TJUH Department of Nursing JeffChart Training Exercises

Jefferson's clinical information system, JeffChart, allows patient caregivers to review patient information and physicians’ orders, document clinical assessments and interventions and chart medication administration on a computer.

**JeffChart Training Pathway Initial Log on**

Students are given a RAP account to complete JeffChart training in the JeffChart practice pathway. This JeffChart training should be completed prior to starting clinical on the units. The clinical course coordinator will give the student’s their JeffChart user numbers the first weeks of fundamentals.

Report any problems to TAC@ 3-7975, if calling explain your role of Jefferson nursing student with temporary account to Jeffchart.

Student computer training incorporates video and “hands on” practice in JeffChart Training/Practice Pathway. You should view the online JeffChart videos prior to completing the JeffChart training exercises.


Students need to watch the following video tutorials, available on the orientation site:

- HIPAA
- Navigating the Chart
- Hotlist Creation
- Flowsheet Documentation
- Intake and Output Documentation
- System Assessment Documentation video.
- Labs and EKG Documentation
- Non-Med Worklist Reviewed
- AccuCheck Documentation
- Student nurse Co-Sign medication
- Nursing Admission History

Once you have viewed the online videos, the next step is practicing in the JeffChart Training Pathway.
Overview of JeffChart

Within JeffChart, orders and clinical documentation are available to all patient caregivers through order entry, order review, flow sheets, worklists, clinical viewer screens, and reports. Multiple users can immediately view the same patient's medical record in JeffChart at the same time.

Orders

Using JeffChart, orders are entered, processed, tracked, changed, and reviewed. Physicians place the majority of orders for patients. In certain circumstances, medical students, nurses, therapists and consulting departments are authorized to enter orders based on standardized practice, licensure and credentialing. Nurses are expected to review orders every two hours.

The focal point of the order process is the patient's Order Profile screen. Medication and non-medication orders are identified by category, number, description, frequency, dose and current status. Display Options allows each user to customize the view of a patient's order profile.

Worklists

Once an order is placed, actions are generated and communicated to the appropriate performing department. Departments find the pending actions on a Worklist – a to-do list. Through a Worklist, the progress of an action is charted.

Unlike the Order Profile screen, Worklists breakdown and separate actions required by an order. In addition to being entered manually, a result may also be charted automatically through an interface with another computer system.

Some worklists are based on unit activity. Other worklists, such as the Medication Administration Record work list, are patient-based. Vital signs, Intake and Output, Assessment and Interventions, Pain Assessment, Blood Administration, and PCA findings are documented in JeffChart on computerized Flow sheets. Different Flow sheets maintain different categories of findings. Modifiers and comments allow a more specific description of a finding.

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To begin the exercises, you will first need to log in to the JEFFCHART Training Pathway through the Remote Access Portal (RAP account).
If you are accessing from your personal computer see Step 1.

If you are accessing from Scott library or LRC Jeff Alumni Hall, Do not use the MAC computers and do not use your iPad. They do not meet the computer requirements. Proceed to Step 2

**Step 1. Computer Requirements for Personal Computer**

If you are using your personal computer, check operating system/Browser requirements first. You need to have the most recent JAVA and Citrix on your computer.

**Operating System/Browser Requirements**

**In order to use the RAP from home you will need to do the following:**

- Windows machines running XP, Vista, 7 are supported.
- You must be up to date on all of your patches in order for RAP to work.
- Please run and re-run Windows Update (from either the control panel or your start menu) to be certain of the update status.
- You will need *Internet Explorer 6.0, or above* - (Supports Java) to use features other than just web browsing.
- You need to have “connect.tjuh.org” as a trusted site.
  - In Internet Explorer, go to Tools -> Internet Options
  - Click on the Security tab
  - Click on the Green Checkmark Icon called Trusted Sites
  - Click on the Sites... button
  - Enter in the url https://connect.tjuh.org
  - Click the Add button
  - Click OK
  - Make sure the security level for this zone is set to LOW.
- Please disable any and all pop-up blockers.

The links below will allow you to download the Citrix and Java client required for RAP and JeffChart.

http://receiver.citrix.com/
http://www.java.com/en/ (Free Java Download link)

Once your operating system/Browser requirements are met proceed to step 2.

**Step 2. Open Internet Browser (Internet Explorer)**

Type web address:  https://connect.tjuh.org
Enter your campus key and password. Click sign in.

Click JeffAPPS-Citrix Web Interface

Go to Logon Type and change “Explicit” to “Anonymous” and logon (you will have to answer some pop ups, open, continue, etc. just keep moving through).

You should be in the T5 Training/Practice Pathway.

T5 Training/Practice pathway, you can log in by:

- Choosing a JEFFCHART Student log in user number SNU01, SNU02, SNU03 etc. to SNU30 to use, enter the user number you chose into space User Number.
- Password is 123456

Once you are in JeffChart Training:

In your hotlist, you may have several patients already loaded. Before you begin any exercises please delete all information by performing the following steps.

- Highlight each patient on chart and click on to “Del Pt” button at bottom of screen.
- Click the Command Screen Icon (Home button on the icon row) to return to the Nursing Base Screen.

You will now enter your practice patient

- Choose a practice patient from this list below to use during practice.
- All practice patients have the last name of STUNURSE from STUNURSE01 to STUNURSE20. The first name for all patients is AM.

| STUNURSE01,AM | STUNURSE11,AM |
| STUNURSE02,AM | STUNURSE12,AM |
| STUNURSE03,AM | STUNURSE13,AM |
| STUNURSE04,AM | STUNURSE14,AM |
| STUNURSE05,AM | STUNURSE15,AM |
| STUNURSE06,AM | STUNURSE16,AM |
| STUNURSE07,AM | STUNURSE17,AM |
| STUNURSE08,AM | STUNURSE18,AM |
| STUNURSE09,AM | STUNURSE19,AM |
| STUNURSE10,AM | STUNURSE20,AM |
Once you have decided which patient to use, from the "Nursing Base Screen:

- **Locate** the following fields found on the right lower section of the screen: Last Name, First Name, and MRN# (medical record number).

- **Type** the practice patient Last Name assigned in the appropriate fields.

- **Press** the enter key. The Patient Name Lookup screen appears **select AM patient**.

Your patient will be in your hotlist. Your patient’s name now displays in the Banner Bar. This means your patient’s electronic record is active in JeffChart.

Remember to Log Off to exit JeffChart when you are finished using the computer.

When you are done charting Log out of JeffChart

1. **Click** the X Log off or press the function key F10 to log out in JeffChart.

DO NOT share your JeffChart "Log In" and password with anyone. After 10 minutes of keyboard inactivity the JeffChart computer system will force your log out.

Pt Info Information Look Up

To find out your patient's home phone number, street address, marital status, or ethnicity:

- **Click** the first chart tab called "Pt/Phys Search, use drop down to select Patient Info-Demographics

- **Review** the information on the screen.

**Click** the Back Screen button, (located at the top left hand side in the row of icons) to go back to the "Nursing Base Screen".
Patient Allergies and Entering a Patient's Height & Weight in JeffChart

To view your assigned patient's allergies:

- **Click** on the second chart tab (top of the screen) called *Clin/Alg*

Entering Height and Weight.

- **Click** the *Update HT/WT* button, found in upper right of the *Clinical Information* section of the *Allergy* screen.
- The *Height / Weight Update* screen will appear.
- **Type** the patient’s height and weight in the appropriate fields. Your patient is 5 ft 4 inches and weighs 150 lbs.

  **TIP:** The data can be entered in either English or Metric format; only the actual numbers need to be entered. Examples: A patient height of 5ft 6in can be entered as either 5.6 or 5 <space> 6. A baby’s length of 19 inches is entered as 0 <space> 19.

- **Click** the *Save Data* button then back out

  The data is converted from English to Metric (or vice-versa) & the date is entered. The weight in grams will also be calculated for all patients. The BSA and BMI are also automatically calculated. The data on this screen will continue to be automatically updated when the patient’s height &/or weight is entered into JeffChart via a flow sheet.

- The most current height and weight will be displayed in Metric format on the *ClinInfo/Allergy* screen.

- To view the patients’ BSA, BMI or weight in grams at any time, **Click** the *Update HT/WT/BMI* button.

- **Click** back out button

- **Click** back out again to return to the home nursing base screen.

**Note:** Nurses, doctors or pharmacists will enter patient allergies. All nursing staff members are taught to enter the height and weight of a patient. The weight and height of a patient is entered on admission by nursing or clerical staff.
If you have not viewed the Flowsheet Documentation Video, watch the video now. If you have viewed the video proceed to the next charting exercise.

Flowsheet Exercises:

Entering Findings in JeffChart. Before starting remember to verify the name and date of birth of your patient on the banner bar at the top of your screen.

Next you will enter your morning vital signs for your patient:

From the Nursing Base Screen

1. **Click** on the FS chart tab (at the top of the screen) for Flowsheets charting

2. **Select** the Flowsheet called *Vitals/CMN* from the drop down menu.

3. **Click** on the following findings under the heading called Vitals.
   
   A red check mark appears to the left of the finding when selected.
   
   - Temp
   - Heart Rate
   - Respiration
   - Systolic BP
   - Diastolic BP

4. **Click** the *Add new column* button to enter your new vital signs.

5. **Answer** the question “ on or off the unit” **Notice** the time and date that now `--------` appears in your new column

6. **Click** on the box that the statistic will be noted

7. **Enter** each finding listed in the “Result” field listed below, then the “**Add**” button to enter the data.

<table>
<thead>
<tr>
<th>Finding</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temp</td>
<td>98.6</td>
</tr>
<tr>
<td>Pulse</td>
<td>68 select modifier: Apical</td>
</tr>
<tr>
<td>Respiration</td>
<td>20</td>
</tr>
</tbody>
</table>
Systolic Blood Pressure | 110  
Diastolic Blood Pressure | 70

Updating a Finding in JeffChart

You realized your patient temperature was really 100.6; you need to update her temperature in JeffChart

From the FS Vitals/CMN Check

- Click on the Temp (F) of findings. The column turns orange when selected.
- Click Update button. The **Update/Delete Finding** screen displays.
- **Update** the following finding: temperature result to: 100.6
- Click the **Update** button to enter the updated finding.
- Click on the button *home* to return to the Nursing Base Screen

Documenting Interventions

You now want to document the interventions you have done for your patient.

From the **Nursing Base Screen**:

1. **Click** on the FS chart tab (top of the screen)
2. **Select** the flowsheet called *Intervention* from the drop down menu.

The flowsheet displays. Under the heading called: **Isolation Precautions**

3. **Select** MDRO (Multiple Drug Resistant Organisms) Precautions
   Under the heading **Care Precautions**. A red check will appear.
4. **Select**: Aspiration Precautions
5. **Click** the **Add New Column** button
6. **Check** the time and date.
7. **Click** the *Add Column* button.

   The Isolation Precaution screen displays.

8. **Select:** MDRO Precautions and **click** the □ check box located in the column on the right. A check mark displays✓, to indicate that your patient has been maintained on MDRO Precautions.

9. **Click** the *Add* button to enter the data.

   The Care Precaution screen displays.

10. **Locate:** Aspiration Precautions and **click** the check box located in the maintained column. A check mark displays, to indicate that the patient has been maintained on Aspiration Precautions.

11. **Click** the *Add* button to enter the data.

12. **Click** the *Diet/Functional* radial button located at the top of the screen to bring up this section of the flow sheet.

   Under the heading *Diet/Hygiene*

   a. **Select:** Nutrition

13. **Click** the *Add New Column* button.

14. **Check** the time and date.

15. **Click** the Add Column button.

   The *Diet/Hygiene* screen display.

   Under the section heading: *Nutrition*

   18. **Select:** Self

   Under the heading: *Hygiene*

   19. **Select:** Partial

   20. **Click** the *Add* button.

   The Diet/Functional screen displays the information
Under the heading: **Activity** click and highlight the box to orange.

**Click** update.

21. **Select:** Chair

Under activity assistance, **Select:** Assistance

22. **Click** the Add button to enter your intervention.

Review your data. Then click the back button to return to the nursing base screen.

If you have not viewed the Intake and Output Documentation Video – (run time: 7:45) watch the video now.

Intake and Output Documentation

- **Click** on the flow sheet (FS)

- **Intake and Output flow sheet** from the drop down menu.

- **Click/select** each component listed below, a check mark will appear next to the component that you selected.
  
  - ☑ Oral cc
  - ☑ Urine cc
  - ☑ Stool #

  **Click** the "Chart Select" button.
  **Enter** each I & O and then click on the add button

<table>
<thead>
<tr>
<th>I &amp; O Components</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oral cc</td>
<td>100</td>
</tr>
<tr>
<td>Urine cc</td>
<td>700</td>
</tr>
<tr>
<td>Stool # with modifier</td>
<td>1 add modifier medium</td>
</tr>
</tbody>
</table>
Urine Output is documented every two hours in JeffChart as part of ETAR (Education, Toilet, Alarm and Response)

**Click** the back button to return to the nursing base screen.

If you have not viewed the Systems Assessment Video (run time 10.30) view this video now.

Assessment Documentation

Please chart your morning assessment for your patient.

From the Nursing Base Screen:

1. **Click** on the FS Chart Tab

2. **Select** “Assessment” menu option
   Click on ROS/Safety

Under the heading “System Assessment”:

1. **Click** on the System Assessment **CV Status**. A check mark ✓ will appear to the left of the finding selected.

2. **Click** the **Add a New Column** button

3. **Check** the time and date

4. **Click** Add **Column** button

The System Assessment Grouped finding screen displays

Under the **Result** column

- Integumentary Status – Abnormal
- Neuromuscular Status – Abnormal
- Respiratory Status – Abnormal
- CV Status – WNL
- GI Status – WNL
- GU Status – WNL
- Pain Status – + see fs - See Pain/PCA/Epidural/CADD Flow sheet
**Note: The within normal criteria “WNL” is defined below the dotted line for each system.**

5. Click on the Add button from the pop-up menu to review to the flow sheet.

An abnormal system assessment needs to be documented on the flow sheet: Assessment. If the patient has pain, you will document the on the appropriate pain flow sheet.

In the Assessment FS, click the button Braden/ Integum

Select the following abnormal Integumentary assessments findings:

- Color Generalized
- Sclera
- Skin Temperature
- Skin Lesion/Rash

Click the Add New Column button

Check the time and date

Click Add Column button

Enter the abnormal assessments individually listed below.

Click the “Add” button after each abnormal assessment finding has been selected.

<table>
<thead>
<tr>
<th>Finding</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Color Generalized</td>
<td>Select “ecchymosis”</td>
</tr>
<tr>
<td>Sclera</td>
<td>Click “skip button” to advance to next finding selected.</td>
</tr>
<tr>
<td>Skin Temperature</td>
<td>Select “fever”</td>
</tr>
<tr>
<td>Skin Rash</td>
<td>Select “macule”</td>
</tr>
</tbody>
</table>

Now chart your neuromuscular assessment

1. Click on the Neuromuscular button located at the top of the screen. This will bring up the Neuromuscular section of the flowsheet. A ✓ will display in the button name when selected.

2. Select the following abnormal Neuromuscular assessment findings:

   ✓ LOC
3. Click the “Add New Column”

The Neuromuscular Abnormal Findings grouped finding screen displays

Under heading LOC

4. Select: Confused.

Under heading: Orientation

5. Select X 2

6. Click the Add button

The Neuromuscular Abnormal Finding grouped finding screen display.

7. Select: Numbness

Under the heading: Muscle weakness divided into sections of UE, LE, UR, UL

8. Select: Present right/left

9. Under the heading: Gait

10. Select Unsteady

11. Click the Add button.

12. Click arrow to move the buttons to the left

13. Choose Resp/Cardiovascular button located at the top of the page. A ✓ will display in the button name when selected.

Under the heading Resp/Cardiovascular heading:

14. Select ✓ Resp Rate.

15. Click the Add New Column button

16. Set the time for the time the abnormal assessment was performed
17. **Click** the *Add Column* button

The Respiratory Abnormal Findings grouped screen displays:

In section: *Resp Rate* double click box

18. **Select**: Decreased

Under the heading *Resp Effort*

19. **Select**: Labored

Under the heading *Cough*

20. **Select**: Non Productive

21. **Click** the *Add* button.

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**Pain Assessment Documentation**

1. **Click** the Flowsheet Chart Tab

2. **Select** the *Pain Management Flowsheet* from the dropdown menu choices.

3. Flow chart column box appears – **Click Add column**

4. **Enter** and **Add** the following information for each finding selected.

   a. **Pain Goal** – In the Results field type in "0". (This number presents the pt.'s pain goal, from a scale of 0-10)

   b. **Pain Scale** - Type "8". (This number presents the pt.'s pain on a scale of 0-10 when assessment performed.)

   c. **Pain Scale Used**: Numeric

   d. **Click ADD**

5. The pain location box appears

6. **Double Click** Pain Location: Neck pain

7. **Click ADD**.
8. The pain intervention box appears

9. **Click** Pain Intervention: Medication and Heat

10. **Click** ADD

11. The Pain Interventions Adverse Effects box appears - **SKIP**

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Pain reassessments need to be completed and documented within 2 hours. You will reassess the pain using the same parameters outlined above and also document the Adverse Effects, if any. You will document the pain reassessment in a separate column to denote the later time performed.

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If you have not viewed the Falls Assessment & Morse Tool Intervention Documentation Video - (run time 3.05) please view it now.

If you have already viewed the video proceed to the next documentation exercise.

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**Fall Risk Assessment**

You are concerned your patient is a fall risk.

From the Nursing Base Screen:

1. **Click** on the FS chart tab.

2. **Select** the **Assessment** flow sheet from the drop down menu

3. Assessment Record displays

   Under the Button **Falls**

4. **Under the Falls risk assessment**: Check history of falls prior

5. **Under General Safety Interventions**: check Sensory items within reach

6. **Under the General Fall Prevention**: Check Level 2 Bed/chair alarm 24 hours
7. **Under Specific interventions: Check toilet every hour**
8. Click the ADD new column button **Check Time and Date**.
9. The Falls Risk Assessment Screen appears
   - **Check history of falls prior, altered mobility/gait and altered mental status**
10. Click the ADD
11. The General Safety Interventions screen appears: **Check Sensory items within reach**
12. Click the ADD
13. The General Fall Prevention Screen appears: **Check level 2 bed/chair alarm**
14. Click the ADD
15. The Specific Intervention screen appears. **Under altered elimination check toilet every hour**
16. Click the ADD button

**Skin Assessment**
From the Assessment page, **Click** the Braden/Integum button
1. Under Braden Assessment Check: **Braden Sensory Perception**
2. Under Sensory/Activity Interventions: **Check Assist with ambulation**
3. Under Moisture/Nutrition/Friction: **Check skin for moisture**
4. Check Add new column **Check Time and Date**
5. The Braden skin scale appears
   a. Check under Braden sensory perception-slightly limited
   b. Check Under Braden moisture consist , occasionally or rarely moist
   c. Check Under Braden activity- walks occasionally
   d. Check Under Braden mobility- slightly limited
   e. Check Under Braden nutrition-adequate
   f. Check Under Braden friction and shear-potential problem
6. **Click Calculate** Score should be 17
7. **Click Add/update**
8. The Pressure Ulcer Prevention interventions screen appears (Braden scale displayed is 3 or less?)
9. At the top **check education patient/family on pu prevention and Implement pain interventions as needed**
10. Under activity **check assist with ambulation**
11. Click Add
12. Under Moisture check skin for moisture.

Documenting on drains

1. Click on the chart tab called Flowsheets
2. Click on Intervention Record from the drop down menu.
3. Under the heading: Other Tubes/Drains:
4. Click on Tube/Drain Order
5. Click the Add New Column button
6. The ADD flowchart column box appears. Click Add Column
7. Select the following interventions and modifiers from the list below.
   a. Tube/Drain Type                               JP (Jackson Pratt) JP/HVI
   b. Tube/Drain Inserted                           Select box, click on today’s date and ok
   c. Tube/Drain Order                              Gravity
   d. Tube/Drain Drainage                           Bilious
   e. Tube/Drain Flush/Irrigation                   Done/Order
   f. Tube/Drain Care-Penrose                       Done/Order
8. Click the Add button

If you have not viewed the Labs & EKG Documentation Video – (runtime 7:20) please view it now. If you have already viewed the video proceed to the next exercise.

If you have not viewed the Non-Med Work List/Non-Medication Variable Time – (runtime 5:10) watch it now. If you have already viewed the video proceed to the next video,

Listen and watch this video. No exercises to complete.
If you have not viewed the Accuchek Documentation Video– (run time 4:52) view it now. If you have already viewed the video proceed to the Accuchek exercise.
Documenting the Results of Accuchek on the MAR

From your base screen:

1. **Activate** your assigned patient.
2. **Click** the MAR/WL chart tab.
3. **Select** the MAR-Current Shift
4. Find the appropriate timed entry for the AccuCheck
5. Click in the Result field. Type 264 as the Accuchek result
6. **Click** the **Save Charting** button.

**Note: The word “Done” will display in the Result field. The result of 264 now displays in the right side of the Amount Column, indicating the action is complete.**

**Note: It is important that the nurse/tech/extern documents the AccuCheck value on the MAR as close to the time performed as possible**

If you have not viewed the Student Nurse Medication Co-Sign Process with Instructor Video (run time 8:45) watch it now. If you have already viewed this video proceed to the MAR exercise.

Medication Administration Record (MAR)

Overview

Documentation of medication administered to patients is recorded on the Medication Administration Record (MAR). There are several MAR that you need to become familiar with.

Let’s start with the MAR-Current Shift.

MAR-Current Shift

- Displays the medications scheduled for the current shift
- Perform MAR documentation
- Review the details of each medication
- Review the order, the details of all charting completed on the MAR
- Review the audit details of all MAR activity
• Shift- The shift MAR will display actions for the current 8 hours nursing shift plus one hour at the end of the shift. This allows for post-shift documentation of medication administration (i.e. 7-3 shift will display a 0700-1600 MAR). (Click on arrows)

MAR Column Details

L = itemizes list of meds on the MAR

D = provides functional ability to change/error out a charted result on the MAR

Order # = identifies the LW order number of the medication order

Status:
- Approved – U/Pending, pending pharmacist verification
  - Do not give medications that have not been verified by the pharmacist.
- Complete – active order, specific action completed
- Held – active order, specific action held
- DC – inactive order, action discontinued
- Retract- will eliminate all past and future actions if never charted.

Date/Time: scheduled date and time of med administration based upon order entry details.

Result: “charting” words identifying the administration / omission of each specific scheduled action. The exception is Accuchek & sliding scale insulin where the result is a number.

Site = Anatomical region for medication administration if applicable.

OC = order comment attached to the order detail at the time of order entry.
Click the right side of the scroll bar to view the OC.

Review the Medication Order Detail

The Order Detail screen allows you to do review the details of any order. Use this feature to review all the details and comments about an order.

Reviewing the Medication Order Detail
From your base screen:

1. Activate your assigned patient.

2. Click the MAR-Current Shift

3. Highlight the Multivitamin or Docusate dose order on the MAR.

4. Click on the Review Order Detail button (bottom left of screen) for additional information concerning the medication order for this action.

5. Take a few minutes to review the medication detail screen of the Multivitamin dose.
   - The display will include all information entered at the time of medication order entry.
   - These details are specific to the medication order, not a specific scheduled action.

6. Back Out to return to the MAR

Charting of Scheduled Medication Actions

The MAR identifies the scheduled time of the action (based on the medication order details). Scheduled doses of medication must be administered by policy + or - 1 hour of the scheduled time. If this time is not changed, it indicates that the medication was administered at the scheduled time.

The nurse may manually change the time in this field to more accurately reflect the time of administration. But please note that by doing this that the medication is not retimed, and future actions will continue on the present schedule.

Co-Signing of Insulin medication order to be administered is NOT done by students. Only two RN's may document insulin.

Charting Medications

Students must always use the Co-Sign option for documenting the administration of a medication. All of their medication documentation must be co-signed by their instructor or RN.
When administering medications, always check the MAR right before administering the medication and always check identify the patient with two patient identifiers (name and date of birth), and Check the patient’s id bracelet.

Charting medication
To chart a medication that has been administered

1. Activate your patient.

2. **Click** the **MAR/WL** Chart tab

3. **Click** the **MAR-Current shift**

Prepare to chart the dose of *Multivitamin or Docusate*

1. Left **click** in the **Result** column.

2. Right click in the **Result** column to bring up chart word options.

3. Double click on “**Cosignreq**” option.

ALWAYS Click the **Save Charting** button before you finish.

The menu selection screen appears.

4. Double **Click** on **Cosignreq** Click on **Save Charting** highlight entry/ then select bottom left entry button.

The chart detail screen appears.

5. Review and then
6. **Click** “**Save Charting**”

To chart a medication as “NOT GIVEN”

Chart the Ferrous Sulfate as *Not Given*

7. **Left click** in the **Result** column.

8. **Right click** in the **Result** column to bring up chart word options.

9. **Double click** on *Not Given* option.
10. **Click** on *Save Charting* option.

11. Select the reason “vomiting” from the Chart Detail screen

12. **Double click** on the reason you did not give the medication from the Not Given menu.

13. **Click** the “Save Charting” 

The Chart Detail displays.

Press the “F12” button at the top of your keyboard and you will return to the MAR-Current shift to check to see the status of the medication. You will also see in the medication was held.

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**MAR Review Audit**

The Review Audit feature allows you to review all actions performed with scheduled medications.

**Review Audit**

From your base screen

1. **Activate** your assigned patient.

2. **Click** the MAR/WL chart tab

3. **Select** the MAR-Current Shift

4. Locate the medication multivitamin?? (Docusate or Fe) that you just charted (cosigned) in the above exercise.

5. Highlight the medication

6. **Click** Review Audit button.

Take a few minutes to examine the Review Action Level Audit Trail screen of the multivitamin.

The actual scheduled action time of when the medication should be administered is listed as well as the actual time the medication was charted and action (held, co-signed) is listed. If the medication action was charted, you can see what student nurse administered the medication.
7. HIGHLIGHT the medication, co-signed

8. **Click** on the Step By Step Detail button.

9. Review what the “Given Note: in the progress note section of the screen.

10. **Click** the “Exit” button to exit the screen.

If you have not viewed the *MAR-PRN, On-Call- Current Shift* video – (run time 4.30) watch it now. If you have already viewed this video proceed to the exercise.

Documenting on the MAR-PRN and On-Call; Current Shift

Your assigned patient complains of a backache and requests pain medication. She has Acetaminophen order. Prior to dispensing the medication you check the PRN to see when the last dose was administered.

Activate the inpatient your assigned patient.

1. Click the MAR/WL chart tab.

2. Select MAR-PRN and On-Call, Current Shift to display the PRN Medication Record.

3. Scroll to the right of the screen to view *Order Comment*. The patient has Acetaminophen ordered for backaches.

4. Select the Acetaminophen order.

5. Click the *Action Level* button and the Medication Worklist for a Specific Order displays

6. Left click in the RESULT filed, then Right CLICK.

7. Double click on the chart word, “Co-Sign”.

8. Click the *Save Charting* button. The time and date will automatically fill in.

9. Highlight “Entry”

10. Click “Select Entry” then “Chart Details” appears

11. Save entry0.
If you have not viewed the "Hotlist Creation and Maintenance Video" – (run time 5.20) watch it now. If you have already viewed this video proceed to the next exercise

Viewer Chart Tab: no video

The Viewer feature in JeffChart allows health care providers to view data entered in JeffChart. This is an extremely useful resource to use, since JeffChart screen access is limited by your job title. For example: Physicians do not have access to the MAR'S or flowsheets. Physicians use the "Charted Med View" to view medications and documentation that have been documented by nursing staff.

Viewer:

With your patient activated.

1. Click on "Viewer" chart tab. A list of all views displays from the drop down menu.

   **NOTE:** You will only get a view that data has been entered into.
   Select the "Assessment Record 1 View" to see the Assessments that you have entered.

2. Close the "Viewer" screen by clicking on the "X" in the upper right hand corner

3. Select the "I&O Vital Signs View" from the Viewer menu to display your patient's Intake & Output record and Vital Signs.
   **Explore** the list of "Viewer" menus options available to you.

This concludes the class.

Exit out of the Jeff Chart by clicking the man leaving the door icon or F10.

Adapted from RN Clinical Information System Training, Manual created by Terri Schwartz