



# 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

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# 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

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**Report by Order** gives you the ability to view results sorted by date and time, with the order as the header.

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<u>**Trend View**</u> provides you with the opportunity to view and compare results for the same test across time.

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Summary	GFR estimated Non African American	>60	>60
Report by Order	GFR estimated African American	>60	>50

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**

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

- Vital Signs
- o Intake and Output
- o Plan of Care
- Assessment and Interventions
- Education / Outcome Record
- o 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

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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)

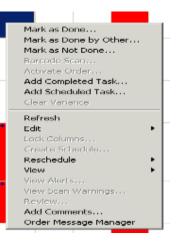


Please reference the "Help" drop down menu for all colors

#### 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:	Unit of Measure				
30					
Route					
by mouth	₹				
Heart Rate	Respiratory Rate Blood Pr	essure			
Comment					
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A "white bubble" over the drop down arrow I 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:					
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		Movement					
		Palpatation					
		Breathing					
		Inadequate pain medication(dose/freq)					
		🔲 Increased Stimuli					
Pre Medicated Sedation Level:							
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Any Questions ????