

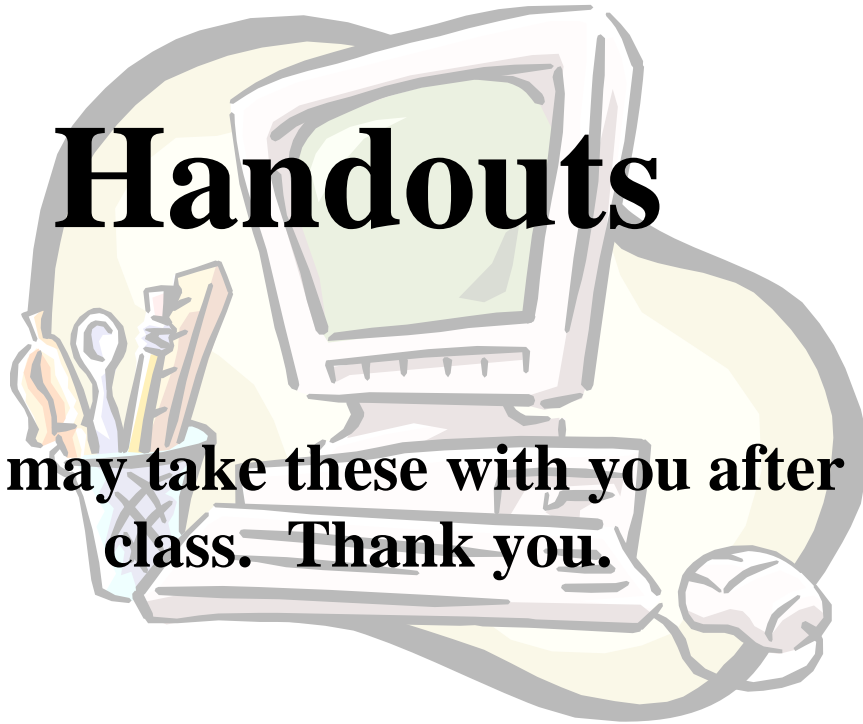
Samaritan Health Services

Meditech Computer Education for
Medical Students

Module: Patients Care Inquiry (PCI)

Handouts

**You may take these with you after
class. Thank you.**



Meditech Security/Passwords/Login

Passwords:

- Passwords automatically expire after 180 days
- Passwords are user defined, must be at least six characters long, must include letters and numbers, and cannot be reused. Example: PAINT1
- Passwords are encrypted in the system
 - No one, not even Information Services, is able to see them
 - Only the user knows his/her password
 - If a person forgets their password, he/she must call the Help Desk; the Help Desk will reset the password option and the user must enter a new password
- If a user tries unsuccessfully to log on to the system three times, he/she will be denied system access for 60 seconds; after the full minute, they may retry

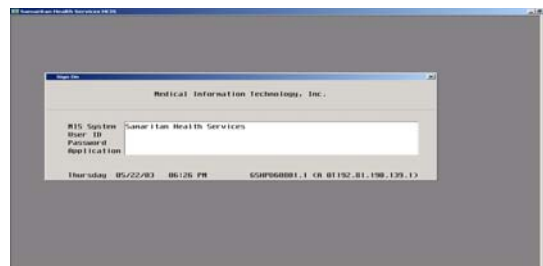
Log On:

1. Double left click on the Meditech Icon on the computer desktop.



Meditech Workstation.Ink

3. Remember all capitals from this point on. At the log on box type in your User ID; this was set up for you by Information Services. The User ID is your first initial followed by your last name, up to 10 characters in length.



4. Type in your password. Use “PASSWORD” as your first password. The system will then prompt you to set up a unique password. Make sure you remember it!

Patient Care Inquiry (PCI) – For Clinical Staff

Access – From the Patient Care Inquiry Module can also happen at time of Login. After logging in with User ID and Password, the access menu appears (the options are dependent on job needs) choose “PCI.SHS” to just view the Patient Care Inquiry without entering into another module. Staff then has several ways to identify a patient that are slightly different than going through the Order Entry Module.

Some of the most commonly used ways to find a patient:

By Name, Number: Staff can type in a patient’s name (lastname, firstname format), Unit Med. Record) # i.e. U/MG###, Account (Visit) # i.e. A/VA###, (both include the alpha & numeric digits and omit leading zeros) or SS# (nnn-nn-nnnn) to find your patient.

By Location (inpatient): Allows you to look up patients in a special location.

By OUTPATIENT location: Allow you to look up patients in a specific outpatient/short stay location.

By recent visit activity (date driven): Patent with any recent Admission activity...

By Admission Date (inpatients)

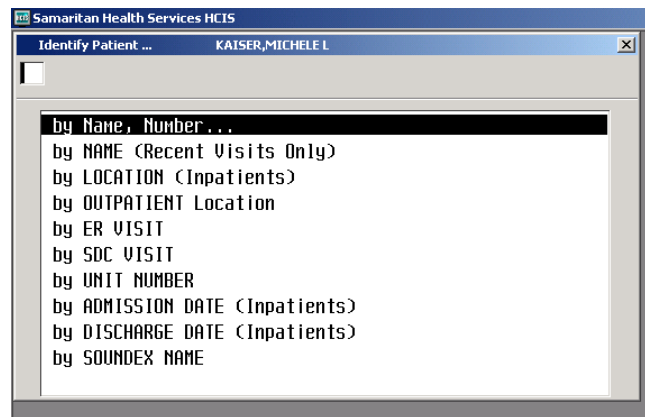
By Discharge Date (inpatients)

By ER Visit

By Surgical Day Care (SDC) Visit

By Soundex: Allows you to identify a patient by using the phonetic sound of the patient’s name.

The following patient data must be entered for the system to search for the patient: Family Name (req.), Proper Name/Initial (req.), Sex (opt.), and Approximate Age (opt.)



Navigation – Once in PCI, navigation is accomplished by using the 4 arrow keys:

⇒ Moves to the next window or more information about the highlighted item;
moves deeper into PCI

⇐ Returns to the previous screen, which is a less detailed window

↑ Or ↓ Moves highlighter bar up and down the items to view

<F11> To Exit

Right <Ctrl> To Checkmark (√) an item

<Shift> + <F8> For Help screen (this is an overview of highlighted item and screen)

Identifying Patients

From Your List of Patients in a Bed – all inpatients for which you are the PCP, admitting physician, family physician, attending physician, consulting and other physician appear on this list. All facilities are included.

From Your List of Patients – access regularly viewed patients (both your inpatients and outpatients).

From Your List of Scheduled Appointments—Lists all of your patients with surgical appointments, selected by specific date. This selection pertains only to providers who schedule surgical procedures in the hospitals.

By Name, Number – Type in a patient’s name (lastname, firstname format); Unit Number (i.e., U/MG##); Account Number (i.e., A/VA###). Include the alpha & numeric digits and omit leading zeros.

Unit Number = Medical Record Number

Account Number = Visit Number

By Soundex – an unlimited search by patient name. Type in the patient name, even if it’s misspelled, the database search will be phonetic. The following patient data must be entered from the system to search for the patient: Family Name; Proper Name/Initial.

By Admission Date (inpatients) – access patients by admission date. All facilities are included and are organized by admission date.

By Recent Visit Activity (date driven) – patient with any recent admission activity. Will indicate (new entries) on the heading if you have any patients.

- By Admission Date (inpatients)
- By Discharge Date (inpatients)
- By ER Visit
- By Surgical Day Care (SDC) Visit

From Your List of ER Patients – access your patients if they have had a recent ED visit. If you have no patients that have been in the ER, it will display “None”.

By Provider – look up patients on a provider’s list. Identify the provider by typing a partial last name and using the Enter Key. This gives you the ability to view their patients.

By Provider Group – type the group’s mnemonic or press <enter> and a list of provider groups will appear, then use the arrow keys to select the group.

By Location – allows you to look up patients in a particular location.

By Outpatient Location – look up (by date) patients in a specific outpatient/short stay location

By Discharge Date (inpatients) – access patients by discharge date. All facilities are included and are organized by discharge time.

By SDC (Surgical Day Care) Visit – access patients by date. All facilities are included and are organized by time.

By ER Visit—all patients admitted to ER, listed by date and in order of admission time.

Identifying Patient Menu Commands

Add “A”– add a patient to your personal list (found in soundex, name/number, by provider pts, by provider group, by location, outpt location, admission date, discharge date, SDC date).

Delete “D” – remove patients from your list (found in patient in bed, your list of patients).

ID patient “I” – found in patient in bed, your list of patients. Screen is the same as the By Name, Number.

Consult “C” - list of patients that have been assigned to you for consultation via Order Entry. Allows you to complete, cancel or print from this screen. Completing or canceling removes the patient from your list. Printing “List of Consultation Orders” gives you “the list” of patients. Printing “Detail of highlighted item” gives you the detail of the consulting reason – this printing is “per patient”.

Round “R” - option to print “Rounds Lists” or “Clinical Rounds Report”.

Rounds List = option to print “yours, provider or provider group” reports. Facility choices can be made by using the right control key (below right Shift key). This report provides you with patient name, room, age, visit reason, attending MD. Clinical Rounds Report = option to print “yours, provider, provider group, selected location, selected patient(s) provider outpatient, provider group outpatient”. A detailed (lengthy) report documenting patient name, room, age, visit reason, attending physician, current medications. **HINT** – this can be many pages so you may want to view it first before you do the print command.

VIEWING PATIENT DATA IN PCI DATA SOURCE (aka TABLE OF CONTENTS)

These are all the possible data sources that a **patient** could have. Remember, only the data sources that have information in them will be on the patient’s PCI screen.

- *NEW*Recent Abnormal Results (since last viewed)
- *NEW*Recent Clinical results (since last viewed)
- Clinical Highlights
- Laboratory Data
- Blood Bank History
- Blood Bank Products
- Microbiology Data
- Anatomical Pathology Reports
- Radiology Reports
- Current Medication Orders
- Medication Orders History
- Medication Reorder List
- Misc. Reorder List
- Transcribed Reports (other than RAD & Path reports)
- Orders
- Visit History
- Admission Demographic Data
- OR Management

**Viewing Patient Data Menu Commands on
Data Source/Table of Contents Screen**

Time “T” – “Change Time Scale” changes the time display so that you can view multiple days and results. The default is currently set to 8 days. When you set this time, it is set per patient/per user.

“Limit Display Based on Timeframe” – entering yes, will review your data sources (table of contents tabs) and will remove those tabs that have not had any activity within the time scale chosen.

Select “S” – select specific patient visits. Parenthesis shows how many accounts are available for viewing.

All accounts – choose which facility(s) for viewing patient’s account (using right control key).

Active accounts – choose which facility(s) for viewing only the active account(s).

Current accounts – choose the current visit of your patient.

Display selected accounts – unable to use at present time.

Allergies “A” – a listing of the documented allergies, height, weight and body surface area. Provides you with information on any adverse drug reaction documented.

Refresh “R” – ability to gather the current results from your patient (up to the minute).

**Viewing Patient Data Menu Commands in the
Various Data Sources**

Laboratory Data

Print “P” – “Print this Summary Report” provides you with the most current results.

“Print History of <lab test>” highlight a specific test and get a printout of the history, as well as a graphic for that specified result. This is based on the time span that is indicated.

“Print this History Report” – available after you’re in a specific test.

“Print details of this highlighted item” – available after you’re in a specific test.

Split “S” – view 2 result sections within one department (i.e., chemistry and coag) in a split screen. Highlight the particular type of lab tests for viewing.

Type “S” to get the next split menu. Highlight the 2nd type of lab test desired for viewing. Your screen will show both requested tests. The bottom ½ screen is the only screen that allows for scrolling.

Left arrow out of the bottom ½ screen, taking you to the main screen, type “F” (FULL) to return your screen to full scale.

Time “T” – See explanation above.

Highlights “H” – compile a variety of results that you are particularly interested in viewing regularly. This is done per patient/per user. Highlight the particular results that you desire to put into the clinical highlights and type “H”. It will appear as nothing has happened, but if you left arrow out, you’ll see a new Data Source added “Clinical Highlights”. When no longer interested in seeing these results, highlight the heading of your results (the ones with the “*”) and type “D” to delete.

Jump “J” – in the split screen function, you can left arrow out of the main menu, choose another type of result and right arrow into the results. Next to the word “Jump” you will note what you are “currently” viewing. When entering “J” you will notice that you have toggled into the other resulting

screen and the word next to “Jump” will indicate the screen you are currently in.

Regraph “R” – view the current reference range that is set.

Custom values allow you to change the reference range to accommodate your particular needs. This is done per patient/per use.

Blood Bank History Data

There are no menu commands, the right arrow takes you directly into the report.

Blood Bank Products

Microbiology Data

Anatomical Pathology Reports

Radiology Reports

Orders

Visit History

Print “P” – see laboratory description.

Split “S” – see laboratory description.

Time “T” – see laboratory description.

Highlights “H” – see laboratory description.

Jump “J” – see laboratory description.

Current Medication Orders

Print “P” – see laboratory description.

Split “S” – see laboratory description.

Allergies “A” – see description at beginning of page 2.

Names “N” – by highlighting the drug and entering the “N”, it provides you with the Trade name and the Generic name.

Jump “J” – see laboratory description.

Medication Order History

Print “P” – see laboratory description.

Split “S” – see laboratory description.

Time “T” – see laboratory description.

Highlights “H” – see laboratory description.

Allergies “A” – see description at beginning of page 2.

Names “N” – see description above.

Jump “J” – see laboratory description.

Monograph “M” – patient’s drug information. Use the enter key when you have chosen the drug. It brings you down to monograph. The number with the E is English and the number with the S is Spanish. Enter a “Y” in the column “Print?” and press enter. The print field will appear – it defaults to “S” meaning screen viewing. If you want to print this, type in your network printer.

Medication Reorder List & Misc. Reorder List

Medication Reorder List:

-Allows you to resume medication orders (i.e., after surgery, transfers to another unit, etc.). Is to be used as an order sheet for medications.

-Allows you to print the discharge medication list. Is to be used part of the medication reconciliation process.

Use the arrow key to highlight Medication Reorder List. Right arrow. There are several confirmation screens you will need to enter through.

You will be prompted to enter your patient’s name.

Choose #1 for Discharge or #2 for Postop/Transfers as applicable.

A “Print on” screen will appear, type in your network printer.

Misc. Reorder List: (works the same a Med Reorder List)

-Allows you to resume misc. orders all the non-med orders, like labs, imaging etc. (i.e., after surgery, transfers to another unit, etc.). Is to be used as an order sheet.