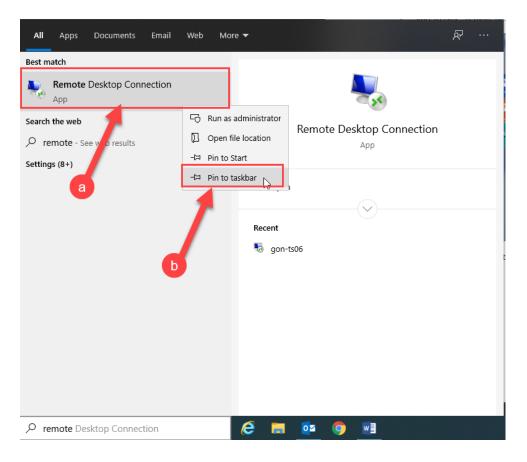


Community Health Nurse – MEDITECH Tip Sheet

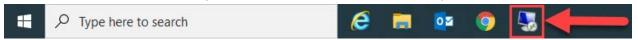
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Connecting to MEDITECH

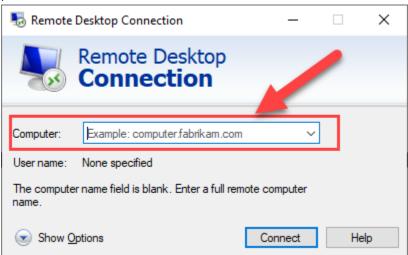
- 1. Click in the search box Type here to search located in the bottom left corner.
- 2. Type "remote".
 - a. Right click "Remote Desktop Connection"
 - b. Select "Pin to taskbar"



3. On the task bar, at the bottom of your screen, select the "Remote Desktop Connection" icon.



 In the "Computer" field type one of these servers GON-TS03, GON-TS04, GON-TS05, GON-TS06, GON-TS07, GON-TS08 and click connect. When prompted enter your GN username and password.



5. When the desktop loads, click the below icon to access MEDITECH.



REGISTRATION for all Clinical Visits

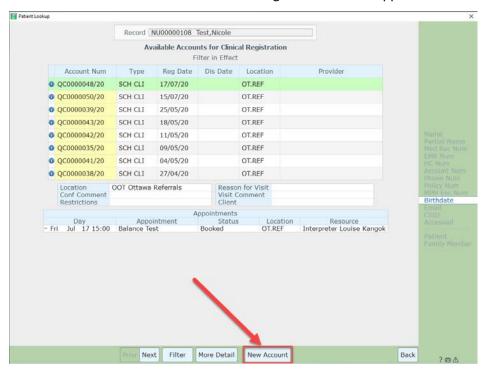
1. Choose **Registration Desktop** from the main Desktop.



- 2. At the Registration Type prompt, select Clinical.
- 3. At the Patient Identifier prompt, enter the <u>Birthdate</u>. The format is <u>DDMMYY</u>.

 HC# and LASTNAME,FIRSTNAME can also be used
- 4. A list of patients will appear with that birthdate. Select the patient you are looking for.

- 5. A Patient Lookup screen will appear showing all previous accounts created. Select <u>New Account</u> at the bottom of the screen.
 - **ONOT** select other visits as this will register a different appointment.



- 6. Across the top buttons, go to the **Insurances** tab.
- 7. Confirm the patients Health Insurance is present and checked off



- 8. Across the top buttons, go to the **Visit** tab.
- 9. Complete the **Service Date/Time**
- 10. Complete the Location.
- 11. At the Attending Provider field, enter the Clinician.
- 12. Complete the Reason for Visit.
- 13. Select **Save** at the bottom of the screen.
- 14. If labels are required, at the Forms to Print Screen, check off the **Community Health Centre Labels**. Enter the quantity in the Copies field and click in the Printer field, choose all printers for Printer list and find your label printer location in the printer field (usually on the label printer as a sticker). Then click OK and Print.

Accessing Patient Chart

1. Open **Provider Care Manager**



2. Click on the Find Patient or Patient Lists



Find Patient will give you patient demographic fields to search for your patient.



Patient Lists will give options find your patient. Choose whichever method works best for your workflow.



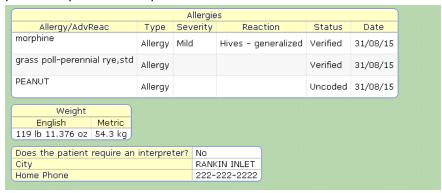
Patient Header

The patient header appears whenever a patient specific routine is opened. The header has common elements that display on all routines in the iEHR but may have a slightly different formatting.

Always review the patient header upon opening any routine to ensure you have the correct patient selected. Immediately hover the mouse over the patient name and then proceed to working in the chart.



• The ¹ symbol contains basic information about Allergies, Height and Weight and if the patient requires an interpreter.



- Age and sex
- Registration status, Location and Room and Bed Number
- Height/Weight, BSA and BMI
- Allergies/Adverse Reactions
- Account Number (QI0000075/12)
- Health Card Number (if not documented, the word "None" appears)
- Medical Record Number (NU00000281), also known as the NU Number

Summary Panel

Open chart defaults to the Summary Panel. Review home medications/allergies and medical history.

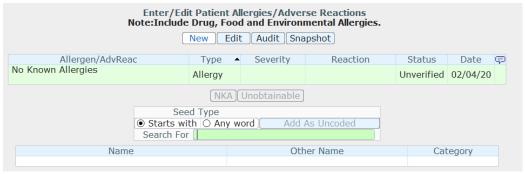
This is the central place to review historical information.

Contains: Problems List, Allergies, Home Medications and Health Maintenance (Medical Surgical History) and Patient Pharmacy.

EMR - Allergies

Understanding patient allergies is a vital part of the patient record. To update and review patient allergies:

- Open the patient's chart
- It will default on the <Summary> page
- Find the Allergy/AdvReac Tab
- Press the blue <**EDIT**> button to open the routine
- Click <New> to enter new allergies OR <Edit> to update existing entries
- Include all possible allergens, not just medication allergies



Unobtainable

- To enter Unobtainable, click the **<Unobtainable>** button
- This will prompt to document a rationale in the Comment field
- Update this prompt as soon as the information can be obtained



The **<Unobtainable>** button will only appear if no allergies have been previously entered.

NKA

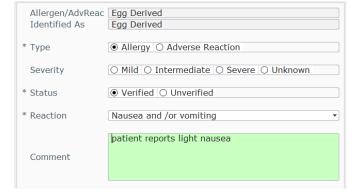
To enter NKA click the < NKA> button. This files as No Known Allergies in iEHR



The <**NKA**> button will only appear if there have been no previously entered allergies

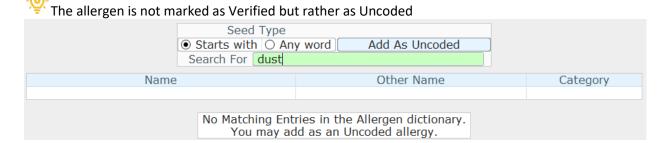
New

- The Allergen lookup is a type ahead lookup, meaning the more you type the smaller the list becomes when you hit <Enter> to search
- Spelling is of great importance when searching an allergen
- Searching by short form or slang terminology will likely not yield any search results
- Status always defaults to Verified
- Reaction is picked from the drop-down list
- Comment can be documented when needed



Entering Allergies not found in the Allergen Lookup - Uncoded Allergies

- Entering an allergen that is not contained in the allergen lookup will generate a warning that there are no matches in the system, and you are prompted to add the allergen as "Uncoded"
- Click on the <Add as Uncoded> button to add this allergen to the list
- The allergen will not be automatically cross checked with medications because it does not exist in the allergen dictionary



Editing Allergies

- If you need to edit an allergen click the <Edit> button and choose the allergen you want to edit
 by highlighting it green
- Make the edits and save

Removing Allergies

- Click Edit and choose the appropriate allergy
- Click the "Remove footer button"
- Indicate the reason for removal.



The history will be available in the "Audit" button

Confirming Allergies

- If a patient's allergies have been documented at a previous visit the allergies should be confirmed with the patient and then entered using the Confirm routine to update the iEHR
 - Click the blue Edit button
 - Check mark all allergies to be confirmed
 - Click the Confirm footer button
- This updates the Date/Time stamp in the iEHR

Entering Compound Medication

- If a patient reports an allergy to a compound medication attempt to determine which compound the patient is allergic to
- The allergy routine will split the compound medication into its separate components
- The routine will identify which medication the component was from
- Remove the component(s) the patient is not allergic by using the edit routine

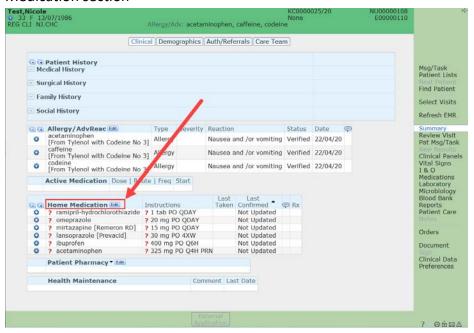




EMR – Home Medications

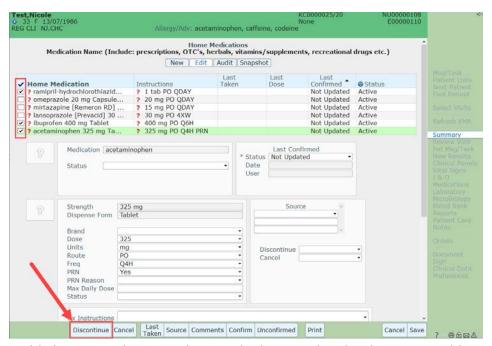
Discontinuing/Editing/Confirming

 From the "Summary" tab on the EMR select the "Edit" button under the Home Medication section

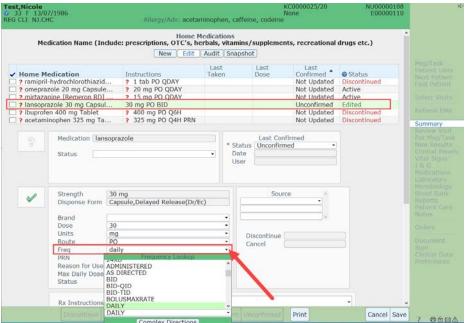


If not needing to discontinue skip to step 3.

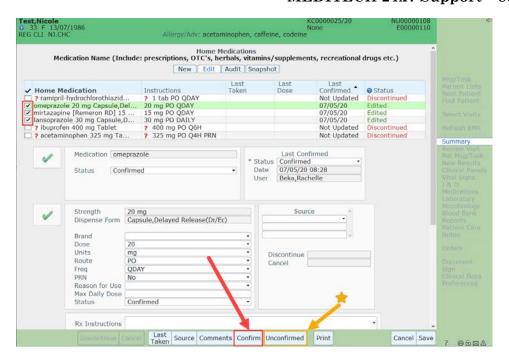
On the next screen select any medications you would like to discontinue and use the "Discontinue" footer button, enter your reason for DC'd and select Ok.



3. Highlight any medications that need editing and make changes or additions to the fields below

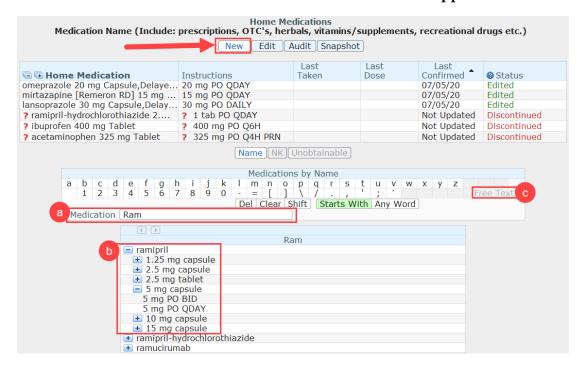


- 4. Select all medications you confirmed with the patient and hit the "Confirm" footer button.
 - ★ If needed, you can also select any medications you did not confirm and hit the "Unconfirmed" footer button.



Adding a New Medication

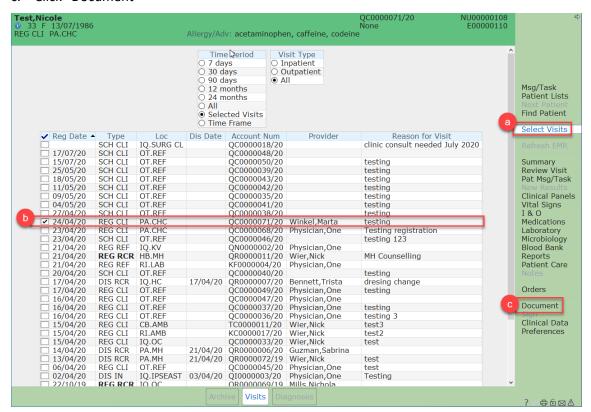
- 1. Make sure the "New" header button is selected
 - a. In the Medication field type the name of the medication
 - b. Choose the medication by:
 - i. Select the 🛨 symbol next to the medication name.
 - ii. Select the symbol next to the strength and form of the medication
 - iii. Select the correct dose, route and frequency (ie. 5 mg PO BID)
 - c. If the medication is not available, you can type out the full name of the medication and add it with the "Free Text" option (you will have to manually fill out all fields and no cross checking is done.)



- 2. On the newly added medication(s)
 - Ensure the Dose, Unit, Route and frequency have been entered and are correct.
 - You may also fill out any other fields, if required or add a patient comment if needed.
- 3. Click "Save" to complete

Documentation

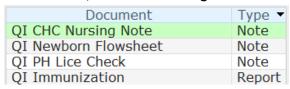
- 1. From the patients EMR
 - a. Click "Select Visits"
 - b. Select your visit to add documentation
 - c. Click "Document"



2. Use the Footer buttons to select "New"



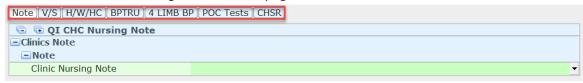
3. Select the appropriate note/report document or select the document using the footer buttons at the bottom, **Standard** & **Manage Favourites**





Once favorites are managed the first time, they stay for all patients after. **See Documentation**Favourites

4. Use the tabs to move through the different pages of the document



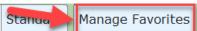
- 5. When finished documenting
 - a. Select "View/Save" in the bottom right corner and review the document
 - b. Adjust the date and time if needed for back dating/timing
 - c. Enter your PIN
 - d. Click "Save"

Documentation Favorites

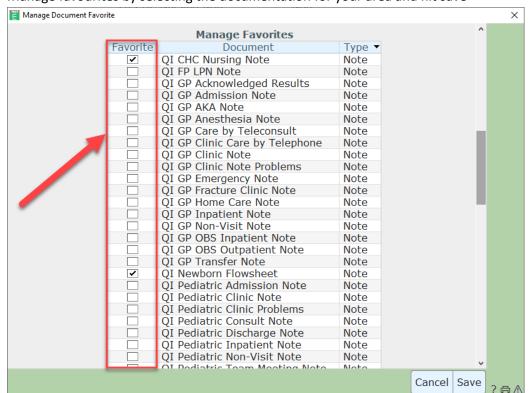
- 1. Enter patients EMR
- 2. Select your visit/account with the patient
- 3. Select "Document"
- 4. Select "New" if applicable



5. Select "Manage Favourites"



6. Manage favourites by selecting the documentation for your area and hit save

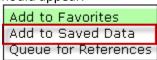


Adding Saved Data to a Note

- 1. Minimize the note or quick save the report. DO NOT sign off with PIN
- 2. Click on orders → new orders. Identify/select and edit desired orders accordingly. Then enter your unique PIN to submit the orders
- 3. After submitting the order, the orders defaults to the current order header tab. Click on the "+" sign beside current order to expand your orders.



4. Under "status", right click on the order (s) you wish to place in the patient note and select "Add to Saved Data". A black diamond should appear.

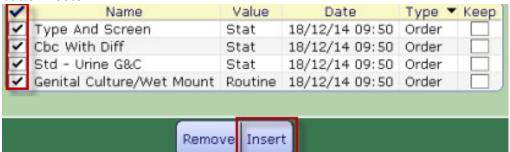




5. Return/maximize the patient note and click "saved data" at the footer

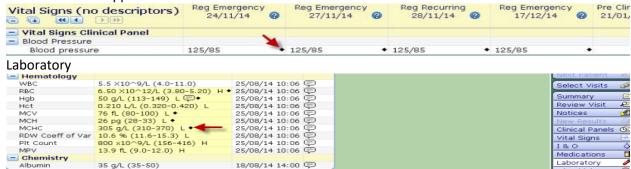


6. A list of items you previously selected to be saved to data will display with a check mark to the left of them. You can deselect an item by simply clicking on the check mark. Click "Insert" at the bottom footer.

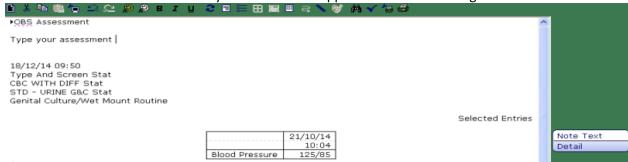


Community Health Nurse – MEDITECH tip sheet MEDITECH 24x7 Support – 867-975-6411

7. To add clinical panel/vital signs, and laboratory results to note: While in patients EMR, identify the items you wish to add. To add items to save data, right click in the desired field and a black diamond should appear.



8. When all items have been inserted your note should appear similar to the image below.



9. Click "OK" to save the note

Orders - Test done on the same day of visit

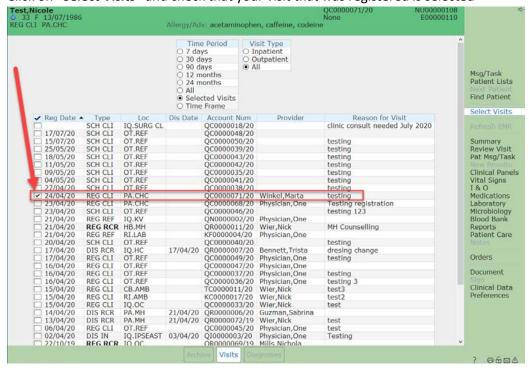
1. Open Provider Care Manager



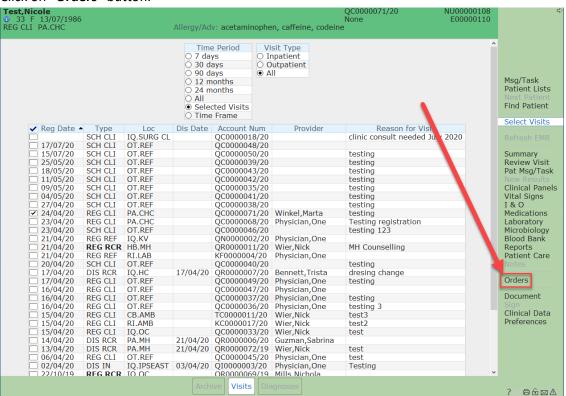
2. Click on Find Patient or Patient Lists to search for your patient.



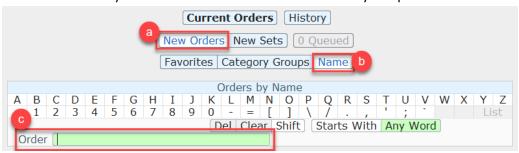
3. Click on "Select Visits" and check that your visit that was registered is selected



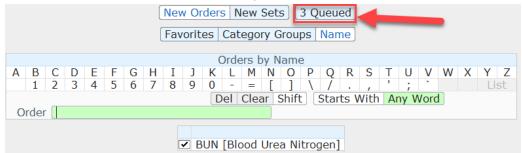
4. Click on "Orders" button.



- 5. Once in the Orders screen
 - a. Click on "New Orders" button
 - b. Click "Name" button
 - c. Search for your orders and check them off to add to your queue

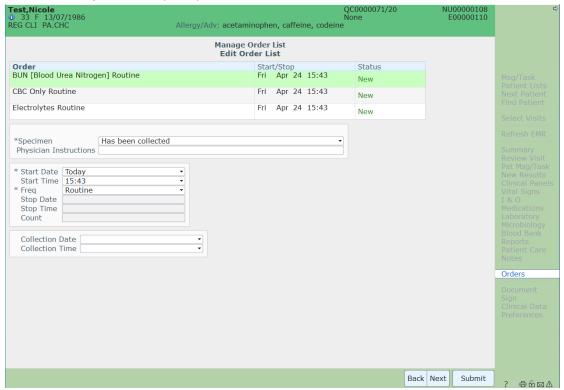


6. When all orders have been added to the queue, click on "Next" button in bottom left corner

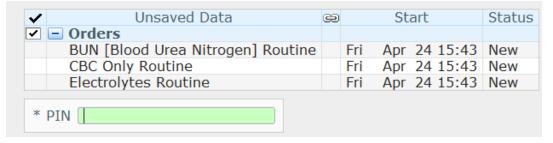


7. The "Manage/Edit Order List" window will open

DO NOT adjust the frequency or start date/time unless needed



- 8. Click on "Submit" button.
- 9. Enter your PIN and press ENTER key.

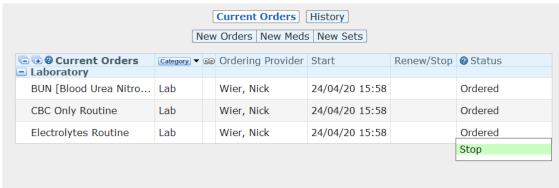


10. You can see the orders you just made in Current Orders tab.



Discontinue/Cancel an Order

1. Navigate to the Order page, click on the Status of the order, then click "Stop"



2. Enter in a mandatory Stop Reason and click OK.



3. Order goes to a status of "Stop".



X-ray Order Requisition Completion

1. Select Imaging and Therapeutic Services

2. Select Receptionist Desktop

- The Department of DI will default in.
- Select Save.
- Tick the box next to the correct patient.
- Select Arrival Time from the right-hand toolbar.
- Select OK.
- ITS Requisition and 2 Labels will print.

3. **Perform the X-Ray**

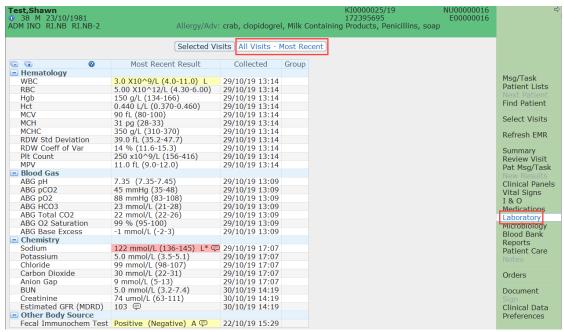
4. Select Technologist Desktop

- Tick the box next to the correct patient.
- Select Record Exam from the right-hand toolbar.
- Complete the following fields:
 - o Status Taken
 - o Start Date Day the x-ray was done.
 - o Start Time Same as the Arrived Time.
 - o End Date Day the x-ray was done.
 - o End Time When the x-ray was finished.
 - o Tech 1 − Who did the x-ray.
 - o Departed Time Same as End Time
 - o Material

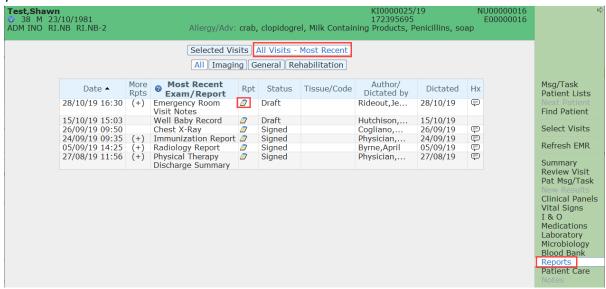
5. Select Save

Review Laboratory results and X-Ray/Ultrasound/Rehab Reports

- From the main menu enter Provider Care Manager and use the Find Patient or Patient Lists to find your patient.
- 2. Click on "Laboratory" button on right hand side to review Lab results
- 3. Click on "All visits Most Recent" button to review all results.



4. Click on "Reports" button on the right hand side. Click on the small clipboard icon of the report you would like to read.

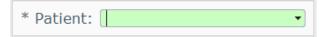


Reprint Outpatient Labels

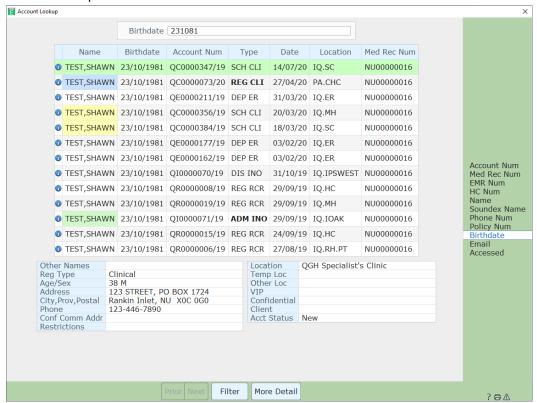
1. Click on CHC labels



- 2. Enter Patient DOB to search for patient
 - **You can also use Lastname, firstname or HC #**



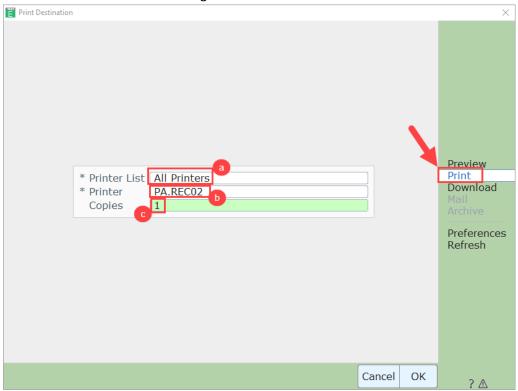
3. Select the visit to print labels for.



4. Select the print footer button



- 5. On the Print Destination screen choose "Print" on the right-hand side then:
 - a. Choose "All Printers" for Printer List
 - b. Choose your locations registration label printer (Example below is Pangnirtung's label printer)
 - c. Choose the number of registration labels



6. Click on "OK" button

Reprint Lab Labels

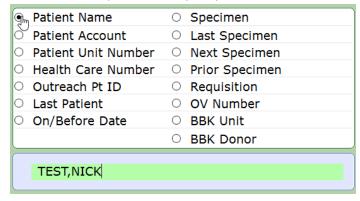
(1) Click on "Reprint LAB Labels"



(2) Select the drop down arrow



(3) Choose an option to find your patient

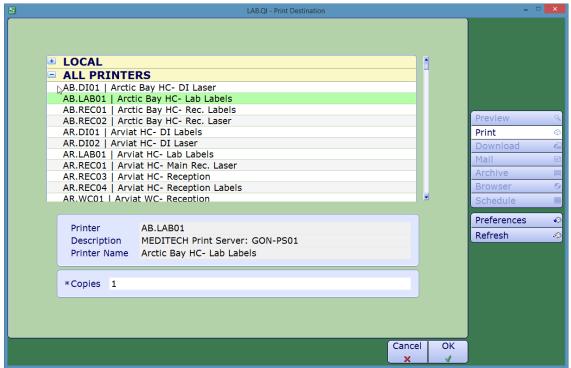


(4) Select the order to reprint

_	QC0000081/18 - TEST,NICK 31/M					
13	Specimen	Status	Collected	Ordered		
1	QI18:TB0000055R	ORD	24/05/18-1323	SPUTUM\EXPEC SPUT: TB SPUCULT		
1	QI18:TB0000048R	ORD	23/05/18-1323	SPUTUM\EXPEC SPUT: TB SPUCULT		
1	QI18:TB0000046R	ORD	22/05/18-1322	SPUTUM\EXPEC SPUT: TB SPUCULT		

- (5) Click "OK"
- (6) Select Print on the right hand menu, click the "+" next to ALL PRINTERS and select your communities MEDITECH LAB Label Printer.

Example below Arctic Bay Lab Label Printer



(7) Select "OK" to begin printing.

Change Your PIN

1. Click on "Change Your Own User PIN" option on your main menu.



- 2. Enter current PIN in the "PIN" field.
- 3. Choose a new PIN that is easy for you to remember and type this PIN in the "Enter New PIN" field and the "Re-enter to Verify" field.
- ONOT share your PIN with anyone, this is your electronic signature



4. Click on "OK" button.

EMR Menu Buttons Overview

EMR Buttons along the right side of the EMR Screen are grouped into functional sections that provide the user with choices to open a section of the health record. The panel that is open is displayed along the bottom of the screen.

The buttons are labeled with the name of the function.

Group: Organize Access				
Select Visits	Select another visit associated with the client. Able to			
	select criteria to restrict the time frame and type of			
Select Visits	visit (i.e. Inpatient, Outpatient)			
Group: Clinical Information				
Summary	Provides a general summary of the current account			
	and displays information usually found on a "kardex",			
	as well as Allergies, Problems, Active Medications,			
Summary	Home Medications and caution information.			
	In Phase 1 includes Active Medications for Inpatients.			
Review Visit	Displays non-clinical client information such as status,			
Review Visit	MRN number, client location, provider associated			
	with the visit, and insurances.			
	Provides a list of all visits that the patient has and			
	allows users to select a specific visit to view			
	information.			

New Results New Results Clinical Panels Clinical Panels	Allows viewing of new LAB results, Diagnostic Imaging or Health Record transcribed reports from the last 24 to 48 hours. If results have not yet been viewed by clinicians, the button is red. This is individualized per clinician. Customized view of data together in one centralized location based on specialities. Can include Lab, Medications, Vital Signs, Immunizations, Assessment responses, etc.
Vials Signs Vital Signs	View or graph client vital signs
I&O I & O	Displays intake and output totals, fluid balance by time periods
Medications Medications	Displays a list of client's medications. Toggle switch allows choice of current or life time list of medications. In "Active", user is able to filter for current, discontinued or All medications. In Phase 1 only includes Inpatient medications entered in Pharmacy module.
Laboratory	Access to lab test results by category with a choice of view in speadsheet format or the Lifetime / Last Results. If results have not yet been viewed by clinicians, the button is red. This is individualized per clinician.
Microbiology Microbiology	Displays microbiology specimen data, with the most recent on the top of the list. Susceptability grid is attached to the display.
Blood Bank Blood Bank	Displays any blood bank related products and tests.
Reports Reports	Access to view Diagnostic Imaging and Health Record dictated/transcribed reports. To view reports, click on the Report Icon. If reports have not yet been viewed by clinicians, the button is red. This is individualized

	per clinician.
	In Phase 2 this section will include images of reports and forms that remain on paper and that have been scanned into the chart. As well as provider documentation.
Patient Care Patient Care	Access to view Assessments, Interventions, and Plan of Care
Notes	Access to view narrative notes written by all care providers. Able to filter and search, then view all notes entered by any provider.
Refresh EMR Refresh EMR	Provides the ability to refresh the screen and if there are any new results/reports/information that has been added to the chart, these will be viewable. The screen automatically refreshes but this provides an instant refresh especially if expecting new results while viewing a patient's record.