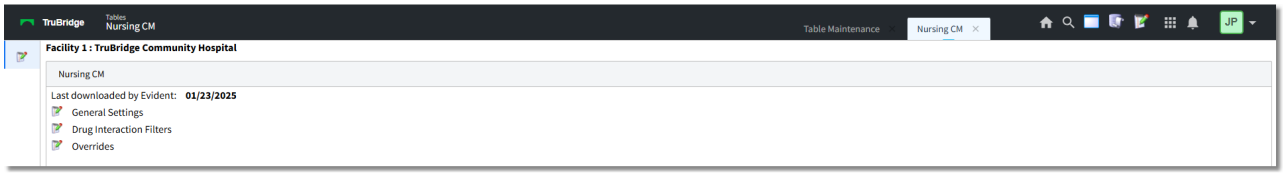
Select **Save**.

The TruBridge EHR will record and display the Employee UBL and the date and time the table entries were saved.

7.3 Clinical Monitoring

The Clinical Monitoring table contains setting that control the Clinical Monitoring in Order Entry for nursing.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Clinical Monitoring**



Nursing Clinical Monitoring

- **Last Downloaded by Evident: MM/DD/YYYY:** Indicates the last date clinical monitoring files were updated.
- **General Settings:** Contains the clinical monitoring option settings.

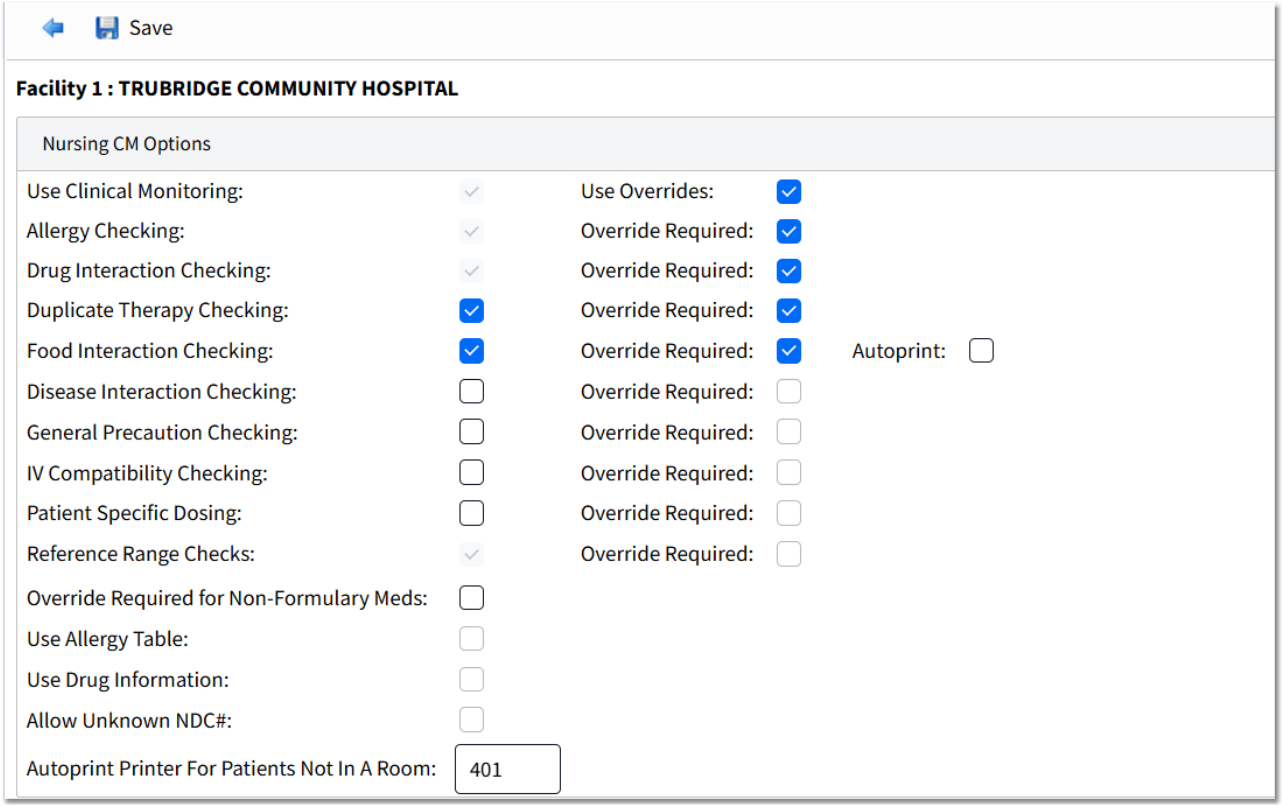
- **Drug Interaction Filters:** Contains the drug interaction filtering option settings.
- **Overrides:** Lists override reasons that can be selected to explain why certain orders were placed despite safety checks being generated for them.

NOTE: *Clinical Monitoring is updated monthly.*

General Settings

The General Settings section contains the Clinical Monitoring options for nursing in Order Entry.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Clinical Monitoring** > **General Settings**



General Settings - Nursing Clinical Monitoring Options

- **Use Clinical Monitoring:** Activates Clinical Monitoring for nursing medication order entry. This field is grayed out but always checked "yes," since some Clinical Monitoring checks are required for Promoting Interoperability.

- **Allergy Checking:** Allows the system to automatically perform allergy checks at the time of order entry. Whenever a medication is entered for a patient, the system compares the new medication to any drug allergy entered on the patient through the TruBridge EHR. If there are any drug allergies documented that correspond to the medication selected, a menu will display showing the drug selected, the allergy, the drug class and any possible symptoms. This field is grayed out but always checked "yes," since this Clinical Monitoring check is required for Promoting Interoperability.

- **Drug Interaction Checking:** Allows the system to automatically perform drug interaction checks at the time of order entry. Whenever a medication is entered for a patient, the system compares the new medication to all medications the patient is currently taking or has taken within the last 24 hours. Any possible interactions will display. The drug interactions are ranked

as contraindicated, major, moderate, or minor. This field is grayed out but always checked "yes," since this Clinical Monitoring check is required for Promoting Interoperability.

- **Duplicate Therapy Checking:** Select the check box to allow the system to automatically perform duplicate therapy checks at the time of order entry. As soon as the medication is selected, the patient's current orders are reviewed for duplicate therapy. Duplicate Therapy Checking is based on the NDC number, which is entered on the Pharmacy Information screen for each medication.

- **Food Interaction Checking:** Select the check box to allow the system to automatically perform food interaction checks at the time of order entry. If a medication that has an interaction to food is selected, the Clinical Monitoring screen displays. A monograph may then be printed or displayed. To auto-print food interactions select **Autoprint**. If the patient is in a room, the report will print to the default nursing station printer. Enter a printer number in the field labeled **Autoprint Printer for Patients Not In A Room** if this report will be utilized for patients not registered in a room.

- **Disease Interaction Checking:** Select the check box to allow the system to automatically perform disease interaction checking at the time of order entry. Whenever a medication is entered for a patient, the system compares the new medication to the diagnosis for the patient to ensure the drug does not interfere with the diagnosis. It will also provide a drug/drug screening for current medications, checking for disease monitoring.

- **General Precaution Checking:** Activates or deactivates General Precaution Checking, which screens a medication's active and inactive ingredients against the patient's age and gender to help determine whether the order should be continued. This checking more specifically provides individual and daily dosing information for pediatric, adult and geriatric age ranges.

- **IV Compatibility Checking:** Select the check box to allow the system to automatically perform IV compatibility checks at the time of order entry. If a medication that is not compatible with an existing medication in the patient's pharmacy profile, the clinical monitoring screen will display. A monograph may then be printed or displayed.

- **Patient Specific Dosing:** Select the check box to allow the system to automatically perform patient specific dosing. Patient specific dosing will run once all order entry fields have been reviewed prior to updating the order. Only Overdose and Sub therapeutic information will be displayed; the PSD window will not display if neither is triggered. A diagnosis, listed at the top of the PSD window, may be added during order entry. Once added, the PSD window may be reloaded.

- **Reference Range Checks:** The system automatically applies reference range checking to medication orders with associated lab tests if these tests have associated reference ranges; this field is by default inaccessible but activated.

- **Use Overrides:** Select the check box to allow the user to enter override reasons at the time of order entry for any medication that meets the checks described above.

- **Override Required:** Select the check box adjacent to each type of Clinical Monitoring Check that requires a reason be documented before proceeding with order entry.

- **Override Required for Non-Formulary Meds:** Select the check box to require an override reason when non-formulary medications are ordered.
- **Use Allergy Table:** This field is not used by Nursing Clinical Monitoring.
- **Use Drug Information:** This field is not used by Nursing Clinical Monitoring.
- **Allow Unknown NDC#:** This field is not used by Nursing Clinical Monitoring.
- **Autoprint Printer For Patients Not In A Room:** When Food Interaction Checking is activated by a check-mark, this field allows a specific printer number to be entered for food interactions to print for any patients not assigned to beds.

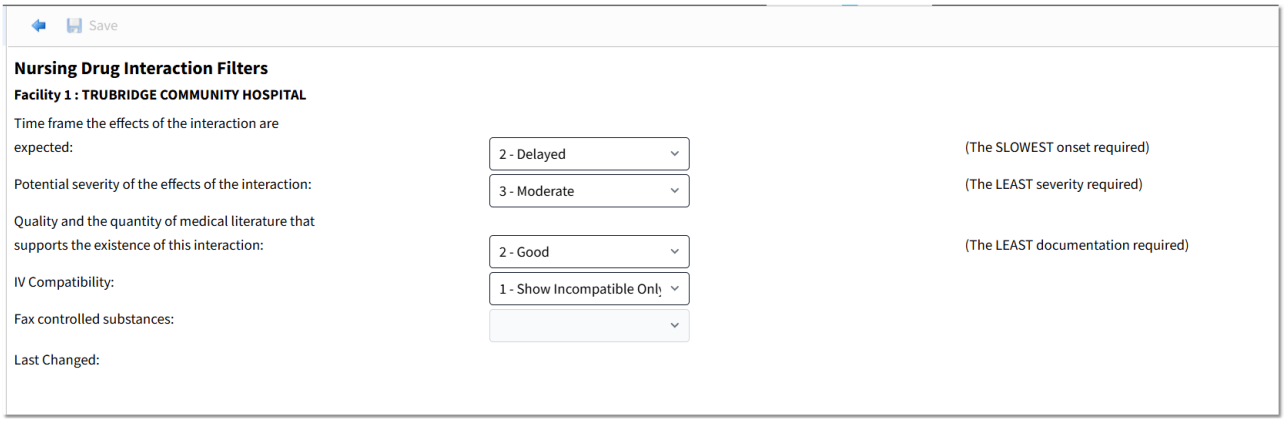
Select **Save** to save any changes.

***NOTE: View Audit** has been moved to **Report Dashboard** and is no longer an option within this application.*

Drug Interaction Filters

Interaction filtering allows drug interaction warnings to be customized in terms of speed of onset, interaction severity, quality and quantity of medical literature available regarding an interaction and compatibility between various intravenous fluids and medications.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Clinical Monitoring** > **Drug Interaction Filters**



Nursing Drug Interaction Filters

- **Time frame the effects of the interaction are expected:** Select the slowest onset required to trigger a warning from the following options:
  - 1 - Rapid
  - 2 - Delayed

- **Potential severity of the effects of the interaction:** Select the least severity required to trigger a warning from the following options:
  - 1 - Contraindicated
  - 2 - Major
  - 3 - Moderate
  - 4 - Minor

- **Quality and the quantity of medical literature that supports the existence of this interaction:** Select the least documentation required to trigger a warning from the following options:
  - 1 - Excellent
  - 2 - Good
  - 3 - Fair
  - 4 - Poor

- **IV Compatibility:** Indicates which IV compatibility checks will be required to trigger a warning. Select from the following options:
  - 1 - Show Incompatible Only
  - 2 - Show Incompatible or Unavailable
  - 3 - Show All Checks

- **Fax controlled substances:** This field is not used by nursing.

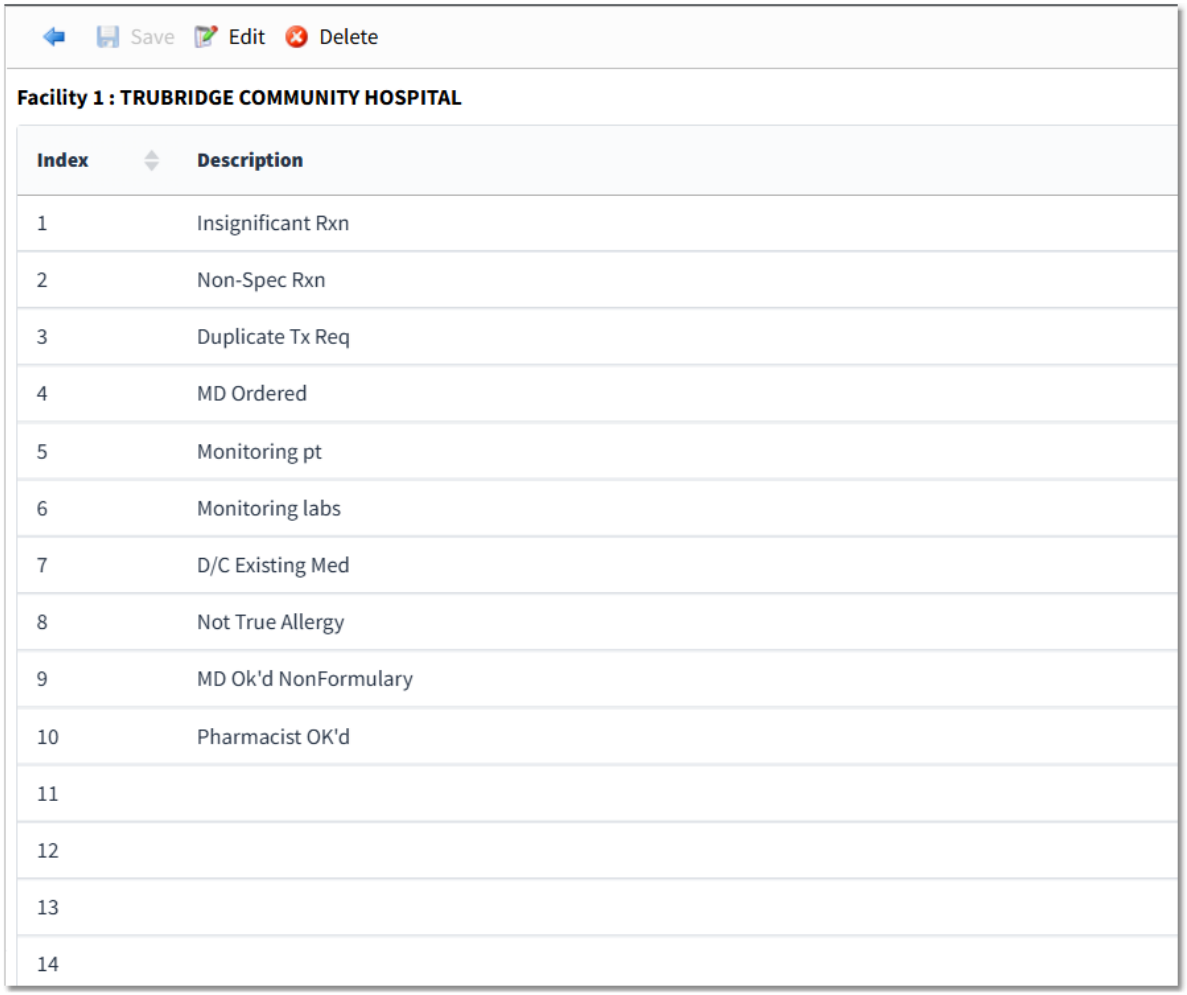
- **Last Changed:** This field is not used by nursing.

Select **Save** to save the changes.

Overrides

Up to 20 override reasons may be entered to address clinical monitoring. In addition to the customizable list, a hard-coded "**Other**" option may be selected during order entry to free-text an override reason.

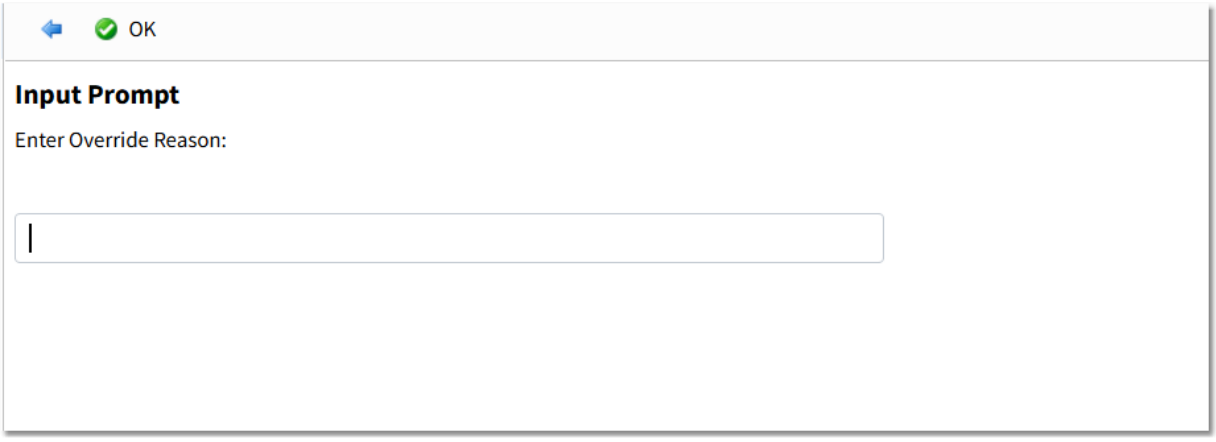
Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Clinical Monitoring** > **Overrides**



Nursing CM Overrides

To Add a Override Reason

1. On the Nursing CM Overrides screen, double-click on the next available Index entry. The Input Prompt screen displays.

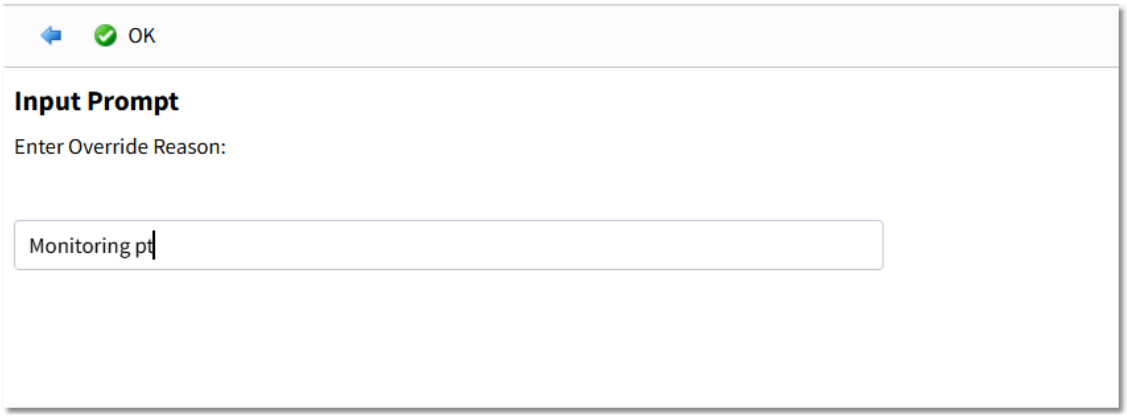


Input Prompt - Enter Override Reason

2. Enter the override reason and select **OK**.

To Edit an Override Reason

1. On the Nursing CM Overrides screen, double-click on the entry. The Input Prompt screen displays.



Input Prompt - Enter Override Reason

2. Make the necessary edits and select **OK**.

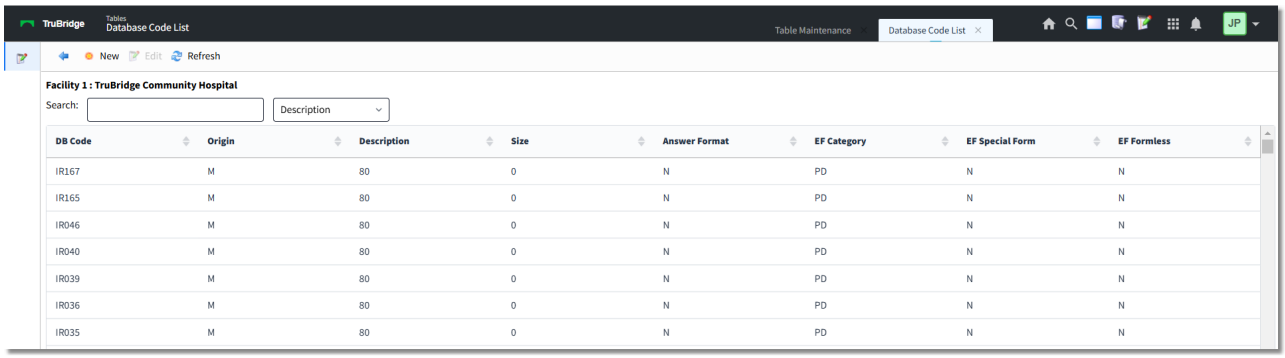
To Delete a Override Reason

On the Nursing CM Overrides screen, select the entry and select **Delete**.

7.4 Database Codes

The Database Codes table stores database codes created for Multi-Application functionality and Ad Hoc Reporting in Flow Charts and Electronic Forms. Database codes are attached to the flow chart and electronic form question if the question should query information for Ad Hoc Reporting and/or to enable Multi-Application functionality.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Database Codes**



Database Codes

The display columns may be sorted by selecting the header. The table displays the following information:

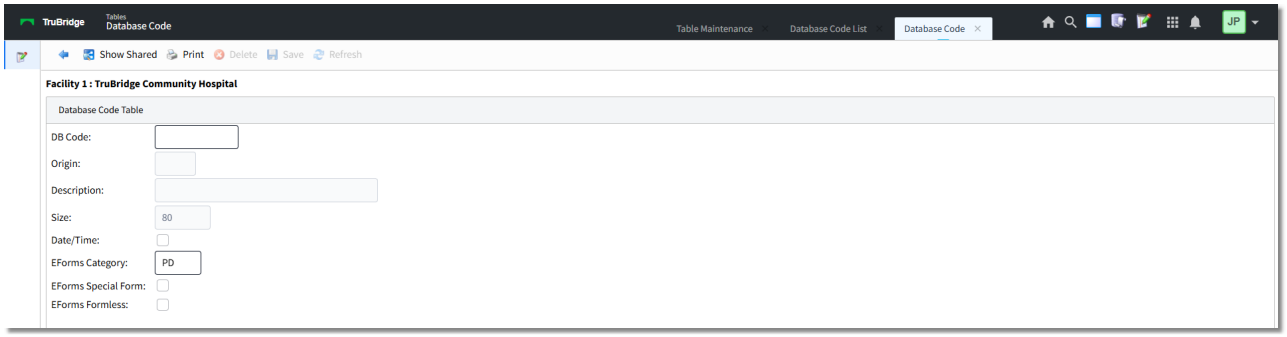
- **DB Code:** Displays the database code.
- **Origin:** The Version 18 release combined multiple tables. This column displays the table from which the code originated before the merge. Codes created after that release was loaded do not display an Origin.
    - **E**: Electronic Forms Database Codes
    - **L**: Electronic Form Loadable Database Codes
    - **M**: Multi-Application Codes
    - **MP**: MPM Database Codes
    - **P**: POC Database Codes
- **Description:** Displays the description of the database code.
- **Size:** Displays the text box size (Electronic Forms only).
- **Answer Format:** DT displays if Date/Time is selected as the answer format (Electronic Forms only).

- **EF Category:** The Version 18 release combined multiple tables. This field displays the Electronic Form Category from which the code originated before the merge. Codes created after that release default to the **PD** category (Electronic Forms only).
    - **HR:** Human Resources
    - **MP:** MPM Patient Data
    - **PD:** Patient Data
- **EF Special Form:** Used by TruBridge only (Electronic Forms only).
- **EF Formless: Y** displays if the code is a formless code. **N** displays if the code is a form code. (Electronic Forms only.)

A search may be performed using any of the eight column headings. Enter the search term in the **Search** field and select the search type from the drop-down**.**

To Create a New Database Code

1. Select **New**. The Database Code screen displays.



Database Code Screen

2. In the **DB Code** field, enter the database code. The code can be up to 10 alpha/numeric characters long.
3. In the **Description** field, enter the description of the database code. The description can be up to 40 alpha/numeric characters long.
4. In the **Size** field, enter a default box width. The default size is 80. (Electronic Forms only.)
5. Select (check) the **Date/Time** check box if the code will be used to capture a date and time. (Electronic Forms only.)
6. The **Eforms Category** field defaults to PD and should not be adjusted.
7. The **EForms Special Form** field is to be used by TruBridge only.

8. Select (check) the **EForms Formless** check box if the documentation associated with the code should populate multiple forms on the same patient account.

9. Select **Save** to save the database code.

To Edit a Database Code

1. Select the database code entry and select **Edit**.

2. Make the appropriate changes.

3. Select **Save**.

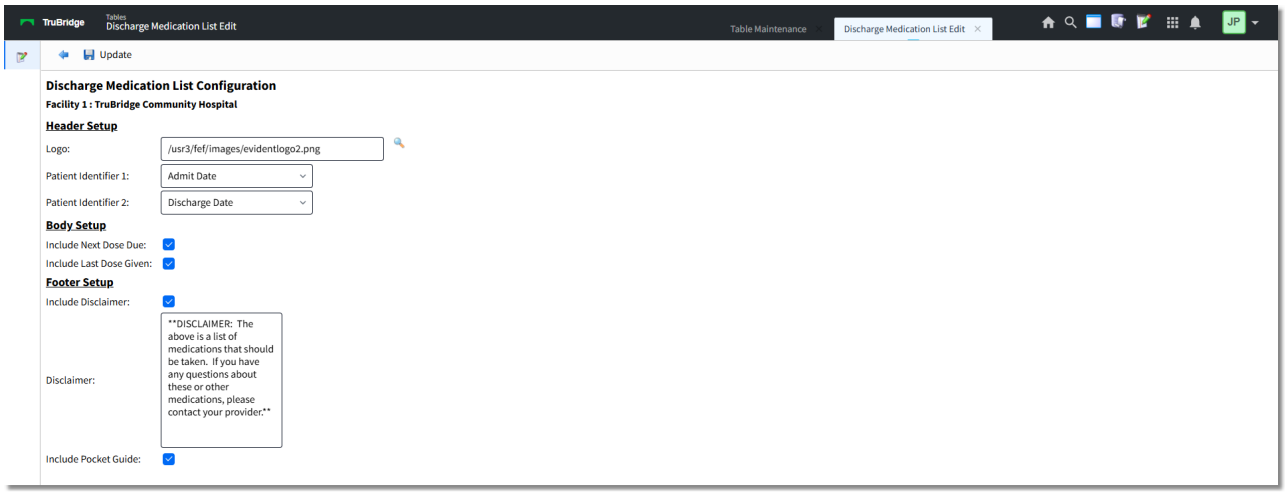
To Delete a Database Code

Double-click on the database code entry and select **Delete**.

7.5 Discharge Medication List

The Discharge Medication List option allows for the configuration of the Discharge Medication List. The Discharge Medication List is designed to be given to the patient at discharge and can be printed from Reports and Attachments.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Discharge Medication List**



Discharge Medication List Configuration

1. Complete the **Header Setup**, **Body Setup**, and **Footer Setup** sections as follows.

Header Setup

- In the **Logo** field, use the Lookup icon to search for and select the facility logo for the Discharge Medication List.
- By default, the Discharge Medication List will display the patient name, account number, and date of birth. The configuration allows for two additional patient identifiers:
  - In the **Patient Identifier 1** field, select either **Admit Date** or **Medical Record Number**.
  - In the **Patient Identifier 2** field, select either **Discharge Date** or **Medical Record Number**.

Body Setup

- The **Include Next Dose Due** check box is selected (checked) by default. When this check box is selected, the next dose due will display if entered on the active prescription in Prescription Entry. Deselect (uncheck) the check box if the next dose due should not display on the Discharge Medication List.
- The **Include Last Dose Given** check box is selected (checked) by default. When this check box is selected, the last dose given will display if entered on the active prescription in Prescription Entry. Deselect (uncheck) the check box if the last dose given should not display on the Discharge Medication List.

Footer Setup

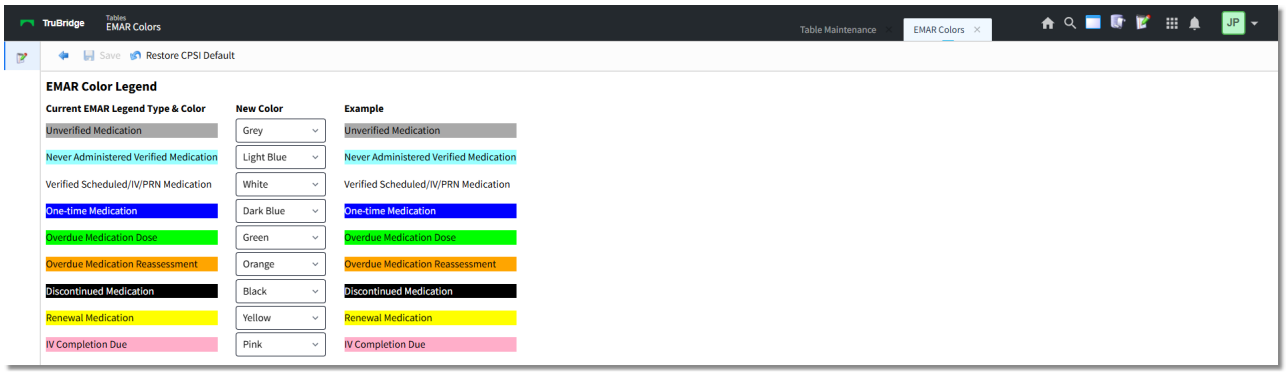
- The **Include Disclaimer** check box is selected (checked) by default. When this check box is selected, the text entered in the **Disclaimer** box will display on the Discharge Medication List. Deselect (uncheck) the check box if the disclaimer text should not appear on the Discharge Medication List.
- In the **Disclaimer** box, the following text displays by default: ***DISCLAIMER: The above is a list of medications that should be taken. If you have any questions, please contact your provider.*** This text will display on the Discharge Medication List in the Disclaimer section. Edit the text as needed.
- The **Include Pocket Guide** check box is selected (checked) by default. When selected, a pocket guide will print at the end of the Discharge Medication List. This is an abbreviated version of the Discharge Medication List that the patient can carry with them. This only includes the medication and Sig line information. Deselect (uncheck) the check box to not include the pocket guide on the Discharge Medication List.

2. Select **Update** to save the changes.

7.6 EMAR Colors Table

The EMAR Colors Table is used to customize the colors that display for the different medication types viewable on the Electronic MAR.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **EMAR Colors Table**



EMAR Color Legend

- **Current EMAR Legend Type and Color**: This column displays the medication types and their corresponding colors as they are currently displaying on the MAR. The following denotes the system default color scheme:
  - Unverified Medication: **Grey**
  - Never Administered Verified Medication: **Light Blue**
  - Verified Scheduled/IV/PRN Medications: **White**
  - One-time Medications: **Dark Blue**
  - Overdue Medication Dose: **Green**
  - Overdue Medication Response/Reaction: **Orange**
  - Discontinued Medication: **Black**
  - Renewal Medication: **Yellow**
  - IV Completion Due: **Pink**

- **New Color**: To modify the color displayed for a medication type, select the applicable color from the drop-down menu. Colors may be used more than once. Available colors include:
  - **Black**
  - **Dark Blue**
  - **Green**
  - **Grey**
  - **Light Blue**
  - **Orange**
  - **Red**
  - **White**
  - **Yellow**
  - **Pink**

- **Example**: This column displays the medication types as they will appear on the EMAR based on the current setup options selected.

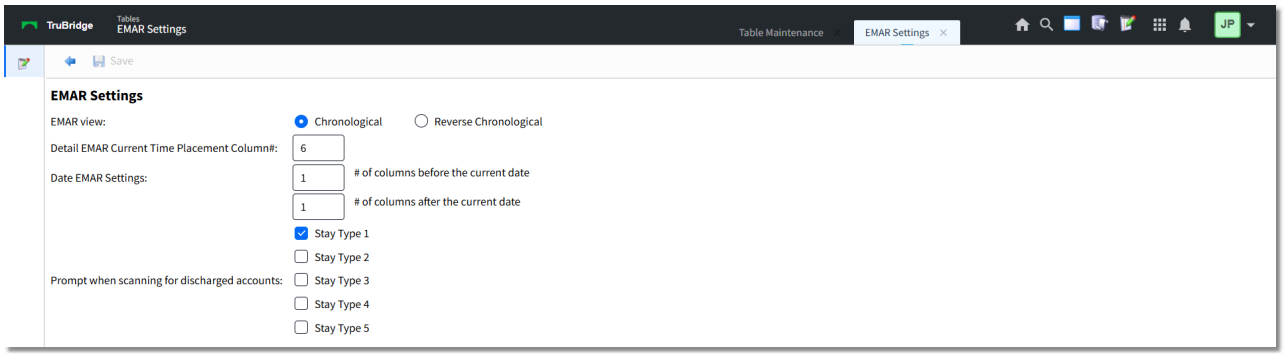
- After setup is complete, the following options are available:
  - **Back Arrow**: Select this option to return to the previous screen. If a change has been made but not saved the following prompt will display: Are you sure you wish to exit without saving? Select **Yes** or **No**.
  - **Save**: Select this option to save modifications.
  - **Restore Evident Default**: Select this option to return setup to the system default shown in the Current EMAR Legend Type and Color column.

NOTE: *If the 'View Only' version of Updated EMAR is being utilized, this table may not be modified. The system default will display via the EMAR.*

7.7 EMAR Settings Table

The EMAR Settings Table is used to customize the EMAR display as it relates to date and time.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **EMAR Settings Table**



EMAR Settings

- **EMAR View**: This option determines the EMAR date/time review order. Select **Chronological** or **Reverse Chronological**.

- **Detail EMAR Current Time Placement Column#**: This field allows for a 2-character numeric entry that defines the column number where the current medication entry line should appear.

- **Date EMAR Settings**: These fields allow for a 2-character numeric entry that determines the number of columns that will display **before the current date** and **after the current date**.

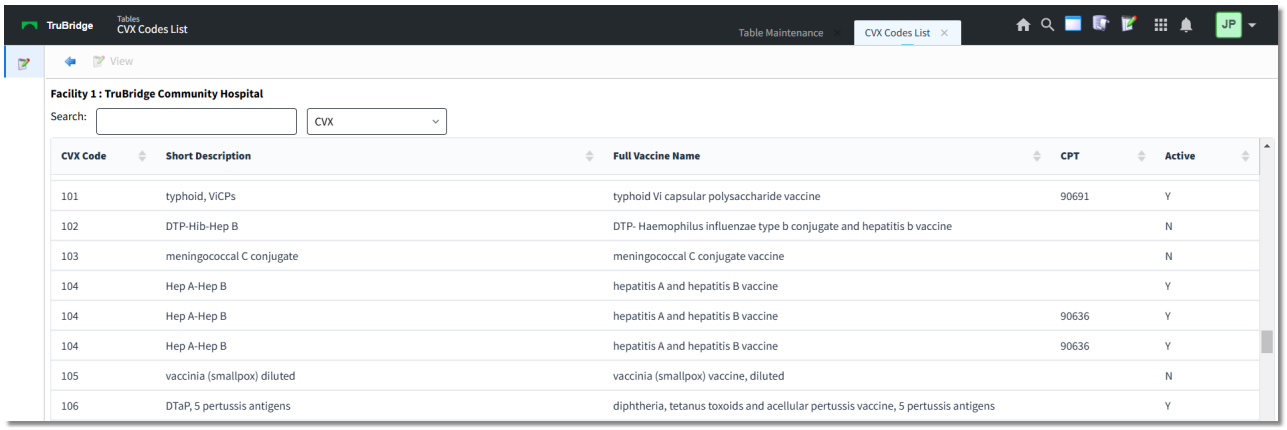
- **Prompt when scanning for discharged accounts**: When a patient's wristband is scanned via MedVerify, a prompt will display that the patient has been discharged if the stay type of the patient matches a **Stay Type** selected in this table.
  - Stay Type 1
  - Stay Type 2
  - Stay Type 3
  - Stay Type 4
  - Stay Type 5

- After setup is complete, the following options are available:
  - **Back Arrow**: Select this option to return to the previous screen. If a change has been made but not saved the following prompt will display: Are you sure you wish to exit without saving? Select **Yes** or **No**.
  - **Save**: Select this option to save modifications.

7.8 Immunization Table

The Immunization Table is a read-only table, updated by TruBridge when changes are received from the CDC.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Immunization Table**



Immunization Table

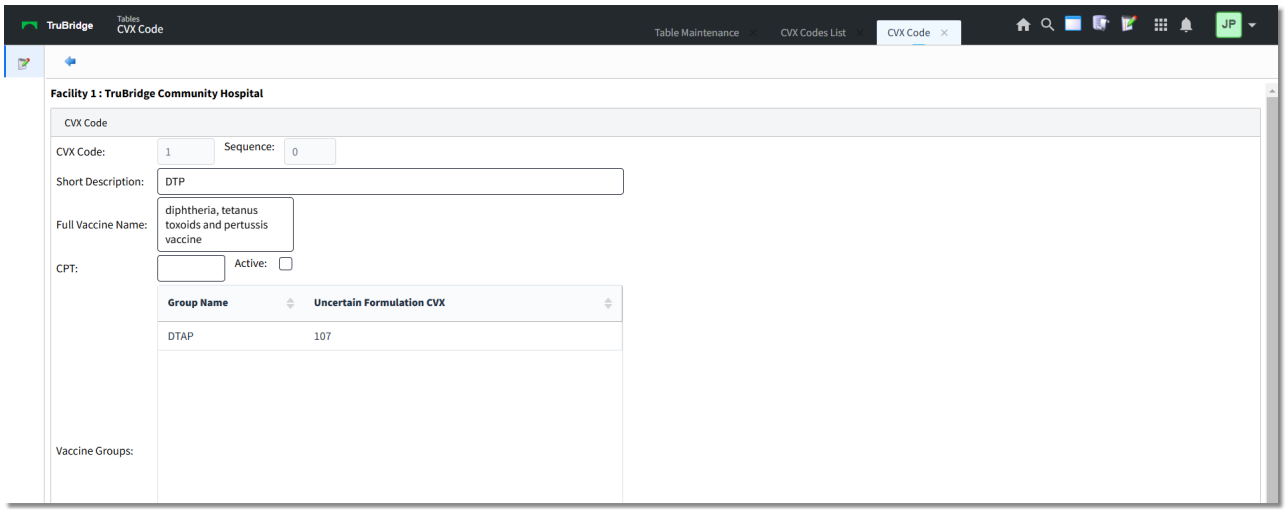
Immunizaton Table Columns

- **CVX Code:** Displays the immunization CVX code.
- **Short Description:** Displays the immunization short description.
- **Full Vaccine Name:** Displays the immunization long description.
- **CPT:** Displays the immunization CPT code.
- **Active:** Displays a **Y** if the immunization is active or a **N** if the immunization is inactive.

To View Immunization Details

1. Select (highlight) the immunization in the list and then select **View** or select a search option from the Search drop-down and enter the search criteria in the Search field. Then select the immunization and select **View**.

2. The immunization details display.



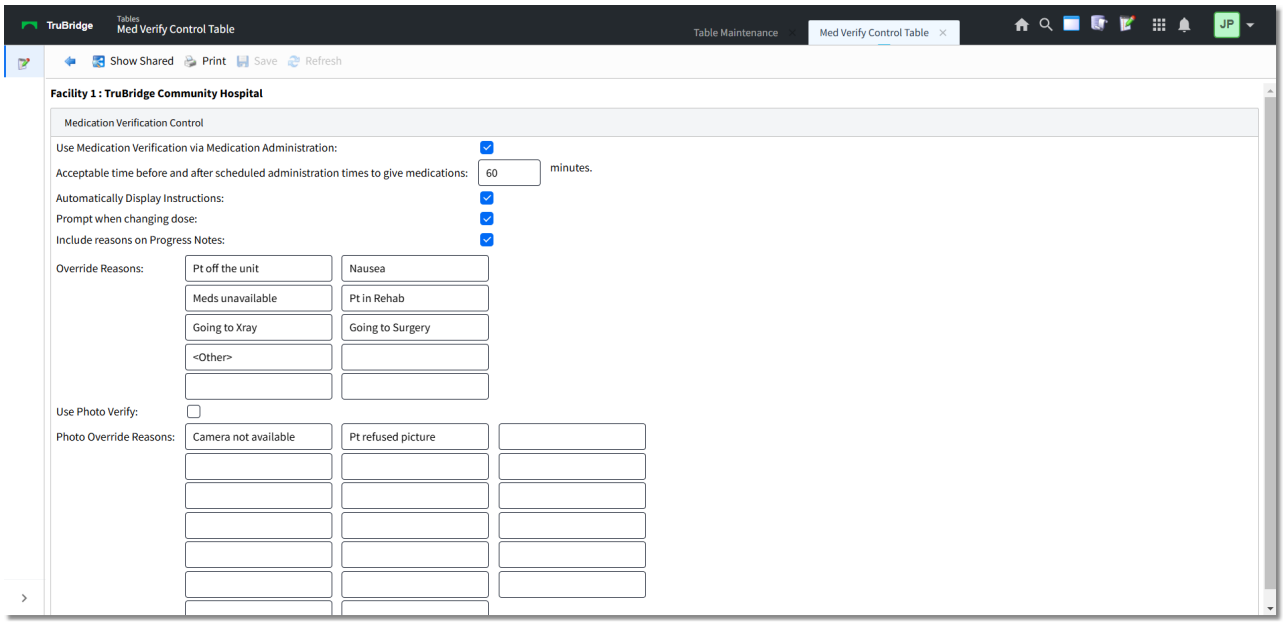
Immunization Details

3. To return to the previous menu, select the **blue back arrow** on the action bar.

7.9 Med Verify Control Table

The Med Verify Control Table houses all Med-Verify settings.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Med Verify Control Table**



Medication Verification Control

- **Use Med Verify Via Medication Admin**: When selected Med-Verify may be accessed from all EMAR screens.

- **Acceptable time before and after scheduled administration times to give medications (Time in Minutes)**: Enter the number of minutes used to determine the acceptable time before and after the schedule date/time to administer medications.

- **Enable PRN administration time range warning**: Select this option to enable the PRN Time Range Warning which generates in Med-Verify if PRN medications are documented too close together in time. The acceptable time range must be entered on each PRN Frequency in the Pharmacy Frequency Table. Please refer to your Pharmacy Department for additional information.

- **Automatically Display Instructions**: Select this option to display Medication Instructions immediately after scanning a medication in Med-Verify.

- **Prompt when changing dose**: If selected, the user will receive a warning prompt when changing the dose of a medication in Med-Verify.

- **Include reasons on Progress Notes**: Select this field to include Override Reasons documented via Med-Verify on the Patient Progress Notes.

- **Override Reasons**: Enter up to ten **Override Reasons** to be used when overriding warning prompts in Med-Verify.

- **Use Photo Verify**: Select this option to enable Photo Verify via Med-Verify.

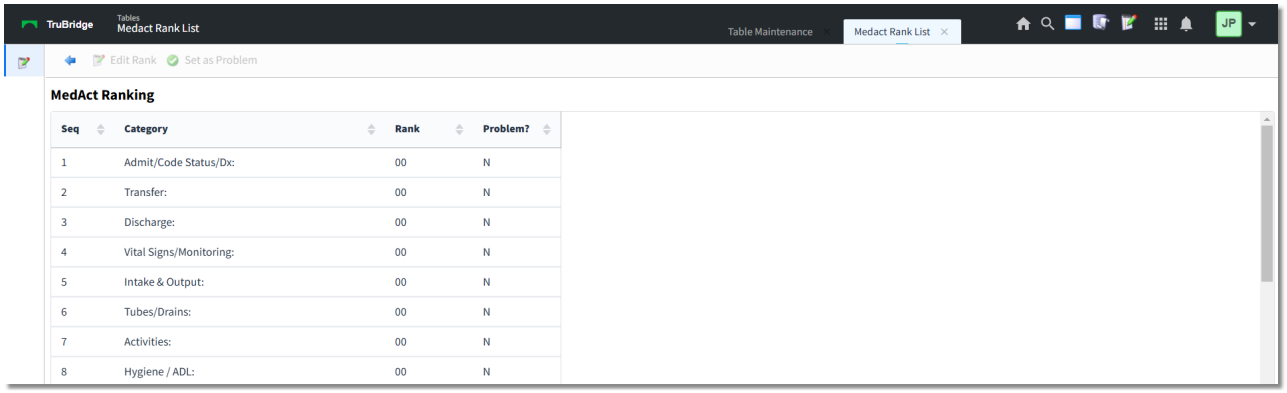
- **Photo Override Reasons**: Enter up to twenty **Override Reasons** to be used when overriding warning prompts in Photo Verify.

- After setup is complete, the following options are available:
  - **Show Shared**: Select to display setup being shared by multiple facilities.
  - **Print**: Select to print setup.
  - **Save**: Select to save modifications.
  - **Refresh**: Select this option to apply any changes made to the setup before the system completes an automatic refresh.
  - **Blue back arrow**: Select to return to the previous screen.

7.10 MedAct Ranking

The MedAct Ranking table allows nursing categories to be ranked and designated as nursing problems.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **MedAct Ranking**



MedAct Ranking

The columns can be sorted by selecting the header. The table displays the following information:

- **Seq:** Organizes the categories in sequential order.
- **Category:** Displays the category name.
- **Rank:** Displays the category rank.
- **Problem?:** Displays a **Y** if the category has been designated as nursing problem and a **N** if the category has not been designated as a nursing problem.

To Edit the Rank of a Category

1. Select (highlight) the entry and select **Edit Rank** or double-click on the entry. The Edit Rank screen displays.

Edit Rank

2. In the **Enter rank** box, enter the rank of the category (numeric value from 1-99). Categories display in chronological order if they are not ranked.

3. Select **OK** to save the rank and return to the list.

NOTE: *The option to sort nursing orders by the MedAct Ranking is available in Order Chronology.*

To Set or Unset a Category as a Nursing Problem

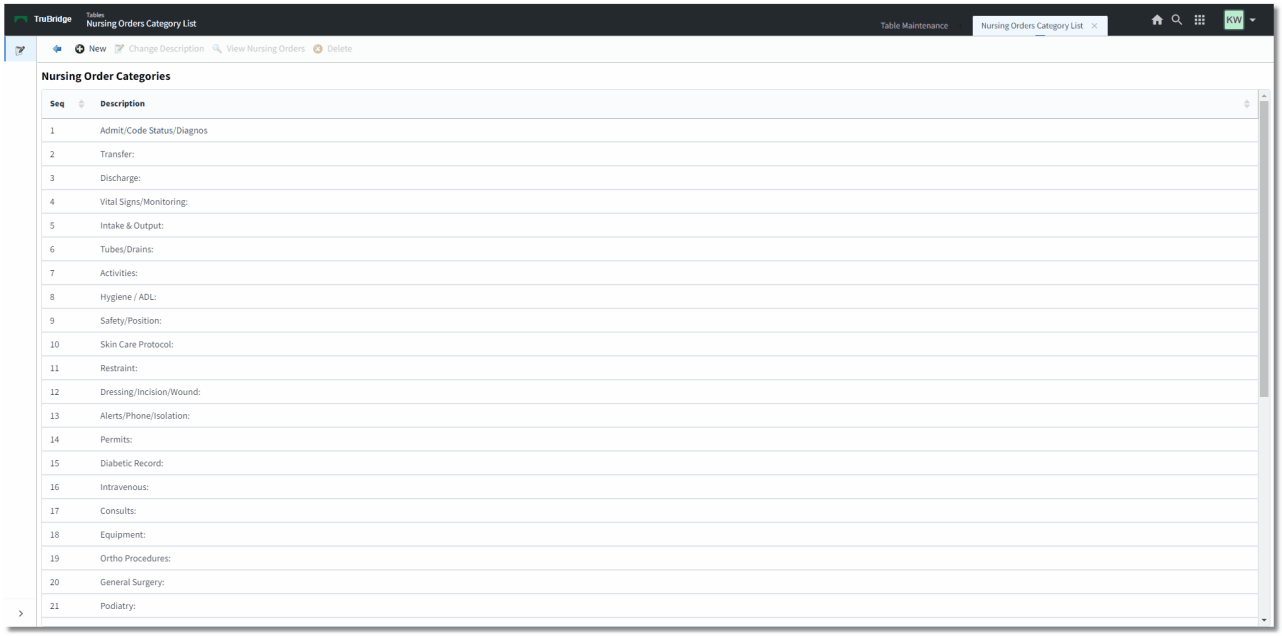
1. Select (highlight) the entry and select **Set as Problem** or **Unset as Problem**.

2. The **Problem?** column entry will reflect a **Y** when the category is set as a problem or an **N** when the category is not set as a problem.

7.11 Nursing Order/Categories

To access Nursing Order Categories setup, go to **Web Client > Tables > Clinical > Nursing > Nursing Orders/Categories**.

The Nursing Order Categories screen is displayed, listing all of the existing categories that have been created.



Nursing Order Categories

- The screen displays two columns of information:
  - **Seq:** Displays the sequence number assigned to each category. By default, the categories are listed by sequence number in numerical order. You can select the column header to reverse the sort order.
  - **Description:** Displays the description of each category. To sort the list by description rather than sequence number, select this column header. Select it again to reverse the sort.

- If the option **Auto MEDACT entry via Ancillary OE** is selected on Page 1 of the POC Control Record, Categories 31-37 are reserved for Nursing Order Categories that correspond to Ancillary Departments determined in the AHIS Table.

- The following categories correspond to the Department Numbers entered in the Order Entry Department fields in the AHIS Control Record, Page 3 (see the Business Office Tables User Guide):
  - Category Number 31: Lab
  - Category Number 32: Xray
  - Category Number 33: PT
  - Category Number 34: RT
  - Category Number 35: EKG
  - Category Number 36: CS

o Category Number 37: Dietary

To Create a New Nursing Order Category

1. From the Nursing Order Categories screen, select **New**. The Nursing Order Category screen is displayed.

   NOTE: *The system holds up to 90 categories. If there are 90 categories already set up, the* ***New*** *option will be grayed out (unavailable).*

New Nursing Order Category

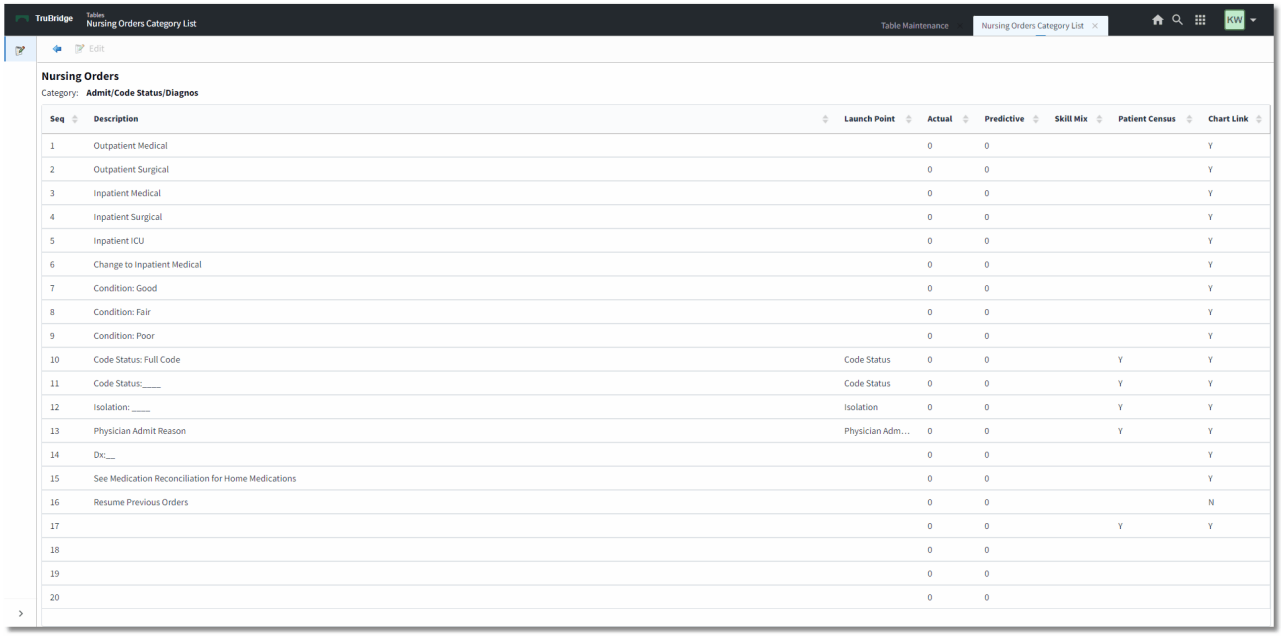
2. In the **Change Description** field, enter a description for the new nursing order category.

3. Select **OK** to save the category and return to the list.

NOTE: *To change the description of an existing category, select it from the list, select* ***Change Description****, edit the description as necessary, and select* ***OK****.*

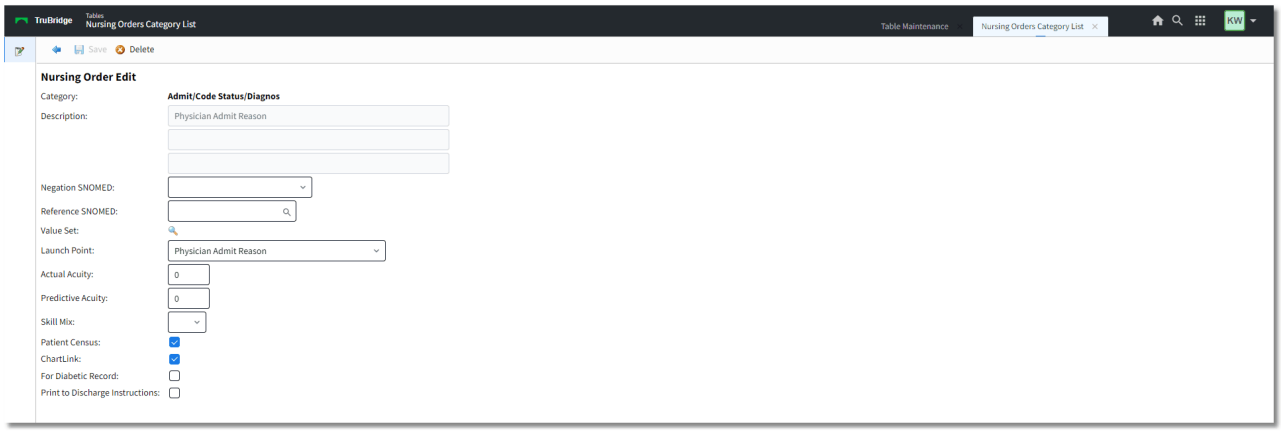
To View and Edit Nursing Orders

To view the nursing orders set up for a particular category, select the category from the Nursing Order Categories list; then select **View Nursing Orders**.



View Nursing Orders

To edit a nursing order in the list, select it and select **Edit**. Then complete or edit the fields as described below.



Nursing Order Edit

- **Category:** Automatically populates based on the selected category.
- **Description:** Use this field to enter the description of the intervention. There are three fields with a 75-character limit in each field.
- **Negation SNOMED:** Negation SNOMED codes are available to select in the drop-down of the setup. These codes include Contraindicated, Treatment not indicated, Refused, and Not indicated. These Negation codes may apply to Nursing Orders where "Patient Refused" is selected during documentation.

- **Reference SNOMED:** Reference SNOMED allows the user to enter a SNOMED for a VTE Prophylaxis device.

- **Value Set:** Allows for a Value Set to be attached or removed from a Nursing Order.

  NOTE: *Nursing order descriptions that contain underscores cannot have these codes attached. When placing a nursing order that has a SNOMED or Value Set attached, users will not be able to change the nursing order description during the Order Entry process. See the section* *Nursing Order SNOMEDs and Value Set* 44 *for more information.*

- **Launch Point:** Select an option from the drop-down to have this intervention direct the user to another area in the TruBridge EHR. For functionality related to CCDA and other Launch Point options, see section on Nursing Order Launch Points 45.

- **Actual Acuity:** Enter the number of Acuity points. See the POC Acuity User Guide for additional information.

- **Predictive Acuity:** Enter the number of Acuity points. See the POC Acuity User Guide for additional information.

- **Skill Mix:** Select the applicable Skill Mix from the job codes listed in the drop-down. See the POC Acuity User Guide for additional information.

- **Patient Census:** Select this option to include the documentation for this Nursing Order on the Patient Census Report.

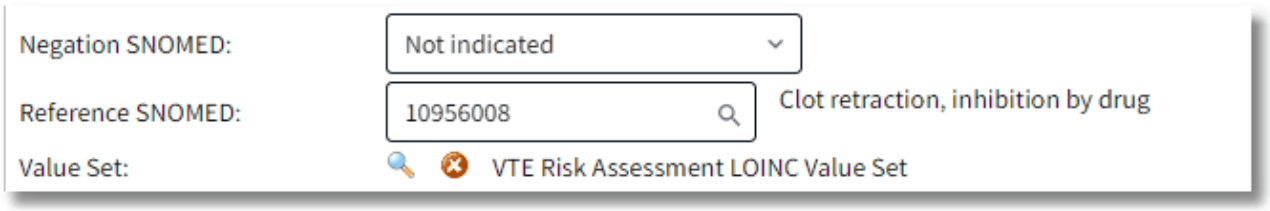
- **ChartLink:** Select this option if the current order should be available for selection by providers via CPOE.

- **For Diabetic Record:** This option is only available on orders in the Diabetic Record Category. More information on this is included in the Diabetic Record Table.

- **Print to Discharge Instructions:** Selecting this option prints this nursing order to the Discharge Instructions.

Nursing Order SNOMEDs and Value Set

This section explains the SNOMED and Value Set fields included in nursing order setup. All three of these may be added to a nursing order for Quality Measures (eCQM) purposes.



CQM Setup for Nursing Orders

- **Negation SNOMED:** Allows a Negation reason to be entered for the nursing order. Select the appropriate Negation SNOMED code from the drop-down list. These codes include Contraindicated, Treatment not indicated, Refused, and Not indicated. These Negation codes may apply to Nursing Orders where "Patient Refused" is selected during documentation on a nursing order.

- **Reference SNOMED:** Allows for a particular SNOMED code to be attached to a nursing order. Reference SNOMED allows the user to enter a SNOMED for a VTE Prophylaxis device.

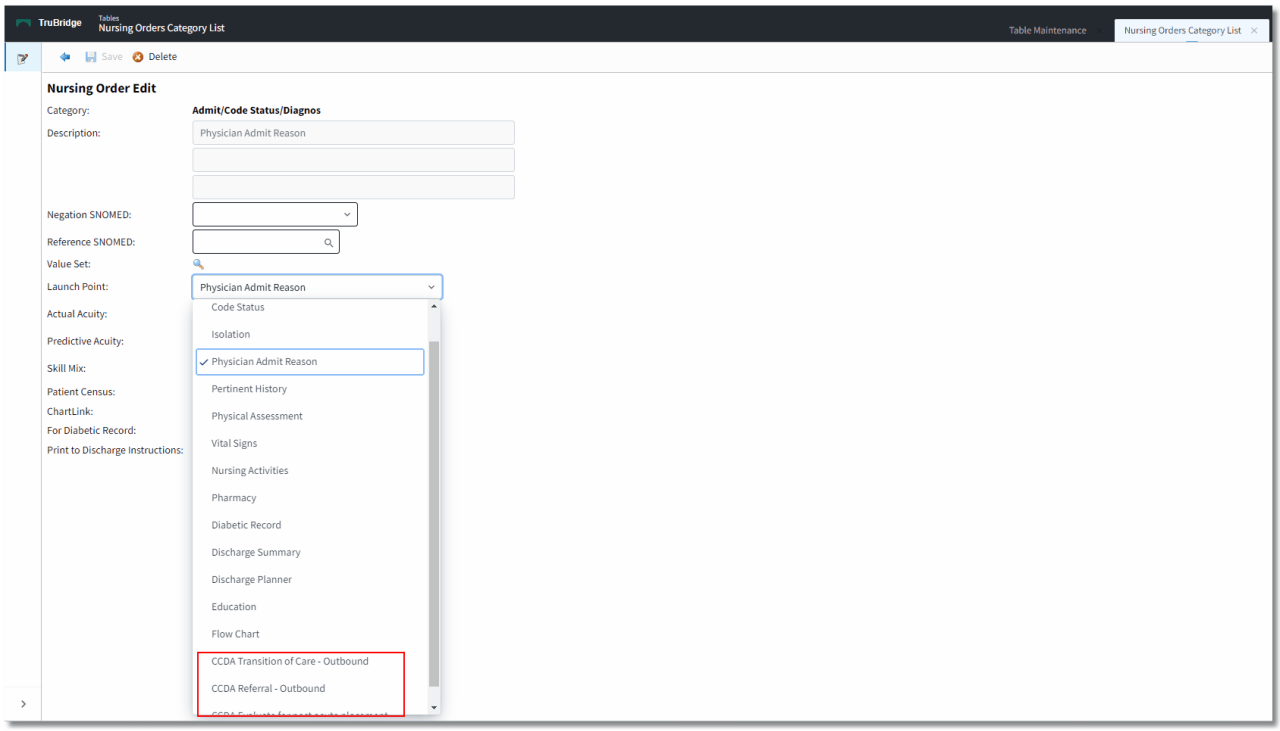
- **Value Set:** Allows a Value Set to be attached or removed from a Nursing Order. To attach a Value Set, select the lookup (magnifying glass) icon, locate the appropriate option, and double-click to select it. Once a Value Set is attached, select the red "x" to the left of it within the field to remove it.

NOTE: *Nursing order descriptions that contain underscores cannot have these codes attached. Also, when placing a nursing order that has a SNOMED or Value Set attached, users will not be able to change the nursing order description during the Order Entry process.*

Nursing Order Launch Points

The **Launch Point** drop-down in Nursing Order setup contains three CCDA options used for post-acute placement: **CCDA Referral - Outbound**, **CCDA Transition of Care - Outbound**, and **CCDA Evaluate**. These launch points are accessed through Order Chronology once the orders have been placed, and they launch the user to the corresponding screen.

The drop-down also includes Order Entry launch points that will update the ID Panel and demographics information when the order is placed. These launch points are for **Suicide Risk**, **Physician Admit Reason**, **Isolation**, and **Code Status**.



CCDA Nursing Order Categories with Functionality in Order Chronology

Launch Points for Order Chronology

- **CCDA Transition of Care - Outbound** will launch the **Referral/Transition of Care** screen when selected in **Order Chronology**.
- **CCDA Referral - Outbound** will launch the **Referral/Transition of Care** screen when selected in **Order Chronology**.
- **CCDA Evaluate for post acute placement** will launch the **Patient Medical Summaries** screen.

For more information on this functionality in Order Chronology, please see the Order Chronology user guide.

Launch Points for Order Entry

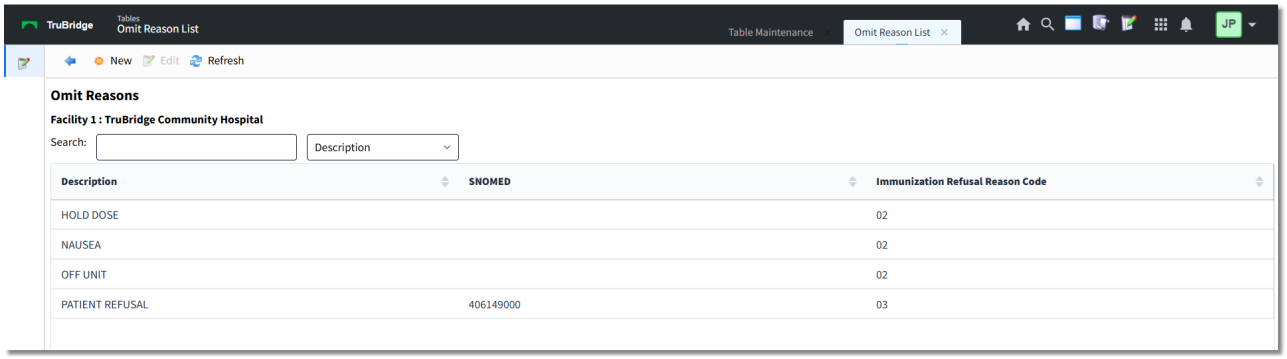
There are several Launch Points in the drop-down list that will update the patient's data via Order Entry. The Nursing Order Description for these orders cannot be edited in Order Entry. When these nursing orders with the attached Launch Points are Updated by Nursing or Signed by a Provider, it will update the patient ID Panel at the top of the patient chart as well as the Census.

- **Suicide Risk:** Adds a Suicide Precaution notification to the ID Panel.
- **Physician Admit Reason:** Adds the selected Physician Admit Reason to the ID Panel.
- **Isolation:** Adds an Isolation notification to the ID Panel. When the user hovers over the notification icon, the selected Isolation option will display.
- **Code Status:** Adds the selected Code Status to the ID Panel. This field will default to either blank or to **Assume Full Code** (depending on the facility default setting) until an order is entered.

7.12 Omit Reasons Table

The Omit Reasons Table displays the list of reasons that a medication is being omitted during the medication administration process. Omit reasons can be added, edited, and deleted in this table.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Omit Reasons Table**



Omit Reasons Table

The table displays the following information:

- **Description:** Displays the omit reason description.
- **SNOMED:** Displays the SNOMED code, if one has been associated with the omit reason.
- **Immunization Refusal Reason Code:** Displays the Immunization Refusal Reason Code that has been associated with the omit reason. The default Omit Reasons and their associated Immunization Refusal Reason Codes are as follows:
  - Absent from Unit (02)
  - Anxiety (02)
  - Hold Order (02)
  - NPO (02)
  - Nausea (02)
  - Parental Decision (00)
  - Patient Refused (03)
  - Religious Exemption (01)
  - Sleeping (02)

A search may be performed by keying the search term in the **Search** field and selecting the appropriate search type from the drop-down. The table may also be sorted by selecting a column header.

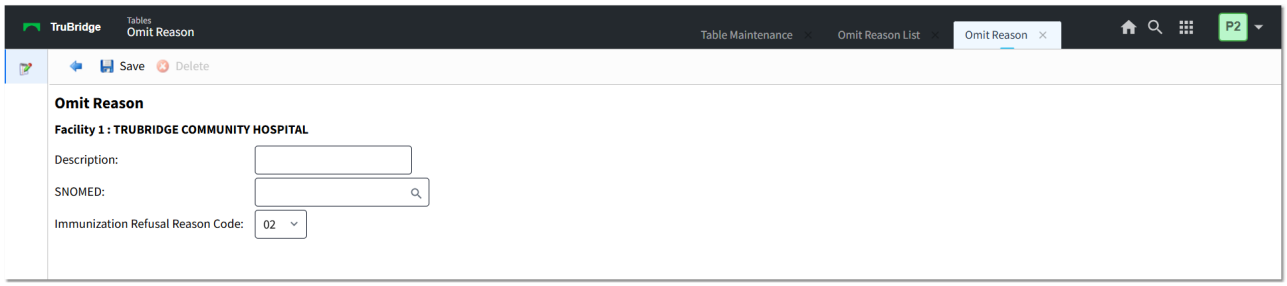
Action Bar Options

- **Blue back arrow:** Select to return to the previous screen.

- **New:** Select to create a new omit reason.
- **Edit:** Select to edit the selected omit reason.
- **Refresh:** Select to refresh the screen.

To Create a New Omit Reason

1. Select **New**.



Omit Reason - New

2. In the **Description** field, type a description (up to 20 characters).
3. In the **SNOMED** field, use the lookup (magnifying glass) icon to search for and select the appropriate SNOMED code.
4. The **Immunization Refusal Reason Code** defaults to **02**. If necessary, use the drop-down to select a different code. Immunization Refusal Reason Code options are:
   - **00** - Parental Decision
   - **01** - Religious Exemption
   - **02** - Other
   - **03** - Patient Decision
5. Select **Save**.
6. Select the **blue back arrow** to return to the Omit Reasons Table.

To Edit an Omit Reason

1. Select the omit reason you want to edit.
2. Select **Edit**.
3. Make the necessary changes and select **Save**.
4. Select the **blue back arrow** to return to the Omit Reasons Table.

To Delete an Omit Reason

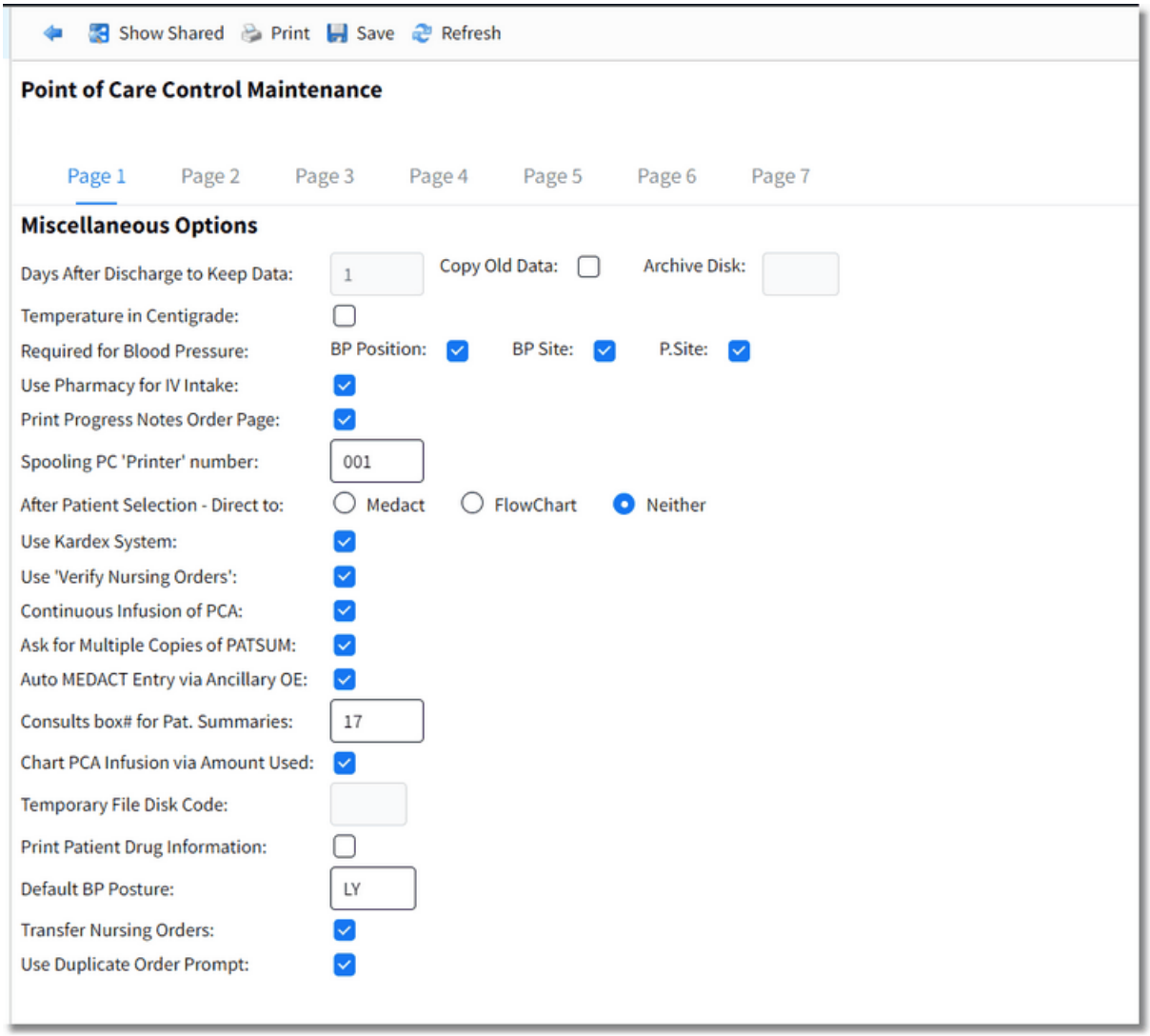
1. On the **Omit Reasons** screen, select the omit reason you want to delete.
2. Select **Edit**.
3. Select **Delete**.
4. Select the **blue back arrow** to return to the Omit Reasons Table.

7.13 POC Control Maintenance

The Point of Care Control Record sets the parameters for the system to follow in recording, retaining, and printing various patient information. These parameters apply to all Point of Care Chart Types. To access the control record via Tables, select **Web Client > Tables > Clinical > Nursing category > POC Control Maintenance**.

Point of Care Control Maintenance - Page 1

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **POC Control Maintenance** > **Page 1**



Point of Care Control Maintenance - Page 1

- **Days After Discharge to Keep Data:** Defines the number of days that all Point of Care data is stored after the discharge date before being moved to the Archive Data Repository (ADR). ADR is a permanent data storage system. 30 days is recommended as the minimum. A longer span of time requires analysis of server space.

  NOTE: *The TruBridge system will automatically change the Pharmacy keep days to one day greater than the Point of Care keep days whether it is changed via the Pharmacy control record, POC control record, or the Financial AHIS table. Please call a TruBridge representative for help with changing the Pharmacy and Point of Care keep days.*

- **Copy Old Data:** Select this option to copy all data in the ns1 directory to the nsa directory. Once ns1 files move to ADR, they are no longer available for POC Ad Hoc Reporting. The nsa directory must be used to obtain data from accounts that have purged.

- **Archive Disk:** If data is to be copied to the nsa directory, TruBridge will determine which archive disk will be used to house the directory (**Blank, 1-4**).

- **Temperature in Centigrade:** Select this option to record, display, and print temperature in Centigrade instead of Fahrenheit.

- **Required for Blood Pressure:**
  - **BP Position:** If selected, the user is required to chart the patient's position when the blood pressure was taken.
  - **BP Site:** If selected, the user is required to chart the blood pressure site.
  - **P. Site:** If selected, the user is required to chart the pulse site.

- **Use Pharmacy for IV Intake:** If selected, the patient's IV medications will be listed in the New Intake Selection drop-down, allowing the user to document each IV intake separately. If not selected, the New Intake Selection drop-down will instead list IV Fluids as an option, and the IV intake is documented collectively.

- **Print Progress Notes Order Page:** Select this option to include a list of the patient's ancillary orders each time the Patient Progress Notes are generated. The ancillary items display at the end of the report.

- **Spooling PC "Printer" number:** This field designates the computer to be used for PC Backup. The three-digit **TTY Number** for the device must be entered in this field.

- **After Patient Selection - Direct to:**
  - **Medact:** Select this option to bypass the Virtual Chart and display the Medact after patient selection.
  - **FlowChart:** Select this option to bypass the Virtual Chart and display the Flow Chart Menu after patient selection.
  - **Neither:** Select this option to not bypass the Virtual Chart after patient selection.

- **Using Kardex System:** If selected, the patient's Diet Order and Special Instructions Order will automatically display on the Medact.

- **Use Verify Nursing Orders:** Select this option if Unverified Nursing Orders require verification. The status (Verified/Unverified) of a Nursing Order is determined by Employee Security for the ordering user.

- **Continuous Infusion of PCA:** Select this option to include a field for Continuous Infusion Rate in PCA Protocol Setup.

- **Ask for Multiple Copies of PATSUM:** If selected, the system will prompt for the number of copies of the Patient Summary to print.

- **Auto MEDACT Entry via Ancillary OE:** Select this option to enable the ability to automatically create Nursing Orders based on ancillary items at the time of order entry.

- **Consults box # for Pat. Summaries:** Enter the **Box Number** for the Consult Category in Nursing Order Setup if Consult Orders placed via the Medact are set to pull to the "Consults" category on Format B of the 24hr Summary and Patient Summary reports.

- **Chart PCA Infusion via Amount Used:** Select to allow PCA medications to be charted by amount of medication used as opposed to the amount of medication left in the syringe. The word “Amount Used” will appear above “Amount Left” on the infusion input menu. The appropriate wording will appear also on the PCA infusion form.

- **Temporary File Disk Code:** (Blank, 1-5) Determines the disk code that will house POC Setup. This field is maintained by TruBridge.

- **Print Patient Drug Information:** Select this option to automatically generate Drug Monographs for medications continued at discharge along with the Discharge Instructions Report.

- **Default BP Posture:** Enter one of the following options to designate a default Blood Pressure Posture:
  - **Blank:** No default posture set
  - **LY:** Lying
  - **SI:** Sitting
  - **ST:** Standing
  - **DR:** Doppler

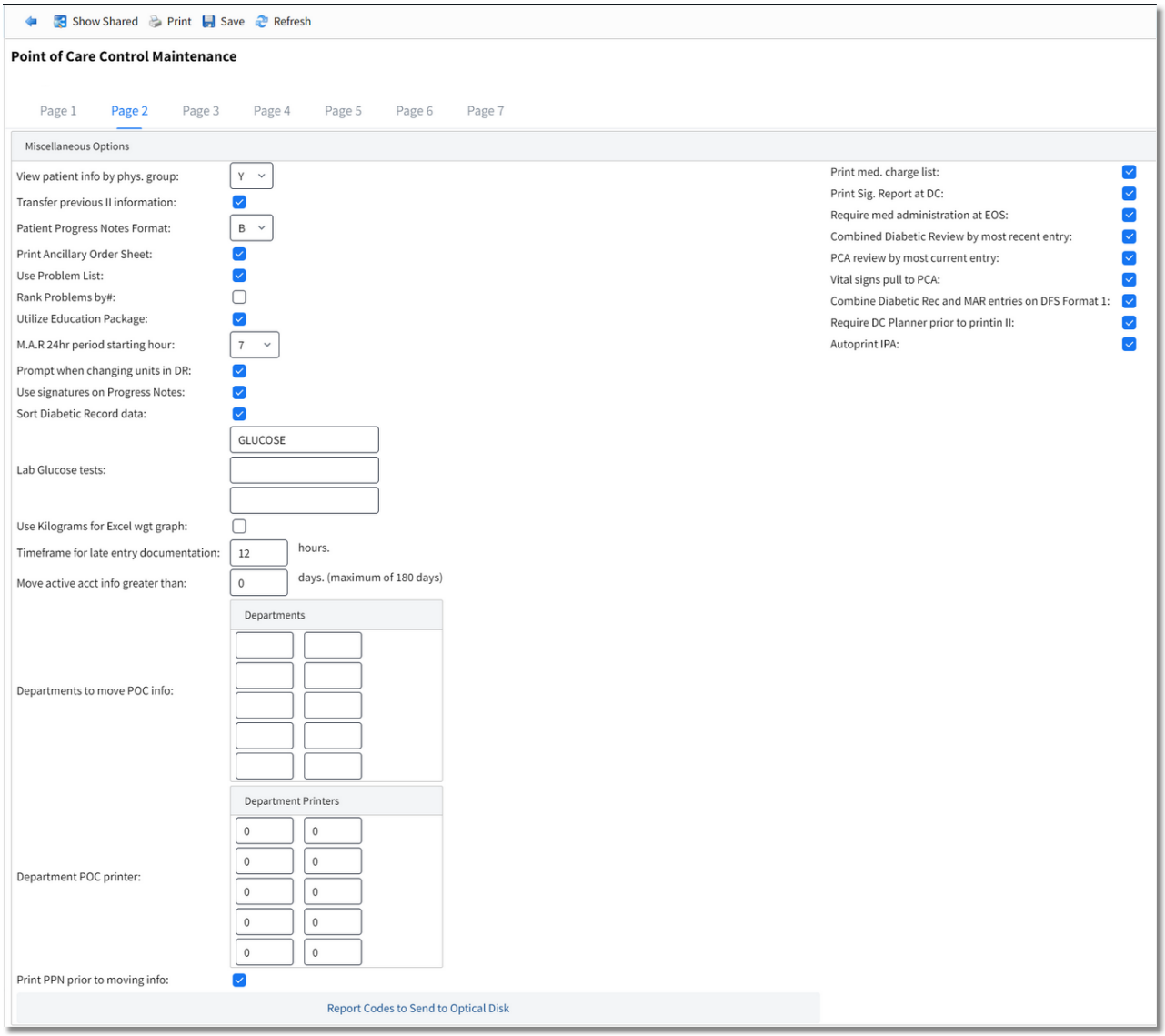
- **Transfer Nursing Orders:** Select this option to enable the ability to transfer Nursing Orders from one account to another.

- **Use Duplicate Order Prompt:** Select this option to prompt users when placing a duplicate ancillary order from Order Entry. The prompt reads, "Duplicate Order Warning. This item was previously ordered on [date/time]. Do you still want to order this item?" Users will need to select Yes or No to close the prompt and proceed.

- After setup is complete, the following options are available:
  - **Blue Back Arrow:** Select this option to return to the previous screen.
  - **Show Shared:** Select this option to view setup being shared by multiple facilities.
  - **Print:** Select this option to print setup.
  - **Save:** Select this option to save modifications.
  - **Refresh:** Select this option to refresh the page.

Point of Care Control Maintenance - Page 2

Select **Web Client** > **Tables** > **Clinical** > **Nursing** > **POC Control Maintenance** > **Page 2**



Point of Care Control Maintenance - Page 2

- **View patient info by phys. group:** **Inactive** (This option controlled how physicians viewed information on patients who were not admitted to their service. This is no longer determined via Point of Care. Please refer to the ChartLink User Guide for additional information.)

- **Transfer previous II information:** Select this option to enable Copy Previous Pertinent History.

- **Patient Progress Notes Format:** Select one of the three formats for Patient Progress Notes listed below:
  - **A:** Information is documented chronologically and prints vertically on the Patient Progress Notes.

  - **B:** Information is grouped chronologically in categories and the information may be prioritized and combined. Documented information prints vertically.
  - **C:** Information is grouped chronologically in categories and the information may be prioritized and combined. Documented information prints horizontally and in two columns.

- **Print Ancillary Order Sheet:** Select this option to automatically print an Ancillary Order Sheet to the default printer if the order is placed via Point of Care.

- **Use Problem List:** Select this option if the Problem List will be utilized. If not selected, Box Numbers cannot be designated as Problem List Categories in Nursing Order/Problem List Setup.

- **Rank Problems by #:** **Inactive** (If selected, Problems displayed by Problem Number on the Problem List. Problem Number is no longer used in Problem List Setup.)

- **Utilize Education Package:** Select this option to enable the Traditional Education Option. If documenting Education via Flow Charts, this option must be selected to utilize the Education Report.

- **M.A.R. 24hr period starting hour:** Determines the timeframe parameters that must be met to generate a final MAR (24 Hour and 5 Day):
  - **07:** 0700 hrs back to 0659 hrs the previous day.
  - **15:** 1500 hrs back to 1459 hrs the previous day.
  - **23:** 2300 hrs back to 2259 hrs the previous day.

- **Prompt when changing units in DR (Diabetic Record):** Select to receive the prompt, "**Are you sure? Y/N**," when changing the dose of insulin in the Diabetic Record.

- **Use signatures on Progress Notes:** Select to include a signature line on the Patient Progress Notes. Nursing displays as Nurse's Signature. Multidisciplinary displays as Signature.

- **Sort Diabetic Record data:** Select this option to view documentation per sliding scale type (SubQ, IV, etc.) on the Patient Progress Notes. If not selected, the documentation will be combined and in chronological order.

- **Lab Glucose tests:** Controls whether a blood glucose test resulted via the facility's lab will generate on the Diabetic Flowsheet (Routine/ICU).The description of the test(s) listed must be set up in the lab's reference range tables. Consult the facility's lab manager or a TruBridge Point of Care support representative for assistance

- **Use Kilograms for Excel wgt graph:** Select this option to display weight in kilograms when using the **Graph Review** option via traditional Vital Signs.

- **Move active acct info greater than:___days. (maximum of 180 days):** The system may be set up to move documentation (ns1) to an alternate directory (**ad1**) for departments with large volumes of documentation, such as Long Term Care Units. Documentation may be set to move **1 to 180** days after admission. The system restarts the countdown of days each time the set number of days expires until the patient is discharged. Documentation housed in ad1 purges to ADR using the same parameters as ns1.

- **Timeframe for late entry documentation ___ hours:** Enter the time (in hours) that flow chart documentation should be labeled as a "Late Entry."

- **Departments to move POC info:** Up to 10 **Point of Care Departments** may be designated to use ad1. Enter the applicable departments in fields **1-10**.

- **Department POC printer:** Patient Progress Notes may be set to automatically print when account documentation moves to ad1. Enter the printer number for each department in the corresponding fields **1-10**.

- **Print PPN prior to moving info:** Select this option to automatically print Patient Progress Notes when account documentation moves to ad1.

- **Report Codes to Send to Optical Disk:** Select this option to display a list of POC Reports available to move to ADR. The reports will purge based on the number of days entered for Days after discharge to keep data 53, after which they must be accessed via Clinical History.The reports available are listed below:

  - 24 Hour Summary - 24HS
  - Activities - NA
  - Critical Care Flowsheet - CCF
  - Diabetic Flowsheet - DFS
  - Discharge Instructions - DI
  - Discharge Planner - DP
  - Discharge Summary - DS
  - Education Report - EDUC
  - Graphic I&O - GR3
  - Initial Interview - II
  - Initial Physical Assessment - PA
  - Medical Order Report - MOR
  - Medication Administration Record - MAR
  - Medication Report - MR
  - O2 Sat Bar Graph - GR4
  - Pain Assessment Flowsheet - PAF
  - Patient Census - PC
  - Patient Drug Information - DM
  - Patient Education Documents - PED
  - Patient Progress Notes - NN
  - Patient Summary - PS
  - PCA Flowsheet - PCA
  - Problem Activity Report - PAR
  - Problem List - PL
  - Shift Summary Report - SS
  - Signature Report - SIG
  - Swan Ganz - SG
  - Transfer Form - TF
  - Vital Signs Bar Graph - GR2

- **Print med. charge list:** Select this option to include a list of the patient's medication charges each time the Patient Progress Notes are generated. The charges display at the end of the report.

- **Print Sig. Report at DC:** Select this option to automatically print the Signature Report when Discharge Reports is selected.

- **Require med administration at EOS:** If selected, the system will review the patient's MAR for non-administered scheduled medications when End of Shift is performed on an account. If all medications have not been administered for the current shift, the user will receive a prompt to review the account but may proceed with End of Shift.

- **Combined Diabetic Review by most recent entry:** When selected, the Subcutaneous and IV Sliding Scale review will display in reverse chronological order.

- **PCA review by most current entry:** Select this option to review PCA documentation in reverse chronological order.

- **Vital signs pull to PCA:** Select this option to include Respiration, Blood Pressure, and Pulse values documented outside of the PCA application on the PCA Infusion Form.

- **Combine Diabetic Rec and MAR entries on DFS Format 1:** Select this option to display Insulin Administrations documented via POC Pharmacy or Med-Verify on the Diabetic Flow Sheet. MAR will display in the BG Level column on all three versions of the Diabetic Flow Sheet. Deselect the option to display documentation for orders entered and documented against via the Diabetic Record.

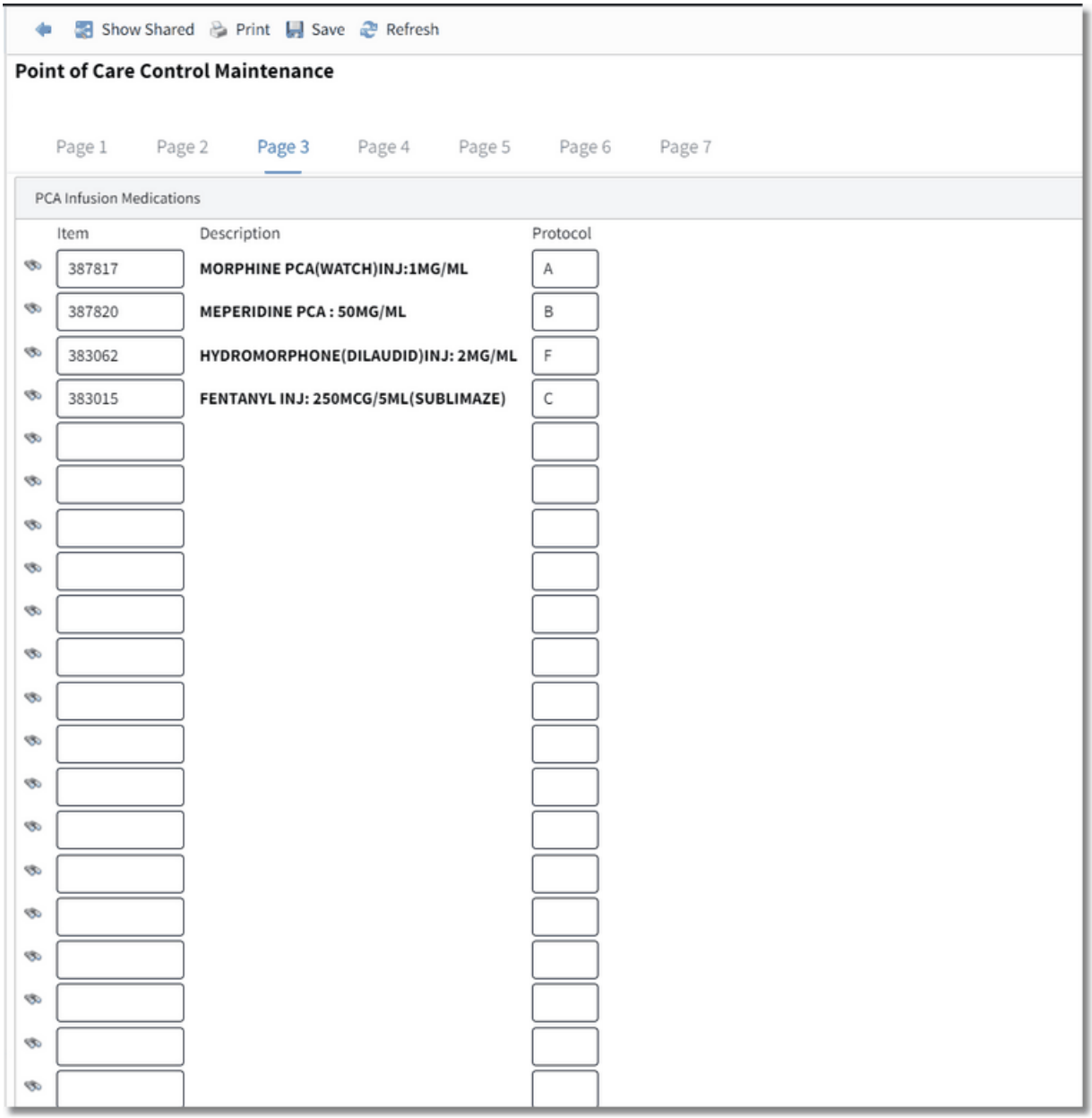
- **Require DC Planner prior to printing II** (Initial Interview): This option requires the Discharge Planner be addressed prior to generating the Initial Interview.

- **Autoprint IPA** (Initial Physical Assessment): If selected, the user will receive a prompt to print the Initial Physical Assessment each time flow chart documentation is saved as initial versus shift data.

- After setup is complete, the following options are available:
  - **Blue Back Arrow:** Select this option to return to the previous screen.
  - **Show Shared:** Select this option to view setup being shared by multiple facilities.
  - **Print:** Select this option to print setup.
  - **Save:** Select this option to save modifications.
  - **Refresh:** Select this option to refresh the page.

Point of Care Control Maintenance - Page 3

Select **Web Client** > **Tables** > **Clinical** > **Nursing** > **POC Control Maintenance** > **Page 3**



Point of Care Control Maintenance - Page 3

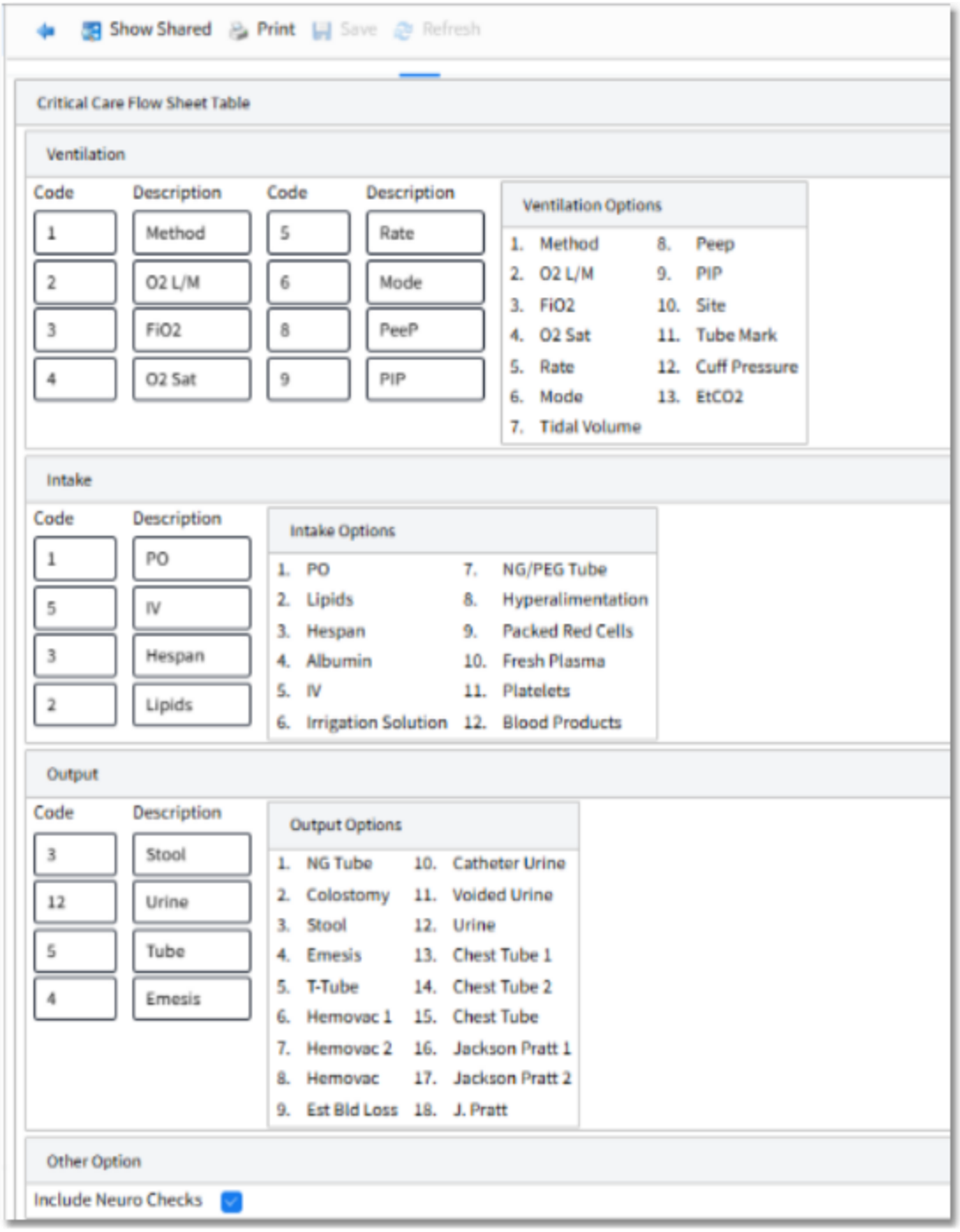
- **PCA Infusion Medications:**
  - **Item:** Up to 20 PCA Pump medications may be entered by keying the item number or by using the looking glass to search for the item in the Pharmacy Formulary. These items will then be available for selection via the PCA Infusion option.
  - **Protocol:** Up to six default protocols may be built in the system. Once the protocols are established, they are associated to the correct item by entering the letter that represents the protocol. In PCA Protocol Setup, the protocols are numbered 1-6. When entered here, the

protocols are designated as A-F. See the section on PCA Protocols in the POC Setup User Guide for additional information.

- After setup is complete, the following options are available:
  - **Blue Back Arrow:** Select this option to return to the previous screen.
  - **Show Shared:** Select this option to view setup being shared by multiple facilities.
  - **Print:** Select this option to print setup.
  - **Save:** Select this option to save modifications.
  - **Refresh:** Select this option to refresh the page.

Point of Care Control Maintenance - Page 4

Select **Web Client** > **Tables** > **Clinical** > **Nursing** > **POC Control Maintenance** > **Page 4**



Point of Care Control Maintenance - Page 4

- **Ventilation Options:** Up to eight options may be selected to display in the Ventilation Mechanics Section of the Critical Care Flow Sheet. Available options are listed below. The description entered for the selected codes may only be up to six characters.
  - 1 - Method
  - 2 - O2 L/M
  - 3 - FiO2
  - 4 - O2 Sat
  - 5 - Rate
  - 6 - Mode
  - 7 - Tidal Volume
  - 8 - PeeP
  - 9 - PIP
  - 10 - Site
  - 11 - Tube Mark
  - 12 - Cuff Pressure
  - 13 - EtC02

- **Intake Options:** Up to four options may be selected to display in the Intake Section of the Critical Care Flow Sheet. Available options are listed below. The description entered for the selected codes may only be up to six characters.
  - 1 - PO
  - 2 - Lipids
  - 3 - Hespan
  - 4 - Albumin
  - 5 - IV
  - 6 - Irrigation Solution
  - 7 - NG/PEG Tube
  - 8 - Hyperalimentation
  - 9 - Packed Red Cells
  - 10 - Fresh Plasma
  - 11 - Platelets
  - 12 - Blood Products

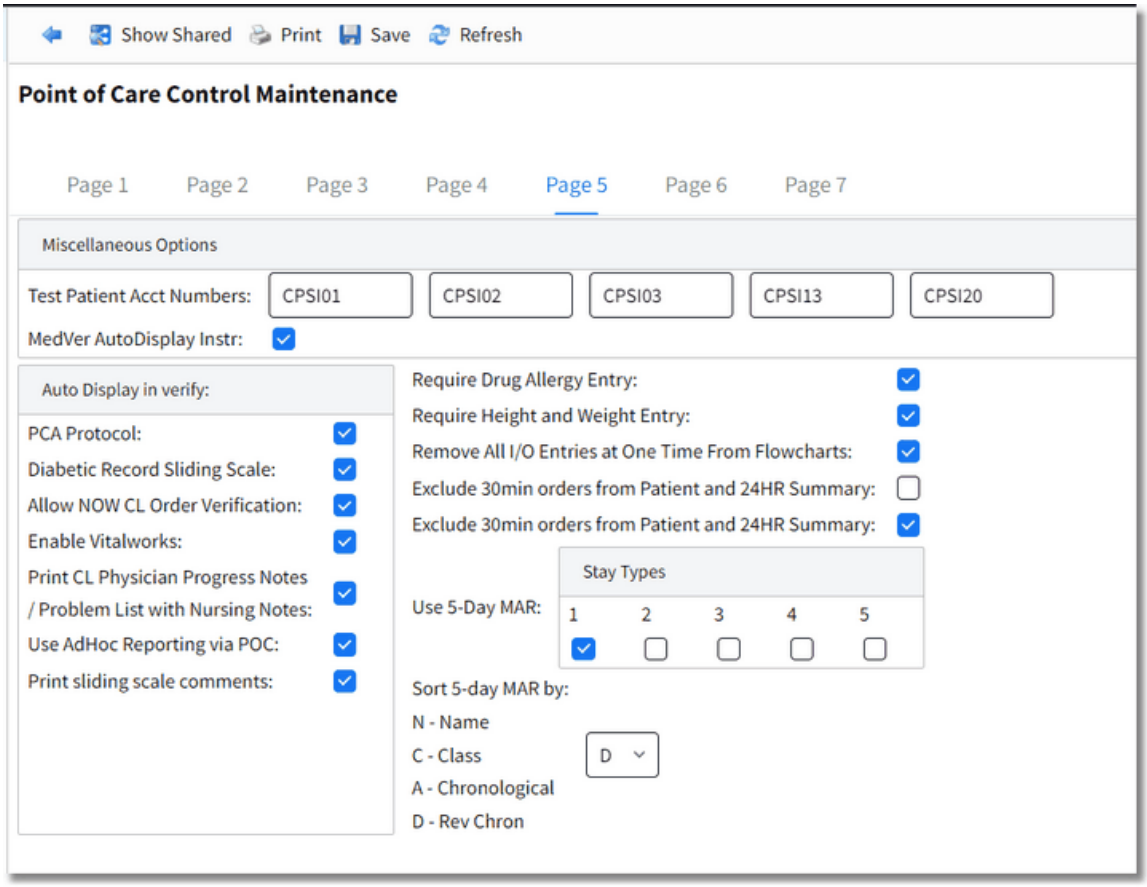
- **Output Options:** Up to four options may be selected to display in the Output Section of the Critical Care Flow Sheet. Available options are listed below. The description entered for the selected codes may only be up to six characters. Some items will display the total of other items. For example, item 12, urine, will display the total of item 10, catheter urine, and item 11, voided urine.
  - 1 - NG Tube
  - 2 - Colostomy
  - 3 - Stool
  - 4 - Emesis
  - 5 - T-Tube
  - 6 - Hemovac 1
  - 7 - Hemovac 2
  - 8 - Hemovac
  - 9 - Est Bld Loss
  - 10 - Catheter Urine
  - 11 - Voided Urine
  - 12 - Urine
  - 13 - Chest Tube 1
  - 14 - Chest Tube 2
  - 15 - Chest Tube
  - 16 - Jackson Pratt 1
  - 17 - Jackson Pratt 2
  - 18 - J. Pratt

- **Include Neuro Checks:** Select this option to include Neuro Check documentation on the Critical Care Flow Sheet. Setup must be housed in Neuro Check Setup in order to pull to this section. See the Neuro Checks section in the POC Setup User Guide for additional information.

- After setup is complete, the following options are available:
  - **Blue Back Arrow:** Select this option to return to the previous screen.
  - **Show Shared:** Select this option to view setup being shared by multiple facilities.
  - **Print:** Select this option to print setup.
  - **Save:** Select this option to save modifications.
  - **Refresh:** Select this option to refresh the page.

Point of Care Control Maintenance - Page 5

Select **Web Client** > **Tables** > **Clinical** > **Nursing** > **POC Control Maintenance** > **Page 5**



Point of Care Control Maintenance - Page 5

- **Test Patient Acct Numbers:** Up to five Test Patient account numbers may be entered at a time to be used in conjunction with the the Delete Test Patient Data option. See the Delete Test Patient Data section in the POC Setup User Guide for additional information.

- **MedVer AutoDisplay Instr:** Select this option to display Medication Instructions immediately after scanning a medication in Med-Verify.

- **PCA Protocol:** Select this option to display the PCA Protocol immediately after selecting the Look option when verifying orders.

- **Diabetic Record Sliding Scale:** Select this option to display the Diabetic Record Sliding Scale and/or Carb Formula immediately after selecting the Look option when verifying orders.

- **Allow NOW CL Order Verification:** Select this option to allow NOW orders placed by the physician via the ChartLink application to go to directly to nursing for verification rather than displaying in pharmacy first.

- **Enable VitalWorks:** Allows sites using VitalWorks software to interface with the TruBridge system.

- **Print CL Physician Progress Notes / Problem List with Nursing Notes:** **Inactive** (Enables progress notes and problem list entries entered by the physician via ChartLink to print to the Patient Progress Notes in POC.)

- **Use Ad Hoc Reporting via Point of Care:** Select to enable the Ad Hoc option via the Whiteboard.

- **Print Sliding Scale Comments:** Select to display Sliding Scale and Carb Formula comments on the Diabetic Flow Sheet.

- **Require Drug Allergy Entry:** If selected, Patient Allergies must be addressed before placing pharmacy orders via POC. The Pharmacy Department may require allergy entry independently of this option.

- **Require Height and Weight Entry:** If selected, Patient Height and Weight must be addressed before placing pharmacy orders via POC. The Pharmacy Department may require height and weight entry independently of this option.

- **Remove All I/O Entries at One Time From Flowcharts:** If selected, when one Intake or Output entry in a Date/Time Column is Amended (stricken), all other Intake and Output entries in the same Date/Time Column are Amended (stricken).

- **Exclude 30min orders from Patient and 24HR Summary:** Select to remove the "check" message associated with medications not given within the 30 minutes window before or after due time from the Patient Summary and 24hr Summary reports.

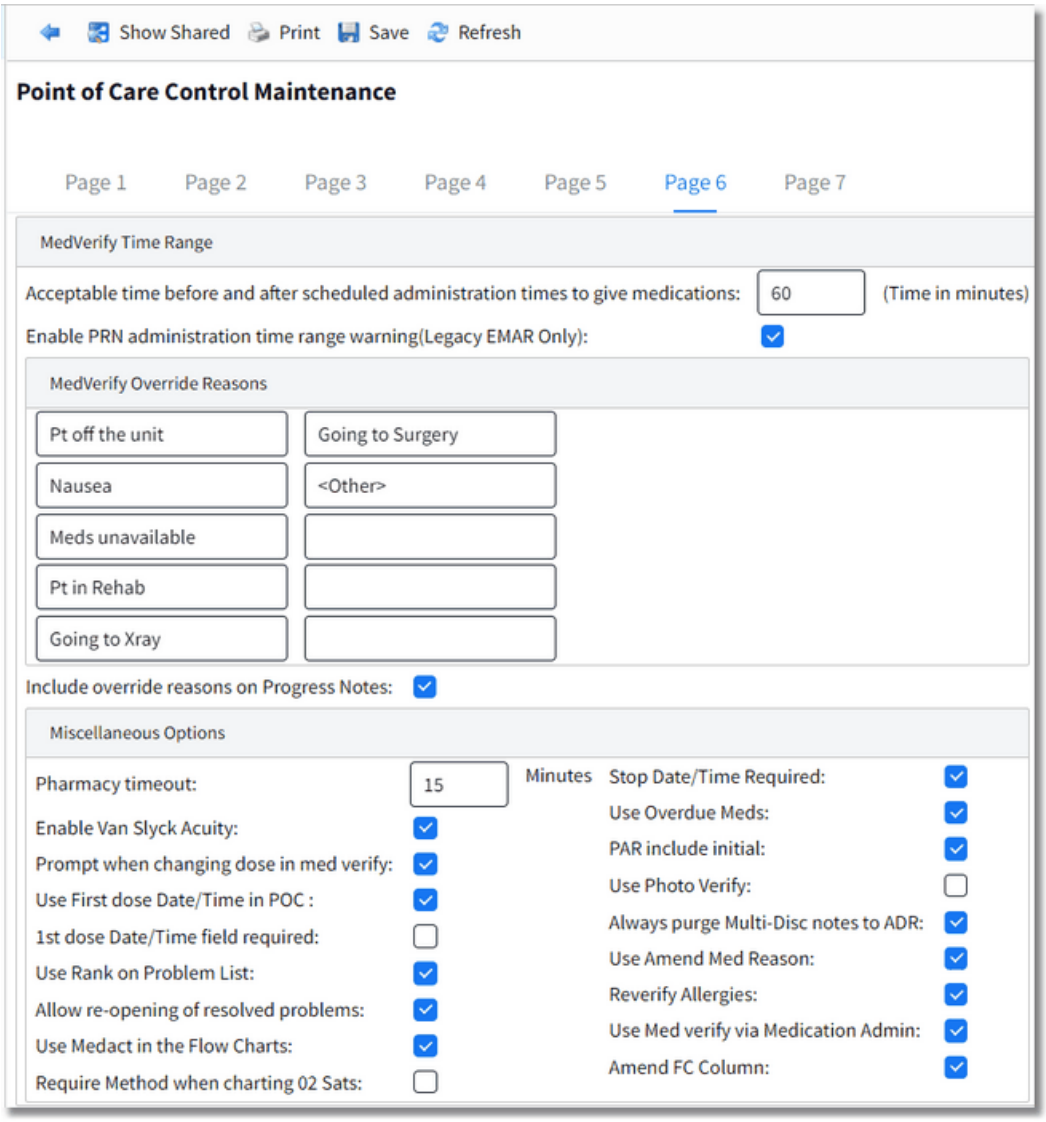
- **Use 5-day MAR:** Select Patient Stay Types (**1-5**) to utilize the 5-Day MAR instead of the 24hr MAR.

- **Sort 5-day MAR by:** Select one of the four options listed below to designate the order in which medications appear on the 5-Day MAR.
  - **N – Name:** Select this option to list medications in alphabetical order by description.
  - **C – Class:** Select this option to list medications by drug class.
  - **A – Chronological:** Select this option to list medications in chronological order of the start date/time.
  - **D – Reverse Chronological:** Select this option to list medications in reverse chronological order of the start date/time.

- After setup is complete, the following options are available:
  - **Blue Back Arrow:** Select this option to return to the previous screen.
  - **Show Shared:** Select this option to view setup being shared by multiple facilities.
  - **Print:** Select this option to print setup.
  - **Save:** Select this option to save modifications.
  - **Refresh:** Select this option to refresh the page.

Point of Care Control Maintenance - Page 6

Select **Web Client** > **Tables** > **Clinical** > **Nursing** > **POC Control Maintenance** > **Page 6**



Point of Care Control Maintenance - Page 6

- **Acceptable time before and after scheduled administration times to give medications (Time in Minutes):** Enter the number of minutes used to determine the acceptable time before and after the schedule date/time to administer medications.

- **Enable PRN administration time range warning (Legacy EMAR Only):** Select this option to enable the PRN Time Range Warning, which generates in Med-Verify if PRN medications are documented too close together in time. The acceptable time range must be entered on each PRN frequency. Contact to your Pharmacy Department for additional information.

- **MedVerify Override Reasons:** Enter one to ten **Override Reasons** to be used when overriding warning prompts in Med-Verify.

- **Include override reasons on Progress Notes:** Select to include Override Reasons documented via Med-Verify on the Patient Progress Notes.
- **Pharmacy timeout:** When the TruBridge EHR is left idle in Medication Verification, this field allows for a timeout to be set. When the armband scan times out, the green check will disappear off of the EMAR based on the number of minutes set up in the control table. See the EMAR/MedVerify User Guide for more information.
- **Enable Van Slyck Acuity:** Select this option to enable access to the Van Slyck Acuity Electronic Form.
- **Prompt when changing dose in med verify:** If selected, the user will receive a warning prompt when changing the dose of a medication in Med-Verify.
- **Use First Dose Date/Time in POC:** Select this option to enable the First Dose Date/Time field on the POC Pharmacy Order Entry menu.
- **1st dose Date/Time field required:** If selected, the First Dose Date/Time field must be OK'd before a POC Pharmacy Order may be updated.
- **Use Rank on Problem List:** Select this option to allow Rank to be entered when the problem is being selected for the patient.
- **Allow re-opening of resolved problems:** Select to enable the Re-Open option on the Problem List.
- **Use Medact in the Flow Charts:** Select to enable the Medact Icon on Flow Charts.
- **Require Method when charting O2 Sats:** If selected, O2 Sats cannot be updated unless a Method is charted. The O2 Combo Box is recommended. When this option is selected, O2 Sat cannot be documented via the Vital Sign Combo Box.
- **Stop Date/Time Required:** Select to enable the ability to enter a Stop Date/Time on the POC Pharmacy Order Entry menu.
- **Use Overdue Meds:** If selected, Overdue Medications will display in green on the EMARs.
- **PAR include Initial:** When selected, the Problem Activity Report will include information charted on the Initial Physical Assessment in Point of Care.
- **Use Photo Verify:** Select this option to enable Photo Verify via Med-Verify.
- **Always purge Multi-Disc notes to ADR:** When selected, the Multi-Disciplinary Progress Notes will purge to ADR separate from the Nursing Patient Progress Notes.
- **Use Amend Med Reasons:** If selected, the user must enter a reason when amending a medication administration.

- **Reverify Allergies:** Select to enable the ability to verify allergies via the 24-hr and 8-hr EMARS, All Current Scheduled Medications, and Med-Verify user areas.

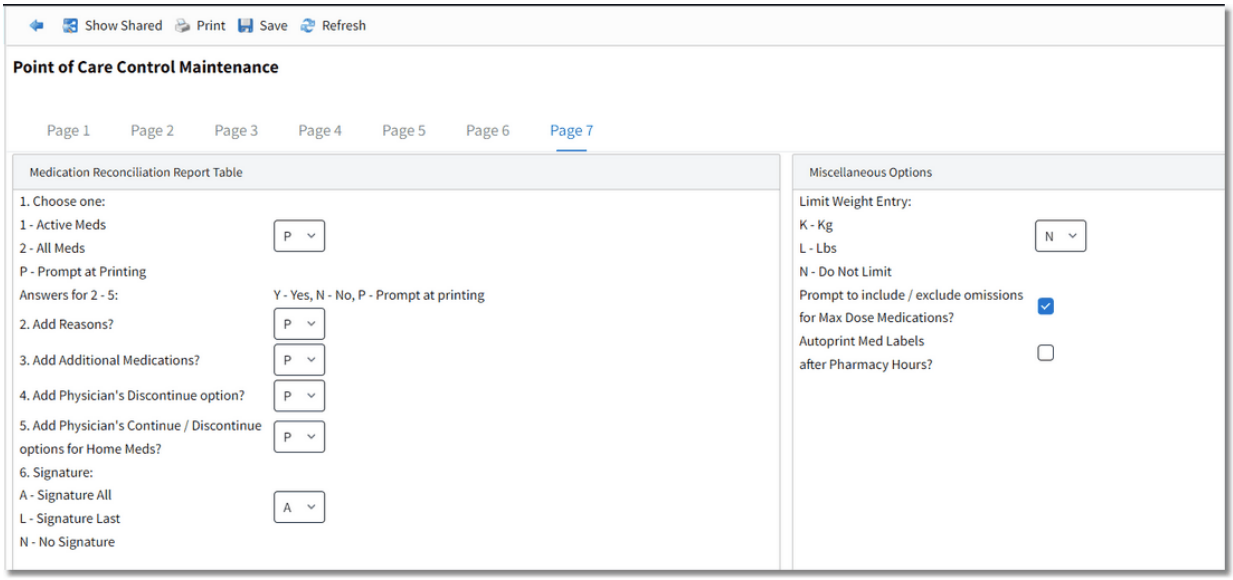
- **Use Med Verify Via Medication Admin:** When selected, Med-Verify may be accessed from all EMAR screens.

- **Amend FC Column:** Select to enable the ability to amend (strike) all data documented under the same Date/Time Column at one time.

- After setup is complete, the following options are available:
  - **Blue Back Arrow:** Select this option to return to the previous screen.
  - **Show Shared:** Select this option to view setup being shared by multiple facilities.
  - **Print:** Select this option to print setup.
  - **Save:** Select this option to save modifications.
  - **Refresh:** Select this option to refresh the page.

Point of Care Control Maintenance - Page 7

Select **Web Client** > **Tables** > **Clinical** > **Nursing** > **POC Control Maintenance** > **Page 7**



Point of Care Control Maintenance - Page 7

- **Medication Reconciliation Report Table:** Use the options below to designate the way in which the report is generated.
  - **1. Choose one:**
    - **1** - Active Meds: Select to display Active Meds only.
    - **2** - All Meds: Select to display All Meds.
    - **P** - Prompt at Printing: Select for the ability to choose at the time of printing. Home Medications are listed on the report regardless of the option chosen here.
  - **2. Add Reasons?**
    - **Y** - Yes: Select to add a reason line for each medication.
    - **N** - No: Select to remove the reason line.

  - o **P** - Prompt at Printing: Select for ability to choose at the time of printing.
- **3. Add Additional Medications?**
  - o **Y** - Yes: Select to add blank lines to write in additional medications.
  - o **N** - No: Select to remove the blanks lines.
  - o **P** - Prompt at Printing: Select for ability to choose at the time of printing.
- **4. Add Physician's Discontinue Option?**
  - o **Y** - Yes: Select to add a Discontinue Option for each Medication on the Pharmacy Profile. The Continue Option is hard-coded.
  - o **N** - No: Select to remove the Discontinue Option.
  - o **P** - Prompt at Printing: Select for ability to choose at the time of printing.
- **5. Add Physician's Continue/Discontinue Options for Home Meds?**
  - o **Y** - Yes: Select to add a Continue/Discontinue Options.
  - o **N** - No: Select to remove the Continue/Discontinue Options.
  - o **P** - Prompt at Printing: Select for ability to choose at the time of printing.
- **6. Signature:**
  - o **A** - Signature All: Select this option to add a physician signature line to each page of the report.
  - o **L** - Signature Last: Select this option to add a physician signature line to the last page of the report.
  - o **N** - No Signature: Select this option to remove the signature line.

- **Limit Weight Entry?**
  - **K** - Kg: Select this option to record Weight in Kilograms/Grams. The system will deactivate the Pounds/Ounces fields, but conversion values will continue to display in the fields.
  - **L** - Lbs: Select this option to record Weight in Pounds/Ounces. The system will deactivate the Kilograms/Grams fields, but conversion values will continue to display in the fields.
  - **N** - Do Not Limit: Select this option for the ability to enter Weight without restriction.

- **Prompt to include/exclude omissions for Max Dose Medications?**: If selected, the user determines if an omission counts as an administration for a Max Dose Medication. If not selected, omissions are automatically deducted from the number of available doses.

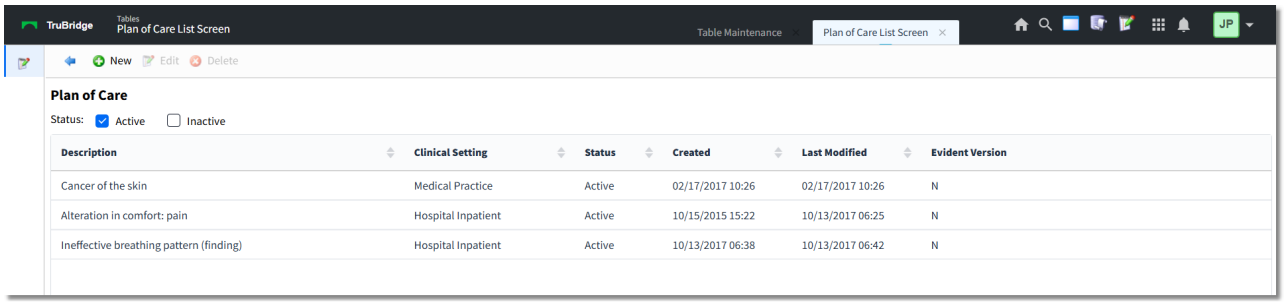
- **Autoprint Med Labels After Pharmacy Hours?**: If selected, medication labels used for Med-Verify will automatically print for each order entered after Pharmacy Hours. Pharmacy hours are set up in the ChartLink Control Table. Please refer to the CL Tables section of the Business Office Tables User Guide for additional information.

- After setup is complete, the following options are available:
  - **Blue Back Arrow:** Select this option to return to the previous screen.
  - **Show Shared:** Select this option to view setup being shared by multiple facilities.
  - **Print:** Select this option to print setup.
  - **Save:** Select this option to save modifications.
  - **Refresh:** Select this option to refresh the page.

7.14 Plan of Care Table

The Plan of Care Table presents the setup options for the Plan of Care Application. The table will allow for the set up of Problems, Goals, Interventions, and Documentation that may be associated with the Plan of Care.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Plan of Care Table**



Plan of Care Table

The Plan of Care Table will display the following information:

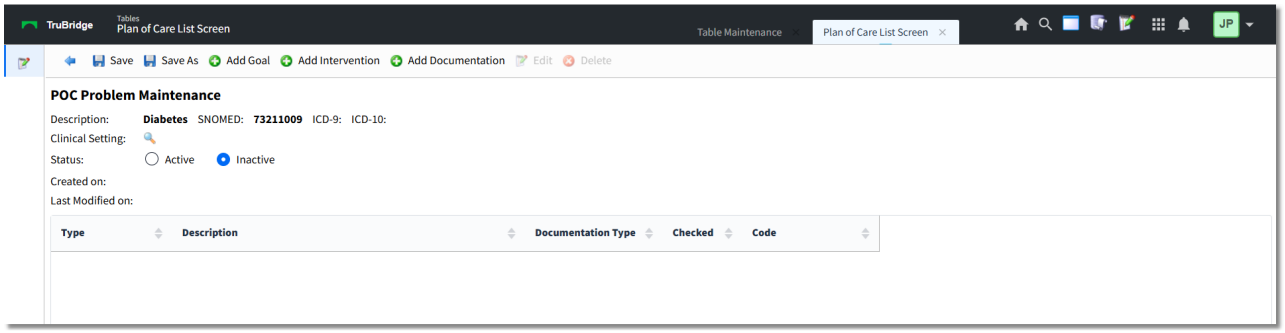
- **Description:** A description of the problem that has been set up
- **Clinical Setting:** The category of the problem that has been set up
- **Status:** Displays the current status of the problem. The default for the table is to display only "Active" problems.
  - **Active:** The problem is an active problem.
  - **Inactive:** The problem is an inactive problem.
- **Created:** The date and time of the problem creation.
- **Last Modified:** The date and time of the last change of the problem.
- **Evident Version:** Displays a **Y** if the setup for the plan of care was provided by TruBridge Content Services.

The Action Bar will display the following options:

- **Back Arrow:** Exits the user back to the Table Maintenance Clinical tab.
- **New:** Allows the user to create a new Plan of Care.
- **Edit:** Allows the user to highlight a problem from the listing and go to the Problem Maintenance screen.
- **Delete:** Allows the user to remove a problem from the list box.

From this screen, the user may select a previously diagnosed problem from the list table or create a new Plan of Care. To create a new Plan of Care, select **New** to open the New Problem screen.The default is to search by description, but the system will also search by ICD10 code. Select the problem to open the Plan of Care Problem Maintenance Screen.

Select **Web Client** > **Tables** > **Clinical** > **Nursing** > **Plan of Care Table** > **New** > **Enter new problem** > **Plan of Care Problem Maintenance Table**



Plan of Care Problem Maintenance

The Plan of Care Problem Maintenance Screen will display the following:

- The selected Problem, along with its SNOMED, ICD9 and ICD10 codes will pull into the Description field.
- The Clinical Setting lookup will allow the user to select the category of the problem.
- The Setting will allow the user to designate the status as "Active" or "Inactive."
- Also displayed will be the date that the problem was last modified.

The Plan of Care Problem Maintenance list box will display the following information:

- **Type:** Shows the type of option set up for the problem. The three options are:
  - **Goal**
  - **Intervention**
  - **Documentation**
- **Description:** Shows the description for the corresponding option set up for this problem.
- **Documentation Type:** This is only used when the Type is selected as Documentation. The two options are:
  - **Section**
  - **Question**

- **Checked:** Displays a **Y** if "Default to Checked" is selected and a **N** if "Default to Checked" is blank.
- **Code:** Shows the types and numbers of any associated codes for that option.

The Action Bar will display the following options:

- **Back Arrow:** Will exit without saving.
- **Save:** Saves any changes made to the Description or Status.
- **Save As:** Will allow the user to copy over the TruBridge version of the plan of care.
- **Add Goal:** Will take the user to the Plan of Care Goal Maintenance screen.
- **Add Intervention:** Will take the user to the Plan of Care Intervention screen.
- **Add Documentation:** Will take the user to the Plan of Care Question List screen.
- **Edit:** Will allow the user to highlight an option from the list box and edit it .
- **Delete:** Will allow the user to highlight an option from the list box and delete it from the problem setup.

To set up a new Goal for a problem, select **Add Goal** from the Plan of Care Problem Maintenance screen.

Select **Web Client > Tables > Clinical > Nursing > Plan of Care Table > New > Enter Problem > POC Problem Maintenance Table > Add Goal**

Plan of Care Problem Goal Maintenance

The Plan of Care Problem Goal Maintenance screen will display the following:

- **Goal:** The magnifying glass to the right of the Goal will allow the user to go to a goal listing to designate a code for the problem.
- **Goal Text Box:** If the user is selecting a goal from the lookup, the selected goal will display in the box. The text box will also allow the user to free-text the goal in the box if preferred.

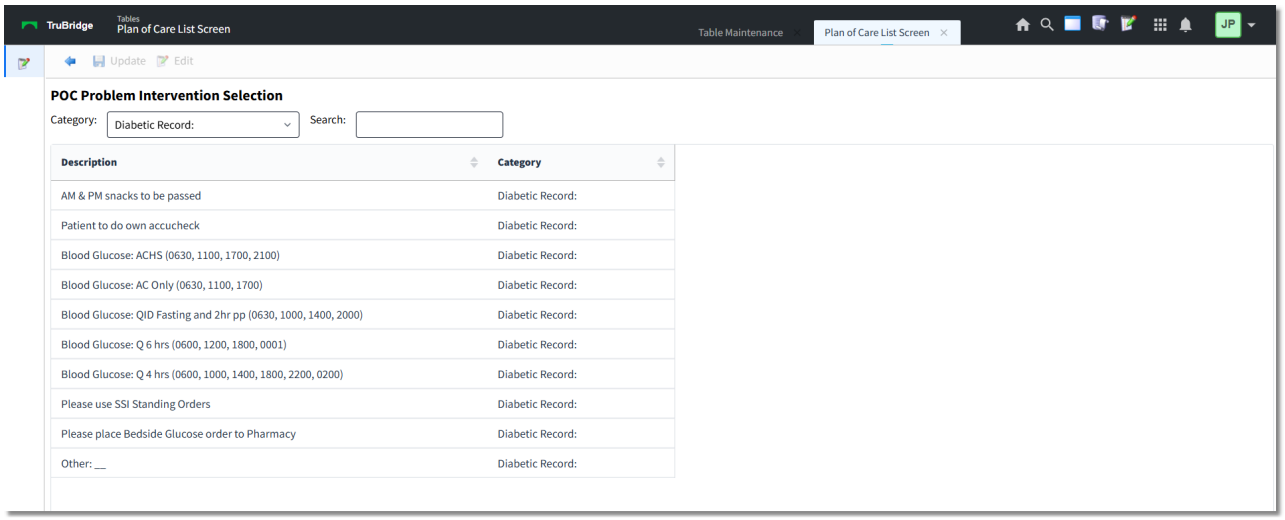
- **Default as checked:** If checked, the goal will appear as already checked on the template associated with the corresponding problem on the end-user side.
- **SNOMED Code:** Will display the codes for the goal in a view only format if the goal lookup is used.

The Action Bar will display the following options:

- **Back Arrow:** Will exit without saving.
- **Update:** Will save all changes and exit the user back to the Plan of Care Problem Maintenance screen.
- **Clear:** Will delete any changes made on the screen.

To set up a new Intervention for a problem, select **Add Intervention**.

Select **Web Client > Tables > Clinical > Nursing > Plan of Care Table > New > Enter Problem > POC Problem Maintenance Table > Add Intervention**



Plan of Care Problem Intervention Selection

The Plan of Care Problem Intervention Selection screen will display the following:

- **Category:** This drop-down menu will house all Nursing order categories with the default being All Categories.
- **Search:** Will allow the user to search within the selected category

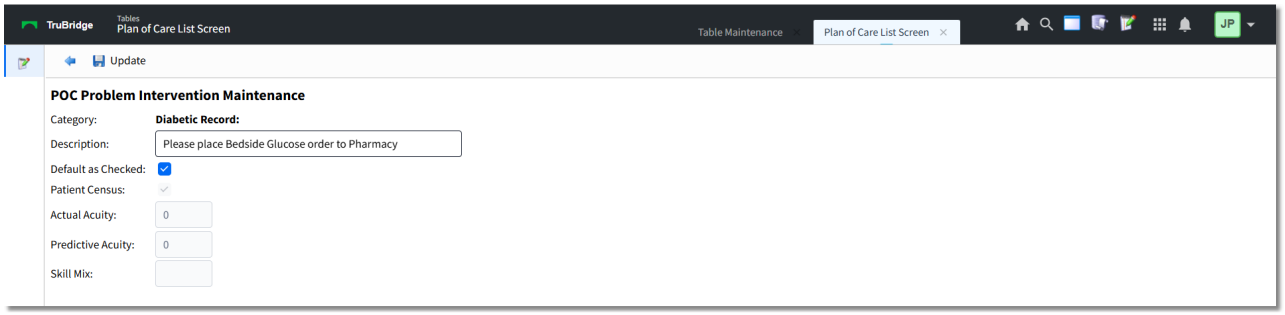
The List Box will display the following:

- **Description:** Will display the nursing orders from the selected category
- **Category:** Will display the category in which the nursing order is located

The Action Bar will display the following options:

- **Back Arrow:** Will exit without saving
- **Update:** Will save the selected nursing order and exit the user to the Plan of Care Problem Maintenance screen
- **Edit:** Allows the user to edit the selected nursing order. Will take the user to the Plan of Care Intervention Maintenance screen

Select **Web Client > Tables > Clinical > Nursing > Plan of Care Table > New > Enter Problem > POC Problem Maintenance Table > Add Intervention > Select Intervention > Edit**



Plan of Care Problem Intervention Maintenance

The Plan of Care Problem Intervention Maintenance screen will display the following:

- **Category:** Will display the category of the nursing order
- **Description:** Will display the nursing order in a text box. This text box will allow the description to be edited. The edited problem will appear on the Problem Maintenance screen but will not change the problem in the master Intervention Maintenance Selection list.
- **Default as Checked:** When selected, the intervention will appear as already checked on the template associated with the corresponding problem on the end-user side.
- **Patient Census:** Will pull what is set up on the order in Nursing Order setup
- **Actual Acuity:** Will pull what is set up in Nursing Order setup
- **Predictive Acuity:** Will pull what is set up in Nursing Order setup

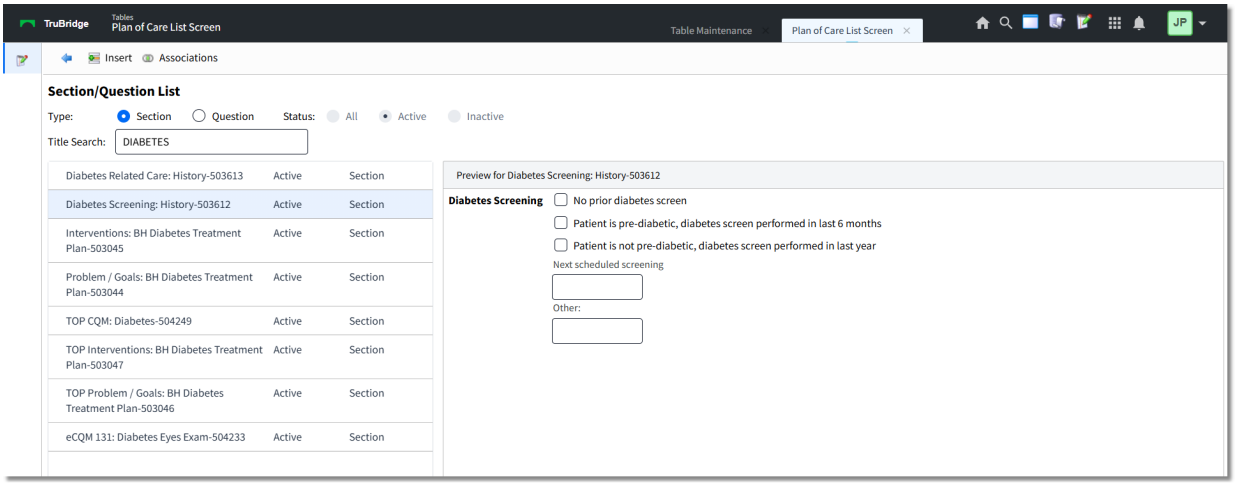
- **Skill Mix:** Will pull what is set up in Nursing Order setup

The Action Bar will display the following options:

- **Back Arrow:** Will exit without saving
- **Update:** Will save all changes and exit the user to the Problem Maintenance screen

To add Documentation to a problem, select **Add Documentation**.

Select **Web Client > Tables > Clinical > Nursing > Plan of Care Table > New > Enter Problem > POC Problem Maintenance Table > Add Documentation**



Plan of Care Section/Question List

The Plan of Care Section/Question List will display the following:

- **Type:**
  - **Section:** Will display only sections
  - **Question:** Will display only questions
- **Status:** Only "Active" sections and questions will be displayed
- **Title Search:** Will allow for a smart search of sections or questions

A listing of the sections or questions will display in the box on the left-hand side of the screen. A single click will allow a preview of the selected section or question to appear in the Preview box on the right-hand side.

The Action Bar will display the following options:

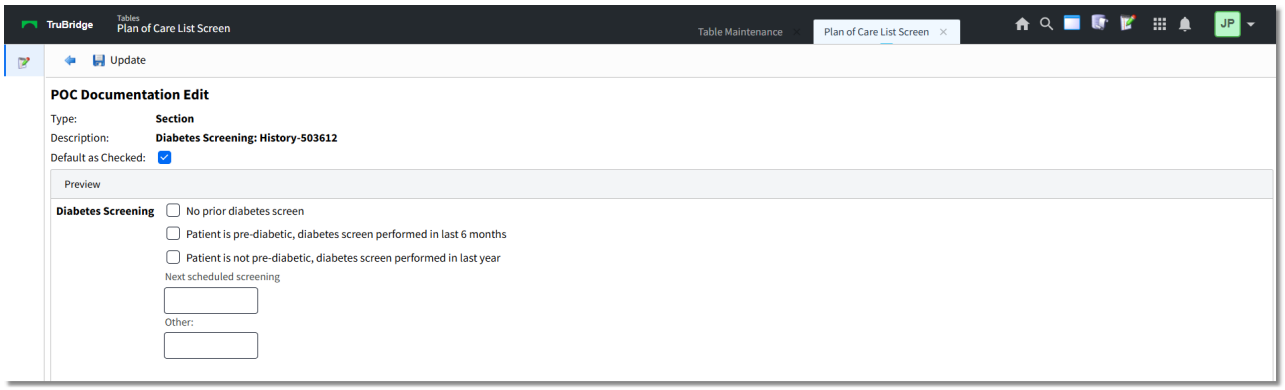
- **Back Arrow:** Will exit without saving

- **Insert:** Saves the highlighted section or question and will exit the user back to the Problem Maintenance screen

- **Associations:** Will only display after a section or question is highlighted. Displays a listing of all documents that include the highlighted section or question.

To add documentation to the problem, select the **Section** or **Question** from the Problem Maintenance screen and then select **Edit**. This will take the user to the Plan Of Care Documentation Edit screen.

Select **Web Client** > **Tables** > **Clinical** > **Nursing** > **Plan of Care Table** > **New** > **Enter Problem** > **POC Problem Maintenance Table** > **Add Documentation** > **Insert** > **Choose Section or Question** > **Edit**



Plan of Care Documentation Edit

The Plan of Care Documentation Edit screen will display the following:

- **Type:** Will display whether it is a section or question

- **Description:** Will display the title of the section or question

- **Default as Checked:** Will allow the goal to appear as already checked on the template associated with the corresponding problem on the end-user side

- **Preview:** Will display all the questions and answers from the selected Section or Question

The Action Bar will display the following options:

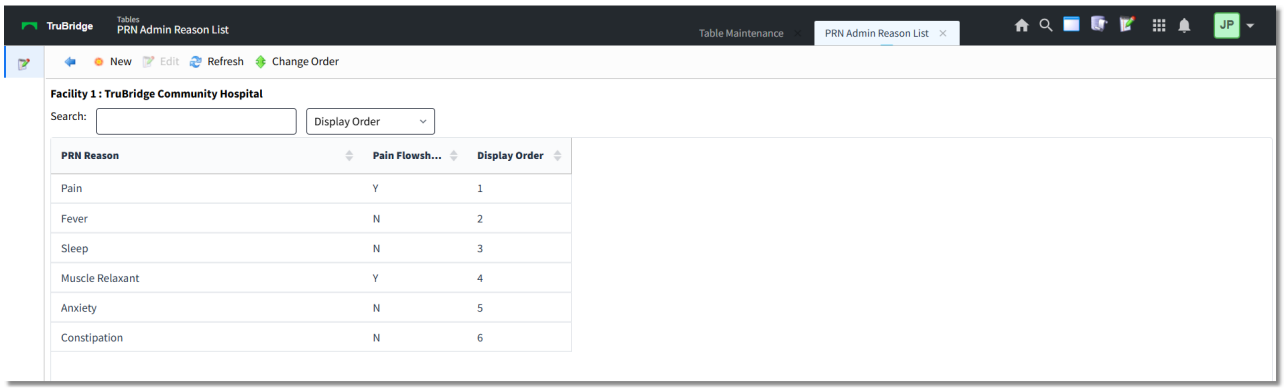
- **Back Arrow:** Will exit without saving

- **Update:** Saves any changes made and will exit the user back to the Problem Maintenance screen

7.15 PRN Administration Reasons

The PRN Administration Reasons table lists the PRN reasons that display for selection during order entry. PRN Reasons can be added, edited, and deleted in this table.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **PRN Administration Reasons**



PRN Administration Reasons Table

The table displays the following information:

- **PRN Reason:** Displays the PRN reason.
- **Pain Flowsheet:** Displays a **Y** if the PRN reason is set to display on the Pain Flowsheet or **N** if the PRN reason is not set to display on the Pain Flowsheet.
- **Display Order:** Displays the numerical order in which the PRN reasons will display for selection.

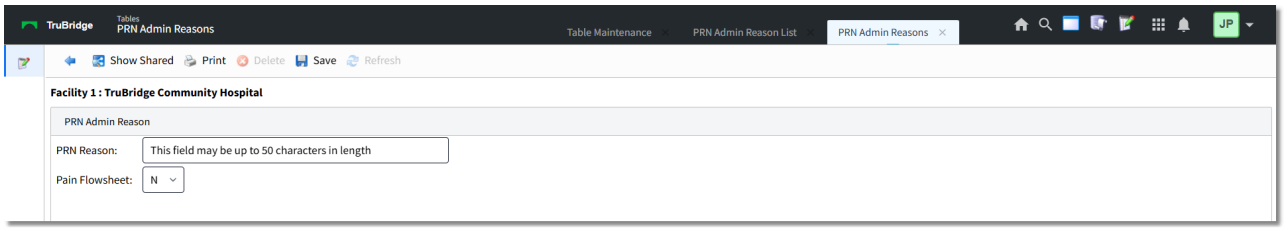
A search may be performed by keying the search term in the **Search** field and selecting the appropriate search type from the drop-down. The table may also be sorted by selecting a column header.

Action Bar Options

- **Blue back arrow:** Select to return to the previous screen.
- **New:** Select to create a new PRN reason.
- **Edit:** Select to edit the selected PRN reason.
- **Refresh:** Select to refresh the screen.
- **Change Order:** Select to change the display order of a PRN reason.

To Create a New PRN Reason

1. Select **New**.



PRN Admin Reason - New

2. In the **PRN Reason** field, enter the PRN reason. This field accepts up to 50 characters.
3. In the **Pain Flowsheet** field, select the drop-down and select **Y** to include the reason on the Pain Flowsheet or **N** to not include the reason on the Pain Flowsheet.
4. Select **Save**.
5. Select the **blue back arrow** to return to the PRN Admin Reason List.
6. Select **Refresh** to update the screen.

***NOTE**: "Other" will display as a hard-coded reason in the list.*

To Edit a PRN Reason

1. Select the PRN reason you want to edit.
2. Select **Edit**.
3. Make the necessary changes and select **Save**.
4. Select the **blue back arrow** to return to the PRN Administration Reasons table.
5. Select **Refresh** to update the screen.

To Delete a PRN Reason

1. Select the PRN reason you want to delete.
2. Select **Edit**.
3. Select **Delete**.
4. Select **Refresh** to update the screen.

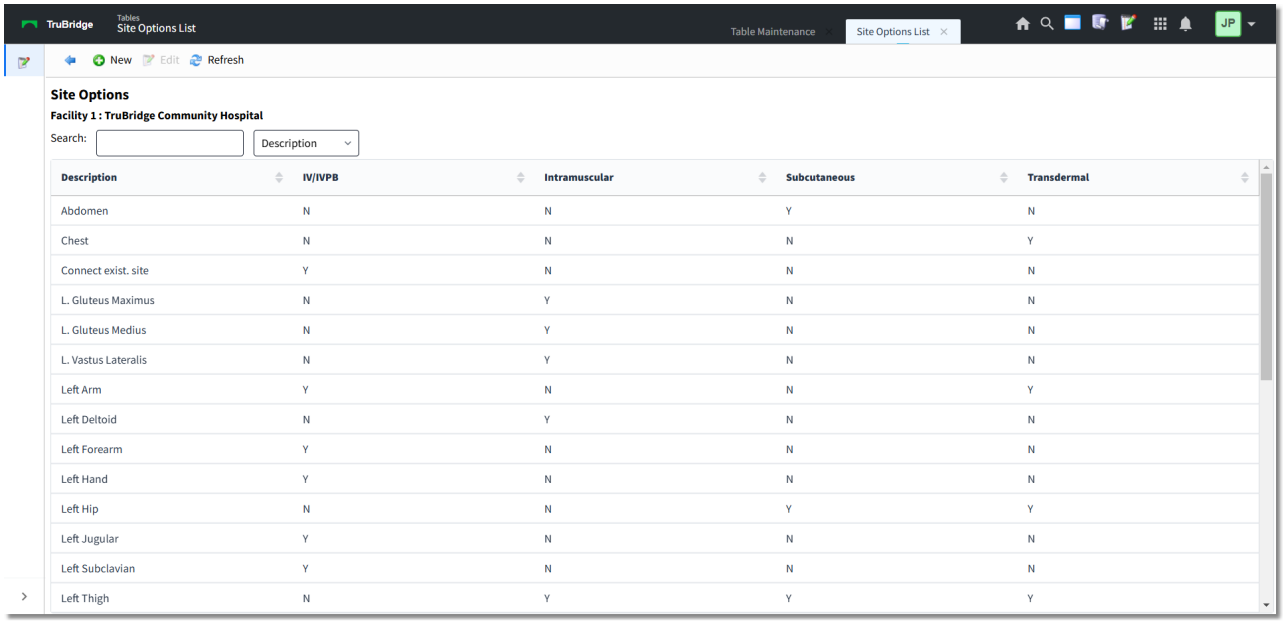
To Change the Display Order of the PRN Reasons

1. Select **Change Order**.
2. Select the PRN reason you want to move.
3. Select **To Top**, **To Bottom**, **Up**, or **Down** to move the reason to the desired order within the list.
4. Make any other necessary changes to the display order and select **Save**.

7.16 Site Options Table

The Site Options Table displays descriptions of **IV/IVPB**, **Intramuscular**, **Subcutaneous**, and **Transdermal** sites where medications are administered. Sites options can be added, edited, and deleted in this table.

Select **Web Client** > **Tables** > **Clinical** > **Nursing category** > **Site Options Table**



Description	IV/IVPB	Intramuscular	Subcutaneous	Transdermal
Abdomen	N	N	Y	N
Chest	N	N	N	Y
Connect exist. site	Y	N	N	N
L. Gluteus Maximus	N	Y	N	N
L. Gluteus Medius	N	Y	N	N
L. Vastus Lateralis	N	Y	N	N
Left Arm	Y	N	N	Y
Left Deltoid	N	Y	N	N
Left Forearm	Y	N	N	N
Left Hand	Y	N	N	N
Left Hip	N	N	Y	Y
Left Jugular	Y	N	N	N
Left Subclavian	Y	N	N	N
Left Thigh	N	Y	Y	Y

Site Options Table

The table displays the following information:

- **Description:** Displays the administration site description.
- **IV/IVPB:** A **Y** displays in this column if the site is selectable when administering intravenous or intravenous piggyback medications. An **N** displays if the site is not applicable to this route.

- **Intramuscular**: A **Y** displays in this column if the site is selectable when administering intramuscular medications. An **N** displays if the site is not applicable to this route.
- **Subcutaneous**: A **Y** displays in this column if the site is selectable when administering subcutaneous medications. An **N** displays if the site is not applicable to this route.
- **Transdermal**: A **Y** displays in this column if the site is selectable when administering transdermal medications. An **N** displays if the site is not applicable to this route.

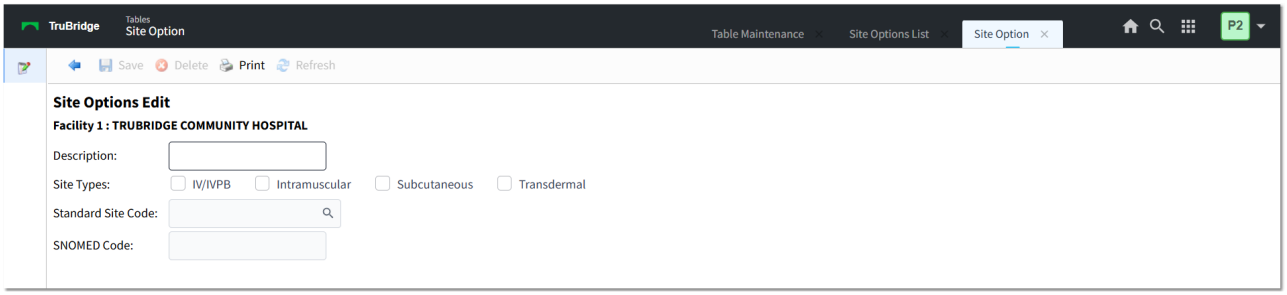
A search may be performed by keying the search term in the **Search** field. The table may be sorted by selecting any of the column headers.

Action Bar Options

- **Blue back arrow:** Select to return to the previous screen.
- **New:** Select to create a new site option.
- **Edit:** Select to edit the site option.
- **Refresh:** Select to refresh the screen.

To Create a New Site Option

1. Select **New**.



Site Options - New

2. In the **Description** field, enter the site description.
3. In the **Site Types** field, select one or more applicable sites. Site types are **IV/IVPB**, **Intramuscular**, **Subcutaneous**, and/or **Transdermal**.
4. In the **Standard Site Code** field, use the lookup icon to search for and select a site code. Search options are **Code** or **Description**.
5. In the **SNOMED Code** field, enter the SNOMED Code.

6. Select **Save**.
7. Select the **blue back arrow** to return to the Site Options Table.
8. Select **Refresh** to update the screen.

To Edit a Site Option

1. Select the site option you want to edit.
2. Select **Edit**.
3. Make the necessary changes and select **Save**.
4. Select the **blue back arrow** to return to the Site Options Table.
5. Select **Refresh** to update the screen.

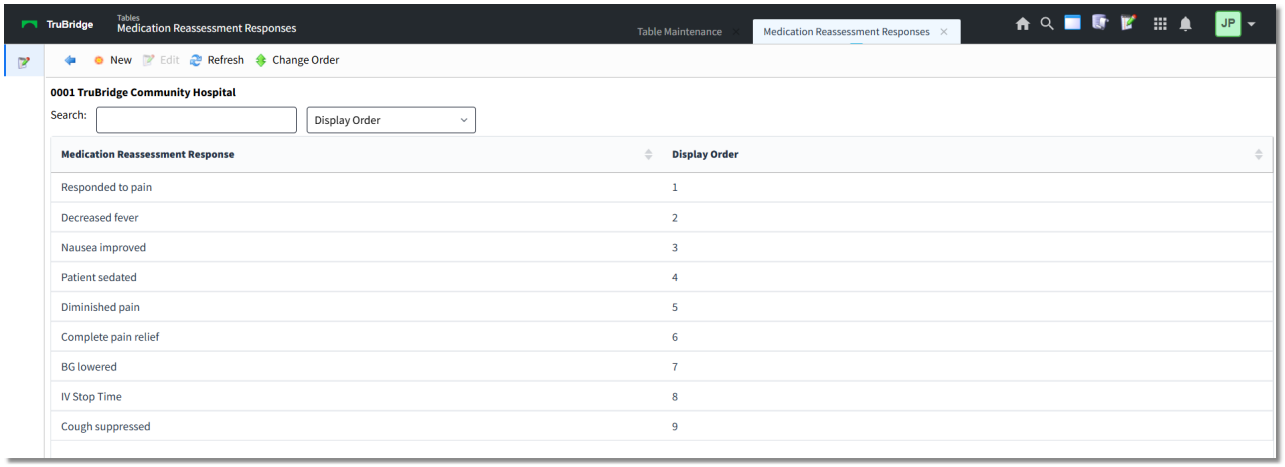
To Delete a Site Option

1. Select the site option you want to delete.
2. Select **Edit**.
3. Select **Delete**.
4. Select **Refresh** to update the screen.

7.17 Medication Reassessment Responses

The Medication Reassessment Response table displays a list of patient responses to a medication. These responses display in a drop-down on the Medication Administration screen when **Reassessment** is selected. Medication reassessment responses can be added, edited, and deleted in this table.

Select **Web Client** > **Tables** > **Clinical** > **Nursing** > **Medication Reassessment Responses**



Medication Reassessment Responses

The table displays the following information:

- **Medication Reassessment Response:** Displays the description of the assessment response.
- **Display Order:** Displays the numerical order in which the assessment response will display for selection.

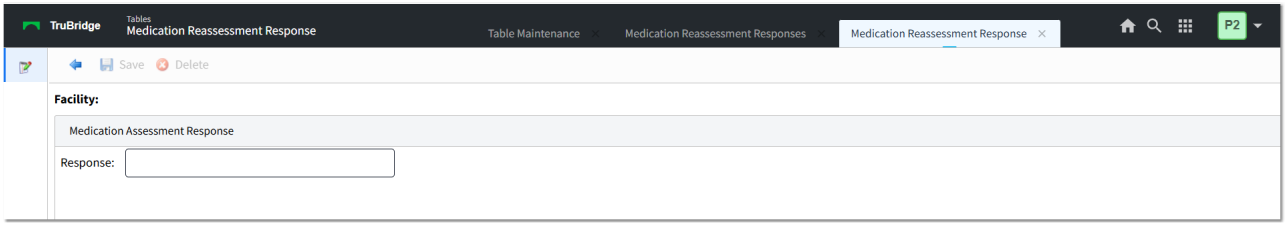
A search may be performed by keying the search term in the Search field and selecting the appropriate search type from the drop-down. The table may also be sorted by selecting a column header.

Action Bar Options

- **Blue back arrow:** Select to return to the previous screen.
- **New:** Select to create a new reassessment response.
- **Edit:** Select to edit the selected reassessment response.
- **Refresh:** Select to refresh the screen.
- **Change Order:** Select to modify the display order of a reassessment response.

To Create a Medication Reassessment Response

1. Select **New**.



Medication Reassessment Response

2. In the **Response** field, enter the response description.
3. Select **Save**.
4. Select the **blue back arrow** to return to the Medication Reassessment Responses table.
5. Select **Refresh** to update the screen.

To Edit a Medication Reassessment Response

1. Select the medication reassessment response you want to edit.
2. Select **Edit**.
3. Make the necessary changes to the response description.
4. Select **Save**.
5. Select the **blue back arrow** to return to the Medication Reassessment Responses table.
6. Select **Refresh** to update the screen.

To Delete a Medication Reassessment Response

1. Select the medication reassessment response you want to delete.
2. Select **Edit**.
3. Select **Delete**.

To Change the Display Order of the Medication Reassessment Responses

1. Select **Change Order**.
2. Select the medication reassessment response you want to move.
3. Select **To Top**, **To Bottom**, **Up**, or **Down** to move the response to the desired display order.

4. Make all necessary changes to the display order and select **Save**.

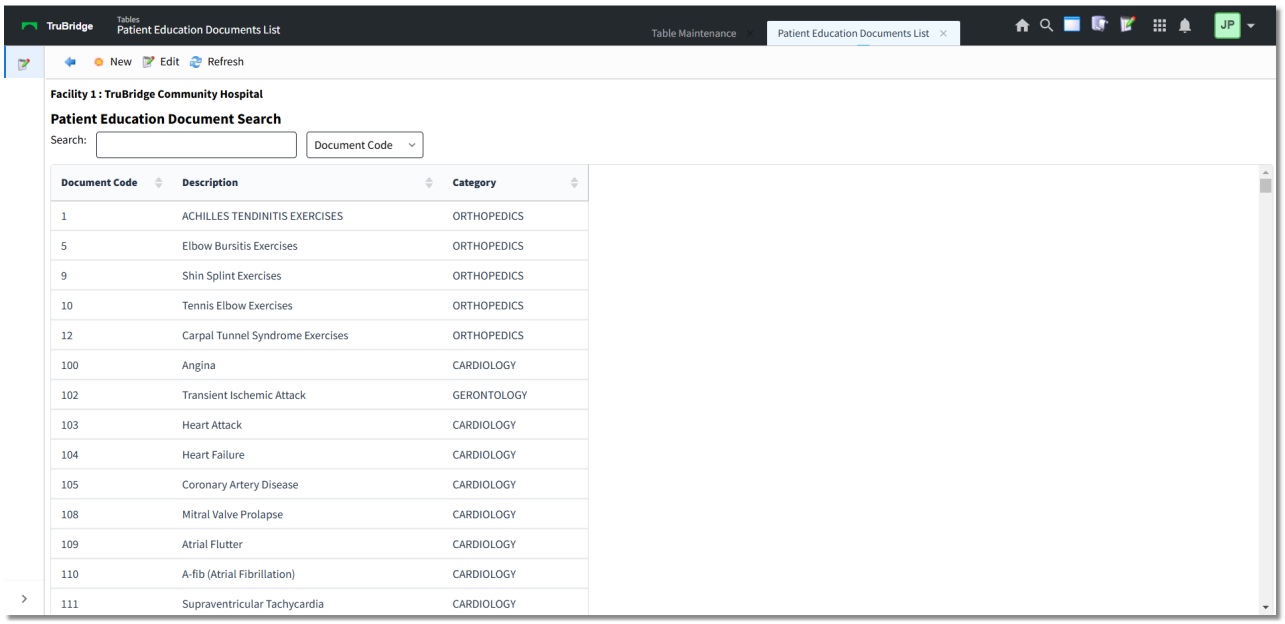
Chapter 8 Patient Education Maintenance

This section discusses setup areas available via Table Maintenance. See the section on Patient Education Maintenance in the Patient Education Documents User Guide for setup via Nursing Administration Functions.

8.1 Document Maintenance

To perform maintenance on an existing document select **Document Maintenance**.

Select **Web Client** > **Tables** > **Clinical** > **Patient Education Maintenance** > **Document Maintenance**



Document Maintenance

The table displays the following information:

- **Document Code**: Displays the topic code of up to six digits
- **Description**: Displays the topic description
- **Category**: Displays the category to which the topic is assigned

The default listing of topics is numerical by Document Code. A search may be performed using one of the three available drop-down searches: **Document Code**, **Description** or **Category**. Key the search term in the search field, then select the **search type** from the drop-down menu to sort the list. The list may also be sorted by selecting a **column header**. Use the **vertical scroll-bar** to view the entire display list.

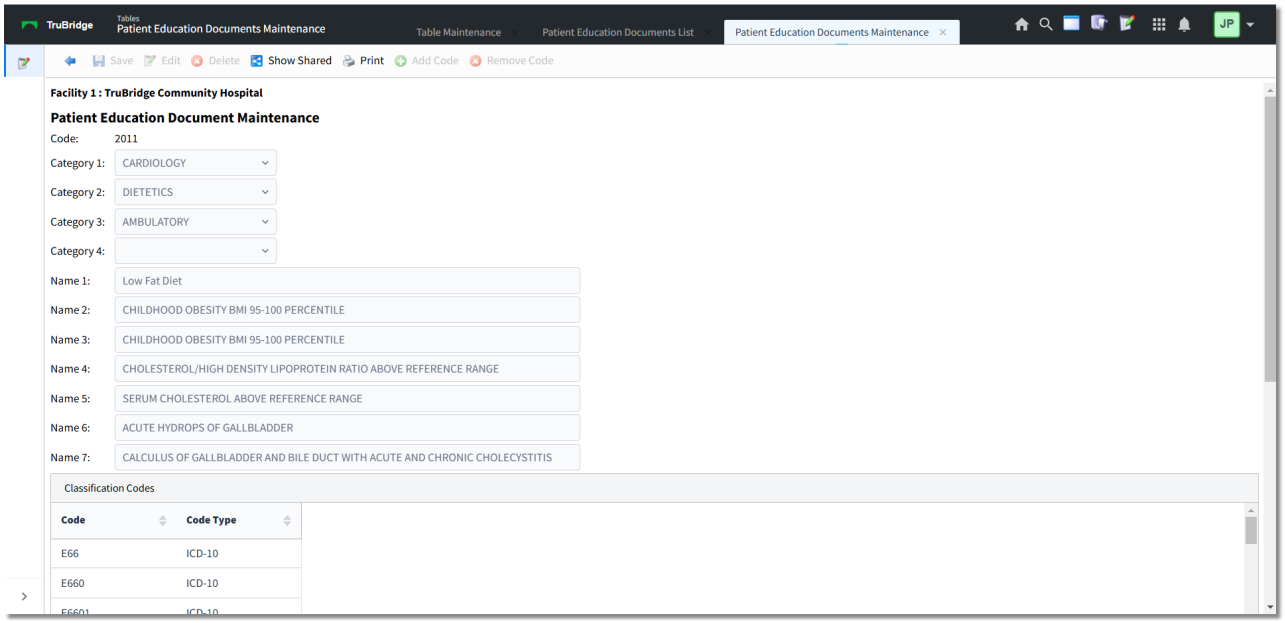
The following actions are available:

- **Blue Back Arrow**: Select this option to return to the previous menu.
- **New**: Select this option to create a custom document. See Create a New Document 85 for setup options.
- **Edit**: Select this option to modify an existing document. See Editing an Existing Document 83.
- **Refresh**: Select this option to manually update the selection list if a documented is created or edited.

Editing an Existing Document

To view Patient Education Document Maintenance, select the **topic** then **Edit**.

Select **Web Client** > **Tables** > **Clinical** > **Patient Education Maintenance** > **Document Maintenance** > **Topic**



Patient Education Document Maintenance

- **Code**: Topics are assigned a unique code up to six digits long.

- **Category 1 - 4**: Topics may be assigned to up to four categories for search purposes. If a custom document has been selected, the Category fields may be modified. Select **Save** on the action bar to save changes. Categories may not be edited for documents provided by Micromedex.

- **Name 1 - 7**: The topic description is displayed in field one. Fields two through seven are utilized for alternate search terms. If a custom document has been selected, the Name fields may be modified. Select **Save** on the action bar to save changes. Names may not be edited for documents provided by Micromedex.

- **Classification Codes**: The Codes and Code Types, including ICD-9, ICD-10, LOINC and/or SNOMED codes, associated with the topic display in this field (if applicable). If a custom document has been selected, codes may be added or removed using the **Add Code** and **Remove Code** options on the action bar. See Create a New Document 85 for additional information. Classification Codes may not be edited for documents provided by Micromedex.

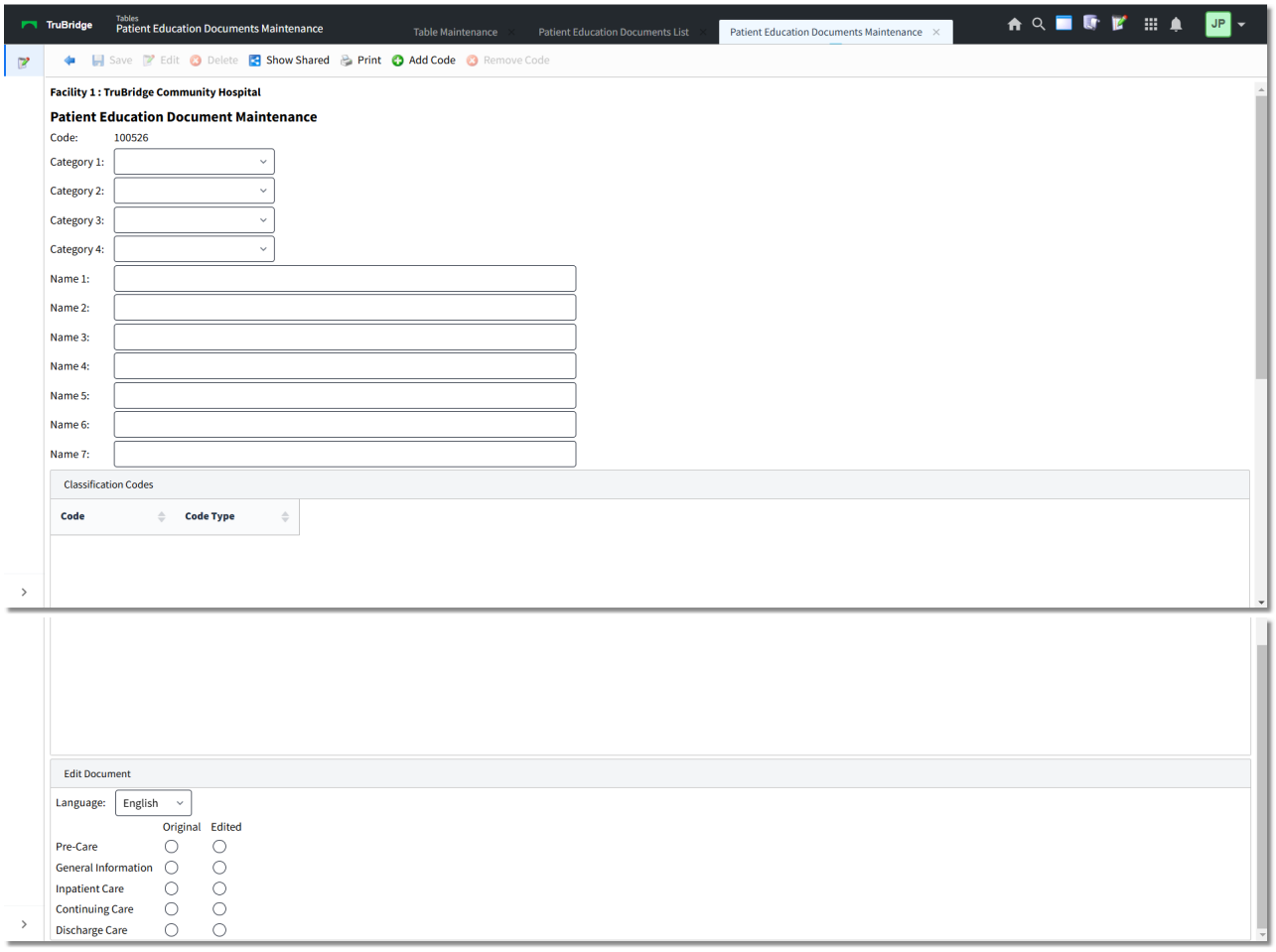
- **Edit Document**: Select **English** or **Spanish** to determine the version of the document to be viewed/edited. To view the original version of a Micromedex document, select the **radio button** in the 'Original' column for the document type then **Edit** on the action bar. To view the edited version of a Micromedex or custom document, select the **radio button** in the 'Edited' column for the document type then **Edit** on the action bar. To delete a custom document, select the **radio button** in the 'Edited' column for the document type then **Delete** on the action bar. Original documents provided by Micromedex may not be deleted. See Create a New Document 85 for additional information on custom documents. At this time, Original Micromedex documents must be modified via Patient Education Maintenance. See Document Maintenance in the Patient Education Documents User Guide.

- Additional options available via the action bar:
  - **Back Arrow**: Select this option to return to the previous screen.
  - **Show Shared**: This option will display setup being shared by multiple facilities.
  - **Print**: Select this option to print setup.

8.2 Create a New Document

To create a new topic and its corresponding documents, select **Create a New Document**.

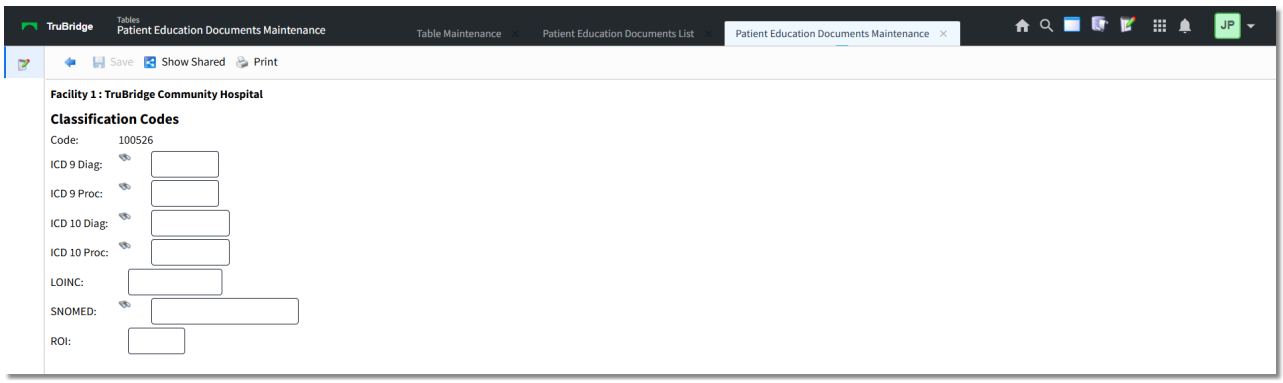
Select **Web Client** > **Tables** > **Clinical** > **Patient Education Maintenance** > **Create a New Document**



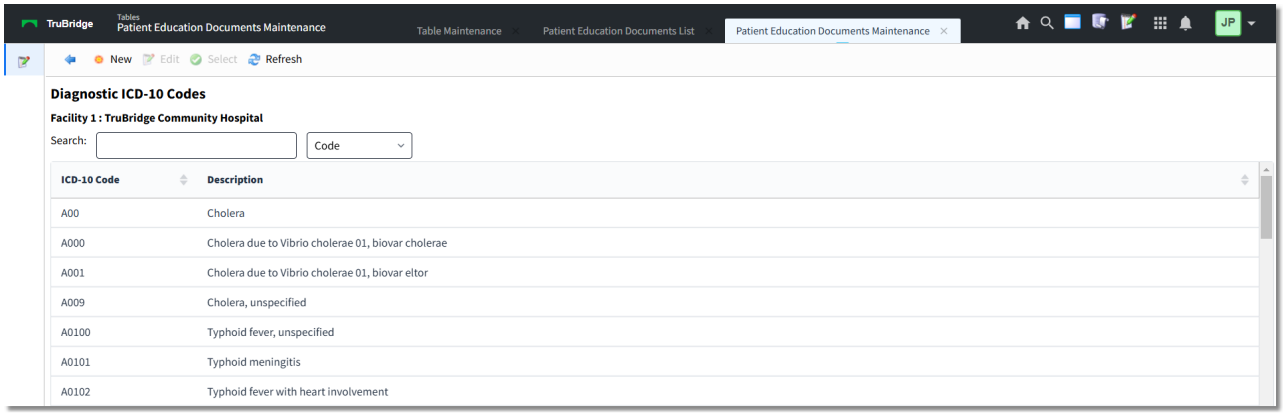
Patient Education Documents

- **Code**: Topics are assigned a unique code up to six digits long.
- **Category 1 - 4**: Enter up to four categories for search purposes. Select **Save** on the action bar to save changes.
- **Name 1 - 7**: Enter the topic description in field one. Enter alternate search terms in fields two through seven if applicable. Select **Save** on the action bar to save changes.
- **Classification Codes**: If applicable, classification codes including ICD-9, ICD-10, LOINC and/or SNOMED codes may be added.
  - Select **Add Code** from the action bar.

- Key the code in the applicable field (LOINC codes must be entered manually), or select the **Binoculars** adjacent to the code type for a lookup menu
- The codes list alphabetically by description. The list defaults to active codes. Select **Exclude expired** to include expired codes in the listing. A code may be located by **Description** or **Code** using the search field and the drop-down menu. The list may also be sorted by the column headers. Select the **description** then **Copy** from the action bar to add the code. Select **Save** from the Classification Code Menu.
- To remove a code, select it from the Patient Education Document Maintenance screen, then select **Remove Code** from the action bar.



Classification Codes



Diagnosis Search

- **Edit Document**: Select **English** or **Spanish** to determine the version of the document to be created. To create the custom document, select the **radio button** in the 'Edited' column for the document type then **Edit** on the action bar to launch Microsoft Word. Enter the document then **save** and **exit** from Word. Select **Yes** to save the custom document or **No** to abort.

- To delete a document, select **English** or **Spanish** to determine the version of the document to be deleted. Select the **radio button** in the 'Edited' column for the document type then **Delete** on the action bar. Select **Yes** to delete or **No** to abort.

Additional options available via the action bar:

- **Back Arrow**: Select this option to return to the previous screen.
- **Show Shared**: This option will display setup being shared by multiple facilities.
- **Print**: Select this option to print setup.

8.3 Update User-Defined Documents

Select **Web Client > Tables > Clinical > Patient Education Maintenance > Update User Defined Documents** to view a list topics for which one or more original documents have been edited. It is recommended that edited documents be reviewed and compared against original documents at each quarterly update. See Document Maintenance 82 for document selection options and maintenance.

8.4 Rebuild Indexes

The Rebuild Indexes option is available for use at any time patient education documents are suspected of being lost or corrupted. This option is commonly used whenever Micromedex quarterly updates are loaded to the system. It may also be used to manually refresh selection lists after a new category or document has been created. Select **Web Client > Tables > Clinical > Patient Education Maintenance > Rebuild Indexes**.

8.5 Set up Cover Page

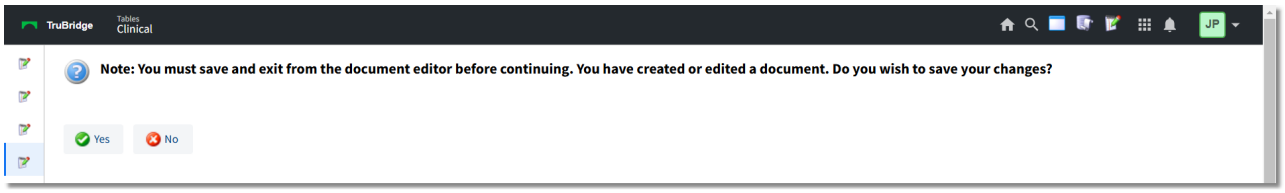
A facility defined cover page may be created to generate with Patient Education Documents when they are printed.

The following TruBridge AR Database codes may be used on the cover sheet to automatically generate data:

- PATNAME: Patient's name
- PATNUM: Patient's account number
- PATSEX: Patient's sex
- PATAGE: Patient's age
- PATADMIT: Patient's admission date
- PATDISCHARGE: Patient's discharge date
- PATMRNUM: Patient's medical record number
- PATTYPE: Patient's stay type
- PATROOM: Patient's room number
- PATBDAY: Patient's date of birth
- PHYS1NUM: Admitting physician's number (system number)
- PHYS1NAME: Admitting physician's name
- PHYS1ABR: Admitting physician's abbreviated name

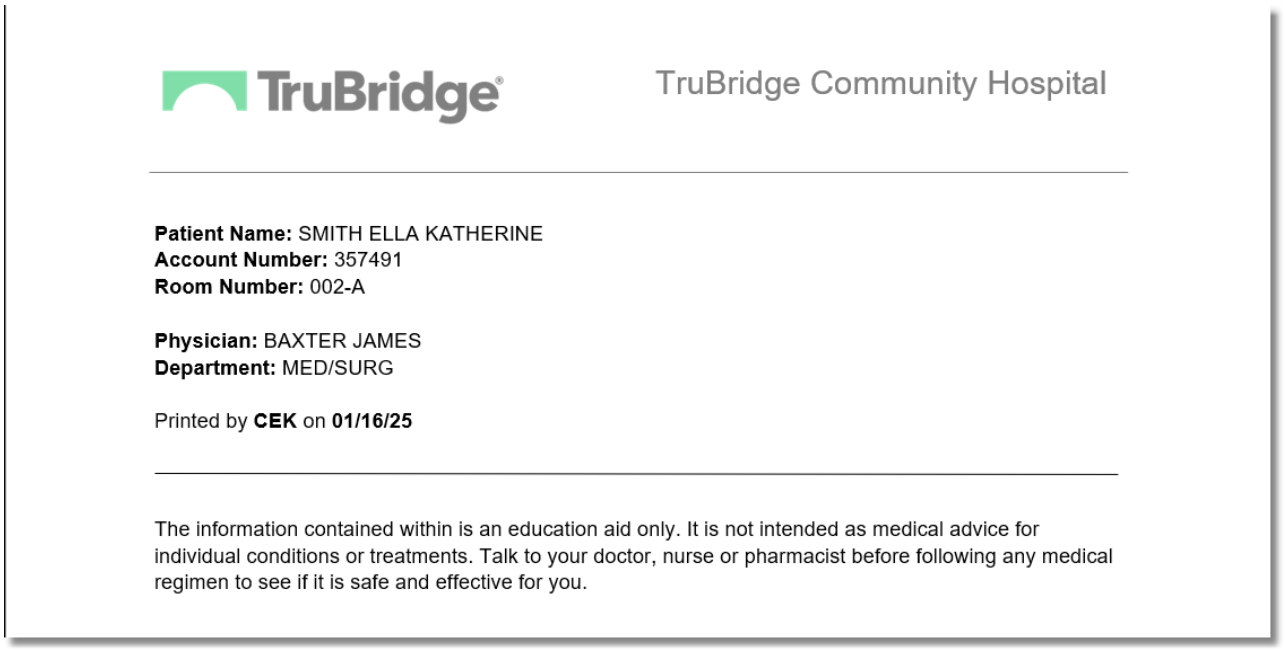
- PHYS2NUM: Secondary physician's number (system number)
- PHYS2NAME: Secondary physician's name
- PHYS2ABR: Secondary physician's abbreviated name
- DEPTNAME: Name of department the document is printed from
- PRINTDATE: Date document printed
- PRINTINIT: Initials of person printing document

Select **Web Client > Tables > Clinical > Patient Education Maintenance > Setup Cover Page** to launch Microsoft Word. Enter the document then **save** and **exit** from Word. Select **Yes** to save the coverpage or **No** to abort.



Save Changes?

Patient Education Document Cover Page



Chapter 9 Pharmacy Control

9.1 Alternating Comp. Table

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

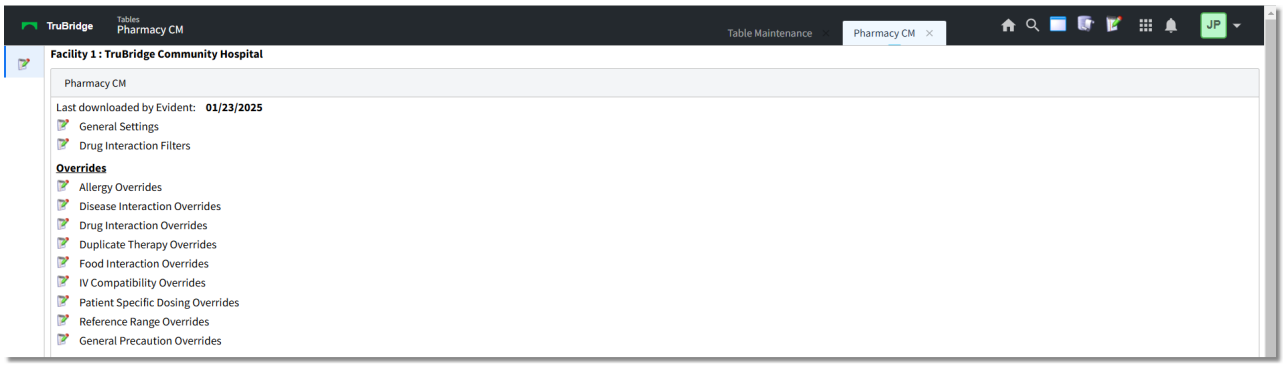
9.2 Charges Pricing Table

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

9.3 Clinical Monitoring

The Clinical Monitoring Control Table is used to define the types and levels of clinical monitoring checks and overrides that the pharmacy department receives during order entry.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring**



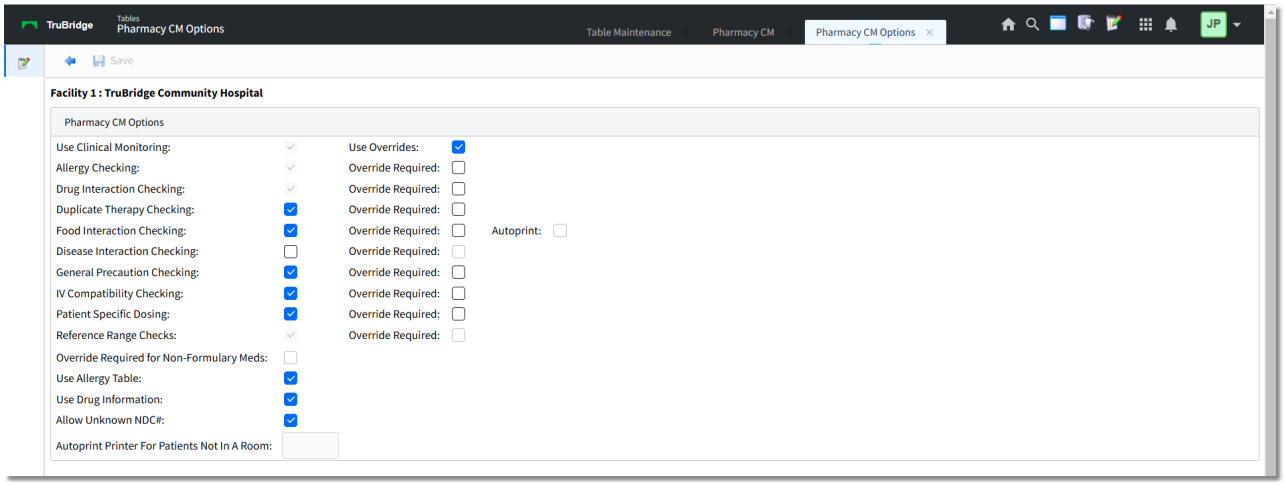
Pharmacy CM

- **Last Downloaded: MM/DD/YYYY:** Indicates the last date clinical monitoring files were updated.
- **General Settings:** Contains the clinical monitoring option settings.
- **Drug Interaction Filters:** Contains the drug interaction filtering option settings.
- **Overrides:** Lists override reasons for each clinical monitoring category.

General Settings

The Clinical Monitoring General Settings section contains all activation options for Pharmacy clinical monitoring.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **General Settings**



Pharmacy CM Options

- **Use Clinical Monitoring:** Activates Clinical Monitoring for pharmacy medication order entry. This field is grayed out but always checked "yes," since some Clinical Monitoring checks are required to meet Meaningful Use.

- **Allergy Checking:** Allows the system to automatically perform allergy checks at the time of order entry. Whenever a drug is entered from the Drug Formulary for a patient, the system compares the new medication to any drug allergy entered on the patient through the TruBridge system. If there are any drug allergies documented that correspond to the medication selected, a menu will display showing the drug selected, the allergy, the drug class and any possible symptoms. This field is grayed out but always checked "yes," since this Clinical Monitoring check is required to meet Meaningful Use. Select **Include Inactive Ingredients** to perform allergy checking for inactive ingredients.

- **Drug Interaction Checking:** Allows the TruBridge EHR to automatically perform drug interaction checks at the time of order entry. Whenever a drug is entered from the Drug Formulary for a patient, the software compares the new medication to all medications the patient is currently taking or has taken within the last 24 hours. Any possible interactions will display. The drug interactions are ranked as contraindicated, major, moderate, or minor. This field is "grayed out" but always checked "yes," since this Clinical Monitoring check is required in order to meet Meaningful Use requirements.

- **Duplicate Therapy Checking:** Select the checkbox to allow the system to automatically perform duplicate therapy checks at the time of order entry. As soon as a medication is selected to be dispensed, the patient's current orders are reviewed for duplicate therapy. The Clinical Monitoring Screen appears and under Duplicate Therapy the similar medication is listed. Both IV and Non-IV

orders are checked for duplicate therapy. Duplicate Therapy Checking is performed using the NDC number that is entered on Pharmacy Information Page 1 for each item.

NOTE: *Duplicate Therapy Checking is not performed on discontinued orders.*

- **Food Interaction Checking:** Select the checkbox to allow the system to automatically perform food interaction checks at the time of order entry. If a medication that has an interaction to food is selected from the Drug Formulary, the Clinical Monitoring screen displays.

NOTE: *The* ***Autoprint*** *option next to Food Interaction Checking is not used by Pharmacy Clinical Monitoring. This option is available in the Nursing Clinical Monitoring table.*

- **Disease Interaction Checking:** Select the checkbox to allow the TruBridge EHR to automatically perform drug-disease interaction checking at the time of pharmacy order entry. The system will compare medication orders to patient diagnoses and alert the user if the medication has the potential to worsen the disease. Disease Interaction Checking utilizes diagnoses information entered via the Physician Problem List, the TruBridge Medical Records Grouper, and the Pharmacy RX Diagnoses.

- **General Precaution Checking:** Activates or deactivates General Precaution Checking, which screens a medication's active and inactive ingredients against the patient's age and gender to help determine whether the order should be continued. This checking more specifically provides individual and daily dosing information for pediatric, adult and geriatric age ranges.

- **IV Compatibility Checking:** Select the checkbox to allow the system to automatically perform IV compatibility checks at the time of order entry. If a medication that is not compatible with an existing medication in the patient's pharmacy profile is ordered, the clinical monitoring screen will display. A monograph may then be printed or displayed. This system uses Trissel's™ 2 IV drug compatibility data set.

- **Patient Specific Dosing:** Select the checkbox to enable the TruBridge EHR to automatically perform patient specific dosing. Patient specific dosing will run once all order entry fields have been OK'd prior to updating the order. Only Overdose and subtherapeutic information will be displayed; the PSD window will not display if neither is triggered. A diagnosis, listed at the top of the PSD window, may be added during order entry. Once added, the PSD window may be reloaded.

- **Reference Range Checks:** The TruBridge EHR automatically applies reference range checking to medication orders with associated lab tests if these tests have associated reference ranges; this field is by default inaccessible but activated. This functionality relates to setup of individual items in Pharmacy Information Page 2

- **Use Overrides:** Select the checkbox to allow the user to enter override reasons at the time of order entry for any medication that meets the checks described above. Custom override reasons may be pre-built in the Overrides 96 section below, and can be set for each type of Clinical Monitoring check.

- **Override Required:** Select the check box adjacent to each type of Clinical Monitoring Check that requires a reason be documented before proceeding with order entry.

- **Override Required for Non-Formulary Meds:** This option is not used during Pharmacy Clinical Monitoring.

- **Use Allergy Table:** Activates the tabular format of allergy information entry. This affects ALL departments, not just pharmacy. When checked (yes), the allergy table is provided by Micromedex and contains medication, food, and environmental allergies.

NOTE: *This field should only be accessed under the direction of TruBridge.*

- **Use Drug Information:** Select the checkbox to activate the Drug Information module, which allows printing of patient education.

NOTE: *This field should only be accessed under the direction of TruBridge.*

- **Allow Unknown NDC#:** Allows Pharmacy to use NDC numbers not listed in the Micromedex database on Pharmacy Information Page 1.

NOTE: *This feature allows entry of invalid NDC numbers. Clinical monitoring will not be performed during order entry for any medication item that has an invalid NDC number.*

- **Autoprint Printer For Patients Not In A Room:** This field is not used by Pharmacy Clinical Monitoring.

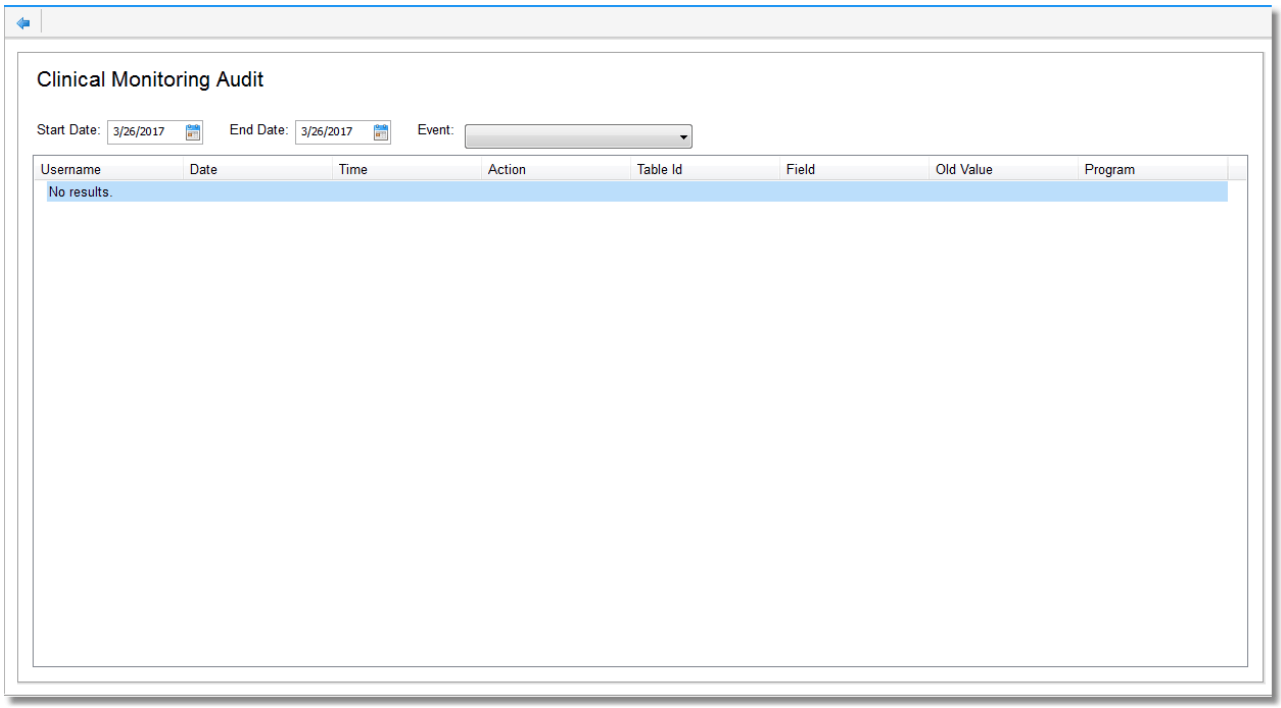
Once any changes are made, be sure to select 

Save from the action bar.

- **View Audit:** The Clinical Monitoring audit log, accessed from the 

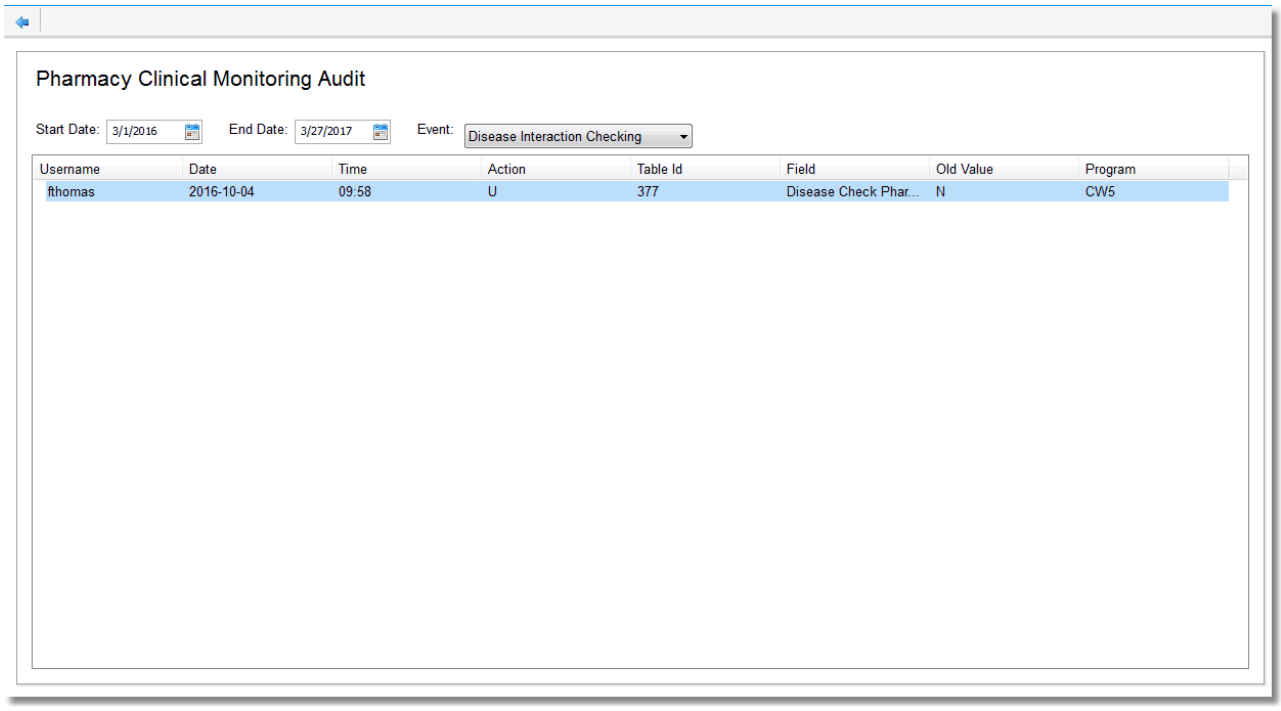
View Audit option on the action bar records each time a Clinical Monitoring check has been turned on or off for a specific date range.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **General Settings** > **View Audit**



Clinical Monitoring Audit

Populate the Start and End Date, then select the **Event** drop-down menu to select the type of clinical monitoring check to review.



Pharmacy Clinical Monitoring Audit

The Clinical Monitoring Audit functions are described below.

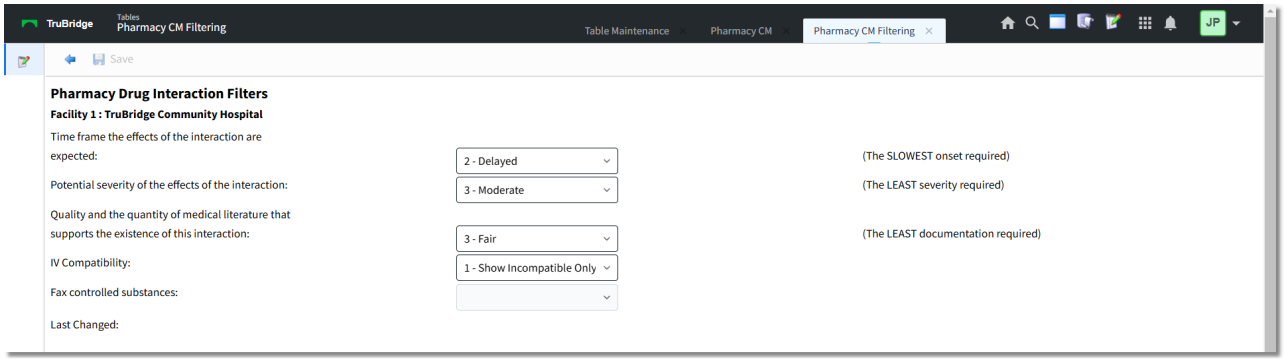
- **Username:** This column shows the logname of the employee who turned a check on or off.
- **Date:** In YYYY-MM-DD format, this column displays the date that the change was made.
- **Time:** This column displays the time the change was made.
- **Action:** A code indicating what sort of action occurred displays in this column.
  - **U:** Indicates the value of the field was updated
- **Table Id:** This field is not used at this time.
- **Field:** This column lists the Clinical Monitoring Check item that has been turned on or off
- **Old Value:** This column indicates what the field's setting was prior to being changed.
  - Fields on the General Settings page display Y or N to indicate checked (Y) or unchecked (N)
  - Drug Interaction Filters display the numeric value located in the specific drop-down menus
- **Program:** This column displays the name of the program from which the action was generated

Select the  **back arrow** to return to the previous screen.

Drug Interaction Filters

Interaction Filtering allows Drug Interaction warnings to be customized in terms of speed of onset, interaction severity, quality and quantity of medical literature available regarding an interaction and compatibility between various intravenous fluids and medications.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **Drug Interaction Filters**



Pharmacy Drug Interaction Filters

- **Time frame the effects of the interaction are expected:** Select the slowest onset required to trigger a warning from the following options:
  - 1 - Rapid
  - 2 - Delayed

- **Potential severity of the effects of the interaction:** Select the least severity required to trigger a warning from the following options:
  - 1 - Contraindicated
  - 2 - Major
  - 3 - Moderate
  - 4 - Minor

- **Quality and the quantity of medical literature that supports the existence of this interaction:** Select the least documentation required to trigger a warning from the following options:
  - 1 - Excellent
  - 2 - Good
  - 3 - Fair
  - 4 - Poor

- **IV Compatibility:** Indicates which IV compatibility checks will be required to trigger a warning, using Trissel's IV compatibility checks. Select from the following options:
  - 1 - Show Incompatible Only
  - 2 - Show Incompatible or Unavailable
  - 3 - Show All Checks

- **Fax controlled substances:** This field is not used in Pharmacy Clinical Monitoring.

- **Last Changed:** This field is not used in Pharmacy Clinical Monitoring.

Once any changes are made, select 

Save from the action bar. To return to the previous screen, select the  **back arrow**.

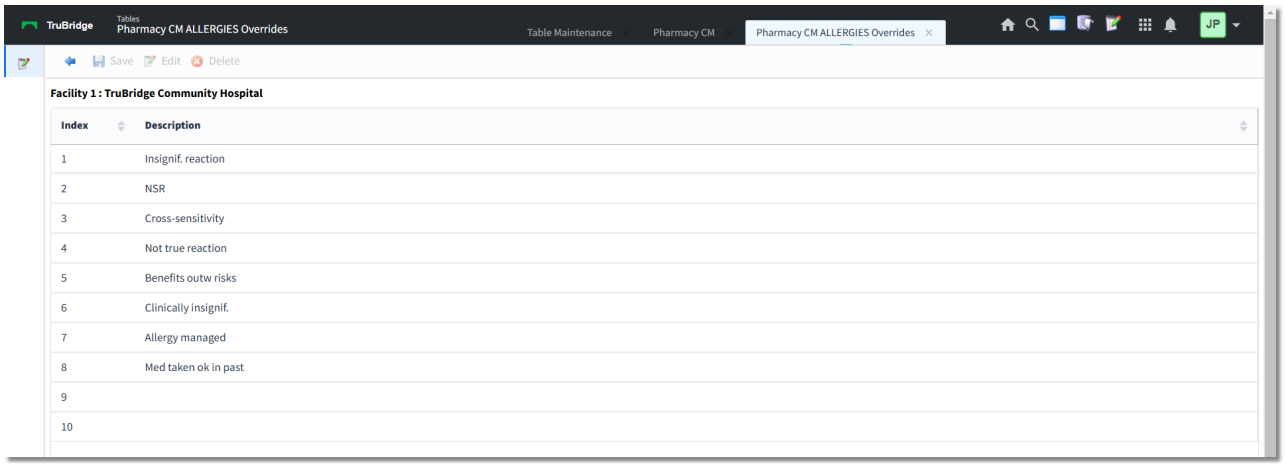
Overrides

Override reasons may be created for each type of clinical monitoring check. A maximum of 10 override reasons may be entered for each of the following categories: Allergies, Disease Interactions, Drug Interactions, Duplicate Therapy, Food Interactions, IV Compatibility, Patient Specific Dosing, Reference Range and General Precautions.

Allergy Overrides

Up to 10 override reasons may be entered to address allergy checks. The Allergy Overrides list consists of 10 lines, with unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **Overrides** > **Allergy Overrides**

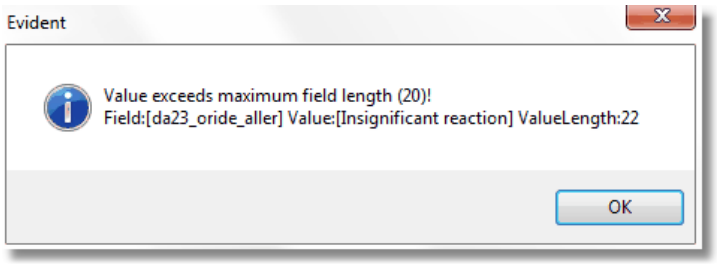


Pharmacy CM Allergy Overrides

1. To enter override reasons, select an entry from the list and select 

Edit from the action bar.

2. Enter the override reason in the field; it can hold a maximum of 20 characters. Select **OK** from the action bar to add to or update the overrides list.
3. To save any changes, select **Save** from the action bar. If any override reason contains more than 20 characters, the system will display the following warning.



Override Field Length Warning

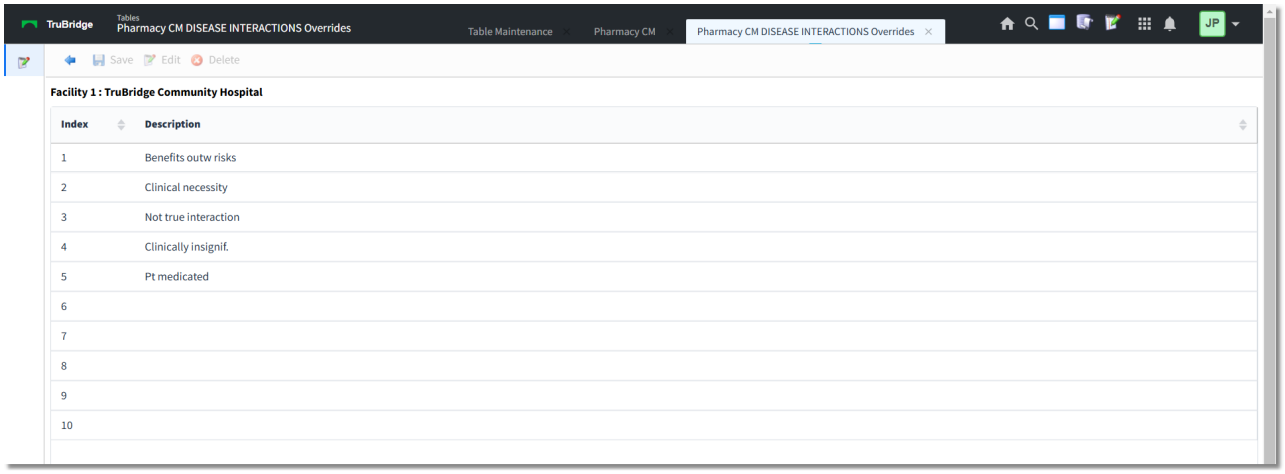
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

Select the **back arrow** to return to the previous screen.

Disease Interaction Overrides

Up to 10 override reasons may be entered to address disease interaction checks. The Disease Interaction Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **Overrides** > **Disease Interaction Overrides**



Disease Interaction Overrides

1. To enter override reasons, select an entry from the list and select 

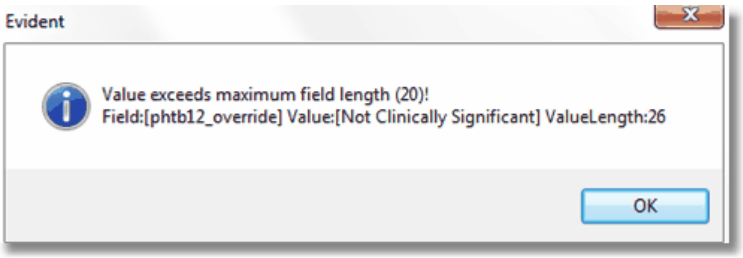
Edit from the action bar.

2. Enter the override reason in the field; it can hold a maximum of 20 characters. Select 

OK from the action bar to add to or update the overrides list.

3. To save any changes, select 

Save from the action bar. If any override reason contains more than 20 characters, the system will display the following warning.



Override Field Length Warning

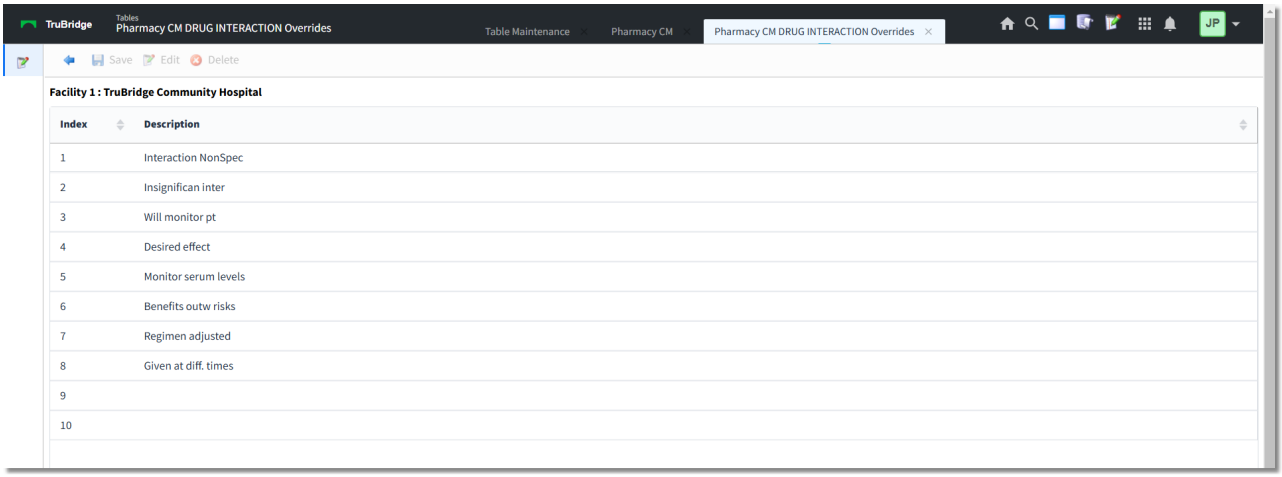
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

Select the  **back arrow** to return to the previous screen.

Drug Interaction Overrides

Up to 10 override reasons may be entered to address drug interaction checks. The Drug Interaction Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **Overrides** > **Drug Interaction Overrides**



Drug Interaction Overrides

1. To enter override reasons, select an entry from the list and select 

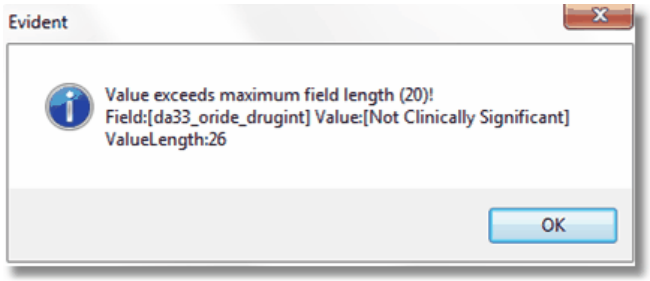
Edit from the action bar.

2. Enter the override reason in the field; it can hold a maximum of 20 characters. Select 

OK from the action bar to add to or update the overrides list.

3. To save any changes, select 

Save from the action bar. If any override reason contains more than 20 characters, the system will display the following warning.



Override Field Length Warning

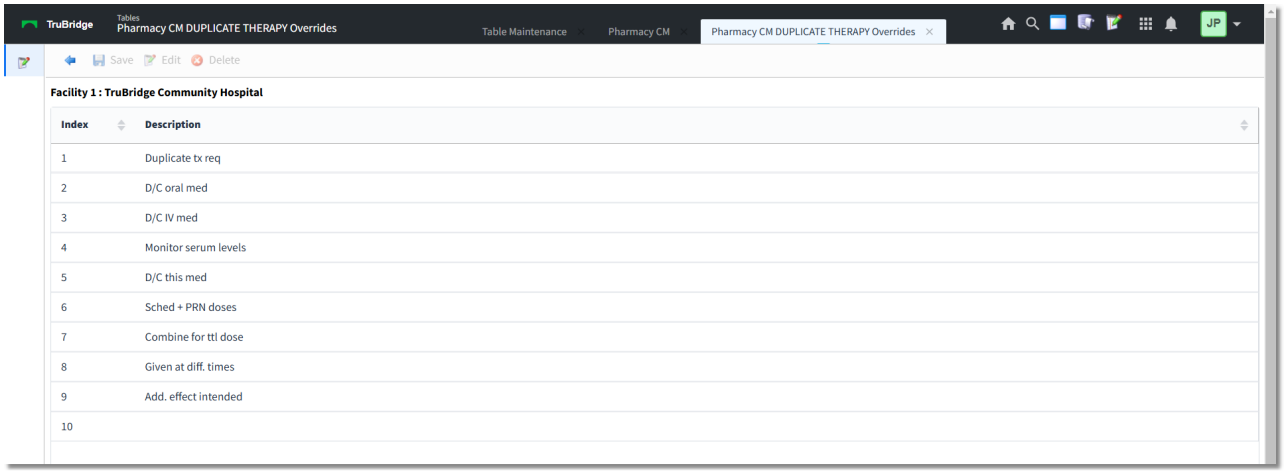
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

Select the  **back arrow** to return to the previous screen.

Duplicate Therapy Overrides

Up to 10 override reasons may be entered to address duplicate therapy checks. The Duplicate Therapy Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

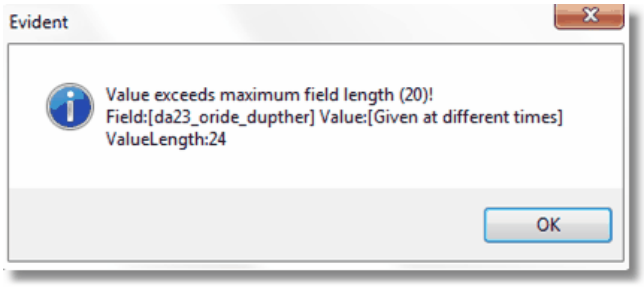
Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **Overrides** > **Duplicate Therapy Overrides**



Duplicate Therapy Overrides

1. To enter override reasons, select an entry from the list and select  **Edit** from the action bar.

2. Enter the override reason in the field; it can hold a maximum of 20 characters. Select **OK** from the action bar to add to or update the overrides list.
3. To save any changes, select **Save** from the action bar. If any override reason contains more than 20 characters, the system will display the following warning.



Override Field Length Warning

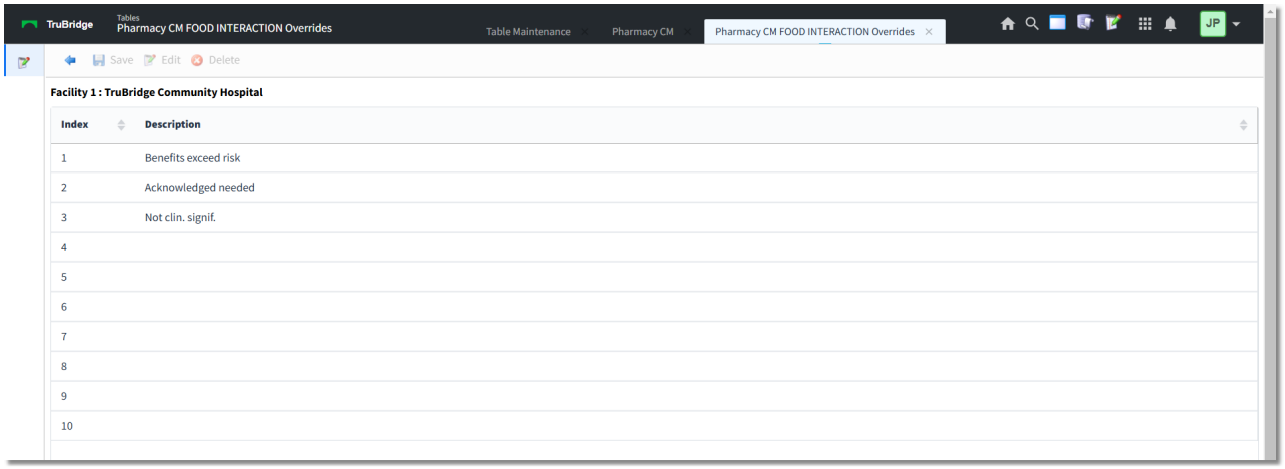
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

Select the **back arrow** to return to the previous screen.

Food Interaction Overrides

Up to 10 override reasons may be entered to address food interaction checks. The Food Interaction Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **Overrides** > **Food Interaction Overrides**

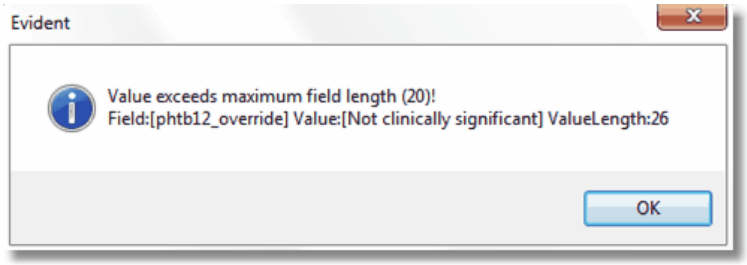


Food Interaction Overrides

1. To enter override reasons, select an entry from the list and select **Edit** from the action bar.

2. Enter the override reason in the field; it can hold a maximum of 20 characters. Select **OK** from the action bar to add to or update the overrides list.

3. To save any changes, select **Save** from the action bar. If any override reason contains more than 20 characters, the system will display the following warning.



Override Field Length Warning

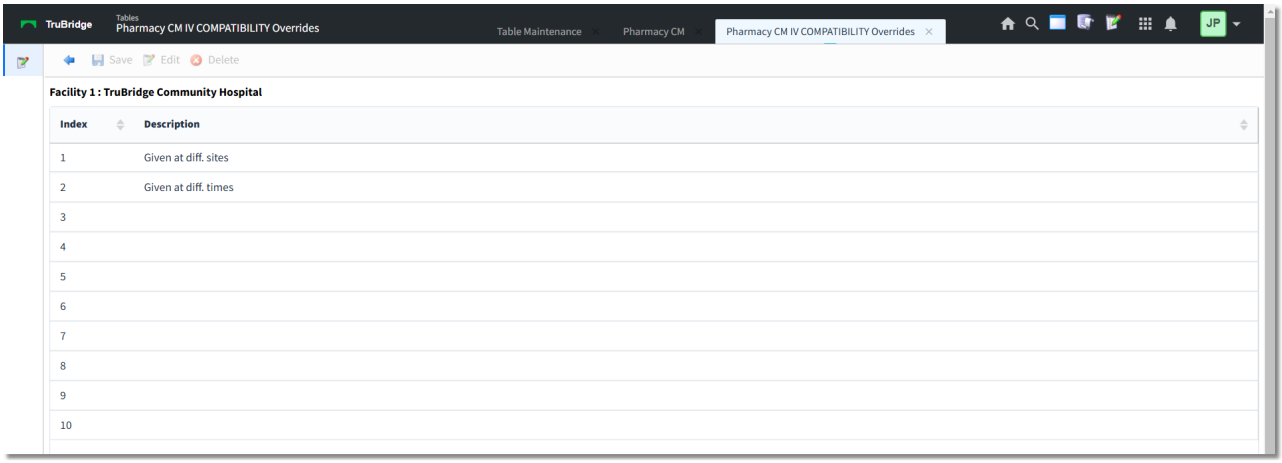
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

Select the  **back arrow** to return to the previous screen.

IV Compatibility Overrides

Up to 10 override reasons may be entered to address IV compatibility checks. The IV Compatibility Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **Overrides** > **IV Compatibility Overrides**

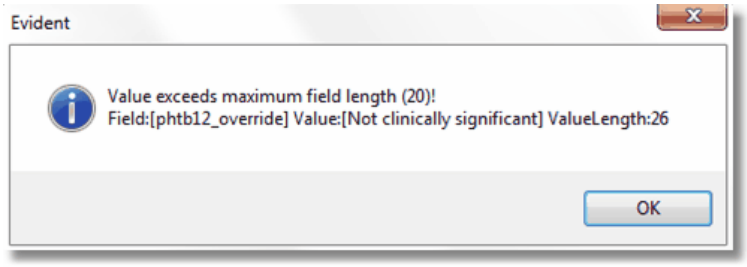


IV Compatibility Overrides

1. To enter override reasons, select an entry from the list and select **Edit** from the action bar.

2. Enter the override reason in the field; it can hold a maximum of 20 characters. Select **OK** from the action bar to add to or update the overrides list.

3. To save any changes, select **Save** from the action bar. If any override reason contains more than 20 characters, the system will display the following warning.



Override Field Length Warning

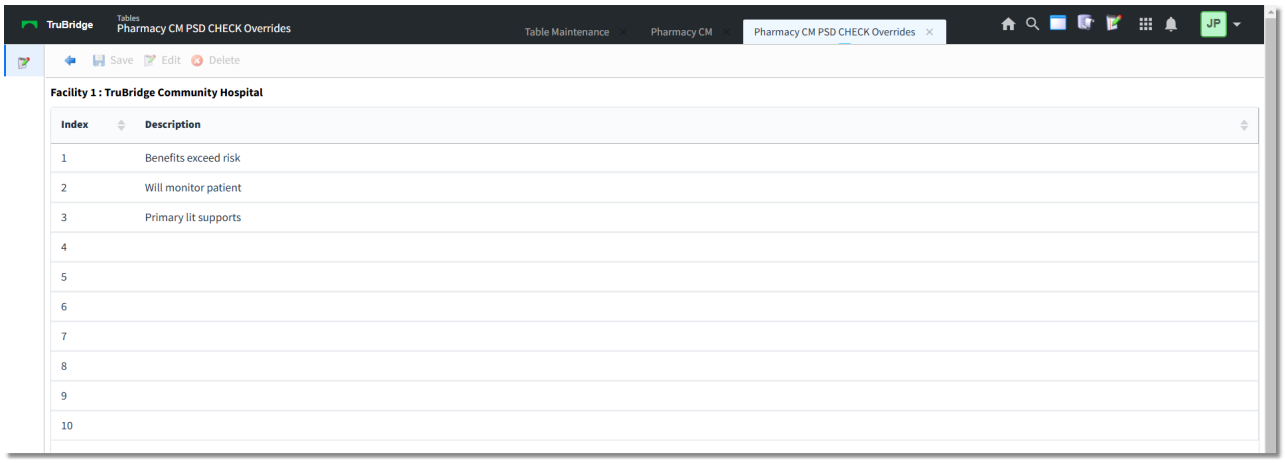
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

Select the  **back arrow** to return to the previous screen.

Patient Specific Dosing Overrides

Up to 10 override reasons may be entered to address patient specific dosing checks. The Patient Specific Dosing Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **Overrides** > **Patient Specific Dosing Overrides**

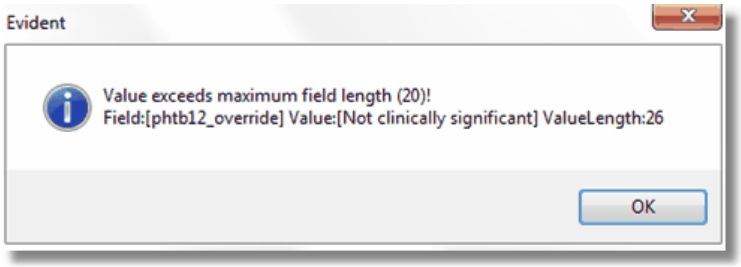


Patient Specific Dosing Overrides

1. To enter override reasons, select an entry from the list and select **Edit** from the action bar.

2. Enter the override reason in the field; it can hold a maximum of 20 characters. Select **OK** from the action bar to add to or update the overrides list.

3. To save any changes, select **Save** from the action bar. If any override reason contains more than 20 characters, the system will display the following warning.



Override Field Length Warning

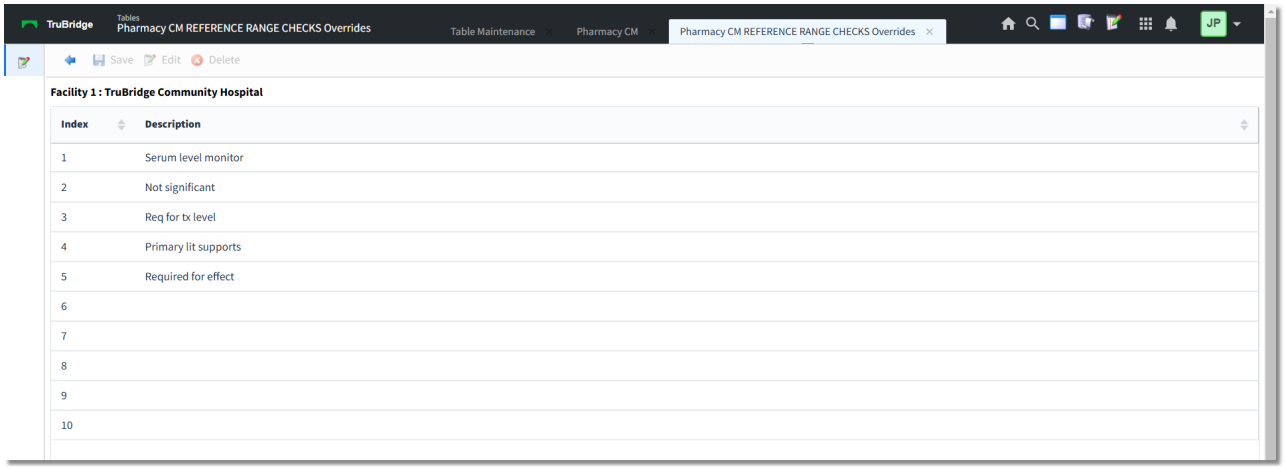
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

Select the  **back arrow** to return to the previous screen.

Reference Range Overrides

Up to 10 override reasons may be entered to address reference range checks. The Reference Range Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **Overrides** > **Reference Range Overrides**

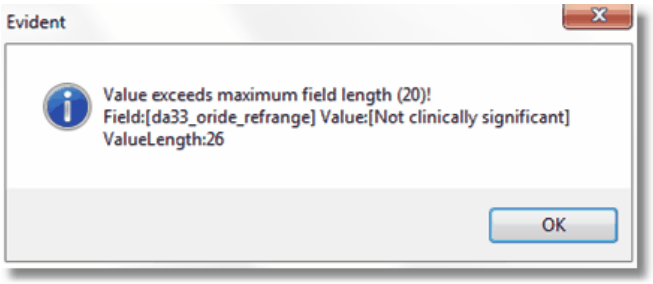


Reference Range Overrides

1. To enter override reasons, select an entry from the list and select **Edit** from the action bar.

2. Enter the override reason in the field; it can hold a maximum of 20 characters. Select **OK** from the action bar to add to or update the overrides list.

3. To save any changes, select **Save** from the action bar. If any override reason contains more than 20 characters, the system will display the following warning.



Override Field Length Warning

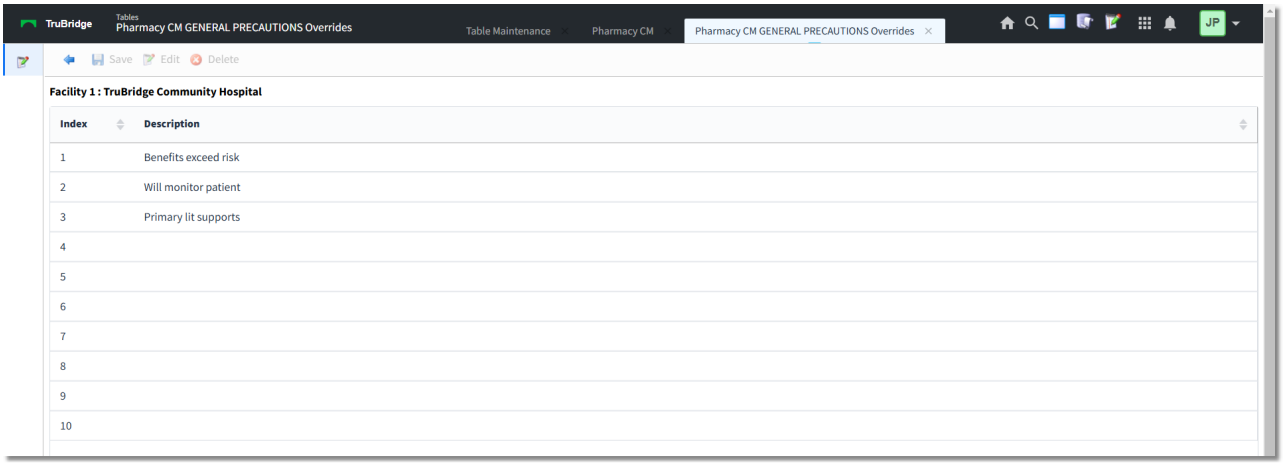
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

Select the  **back arrow** to return to the previous screen.

General Precaution Overrides

Up to 10 override reasons may be entered to address general precaution checks. The General Precaution Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacy Control** > **Clinical Monitoring** > **Overrides** > **General Precaution Overrides**

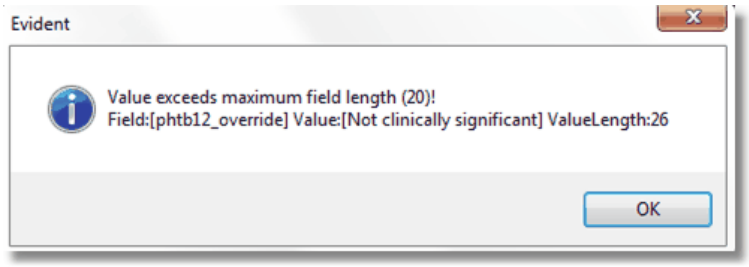


General Precaution Overrides

1. To enter override reasons, select an entry from the list and select **Edit** from the action bar.

2. Enter the override reason in the field; it can hold a maximum of 20 characters. Select **OK** from the action bar to add to or update the overrides list.

3. To save any changes, select **Save** from the action bar. If any override reason contains more than 20 characters, the system will display the following warning.



Override Field Length Warning

The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

Select the  **back arrow** to return to the previous screen.

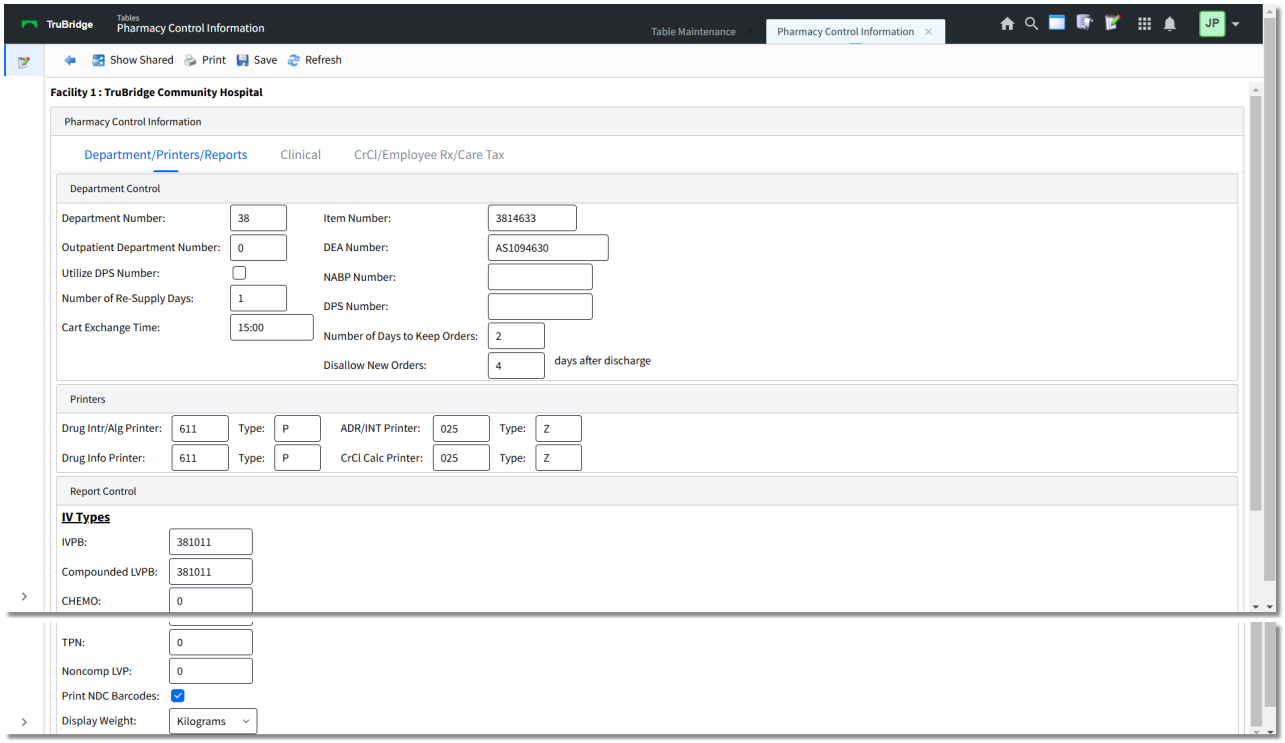
9.4 Control Information

The Pharmacy Control Information Table sets the parameters for the system to follow in calculating, displaying, retaining, and printing various patient information. To access the table via Web Client, select **Tables > Clinical > Control Information**.

The Pharmacy Control Information Table is also accessible via the Pharmacy Department. See the Pharmacy Control Information Section in the Pharmacy Setup user guide.

Control Information Page 1

Select **Web Client** > **Tables** > **Clinical** > **Control Information**



Pharmacy Control Information Department/Printers/Reports

- **Department Number**
  - Default: Blank
  - Options: 2 or 3-digit Pharmacy department number.
  - Usage: The pharmacy department number is determined at the time of system installation. This switch should never be changed. The number in this field matches the number located in the upper right hand corner of the Hospital Base menu.

- **Outpatient Dept. Number**
  - Default: Blank
  - Options: 3-digit outpatient pharmacy department number.
  - Usage: Used to enter the 3-digit outpatient pharmacy department number for facilities with an outpatient pharmacy. Although the outpatient pharmacy department is a separate department, both utilize the same pharmacy tables but have separate item masters.

- **Utilize DPS Number**
  - Default: Blank, or no entry
  - Options: Y (yes), ✓ (check mark), or N (no)
  - Usage: Determines whether the system will prompt for entry of a triplicate serial number for submission to the Texas Department of Public Safety. This prompt will occur during outpatient prescription order entry.

- **Number of Re-Supply Days**
  - Default: 1
  - Options: This field should always be 1.
  - Usage: This field is an indication of how often medication carts are exchanged. The number entered displays on **Resupply Days** of the Non-IV Order Entry screen. Indicates that the

resupply amount in **Resupply Quantity** of the Non-IV Order Entry screen is a one day resupply amount.
- o When the Cart Fill List-Charging is printed, the option of choosing multiples of the resupply days is available.
- o With the number of resupply days set to one, the Cart Fill List can be printed for a two, three, or four-day resupply.
- o If the resupply days are set to two, three, or four, the list can only be printed for multiples of these days (four days, six days, eight days, etc).
- o There is more flexibility if this field is set for one day.

- **Cart Exchange Time**
  - Default: Blank
  - Options: 4-digit military time.
  - Usage: The Cart Fill List Charging, Catch Up List and Cart Label Charging must be run prior to the time listed in this field. If those reports are run AFTER this time then the charging times are for the FOLLOWING day and the next morning.

EXAMPLE: *Cart Exchange Time is set to 1500. Pharmacy normally runs the Cart Fill List June 05 at 1400. If the Cart Fill List is run at 1430, then the Cart Fill List prints for June 05 at 1500 to June 06 at 1459. If pharmacy runs the Cart Fill List after 1500, the Cart Fill List prints for June 06 1500 to June 07 at 1459. It is very important to run both the Cart Fill and Catch Up Lists prior to the Cart Exchange Time.*

NOTE: *A Cart Fill period consists of the Cart Exchange Time + (the number of days X 24 hours). The number of days are entered when the Cart Fill List is printed. Charges are based on this period. The cart exchange time and the number of days from the Cart Fill List are also used to calculate Catch Up List doses due.*

- **Item Number**
  - Default: Blank
  - Options: Last used pharmacy item number.
  - Usage: The system has the ability to auto-assign the next available number when creating a new item from item maintenance.

- **DEA Number**
  - Default: Blank
  - Options: Hospital Pharmacy DEA Number.
  - Usage: The pharmacy DEA number is input at the time of the pharmacy install for pharmacy records.

- **NABP Number**
  - Default: Blank
  - Options: National Association of Boards of Pharmacy number.
  - Usage: This number is required for some Electronic Controlled Substance Reporting.

- **DPS Number**
  - Default: Blank
  - Options: Department of Public Safety Number.
  - Usage: This number is required for Texas Electronic Controlled Substance Reporting.

- **Number of Days to Keep Orders**
  - Default: 99
  - Options: 1-999
  - Usage: Allows pharmacy to retain orders for a maximum of 999 days after patient discharge. If the field is left blank, or up to 999 days is entered in this field, pharmacy orders purge 999 days after patient discharge. Purged pharmacy orders can still be accessed via **Pharmacy Order History.**
    - The purge of pharmacy orders occurs on a weekly basis (usually Wednesday morning before 6 AM, but this can vary by site). Due to the weekly basis of order purging, some orders are kept longer, depending upon the day of patient discharge and order purge.
    - For most hospitals, keeping orders for 99 days past discharge is sufficient.

  NOTE: *This field relates only to orders. Patient charges are kept in the system for over two years. The TruBridge system will automatically change the Point of Care keep days to one day less than the Pharmacy keep days whether it's changed via Pharmacy Control Information or the POC Control Record. Please call a TruBridge representative for help with changing the Pharmacy and Point of Care keep days.*

- **Disallow New Orders**
  - Default: 3-5
  - Options: 1-99
  - Usage: Determines the number of days after discharge that new orders can be entered. If the pharmacy is closed when a patient is discharged, new orders are not entered until the next pharmacy business day. Some pharmacies are closed during weekend hours and new orders are not entered until Monday. This field is typically set from three to five days depending upon pharmacy hours of operation.

  NOTE: *This field only prevents new order entry. Charges can be entered against old orders until the orders are purged from the system (See Number of Days to Keep Orders).*

- **Drug Interaction/ Allergy Printer**
  - Default: Blank
  - Options: 3-digit printer number or S for workstation printer.
  - Usage: Establishes which printer Drug Interaction and Allergy monographs print. The type of printer being use to print monographs must be entered in the **TYPE** field. This information allows the program to print the monographs with the correct format.
    - The printer types are:
      - M - Microline (Okidata 320p or Turbo)
      - E - Epsilon (Okidata 395)
      - P - Postscript (Lexmark Laser)
    - If a different printer type is needed, please call TruBridge for the appropriate code.
    - Before using a line printer for drug interactions, TruBridge must make some internal system adjustments. Please call TruBridge if you plan to print interactions to a line printer.
    - If printing Ancillary Results or if TruBridge sets up the Temporary Orders/DC's to automatically print to the Pharmacy on a daily basis, these reports will automatically be sent to the printer specified for Drug Interactions in the Pharmacy Control Table. This is entered during TruBridge install.

- **Drug Information Printer**
  - Default: Blank

- Options: 3-digit printer number or S for workstation printer.
- Usage: The Drug Information (Patient Monographs) printer field uses the same criteria as the Drug Interaction printer field. Please see Drug Interaction printer for details. Entered prior to install.

- **ADR/Intervention Printer**
  - Default: Blank
  - Options: 3-digit printer number or S for workstation printer.
  - Usage: The Adverse Drug Reaction/Intervention printer field uses the same criteria as the Drug Interaction printer field. Please see Drug Interaction printer for details. Entered prior to install.

- **CrCl Calculation Printer**
  - Default: Blank
  - Options: 3-digit printer number or S for workstation printer.
  - Usage: The Creatinine Clearance Calculation printer field uses the same criteria as the Drug Interaction printer field. Please see Drug Interaction printer for details. Entered prior to install.

NOTE: *When the printer type is changed in field 22 of port maintenance in the device control table, fields C, D, E, and F will update accordingly.*

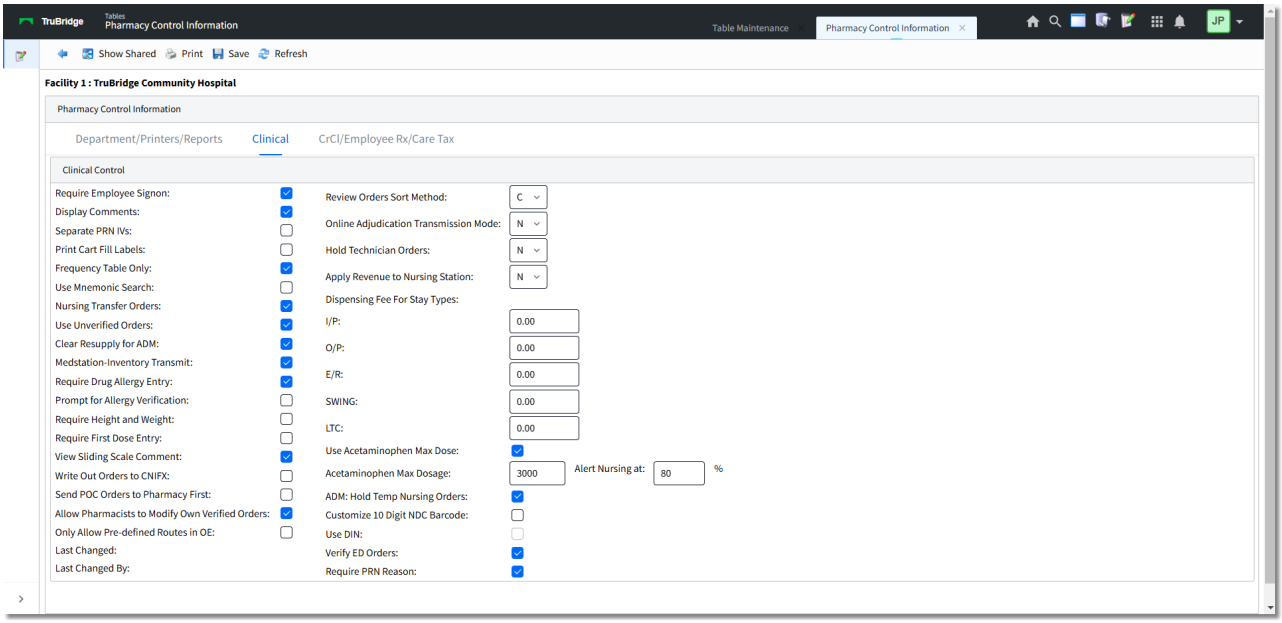
- **IV Types**
  - Default: Blank
  - Options: Accepts item numbers for the various IV Admixture Fees.
  - Usage: These item numbers track charges and credits for the IV Therapy Section of the Pharmacy Statistics Report.
    - Item numbers must be created and named for each section to be counted such as IVPB Type, Chemo Type, etc.
    - Once created, the item numbers need to be added into the Pharmacy Control Information Table on **IV Types** next to the corresponding name. The item numbers are then attached to the IV's as entered, usually in the Procedure Charge field of IV Order Entry or Predefined information.
    - When the Statistics Report is generated, each field is tabulated and printed on the bottom of the report.

- **Print NDC Barcodes**
  - Default: Blank, or no entry
  - Options: Y (yes), ✓ (check mark), or N (no)
  - Usage: Allows barcodes to print on IV and Non-IV labels. Barcodes can then be scanned using the Medication Verification application.

- **Display Weight**
  - Default: Pounds
  - Options: Grams, Kilograms, and Pounds
  - Usage: Determines how the patient's weight will display via Pharmacy screens and reports

Control Information Page 2

Select **Web Client** > **Tables** > **Clinical** > **Control Information** > **Clinical**



Pharmacy Control Information Clinical

- **Require Employee Signon**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: The employee sign on option is used to distinguish between orders entered by a registered pharmacist and orders entered by other personnel. Orders entered by non-pharmacists are in a temporary status until a pharmacist OK's the orders.
    - o Activation of this feature requires that pharmacy employees have their initials and sign on password entered in the Employee Master Record. The Payroll department normally updates the Employee Master Record.
    - o Be sure that on each Employee Master Record, the Begin Date (Hire Date) is filled in. This is not a required field; however, if it is left blank, the system (after every payroll run) puts a "T" for Terminated into their Master Record. The system will not allow the employee to sign onto the system if there is a "T" in their Master Record.
    - o The registered pharmacist switch is indicated in System Management Department Maintenance.

- **Display Comments**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Allows comments entered via Pharmacy to auto display when initially accessing order entry for the selected account. Comments will only display when initially accessing order entry. Comments will not display on successive orders. If the Pharmacy Selection screen is exited, and the patient re-accessed, the Comment screen will again display upon selecting order entry.

- **Separate PRN IVs**

- Default: Blank
- Options: Yes, ✓ (check mark), or No, blank.
- Usage: Controls how PRN IV medications display on the MAR.
  - o Y: Allows IV medications ordered as PRN to display and print in the PRN section of the MAR.
  - o N: IV medications ordered as PRN will print and display in the IV section of the MAR.

- **Print Cart Fill Labels**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Works in conjunction with **Print NDC Barcodes** to allow barcode medication labels to print when Cart Fill and Catch Up List are generated. Barcode labels are used with the Medication Verification application.

- **Frequency Table Only**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Controls whether or not a frequency not listed in the frequency table can be entered during pharmacy order entry. This switch will also affect POC pharmacy order entry.
    - o Yes: A valid frequency from the frequency table must be entered. A (?) question mark can be entered in the frequency field to display table.
    - o No: Allows any frequency to be entered in the frequency field.

- **Use Mnemonic Search**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Allows mnemonics to be entered during IV and Non-IV Order Entry. A lookup can be displayed by entering a partial mnemonic during order entry.
    - o Yes: Use mnemonics during Order Entry. Press <Alt> +F1 to toggle between mnemonic and description search.
    - o No: Use traditional description search for Order Entry.

- **Nursing Transfer Orders**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Allows nursing to transfer active medication orders from an old account number to a new account number.

- **Use Unverified Order**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Used at sites with Point of Care/Nursing Order Entry. This feature provides a means for nursing to receive notification each time Pharmacy enters an order for a patient and gives the nurse the ability to verify each order. This feature, although required for Point of Care, should not be used without consulting TruBridge for more information and training.

- **Clear Resupply for ADM**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Clears the resupply quantity for orders when the medication is in the Automated Dispensing Machine.

- **Medstation-Inventory Transmit**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Only for Omnicell inv transfer for Rx to nursing station.

- **Require Drug Allergy Entry**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Controls whether or not an allergy must be entered prior to order entry.
    - Yes: Drug Allergies must be entered prior to a medication order being processed. The system will automatically display the Clinical Information screen if no allergy has been entered and an attempt is made to place a medication order.
    - No: Allows medication orders to be processed without allergies being entered.

- **Prompt for Allergy Verification**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Controls whether users are required to verify allergies prior to order entry or medication administration.
    - Yes: A popup prompt appears when entering Order Entry (OE or CPOE) or Med Administration (EMAR, Verify Orders, and Order Chronology). The prompt appears only if the patient has not had allergies verified. It reads, "This patient has not had allergies verified. Do you wish to verify allergies now?" If user selects Yes, the system launches them to the Allergies application to verify the allergies. If user selects No, they remain in Order Entry/Med Administration and can proceed without verifying.
    - No: The popup prompt for allergy verification will not appear when performing order entry or medication administration.

- **Require Height and Weight**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Controls whether or not height and weight must be entered prior to order entry.
    - Yes: Height and Weight must be entered prior to a medication order being processed. The system will automatically display the Clinical Information screen if height and weight have not been entered, and an attempt is made to place a medication order.
    - No: Allows medication orders to be processed without height and weight being entered.

- **Require First Dose Entry**
  - Default: Current Date / Time
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: If set to Y (Yes), a 1st Dose Date and Time must be entered on non-IV orders before the order can be saved.

- **View Sliding Scale Comment**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Allows comments entered in the Diabetic Record Sliding Scale via Point of Care to display in order review. Upon selecting **VP-View Protocol** on select insulin items, comment entries display along with the sliding scale.

- **Send POC Orders to Pharmacy First**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Prevents verification and administration of pharmacy orders prior to pharmacy verification.
    - Yes: The system will hide unverified pharmacy orders from the Verify Orders list/app until a pharmacist verifies them. This will apply only during pharmacy hours (set up in the CL Table).
    - No: Allows pharmacy orders to show in the Verify Orders list/application prior to pharmacy verification.

- **Allow Pharmacist to Modify Own Verified Orders**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Allows a pharmacist to modify medication orders they entered or verified even after these orders have been verified by nursing.

- **Review Orders Sort Method**
  - Default: C - Chronological.
  - Options: A-Alpha, C-Chronological, F-Frequency
  - Usage: Determines the default Sort when viewing orders via the Pharmacy Profile.

- **OL Adjudication Transmit Mode**
  - Default: N (no)
  - Options: A – Auto, H - Hold, N - None
  - Usage: Allows pharmacy to transmit online adjudication automatically after exiting out of order, hold for a batch transmit from Claims log or not process Online Adjudication at all.

- **Use Medication Verification**
  - Default: Blank, or no entry
  - Options: Y (Yes w/o POC), N (No), or P (Yes with POC)
  - Usage: Allows the Medication Verification Application to be used by nursing.
    - Y: Use NDC scanning without Point of Care
    - N: Do not use this function at all. The option will display in POC but will not be accessible.
    - P: Allow the Medication Verification Application to be accessible from Point of Care.

  NOTE: *Password required. Contact TruBridge support to activate.*

- **Hold Technician Orders**
  - Default: N (no)
  - Options: A (ADM), P (POC), B (Both), N (None)
  - Usage: Gives pharmacy control of how Temp Tech orders are sent out to Point of Care and the ADM. Satisfies some state regulations.
    - A: Holds technician orders from the ADM
    - P: Holds technician orders from POC
    - B: Hold technician orders from both the ADM and POC
    - N: Hold technician orders from None. Technician orders cross to both the ADM and POC prior to verification by a pharmacist.

- **Apply Revenue to Nursing Station**

- Default: N (no)
- Options: N (no), Y (yes)
- Usage: When set to Y (yes), this switch will allow revenue for pharmacy items charged via Cart-fill, Catch-up, IV batch, and charging from the profile to be given to the nursing station in which the patient is housed. In order to set the switch to Y, call TruBridge support.

- **Dispensing Fees for Stay Types**
  - Default: Blank
  - Options: Free text dollar amount for the dispensing fee based on stay type.
  - Usage: If there is a dispensing fee based upon patient stay type, it can be entered in this field.This may be used with online adjudication.

- **Use Acetaminophen Max Dose**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Activates the Acetaminophen Dosing feature. Allows the option to add a maximum dose of acetaminophen per 24-hour period and to define at what percentage nursing should be alerted.

- **ADM: Hold Temp Nursing Orders**
  - Default: N (no)
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Controls when Temporary Nursing orders are sent to Automated Dispensing Machines. If the switch is selected and the Pharmacy department is closed, orders entered by nursing will be held in the Patient Documentation Verify Screen until verified. Pharmacy hours are defined in the ChartLink Control Table.

- **Customize 10 Digit NDC Barcode**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Allows McKesson™ repackaging labels to scan correctly for Medication Verification. This switch is password protected. Please contact TruBridge support for information about this feature.

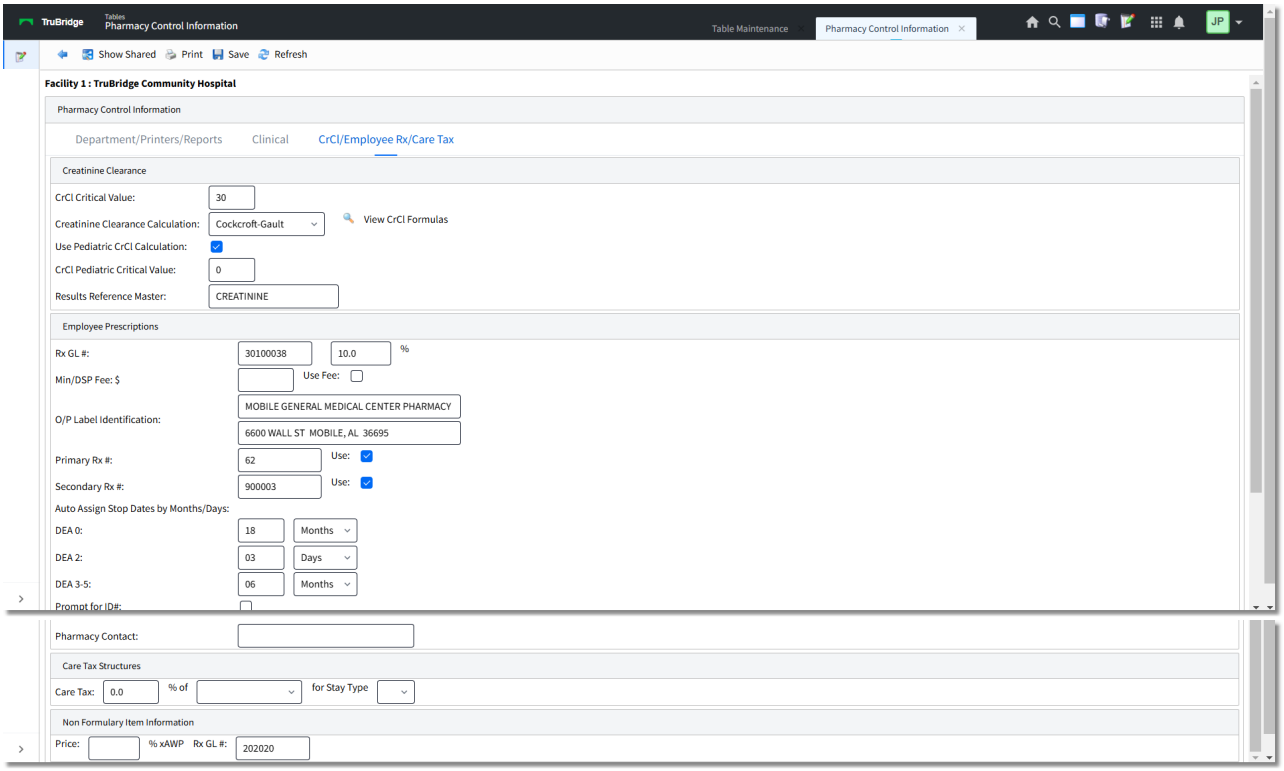
- **Verify ED Orders**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: If this switch is selected, medication orders placed on patients located in the Emergency Department will be routed to the Pharmacy Order Verification queue. Medication orders will continue to auto-verify for nursing. The unverified medication orders will remain active from Order Chronology to allow ED users to administer, modify, or discontinue the medications.

  NOTE: *This switch is only accessible if using EDIS and the Emergency Department switch is enabled.*

- **Require PRN Reason**
  - Default: Yes
  - Options: Yes, ✓ (check mark) or No, blank.
  - Usage: Makes the reason required at order entry for PRN frequency medication orders. If checked, the user must populate the "PRN Reason" field before updating or signing the order.

Control Information Page 3

Select **Web Client** > **Tables** > **Clinical** > **Control Information** > **CrCl/Employee Rx/Care Tax**



Pharmacy Control Information CrCl/Employee Rx/ Care Tax

- **Creatinine Clearance Critical Value**
  - Default: Blank
  - Options: 01 - 99
  - Usage: Indicates the value that has been determined to be a critically low Creatinine Clearance Level. The flashing number on the patients Pharmacy Selection Screen indicates the potential critical Creatinine Level.

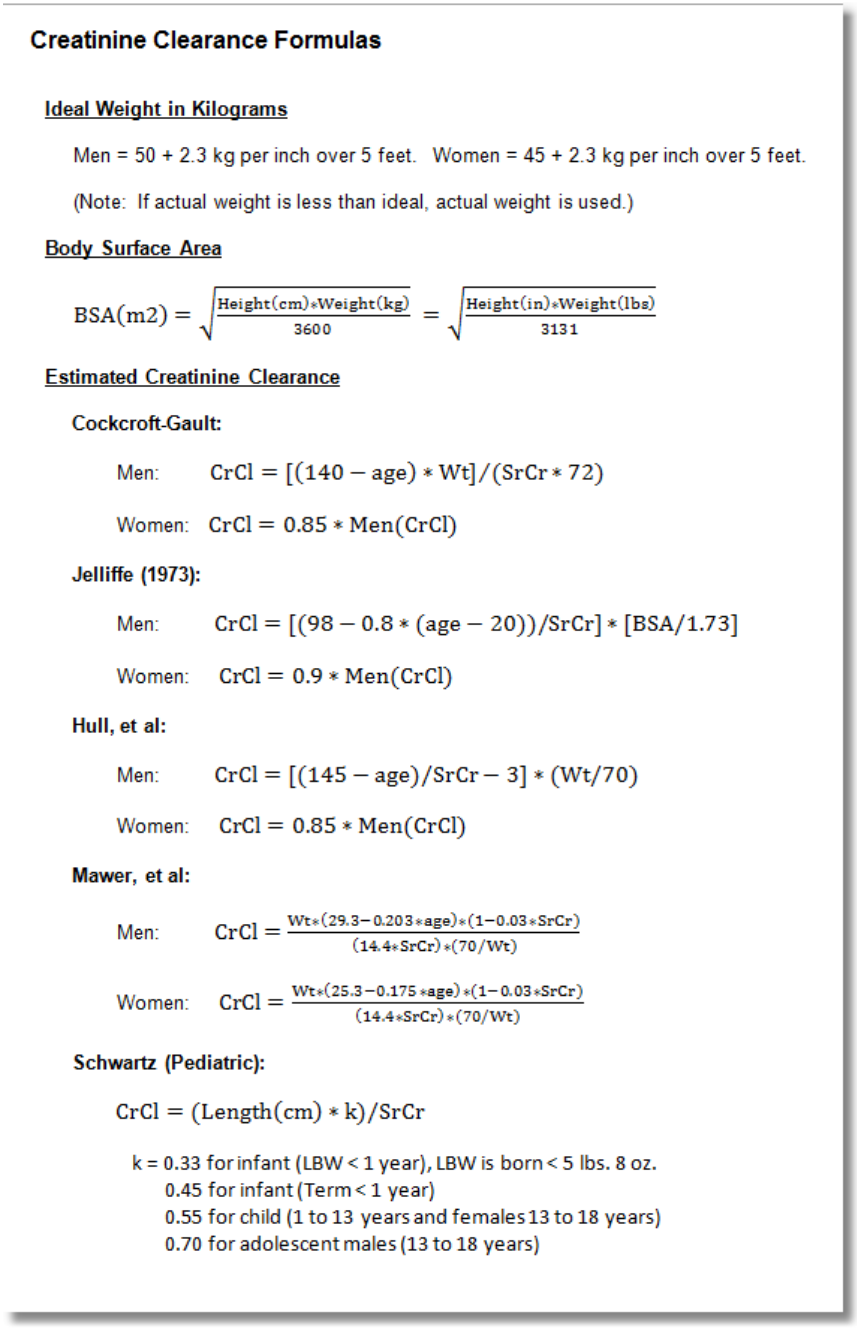
- **Creatinine Clearance Calculation**
  - Default: Blank
  - Options: 1 – Cockcroft-Gault, 2-Jelliffe, 3-Hull, 4-Mawer, 5-Schwartz
  - Usage: There are five formulas for pharmacy to use to calculate creatinine clearance. Enter the number that corresponds to the formula needed. At the bottom of Page 2, type "X" to display the Creatinine Clearance Formulas.

- **Use Pediatric CrCl calculation**
  - Default: Blank
  - Options: Yes, ✓ (check mark), or No, blank.
  - Usage: Enables use of the Schwartz Creatinine Clearance Formula for pediatric patients

- **CrCl Pediatric Critical Value**
  - Default: Blank
  - Options: 01-99

- Usage: Indicates the Pediatric value that has been determined to be a critically low Creatinine Clearance Level.

- **View CrCl Formulas**
  - Default: Blank
  - Options: 1-Cockcroft-Gault, 2-Jelliffe, 3-Hull, 4-Mawer, 5-Schwartz
  - Usage: Select the View CrCl Formulas option to view the available CrCl formulas.



Creatinine Clearance Formulas

Ideal Weight in Kilograms

Men = 50 + 2.3 kg per inch over 5 feet. Women = 45 + 2.3 kg per inch over 5 feet.

(Note: If actual weight is less than ideal, actual weight is used.)

Body Surface Area

$$BSA(m2) = \sqrt{\frac{Height(cm) * Weight(kg)}{3600}} = \sqrt{\frac{Height(in) * Weight(lbs)}{3131}}$$

Estimated Creatinine Clearance

Cockcroft-Gault:

Men: $CrCl = [(140 - age) * Wt]/(SrCr * 72)$

Women: $CrCl = 0.85 * Men(CrCl)$

Jelliffe (1973):

Men: $CrCl = [(98 - 0.8 * (age - 20))/SrCr] * [BSA/1.73]$

Women: $CrCl = 0.9 * Men(CrCl)$

Hull, et al:

Men: $CrCl = [(145 - age)/SrCr - 3] * (Wt/70)$

Women: $CrCl = 0.85 * Men(CrCl)$

Mawer, et al:

Men: $CrCl = \frac{Wt*(29.3-0.203*age)*(1-0.03*SrCr)}{(14.4*SrCr)*(70/Wt)}$

Women: $CrCl = \frac{Wt*(25.3-0.175*age)*(1-0.03*SrCr)}{(14.4*SrCr)*(70/Wt)}$

Schwartz (Pediatric):

$CrCl = (Length(cm) * k)/SrCr$

k = 0.33 for infant (LBW < 1 year), LBW is born < 5 lbs. 8 oz.
0.45 for infant (Term < 1 year)
0.55 for child (1 to 13 years and females 13 to 18 years)
0.70 for adolescent males (13 to 18 years)

View CrCl Formulas

- **Results Reference Master**
  - Default: CREATININE
  - Options: 20-character free text field.
  - Usage: Enter into this field the result code (Reference Range) for reporting the Serum Creatinine per established laboratory guidelines.

Employee Prescriptions

The following information is only valid for accounts which have a $ or + in the Service Code of the Patient Maintenance screen.

- **Rx GL #**
  - Default: Blank
  - Options: For Employee prescription or LTC general ledger number.
  - Usage: Contains a General Ledger number and a cost plus percentage for charging employee prescriptions. The COST or AWP pulls from page 2 of the item master and adds or subtracts a percentage per unit. If no percentage is added in the table, only the COST or AWP of the item is charged to the patient account. Patient must have a <+> AWP or <$> cost service code for formulary to pull as patient charge.
    - **Min/DSP Fee** - used to set a minimum charge for employee prescriptions. If the calculated charge is less than the set minimum charge amount, then a default dollar amount minimum can be set.
    - ***EXAMPLE****: if the calculated cost of the prescription is 80 cents (including the percentage if one is set), but the amount in the Min/DSP Fee field is $1.00, the charge is $1.00 for the RX not $.80.*
    - The **Min/DSP Fee** field can also be used as a Fee field.
      - If pharmacy charges a fee per prescription in addition to or instead of a percentage, the minimum charge field can serve as a fee if **Use Fee:** is set to Y (yes).
      - The charge will consist of adding the amount in the fee field to the calculated cost of the RX. In the above example, the employee is charged $1.80 if the Fee was set to Y. This overrides the minimum as discussed above.

- **O/P Label Identification**
  - Default: Blank
  - Options: Maximum of 40 characters per line - 2 lines.
  - Usage: The outpatient label is formatted differently from the inpatient hospital label. The information prints at the top of the outpatient label. Added during TruBridge install.
    - **EXAMPLE:**

      TRUBRIDGE COMMUNITY HEALTH SYSTEM
      6600 WALL STREET MOBILE, AL 36695

- **Primary and Secondary RX #**
  - Default: Zeros
  - Options: Modify to match existing Rx numbers used by facility or begin new set of treatment numbers.
  - Usage: Part of the RX number generator. The next Outpatient/Employee prescription number can be entered into line 9. Both a Primary and a Secondary beginning prescription number may be entered.

- o The Automatic RX counters have an activation switch. The activation switches can be set to "Y" or "N." Note that if the switch is left blank, then "Y" is assumed. The prescription counters are active only when an order is entered through selection X-EMPLOYEE/LTC.
- o Based on the settings of the prescription counter switches, prescription numbers can be automatically assigned based on the schedule classification upon the completion of a new order.
  - If both counters are set to "Y," then the Primary Counter assigns numbers for all medications excepting Schedule II's. The Secondary Counter assigns numbers for Schedule II medications only.
  - If the Primary Counter is set to "Y," and the Secondary Counter is set to "N", then the Primary Counter assigns numbers for all medications including Schedule II's.
  - If the Primary Counter is set to "N," and the Secondary Counter is set to "Y," then the Secondary Counter will assign numbers for Schedule II medications only.
  - If both the Primary and Secondary Counters are set to "N" then no prescription numbers will be automatically assigned.

- **Auto Assign Stop Dates by "M"onth/"D"ays**
  - Default: 12 Months-Non controlled / 6 Months-DEA class 3-5 / 1 Day-DEA class 2
  - Options: 0-99 numeric field for number of months or days. M–Months or D-Days
  - Usage: Allows the system to assign an autostop date for prescriptions. Autostop dates can be defined for non-controlled medications, DEA class 3-5 and DEA class 2 prescriptions. Autostops can be defined for 1 day.

- **Prompt for ID#**
  - If checked, a box will appear for the pharmacy employee to enter the person's ID information (driver license or other state issued ID) if they are picking up a prescription. Required for the state of Ohio.

- **Pharmacy Contact**
  - This is a 30-character free text field. The contact name will be added to the file when the Electronic Controlled Substances Report is generated for the state of Alabama.

- **Care Tax Structures**
  - The state of Minnesota allows a 2% vendor fee to be added to the charge for outpatient prescriptions.

- **Care Tax**
  - Default: Blank
  - Options: 1-99 Percent
  - Usage: Allows a percentage of awp, cost, or patient price to be calculated for patients of a certain Stay Type.

- **Non Formulary Item Information**
  - Allows the calculation of a non formulary item patient price.

- **Price**
  - Default: Blank
  - Options: 1-999 Percent
  - Usage: Allows a percentage to be added to or subtracted from awp to calculate a patient charge for non formulary medication items.

- **Rx GL #**
  - Default: Blank
  - Options: General Ledger number
  - Usage: General Ledger number for employee or LTC non formulary medication.

The following options are available on the action bar:

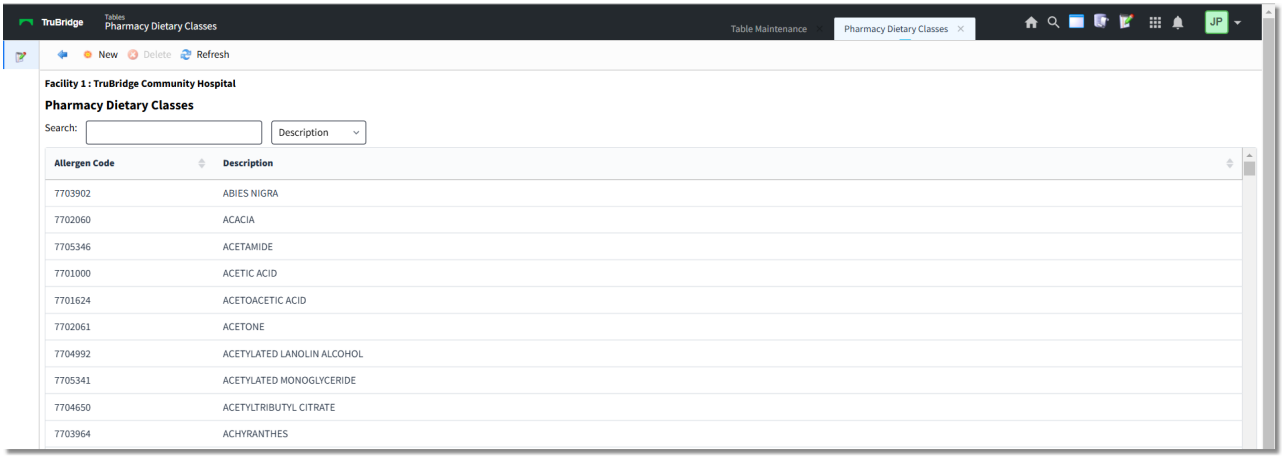
- **Show Shared**: If the site is sharing tables, when this option is selected, the fields that are shared between facilities will be highlighted in yellow.
- **Print**: Displays the table settings in Adobe
- **Save**: Saves changes made to the table settings
- **Refresh**: Allows changes to display immediately

Select  **Back Arrow** to return to the previous screen.

9.5 Dietary Classes

Dietary Classes provides a table to store allergies that the user deems as food but are classified as something other than “FOOD” by Micromedex. One example is egg which is designated as “CLASS”. Adding an allergy to this table allows the TruBridge EHR to use the allergen code and send this allergy to Dietary reports and labels. The table has been preloaded with a file provided by Micromedex.

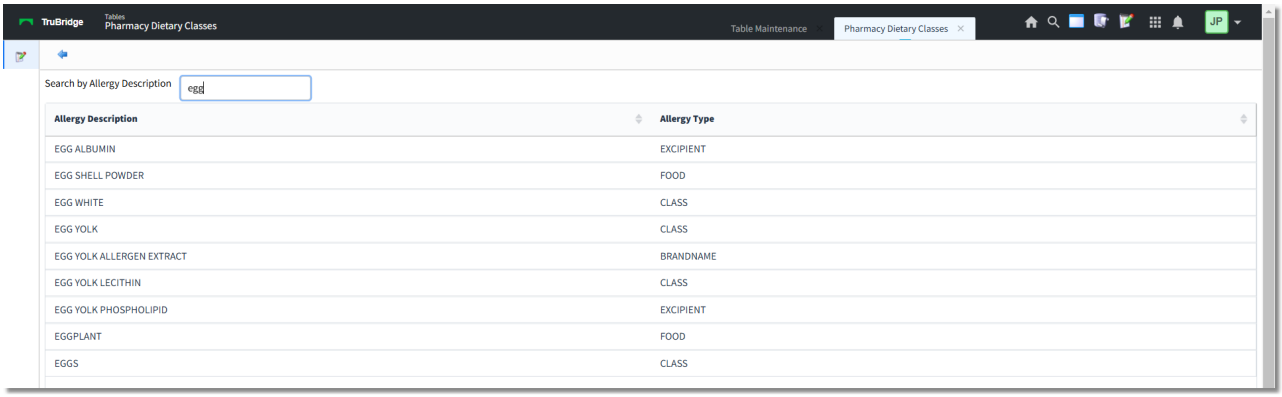
Select **Web Client** > **Tables** > **Clinical** > **Dietary Classes**



Dietary Classes

1. Utilize the **Search** feature to determine if an allergy already exists in the table.
2. If the allergy is not listed, select **New** and use the search feature to find an allergy from the Micromedex database.

Select **Web Client** > **Tables** > **Clinical** > **Dietary Classes** > **New**



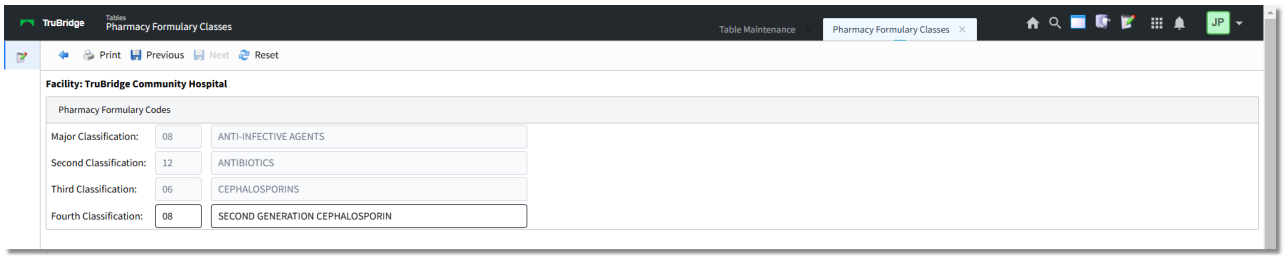
Allergen Code Lookup

3. Double click or select the allergy and then select **Back Arrow** to add the allergy to the table.
   - Additional options are available on the action bar to update the Dietary Classes Table.
     - **Delete**: deletes the selected allergy from the Dietary Classes table
     - **Refresh**: Allows changes to display immediately in the allergy list

9.6 Formulary Codes

Formulary Codes or American Hospital Formulary Service (AHFS) codes are a classification system that allows the grouping of medications with similar therapeutic characteristics. The codes must be created in the **Formulary Codes** table before being added to an item.

Select **Web Client** > **Tables** > **Clinical** > **Formulary Codes**



Formulary Codes

1. The formulary therapeutic category is divided into four two-character numeric sections:
   - The first two characters are the major classification.
   - The second two characters are the sub-classification.
   - The third two characters are further classification.
   - The fourth two characters are also further classification.
     - Zero-Zero is a valid character in this field.

2. Each classification must be linked to a description.

The Formulary Table allows creating and editing of the therapeutic classes located on **Formulary Code** of the Pharmacy Information Screen.

1. Enter the first 2-digit code.

2. If the code exists, the description appears on the Description Line and the cursor advances to Enter line. The options available are as follows:
   - **Reset** allows the current description to be changed.
   - **Reset** also allows the current code and description to be deleted. This option is not viable if there are existing sub-classifications beneath the current selection.
   - **Next** allows additional entries at the current level.
   - **Next** allows entries to the next sub-level.
   - **Previous** allows return to previous field.
   - These options are applicable to each of the four classification levels.

3. If the code does not exist, the word "NEW" appears at the right side of the description line. Enter the new description, up to 35 characters in length, and press <Enter>.

4. To exit the Formulary Table, press the back arrow at the bottom left in the action bar.

9.7 Frequencies - Non-IV

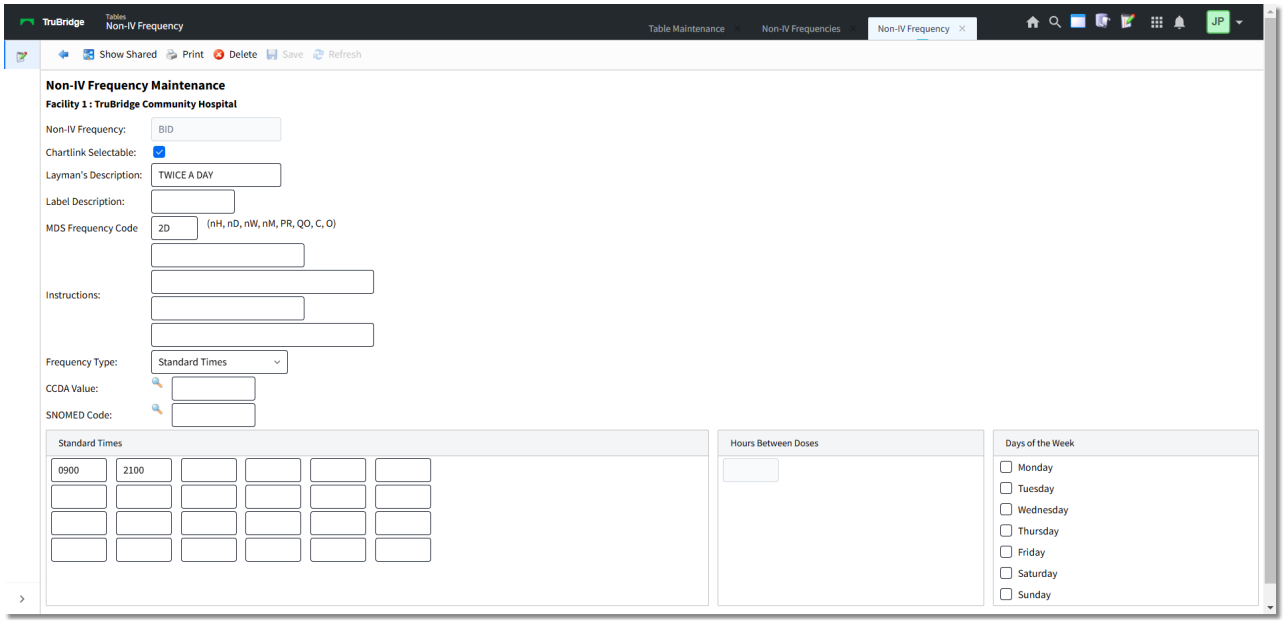
Frequency tables may be set up for both IV and Non-IV order entry. Each table must be set up separately.

The Frequency Table sets standard administration times for frequency codes entered in Frequency of Non-IV & PRN Order Entry. Standard administration times display on the following:

- Pharmacy Labels
- Cart Fill List
- Catch-Up List
- Active Order List
- EMAR

Cart Fill and Catch-Up Lists use the Frequency Table in conjunction with Cart Exchange Time set up in the Pharmacy Control Information Table to determine the number of doses needed for a specified cart fill.

Select **Web Client** > **Tables** > **Clinical** > **Frequencies - Non-IV**



Non-IV Frequency Maintenance

- **Non-IV Frequency**
  - Default: Blank
  - Options: Up to a 20-character frequency code.
  - Usage: Describes the frequency. The frequency can be selected by description from a lookup display during time of order entry.

- **Frequency Types**
  - **Standard Times**
    - Default: Blank
    - Options: Administration times entered in military format.
    - Usage: Up to 24 times can be entered.

  - **Hours Between Doses**
    - Default: Blank
    - Options: Enter the number of hours between doses.
    - Usage: The system will calculate administration times based on the start time of the order.

  - **Days of the Week**
    - Default: Blank
    - Options: Choose some or all days of the week.
    - Usage: Administration time for the selected day(s) is based on the start time of the order.

- **Chartlink Selectable**
  - Default: Blank
  - Options: √ (yes) or Blank (no)
  - Usage: Allows the frequency to be selectable from a drop-down box in the CPOE application.

- **Layman's Description**
  - Default: Blank
  - Options: Up to a 20-character Layman's term.
  - Usage: Was traditionally used with the Discharge Summary and Instructions application in the Point of Care application. Converted the frequency to Layman's Terms in the medication section of the Discharge Instructions Report. However, now the system uses the Layman term set up in the Prescription Entry Frequency crosswalk table.

- **Label Description**
  - Default: Blank
  - Options: Up to a 10-character label description.
  - Usage: Allows a frequency description different than the one entered during order entry to print to the label. The description prints to the label ONLY and does not affect printed reports.

- **MDS Frequency Code**
  - Default: Blank
  - Options: Two character MDS (Minimum Data Set) frequency code.
  - Usage: Used for facilities using the RAI application.

- **Instructions**
  - Default: Blank
  - Options: Up to four lines of instructions.

- Usage: Allows up to four lines of instructions pertinent to the frequency to be predefined. Upon entry of a frequency in Employee/LTC order entry, the predefined frequency instructions automatically display.

- **Minimum Time Between PRN doses**
  - Default: Blank
  - Options: Hours and minutes
  - Usage: Works in conjunction with the Medication Verification application. Sets a minimum time range for nursing administration of PRN doses of medication. If nursing tries to administer an order with a PRN frequency outside this time frame, i.e. too early, the system will display the following prompt: Administration interval is too short. Continue? If Yes is selected, an override reason must be entered. If No is selected, the administration is aborted.

- **CCDA Value**
  - *Default: Blank*
  - *Options: Enter a value or select the CCDA Value lookup to associate a CCDA Value with the Frequency.*
  - *Usage: For Promoting Interoperability certification (Clinical Information Reconciliation). The system will check for a medication frequency value of an imported CCD to determine if a medication frequency will be imported.*

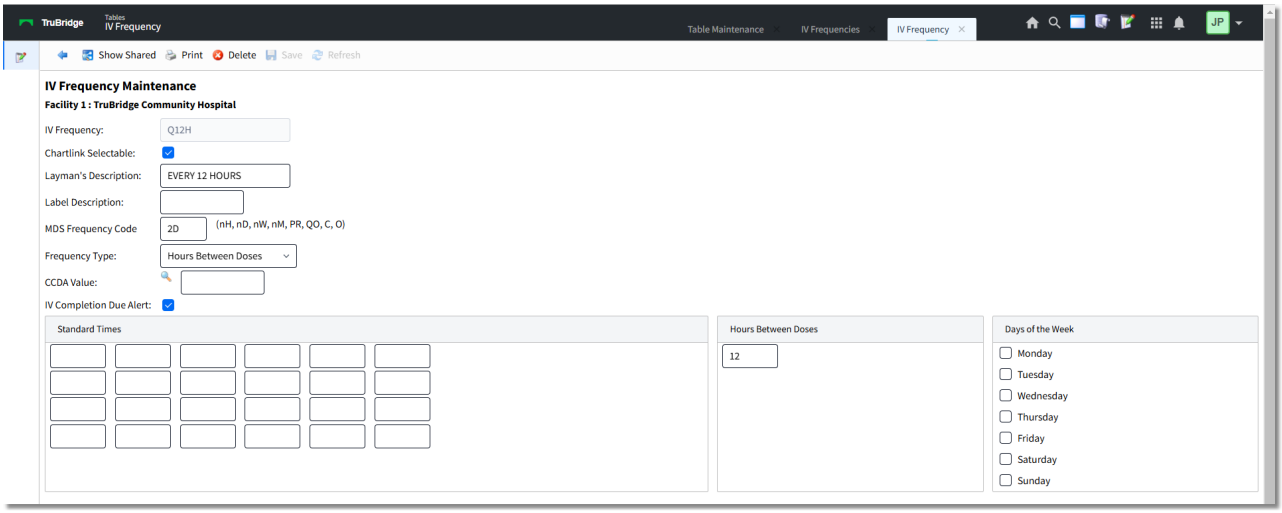
- **SNOMED Code**
  - *Default: Blank*
  - *Options: Enter a value or select the SNOMED Code lookup to associate a SNOMED Code with the Frequency.*
  - *Usage: For Promoting Interoperability certification.*

9.8 Frequencies - IV

The Frequency Table sets standard administration times for frequency codes entered in Frequency of IV Order Entry. Standard administration times display on the following:

- Pharmacy Labels
- IV Active Order List
- Active Order List
- EMAR

Select **Web Client** > **Tables** > **Clinical** > **Frequencies - IV**



IV Frequency Maintenance

- **IV Frequency**
  - Default: Blank
  - Options: Up to a 20-character frequency code.
  - Usage: Describes the frequency. The frequency may be selected by description from a lookup display during time of order entry.

- **Chartlink Selectable**
  - Default: Blank
  - Options: √ (yes) or Blank (no)
  - Usage: Allows the frequency to be selectable from a drop-down box in the CPOE application.

- **Layman's Description**
  - Default: Blank
  - Options: Up to a 20-character Layman's term.
  - Usage: Was traditionally used with the Discharge Summary and Instructions application in the Point of Care application. Converted the frequency to Layman's Terms in the medication section of the Discharge Instructions Report. However, the TruBridge EHR will now use the Layman term set up in the Prescription Entry Frequency crosswalk table.

- **Label Description**
  - Default: Blank
  - Options: Up to a 10-character label description.
  - Usage: Allows a frequency description different than the one entered during order entry to print to the label. The description prints to the label ONLY and does not affect printed reports.

- **MDS Frequency Code**
  - Default: Blank
  - Options: Two character MDS (Minimum Data Set) frequency code.
  - Usage: Used for facilities using the RAI application.

- **Frequency Type:**
  - **Standard Times**
    - Default: Blank
    - Options: Administration times entered in military format.
    - Usage: Up to 24 times may be entered.

  - **Hours Between Doses**
    - Default: Blank
    - Options: Enter the number of hours between doses.
    - Usage: The system will calculate administration times based on the start time of the order.

  - **Days of the Week**
    - Default: Blank
    - Options: Choose some or all days of the week.
    - Usage: Administration time for the selected day(s) is based on the start time of the order.

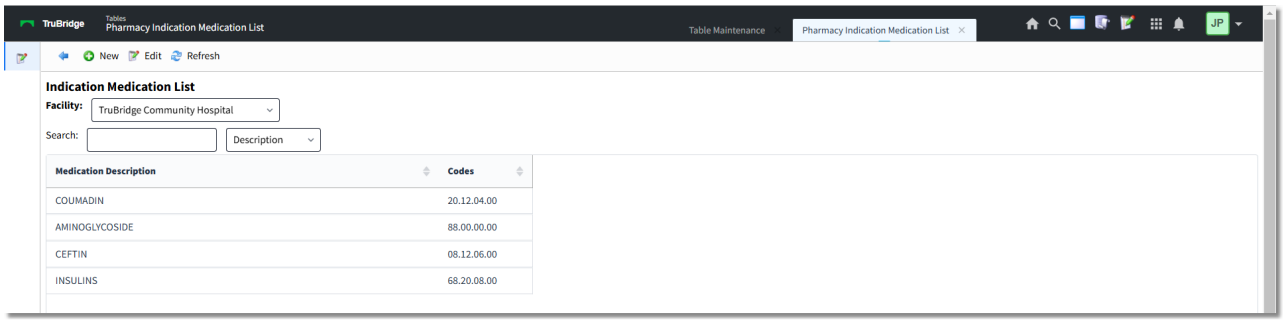
- **CCDA Value**
  - Default: Blank
  - Options: Enter a value or select the CCDA Value lookup to associate a CCDA Value with the Frequency.
  - Usage: For Promoting Interoperability certification (Clinical Information Reconciliation). The system will check for a medication frequency value of an imported CCD to determine if a medication frequency will be imported.

NOTE: *Each CCDA Value code may only be associated with one frequency.*

9.9 Indications of Use

The Indications of Use table allows the facility to create a pre-defined list of Indications for Antibiotic medications that are available in the pharmacy's formulary. The table must be set up by the pharmacist or an administrator.

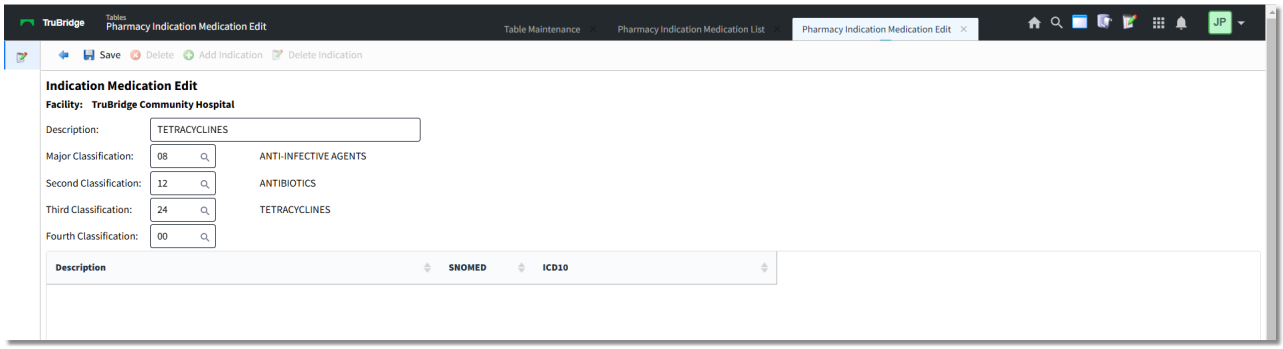
Select **Web Client** > **Tables** > **Clinical** > **Indications of Use**



Indication Medications

Select **New** to add a description to the table. Then use the magnifying glass icon to select from the lists of classifications that apply to the medication. Select **Save** to save the entry.

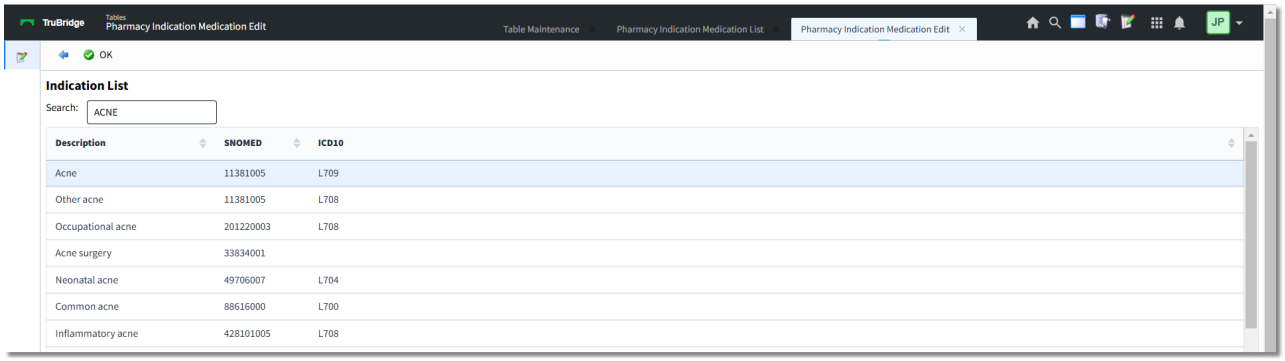
Select **Web Client** > **Tables** > **Clinical** > **Indications of Use** > **New**



Indication Medication Edit

Once the entry has been saved, up to 20 Indications may be added from the Indication. Utilize the Search field to locate the desired Description, SNOMED, and ICD10 codes. Single-click and select "OK" or double-click on the desired Description. Select Add Indication to continue adding Indications.

Select **Web Client > Tables > Clinical > Indications of Use > Select Description > Add Indication**



Indication List

The list of selected Indications will appear in the drop-downs on the Medication Order Edit screen for the designated medication classes. An Indication may be set to be required per medication by selecting the pharmacy item in the Item Master then selecting Pharmacy Information, Page 2 and checking Indication Required.

9.10 Instructions

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table in the Department Specific tables.

9.11 Interactions/Indicators

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table in the Department Specific tables.

9.12 Intervention Type

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table in the Department Specific tables.

9.13 Intervention Without Outcome

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table in the Department Specific tables.

9.14 Intervention Outcome Due to

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table in the Department Specific tables.

9.15 Intervention Status

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table in the Department Specific tables.

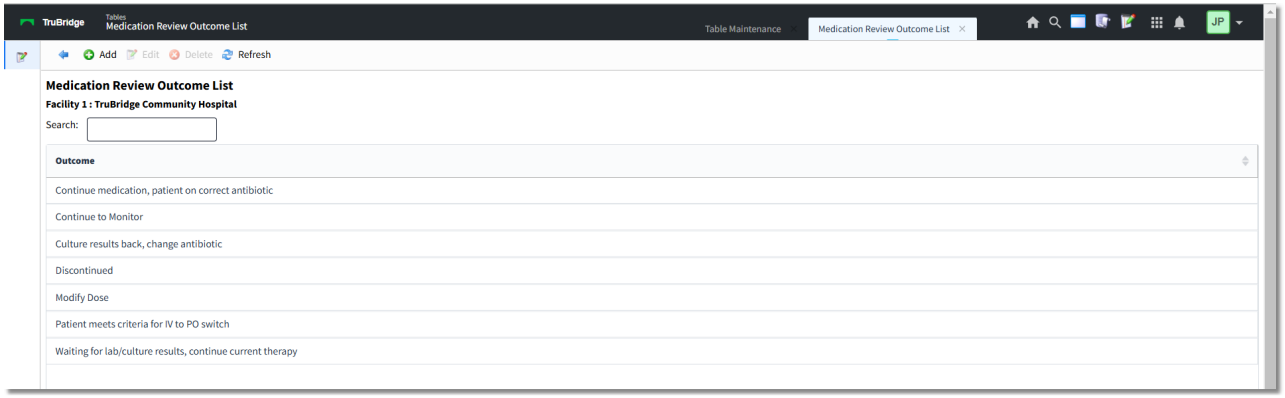
9.16 Intervention Time/Cost

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table in the Department Specific tables.

9.17 Medication Review Outcome

The Medication Review Outcome table allows outcomes to be predefined that may be utilized when performing antimicrobial reviews. The outcome defines the status and/or progress of the antibiotic administrations.

Select **Web Client > Tables > Clinical > Medication Review Outcome**



Medication Review Outcome List

NOTE: *Outcomes in the table may be edited or deleted until they are used in documentation at which point they may no longer be edited or deleted.*

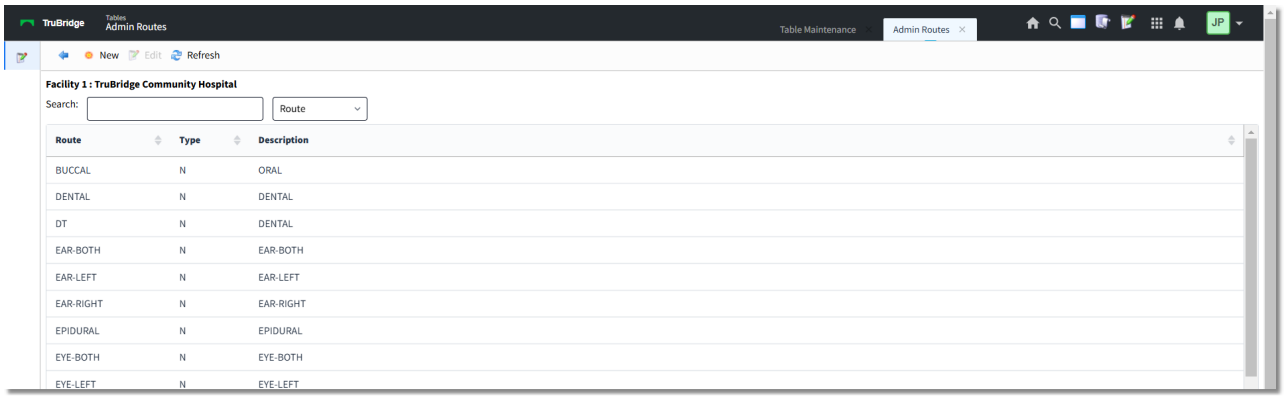
9.18 Patient Pay Code Table

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table in the Department Specific tables.

9.19 Route Table

The Route Table allows for the creation of facility-defined routes of administration to be used during order entry for the Pharmacy, Patient Documentation, and CPOE applications.

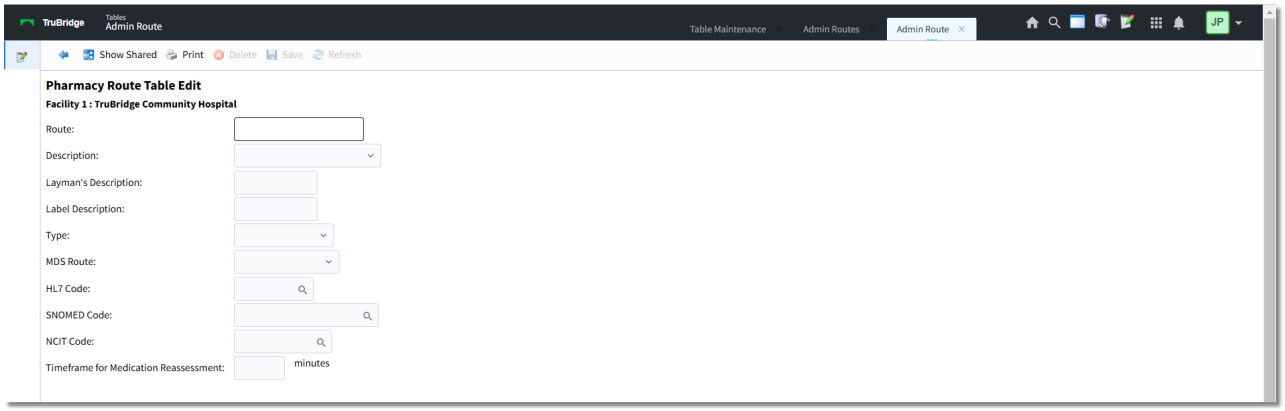
Select **Web Client** > **Tables** > **Clinical** > **Route Table**



Route Table

Select **New** to create a new route or choose an existing route and select **Edit**.

Select **Web Client** > **Tables** > **Clinical** > **Route Table** > **New**



New Route

- **Route:** Enter the desired route code. This is a 20-character field.
- **Description:** Using the drop-down, select the appropriate description.
- **Layman's Description:** May be used with the Discharge Summary and Instructions Report in the Point of Care application to convert the route to Layman's terms or a patient readable format in the medication section. This is a 20-character field

- **Label Description:** Allows a 10-character route description different than that the one entered during order entry to print to non-IV and IV patient labels. The description prints to the label ONLY and does not affect printed reports. If this field is left blank, the label route will default to the first ten characters from the route field.

- **Type:** The route type determines which order entry screen will be available during Pharmacy and Physician Order Entry.

- **MDS Route:** Minimum Data Set Route. For use with the RAI application.

- **HL7 Code:** Using the magnifying glass icon, select the code from the **Standard Route Table**. The purpose of this field is to cross-reference the facility defined route to the HL7 route code for immunization reporting.

- **SNOMED Code:** Using the magnifying glass icon, select the Systematized Nomenclature of Medicine or SNOMED code to be associated with a route for the purpose of Quality Measures reporting.

- **NCIT Code**: Using the magnifying glass icon, select the correct description and code from the National Cancer Institute Thesaurus (NCIT) list to be associated with the route for the purpose of immunization reporting.

- **Timeframe for Medication Reassessment:** The timeframe (in minutes) to require the nurse to have to document a medication assessment after administering a medication. (See the *Item Master* section of the *Table Maintenance - Control User Guide* for more details.)

The following options are available on the action bar:

- **Show Shared**: If the site is sharing tables, when this option is selected the fields that are shared between facilities will be highlighted in yellow.

- **Print**: Displays the table settings in Adobe

- **Delete**: Deletes the table settings

- **Save**: Saves changes made to the table settings

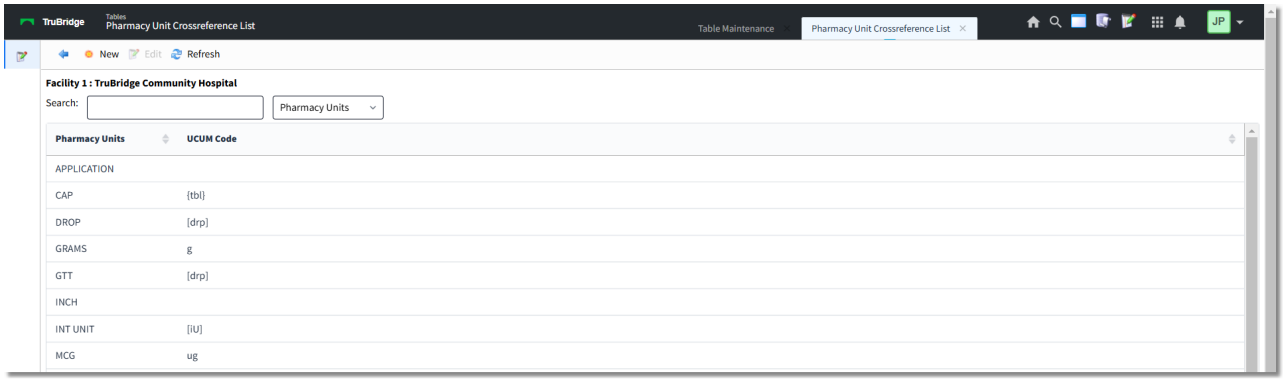
- **Refresh**: Allows changes to show immediately in the route list

Select  **Back Arrow** to return to the previous screen.

9.20 Units Table

The Units Table was created to cross-reference the pharmacy item master **Other Units** entries with Unified Code for Units of Measure or UCUM codes. UCUM codes are the standard codes necessary to report immunizations.

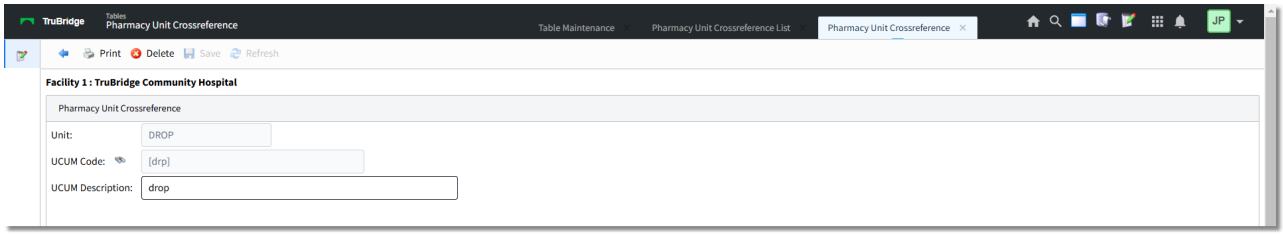
Select **Web Client** > **Tables** > **Clinical** > **Units Table**



Units Table

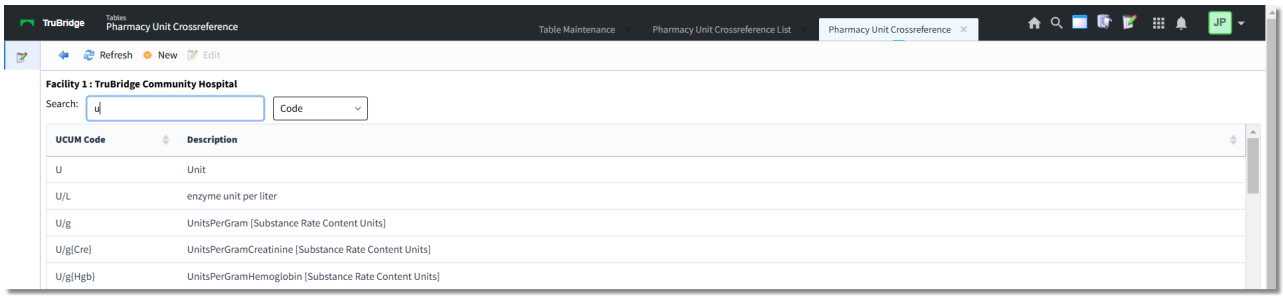
1. To enter a new unit, select **New** or choose an existing unit by selecting **Edit** or double clicking the unit.

Select **Web Client** > **Tables** > **Clinical** > **Units Table** > **Select a unit**



Pharmacy Unit Crossreference List

2. Select the **Binoculars** icon to access the UCUM list.



Pharmacy UCUM Code List

3. Enter the description of the unit to be referenced.
   - The default search is **Code**, but may be changed to **Description** by using the drop-down search topic to the right of the search window.

4. Double click to select the UCUM code.
   - The unit is now cross-referenced to the UCUM code. .

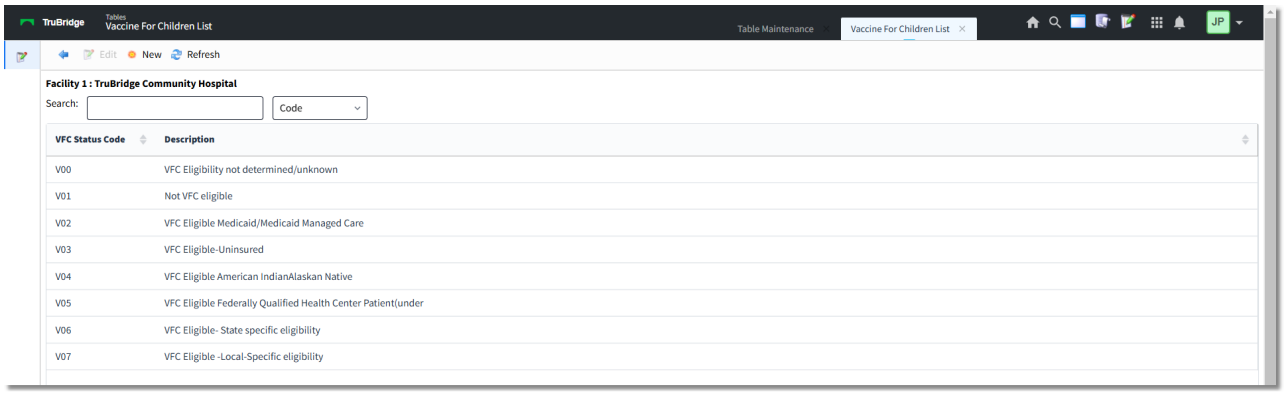
5. Select **Save** to save changes made to the table settings.
   - The following options are also available on the action bar:
     - **Print**: Displays the table settings in Adobe
     - **Delete**:Deletes the table settings
     - **Refresh**: Allows changes to show immediately in the Physicians list

6. Select **Back Arrow** to return to the previous screen.

9.21 VFC Status Table

The VFC (Vaccines for Children) Program is a federally funded program that provides vaccines at no cost to children who might not otherwise be vaccinated due to inability to pay. State immunization registries require documentation stating whether the administered immunization is a VFC vaccine and if the patient is eligible to receive a VFC vaccine. For Meaningful Use reporting, a new table that contains VFC codes has been created. New codes and descriptions may be added to the table if necessary. TruBridge has preloaded the eight existing codes.

Select **Web Client** > **Tables** > **Clinical** > **VFC Status Table**

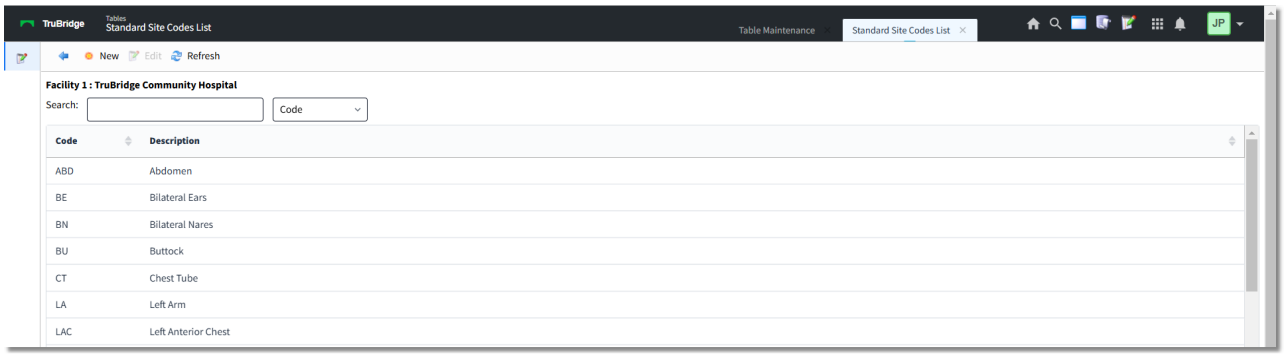


VFC Status Table

9.22 Standard Site Table

The Standard Site table is used to cross-reference standardized HL7 site codes to facility-defined site codes entered in the Site Options table 76. These codes are transmitted to the designated immunization registry.

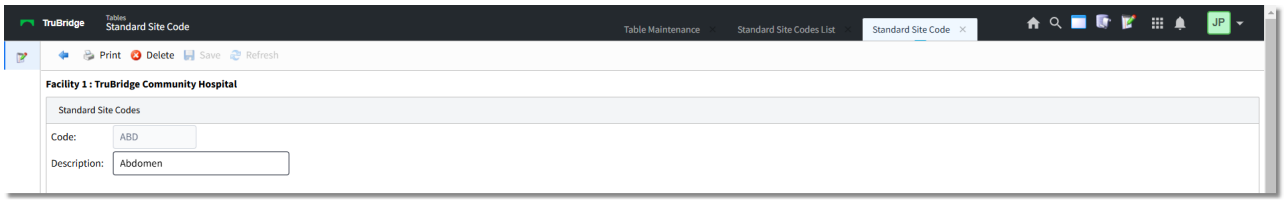
Select **Web Client** > **Tables** > **Clinical** > **Standard Site Table**



Standard Site Table

Select **New** to enter a new site code, or select an existing code from the list and select **Edit**.

Select **Web Client** > **Tables** > **Clinical** > **Standard Site Table** > **Select a Code**



Standard Site Table

- **Code:** Enter the HL7 site code. This may be up to six characters in length.
- **Description:** Enter the description of the site code. This may be up to 30 characters in length.

NOTE: *The table comes pre-populated with a substantial list of codes,* but the option to add new codes is available.

The following options are available on the action bar:

- **Print**: Displays the table settings in Adobe
- **Delete**:Deletes the table settings
- **Save**: Saves changes made to the table settings

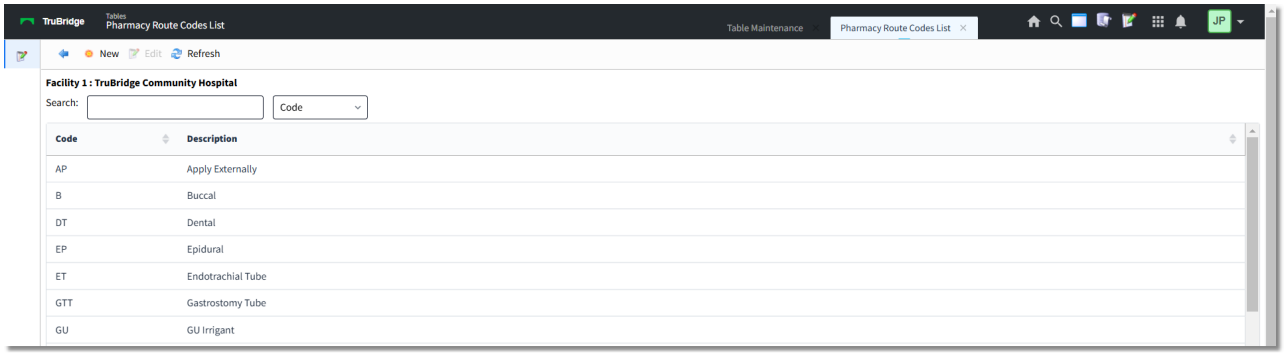
- **Refresh**: Allows changes to show immediately in the Standard Site Table

Select  **Back Arrow** to return to the previous screen.

9.23 Standard Route Codes

The Standard Route Code Table is preloaded with standardized HL7 route codes to be transmitted to immunization registries. The standard route code is cross-referenced to the facility-specific route via the Department Specific **Route Table**.

Select **Web Client** > **Tables** > **Clinical** > **Standard Route Table**



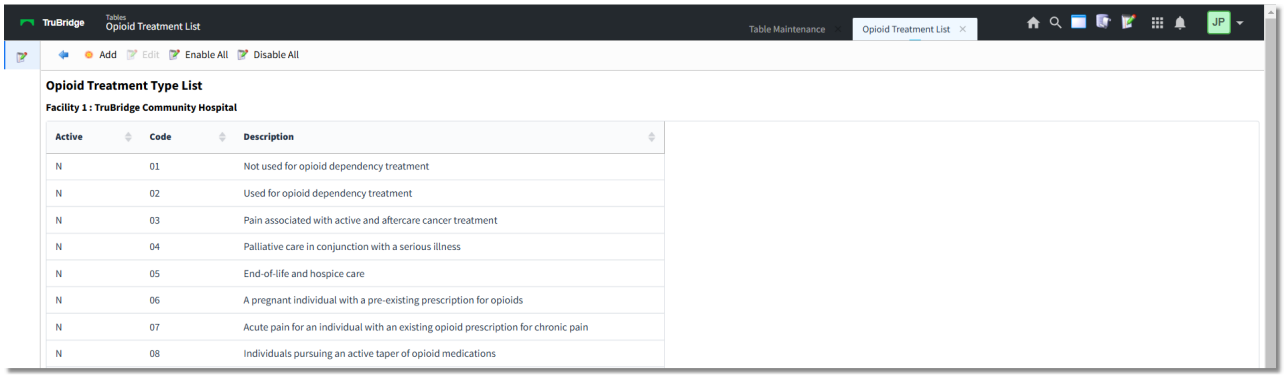
Standard Route Codes

9.24 Opioid Treatment Types

The Opioid Treatment type field is needed to explain the reason for the opioid prescription. With the Electronic Controlled Substance Report update, the Opioid Treatment Types table is a list that's used during Pharmacy Order Entry, if applicable. The table shows as a drop-down option on the RX Information page of Pharmacy Order Entry. The entries can save up to 100 characters.

NOTE: *See the Pharmacy User Guide for more information on Order Entry/RX Information.*

Select **Web Client** > **Tables** > **Clinical** > **Opioid Treatment Types**



Opioid Treatment Type List

Chapter 10 Pharmacy Report Control

Pharmacy Report Control allows parameters to be set for the system to follow when printing various reports and patient labels. Daily pharmacy reports may be set to automatically print every day at specified times. To access the report control tables via Table Maintenance, open UX and select **Tables > Clinical > Pharmacy Report Control** section.

The Pharmacy Report Control Information table is also accessible via the Pharmacy Hospital Base Menu. See the Pharmacy Report Control Information Section in the Pharmacy Setup User Guide.

10.1 Active Order List

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.2 ADM Exception Report

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.3 Cart Fill and Catch-Up List

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.4 Cart Label Charging

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.5 Clinical Deficiency Report

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.6 CrCl Status Report

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.7 DC/Discharge/Transfer Labels

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.8 Detail Interventions / ADRs Report

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.9 End of Day Report Control Information

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.10 Final Patient Drug Profile Options

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.11 IV Active Order List

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.12 IV Batch Labels

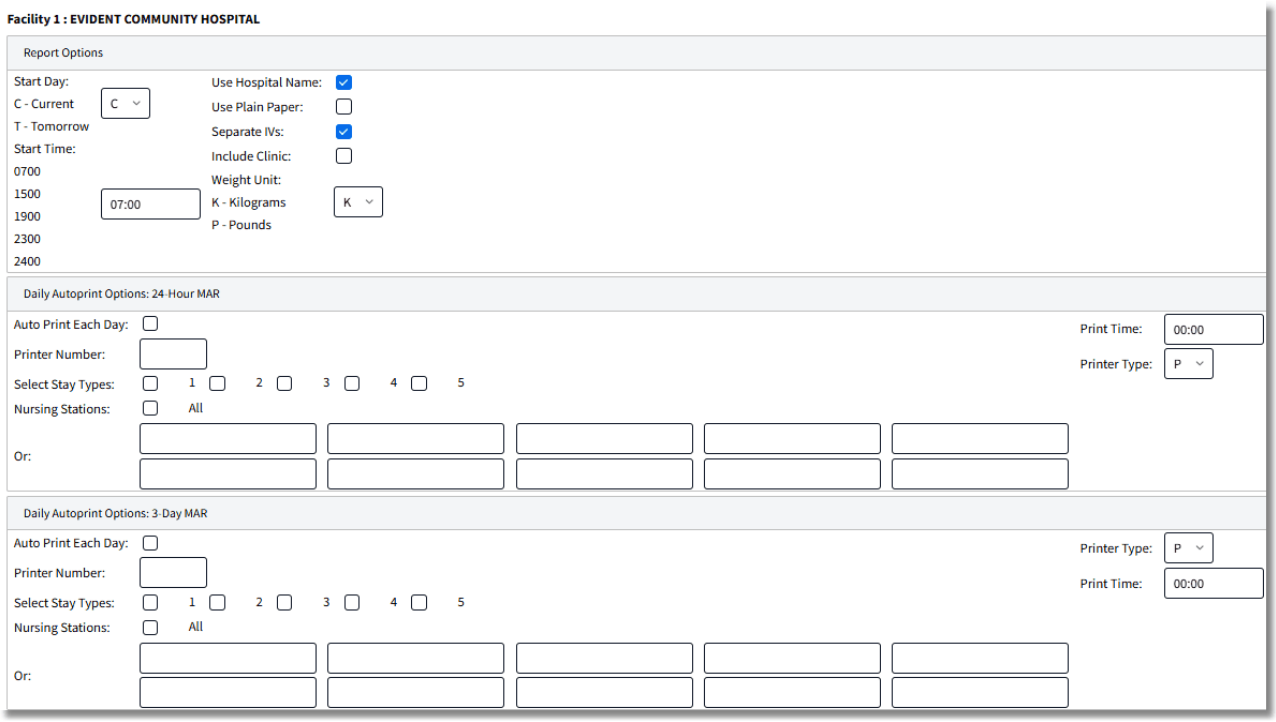
This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.13 Label Control

This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

10.14 MAR Report

To access the MAR Report Options, select **Tables > Clinical > Pharmacy Report Control category > MAR Report**



MAR Report Options

- **Start Day**
  - Default: Blank, or no entry
  - Options: C-Current Date or T-Current Date Plus One
  - Usage: Allows the report to be printed either for the current date or for the following day.

- **Start Time**
  - Default: Blank, or no entry
  - Options: 0700, 1500, 1900, 2300, 2400
  - Usage: Sets the times that doses print on the MAR. If start time is set for 0700, the MAR prints for the doses at 0700 and the next day at 0659.

- **Use Hospital Name**
  - Default: Blank, or no entry
  - Options: Y (yes) (check mark ✓), or N (no)
  - Usage: Allows the Hospital Name to print on the MAR.

- **Use Plain Paper**
  - Default: Blank, or no entry
  - Options: Y (yes) (check mark ✓), or N (no)
  - Usage: Allows the MAR to print on plain white paper. Select <N> if the hospital is using the pre-formatted MAR forms.

- **Separate IVs**
  - Default: Blank, or no entry
  - Options: Y (yes) (check mark ✓), or N (no)
  - Usage: Allows IV orders to print on the last page separate from Routines and PRNs.

- **Include Clinic**
  - Default: Blank, or no entry
  - Options: Y (yes) (check mark ✓), or N (no)
  - Usage: Determines if Clinic patients print on the MAR.

- **Weight Unit**
  - Default: Blank, or no entry
  - Options: P-Pounds or K-Kilograms
  - Usage: Determines if recorded weight displays in pounds or kilograms.

Daily Autoprint Options: 24-HR MAR

- **Automatically Print Each Day / Print Time**
  - Default: Blank, or no entry
  - Options: Y (yes) (check mark ✓), or N (no)
  - Usage: Allows report to be set to automatically print. This switch must be set to <Y> in order for other options to be accessible. Once selected, the desired time for the report to print should be entered in military format.

  NOTE: *Reports can only be set to print at the top of the hour.*

- **Printer Number/ Printer Type**
  - Default: Blank, or no entry
  - Options: 3-digit printer number and printer type code
  - Usage: Used to enter the printer number and type of printer to which the report will be sent. The printer type allows the report to be sent in the correct format. Printer types are as follows:
    - M - Okidata 320p or Turbo
    - E - Okidata 395
    - P - Lexmark Laser

- **Select Stay Types**
  - Default: Blank, or no entry
  - Options: Y (yes), ✓ (check mark), or N (no)
  - Usage: Designates the stay types for which the report will print. One or more stay types can be selected.

- **Select Nursing Stations**
  - Default: Blank, or no entry
  - Options: Y (yes) (check mark ✓), or N (no) or entry of select nursing departments.
  - Usage: Allows the report to print for ALL or up to ten selected nursing stations. If ALL is selected, it will not be possible to enter select nursing stations.

Daily Autoprint Options: 3-Day MAR

- **Automatically Print Each Day / Print Time**
  - Default: Blank, or no entry
  - Options: Y (yes) (check mark ✓), or N (no)
  - Usage: Allows report to be set to automatically print. This switch must be set to <Y> in order for other options to be accessible. Once selected, the desired time for the report to print should be entered in military format.

  NOTE: *Reports can only be set to print at the top of the hour.*

- **Printer Number / Printer Type**
  - Default: Blank, or no entry
  - Options: 3-digit printer number and printer type code
  - Usage: Used to enter the printer number and type of printer to which the report will be sent. The printer type allows the report to be sent in the correct format. Printer types are as follows:
    - M - Okidata 320p or Turbo
    - E - Okidata 395
    - P - Lexmark Laser

- **Select Stay Types**
  - Default: Blank, or no entry
  - Options: Y (yes) (check mark ✓), or N (no)
  - Usage: Designates the stay types for which the report will print. One or more stay types can be selected.

- **Select Nursing Stations**
  - Default: Blank, or no entry
  - Options: Y (yes) (check mark ✓), or N (no) or entry of select nursing departments.
  - Usage: Allows the report to print for ALL or up to ten selected nursing stations. If ALL is selected, it will not be possible to enter select nursing stations.

10.15 Physician Reorder Report Table

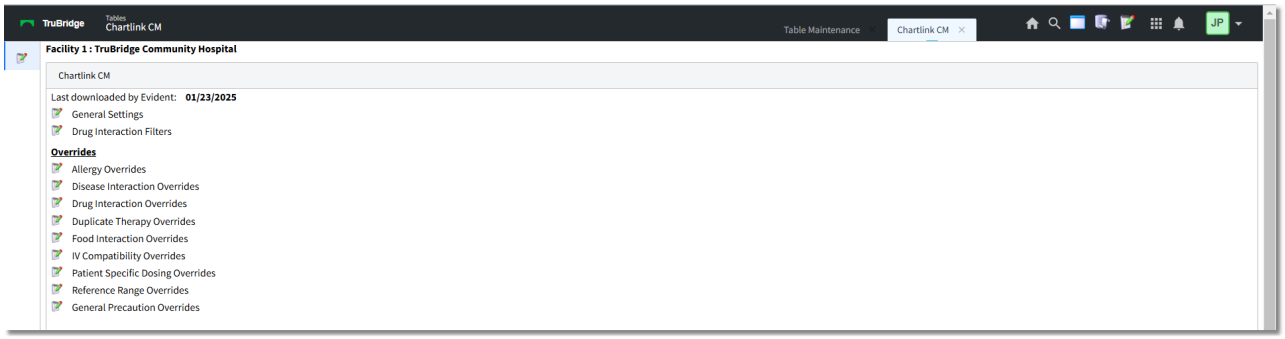
This table is not used at this time; please refer to the Pharmacy Setup User Guide for options on setting this table.

Chapter 11 Physician Application

11.1 Clinical Monitoring

The ChartLink Clinical Monitoring table is located under the Physician Application header in the Clinical tab of Table Maintenance. These fields will control the settings for Clinical Monitoring in CPOE and Updated CPOE.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring**



Chartlink Clinical Monitoring

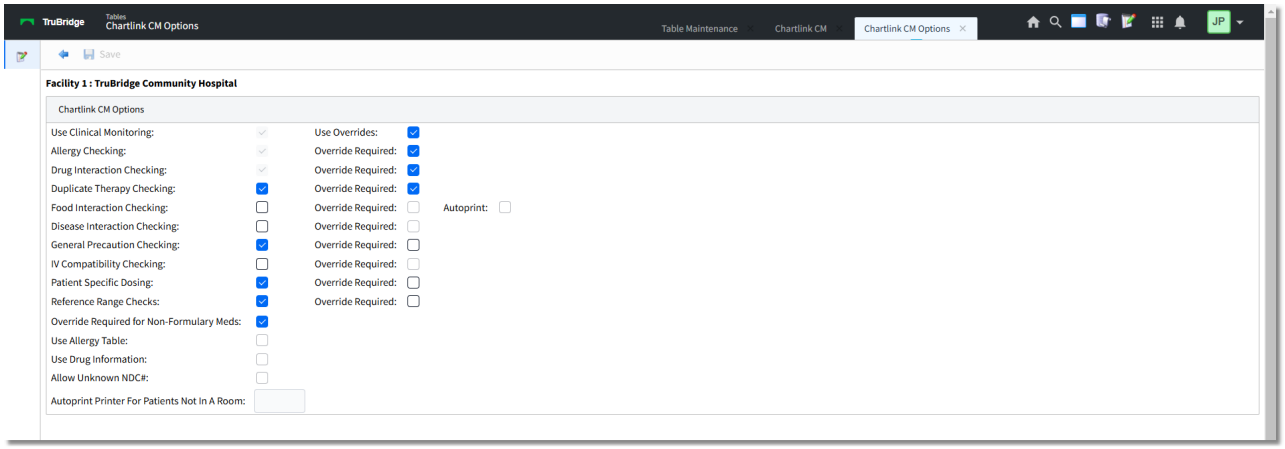
- **Last Downloaded by Evident: MM/DD/YYYY:** Indicates the last date clinical monitoring files were updated.
- **General Settings:** Contains the clinical monitoring option settings
- **Drug Interaction Filters:** Contains the drug interaction filtering option settings
- **Overrides:** Lists override reasons for each clinical monitoring category

General Settings will control the Clinical Monitoring notifications and overrides.

General Settings

The Clinical Monitoring General Settings section contains all activation options for CPOE and Updated CPOE Clinical Monitoring.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **General Settings**



Chartlink CM Options

- **Use Clinical Monitoring:** Activates Clinical Monitoring for prescription entry. This field is grayed out but always checked "yes," since some Clinical Monitoring checks are required to meet Meaningful Use.

- **Allergy Checking:** Allows the system to automatically perform allergy checks at the time of order entry. Whenever a drug is entered for a patient, the system compares the new medication to any drug allergy entered on the patient through the TruBridge system. If there are any drug allergies documented that correspond to the medication selected, a menu will display showing the drug selected, the allergy, the drug class and any possible symptoms. This field is grayed out but always checked "yes," since this Clinical Monitoring check is required to meet Meaningful Use. If **Include Inactive Ingredients** is selected, the system will check inactive ingredients in each medication against the patient's listed allergies.

- **Drug Interaction Checking:** Allows the system to automatically perform drug interaction checks at the time of order entry. Whenever a drug is entered for a patient, the system compares the new medication to all medications the patient is currently taking or has taken within the last 24 hours. Any possible interactions will display. The drug interactions are ranked as contraindicated, major, moderate or minor. This field is grayed out but always checked "yes," since this Clinical Monitoring check is required to meet Meaningful Use.

- **Duplicate Therapy Checking:** Select the check box to allow the system to automatically perform duplicate therapy checks at the time of order entry. As soon as a medication is selected, the patient's current orders are reviewed for duplicate therapy. The Clinical Monitoring Screen appears and under Duplicate Therapy the similar medication is listed. The system performs this check on both IV and Non-IV orders by looking at the NDC number on the order, which pulls from Pharmacy Info page 1.

- **Food Interaction Checking:** Select the check box to allow the system to automatically perform food interaction checks at the time of order entry. If a medication that has an interaction to food is selected, the Clinical Monitoring screen displays.

NOTE: *The* ***Autoprint*** *option next to Food Interaction Checking is not used by ChartLink Clinical Monitoring.*

- **Disease Interaction Checking:** Select the check box to allow the system to automatically perform drug-disease interaction checking at the time of order entry. Whenever a drug is entered from the Drug Formulary for a patient, the system compares the new medication to the diagnosis for the patient to ensure the drug does not interfere with the diagnosis. It will also provide a drug/drug screening for current medications, checking for disease monitoring.

- **General Precaution Checking:** Activates or deactivates General Precaution Checking, which screens a medication's active and inactive ingredients against the patient's age and gender to help determine whether the order should be continued. This checking more specifically provides individual and daily dosing information for pediatric, adult and geriatric age ranges.

- **IV Compatibility Checking:** Select the check box to allow the system to automatically perform IV compatibility checks at the time of order entry. If a medication that is not compatible with an existing medication in the patient's pharmacy profile is ordered, the clinical monitoring screen will display. A monograph may then be printed or displayed. Clinical Monitoring uses Trissel's IV compatibility checks.

- **Patient Specific Dosing:** Select the check box to allow the system to automatically perform patient specific dosing. Patient specific dosing will run once all order entry fields have been OK'd prior to updating the order. Only Overdose and Sub therapeutic information will be displayed; the PSD window will not display if neither is triggered. A diagnosis, listed at the top of the PSD window, may be added during order entry. Once added, the PSD window may be reloaded.

- **Reference Range Checks:** The system automatically applies reference range checking to medication orders with associated lab tests if these tests have associated reference ranges; this field is by default inaccessible but activated.

- **Use Overrides:** Select the check box to allow the user to enter override reasons at the time of order entry for any medication that meets the checks described above. Custom override reasons may be pre-built in the Overrides 241 section below, and can be set for each type of Clinical Monitoring check.

- **Override Required:** Select the check box adjacent to each type of Clinical Monitoring Check that requires a reason be documented before proceeding with order entry.

- **Override Required for Non-Formulary Meds:** Select the check box to require an override reason when non-formulary medications are ordered.

- **Use Allergy Table:** This option is not used during ChartLink clinical monitoring.

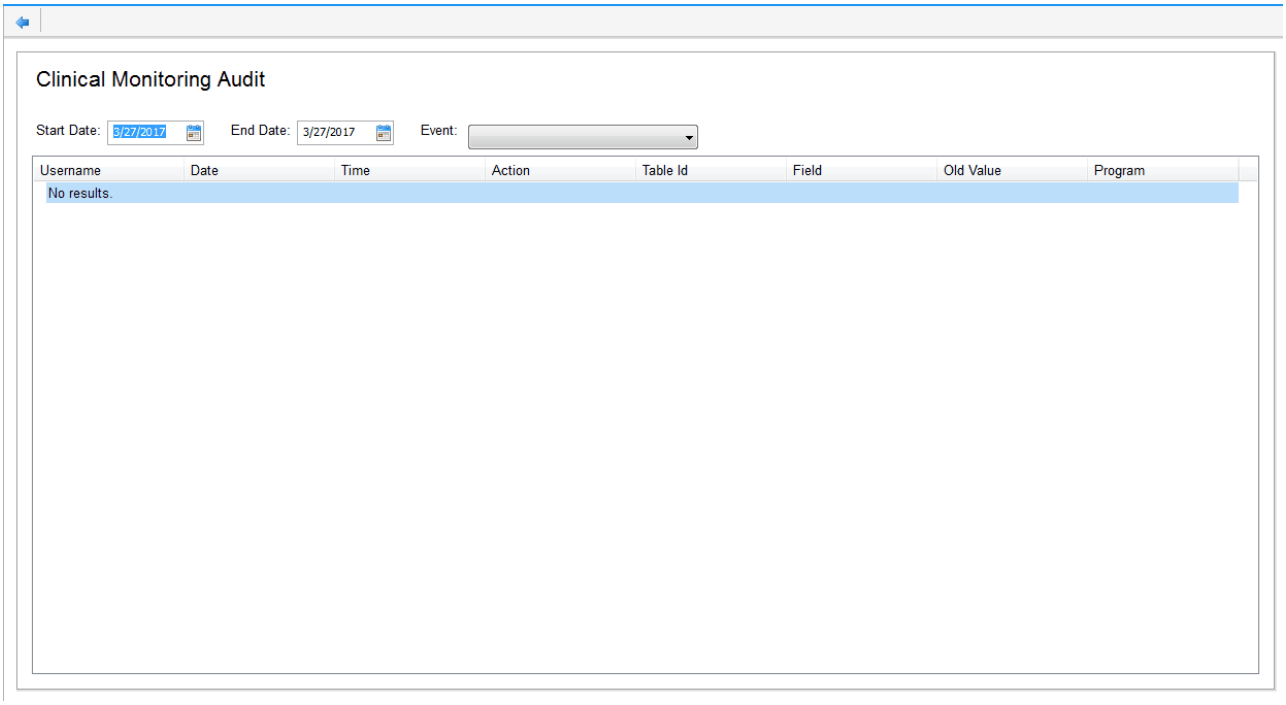
- **Use Drug Information:** This option is not used during ChartLink clinical monitoring.

- **Allow Unknown NDC#:** This option is not used during ChartLink clinical monitoring.
- **Autoprint Printer For Patients Not In A Room:** This option is not used during ChartLink clinical monitoring.
- **Save** 

: Once any changes are made, be sure to select this option from the action bar.
- **View Audit** 

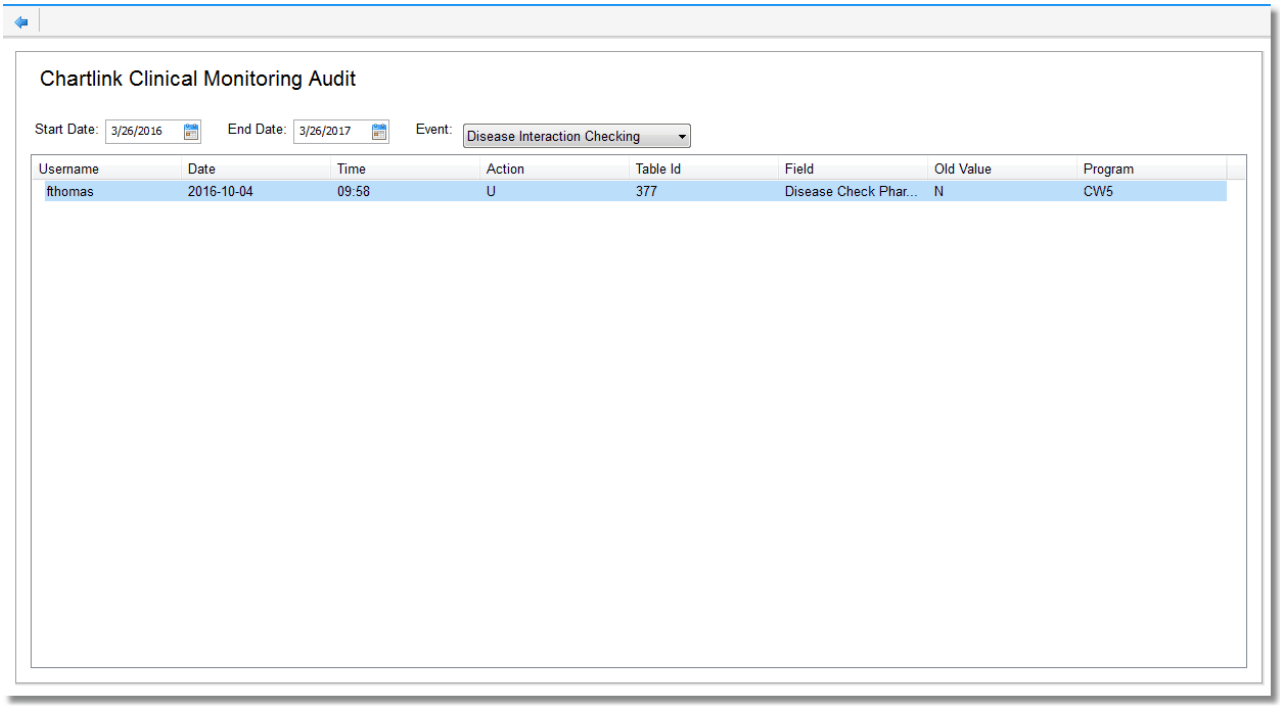
: The Clinical Monitoring audit log, accessed from the **View Audit** option on the action bar, records each time a Clinical Monitoring check has been turned on or off for a specific time frame.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **General Settings** > **View Audit**



Clinical Monitoring Audit

Populate the Start and End Date, then select the **Event** drop-down menu to select the type of clinical monitoring check to review.



Chartlink Clinical Monitoring Audit

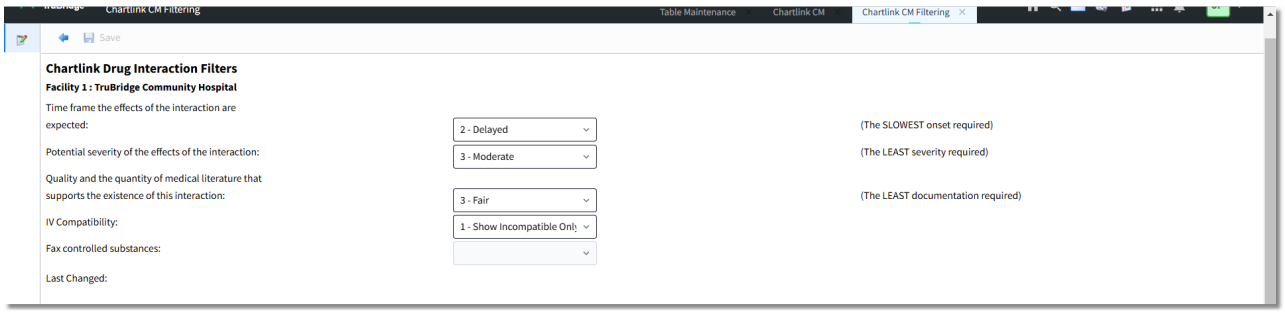
The Clinical Monitoring Audit functions are described below.

- **Username:** Shows the logname (UBL) of the employee who turned a check on or off
- **Date:** In YYYY-MM-DD format, shows the date the change was made
- **Time:** Shows the time the change was made
- **Action:** A code displays in this column, indicating what sort of action occurred.
  - **U:** Indicates the value of the field was updated
- **Table Id:** This field is not used at this time.
- **Field:** Names the Clinical Monitoring Check item that has been turned on or off
- **Old Value:** Indicates what the field's setting was prior to being changed.
  - Fields on the General Settings page display Y or N to indicate checked (Y) or unchecked (N).
  - Drug Interaction Filters display the numeric value located in the specific drop-down menus.
- **Program:** Displays the name of the program from which the action was generated
- **Back Arrow**  **:** Select this to return to the previous screen.

Drug Interaction Filters

Interaction Filtering allows Drug Interaction warnings to be customized in terms of speed of onset, interaction severity, and the quality and quantity of medical literature available regarding an interaction.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Drug Interaction Filters**



Chartlink Drug Interaction Filters

- **Time frame the effects of the interaction are expected:** Select the slowest onset required to trigger a warning from the following options:
  - 1 - Rapid
  - 2 - Delayed

- **Potential severity of the effects of the interaction:** Select the least severity required to trigger a warning from the following options:
  - 1 - Contraindicated
  - 2 - Major
  - 3 - Moderate
  - 4 - Minor

- **Quality and the quantity of medical literature that supports the existence of this interaction:** Select the least documentation required to trigger a warning from the following options:
  - 1 - Excellent
  - 2 - Good
  - 3 - Fair
  - 4 - Poor

- **IV Compatibility:** Indicates which IV compatibility checks will be required to trigger a warning. Select from the following options:
  - 1 - Show Incompatible Only
  - 2 - Show Incompatible or Unavailable
  - 3 - Show All Checks

- **Fax controlled substances:** This functionality is not used by ChartLink Clinical Monitoring.

- **Last Changed:** This field is not used by ChartLink Clinical Monitoring.

- **Save** 

: Once any changes are made, select Save from the action bar.

- **Back Arrow**  **:** To return to the previous screen, select this option from the action bar.

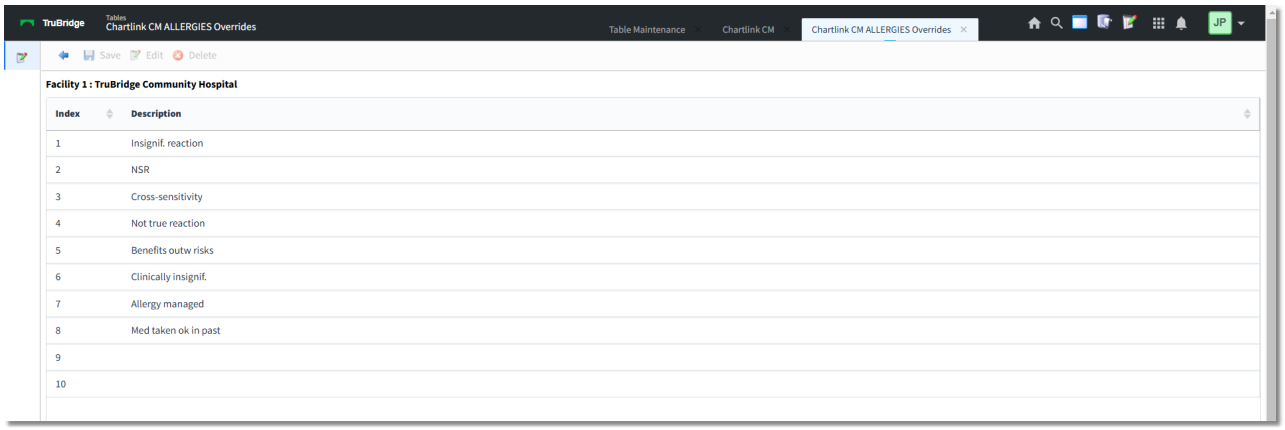
Overrides

Override reasons may be created for each type of clinical monitoring check. A maximum of 10 override reasons may be entered for each of the following categories: Allergies, Disease Interactions, Drug Interactions, Duplicate Therapy, Food Interactions, IV Compatibility, Patient Specific Dosing, Reference Ranges and General Precautions.

Allergy Overrides

Up to 10 override reasons may be entered to address allergy checks. The Allergy Overrides list consists of 10 lines, with unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Allergy Overrides**



ChartLink CM Allergy Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

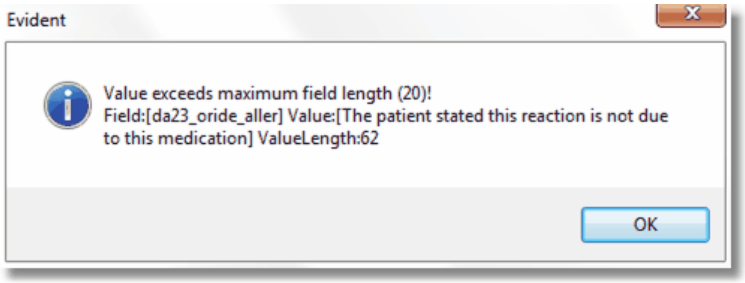
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Allergy Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

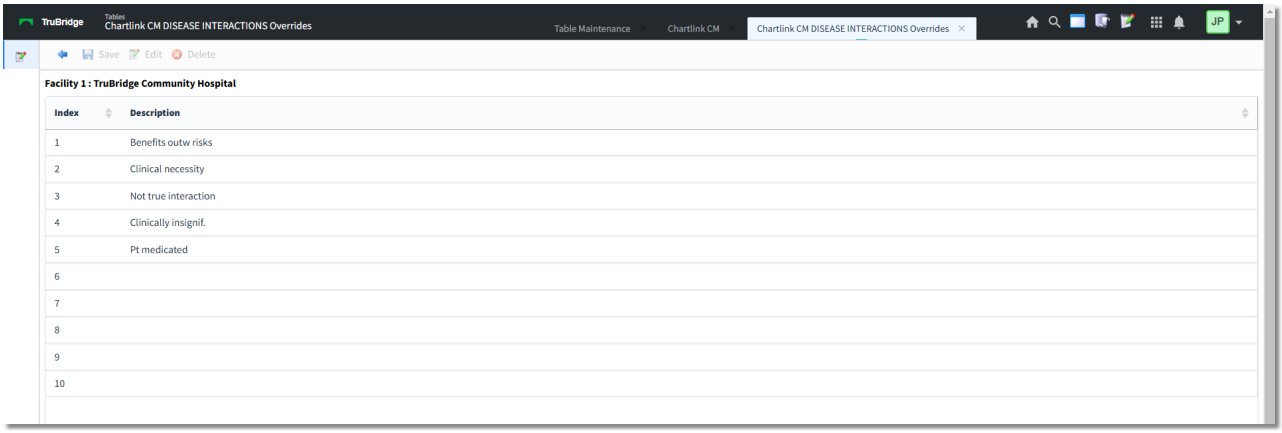
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back Arrow**  **:** Select to return to the previous screen.

Disease Interaction Overrides

Up to 10 override reasons may be entered to address disease interaction checks. The Disease Interaction Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Disease Interaction Overrides**



Disease Interaction Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

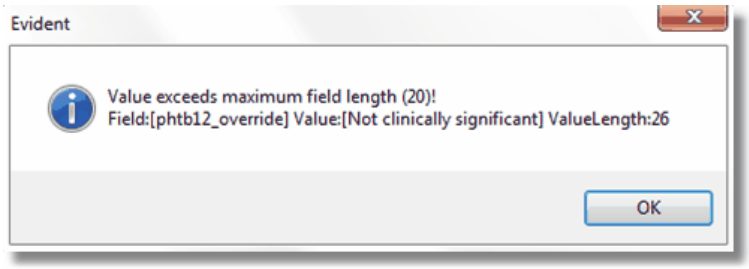
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Disease Interaction Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

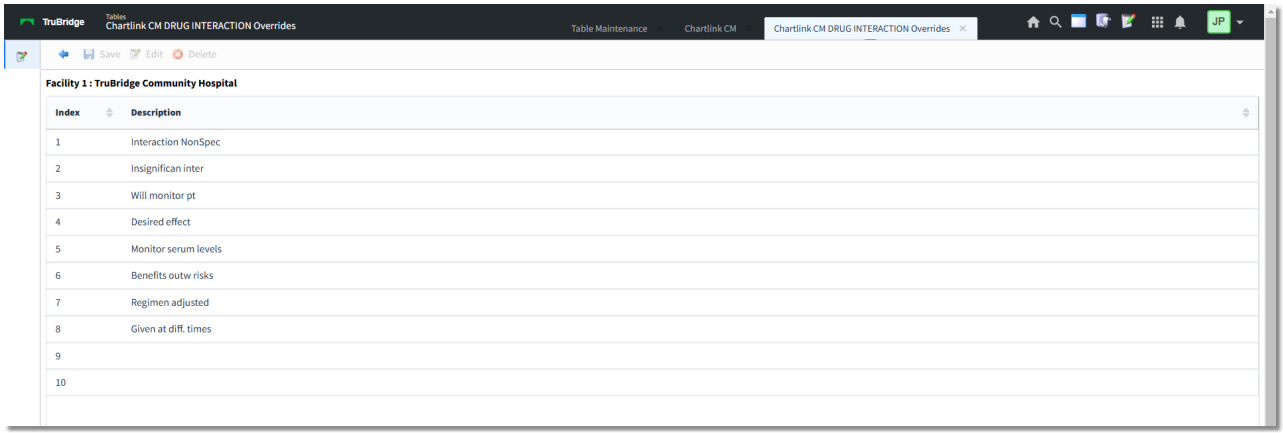
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back Arrow**  **:** Select to return to the previous screen.

Drug Interaction Overrides

Up to 10 override reasons may be entered to address drug interaction checks. The Drug Interaction Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Drug Interaction Overrides**



ChartLink Drug Interaction Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

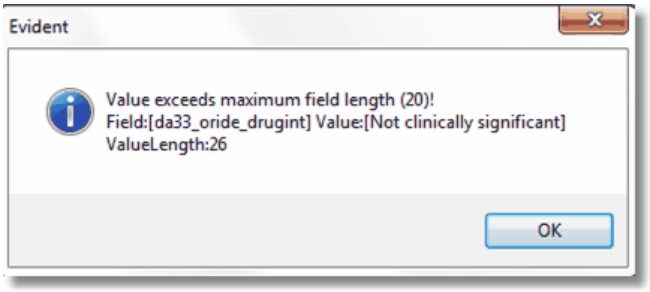
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Drug Interaction Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

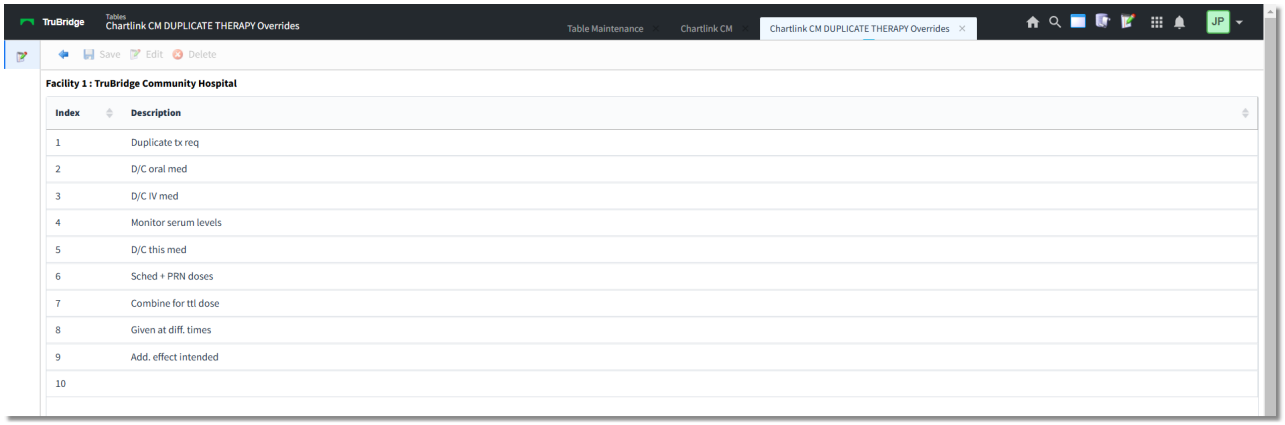
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back Arrow**  **:** Select to return to the previous screen.

Duplicate Therapy Overrides

Up to 10 override reasons may be entered to address duplicate therapy checks. The Duplicate Therapy Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Duplicate Therapy Overrides**



ChartLink Duplicate Therapy Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

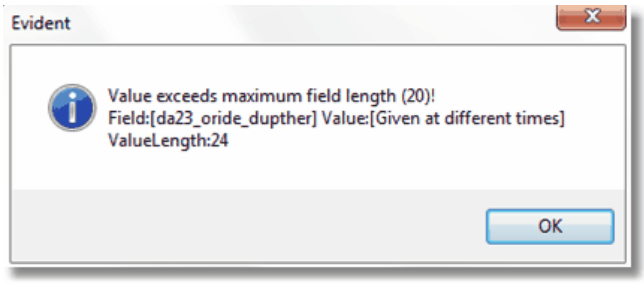
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Duplicate Therapy Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

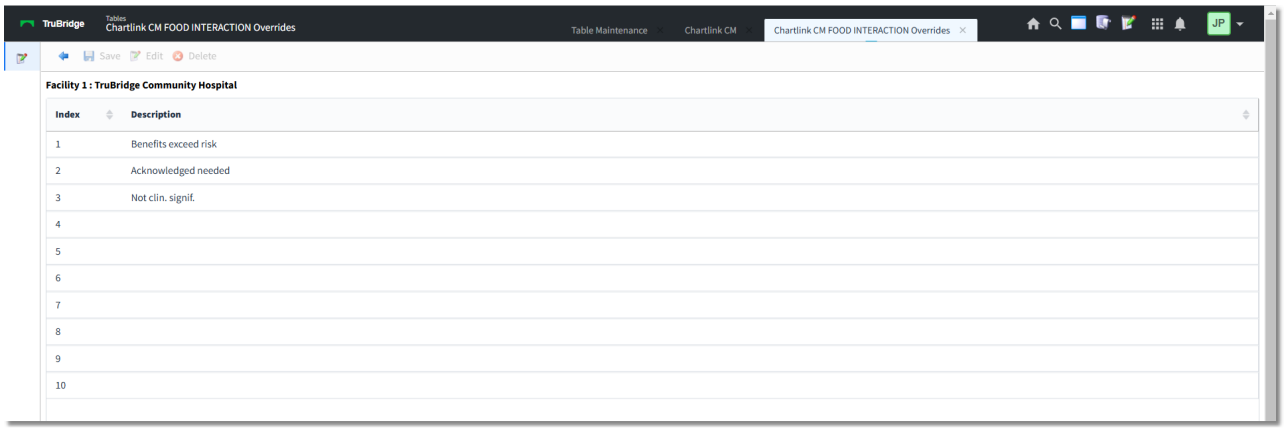
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back arrow**  **:** Select to return to the previous screen.

Food Interaction Overrides

Up to 10 override reasons may be entered to address food interaction checks. The Food Interaction Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Food Interaction Overrides**



Food Interaction Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

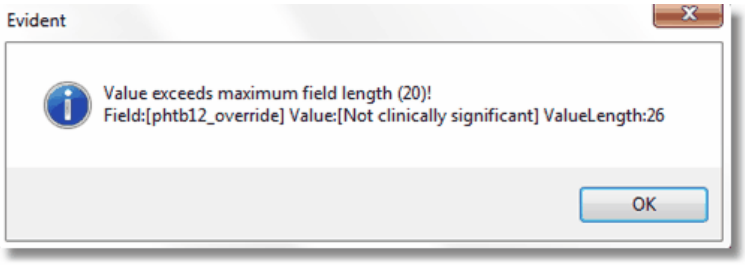
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Food Interaction Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

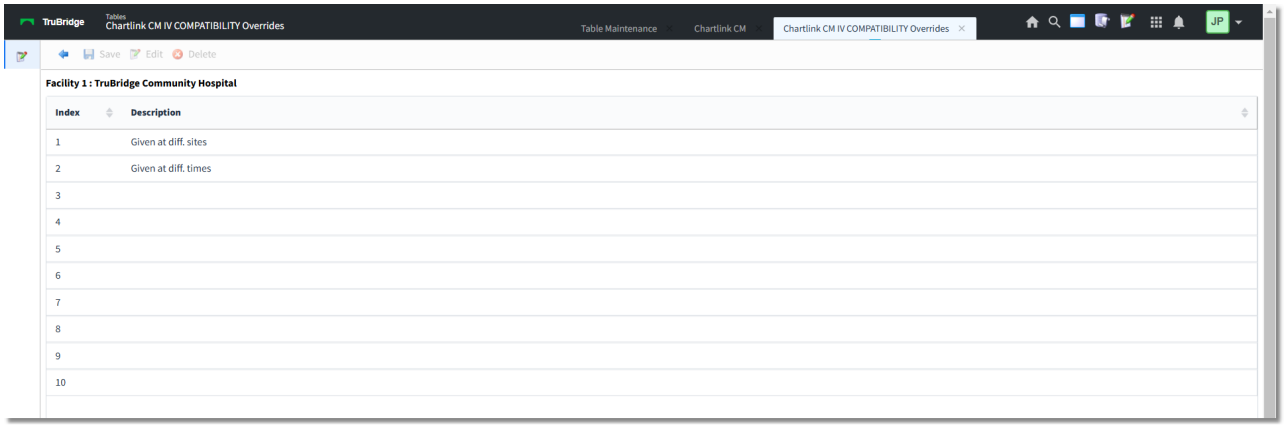
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back arrow** 
: Select to return to the previous screen.

IV Compatibility Overrides

Up to 10 override reasons may be entered to address IV compatibility checks. The IV Compatibility Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **IV Compatibility Overrides**



IV Compatibility Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

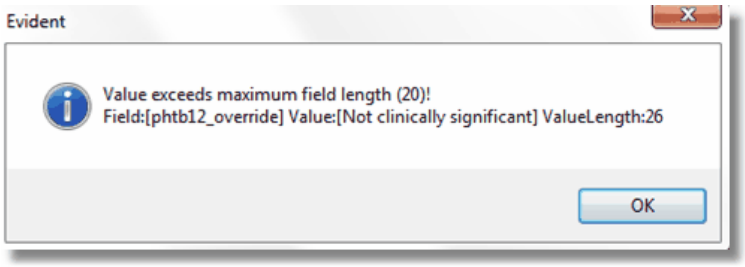
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time:

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **IV Compatibility Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

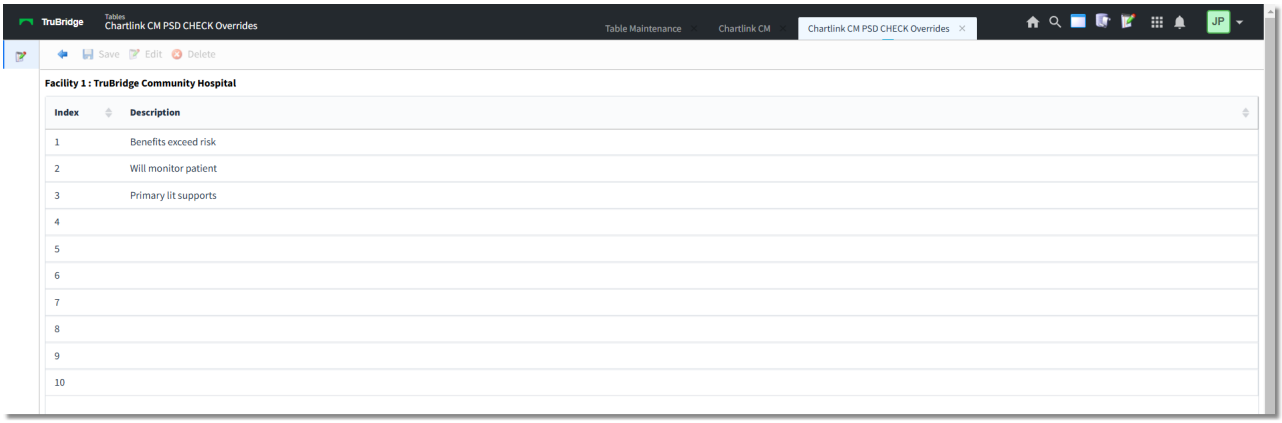
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back arrow**  **:** Select to return to the previous screen.

Patient Specific Dosing Overrides

Up to 10 override reasons may be entered to address patient specific dosing checks. The Patient Specific Dosing Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Patient Specific Dosing Overrides**



Patient Specific Dosing Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

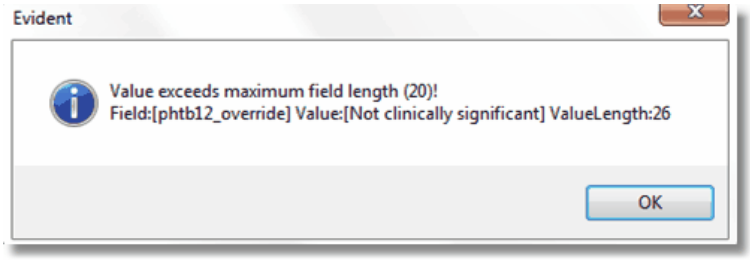
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time:

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Patient Specific Dosing Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

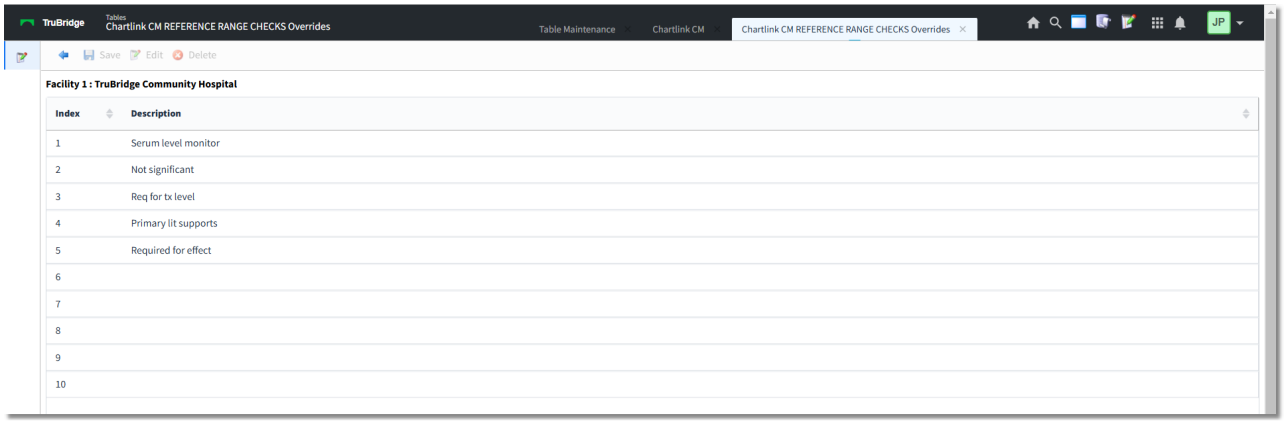
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back arrow**  **:** Select to return to the previous screen.

Reference Range Overrides

Up to 10 override reasons may be entered to address reference range checks. The Reference Range Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Reference Range Overrides**



Reference Range Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

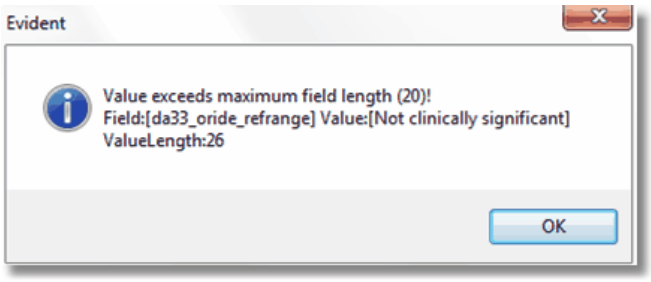
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time:

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **Reference Range Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

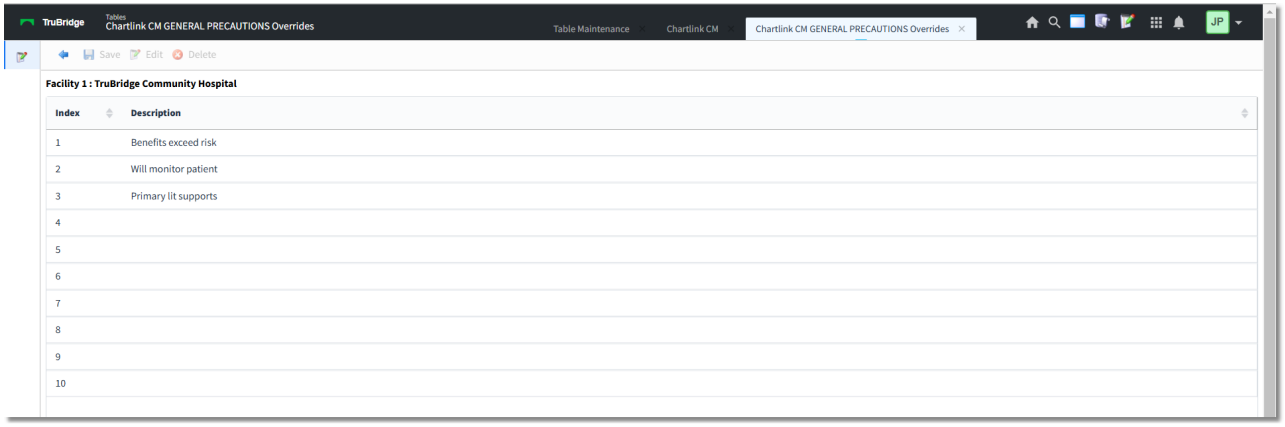
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back Arrow**  **:** Select to return to the previous screen.

General Precaution Overrides

Up to 10 override reasons may be entered to address general precaution checks. The General Precaution Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **General Precaution Overrides**



General Precaution Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

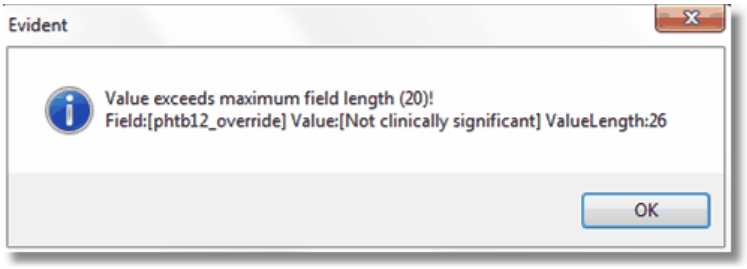
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time:

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Clinical Monitoring** > **Overrides** > **General Precaution Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back Arrow**  **:** Select to return to the previous screen.

11.2 Reminders

This table is no longer in use.

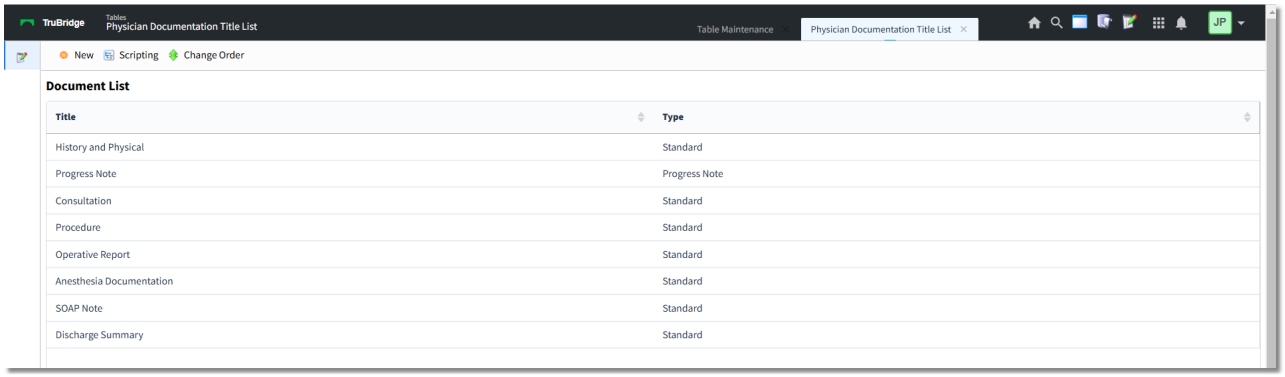
11.3 Physicians

Please refer to Physicians chapter in the Table Maintenance-Control User Guide for more information on this topic.

11.4 Physician Documentation Titles

The physician documentation titles table will allow multiple titles to be set up for physician use. The type may be designated as standard or progress note.

Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Titles**

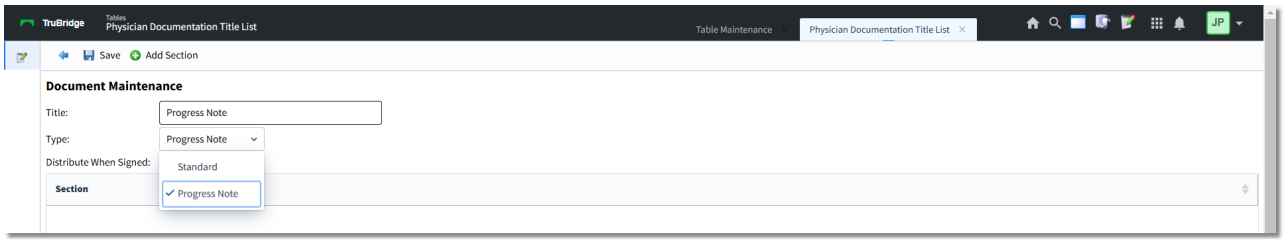


Document List

- **Title:** The table allows an unlimited number of titles to be created. Titles will display in physician documentation in the same order as in the table.
- **Type:** The note titles may be saved as a type of Standard or Progress Note. The Progress Note type is a core objective for Stage 2 of Meaningful Use. When a provider selects a note title with a type of Progress Note and completes and signs the note, this will be recorded on the MU Stage 2 Report.

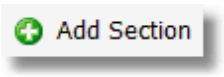
To create a new Title, the user may select the **New** button and enter a title and select a note type**.**

Select **Web Client** > **Tables** > **Clinical** > **Physician Documentation Titles** > **Select Title** > **Edit**



Document Maintenance

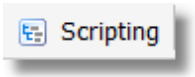
Select **Save**  to save any changes.

The **Add Section** 

button will allow sections to pull to the documentation area in Physician Documentation when the title is selected.

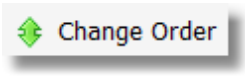
***NOTE**: Please see the Physician Documentation Sections 210 chapter for further information.*

The blue back arrow will return the user to the Document List screen.

Scripting 

allows the set up of a note to pull to Physician Documentation.

***NOTE**: Please see the Scripting 166 chapter for further information.*

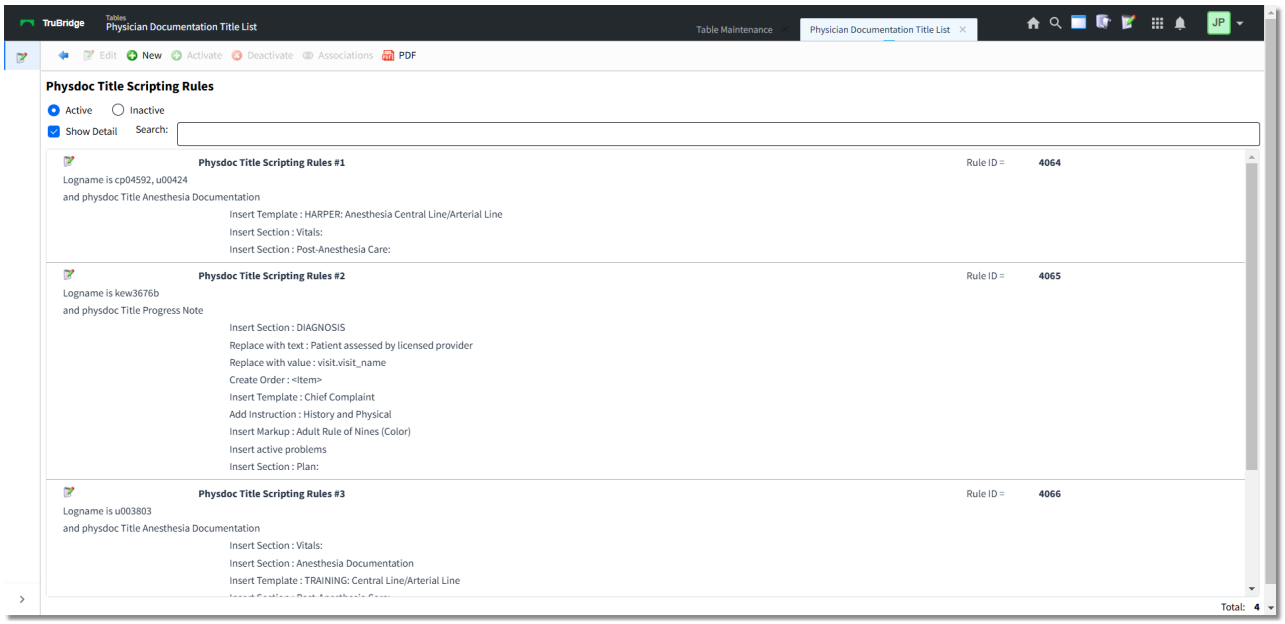
The **Change Order** 

button allows the user to change the order in which the titles appear in the list. When selected, new buttons will appear on the action bar at the bottom. Once a title has been selected from the list, the user may then move it to the top of the list, the bottom of the list or move it up/down an entry in the list.

Scripting

Scripting allows certain information to pull when a note title is selected in Physician Documentation. Information set up in this table will determine what pulls to the note.

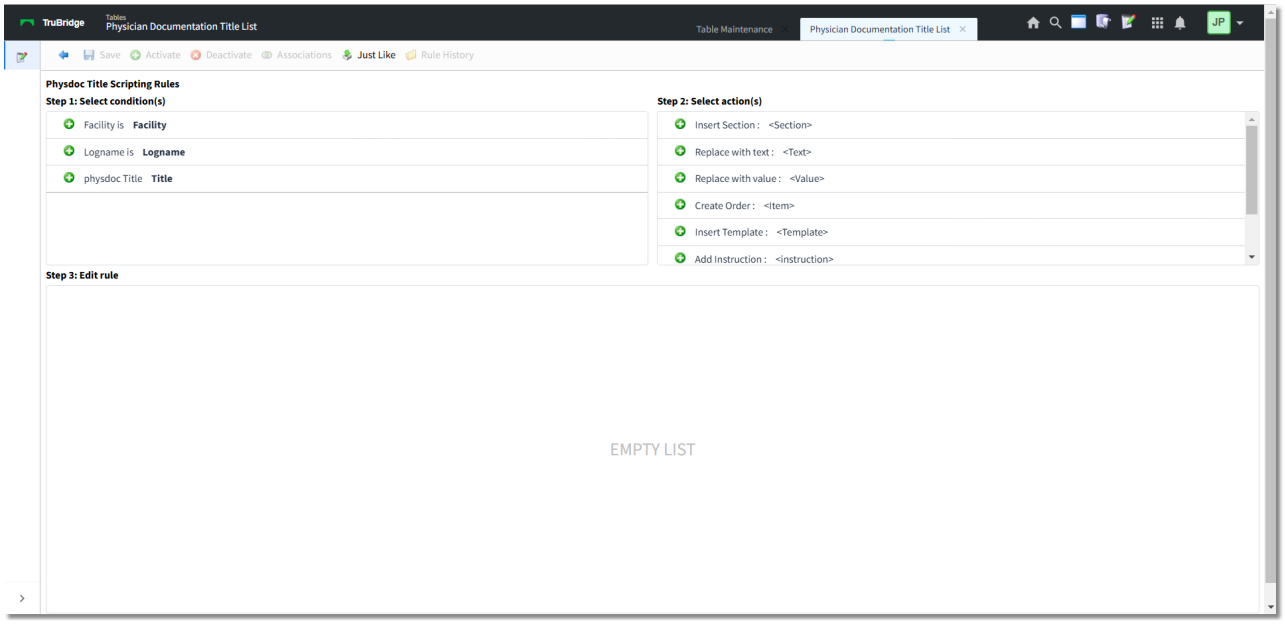
Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting**



Rules

Any existing scripts will pull in a list format for the user to select to edit. The user may highlight any title and then select Edit to be taken to the script setup screen or simply double-click the title. If the user wishes to create a new script, they may select the New 

button. The Deactivate button may be selected to place the rule in the Inactive file.



Rules

Select **OK** to save changes to a Title Script. Select **New** to create a new Title Script. Select **Delete** to delete a Title Script.

Step 1: Select conditions(s)

- **Logname is User:** Select this option to assign a script to a specific UBL.
- **Facility is Facility:** Select this option if the facility has multiple companies and this script should apply to certain companies.

NOTE: *If a user or company is not specified, the script will apply to all users and all companies.*

- **Physdoc Title is Title:** Select this option to attach a script to a note title.

Step 2: Select action(s)

Select the  **green circle icon** next to each option to select that item.

- **Add Section Section:** Select this option to name a section in the script. This will pull bold and underlined.
- **Add text Text:** Select this option to enter a free-text sentence.
- **Add value DataValue:** Select this option to select a database code. This allows information from the patient's visit to pull to the script.

- **Create Order Item:** Select this option to pull order(s) to the script.
- **Insert template Template:** Select this option to pull a template to the script.
- **Insert instruction Instruction:** Select this option to pull an instruction to the script.
- **Insert markup Markup:** Select this option to pull a markup to the script.
- **Insert active problems:** Select this option to pull the problem list to the script.

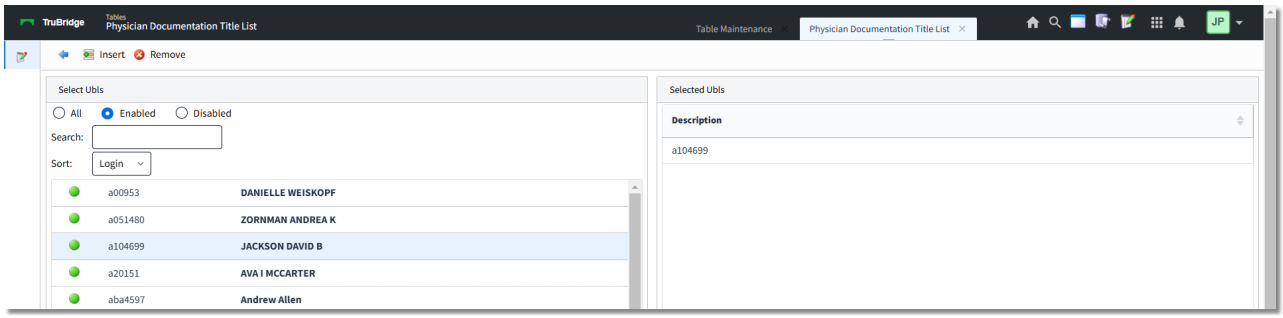
Select the  **green plus sign** next to each option to add additional items.

Step 3: Edit the rule description

NOTE: *The order that the options in Step 2 are selected will determine the order the options pull to Step 3 and to the note.*

- **Logname:** Select **Logname** to select the UBL for this script and select **Insert**.

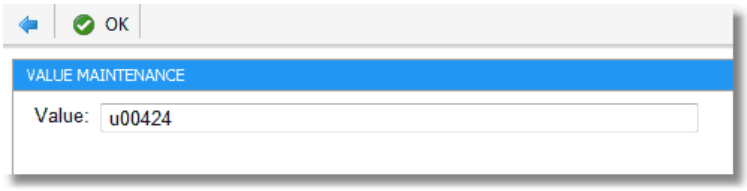
Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **User**



Set values

- **Save:** Select this option to save any changes.
- **New Value:** Select this option to add a UBL.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **User** > **New Value**

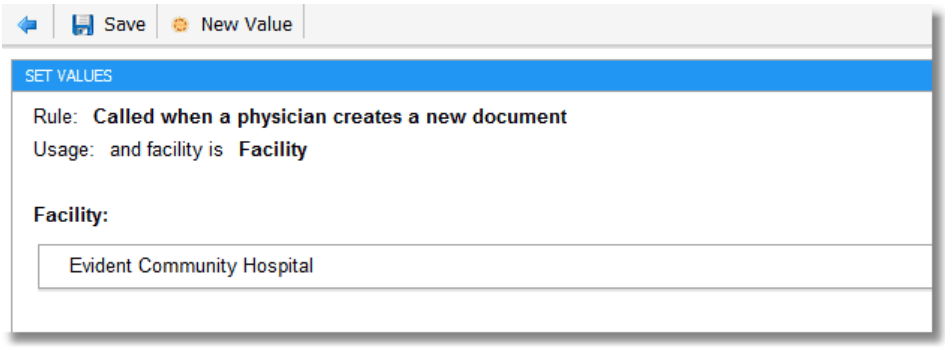


Value maintenance

Select **OK** to save the information.

- **and facility is Facility:** Select **Facility** if the facility has multiple facilities and this script should be utilized by certain facilities. The facility number should be indicated in the value maintenance field.

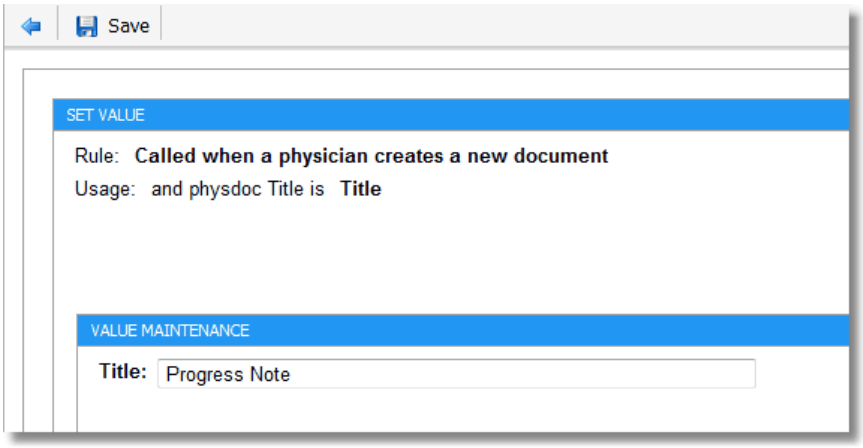
Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **Facility**



Set values

- **Save:** Select this option to save any changes.
- **New Value:** Select this option to add a facility.
- **and physdoc Title is Title:** Select **Title** to enter the note title for the script.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **Title**



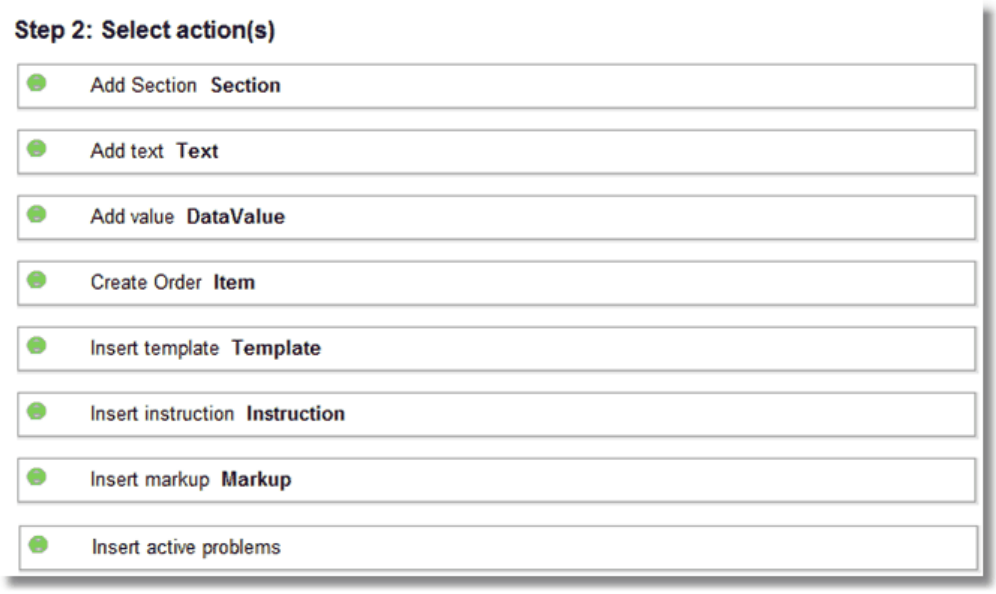
Set value

Select **Save** to save the information.

NOTE: *The title must be entered exactly as it is in the Physician Documentation Titles table.*

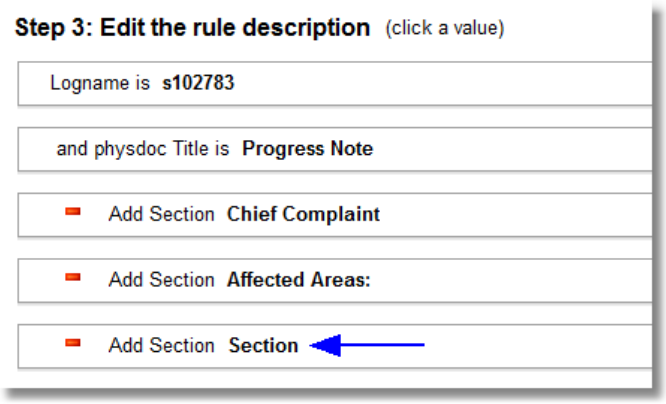
- **Add Section Section:** Select **Section** to create a header in the script.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **Section**

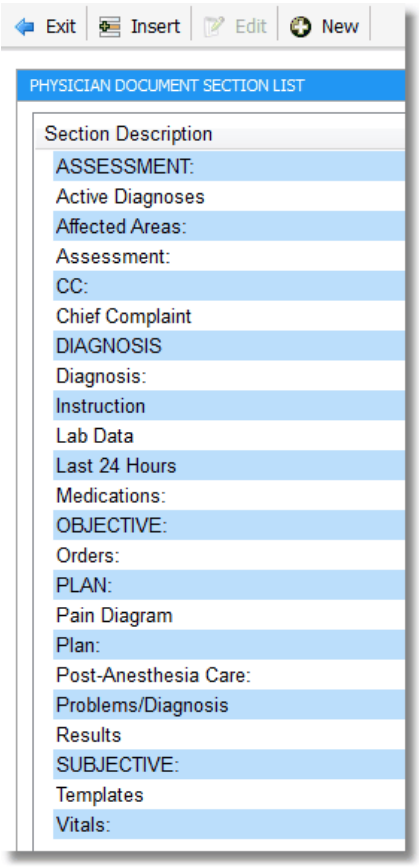


Rules

Once the user selects the green circle next to Add Section Section, the action will move under Edit the rule description. The user will then select the bold **Section** and this will open the Physician Document Section List.



Rules



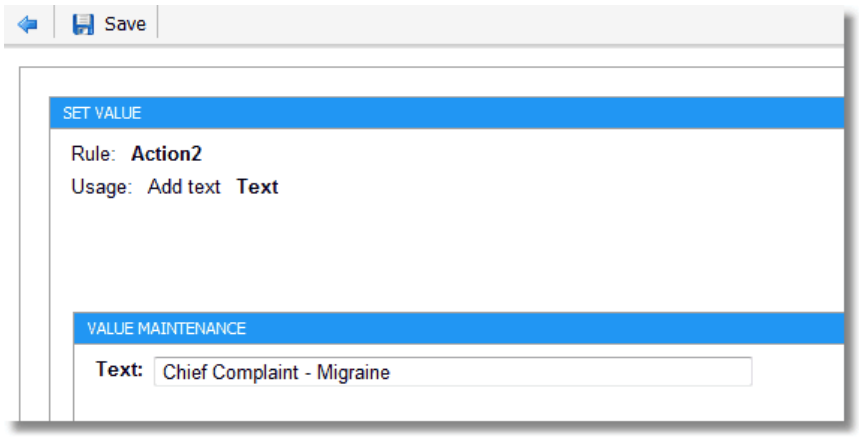
Physician Documentation Section List

From the Section Description list, the user may select a section and **Insert** to add the section to the script. Select **Exit** to exit this table. Select **New** to create a new Section.

***NOTE**: Please see the chapter Physician Documentation Sections 210 for further information.*

- **Add text Text:** Select **Text** to enter a free-text field.

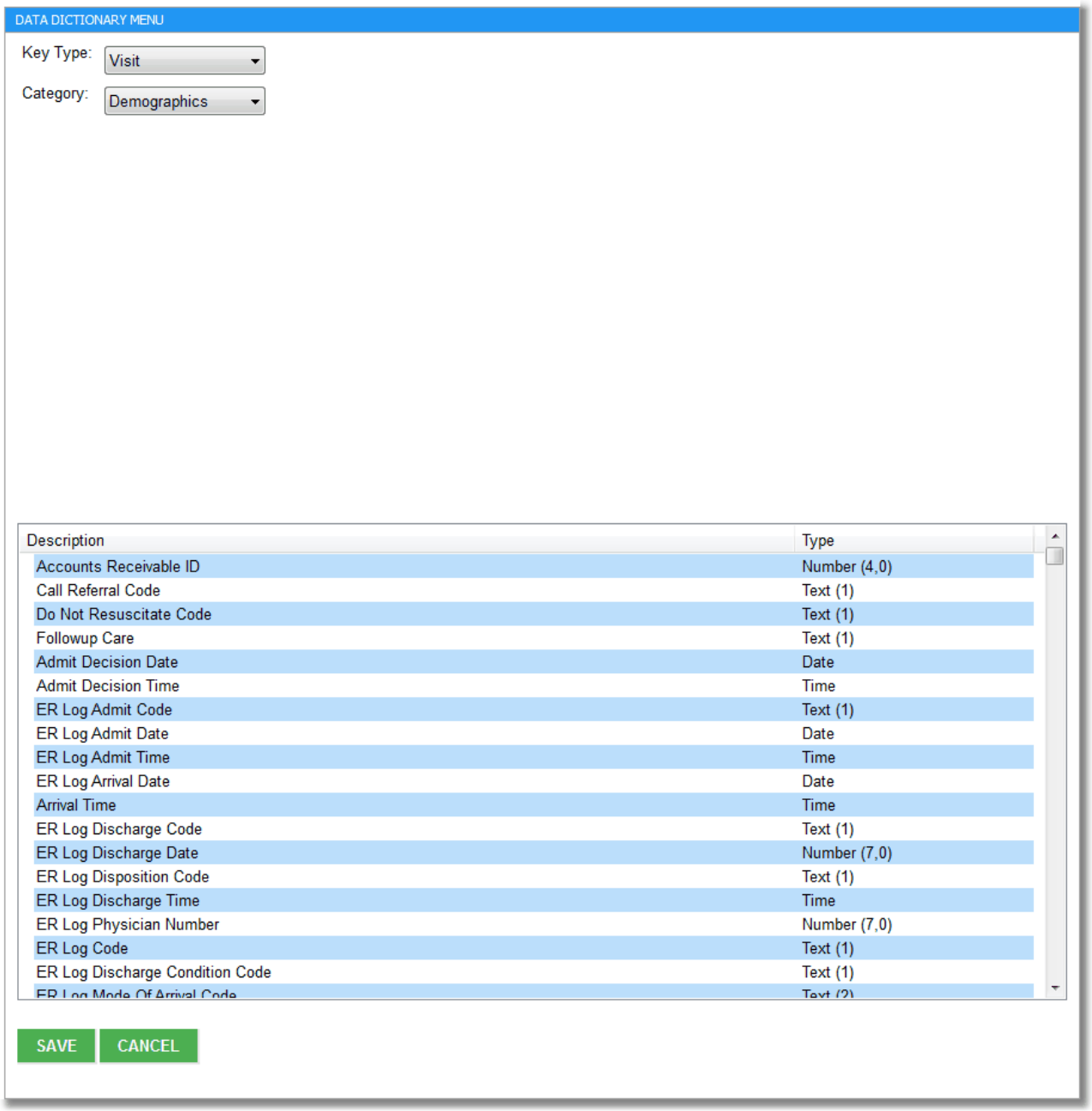
Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **Text**



Set value

- **Add value DataValue:** Select **DataValue** to select a database code. This allows information from the patient's visit to pull to the script.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **DataValue**



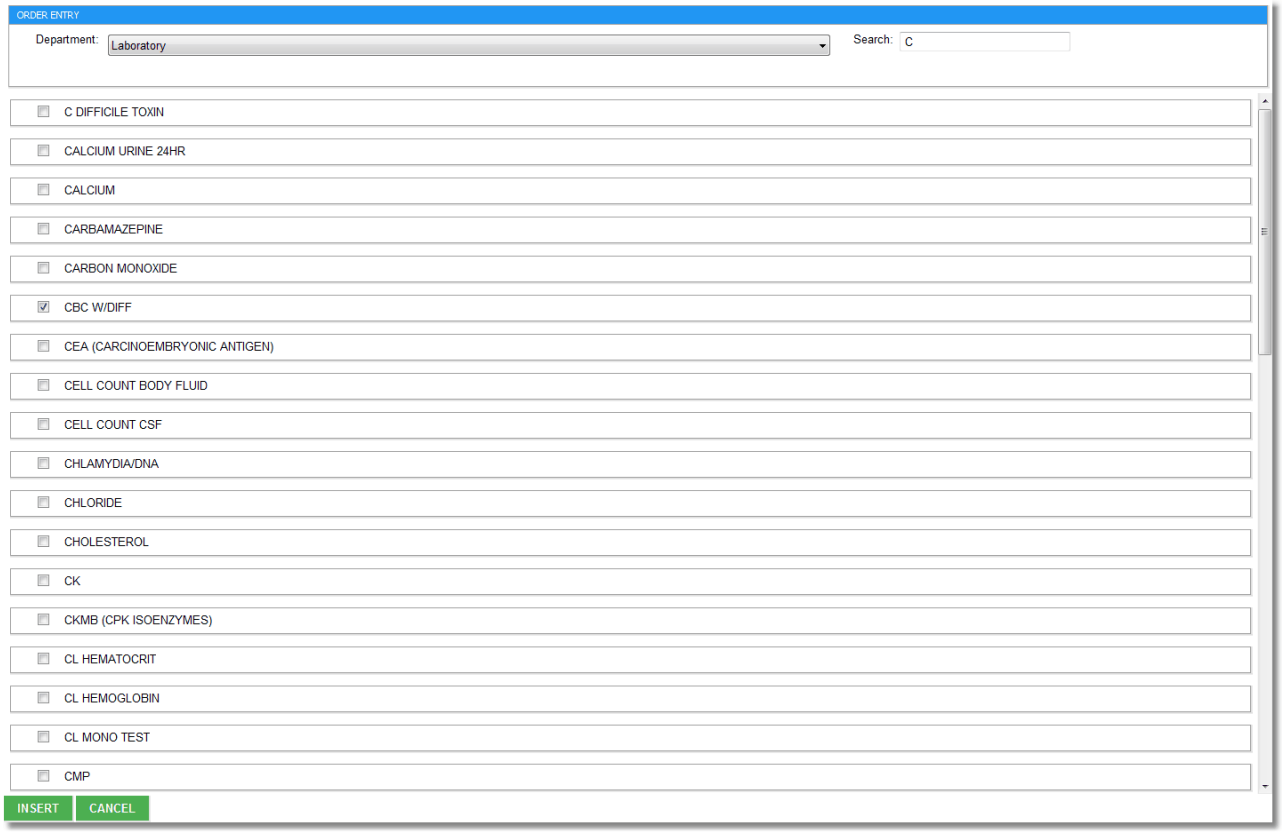
Data Dictionary Menu

- **Key Type:** Select **Visit** from the drop-down.
- **Category:** Select **Clinical Data** from the drop-down.

Select the desired datavalue and then select **Save**. Select **Cancel** to exit the table without saving. **New** is for future use.

- **Create Order Item:** Select **Item** to select an order to pull to the script.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **Item**



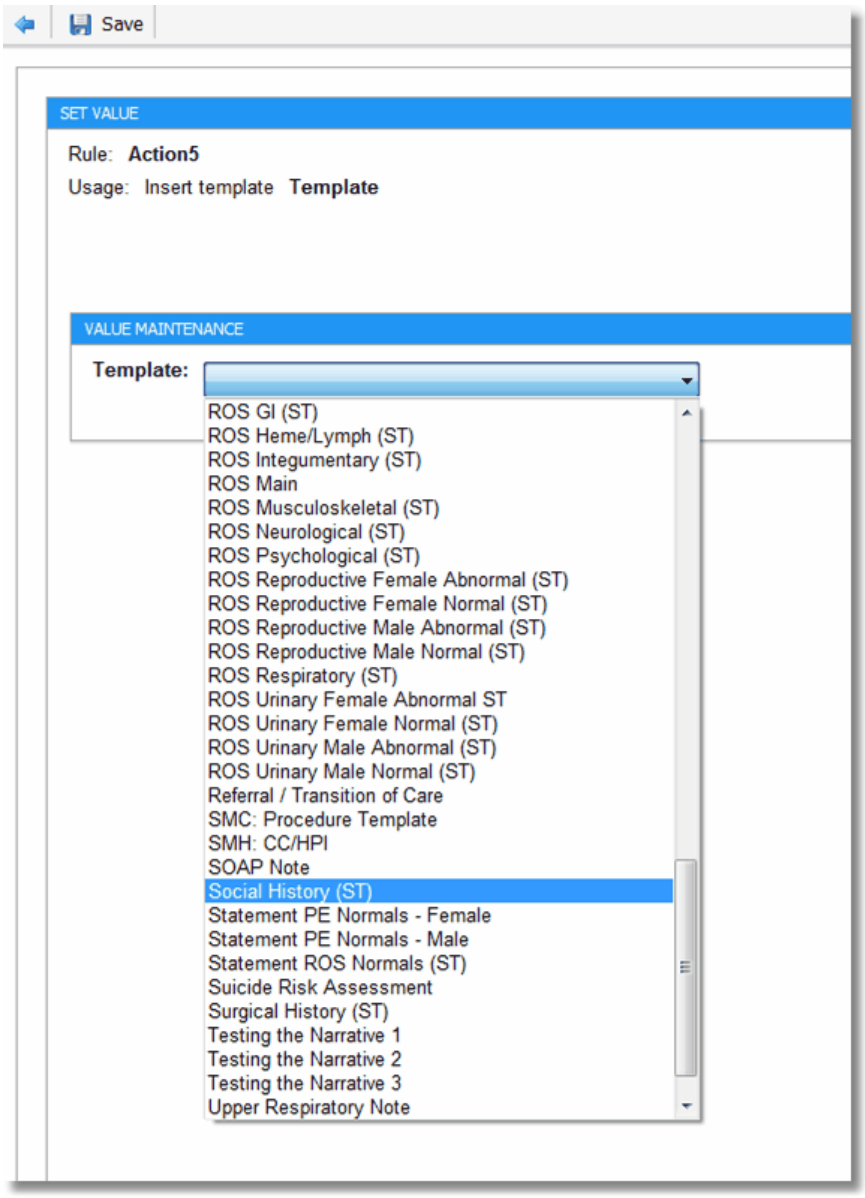
Order Entry

- **Department:** Select the desired department from the drop-down.
- **Search:** Enter in the desired order.

Select the checkbox of the desired item. Then select **Insert** to save this order. Select **Cancel** to exit the table without saving.

- **Insert template Template:** Select **Template** to select a template to pull to the script.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **Template**



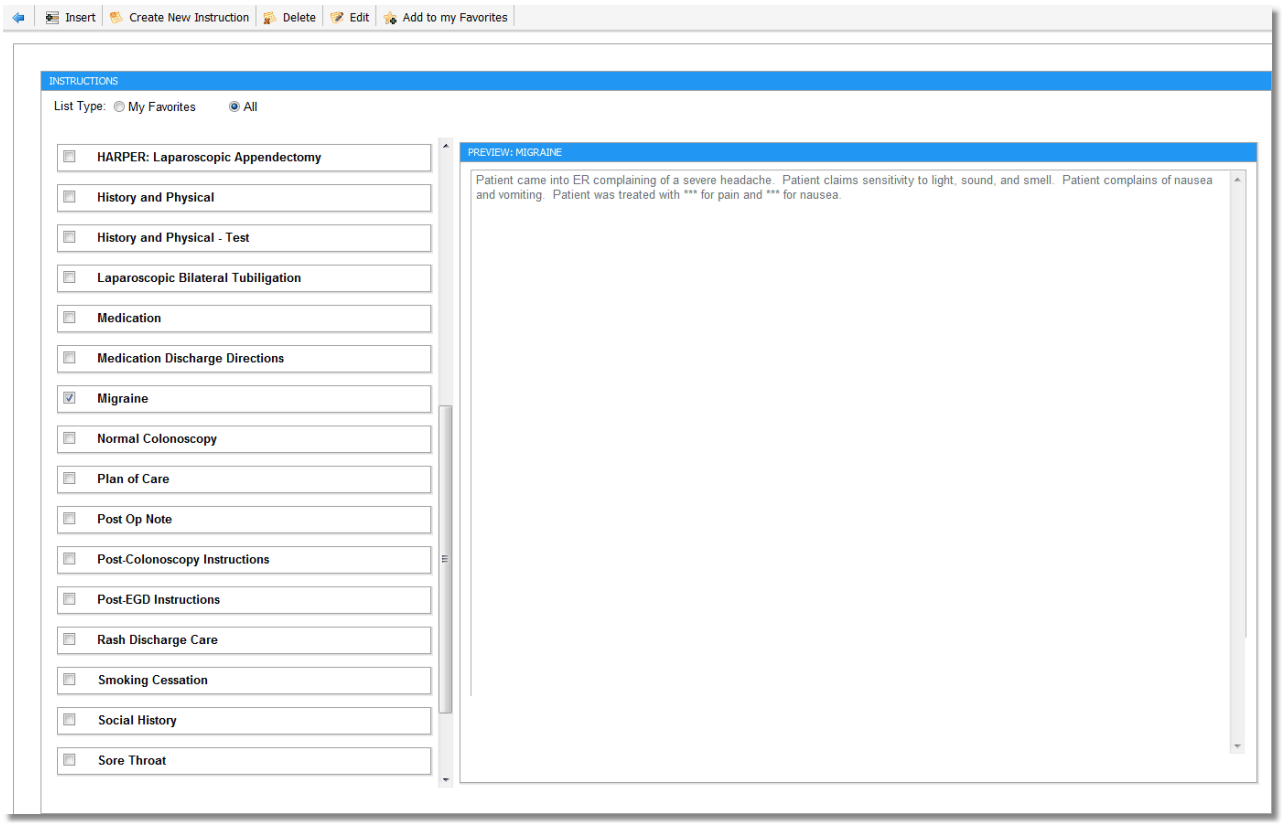
Set value

- **Template:** Select the desired template from the drop-down.

Select **Save** to save the information.

- **Insert instruction Instruction:** Select **Instruction** to select or create an instruction to pull to the script.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **Instruction**



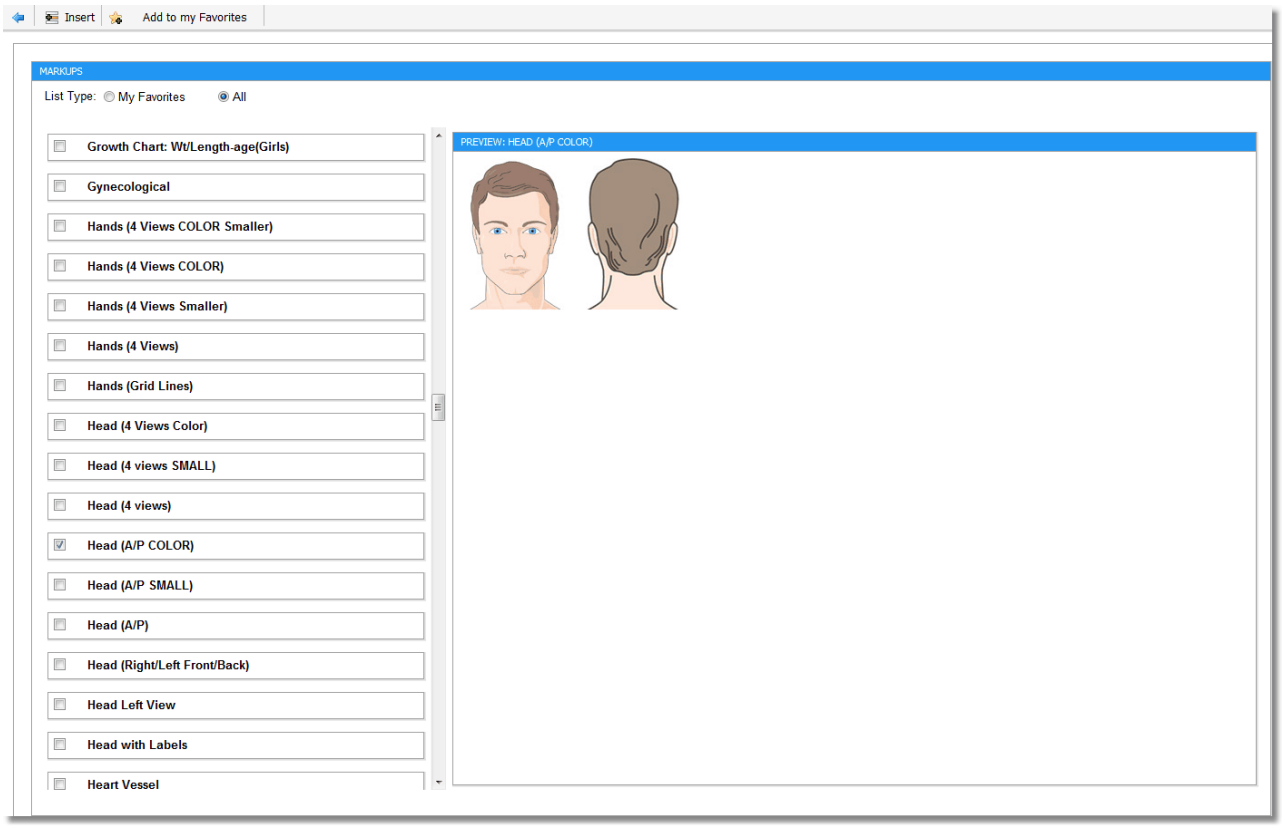
Instructions

Select the checkbox of the desired Instruction or select **Create New Instruction** to enter a new instruction into the table.

Select **Insert** to insert this instruction into the script or select **Cancel** to exit the table without saving.

- **Insert markup Markup:** Select **Markup** to select a markup to pull to the script.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **Markup**



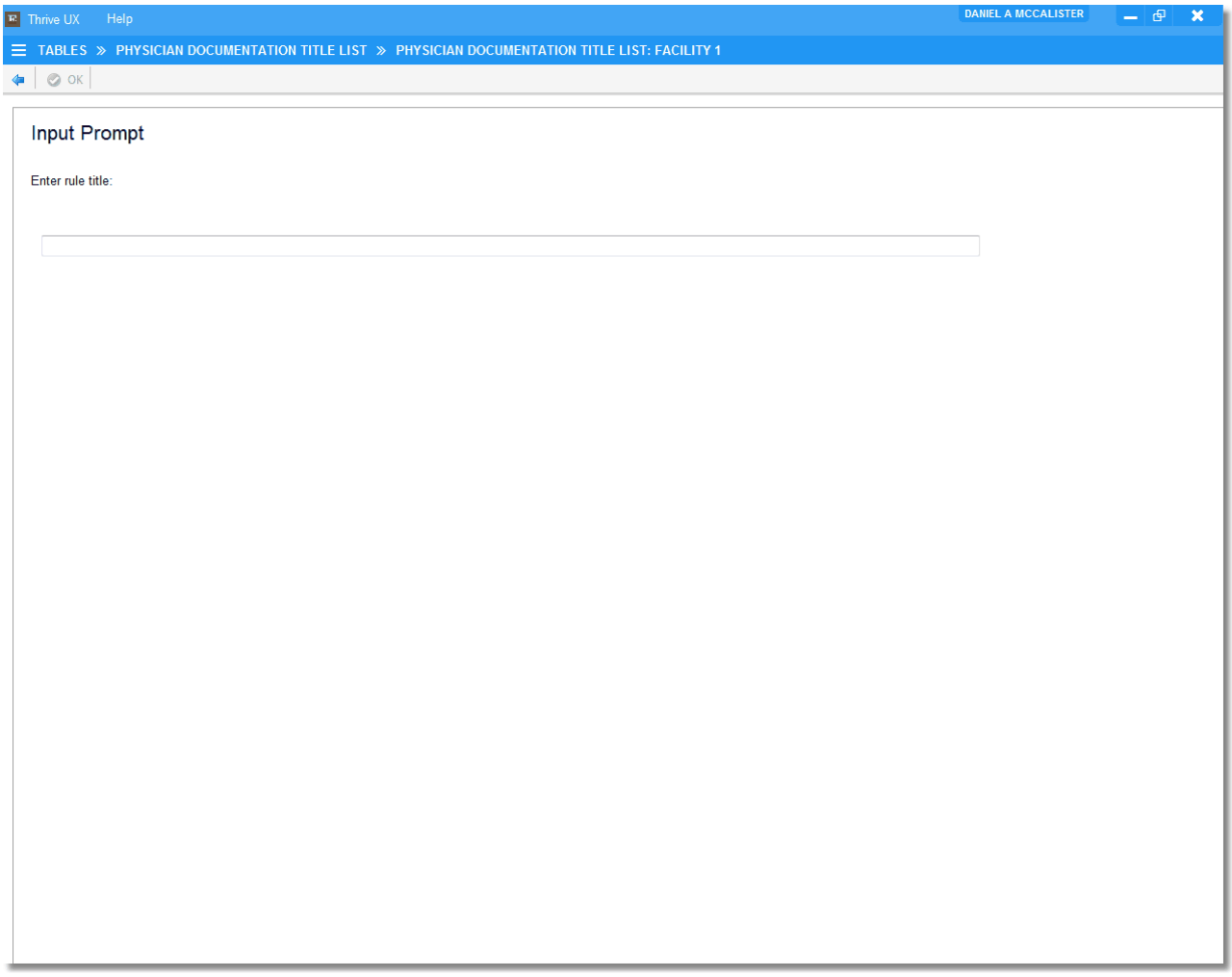
Markups

Select the checkbox beside the desired markup.

Select **Insert** to insert this markup into the script or select **Cancel** to exit the table without saving.

- **Insert active problems:** This option will pull the active problems listed in the Physician Problem List to the script.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Titles** > **Scripting** > **Save**



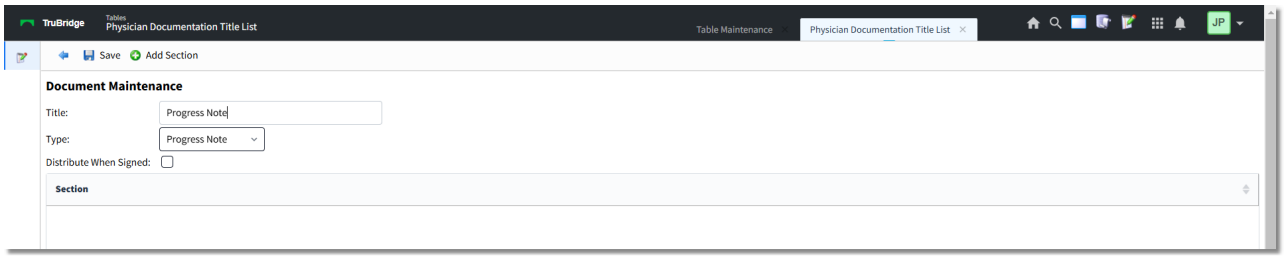
Rule Title

Once **Save** has been selected, the user will be prompted to give the Title Script a rule title. This title will be saved alphabetically in the Rules list**.**

Report Distribution

A specific Physician Documentation title may be set for report distribution.

Select **Web Client > Tables > Clinical > Physician Documentation Titles > Select Title > Edit**



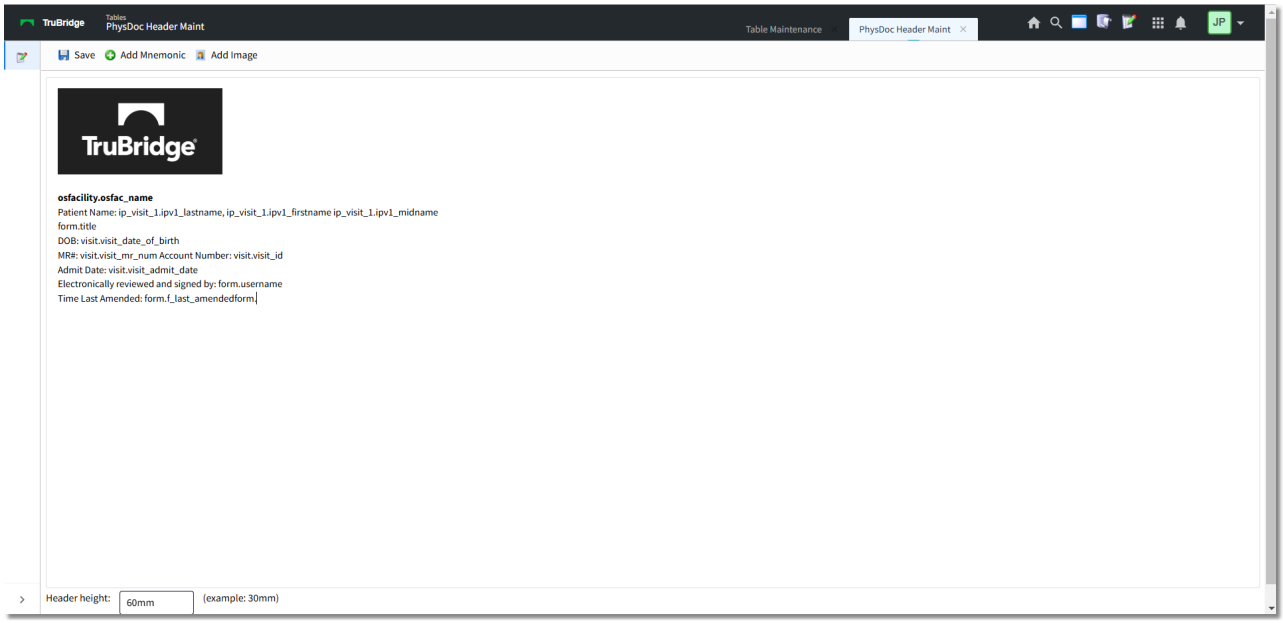
Document Maintenance

Select the **Distribute When Signed** checkbox in order to enable a provider to receive signed Physician Documentation documents by fax, print or various modes. The provider must be set up initially on Page 3 of the Physician Maintenance table. See the Physician chapter in the Table Maintenance - Control User Guide.

11.5 Physician Documentation Header

The header will pull to the top of each page of the note that is signed via Physician Documentation.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Header**



Physician Documentation Header

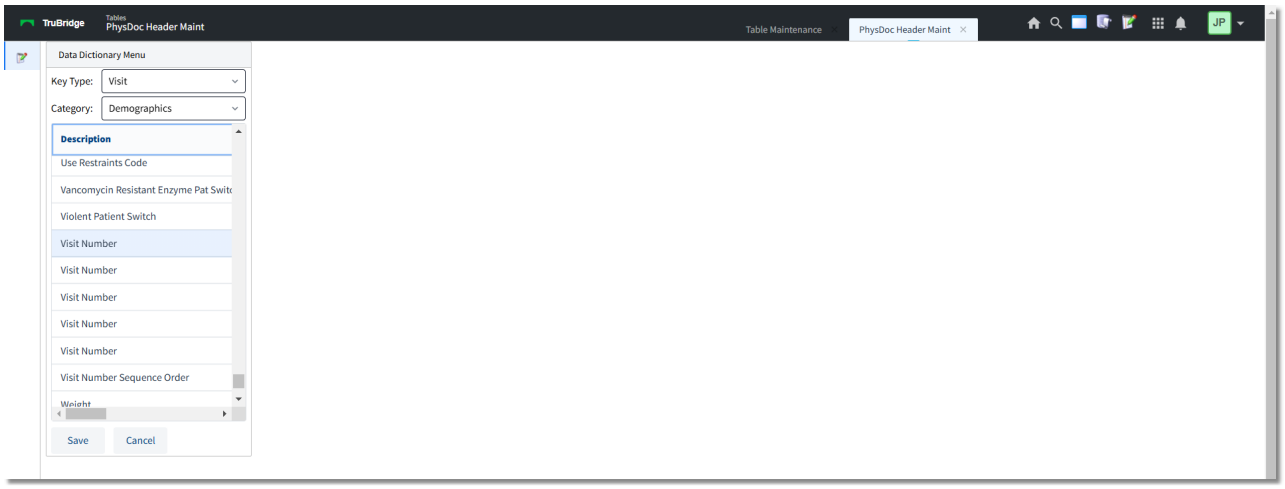
NOTE: *Any of the above information may be bold, italicized, underlined, centered, left/right aligned, large/small font. Highlight the desired information and right click with the mouse to make the changes.*

Header height: Enter the desired height of the header.

Select **Save** to save the information.

Select **Add Mnemonic** to add information to the header.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Header** > **Add Mnemonic**



Data Dictionary Menu

- Select **Visit** from the drop-down.
- Select **Demographics** from the drop-down.

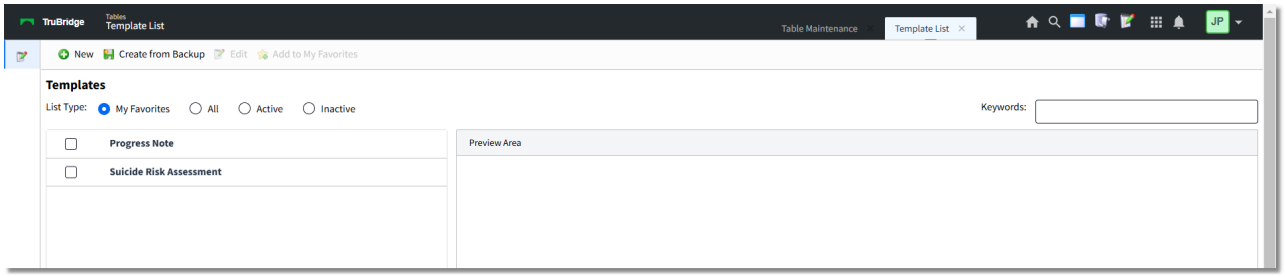
Select the desired datavalue and then select **Save**. Select **Cancel** to exit the table.

Add Image allows a path to be entered to the image to be included on the Physician Documentation header. Contact TruBridge Software Support for assistance with this.

11.6 Physician Documentation Templates

This chapter will explain the process for creating a new template.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Templates**
or
Select **Web Client** > **Charts** > **Inpatient Test Account** > **Documentation** > **Templates**



Templates

List Type

- **My Favorites:** Select this radio button to view the templates that the signed-on UBL has saved to favorites.
- **All:** Select this radio button to view a list of all library templates.
- **Active:** Select this radio button to see all Active templates.
- **Inactive:** Select this radio button to see all Inactive templates.

NOTE: *The Active and Inactive radio buttons are only available in Table Maintenance.*

- To preview an existing template, select the checkbox next to the template title or select the template title. The template will then appear in the preview window on the screen.
- **Keywords:** Enter in the desired template name to lookup the template.
- **New:** Select this option to create a new template.
- **Create from Backup:** This option is used by conversion.
- **Edit:** After selecting the desired template, select **Edit** to make changes to that template.
- **Add to my Favorites:** After selecting the desired template, select this option to add the template to My Favorites.

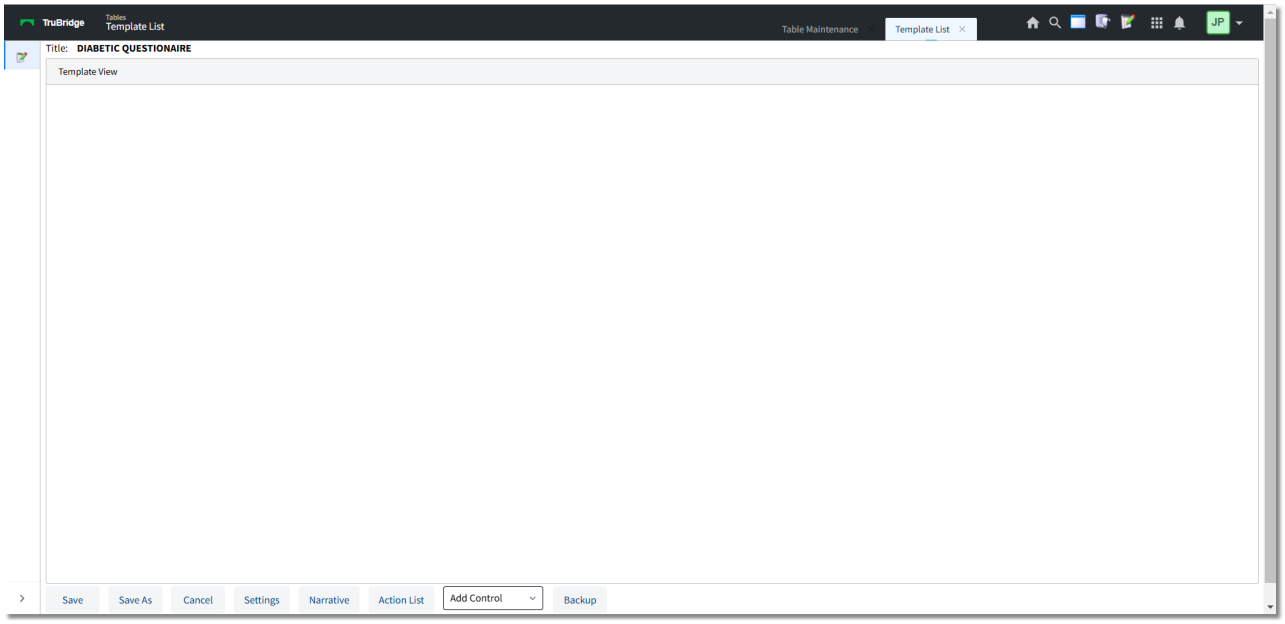
NOTE: *The Insert and Cancel options are only available in Chartlink.*

Template View

The Template View screen is where new templates are built and existing templates are edited. If selecting to create a New template, the screen will initially appear blank with only the grid on the page.

To build a new template, select **New**.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Templates** > **New**

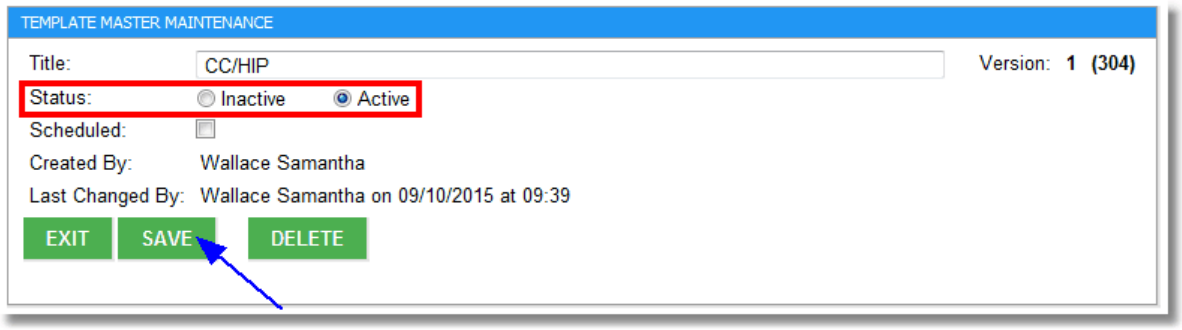


Template View

The Template View window is in a dot grid layout to allow the template builder to be able to align the controls.

- **Save:** Select this option to save any changes made to the template.
- **Save As:** Select this option to copy the existing template to create a new template. The system will prompt for the new template name to be entered..
- **Cancel:** Select this option to cancel any changes made to the template.
- **Settings:** Select this option to make any changes to the Template Master Maintenance.

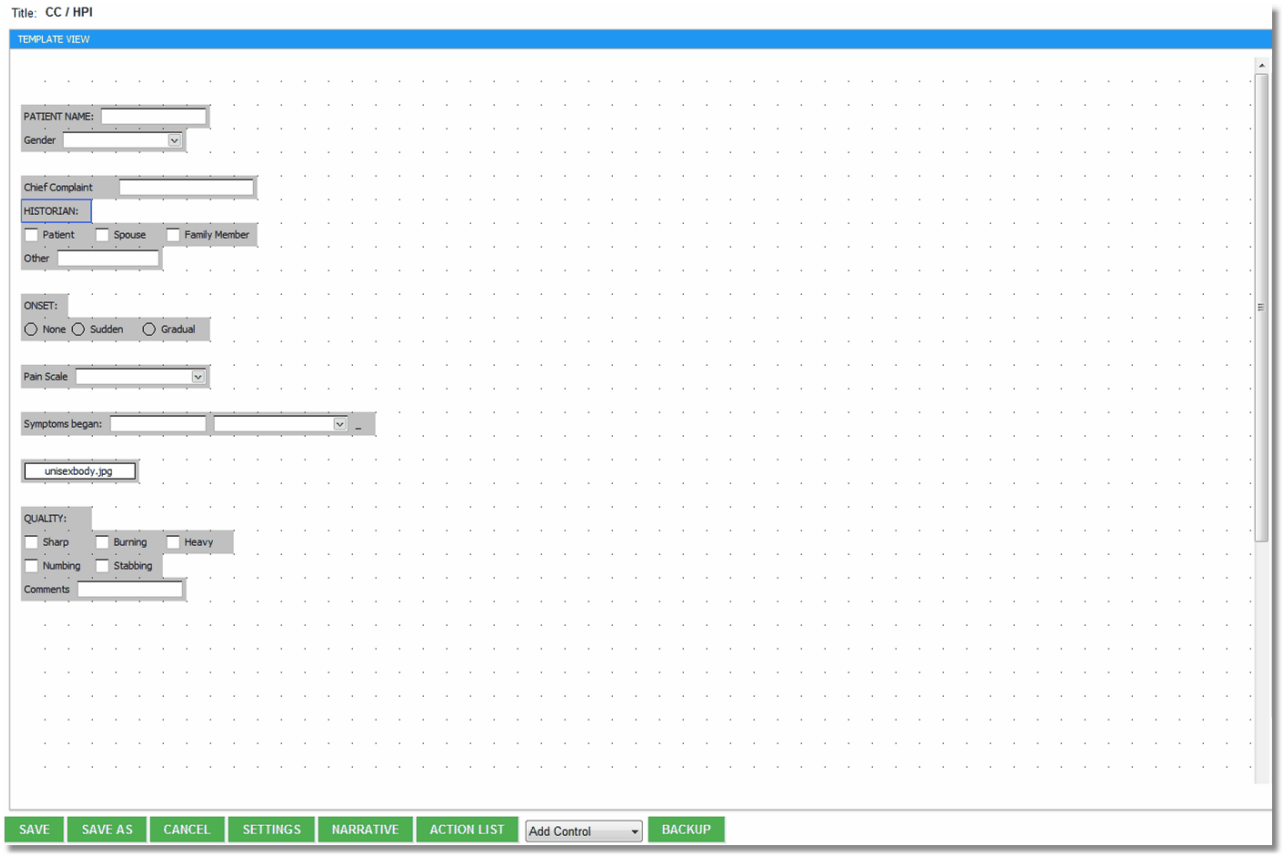
Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Templates** > **New** > **enter template title** > **Settings**



Template Master Maintenance

- **Title:** This is the title of the template.
- **Status:** This allows a template to be active or inactive.

  NOTE: *Inactive templates are only viewable in Table Maintenance.*
- **Created By:** Shows the name associated with the UBL that created this template.
- **Last Changed By:** Shows the name of the last user that edited the template along with the date and time the editing occurred.
- **Exit:** Select this option to exit Settings.
- **Save:** Select this option to save any changes made to the Title or Status.
- **Delete:** Select this option to delete this template. The system will prompt, "Are you sure you want to delete this template?" Select **Yes** to delete the template. Select **No** to keep this template.
- **Narrative:** See Narrative 208.
- **Action List:** Select this option to see information that has been set up in the Action field of any text boxes, radio buttons, drop-down menus or checkboxes.
- **Add Control:** See following chapters for control functionality.
- **Backup:** This option is used by the TruBridge conversion department.

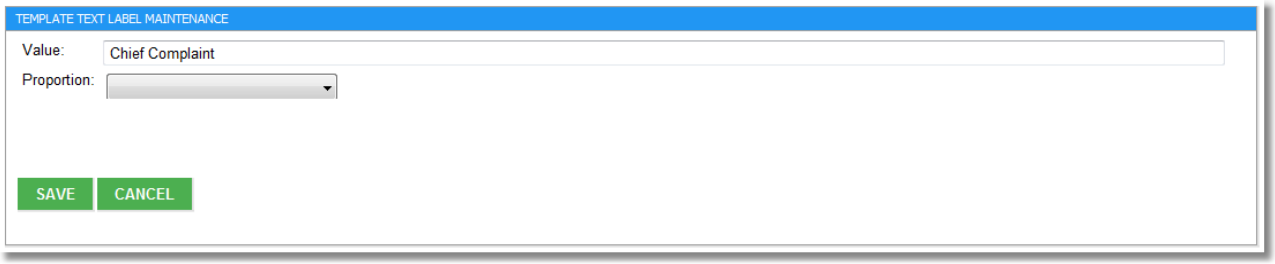


Template View

Text Label

A Text Label may be used as a header or as a blank space in the template.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Text Label**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Text Label**



Template Text Label Maintenance

- **Value:** Enter the header information.
- **Proportion: Leave this field blank.**

NOTE: *To use a Text Label as a blank space in the template, leave both fields blank. This feature is most often used when adding a proportion.*

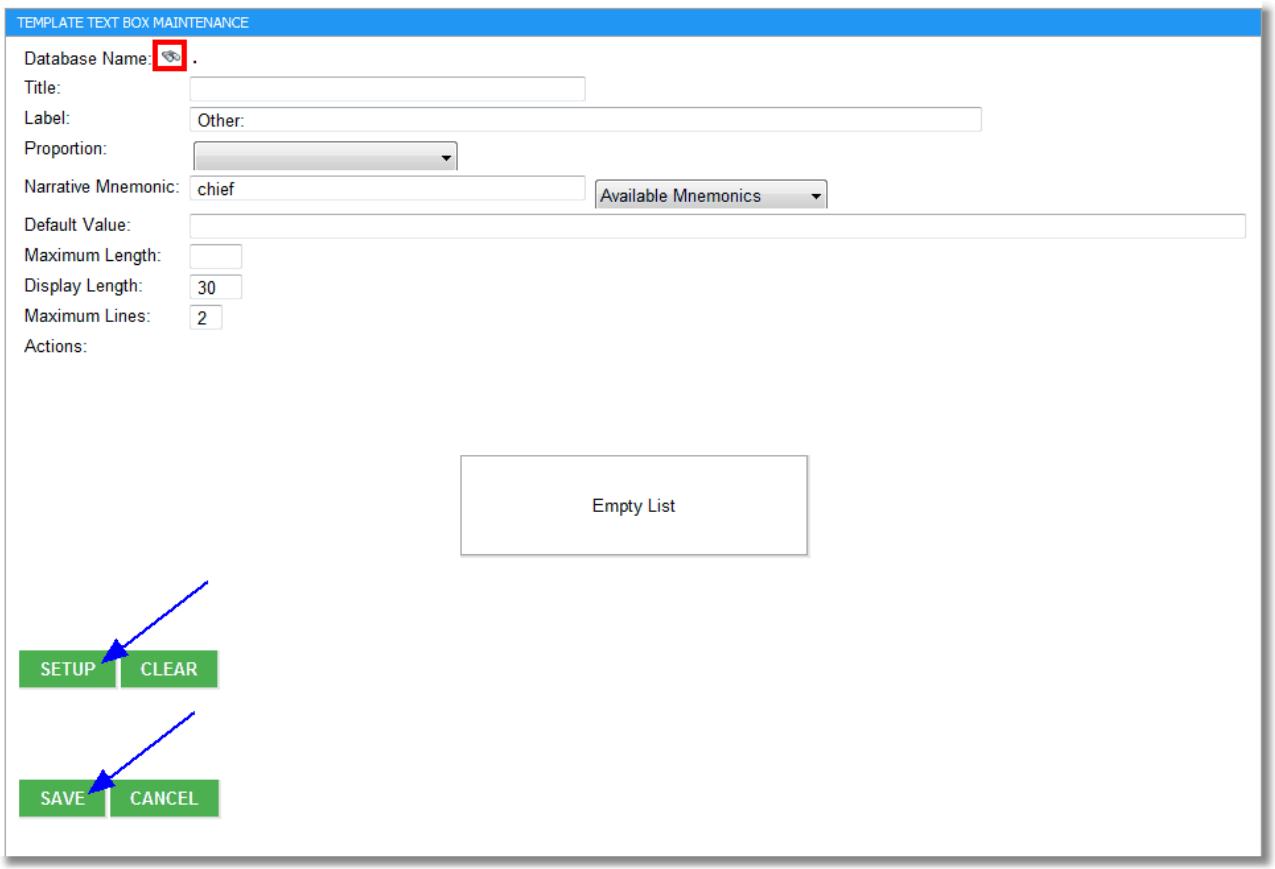
Select **Save** to save the information.

Select **Cancel** to exit the table without saving.

Text Box

Text boxes are utilized for free-texting within a template or pulling in patient information if a Database Name is attached.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Text Box**



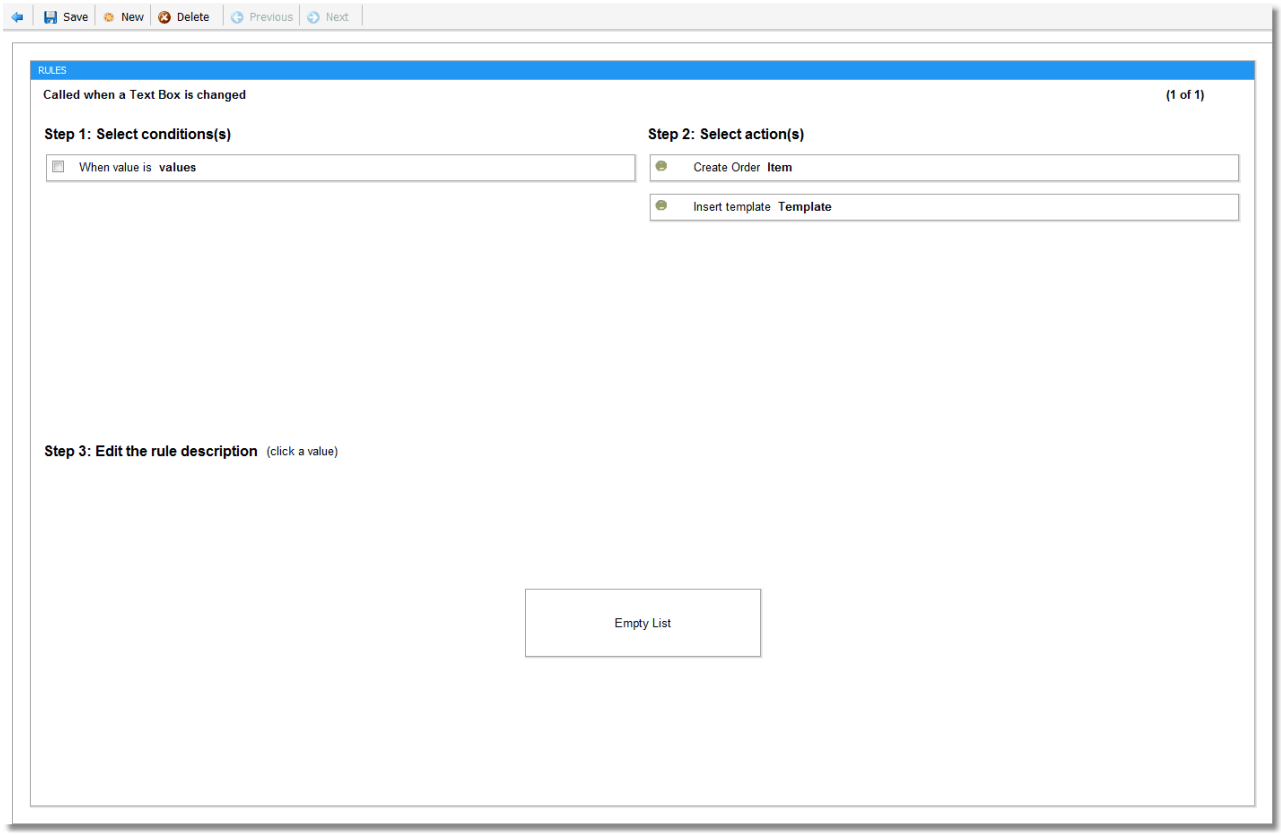
Template Text Box Maintenance

- **Database Name:** Select the  **binoculars icon** to select a datavalue to automatically pull to this text box.
- **Title:** This field should be left blank. If information is entered in this field, it will be viewable in the Narrative Available Mnemonics Control window only.
- **Label:** Leave this field blank or enter the label for the text box. Information entered here will display on the template view.
- **Proportion:** This field should be left blank.
- **Narrative Mnemonic:** Enter the user-defined mnemonic. This mnemonic allows information to pull to the note. Spaces and special characters should not be used.
- **Available Mnemonics:** Select the drop-down menu to select an existing mnemonic. This option would be used when creating a group.
- **Default Value:** This field should be left blank. If information is listed here, it will display as pre-populated inside the text box.
- **Maximum Length:** Leave this field blank. If a value is placed in this field, that value will limit the number of characters that can be entered in the text box.
- **Display Length:** Enter the number of characters to be displayed for this text box.
- **Maximum Lines:** Enter the number of lines for this text box. A value placed in this field will allow the display height of the text box to be increased.
- **Actions:** Displays orders or templates that are associated with this text box.
  - **Setup:** Select this option to set up orders or templates for this text box.
  - **Clear:** This option is for future use.

Select **Save** to save the information.

Select **Cancel** to exit the table without saving.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Text Box > Setup**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Text Box > Setup**



Text Box Rule Builder

Select **OK** to save changes. Select **New** to create a new action. Select **Delete** to delete the action.

The **Previous** and **Next** options will be illuminated if there is more than one rule setup within the template. This will allow for toggling back and forth without leaving the rules screen.

Step 1: Select conditions(s)

- **When value is values:** Select this option to have the sub template or order pull when the value is typed in the text box in documentation.

Step 2: Select action(s)

Select the  **green circle icon** next to each option to select that item.

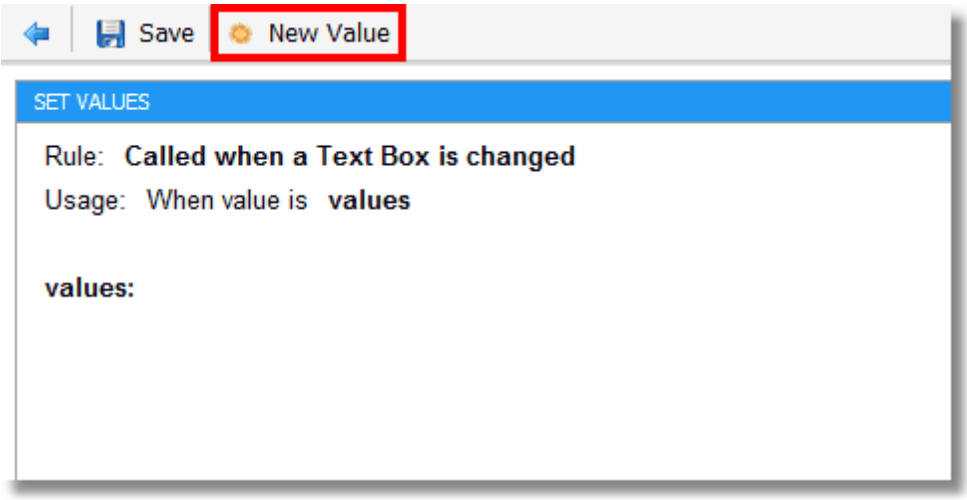
- **Insert Order Item:** Select this option to pull order(s) in the template.
- **Insert template Template:** Select this option to have a template pull within the main template.

Select the  **green plus sign** next to each option to add additional items.

Step 3: Edit the rule description

- **When value is values:** Select **values**.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control >Text Box > Setup > values**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Text Box > Setup > values**



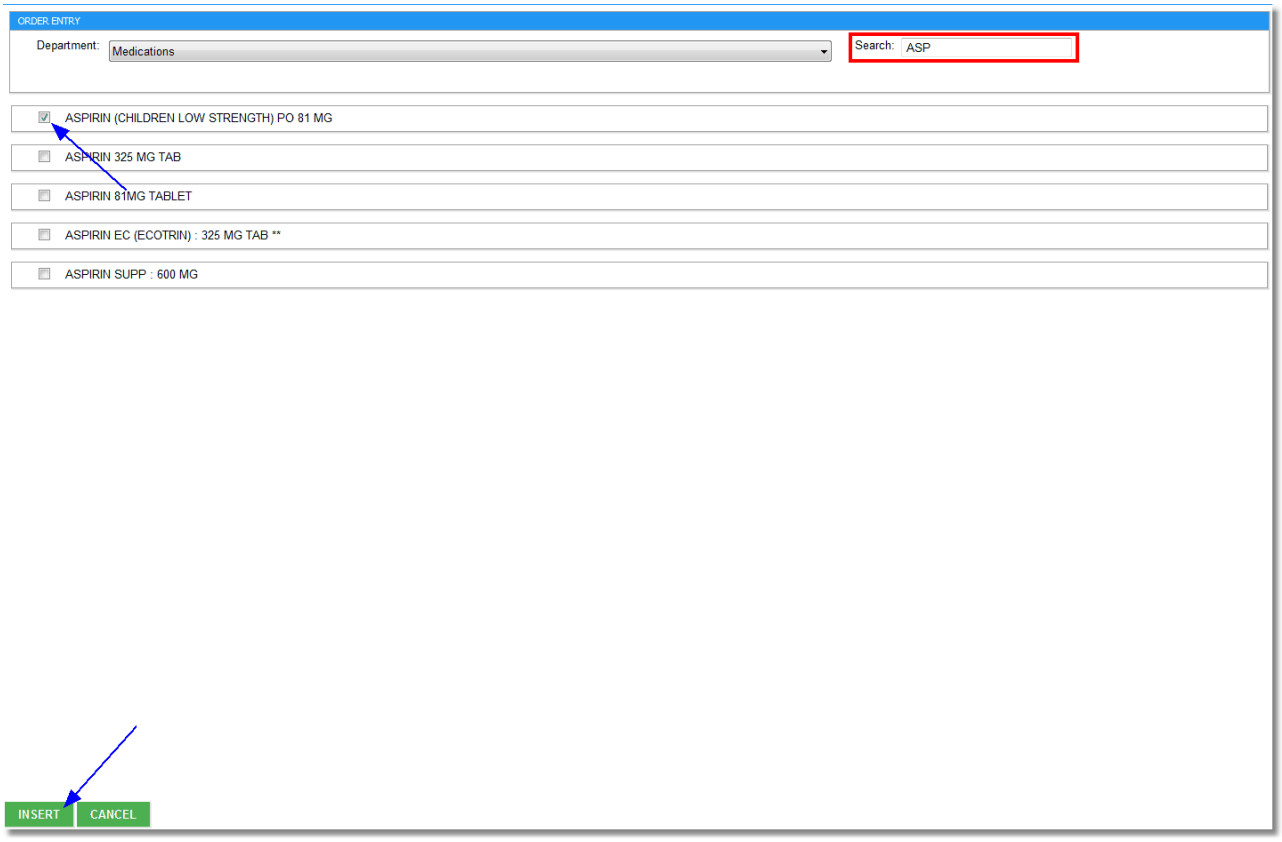
Text Box - Set Values

- **Save:** Select this option to save any changes.
- **New Value:** Select this option to add a value.

NOTE: *When the provider is documenting on the template, if he/she enters this value into this text box the order/templates will pull based on how the information is entered below. The value must be entered exactly as it is here.*

- **Create Order Item:** Select **Item**.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Text Box > Setup > Item**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Text Box > Setup > Item**



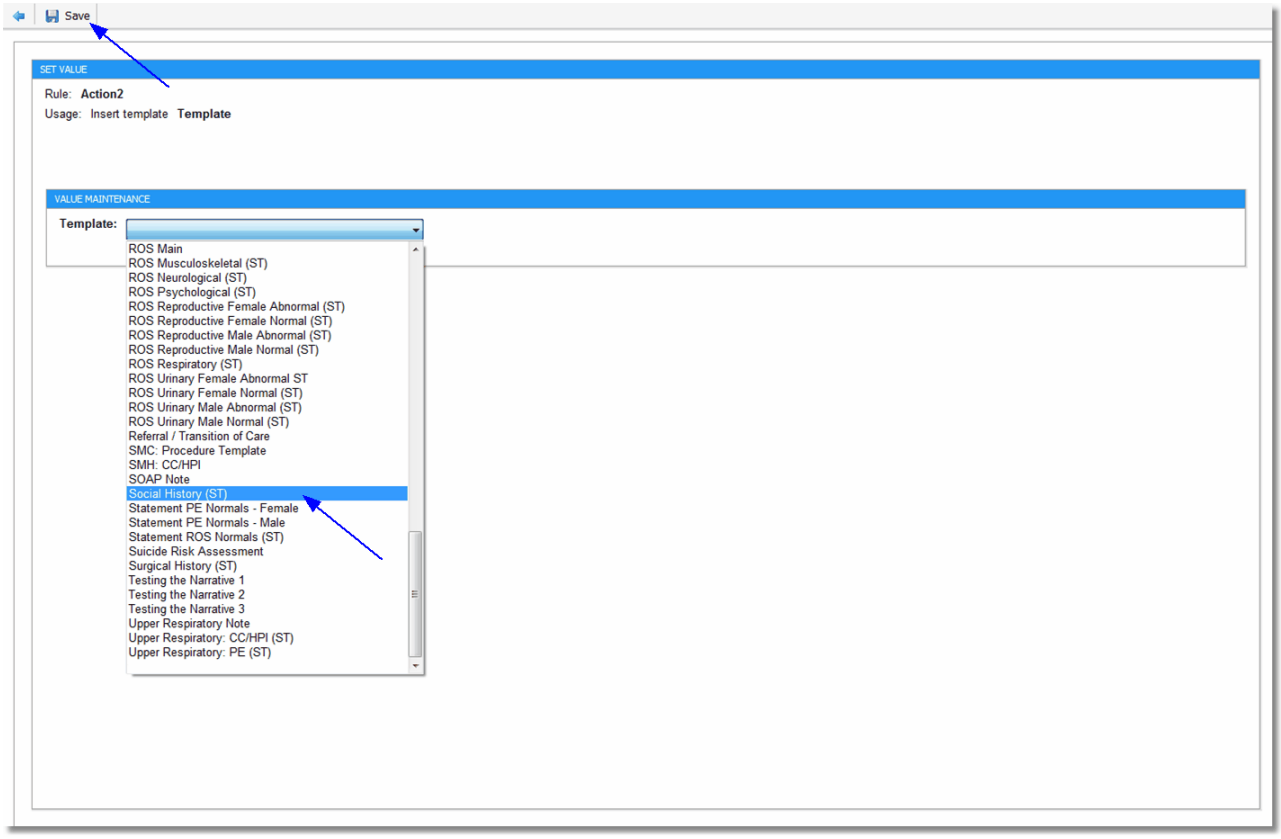
Text Box - Order Entry

- **Department:** Select the desired department from the drop-down.
- **Search:** Enter in the first few letters of the item.

Select the checkbox of the desired order. Select **Insert** to include the order in the template. Select **Cancel** to exit the table without saving.

- **Insert template Template:** Select **Template**.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Text Box > Setup > Template**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Text Box > Setup > Template**



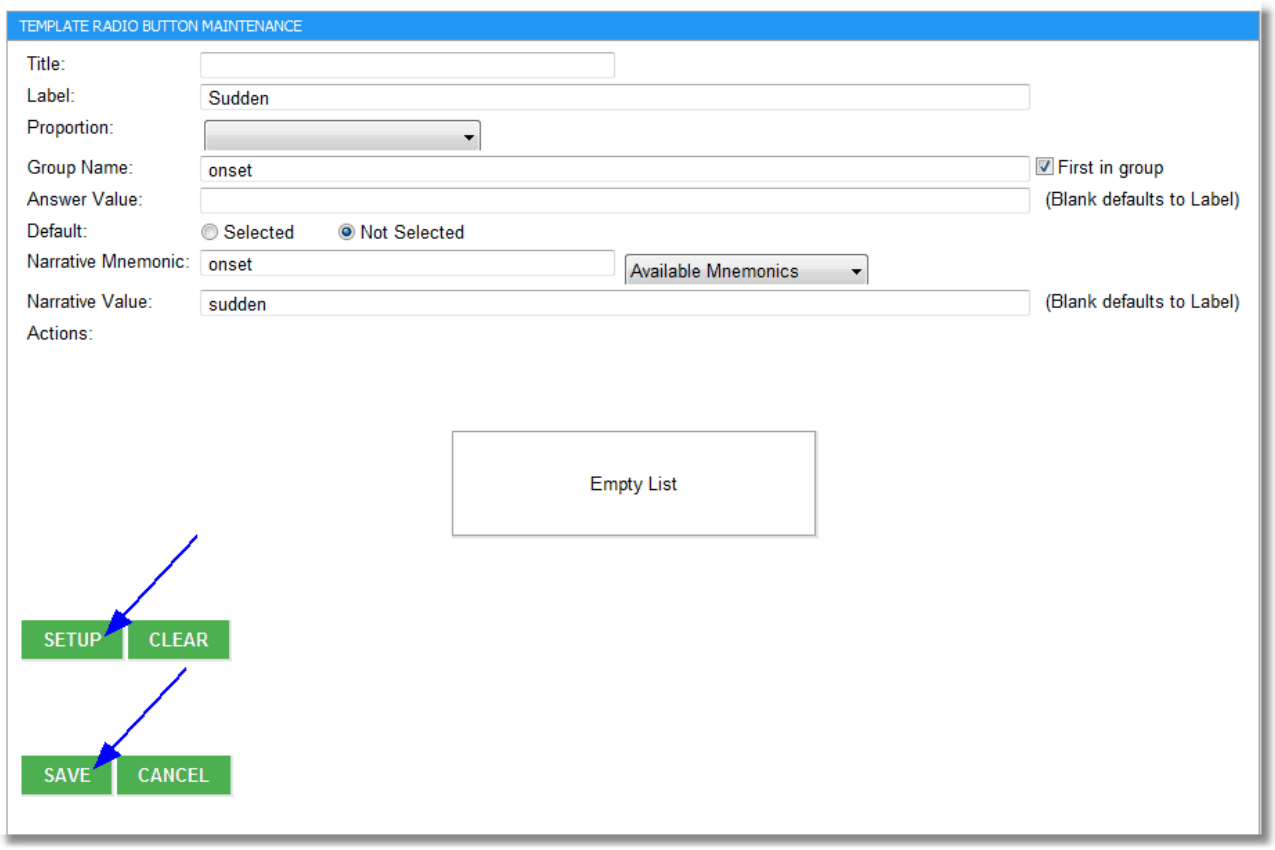
Set Value

- **Template:** Select the desired template from the drop-down.

Select **Save** to save this information.

Radio Button

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Radio Button**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Radio Button**



Template Radio Button Maintenance

Radio buttons are utilized when the user will make a single selection from a list or group of options. Ex: Admit/Deny, Positive/Negative, Yes/No, etc.

- **Title:** Leave this field blank. If information is entered in this field, it will be viewable in the Narrative Available Mnemonics Control window only.
- **Label:** Enter the title of the radio button. Information entered here will display on the template view.
- **Proportion:** This allows information to be evenly spaced in the template.
- **Group Name:** Each group of radio buttons must have a group name. Enter the user-defined group name.

- **First in group:** Select this field for the first radio button of the collection only.

- **Answer Value:** Leave this field blank.

- **Default:**
  - **Selected:** Select this option if this radio button should default to being selected.
  - **Not Selected:** Select this option if this radio button should default to not being selected.

- **Narrative Mnemonic:** Enter the user-defined mnemonic. This mnemonic allows information to pull to the note. Spaces and special characters should not be included.

- **Available Mnemonics:** Select the drop-down menu to select an existing mnemonic. This option would be used when creating a group.

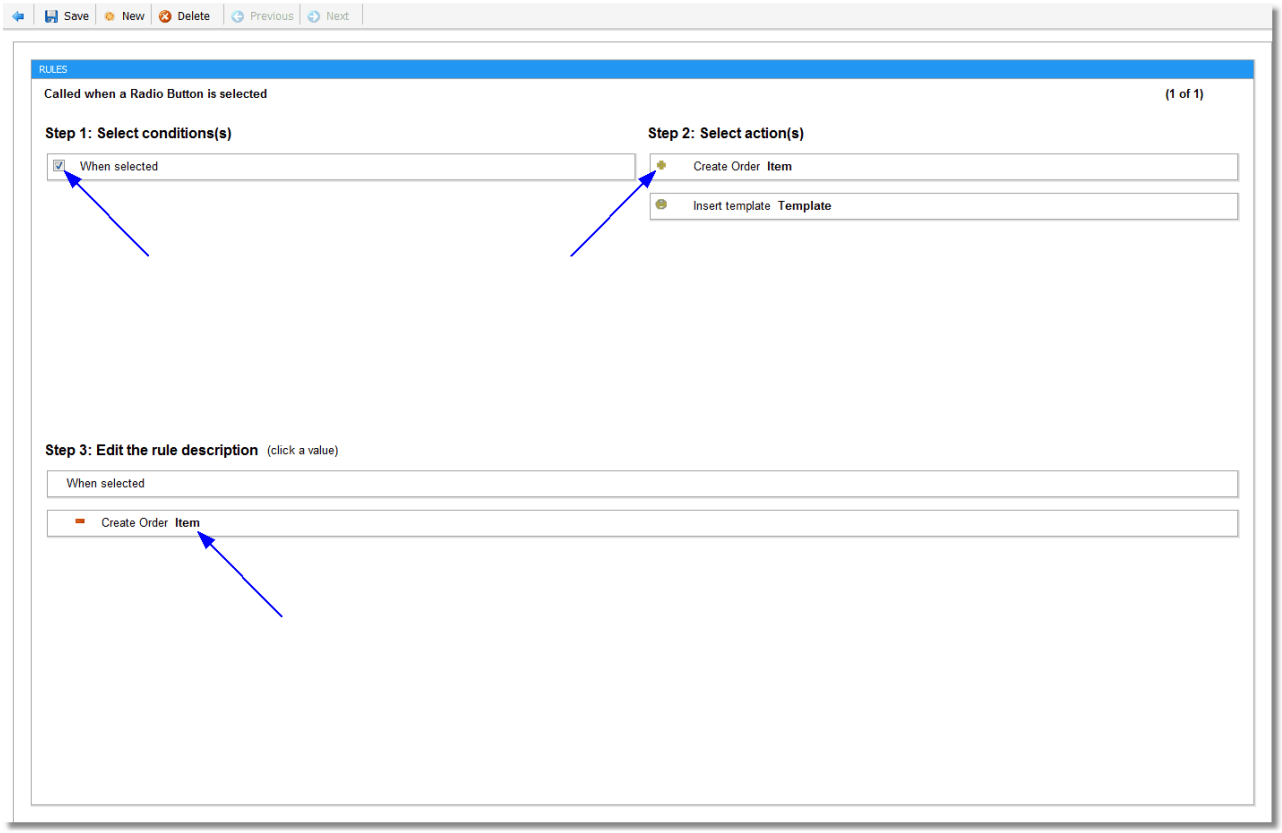
- **Narrative Value:** Enter the information that should pull to the note if this radio button is selected. Otherwise, leave this field blank, and the information in the Label field will pull to the note.

- **Actions:** Displays orders or templates that are associated with this radio button.
  - **Setup:** Select this option to set up orders or templates for this radio button.
  - **Clear:** This option is for future use.

Select **Save** to save the information.

Select **Cancel** to exit the table without saving.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Radio Button > Setup**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Radio Button > Setup**



Radio Button - Rule Builder

Select **OK** to save changes. Select **New** to create a new action. Select **Delete** to delete the action.

Step 1: Select conditions(s)

- **When Selected:** Select this option to have the sub template or order pull when the radio button is selected.

Step 2: Select action(s)

Select the  **green circle icon** next to each option to select that item.

- **Insert Order Item:** Select this option to pull order(s) in the template.

- **Insert template Template:** Select this option to have a template pull within the main template.

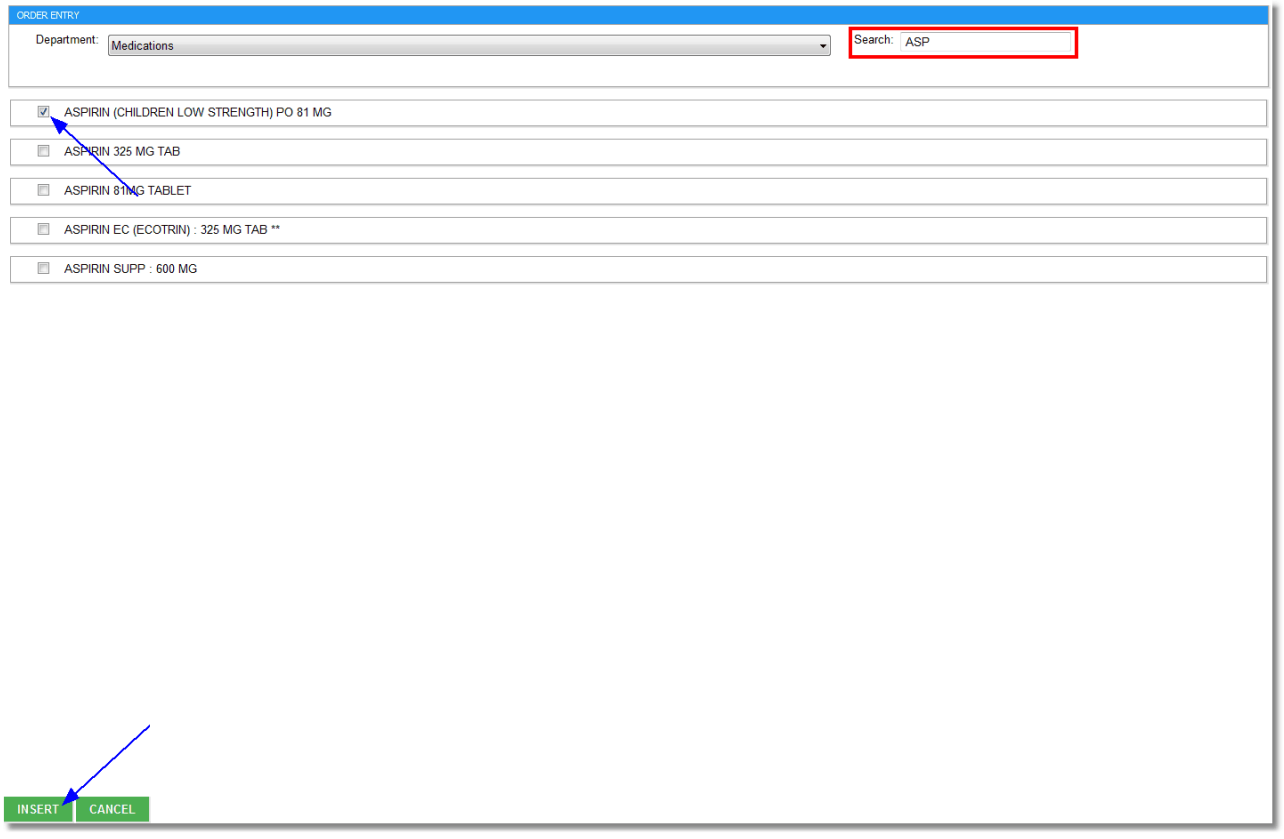
Select the  **green plus sign** next to each option to add additional items.

Step 3: Edit the rule description

- **When selected**

- **Create Order Item:** Select **Item**.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Radio Button > Setup > Item**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Radio Button > Setup > Item**



Radio Button - Order Entry

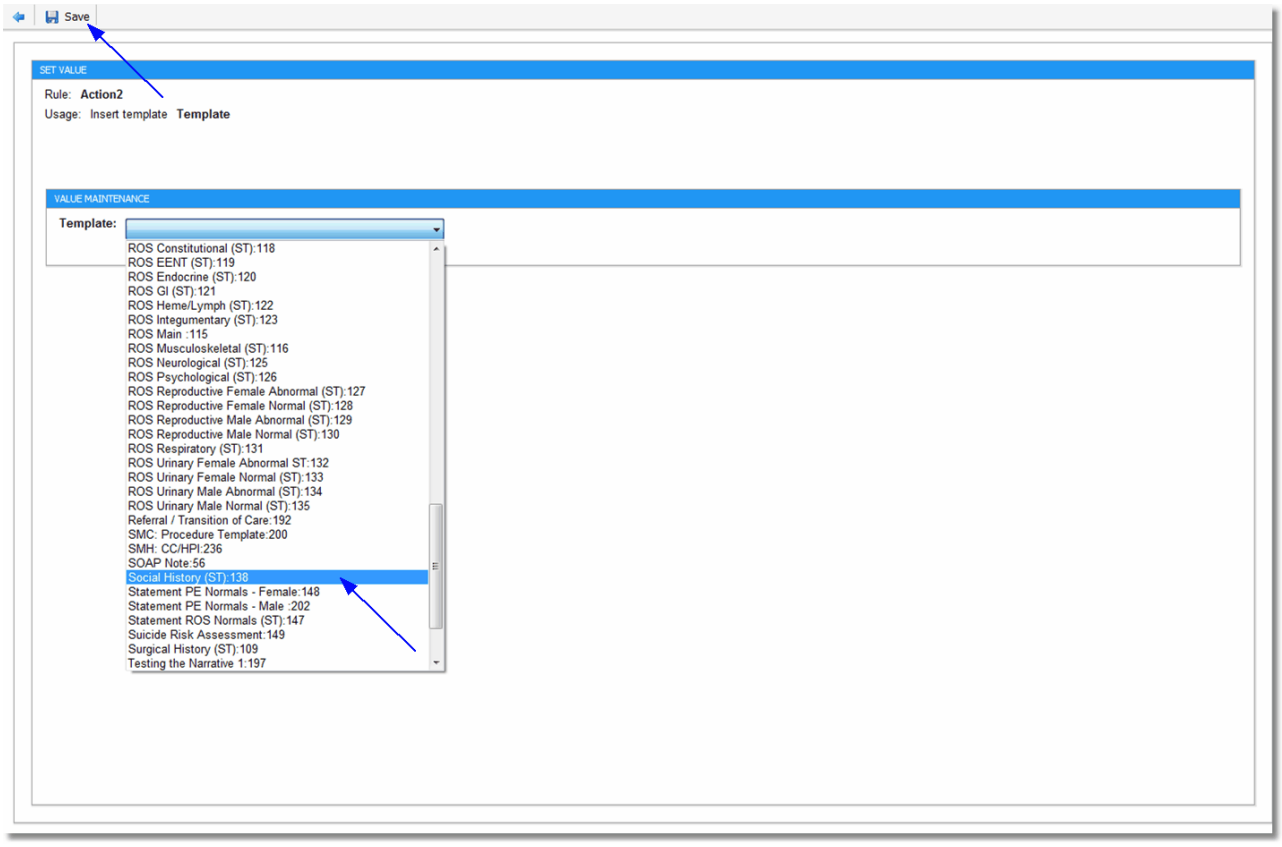
- **Department:** Select the desired department from the drop-down.

- **Search:** Enter in the first few letters of the item.

Select the checkbox of the desired order. Select **Insert** to attach the order to the radio button and include the order in the template. Select **Cancel** to exit the table without saving.

- **Insert template Template:** Select **Template**.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Templates** > **New** > **enter title of template** > **Add Control** > **Radio Button** > **Setup** > **Template**
or
Select **Web Client** > **Charts** > **Inpatient Test Account** > **Documentation** > **Templates** > **New** > **enter title of template** > **Add Control** > **Radio Button** > **Setup** > **Template**

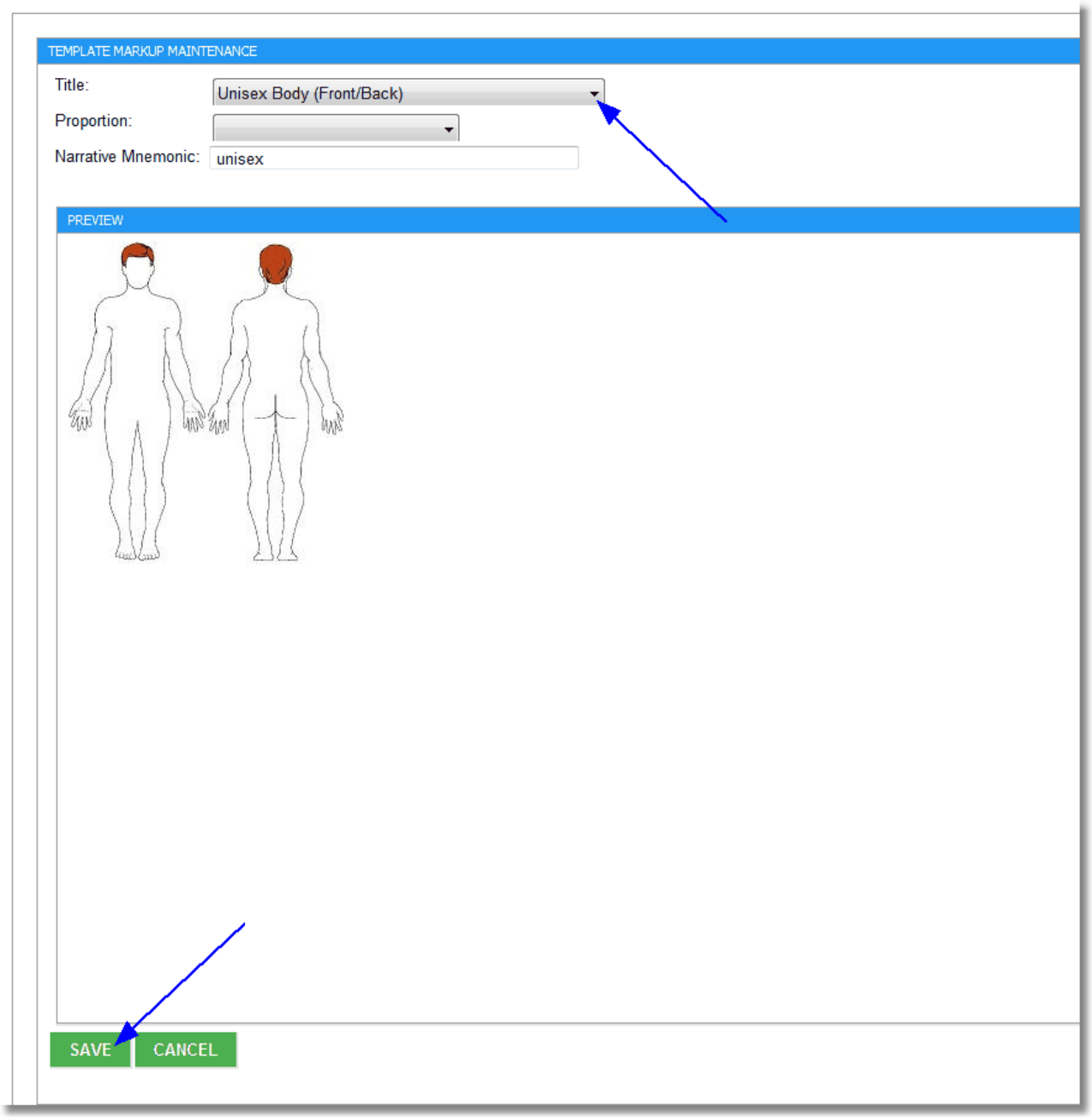


Radio Button - Set Value

Select the title of the desired template. Select **Save** to attach the template to the radio button and include the template in the main template. Select **Cancel** to exit the table without saving any changes.

Markup

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Markup**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Markup**



Template Markup Maintenance

- **Title:** Select the desired markup from the drop-down.

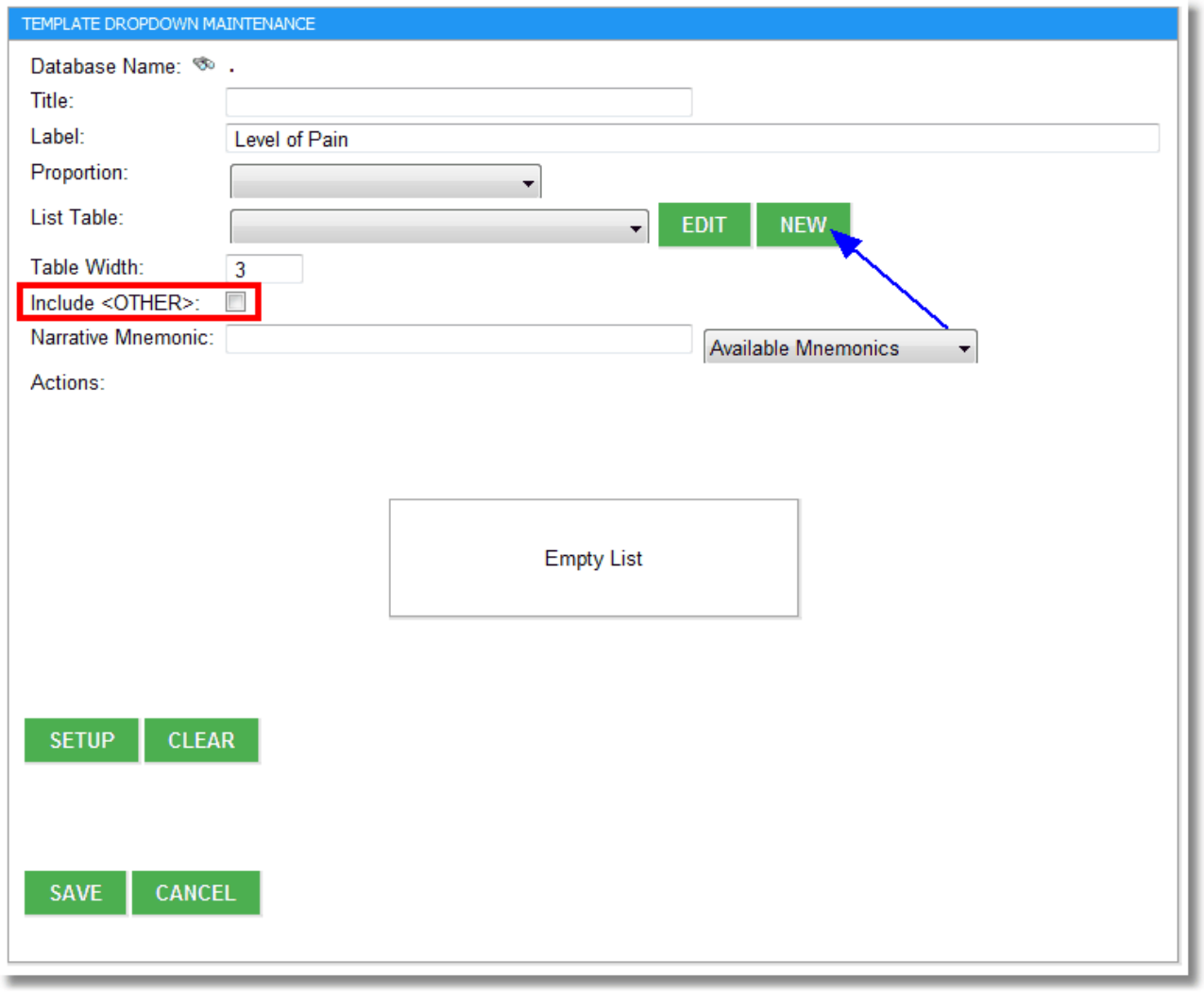
- **Proportion:** Leave this field blank.
- **Narrative Mnemonic:** Enter the user-defined mnemonic. This mnemonic allows the markup to pull to the note. Do not include spaces or special characters.

Select **Save** to save the information.

Select **Cancel** to exit the table without saving.

Drop-down Menus

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > DropDown**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > DropDown**



10.59 Template Dropdown Maintenance

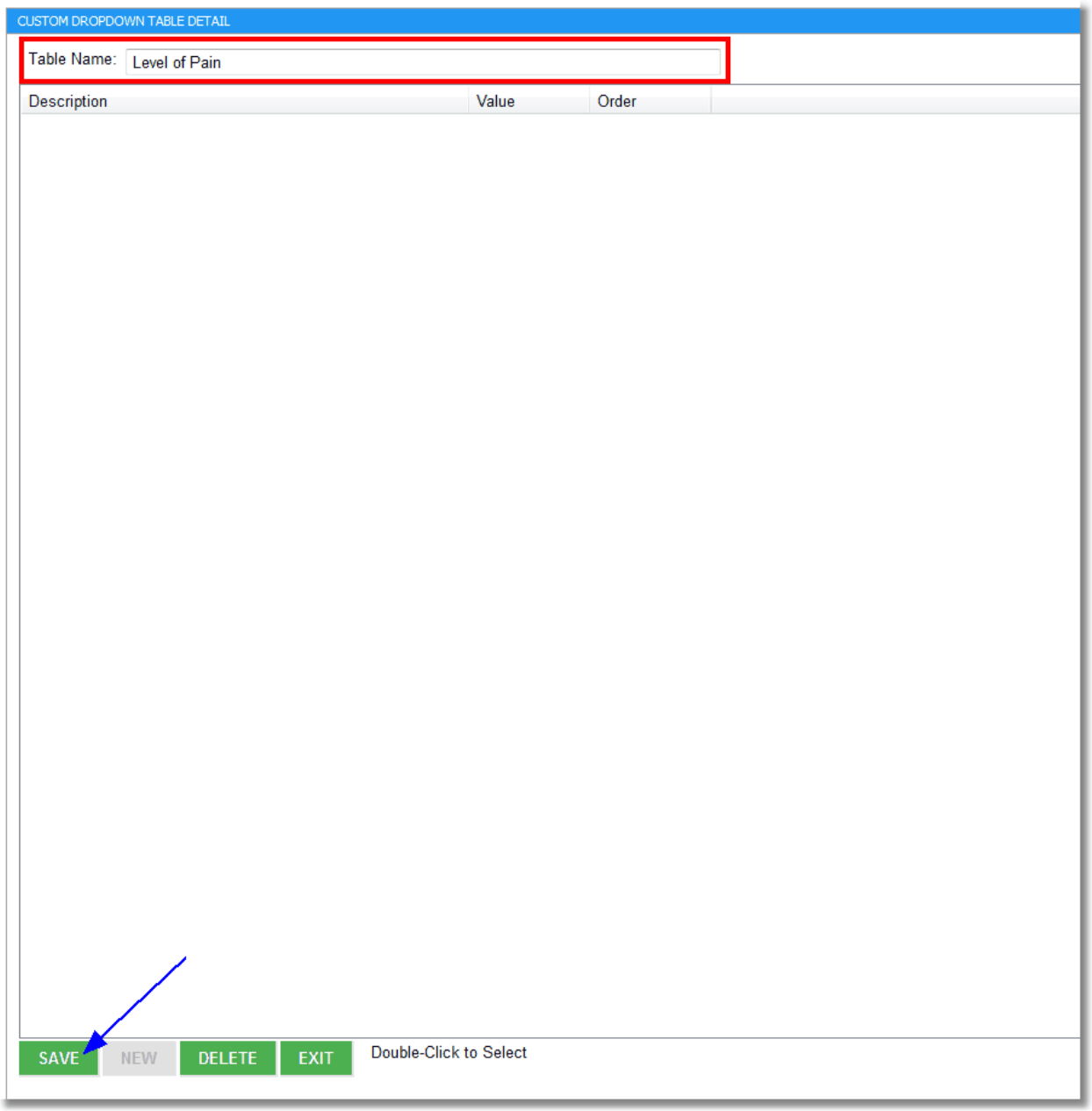
- **Database Name:** This field should be left blank.
- **Title**: This field should be left blank. If information is entered in this field, it will be viewable in the Narrative Available Mnemonics Control window only.
- **Label:** Leave this field blank or enter the label for the drop-down menu. Information entered here will display on the template view.
- **Proportion:** This field should be left blank.
- **List Table:** Select the desired drop-down table.
  - **Edit:** Select the desired drop-down table then select **Edit** to make any changes.
  - **New:** Select this option to add a new drop-down table.
- **Table Width:** Enter the display length of the drop-down table.
- **Include <OTHER>:** Select this field if "Other" should pull as the last option in the drop-down. The user will be directed to a free text text box in order to enter information if this option is selected.
- **Narrative Mnemonic:** Enter the user-defined mnemonic. This mnemonic allows information to pull to the note. Spaces and special characters should not be included.
- **Available Mnemonics:** Select the drop-down to select an existing mnemonic. This option would only be used when creating a group. Items containing the same Narrative Mnemonic will pull into the note with the word "and" and/or commas if more than one selection is made.
- **Actions:** Displays orders or templates that are associated with this drop-down menu.
  - **Setup:** Select this option to set up orders or templates for this drop-down menu.
  - **Clear:** This option is for future use.

Select **Save** to save the information.

Select **Cancel** to exit the table without saving.

To create a new dropdown list, select **New.** To edit an existing list, select the **List Title** drop-down, select the desired list and then select **Edit.**

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter Table Name > Add Control > DropDown > New**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter Table Name > Add Control > DropDown > New**

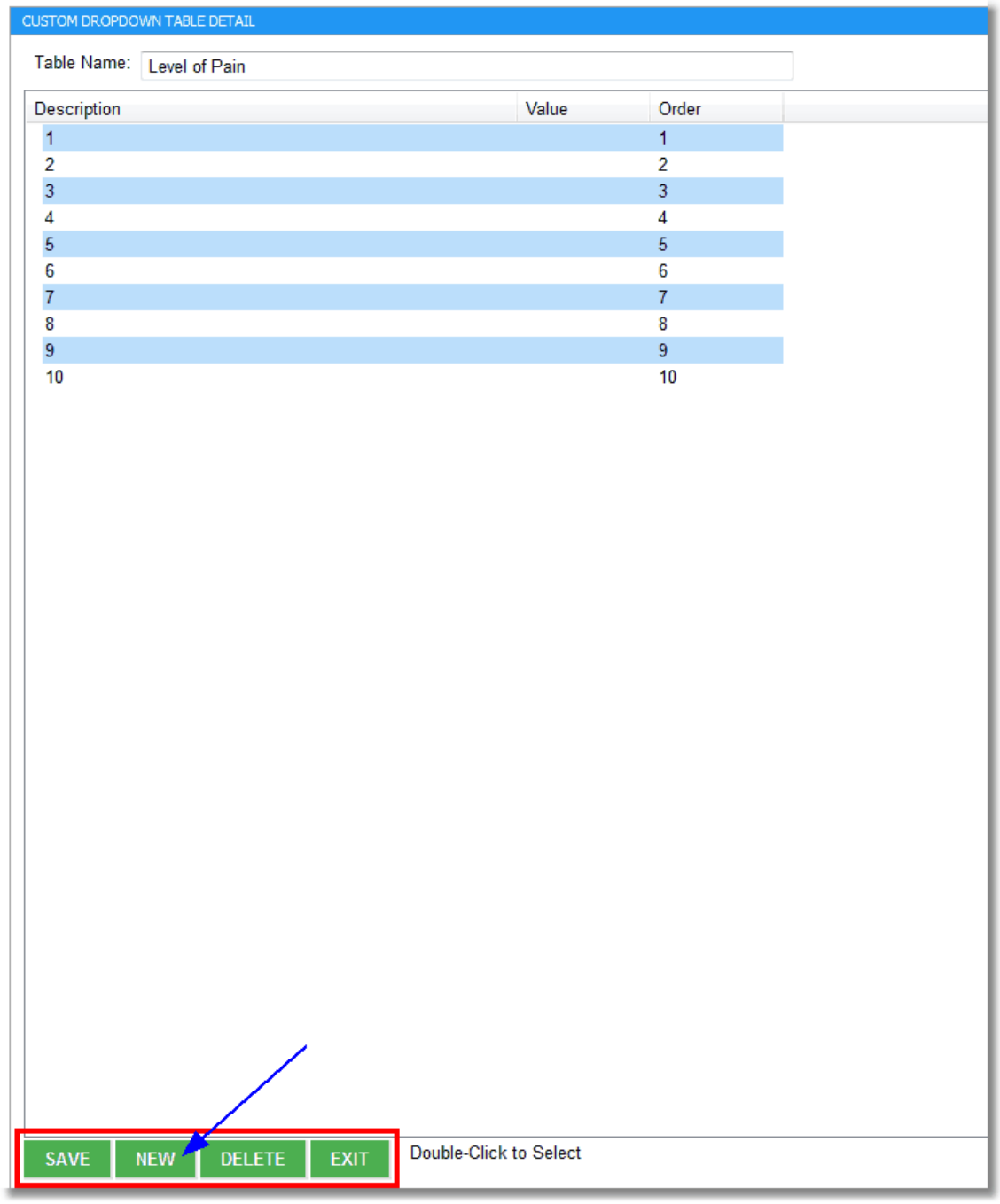


Custom Dropdown Table Detail

- **Table Name:** The name of the drop-down table.

Select **Save** to save the information in this table.

In UX, select **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Templates** > **New** > **enter Table Name** > **Add Control** > **DropDown** > **New**

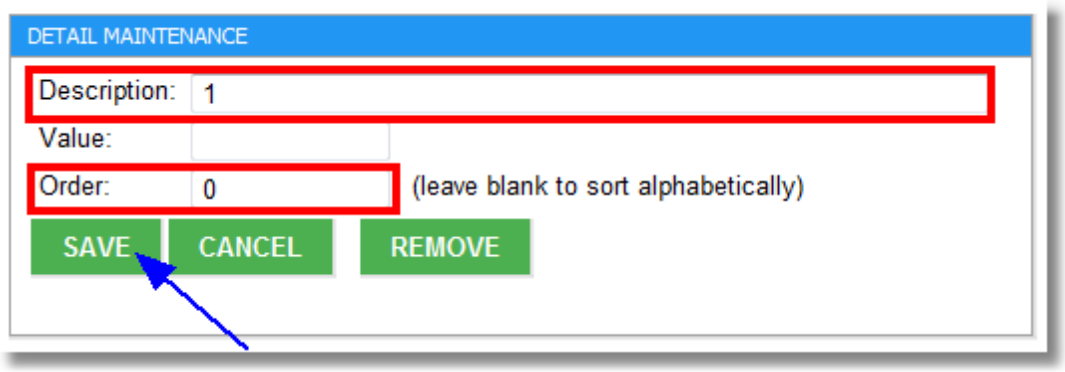


Custom Dropdown Table Detail

Select **New** to add a new line of detail to this table. Select **Delete** to delete this table. Select **Exit** to exit this table.

Select **New** or the desired line to make changes/corrections.

In UX, select **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Templates** > **New** > **enter Table Name** > **Add Control** > **DropDown** > **New**



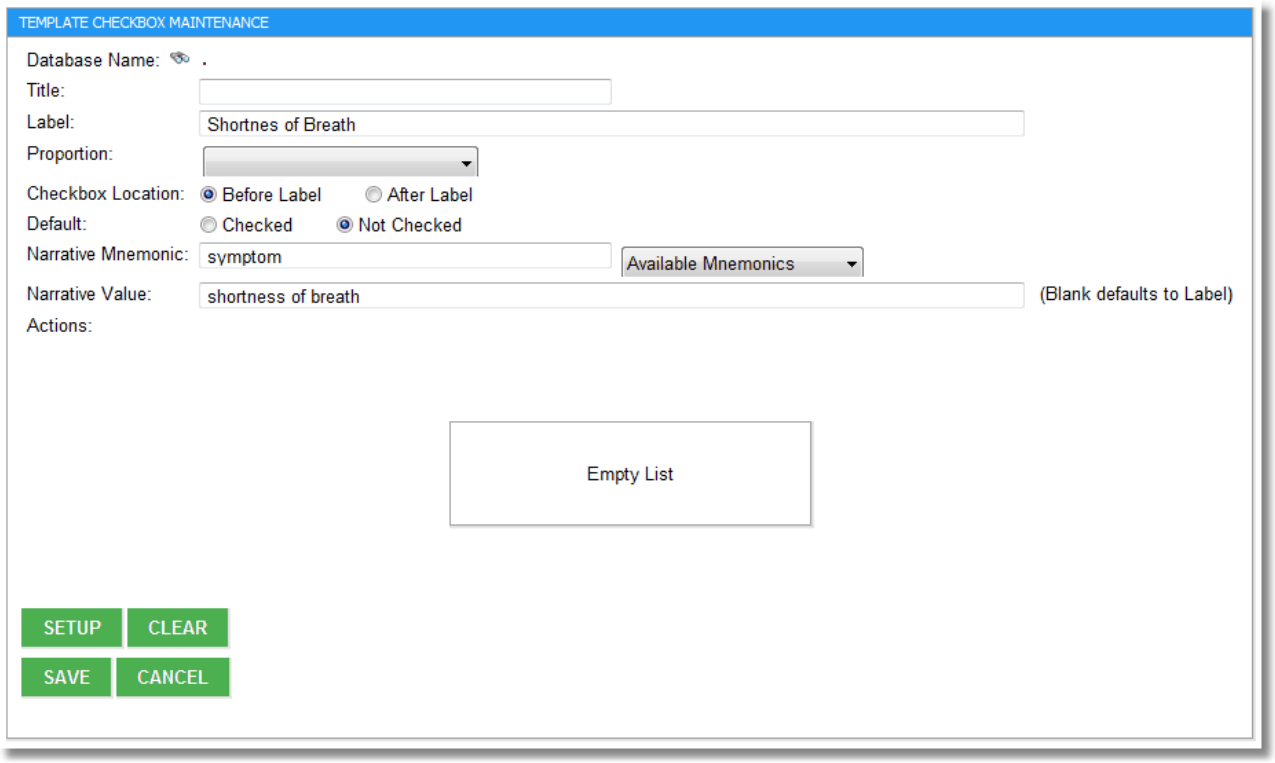
Detail Maintenance

- **Description:** Enter the description for this line of detail.
- **Value:** This field should be left blank.
- **Order:** This field will set the order that the description of the item will appear in the drop-down list from Physician Documentation. If left blank, the order will default alphabetically.

Select **Save** to save this detail. Select **Cancel** to exit this detail without saving. Select **Remove** to remove this detail from the table.

Checkbox

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Templates** > **New** > **enter title of template** > **Add Control** > **Checkbox**
or
Select **Web Client** > **Charts** > **Inpatient Test Account** > **Documentation** > **Templates** > **New** > **enter title of template** > **Add Control** > **Checkbox**



Template Checkbox Maintenance

- **Database Name:** Leave this field blank.
- **Title:** Leave this field blank. If information is entered in this field, it will be viewable in the Narrative Available Mnemonics Control window only.
- **Label:** Enter the label for the checkbox. Information entered here will display on the template view.
- **Proportion:** This allows information to be evenly spaced in the template.
- **Checkbox Location:**
  - **Before Label:** Select this radio button to have the label before the checkbox.
  - **After Label:** Select this radio button to have the label after the checkbox.
- **Default:**
  - **Checked:** Select this radio button to have the checkbox preselected.

- **Not Checked:** Select this radio button to have the checkbox blank.

- **Narrative Mnemonic:** Enter the user-defined mnemonic. This mnemonic allows information to pull to the note. Spaces and special characters should not be included. Items containing the same Narrative Mnemonic will pull into the note with the word "and" and/or commas if more than one selection is made.

- **Available Mnemonics:** Select the drop-down menu to select an existing mnemonic. This option would be used when creating a group. Items containing the same Narrative Mnemonic will pull into the note with the word "and" and/or commas if more than one selection is made.

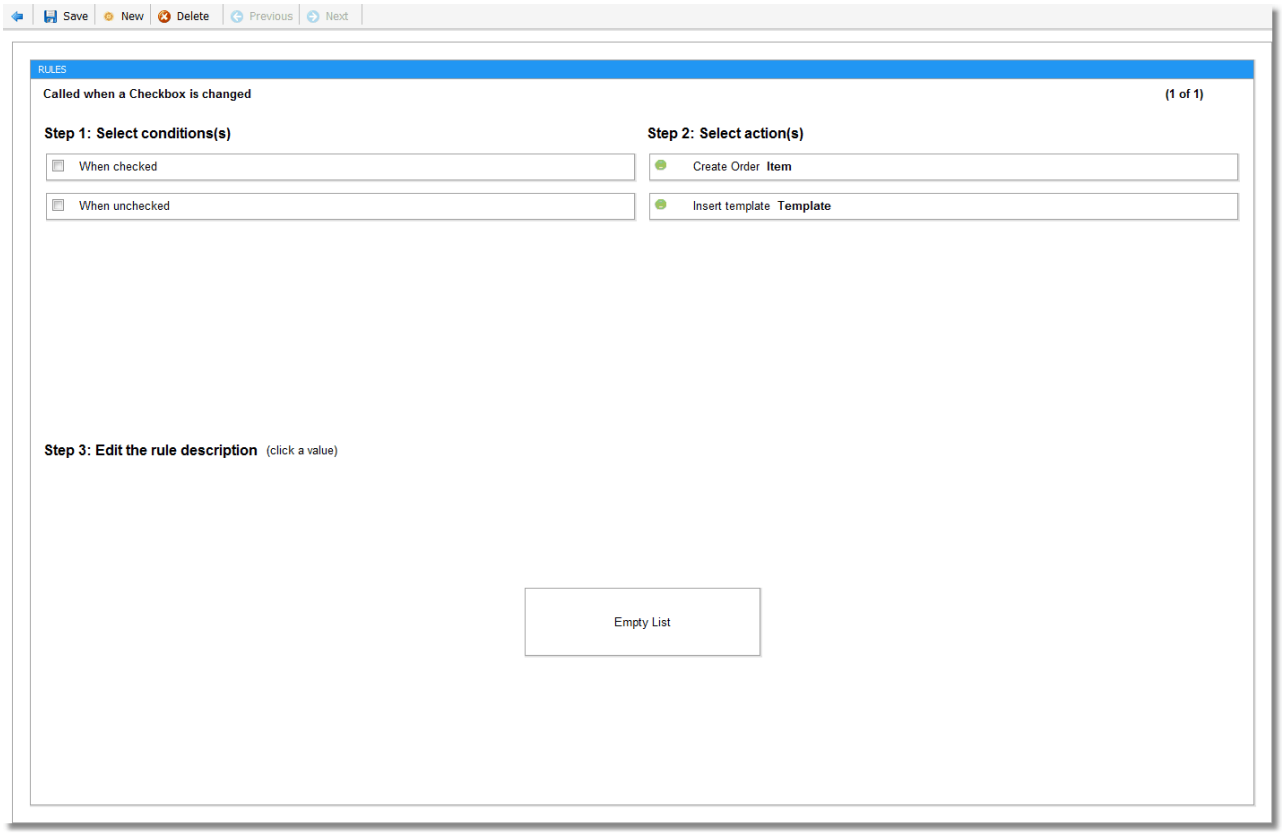
- **Narrative Value:** Enter the information that should pull to the note if this checkbox is selected. Otherwise leave this field blank, and the information in the Label field will pull to the note.

- **Actions:** Displays orders or templates that are associated with this check box.
  - **Setup:** Select this option to set up orders or templates for this check box.
  - **Clear:** This option is for future use.

Select **Save** to save the information.

Select **Cancel** to exit the table without saving.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Checkbox > Setup**
or
Select **Web Client > Charts > Inpatient Account > Documentation > Templates > New > enter title of template > Add Control > Checkbox > Setup**



Checkbox - Rule Builder

Step 1: Select conditions(s)

- **When checked:** Select this option to have the sub template or order pull when the check box is selected.
- **When unchecked:** Select this option to have the sub template or order pull when the check box is not selected.

Step 2: Select action(s)

Select the  **green circle icon** next to each option to select that item.

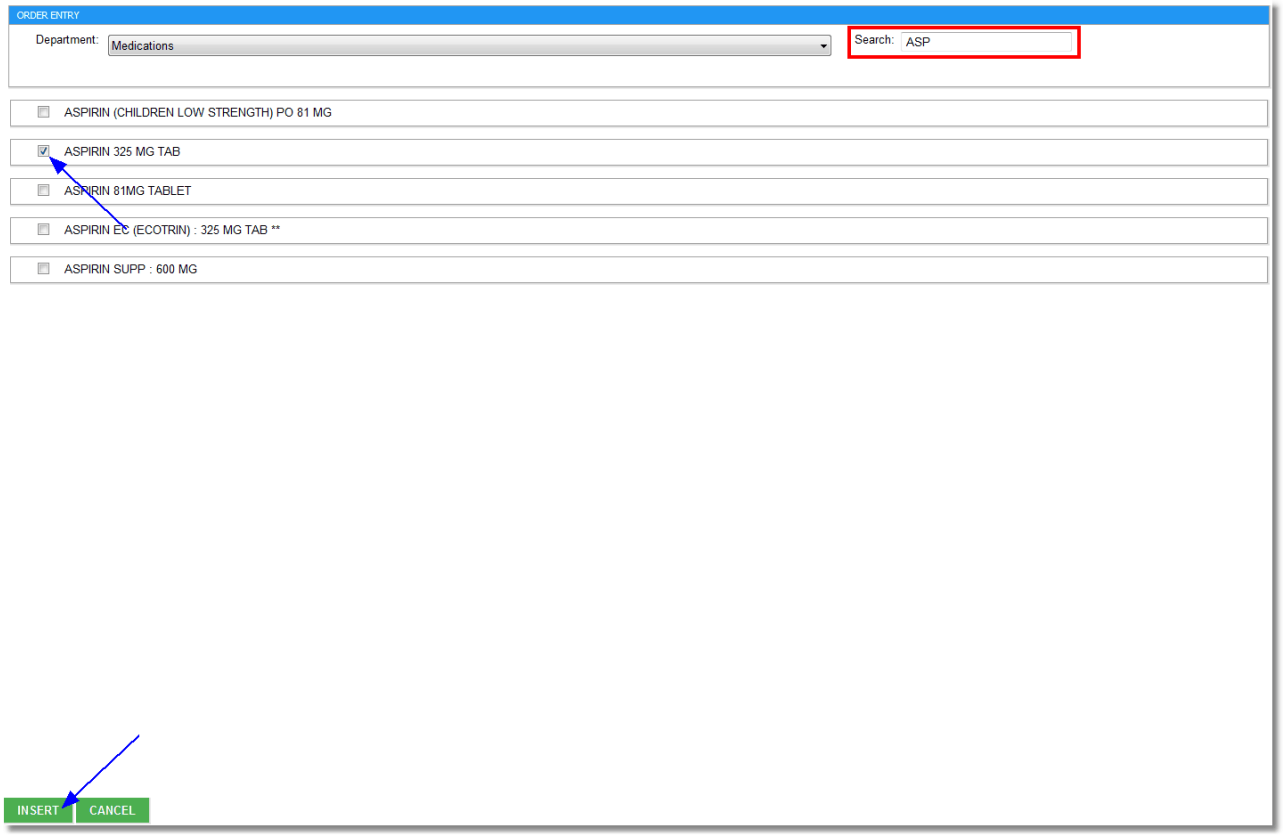
- **Insert Order Item:** Select this option to pull order(s) in the template.
- **Insert template Template:** Select this option to have a template pull within the main template.

Select the  **green plus sign** next to each option to add additional items.

Step 3: Edit the rule description

- **When checked/unchecked**
- **Create Order Item:** Select **Item**.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Checkbox > Setup > Item**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Checkbox > Setup > Item**



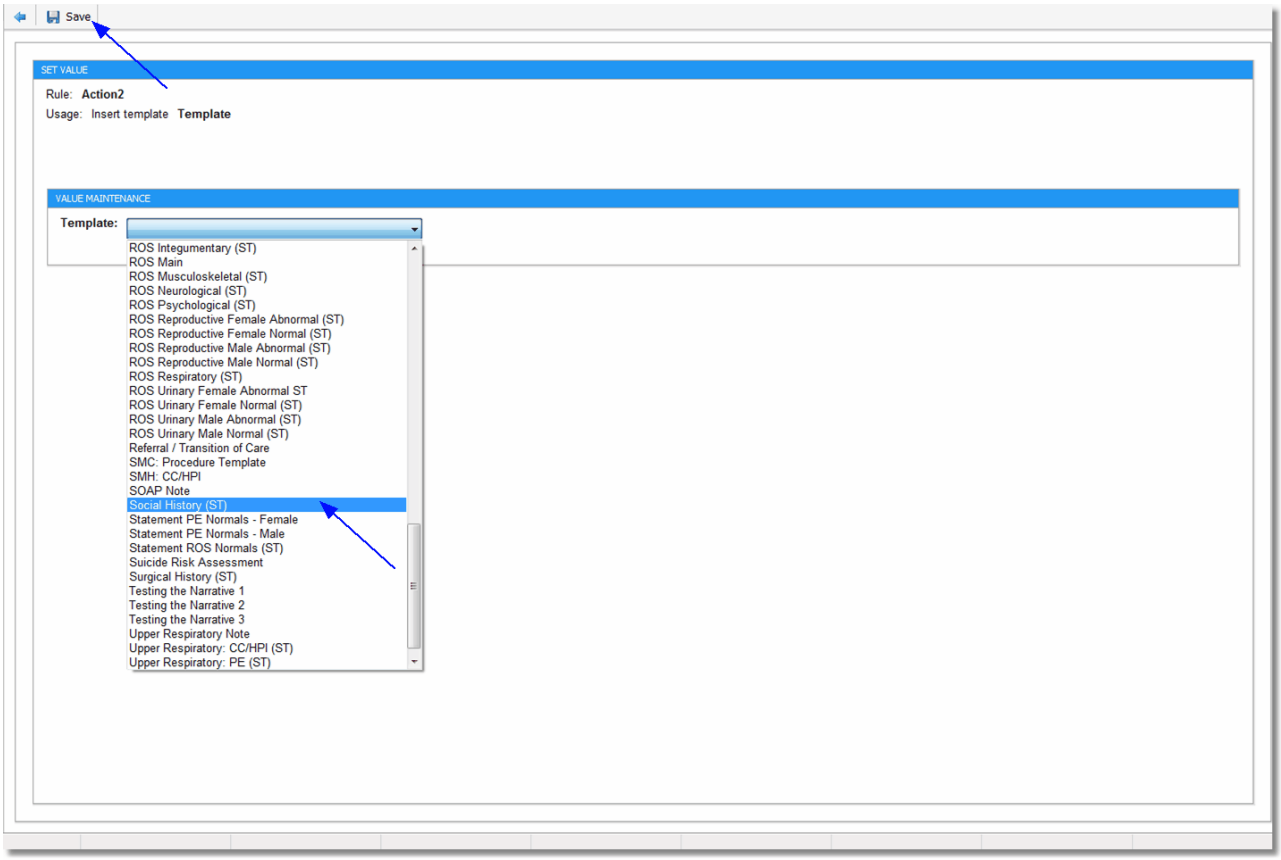
Checkbox - Order Entry

- **Department:** Select the desired department from the drop-down.
- **Search:** Enter in the first few letters of the item.

Select the checkbox of the desired order. Select **Insert** to include the order in the template. Select **Cancel** to exit the table without saving.

- **Insert template Template:** Select **Template**.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Add Control > Checkbox > Setup > Template**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Checkbox > Setup > Template**



Check box - Set Value

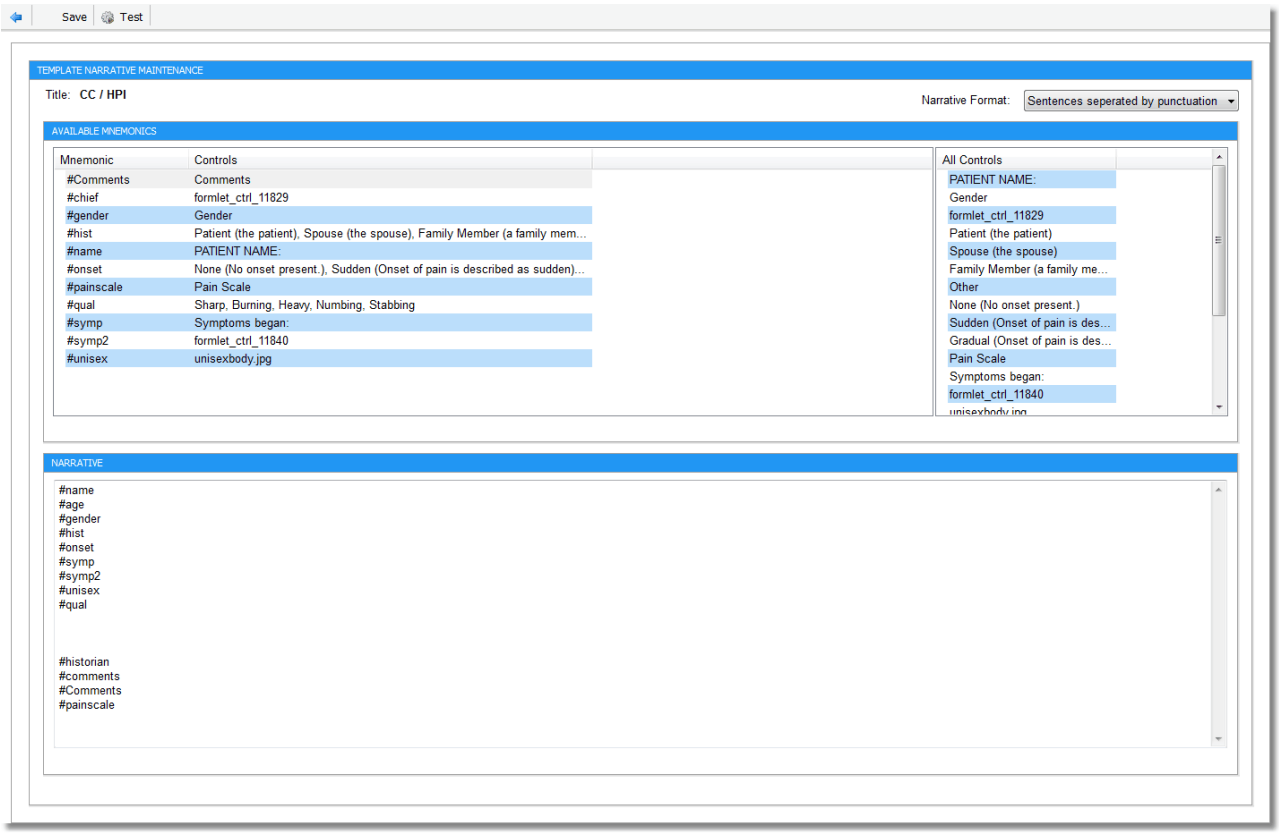
- **Template:** Select the desired template from the drop-down menu.

Select **Save** to save this information.

Narrative

The narrative controls how information will pull to the note once the template has been documented on by the provider.

Select **Web Client > Tables > Clinical > Physician Application > Physician Documentation Templates > New > enter title of template > Narrative**
or
Select **Web Client > Charts > Inpatient Test Account > Documentation > Templates > New > enter title of template > Add Control > Narrative**



Template Narrative Maintenance

- Narrative Format: The dropdown options are **Sentences separated by punctuation** and **Sentences separated by new line**. These control the way the narrative may be formatted.
  - **Sentences separated by punctuation:** This option means that multiple mnemonics may share the same line and that the mnemonics may be set as optional. To make a mnemonic optional, manually change the # (pound) sign to an ***** (asterisk). Multiple mnemonics on the same line built with asterisks will pull only the items addressed. If a # (pound) mnemonic is on a line with additional mnemonic, the # (pound) mnemonics must be addressed in order for them to pull to the note.
  - **Sentences separated by new line:** This is the traditional narrative format. This format does not allow for the optional mnemonics. Multiple mnemonics may share the same line, but all

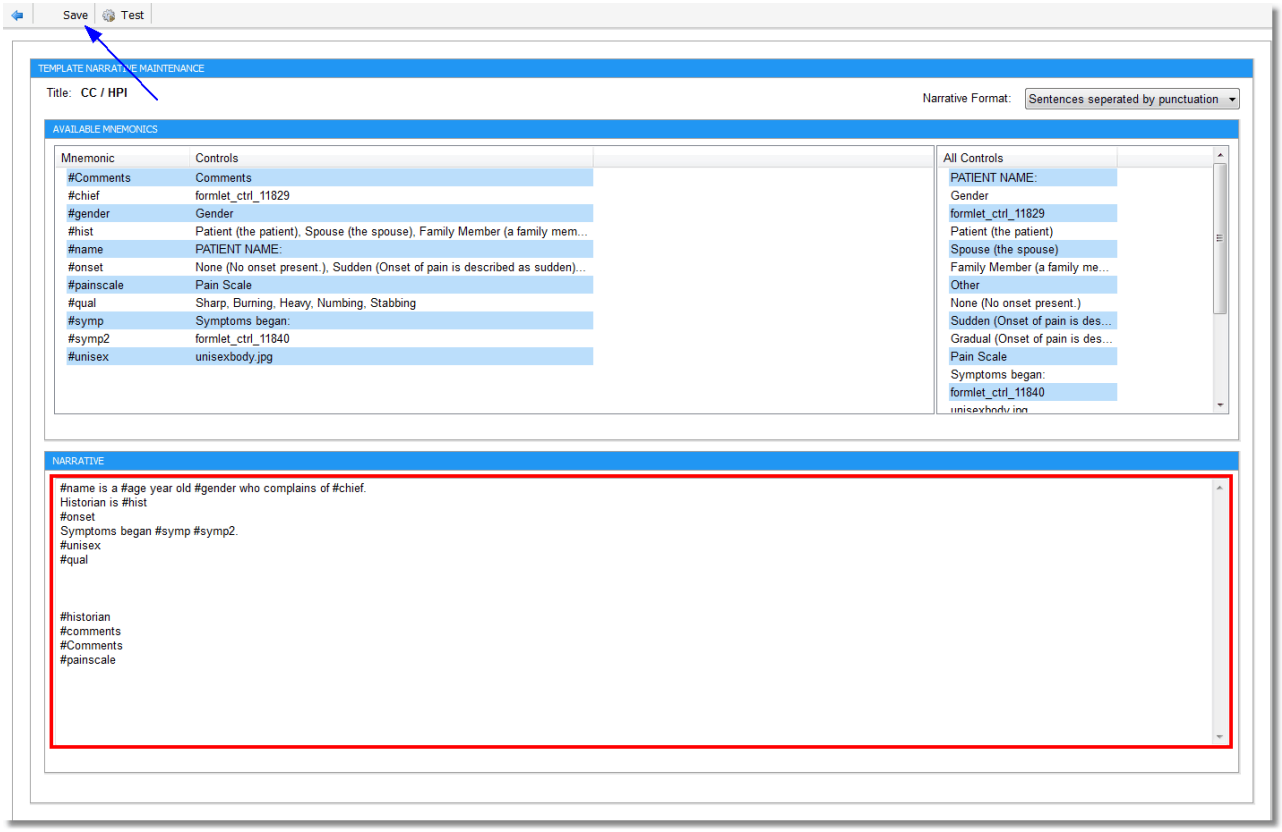
mnemonics that share the same line in the narrative must be addressed or the entire line will not pull. This is often built with each mnemonic on a separate line.

Available Mnemonics

- **Mnemonic:** This section displays all mnemonics that have been set up in the template. If a mnemonic is selected here, it will pull to the bottom of the Narrative.
- **Controls:** This section displays what is associated with the mnemonic.
- **All Controls:** This section displays every piece of the template, ie. check boxes, radio buttons, text boxes.
- **Narrative:** This section controls what pulls to the note when the provider documents the template. All labels must be rebuilt in the narrative except for check boxes and radio button labels.

Select **Save** to save the information. **Test** allows the narrative to be tested.

Select **Web Client** > **Charts** > **Inpatient Test Account** > **Documentation** > **Templates** > **New** > **enter title of template** > **Add Control** > **Narrative**

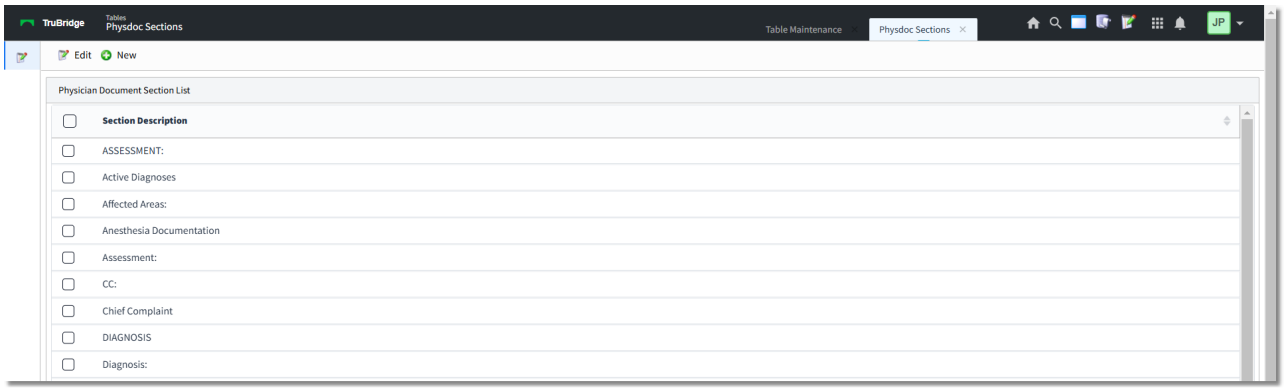


Template Narrative Maintenance

11.7 Physician Documentation Sections

Physician Documentation Sections allows the set up of a section header. Sections may be set up to pull to individual titles as the title is selected from Physician Documentation. Sections may also be added into the title scripting setup. The section header will pull to the note in bold font and underlined.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Sections**



Physician Documentation Section List

The section list will show all previously created section descriptions. If an existing description is selected, the **Edit** button will become available or the user may double-click the description to edit. For a new section description, the user may select **New**.

The user will enter the **Section Description** as it should appear in the note.

The **Action** option will allow the section to function as a link that will pull documented information on the patient. For instance, the Problems action will pull to the Problem List screen for the user to select and insert problem entries. This field is not required and may be left blank.

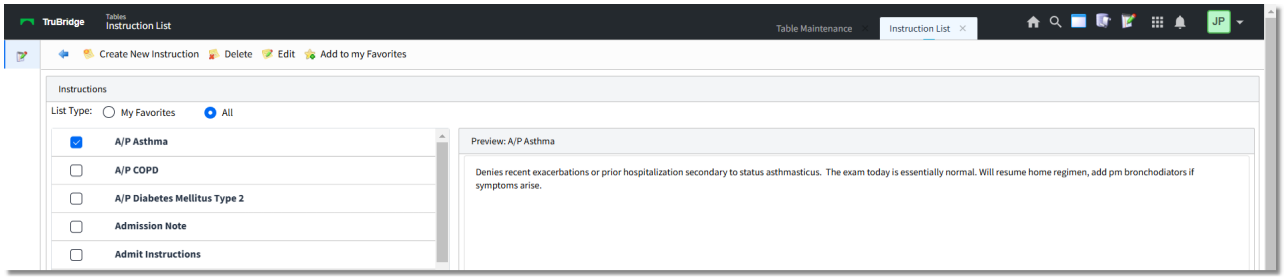
The **Pull to** option will allow the user to also pull the section information to the CDA Instructions. This field is not required and may be left blank.

The Quality Measures Section has been programmed to allow the user to use a Title Script as a launch point into the Documentation application to answer necessary Quality Measure questions. All information documented will pull back into the Phys Doc final note.

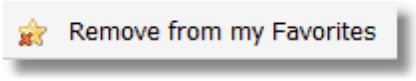
Select **Save** to save the information or **Delete** to delete the entry.

11.8 Physician Documentation Instructions

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Instructions**

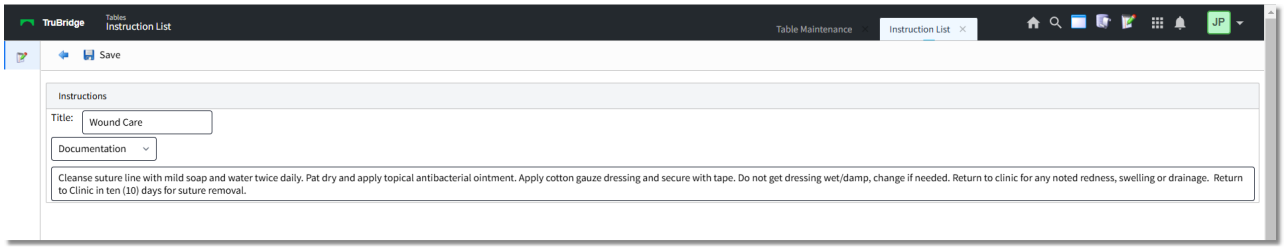


Instructions

- **My Favorites:** Select this radio button to view the signed on UBL's favorite instructions.
- **All:** Select this radio button to view a list of all instructions in the table.
- **Create New Instruction:** Select this option to enter a new instruction into the table.
- **Delete:** To delete an instruction, select the instruction and then **Delete**.
- **Edit:** To edit an instruction, select the Instruction and then **Edit**.
- **Add to my Favorites:** Allows an instruction to be listed under My Favorites for the signed on UBL.
- **Remove from my Favorites:** 

Allows an instruction to be removed from My Favorites for the signed on UBL.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Instructions** > **Create New Instruction**



Instructions

- **Title:** Enter the title of the instruction. In the next field enter the instruction text.

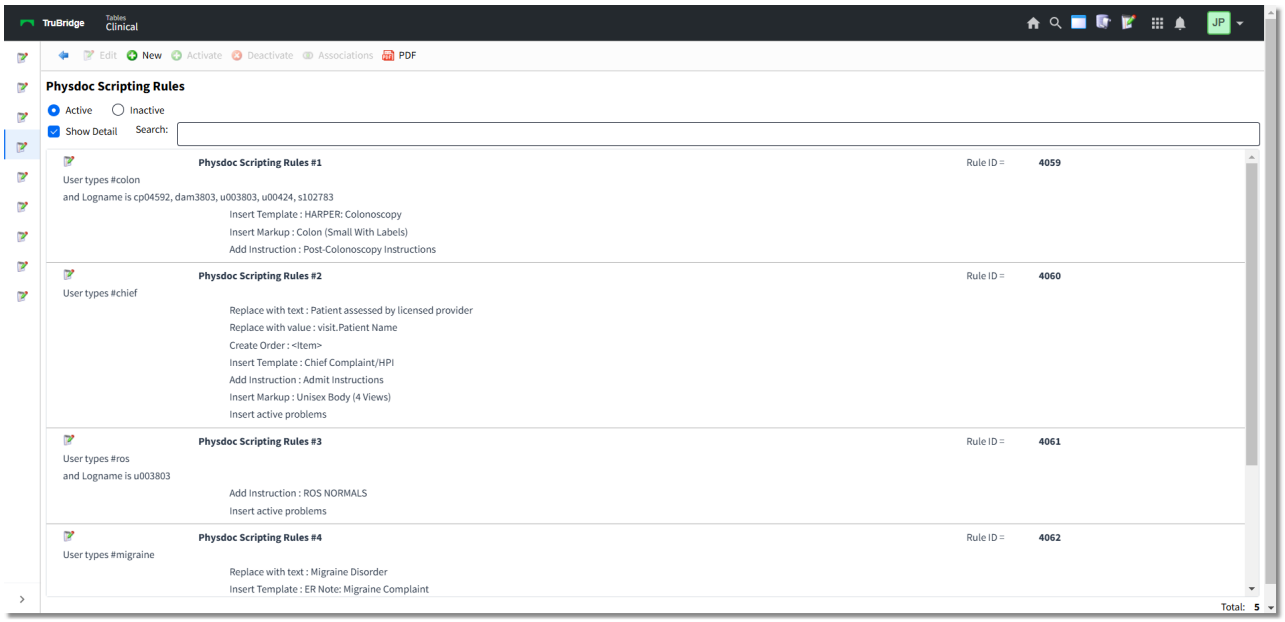
Select **Save** to save the instruction or **Cancel** to exit the table without saving.

- **Cancel:** Select to exit the table without saving.

11.9 Physician Documentation Scripting

Physician Documentation Scripting allows the provider to type in a macro and have information automatically pull. Based on the setup in this table will determine what pulls to the note. An unlimited number of macros can be created.

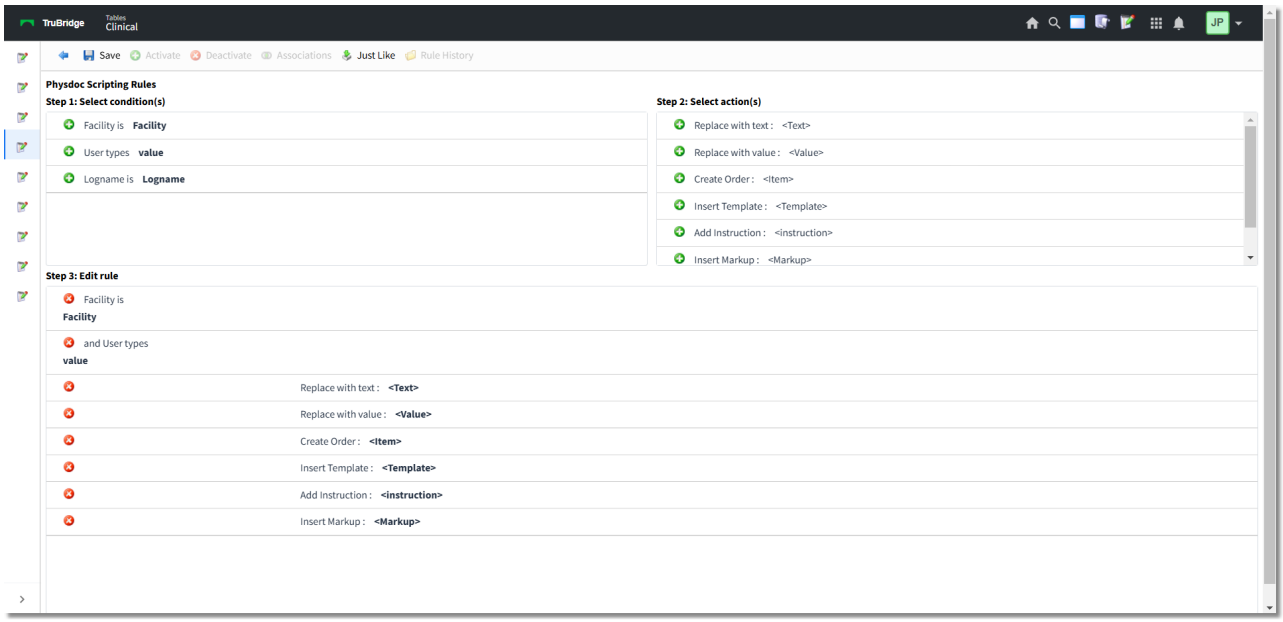
Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Scripting**



Rules

Once the Rules screen is open, a list of all current Macros will appear. To edit an existing Macro, highlight the rule and select **Edit**, or simply double-click the rule. To create a new Macro, select **New**.

Select **Web Client** > **Tables** > **Clinical** > **Physician Application** > **Physician Documentation Scripting** > **New**



Rules

Select **OK** to save changes. Select **New** to create a new script. Select **Deactivate** to remove the script. Once deactivated, the rule can be found on the Rules page by selecting the **Inactive** radio button.

Step 1: Select conditions(s)

- **User types value:** Select this option to assign a script/macro that the provider will type to have the set up of this table pull.
- **Logname is User:** Select this option to assign a script to a specific UBL.
- **Facility is Facility:** Select this option if the facility has multiple companies and this script should apply to certain companies.

NOTE: *If a user or company is not specified, the script will apply to all users and all companies.*

Step 2: Select action(s)

Select the  **green circle icon** next to each option to select that item.

- **Replace with text Text:** Select this option to enter a free-text sentence.
- **Replace with value DataValue:** Select this option to select a database code. This allows information from the patient's visit to pull to the script.
- **Create Order Item:** Select this option to pull order(s) to the script.
- **Insert template Template:** Select this option to pull a template to the script.
- **Insert instruction Instruction:** Select this option to pull an instruction to the script.
- **Insert markup Markup:** Select this option to pull a markup to the script.
- **Insert active problems:** Select this option to pull the problem list to the script.

Select the  **green plus sign** next to each option to add additional items.

Step 3: Edit the rule description

NOTE: *The order that the options in Step 2 are selected will determine the order the options pull to Step 3 and to the note.*

- **User types value:** Select **value** to enter in the macro used for this script. This macro must begin with a # (pound sign) and not have any spaces.
- **and logname is User:** Select **User** to enter the UBL for this script.
- **Save:** Select this option to save any changes.
- **New Value:** Select this option to add a UBL.

Select **OK** to save the information.

- **and facility is Facility:** Select **Facility** if the facility has multiple companies and this script should apply to certain companies.
- **Save:** Select this option to save any changes.
- **New Value:** Select this option to add a facility.
- **Replace with text Text:** Select **Text** to enter a free-text field.

- **Replace with value DataValue:** Select **DataValue** to select a database code. This allows information from the patient's visit to pull to the script.
- **Key Type:** Select **Visit** from the drop-down.
- **Category:** Select **Demographics** from the drop-down.

Select the desired data value and then select **Save**. Select **Cancel** to exit the table without saving.

- **Create Order Item:** Select **Item** to select an order to pull to the script.
- **Department:** Select the desired department from the drop-down.
- **Search:** Enter in the description of the item. This field is a smart search and will begin populating results as text is entered.

Select the checkbox of the desired item. Then select **Insert** to save this order. Select **Cancel** to exit the table without saving.

- **Insert template Template:** Select **Template** to select a template to pull to the script.
- **Template:** Select the desired template from the drop-down.

Select **Save** to save the information.

- **Insert instruction Instruction:** Select **Instruction** to select or create an instruction to pull to the script.

Select the checkbox of the desired Instruction or select **Create New Instruction** to enter a new instruction into the table.

Select **Insert** to insert this instruction into the script or select the **Blue Back Arrow** to exit the table without saving.

- **Insert markup Markup:** Select **Markup** to select a markup to pull to the script.

Select the checkbox beside the desired markup.

Select **Insert** to insert this markup into the script or select **Blue Back Arrow** to exit the table without saving.

- **Insert active problems:** This option will pull the Physician Problem List entries to the script (documentation).

Once the Save option has been selected, the user will be asked to give the macro a title. This title will display in an alphabetical listing on the Rules page.

11.10 Physician Security

Please refer to the Physician Security chapter in the Table Maintenance-Control user guide for more information on this topic.

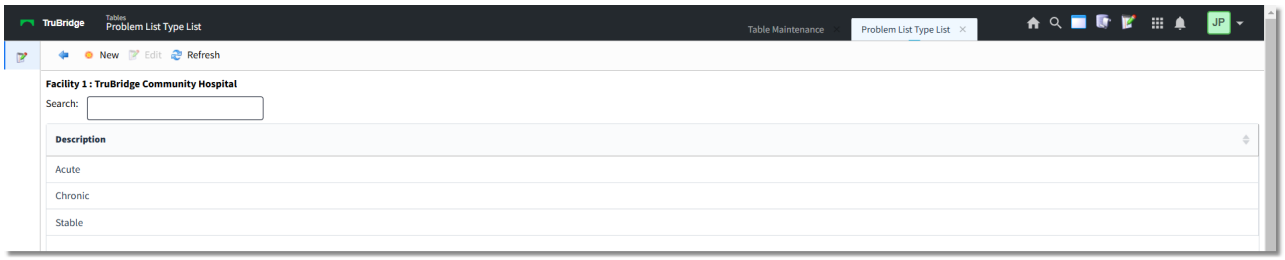
11.11 Physician Group

Please refer to the Physician Groups chapter in the Table Maintenance - Control user guide for more information on this topic.

11.12 Problem List Type

The Problem List Type is a description of the status of the problem. Any entries set up in the table will display in a drop down on the Physician Detail entry screen as well as the Problem Display screen.

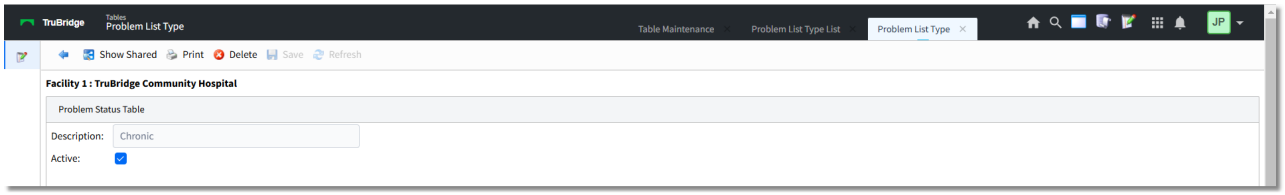
Select **Web Client** > **Tables** > **Clinical** > **Problem List Type**



Problem List Type

To return to the previous screen, select the blue back arrow. To add a status to the list (which will appear in the drop-down within the Problem Detail screen within the Physician Problem List), select **New**. To edit an existing entry, select the description and then choose **Edit**. To refresh the screen after creating and saving an entry or after deleting an existing entry, select **Refresh**.

Select **Web Client** > **Tables** > **Clinical** > **Problem List Type** > **New**



Problem Status Table

In the **Description** field, enter the desired status description. The **Active** checkbox will indicate whether the problem entry should remain on the Active Problem Display screen or, if left unchecked, the problem entry will appear on the Inactive Problem Display screen.

Once entered, select **Save** to save the entry and then select the blue back arrow to return to the list screen. If an existing entry is selected to edit for removal, select **Delete** to remove from the table and then **Yes** to confirm the deletion of the entry.

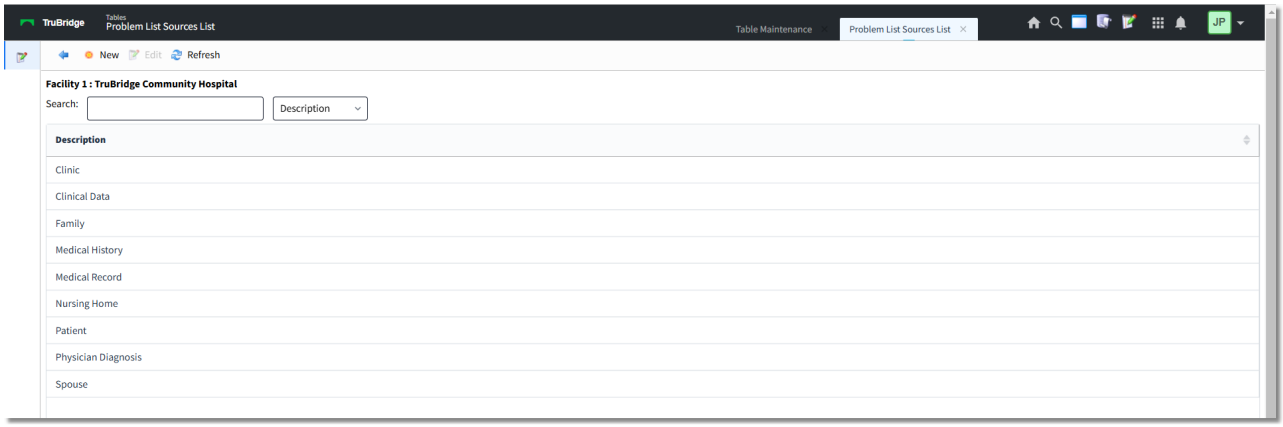
NOTE: *The* ***Resolved*** *and* ***Entered in Error*** *statuses are both hard-coded and do not need to be manually entered into the Problem List Type table as they will automatically appear within the Problem Entry Status drop-down for selection.*

There is no limit to the number of entries that may be added to the list.

11.13 Problem List Source

The Problem List Source indicates from where the information regarding the problem has been initiated. For instance, has the diagnosis been made from the Provider, has the patient indicated the problem, or has it come from an existing medical record? Any entries set up in the table will display in a drop down on the Physician Detail entry screen as well as the Problem Display screen.

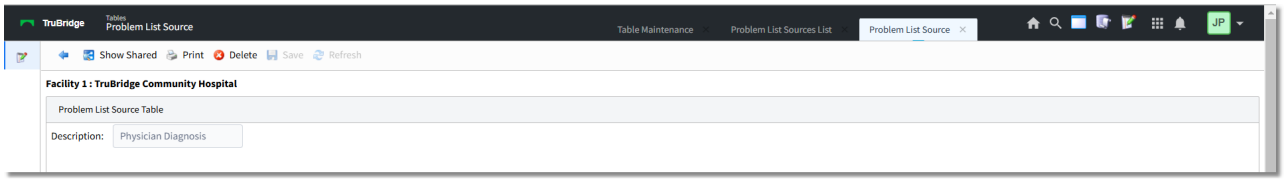
Select **Web Client** > **Tables** > **Clinical** > **Problem List Source**



Problem List Source Table

To return to the previous screen, select the blue back arrow. To add a source to the list (which will appear in the drop-down within the Problem Detail screen within the Physician Problem List), select **New**. To edit an existing entry, select the description and then choose **Edit**. To refresh the screen after creating and saving an entry or after deleting an existing entry, select **Refresh**.

Select **Web Client** > **Tables** > **Clinical** > **Problem List Source** > **New**



Problem List Source Table

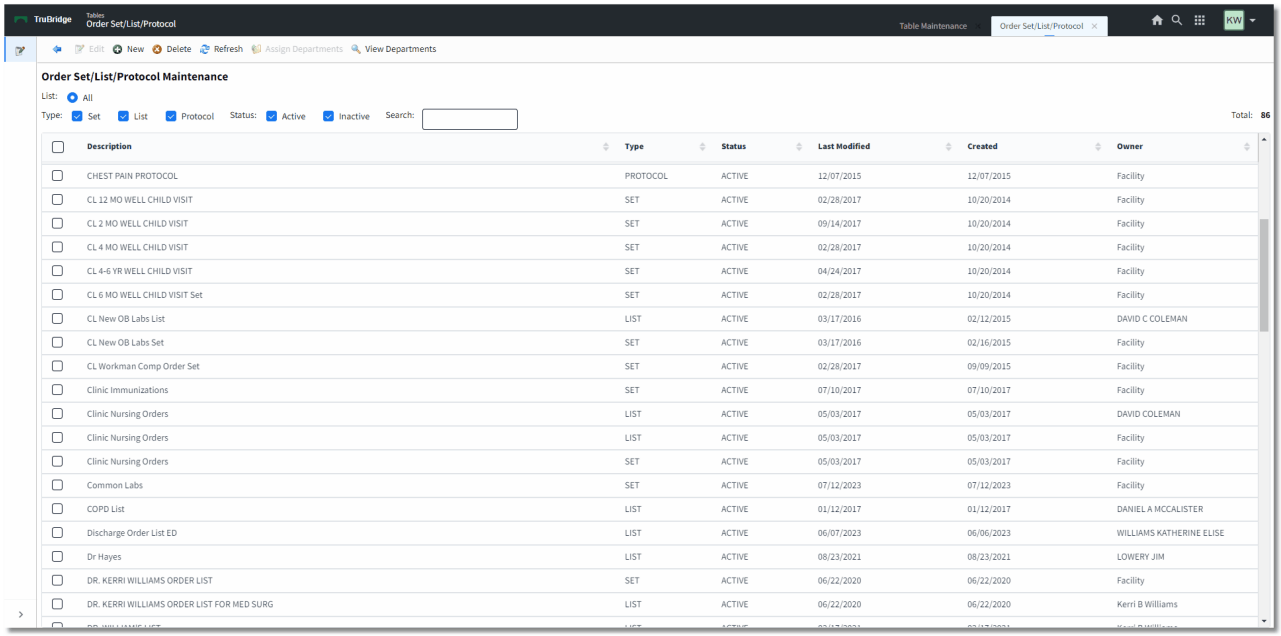
In the **Description** field, enter the desired status description. Once entered, select **Save** to save the entry and then select the blue back arrow to return to the list screen. If an existing entry is selected to edit for removal, select **Delete** to remove from the table and then **Yes** to confirm the deletion of the entry.

***NOTE**: Within the Problem Detail screen while creating an entry, there is an option to add a new source. If a user creating a problem entry chooses to add a new source from the Physician Problem List, the new entry will be saved to the Problem List Source Table and may only be edited or removed from within the table.*

11.14 Order Set/List/Protocol Maintenance

The Order Set/List/Protocol Maintenance table allows the creation of new Order Sets, Order Lists, and Protocols. Existing Sets, Lists, and Protocols may also be edited in this table. **Order Sets** may be utilized by providers and other hospital ordering departments. **Physician Lists** will be provider (UBL) specific and may be edited to meet the specifications and preference of that provider. Physician lists will also be selectable from nursing order entry. **Facility Lists** will be available in the drop-down to the assigned nursing department(s). **Protocol** orders will be accessible from nursing order entry to the assigned nursing department(s).

Select **Web Client** > **Tables** > **Clinical** > **Order Set/List/Protocol Maintenance**



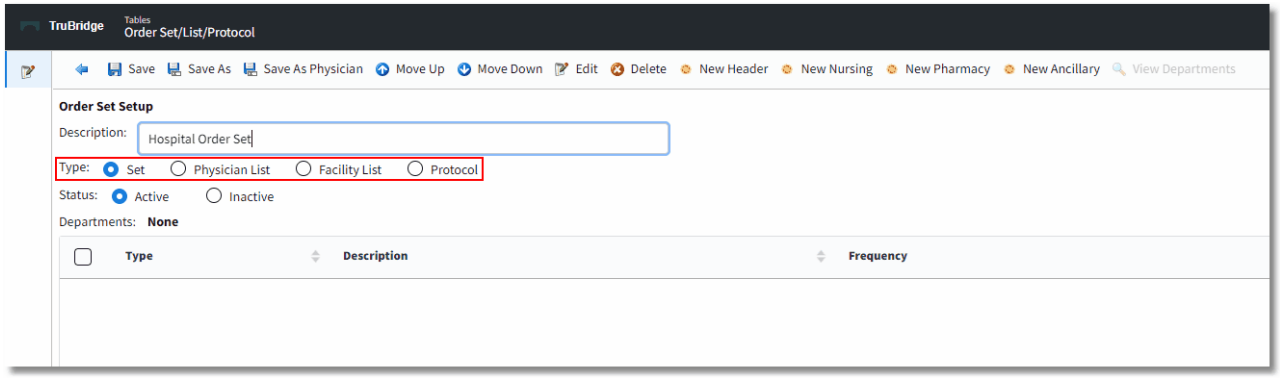
Order Set/List/Protocol Maintenance

- Any existing order sets, order lists and protocols will display. The **Type** options consists of check boxes titled **Set**, **List**, and **Protocol**. All check boxes will default as checked but may be selected/deselected to expand or narrow the search.
- The **Status** field options consists of check boxes titled **Active** and **Inactive**. The check boxes will default as checked, but may be selected/deselected to show only active lists (the lists that are currently available) or inactive lists (the lists that are under construction or obsolete).
- The **Search** field may be used to find a set/list/protocol by keyword.
- The **Description** column will display the title of each order set, list, and protocol.
- The **Type** column indicates whether the item is a **Set**, **Protocol**, or **List** (**Physician** or **Facility** - see Owner Column).

- The **Status** column indicates whether the item is **Active** or **Inactive**.
- The **Last Modified** column will display the date of the last time the order set, list, or protocol was accessed and edited.
- The **Created** column will display the date of the creation of the order set, list or protocol.
- The **Owner** column will display the name of the provider who owns the order list or it will display Facility if it is an order set or facility list.
- The blue back arrow will return to the previous page.
- The **New** option will prompt for the creation of a new order list, order set or protocol.
- The **Delete** option will prompt for the deletion of a selected item in the list.
- The **Assign Departments** option is for the Protocol and Facility List options and will determine which nursing departments will be able to access the Protocol or Facility List from the **Description** drop-down on the Order Entry page.
  - Select the desired description to highlight it and then select **Assign Departments** to choose the available nursing departments from the list.
  - The department look-up table will display, a **Search** field will be available and will default to **Search by Number**. To search by the department title, select **Description** from the **Search drop-down**.
  - Locate the desired department and select to highlight the description, then choose **Select** from the action bar.

  ***NOTE**: Protocols and Facility Lists may be assigned to more than one department.*
- The **View Departments** option may be used to view the assigned departments for Protocols and Order Lists.
  - Select a Protocol or Facility List description and then select **View Departments** to view the departments to which that Protocol or Facility List has been assigned.
  - To remove an assigned department, select the department, and then select **Remove** from the action bar.
- To create a new order set, list, or protocol select **New.**

Select **Web Client** > **Tables** > **Clinical** > **Order Set/List/Protocol Maintenance** > **New**



Order Set Setup

- **Description** is the title of the order list or set and is user-defined.
- **Type** will indicate if it is an Order Set, Physicians List, Facility List or Protocol. The default is Set, but may be changed to List or Protocol.
- **Status** indicates whether the set or list will be available for ordering via Order Entry. Active will be available through Order Entry. Inactive will not be available for Order Entry and may be set to this if the Set or List is still being constructed.
- **Departments** indicates what hospital departments will have access to the Order Set or List in their default drop-down. The Departments may be assigned to the Order Set/List/Protocol from the primary screen's Assign Departments option (see above).
- The **blue back arrow** will return to the previous page.
- The **Save** option will save any progress or recent changes to the order set. This should be selected prior to exiting the table.
- The **Save As** option will allow the order set to be saved under a new name and all setup will be copied to the new order set. Once saved, the new order set may be selected and edited.

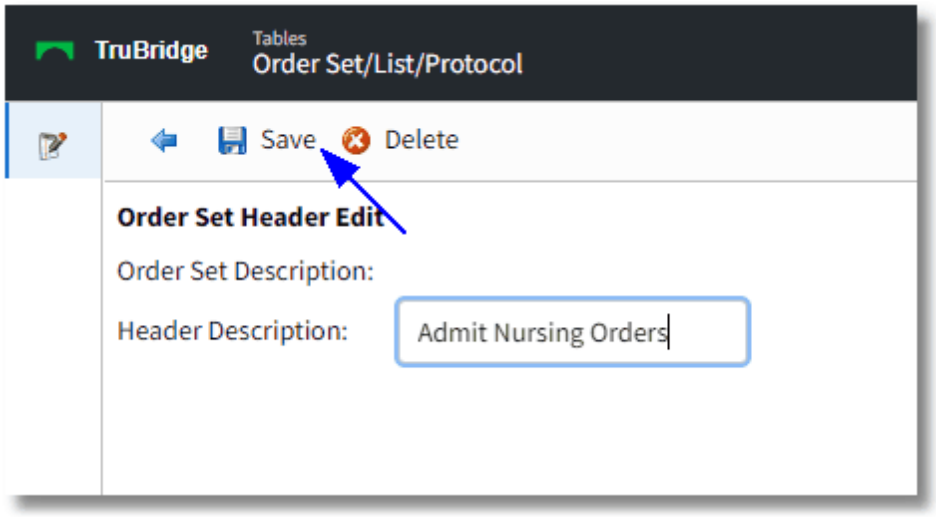
  NOTE: *This will not replace the original order set.*

- The **Save As Physician** option will allow the order set or order list to be saved as an order list for a specific provider. Once saved, the assigned provider will be able to find the order list description in their custom order lists within OE.
- The **Move Up** and **Move Down** options will allow a selected item in the order set to be moved up or down to rearrange the order of the list.
- The **Edit** option will allow for the editing of an existing set or list.
- The **Delete** option will allow for the deletion of a selected item in order set or list.

- The **New Header** option will allow for the creation of a new header within the order set or list. A header will appear as bold text within Order Entry and gives the set/list a more organized appearance. Enter a header description and select **Save**.

NOTE: *Headers are not selectable within OE and have no functionality in the Order Entry process.*

Select **Web Client** > **Tables** > **Clinical** > **Order Set/List/Protocol Maintenance** > **New** > **New Header**

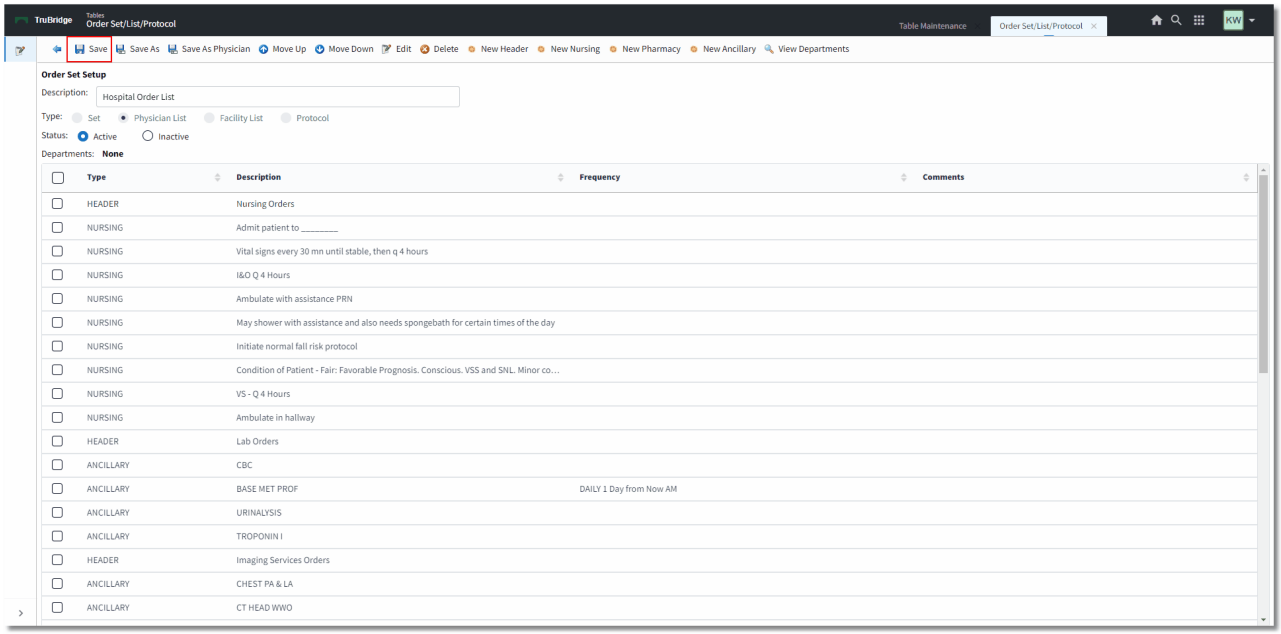


Order Set Header Edit

Please see the sub-chapters for how to add each order type: Nursing Orders 224, Ancillary Orders 226, and Pharmacy Orders 228.

Once all items have been edited select **Save** to save all changes prior to exiting the Order Set Setup. Select the **Blue Back Arrow** to return to the Order Set/List/Protocol Maintenance screen.

Select **Web Client** > **Tables** > **Clinical** > **Order Set/List/Protocol Maintenance** > **New** > **Save**

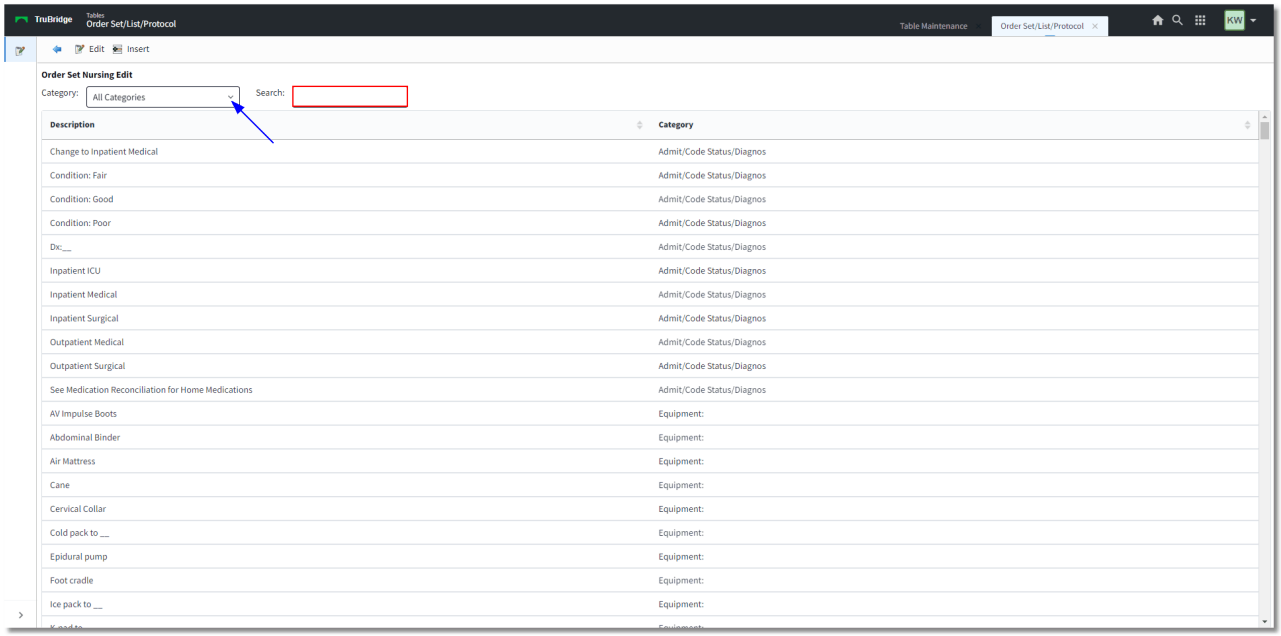


Order Set Setup

Nursing Orders

- The **New Nursing** option will populate a list of nursing orders and categories.

Select **Web Client** > **Tables** > **Clinical** > **Order Set/List/Protocol Maintenance** > **New** > **New Nursing**

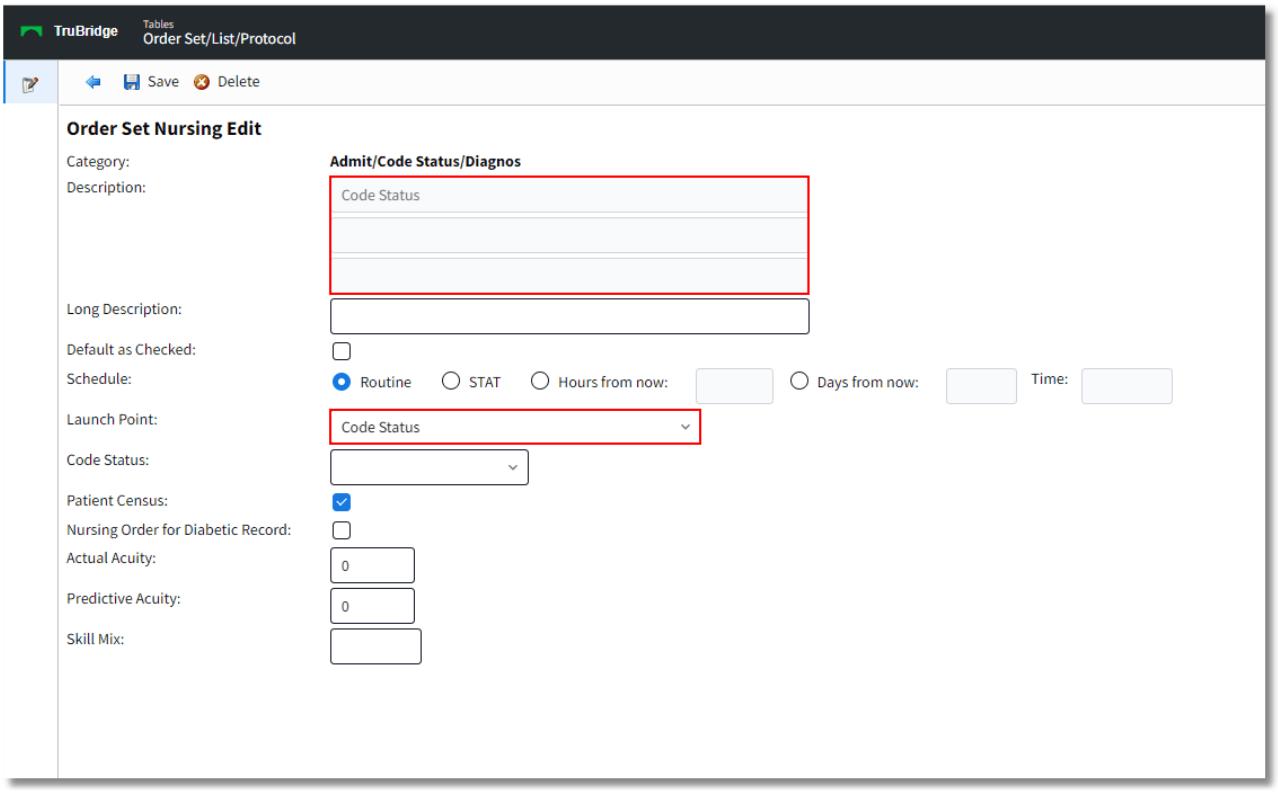


Order Set Nursing Edit

- The Order Set Nursing Edit screen will open with options to search by All Categories as the default. To search for a specific Nursing Orders category, select the drop-down list and choose the desired category. The **Search** field will utilize a keyword search by description and results will begin to populate as the text is entered.

- Select a **Description** and then select **Insert** to add to the Order Set/List. After the order is inserted, the screen will automatically return to the order set setup screen. An order may also be added to the Order Set/List if it is double-clicked, but this will open the order editing screen. A description may also be edited by selecting the description and then selecting **Edit**.

Select **Web Client** > **Tables** > **Clinical** > **Order Set/List/Protocol Maintenance** > **New** > **New Nursing** > **Edit**



Order Set Nursing Edit

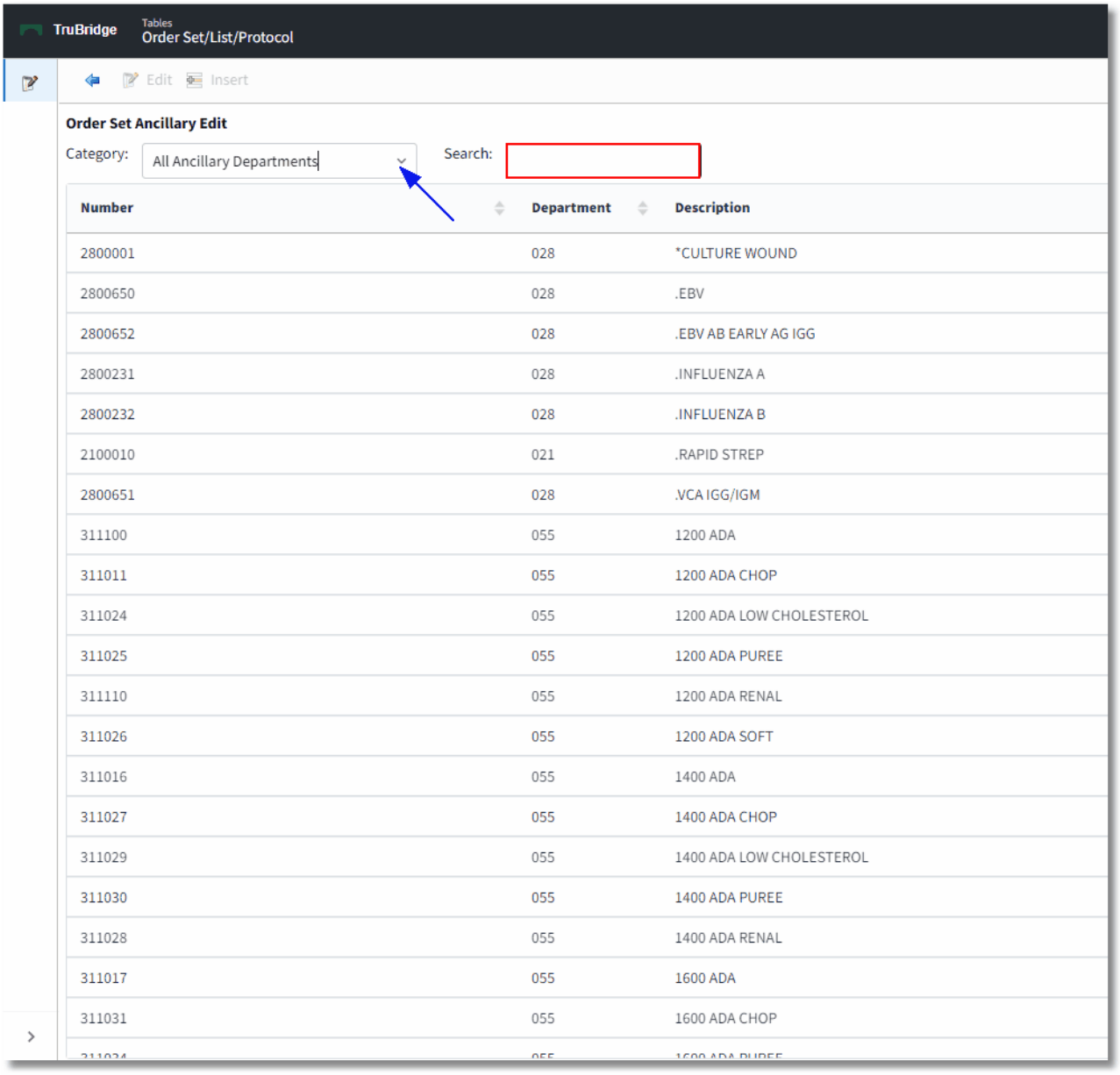
- Once the editing screen is open, the **Description** field text may be changed. Three fields of up to 75 characters each may be used to enter the description. The item being edited should be selected by the correct **Category** (as this may not be changed) so that it will populate correctly to the **MedAct**. **Save** may be selected after any changes are made. Note that if a Launch Point is attached to a Nursing Order via Nursing Order Category setup or added while creating the Order Set/List, the Description is grayed out and cannot be changed during Order Entry. The user will have to select a Code Status from a drop-down in Order Entry to address the order.

- **Default as Checked** will determine whether or not the item is pre-checked once the set/list is accessed in OE.

Ancillary Orders

The **New Ancillary** option will populate a list of ancillary items within the hospital item master.

Select **Web Client** > **Tables** > **Clinical** > **Order Set/List/Protocol Maintenance** > **New** > **New Ancillary**



Order Set Ancillary Edit

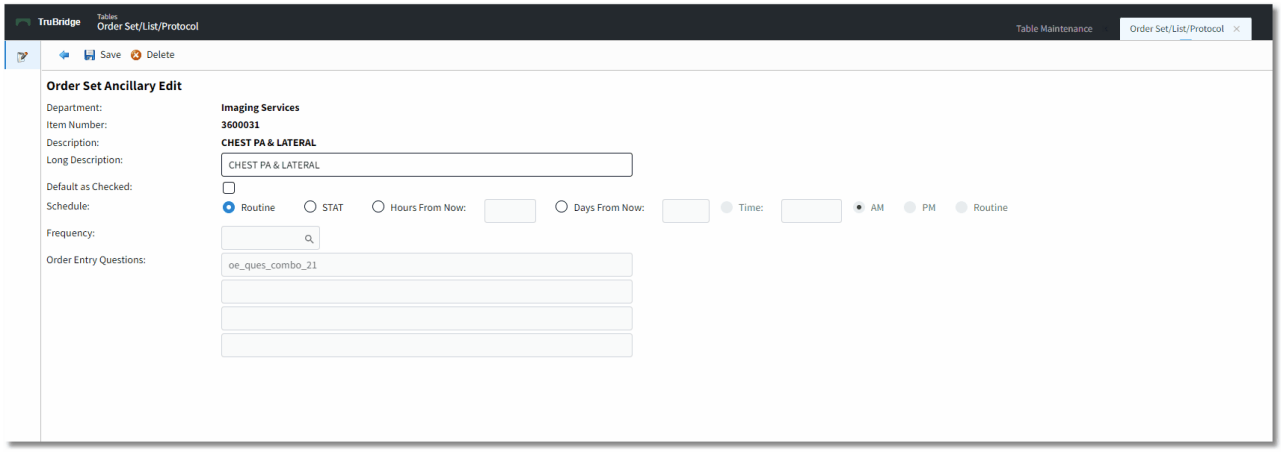
- The Order Set Ancillary Edit screen will open with options to search by All Ancillary Departments as the default. The search may be narrowed down by selecting a specific ancillary department from the drop-down. The item number will display in the left column and the item description will display in the following column.

- **The Search** field will utilize a keyword search by description and results will begin populate as the text is entered.

- The **Number, Department** number, and **Item Description** columns may be selected to sort items. The listing will default numerically by item number.

- Select a **Description** and then select **Insert** to add to the order set/list. After the order is inserted, the screen will automatically return to the order set setup screen. An order may also be added to the set/list if it is double-clicked, but this will open the order editing screen. A description may also be edited by selecting the description and then selecting **Edit**.

Select **Web Client** > **Tables** > **Clinical** > **Order Set/List/Protocol Maintenance** > **New** > **New Ancillary** > **Save**



Order Set Ancillary Edit

- Once the item is selected for editing, the Order Set Ancillary Edit screen will open. The department number, the item number and the item description will display and may not be changed. The **Long Description** field may be added to display additional information, but is not required. If a Long Description is entered, it will pull to the Search Orders box within OE and display instead of the item description.

- **Default as Checked** will determine whether or not the item is pre-checked once the set/list is accessed in OE.

- **Schedule** allows the item to be set as a Routine order or a STAT order within the set/list. Hours from now allows the item to be ordered within a defined number of hours from the time the order is being placed. Days from now allows the item to be ordered within a defined number of days from the time the order is being placed. Time may be entered if the order should be take place at a specific time of the day. For instance, one might schedule a CHEST PA & LATERAL 1 **Days From Now** at a **Time** of 0600 (6am).

- **Frequency** will allow an item to be set to generate multiple orders on a scheduled timeline. To change the frequency, select the magnifying glass icon and it will populate a table of all of the hospital frequencies.

- **Order Entry Questions** will reflect any questions that have been built on the item from **System Menu > Charge Tables and Inventory > Search for Item** and edit the **Order Entry Questions** and **Physician Chartlink Questions**.

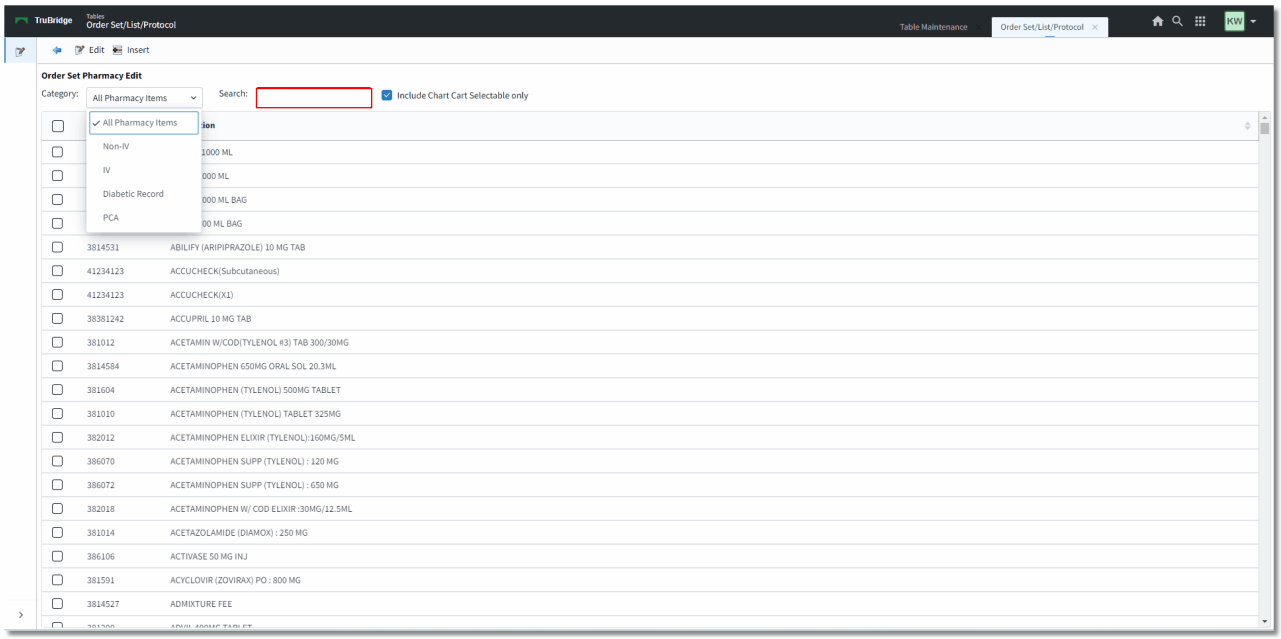
- Once all editing on the item has been completed, select **Save** to save the item and return to the Order Set Setup screen. Hovering over an item description that is too long to fully display in the description field will display the full description in a wrapped-text.

NOTE: *If* ***AM*** *is selected for the Scheduled Date/Time when an item is added to a list via CPOE, the item will save to the list as "Days from Now - 1" and "AM."*

Pharmacy Orders

The **New Pharmacy** option will populate a list of medication items within the hospital formulary.

Select **Web Client** > **Tables** > **Clinical** > **Order Set/List/Protocol Maintenance** > **New** > **New Pharmacy**



Order Set Pharmacy Edit

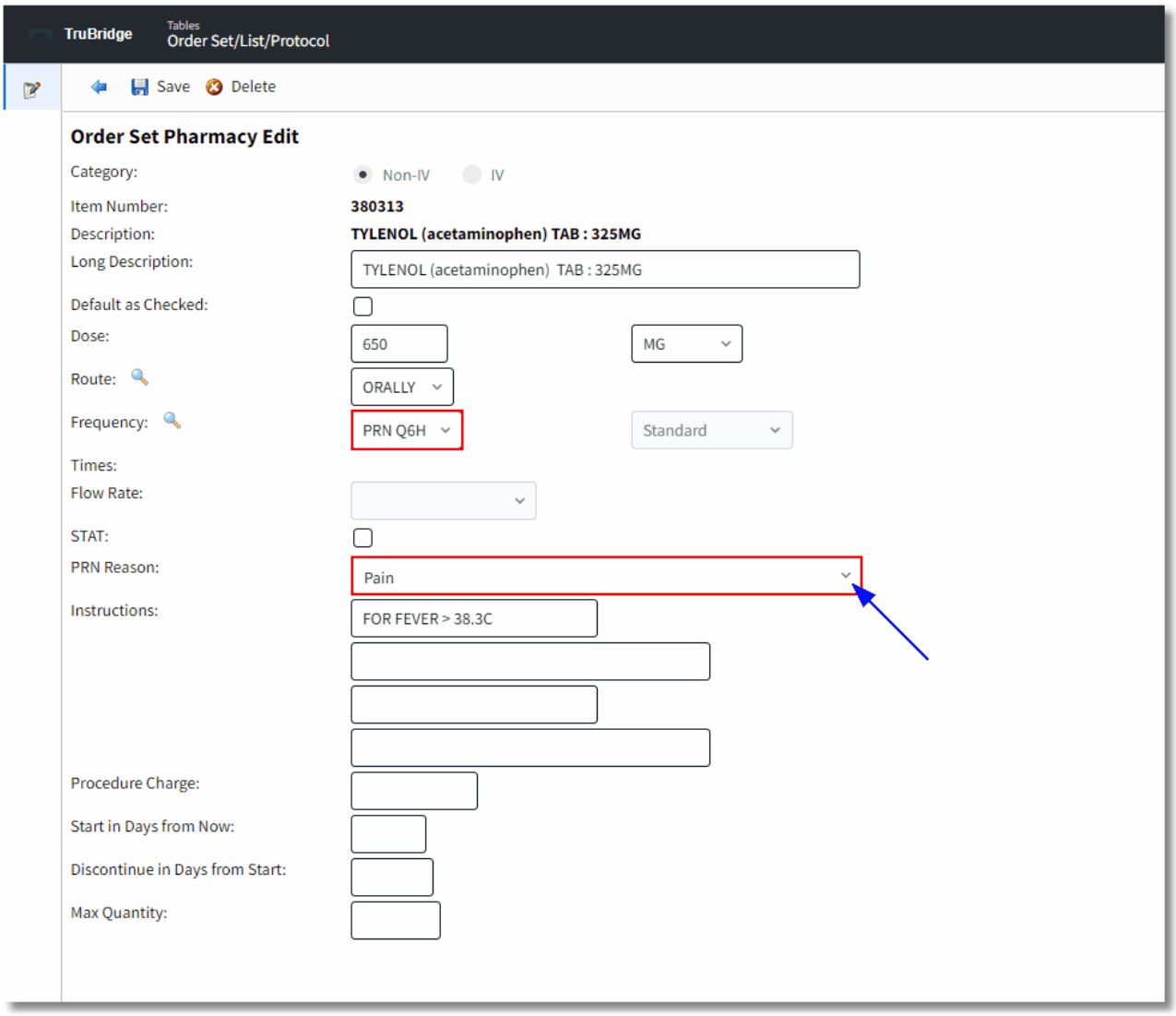
- The Order Set Pharmacy Edit screen will open with options to search by All Pharmacy Items as the default. The search may be narrowed down by selecting Non-IV, IV, Diabetic Record and PCA from the drop-down. The item number will display in the left column and the item description will display in the following column. **Chart Cart Selectable Only** should be checked as this will display items that are ordered by nursing and providers, but excludes items that are specific to the Pharmacy Department only.

- The **Number** and **Item Description** columns may be selected to sort items. The listing will default by alphabetic description.

- The **Search** field will utilize a keyword search by description and results will begin to populate as the text is entered.

- Select a **Description** and then select **Insert** to add to the order set/list. After the order is inserted, the screen will automatically return to the order set setup screen. An order may also be added to the set/list if it is double-clicked, but this will open the order editing screen. A description may also be edited by selecting the description and then selecting **Edit**.

Select **Web Client** > **Tables** > **Clinical** > **Order Set/List/Protocol Maintenance** > **New** > **New Pharmacy** > **Save**



Order Set Pharmacy Edit

- Once the item is selected for editing, the Order Set Pharmacy Edit screen will open. The Category, the item number and the item description will display and may not be changed. The **Long Description** field may be added to display additional information, but is not required. If a long description is entered, it will pull to the Search Orders box within OE and display instead of the item description.

- **Default as Checked** will determine whether or not the item is pre-checked once the set/list is accessed in Order Entry.

- **Dose** will reflect the item dose and unit. Both fields may be edited to customize the order set/list.

- **Route** will reflect the item route. To change the route, select the magnifying glass icon and it will populate a table of all of the hospital routes.

- **Frequency** will reflect the item frequency. To change the frequency, select the magnifying glass icon and it will populate a table of all of the hospital frequencies. (See below for the **PRN Reason** and **Indication** based upon the default frequency.)

- **Times** will reflect any standard/scheduled times on the selected frequency.

- **Flow Rate** may be set for any IV items.

- **STAT** will set any item as a Stat or Now order.

- **PRN Reason**: If a PRN Frequency has been assigned to the pharmacy item, an existing or new PRN Reason may be added to the item in the Order Set/List so that it will pull the pre-defined PRN Reason for the item when it is ordered. Pharmacy may or may not have the PRN Reason field set up as Required. The drop-down for PRN Reasons should use the PRN Administration Reasons table and include an <OTHER> option.

- **Indication**: If a default frequency with set times/hours (QID, BID) in the pharmacy frequency table has been assigned to the item, the Indication field will appear and a magnifying glass icon is available to search for and pull in a default Indication reason for the medication. When the item is ordered from the Order List/Set, it will pull the pre-defined Indication listed in this field. Pharmacy may have certain items set with an Indication Required, especially for Antimicrobial agents.

- **Instructions** will reflect in the comments box of the item.

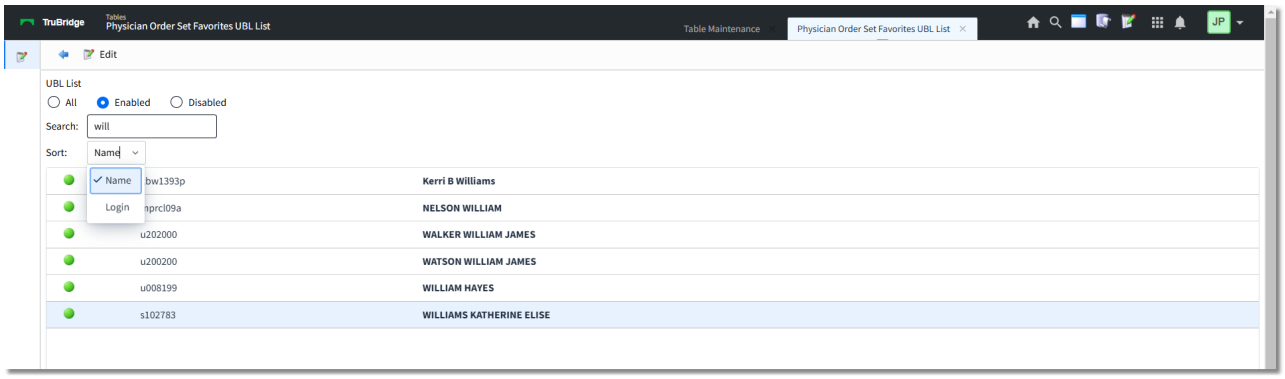
- Once all editing on the item has been completed, select **Save** to save the item and return to the Order Set Setup screen.

11.15 Physician Order Set Favorites

The Physician Order Set Favorites table will allow an administrator to create order set favorites for providers.

When this table is selected, a screen listing all provider names and logins will display. A search may be done by entering a name or the physician login. Once a provider has been located, select the name and then select **Edit** or double-click the provider name.

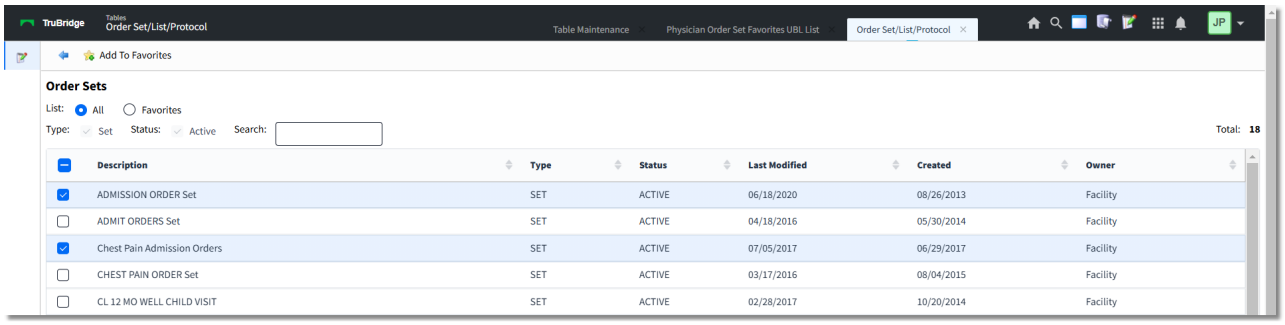
Select **Web Client** > **Tables** > **Clinical** > **Physician Order Set Favorites**



UBL List

If a provider already has sets added to his/her favorites, a display of those existing favorites will display. If no favorites have been established, the order set selection screen will display.

Select **Web Client** > **Tables** > **Clinical** > **Physician Order Set Favorites** > **select Provider**



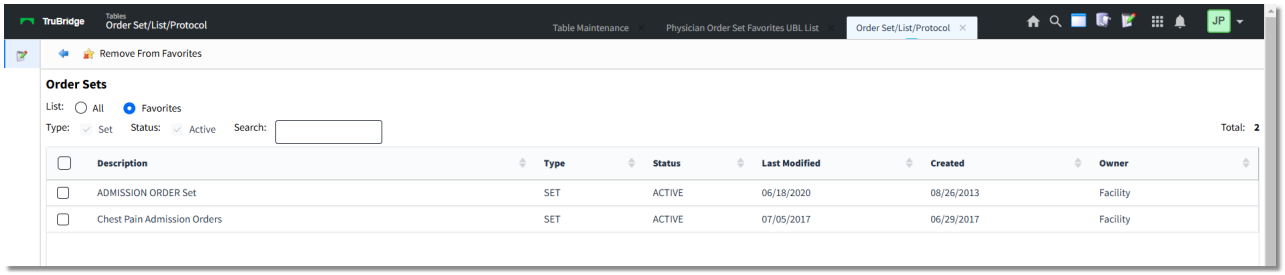
Order Sets

The screen titled **Order Sets** will have the following:

- **List**: **All** display all order sets available for the facility and **Favorites** will display all order sets that have been added to the favorites for the selected provider.

- The action bar options will change depending upon the selected radio button:
  - **Add to Favorites** will display when **All** is selected. The order set may be selected individually or multiple sets may be selected by holding down Ctrl while selecting with the mouse. Once the desired set(s) are selected, choose **Add to Favorites** to add them to the provider's favorites.
  - **Remove from Favorites** will display when **Favorites** is selected. The order set may be selected individually or multiple sets may be selected by holding down Ctrl while selecting with the mouse. Once the desired set(s) are selected, choose **Remove from Favorites** to remove them from the provider's favorites.

Select **Web Client** > **Tables** > **Clinical** > **Physician Order Set Favorites** > **select Provider**



Order Sets

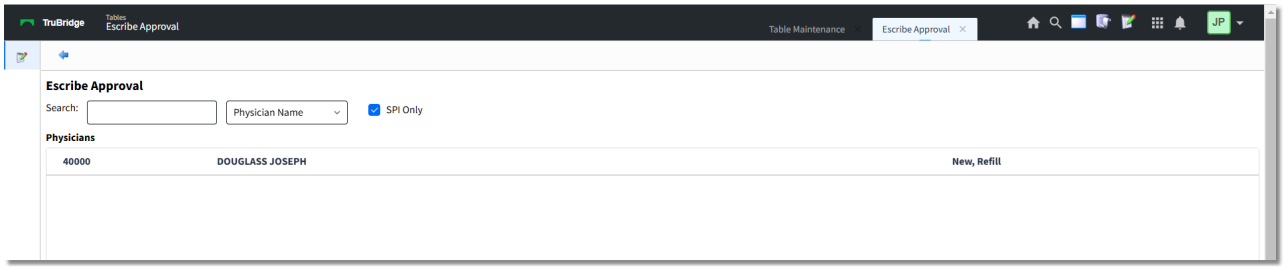
Chapter 12 Prescription Entry

12.1 EScribe Approval

The functionality of prescribing controlled substances electronically, which is being mandated by some states, has been added to the TruBridge EHR. Changes have been made to the files sent and received between TruBridge, pharmacies, and authentication screens to accommodate the certification of TruBridge Escribe 2.0 + EPCS. Changes that will affect all users are listed below.

1. When EPCS is not enabled, this table will display as view-only, displaying the physician information and service levels for providers who are set up to send electronic prescriptions. If EPCS is enabled, there will be an additional column displaying the EPCS status as well as an option to check the status of a selected provider and an option labeled "EPCS LAC" (Logical Access Control).
   - The option directs the user to the screen where the Active Grant, a step for utilizing EPCS, may be given to providers who are enrolled for EPCS. The authentication will require a System Administrator with access to LAC and a provider who is currently active in EPCS.
   - The "EPCS LAC" option will initially be available to any user who has Rule Based Security access to Table Maintenance. A default Deny rule has been included in the software update, entitled "Deny Escribe Logical Access in Table Maintenance" and may be located under the Screen tab in Identity Management. This rule should be added for users who have access to Table Maintenance, but who should not be allowed to access LAC for EPCS.

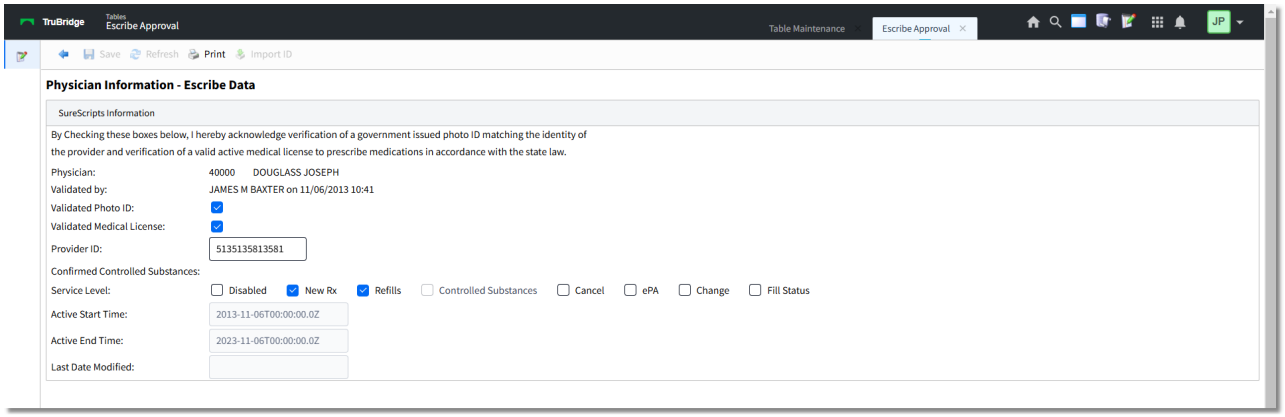
Select **Web Client** > **Tables** > **Clinical** > **Escribe Approval**



Escribe Approval

2. Once the Active Grant has been given, the user may double-click the provider name in the Escribe Approval table to access the Physician Information - Escribe Data screen (that may also be accessed via page 3 of Physician Security) in order to grant final access to EPCS by selecting the check box for the service level Controlled Substances. The checkbox will only become enabled if all of the preliminary steps for EPCS enrollment have been completed.

Select **Web Client** > **Tables** > **Clinical** > **Escribe Approval** > **double-click Provider name**



Physician Information - Escribe Data

3. Service levels include:

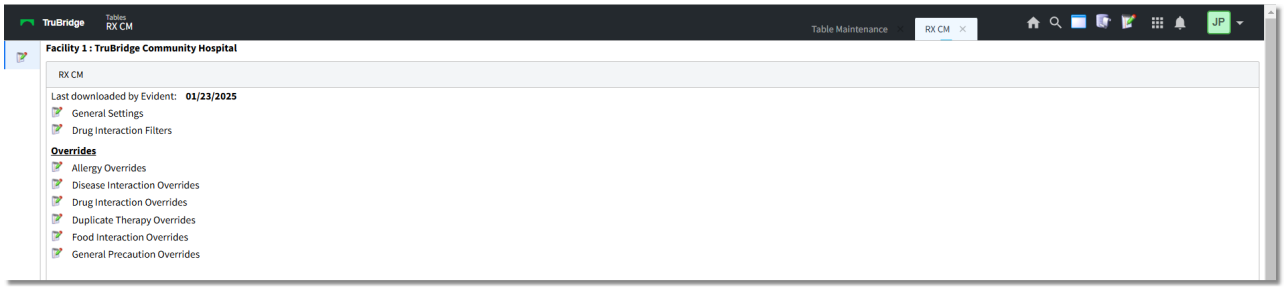
- **New** Prescription (Service Level is 1): Allows prescriber to create a new prescription for a patient.
- **Refills** (Service Level is 2): Allows prescriber to address refill requests from patients/pharmacy.
- **Cancel** (Service Level is 16): Allows prescriber to cancel a pending prescription.
- **ePA** (Service Level is 128): Electronic Prior Authorization will be available to send an authorization request for medications that require a Prior Authorization.
- **Change** (Service Level 4): Allows prescriber to edit a pending prescription and resubmit it.

NOTE: *Service Level codes are used to determine the messaging capabilities of a prescriber.*

12.2 Clinical Monitoring

The Clinical Monitoring Control Table is used to define the types and levels of clinical monitoring checks and overrides that appear during prescription entry.

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring**



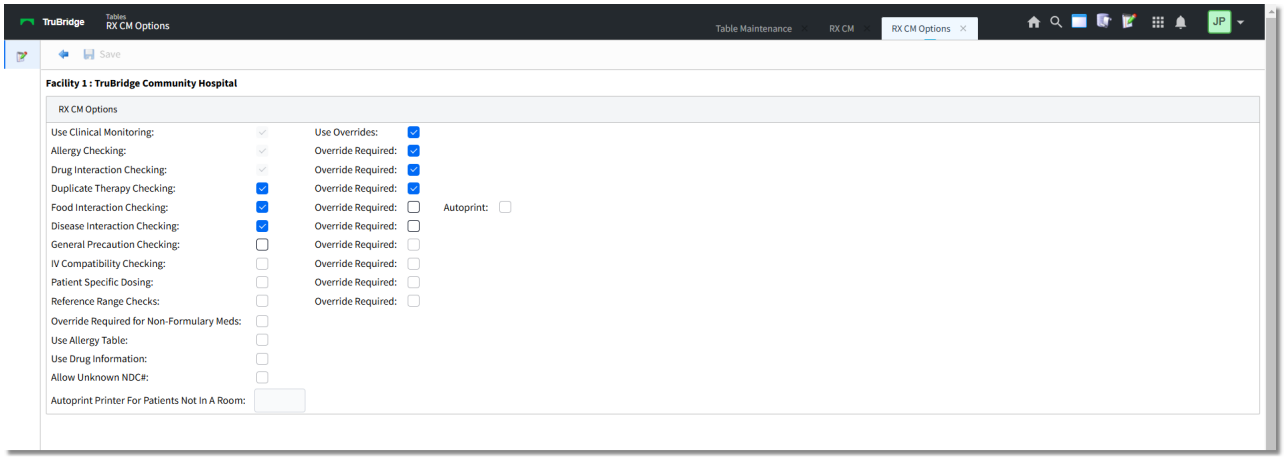
RX CM

- **Last Downloaded: MM/DD/YYYY:** Indicates the last date clinical monitoring files were updated.
- **General Settings:** Contains the clinical monitoring option settings.
- **Drug Interaction Filters:** Contains the drug interaction filtering option settings.
- **Overrides:** Lists override reasons for each clinical monitoring category.

General Settings

The Clinical Monitoring General Settings section contains all activation options for Prescription Entry Clinical Monitoring.

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **General Settings**



RX CM Options

- **Use Clinical Monitoring:** Activates Clinical Monitoring for prescription entry. This field is grayed out but always checked "yes," since some Clinical Monitoring checks are required to meet Meaningful Use.

- **Allergy Checking:** Allows the system to automatically perform allergy checks at the time of prescription entry. Whenever a drug is entered for a patient, the system compares the new medication to any drug allergy entered on the patient through the TruBridge system. If there are any drug allergies documented that correspond to the medication selected, a menu will display showing the drug selected, the allergy, the drug class, and any possible symptoms. This field is grayed out but always checked "yes," since this Clinical Monitoring check is required to meet Meaningful Use. **Include Inactive Ingredients** is not available for prescription entry clinical monitoring.

- **Drug Interaction Checking:** Allows the system to automatically perform drug interaction checks at the time of prescription entry. Whenever a drug is entered for a patient, the system compares the new medication to all medications the patient is currently taking or has taken within the last 24 hours. Any possible interactions will display. The drug interactions are ranked as contraindicated, major, moderate or minor. This field is grayed out but always checked "yes," since this Clinical Monitoring check is required to meet Meaningful Use.

- **Duplicate Therapy Checking:** Select the check box to allow the system to automatically perform duplicate therapy checks at the time of prescription entry. As soon as a medication is selected to be dispensed, the patient's current prescriptions are reviewed for duplicate therapy. The Clinical Monitoring Screen appears, and under Duplicate Therapy, the similar medication is listed. If an active medication is continued via Prescription Writer, the system performs this check by looking at the NDC number on the order, which pulls from Pharmacy Info page 1, and creates the prescription based on that NDC but includes the full item description from Truven Micromedex. If a new prescription is created in Prescription Writer by using the New Prescription option, the NDC is pulled directly from Micromedex and duplicate therapy checking is performed based on that.

  NOTE: *Duplicate Therapy Checking is not performed on discontinued orders.*

- **Food Interaction Checking:** Select the check box to allow the system to automatically perform food interaction checks at the time of prescription entry. If a medication that has an interaction to food is selected, the Clinical Monitoring screen displays.

  NOTE: *The* ***Autoprint*** *option next to Food Interaction Checking is not used by Prescription Clinical Monitoring.*

- **Disease Interaction Checking:** Select the check box to allow the system to automatically perform drug-disease interaction checking at the time of prescription entry. Whenever a drug is entered from the Drug Formulary for a patient, the system compares the new medication to the diagnosis for the patient to ensure the drug does not interfere with the diagnosis. It will also provide a drug/drug screening for current medications, checking for disease monitoring.

- **General Precaution Checking:** Activates or deactivates General Precaution Checking, which screens a medication's active and inactive ingredients against the patient's age and gender to

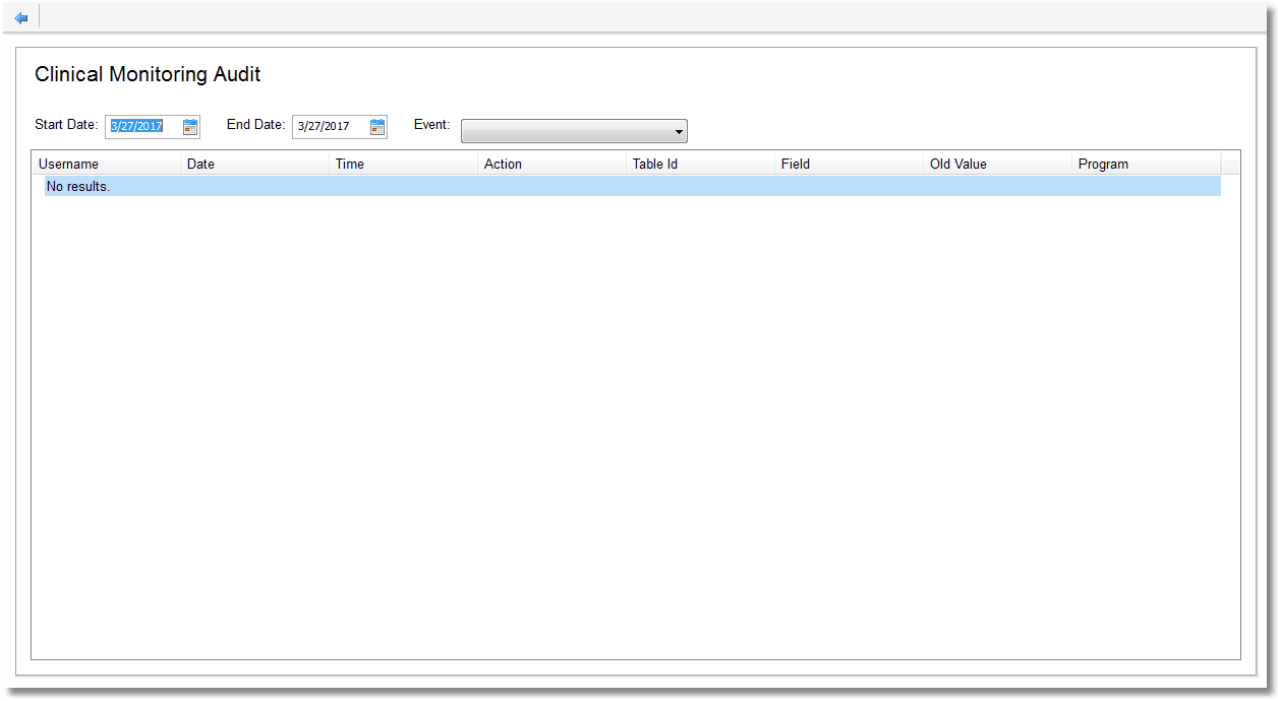
help determine whether the order should be continued. This checking more specifically provides individual and daily dosing information for pediatric, adult and geriatric age ranges.

- **IV Compatibility Checking:** IV compatibility checks are not performed during prescription entry.
- **Patient Specific Dosing:** Patient Specific Dosing checks are not performed during prescription entry.
- **Reference Range Checks:** The system does not check against laboratory reference ranges during prescription entry.
- **Use Overrides:** Select the check box to allow the user to enter override reasons at the time of order entry for any medication that meets the checks described above. Custom override reasons may be pre-built in the Overrides 241 section below and can be set for each type of Clinical Monitoring check.
- **Override Required:** Select the check box adjacent to each type of Clinical Monitoring Check that requires a reason be documented before proceeding with order entry.
- **Override Required for Non-Formulary Meds:** This option is not used during prescription entry clinical monitoring.
- **Use Allergy Table:** This option is not used during prescription entry clinical monitoring.
- **Use Drug Information:** This option is not used during prescription entry clinical monitoring.
- **Allow Unknown NDC#:** This option is not used during prescription entry clinical monitoring.
- **Autoprint Printer For Patients Not In A Room:** This option is not used during prescription entry clinical monitoring.
- **Save** 

: Once any changes are made, be sure to select **Save** from the action bar.
- **View Audit** 

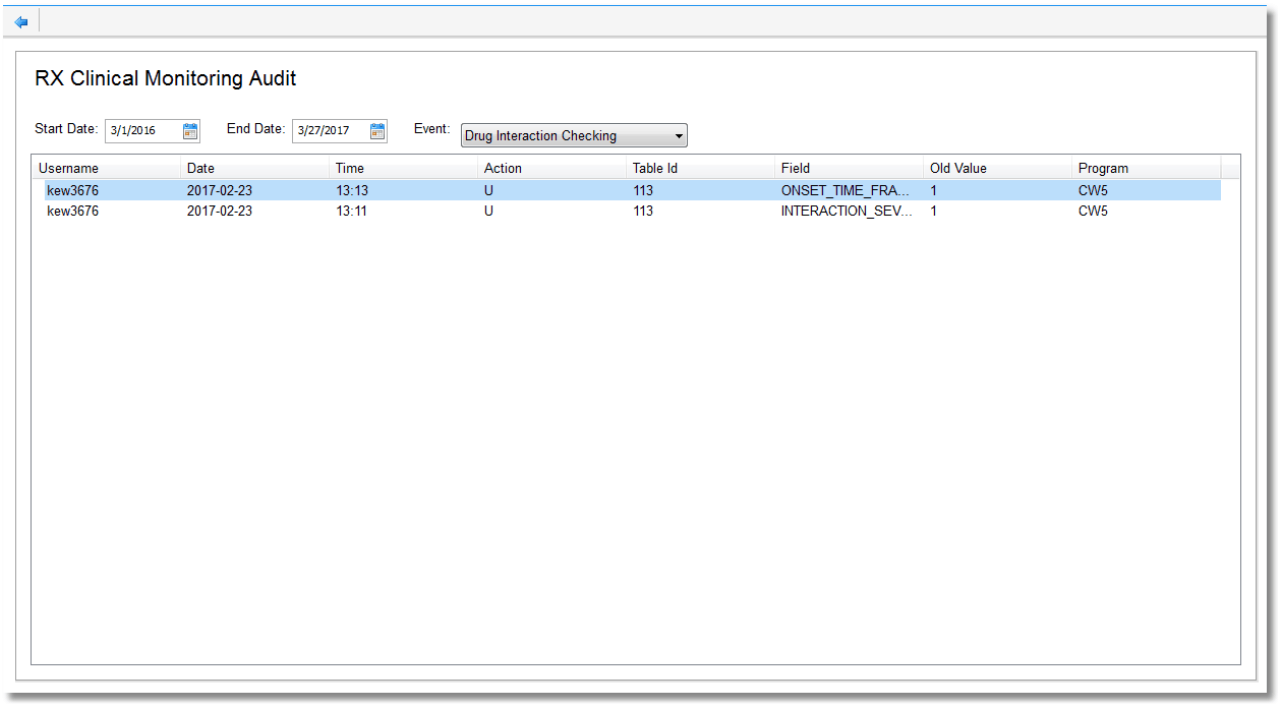
: The Clinical Monitoring audit log, accessed from the **View Audit** option on the action bar, records each time a Clinical Monitoring check has been turned on or off for a specific date range.

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **General Settings** > **View Audit**



Clinical Monitoring Audit

Populate the Start and End Date, then select the **Event** drop-down menu to select the type of clinical monitoring check to review.



RX Clinical Monitoring Audit

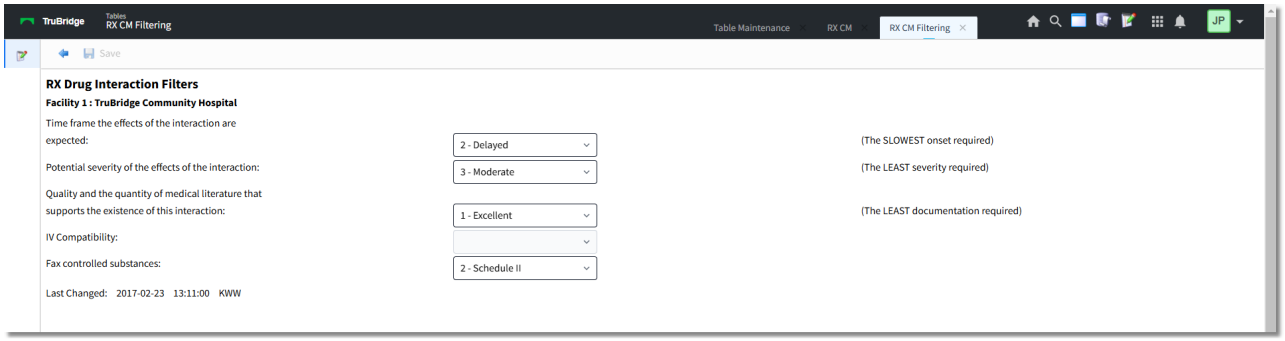
The Clinical Monitoring Audit functions are described below.

- **Username:** Shows the logname (UBL) of the employee who turned a check on or off
- **Date:** In YYYY-MM-DD format, shows the date the change was made
- **Time:** Shows the time the change was made
- **Action:** A code displays in this column, indicating what sort of action occurred.
  - **U:** Indicates the value of the field was updated
- **Table Id:** This field is not used at this time.
- **Field:** Names the Clinical Monitoring Check item that has been turned on or off
- **Old Value:** Indicates what the field's setting was prior to being changed.
  - Fields on the General Settings page display Y or N to indicate checked (Y) or unchecked (N)
  - Drug Interaction Filters display the numeric value located in the specific drop-down menus
- **Program:** Displays the name of the program from which the action was generated
- **Back Arrow**  **:** Select the **back arrow** to return to the previous screen.

Drug Interaction Filters

Interaction Filtering allows Drug Interaction warnings to be customized in terms of speed of onset, interaction severity, and the quality and quantity of medical literature available regarding an interaction.

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Drug Interaction Filters**



RX Drug Interaction Filters

- **Time frame the effects of the interaction are expected:** Select the slowest onset required to trigger a warning from the following options:
  - 1 - Rapid
  - 2 - Delayed

- **Potential severity of the effects of the interaction:** Select the least severity required to trigger a warning from the following options:
  - 1 - Contraindicated
  - 2 - Major
  - 3 - Moderate
  - 4 - Minor

- **Quality and the quantity of medical literature that supports the existence of this interaction:** Select the least documentation required to trigger a warning from the following options:
  - 1 - Excellent
  - 2 - Good
  - 3 - Fair
  - 4 - Poor

- **IV Compatibility:** IV compatibility filtering is not used during prescription entry clinical monitoring.

- **Fax controlled substances:** Choose from the following options the highest schedule of controlled substances to fax to a receiving pharmacy, or to disallow faxing of controlled substances. The setting should be made based on state guidelines.
  - **1 - Schedule I:** All schedules of controlled substances and non-scheduled drugs can be faxed.
  - **2 - Schedule II:** Drugs in Schedules II through V, and non-scheduled drugs, can be faxed.
  - **3 - Schedule III:** Controlled substances in Schedules III, IV and V drugs, as well as non-scheduled drugs, can be faxed.
  - **4 - Schedule IV:** Drugs in Schedules IV, V and non-scheduled drugs can be faxed.
  - **5 - Schedule V:** Drugs in Schedule V and non-scheduled drugs can be faxed.
  - **n/a:** Do not fax controlled substances.

NOTE: *When prescribing multiple new medications, if one or more do not fall into the class as defined in the field above, none of them will be faxable.*

- **Last Changed:** This field indicates the last date and time (in YYYY-MM-DD HH:MM:SS format) that the **Fax controlled substances** field was changed, along with the initials of the employee who made the changes.

- **Save** 

: Once any changes are made, be sure to select Save from the action bar.

- **Back Arrow**  **:** To return to the previous screen, select this option from the action bar.

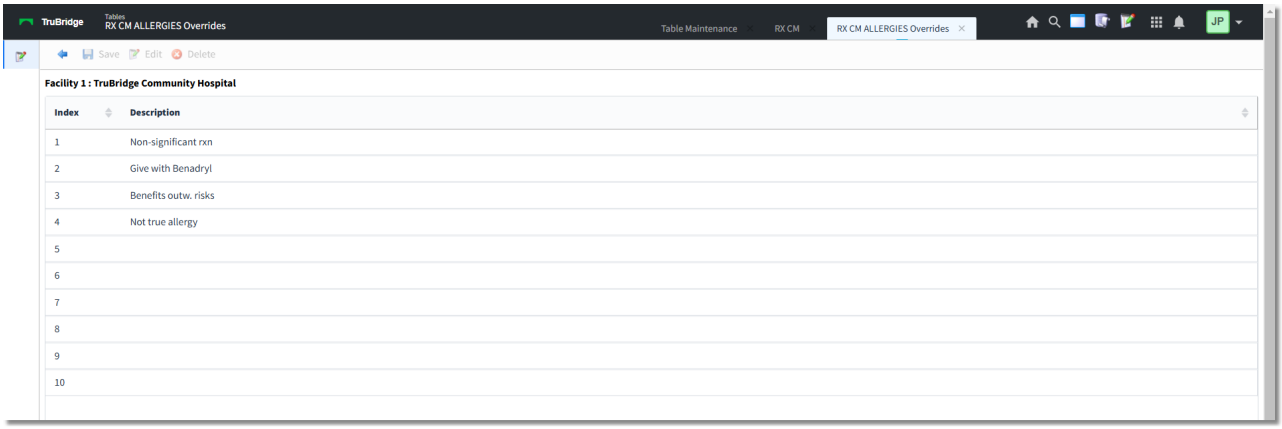
Overrides

Override reasons may be created for each type of clinical monitoring check. A maximum of 10 override reasons may be entered for each of the following categories: Allergies, Disease Interactions, Drug Interactions, Duplicate Therapy, Food Interactions and General Precautions.

Allergy Overrides

Up to 10 override reasons may be entered to address allergy checks. The Allergy Overrides list consists of 10 lines, with unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **Allergy Overrides**



RX CM Allergy Overrides

- **Edit** 

: To enter override reasons, select an entry from the list, and select this option from the action bar.

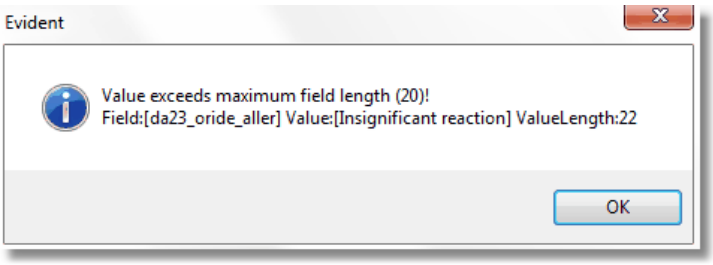
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time:

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **Allergy Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

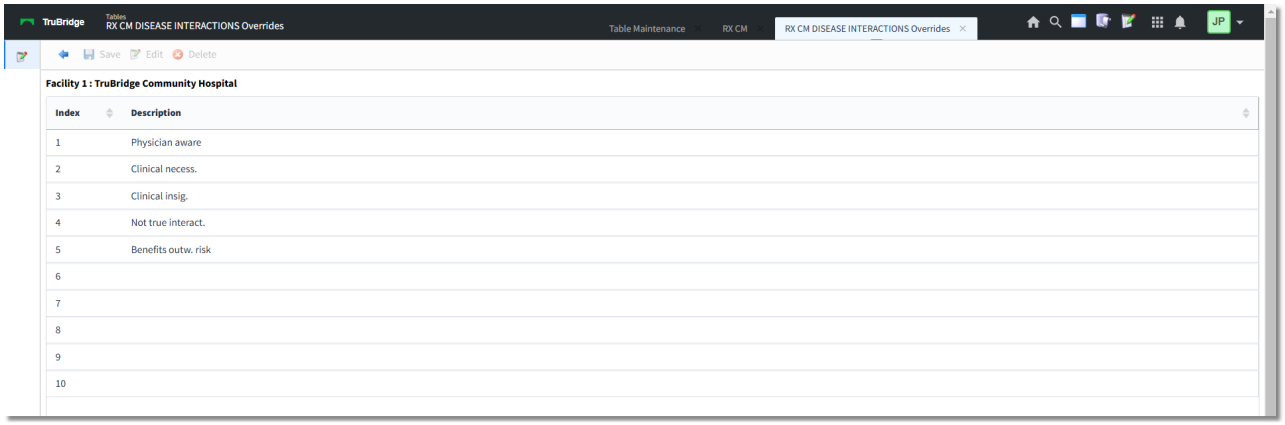
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back Arrow**  **:** Select to return to the previous screen.

Disease Interaction Overrides

Up to 10 override reasons may be entered to address disease interaction checks. The Disease Interaction Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **Disease Interaction Overrides**



Disease Interaction Overrides

- **Edit** 

: To enter override reasons, select an entry from the list, and select this option from the action bar.

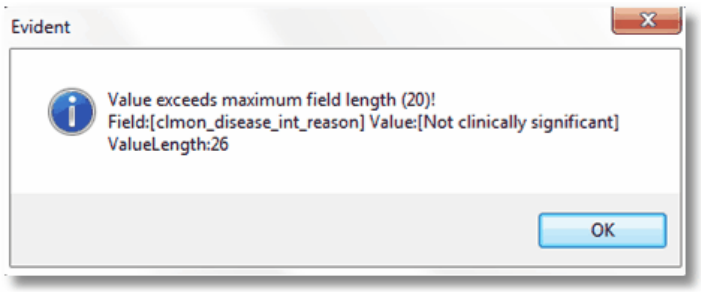
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time:

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **Disease Interaction Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

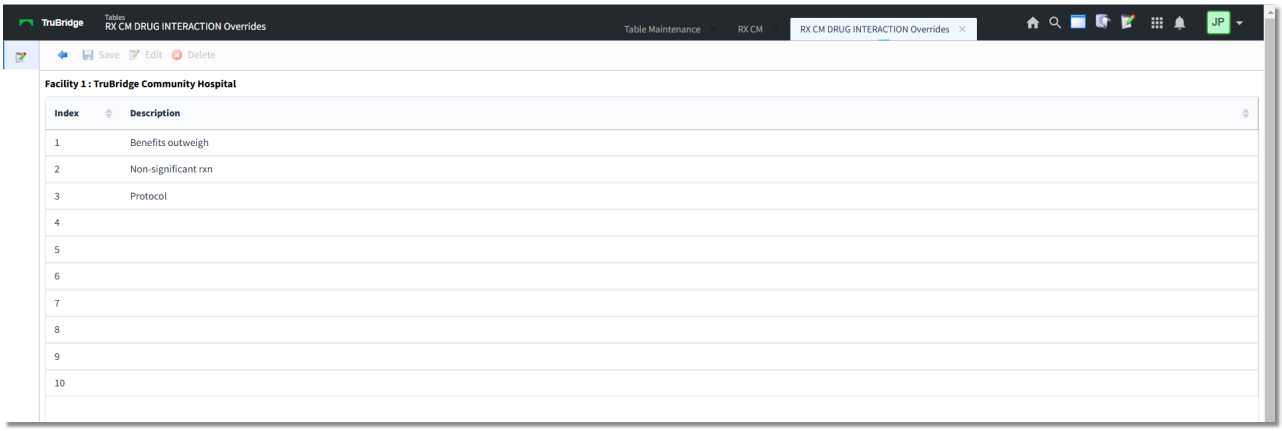
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

Back Arrow  **:** Select to return to the previous screen.

Drug Interaction Overrides

Up to 10 override reasons may be entered to address drug interaction checks. The Drug Interaction Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **Drug Interaction Overrides**



Drug Interaction Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

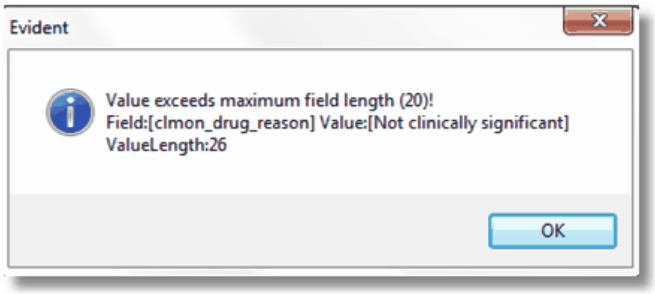
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time:

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **Drug Interaction Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

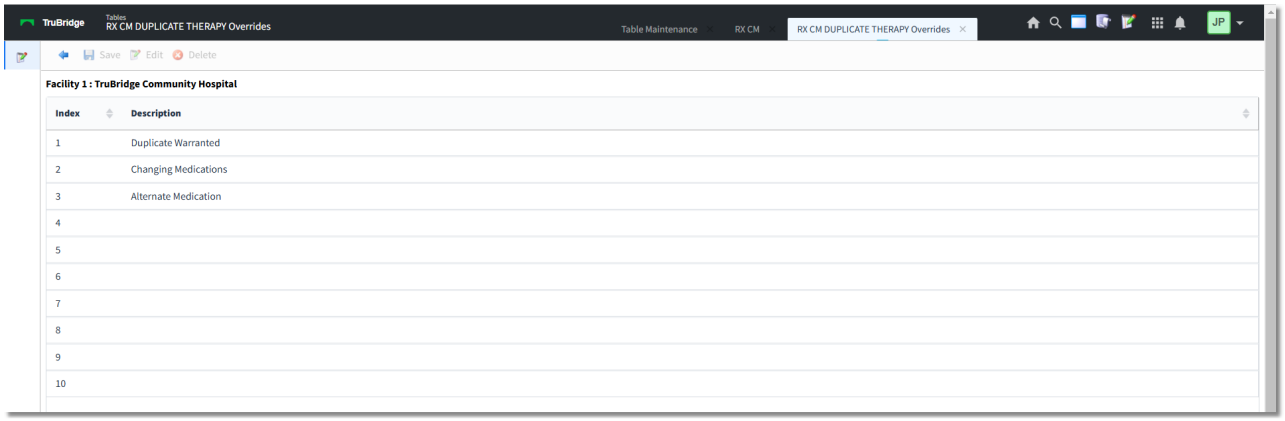
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back Arrow**  **:** Select to return to the previous screen.

Duplicate Therapy Overrides

Up to 10 override reasons may be entered to address duplicate therapy checks. The Duplicate Therapy Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **Duplicate Therapy Overrides**



Duplicate Therapy Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

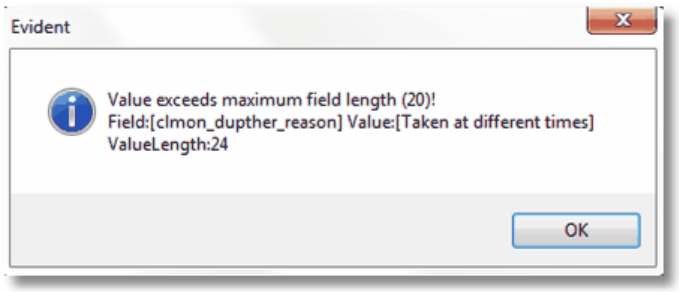
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time:

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **Duplicate Therapy Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

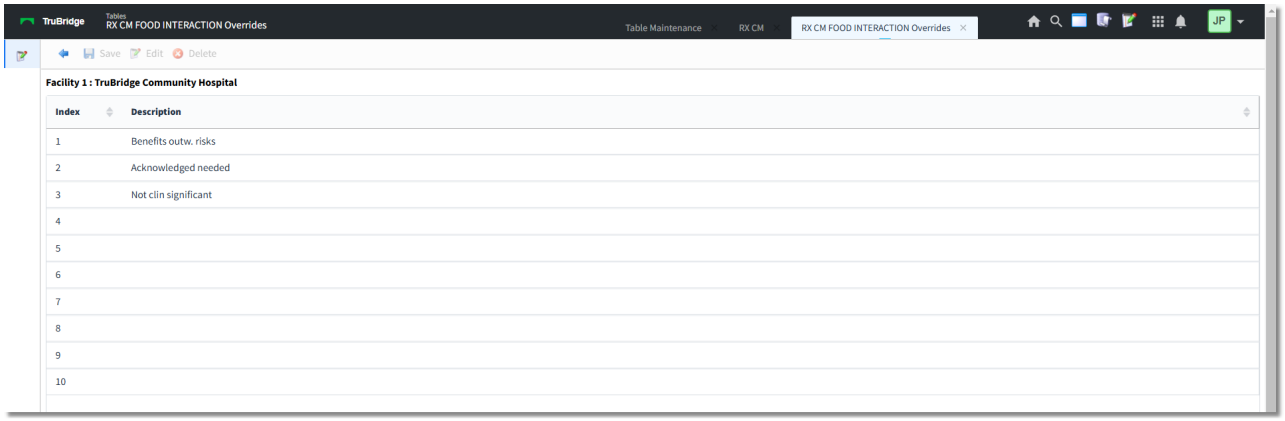
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back arrow**  **:** Select to return to the previous screen.

Food Interaction Overrides

Up to 10 override reasons may be entered to address food interaction checks. The Food Interaction Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **Food Interaction Overrides**



Food Interaction Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

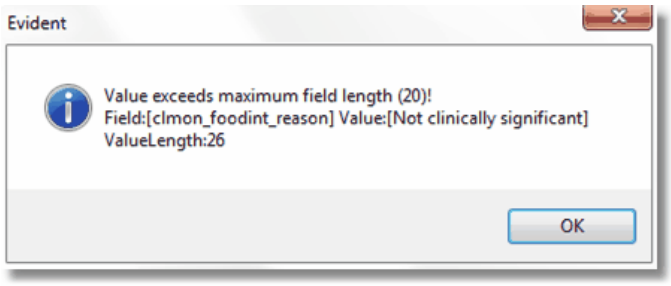
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time:

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **Food Interaction Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

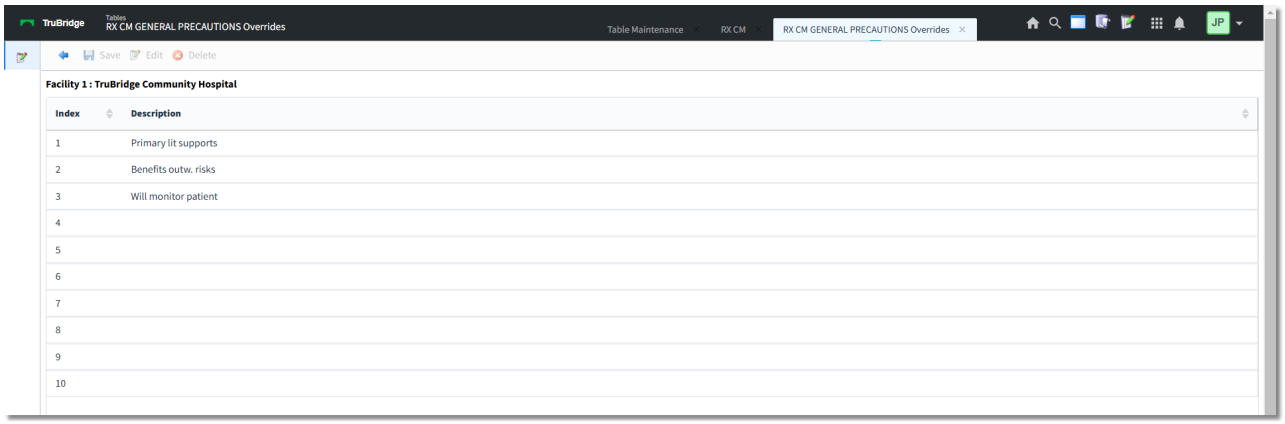
The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back Arrow**  **:** Select to return to the previous screen.

General Precaution Overrides

Up to 10 override reasons may be entered to address general precaution checks. The General Precaution Overrides list is made up of 10 lines, with any unused fields left blank, as in the example below. In addition to the customizable list, a hard-coded "other" option may be selected during order entry to free-text an override reason.

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **General Precaution Overrides**



General Precaution Overrides

- **Edit** 

: To enter override reasons, select an entry from the list and select this option from the action bar.

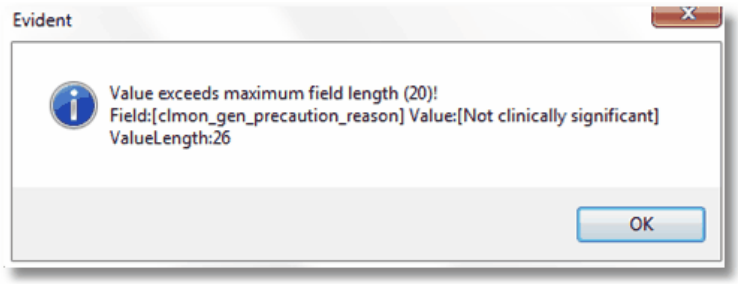
- **OK** 

: Enter the override reason in the field; it can hold a maximum of 20 characters. Select OK from the action bar to add to or update the overrides list.

- **Save** 

: To save any changes, select this from the action bar. If any override reason contains more than 20 characters, the system will prompt a warning at this time:

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Clinical Monitoring** > **Overrides** > **General Precaution Overrides** > **Override** > **OK** > **Save**



Override Field Length Warning

The warning includes the maximum field length, the length of the value entered, and the entry in detail. To acknowledge, select **OK**. Before this table can be saved, any field that is too long should either be corrected or deleted. Once the field in question has been appropriately addressed, the Save feature will function as intended.

- **Back Arrow**  **:** Select to return to the previous screen.

12.3 Control Table

The Control Table in Table Maintenance allows for E-Scribe to be turned on for a facility or multi-facility with a shared profile. By selecting the checkbox to the right of Use E-Scribe

Select **Web Client** > **Tables** > **Clinical** > **Prescription Entry** > **Control Table**

Prescription Entry Control

The blue back arrow will return to the main Clinical screen.

1. The Show Shared option will highlight any fields that are sharing the same profile with another facility (multi-facility).

2. The Print option generates a PDF copy of the table along with current settings/selections.

3. Save will save any changes made to the table.

4. Refresh will refresh the screen to reflect recent changes.

5. The **Use E-Scribe** check box will enable the ability to use the Electronic Prescription functionality via Prescription Entry. The date that the switch is selected will pull to the MU II Stats report.

6. The **Use EPCS** check box will allow the activation of EPCS along with a port number field. Since EPCS is a purchased TruBridge application, the check box is only active for TruBridge lognames.

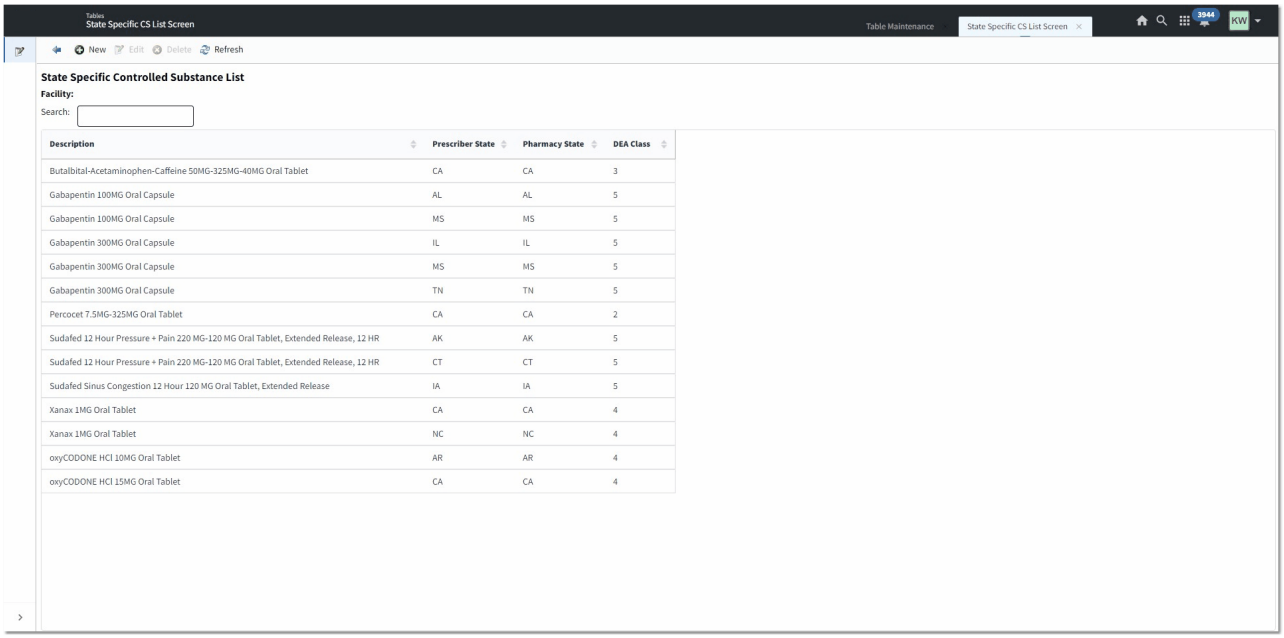
7. **Use IMA** is for activating Insights for Medication Adherence.

8. The Autogen Report Logname field controls who can view the auto gen reports via the Report Image System > ADR option. It will only be used for one user per site and only house one record that will be the logged PHI printer of the reports: Unauthorized Access, System Access Report, E-Scribe Service Level, and Prescription Detail Audit.

12.4 State Specific CS

The State Specific CS table may be used to manually add and maintain State Specific Controlled Substances in Table Maintenance. The Search field utilizes Smart Search functionality and will populate results alphabetically based on the entered text.

Select **Web Client** > **Tables** > **Clinical** > **State Specific CS**



State Specific Controlled Substance List

The screen contains four columns that may be sorted by selecting the header. The header options are: Medication Description, Prescriber State, Pharmacy State, and DEA Class.

The Action bar options are as follows:

1. The **Back Arrow** returns the user to Table Maintenance.

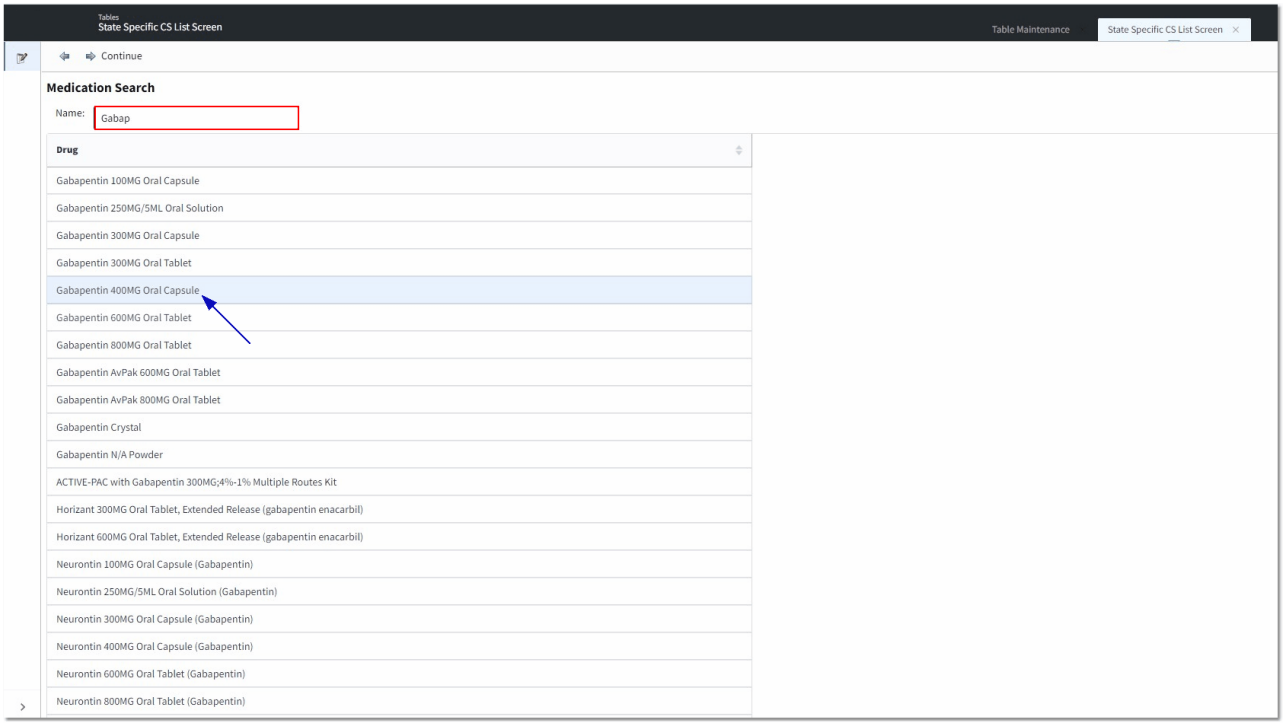
2. The **New** option directs the user to the Smart Search screen to search MicroMedex for the desired medication. When this option is selected, the Action bar options for Custom and Delete will disappear. The Original Med div, checkbox_formulary_only, and search div will be hidden.

3. The **Edit** option will become available when an existing entry is selected. Selecting Edit or double-clicking the entry will direct the user to the State Specific Controlled Substance Edit screen.

4. The **Delete** option will become available when an existing entry is selected. Selecting Delete will remove the selected entry from the table. Duplicates are not allowed in the State Specific CS table. This table will be shared across facilities. The additions and deletions from the table are logged for auditing purposes.

5. The **Refresh** option will reflect any recent changes to the table.

Select **Web Client** > **Tables** > **Clinical** > **State Specific CS** > **New**



Medication Search

To add a new medication to the list, select **New** and use the Medication Search screen to locate the desired medication. Double-click the medication or select the medication and then select **Continue**.

The Edit screen may be accessed once a medication has been selected. This screen contains the following Action bar options:

1. The **Back Arrow** will return the user to the main State Specific CS screen.

2. The **Save** option saves the new entry and adds it to the existing table.

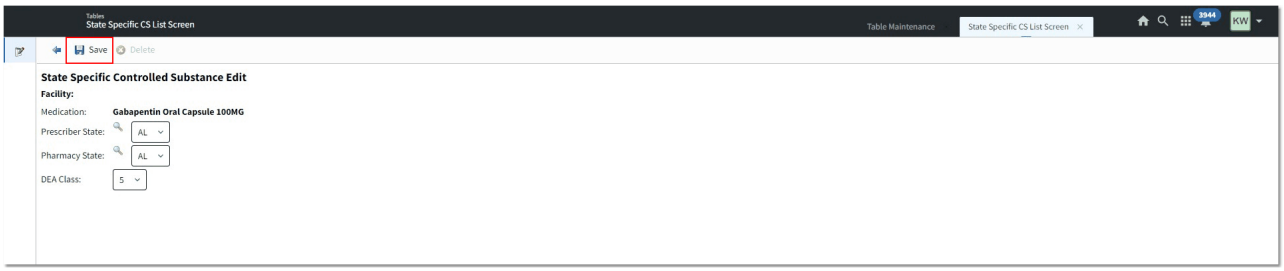
3. The **Delete** option deletes the selected entry from the table.

The **Prescriber State** and **Pharmacy State** will default to the state listed in the Physicians table for the 999999 physician. The drop-down list will contain the states that populate by the zip codes loaded in the Zip Codes table under the Prescription Entry header. The magnifying glass icon may be selected to locate the state if it is not listed in the drop-down.

The DEA Class field is a drop-down with the options 2, 3, 4, and 5.

Select **Save** to save the new entry once all fields have been addressed.

Select **Web Client** > **Tables** > **Clinical** > **State Specific CS** > **New** > **Select Med** > **Continue**

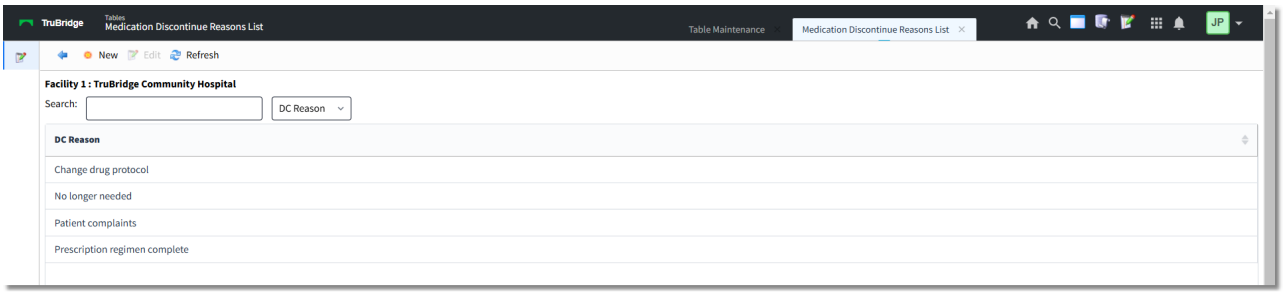


State Specific Controlled Substance Edit

12.5 Discontinue Reasons

The Discontinue Reasons table is available for setting up a default list of discontinuing home medications during a discharge reconciliation. These may be set up on a site basis but typically include common reasons for discontinuing a home medication. From within the Medication Reconciliation/Prescription Entry applications, the users will have the ability to enter an OTHER reason if none of the listed DC Reasons are sufficient.

Select **Web Client** > **Tables** > **Clinical** > **Discontinue Reasons**



Discontinue Reasons

The blue back arrow returns to the main Clinical page.

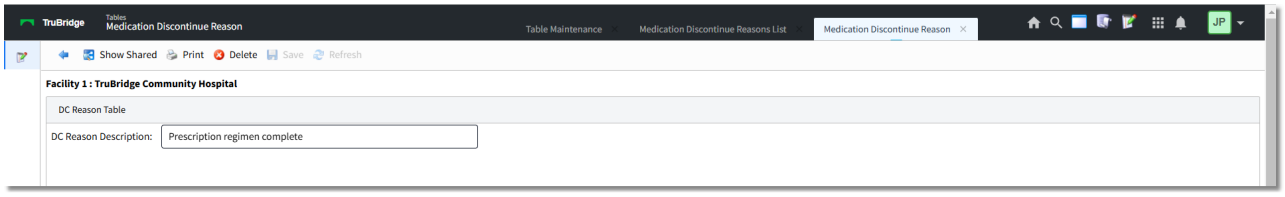
The **New** option will add a new DC Reason to the list.

The **Edit** option will allow for the editing of an existing DC Reason.

The **Refresh** option will refresh the screen once changes have been made.

To add a new Description:

Select **Web Client** > **Tables** > **Clinical** > **Discontinue Reasons** > **New**



Discontinue Reason Description

In the **DC Reason Description** field, a discontinue reason of up to 60 characters long may be entered.

The blue back arrow will return to the main Clinical screen.

The **Show Shared** option will highlight any fields that are sharing the same profile with another facility (multi-facility).

The **Print** option generates a PDF copy of the table along with current settings/selections.

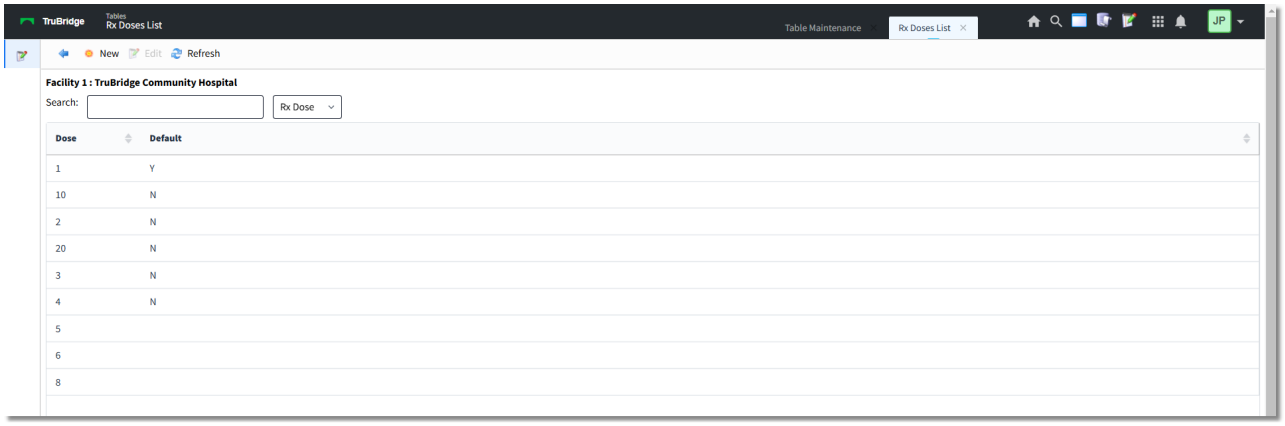
Save will save any changes made to the table.

Refresh will wipe out any changes made in the field prior to saving.

12.6 Doses

The Doses table allows for different dose amounts to be entered and a default dose to be defined for use in Home Medication Entry and Prescription Entry.

Select **Web Client** > **Tables** > **Clinical** > **Doses**

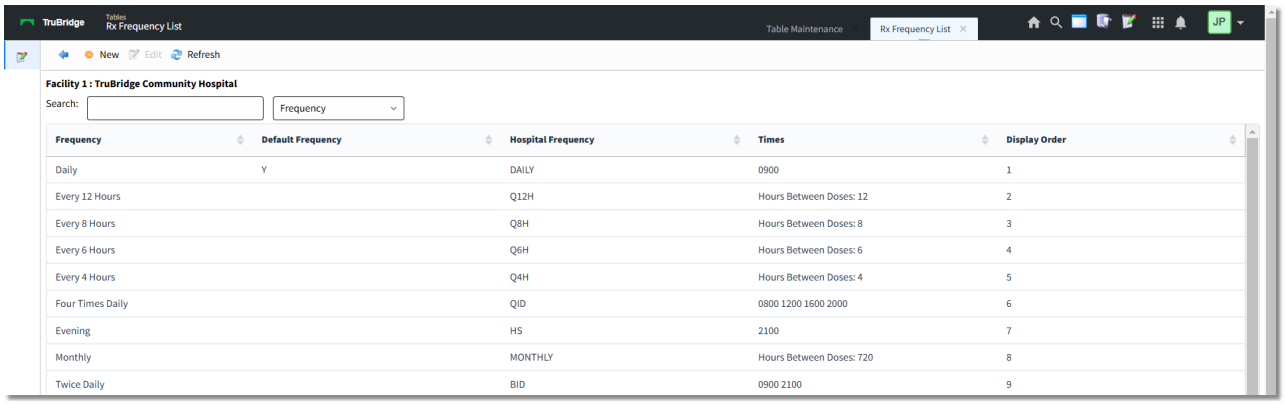


Doses Table

12.7 Frequencies

The **Frequencies** table allows for the setup of frequencies that are selected when utilizing the Home Medication Entry and New Prescription options. These frequencies display in a drop-down in both the Medication Reconciliation and Prescription Entry applications. Since the information on the patient's discharge medications will pull to the patient's Discharge Instructions report, these frequencies are typically entered in layman's terms. During setup, frequencies are linked with the pharmacy hospital frequency table to allow for an easy transition between Admission Reconciliation and Prescription Entry.

Select **Web Client** > **Tables** > **Clinical** > **Frequencies**



Frequency	Default Frequency	Hospital Frequency	Times	Display Order
Daily	Y	DAILY	0900	1
Every 12 Hours		Q12H	Hours Between Doses: 12	2
Every 8 Hours		Q8H	Hours Between Doses: 8	3
Every 6 Hours		Q6H	Hours Between Doses: 6	4
Every 4 Hours		Q4H	Hours Between Doses: 4	5
Four Times Daily		QID	0800 1200 1600 2000	6
Evening		HS	2100	7
Monthly		MONTHLY	Hours Between Doses: 720	8
Twice Daily		BID	0900 2100	9

Frequencies

Any column header may be selected to re-order the columns either alphabetically or numerically. The Search field may be utilized for searching for specific frequencies, hospital frequencies and display order.

The blue back arrow returns to the main Clinical page.

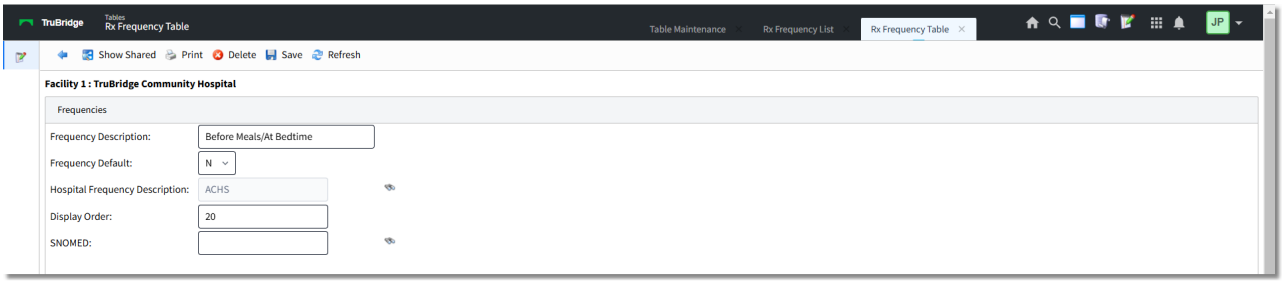
The **New** option will add a new frequency description to the list.

The **Edit** option will allow for the editing of an existing frequency entry.

The **Refresh** option will refresh the table screen once changes have been made.

To add a new Description:

Select **Web Client** > **Tables** > **Clinical** > **Frequencies** > **New**



New Frequency

The **Show Shared** option will highlight any fields that are sharing the same profile with another facility (multi-facility).

The **Print** option generates a PDF copy of the table along with current settings/selections.

Delete will remove the entry from the table.

Save will save any changes made to the table.

Refresh will wipe out any changes made in the field prior to saving.

In the **Frequency Description** field, enter the layman's description of the frequency.

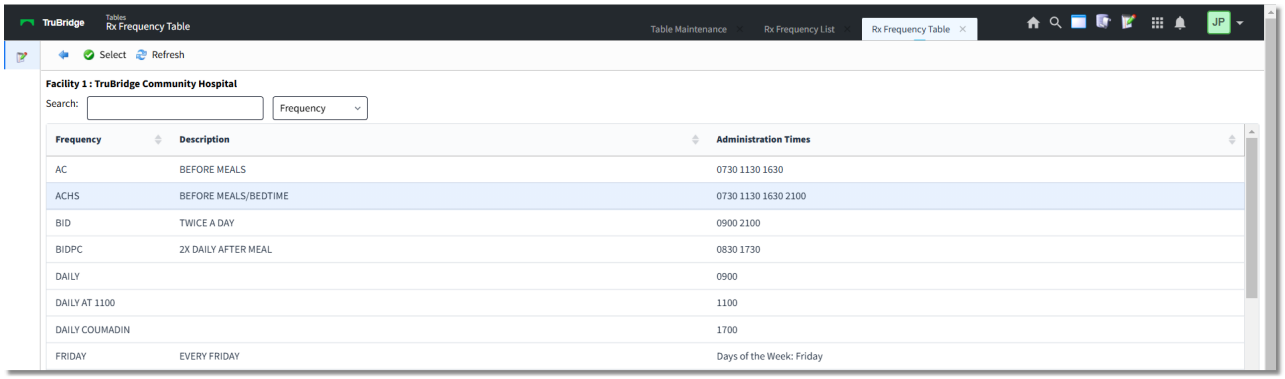
The **Frequency Default** field indicates whether the description that will automatically pull into the Frequency drop-downs located within the **Home Medication Entry** and entering new prescriptions in **Prescription Entry**. Only one frequency may be set as the default.

The **Hospital Frequency Description** is located by selecting the binocular icon to the right of the field. The binocular icon will load the Pharmacy's frequency table. The appropriate description should be selected

The **Display Order** field will set the order that the frequency will appear in the drop-downs of the applications.

To link the Frequency Description to the Hospital Frequency Description, select the binoculars.

Select **Web Client** > **Tables** > **Clinical** > **Frequencies** > **New**



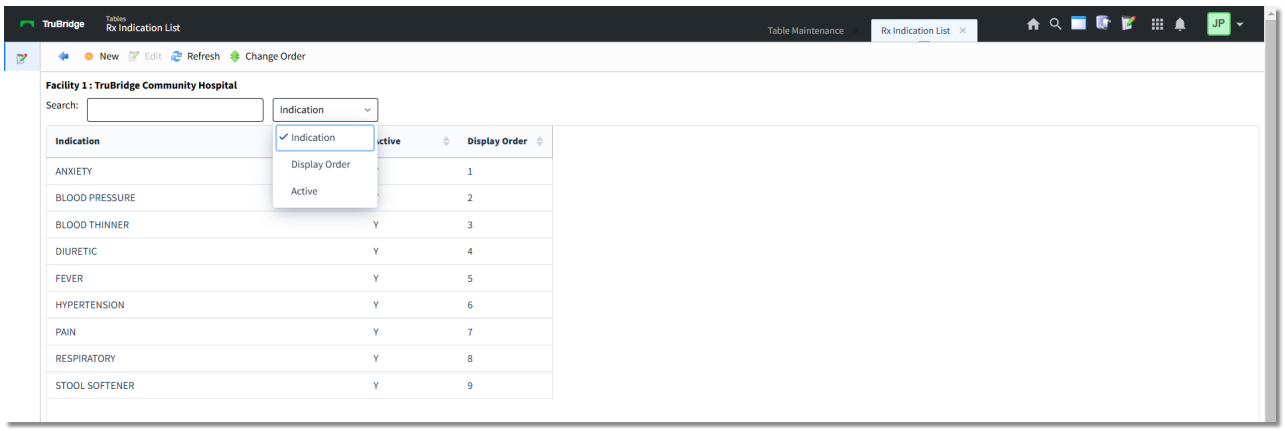
Hospital Frequency Table

Once the table is accessed, the appropriate description may be selected by double-clicking or by selecting and then choosing **Select**. Once the selection is made, the previous screen will appear. Select **Save** to save the new frequency entry to the table.

12.8 Indications

The **Indications** table allows for the entry of an indication (reasons for taking the medication) to be utilized in the Home Medication/Prescription Entry screens. Indications will appear as an optional drop-down field.

Select **Web Client** > **Tables** > **Clinical** > **Indications**



Indications

The **Search** field may be used to search for an indication by description, display order, or the Active status.

The blue back arrow returns to the main Clinical page.

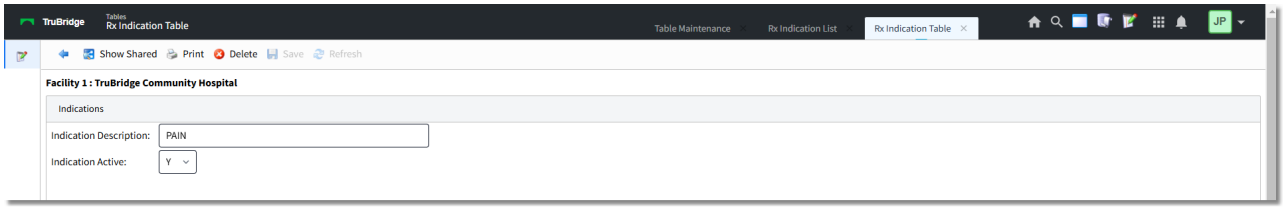
The **New** option will allow for the creation of a new indication entry.

The **Edit** option will allow for the editing existing indication entries.

The **Refresh** option will refresh the table screen once changes have been made.

The **Change Order** option will allow the list to be reordered as to how it will populate to the drop-down in the applications. Once a description is selected, it may be moved **Up**, **Down**, **To Top** or **To Bottom**.

Select **Web Client** > **Tables** > **Clinical** > **Indications** > **New**



Indications

The **Show Shared** option will highlight any fields that are sharing the same profile with another facility (multi-facility).

The **Print** option generates a PDF copy of the table along with current settings/selections.

Delete will remove the entry from the table.

Save will save any changes made to the table.

Refresh will wipe out any changes made in the field prior to saving.

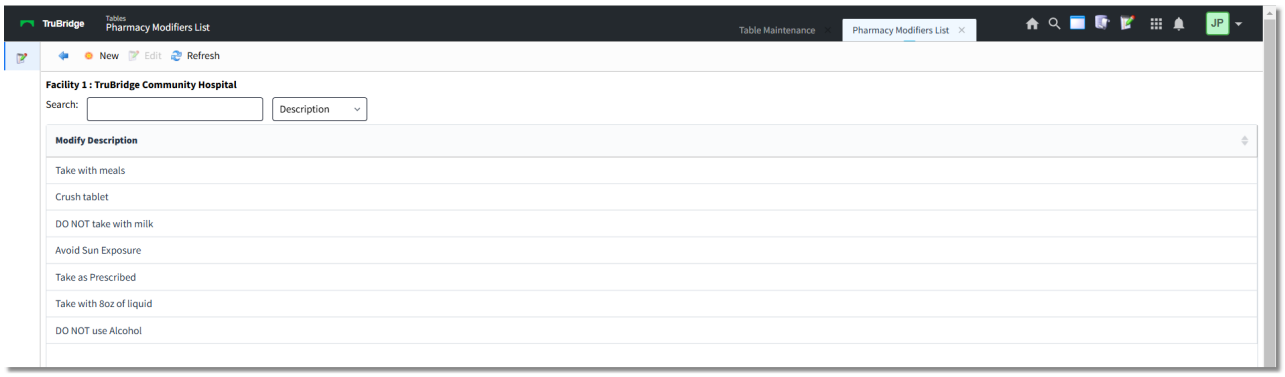
In the **Indication Description** field, enter the indication description which will populate to the drop-down in the Home Medication/Prescription Entry screens.

The **Indication Active** field indicates whether or not the description will actively appear in the drop-down. If set to No, the description will not appear in the drop-down.

12.9 Modifiers

The **Modifiers** table allows for the setup of modifying descriptions that may be used during the Prescription Entry process. These will pull to the Sig line in Prescription Entry and once the medication is processed, it will appear on the Discharge Instructions report on the Prescription Detail line.

Select **Web Client** > **Tables** > **Clinical** > **Modifiers**



Modifiers

The **Search** box may be used to locate a specific description in the Modify Description list.

The blue back arrow returns to the main Clinical page.

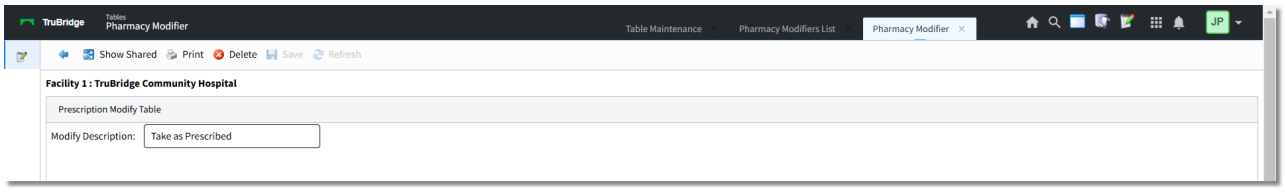
The **New** option will add a new modifier description to the list.

The **Edit** option will allow for the editing of an existing frequency entry.

The **Refresh** option will refresh the table screen once changes have been made.

To add a new Modify Description:

Select **Web Client** > **Tables** > **Clinical** > **Modifiers** > **New**



Modifiers

The **Show Shared** option will highlight any fields that are sharing the same profile with another facility (multi-facility).

The **Print** option generates a PDF copy of the table along with current settings/selections.

Delete will remove the entry from the table.

Save will save any changes made to the table.

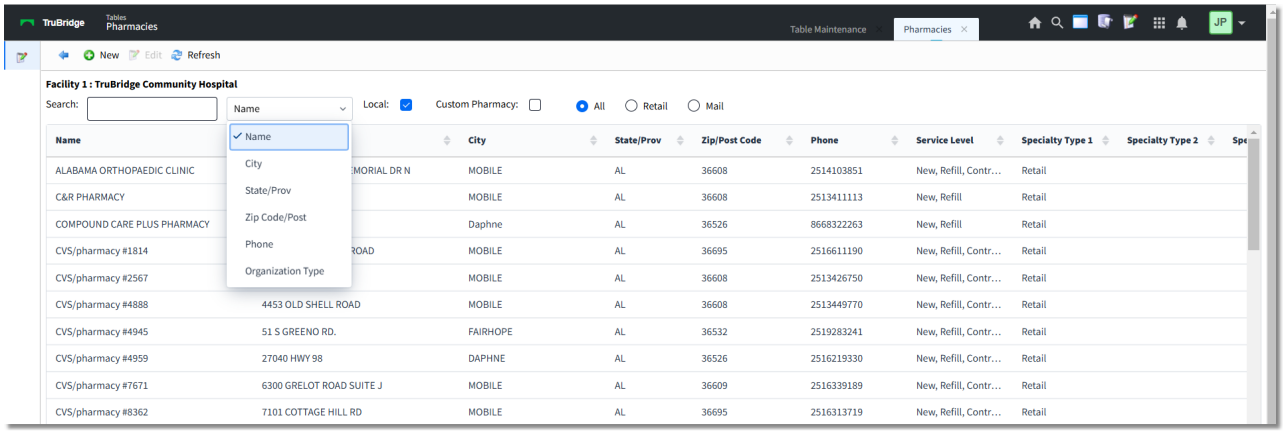
Refresh will wipe out any changes made in the field prior to saving.

Enter the **Modify Description** in the text field and select **Save** to save the entry to the Modifiers table.

12.10 Pharmacies

The Pharmacies table displays a list of pharmacies that accept electronic prescriptions from SureScripts, TruBridge's electronic prescription vendor. Prescriptions may be created and sent electronically through the EScribe application.

Select **Web Client** > **Tables** > **Clinical** > **Pharmacies**



Pharmacies

The **Search** field may be used to locate a specific pharmacy in the list by Name, City, State, Zip Code, Phone number, or Organization Type.

The **Local** checkbox indicates that the list will only pull in pharmacies that have a zip code entered in the Zip Codes 266 table, allowing the pharmacies list to generate only local area pharmacies when the checkbox is checked.

The radio buttons indicate whether the list will display All pharmacy Specialty Types, only Retail Specialty Types or only Mail Order Specialty Types.

The Pharmacies list headers display the pharmacy name, address, city, state, zip code, phone number, service level, specialty type one and specialty type 2.

The blue back arrow returns to the main Clinical page.

The **New** option may be used in the following instances:
1. For sites not using EScribe, the list will be blank. The site may create Custom Pharmacies so that they may fax prescriptions.
2. For sites utilizing the EScribe application, not all pharmacies will be listed in the SureScripts database because not all pharmacies accept electronic prescriptions through SureScripts. If a local pharmacy is not registered with SureScripts, the site may create a Custom pharmacy so that they may fax prescriptions.

The **Edit** option will allow for the editing of certain fields within the pharmacy's information. Accessibility to these fields is mostly grayed-out so that no information populating from SureScripts may be edited.

NOTE: *Facilities outside of the United States utilize a different address format. If a foreign address format is used, the province/territory and postal code show on the Pharmacy Address Table. A TruBridge representative will need to be contacted in order for the foreign address fields to be activated.*

The **Refresh** option will refresh the table screen once changes have been made.

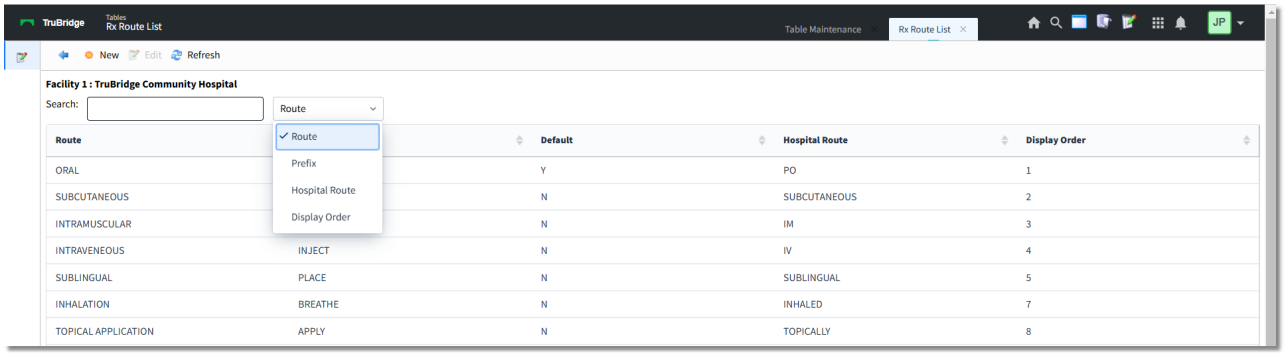
NOTE*: This table populates from a script.*

NOTE: *Surescripts updates this list nightly and a full replacement is done on a weekly basis. Any custom pharmacies added by a facility will not be updated.*

12.11 Routes

The **Routes** table allows for the setup of routes that are selected when utilizing the Home Medication Entry and New Prescription options. These routes display in a drop-down in both the Medication Reconciliation and Prescription Entry applications. Since the information on the patient's discharge medications will pull to the patient's Discharge Instructions report, these routes are typically entered in layman's terms. During setup, routes are linked with the pharmacy hospital frequency table to allow for an easy transition between Admission Reconciliation and Prescription Entry.

Select **Web Client** > **Tables** > **Clinical** > **Routes**



Routes

The **Search** field may be used to locate a specific route in the list by route description, route prefix, hospital route or display order.

The Routes list headers display the route description, the route prefix, default, the hospital route, and the display order..

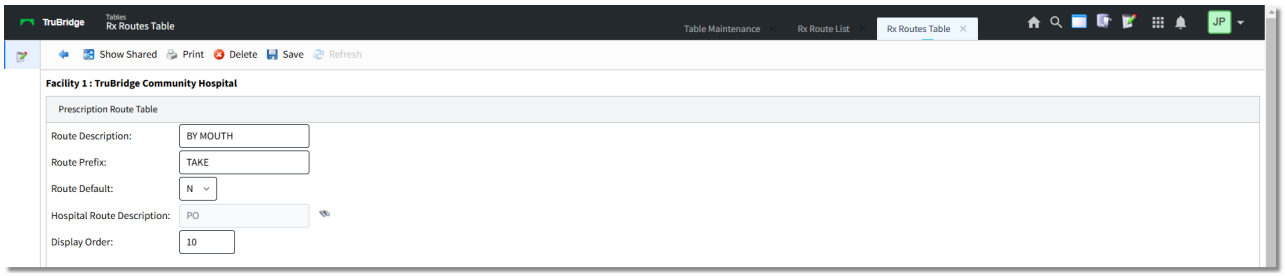
The blue back arrow returns to the main Clinical page.

The **New** option will allow for the creation of a new route entry.

The **Edit** option will allow for the editing existing route entries.

The **Refresh** option will refresh the table screen once changes have been made.

Select **Web Client** > **Tables** > **Clinical** > **Routes** > **New**



Routes

The **Show Shared** option will highlight any fields that are sharing the same profile with another facility (multi-facility).

The **Print** option generates a PDF copy of the table along with current settings/selections.

Delete will remove the entry from the table.

Save will save any changes made to the table.

Refresh will wipe out any changes made in the field prior to saving.

In the **Route Description** field, enter the layman's term description which will populate to the Home Medication/Prescription Entry screens.

The **Route Prefix** will display in the Sig line in prescription entry. E.g. Take By Mouth.

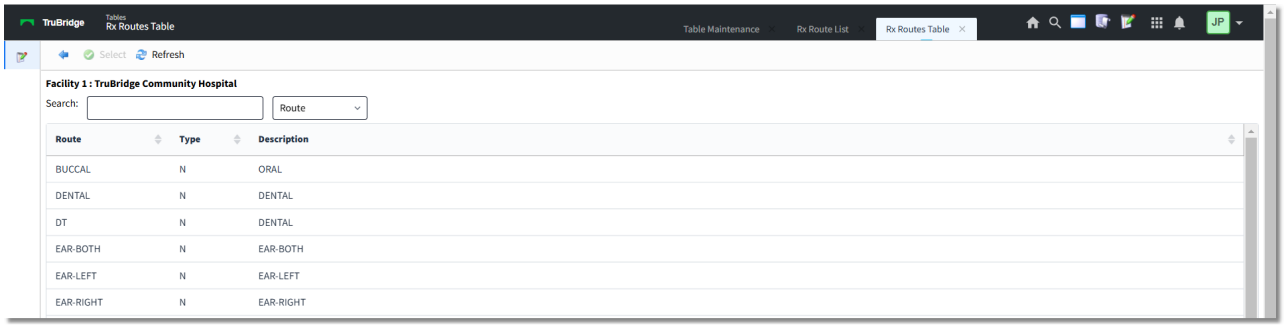
The **Route Default** indicates the default route for Home Medication entry.

The **Hospital Route** displays the associated hospital route. Selecting the binocular icon will populate the hospital pharmacy route table.

The **Display Order** field controls the order the routes will display in the route drop-down within the Home Medication/Prescription Entry screens.

NOTE: *If the route "BY MOUTH" is in the route table, then the Truven data will prompt the route field to use that route title. If "BY MOUTH" is not present, but "ORAL" is, then the Truven data will prompt the route field to use ORAL instead. If neither "BY MOUTH" or "ORAL" are in the route table, then the TruBridge EHR will pull the default route.*

Select **Web Client** > **Tables** > **Clinical** > **Routes** > **New**



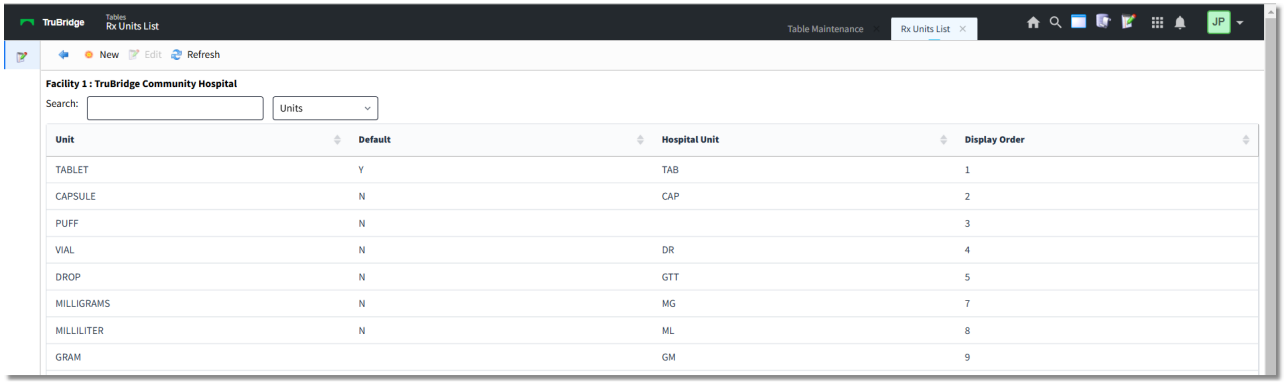
Routes

Once the table is accessed, the appropriate description may be selected by double-clicking or by selecting and then choosing **Select**. Once the selection is made, the previous screen will appear. Select **Save** to save the new route entry to the table.

12.12 Units

The **Units** table allows for the setup of units that are selected when utilizing the Home Medication Entry and New Prescription options. These units display in a drop-down in both the Medication Reconciliation and Prescription Entry applications. Since the information on the patient's discharge medications will pull to the patient's Discharge Instructions report, these units are typically entered in layman's terms. During setup, units are linked with the pharmacy hospital **Frequency Table** to allow for an easy transition between Admission Reconciliation and Prescription Entry.

Select **Web Client** > **Tables** > **Clinical** > **Units**



Units

The **Search** field may be used to locate a specific unit in the list by unit description, hospital unit, or display order.

The Units list headers display the unit description, the default, the hospital unit, and the display order.

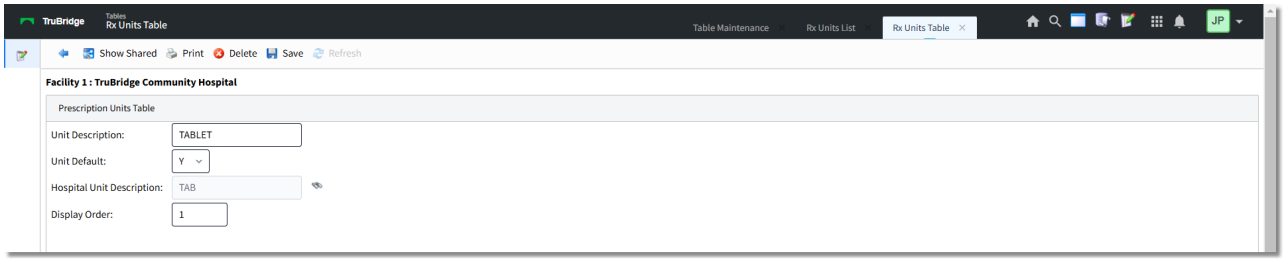
The blue back arrow returns to the main Clinical page.

The **New** option will allow for the creation of a new unit entry.

The **Edit** option will allow for the editing existing unit entries.

The **Refresh** option will refresh the table screen once changes have been made.

Select **Web Client** > **Tables** > **Clinical** > **Units** > **New**



Units

The **Show Shared** option will highlight any fields that are sharing the same profile with another facility (multi-facility).

The **Print** option generates a PDF copy of the table along with current settings/selections.

Delete will remove the entry from the table.

Save will save any changes made to the table.

Refresh will wipe out any changes made in the field prior to saving.

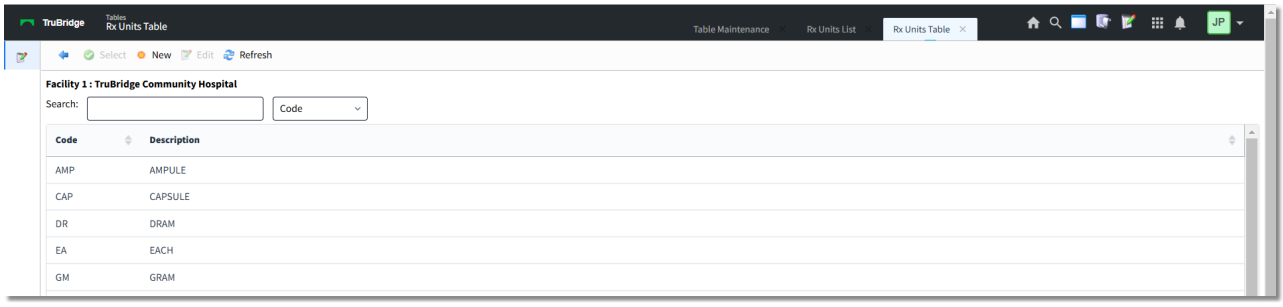
In the **Unit Description** field, enter the layman's term description which will populate to the Home Medication/Prescription Entry screens.

The **Unit Default** indicates the default unit for Home Medication entry.

The **Hospital Unit Description** displays the associated hospital unit. Selecting the binocular icon will populate the hospital Pharmacy Dosage Units table.

The **Display Order** field controls the order the units will display in the unit drop-down within the Home Medication/Prescription Entry screens.

Select **Web Client** > **Tables** > **Clinical** > **Units** > **New**



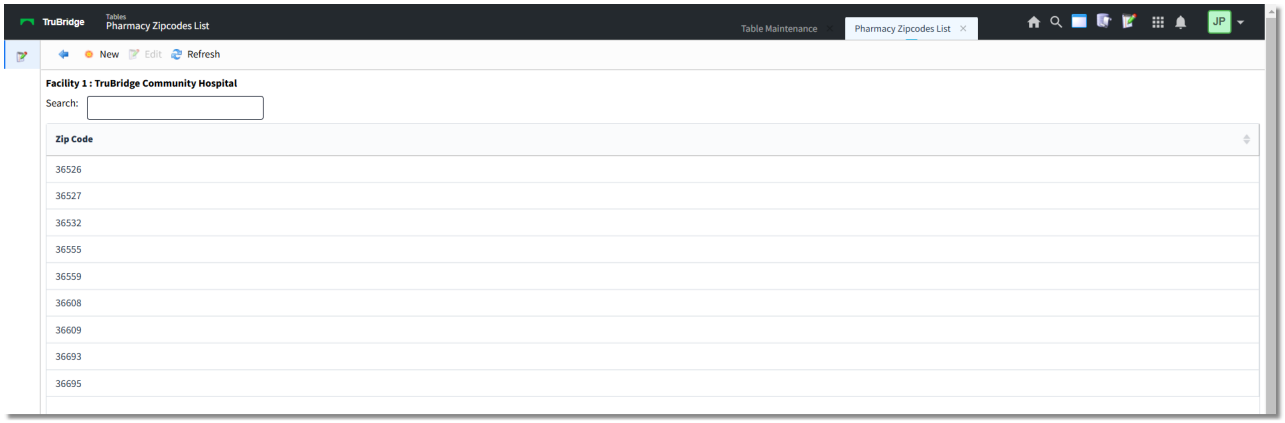
Units

Once the table is accessed, the appropriate description may be selected by double-clicking or by selecting and then choosing **Select**. Once the selection is made, the previous screen will appear. Select **Save** to save the new unit entry to the table.

12.13 Zip Codes

The **Zip Codes** table allows for the entry of local area zip codes for the EScribe application. Once the zip codes are loaded, the Pharmacies 260 table will be able to load the local pharmacies (when the **Local** checkbox is checked) that accept electronic prescriptions through SureScripts.

Select **Web Client** > **Tables** > **Clinical** > **Zip Codes**



Zip Codes

The **Search** field may be used to locate a specific zip code in the list.

The blue back arrow returns to the main Clinical page.

The **New** option will allow for the creation of a new zip code entry.

The **Edit** option will allow for the editing existing zip code entries.

The **Refresh** option will refresh the table screen once changes have been made.

Select **Web Client** > **Tables** > **Clinical** > **Zip Codes** > **New**

Zip Codes

The **Show Shared** option will highlight the field if it is sharing the same profile with another facility (multi-facility).

The **Print** option generates a PDF copy of the entry along with current settings/selections.

Delete will remove the entry from the table.

Save will save any changes made to the table.

Refresh will wipe out any changes made in the field prior to saving.

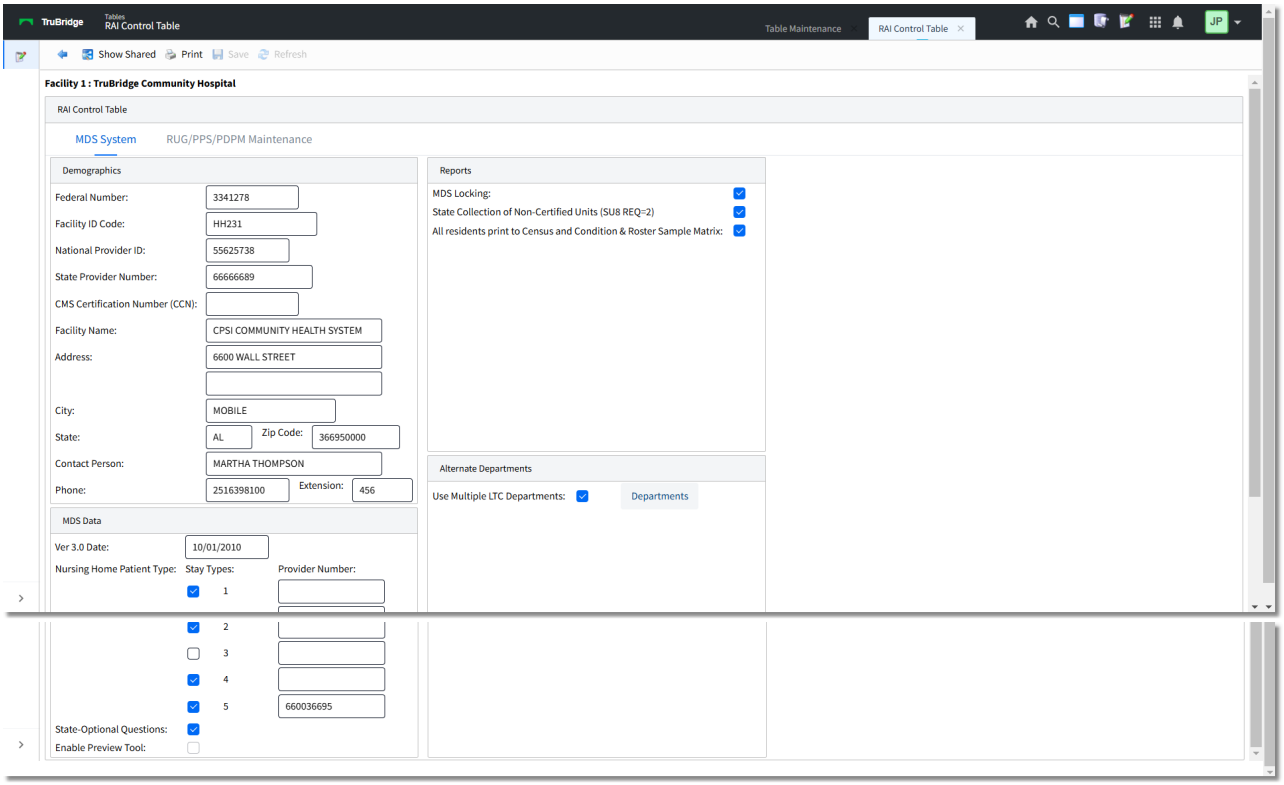
Enter the zip code in the **Zip Code** field and select **Save** to save the entry to the table.

Chapter 13 QI/Regulatory

13.1 RAI Control Table

The RAI Control Table contains the facility and reimbursement settings for the Resident Assessment Instrument application used to submit assessment data on long term care residents and swing bed patients to CMS and the state.

Select **Web Client** > **Tables** > **Clinical** > **RAI Control Table**



RAI Control Table

The RAI Control Table consists of two tabs: **MDS System** settings, and **RUG/PPS Maintenance**. Each of these areas contains multiple sections that will be described in detail below.

MDS System

When the RAI Control Table is opened, it defaults to the MDS System tab, which contains four sections: Demographics, Reports, MDS Data and Alternate Departments. Each of these sections will be discussed in depth below. This table may also be accessed under the Nursing Administration department's Print Reports menu from **Hospital Base Menu > Print Reports > RAI Control Maintenance**.

NOTE: *In any area of the RAI Control, the user should be sure to select* 

Save *after making changes.*

Demographics:

This section contains information that is required for submitted data to be accepted by the state and ultimately by CMS.

- The **Federal Number** is the facility's Medicare Provider Number. There is a 12-character maximum for this field.
- The **Facility ID Code** is provided to the facility by the state. The user may enter up to 16 characters in this field.
- The **National Provider ID** is a HIPAA standard that is used by all covered healthcare providers. This field accepts entry of 10 characters.
- The **State Provider Number** is the Medicaid Provider Number that is defined by the state. This is required for facilities that provide health services to Medicaid recipients.
- The **CMS Certification Number (CCN)**, or Medicare Certification Number, field allows up to 12 characters to be entered.
- The **Facility Name** field designates the facility's name as it appears according to the state records. Up to 30 characters may be entered here.
- The **Facility Address** fields designate the facility's address as it appears according to the state records. Up to 30 characters may be entered in each of the first two Address lines; up to 20 characters may be entered for the City field; two characters are allowed for the State field and up to nine characters may be placed into the Zip Code field.
- The **Contact Person**, **Phone** and **Extension** fields allow the name of the facility contact person, as well as the contact's phone number (and extension if applicable), to be entered.

NOTE: *The Facility Name, Address, City, State and Contact Person fields should be entered in all caps.*

Reports:

This section contains general information about various reporting options available in the RAI system.

- The **MDS Locking** field consists of a check-box and is used to allow or disallow assessments in the RAI system to be locked.

- **State Collection of Non-Certified Units (SUB-REQ=2)** indicates that the facility's state may collect assessment data on residents in units that are not Medicare certified. This field consists of a checkbox to designate whether or not the state collects data in this situation.

- The field **All residents print to Census and Condition & Roster Sample Matrix** indicates whether the facility will utilize the CMS-Form 672 (Census and Condition Report) and CMS-Form 802 (Roster/Sample Matrix report). Refer to the Resident Assessment Instrument user guide for more detailed information about these reports.

NOTE: *This section previously contained a field allowing the user to select which format of the Tickler Report was active. This field was a holdover from MDS 2.0 and has been removed with the introduction of a newer Tickler Report. Please see the Resident Assessment Instrument user guide for more details.*

MDS Data:

- The **Ver 3.0 Date** field indicates the date the facility began using the MDS 3.0 update to the RAI system. If unsure of what should be placed in this field, the user may type 100110 (October 1, 2010), which was the MDS 3.0 start date mandated by CMS, then press Enter on the keyboard.

- The TruBridge system uses up to five patient stay types to define in-patients, out-patients, emergency department patients, and up to two user-defined other types of patients. The **Nursing Home Patient Type** field allows the user to select which stay type(s) will grant access to the RAI System, as well as which types of patients will be included when running the RAI Tickler Report. To grant a stay type access to the RAI System, select the box next to each numeric (1-5) stay type to make a check mark appear in the box, and address the Provider Number next to that stay type if applicable.

  NOTE: *Facilities with both a nursing home or long term care and a swing bed unit may need to mark multiple stay types.*

- The **Provider Number** fields, located next to each stay type, define each stay type's Medicaid Provider Number. Up to 15 characters may be entered here.

- The **State-Optional Questions** field activates or inactivates, by way of a check box, specific fields in certain sections and assessment types that may be required by the facility's state.

NOTE: *This field does not apply to Section S.*

Alternate Departments:

- The option to **Use Multiple LTC Departments** is indicated if the facility has multiple departments that submit RAI assessment data, if each department has a separate set of provider numbers and receives reimbursement separately, as separate facilities. A common example of this is a hospital with a swing bed unit and an associated yet separate long term care facility that is off campus.

- If multiple departments are indicated, a button labeled **Departments** may be selected that will allow the user to address the demographic fields for each separate department.

NOTE: *Alternate departments may be required if each unit utilizes separate provider numbers.*

- Up to six additional departments may be entered in this area.

- If changes are made on this screen, select 

Save.

- Select the  **back arrow** from the action bar to return to the previous screen.

RUG/PPS Maintenance

The RUG/PPS Maintenance tab of the RAI Control Table controls the facility's RUG calculation types, as well as Case Mix Index values, used in determining the RUG scores for reimbursement.

Options on this screen are separated into Federal (Medicare), which encompasses facilities in urban settings and those in rural locations, and State (Medicaid). This information is defined by CMS and/or the facility's state.

NOTE: *Any questions regarding the difference between Urban and Rural location or what RUG code grouper or calculation type should be used by the facility should be discussed with these governing bodies.*

Federal:

- The **Rate Table Utilized** field allows the user to choose Urban or Rural from a drop-down menu.

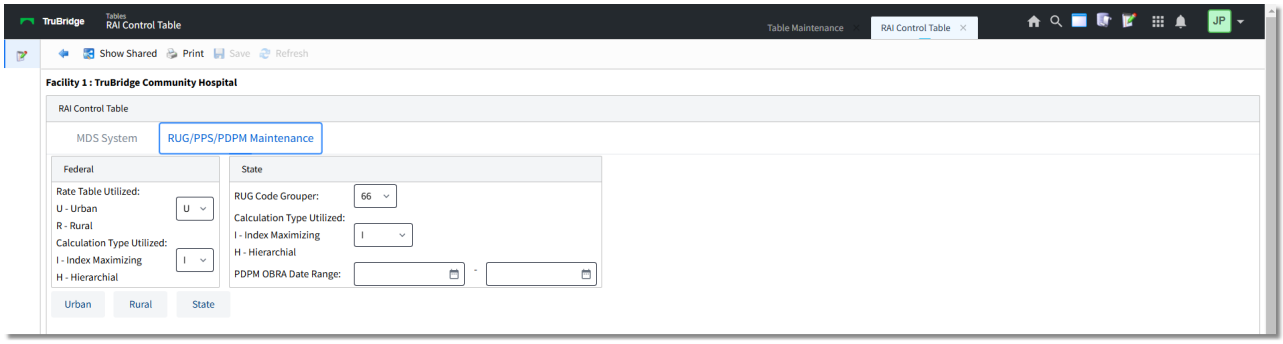
- The **Calculation Type Utilized** field allows the user to select Hierarchical or Index Maximizing from a drop-down menu.

State:

- The **RUG Code Grouper** field allows the user to select any of the following RUG code groupers:
  - 34 - RUG III
  - 44 - RUG III
  - 48 - RUG IV
  - 53 - RUG III
  - 57 - RUG IV
  - 66 - RUG IV

- The **Calculation Type Utilized** field allows the user to select Hierarchical or Index Maximizing from a drop-down menu.

Select **Web Client > Tables > Clinical > RAI Control Table > RUG/PPS Maintenance**



RAI Control Table - RUG/PPS Maintenance

Reimbursement Rate Tables:

Additional options allow the user to access the reimbursement rate tables for Urban, Rural, and State; each table functions the same way, but may include different RUG codes and Case Mix Index values. The user then has the ability to apply total reimbursement rate values if needed.

If the user would like to make changes to the Total Rate value or there is a mandated need to update the CMI for Group value, these areas may be addressed by selecting the line to be altered and selecting 

Edit.

If changes are made, be sure to select 

Save. Select the  **back arrow** to return to the Rates and Indices listing.

13.2 Quality Measures Reporting

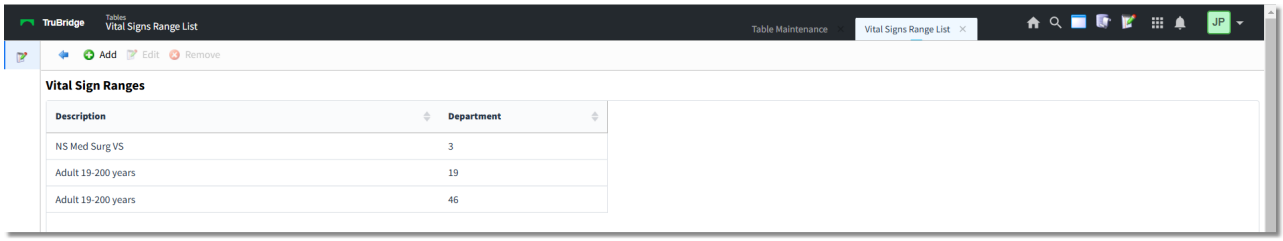
This table is not used at this time.

Chapter 14 Vital Signs

14.1 Vital Sign Ranges

The Vital Sign Ranges table allows vital sign ranges to be set for a department by gender and an age range. Once a range is set up, vital sign entries that fall outside the range for a patient registered in the department who meets the gender and age criteria will be highlighted in red. Vital sign ranges may be added, edited, and removed in this table.

Select **Web Client** > **Tables** > **Clinical** > **Vital Signs category** > **Vital Sign Ranges**



Vital Signs Ranges Table

The table displays the following information:

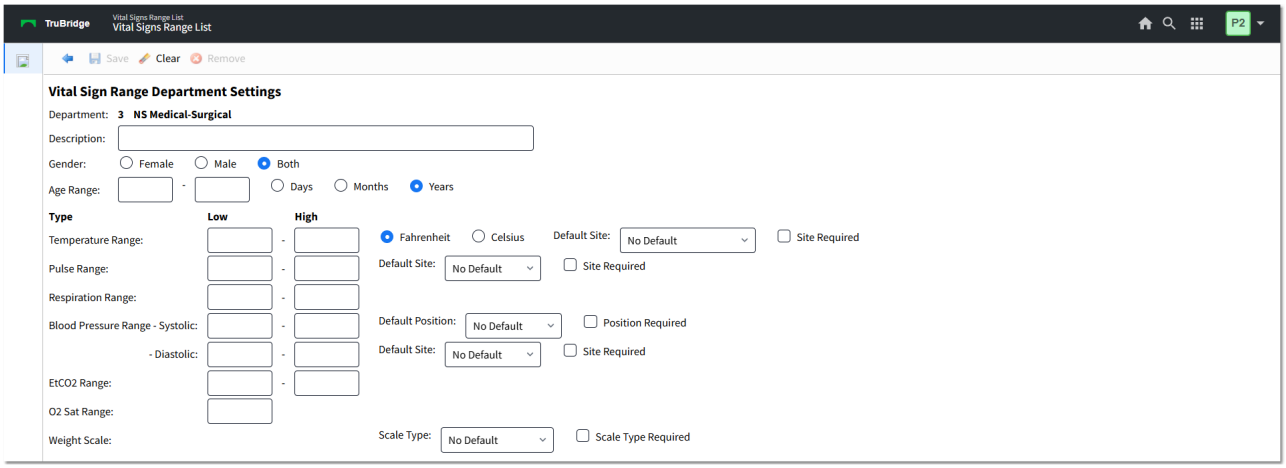
- **Description:** Displays the description of the vital sign range.
- **Department:** Displays the department associated with the vital sign range.

Action Bar Options

- **Blue back arrow:** Select to return to the previous screen.
- **Add:** Select to create a new vital sign range.
- **Edit:** Select to edit a vital sign range.
- **Remove:** Select to remove a vital sign range.

To Add a Vital Sign Range

1. Select **Add**.
2. On the **Department List** screen, select the department the vital sign range is being created for. The **Vital Sign Range Department Settings** screen is displayed.



Vital Sign Range Department Settings

3. In the **Description** field, enter a description for the new vital sign range. This field accepts up to 75 characters.

4. In the **Gender** field, select whether this vital sign range applies to **Female** patients, **Male** patients, or **Both**.

5. In the **Age Range** field, specify the ages this vital sign range applies to. First select **Days**, **Months**, or **Years**; then enter the appropriate numbers in the two text fields.

   NOTE: *Age ranges may not overlap in the same department, and if an age range is set up as Days, it may not exceed 28 days.*

6. Set up the vital sign **Type** as follows.

   - **Temperature Range:** Enter the low and high values in the appropriate text boxes. Up to 5 characters may be entered including a decimal point.
     - Select whether the temperature range you entered is in **Fahrenheit** or **Celsius** degrees.
     - If desired, select a **Default Site**. Options include the following:
       - No Default
       - Oral
       - Rectal
       - Axillary
       - Tympanic
       - Bladder
       - Swan Ganz
       - Temporal Scanning
       - Temporal
       - Temporal Artery
     - Select the **Site Required** check box to require that a site be selected when charting temperature in the Vitals application.

   - **Pulse Range:** Enter the low and high values in the appropriate text boxes.
     - If desired, select a **Default Site**. Options include the following:
       - No Default

    - Pulse Ox
    - Radial
    - Brachial
    - Femoral
    - Carotid
    - Apical
    - Monitor
  - Select the **Site Required** check box to require that a site be selected when charting pulse in the Vitals application.

- **Respiration Range:** Enter the low and high values in the appropriate text boxes.

- **Blood Pressure Range:** Enter the low and high values for both **Systolic** and **Diastolic** in the appropriate text boxes.
  - If desired, select a **Default Position**. Options include the following:
    - No Default
    - Lying
    - Sitting
    - Standing
    - Doppler
  - Select the **Position Required** check box to require that a position be selected when charting blood pressure in the Vitals application.
  - If desired, select a **Default Site**. Options include the following:
    - No Default
    - Right Arm
    - Left Arm
    - Right Leg
    - Left Leg
  - Select the **Site Required** check box to require that a site be selected when charting blood pressure in the Vitals application.

- **EtCO2 Range:** Enter the low and high values in the appropriate text boxes.

- **O2 Sat Range:** Enter the low value in the text box. O2 Sat levels may not exceed 100.

- **Weight Scale:** If desired, select a default **Scale Type** from the drop-down. Options include the following:
  - No Default
  - Stated
  - Bed Scale
  - Floor Scale
  - Sling Scale
  - Chair Scale
  - Newborn Scale
  - Estimated

7. Select **Save** to save the vital sign range entry.

8. Select the **blue back arrow** to return to the Vital Sign Ranges table.

To Edit a Vital Sign Range

1. Select the vital sign range you want to edit.
2. Select **Edit**.
3. Make the desired changes to the vital sign range.
4. Select **Save**.
5. Select the **blue back arrow** to return to the Vital Sign Ranges table.

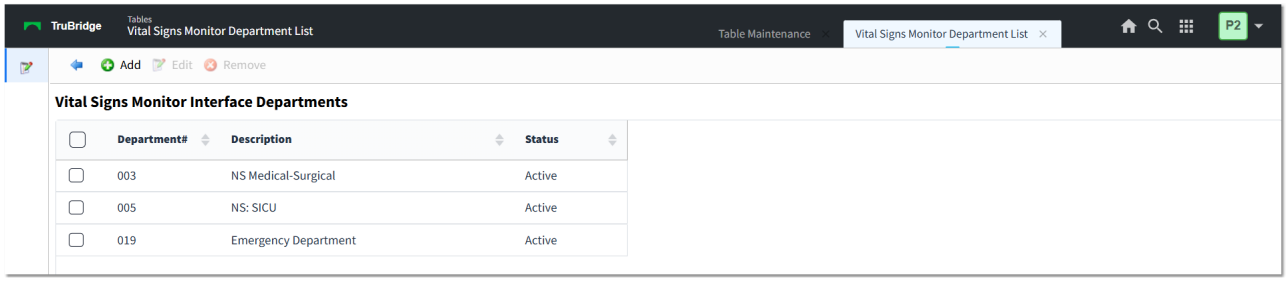
To Remove a Vital Sign Range

1. Select the vital sign range you want to remove.
2. Select **Remove**.

14.2 Monitor Interface Departments

The Monitor Interface Departments table displays a list of departments that have been set up to receive vital signs from an interface. The setup allows the department to specify if the vital signs from the interface will be automatically imported, manually imported, or not imported into the Vitals application. An interface must be purchased.

Select **Web Client** > **Tables** > **Clinical** > **Vital Signs category** > **Monitor Interface Departments**



Vital Signs Monitor Interface Departments Table

The table displays the following information:

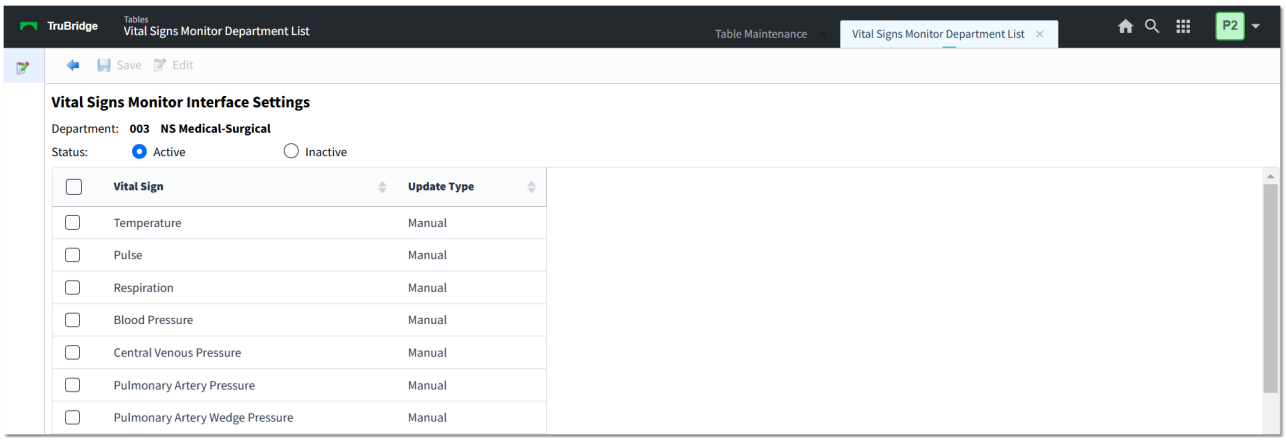
- **Department #:** Displays the interface department number.
- **Description:** Displays the interface department name.
- **Status:** Displays the status of the interface department (**Active** or **Inactive**).

Action Bar Options

- **Blue back arrow:** Select to return to the previous screen.
- **Add:** Select to set up a new interface department.
- **Edit:** Select to edit an interface department.
- **Remove:** Select to remove an interface department.

To Add New Interface Settings for a Department

1. Select **Add**.
2. On the **Department List screen**, double-click on the department the interface settings are being set up for. The Vital Signs Monitor Interface Settings screen displays.



Vital Signs Monitor Interface Settings

3. The status of **Inactive** is selected by default. This selection will not import the department vital signs from the interface. Select **Active** if the department vital signs should be imported from the interface.
4. The table displays a **Vital Sign** and **Update Type** column. Select a vital sign entry and select **Edit** or double-click on the entry. The Department Vital Signs Monitor Interface Settings screen displays for the selected vital sign.

Department Vital Signs Monitor Interface Settings - Temperature

5. In the **Update Type** field, select the update type for the vital sign from the interface. Options are:
   - **Manual:** (default) Select to manually import the vital sign from the interface.
   - **Auto:** Select to automatically import the vital sign from the interface.
   - **None:** Select if the vital sign should not be imported from the interface.

6. Select **Save**.

7. Repeat Steps **4**, **5**, and **6** for the necessary vital sign entries in the table.

To Edit Interface Settings for a Department

1. On the **Vital Signs Monitor Interface Departments** screen, select the department entry.

2. Select **Edit**.

3. Make the necessary changes and select **Save**.

To Remove Interface Settings for a Department

1. On the **Vital Signs Monitor Interface Departments** screen, select the department entry.

2. Select **Remove**.