



**Milton Keynes** 

**NHS Foundation Trust** 

**University Hospital** 

# A little book of eCARE for nursing



May 2018

Handy quick reference guides on how to use the system can be found here:

## Nursing Topics

- Where to Start?
- Nursing Workflow
- Types of Documentation
- Where can I get help?
- Top Tips
- If something doesn't work.....
- Adult Quick View
- Adult Assessments
- Tasks
- Care Compass
- Icon Glossary



### Where to Start? Entering the system

- Turn the computer on by pressing the sensitive button on the lower aspect of the computer, which is on the right hand side.
- If a blue screen appears and asks for a password type in your network password that you normally use to access a computer.
- Place your smartcard on/in the reader depending on which device you are using.
- Double click on the eCARE icon on the desktop.
- Locate the icon that is relevant to the part of the system that you need to enter (ED First net, Wards/Departments Power chart). Click on the icon to enter the system.
- You will land on the Home page of the system.



### Where to Start? First things First.....

In order to interact with patients you need to initially search for a patient in the search button on the tool bar, or if you are working on a ward / department you can set up a patient list and identify which location you are working in.

The advantage of clicking on a patient's record in a location list is that you will always have the right encounter in the system. Once the patient has been transferred or discharged from the list they will no longer show in the list.

If you have searched for the patient, the system will show you the patient's encounters. Please be careful to ensure that you pick the right encounter as recording in inpatient settings and outpatient settings are slightly different.



## Where to Start? So you have identified a patient

Once you have double clicked on the patient's name in either the search results or on the patient list it will open the patient's record. The action of opening the record will ensure that you establish an electronic relationship with the patient.

If you want to pick a patient from a location list and you have used care compass, whiteboard or doctor's worklist the patient's name may be greyed out. There is a button at the top of the board where it states 'establish relationship'. Here you can select the whole list of patients or you can select individual patients that you may be interacting with. The system will then ask you to identify your role with the patient.



### Where to Start? Initial assessments

In order to get you started on the system a selection of assessments have been automatically triggered. This occurs when the patient registers into ED or alternatively is registered on the system and is admitted onto a ward/department. These can be found in 'Tasks' and under 'Patient Care'.

The assessments are required to be reviewed when the patient has been in the organization for six hours.

Assessments that are triggered on the system are:

- Adult Basic Admission Assessment (incl. Vitals, GCS, Pain assessment)
- Activities of Daily Living (a holistic overview of how the patient is)
- Environmental Assessment (bed space assessment, specialist equipment)
- Safety Assessment (MUST, Waterlow, Falls, Skin Assessments)

All of these can be found in the tasks in the main menu when in the patient's record.



### Nursing Workflow where do you go next?

Once the initial assessments are completed, the results may trigger alerts if any responses that have been entered require further intervention/review. The alerts pop up on a little window and will suggest :care plans; warnings such as Amber/Red NEWS scores and actions to be taken to escalate and/or will request that you complete a Sepsis Screening Tool if the NEWS score is over 5.



### Nursing Workflow assessments can trigger alerts

Care plans can be reviewed in Requests/Care Plans and will be under the suggested care plans - they can be accepted/rejected. If you accept them you will need to review, initiate and sign the documentation.

Vital observations that create NEWS alerts will require the nurse to manage how the patient's care is escalated. It will normally require increased frequency of vitals. This can be ordered in requests/care plans and Quick Orders with the frequency of assessments required applied.

If the Sepsis Screening Tool is initiated this will require documenting as a priority. If the patient is at risk of Sepsis urgent action and escalation is needed. Time is critical.



### Nursing Workflow Handover, Situation/Background, Assessment and Recommendation

When you have a patients record open, in the menu there is an area called Nurse Workflow. The section is divided into four separate tabs: 1) Handover; 2) Situation/Background; 3) Assessment and 4) Recommendation.

- 1) Handover is a great tool to give an overview of the patient from presenting complaint, past medical history, medication, labs, vitals and any requests/orders the patient may be waiting for. It also enables smooth shift handover with staff documenting (free text) any specific elements that other nurses / MDT may need to see and obviously acts as a clear audit tool for accountability of care transfer from shift to shift.
- 2) Situation / Background consists of an area that has a number of squares with information in them. You can find diet, emergency contact and documents in here. This area can be edited for your personal preference; so if vitals is your main focus when looking after the patient and you like to see that first, you can colour the square and drag and drop the square to the top of the screen if required (you can do that by using the three lines and the arrow, which will allow you to adapt the page as you so wish).



### Nursing Workflow Handover, Situation / Background, Assessment and Recommendation

Continued...

- 3) Assessment tab is where you will find all documents, medication list, labs and any diagnostics the patient may have undergone.
- 4) Recommendation tab is where you will find plans of care, education and the discharge plan.



### **Types of Nursing Documentation: Clinical Note**

		🗇 Full screen 👼 Print 📌 6 minutes ago	
<ul> <li>Construction</li> <li>Const</li></ul>	III April 2018 - 11 May 2018 : 11 out of 11 documents are accessible. (Date Range) In Error Docume         Result type:       Clinical Clerking Note         Result date:       08 May 2018 12:03 BST         Result title:       ESC nursing         Performed by:       ESR SCR CPIS , Five Nurse on 08 May 2018 12:05 BST         Verified by:       ESR SCR CPIS , Five Nurse on 08 May 2018 12:05 BST         Visit info:       4135929, RD8-GH, Inpatient, 28/Mar/18 -         Presenting Complaint         multiple lacerations to hands that keep appearing         No Valid Results       Assessment and Plan         Actice kidney injury stage 2 (disorder)       Clinical Leading Group         Been By: Flynn ,Julian Robert (12/04/18 16:21:00)       Seen By: Seen By (12/04/18 16:21:00)	ents Filtered  Problem List/Past Medical History  Ongoing Safeguarding issues Historical No qualifying data  Pedications  Ingatient  aML/Odipine, 5 mg, oral, ONCE a day Asplini, 75 mg, oral, ONCE a day Asplini, 75 mg, oral, ONCE a day Fertanyi 12micrograms/hour transdermal patches, 1 patch, transDERMAL, every SEVENTY WO hours Folic aidd, 5 mg, oral, ONCE a day Asplini, 75 mg, oral, ONCE a day Asplini, 75 mg, oral, ONCE a day Pertanyi 12micrograms/hour transdermal patches, 1 patch, transDERMAL, every SEVENTY WO hours Folic aidd, 5 mg, oral, ONCE a day Asplini, 75 mg, oral, ONCE a day Paracetamol, 30 gu, oral, TMECE a day Paracetamol, 1 gu, oral, FOUR times a day, PRN Home Paracetamol, 1 gu, oral, FOUR times a day, PRN Home No Known Allergies	<ul> <li>Purpose: for clinical staff to view patient care notes</li> <li>Displays: All power forms, Clinical notes and documentation does not include iView</li> </ul>
<ul> <li>By Type</li> <li>By Status</li> <li>By Date</li> <li>Performed By</li> <li>By Encounter</li> <li>Image: A status</li> </ul>			documentation

### Types of Nursing Documentation: Documents

< 🔹 🛉 Documentation			[□] Full screen 👘 Print 📌 1 minutes ago
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New Note X List			4 Þ
Note Type List Filter:	All (10) Favourites (0)		Q Search
*Type:	*Note Templates		
RRT Note	Anne 🗸	Description	
	Clerking and Post Take Note	Clerking and Post Take Note	
Title:	ED Definitive Assessment	ED Definitive Assessment	
Progress Note	🚖 ED RAT	ED RAT	
*Date:	ED Senior Review	ED Senior Review	
11/May/2018 🗰 0833 BST	🚖 Handover Note	Handover Note	
*Author:	Nurse Handover Template	Nurse Handover Template	
ERS SCR CPIS , Nurse	Outpatient Letter	Outpatient Letter	
	😭 Outpatient Note	Outpatient Note Template	
	📌 Progress Note	Progress Note	
	SOAP Note	SOAP Note	
			OK Cancel

**Purpose:** to create templated documents that draw information from the system

### **Displays:**

Documentation some power forms are not visible in documentation and can be found in forms or clinical note



## Where can I get help (digital)

- eCoach when you are in the eCARE system there is a button called eCoach on the toolbar
- Microsite Digital.mkuh.nhs.uk is the Trust's eCARE microsite. When you enter the site and select 'Info for staff' there are all sorts of things that will help you such as Quick Reference Guides, Videos and frequently asked questions (FAQs)
- IT the team staff a helpdesk and are available on 87000. They will take calls on any issues to do with logging on, role issues, eCARE system issues and, of course, anything wrong with the computer itself.
- Intranet eCARE has it's own section on the Intranet full of useful information. This compliments the information available on the microsite Digitial.mkuh.nhs.uk



## Where can I get help (human)

- Masterclasses after Go Live the eCARE project team will set up a series of masterclasses for those staff that want refreshers or feel that certain processes are taking them too long. Once the system has been live for six weeks Cerner work in collaboration with the Trust and send in a small team of coaching assistants who can ensure that they coach at a local level or share best practice with individuals who may want to know a more efficient way of doing things.
- Training there will be ongoing training made available to all new staff and staff returning from periods of extended leave. This will be advertised on the intranet.
- Superusers in each ward or department Superusers have been identified to ensure there is someone around on each shift to provide at the elbow support for staff. The Superusers will also know how to escalate any concerns and who best to contact for any particular issues.
- eCARE Buddies the buddies are staff that have had additional awareness and training on the system or will have had involvement in the build and design of the software.



## What happens if something doesn't work?

• Escalate, escalate, escalate.....

 If you think that there is something in the system that isn't working as easily as you think it should or if you are clicking on something and nothing is happening then please let IT helpdesk know on ext:87000



### **Adult Quick View**

🗧 🔶 ᠇ 🔥 Assessments/Fluid Balance		[므] Full screen 🖷 Print 之 0 minut
= 📑 🔐 🖌 😥 🗞 📑 🗮 🗙		
Adult Quick View Vital Signs	✓ Last 24 Hours	►
Vital Signs Glasgow Coma Assessment	Find Item  Critical High Low Abnormal Unauth Flag  And  Or	
Pupils Assessment		
Peak Flow	Result Comments Flag Date Performed By	
Point of Care Tests		
Pain Assessment		
Pain Interventions		
Limb Check		
Pulses		
Nurse Rounding		
Environmental Safety Management		
Skin Assessment	11/May/18 ■ 11/May/18 11/May/18 11/May/18	
Skin/Wound Assessment	💐 📝 📴	
Waterlow Assessment	✓ Vital Signs	
Pressure Relieving Equipment	Temperature DegC	
Falls	Temperature Location	
Bed Rails Risk Assessment	Heart Rate bpm	
Education	Respiratory Rate br/min	
Patient and Family Education	SBP/DBP Cuff mmHg	
Behavioural Chart	Blood Pressure Cuff Size	
Last Menstrual Period (LMP)	Blood Pressure Position	
Last Ate or Drank	Mean Arterial Pressure, Cuff mmHg	
	SpO2 %	
	Oxygen Therapy	
	Oxygen Flow Rate L/min	
	Inspired O2 %	
	AVPU Conscious Level	
	Looks unwell:	
	△ Early Warning Score	
	Alert Type	
	♦ Alert Suppress	
	EWS Total	
	EWS Category	
	EWS Type	
	EWS Status	
	△ Pain Assessment	
	Pain Present (or Suspected)	
	Patient Taking Opiates	
	Pt Under 5 or Unable to Communicate	
	LA-	
AdultAssessments	△ Pain Interventions	
Adult Lines - Devices	Pharmacological Therapy	
	Nonpharmacological Therapy	
Fluid Balance		
Kedication Related Monitoring	Patient offered drink Call Bell within Reach	
ED Adult Systems Assessment	Call Bell within Keach Patient Position	

Purpose: Adult Quick View should have all the assessments that you may perhaps find at the end of the bed.



### Adult Assessments

■ ■ ↔ ✓ Ø % ■ ■ ×																		
Adult Quick View	4					Last 24	Hours											
Adult Assessments	Find Item  Critical High					0	And 🔘 🗘											
Respiratory	Find Item   Critical High	Low Abn	ormal 🔄 Una	Jth 🔄 Hag			And 🥑 C	Jr										
Activities of Daily Living Adult	Result Con	nments FI	ag Date		Perfo	ormed By												
Airway Management																		-
Bladder																		
Bladder Scan/Postvoid Residual Bowel																		
Bowel Breath Sounds Assessment																		
Breath Sounds Assessment Cardiovascular																		
Cardiovascular Chest Drains																		
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ECG	in 12 🗗					11/May/1										May/18		
Enema Administration Information	🗮 📈 🗗	09:00 -	g 08:00 - 🕴	07:00 -	06:00 -	05:00 -	04:00 -	03:00 -	02:00 -	01:00 -	00:00 -	23:00 -	22:00 -	21:00 -	20:00 -	19:00 -	g 18:00 -	17:00
Equipment		09:59 BST	08:59 BST	07:59 BST	06:59 BST	05:59 BST	04:59 BST	03:59 BST	02:59 BST	01:59 BST 0	0:59 BST	23:59 BST	22:59 BST	21:59 BST	20:59 BST	19:59 BST	18:59 BS	T 17:59 B
Gastrointestinal	Activities of Daily Living Adult																	
Gastrointestinal Tubes	⊿ Patient Safety and Orientation																	
Gastrointestinal Tubes Genitourinary	Safety and Orientation																	
GI Ostomy	⊿ Communication																	
Haemodynamic Measures	First Language																	
Implanted Devices	Interpreter Required																	
Incentive Spirometry	Any Hearing Problems																	
Interpreter Services	Any Speech Problems																	
Interpreter Services	Any Visual Problems																	
Measurements	Any Problems Understanding																	
Mental Status/Cognition	Capacity to make the required decision?																	
Merical Status/Cognition Musculoskeletal	Communication Care Plan Required																	
MUST Nutritional Assessment	⊿ Breathing																	
Non-Invasive Ventilation	Patient Smokes																	_
Oedema Assessment	Breathing Problems																	
Oxygenation Results	Age Started Smoking																	
Psychosocial	Cigarettes per Day																	
Safe Patient Handling	Ex-Smoker: Date of Cessation																	
Seizure Assessment	Refer to Smoking Cessation Nurse																	
Surgical Drains/Tubes	Breathless at Rest																	_
System Symptoms	Breathless on Mild Exertion																	_
Urinary Catheter	Breathless Lying Down																	_
Urostomy	Breathless After Short Walk																	_
Croatony	Breathless Climbing Stairs																	
	Patient has Dry Cough													L				
	Patient Coughs up Sputum																	
	Nebuliser at Home	_																
A MUSE CONTRACTOR	Oxygen Compressor at Home	_																
dult Lines - Devices	Oxygen Cylinder at Home	_																
luid Balance	Tracheostomy Present on Admission	_																
ledication Related Monitoring	Inhalers Used at Home	_																
ED Adult Systems Assessment	Peak Flow Readings at Home Regular Exercise Taken																	_

Purpose: All other assessments that are on the system should be found in here. If you can't find anything in this section please refer to your folder and review the start, stop, continue as to whether the assessment is still on paper.





> -	🔒 🔒 Task List										[0] Full screen	Print	æ or
86	1 🗴 🔍 🖽												
						Friday 11 May 2018	08:00:00 BST - Friday 11 May	2018 20:00:0	0 BST				
ient Ca	re Nurse Collect/Supply	Referrals	Outpatients	Safeguarding Cases	Safeguarding Alerts								
k retriev	al completed												
	cheduled Date and Time	Task Status	Task Description	1		Order Details		Order Status	Charted By				
	4/Apr/2018 14:48 BST	Overdue	Sepsis Screening						,				
9 \Lambda 04	4/Apr/2018 14:49 BST	Overdue	Sepsis Screening										
	4/Apr/2018 14:49 BST	Overdue	Sepsis Screening	g									
	5/Apr/2018 10:31 BST	Overdue	Sepsis Screening										
	6/Apr/2018 15:53 BST	Overdue	Sepsis Screening										
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ĝ <sup>27</sup>	7/Apr/2018 14:00 BST	Overdue	Environmental S	Safety		Requested Start Da Ordered automatic	ate/Time 27/Apr/18 14:00:00 BST ally on admission.	Ordered					
ŷ <sup>28</sup>	8/Apr/2018 08:00 BST	Overdue	Activities of Dail	ly Living Assessment		Requested Start Da Ordered automatic	ate/Time 28/Apr/18 08:00:00 BST ally on admission.	Ordered					
g 28	8/Apr/2018 08:00 BST	Overdue	Safety Assessm	lent		Requested Start Da Ordered automatic	te/Time 28/Apr/18 08:00:00 BST ally on admission.	Ordered					
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ig 01	1/May/2018 14:00 BST	Overdue	Environmental S	Safety			te/Time 01/May/18 14:00:00	Ordered					
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ý 04	4/May/2018 14:00 BST	Overdue	Environmental S	Safety			te/Time 04/May/18 14:00:00	Ordered					
y 05	5/May/2018 08:00 BST	Overdue	Activities of Dail	ly Living Assessment			te/Time 05/May/18 08:00:00	Ordered					
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g 06	6/May/2018 14:00 BST	Overdue	Environmental S	Safety			te/Time 06/May/18 14:00:00	Ordered					
g 07	7/May/2018 14:00 BST	Overdue	Environmental S	Safety			te/Time 07/May/18 14:00:00	Ordered					
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	1 Mary 2010 10-20 CCT	Dendine	Anti-active Ct			Ordered automatic		Ordered					
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Purpose: these can be reached in various ways in the system but one of the easiest ways is to go into the Task list itself from the Menu section. You can change the order of these by clicking in the column header so you could move the most recent to the top if you clicked on Scheduled Date and Time.



### **Care Compass**

: 🌇 CareCompass	🚮 Home 🖃 Message Centre 🔹 Patient List 🧊 🕻 😋 Insignia 🍃 🗄 🐋 New Sticky Note 🔧	View Sticky Notes 🏥 Suspend 🚽 Exit	🔝 Calculator 🏻 🎢 AdHoo	: IIIIIIMedication Administration	n 🕼 Specimen Collection 🔒	PM Conversation 👻 💦 Dep	art 📴 Communicate 👻 🗎 Me	dical Record Request 🎬 Result Cop	/ 🛄 Relati	ed Records
XXXTEST, BAT	MAN ×								í	Recent • Name • Q
CareCompass									(D) Ful	l screen 🖷 Print 💸 15 minutes ago
	ع الله الله الله الله الله الله الله الل									
Patient List: RD	8-GH Ward 07 🗹 💥 List Maintenance 🛛 🕂 Add Patient 🔹 Establish Relat	onships								🥹 2 🛛 🥹
Location	Patient	Visit				Care Team			EWS T	Activities
Bay 01 - B	A XXXTEST, WOLVERINE           IP         51yrs   Male     No Known Allergies	<ul> <li>multiple lacerations to hands that LOS: 6w 2d</li> </ul>	t keep appearing			Webber , :	lane Elizabeth		12	PRN/Continuous
Bay 01 - B	XXXTEST, SUPERMAN 54yrs   Male     No Known Allergies	 LOS: 18d				O'hara , Ri	chard James		10	
🍪 Bay 01 - B	VXXTEST, HULK 48yrs   Male   Full Resuscitation   Allergies	elective admission for left hip rep LOS: 6w 2d	blacement			Webber , 3	lane Elizabeth		6	131
Bay 01 - B	XXXTEST, IRON MAN 53yrs   Male     No Known Allergies	heart problems LOS: 5w				Webber , 2	lane Elizabeth		7	141
Bay 01 - B	TEST, MEDICAL PATIENT     67yrs   Female     Allergies	abdominal pain LOS: 25d				O'hara , Ri	chard James		6	205 PRN/Continuous
Bay 01 - B	MEDICS, CCCTEST 30yrs   Male     No Relationship Exists	-				-				-
Bay 02 - B	XXXTEST, SPIDERMAN 54yrs   Male   Full Resuscitation   Allergies	Central crushing chest pain LOS: 6w 2d				Webber , 2	lane Elizabeth		7	250+
Bay 02 - B	XXXTEST, BATMAN 53yrs   Male   Full Resuscitation   Allergies	 LOS: 20d				Phillips , De	borah Joan		0	PRN/Continuous
Bay 02 - B	XXXTEST, FLASH 43yrs   Male     Allergies	patient can't keep still, seems ag LOS: 17d	jitated and some of his	actions blurr in front of yo	our eyes	O'hara , Ri	chard James		8	PRN/Continuous
Bay 02 - B	XXXTEST, SAM 30yrs   Male     No Relationship Exists	-				-				-
Bay 02 - B	KEST, SURGICAL PATIENT     68yrs   Male   Do Not Resuscitate, Full Re   No Known Allergies	 LOS: 25d				Phillips , De	borah Joan		8	19
Bay 02 - B	XXXTEST, THOR 408-009-2075     47yrs   Male   Full Resuscitation   No Known Allergies	Painful left wrist after fall onto o LOS: 6w 2d	utstretched hand			Webber , :	lane Elizabeth		7	26
Bay 03 - B	HACK, MIKE 41yrs   Male     No Relationship Exists	-				-				-
Bay 03 - B	EDWARDS, BRENDA 470-686-8068					-				
Activity Timeline	70ure   Female     No. Relationshin. Eviste									•
Overdue	10:00 11:00 12:00	13:00	14:00	15:00	16:00	17:00	18:00	19:00	20:00	21:00

Purpose: The care compass will probably be a nurse's most regular port of call to see patients and look at activities. You can access tasks, patient visit details and it allows you to have an overview of all your allocated patients at any one time.



### **Navigation Toolbar**

Button	Action
	Home. Takes you to the Home view. By default, the Home view includes the Inbox Summary and Schedule, however, this view can be customized by your systems administrator to suit your facility's needs.
	Schedule. Opens the Schedule workspace. The Schedule allows you to see your schedule and those of others, in daily, weekly, and monthly views.
Å	Patient Chart. Opens the Patient list. The Patient list is a listing of all individuals that have a chart in the system.
	Message Center. Opens Message Center. Message Center allows you to quickly view and sign Results, Documents, Messages, and Orders. Through it, you can communicate with other clinicians.



#### **Patient Context Toolbar**

Button	Action	
BettyClark 🛛	<patient> Indicates which patient's chart is currently active.</patient>	
	Recent Patients. Allows you to open the chart of a patient that you recently viewed.	
٩	Patient Search. Allows you to search for a patient's chart by patient name or Medical Record Number (MRN).	
2	As of. Tells you the last time the data on the display was refreshed. Click to perform a manual refresh.	
<b>~</b>	Previous Patient's Chart. Opens the chart of the patient listed just before the current patient.	
➡	Next Patient's Chart. Opens the chart of the patient listed just after the current patient.	
	reference guides on how to use the system can be found here: igital.mkuh.nhs.uk/info-for-staff/quick-reference-guides/	

### **Flowsheet Toolbar**

Besides the general patient chart toolbar, the Flowsheet has a special toolbar that enables you to perform specific tasks quickly. A description of the buttons and their actions follows:

Button	Action
<mark>ីរិង</mark> Graph	Generates a graph illustrating the selected data categories. See Graphing a Patient's Test Results
Seeker	Opens the Seeker to allow you to focus on an area of the flowsheet that contains results. Critical result values are represented in red. Areas of intense result activity are displayed with a wide bar; individual results are displayed as a line.
Bign	Allows you to sign all discrete results you have ordered but have not yet signed. Only the results in view on the screen are endorsed.
🛞 Bookmark	Marks all new results values as reviewed (read). If you have selected a font color for new results, this changes all the new results colored values to the default text color. Critical values retain their special color.
Sign Charting	Saves and signs any charting you have entered on a custom or activity flowsheet.
Cancel Charting	Cancels the charting session without saving any data.



### **PowerNote Toolbar**

<u>~</u>	Open an Existing Note. Lets you select an encounter pathway, and open encounter and pre-completed notes. The Open Note dialog box opens.
<b>2</b>	
	Save. Saves your work.
	Sign. Lets you sign the current encounter note. The Sign Note dialog box opens.
*	Cut. Reserved for future use.
	Copy. Places a copy of the selected text onto the clipboard.
<b>6</b>	Paste. Copies the text from the clipboard.
44	Find the Specified Term. Lets you search for specific text. The Find dialog box opens.
3	Print. Opens the print dialog box for your printer.
4	Find Previous Recommended Term. Locates the next recommended term (indicated by blue text).
4	Find Next Recommended Term. Locates the previous recommended term (indicated by blue text).



### Numbers to help you

Superuser (insert the number of your local Superuser here)

IT helpdesk ext: 87000

A little ebook of eCARE Nursing

Compiled by Sharon Webb, Chief Nursing Information Officer - May 2018

