

SCM MANUAL

for

CLINICAL NURSING INSTRUCTORS

SCM Overview

Welcome to Automation of Nursing Documentation using the SCM Module. The goal of this manual is that you will become familiar with the documentation basics so you adhere to patient safety and quality of care. SCM is solely focused on patient safety.

Important Points to Remember:

- Your user ID and password are highly confidential
- If you feel anyone has accessed your code, please notify Information Systems (x8921) immediately
- Your code is your electronic signature
- You will be the only one capable of signing on to SCM. Students do not have this privilege.
- You will only be able to see the patients on the unit to which you are assigned.
- Never leave the computer once you have signed on.
- Don't forget to click the red sign off icon when you're done.

Logging In

Log On Screen

The screenshot shows the Eclipse Gateway Login window. At the top, it says "Eclipse Gateway Login" and "Eclipse Sunrise Enterprise™ 5.5". Below this is a login form with a tab labeled "Username/Password". The form contains two input fields: "User Name:" and "Password:". Below the fields is a message: "This System should only be accessed by Authorized Users." and a friendly message: "Have a great day!". At the bottom, there is a "Need Help?" link, "Login" and "Cancel" buttons, and a status bar showing "Current Workgroup: RW1". A small copyright notice is visible at the very bottom.

Log In

1. Enter your User name and Password

- User Name
- Password

- Click 

Toolbar

Under the drop down menu is the *Toolbar*.

If you hover over an icon with the mouse in the Toolbar, the purpose of the icon will display beneath the icon and in the lower left hand corner of the screen. (In general, if a function is grayed out it means you do not have access to perform that function.)

Print Reports



Print medical reports. Those would be Patient Care Summary and Laboratory Results.

Please note: The appropriate report will print on the patient that is highlighted. You will not be able to print a Patient Care Summary on all patients you have chosen for your students at one time. You will only have the capability of printing one PCS at a time. The next page will explain in detail how to print these reports.

Printing Reports

Patient Care Summary

- Click on Printer Icon
- Report Category => Patient List Reports
- Choose "Patient Care Summary – Selected Patient"
- Selection Criteria will require that a shift* time be selected from the dropdown – Choose the appropriate time frame for the shift
- Click => OK => The Report will Print!

Laboratory Results

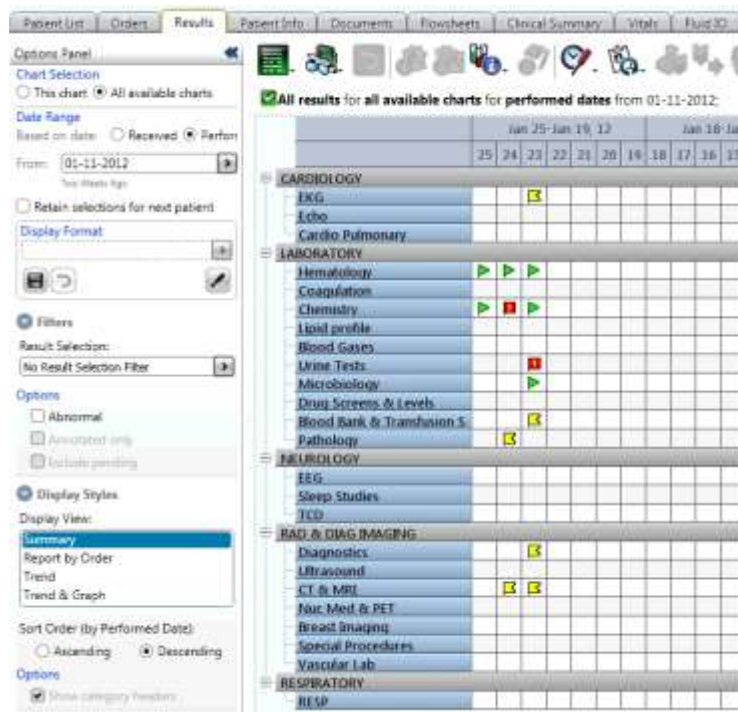
- When you have chosen a patient, select the “Results” tab.

Results Selection

- Under Result Selection, click the Display View Icon

1. Summary
2. Report by Order
3. Trend View
4. Trend and Graph

Summary View gives you a view at a glance



[illegible]

Patient List **Orders** **Results** Patient Info Documents Flowcharts Clinical Summary Vitals

Options Panel

Chart Selection
☐ This chart ☒ All available charts

Date Range
 Based on date: ☐ Received ☒ Performed
 From: 09-28-2011
Start of This Chart

☒ Retain selections for next patient

Display Format
[Modified] Microbiology (Rep...)

Filters
Result Selections
No Result Selection Filter

Options
☐ Abnormal
☐ Annotated only
☒ Include pending

☒ Display Styles
Display View:
Summary Report by Order
Trend

All results for all available charts for performed dates from 09-28-

	29Sep11 05:00	28Sep11 05:00
Hematology		
Hematology		
WBC	* 8.4 *	8.4
RBC	* ↓ 3.60 *	↓ 3.65
Hemoglobin	* ↓ 11.3 *	↓ 11.4
Hematocrit	* ↓ 33.6 *	↓ 33.8
MCV	* 93.3 *	92.8
Platelet Count	* ↓ 115 *	↓ 90
Coagulation		
Coagulation		
Prothrombin Time	12.3 ↑	13.4
aPTT	1.11	1.25
Chemistry		
Chemistry		
Glucose	↑ 136	↑ 185
BUN	↑ 34	↑ 31
Creatinine	0.7	0.8
GFR estimated Non African American	> 60	> 60
GFR estimated African American	> 60	> 60

Trend and Graph allows you to trend or graph specific data

TO PRINT

- Choose the date(s) you wish to look at by highlighting and segregating those tests you want to print
- Click on Trends and only those date(s) and tests will appear
- Click on the Printer Icon
- You will see Report Category open up with Results Reports
- Highlight the one format you want (there are 2)
- Click on Print!

Flowsheet Tab

[illegible]

Flowsheets can be found in the lower left hand corner and include:

- Vital Signs
- Intake and Output
- Plan of Care
- Assessment and Interventions
- Education / Outcome Record
- Guideline Assessment / Outcome Record
- Progress Notes

Vital Signs and Fluid Intake and Output Tabs

*** These tabs are “View Only” ***

These views were created for clinicians to provide a summary review of vital signs and I&O's. Filters allow the users to set the timeframe for result viewing. The vital signs default view is for the last 24 hours but can be set to meet your requirements for up to 5 days. The Fluid IO displays a view of columns providing the last 7 days of I&O information including daily weights. It also displays a Length of Stay total. The Intake and Output view is further broken down by shift and category (i.e.: Oral, Parenteral).

1. **Click** on the “Vitals” tab
2. **Click** on drop down arrow next to display
3. **Select** “Both”
4. **Click** on gray slide arrow in the middle of the yellow section and move to the left or right to define the time period for your view

*** All parameters (ie: Systolic BP, Diastolic BP, Temperature) with check marks next to them will appear in the view you choose ***

Medication Summary Tab

Provides an easy way to view all documented medications for the selected patient



Worklist Manager



The Worklist Manager is where to chart medications
Medications will not flow to the worklist, to be charted on, until they are verified by the pharmacist.

Colors of the Worklist

- Yellow – scheduled task
- Red – Overdue task – NEEDS to be charted out
- Magenta – PRN medication
- Turquoise – Continuous task
- Light Green – unscheduled task (ie:influenza vaccine)

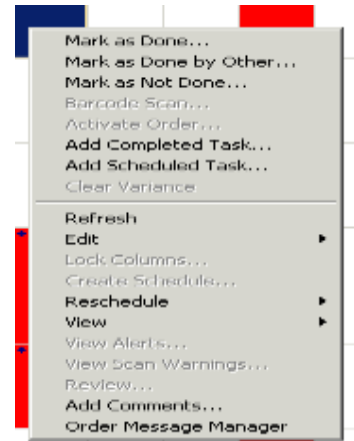


Please reference the “Help” drop down menu for all colors

Document

“Mark as Done”

1. Right click on the appropriate time cell for the medication you wish to chart
2. Select “Mark as Done”



“Mark as Not Done”

1. Right click on the appropriate time cell for the medication you wish to chart
2. Select “Mark as Not Done”
3. Specify Reason


Please Note: It will be the instructor’s electronic signature on a given medication. In the Comment Box, you have the capability of typing the student’s name and SN and the school. 11

Administered At
Date: 01-27-2012 Time: 14:00

Task Information
Task: Maalox Plus - Al Hydrox/Mg OH/Simethicone 30 ml, by mouth, every 6 hours, PRN indigestion Start date: 01-22-2012 Stop date: 04-21-2012
Dispensed as: Maalox Plus - Al hydroxide/Mg hydroxide/ simethicone 225 mg-200 mg-20 mg/5 mL SUSP GiveTOTAL 30 ml

Start Date/Time: 01-22-2012 09:50 Stop Date/Time: 04-21-2012 23:59

Dose Given: 30 Unit of Measure: ml
Route: by mouth
Heart Rate: Respiratory Rate: Blood Pressure:
Comment:

A "white bubble" over the drop down arrow  indicates that the RN can type in information in that specific area (ex. Pain Description and Pain Aggravating Factors). If the patient is unable to describe pain - the RN can type the information in that field

Pre-Intervention Pain Assessment

Cultural/religious, ethical, spiritual, and/or personal barriers to pain management have been assessed.

Pain Scale Used: Pain Level/Score: Acceptable Pain Level:

Pain Location: Pain Description: Pain Aggravating Factors:
 Clear

☐ Movement
☐ Palpitation
☐ Breathing
☐ Inadequate pain medication(dose/freq)
☐ Increased Stimuli

Pre Medicated Sedation Level:

Any Questions ???