

COMPASS Update

Improvements Made During August

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Updates to Existing Order Sets

- **Asthma Admission to Med/Surg Pedi order set**
 - The “prednisolone“ med order has been replaced with a “prednisolone per protocol” order.

New Single Orders

- **Pedi Telemetry Monitoring order**
 - Order now has 6 required fields as outlined above.
 - Monitor type is a drop down with 2 choices: bedside or remote.
 - Monitoring level instructs nurse as to the parameters, and exceptions to patient monitoring, e.g. may be off monitor for brief periods.
 - Indications for monitoring lists reasons that monitoring is required, and is multi-select.

The screenshot displays a software interface for 'Nursing Orders'. At the top, a blue header bar shows 'Telemetry Monitor - Pedi Order' with a timestamp of '08/17/2010 2:57 CDT' and the status 'Continuous'. Below this, a section titled 'Details for Telemetry Monitor - Pedi' is visible, with sub-tabs for 'Details' and 'Order Comments'. The 'Details' tab is active, showing a list of order details on a yellow background:

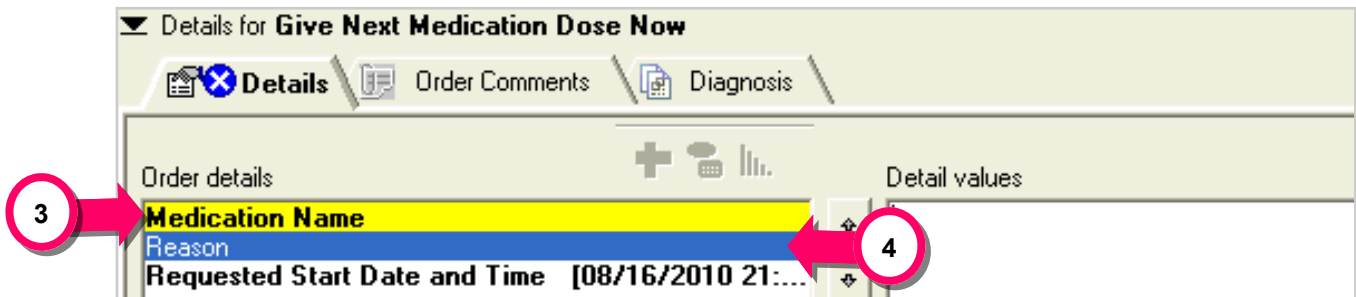
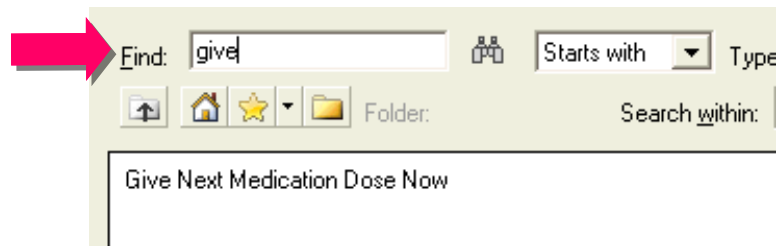
- Monitor Type
- Monitoring Level
- Indications for Monitoring
- Arrhythmia of Concern
- Notify For Heart Rate Less Than
- Notify for Heart Rate Greater Than

- **Two new orders used for chemistry tests from synovial fluid specimens are available:**
 - Glucose Joint Fluid
 - Protein Joint Fluid
- **A CT Angiogram Abdomen/Pelvis w/ Contrast order has been added.**

New Single Orders

- **Give Next Medication Dose Now order available August 30**

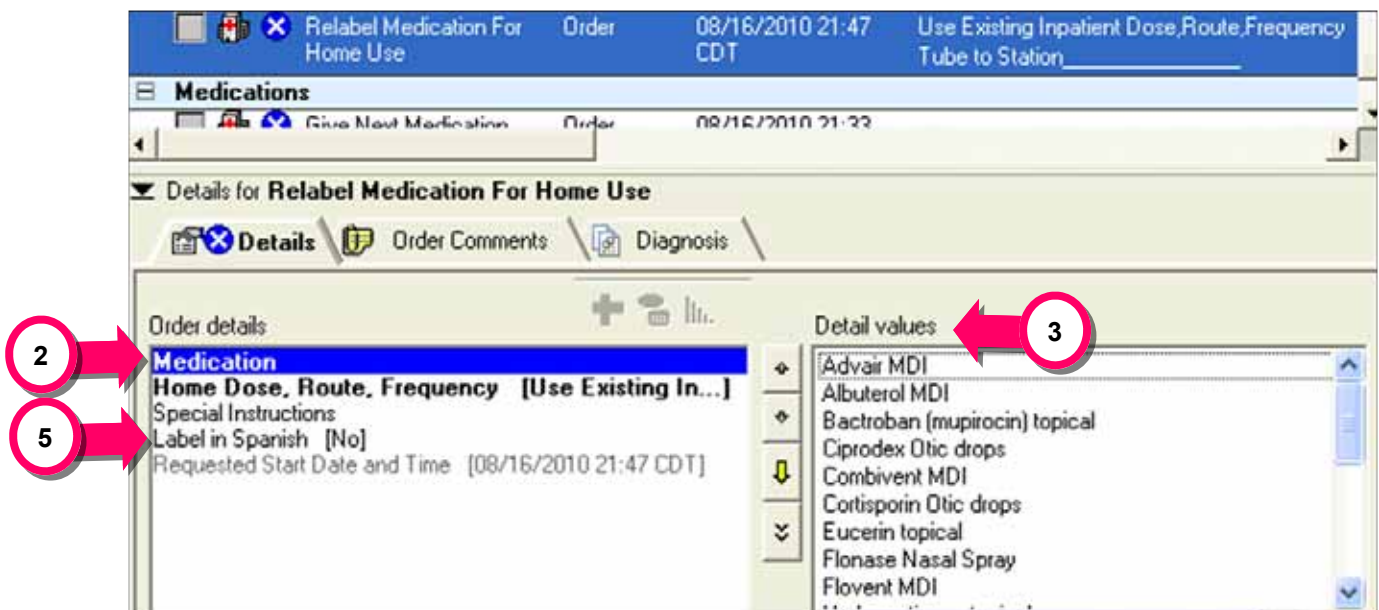
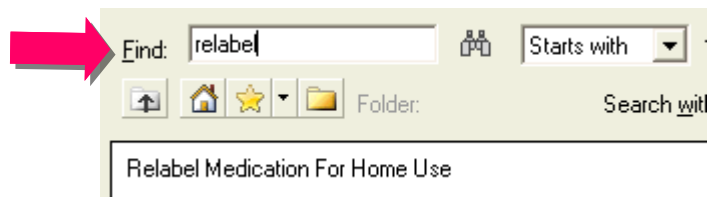
1. Use in lieu of communication orders to change the administration time to now for a single dose of a medication
2. May be used for any medication that needs to be given ahead of schedule to meet a specific need
3. Has one required field: medication name
4. Reason is not a required field, but should be completed to document in the chart the reason for change to dosing schedule
5. Once signed, the order will not appear in the medication section of the orders view until nurse completes the task.
6. The order is viewable in the inactive orders view only.



New Single Orders

- **Re-label Medication for Home Use order available August 30**

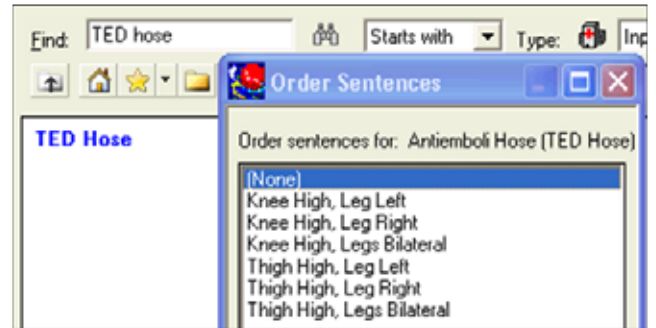
1. Use in lieu of communication orders to nursing regarding the relabeling of inpatient medications for use after discharge for home use
2. Has one required field: medication name
3. Medications that are permitted for relabeling by hospital policy are listed in the drop down menu
4. Home dose, route, frequency defaults to inpatient dose regimen, but may be modified if needed.
5. If patient is Spanish speaking, change the Label in Spanish question to **Yes**
6. Order will print a requisition that nurse sends to pharmacy along with medication
7. Nurse will fill in the blank regarding the appropriate tube station for medication return



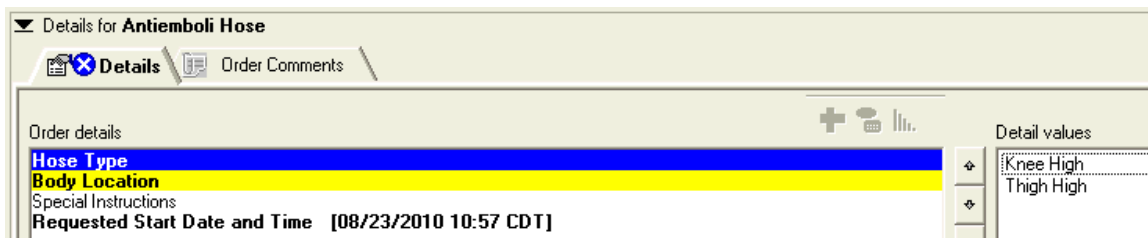
Updates to Existing Order Sets

• TED Hose

- Combines Knee High and Thigh High single orders
- Synonyms for order:
- Stockings Antiemboli
- Hose Antiemboli

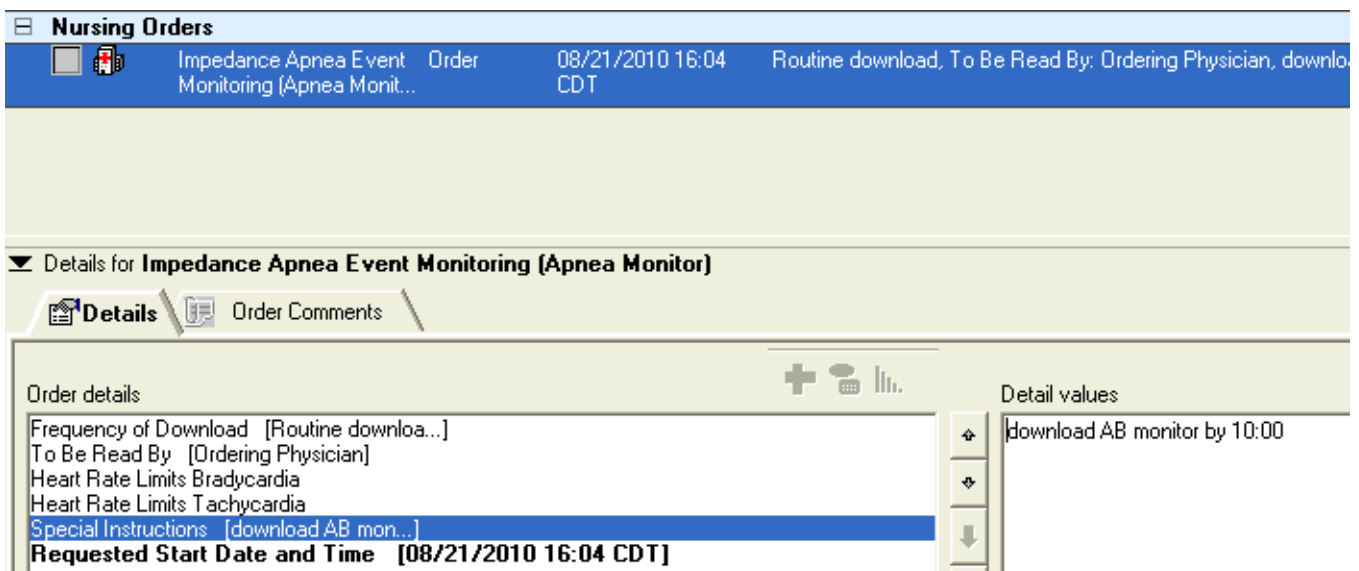
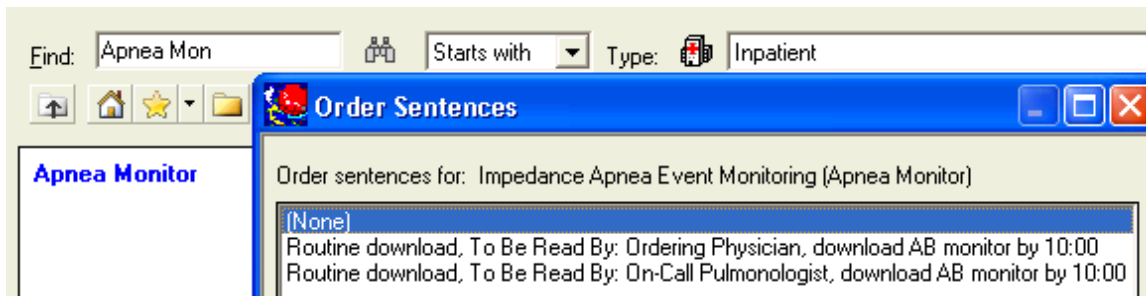


- Ability to specify the hose type and body location



• Apnea Monitor

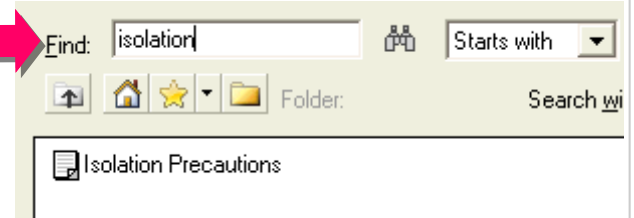
- New Fields for Frequency of download, To be Read by, and Heart Rate Limits



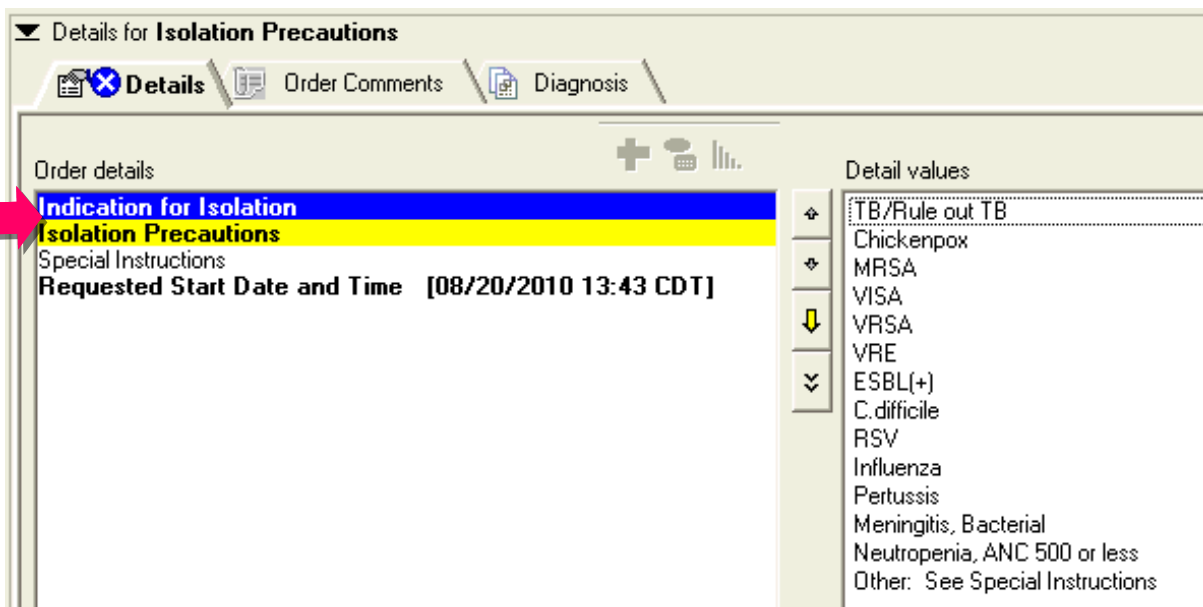
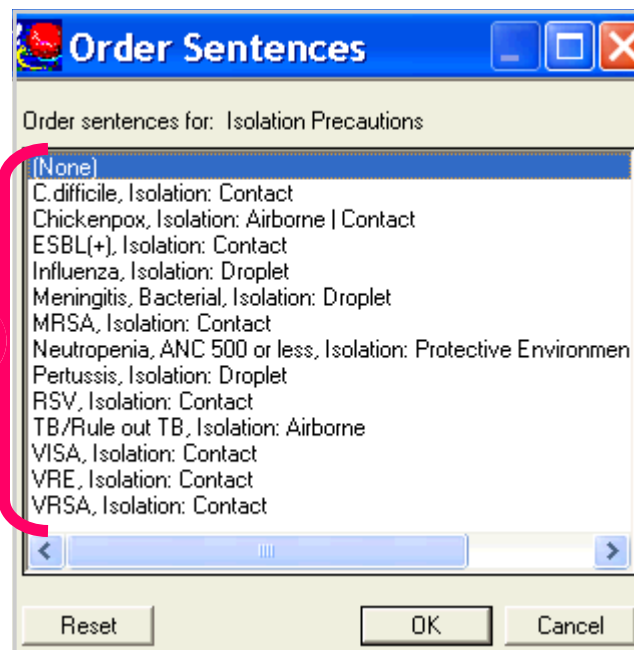
Updates to Existing Single Orders

- Isolation Precautions order available August 30**

Isolation Precautions order will be improved as follows:



1. Order sentences for Indication for Isolation with corresponding isolation precautions
2. Order has two required fields: Indication for Isolation and Isolation Precautions
3. May select multiple details for Indication for Isolation and Isolation Precautions



Updates to Existing Single Orders

- **Isolation Precautions (cont)**

4. Order includes reference link to policy and procedures and isolation guidelines. Click on the icon which looks like a piece of paper (4a) to open the link (4b).

		Order Name	Status	Details
Nursing Orders				
<input type="checkbox"/>		Isolation Precautions	Order	Continuous Order
<input checked="" type="checkbox"/>		Order Entry Details	Ordered	q0500 Order entered by the SYSTEM sec
<input checked="" type="checkbox"/>		Patient Education	Ordered	q12h Order entered by the SYSTEM sec
<input checked="" type="checkbox"/>		Review Plan of Care	Ordered	q0h

4a

Decision Support

IDENTIFIED ORDER: **Isolation Precautions**

Reference

Isolation Precautions

CarePlan information
 Chart guide
 Nurse preparation
 Patient education
 Policy and procedures
 Scheduling information

An extensive list of conditions with corresponding isolation precaution categories can be found at:

[Conditions Requiring Isolation Precautions](#)

An extensive list of Pediatric conditions with corresponding isolation precaution categories can be found at:

[Pediatric Conditions requiring Isolation Precautions](#)

Isolation Precaution Categories

Airborne Isolation Precautions are used for patients having, or are suspected of having, an infection with an organism transmitted in size that are capable of traveling via air currents).

Droplet Isolation Precautions are used for patients with known or suspected infection with organisms that are transmitted by drop generally drop to the floor within 3-6 feet of a patient).

Contact Isolation Precautions are used for patients with known or suspected infections or evidence of syndromes that represent a through direct skin-to-skin contact or through contact with a contaminated surface or patient care item in the patient's environment.

4b

- **Order Frequency of qHS available**

Clinicians may now find the order frequency qHS for “hour of sleep” in the order frequency list in the order details screen.

Details for **zolpidem (Ambien)**

Details
 Order Comments
 Diagnosis

Order details

Strength dose [5]
Strength dose unit [mg]
Route of administration [PO (oral)]
Frequency [qHS]
 PRN [Yes]
PRN reason [Insomnia]
 Duration
 Duration unit
 Special Instructions
 Brand Name (Reference only)






Detail values

qdayDinner
 qdayLunch
 qdayPCbkfst
 qdayPCdinner
 qdayPClunch
 qFriday
 qFriSun
 qFSSun
qHS

Updates to Existing Single Orders

- **Respiratory Orders Updated**

As part of a larger Respiratory Therapy re-design project, RT orders were recently evaluated. On September 1, these orders will be updated as necessary in COMPASS. For complete details, please see the Respiratory Orders Update published on August 23.

Acapella	Negative Inspiratory Force (not PFT lab)
Apnea Test	Negative Pressure Ventilation
Assisted Cough	 Oxygen
 BiPAP CPAP	Patient Education Resp
Blood Gas Lab Analysis	Peak Expiratory Force (not PFT lab)
Chest Physiotherapy	Peak Flow
Cough Assist Device	 Pedi Asthma Albuterol Titration Protocol
End Tidal Carbon Dioxide Monitoring	Pedi Asthma Education / Action Plan
EZPAP	 Pedi Bronchiolitis Albuterol Protocol
Flutter	Positive Expiratory Pressure
High Frequency Oscillatory Ventilation	Pulse Oximetry Recording Resp
Intra Pulmonary Percussive Ventilation	Respiratory Muscle Training
IPPB Treatment	RSV Specimen Collection Resp
IS by Resp Care	Sputum Collection by Resp
Mask CPAP Nebulizer	Transcutaneous Monitoring (CO2 or O2)
Medical Gas Delivery - Helium Oxygen	 Ventilator
Nasal CPAP	Vital Capacity (not PFT lab)
Nasotracheal Suctioning	

Updates to Data Viewing

- **Banner Bar: Multi Drug Resistant Organisms**

- When a lab report confirms the patient has a Multi-Drug Resistant Organism (MRSA, VRE, etc.), the Alerts section of the banner bar will update automatically
- The MDRO Alert will remain on the patient's chart in the banner bar from encounter to encounter
- The Alert for C. Diff will auto discontinue upon discharge
- The Infection Prevention Office will manually discontinue the C. Diff Alert, if the patient meets criteria for discontinuation of the alert during inpatient stay

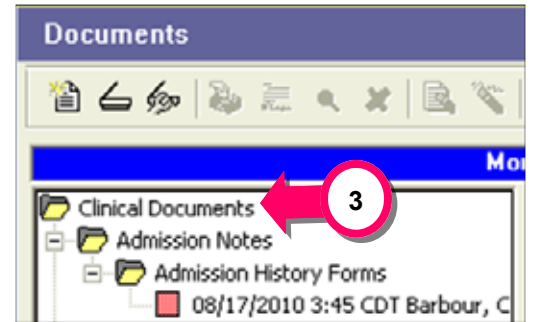
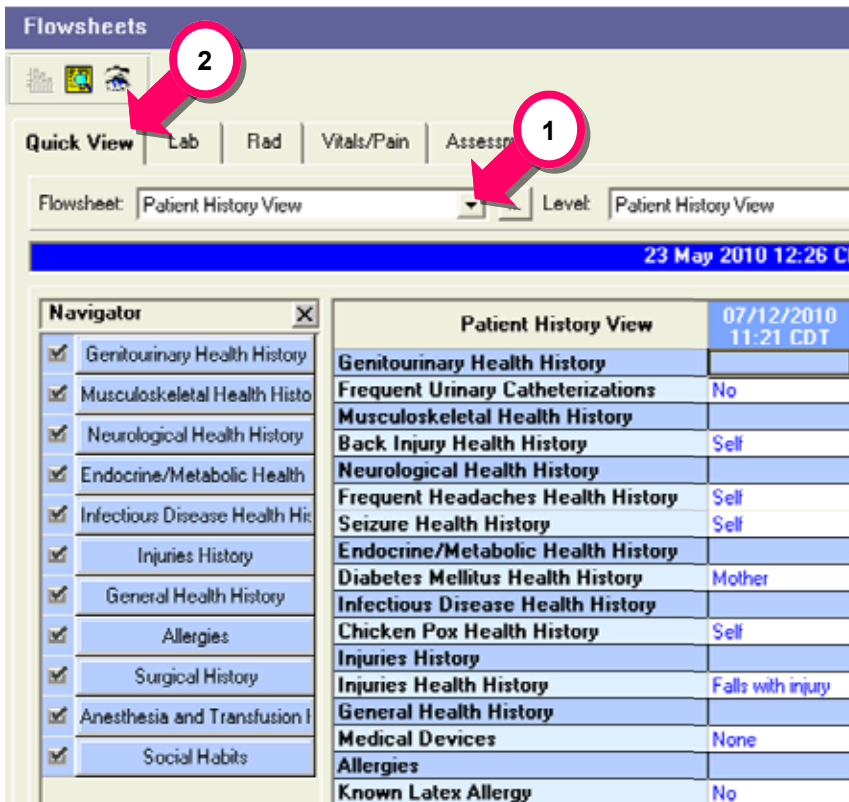
Inpatient [07/20/10 9:40 - <N...
Alerts:MRSA
Code Status:Full Code

Updates to Data Viewing

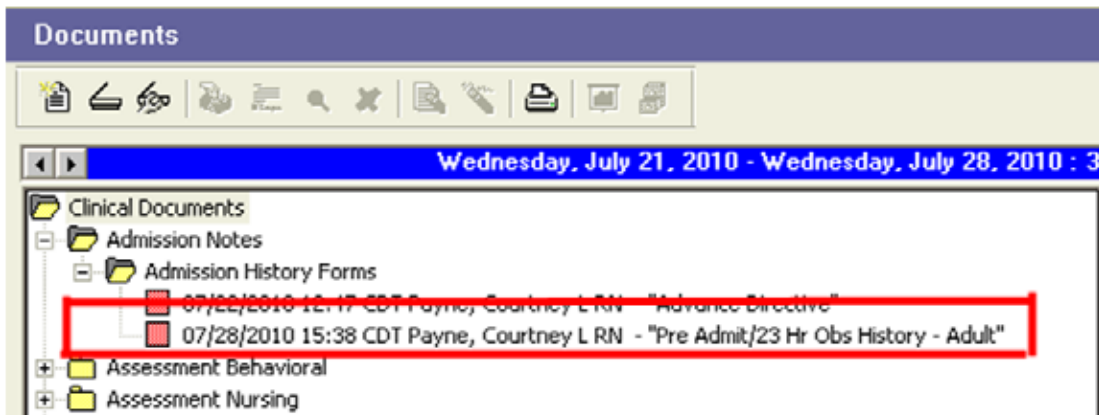
- Flowsheets View Improvements

- Patient History View Changes on August 30

Patient history will be viewable in Flowsheets in the Patient History View (1) on the Quick View tab (2). This information is entered by nursing on triage, pre-admission testing, and admission history forms. This same information may be found in a different format by accessing the Documents folders (3) on the Documents tab.



Please note patient history documentation has aligned across paper and CPOE sites. Pre-admission testing patient history forms for surgical patients may be used for 23-hour Observation patients as well. Nurses in these specialties will use an abbreviated version of the Admission History Form. If these patients become inpatients, the info from the PAT/23 hr Obs forms will be viewable from the Patient History View. If you are unable to view, check your date range to include the pre-inpatient time period.



Updates to Data Viewing

- **Flowsheets View Improvements (cont)**

- **Respiratory Care View Re-Design on September 1**

The Respiratory Therapy view in Flowsheets has undergone major revisions. Major reorganization of navigator sequence is displayed at right.

Navigator	
<input checked="" type="checkbox"/>	Vital Signs-Resp
<input checked="" type="checkbox"/>	Oxygen Delivery
<input checked="" type="checkbox"/>	Specialty Gas
<input checked="" type="checkbox"/>	Breath Sounds / Breathing
<input checked="" type="checkbox"/>	Additional Assessments-Resp
<input checked="" type="checkbox"/>	End Tidal/Transcutaneous
<input checked="" type="checkbox"/>	Vent General
<input checked="" type="checkbox"/>	Vent Setting Basic
<input checked="" type="checkbox"/>	Vent Setting Insp
<input checked="" type="checkbox"/>	Vent Setting BiLevel/APRV
<input checked="" type="checkbox"/>	Vent Monitoring Basic
<input checked="" type="checkbox"/>	Vent Monitoring Advanced
<input checked="" type="checkbox"/>	Trial/Wean Assessment
<input checked="" type="checkbox"/>	Spontaneous Mechanics
<input checked="" type="checkbox"/>	Vent High Frequency
<input checked="" type="checkbox"/>	Blood Gases
<input checked="" type="checkbox"/>	Airway Assessment/Care
<input checked="" type="checkbox"/>	Surfactant Administration
<input checked="" type="checkbox"/>	Cough/Suction
<input checked="" type="checkbox"/>	Respiratory Eval and Treat Adult
<input checked="" type="checkbox"/>	Asthma Education/Action Plan
<input checked="" type="checkbox"/>	Asthma Severity Score/Protocol
<input checked="" type="checkbox"/>	Bronchiolitis Severity/Protocol Pedi
<input checked="" type="checkbox"/>	Physician/Provider Contact-Resp
<input checked="" type="checkbox"/>	Therapy Resp
<input checked="" type="checkbox"/>	Peak Flow
<input checked="" type="checkbox"/>	Incentive Spirometry
<input checked="" type="checkbox"/>	BiPAP CPAP Settings
<input checked="" type="checkbox"/>	BiPAP CPAP Monitoring
<input checked="" type="checkbox"/>	Home BiPAP/CPAP Protocol
<input checked="" type="checkbox"/>	Intubation/Extubation
<input checked="" type="checkbox"/>	Apnea Test
<input checked="" type="checkbox"/>	Plan of Care-Resp

Updates to Data Viewing

- Flowsheets View Improvements (cont)

- Respiratory Care View (cont)

Examples of how data will display in Flowsheets for adult patient:

19 February 2010 2:50 CST - 04 August 2010 17:28 CDT (48 Hours Preadmit to Current Date)								
Navigator	Respiratory Care View	08/04/2010 14:10 CDT	08/04/2010 14:05 CDT	08/04/2010 12:00 CDT	08/04/2010 10:00 CDT	08/04/2010 8:15 CDT	08/04/2010 8:00 CDT	
<input checked="" type="checkbox"/> Vital Signs-Resp	Vital Signs-Resp							
<input checked="" type="checkbox"/> Oxygen Delivery	<input type="checkbox"/> Peripheral Pulse Rate	86	88	77	75	80	84	
<input checked="" type="checkbox"/> Breath Sounds / Breathing	<input type="checkbox"/> Respiratory Rate	18	22	16	24	18	22	
<input checked="" type="checkbox"/> Cough/Suction	Oxygen Delivery							
<input checked="" type="checkbox"/> Respiratory Eval and Treat A	<input type="checkbox"/> Oxygen Saturation	92	95	92	90		91	
<input checked="" type="checkbox"/> Therapy Resp	<input type="checkbox"/> Oxygen Flow Rate	1	2	2	2		2	
<input checked="" type="checkbox"/> Plan of Care-Resp	Oxygen Delivery Method	Nasal Cannula, P Nasal Cannula, P Nasal Cannula, P Nasal Cannula, P						Nasal Cannula, F
	Breath Sounds / Breathing							
	Breath Sounds-All Regions	Clear		Clear				
	Upper Anterior Breath Sounds-Left		Clear		Clear	Clear	Clear	
	Upper Anterior Breath Sounds-Right		Clear		Clear	Clear	Clear	
	Lower Anterior Breath Sounds-Left		Decreased/Dimin		Decreased/Dimin	Decreased/Dimin	Decreased/Dimin	
	Lower Anterior Breath Sounds-Right		Decreased/Dimin		Decreased/Dimin	Decreased/Dimin	Decreased/Dimin	
	Upper Posterior Breath Sounds-Left				Clear		Clear	
	Upper Posterior Breath Sounds-Right				Clear		Clear	
	Lower Posterior Breath Sounds-Left				Decreased/Dimin		Decreased/Dimin	
	Lower Posterior Breath Sounds-Right				Decreased/Dimin		Decreased/Dimin	
	Aeration Post Treatment	Improved				Unchanged		
	Respirations	Unlabored			Prolonged expirat		Prolonged expirat	
	Cough/Suction							
	Cough Type		Spontaneous		Spontaneous	Spontaneous		
	Cough Description		Strong productive		Strong non-produ	Strong productive		
	Sputum Amount		Small			Small		
	Sputum Consistency		Thick			Thick		
	Sputum Color		Yellow			Yellow		
	Respiratory Eval and Treat Adult							
	Procedure				Resp Eval & Trea			
	Therapy Indicators				COPD, Home net			
	Oxygen Indicators				Known CO2 reter			
	Protocols Selected				Inpatient Medicat			
	Home Therapy Ordered				Medication			
	Smoking Pack Years				20 or greater year			
	Pulmonary Disease				Pulmonary diseas			
	Surgical				None			
	Chest X-ray				Chronic changes			
	Breathing Rate				21 - 30 bpm			
	Breathing Effort				Dyspnea with act			
	<input type="checkbox"/> Breathing Effort Sub-Score				2			
	Breathing Effort Score				1			
	Breath Sounds				Decreased/Dimin			
	Oxygen Use				1 - 3 LPM/Less th			
	Cough				Strong non-produ			
	Sputum				None			
	Level of Activity				Ambulatory with a			
	Inspiratory Capacity				Not applicable			
	<input type="checkbox"/> Evaluation Score				11			
	Evaluation Result				Therapy added, T			
	Comments				Nebs decreased I			
	Therapy Resp							
	Therapy Delivered							
	<input type="checkbox"/> Number of Med Delivery Procedure		Nebulizer 1		Inhaler 1		Nebulizer 1	
	Inhaler Delivery Method				Inhaler only			
	Nebulizer Delivery Method		Mouthpiece				Mouthpiece	
	Therapy Not Delivered			PRN therapy not				
	Plan of Care Resp							
	Plan Of Care Review						Plan updated	
	Plan Of Care Item						Oxygen, Breathin	
	Oxygen Plan						Education: Oxyge	
	Oxygen Goal						Oxygen at home	
	Difficulty Breathing Plan						Education: There	
	Difficulty Breathing Goal						Breathing difficult	

Updates to Data Viewing

- Flowsheets View Improvements (cont)

- Respiratory Care View (cont)

Examples of ventilated patient data::

Vent General				
Vent Procedure		Check	Setting change	(c) Placed on (c) PB 840
Vent Model				
Vent Setting Basic				
Ventilator Mode		CPAP / Sportac	CPAP / Sportac	(c) A/C
Tidal Volume, Set				(c) 550
Ventilator Frequency, Set				(c) 14
PEEP/CPAP	5	5		(c) 5
Pressure Support	5	5		
Temperature Inspired Gas	35	36		(c) 36
Vent Setting Insp				
Inspiratory Time (TI)				(c) 0.9
Inspiratory Rise Time %	50	50		(c) 50
Vent Monitoring Basic				
Peak Inspiratory Pressure				
Plateau Pressure				
Mean Airway Pressure			7	6.8
PEEP Total			5	5
Tidal Volume, Exhaled				
Tidal Volume, Spontaneous			565	558
Exhaled Minute Volume (Total)			8.2	11.2
Exhaled Minute Volume (Spont)			8.2	11.2
Inspiratory to Expiratory (I:E) Ratio			1:1.5	1:1.8
Trial/Wean Assessment				
VE Less Than 15 LPM				Yes
O2 Percent Less Than Or Equal To 50%				Yes
PEEP Less Than Or Equal To 5 cmH2O				Yes
Cough/Gag Reflex Present				Yes
OII Pressors				Other: Dopa 5 is t
Off ICP Monitoring				Yes
Off Therapeutic Hyperventilation				Yes
Trial/Wean Type				Protocol
Trial/Wean Procedure				Start
Nurse Notification				Yes
Spontaneous Mechanics				
Spont Mech Negative Inspiratory Force	-42			
Spont Mech Vital Capacity	1.8			
Spont Mech Respiratory Rate			14	20
Spont Mech Minute Volume			8.2	11.2
Spont Mech Tidal Volume - Average			585.7	560
Spont Mech RSBI			23.9	35.7
Airway Assessment/Care				
Airway Safety/Precaution Items				
Airway Placement Verified				
Airway Type				
ETT Description				
ETT Marking				
ETT Marking Location				
ETT Position				
ETT Internal Position				
Airway/Nasal CPAP Prong Size				
Airway Cuff Pressure				
Airway Securing Method				
Airway Care Activity				
Oral Care				
Cough/Suction				
Cough Type	Spontaneous	Stimulated/induc	Stimulated/induc	
Cough Description	Strong non-produ	Strong productive	Strong productive	
Suction Device		Inline catheter	Inline catheter	
Suction Route		Artificial airway	Artificial airway	
Sputum Amount		Small	Small	
Sputum Consistency		Thin	Thick	
Sputum Color		White	Brown	
Patient Tolerance Suction		Tolerated/well	Tolerated/well	
Therapy Resp				
Therapy Delivered	Nebulizer		Inhaler	
Number of Med Delivery Procedures	1		1	
Inhaler Delivery Method			Inline	
Nebulizer Delivery Method	Mask			
Intubation/Extubation				
Intubation/Extubation Activity	Extubation			
Extubation Result	With adverse effe			
Adverse Extubation	Post extubation st			

Updates to Data Viewing

- Flowsheets View Improvements (cont)

- Respiratory Care View (cont)

Examples of pediatric asthma patient data:

Asthma Education/Action Plan					
Asthma ED: Use of Controllers					Documented
Asthma ED: Methods / Timing / Rescue Med					Documented
Asthma ED: Environment & Trigger Control					Documented
Asthma Severity Score/Protocol					
Asthma Score Accessory Use / Resp Effort	Intercostal	Intercostal	Intercostal	Intercostal	Intercostal, Supr
Asthma Score Auscultation	Expiratory wheezi	Expiratory wheezi	End-Expiratory wf	Expiratory wheezi	Inspiratory/Expi.
Asthma Score Respiratory Rate	Increase of 31 Tc	Up to 30% increa	Increase of 31 Tc	Up to 30% increa	Greater than 50%
Asthma Score Oxygen Requirements	Less than/equal t	Less than/equal t	Less than/equal t	Less than/equal t	Greater than 2 L
<input checked="" type="checkbox"/> Asthma Severity Score	6	5	5	5	11
Asthma Protocol Initial Acuity					Yes
Asthma Protocol Phase	2	2	2	2	4
Asthma Protocol Albuterol Given	Yes	No	Yes	No	Yes
Asthma Protocol Next Assess	* In Error	0100	* In Error	2200	(c) 2000
Asthma Score Comments	Had to give 10 m				
Physician/Provider Contact-Resp					
Provider Contacted					ZZT est. Phys
Pedi Asthma Protocol Contact Reason					Ineligible for pati
Pedi Asthma Protocol Ineligibility					Cystic Fibrosis
Contact Comments					Informed Dr. ZZ
Therapy Resp					
Therapy Delivered	Nebulizer		Nebulizer		Nebulizer, Cont
<input checked="" type="checkbox"/> Number of Med Delivery Procedures	1		1		1
Nebulizer Delivery Method	Mask		Mask		(c) Mask
<input checked="" type="checkbox"/> Nebulizer Elapsed Time, Continuous					60
Plan of Care-Resp					
Plan Of Care Review					Plan updated
Plan Of Care Item					Oxygen, Breathi
Oxygen Plan					Education: Oxyg
Oxygen Goal					Oxygen at home
Difficulty Breathing Plan					Education: Thes
Difficulty Breathing Goal					Breathing diffic

Example of pediatric Bronchiolitis:

Navigator <input checked="" type="checkbox"/> Vital Signs-Resp <input checked="" type="checkbox"/> Oxygen Delivery <input checked="" type="checkbox"/> Breath Sounds / Breathing <input checked="" type="checkbox"/> Cough/Suction <input checked="" type="checkbox"/> Bronchiolitis Severity/Protocol P <input checked="" type="checkbox"/> Physician/Provider Contact-Resp <input checked="" type="checkbox"/> Therapy Resp	Respiratory Care View						
	Bronchiolitis Severity/Protocol Pedi	08/04/2010 4:25 CDT	08/04/2010 4:00 CDT	08/04/2010 3:45 CDT	08/04/2010 0:15 CDT	08/04/2010 0:00 CDT	08/04/2010 2:00 CDT
	Bronchiolitis Scored By	Respiratory Care	Respiratory Care	Respiratory Care	Respiratory Care	Respiratory Care	Respiratory Care
	Bronchiolitis Score Accessory Muscle	No accessory mu	No accessory mu	No accessory mu	No accessory mu	No accessory mu	Intercostal, Subor Inter
	Bronchiolitis Score Auscultation	Expiratory wheezi (c)	Expiratory whe	Inspiratory/Expira	Breath sounds dir	Expiratory wheezi	Insp
	Bronchiolitis Score Respiratory Rate	Rate up to 30% a	Rate up to 30% a	Rate up to 30% a	Rate up to 30% a	Rate up to 30% a	Rate up to 30% a
	Bronchiolitis Score O2 Requirements	Nasal Cannula 1-;	Nasal Cannula 1-;	Nasal Cannula 1-;	Nasal Cannula 1-;	Nasal Cannula 1-;	Nasal Cannula 1-; Nas
	<input checked="" type="checkbox"/> Bronchiolitis Score Severity	4	(c) 4	5	6	6	9
	Patient Response	No change			No change		
	Process	Return to Nursing	Respiratory involv	Respiratory involv	Respiratory involv	Respiratory involv	Respiratory involv
	Next Resp Assess				0400		0000
	Physician/Provider Contact-Resp						
	Provider Contacted	Auth. Michael J C					
	General Contact Reason						
	Pedi Bronchiolitis Contact Reason	Patient improved					
Contact Comments	Called to inform of						
Therapy Resp							
Therapy Delivered		Nebulizer			Nebulizer		
<input checked="" type="checkbox"/> Number of Med Delivery Procedures		1			1		
Nebulizer Delivery Method		Mask			Mask		

Updates to Data Viewing

- Flowsheets View Improvements (cont)

- Modified Ashworth Scale

The Modified Ashworth Scale is used by nursing to assess limb spasticity on pediatric patients involved with Baclofen trials at DCMC. The results are viewable in Flowsheets by selecting the Assessment View tab(1) and selecting Modified Ashworth Scale from the navigator menu (2).

The screenshot shows the 'Flowsheets' application window. At the top, there are navigation tabs: 'Quick View', 'Lab', 'Rad', 'Vitals/Pain', and 'Assessment'. The 'Assessment' tab is selected, indicated by a red arrow and a circled '1'. Below the tabs, there are dropdown menus for 'Flowsheet: Assessment View' and 'Level: Assessment View'. A date and time stamp '01 August 2010 9:39 CDT - 03 A' is visible. On the left side, there is a 'Navigator' panel with a list of items. The 'Modified Ashworth Scale' item is checked and highlighted, indicated by a red arrow and a circled '2'. The main area displays a table with the following data:

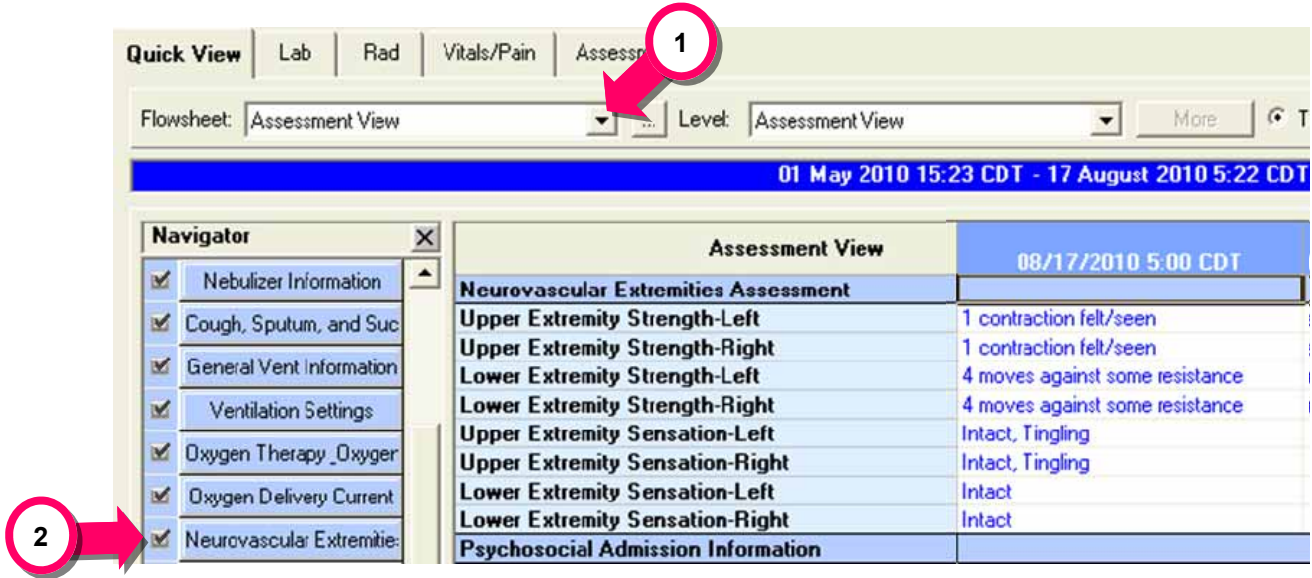
Assessment View	08/02/2010 9:39 CDT	08/02/2010 9:36 CDT
Modified Ashworth Scale		
Performed By	Nursing	Nursing
Scapular Elevator-Left	1+	3
Scapular Elevator-Right	1+	
Shoulder Flexor-Left	1+	3
Shoulder Flexor-Right	1+	
Shoulder Extensor-Left	1+	3
Shoulder Extensor-Right	1+	
Shoulder Abductor-Left	1+	3
Shoulder Abductor-Right	1+	
Shoulder Adductor-Left	1+	3
Shoulder Adductor-Right	1+	
Shoulder External Rotator-Left	1+	3
Shoulder External Rotator-Right	1+	
Shoulder Internal Rotator-Left	1+	3
Shoulder Internal Rotator-Right	1+	
Elbow Flexor-Left	1+	3
Elbow Flexor-Right	1+	
Elbow Extensor-Left	1+	3
Elbow Extensor-Right	1+	
Forearm Pronator-Left	1+	3
Forearm Pronator-Right	1+	
Forearm Supinator-Left	1+	3
Forearm Supinator-Right	1+	
Wrist Flexor-Left	1+	3
Wrist Flexor-Right	1+	
Wrist Extensor-Left	1+	3
Wrist Extensor-Right	1+	
Finger Flexor-Left	1+	3
Finger Flexor-Right	1+	
Finger Extensor-Left	1+	3
Finger Extensor-Right	1+	
Hip Flexor-Left	1+	3
Hip Flexor-Right	1+	
Hip Extensor-Left	1+	3

Updates to Data Viewing

- Flowsheets View Improvements (cont)

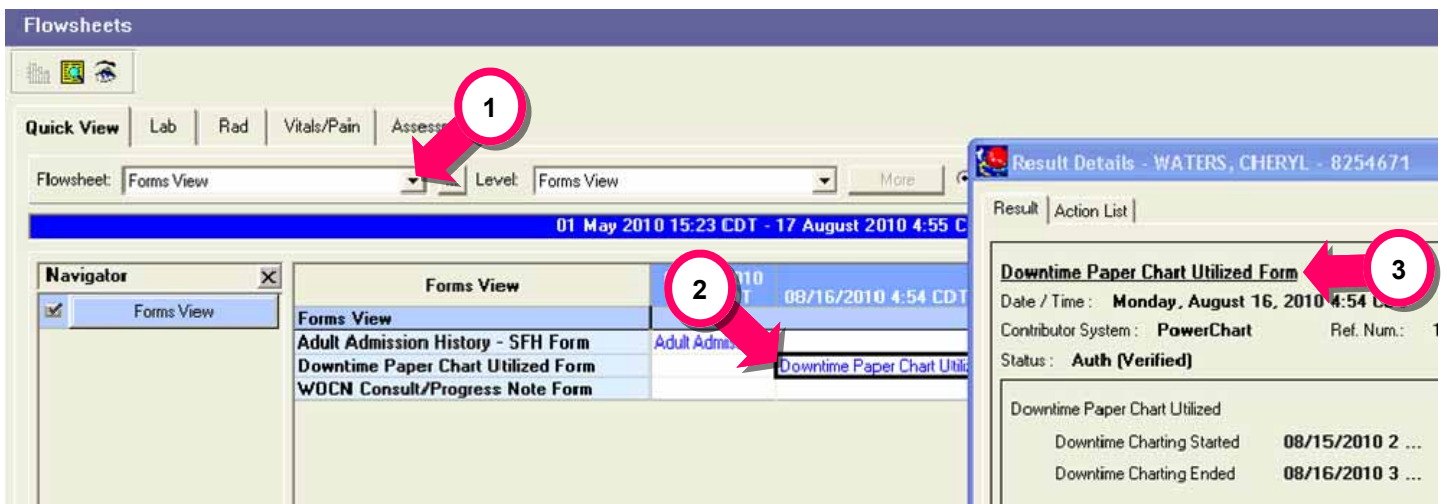
- Neurovascular Assessments

To view Neurovascular Extremities Assessments, choose the Assessment View (1) in Flowsheets, and select Neurovascular Extremities Assessment from the navigator band (2). This grouper will display nursing documentation of each extremity's strength, tone and sensation.



- Paper Chart Utilized

When a prolonged period of COMPASS downtime occurs, nurses are directed to chart the period of time that paper downtime forms were utilized. Actual clinical documentation will be on the COMPASS paper downtime forms in the paper chart, but information regarding the period that downtime paper charting occurred is viewable in the Flowsheets in the Forms View (1). Right-click to view details or double click in the Downtime Paper Chart Utilized cell (2) to open the detail window (3).



Updates to Data Viewing

- Multidisciplinary View**

- Nurses are required by policy to document the problems on the patient's Plan of Care every 24 hours. The Plan of Care remains on paper, but their charting is viewable via the Multidisciplinary View.
- Open the Nursing section (1) to view details.

Menu

- Orders + Add
- Patient Summary
- Caredex View
- Graphic View
- I-View
- Multidisciplinary View
- MAR
- MAR Summary



Multidisciplinary View

[Expand All](#) | [Collapse All](#)

Discipline
Last Charted Results

Nursing		
07:00 to 19:00		
07:00-11:00 (07/28/2010)		
11:00-15:00 (07/28/2010)		
12:58	Neurological Intervention and/or Note	Explained Dilantin medication and drug levels. Pt. had EEG at bedside.
15:00-19:00 (07/28/2010)		
16:16	Neurological Evaluation Comments	No seizures this shift. Limited visual and auditory stimuli. Remains oriented, no change in neuro assessment
16:16	Respiratory Evaluation Comments	Breath sounds less coarse this afternoon. Is tolerating neb treatments. Denies SOB.
16:16	Gastrointestinal Evaluation Comments	Continues to complain of nausea when food is in the room. Drank some ensure. Discussed nausea medicine with patient and family
16:16	Integumentary Evaluation Comments	Dressing remains dry and intact to shoulder wound.
16:16	Family Interaction Note	Wife remains at bedside and is participating in patient's ADLs
16:16	General Asmt Evaluation Comments	Had to remind patient several times not to take his dressing off. Right arm remains in wrist restraint.
Case Management/Social Work		
Physical Therapy		
Occupational Therapy		
Speech Therapy		
Nutrition		

Goals
Last Charted Results

Goals
Last Charted Results

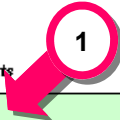
PT Goals

OT Goals

ST Goals

Nutrition Goals

Cardiac Rehab Goals



Information for DCMC Physicians

- Pediatric Immunization Schedule Info on August 30**

- To access the Pediatric Immunization Schedule, click Pt Information on the Menu (1). Select the Immunization tab in the open window.
- COMPASS will check the patient's immunizations against the CDC's guidelines and the patient's date of birth. The schedule will update to the next due date for the immunization. Colored boxes will indicate whether immunizations are safe to give. Doses due now will be green (3), those overdue will be pink, and those not safe to administer will be gray (4).
When nurses update the immunization record or document administration of immunizations on the eMAR, the information will be viewable on the Immunizations tab of the Patient Information view.

Menu

- Multidisciplinary View
- MAR
- MAR Summary
- Task List
- Flowsheets
- Caredex View
- Caredex - Clinician View
-
- Allergies + Add
- Clinical Summary
- Diagnoses and Problems
- Discharge Summary
- Documents
- Forms
- Growth Chart
- Med Profile
- ICD Micro
- Micro
- Overview
- Pt Education
- Pt Information**
- Reference

Pt Information

Pt Demographics | Visit List | Relationships | Face Sheet | Census History | **Immunizations** | Immunization Schedule

Childhood Immunizations										
	0 mo	1 mo	3 mo	5 mo	7 mo	13 mo	17 mo	19 mo	22 mo	2 yr
Hepatitis B	H...	Hep B Dose 2				Hep B Dose 3				
Polio		IPV...	IPV...			IPV Dose 3				
Influenza										a Dose 1
Hepatitis A										2

Previous Immunizations Hide Uncharted Records

IPV Dose 3
 Recommended from 6 months to 18 months
 Minimum safe age to next dose: 0 days
 Maximum effective interval to next dose: 0 days
 Maximum safe interval to next dose: No Maximum
 Recommended interval to next dose: 60 months
 Minimum safe age: 3 months
 Maximum safe age: 231 months