



SCM LOG IN

- Enter your UID # → **Tab key**
- Enter your network password
- UID & Password → lower case always


CHARTING: PATIENT CARE PROFILE

- Toolbar → click **Enter Document** (paper /w pen)  icon
- The next screen is the **Document Entry Worksheet** → click and type “k” in “Content of” window
- Double click **KBC HF Adult Patient Profile** or highlight it and click the **Open** button
- Topics are on the left of the screen (**Sections Flyout** → **Pin in place**) Click
- **Retrieve Last Charted Values** button at bottom left of section flyout.
- Must do each section separately
- View and verify the data, may open **Preview** button and view where data is coming from indicated by superscript numbers
- Click **Insert Default Values** to bring in pre-selected information in some sections-Verify → **Save Peds/Mother/Baby/NICU-Click Copy Forward-select Profile to copy from-Check boxes-Verify-Save**
- **Manual Entry**- Click to highlight a **Section** and fill out the related data to the right
- This **the Patient’s Story** so only fill out the data pertaining to what he tells you
- **Medical Surgery History, Immunizations, and Home Meds** once entered will be listed in subsequent visits


1. Medical Surgical History

- Click **Caduceus** icon 
- **Past Medical HX** is the default
- Enter the diagnosis using either **Favorites** or the **Full Catalog Search**
- **To Edit or Delete** → highlight the diagnosis and use the **Action List** on the right

2. Immunizations/Code Status

- Click the **Significant Event** icon 
- Choose the **Type** (Vaccination)
- Choose the **Event** (Received)
- Choose the **Date**

3. Medications

- Click the **Rx** icon 
- Click **Add Hx lower left tab**
- In drug **Search** area, type first few letters of drug ex. “**Teno**”
- Select drug from list – “**Tenormin**”
- Select the drug with dose “**Tenormin 50 mgs**”
- Fill in the drug details below:
 - **Dose** → **1.0 blows in**
 - **Dosage unit** → type “**t**” → tab(s) blows in
 - **Frequency** → type “**o**” for **once**
 - Scroll to – **once a day**
- Click **Submit icon** or **blue Submit hyperlink**
- Continue adding Medications → use the ‘**X Close**’ to exit when finished

Correct a Medication


- If it is a dose correction - must be Cx and reentered
- Instructions can be edited
- Double click **Rx icon** → **right** click drug to be corrected
- Select **Disc/Cancel** if dose, **Edit Hx Meds** for instructions
 - To Cancel, – select **Cancel Rx** from new screen → Add the drug with the corrected dose
 - To edit the instructions – type your corrections in the Edit window and resubmit

4. Incomplete Chart – Exit and Return

- Before exiting, click the **Incomplete** box at bottom of flowsheet
- Click **Submit** → goes to Document Entry Worksheet
- Return by clicking the **Document tab**
- Change **Display View** → select **Report View**
- Click to highlight the Document /w **INCOMPLETE**
- **Right** click → select **Modify Document**
- Can click **Preview (top R)** to see overall document → **OK** to close review box
- Remove the √ from Incomplete box when Profile is complete → **Save**

PATIENT LIST ICONS

Allergies

- Click the **Allergy** icon 
- **Drug** is the default (**Food, Drug Category** etc. select from list)
- Type the first few letters of the Allergen
- List will automatically scroll to allergen
- **Select all reactions that apply**
- Select the reactions → **OK** to box
- To add another allergy, click **Apply** and repeat the process
- To submit after last allergy → click **OK**

CHARTING: FLOWSHEETS-

Click Flowsheet Tab

All Flowsheets are located on the left of your screen in the bottom box

Time Columns

- **Right** click the gray area at the top of the Flowsheet or use the Time Column Icon
- Select **Add Single Time Column**
- To change time → Right click the time and choose **Change Time** → need reason.
- A closed lock at the top of your column indicates someone else is in that time column

Parameters

- Most Flowsheets have pre-printed parameters
- To add a parameter, **right** click the gray area at the top of the Flowsheet
- Select **Add Parameter**
- Click the **Expand (plus sign) button** to open up the categories
- Scroll to find what you want and click once to select the **parameter**
- Click **Add** and then **OK** when you have selected all

KBC Flowsheets:

#1. Plan of Care/ Clinical Practice Guidelines

- CPGs are evidenced-based and based on best practice and define how we care for our patients. The Green CPG parameters are visible on every flowsheet but are added from the POC FS
- To add these to the Plan of Care FS → Right Click and **Add Parameter**
- Click the **Expand (plus sign) button** to open up the categories
- Scroll to find the CPG you want

- Click once to select the **parameter** – **do not click the plus sign** in front of the “tent”
- Click **Add →OK** to add the CPG to the POC Flowsheet
- Add only **One Time Column**
- Left click in data cell and free text an **individualized statement** in data cell box
- To read the CPG, from the Plan of Care Flowsheet (POC)**

- Right click anywhere on the Green parameter which you added to a flowsheet
- Select **Show Reference Data**
- Click the **blue .pdf** link at the top of the window which appears
- Click **Open** to generate that guideline
- Can be minimized on your Start Bar by clicking the “.” sign

To read the CPG, from any other Flowsheet

- Tool Bar →click **Flowsheet Manager** icon (paper with 3 labels)
- Brings up a small version of the POC flowsheet then proceed as above



#2. Assessment & Intervention FS

- WDL** – charting to a defined standard. Hovering over the arrow tells you the standard
- POC** – charting to the specific guideline in the Plan of Care. You must know the guidelines.
- Can right click in parameter and choose **Modify Row Label** to free text a comment which will show in the parameter (e.g. add IV site, gauge, type and date of insertion)
- Fill out the data cells → **Click OK after each data cell is completed.**

IV Documentation

- The **Vascular Access** parameter is used for charting all **IV Insertions, Assessments, and Discontinuations.**
- There is one default parameter but you can add more parameters for additional IVs
- Label the Vascular Access parameter to reflect the IV site:
 - Right click in the parameter → choose **Modify Row Label**
 - From the drop down menus fill in the: **Site, Type, Gauges/length**
 - In the Comment section type in the **start date**

- When you discontinue an IV – d/c the associated Vascular Access parameter.

#3. Education/Outcome Record

- Teaching /Learning Assessment**
 - Must be filled in on admission → Comes from Profile if filled out there.
- Individualized Goals/Outcomes** – can be developed with pt but not mandatory.
- Patient Safety/Generic Goals/Outcomes** – address JCAHO requirements to educate the patient. **Fill out Patient Safety Ed w/in 24 hours**
- CGP Goals/Outcomes** – are related to the Guidelines selected in the POC
- Literature/Videos Given** - include reviewing of Daily Planners here/Core Measure Packets

#4. Guideline Assessment/ Outcome Eval. FS

- Potential Complications** – chart if S/Sx are present. If present select them
- Outcome Evaluation** – chart box
- Summary Statement** –give a brief overview of patients condition or day.

VS FS

- Add parameters & Time columns as needed
- Drips auto calculate /w weight for calcs entry

I/O FS

- Add parameters & Time columns as needed
- Time columns default to 0600 & 1800
- ICUs: Chart I/O every hour
- PCU/Med Surg: Clear all pumps end of shift and chart volume indicated on pump
- IVPBs do not need to have name of meds. documented here. They are recorded on the eMAR.
- PRBC admin requires a Misc. Note “No blood transfusion reaction noted”.

Restraint FS

- Fill out completely for patients in restraints per policy
- Some info initiated on A & I FS

Baker/ Marchman Act. Suicide FS

- Use for all patients that meet the criteria



SUNRISE CLINICAL

MANAGER (SCM)

DOCUMENTATION

WITH

KNOWLEDGE BASED

CHARTING (KBC)

A NURSES QUICK

REFERENCE

GUIDE



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