

Paragon Training – Nursing Students

Login – use Network ID/ password. *Will prompt you to enter credentials twice*

Applications – Clinical Care Station

Care Glance – will launch census in order to view patients and access documentation

You can organize the patients by name and location by clicking on the gray area. It will arrange them in either alphabetical or numerical order, depending on which you select.

REMINDER – to exit any parts of the system – ALWAYS use the yellow arrow or the door!

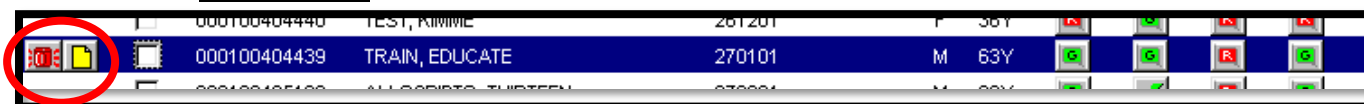


Documentation

Select (highlight) the patient

Alerts – **Red alert** – suicide/elopement precautions

Sticky note – nurse to nurse communication/care notes



Documenting on the patient flowsheet


Change unit type (file folders) – select appropriate type for unit you are working



Click on flowsheets (thermometers/hockey sticks)



- When the flowsheet opens up – right click and then hover over “New” to see the categories where you can chart.
- You will select the appropriate category that you want to document (i.e.-“Vital Sign Entry” or “I/O”). The next screen will allow you to document the values. Fill out each area appropriately – including location of

temperature, blood pressure, etc. (see below). You can use the exclamation point to make the entry significant or the noted pad to add additional information concerning the entry - 

- If you need to insert multiple vital signs, click the “insert new” button and it will bring the vitals to the lower portion of the screen (see below). You can edit entries by clicking the box at the top of the entry – it will bring that documentation into the edit fields.

Date	Time	Temp	Pulse	RR	BP
08/20/2014	11:43	98.0 F	72	20	120/80

- Once complete, you can click “OK” – it will bring you to the flowsheet screen.

Flowsheet - for TRAIN, EDUCATE - Visit ID: 000100404439 - Location: 270101 - DOB: 10/10/1950

Patient: TRAIN, EDUCATE Visit ID: 000100404439 MR #: 05300439 Gender: M Allergies:

Location: CVRA 270101 Attending: ACCARDO, SHAUN L. Admit Date: 04/01/2014 16:07 DOB: 10/10/1950

Service: BB - MEDICINE SERVICE Diagnosis:

	08/21/2014 06:59	08/20/2014 14:59	08/20/2014 11:40	08/20/2014 09:48	08/20/2014 08:50	08/20/2014 08:44	08/20/2014 08:41	08/20/2014 08:00	08/20/2014 07:51	08/20/2014 06:59	08/19/2014 14:59	08/19/2014 13:57	08/19/2014 12:00	08/19/2014 10:00	08/07/2014 06:59	08/06/2014 14:14
Vitals			+				+	+				+	+	+		
Temp			98.0 F				102.5 F	102.0 F			98.0 F	102.0 F	98.4 F			
Pulse			78				H	H				H				
RR			20				L	12				14				
O2 Sat %			100%				89%	98%				98%				
BP			125/80				200/130	120/60				112/78				
Ht							H	L				63.00 in				

Home Prev << Next >> End Close

- You can expand (using the small + next to all) and review your documentation which will be highlighted in yellow.
 - **As long as it is yellow, you can edit/correct information. – to edit, click on the box where the documentation needs to be changed, correct documentation, then click “OK”**
- Once you have completed all documentation, click the yellow arrow to exit and save the information.

Documenting on the patient assessment sheet –

Assessments

- Highlight the correct patient in Care Glance
- Click on “Change Unit Type” icon

 - Select the unit type where you are working
 - Click “OK”

- Click “Perform Assessment” icon

 - Select “Daily Assessment” to chart your systems assessment
 - “Backdate/time” Box will appear. Adjust the time accordingly (if needed)
 - Select “OK”
 - Click on the tabs to open each area of documentation
 - When finished, Click on the Yellow Arrow to save information and exit

Viewing Labs and Radiology Results:

- Highlight the patient in “Care Glance”
- Click the “NR” (New Results) box on the Care Glance screen
 - “Double” click on the test
 - Review the results
 - Yellow arrow to save information

OR

- Highlight patient in “Care Glance”

- Click “Patient Profile” (Black and White Face)
 - Click the “H”
 - Highlight the visit
 - “Single” click and the bottom section will display lab/rad tabs
 - Click on tabs to view results
 - To exit click on the “X” (right corner)

Care Glance

Legend X

<p>Admission Assessment (AA)</p> <ul style="list-style-type: none"> Not Started In Process Complete <p>Care Plan (CP)</p> <ul style="list-style-type: none"> Not Started Pending Initiation Initiated Initiated - Visit Disch/Pend Disch Care Plan Complete <p>Interventions (Int)</p> <ul style="list-style-type: none"> Current Pending Action Overdue No Plan Initiated <p>Medications (RX)</p> <ul style="list-style-type: none"> Visit has Scheduled Medication(s) Due Medication(s) Overdue Medication(s) Visit has no Medication(s) <p>Flowsheets (FS)</p> <ul style="list-style-type: none"> Flowsheet Data Present No Flowsheet Data Present <p>New Results (NR)</p> <ul style="list-style-type: none"> New Abnormal Result(s) New Normal Result(s) No New Result(s) 	<p>Other</p> <ul style="list-style-type: none"> Alert Sticky Note <p>Medication Reconciliation (MR)</p> <ul style="list-style-type: none"> Home Medication Review Needed Medication Reconciliation Needed Medication Reconciliation Completed No Medication Reconciliation Action Required <p>Medical Record Documentation (Doc)</p> <ul style="list-style-type: none"> Visit has Transcription(s)/Documentation Visit has no Transcription(s)/Documentation <p>CPOE Order Manager Workqueue (OM WQ)</p> <ul style="list-style-type: none"> Stat Order(s) Pending Non-Stat Order(s) Pending No CPOE Orders to Process <p>CPOE Pharmacy Ord Workqueue (RX WQ)</p> <ul style="list-style-type: none"> Stat Order(s) Pending Non-Stat Order(s) Pending No CPOE Orders to Process <p>CPOE Order Acknowledge (ACKN)</p> <ul style="list-style-type: none"> Stat Order Acknowledgement(s) Required Non-Stat Order Acknowledgement(s) Required Deferred CPOE Orders to Acknowledge No CPOE Orders to Acknowledge
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<p>“AA” (Admission Assessment) bubble</p> <ul style="list-style-type: none"> • Will be <u>GREEN</u> when the Admission process is complete <p>“CP” (Care Plans) bubble</p> <ul style="list-style-type: none"> • <u>GREEN</u> = Care plans have been initiated <p>“Rx” (med) bubble</p> <ul style="list-style-type: none"> • <u>RED</u> = late med • <u>YELLOW</u> = med due • <u>GREEN</u> = no meds due <p>“FS” (flowsheet) bubble</p> <ul style="list-style-type: none"> • Will be <u>GREEN</u> because documentation is present • Can launch Flowsheet from here <p>“NR” (new result or Lab) bubble</p> <ul style="list-style-type: none"> • <u>WHITE</u> = all results have been viewed • <u>RED</u> = New unviewed ABNORMAL results • <u>GREEN</u> = New unviewed NORMAL results <p>“MR” (med reconciliation or home meds) bubble</p> <ul style="list-style-type: none"> • Will be <u>WHITE</u> because no home meds <p>“DOC” (Medical Records)</p> <ul style="list-style-type: none"> • Will be <u>WHITE</u> because used by Medical Records 	<p>“INT” (Interventions) bubble</p> <ul style="list-style-type: none"> • <u>YELLOW OR RED</u>, <u>MUST BE</u> addressed before you give report • Click on the “INT” bubble • Change the “mode” to “set as complete” • Scroll down to search for any “red” interventions • Click the <input type="checkbox"/> next to the “red” intervention • After selecting the interventions, Click “close”. “INT” bubble will be <u>GREEN</u> <p>“OM WQ” (Order Management) bubble</p> <ul style="list-style-type: none"> • <u>WHITE</u> = no orders to process • <u>YELLOW/RED</u> = order need to be processed • Can be <u>YELLOW</u> or <u>RED</u> when waiting for Stool or Urine sample <p>“RX WQ” (Pharmacy use only) bubble</p> <p>“ACKN” (Acknowledge orders) bubble</p> <ul style="list-style-type: none"> • <u>RED</u> = STAT orders to be acknowledged • <u>YELLOW</u> = ROUTINE orders to be acknowledged • <u>WHITE</u> = No orders to be acknowledged
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