

Chapter XII: Enter and Maintain Patient Information

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Patient Information Data Entry Overview

The **Patient Info** chart section contains a list of **Data Entry** options. You can click on an option to add new, or in some cases, maintain specific patient information.

The data entry options are primarily used to add new patient information. To edit existing information, you can select data in the **Summary View** and click **Details** to display the corresponding **Details** dialog box. You can use the **Details** dialog boxes to edit, discontinue, and delete information. Some information will only be modify via the MIS system and then interfaced into CRIS. Only the items that can directly entered into CRIS will be addressed in this section.

Maintain Allergy Information

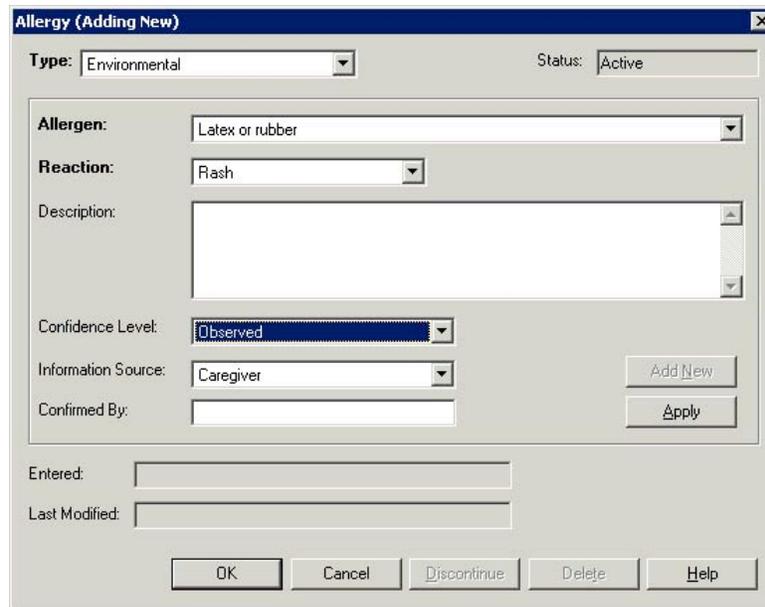
You can add patient allergies by clicking the **Allergy** data entry option in the **Patient Info** chart section. For example, if you've been informed that a patient has a penicillin allergy, you would first check to see if the allergy has been entered by looking at the **Allergies/Comments Summary View**.

To add an allergy

1. In the **Patient Info** chart section **Data Entry** list, select **Allergy**. The **Allergy (Adding New)** dialog box opens.
2. Select a **Type** from the drop-down list.
3. Select an **Allergen** from the drop-down list.
4. Select a **Reaction** from the drop-down list.
5. If desired, enter a **Description** of the allergy.
6. If desired, select a **Confidence Level** from the drop-down list.
7. If desired, select an **Information Source** from the drop-down list.
8. If desired, enter the name of the person who confirmed the allergy in the **Confirmed By** field.
9. Click **OK**.

To edit an allergy

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click an allergy, or select an allergy and click **Details**. The **Allergy Details** dialog box opens.
3. Make the desired edits. Note that you cannot edit the **Type** or **Allergen**.
4. Click **OK**.



Screen 1: Allergy Details Dialog Box

To discontinue an allergy

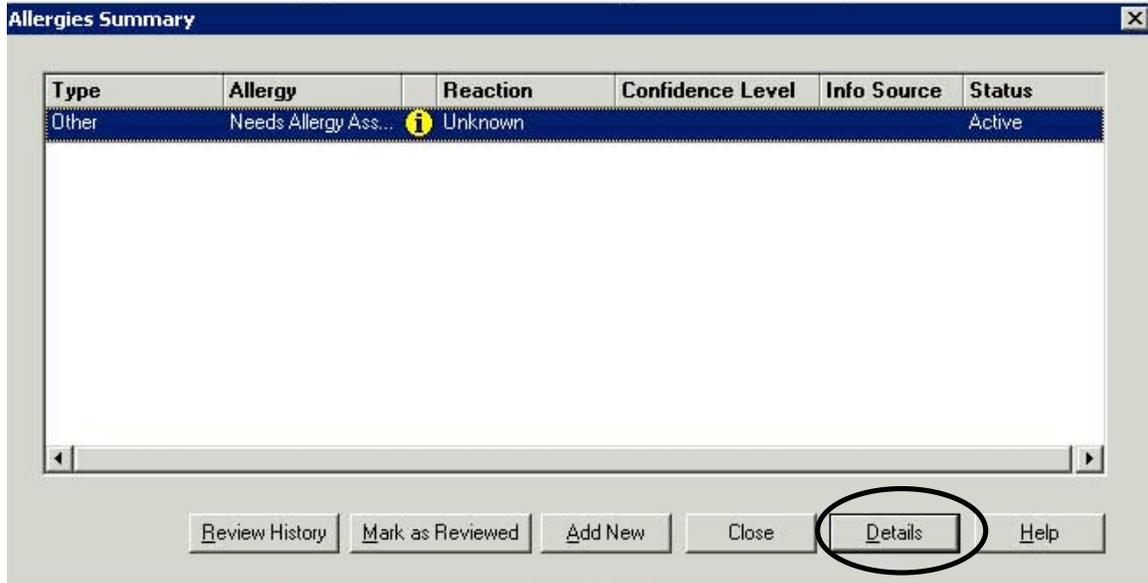
1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click an allergy, or select an allergy and click **Details**. The **Allergy Details** dialog box opens.
3. Click **Discontinue**.
4. Click **OK**. The status of the allergy changes to **Inactive**.

To delete an allergy

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click an allergy, or select an allergy and click **Details**. The **Allergy Details** dialog box opens.
3. Click **Delete**. A confirmation message displays.
4. Click **OK**.

Needs Allergy Assessment

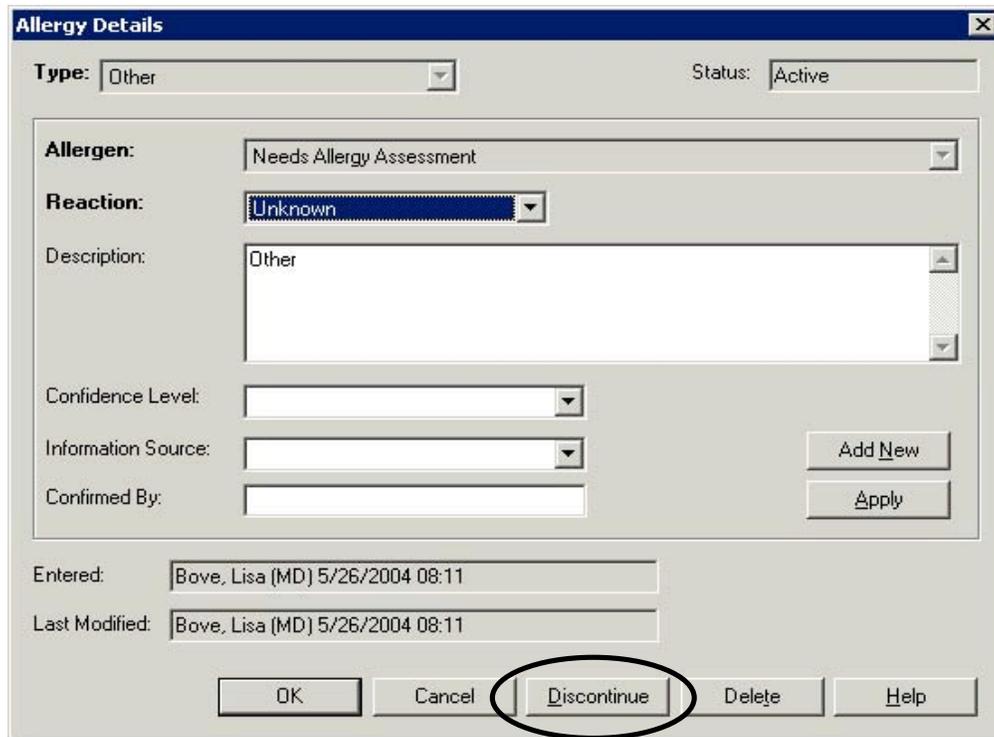
All patients migrated from MIS to CRIS will have an allergy called **Needs Allergy Assessment**. This was added to the patient's record during data migration and needs to be updated the first time a patient is seen after CRIS is live. The Needs Allergy Assessment allergy should be discontinued and actual patient allergies added.



Screen 2: Needs Allergy Assessment window

To discontinue the Needs Allergy Assessment allergy

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click the Needs Allergy Assessment allergy and click **Details**. The **Allergy Details** dialog box opens.

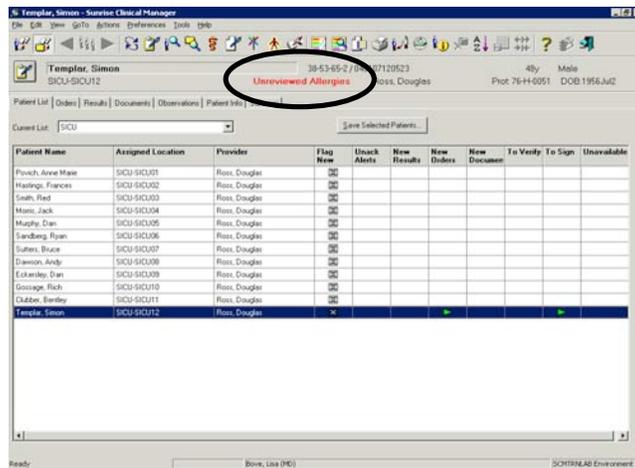


Screen 3: Allergies Detail window

3. Click **Discontinue**.
4. Click **OK**. The status changes to **Inactive**.
5. Add patient allergies as needed.

Mark Allergies Reviewed

Once allergies have been discussed with the patient, they can be marked as reviewed.



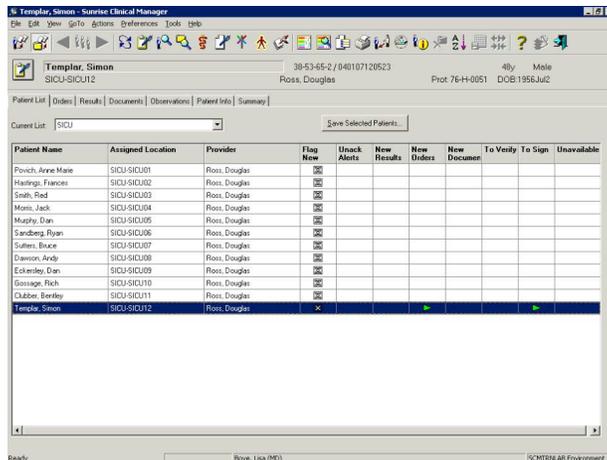
Screen 4: Unreviewed Allergies

To mark all new allergies as reviewed

Do one of the following:

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**, and click **Mark as Reviewed**.
2. In the **Allergies Summary** dialog box, click **Mark as Reviewed**.

Once an allergy is reviewed, the patient header changes.



Screen 5: Reviewed Allergies

Maintain Care Provider Information

You can add care provider information by clicking the **Care Provider** data entry option in the **Patient Info** chart section. You can add new care providers, or add yourself as a care provider.

Expiration Date: / / Status: Active

Type: Physician
Role: Consultant
Name: DeChristoforo, Robert

Name	Occupation	Org Unit
DeChristoforo, Robert	PharmD	Clinical Research
Defensor, Rubi	RN	Dept Clinical Rese

Phone:

Type	Number	Note

Entered: Add Me
Last Modified: Add New

OK Cancel Delete Help

Screen 6: Add a Care Provider

To add a new care provider to a single patient

1. In the **Patient Info** chart section **Data Entry** list, select **Care Provider**.
2. The **Care Providers (Adding New)** dialog box opens.
3. Select a care provider **Type** from the drop-down list.
4. Select a care provider **Role** from the drop-down list.
5. Enter the care provider **Name**. As you enter each letter of the name, a list of matching names displays in a list below the **Name** field. If the name you want is in the list, you don't have to finish typing it. Select the name from the list. The care provider's phone numbers display.
6. Click **OK**.

To add yourself to the list of active care providers

1. In the **Patient Info** chart section **Data Entry** list, select **Care Provider**.
The **Care Providers (Adding New)** dialog box opens.
2. Choose your provider **Role**.
3. Click **Add Me**. Your name and phone numbers display.
4. Click **OK**.

To discontinue a care provider

1. In the **Patient Info** chart section **Summary Views** list, select **Care Providers**.
2. Double-click on a care provider name, or select a care provider name and click **Details**. The **Care Provider Details** dialog box opens.
3. Enter an **Expiration Date**.
4. Click **OK**. The care provider status changes to **Inactive**.

To delete a care provider

1. In the **Patient Info** chart section **Summary Views** list, select **Care Providers**.
2. Double-click on a care provider name, or select a care provider name and click **Details**. The **Care Provider Details** dialog box opens.
3. Click **Delete**. A confirmation message displays.
4. Click **OK**.

Maintain Comment Information

Comments are similar to general information in MIS. Some comments will be interfaced into CRIS from Admissions, which appear in all capital letters. You can add other comments concerning the patient as needed. There are seven data entry types available to you:

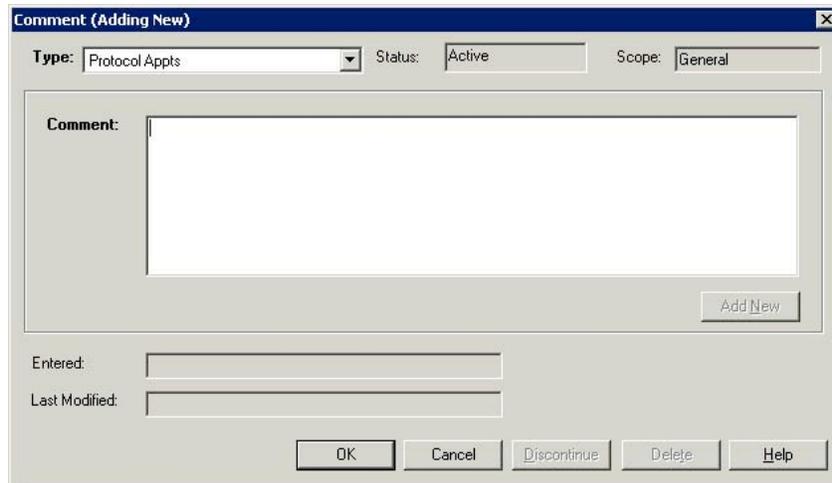
- Advance Directives
- Interpreter
- Other
- Prosthesis
- Protocol Appts
- Special Needs
- VAD Line Hx

You can add comments by clicking the **Comment** data entry option in the **Patient Info** chart section.

Comment Type	Comment Field	Scope	Multiple Entries	Entered By
Adv. Directives	Enter the of type of Advance Directive	This chart	Yes	Nursing staff following documentation
Chief Complaint	Admitting Diagnosis	General		Interfaced
Citizen	Citizenship	General		Interfaced
Father's Name	Patients fathers name	General		Interfaced
First Encounter	Date of first encounter	General		Interfaced

Comment Type	Comment Field	Scope	Multiple Entries	Entered By
Header 1	Displays in header, top portion of screen. To be used for Protocol Number ONLY at this time. (Need to limit rights)	This chart		Interfaced
Header 2	Displays in header only if selected. No designated use at this time.	This chart		
Interpreter	Enter primary language, interpreter contact phone number, appointments, arrangements	This chart		Entry by Nursing, Anesthesia, Social Work
Mother's Name	Patients mothers name	General		Interfaced
Occupation	Normal occupation	General		Interfaced
Other	Any other general comments or communications not covered under other categories	This chart	Yes	Nursing
Prosthesis	Enter any device patient has or is using	General	Yes	Entry by Rehab, Nursing
Protocol Appts	Scheduled tests or appointments that are not otherwise noted on the Orders Summary.	General	Yes	Entry by Prescribers, study coordinators and research nurses
Pt Maiden Name	Patients maiden name	General	No	Interfaced
Special Needs	Enter any special needs, disabilities etc	General	Yes	Entry by Nursing
VAD Line Hx (Also, entered in Clin Doc)	Suggested content to be entered into the description field as follows: Type of VAD (tunneled, percutaneous, implanted), Insertion date and location, Access/reaccess date, Type of access needle, Special dressing requirements, Sutured in place, Line complications (unable to draw back, pertinent imaging studies, interventions performed for clotted ports)	General	Yes	Entry by Nursing and VAD Service staff

Table 1: Comment Types



Screen 7: Comment Details Dialog Box

To add a comment

1. In the **Patient Info** chart section **Data Entry** list, select **Comment**. The **Comment Details (Adding New)** dialog box opens.
2. Select a comment **Type** from the drop-down list.
3. Enter the comment.
4. Click **OK**. The new comment displays in the **Allergies/Comments Summary Views** list.

To edit a comment

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click a comment, or select a comment and click **Details**. The **Comment Details** dialog box opens.
3. Edit the comment.
4. Click **OK**.

To discontinue a comment

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click a comment, or select a comment and click **Details**. The **Comment Details** dialog box opens.
3. Click **Discontinue**.
4. Click **OK**. The status of the comment changes to **Inactive**.

To delete a comment

1. In the **Patient Info** chart section **Summary Views** list, select **Allergies/Comments**.
2. Double-click a comment, or select a comment and click **Details**. The **Comment Details** dialog box opens.
3. Click **Delete**. A confirmation message displays.
4. Click **OK**.

Maintain Height/Weight Information

Height and weight should be entered into the Vital Signs flowsheet. Once saved into this flowsheet, height and weight will be copied into the **Height/Weight** data entry option in the **Patient Info** chart section.

CRIS has two BSA formulas. If the patient is 18.0 years or younger, the Pediatric BSA formula is used. If the patient is older than 18.0 years, the Standard BSA formula is used. If the age of the patient cannot be determined due to a missing birth year, then the Standard BSA formula will be used.

The following formulas are used to calculate body surface area:

- Standard BSA = $\text{Height}^{0.725} \times \text{Weight}^{0.425} \times 0.007184$
- Pediatric BSA = Square Root ($\text{Height} \times \text{Weight} / 3600$)

Height is measured in centimeters; weight in kilograms and the result (BSA) is in square meters in both formulas. The BSA is rounded to two decimal places.

This height and weight will be used for drug calculations during order entry unless modified by the ordering Prescriber.

Maintain Significant Event Information

You can capture major events called Significant Events that can be viewed across visits and will not need to be re-entered. There are five data entry types available to you.

- Consents
- Immunizations
- Isolation Status
- Tracheostomy History
- Transfusion History

You can add significant events by clicking the **Significant Event** data entry option in the **Patient Info** chart section. Some of the types will have a scope of **General** (such as Immunization History or Surgical Procedures), and some of which will have a scope of **This Chart** (such as Critical Incidents).

Significant Event Type	Event/Description	Scope	Entered By
Consents	Used for entering type of consent and dates signed. Pull down menu options (events): <ul style="list-style-type: none"> • <input type="checkbox"/> Blood administration consent • <input type="checkbox"/> Notification of information practices • <input type="checkbox"/> Protocol consent Additional information to be entered in the Description Field	General	Entry by Nursing
Immunizations	Used to enter patient’s immunization status. Pull down menu options (events): <ul style="list-style-type: none"> • <input type="checkbox"/> DPT • <input type="checkbox"/> H Influenza • <input type="checkbox"/> Hepatitis A • <input type="checkbox"/> Hepatitis B • <input type="checkbox"/> Influenza • <input type="checkbox"/> MMR • <input type="checkbox"/> Oral Polio • <input type="checkbox"/> Other • <input type="checkbox"/> Pneumococcal • <input type="checkbox"/> Varicella Additional information to be entered in the Description Field	General	Entry by Nursing
Isolation Status (Will also be placed as an order by Epidemiology)	Used to enter patient’s isolation status. Pull down menu options (events): <ul style="list-style-type: none"> • <input type="checkbox"/> AFB Isolation • <input type="checkbox"/> CNS Precautions • <input type="checkbox"/> Contact Isolation • <input type="checkbox"/> None • <input type="checkbox"/> Respiratory Isolation • <input type="checkbox"/> Special Respiratory Isolation • <input type="checkbox"/> Strict Isolation Additional information to be entered in the Description Field	General	Entry by Epidemiology and Nursing (if needed)
Tracheotomy	Free Text	General	Health care provider
Transfusion History	Used to enter patients transfusion history	General	Entry by DTM and

Significant Event Type	Event/Description	Scope	Entered By
(This also occurs in more detail in Clin Doc)	information. Pull down menu options (events): <ul style="list-style-type: none"> <input type="checkbox"/> Allergic Reaction <input type="checkbox"/> Anaphylactic Reaction <input type="checkbox"/> Febrile Nonhemolytic Reaction <input type="checkbox"/> HLA Matched Platelet Restrictions <input type="checkbox"/> Other <input type="checkbox"/> Patient Antibodies <input type="checkbox"/> Pre-Medication <input type="checkbox"/> Prior Transfusion <input type="checkbox"/> Refusal of Blood Products <input type="checkbox"/> Septic Reaction <input type="checkbox"/> Washed Blood Restrictions Additional information to be entered in the Description Field		Nursing

Table 2: Significant Event Types

To add a significant event

1. In the **Patient Info** chart section **Data Entry** list, select **Significant Event**.
2. The **Significant Event Details** dialog box opens.
3. Select a significant event **Type** from the drop-down list.
4. Choose an **Event** from the drop-down list, or enter text about an event.
5. Enter a **Description** of the event, if desired.
6. Enter the **Date** the significant event occurred. You can enter a partial or full date.
7. Click **OK**.

Significant Event (Adding New)

Type: Isolation Status Status: Active Scope: General

Event: [None]

Description: [AFB Isolation, CNS Precautions, Contact Isolation, Respiratory Isolation, Special Respiratory Isolation, Strict Isolation]

Date: Month Year
 M/Y
 Full Date

Add New Apply

Entered: []
Last Modified: []

OK Cancel Discontinue Delete Help

Screen 8: Significant Events Dialog Box

To edit a significant event

1. In the **Patient Info** chart section **Summary Views** list, select **Significant Events**.
2. Double-click a significant event, or select a significant event and click **Details**.
3. The **Significant Event Details** dialog box opens.
4. Make the desired edits. Note that you cannot edit the **Type** or **Event**.
5. Click **OK**.

To discontinue a significant event

1. In the **Patient Info** chart section **Summary Views** list, select **Significant Events**.
2. Double-click a significant event, or select a significant event and click **Details**.
3. The **Significant Event Details** dialog box opens.
4. Click **Discontinue**.
5. Click **OK**. The status of the significant event changes to **Inactive**.

To delete a significant event

1. In the **Patient Info** chart section **Summary Views** list, select **Significant Events**.

2. Double-click a significant event, or select a significant event and click **Details**.
3. The **Significant Event Details** dialog box opens.
4. Click **Delete**. A confirmation message displays.
5. Click **OK**.

Enter consent information as a Significant Event

Consent information is entered in the Patient Info Significant Event section.

The screenshot shows a dialog box titled "Significant Event (Adding New)". At the top, there are three dropdown menus: "Type" (set to "Consents"), "Status" (set to "Active"), and "Scope" (set to "General"). Below these is a section for "Event" with a dropdown menu that is open, showing three options: "Blood administration consent", "Notification of information practices", and "Protocol consent". To the right of the "Event" dropdown is a "Description" text area. Below the "Event" and "Description" fields are "Date" fields for "Month" and "Year", and a "Full Date" field with a date picker. There are "Add New" and "Apply" buttons to the right of the date fields. At the bottom, there are "Entered:" and "Last Modified:" text boxes. At the very bottom are buttons for "OK", "Cancel", "Discontinue", "Delete", and "Help".

Screen 9: Enter consent information

1. In the **Patient Info** chart section **Data Entry** list, select **Significant Event**.
2. The **Significant Event Details** dialog box opens.
3. Select the **Type Consents** from the drop-down list.
4. Choose a consent **Type** from the drop-down list, or enter text about an event. Options include
 - a. Blood administration consent
 - b. Notification of information practices and
 - c. Protocol consent.
5. Enter additional information about the consent into the **Description** field, if desired.
6. Enter the **Date** the consent was signed. You can enter a partial or full date.
7. Click **OK**.

Enter isolation status as a Significant Event

The Epidemiology Service staff member enters the isolation status under Significant Events after the isolation order is reviewed for appropriateness.

Significant Event (Adding New)

Type: Isolation Status Status: Active Scope: General

Event: [Dropdown]

Description: [List: AFB Isolation, CNS Precautions, Contact Isolation, None, Respiratory Isolation, Special Respiratory Isolation, Strict Isolation]

Date: Month Year

M/Y

Full Date

Add New Apply

Entered:

Last Modified:

OK Cancel Discontinue Delete Help

Screen 10: Isolation documentation

1. In the **Patient Info** chart section **Data Entry** list, select **Significant Event**.
2. The **Significant Event Details** dialog box opens.
3. Select the **Type Isolation Status** from the drop-down list.
4. Choose an isolation **Type** from the drop-down list, or enter text about an event.
5. Enter additional information about the consent into the **Description** field, if desired.
6. Enter the **Date** the isolation was ordered. You can enter a partial or full date.
7. Click **OK**.

Enter VAD line history as a Comment

VAD line history information is entered in the Patient Info Comments section.

Comment (Adding New)

Type: Status: Active Scope: This Chart

Comment Details (Adding New)

Mother's Name
Occupation
Other
Prosthesis
Protocol Appts
Pt Maiden Name
Special Needs
VAD Line Hx

Add New

Entered:

Last Modified:

OK Cancel Discontinue Delete Help

Screen 11: Enter VAD Line History

1. In the **Patient Info** chart section **Data Entry** list, select **Comment**. The **Comment Details (Adding New)** dialog box opens.
2. Select the comment **Type VAD Line Hx** from the drop-down list.
3. Enter any significant information about into the **Comment** field.
4. Click **OK**.