Reception

Reception Routines

Click on the 

button to proceed to the ***Patient Reception*** screen

Choose one of 4 reception forms based on how they present to the Emergency Department

Walk In

Walk In is the most common method for adding a patient to the tracker. This routine is used for all patients that appear in your triage area that have just “walked in” the door or for patients arriving via EMS without warning.

EMS

This routine is for the occasions when EMS informs the department that they are en route to your department with a patient. It allows you to indicate to all staff that there is a patient incoming, provide an estimated time of arrival (ETA) and block a treatment space to ensure its availability upon their arrival.

Transfer

For the rare occasions that a patient is brought from the ward (as an inpatient) into the Emergency Department for care, use the transfer routine. This allows you to place a patient on the tracker without affecting their admission status and will not create a duplicate account.

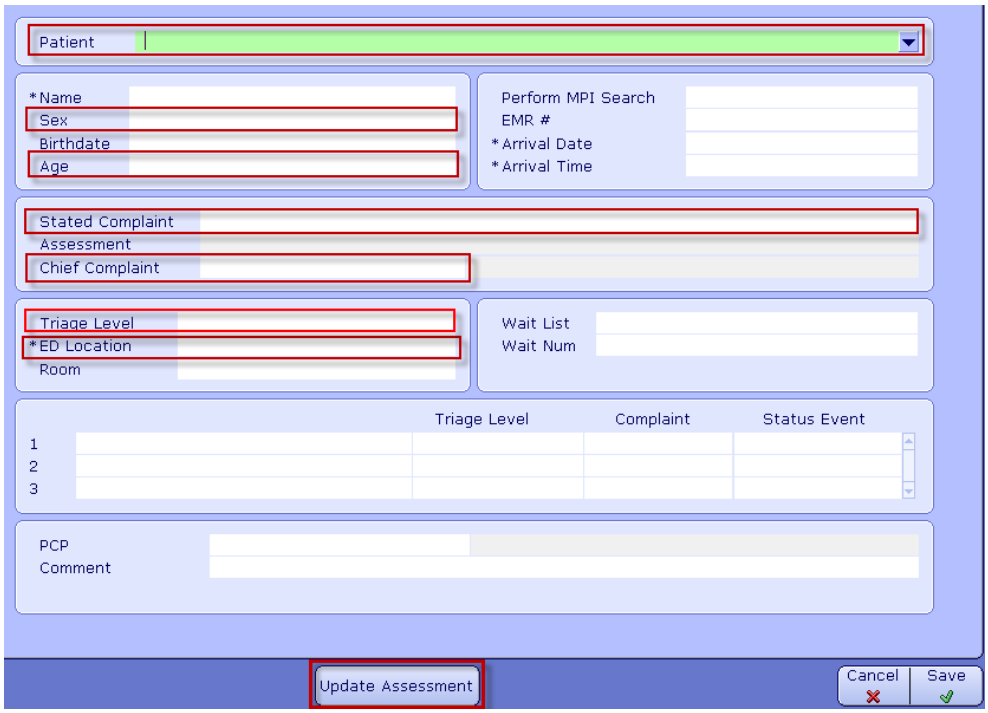
Call In

When a physician’s office calls to tell you that they are sending you a patient, use this routine. It is assumed that you will be able to obtain patient demographics (name, health care number) to add the patient to the tracker. Very similar functionality to the EMS routine and adds the patient to the incoming tracker.

Notes:

- If your site **uses** an electronic assessment form to capture the details of the initial triage assessment, the Triage Level field depicted below is not required as this information is captured using the electronic Triage Assessment form. See the **Documenting the Triage Assessment** section for more details.
- If your site **does not use** an electronic assessment form to capture the details of the initial triage assessment, the Update Assessment button will not be accessible and is not required.

Walk In



For the Reception routines that require an entry in the **Patient** field (Walk In, EMS at Check In, Transfer, Call In), there are multiple ways to bring a patient into the trackers.

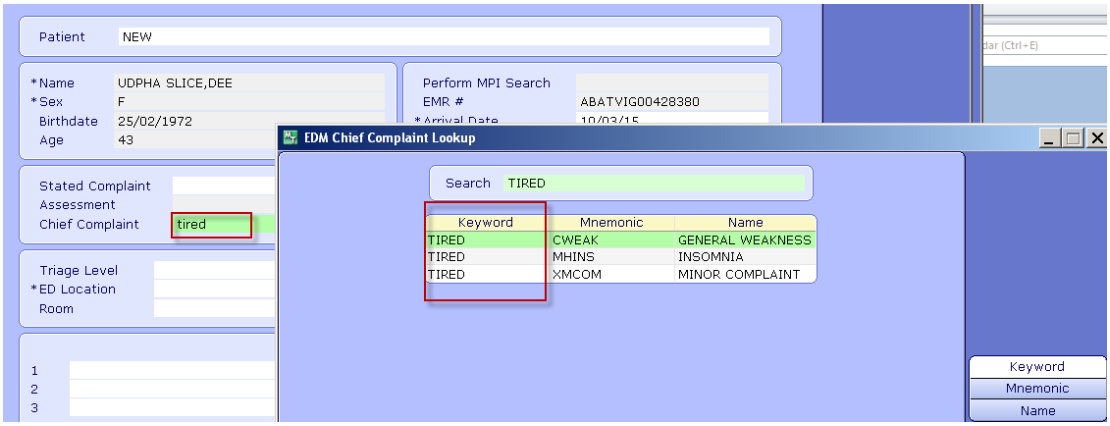
- ULI/PHN
  - To search for a patient by their Unique Lifetime Indicator (ULI) or Personal Health Number (PHN) as issued by Alberta Health and Wellness, begin by entering the ULI/PHN search shortcut: # followed by the 9 digit number ULI/PHN. For out-of-province patients that have been to your facility before, enter P# and their provincial health care number.
- Name
  - Patients **without** a Health Number or where the Health Number is unknown enter the patient's full surname followed by a comma and the patient's first name.

- Unknown Patient
    - Follow your hospital's procedures for entering in a temporary patient name.

Complete required/relevant fields

- Age
- Sex
- Stated Complaint
    - A free text field to document what the patient is complaining of
- Chief Complaint
    - Typing in a keyword and hitting Enter will provide you with a list of Chief Complaints associated to that keyword:

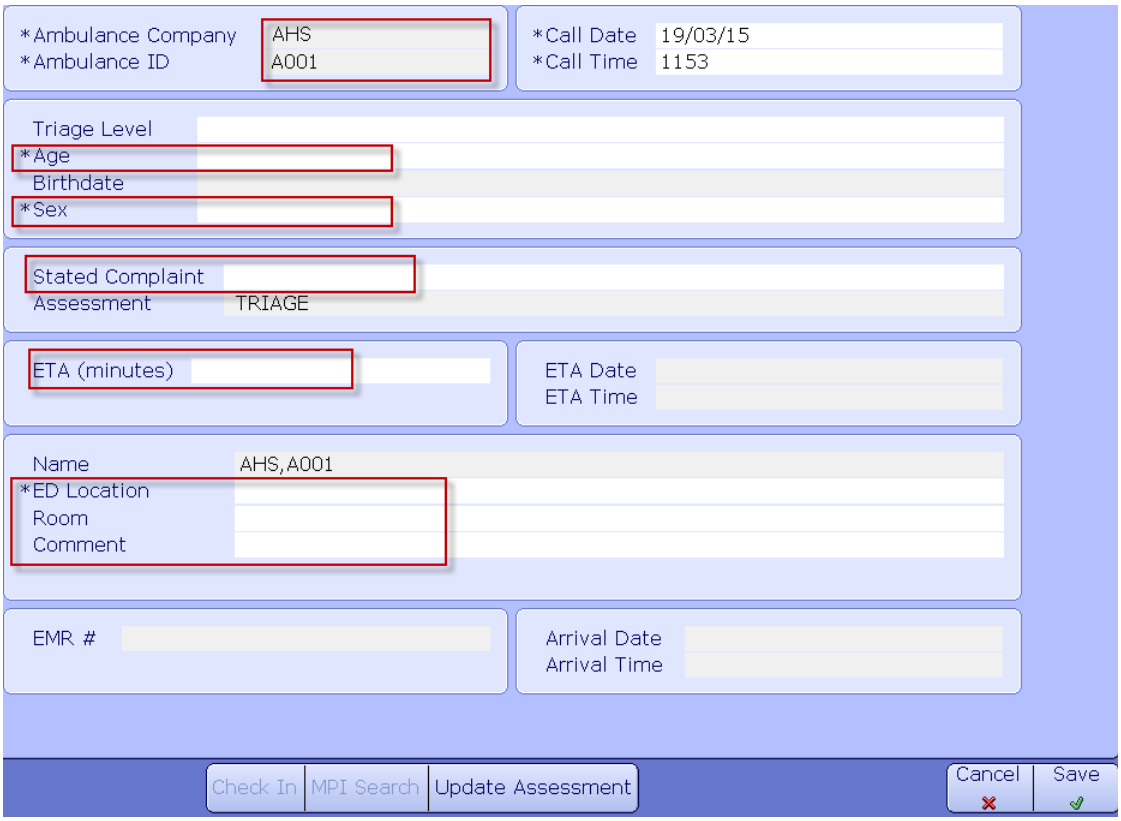
    Ex: Tired



- Triage Level (where required)
    - Enter CTAS score
- ED Location
    - Enter past to populate the default location or F9 or select the drop down bar to choose from a list of locations. Note: to view all available locations, you need to delete the current location.
- Update Assessment (Walk In, EMS and Call in – where required)
    - Fill in appropriate fields and F12 or Save to finish Reception routine
- File Reception Routine: Click F12 or Save to save the patient record and return to the tracker

- Upon filing, the patient name will appear in the appropriate trackers.

EMS



This screen will automatically appear if accessing the Reception routine directly from the Incoming tracker.

In the Ambulance Company field, you will notice that there is a default company listed. You can change this to match the appropriate company by highlighting the field, deleting what is in there and clicking on the down arrow or pressing F9. Choose the right company and press Enter.

The Ambulance ID will be automatically generated with a number. This will become the patient's temporary name that will appear on the trackers (typically, you will not know the patient name for the incoming EMS patients). You will be able to update this when you perform the Check In routine.

The Call Date and Time will automatically populate with the date and time you are completing this.

Triage Level will not be required until Check In.

Age and Sex must be entered.

The Stated Complaint will be the reason you are told the patient is being brought to the Emergency Department.

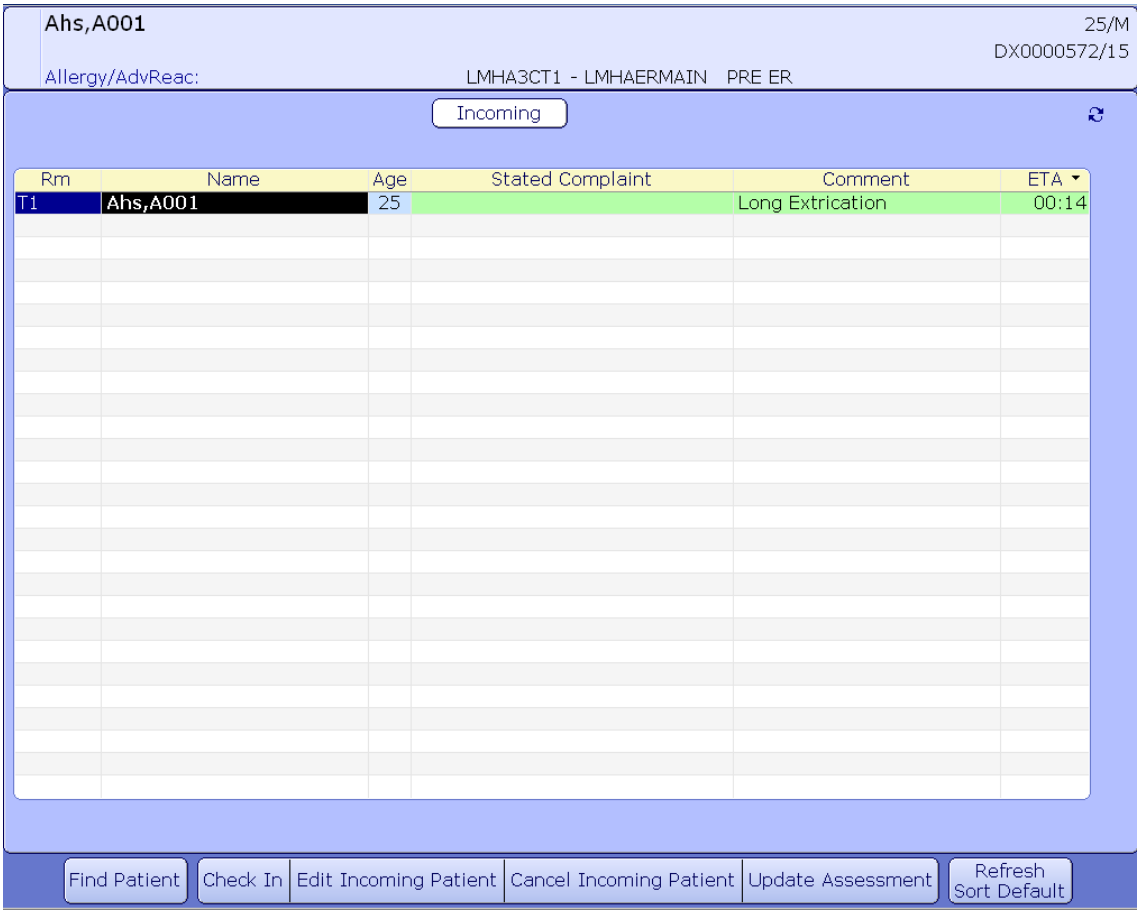
The ETA is the estimated time of arrival in minutes.

You can choose to place the patient into a location prior to their arrival and block a treatment space.

The Comment box in this routine is the same as the tracker Patient Comments and will appear on the tracker. Here you can note general information such as “long extrication” or “intubated.”

For those that utilize the Triage Assessments electronically, you will not enter anything until you perform the Check In routine.

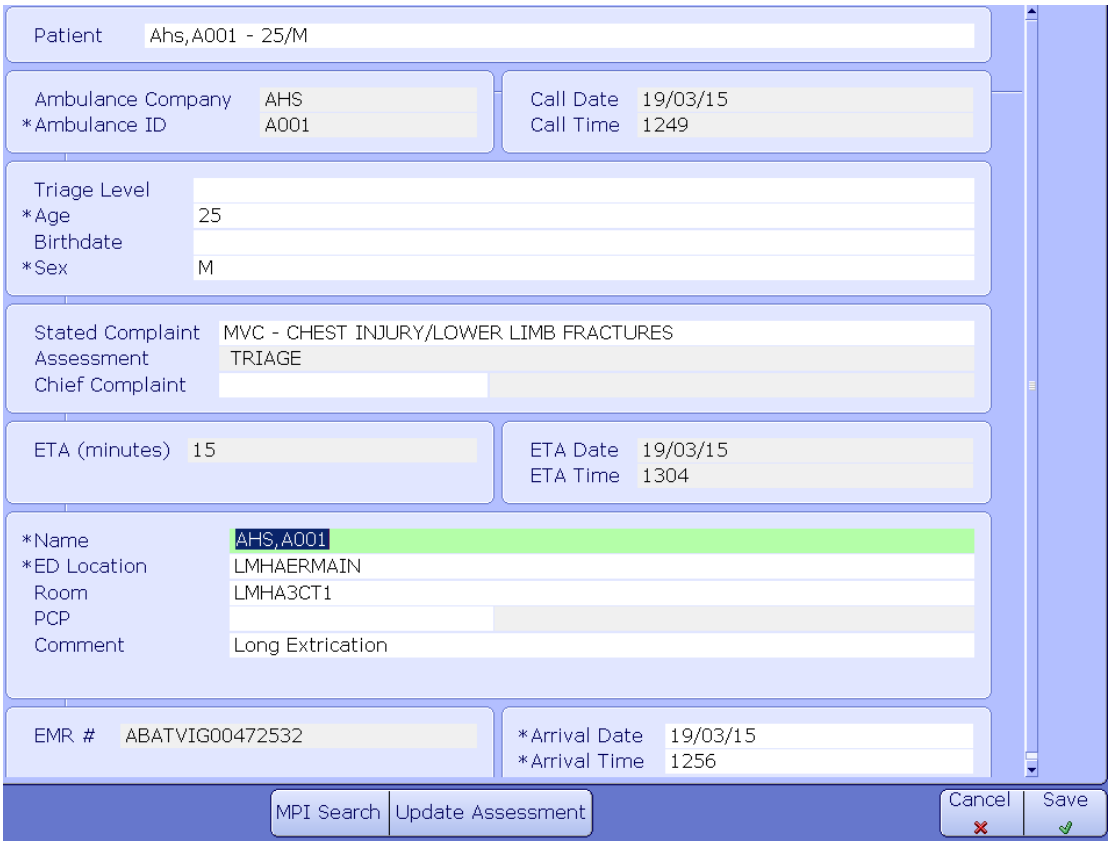
Save this and the patient will appear on the Incoming tracker and, if on other trackers, their status will show them as Incoming.



NOTE: Incoming patients can only be “Checked In” via the Incoming Patient tracker.

Check In

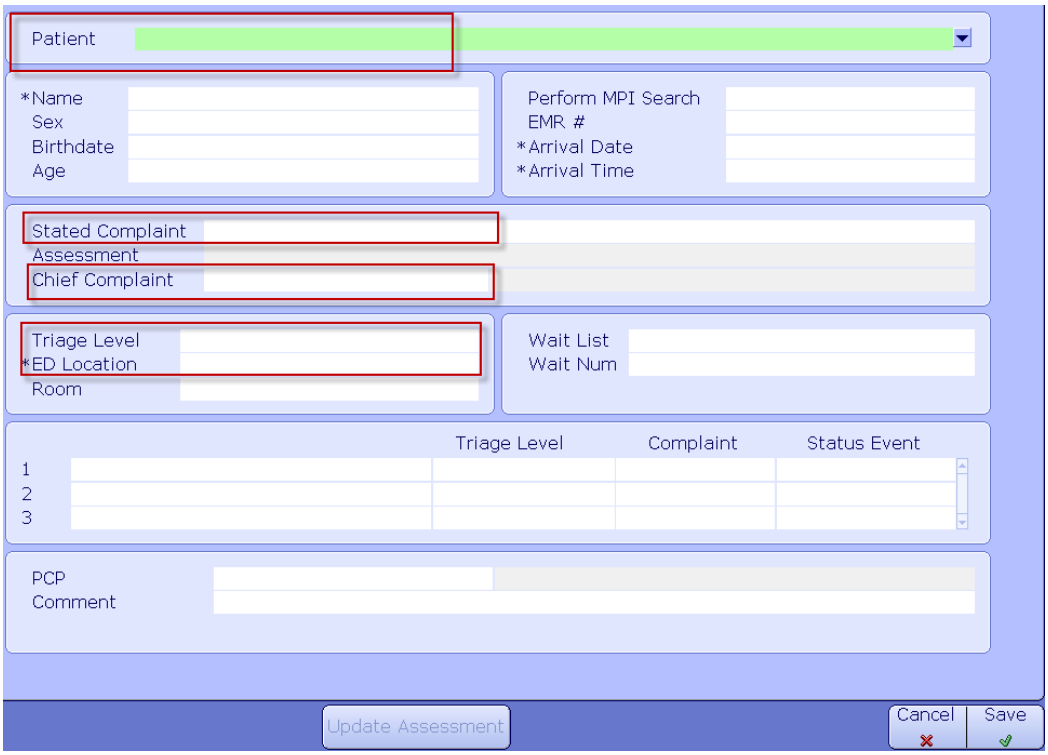
For both EMS and Call In patients, when the patient arrives, go to the Incoming Tracker (above) and select Check In from the bottom buttons. That will return you to the Reception Routine in order to update pertinent patient information.



Note that you will be brought directly to the Name field. From here, enter the patient's health care number or LASTNAME,FIRSTNAME (same procedure as Walk In).

You will be required to add a Chief Complaint and Triage Level at this time (if your site uses the electronic assessment, complete the assessment and the Triage Level is required there).

Transfer



To bring an inpatient into the EDM Trackers, you must enter the patient's account number.

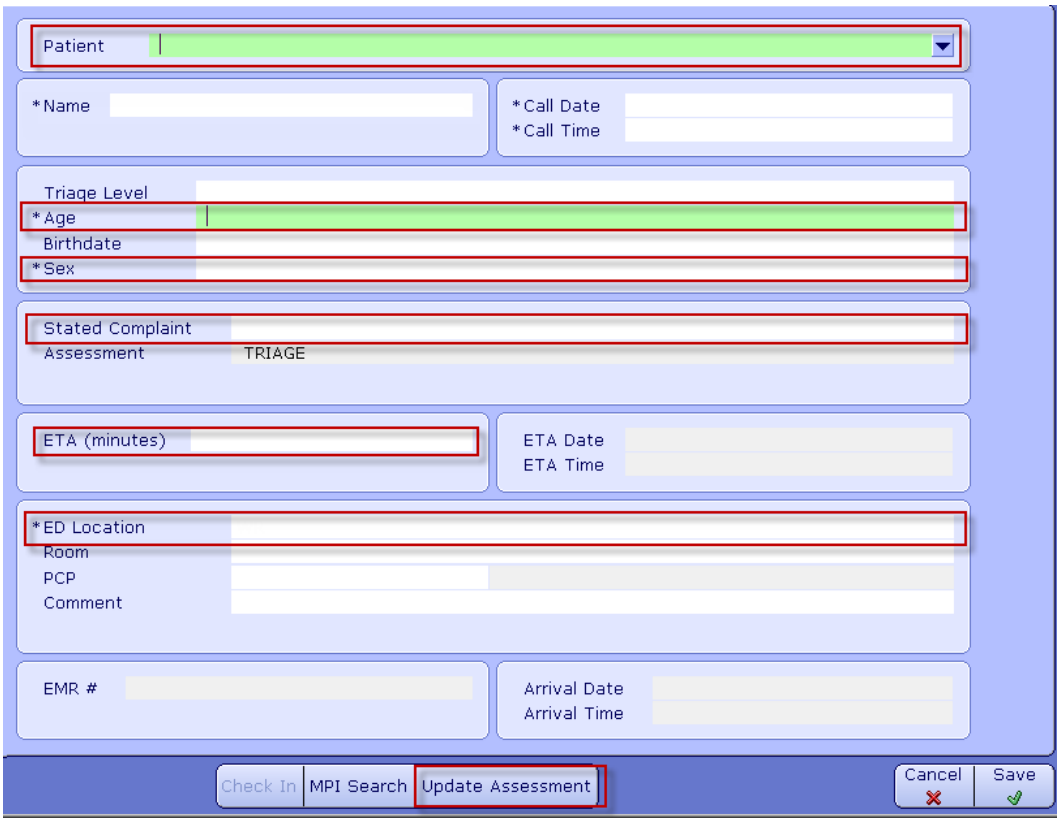
- Entering a patient account number is the most accurate. The account number is a visit number related to the patient's current visit in a specific facility. A new Account Number is assigned each time a person is registered to the facility. **This is the recommended option when receiving a patient through a transfer as this will immediately populate the demographic and admission details.**
- Patients can be searched for by unit number for a specific facility. The Unit Number is unique to the person and all visits attached to one medical record

If the patient was originally admitted through the Emergency Department, you may see their original triage information appear upon entering their account number. That is normal and there is no need to change anything other than the patient's location. **NOTE: A patient departed from Emergency for admission may not appear on patient based trackers as their status will remain "Depart" (Admitted Patient for Red Deer) until you change it.**

NO sites are using the electronic Triage Assessment for inpatients coming into the Emergency Department. Do not complete the assessment for these patients.

Patients brought in through the Transfer reception cannot be departed through the Departure Routine but must simply be departed by changing their Status to Depart (or, for Red Deer, Admitted Patient).

Call In



When a physician's office calls in to inform you that they are sending you a patient, obtain the patient's health care number (as a physician's office should have that available) and enter that into the Patient field in order to add them to the Incoming tracker.

Triage Level, Chief Complaint and, if being used, electronic Assessment will be completed when you perform the Check In routine.

Documenting the Triage Assessment

The following section only applies if your site uses an electronic assessment form to capture the details of the initial triage assessment.

Note: at the time of document creation, the electronic triage assessment form will not be used when patient is received through an inpatient transfer. Check with your team lead for current process.

Before completing the Reception Routine for Walk In patients or while "Checking In" EMS or Call In patients, click on the 

button on the bottom of the screen to launch the electronic ***Triage Assessment*** form.

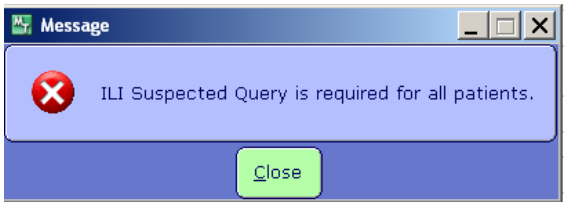
→ Complete **only** the pertinent fields on this assessment. Below is an explanation of how to document some of the different fields.

- **Note**: Some fields are mandatory

→ Use the mouse or keyboard (tab key or up/down arrows) to move from field to field.

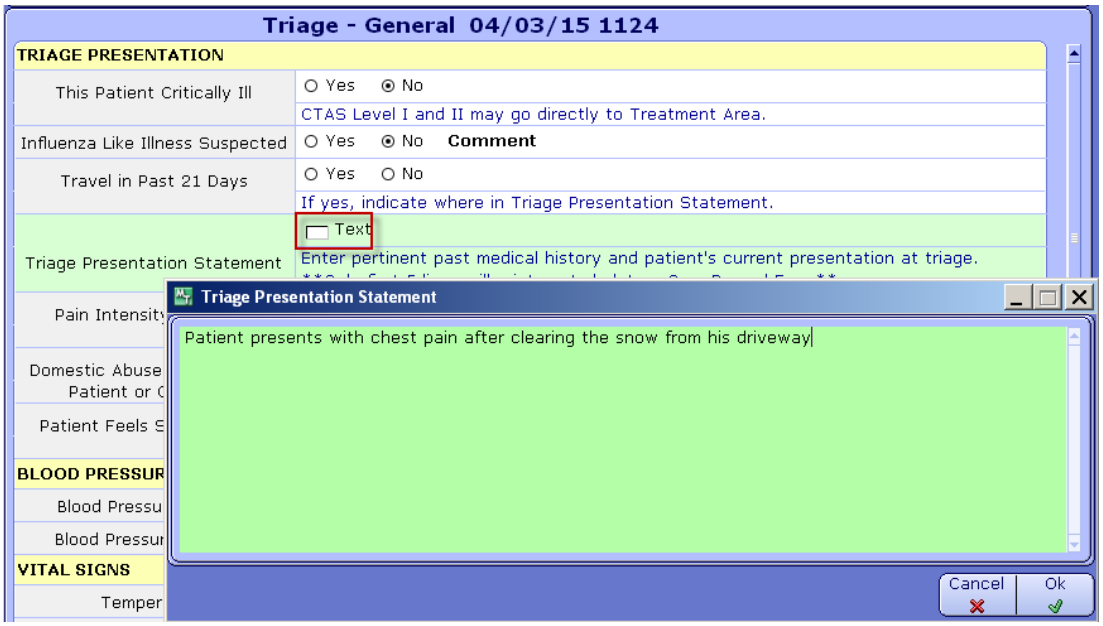
Influenza Like Illness (ILI) Suspected

→ This is a mandatory field, if you try to save the assessment without documenting suspected ILI, you will be prompted to do so before being able to file



Triage Presentation Statement

→ Where there is a **Text** or **Comment** box to document in such as the triage presentation statement, clicking on the box next to the word Text or Comment will open a free text field to chart in.

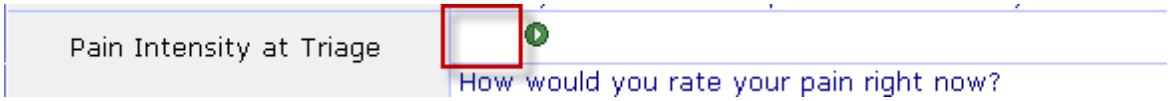


Be certain to enter pertinient past medical history in this box as well as their current triage information.

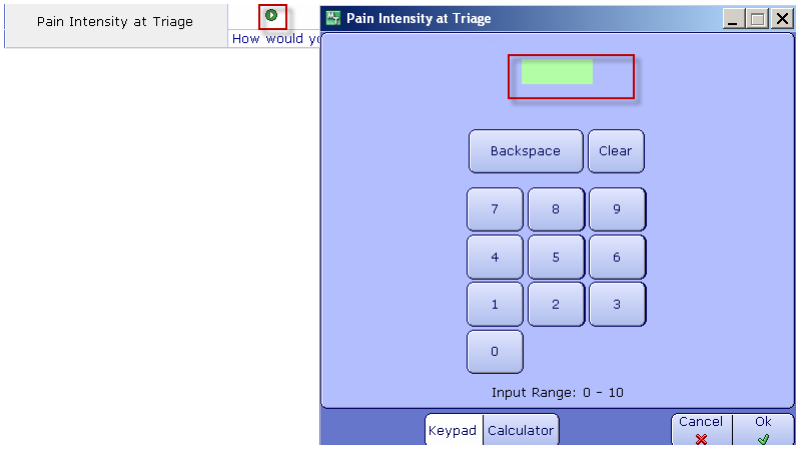
→ Click  or F12 to complete the free text entry.

Pain Intensity at Triage

→ Clicking into the blank space next to the green arrow will allow you to enter a number.



→ Clicking on the green arrow will launch a number pad. You can click on the appropriate numbers or type them in the open field. Click **OK** to save.



***Note**: All number fields in the assessment will respond the same way.

Vitals

→ Enter the vitals by documenting in the free space next to each heading or by clicking on the green arrow to bring up the keypad window

BLOOD PRESSURE (Occurrence # 1)		
Blood Pressure Systolic	176	(mmHg)
Blood Pressure Diastolic	88	(mmHg)

→ Should the need occur to repeat the patient blood pressure while they remain with you in Triage, click the Insert Occurrence button on the bottom of the screen.

- You will see "Occurrence #2" appear immediately below the 1st occurrence:

BLOOD PRESSURE (Occurrence # 1)		
Blood Pressure Systolic	176	(mmHg)
Blood Pressure Diastolic	88	(mmHg)
BLOOD PRESSURE (Occurrence # 2)		
Blood Pressure Systolic		(mmHg)
Blood Pressure Diastolic		(mmHg)

→ Continue to complete **only the pertinent fields.**

VITAL SIGNS	
Temperature	38 (degrees Celsius)
Temperature Source	○ Temporal Artery ○ Tympanic ○ Other
Pulse Rate	122 (beats per minute)
Pulse Rhythm	○ Regular ◉ Irregular
Respiratory Rate	44 (breaths per minute)
Pulse Oximetry	96 (%)
Pulse Oximetry Comment	room air
Glucose Meter Reading	5 (mmol/L)
Glucose Meter Reading Comment	
Last Menstrual Period	
Last Menstrual Period Comment	

Weight

→ Complete either **Estimated/Reported Weight** or **Actual Weight**

WEIGHT	
Estimated/Reported Weight (kg)	(kg)
Actual Weight (kg)	(kg)

***Note: Actual Weight,** if used, will populate in other applications of Meditech, such as the patient Header of the EMR

Medications/Immunizations

MEDICATIONS/IMMUNIZATIONS	
Tetanus within Last 5 Years	○ Yes ◉ No ○ Unknown
Medications	◉ Need Med.Rec Record (MRR) ○ None
Medication Comments	Enter pertinent medications in Comments (75 character limit)

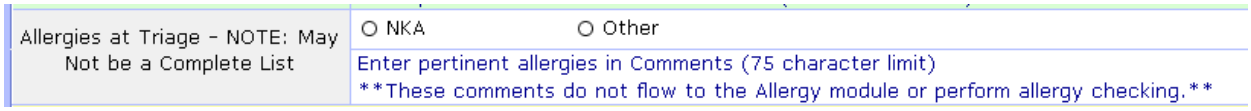
→ Clicking **Need Med Rec Record** means the patient is taking medications and a full list will need to be obtained after triage

- Use the **Medication Comments** to document any medications that may be pertinent to thepatient presentation. **Note**: There is a 75 character text limit.

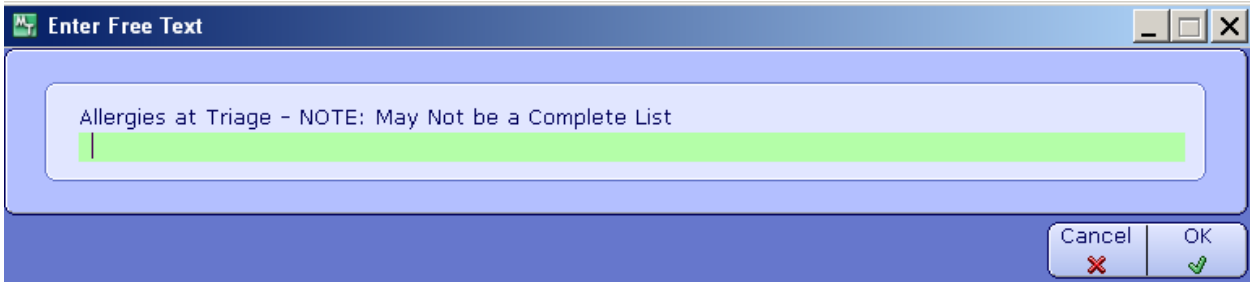
→ Click **None** to indicate the patient does not take any medication

Allergies at Triage

This section allows you to indicate any allergies pertinent to stated or Chief Complaint and **does not replace the Allergy module.**



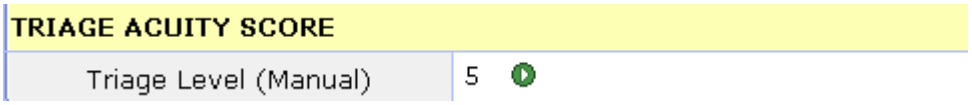
If selecting **Other**, you will a pop up window will allow you to document free text (limited to 75 characters)



NOTE: Allergies recorded here do NOT flow into the Allergy module or perform allergy checking.

Triage Acuity Score

The **Triage Acuity Score** (or CTAS level) section is the final section on the assessment and is required before you can file this assessment.



→ Click on the empty field to type the number in or click on the green arrow to use the keypad pop up window

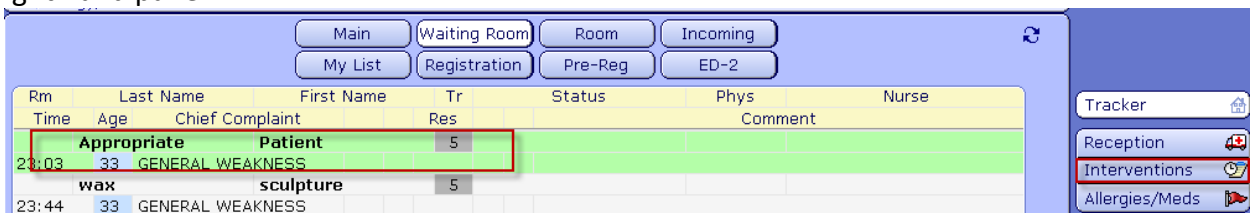
→ Click **F12** or 

to save the record
→ A confirmation box will appear
→ Click **Yes** to File
→ You will automatically be returned to the Reception screen.
→ You must then Save the Reception routine.

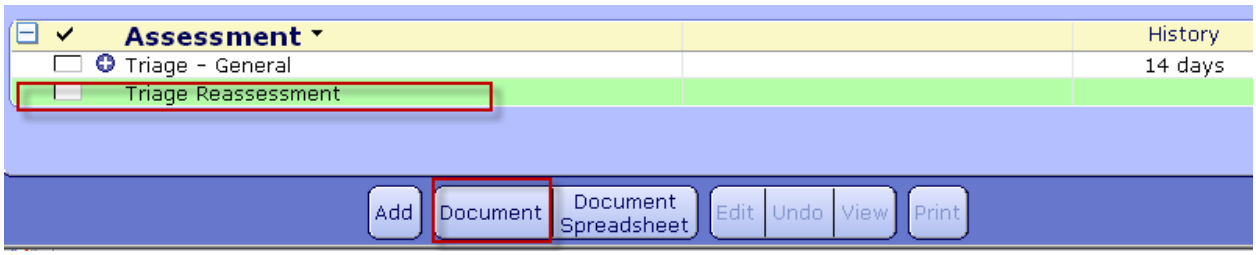
Triage Reassessment (for sites performing electronic reassessments)

As per standard care processes, patients may need to be reassessed. Follow the steps outlined below to complete reassessments as required.

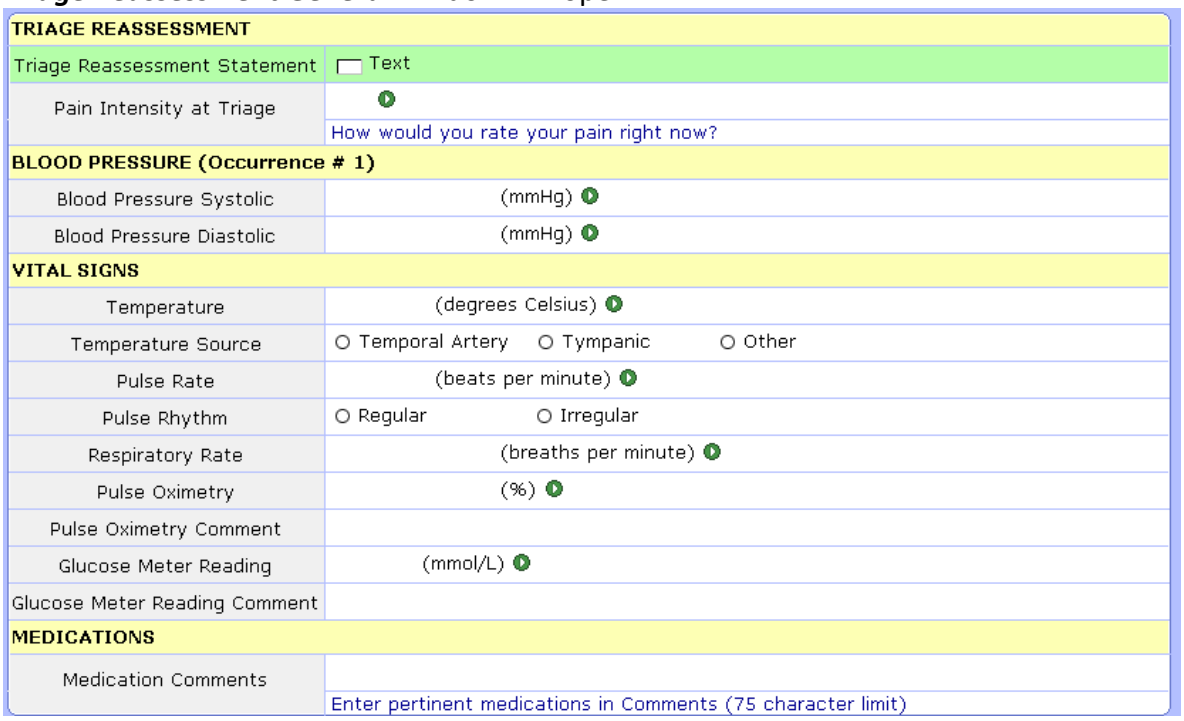
1. Chose the appropriate patient from the ***Waiting Room*** tracker and click on the **Interventions** button on the right hand panel



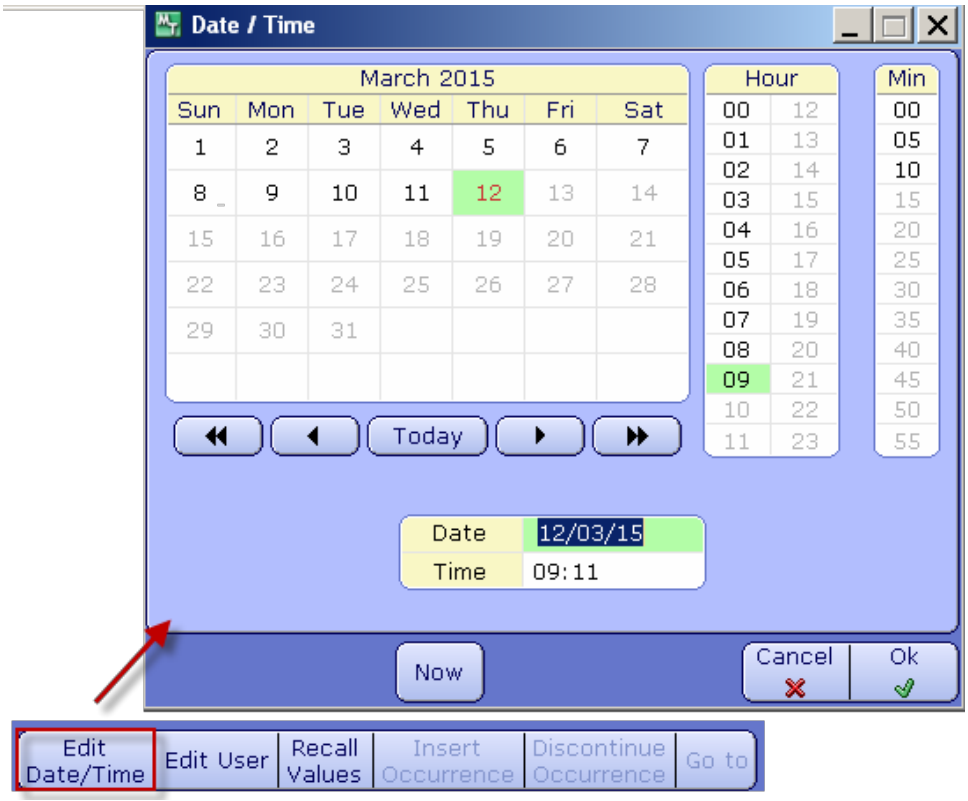
2. Highlight **Triage Reassessment** by clicking on it or check marking it and click on the document button at the bottom of the screen



3. The ***Triage Reassessment General*** window will open.



4. The date and time of the assessment will default to the current date/time, however if you are documenting a late entry, the date/time can be edited after opening the assessment be selecting the **Edit Date/Time** button at the bottom of the screen.

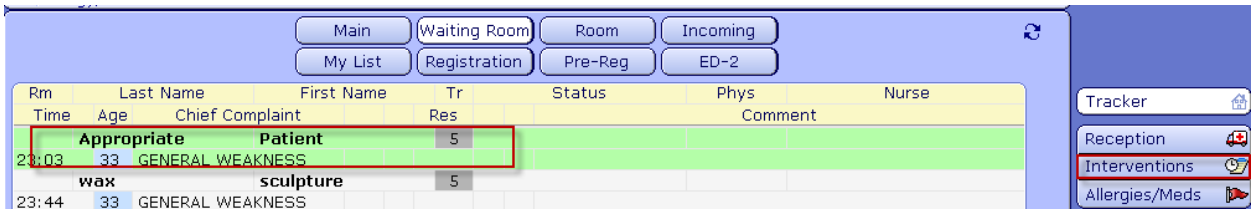


5. Complete the **Triage Reassessment** by documenting only the pertinent patient findings and click F12 or Save to save

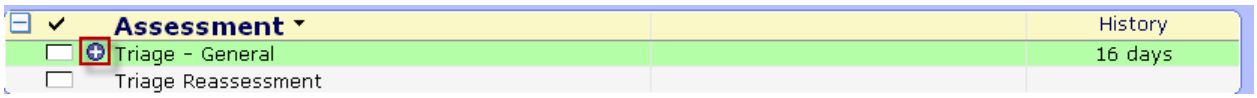
Editing

If you documented something incorrectly or missed some detail, you can edit a document after it has been filed.

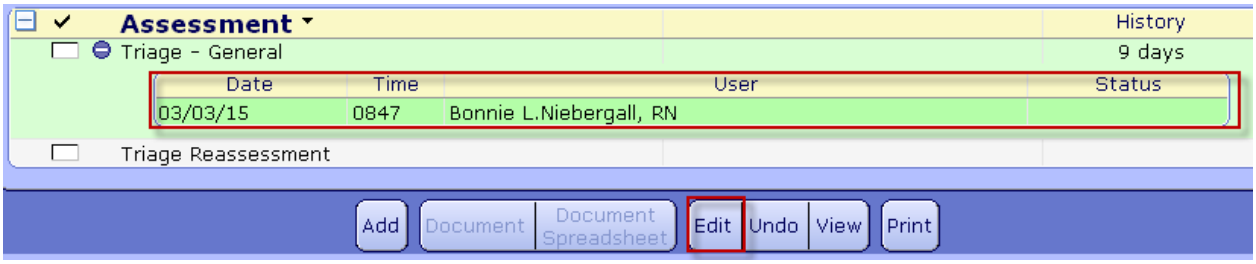
1. With the appropriate patient selected on the tracker, click on the **Interventions** button on the right hand panel



2. From the list of interventions, click on the '+' next to the one you wish to correct to reveal a history of every instance this intervention was filed.

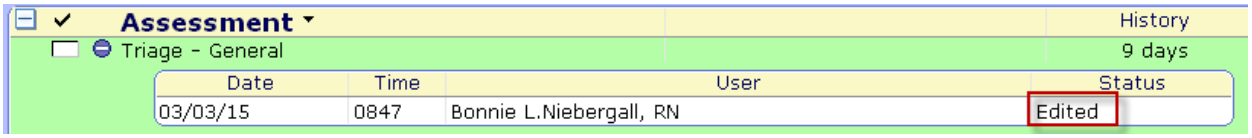


3. Select the entry you wish to correct (in many cases there will only one to choose from) and click on the **Edit** button at the bottom of the screen.



4. After completing the edit, file using the 

5. Having another look at the history be selecting the '+' button will indicate an edit was made, however the EMR will show only the most recent edit.

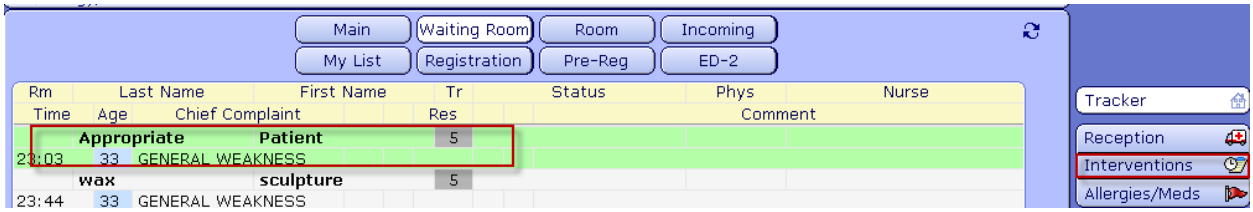


Removing Documentation (Undo)

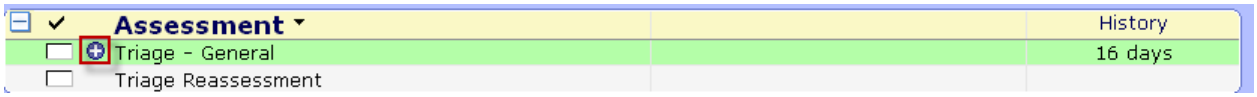
If documentation is placed on the wrong patient in Meditech it will need to be removed. Ideally this is discovered while the patient is still within the department and this task can be completed by the person who entered the documentation. If this is not found until the patient has left or the person who entered it is no longer there, the manager or their designate has access to remove other people's documentation.

To remove documentation when the patient is still in the department:

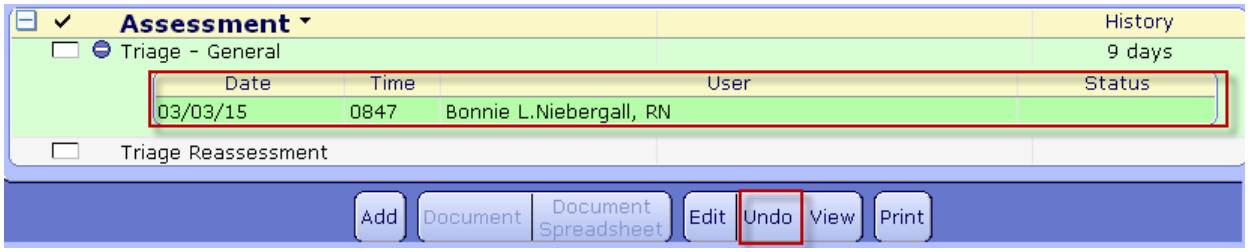
1. With the appropriate patient selected on the tracker, click on the **Interventions** button on the right hand panel



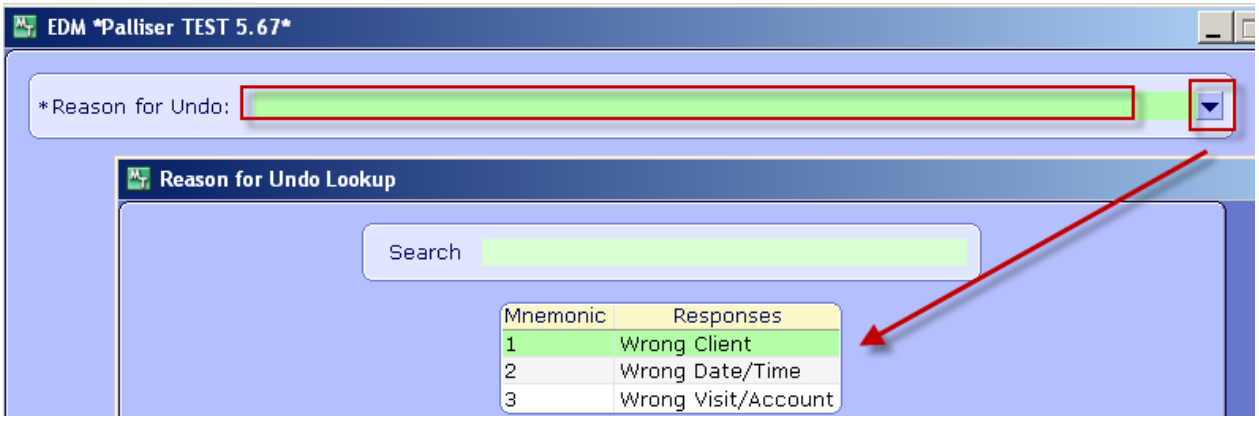
2. From the list of interventions, click on the '+' next to the one you wish to correct to reveal a history of every instance this intervention was filed.



3. Select the entry you wish to correct (in many cases there will only one to choose from) and click onthe **Undo** button at the bottom of the screen.

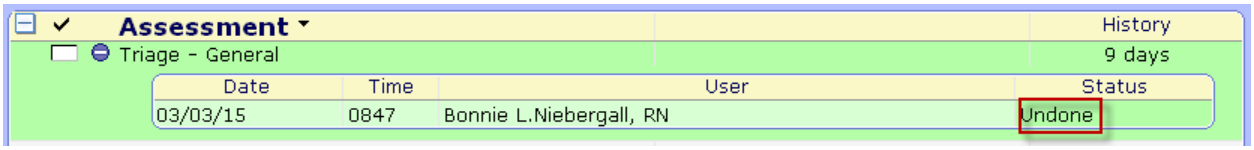


4. You will then be requested to enter a “Reason for Undo”. You can enter free text in the field provided or choose the drop down menu to select from 3 options.



5. 

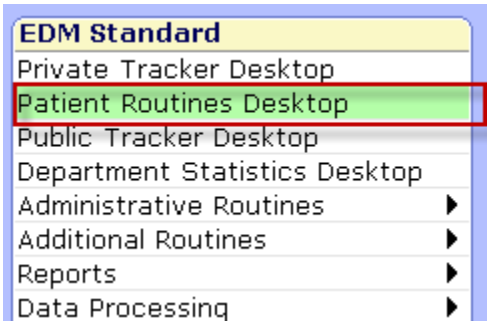
The document is now removed from the patient record. It still leaves notations in the audit trail for legal purposes.



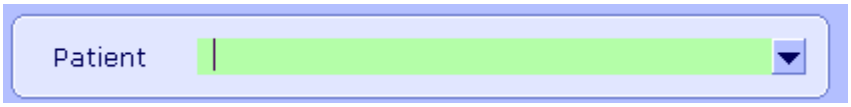
Removing documentation when the patient has left the department:

***Note:** This can only be done by the manager or designate

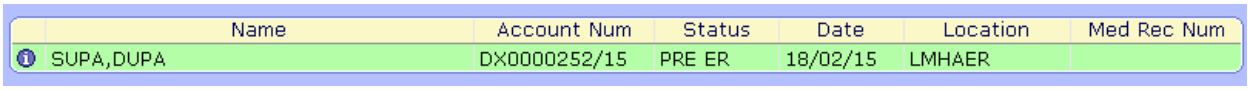
1. From the EDM Desktop enter into the Patient Routines desktop



2. Search for your patient



3. Select patient to confirm



	Name	Account Num	Status	Date	Location	Med Rec Num
ⓘ	SUPA,DUPA	DX0000252/15	PRE ER	18/02/15	LMHAER	

4. Click on the intervnetions button from the right hand panel

5. Repeat steps in the section above to edit/undo documentation

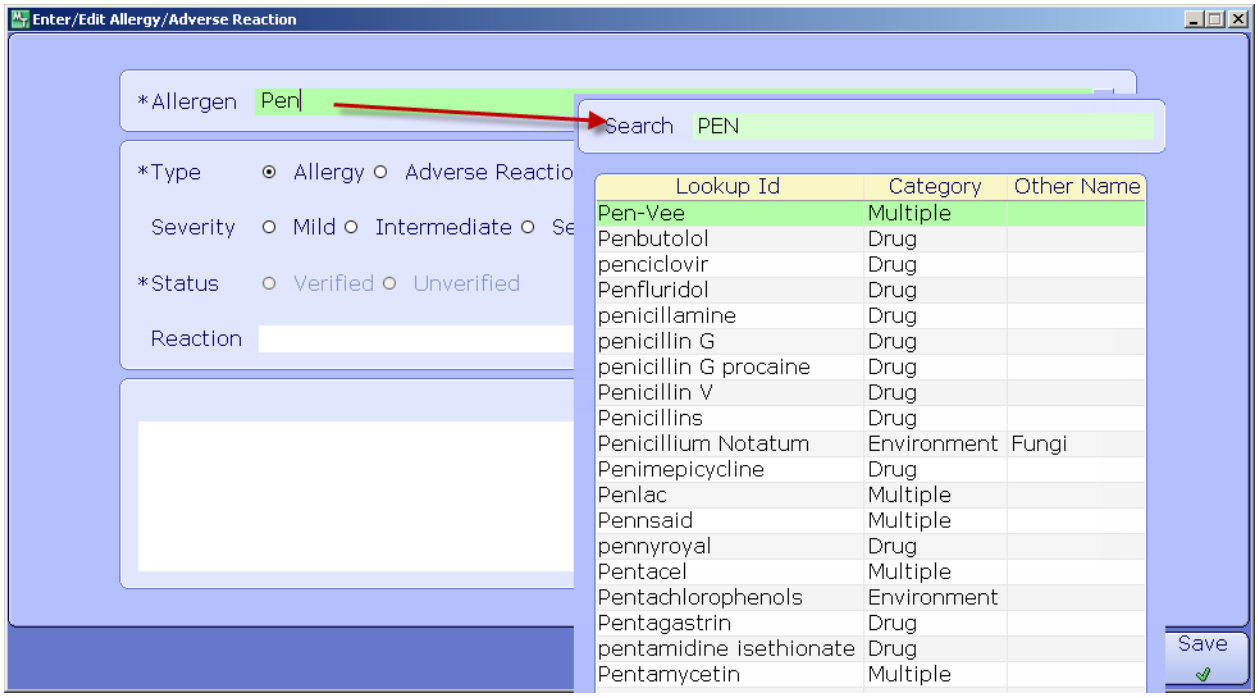
Documenting Allergies

All patients should have their allergies documented electronically. EDM allows nursing staff to easily document allergies by highlighting the correct patient on the tracker and then clicking on the Allergies/Meds button. This opens up the Allergies routine:

For patients with No Known Allergies/Adverse Reactions, you can simply click on the NKA button and save.

For unconscious or uncooperative patients, you can choose the UNOBTN (unobtainable) button. You will then be presented with the allergy entry screen. In the Comment box, enter the reason for not being able to obtain the patient's allergies at this time.

For all other allergies, choose the Enter New button from the bottom and you will be presented with the Enter/Edit Allergy/Adverse Reaction screen. On the Allergen line, type in a few letter of the allergy and hit the down arrow or F9 to look up the allergy in the Allergy directory list.



The same can be done for Reaction. NOTE: Reactions are case sensitive and must be entered in with CAPITALS in order to search the directory.

Save the Allergy and you will automatically return to the Allergy desktop. Save and the Allergy entry is complete.

Note, if an entry of NKA or UNOBTN were previously made on the patient, adding a new allergy will automatically remove the NKA or UNOBTN.

The patient header on your trackers will now show the patient's allergies and the  can be clicked on for more information.