PICIS

System Configuration Guide

Anesthesia Manager

PACU Manager

Critical Care Manager

Preop Manager

Picis Perioperative and Critical Care 10.0

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Refer to the *Release Notes* for date of manufacture.

Document may include cautionary statements.

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Unique Device Identifier (UDI)	For UDI information, refer to the *Release Notes*.

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1

Introduction

Overview

This manual describes the configuration of Provy Manager, Anesthesia Manager, PACU Manager and Critical Care Manager. All the aspects of the configuration also affect eVitae. You can customize each application and the contents of the database to support the practices of individual departments or caregivers.

The manual primarily describes the following configuration tools:

- **Customizer**. For configuring applications at "template" workstation and system-wide levels.
- **DB Editor**. For configuring clinical items in the CAR database and for maintaining application security in systems that do not integrate with CIP Manager.

  Note: "CAR" is the name given to the database used by Provy Manager, Critical Care Manager, Anesthesia Manager and PACU Manager.

- **ADT Administrator**. For configuring Census List windows for the different applications (this program can also be used for ADT actions such as transferring and discharging patients).

Configuration is typically performed by an implementation specialist when the system is installed. However, a user with access to these tools can modify configuration settings at any time.

If you are upgrading your system from a previous version, please refer to the Technical Upgrade Guide.

Note: In this manual, references to file paths assume that Pcts software has been installed in the default installation folder, "\InProgramFiles\InPcts\". If this is not the case, you should adjust the paths accordingly.

Note: Screenshots in this guide were taken using various operating systems. Color schemes, fonts and borders may appear differently in your operating system.

What's New

New in Pcts 19C

You can now create a hospital-level quality measure form using the Forms Builder in Customize. End users complete and submit the form as needed. A new tool allows hospital administrators to create NHSN-compliant XML reports of submitted forms for sending to appropriate agencies.

For more information, see:

Quality Measure Forms on page 79
The Export Tool for Quality Measures on page 373

Background Concepts

Orders Integration

Pcts programs can integrate with external orders systems, such as a Physician Orders Entry System (POES). Note that nothing specifically needs to be done with Customize or DB Editor to allow orders integration.

Multibed Workstations

Unlike bedside workstations, multibed workstations are not associated with specific patient locations, but instead allow users full access to a group of patients in a department.

This type of workstation is appropriate for low-acuity recovery units, and clinician work and lounge areas. Users at these workstations can typically view and document data for all patients that are listed in the Census window. The bedside workstation type continues to be appropriate for patients in operating rooms and other high-acuity areas.

The workstation type is selected during installation. After installation, you must create an entry for each host in the units served by multiple workstations.

Note: You can change the workstation type at any stage using the configuration tool (see the Server Installation Guide) or DB Editor (see Image Management and Patient Locations on page 321).

Remote Access Type

This workstation setting determines the type of access users have to remote patients. "ViewChart" allows charting. "View Only" allows viewing but no charting. This configuration is designed for doctors' lounges or ICU rounds rooms where charting and order entry are needed. Multihead workstations with View-only access may be situated at the front desk of an operating room department for viewing data for patients in different operating rooms.

You configure a workstation's access type (ViewChart or View only) using Customize.

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Customize

Customize Overview

Actions you can perform with Customize fall into the following general categories:

- Creating "printout models"
- Creating a hospital-level quality measures form
- Setting up "configuration sets" and "workgroups"
- Editing a configuration set. (This consists of editing "application templates", Proxy Manager settings and workstation settings as well as assigning and configuring printout models for configuration sets.)

Note: If your site uses "Content Library" database content and configurations, the amount of configuration you need to do should be minimal. (Please see the Content Library Guide for more details.)

Nomenclature

A **configuration set** is a combination of application templates, Proxy Manager settings and workstation settings. All settings are stored in the CAR database.

Application Templates are settings used by Anesthesia Manager, PACU Manager and Critical Care Manager. A patient's chart is based on the template selected at the start of the session. Customize allows you to configure templates to support the practices of individual departments or caregivers.

Workgroups are logical computer groupings to which configuration sets can be applied.

Printout models are customizable templates used to create physical or PDF printouts.

Starting and Quitting Customize

Customize is typically available at each workstation where Anesthesia Manager, PACU Manager or Critical Care Manager is installed. You must be a member of a user group with the system right Customize to open it.

Start Customize

1. Click **Start** > **All Programs** > **Picis Products** > **Utilities** > **Customize**.
2. Enter a valid user name and password to log on to the system.

Note: If your system is configured to use Directory Services Authentication, the **Change Password** button is disabled and a control for choosing the **Domain** may be present.

Quit Customize

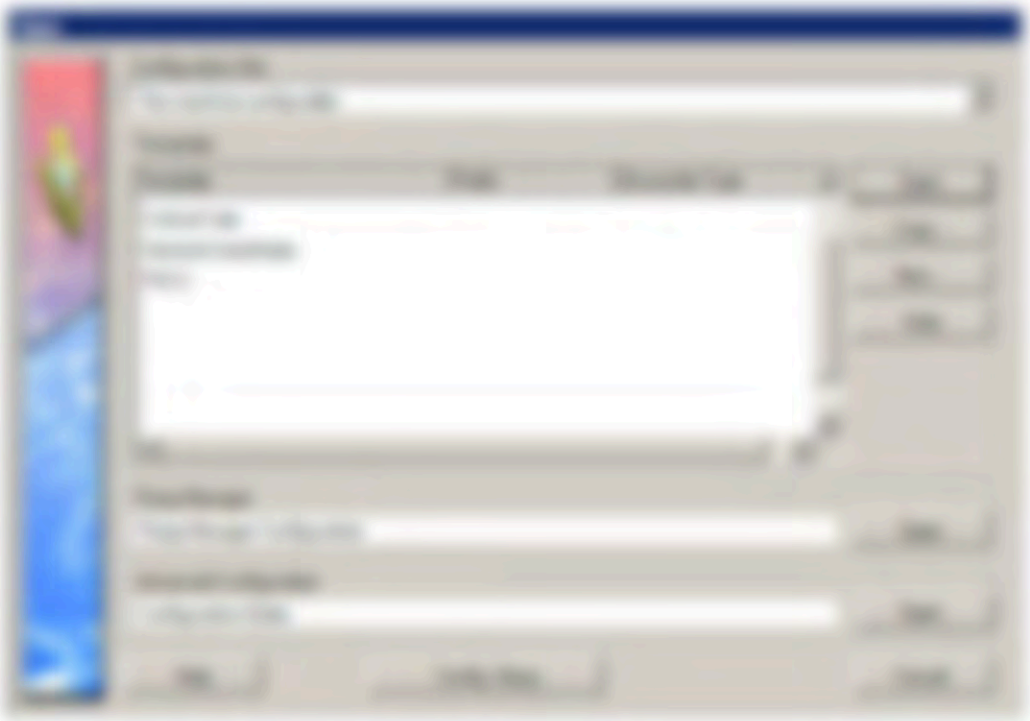
- On the **File** menu, click **Exit**.

Working with Customize

When you open Customize only the **File** and **Help** menus are initially available and there is just one button (the **Open** button).

The **File** menu provides access to the **Picis Printout Builder**. Use this to create printout models and apply them to configuration sets. The Picis Printout Builder is described in section Printout Models on page 21.

The **Open** button provides access to the "Open" window. Use this to configure template, workstation and configuration set settings.



The "Open" window with example templates.

(Templates appear after you select a configuration set.)

The different elements of this window are described in the following table.

Element	Description of use
Configuration set	You must select the configuration set that you want to edit prior to opening either a template, the Proxy Manager configuration, or the advanced configuration. (The only part of the program you can access without first selecting a configuration set is the configuration setup, via the **Config. Setup** button.) The list of configuration sets includes "This machine configuration" and "Hospital configuration" plus other configuration sets used by the hospital. **Note:** Users with restricted system rights will only be able to choose "This machine configuration". When working with "This machine configuration" any setting that you perform affects only the local workstation. When working with "Hospital configuration" any setting that you perform affects all workstations in the system except where settings are overridden by lower level configuration sets.

Element	Description of use
Templates	After selecting a configuration set, you can open a template for editing, create a brand new template, copy a template or hide a template. **Editing**. Any template edits you make are on machines linked to the selected configuration set. Note that besides template-specific settings opening any template also gives you access to the "Workstation" menu, which provides a subset of the most common workstation settings. Although these settings can also be changed using the configuration editor the advantage of using the Workstation menu is that editing is restricted to valid values. **Copying**. After clicking **Copy** you can copy a template from any configuration set to any other configuration set. (You do not need to select a template before clicking **Copy**.) **Hiding**. You can hide a template so that it does not appear at machines linked to the selected configuration set. For more information, see Hiding Templates on page 113. **Note**. The Prefix and Encounter Type settings are read-only. If you need to change the prefix or encounter type of an existing template you must use **DB Editor**. For more information, see Auxiliary Databases Tables on page 245.
Pweje Manager "Open" button	After selecting a configuration set, you can click this button to edit Pweje Manager settings.
Config. Setup	Click this button to create configuration sets and workgroups and to link configuration sets to workgroups (which effectively assigns the configuration sets to workstations). **Note**. Additional security rights are required to use this feature. The button will be disabled for users without such rights.

Editing a configuration set - what you can do

- Edit a template. For more information, see What You Can Configure on page 109.
- Create a new template. For more information, see Working With Templates on page 110.
- Create a copy of a template. For more information, see Working With Templates on page 110.
- Edit workstation settings. For more information, see Workstation Configuration on page 117.
- Edit Pweje Manager settings. For more information, see Pweje Manager Configuration on page 201.

Note: Prior to any of these actions you must first select an appropriate configuration set from the drop down list.

Setting up workgroups and configuration sets - what you can do

- Create workgroups and assign computers to them. For more information, see Creating and Editing Workgroups on page 21.
- Create/edit configuration sets and assign them to workgroups. For more information, see Creating, Editing and Assigning Configuration Sets on page 20.

The Customize Toolbar

After opening a new or existing template the following toolbar is available:

Opens the "Open" window. (For more information, see Working with Customize on page 33)

Saves any changes made to the open template and workstation settings

Advanced Settings window. (For more information, see The Advanced Settings Window on page 173)

Configuration Parameters opens to the Preferences tab)

Physiologic Variables

Protocols

Events

Fluid Balance

Patient Summary

Medication Summary

Demographics Editor

Trends

Flowsheets

Timers

Quick Links

Welcome

3

Configuration Sets and Workgroups

About Configuration Sets and Workgroups

Configuration sets

Proxy Manager settings, application templates and workstation settings and can be combined in a "**configuration set**". You can use Customizer to create and edit configuration sets and assign them to groups of workstations, called "**workgroups**".

Configuration sets are stored in the database; when Proxy programs run they retrieve setting values from the configuration sets that are assigned to their workgroup.

Any given workstation has multiple configuration sets applied to it. Configuration sets are applied in the following order:

1. Proxy default configuration.
   Contains all required entries with their respective default values. The Proxy default configuration cannot be edited.
2. Hospital configuration.
   Used for general hospital settings that differ from the Proxy default configuration. (The hospital configuration is applied to all workstations in the system regardless of whether or not they are assigned to workgroups.)
3. Configuration sets assigned to computer "workgroups".
   Used for settings that apply to some workstations, but not others. You can specify the order in which they are applied.
4. The local workstation configuration.
   This is listed as "This machine configuration" in Customizer.

Used for settings that apply only to this local workstation.

Note: In this guide, the different types of configuration set are also referred to as "levels", with the "highest" level being the Prizo default configuration and the "lowest" level being the local workstation configuration.

Note: For servers, only the Prizo default configuration and the local workstation configuration are applied.

If the same entry has different values in different configuration sets, the value used by the software is that of the last configuration set applied to the workstation. (See the examples at the end of this section.)

Note: An entry can be a list of items. In the case of conflicts between such entries the software uses the entire list from the last configuration set applied to the workstation (there is no merging of list items from different configuration sets).

Configuration set versions

Configuration sets can be versioned — you can create updated versions of the same name and make any version the active version. When you create a new configuration set it is given the version number "1". Each time you create a new version it is an exact copy of the highest available one and the version number incremends by 1. When you open a configuration set in Customize it is always the last version that is edited.

You can only set one version as the active version. This is the version that will be applied to computers.

Note: By default, a new configuration set version is deactivated. When it is ready to be applied to workstations, you should set it as the active version.

CAUTION: Customize always opens the latest version of a configuration set for editing. After creating a new version of a configuration set, you can no longer edit an earlier version.

The Hospital Configuration

The hospital configuration cannot be versioned. Because of this and to reduce complexity, edits to the hospital configuration should be kept to an absolute minimum. It should only include settings that are common to all workstations and unlikely to need changing with time, such as the GUI language or print server network address. It should not include rule templates.

Best Practice: Even if your Prizo system consists of a single department with identical workstation settings, create a configuration set for this whole department rather than entering all configuration parameters at the hospital level.

"This Machine Configuration"

Local machine configurations are useful for testing configuration changes prior to applying them to other machines. However, the configurations cannot be accessed remotely. Because of this, Prizo recommends that for testing the effect of configuration settings you proceed as follows:

a. Create a "test" configuration set with a name that includes the machine name.
b. Create a "test" workgroup containing only the test workstation.
c. Apply the "test" configuration set to the "test" workgroup.
d. Edit the "test" configuration set as required.

Workgroups

Configuration sets are applied to computers via "workgroups". **Workgroups** are logical computer groupings. Configuration sets are linked to computers in the following way:

- You create workgroups and add computers to them.
- You assign configuration sets to workgroups.

Note: A computer can only belong to one workgroup.

Note: A configuration set can be applied to more than one workgroup.

Note: A workgroup can have multiple configuration sets applied to it. (You can set the order in which the configuration sets are applied.)

Examples

In the following examples, configuration sets A and B are applied to the same workgroup and configuration set B is applied after configuration set A.

Example 1

Configuration set	Value of a certain parameter
Prizo default	0
Hospital	5
Configuration Set A	not set
Configuration Set B	not set
Local workstation	not set

Configuration Sets and Workgroups

Result: The value 'A' gets applied to the workstation.

Example 2

Configuration set	Value of a certain parameter
Price default	A
Hospital	A
Configuration Set A	A
Configuration Set B	not set
Local workstation	not set

Result: The value 'A' gets applied to the workstation.

Example 3

Configuration set	Value of a certain parameter
Price default	A
Hospital	A
Configuration Set A	A
Configuration Set B	B
Local workstation	not set

Result: The value 'B' gets applied to the workstation.

Example 4

Configuration set	Value of a certain parameter
Price default	A
Hospital	A
Configuration Set A	A
Configuration Set B	B
Local workstation	M

Result: The value 'M' gets applied to the workstation.

Creating and Editing Workgroups

This section describes how to perform the following tasks:

- View the computer/workgroup assignments
- Create a workgroup
- Add workstations to a workgroup
- Rename a workgroup
- Delete workgroups

Note: The Configuration Management system right is required for these tasks.

(For information on creating and editing configuration sets, see Creating, Editing and Assigning Configuration Sets on page 23.)

Best Practice: Keep the number of workgroups to a minimum to reduce maintenance.

Best Practice: Create a workgroup named DMXzUTE for Prizo workstations that are no longer used. Do not assign any configuration sets to the workgroup.

Best Practice: Create a workgroup named DRM DBLT for Prizo workstations that only have "administrative module" programs installed. Do not assign any configuration sets to the workgroup.

View the computer/workgroup assignments

1. In the "Open" window, click **Config**, **Setup**.
2. Click the **Computers and Workgroups** tab.
   Unassigned computers are shown in the left pane, assigned computers are shown in the right pane beneath the names of the workgroups to which they are assigned.
3. If necessary, filter the list of unassigned computers by entering text in the **Computer name filter** box. Only computer names that contain the text will be listed. (To remove a filter, click the **x** on the right side of the filter box.)
4. If necessary, filter the list of assigned computers by entering text in the **Workgroup/ Machine name filter** box. Only computer names that contain the text will be listed. (To remove a filter, click the **x** on the right side of the filter box.)
5. Click **Close**.

Create a workgroup

1. In the "Open" window, click **Config**, **Setup**.
2. Click the **Computers and Workgroups** tab.
3. Click **Add**.

4. In **Description**, enter a workgroup name and click **OK**.
5. If necessary, filter the computers as described in the previous procedure.
6. Add one or more computers to the workgroup by selecting the computer name(s) on the left and then clicking the double right-arrow.

   Note To select multiple computers, hold down the shift or ctrl key while you click the items. Shift allows you to select adjacent items. ctrl allows you to select non-adjacent items.

7. Click **Close**.

Add workstations to a workgroup

1. In the "Open" window, click **Config. Setup**.
2. Click the **Computers and Workgroups** tab.
3. If necessary, filter the computers as described in Step 3 in the previous procedure.
4. Select one or more computers in the left pane.

   Note To select multiple computers, hold down the shift or ctrl key while you click the items. Shift allows you to select adjacent items. ctrl allows you to select non-adjacent items.

5. Either...

   Select the workgroup name in the right pane and then click >>.

   Or...

   Use "drag and drop" functionality. Click the selected computers, keep the left mouse button pressed while you move the cursor directly above a workgroup name in the right pane and then release the mouse button.
6. Click **Close**.

Remove workstations from workgroups

1. In the "Open" window, click **Config. Setup**.
2. Click the **Computers and Workgroups** tab.
3. If necessary, filter the computers as described in Step 3 in the previous procedure.
4. Select one or more computers in the right pane.

   Note To select multiple computers, hold down the shift or ctrl key while you click the items. Shift allows you to select adjacent items. ctrl allows you to select non-adjacent items.

5. Either...

   Click <<.

   Or...

Use "drag and drop" functionality. Click the selected computers, keep the left mouse button pressed while you move the cursor anywhere in the left pane and then release the mouse button.

8. Click **Close**.

Rename a workgroup

1. In the "Open" window, click **Config**, **Setup**.
2. Click the **Computers and Workgroups** tab.
3. If necessary, filter the computers as described in Show the computer/workgroup assignments on page 27.
4. Select a workgroup in the right pane and click **Edit**.
5. In **Description**, modify the workgroup name.
6. Click **Close**.

Delete workgroups

1. In the "Open" window, click **Config**, **Setup**.
2. Click the **Computers and Workgroups** tab.
3. If necessary, filter the computers as described in Show the computer/workgroup assignments on page 27.
4. Select one or more workgroups in the right pane.

   Note: To select multiple workgroups, hold down the SHIFT or CTRL key while you click the items. SHIFT allows you to select adjacent items. CTRL allows you to select non-adjacent items.

5. Click **Delete**.
6. Click **Close**.

Creating, Editing and Assigning Configuration Sets

This section describes how to perform the following tasks:

- Show configuration sets and their assignments to workgroups
- Create a configuration set
- Create a new version of a configuration set
- Rename a configuration set
- Delete a configuration set
- Select the active version of a configuration set
- Deactivate a configuration set
- Edit a configuration set

3 Configuration Sets and Workgroups

- Assign configuration sets to a workgroup
- Edit a configuration set

(For information on assigning configuration sets to computers, see Creating and Editing Workgroups on page 27.)

Note: For all of these tasks except editing a configuration set, the Configuration Management system right is required.

Best Practice: Keep the number of configuration sets to a minimum to reduce maintenance.

Best Practice: Before editing a configuration set, create a new version and keep it inactive until it is ready to be applied to workstations.

Best Practice: Before editing a configuration set, make sure the machine is in a workgroup that has the configuration set applied to it. This will allow you to see the effect of configuration changes at that workgroup. (If an edited configuration set is also applied to other workgroups Pcm+ recommends that you verify application behavior at a workstation belonging to each of those workgroups following any changes.)

CAUTION: Pcm+ recommends that your hospital establishes communication guidelines to avoid multiple users editing a configuration set at the same time. (Customize does not prevent simultaneous editing and the results can be unpredictable.)

View configuration sets and their assignments to workgroups

1. In the "Open" window, click **Config**, **Setup**.
2. Click the **Configuration Sets and Workgroups** tab.
   The left pane shows all configuration sets; assigned configuration sets are shown in the right pane beneath the names of the workgroups to which they are assigned.
3. If necessary, filter the list of unassigned configuration sets by entering text in the **Configuration Set name filter** box. Only configuration set names that contain the text will be listed. (To remove a filter, click the x on the right side of the filter box.)
4. Click **Close**.

Create a configuration set

1. In the "Open" window, click **Config**, **Setup**.
2. Click the **Configuration Sets and Workgroups** tab.
3. If necessary, filter the configuration sets, as described in the previous procedure.
4. Click **Add**.

5. To start with a blank configuration set (based on the Pros default configuration), select **New blank configuration set**.
6. To start with a copy of an existing configuration set, select **Based on an existing configuration set** and then select the configuration set that you want to copy from the drop-down list.
7. Click **OK**.
   The new configuration set is created and a window such as the following opens:

8. In **Description**, type a name for the configuration set.

   Note: The hash character, #, is not permitted at the beginning of the name.

9. Click **OK**.
10. Click **Close**.

Create a new version of a configuration set

1. In the "Open" window, click **Config, Setup**.
2. Click the **Configuration Sets and Workgroups** tab.
3. If necessary, filter the configuration sets as described in *Show configuration sets and their assignments to workgroups on the previous page*.
4. Select a configuration set and then click **Edit**.
   (You can filter the list of configuration sets by entering text in the **Configuration Set name filter** box. Only configuration set names that contain the text will be listed.)
5. Click **New version**.
6. In **Description**, enter a name for the version and click **OK**.
7. To set the version as the active version, select the checkbox next to it.
8. Click **OK**.
9. Click **Close**.

Rename a configuration set

1. In the "Open" window, click **Config, Setup**.
2. Click the **Configuration Sets and Workgroups** tab.

3. If necessary, filter the configuration sets as described in View configuration sets and their assignments to workgroups on page 29.
4. Select a configuration set and then click **Edit**.
   (You can filter the list of configuration sets by entering text in the **Configuration Set name filter** box. Only configuration set names that contain the text will be listed.)
5. In **Description**, change the name.
6. Click **OK**.
7. Click **Close**.
8. Restart Customize for the change to be reflected in all parts of the application.

Delete a configuration set

1. In the "Open" window, click **Config. Setup**.
2. Click the **Configuration Sets and Workgroups** tab.
3. If necessary, filter the configuration sets as described in View configuration sets and their assignments to workgroups on page 29.
4. Select a configuration set and then click **Delete**.
   (You can filter the list of configuration sets by entering text in the **Configuration Set name filter** box. Only configuration set names that contain the text will be listed.)
5. Click **Yes** when prompted for confirmation.
6. Click **Close**.

Select the active version of a configuration set

1. In the "Open" window, click **Config. Setup**.
2. Click the **Configuration Sets and Workgroups** tab.
3. If necessary, filter the configuration sets as described in View configuration sets and their assignments to workgroups on page 29.
4. Select a configuration set and then click **Edit**.
   (You can filter the list of configuration sets by entering text in the **Configuration Set name filter** box. Only configuration set names that contain the text will be listed.)
5. Select the checkbox next to the version that you want to activate.
6. Click **OK**.
7. Click **Close**.

Note: Only one version can be active at a time.

Deactivate a configuration set

1. In the "Open" window, click **Config. Setup**.
2. Click the **Configuration Sets and Workgroups** tab.

3. If necessary, filter the configuration sets as described in View configuration sets and their assignments in workgroups on page 29.
4. Select a configuration set and then click **Edit**.
   (You can filter the list of configuration sets by entering text in the **Configuration Set name filter** box. Only configuration set names that contain the text will be listed.)
5. Clear the checkbox next to the active version to deactivate it.
6. Click **OK**.
7. Click **Close**.

Edit a configuration set

- In the "Open" window, select the configuration set you want to edit in the **Configuration Set** drop-down list.

  Note: If you do not have the Configuration Management system right only "This machine configuration" will be available to you. Any edits you perform will only affect the local workstation.

  Any editing you perform will affect the selected configuration set. If the configuration set is active you will be shown a warning message indicating that any edits you make will affect any machines linked to the configuration set.

  You have the following options:

  - Edit a template. For more information, see What You Can Configure on page 139.
  - Create a new template. For more information, see Working With Templates on page 139.
  - Create a copy of a template. For more information, see Working With Templates on page 139.
  - Edit workstation settings. For more information, see Workstation Configuration on page 171.
  - Edit Proxy Manager settings. For more information, see Proxy Manager Configuration on page 181.

Note

Besides using Customize, you can also edit configuration sets as follows:

- Use Anesthesia Manager, PACU Manager or Critical Care Manager to create screen layouts and link them to configuration sets. For more information, see the Workstation User Guide.
- Use ADT Administrator to create census lists and link them to configuration sets. For more information, see Census Windows on page 275.

Assign configuration sets to a workgroup

1. In the "Open" window, click **Config. Setup**.
2. Click the **Configuration Sets and Workgroups** tab.

3. If necessary, filter the configuration sets as described in Show configuration sets and their assignments to workgroups on page 29.
4. Select one or more configuration sets in the left pane.

   Note: To select multiple configuration sets, hold down the Shift or Ctrl key while you click the items. Shift allows you to select adjacent items, Ctrl allows you to select non-adjacent items.

5. Either:

   Select the workgroup name in the right pane and then click OK.

   Or:

   Use "drag and drop" functionality. Click the selected configuration sets, keep the left mouse button pressed while you move the cursor directly above a workgroup name in the right pane and then release the mouse button.

   Note: Customize will add a prefix number next to the configuration set name indicating the order in which it will be applied to the workgroup. Number 1 is applied first, then number 2 and so on. In the case of conflicting settings, the last of the relevant configuration sets applied takes priority.

6. If you apply more than one configuration set to a workgroup you can use the **Up** and **Down** buttons to change the order in which they are applied.
7. Click **Close**.

Example: This example shows two workgroups for computers within the OR department. For each workgroup, a common configuration set is first applied and then an area-specific configuration set. Settings from the specific configuration sets override those of the common configuration set.

- Anesthesia Workgroup
  - OR Dept Configuration Set
  - Anesthesia Configuration Set
- PACU Workgroup
  - OR Dept Configuration Set
  - PACU Configuration Set

Remove configuration sets from workgroups

1. In the "Open" window, click **Config. Setup**.
2. Click the **Configuration Sets and Workgroups** tab.
3. If necessary, filter the configuration sets as described in Show configuration sets and their assignments to workgroups on page 29.
4. Select one or more configuration sets in the right pane.

Note: To select multiple configuration sets, hold down the Shift or Ctrl key while you click the items. Shift allows you to select adjacent items. Ctrl allows you to select non-adjacent items.

3. Either...

   Click **Remove**.

   Or...

   Use "drag and drop" functionality. Click the selected configuration sets, keep the left mouse button pressed while you move the cursor anywhere in the left pane and then release the mouse button.

4. Click **Close**.

Configuration Troubleshooting

This section describes the troubleshooting steps to perform when faced with certain issues related to configuration sets. Perform the steps in the order shown.

Edits made to a configuration are not reflected in the end user application at a certain machine

For the sake of brevity, this configuration is referred to as "the edited configuration" in the following steps.

1. Restart the application concerned and check if the issue persists. If it does, proceed to the next step.
2. Check that the machine is classified as a workstation (the hospital configuration and configuration sets are never applied to servers).

   In DB Editor, drill down to the **Departments and Locations** > **Locations** folder and check the machine type of the machine. It should be null or "CSP". If it is one or the other, proceed to the next troubleshooting step. Any other value indicates the machine is set up as a server.
3. (Skip this step if the edited configuration is the hospital configuration). Check that the last revision of the edited configuration set is active. If it is not, set it as active.
4. (Skip this step if the edited configuration is the hospital configuration). Check that the edited configuration is applied to the workgroup that the machine is in.
   a. Identify the workgroup that the machine is in.
   b. Check that the edited configuration is applied to this workgroup. If it is not, determine if this is an error or "by design" and proceed accordingly. If it is, proceed to the next step.
5. Check that the expected value is not overridden by a value from another configuration.
   a. Open "This machine configuration" at the machine concerned. In the Configuration Editor, open the section containing the entry that was edited and check the text shown in the "Configuration Set" column for that entry. The text indicates the origin of the value that is eventually applied at the workstation. If the origin is not the configuration that you edited,

determine if this is an error or "by design" and proceed accordingly. If the origin is the configuration that you edited, proceed to the next step.

8. Close this and your application concerned. In Windows Explorer, search for the file CustomConfigCache.cmi and delete it. Restart the application and check if the issue persists.

An expected template from a configuration set is not shown in the template list

This has likely been set up this way by the system administrator to restrict editing of templates that are not applicable to the workgroup that the workstation belongs to. Contact your System Administrator for more information.

4

Printout Models

Note: Excel-based printout are no longer supported for new or upgrading customers. Printout models are considerably easier to create and maintain using the Printouts Builder and do not require either Microsoft Excel or a CPS server.

Note: This section describes how to create and deploy printout models. For information on configuring how these models are used, please see the following sections:

Template-level printout settings: Printouts (template settings) on page 111

Workstation-level printout settings: Printout Viewer (workstation settings) on page 225 **and** Automated Printouts (workstation settings) on page 228

About Printout Models

The Price Printouts Builder allows you to create complex printout templates, called "models". After creating a printout model you assign it to configuration sets. All workgroups to which those configuration sets are applied, and users can select the linked printout model when printing.

Printout models consist of one or more "sections". When printed, each section starts on a new page so will generate at least one printed page. However, there is no direct correlation between the number of sections and the number of printed pages. In the Printout Builder a section may look like a single page, but when filled with real pattern data it can correspond to more than one page.

Printout Models

About Printout Models

Sections contain "blocks" that pull in patient data from the database when the printout is created. The section's layout type determines how blocks position themselves on the page and how the blocks respond to overflowing data. (For information on layout types, see Layout Types on page 71.)

Besides layout type, each section can have its own page orientation (landscape or portrait), header and footer.

Workflow for Creating and Deploying a Printout Model

A typical workflow for creating and deploying a printout model is as follows:

1. Create the first version of the model.
2. Create library items that you may need — images and custom query blocks. (Library items you create are available for all printout models.)
3. Set the page size, margins and global font. (This is the default font. It can be overridden in a block's properties.)
4. Create one or more sections.
5. For each section, configure the header, footer and layout style.
6. For each section, add blocks and containers as required.
7. Rearrange sections as required.
8. Preview the model.
9. Publish the model.
10. Link the published model to configuration sets.

The model becomes available for use at workstations to which those configuration sets are applied.

Opening and closing the Printout Builder

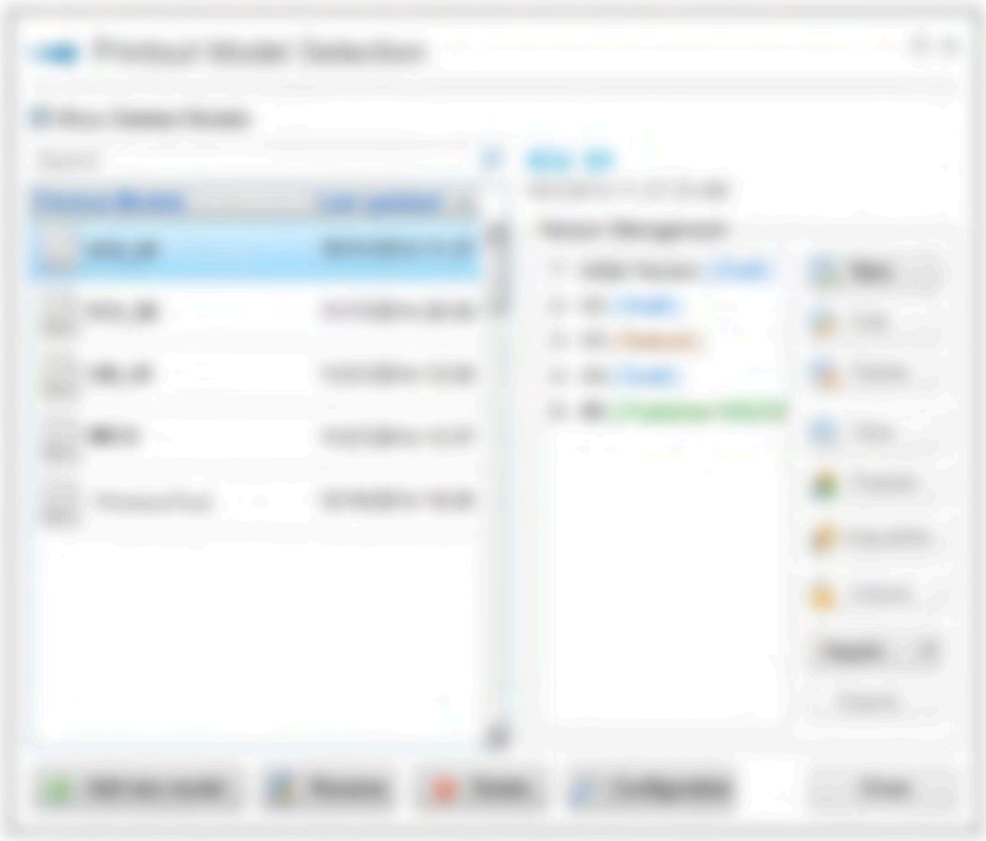
Open the Printout Builder

1. Start Customize, as described in Starting and Quitting Customize on page 13.
2. On the **File** menu, click **Forms Builder** → **Printouts**.
   The Printout Model Selection window appears.

Close the Printout Builder

- Click **Close**.

The Printout Model Selection Window



The left side of the window shows the printout models available.

The right side of the window shows the versions available for the selected model and their status – draft, published or retired. (In the screenshot V3 was the first published version. This version was automatically retired when V4 was published.)

This window is the starting point for creating and editing models (and versions of them) and for assigning models to configuration sets. You can also use this window to create backups and copies of printout models/versions.

Hide/show deleted models

- To show deleted models, select **Show deleted models** at the top of the window.

  Deleted models are shown in italics.

Search for a model

- You can also search for models by name - as soon as you start typing in the **Search** field the pane will display only the entries whose names contain the typed text.

Sort the list of models

- To sort the list of models alphabetically, click the column header "**Printout Models**". (Click the header a second time to reverse the order.)
- To sort the list of models by date (most recent first), click the column header "**Last updated**". (Click the header a second time to reverse the order, so that the earliest is first.)

Create a new model

1. Click **Add new model**.
2. In the window that appears, type a name for the model and click **OK**.
   The Printout Builder window opens for editing.

Note: The first time that you create or open a printout model after starting Customize it can take several minutes to open.

Note: Even if you do not make any edits yet you must save the model when closing the Printout Builder in order for the model to be created correctly.

Rename a model

1. Select the model and click **Rename**.
2. In the window that appears, type a new name for the model and click **OK**.

Delete a model

1. Select the model and click **Delete**.
2. You will be shown a warning message. Click **Yes** to proceed.

Note: The name of the model will appear in italics in the Printout Selection window if **Show deleted models** is selected). It will no longer be available at any workstations. (However, a broken link between the model and any configuration sets that is applied to is maintained. If you later restore the model it will be linked to the configuration sets that it was linked to at the time of deletion.)

Restore a deleted model

1. Select the deleted model.
   When you do this, the "**Delete**" button changes to an "**Enable**" button.
2. Click **Enable**.

Printout Models

The Printout Model Selection Window

Back up a printout model version

1. In the left pane, select a model.
2. In the right pane, select a version of that model.
3. Click **Export**.
4. Browse to the folder where you want to store the printout model file, type a name for it and click **Save**.

The file is saved with the extension .DPMX (Open Printout Model).

Create a new printout model by copying an existing model version

1. In the left pane, select the model you want to copy.
2. In the right pane, right-click the particular version you want to copy and select **Copy as new model**.
3. In the window that appears, type the name you want for the new model and click **OK**.
4. The new model is added to the list of models and opens for editing.

Create a new printout model version by copying an existing model version

1. In the left pane, select the model you want to copy.
2. In the right pane, right-click the particular version you want to copy and select **Copy as new version**.
3. In the window that appears, type the name you want for the new version and click **OK**.
4. The new version is added to the list of versions for the currently selected model.

Create a new printout model by importing a backup

1. Back up the printout model version that you want to duplicate following the "Back up..." step-by-step procedure.
2. Click **Import** > **Import as a new model**.
3. Browse to the folder where the backed up (DPMX) file is located, select it and click **Open**.
   The printout model opens for editing.

Note: Even if you do not make any edits yet you must save the model when closing the Printout Builder in order for the model to be created correctly.

Create a new printout model version by importing a backup

1. Back up the printout model version that you want to import following the "Back up..." step-by-step procedure.
2. In the left pane, select the model into which you want to import the printout model version.
3. Click **Import** > **Import as a new version**.
4. Browse to the folder where the backed up (DPMX) file is located, select it and click **Open**.

The printout model version opens for editing.

Note: Even if you do not make any edits yet you must save the version when closing the Printout Builder in order for the model to be created correctly.

Versioning and Publishing

When you create a printout model, it has an initial Version with the status "Draft".

Versions in draft status can be edited, but are not available to end users.

Best Practice: When editing a model, create new versions as you go along. Versions serve as backups that you can easily revert to if needed.

When you have finished editing a model, you must publish it before you can assign the model to a configuration set and make it available for end users. After publishing the model you can no longer edit the published version. The status changes to "Published".

If you want to make further edits to a model after publishing it, create a new version. (The new version will initially look just like the version it is based on.) Edit the new version as required. When you are ready to replace the published version with the new version, just publish it. This will publish the new version and retire the previously published version, setting its status to "Retired". At end user workstations where the printout model is available, the new published version automatically replaces the retired version. (End users only ever see the name of the model, not the version.)

When a version is opened for editing it becomes locked. The lock prevents Customize users at other workstations from simultaneously editing the same version. Those users see a padlock symbol next to the version name, together with the name of the user who is holding the version. Sometimes the lock may need to be removed manually (for example, if a user's machine freezes or if a user is off work sick while still logged in to the application).

Create a new version

1. Select the model in the left pane.
2. On the right, click **New**.

A new version will be created based on the last version of the model.

Open a version for editing

1. Select the version in the right pane.
2. Click **Edit**.

Delete a version

Note: Deleting a version is permanent. Unlike deleting a printout, the action cannot be reversed.

1. Select the version in the right pane.

2. Click **Delete**.

Open a print preview for a version

1. Select the version in the right pane.
2. Click **Print**.

Publish a version

1. Select the version in the right pane.
2. Click **Publish**.

Note: Publishing a version automatically retires the previously published version of the same printout model.

Unlock a locked version

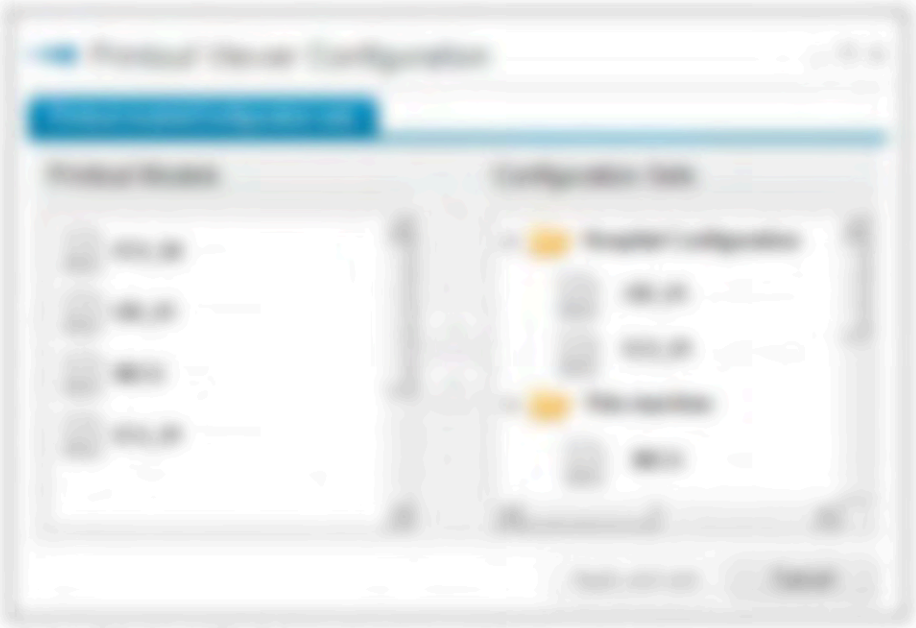
1. Select the version in the right pane.
2. Click **Unlock**.

Assigning Models to Configuration Sets

After publishing a model, you can assign it to one or more configuration sets. (The model will then become available at workstations to which the configuration set is applied.)

Assign a model to a configuration set

1. Click **Configuration**.
   The Printout Viewer Configuration window appears. The left pane shows published printout models.



2. Under **Printout Models**, select a model.
3. Under **Configuration Sets**, select a configuration set.
4. Click the right arrow ( ) to assign the selected model to the selected configuration set.
5. Click **Apply and exit**.
   A confirmation message appears.
6. Click **Close**.

Remove a model from a configuration set

1. Click **Configuration**.
2. In the **Configuration Sets** pane, locate the configuration set that you want to remove the model from and select the model beneath it.
3. Click the left arrow ( ) to remove the selected model from the configuration set.
4. Click **Apply and exit**.
   If any automated printout instance is associated with the model (see Automatic Printouts: workstation settings on page 228) a warning message will advise you that the instance will not execute correctly if you choose to proceed.
   A confirmation message appears.
5. Click **Close**.

The Printout Builder Window

Best Practice: Before editing printouts, check the setting of the Printout Builder autosave feature. For more information, see Print options on page 223.

When you open a version for editing, the Printout Builder window appears. The window has four areas:

- **Top**: Ribbons with page/section controls and other configuration settings
- **Center**: Design area
- **Left**: Drag- and-drop components
- **Right**: Properties for the component that is selected in the Design Area

Ribbons

Ribbon	Used for
Home	Opening, saving, renaming, publishing and previewing a printout model Creating/deleting library query blocks Creating/deleting library images
Printout	Naming printout versions Configuring the global font setting for the printout Setting printout page size and margins Adding and removing printout sections
Section	Naming and ordering printout sections Setting section orientation (portrait, landscape) Adding/removing a section header/footer Setting section layout type (fixed - continuous)

Note: Changing to another ribbon does not affect what is shown in the design area.

Components

The components area contains standard provided "blocks" as well as any custom query blocks that you create yourself. It also contains "containers". (For information on containers, see Containers on page 15.)

Blocks are loosely categorized by their type.

Basic Blocks

Barcode — a barcode generated from a specified patient identification field.

Field — a set of handy fields that you can add to the printout. (For example, the number of pages in the printout.)

Image — any image from the image library. Often used in headers.

Label — used to add free text to the printout. (Includes standard Rich Text Formatting capability.)

Preop Data — Data that is usually entered in Preop Manager during the preoperative evaluation

Anesthesia Plan

Body Systems

4

Printout Models

The Printout Builder Window

Vital Signs

Admission Data — Data that is usually entered in the ADE before the Pcis session starts

Asim Ad/Ab/Bd/Ab/Bd/Blood Type

Anesthesia Times

ASA Level

Chief Complaints

Demographics

Diagnoses

Documents

Emergency Contact(s)

Home Medications

Hospital Information

Medical Team

Miscellaneous (from the Demographics window)

Notes (Demographics)

Patient Identification

Procedures

Required Events

Patient Record Data — Data that is usually entered during the session

Allergies

Assessments

Billing Information

Events

Fluids Detail

Fluid Balance

Fluids In

Fluids Out

Insurance Coverage

Laboratory

Medications

Medication Details

Notes (Patient Summary)

Nursing Care Details

Physiologic variables

Precautions

Scores

Trends

Waveforms* (this block can only be added to a continuous section and cannot be in a container)

Sepsis Notifications* (this block shows user documentations related to sepsis notifications. It does not show the notifications themselves.)

(*For customers that have purchased this functionality.)

Containers

Fixed container

Auto-fit container

(For more information on containers, see Containers on page 75.)

Query blocks

Query-based blocks that your site has created

Selected Block Properties

Each component has properties that you can edit once the component is in the design area. You edit a component's properties in the "Block Configuration" panel to the right of the design area.

When opening a printout for editing, the Block Configuration panel is collapsed. There are two ways to expand it:

- Right-click the component in the design area and select **Properties**.
- Select the component in the design area and then click **Block Configuration** to the right of the design area.

For detailed information on block properties, see the following section.

Block/Container Configuration

For containers, the only property that you can set is the font size.

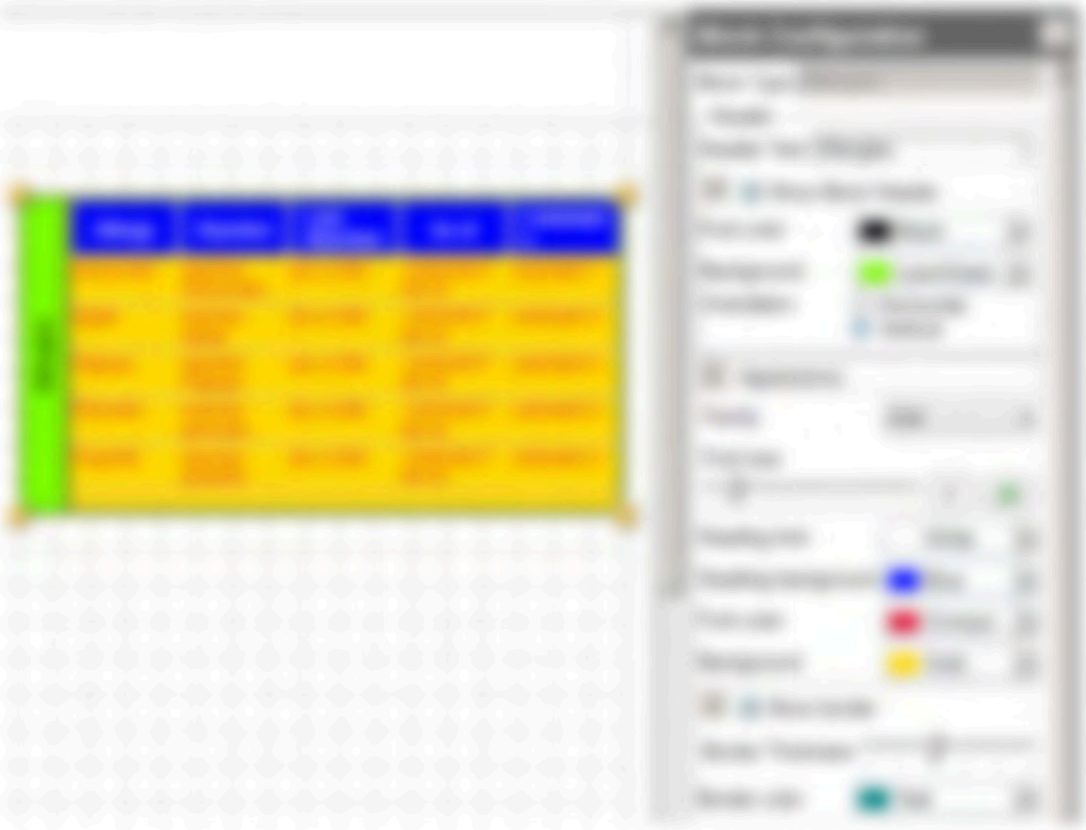
Note: For containers, the font size controls the font size used by all blocks within the container except those for which a specific font size has been set locally in the properties of the block.

For blocks, there are a number of standard properties possessed by all blocks as well as some block-specific properties.

Standard properties for blocks

The following properties are standard for many blocks. (Notes are provided for settings that are not self-explanatory.)

Formatting controls



Notes

- If you specify a particular font size for a block it will no longer respond to font size changes made for the whole printout (or for the container if the block is in a container). You can revert

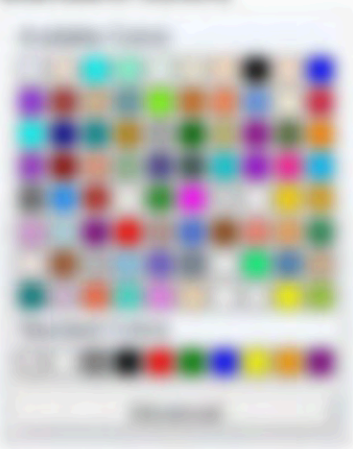
the font size back to the default by clicking this button . After you do this, the block will resume responding to font size changes made at the container and product levels.

- For more information on color settings, see [Standard colors on the next page] and [Advanced colors on the next page].
- The **Heading Font** and **Heading Background** settings refer to column headings. The **Font color** and **Background** settings below those refer to table body rows.
- Settings in the **Show Block Header** section all refer to the block header.
- The **Orientation** setting for headers determines whether the header ran horizontally across the top of the block or vertically down its left side.

Other Controls

Sort Sort by date ascending Sort by date descending	**Notes:** • Some blocks have additional sort options.
Format Tabular Comma-separated Single Line	(Blocks with a column structure only) **Tabular**: Data arranged in a grid structure. (If you select this, the **Show column headers** setting appears). **Comma-separated**: Each entry has comma-separated values and entries are separated by line breaks. (If you select this setting, a **Columns** setting appears. This allows you to specify the number of columns you want across the page. Data will wrap within each column and spill over from one column to the next (newspaper style). **Single Line**: Each entry has comma-separated values, but in this case there are no line breaks; entries are separated by semi-colons.
Columns	Select the columns that you want to show in the block.
Ordering	Select the fields that you want to display in the block and use the Up and Down arrows to change the order in which you wish to display them.

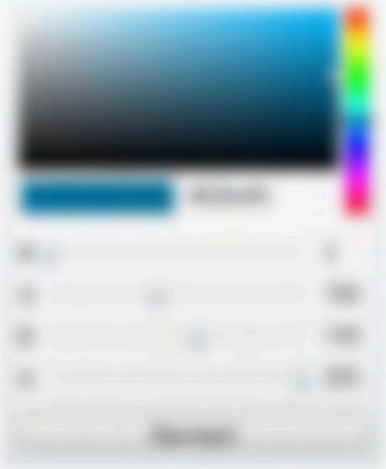
Standard colors



Colors are listed in alphabetical name order. (The first color in the top left appears to be white but is actually "AliceBlue".) You can see the name of a color by moving the cursor over it -- a tooltip with the name is displayed.

Select a color or click **Advanced** to access the entire range of colors.

Advanced colors



This window allows you to select a color in three ways:

Option A: First change the slider position on the vertical color bar to the region of color that you are interested in. Then in the central window click the precise color that you want.

Option B: Type the hexadecimal code for the color in the central field. (Note that you can also paste a value into this field.)

Option C: Enter an RGB value by either dragging the RGB sliders to the values that you want or typing a value in the field to the right of each slider.

Note: The slider labeled "A" stands for "Alpha channel". Drag this slider to set the transparency of the item (header text or header background) if needed.

Column widths

For tabular blocks that do not represent flowsheet data (for example, the Events block) you can adjust the widths of all columns. (For blocks representing flowsheet data, you can only adjust the width of the first column as described in the following section.)

- To change the width of any column, first move the cursor over the dividing line to the right of the column until the cursor changes as follows:

Then click the dividing line and hold down the mouse button as you drag it to the desired width before releasing the button.

Block-specific Properties

This section describes the following blocks:

- Allergies
- Anesthesia Plan
- Assessments
- Barcode
- Body Systems
- Events
- Field
- Fluid Balance
- Fluids In
- Fluids Out
- Image
- Label
- Laboratory
- Medication Details
- Medications
- Notes
- Physiological variables
- Query Blocks
- Required Events
- Required Events
- Sepsis Notifications
- Trends
- Waveforms
- Vital Signs

Allergies

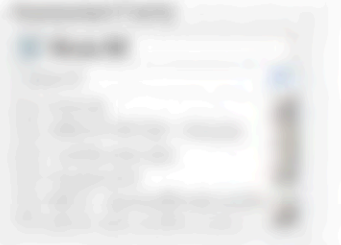
Show	Specify whether to show medication allergies, other allergies, or both.

Anesthesia Plan

Anesthesia Plan Types	Select the anesthesia plan types that you want to show in the block. To show all types, click **Show All**.
Columns	Allows you to specify the number of columns you want across the page. Data will wrap within each column and split over from one column to the next (newspaper style).

Assessments

Assessment Family – **Show All** – **Search**	Select the families you want to be displayed. To select all families, click **Show All**. To select specific families, click them individually. You can also search for entries by name - as soon as you start typing in the **Search** field the panel will display only the entries whose names contain the typed text.



Barcode

Patient ID	Select the barcode source. Choose from the following identifiers: • Account Number • PTID1, PTID2, PTID3 • ADMID1, ADMID2, ADMID3
Show value in text format	Select this option to show the text equivalent immediately below the barcode. Note that the overall block height is not affected.

Body Systems

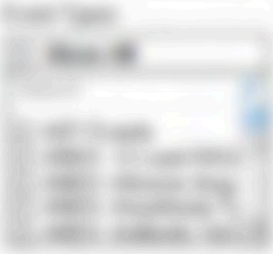
Body Systems Exam Type	Select the body system exam types that you want to show in the block. To show all types, click **Show All**.
Columns	Allows you to specify the number of columns you want across the page. Data will wrap within each column and split over from one column to the next (newspaper style).

Demographics

Ordering	Besides selecting the fields that you want to display in the block and the order in which you want to display them, you can also rename the field titles.

Events

Group by Event Type	Select this to display events grouped by event type. The groupings are presented in alphabetical order of event type (though the Event Type itself is not displayed). Within each event type grouping, the associated events are listed according to the **Sort** setting.
Event Types – **Show All** – **Search**	Select the event types you want to be displayed. To select all event types, click **Show All**. To select specific event types, click them individually. You can also search for entries by name, opt each as you start typing in the **Search** field the pane will display only the entries whose names contain the typed text.



Field

Alignment Left Center Right	Specify the text alignment—left aligned, center aligned or right aligned.
Field Library	Select the field that you want to show on the printout. – Name – Page number – Printed date – Printout – #Fields, #Fields, #Fields – Total pages – User

Fluid Balance

Family Behavior	Specify the fluid types and families to show in the block. Click the check box next to a fluid type (blood products, drips, urine, IV Fluids etc.) to select all families of that type. Alternatively, click the drop-down arrow next to the fluid type to display the families and then select just the families you want to be shown.

Fluids In

Only print documented fluids	Select this setting if you only want to print documented fluids. When this setting is cleared, there will be an empty row for each undocumented fluid.
Interval in minutes	Set the time in minutes that each column will correspond to. 5, 10, 15, 20, 30 or 120.
Family Behaviors	Specify the types of fluid to show in the block, choosing from blood products, drips, and IV Fluids. **Note:** If you want each type to be shown in its own block you can do so by adding multiple instances of the Fluids In block and setting the Family Behavior of each block accordingly.
Number of columns	Specify between 1 and 24 time columns to show on one page. **Note:** In addition to the specified time columns there is always a "Total" column on each page showing the totals for the covered period. For blood products and IV fluids, the Total column shows the total volume. For drips, the Total column shows either the total volume or the total dose depending on the configuration.
Width	Enter the width (in pixels) of the first column. (Other columns adjust their size automatically depending on the **Number of columns** setting.)
Show dose for drips	For drips only. Select this option if you want the block to show doses (such as mg/kg/min). When this option is cleared, drips show volume rates (such as 5L/h).
Show dose for drips (Total)	For drips only. Select this option if you want the "Total" column to show the total dose. When this option is cleared, the "Total" column shows the total volume.

Note: You cannot show boxes when there are mixed products or N Scale in the stock. If you select either of the above settings, the other field types become "greyed out" to indicate that they will not appear.

Provide Data

Interval in minutes	Set the time in minutes that each column will correspond to: 5, 10, 15, 20, 30 or 120.
Number of columns	Specify between 1 and 24 time columns to show on one page. **Note:** In addition to the specified time columns there is always a "Total" column on each page showing the total volumes for the covered period.
Width	Enter the width (in pixels) of the first column. (Other columns adjust their size automatically depending on the **Number of columns** setting.)

Image

Image Library **Search**	This pane shows icons for all images in the Image Library. To see the full size version of an image, move the cursor over its icon. You can also search for images by name – as soon as you start typing in the **Search** field the pane will display only the images whose names contain the typed text.	
Stretch to fit	Select this option if you want your image to be proportionally resized to fit the container. When this option is cleared, the image appears at its full size. If the image is larger than the block it will be cropped.	
Transparency	Drag the slider to set the image transparency.	

Label

Caption	Type the text that you want to appear in the label. Format the text using the standard document formatting controls in the local toolbar. **Tip:** The text in block headers is always left justified. If you want a particular block's header to be center justified or right justified, hide the header and instead use a suitably formatted label block, positioning it in the same place where the other block's header would be.

Laboratory

Analysis – **Show All** – **Search**	Select the analyses you want to be displayed. To select all analyses, click **Show All**. To select specific analyses, click them individually. You can also search for entries by name - as soon as you start typing in the **Search** field the pane will display only the entries whose names contain the typed text.

Medication Details

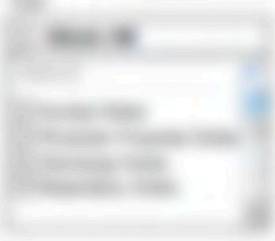
Columns	Select the columns that you want to show in the block.

Medications

Include absolute dose for patient weight	If you select this option, for each medication that is based on patient weight two rows will be shown – one for the dose relative to patient weight (e.g. 1 mg/kg) and another with the absolute dose taking the patient's weight into account (e.g. 70mg, for a 70 kg patient).
Interval in minutes	Set the time in minutes that each column will correspond to: 5, 10, 15, 20, 30 or 120.
Form	Select this option if you want the medication name to include the form in which the medication was administered e.g. capsule.
Number of columns	Specify between 1 and 24 time columns to show on one page. **Note**: In addition to the specified time columns there is always a "Total" column on each page showing the total volumes for the covered period.
Width	Enter the width (in pixels) of the first column. (Other columns adjust their size automatically depending on the **Number of columns** setting.)
Only print documented medications	Select this setting if you only want to print documented medications. When this setting is cleared, there will be an empty row for each undocumented medication.

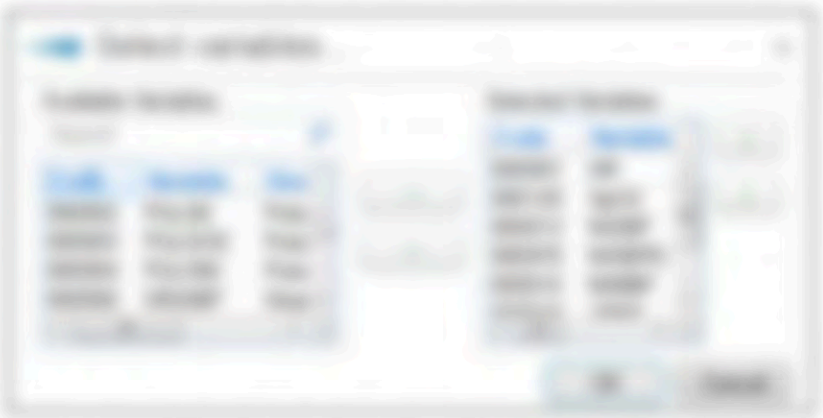
Notes

Type	Select the Patient Summary note types you



Show All **Search**	want to be displayed. To select all note types, click **Show All**. To select specific note types, click them individually. You can also search for entries by name - as soon as you start typing in the **Search** field the pane will display only the entries whose names contain the typed text.

Physiological variables

Insert Emergency Data	Select this option to include any emergency data columns in the block.
Select variables... **The pane at the bottom of the Properties window shows the variables selected for display.**	1. To change the selection (or the order in which variables display) click **Select variables**. The following window appears:  2. In the left pane, select the variables you want to display in the block and then click the right arrow ( ). **Filtering** You can filter the view to show specific variables - as soon as you start typing in the **Search** field the pane will display only the variables whose names contain the typed text. **Selecting Items** You can hold down the SHIFT key and click the first and last items in a group of contiguous items to select all of them. You can hold down the CTRL key and click individual items to make a multiple selection. 3. To change the position in which a variable is displayed, select the

	variable in the right pane and click the up ( ) or down ( ) arrow as required. 4. To remove variables from the selection, select the variables in the right pane and click the left arrow ( ). 5. Click **OK**.
Snapshot	Select this option to include any snapshot columns in the block.
Interval in minutes	Set the time in minutes that each column will correspond to: 5, 10, 15, 30, 60 or 120. **Note:** Columns show the last values received in the time period that they represent rather than the mean values.
Number of columns	Specify between 1 and 24 time columns to show on one page. **Note:** If the block includes snapshot or emergency data columns these are included in the column count. **Example:** You set an interval of 60 minutes and 24 time columns per page. Ordinarily, this would cover a whole day on each page that the block is printed. However, if a printed block on a page includes one snapshot then the total period covered on that page will be reduced to 23 hours.
Width	Enter the width (in pixels) of the first column. (Other columns adjust their size automatically, depending on the **Number of columns** setting.)

Query Blocks

Columns **Header**	To change a column header... 1. Click **Columns** and select the column identifier. 2. In **Header**, type the text you want as the column header.
Edit SQL	Select to edit the SQL query code, change the column widths or change the block title. Configuration is performed in the same way as when creating a query block. For more information, see Custom Query Blocks on page 72. **Note:** Changes only affect the current block, the library item on which the block is based is not modified.

Required Events

Show	Specify whether to include milestone events, other events, and required types.

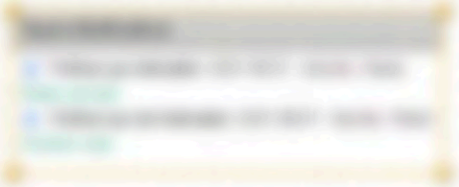
Scores

Show Score Items	Select this checkbox to show items beneath score totals. (Otherwise, only the totals are shown.)
Score Family – **Show All** – **Search**	Select the families you want to be displayed. To select all families, click **Show All**. To select specific families, click them individually. You can also search for entries by name—as soon as you start typing in the **Search** field the pane will display only the entries whose names contain the typed text.

Sepsis Notifications

Show Notification Details	Select this setting to show additional details for each documentation — abnormal values that triggered the notification and any checkbox responses made by the user.

Checkbox cleared



Checkbox selected

Notifications – **Show All**	This section is designed for future use. For this release, **Show All** and **Sepsis Notifications** should always be selected.

Search

Trends

The **Interval in minutes**, **Number of columns**, and **Select variables** settings behave the same as those of the same name for the Physiology Variables block. See the information on that block.

Trend Setup

Click to open the Trend Setup window and configure how each selected variable appears in the Trends block.

1. If you want an overall y-axis for all trends, under **Options**, either set the axis range in the **From** and **To** boxes or, if you want the y-axis to adjust automatically to the data received, select **Auto-scale**.
   This axis is applied to all variables that do not have an independent y-axis defined.
2. Set characteristics for each variable, as follows:
   - Under **Style**, select a type of graph (line, scatter or bar).
   - Under **Color**, click the drop-down box and select a color.

     Note: The color does not affect markers; they are always black. This means that for scatter-style trends, the color only affects the y-axis (if the variable has its own y-axis).

   - Under **Markers**, select a character if you are configuring a scatter graph. For line graphs, markers are optional.
   - To display the value for each data point, click the **Value** check box.

If the typical range of values for a parameter is not compatible with the overall y-axis (vertical), create a separate y-axis for the parameter. Click the **Y-Axis** check box and enter the range for the axis in the **Point** and **To** boxes.

Vital Signs

Vital sign names	Select the vital signs that you want to show in the block.
Columns	Allows you to specify the number of columns you want across the page. Data will wrap within each column and spill over from one column to the next (newspaper style).

Miscellaneous

Paper speed	Set the x-axis scale by selecting one of the following "speeds" (mm/s): 1, 5, 10, 12.5, 25, 50. Select the fields that you want to be displayed.
Fields visibility	⚠ **CAUTION** To avoid any possible confusion by people reading the printout, make sure **Scale** and **Grid** are selected.

Tags

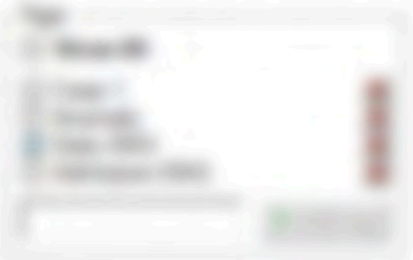
This section allows you to create tags, which end users can assign to waveform snapshots in Anesthesia Manager etc.

To create a tag, enter a name for it in the empty field and then click **Add tag**. (To remove a tag, click the red x next to it.)

Note: When you create a tag it becomes available for all printout models, not just the one you are editing. If you remove a tag, it is removed from all printout models for which it is selected.

For each tag, you can specify whether you want waveform snapshots with that tag to be displayed in the printout.

If you do not select any tags or if you select **Show All**, then all waveform snapshots are displayed, both tagged and untagged.



Printout Management

This section describes standard tasks using the following commands on the Home ribbon:

- Open
- Save
- Rename
- Publish
- Close
- Preview

Switch to another printout model or version

- On the **Home** ribbon, click **Open**.

The printout model you are viewing closes (prompting you to save changes if there are any) and the Printout Model Selection window opens.

Save changes to the version

- On the **Home** ribbon, click **Save**.
- Alternatively, click CTRL S.

Rename the version

1. On the **Home** ribbon, click **Rename**.
2. In the window that appears, type a new name for the version and click **OK**.

Publish the version

- On the **Home** ribbon, click **Publish**.

Note: You cannot "un-publish" a version. If you want to immediately make a published version unavailable at end-user workstations, delete the model (you can later restore it if needed.).

Note: You can also publish a version from the Printout Model Selection window.

Close the version

- On the **Home** ribbon, click **Close**. (You will be prompted to save the version if changes have been made.)

Preview the version to see how it will look when printed

You can create a preview of a 4 hour period using dummy data or (if you have the necessary system rights) you can create a preview using real data by selecting a suitable patient and period.

- To create a preview of a 4 hour period using dummy data, on the **Home** ribbon, under **Print Preview**, click **4 Hours** and then click **Preview**.

  The Print Preview window appears.

- To create a preview using real data, on the **Home** ribbon, under **Print Preview**, click **Select Patient** and then click **Preview**.

  The Census List window appears. Select a patient and then click **Open**.

  The Printout Viewer window appears. Select a time period to print and then click **Print**.

  The print preview is shown in the right pane.

Working in the Preview window

You can move between pages using the scroll bar on the right.

You can search for text by typing it in the search box at the bottom.

You can perform various actions from the toolbar:

- Print. (Opens the Print window from which you can select a printer and print to it.)
- Copy selected text to the operating system's clipboard
- Zoom in
- Zoom out
- Reset zoom to 100%
- Zoom to the page width
- Zoom to see the full page
- Zoom to see two pages

Creating Library Items

You can create two types of library item for use in any printout model:

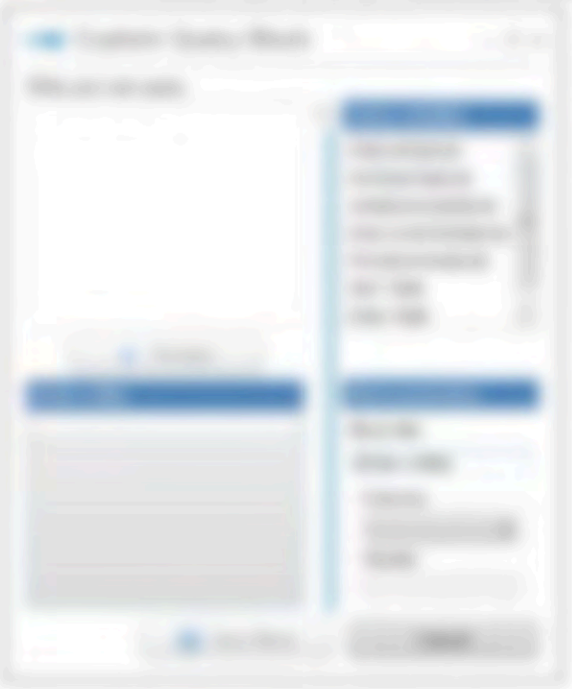
- Custom query blocks
- Images

Custom Query Blocks

Custom query blocks give access patient information that is not accessible with standard blocks. You create custom query blocks by writing or pasting an SQL query into a blank block (Upgrading sites that are currently using Excel-based printouts can also create a custom query block by importing from an .INI file.)

Create a custom query block

1. On the **Home** ribbon, under **Standard Libraries**, click **Query Blocks** > **New Query Block**.



2. Under **Block title**, enter a title for the block.
3. Under **Write your own query**, type the SQL query or paste it from a third-party application.

   Note: The **Query variables** list contains variables to help you restrict the amount of data shown as well as other handy variables.

Example:
Use Time table the code @Time, Datatill patientaltbund limits data to the current patient

Double-click a variable to add the corresponding SQL code at the cursor position.

4. Click **Preview** to see a preview of how the block will look on a printout using fictitious data. You will be shown error messages for any SQL errors, the preview will only be shown when all issues have been fixed.

   Note: Once the preview is successful you will be able to rename column headers and save the block.

5. To rename a column header, select the column from the drop-down list under **Columns** and then enter the name in the **Header** field.
6. To change the width of any column, first move the cursor over the dividing line to the right of the column until the cursor changes as follows:

Then click the dividing line and hold down the mouse button as you drag it to the desired width before releasing the button.

7. When you are done, click **Save Block**.

Example

This example shows the SQL query used to retrieve all time column names from the patient's chart in the selected timeframe:

```
declare @chartid as integer, @_startdate, @_enddate,
-- Create Procedure Report_ [ ] @chartid [ ] @_startdate, @_enddate, [ ]
as begin
-- Insert statements for procedure here
declare @date1 as [date] = @_startdate, @date2 as [date] = @_enddate
if @chartid = 0 or @chartid = '' set @chartid = NULL
if @_startdate = '' or @_enddate = '' set @_startdate = NULL
select
declare @chartid [ ] @chartid, @_startdate, @_enddate,
-- Insert statements for procedure here
declare @date1 = [date] @_startdate, @date2 = [date] @_enddate
if @chartid = 0 or @chartid = '' set @chartid = NULL
if @_startdate = '' or @_enddate = '' set @_startdate = NULL
select
end
-- Create Procedure Report_ [ ] @chartid [ ] @_startdate, @_enddate, [ ]
as begin
-- Insert statements for procedure here
declare @date1 as [date] = @_startdate, @date2 as [date] = @_enddate
if @chartid = 0 or @chartid = '' set @chartid = NULL
if @_startdate = '' or @_enddate = '' set @_startdate = NULL
select
end
```

If you were to copy/paste this code into a custom query block and click Preview you would see columns similar to the following:

chartid [int]	default [int]	[date]
[null]	[null]	[date]

Note: When copy/pasting make sure that special characters like quotation marks and operators (=, <) are retained.

For sites upgrading from Excel-based printouts only: Create custom query blocks from an .IM file

1. On the **Home** ribbon, under **Standard Libraries**, click **Query Blocks** > **Import .IM file**.
2. Browse for an (Excel) printout .IM file and click **Open**.
   A window appears showing the blocks from the .IM file that can be imported. (Only those containing SQL).
3. Select one or more blocks and click **Import selected blocks**.

Note: To select more than one block, you can hold down the Shift or Ctrl key while you click. Shift allows you to make adjacent selections. Ctrl allows you to select non-adjacent blocks.

A new query block is created for each .fdr file block that you imported. These blocks contain SQL code from the .fdr file as well as column names and widths. Edit each block's properties as required.

Edit or delete a query block

1. On the **Home** ribbon, click **Standard Libraries** > **Query Blocks**.
2. To edit a query block, click it (or right-click it and select **Edit**).
   To delete a query block, right-click it and select **Delete**.

Note: The block will not be removed from any printout models to which it has been added.

Images

You can import any of the following formats: JPEG, BMP, PNG, GIF. The maximum file size is 1MB.

Note: When you add an image to the library, you are uploading it to the database; the image is not stored anywhere as a file.

Add an image to the image library

1. On the **Home** ribbon, under **Standard Libraries**, click **Images** > **Upload Image**.
2. Browse to the folder where the image file is located, select it and click **Open**.

Rename or delete an image

1. On the **Home** ribbon, under **Standard Libraries**, click **Images**.
2. To rename an image, right-click it and select **Rename**. Enter a new name and click **OK**.
   To delete an image, right-click it and select **Delete**.

Note: The image will not be removed from any printout models to which it has been added.

Setting Global Properties

Global properties apply to the whole printout model version. You can set the following properties:

- Version name
- Page size
- Margins

- Font
- Font size

> **Note:** The setting controls the font size used by all blocks and containers except those for which a specific font size has been set locally in the properties of the block/container.

Change the version name

1. On the **Printout** ribbon, under **Version Details**, click **Rename**.
2. Type a new name for the version and click **OK**.

Set the page size

- On the **Printout** ribbon, under **Page Size**, click the drop-down selector and select a page size.

Set the font

- On the **Printout** ribbon, under **Font**, click **Family** and select a font family.

Set the font size

- On the **Printout** ribbon, under **Font**, click **Size** and select a font size.

Set the margins

- On the **Printout** ribbon, under **Margins**, click the appropriate setting (**Left**, **Right**, **Top**, **Bottom**) and select a size (sizes are in inches).

Working with Sections

A printout model must contain at least one section. You can add as many other sections as you like.

Sections allow you to control such things as page orientation and the behavior regarding data that does not fit on a page. (For more information about such behavior, see About Block Types, Section Layouts and Containers on page 80.)

> **Example:** A printout model has three sections — a portrait section for entities that are not time-related, such as demographics and allergies, a second portrait section for events, a landscape section for entities that are time-related, such as foods and medications.

Each section starts on a new page when printed.

Adding, Removing and Ordering Sections

Add a section

- At the bottom of the design area, click the new section icon (+).

Or

- On the **Printout** ribbon, under **Sections**, click **Add Section**.

Note: A new section is always added after (to the right of) existing sections. It does not depend on the section that is being viewed at the time.

Remove a section

1. At the bottom of the design area, click a section tab to select that section.
2. On the **Printout** ribbon, under **Sections**, click **Remove Section**.

Reorder sections

1. At the bottom of the design area, click a section tab to select the section whose position you want to change.
2. On the **Section** ribbon, under **Name and Order**, click the up arrow (↑) or down arrow (↓) as required to move the section relative to other sections in the printout model.
3. Repeat for other sections in the printout model as required.

Setting Section Properties

You can set the following properties for each section:

- The section name (sections are named Section 1, Section 2 etc. by default).
- Headers and footers.

  Note: There is no global header for the entire printout and when you create a header for one section it is not automatically carried forward to new sections. If you want a single header for the entire printout you must create an identical header in each section. (Likewise for footers.)

- Printed page orientation (portrait or landscape).
- Layout type (fixed or continuous).

Rename a section

1. At the bottom of the design area, click a section tab to select that section.

2. On the **Section** ribbon, under **Name and Order**, click **Rename**.
3. Type a new name and click **OK**.

Add a header region

1. At the bottom of the design area, click a section tab to select that section.
2. On the **Section** ribbon, under **Header and Footer**, click **Header**.

An empty header region is added to the printout immediately below the top margin. Any overlapping content is pushed down so as not to overlap with the header. Displaced content can in turn push other content down the page. For pages with fixed layouts this may result in blocks/containers being pushed beyond the lower limits of the section. You must either remove such content or resize it to stay within the section limits.

3. Adjust the height of the header as required.
   a. Move the cursor over the bottom orange line until the cursor changes.
   b. Click and hold down the mouse button while you "drag" the line to resize the header and then release the button.
4. Add blocks and containers to the header as required.

Add a footer region

1. At the bottom of the design area, click a section tab to select that section.
2. On the **Section** ribbon, under **Header and Footer**, click **Footer**.

An empty footer region is added to the printout immediately above the bottom margin. Unlike adding a header region, any overlapping content is obscured rather than displaced. In some cases it may appear to be part of the footer when actually it isn't. You must either remove such content or resize it to stay within the section limits.

3. Adjust the height of the footer as required.
   a. Move the cursor over the top orange line until the cursor changes.
   b. Click and hold down the mouse button while you "drag" the line to resize the footer and then release the button.
4. Add blocks and containers to the footer as required.

Specify a global header/footer

- If you want a header/footer to apply to the whole printout, open its properties (Block Configuration window) and select **Use globally**.

  If an existing section already has a header/footer, its **Suppress global setting** setting is selected and the header/footer is not overwritten.

  If a new section is created, the **Suppress global setting** setting for its header/footer is selected by default.

Edit a global header/footer

1. Open any section that has the global header/footer (it does not need to be section in which it was originally created).
2. Edit the header/footer as required.

   CAUTION: When you do this, you are editing the global header/footer, not just the section header/footer. There is no warning message.

Create a section-specific header/footer when you are using a global one

1. In the section where you want the override, open the header/footer properties (Block Configuration window) and select **Suppress global setting**.
2. Edit the header/footer as required.

   Note: When you do this, you are editing the section's header/footer, not the global header/footer.

Section orientation (portrait, landscape)

1. At the bottom of the design area, click a section tab to select that section.
2. On the **Section** ribbon, under **Orientation**, click **Portrait** or **Landscape** as required.

Section layout type (fixed, continuous)

1. At the bottom of the design area, click a section tab to select that section.
2. On the **Section** ribbon, under **Layout Type**, click **Fixed** or **Continuous** as required.

For information on layout types, see Layout Type of page.

Editing a section

Editing a section involves the following tasks:

- Adding blocks and containers to the section

> **Note:** The blocks and containers you can add depend on the layout type. (For more information, see Layout Type on page ...) Note also that you can add the same items to a header and footer as you can add to the main body of a section.

- Copying configured blocks/containers from one section to another
- Positioning and sizing added blocks/containers
- Configuring block properties

Add a block/container to a section

1. Select the item in the Available Blocks pane to the left.
2. Keeping the mouse button pressed "drag" the item to where you want it in the right pane and then release the mouse button to "drop" the item.

> **Note:**
>
> When you drop a block into a fixed layout or into a fixed container it adopts a default size that you can then adjust.
>
> When you drop a block into a continuous layout, the block's width matches the available page width (minus margins). Likewise, when you drop a block into an autofit container, the block's width matches the container width. In both cases, the height is nominal and neither height nor width can be adjusted.

Copy a configured block/container to another section

1. Set the properties of the item you want to copy as required.
2. To copy the item, either select it and use the CTRL-C key combination or right-click it and select **Copy**.
3. Open the section in which you want to paste the item.
4. To paste the item, either use the CTRL-V key combination or right-click anywhere in the right pane and select **Paste**.
   The duplicated item is pasted in the center of the section.

Position a block/container

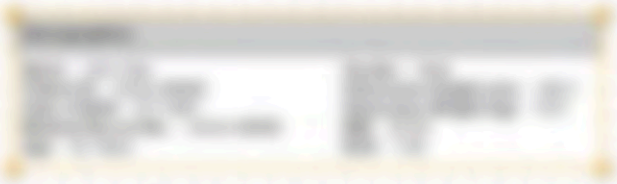
- Click anywhere inside the block/container. Keeping the mouse button pressed "drag" the item to where you want it and then release the mouse button to "drop" the item.
- Alternatively, select the block and then click an arrow button on the keyboard to move the block up, down, left or right, as required.

For blocks/containers in continuous layouts or in autofit containers, you can only change the vertical position of the block with respect to other blocks. (In other words, you can change the order in which the blocks appear.) The horizontal position is fixed.

Resize a block/container

Note: You can only resize blocks and containers that are in fixed layouts or in fixed containers.

1. Click the block.
   Sizing handles appear at the corners. You can use these to change the block's dimensions and/or reposition the block.



   Example block showing sizing handles

2. Move the cursor over a sizing handle until the cursor changes.
3. Click and hold down the mouse button while you "drag" the sizing handle to resize the item.
4. Repeat for other sizing handles as required.

Change the magnification

You can change the magnification in the Printout Builder using the zoom control in the bottom right of the design area.

To zoom in, either click the magnifying glass button on the right or drag the vertical bar to the right. To zoom out, either click the magnifying glass button on the left or drag the vertical bar to the left.

To return quickly to the default 100% zoom level, click the following button:

Note: Changes to zoom level do not affect the printout.

About Block Types, Section Layouts and Containers

When you add a block to a section you set the block's dimensions. If the data for a particular block does not fit within those dimensions when printing the block is said to "overflow". Generally speaking, overflow can occur vertically, horizontally or both. Vertical overflow means the patient chart has more rows of data than can ordinarily be shown in the block. Horizontal overflow means

the patient chart has more (total) columns than can ordinarily be shown in the block. How a block handles overflow depends on the block type, section layout type and use of containers.

Block Types

Blocks can be categorized as either temporal (having time columns) or non-temporal. The probability of overflow depends on the block, as shown in the following tables.

Temporal Blocks	Probability of horizontal (time column) overflow
Fluids IN	High
Fluids OUT	High
Physiologic Variables	High
Trends	High

The probability of vertical (row) overflow for a temporal block depends on the block's vertical size in the printout model compared with the average number of expected data rows.

Non-Temporal Blocks	Probability of vertical (row) overflow
Allergies	Medium
Assessments	High
Demographics	None
Diagnosis	Low
Events	High
Precautions	Low
Procedures	Low
Scores	Medium

Non-temporal blocks do not have time columns and so there is never any horizontal (time column) overflow for them.

You can add blocks directly to sections or you can add them to containers. In both cases, there is no restriction on the number of blocks that you can add.

You can add the same type of block multiple times. You might want to do this in order to effectively rearrange the fields for a block.

Example

In the Demographics block, the Gender field is listed after the DOB field. If you want the Gender field listed before the DOB field you could add the Demographics block to a section twice — set the first occurrence to show the Gender field only and set the second occurrence (below it) to show the DOB field.

Layout Type

There are two layout types:

- Fixed
- Continuous

Fixed Layout

Fixed layouts are most suitable for sections with temporal blocks (for which there is a high probability of horizontal overflow). The visible page size in the Printouts Builder is the same as the actual page size. The position and size of blocks in the Printouts Builder are also the same as in the actual printout. For this reason, a background grid is shown for fixed layouts. This helps you size and align containers and blocks. The grid is not shown on actual printouts.) There are no restrictions on the relative position of one block with respect to its neighbors — they can be above, below or to the side. In a fixed layout, blocks can overflow horizontally, vertically or both. When overflow occurs, the block repeats on each page until all the data for that block is printed — the size and position of the block remaining fixed. Other blocks on the same page as the overflowing block repeat on each overflow page.

Printout Models

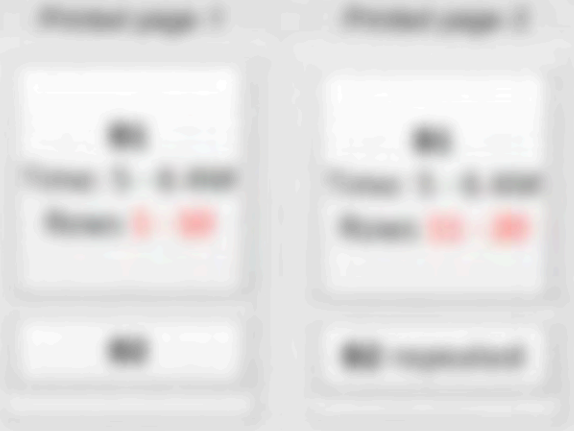
Layout Type

EXAMPLES: PAGE LAYOUT

In these examples, all pages are part of the same section. There are two blocks in the section – B1 and B2. The vertical size of B1 is enough to show 10 rows of data. The horizontal size of B1 is enough to show 12 x 5 minute columns covering one hour.

The examples show how data overflows for B1 vertically (more than 10 rows) and horizontally (more than 12 time columns). B2 does not overflow, but repeats on each overflow page.

Blocks with vertical overflow



Besides adding blocks directly, you can also add fixed containers or autofit containers to a fixed layout section. For more information, see Containers on page 73.

Continuous Layout

Continuous layouts allow you to make the most of the page by avoiding empty space and repeated data. Such layouts can include non-temporal blocks and fixed containers.

Note: You cannot add temporal blocks or autofit containers to a continuous layout.

Printout Models

Layout Type

The visible page size in the Printouts Builder is one continuous page. It does not correspond with the actual page size. When you add a block to the layout it's actual position is not important, just its vertical position with respect to other blocks. The size of the block is also not important — blocks have nominal heights and these cannot be changed.

When printing, each block in a continuous layout adjusts its height so as to contain all data from the patient chart for the block in question. This behavior is referred to as "auto-filling". Auto-fit occurs vertically, but not horizontally. block widths do not change when printing. The block placed highest on the page auto-fits first, and all subsequent blocks auto-fit afterwards. If there is more data for a block than will fit on the page the block splits, spilling over to next page and auto-filling to the remaining data.

When you place a block in the section the block's width automatically matches the page width (minus the margins). You can also place two or more blocks side by side. When printing they auto-fit to the height of the block that has most data.

Example: B1 and B2 are next to each other. B1 has autogrown to show 10 rows of data. B2 has only two rows of data but has autogrown to the same height as block B1.

In a continuous layout, the concept of overflowing data does not really apply because the height of each block seen in the Printout Builder is not significant. Each block either auto-sizes to the amount of data in it or, if there is no data in it, only the header is shown.

The height of blocks seen in the Printout Builder depends solely on the number of example rows shown for each block.

In the printed pages, all blocks auto-fit their contents except for block B2, which auto-grows to the height of the adjacent block-B1.

Note that block B3 spills over the page because there are 18 rows of data to be displayed in it, but only room left on the first page for 10 rows of data.

Besides being able to add blocks to a continuous section you can also add fixed containers. (You cannot add autofit containers). For more information, see Containers below.

Containers

You can also add containers to a section. Containers are used for two purposes:

- To override the layout behavior locally - when a fixed container is used in a continuous section that part of the printout behaves like a fixed layout, when an autofit container is used in a fixed section that part of the printout behaves like a continuous layout.
- To group blocks so that they can be moved around together.

After adding a container to a section, you can proceed to add blocks to the container.

Fixed Containers

You can add a fixed container to either a fixed layout or continuous layout.

Fixed containers never change their size. They appear at exactly the same height in printouts as they appear in the Printout Builder.

As with fixed layouts, there are no restrictions on the relative position of one block with respect to its neighbors within the container - they can be above, below or next to each other. When printing, all blocks within the container remain the same size and in the same position relative to one another. blocks do not auto-fit to their contents. When adding blocks to fixed containers you must ensure that the blocks are large enough to account for all possible data that might realistically occur.

Best Practice: Fixed containers are intended for use with blocks that do not overflow, such as Demographics, Diagnoses and Procedures.

Adding a fixed container to a fixed layout section

The only reason to use a fixed container in a fixed layout section is to keep the blocks together so that they can be easily moved around if need be - the behavior of the blocks is the same as the

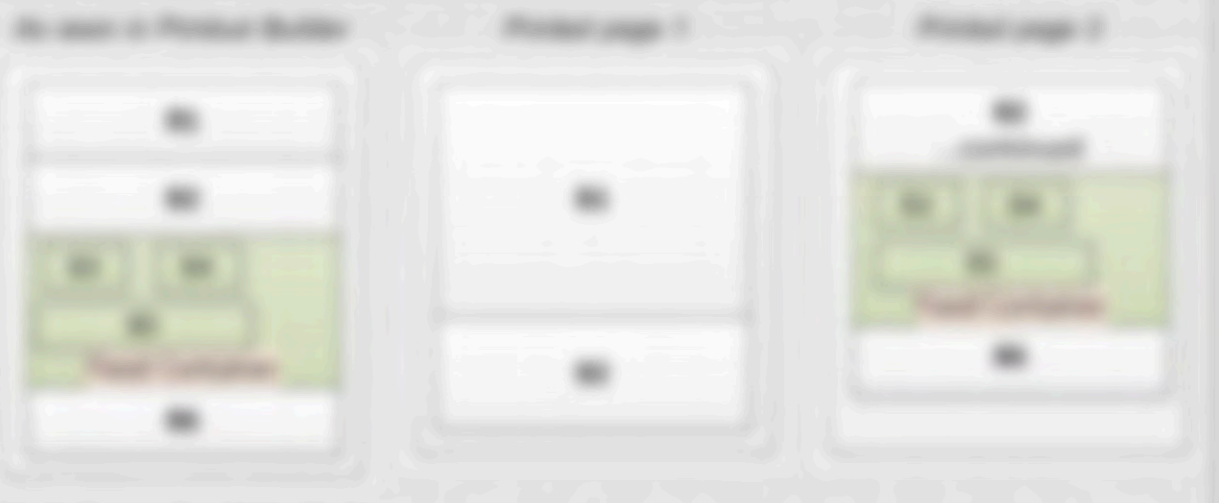
behavior of other blocks in the section that are outside the container.

Adding a fixed container to a continuous layout section

Using a fixed container in a continuous layout section ensures that blocks within the container do not autogrow to fit their contents but remain the same size and position relative to one another.

CAUTION: When a fixed container is placed in a 'continuous' section the behavior of overflowing data is unpredictable. For this reason, if a fixed container is in a continuous section you must not include time-based blocks in the container.

EXAMPLE: FIXED CONTAINER IN A CONTINUOUS LAYOUT



In the printed pages, blocks B1, B2 and B6 auto-fit their contents while blocks B3, B4 and B5 remain fixed.

Auto-fit Containers

You can add an autofit container to a fixed layout.

Note: You cannot add an autofit container to a continuous layout.

Like fixed containers, autofit containers never change their overall size. They appear at exactly the same height in printouts as they appear in the Printout Builder.

Unlike fixed containers, each block within an autofit container auto-fits to the size of its contents, except for the last block within the container, which autofits to the remaining space in the container. Overflow behavior is similar to that for fixed layouts. Blocks in autofit containers can overflow horizontally, vertically or both. When overflow occurs, the autofit container and the overflowing block

repeat on each page until all the data for that block is printed — the size and position of the block remaining fixed. The headers and frames of other blocks in the container repeat too, but without any data. If the overflowing block is not the last block in the container it will autofit as much as possible but always leaving enough space below (in the container) for at least one item in each other block.

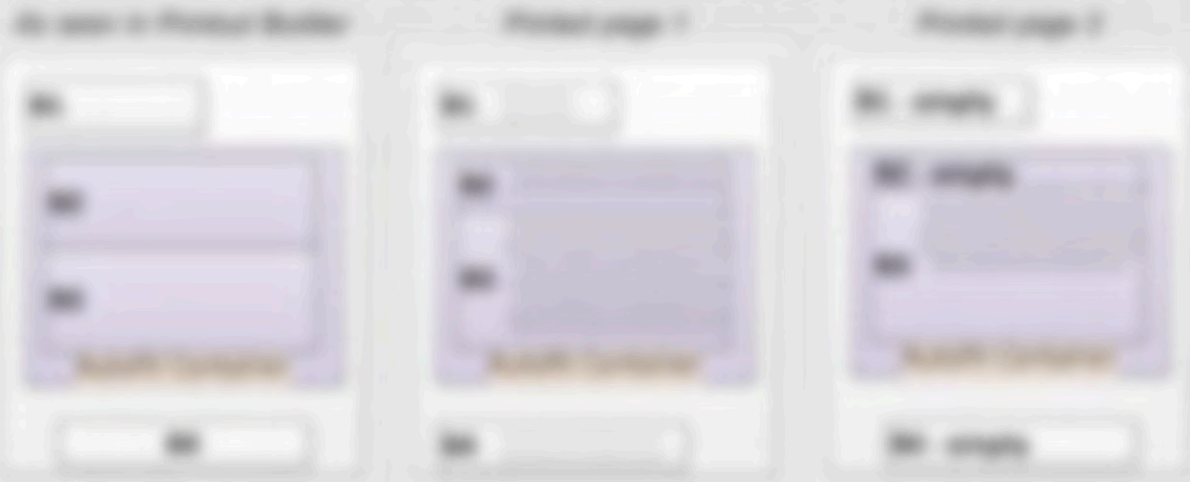
Best Practice. Position the blocks that you expect to be smaller at the top of the container so that they get printed in their entirety before any overflowing blocks.

EXAMPLES: AUTOFIT CONTAINER IN A FIXED LAYOUT

In these examples, the vertical size of the autofit container in the Printout Builder is equivalent to 14 rows of data. Blocks B1 and B4 have no overflow.

Vertical overflow for a block within the container

B2 and B3 correspond to 2 rows and 12 rows of data on the patient chart respectively.



Note that the heights of B2 and B3 are irrelevant

B2 takes up 2 rows

B3 takes up all remaining space (= 9 rows)

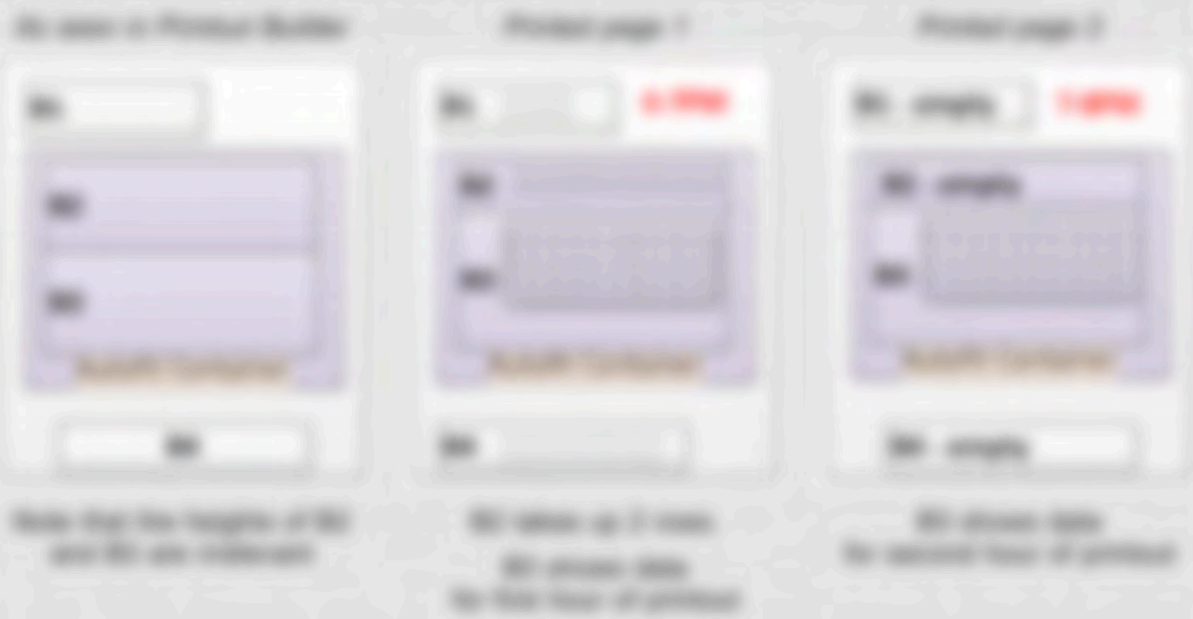
B1, B2, B4 just show headers

B3 shows remaining data (12 - 9 = 3) rows, and block autogrows to container height

Note. Reduce the chance of vertical overflow for an autofit container by increasing its height.

Horizontal (time) overflow for a block within the container

B2 and B3 correspond to 2 rows and 5 rows of data on the patient chart respectively.



Vertical and horizontal overflow for a block within the container

This scenario is basically the same as for vertical and horizontal overflow in a fixed layout – all rows are printed for the first time period then all rows are printed for the next time period, and so on. (See the last example in the section Fixed Layout, on page 7-7.)

5

Quality Measure Forms

About Quality Measure Forms

Forms consist of one or more "sections". Sections contain "blocks" that pull in patient data from the database when the form is created.

A typical workflow for creating and deploying a Quality Measure Form is as follows:

1. Create the first version of the form.
2. Create new measures in the standard library. (Library items you create are available for all versions of a form.)
3. Create one or more sections.
4. For each section, add the Measure blocks and other blocks as required. (The process for adding other blocks in the same as for creating printout models. For more information, see Printout Models on page 21-1.)
5. Rearrange sections as required.
6. Preview the model.
7. Publish the model.
8. Users submit forms as they work with patient charts.
9. The hospital uses the Export Tool to create NHSN-compliant XML reports as needed.

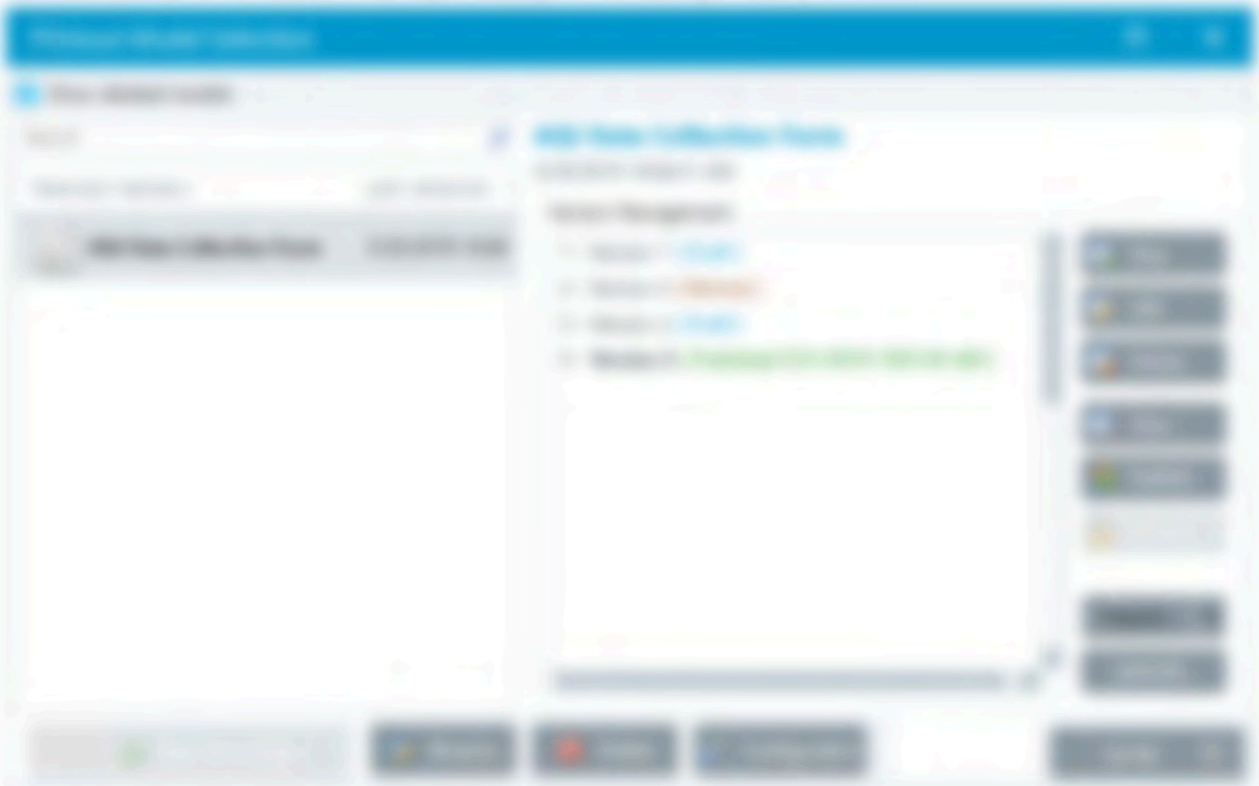
This section covers the creation and publishing of quality measure forms.

For information on submitting forms, see the *Workstation User Guide*.

For information on using the Export Tool to create an XML report, see The Export Tool for Quality Measures on page 213.

Managing Quality Measure Form Versions

Quality Measure Forms are managed using the following window:



The left side of the window shows the form name.

The right side of the window shows the versions available for the form and their status — draft, published or retired. (In the screenshot, V2 was the first published version. This version was automatically retired when V4 was published.)

The window is similar to the window used for configuring protocol models. However, unlike protocol models, there is generally only one form available and you cannot directly create new forms, just new versions of an existing form. For this reason, the **Add new...** button is disabled and the **Search** box at the top left is redundant. Note also that the **Configuration** button applies only to Protocol Models not Quality Measure Forms.

Although you cannot add a new form directly, you can import a form (for instance, you might want to import a form from your Test environment). Note, however, that PCIe only supports one published form at a time.

Best Practice: If you import a new form, delete the previous form.

Open the Quality Measures Form Builder

1. Start Customize, as described in Starting and Exiting Customize on page 13.
2. On the **File** menu, click Forms Builder → Quality Measures.

Close the Quality Measures Form Builder

- Click **Close**.

Rename a form

1. Select the form and click **Rename**.
2. In the window that appears, type a new name for the form and click **OK**.

Back up a form version

1. In the left pane, select the form.
2. In the right pane, select a version of that form.
3. Click **Export**.
4. Browse to the folder where you want to store the form, type a name for it and click **Save**.

The file is saved with the extension .DFMX.

Create a new form version by copying an existing form version

1. In the left pane, select the form.
2. In the right pane, right-click the particular version you want to copy and select **Copy as new version**.
3. In the window that appears, type the name you want for the new version and click **OK**.
4. The new version is added to the list of versions for the currently selected form.

Create a new form by importing a backup

1. Back up the form version that you want to duplicate following the "Back up a form" step-by-step procedure.
2. Click **Import** > **Import as a new model**.
3. Browse to the folder where the backed up (.DFMX) file is located, select it and click **Open**.

   The form opens for editing.

Note: Even if you do not make any edits yet you must save the form when closing the Forms Builder in order for the form to be created correctly.

Best Practice: Delete the previous form.

Create a new form version by importing a backup

1. Back up the form version that you want to import following the "Back up a form version" step-by-step procedure.
2. In the left pane, select the form.
3. Click **Import** > **Import as a new version**.
4. Browse to the folder where the backed up ZIPWFI file is located, select it and click **Open**.
   The form version opens for editing.

Note: Even if you do not make any edits yet you must save the form when closing the Forms Builder in order for the form to be created correctly.

Hide/show deleted forms

- To show deleted forms, select **Show deleted models** at the top of the window.
  Deleted forms are shown in italics.

Delete a form

1. Select the form and click **Delete**.
2. You will be shown a warning message. Click **Yes** to proceed.

Note: The name of the form will appear in italics in the window if **Show deleted models** is selected). It will no longer be available at any workstations.

Restore a deleted form

1. Select the deleted form.
   When you do this, the "**Delete**" button changes to an "**Enable**" button.
2. Click **Enable**.

Versioning and Publishing

When you create a form, it has an initial Version with the status "Draft".

Versions in draft status can be edited, but are not available to end users.

Best Practice: When editing a form, create new versions as you go along. Versions serve as backups that you can easily revert to if needed.

When you have finished editing a form, you must publish it to make it available for end users. After publishing the form you can no longer edit the published version. The status changes to "Published".

If you want to make further edits to a form after publishing it, create a new version. (The new version will initially look just like the version it is based on.) Edit the new version as required. When you are ready to replace the published version with the new version, just publish it. This will publish the new version and retire the previously published version (setting its status to "Retired"). At end user workstations where the form is available, the new published version automatically replaces the retired version. (End users only ever see the name of the form, not the version.)

When a version is opened for editing it becomes locked. The lock prevents Customizer users at other workstations from simultaneously editing the same version. Those users see a padlock symbol 🔒 next to the version name, together with the name of the user who is locking the version. Sometimes the lock may need to be removed manually (for example, if a user's machine freezes or if a user is off work sick while still logged in to the application).

Create a new version

1. Select the form in the left pane.
2. On the right, click **New**.

A new version will be created based on the last version of the model.

Open a version for editing

1. Select the version in the right pane.
2. Click **Edit**.

Delete a version

Note: Deleting a version is permanent. Unlike deleting a form, the action cannot be reversed.

1. Select the version in the right pane.
2. Click **Delete**.

Preview a version

(This allows you to see how end users will see the form.)

1. Select the version in the right pane.
2. Click **View**.

Publish a version

1. Select the version in the right pane.
2. Click **Publish**.

Unlock a locked version

1. Select the version in the right pane.
2. Click **Unlock**.

Editing the Quality Measure Form

Best Practice: Before adding forms, check the setting of the Forms Builder autosave feature. For more information, see The options on page 215.

When you open a version for editing, the Forms Builder window for Quality Measure forms appears. The window is essentially the same as the window for configuring printout models. The only differences are as follows:

- The Standard Libraries section includes a Quality Measures library.
- There is a new block category, Quality Measures, with a Measures block that can be added to a form.

Details of the Quality Measures library and the Measures block are described in this section. For a detailed description of the ribbons and other blocks, instructions for setting up the form layout, instructions for adding blocks and editing their parameters, see The Forms Builder Window on page 73.

Quality Measures Library

The Quality Measures library allows you to create Quality Measures as standard items for adding to any form.

You can import/export measures to/from the Quality Measures library using CSV files. When you export, all measures are exported as a single CSV file. When you import, all measures in the selected CSV are imported.

Note: The import removes ALL previous measures from the library and adds the imported measures.

Best Practice: Before importing measures, back up the current measures by exporting them. If you want to retain any measures, open the backed up CSV file in Microsoft Excel or another CSV

editor, locate the rows corresponding to the measures that you want to retain and copy those rows to the bottom of the CSV file that you will use for importing.

Import measures to the Quality Measures library

1. On the **Home** ribbon, under **Standard Libraries**, click **Quality Measures** > **Import**.
2. Browse to the folder where the CSV file is located, select it and click **Open**.

Back up measures from the Quality Measures library

1. On the **Home** ribbon, under **Standard Libraries**, click **Quality Measures** > **Export**.
2. Browse to the folder where you want to save the CSV file, enter a **Filename** and click **Save**.

Delete a measure from the Quality Measures library

1. On the **Home** ribbon, under **Standard Libraries**, click **Quality Measures**.
2. Right-click the measure and select **Delete**.

   Note: The measure will not be removed from any forms to which it has been added.

   Note: This action is irreversible.

Create a new measure in the Quality Measures library

1. On the **Home** ribbon, under **Standard Libraries**, click **Quality Measures**.
2. Click **New Measure**.
   The Measure Block Designer window appears.

You edit the measure in the same way as you can with a measure directly on a form. For more information, see The Measure Block Designer window on the next page.

Adding the Measure Block to a Form

The process for adding a block to the same as for printout models.

Add a Measure block to a section

1. In the Available Blocks pane to the left, select the **Measure** block.
2. Keeping the mouse button pressed "drag" the block to where you want it in the right pane and then release the mouse button to "drop" it.

Measure Block Properties

As with printout models, you edit a block's properties in the "Block Configuration" panel to the right of the design area.

When opening a form for editing, the Block Configuration panel is collapsed. There are two ways to expand it:

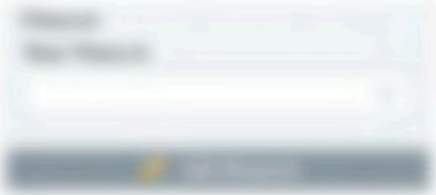
- Right-click the block and select **Properties**.
- Select the block and then click **Block Configuration** to the right of the design area.

Editing Measure Blocks

For Measure blocks you can set **Appearance** properties and **Measure** properties.

Appearance properties are the same as those common to many printout blocks and described in Standard properties for blocks on page 44.

The following settings are specific to Measure blocks:



Base Measure is a drop-down list showing all measures in the library.

There are three ways to proceed:

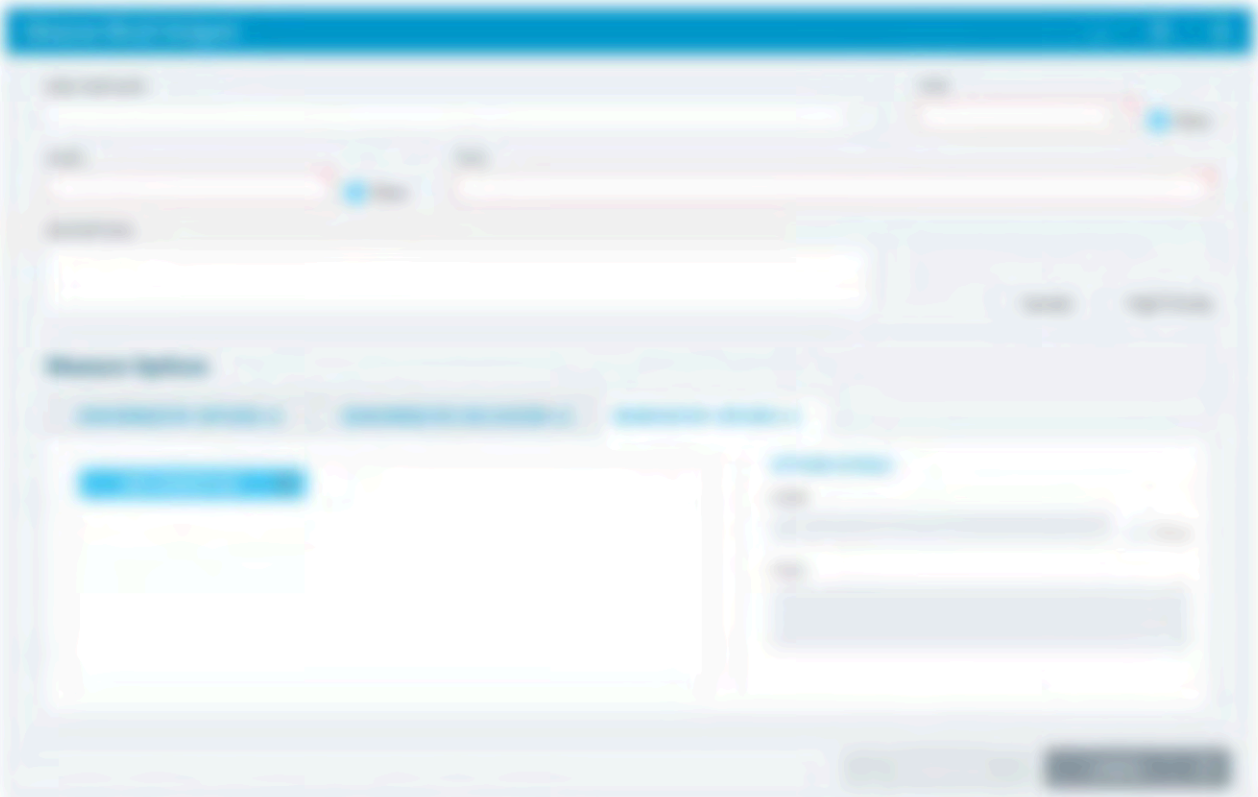
- In **Base Measure**, select a base measure and do not edit it.
- In **Base Measure**, select a base measure and then click **Edit Measure** to edit it.
- Click **Edit Measure** without selecting a base measure. This allows you to create a new measure specific to the form.

Note: New measures and edits you make to existing measures are not propagated to the base measures in the library.

Best Practice: If you may need to reuse a measure in another version of the form or another form, create/edit the measure in the library rather than in the form.

The Measure Block Designer window

When creating a new measure in the standard library or editing a measure block without first selecting a base measure, the Measure Block Designer window looks like this:



Mandatory fields are shown with a red outline.

For a general discussion of the terminology used in this window, see the section on Quality Measures in the *Workstation User Guide*.

Show	This check box appears in various places next to other fields. Select **Show** to show the adjacent field on the form. Clear the check box to hide the field from end users.
Basic Measure	For new measures, this field is blank. When editing an existing measure, this field shows the name of the measure you are editing.

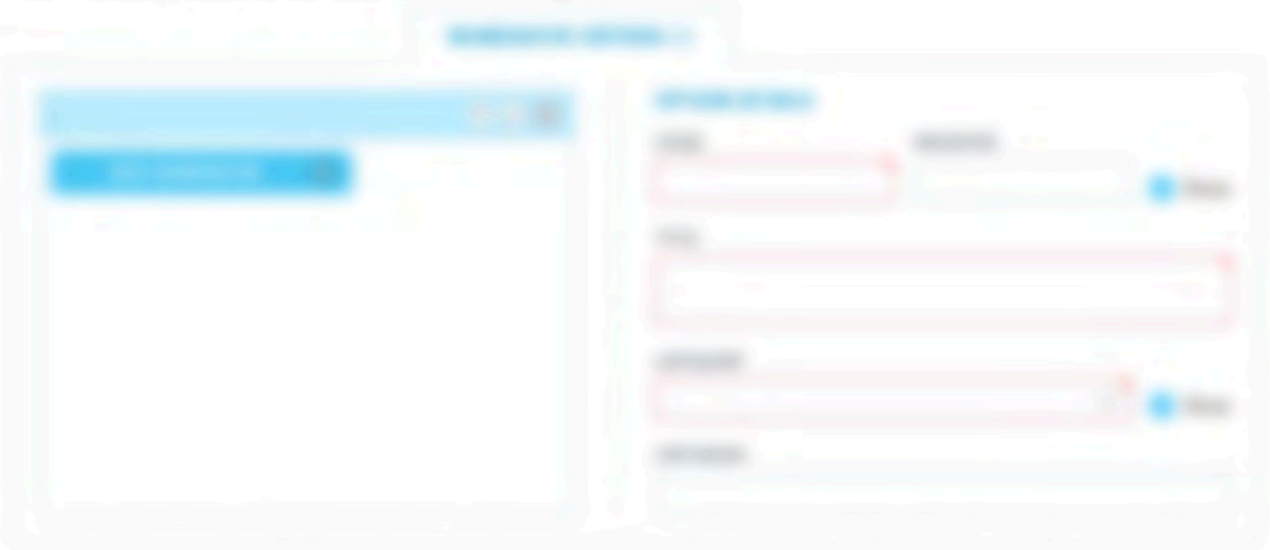
Quality Measure Forms

Editing the Quality Measure Form

Type	One of the following measure types: • Outcome • Intermediate Outcome • Process • Structure • Efficiency If you select **Show** for this field, the selected type is automatically shown on the form after the title. **Example:** Postoperative Beta Blocker – Process
Code	A code that your hospital and relevant external agencies use to identify the quality measure. **Example:** AMI - 8
Title	A title for the measure.
Description	A description of the measure. Note that this description only appears in this window. It is not shown to end users.
Inverse	Identifies the measure as an inverse measure on the form seen by end users. **INVERSE MEASURE**

NUMERATOR CRITERIA Tab

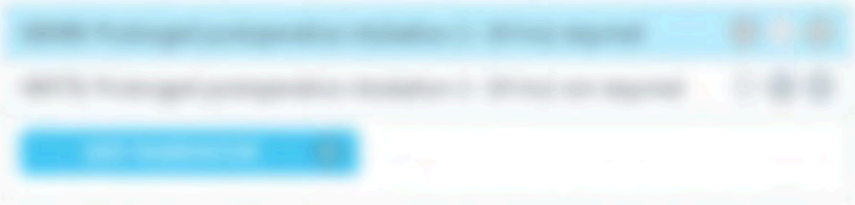
After clicking **Add Numerator**, the tab changes as follows:



For each numerator, you must specify a **Code**, a **Title**, an optional **Modifier**, and a **Category** selecting from one of the following:

- Performance Met
- Performance Not Met
- Denominator Exception

If there is more than one numerator, you can select one and use the arrow buttons on the right of the pane to change the order in which it appears on the form.



To delete a selected numerator, click the ✖ to the right of its name.

The **Criteria** box allows you to create "composite measures" in which numerators are grouped together with a common heading.

Example of a form with numerator criteria grouped together

To group numerators together under a heading, for each numerator that you want to group under the same heading text in the **Criteria** box. Note that the heading text you enter must be exactly the same (including spaces and capitalizations) for all the numerators of the group. Groups are shown on the form according to the relative position of the first numerator within each group.

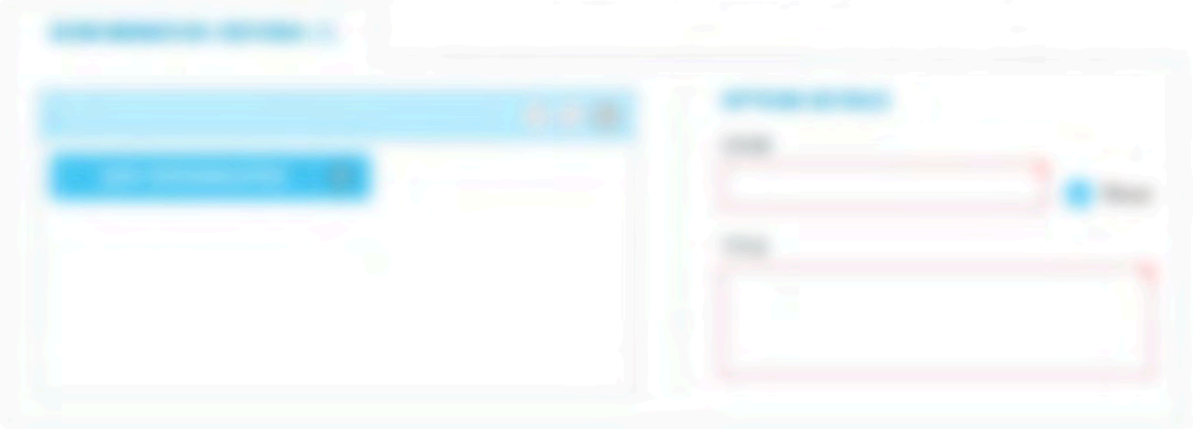
Best Practice: Keep criteria of the same group next to each other on the Numerator Criteria tab.

Note: Any ungrouped numerators on the form will be listed beneath the heading "Numerator Criteria".

DENOMINATOR CRITERIA and DENOMINATOR EXCLUSIONS Tabs

The behavior of these tabs in the Measure Work Designer is identical.

After clicking **Add Denominator** or **Add Denominator Exclusion**, the tab changes as follows:



Example of the Denominator Criteria tab. The Denominator Exclusions tab is the same but with the text "Denominator" replaced by "Denominator Exclusion".

For each entry (Denominator or Denominator Exclusion), you must specify a **Code** and a **Title**.

Setting the order of entries and deleting them is the same as previously described for nominator criteria.

6

Rule-Based Notifications for Sepsis

Rule Criteria

Criteria are hospital-dependent; each hospital liaises with Picis to define a custom algorithm based on the criteria that the hospital requires (subject to limitations). For more information, please contact your Picis representative.

Note: For criteria based on physiologic variables, the hospital liaises with Picis to agree the accepted Child's Link (CRL) codes and Laboratory components. For more information, see Supported CRL Codes & Laboratory Components for Rule-Based Sepsis Notifications on page 80.

Configuration

There are several aspects to this configuration:

- In DB Editor, assign the system right "Rule-based Notification System Edit" to the users who need to acknowledge notifications. For more information, see System Rights on page 251.
- In DB Editor (in the Rule Symptoms auxiliary table), add to or edit a list of symptoms and risk factors that users must check when acknowledging a notification. For more information, see Rule-Based Notifications for Sepsis on page 249.

- Using DB Editor and Customize, ensure that items required for the rules are present on one or more flowsheets. (A full list of required CMs, codes and laboratory components can be found in Appendix C: Supported CMs, Codes & Laboratory Components for Rule-Based Sepsis Notifications on page 361.)
- In Customize, use the Configuration Editor to enable "Rule-Based Notifications" at workstation and template levels.
- In Customize, at the template level, set the minimum time before a notification can be shown again after a notification has been acknowledged.
- In Customize, at the template level, add a new order – "Sepsis" – to flowsheets so that users can view or edit documentation related to the notifications. (Users perform this initial documentation in the Sepsis Screening window.)
- In Customize, use the Printouts Builder to add the Sepsis block to printout models as needed.

Enable Rule-Based Notifications at workstations

(This procedure makes the Rule-Based Notifications tab and Sepsis Notifications printout block available in Customize.)

1. Open a configuration set in Customize.
2. Using the Configuration Editor, set **CPSWP** > **PCSWPP** > **RuleBasedNotification** > **isInstalled** to True.
3. Close Customize.

Enable Rule-Based Notifications at the template level

1. Open a configuration set in Customize.
2. Open the Configuration Editor.
3. For each template that you want to configure, set **REAL7360** > **[template_prefix]** > **APPLICATION** > **DecisionSupport** to True.
4. Close Customize.

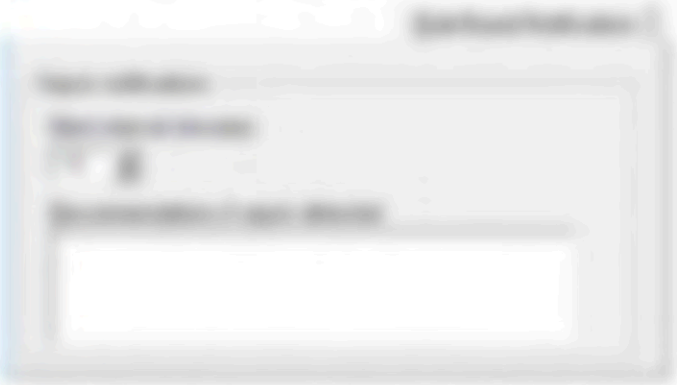
Note: After activating sepsis notification functionality in a template, for the functionality to become available for current patient sessions, you must discharge and readmit any patients admitted to workstations where the template is in use.

Note: The algorithm only uses data that corresponds to the timeframe of the Picis admission. Laboratory or physiologic data for times prior to the admission are not considered.

Configure Rule-Based Notifications

1. Open a template in Customize.
2. Click the **Configuration Parameters** button and then click **Rule-Based Notifications**.
   Or, click **Template** > **Configuration Parameters** > **Rule-Based Notifications**.

The following window appears:



3. In **Silent interval**, select the number of minutes that must pass after a notification has been acknowledged before a sepsis notification can be shown again.

   Note: Only values between 10 and 4320 (72 hours) are valid. If you enter a value outside this range, it will automatically be replaced with either the last entered value or the default value of 240 minutes (4 hours) if no value has been previously entered.

   Note: Regardless of this setting, the system checks for the sepsis status every five minutes. Because of this there may be a delay of up to five minutes before sepsis is detected (initially and following each silent period).

4. In **Recommendations if sepsis detected**, enter any notes that you want users to see in the Sepsis Screening window.

   Note: If a user at workstation A simultaneously views a patient admitted to workstation B, the Sepsis Screening window will show recommendations configured for workstation A, not workstation B.

   Best Practice: For each template, use the same recommendation text at all workstations in the hospital unit.

5. Click **Close**.

Add a Sepsis score to Flowsheets

Notes:
- You add the Sepsis score in the same way as you would add GCS or APACHE II scores.
- End users cannot add the score manually during a session.
- The score can only be used to view or edit existing documentation; users perform the initial documentation in the Sepsis Screening window.

1. Open a template in Customize.
2. Click the **Flowsheets** button.

Or, click **Template** > **Flowsheets**.

3. Select a flowsheet and then click **Setup**.
4. Select a flowsheet section and then click **Setup**.
5. In the bottom left of the screen, select **Sepura notifications**.
6. Click **OK**.
7. Click **Close** twice to return to the main window.

7

Application Template Configuration

About Application Templates

A patient's chart is based on the template selected at the start of the session. Templates determine the content and layout of the chart, as well as certain aspects of application behavior. By developing multiple templates, you can provide chart formats for different clinical environments, case types, and clinician preferences.

Note: Templates are groupings of database settings in the database, not actual template files.

In the ADT window that is shown when starting a session, users can ordinarily select any template that is active in the system from a list. If the selected template is not in any configuration set applied to the current workstation a message will be shown and the record will open using default settings (from the **Routines** > **pcw_AT** panel). (There are various ways to remove templates from this list. For more information, see Hiding Templates, on page 153.)

Note: For actions that can be performed while there is no selected patient, such as exiting the application, any relevant settings will be taken from the template used to view the last admitted patient at the workstation.

You can configure a template list to be shown to end users when they access records as follows:

- At a bedside workstation, when viewing the chart of a patient admitted at another bedside workstation or via a multibed workstation.

- In a multiseat workstation, when viewing the chart of a patient admitted at a bedside workstation or via another multiseat workstation.
- When viewing the chart of a patient who has been transferred.
- When viewing the chart of a patient who has been discharged.

The template list will show all active templates in the system (that is, all active templates in the Environment Types table in DB Editor). If the selected template is not in any configuration set applied to the current workstation a message will be shown and the record will open using default settings (from the **Realtime** > **gca_ifr** zone).

If you instead configure the system so as not to show a template list for the aforementioned situations, the last template used for a session of that patient will be used. If that template is not in any configuration set applied to the current workstation a message will be shown and the record will open using default settings (from the **Realtime** > **gca_ifr** zone).

Note: You can change the default system template. For more information, see The Default System Template on page 411.

For more information about the template list parameter, see Template List on page 418.

How eView Uses Templates

The following functionality in eView depends on the template used for the current session:

- Patient Summary
- Shifts for the Fluid Balance

Note: The template is selected in Anesthesia Manager, PACU Manager or Critical Care Manager when starting the session. It is not selected in eView itself.

Templates, Sessions and Encounters

A session represents the period of time that a patient is admitted to a location in the Picis system (a bedside workstation or multiseat workstation). A location could be an operating room or a bed in an ICU or PACU. One or more consecutive sessions (typically in different beds or rooms) in a department or care area constitutes an encounter. The patient's record contains data from all encounters in the admission.

The system considers two sessions to be part of the same encounter when the templates used share the same encounter type. Templates for induction, intraoperative and postoperative care units might have an encounter type called Perioperative. Templates for different intensive care units (CVICU, MICU, MSICU, PICU and NICU) might share one called Critical Care. Each hospital creates and names the encounter types it needs.

The time bar displays the encounter type and template name for each session to identify the clinical environment that corresponds to the data. Users can select an entire encounter when viewing fluid balance demographics data, and when creating printouts.

Encounter types have a property that classifies them as ICU-related or not ICU-related. This property affects various aspects of the application. For more information, See [Supports ICU-only Tools on page 273].

Sample Templates

The default workstation installation includes a number of sample templates that have been designed to cover the needs of the basic environments within a hospital. Although these templates can be used 'as is' you will likely need to modify clinical database content (using DB Editor) and templates (using Customizer) to obtain the configuration you want. (If your site has "Content Library" database content, the amount of configuration you need to do is reduced—please see the Content Library Guide for more details.) The encounter types and "ICU property" used by these templates are as follows:

Encounter Type ("ICU" property in brackets)	Template Name	Prefix
Wing back to OR (0)	Wing back to General Anesthesia	ABKGA
	Wing back to PACU	ABKPAC
	Wing back to ICU Anesthesia	ABKICU
General Anesthesia (0)	Surgical Prep Area	PREOP
	Cardiovascular Anesthesia	AneCV
	PACU	PACU
	General Anesthesia	OpenA
	Ventilation/Consensus	VTMD
	Epidural/Regional/Spinal	EPI
ICU (1)	PACU	PACU
	Critical Care	CCM
Neonatal ICU (1)	NICU	NICU

1 For a description of ICU Property, see [Template Encounter Types on page 273].

The main features of these templates are as follows:

Flowsheets	The CCM, PICU, and NICU templates include flowsheets for physician, nursing, and respiratory therapy clinicians. The PACU and IMPHC templates include flowsheets for Phase I and Phase II nursing documentation. The Epoch, STMC, EPMF and ArchY templates and templates with an encounter type of "Bring back to the OR" include flowsheets for anesthetists. The ArchY and BBCH templates include a flowsheet for perfusionists.
Macros	Templates with an encounter type of "General Anesthesia" or "Bring back to OR" include macros for documenting key anesthesia events from the main toolbar. The CCM, PICU, NICU and PACU templates include macros for admission activities and Non-OR Time Out activities.
Modules	The anesthesia templates include links for the Concurrency and QR modules. All templates include a link for Proxy Manager. All templates include the Supervisory Anesthesia module (SAM). This is used for compliance statements in anesthesia templates and for documentation requiring a co-signature in PACU, CCM, PICU and NICU templates.
Patient Summary	The CCM, PICU, NICU, and PACU templates include a toolbar button for the Patient Summary. (It is accessible via a menu command in the Anesthesia templates.)
Care Metrics	The CCM, PICU and NICU templates include a menu command for the Care Metrics module.

For more details on the templates, including a description of each toolbar button, please see the Content Library Guide.

Working With Templates

Creating Custom Templates

If you are installing the program for the first time, Picis recommends that you proceed in the following order:

1. Remove the sample templates that will not be used at your hospital.
2. Create/edit templates for the whole hospital (as part of the hospital configuration set).

3. Create/edit templates for the different environments within the hospital.
4. Create/edit template intended for specific workgroups.

Best Practice: Keep the number of templates to a minimum to reduce maintenance and upgrade work.

The template name is displayed on the time bar on flowsheets and in the ADT window when end users start a session.

Each template has a prefix and encounter type associated with it. The prefix is part of the core name for the template settings and also appears in the "About" window in AnesthesiaWorkgage, PACU Manager and Critical Care Manager. The encounter type is the care area associated with the template. It appears in various places, such as the time bar (in parentheses) and controls various aspects of the program behavior. (For more information, see Template Encounter Types on page 270.)

You can create new templates from scratch (based on the default installation settings in the **Runtime** > **PCS_EP** area) or by copying another template.

You can copy another template into the same configuration set (with a new name) or into another configuration set.

Note:
When creating a template (by clicking the "New" button or by copying another template) both the name and prefix of the new template must be unique across the whole system.
- If the description and prefix of the new template match those of a template that already exists in the system you will be shown a message and prompted to proceed (overwriting the template settings) or cancel.
- If just the prefix (but not the description) matches the prefix of a template that already exists in the system you will not be able to create the template. A message will indicate that a unique prefix is needed.
- If just the description (but not the prefix) matches the description of a template that already exists in the system you will not be able to create the template. A message will indicate that you can, however, overwrite the template by using the same prefix.

Open a template for editing

1. In the "Open" window, next to **Configuration Set** select a configuration set.
2. Click a template name on the list.
3. Click **Open**.

Create a new template based on default settings

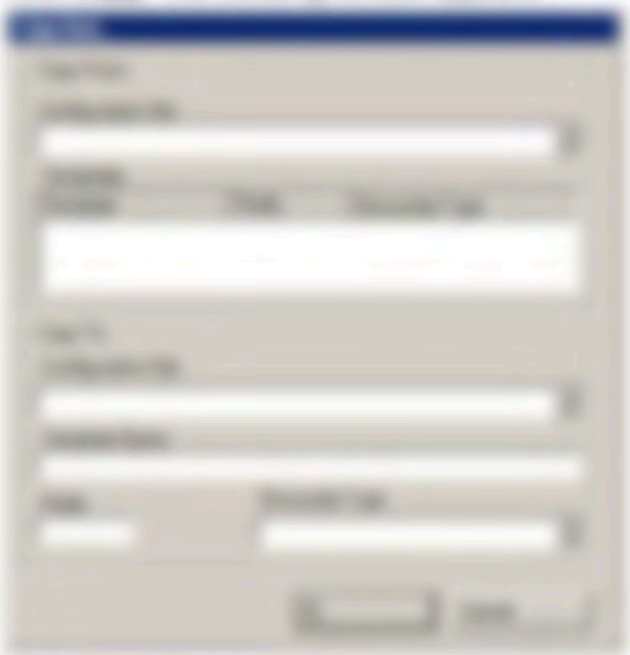
1. In the "Open" window, next to **Configuration Set** select the configuration set you want to add the template to.
2. Click **New**.

   - In **Description**, enter a name for the template.
   - In **Prefix**, enter an alphanumeric abbreviation of up to five characters.
   - In **Encounter Type**, select a care area with which to associate the template.
3. Click **OK**.

Note: If your site uses or plans to use Enterprise Anesthesia, you must make sure that templates for OR and PACU have the same encounter type.

Create a new template based on an existing template

1. In the "Open" window, next to **Configuration Set** select any configuration set (it does not matter which one).
2. Click **Copy**. The following window appears:



3. In the **Copy From** pane, select the configuration set from which you want to copy a template. All templates from that configuration set will be shown in the box.
4. Select a template from the box.
5. In the **Copy To** pane, select the configuration set to which you want to copy the template.
6. In **Template name**, enter a name for the template.
   - In **Prefix**, enter an alphanumeric abbreviation of up to five characters.
   - In **Encounter Type**, select a care area with which to associate the template.
7. Click **OK**.

Note: If your site uses or plans to use Intelligence Anesthesia, you must make sure that templates for OR and PACU have the same encounter type.

Note: The configuration set into which you copied the template becomes the selected configuration set in the "Open" window.

Change the name, prefix or encounter type of a template

You can change the name, prefix or encounter type of a template in the Environment Types auxiliary table in DB Editor. (You cannot change these properties using Customize.) For more information about editing auxiliary tables, see Auxiliary Databases Tables on page 219.

Hiding Templates

The ADT window of end user applications ordinarily lists all templates in the system regardless of whether or not they are in any configuration set applied to the computer in question.

The Customize "Open" window ordinarily lists all templates in the selected configuration set.

There are a number of ways to hide templates so that they are no longer shown in these windows.

- Set the template as inactive for the whole system. This is done by editing the Environment Types auxiliary table in DB Editor. For more information, see the System Configuration GuideAuxiliary Databases Tables on page 219.
- Hide or delete a template for a configuration set. Workstations linked to the configuration set will not list the hidden/deleted template in either the ADT window or the Customize "Open" window.

  Example
  Configuration Set A has two templates — Template 1, Template 2
  Configuration Set B has two templates — Template 1, Template 3

  For Configuration Set A you hide or delete Template 1.

  Workstation "Alpha" has configuration set A applied to it (task). At this workstation Template 1 is no longer visible in the ADT window. You open Customize at this workstation and select Configuration Set A in the drop-down list. Template 1 is not listed. You now select Configuration Set B in the drop-down list. Template 1 is not listed.

  Workstation "Beta" has configuration set B applied to it (task). At this workstation Template 1 is still visible in the ADT window. You open Customize at this workstation and select Configuration Set A in the drop-down list. Template 1 is listed. You now select Configuration Set B in the drop-down list. Template 1 is listed.

  Best Practice: Hide templates rather than deleting them.

Delete a template from a configuration set

- You delete a template from a configuration set by deleting the corresponding configuration zone in the (Realtime) world using the Configuration Editor. (For more information on using the Configuration Editor, see The Configuration Editor, on page 33.)

> **Note:** This method only works for templates that your hospital has created. You are unable to delete zones that correspond to templates provided with the Prism default configuration.

Hide a template for a configuration set — preferred method

The recommended way to hide a template for a configuration set is to select the template in the Customize "Open" window and then click **Hide**. When you do this the OBCHID of that template is added to the end of the "ListReservedTypes" configuration entry. (See the next procedure.)

Hide a template for a configuration set — advanced method

Edit the following entry using the configuration editor:

World	Zone	Section	Entry
OBGEN	ADT	General	ListReservedTypes

Possible Values
OBCHIDs of templates that you want to hide. You can find the OBCHID of any template by looking in the Environment Types auxiliary table in DB Editor. You must prefix the number you see in DB Editor with a zero. **Note:** To add, edit or delete items in a list, right-click the list and select the relevant command.

> **Best Practice:** Prism recommends that you do not edit the ListReservedTypes entry for the hospital configuration. Doing so can make it difficult to troubleshoot configuration issues.

Note that the template in question does not necessarily need to be in the configuration set for which you edit the "ListReservedTypes" setting.

> **Example:**
> Configuration Set A has one template — Template 1
> Configuration Set B has one template — Template 2
>
> For Configuration Set A you hide or delete Template 2 (a template that does not exist in Configuration Set A).
>
> A workstation has configuration sets A and B applied to it. Configuration Set A is applied last.

Although Configuration Set B includes Template 2.1 is not available at the workstation (in either the ADT window or the Customize "Open" window) because it has been hidden by Configuration Set A.

Unhide a template for a configuration set

Regardless of the method used to hide the template, you can only "unhide" a template by deleting its associated DBKVD from the LustReservedTypes entry. (See the previous procedure for details.)

What You Can Configure

Templates contain settings related to the following aspects of the patient record:

- Content and layout of the Demographics and Patient Summary modules.

  (See Demographics on page 130 *and* Patient Summary on page 134*)*
- Required data for every case.

  (See Configure a Demographics section on page 142 *and* Configure required functional types and clinical priorities on page 139*)*
- Preferences for application behavior when opening and closing the application, and starting and ending patient sessions.

  (See Starting and Ending Sessions on the next page*)*
- Ability of users to edit and delete different types of data.

  (See Preferences for Device Data on page 138*)*
- Custom flowsheets.

  (See Flowsheets on page 145*)*
- Format of the Fluid Balance window.

  (See Fluid Balance Window on page 152*)*
- Protocols.

  (See Protocols template settings on page 111*)*
- Available features, accessories, and "quick links" in the application.

  (See Quick Links on page 156 *and* Timers on page 159*)*
- Configuration of the toolbar, Vital Signs bar, and Patient Bar.

  (See Ribbon Buttons on page 161*,* Vital Signs Bar on page 126*, and* Patient Bar and Notifications Window on page 116*)*
- Clinical content available to users for documenting patient data.

  (See Protocols on page 97 *and* Events on page 105*)*

- Screen layouts and macros.
  (See Quick Links, on page 78 and Configure a macro as a quick link on page 157.)

Key Template Configuration Parameters

Starting and Ending Sessions

You can configure the system to do the following when users start and end sessions:

- Require a log on to start a new session.
- Require users to log on before closing the application. (For example, if the last user was logged off automatically.)
- Configure application to exit between patients.
- Prompt users for confirmation when quitting an application.
- Prompt users to discontinue orders when transferring a patient.
- Display the Demographics window when ending a session (transferring or discharging). This feature would typically be used in the ER to allow users to check that all required information has been documented. (See also Demographics on page 126.)
- Configure the number of hours a record can remain in transfer status before it is automatically discharged.

Note: A clinical supervisor can undo a manual or automatic discharge using ADT Administrator. For more details and information about fluid volume calculations during automatic discharge, see the appendix on ADT Administrator in the Workstation User Guide.

Require a log on to start a new session

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Log on required to start new session** check box.
3. Click **Close**.

Require users to log on before closing the application

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Click one of these commands:

- **Can only close application if user is logged on.**
- **Can close application without user being logged on.**
- **User can close application without being logged on (unless a patient is admitted).** (Only relevant for bedside workstations.)

3. Click **Close**.

This feature is intended for the situation where the user has been automatically logged off.

Configure application to exit between patients

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Close application between patients** check box.
3. Click **Close**.

Prompt users for confirmation when exiting an application

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Prompt for confirmation when exiting application** check box.
3. Click **Close**.

Prompt users to discontinue orders when transferring a patient

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Set the system to prompt users to discontinue orders on a patient's chart when transferring a patient out of a location or in to another (or both):
   - To allow users to discontinue some or all orders when transferring the patient out of a bed or room, select the **Prompt to discontinue orders when transferring patient OUT** check box.
   - To allow users to discontinue some or all orders from the previous session when transferring a patient into a bed or room, select **Prompt to discontinue orders when transferring patient IN** check box.
   - To allow users to discontinue only the orders for which they have appropriate access rights, select the **Apply access rights when discontinuing orders during patient transfers** check box. (Prescription rights may be required to discontinue an order. (See [link] (needed to prevent a cross-reference error) on page 123). With this option selected, some users may be unable to discontinue some orders.)
3. Click **Close**.

Display the Demographics window when ending a session

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.

2. Select the **Open Demographics on transfer/discharge** check box.
3. Click **Close**.

Configure the Home screen

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. In **Home Screen**, select a screen layout. (Screen layouts are created in Anesthesia Manager, PACU Manager, or Critical Care Manager using the **Save Screen As** command on the **Screen Layouts** menu.)
3. Click **Close**.

Configure the number of hours a record can remain in transfer status before it is automatically discharged

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. In **Auto-discharge in hours**, enter the number of hours that a record can be in transfer status before it is automatically discharged. (A value of 0 disables automatic discharge.)

   Note This does not discharge the patient from the MIS.

3. Click **Close**.

Preferences for Device Data

You can configure data-editing parameters as follows.

- Allow users to edit data from devices. This option does not affect manual data entry for non-physiologic variables.
- Allow users to edit device data after it has been validated. (The validation feature is typically used in critical care environments but not perioperative ones. See also Configuration Options for All Flowsheets on page 139.)
- Change the color that identifies edited values on flowsheets. The default color is red. If users might confuse a red value with indicator status, for example, you can use another color.
- Set the default status for indicators. Indicators identify values that are outside of configured indicator limits for a variable.

Allow users to edit device data

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Device data can be edited** check box.
3. When you have finished setting data-editing parameters, click **Close**.

Allow users to edit validated device data

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Device data can be edited after validation** check box.
3. When you have finished setting data-editing parameters, click **Close**.

See also Configuration Options for All Flowsheets on page 195

Set the color for edited device data

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. In **Edited Data Color**, set the color for data that has been edited manually.
3. Click [redacted] to open a palette of colors.
4. Select a color.
5. Click **OK**.
6. When you have finished setting data-editing parameters, click **Close**.

Enable indicators for physiologic variables

Prior "Notifications" are indicators that are pre-defined by the user.

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Notifications: ON** check box.
3. Click **Close**.

If this setting is enabled, data for a physiologic variable that is outside a predefined range appears in red on the Vital Signs Bar. (See Configure variable properties, on page 227.)

In addition, selecting the **Notifications: On** check box enables the following actions:

- Users can set notification limits in Anesthesia Manager.
- Notification limits set in Customize can be changed from the Properties window for the variable in Anesthesia Manager.
- A value outside of the indicator limit appears outlined in red on flowsheets and in the Physiologic Variables Summary.

Note: "Notifications" are visible indicators. Users must always attend to alarms from individual medical devices when working with patients.

Shifts and Time Intervals

You can set a number of time-related parameters for the template.

- **Physiologic Data Interval**. The frequency for capturing device data automatically. A new column of device readings is added to the patient chart at this interval. Users can change the interval during a session (if the command is included in the template).
- **Emergency Data Reserve**. The number of hours of device data that are stored in a temporary buffer. Users can recover data from the buffer and add it during a session.
- **Daily Shifts**. The number of shifts, and the starting and ending time for each. This information is used in the Fluid Balance window and in the Patient Summary.

Set the device data storage interval

1. Click the **Configuration Parameters** button and then click **Intervals and Shifts**.
   Or, click **Template** > **Configuration Parameters** > **Intervals and Shifts**.
2. In the **Physiologic Data Interval** box, select an interval. To set a custom interval, click the **Other** check box and enter an interval.
   Recommended intervals:
   ICU: 10–30 minutes
   OR: 2–5 minutes
3. When you have finished setting time-related parameters, click **Close**.

Note: The data storage interval is the same for all connected devices.

Note: The minimum interval for data storage is one minute even if a connected device is capable of sending data more frequently. If necessary, end users can insert emergency data with an interval as low as 30 seconds. (See Set the capacity of the emergency data reserve, below.)

Note: The value stored during the data interval is calculated according to the mathematical function property for the variable in question (see Configuring Physiologic Variables, on page 123). For example, for one variable the value stored could be the average of all data received in the interval, while for another variable the value stored could be the last data received in the interval.

Set the capacity of the emergency data reserve

1. Click the **Configuration Parameters** button and then click **Intervals and Shifts**.
   Or, click **Template** > **Configuration Parameters** > **Intervals and Shifts**.
2. In the **Emergency Data Reserve** box, select the number of hours of emergency data that you want to maintain in reserve.

Best Practice: Philips recommends that you set this value to the maximum of six hours and only decrease this setting if you experience memory problems at workstations.

3. When you have finished setting time-related parameters, click **Close**.

Configure the daily shift schedule

1. Click the **Configuration Parameters** button and then click **Intervals and Shifts**.
   Or, click **Template** > **Configuration Parameters** > **Intervals and Shifts**.
2. Under **Daily Shifts**, select up to four shifts.
3. Enter the starting time of each shift based on a 24-hour clock. Shifts must be equal in length and the starting times must be entered in chronological order.
4. When you have finished setting time-related parameters, click **Close**.

Printouts (template settings)

You create printout models using the Printout Builder as described in Printout Models on page 77.

Depending on the clinical environment you may need to configure the behavior of printouts as follows:

- **Display printout viewer on transfer/discharge**. The application can open the Printout Viewer window automatically when the user ends a session. This feature is typically used in Anesthesia Manager and PACU Manager.
- **Prompt to transfer/discharge after printing**. The application can open a window after a printout is manually created. The window allows the user to transfer or discharge the patient. (The will not appear if a printout is automatically created.)

Open the Printout Viewer window when transferring a patient

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Display Printout Viewer on transfer** check box.
3. Click **Close**.

Open the Printout Viewer window when discharging a patient

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Display Printout Viewer on discharge** check box.
3. Click **Close**.

Transfer or discharge patient after printing

1. Click the **Configuration Parameters** button.

Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Prompt to transfer/discharge after printout** check box.
3. Click **Close**.

Patient Bar and Notifications Window

The Patient Bar appears at the top of the patient chart and contains basic patient information and the Precautions/Allergies box.

The bar can also include a number of status icons to the right of the Allergies/Precautions box as described in the following table.

Icon	Notes
Notifications Icon	The icon is always displayed. The color changes according to the notification status.
Potential Interactions Icon	The icon is displayed when interaction checking is enabled for the entire system (in DM Editor).
Pending Tasks Icon	This icon can be enabled or disabled for each template. **Best Practice:** Enable this icon if pending tasks are likely to be present on patient charts.

Users can click the Notification icons to see more information about any notifications. You should configure the types of notifications that users will see using the guidelines in the following table.

Notifications Window

Data Type	Guidelines for enabling notifications
Demographic data	Enable when your system has a HIS or Laboratory link.

Note Type	Guidelines for enabling notifications
Microbiology results	Enable when your LIS sends microbiology results.
New orders	Enable when you want users to acknowledge new orders that appear in the program.
External orders	Enable when your system links to an order entry system whose orders do not appear in the program and you want users to acknowledge such orders.
Inbound order rejections	Enable when your system links to an order entry system whose orders ordinarily appear in the program and you want users to acknowledge any failed orders.
Outbound order rejections	Enable when your system links to an external pharmacy system to which order messages are ordinarily sent and you want users to acknowledge any failed orders.

Note: For more information on any of the Patient Bar icons, please see the Workstation User Guide.

What you can configure

- Demographics fields to show beneath the patient name. The fields are configured at the workstation level, regardless of the template. For more information, see Demographics and Patient Bar Workstation Settings on page 173.
- Data elements (medication allergies, other allergies, precautions) to include in the Allergies/Precautions box.

  (For more information, see Configure the Allergies/Precautions Box on the next page 1)
- Enable the pending tasks icon.
- Configure notifications to be shown for new demographics, new microbiology results, new orders, new external orders, and new order interface error messages.

- Configure the number of hours that an acknowledged notification will be shown by default in the Notifications window (after the configured period, users will only be able to see acknowledged notifications if they select the "Show History" check box at the bottom of the window). Note that unacknowledged notifications will always be visible regardless of this setting.
- For a demographics notification, configure the behavior of the **View Details** button. For more information, see Demographics Notifications, on page 213.

Configure the Allergies/Precautions box

1. Click the **Configuration Parameters** button and then click **Allergies/Precautions box**.
   Or, click **Template** > **Configuration Parameters** > **Allergies/Precautions box**.
2. Under **Allergies and Precautions**, click the box next to a category to show items from that category in the Allergies/Precautions box.
3. Under **Allergies and Precautions**, click a category name and then click the up or down arrow to move it up or down on the list. The categories are displayed in the specified order.
4. Click **Close**.

Note Users can see all documented allergies and precautions in the Demographics window regardless of the configuration of the Allergies/Precautions box.

Note The system right for program `cwir` is needed to open the Allergies box from the Patient Bar.

Enable the Pending Tasks Icon

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Display care teamm** check box.
3. Click **Close**.

Notification window: Show notifications for new microbiology results

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Show microbiology notifications** check box.
3. Click **Close**.

Notification window: Show notifications for new orders

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Show new order notifications** check box.
3. Click **Close**.

Notification window: Show notifications for new external orders

This is performed using the Configuration Editor. For more information, see External Order Notifications on page 207.

Notification window: Show notifications for new demographics

This is performed using the Configuration Editor. For more information, see New Demographic notifications.

Notification window: Show notifications for inbound order rejections

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Show Inbound Order error notifications** check box.
3. Click **Close**.

Note: Users need the "Order Interface Error Acknowledge" security right to acknowledge order rejection messages. See System Rights on page 251 for more details.

Notification window: Show notifications for outbound order rejections

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. Select the **Show Outbound Order error notifications** check box.
3. Click **Close**.

Note: Users need the "Order Interface Error Acknowledge" security right to acknowledge order rejection messages. See System Rights on page 251 for more details.

Notification window: Configure the number of hours an acknowledged notification will be shown by default

1. Click the **Configuration Parameters** button.
   Or, click **Template** > **Configuration Parameters** > **Preferences**.
2. In **Time to archive a notification in hours**, enter the number of hours that an acknowledged notification should be shown by default.
3. Click **Close**.

Required and Recommended Fields

You can configure required and recommended data in two places:

- The Demographics Editor

- The Required/Recommended Fields Configuration window

The Demographics Editor

Configuration of required data using the Demographics Editor is covered in detail in Demographics on page 1-29. The editor allows you to configure the following:

- Demographics data that must be documented
- Key events that must be documented in a certain order
- Key event families that must be documented

End users see any missing data highlighted in red in the Demographics module, but there is no restriction on the ability to transfer or discharge a patient without this data.

Required/Recommended Fields Configuration window

This window allows you to configure selected data from the following types as either required or recommended:

- Events
- Physiological variables
- Treatment families
- Treatments

End users see any missing data highlighted in red in the Quality Measures window. In the case of required data, end users are not able to transfer or discharge a patient until the data has been entered. (Clinical supervisors can override this restriction using ADT Administration.)

Configure required or recommended data

1. Click **Template** > **Required/Recommended Field Configuration**.
2. To expand a section, click the + to the left of the section name.
3. To see only the data that has already been configured as required or recommended, click **Show Required/Recommended**. Otherwise, click **Show All**.
4. To search for an item, type its name in the **Search** box. You will be shown matches that contain the sequence of characters that you have typed as soon as you start typing.
5. For each item that you want to configure, click **Required** or **Recommended** as needed.
6. Click **OK**.

Waveforms

This section applies to customers who have purchased waveforms functionality.

Drivers

In order to process waveforms, specific drivers are required for the devices in question. Please consult your Picis representative for information on supported devices. If you would like a driver for a waveform-capable device that is not currently supported, please submit a driver request. Note that a charge may be payable.

Driver files must be placed in the following folder at each workstation where the devices will be used:

%ProgramFiles%\Picis\Drivers.net\Device

Configuration files

Each waveform-capable driver file requires an accompanying configuration file (in the same folder).

Driver configuration files are provided by Picis and should not be edited by sites. (Note for Picis personnel: further information is available in the Picis internal information Document.)

Physical connection

Waveform-capable devices must be physically connected to the workstation via the RS-232 serial port, just like any other physiological variables device.

Menus

To use waveforms, you must enable the **Waveforms** and **Waveform Snapshots** menus. For more information, see Picis Buttons, on page 151.

Template Configuration

You can configure auto-snapshot behavior and default resolution. To do this, you must first enable the Waveforms tab in Customize. (This also makes the Waveforms protocols block available.)

Enable the Waveforms tab in Customize at workstations

1. Open a configuration set in Customize.
2. Using the Configuration Editor, set **GPSWR** > **PCSWR** > **Waveforms** > **IsInstalled** to True.
3. Close Customize.

Auto-Snapshots

You can configure the application to take an automatic snapshot of a waveform at the start of a shift, a session, or both. (Note that accessing a patient when restarting the application is considered as starting a session.) Auto-capture produces one snapshot for each waveform device and each snapshot includes all available channels. The system shows an information message on screen whenever a new auto-captured snapshot is made so that the user can review the snapshot if needed. (If there is no user logged on at the time, the message will be shown to the next user who logs on.)

You can also configure the following aspects of auto-snapshots:

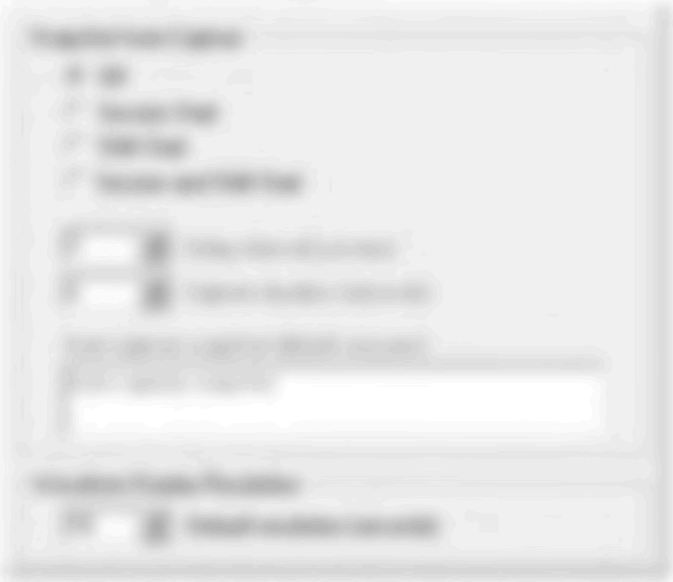
- The delay after the sessionshift start before the snapshot capture initiates. The value can be between 1 and 60 minutes (the default is 5 minutes).
- The duration of the capture. The value can be between 5 and 120 seconds (the default is 5 seconds).
- A comment for the captured waveform.

Default Resolution

The default waveform resolution controls the time range shown when a user opens the Waveforms window. You can set it to between 5 and 45 seconds. The default installation setting is 10 seconds, meaning the window shows 10 seconds of data. Users can change the resolution on-the-fly.

Configure auto-snapshot behavior and default resolution of the Waveforms window

1. Open a template in Customize.
2. Click the **Configuration Parameters** button and then click **Waveforms**.
   Or, click **Template** > **Configuration Parameters** > **Waveforms**.
   The following window appears:



3. Select the triggering event for the automatic snapshots.
4. In **Delay interval**, select the delay after the trigger event before the waveform snapshot is taken (in minutes).
5. In **Capture duration**, select the time range of the captured waveform (in seconds).
6. (Optionally) Add a default comment to be shown for the auto-captured waveform.

7. In **Waveform Display Resolution**, select the default time range to be shown when a user opens the Waveforms window.

Devices and Physiologic Variables

About Physiologic Variables

In Anesthesia Manager, PACU Manager and Critical Care Manager the term physiologic variable refers to device-related data and other physiologic data that appears on the standard Physiologic Variables flowsheet. Data is typically supplied by devices connected to the workstation. If not supplied by a device, data for a parameter can be entered manually. Heart Rate, for example, is typically supplied by a device, while Patient Weight is entered manually. The Physiologic Variables flowsheet can contain up to 960 variables. Six variables from the flowsheet can appear on the optional Vital Signs bar.

Derived variables are physiologic variables that obtain their data from calculations performed on data for other physiologic variables. Calculations may use constants from the database as well as data from devices. You cannot enter data manually for derived variables.

Physiologic variables are sometimes also used for laboratory parameters, particularly items that are analyzed at the bedside, such as glucose and arterial blood gases. Philips recommends using physiologic variables for laboratory results that are entered manually by caregivers. (Laboratory components, the other type of laboratory data, are designed for use with a link to the laboratory system.)

Note Data from infusion pumps connected to the workstation is displayed with other fluid intake data; it is not shown with physiologic variables.

Note Devices are usually physically connected to the serial ports on a computer via a port replicator hub (for example, a "Digiboard"). The replicator allows a workstation to expand the number of ports from the standard one or two to 16.

About Derived Physiologic Variables

Note Derived physiologic variables must have the data type "numeric", not "text", otherwise various errors might occur when a user tries to edit another physiologic variable in the same time column.

You can check the data type of any variable using Customize, as follows:

1. On the **Template** menu, click **Physiologic variables**.

2. Click **Next** below to move to the "Physiologic Variables Flowsheet" window of the wizard.
3. Click **Properties**.
   The window that opens shows all properties for the variable that was selected by default in the Physiologic Variables Flowsheet window. The data type can be seen in the **Format** setting.
   If the variable is numeric, the value is 0, 0.0, 0.00 etc., otherwise, the variable is text.
4. You can cycle through all physiologic variables without leaving this window, by using the arrows next to the variable's name.

Note: Philips recommends that customers contact Client Operations before changing a data type.

Configuring Physiologic Variables

Best Practice: Since any medical device in the hospital that is capable of connecting to the program is be used at all workstations. For this purpose, before configuring physiologic variables at a workstation, you should copy the driver files for all such devices in the hospital to the local folder for drivers - by default, "C:\Program Files\Philips\Patient Data\Interfaces\Device".
(Actual devices do not need to be present at the time of configuration, just their driver files.)

The Physiologic Variables wizard guides you through the process of configuring devices that are connected to the workstation. In this process, you also select the variables for the Physiologic Variables flowsheet and the Vital Signs bar.

You can modify an existing configuration by going to the corresponding wizard step and making needed changes. Variables selected using this wizard can be used when configuring custom flowsheets and trends.

Some steps involve workstation settings and others involve template settings.

- Hardware-related steps affect the system at the workstation level and remain in effect for all sessions at the workstation thereafter. When you change a hardware setting while working in a template, the setting changes for all templates.
- Template-related steps are hardware-independent and affect the system at the template level. These settings can vary from template to template. When you change a hardware-independent setting, it changes only for the template you are working with.

Step	Task	Level
Devices and Ports	Assign device drivers to ports.	Workstation

Area	Task	Level
Devices and Variables	Select variables from each device to include on the patient chart. (When a variable is included from one device it is no longer available for selection from another.)	Workstation
Physiologic Variables Assistant	Create and edit any needed custom variables using wildcards. Add variables that require manual data entry. Add derived variables as necessary. Arrange the variables in the order in which you want them to appear on the patient chart. Set variable properties as necessary.	Template (however, if you remove a physiologic variable in this step, it is removed from all templates).
Flowsheet Preview	Review the list of variables.	Template
Vital Signs Bar	Select variables to appear on the Vital Signs bar. Configure supplementary information for the bar (fluid balance or patient weight, height, and BSA).	Template

Derived variables get their data using the associated formula in the database. You can view the database formula while using the Physiologic Variables wizard.

Assign a device driver to a port

1. Click the **Physiologic Variables** button.
   Or, click **Template** > **Physiologic Variables**.
2. In the **Available Drivers** box, click a driver name to select it.
3. In the **Communication Ports** box, click the number of the port where the device is connected and then click >>.
   (Click << to remove a device driver from a port.)
4. Click **Next** >> to select physiologic variables for the patient chart.

Select variables from each device for inclusion on the patient chart

> **CAUTION** You must not select any variables that have been configured as derived variables. Doing so could result in data loss. (To see the derived variables in your system, click **Derived Variables** in the Devices and Variables window.)

1. Click the **Physiologic Variables** button.

Or, click **Template** > **Physiologic Variables**.

2. Click **Next** >> to go to the Devices and Variables window.
   The **Drivers and Variables** box on the left shows the drivers configured for the workstation along with their port numbers.

   Note: A green check mark next to a variable name indicates that the variable is selected. The variable name appears in the **Selected Variables** box on the right along with the name of the driver.

3. To expand the list of variables that a driver can provide, double-click the driver name. (Double-click the name again to condense the list.)
4. To select all available variables that a driver can provide, click the driver and then click **Add** >>.

   Note: If a variable has already been selected from another driver it will be unavailable.

   Best Practice: Before clicking **Add** >> always expand the list of variables for the driver to see those that will be selected.

5. To select a single variable from a driver, click the variable name beneath the driver name.
6. To remove a variable from the selection, do the following.
7. Click the variable name in the left pane.
   Or, click the variable name in the right pane and then click << **Remove**.
8. To remove all selected variables, click **Remove All**.
9. To specify a different device to provide data for a variable, do the following.
   Click the variable name under the name of the assigned driver to remove it. Then click the variable name under the preferred driver.
   Or, right-click the variable name in the **Selected Variables** box. Then point to **Assign Driver** and select the preferred driver.
10. Click **Next** >> to add manual and derived variables and adjust the order of variables on the list.

Select derived variables

1. Click the **Physiologic Variables** button.
   Or, click **Template** > **Physiologic Variables**.
2. Click **Next** >> twice to go to the Physiologic Variables Flowsheet window if necessary.
3. In the **Selected Variables** box, click the variable under the insertion point for the new variable. (The new variable will be added above the selected variable.)
4. In the **Draft's Code Library** box, double-click the derived variable you want to add.

Note: If you want a device to supply data for a derived variable, return to the previous step in the wizard and select the variable under the corresponding driver.

5. In the **Selected Variables** box, click the derived variable and then click **Properties**.

Change the properties of the variable if necessary. (See Configure variable properties, below.) When you have finished, click **Close**.

6. Click **Close**.
7. Click **Next** >> to see a preview of the physiologic variables list as it will appear on the Physiologic Variables flowsheet.

Select variables for manual entry

1. Click the **Physiologic Variables** button.
   Or, click **Template** > **Physiologic Variables**.
2. Click **Next** >> twice to go to the Physiologic Variables Flowsheet window if necessary.
3. In the **Selected Variables** box, click the variable under the insertion point for the new variable. (The new variable will be added above the selected variable.)
4. In the **Click to Code Library** box, double-click the variable you want to add. (If you need to create a custom variable, choose an available "Whiteport Variable" (codes 001 through 038).

   Note: If you need to add a physiologic variable, return to the previous wizard step and select the variable under its driver. Variables added in the current window cannot be linked to devices.

5. In the **Selected Variables** box, click the variable and then click **Properties**.
   View and change the properties of the variable if necessary. (See Configure variable properties, below.) When you have finished, click **Close**.
6. Click **Next** >> to see a preview of the physiologic variables list as it will appear on the Physiologic Variables flowsheet.

Note: For Intensive Care templates, make sure that the Patient Weight variable (code 305) is present.

Adjust the order of variables on the flowsheet

1. Click the **Physiologic Variables** button.
   Or, click **Template** > **Physiologic Variables**.
2. Click **Next** >> twice to go to the Physiologic Variables Flowsheet window if necessary.
3. In the **Selected Variables** box, click a variable and then click the up or down arrow to move it up or down on the list.
4. Click **Next** >> to see a preview of the physiologic variables list as it will appear on the Physiologic Variables flowsheet.

Configure variable properties

1. Click the **Physiologic Variables** button.
   Or, click **Template** > **Physiologic Variables**.
2. Click **Next** >> twice to go to the Physiologic Variables Flowsheet window if necessary.
3. Click **Properties**.

4. In **Variable**, choose the variable you want to work with.
   Set the properties (see the table below).
5. Click **Close**.

Variable Property	Description
Show copy forward symbol	Determines whether or not a blue arrow appears next to values for variables configured for copy-forward data entry. This property can only be selected if the **Copy Forward** variable property has been selected. **Best Practice**: Always enable this setting for variables that are configured to allow data to be copied forward.
Copy Forward	Data for the variable is entered manually and automatically repeated in succeeding "sampling" columns until a new value is entered. **Note**: You cannot set the ability to copy forward a physiologic variable that is linked to a device.
Mathematical Function	Allows you to select the method for representing device data. You can configure a variable to display data in one of the following ways: **Average**: average of all values received during the data interval. **Median**: value which has an equal number of values above and below it (during the interval). **Last Value**: last value received during the data interval. For example, the user would see different values in the cell depending on the data type: [illegible] [illegible] [illegible] MEDIAN: 50% of the values are below this value and 50% are above. **Note**: This setting controls the way in which data from a device is stored in the database and shown in each "sampling" column. It is not related to the way that data is displayed when a flowsheet column includes more than one "sampling" column – in this scenario the value shown is always that of the last sampling column in the time frame that the flowsheet column represents.

Variable Property	Description
Notification Limits	Limits that define the levels at which indications are triggered.
Artifact Limits	Limits that allow you to reject data generated by electrical or mechanical interference. Artifact limits are also useful for filtering out zero values when a device is turned off during a session. **Best Practice**: Use artifact limits to prevent data-entry errors by limiting the values that can be entered for a non-physiologic variable. For example, in neonatal intensive care units, users are accustomed to documenting patient weight in grams. Philips handles all weights in kilograms. The rejection limits for Patient Weight can be set to discard values that are impossible for a newborn.
Format	The format for the data as a number with up to three decimal places, or text.

Review the physiologic variables list

1. Click the **Physiologic Variables** button.
   Or, click **Template** > **Physiologic Variables**.
2. Click **Next** >> three times to go to the Flowsheet Preview window if necessary.
   The preview shows details of the variables you have chosen for the Physiologic Variables flowsheet. You can sort the variables by any of the columns in the preview window without changing the configured order. Use the **Restore** button to return to the configured order after sorting.
   Click << **Previous** to return to previous steps to add, remove or move variables if needed.
3. Click **Next** >> to select variables for the Vital Signs tab. Or, if you are finished, click **Close**.

APACHE II Score

If you want to allow users to calculate a patient's APACHE II score, the following variables must be present in ALL templates that might be used during the first 24 hours of a patient's stay in the ICU:

- Heart Rate (1001),
- Mean Arterial Pressure (1013, 862, 886, 333, 315, 8722),
- Rectal Temperature (1007, 859, 884-894, 8867)
- Resp Rate, Vent (1100, 880, 1967),
- FiO2 (1130, 12P),
- A-aDO2 (1190), derived using this formula:
  $(Pb - 47) * (FiO_2 - \frac{PaCO_2}{0.8}) - PaO_2$

Where X is the barometric pressure which can be configured in Customize (Advanced Workstation Settings). Its value is usually 747.

- PaO2/ (CSO), unless this data is provided by the lab component with DBCSO.
- PaO2 (CSY), unless this data is provided by the lab component with DBCSO.
- Arterial pH (CSW), unless this data is provided by the lab component with DBCSO.
- Hematocrit (CSY), unless this data is provided by the lab component with DBCSO.
- Serum Sodium (CSW), unless this data is provided by the lab component with DBCSO.
- Serum Potassium (CSW), unless this data is provided by the lab component with DBCSO.
- White Blood Cell Count (CSW), unless this data is provided by the lab component with DBCSO.
- Serum Creatinine (CSW), unless this data is provided by the lab component with DBCSO.

If For variables with more than one CNL code, the system looks in the template for each code in a predetermined order and uses the value from the first one found for the calculation.

Note that the Glasgow Coma Scale score is also reported.

Vital Signs Bar

The Vital Signs bar displays the most recent data for up to six physiologic variables, highlighting in red any values that are within the indicator range. The bar also shows the current Physiologic Data Interval at the top and, if configured, the patient's fluid balance. The fluid balance is useful in perioperative environments.

This accessory is only available at bedside workstations.

Choose what to display on the Vital Signs bar

1. Click the **Physiologic Variables** button.
   Or, click **Template** > **Physiologic Variables**.
2. Click **Next** >> four times to go the Vital Signs Bar window if necessary.
3. In the **Chart Variables** box, double-click a variable to add it to the list. You can include up to six variables on the Vital Signs bar.
4. To remove a variable from the list, click it in the box on the right, and then click <<.
5. To remove all variables from the list, click <<**Remove All**.

6. Use the **Move** arrows to change the position of the variable on the Vital Signs bar.
7. Under **Bar Includes**, click **Fluid intake and output** to display the fluid balance at the bottom of the bar.
8. Click **Close**.

Main Chart Features

Protocols

A protocol is a predefined group of standard orders.

Protocols can be associated with a template so that the orders are added to the patient chart automatically at the start of a session. Users can also add protocols during a session by choosing them from the 'protocol library' of the **Protocols** command on the **Orders** menu is configured. (See Configure Orders on page 351.)

Each template can have a different protocol library.

Protocols can include orders from any of the treatment categories in the database (Medications, Fluid Intake, Fluid Output, Laboratory Components, Respiratory, Assessments, QA Indicators, Equipment, Scores, and Nursing Care).

You can associate up to three protocols with a template:

Default	Anesthesia Manager, PACU Manager, Critical Care Manager Orders that are added to every patient's chart at the start of a session. (When starting a session with a transfer patient, a user can choose to skip the default protocol to avoid duplicating items already on the chart from the last session.)
Equipment	Anesthesia Manager, PACU Manager Items to display in the Equipment window for documenting the devices, instruments and supplies used in a surgical procedure.
QA Indicators	Anesthesia Manager, PACU Manager Items to display in the QA Indicators window for documenting quality assurance criteria.

Medications, fluids, and laboratory components appear on the corresponding standard flowsheet. Items from these groups also appear on the custom flowsheets that have been configured for them. (See Create or edit a Minute Flowsheet section on page 333.)

Equipment tabs appear in the Equipment window and quality assurance criteria appear in the QA Indicators window. Clinicians may want to see these items on flowsheets instead of, or in addition to, the specialized windows. By default, the system is configured to exclude items in the Equipment and Quality Assurance categories from flowsheets. To show these items on custom flowsheets, see Show equipment checklists on flowsheets on page 101 and Show QA indicators on flowsheets on page 104.

Configure a default protocol

1. Click the **Protocols** button.
   Or, click **Template** > **Protocols**.
2. In **Default Protocol**, select a protocol.
3. Click **Close**.

Configure items for the Equipment window

1. Click the **Protocols** button.
   Or, click **Template** > **Protocols**.
2. In **Equipment**, select a protocol.
3. Click **Close**.

Configure items for the QA Indicators window

1. Click the **Protocols** button.
   Or, click **Template** > **Protocols**.
2. In **QA Indicators**, select a protocol.
3. Click **Close**.

Add one or more protocols to the library

1. Click the **Protocols** button.
   Or, click **Template** > **Protocols**.
2. Click the **Library** tab.
3. In the **Available Protocols** box, select one or more protocols to add and then click >>.
   To select a group of protocols, you can hold down the SHIFT or CTRL key while you click. SHIFT allows you to make adjacent selections. CTRL allows you to select non-adjacent events.
4. Click **Close**.

Events

Events allow caregivers to record milestones in a session. Each template includes a library of events that are relevant to the environment or case type. During a session, users select events from the library and add them to the events log.

Events are grouped in event types and event sets to make them easy to locate. Event types are groups of clinically related events, such as those related to the patient's airway. Event sets are groups of events that are usually documented together during surgery.

The database contains the complete list of events and event types in the system. You can modify the event library for a template by choosing events from one or more event types, and by choosing the event sets to show. You can also add new events to the database. If you want to create new event types, see Building Database Tables on page 226.

For information on creating event sets, see Event Sets and Macros on page 213. In addition to the content of the events library, you can configure the Events window in several other ways.

What you can configure

- Whether to show the date for each event in addition to the time.

  For more information, see Include the date in the Events log on page 131.

- Whether users can delete events and, if so, whether this includes only their own events or also those documented by other users, and the time limit.

  For more information, see Allow users to delete events on page 131.

- Whether to require confirmation when a user deletes one event. The system automatically prompts users for confirmation when they delete multiple events.

  (For more information, see Allow users to delete events on page 131.)

- Which tab (Event Sets, All Events, Keyword Search) to display by default in the Add Events window.

  (For more information, see Set the default tab in the Add Events window on page 131.)

- The default event type in the Supervisory Anesthesia Module (SAM) window.

  (For more information, see Select default supervisory event type on page 132.)

- Event sets and event macros.

  (For more information, see Create or edit an event set on page 213 and Configure an event set as a macro on page 213.)

- Macro toolbar.

  (For more information, see Configure a macro as a quick link on page 132.)

Add one or more events to the events library

1. Click the **Events** button.
   Or, click **Template** > **Events**.
2. In **Type**, select the type of events to add.
3. In the **Available Events** box, select one or more events to add and then click >>.

To select a group of events, you can hold down the SHIFT or CTRL key while you click. SHIFT allows you to make adjacent selections. CTRL allows you to select non-adjacent events.

4. Repeat steps 3 and 4 to add events from other event types.
5. Use the arrow buttons ( ) to set the order of events in the library.
6. Click **Close**.

Tip: To see the event type for an event in the **Selected Events** box, hold the cursor over its name.

Note: For Professional Plan billing, you must make sure that your template includes the events "Anesthesia Start", "Anesthesia Finish", and "Staff Billing Login".

Create a new event and add it to the events library

1. Click the **Events** button.
   Or, click **Template** > **Events**.
2. Click **New**.
3. In **Type**, select the type of event to create.
4. In the **Description** box, enter the event text.
5. Click **OK**.
6. Use the arrow buttons ( ) to set the position of the event in the library.
7. Click **Close**.

Remove one or more events from the library

Note: You cannot use Customize to inactivate an event. This must be done using DB Editor.

1. Click the **Events** button.
   Or, click **Template** > **Events**.
2. In **Type**, select the type of event(s).
3. In the **Selected Events** box, click one or more events to delete.
   To select a group of events, you can hold down the SHIFT or CTRL key while you click. SHIFT allows you to make adjacent selections. CTRL allows you to select non-adjacent events.

Note: In systems that are integrated with DR Manager, you should not remove shared events, such as Anesthesia Start, Anesthesia End, and Anesthesia Types.

4. Click **Delete**. (This removes the event from the library, leaving it available for later selection. If necessary, it does not delete it from the database.)
   To remove all events, click **Clear All**.
5. Click **Close**.

Note: Do not delete the Memo system event from any template.

Include the date in the Events log

1. Click the **Events** button.
   Or, click **Template** > **Events**.
2. Click **Show date in events log**.
3. Click **Close**.

Note: The date is less useful in perioperative environments where sessions generally last less than one day.

Allow users to delete events

1. Click the **Events** button.
   Or, click **Template** > **Events**.
2. To allow users to delete events that they themselves entered, click **Users can delete own events**.
3. To allow users to delete events that other users entered, click **Users can delete events entered by others**.
4. To prompt users for confirmation when deleting a single event, click **Prompt for confirmation when deleting events**.
5. To prevent deletion of events that occurred too far back in time, enter a value greater than 0 in **Time limit in hours for deleting events**. Note that this prevents deletion of an event based on the time it occurred, not the time it was documented.
6. Click **Close**.

The Events window includes the **Delete** button if any of these options are selected.

Set the default tab in the Add Events window

1. Click the **Events** button.
   Or, click **Template** > **Events**.
2. In **Default Tab for Add Events window**, select a tab.
3. Click **Close**.

Add an event set to the library

1. Click the **Events** button.
   Or, click **Template** > **Events**.
2. Click the **Event Set** tab.
3. In the **Available Event Sets** box, select one or more event sets to add and then click >>.

To select a group of events, you can hold down the Shift or Ctrl key while you click. Shift allows you to make adjacent selections. Ctrl allows you to select non-adjacent events.

(To create a new event set, click **New** then follow the instructions in the section Event Sets and Warns on page 212.)

4. Use the arrow buttons ( ) to set the order of event sets in the library.
5. Click **Close**.

Select default supervisory event type

1. Click the **Events** button.
   Or, click **Template** > **Events**.
2. Click the **Shift** tab.
3. In **Default Event Type**, select an event type.
4. Click **Close**.

Note: At least one event of the chosen event type must be configured for the template.

Fluid Balance Window

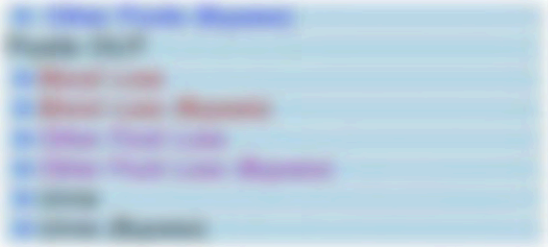
The Fluid Balance window shows total fluid intake and output graphically. You can choose from three formats:

- Bar graph with multiple time views (Shift, Day, Week, Admission, and optionally, Session and Encounter). Users can scroll in all time views except Admission.

  You can set the default time view and, for all time views except Admission, the time period (current or previous).
- Pie chart showing the overall balance for the admission and, optionally, for the encounter as well.
- A special version for cardiac bypass surgery is available with three pie charts: one for fluids documented by the anesthesiologist, another for fluids documented by the perfusionist, and a third for total intake and output.

For a fluid to appear on the bypass fluids pie chart, it must belong to a fluid family that is designated for bypass. You can configure any fluid family in the database for bypass. It is helpful to include the word "bypass" in the name of bypass fluids, as shown in the following example:

Fluids On
- Blood Products
- Blood Products (Bypass)
- Medications Infusions
- Medications Infusions (Bypass)
- Other Fluids



If you cannot find suitable fluid families in the database, you can create them using DB Editor.

Configure the fluid balance window

1. Click the **Fluid Balance** button.
   Or, click **Template** > **Fluid Balance**.
2. In **Format**, select the fluid balance type.
3. Click **Include all time views**, to add buttons for the "Session" and "Encounter" views (bar graphs) or for the "Encounter" view (pie charts).
4. For bar graphs, under **Default View**, select a default view from the following:
   Shift, Day, Week, Session, Encounter, or Admission.
   Under **Default Viewing Period**, select a default time period.
   The default time period can be the current period or the previous period for the chosen default view (for example, the current session or previous session, if session is chosen as the default view).
5. Click **Close**.

Configure bypass fluid families

1. Click the **Fluid Balance** button.
   Or, click **Template** > **Fluid Balance**.
2. In **Format**, select **Triple pie chart**.
3. Click **Bypass fluids**.
4. Under **Available Fluids Families**, select the names of the families to use for documenting bypass fluid intake and output.
5. Click >>. The bypass families are added to the selection list.
6. To remove a family from the selection list, click its name in **Fluids Families for Bypass**. Then click **Delete**.
7. Click **Close**.

Patient Summary

The Patient Summary provides an overview of patient data from a particular time period to help clinicians track patient progress and communicate key information. Users can generate a summary whenever needed, for example at the start or end of a shift. Users can also add different types of notes to a report. If a suitable link is available, users can send streamlined reports to the hospital information system (HIS).

A summary can include the sections listed in the following table.

Section	Data Displayed
Allergies	Allergies documented in the Demographics window
Notes	Notes entered by clinicians in the Patient Summary module
Events	Events from either the selected viewing period or the last 12 hours, depending on user selection
Data Tables	Predefined tables showing data for selected physiologic variables and laboratory components
Active Orders	Active fluids, medications and protocols
Assessments and Scores	Results of nursing assessments and scores
Fluid Balance	Fluid balance for the current shift, previous shift, current day, previous day, and the entire admission
Diagnoses and Procedures	Diagnoses and procedures documented in the Demographics window

What you can configure

- Sections to include in the report.
  (See Configure sections for a report on the facing page.)
- Tables for physiologic data.
  (See Add a physiologic data table on page 136.)
- Tables for laboratory results.
  (See Add a laboratory table on page 137.)
- The order of data tables in a report.
  (See Change the order of data tables on page 138.)

- Viewing periods that users can select when creating reports.

  (See Configure viewing periods for the report below*.)*
- Note types available to users.

  (See Create or modify a note type on page 326*.)*
- You can allow users to send streamlined reports to the IHD and configure the different possible report types. This is a workstation setting.

  (See Patient Summary Export to the IHD on page 259*.)*

Configure viewing periods for the report

1. Click the **Patient Summary** button.
   Or, click **Template** > **Patient Summary**.
2. Click the **Viewing Periods** tab.
3. Under **Configure Viewing Periods for**, click **Current Report tab** or **Notes tab**.
4. In **Standard Periods**, click each viewing period you want to include and then click >>.
   The **Standard Periods** box includes **Current shift**, **Previous shift**, **Current day** and **Previous day**. For details on setting shift times, see Configure the daily shift schedule on page 111.
   The **<Starting date> to <Ending date>** viewing period allows users to define a custom viewing period.
5. To create a view period, do the following:
   - In the **Custom Period** box, enter a name for the viewing period.
   - In **Duration** enter the duration of the period in hours (up to 96).
   - Click >> to add the period to the **Selected Time Periods** box. Repeat this step for each custom period you want to add.
6. To remove a viewing period from the list, click it in **Selected Time Periods** and then click <<. (Note that you cannot remove the All Notes viewing period.)
7. Set the order of viewing periods for both the main report and notes:
   - In the **Selected Time Periods** box, click a time period.
   - Click the up or down arrow to move it to the new position.
8. Set the default time period:
   - In the **Selected Time Periods** box, click a time period.
   - Click **Set as Default**.

   Or, in **Current Configuration**, under Current Report tab, click a viewing period.
9. When you have finished configuring the Patient Summary, click **Close**.

Configure sections for a report

1. Click the **Patient Summary** button.
   Or, click **Template** > **Patient Summary**.

2. Choose the patient identification number to display on the report as follows:
   - In the **Current Configuration** box under **Heading** and **Number**, click an identification number.
3. Choose sections to include on the report:
   - In the **Current Configuration** box, under each corresponding heading, select the check box for each section to include.
   - Clear check boxes for sections you do not want to include.
4. Set the sort order for notes:
   - In the **Current Configuration** box, under **Notes**, click **Sort by date - ascending** to display notes from oldest to newest or click **Sort by date - descending** to display notes from newest to oldest.
5. Edit the title of a section or subsection:
   - In the **Current Configuration** box, select the title.
   - Click **Edit**.
   - Enter the new text.
   - Click **OK**.
6. Rearrange report sections:
   - In the **Current Configuration** box, select a title.
   - Click the up or down arrow to move it to the new position.
7. When you have finished configuring the Patient Summary, click **Close**.

Add a physiologic data table

1. Click the **Patient Summary** button.
   Or, click **Template** > **Patient Summary**.
2. Click the **Data Tables** tab and then click the **Physiologic** tab.
3. Click **New** to display a window for selecting variables for a new table.
4. When you have finished selecting variables, click **OK**.
   The system creates a new table with the selected variables and adds it to the **Table ID** box with a default identification code (xxxxx1, xxxxx2, etc.).
5. With the table's new code highlighted in the **Table ID** box, enter a title for the physiologic table in the **Title** box.
6. Configure the values to display for each variable as follows:
   - Click **Show lowest, highest and last values** to display the lowest, highest, and most recent values received during the time period.
   - Click **Use reference variable** to display data for all variables based on the availability of data for a reference variable. The table includes a column for every available value for the reference variable. The reference variable does not have to be part of the table, although it usually is.

- In **Reference Variable**, select the variable to use. Note that the reference variable is usually a spinnable or manually-entered variable.
- In the **Number of Columns** box, enter the number of results to display (up to eight). The table shows this number of results, if available, even if they were not collected in the time period covered by the report.

7. To change the position of a variable on the table, select it in the box in the lower left corner and then click the up or down arrow.
8. When you have finished configuring the report, click **Close**.

Example of a table that uses a reference variable

Use reference variable activated.
Reference variable: Cardiac Output (CO).
Number of columns: 4.
Other variables: Heart Rate (HR), Diastolic Blood Pressure (DBP%), Systolic Blood Pressure (SBP%), Respiratory Rate (RR).

Whenever a result is available for CO the latest results of the other variables are shown.

CO	4.54	4.89	4.54	4.14
HR	140	90	110	100
DBP%	80	70	90	70
SBP%	150	140	130	120
RR	12	14	9	11

Add a laboratory table

Before you can add a laboratory table, the lab link must be created and turned on and the elements in the four database tables (Analysis, Parts, Performcomponents, and Components) must be created.

1. Click the **Patient Summary** button.
   Or, click **Template** > **Patient Summary**.
2. Click the **Data Tables** tab and then click the **Laboratory** tab.
3. Click **New** to display a window for selecting analyses for a new table.
4. When you have finished selecting analyses, click **OK**.
   The system creates a new table with the selected analyses and adds it to the **Table ID** box with a default identification code (chart1, chart2, etc.).
5. With the table's new code highlighted in the **Table ID** box, enter a title for the laboratory table in the **Title** box.
6. In the **Number of Columns** box, enter the number of results to display (up to eight). The table shows this number of results, if available, even if they were not collected in the time period covered by the report.

7. To change the position of an analyte on the table, select it in the box in the lower left corner and then click the up or down arrow.
8. When you have finished configuring the report, click **Close**.

Change the order of data tables

1. Click the **Patient Summary** button.
   Or, click **Template** > **Patient Summary**.
2. Click the **Data Tables** tab.
   The tab shows the physiologic data tables and laboratory tables configured for the Patient Summary.
3. On the **Layout** tab, click a table name and use the arrow buttons to move it up or down on the list.
4. To remove a configured table from the Patient Summary without deleting it, click the check box next to the table name. (Click the check box a second time to reinsert the table.)
5. Click **Close**.

Add or remove a parameter from a data table

1. Click the **Patient Summary** button.
   Or, click **Template** > **Patient Summary**.
2. Click the **Physiologic** tab or the **Laboratory** tab.
3. In the **Table ID** box, select the code or title for the table you want to edit.
4. Click **Setup**.
5. In the **Available Variables** or **Available Analytes** box, select the parameters you want to add to the table. Then click **Add** >>.
6. In the **Selected Variables** or **Selected Analytes** box, select the parameters you want to remove from the table. Then click << **Remove**.
7. Click **OK**.

Delete a table

1. Click the **Patient Summary** button.
   Or, click **Template** > **Patient Summary**.
2. Click the **Physiologic** tab or the **Laboratory** tab.
3. In the **Table ID** box, select the code or name for the table you want to delete.
4. Click **Delete**.
5. Click **Close**.

Configure the patient summary for export to the IVR

This is configured at the workstation level using Configuration Editor. See Patient Summary Export to the IVR on page 229.

Medication Summary

The Medication Summary shows all medication doses administered in a time period and the total doses for each medication. Available time periods include the last 4, 8, 12, or 24 hours, the current encounter, and the entire admission.

What you can configure

- The default sort order for the list of medications.
- The default time period for which to display data.
- How to display total doses for medications ordered with a dose based on body weight.

Configure the Medications Summary

1. Click the **Medication Summary** button.
   Or, click **Template** > **Medication Summary**.
2. In the **Sort Medications by** box, select a default sorting criteria for the medication list:
   - **Medication name** to sort medications alphabetically by their names.
   - **Administration time** to sort medications chronologically by the first dose.
   - **Family name** to sort medications alphabetically by the name of the family to which they belong. If you select this option, the name of the family is included in the display.
3. In the **Default Viewing Period** box, select the viewing period to display by default.
4. To include an extra row for medications that were ordered with a dose based on patient weight, select **Include calculated values for weight-based doses**. The first row for the medication shows values per unit of body weight; the extra row shows calculated values using the weight documented for the patient.
   If you do not select this option, the summary window displays only the weight-based values.
5. Click **Close**.

Demographics

You can configure the Demographics window with the Demographics Editor in Customize. To use the Demographics Editor, you must belong to a user group with the system right Manage Configure. After a configuration has been created, it can be used in other templates by exporting and importing it.

For a full list of possible sections and content within them, see the *Workstation User Guide*.

What you should know

The way that each country uses the **Race** and **Ethnicity** fields in the **Patient Identification** section) is likely to differ as governmental guidelines vary widely. Even within a country, hospitals

may adopt different approaches. By way of example, the following table shows meaningful race criteria from the American Recovery and Reinvestment Act of 2009 (ARRA).

RACIAL CATEGORIES	ETHNIC GROUPS
White Black or African American American Indian or Alaska Native Asian Native Hawaiian or Other Pacific Islander Unknown	Hispanic or Latino Not Hispanic or Latino Unknown

Example of race and ethnic group usage

What you can configure for the template

- The sections, subsections, and data elements to include and their order.
- The headings, subheadings, and labels for data elements within sections.
- The read-only status of each subsection and element.
- The items required for completing a case. (Required items are highlighted in the Demographics window until the user enters data for them.)

> **Best Practice**
> For templates that include the Rapids Log, configure any data that is needed for billing as required. (See the *Workstation User Guide* for more information.)

These settings are configured via the **Template > Demographics Editor** window.

> **Note:** The **Options** button in the **Template > Demographics Editor** window provides access to other demographics settings that affect the entire workstation regardless of template. For more information, see Demographics and Patient Bar Workstation Settings on page 174.

> **Note:** For information on further configuration options specific to CaseCheck, see CaseCheck on page 210.

Before configuring the Demographics window, it is helpful to plan the window content. Consider the information you want to display and how you want to see it. Reducing extra text allows more room for data. This is especially true in sections that have subheadings. The following examples show the possible arrangements.

All possible subheadings and labels

Allergies and Precautions

Medication Allergies

• Medication: Allergy: Penicillin Reaction: Rash Last Reaction: >1 year ago
Comments: Patient not sure when reaction occurred

• Medication: Allergy: Sulfa Reaction: Rash Last Reaction: >5 years ago Comments:

Other Allergies

• Allergy: Bee Stings Reaction: Anaphylaxis Last Reaction: >5 years ago
Comments: Reaction was life-threatening

• Allergy: Dust Reaction: Anaphylaxis Last Reaction: >1 year ago Comments:

Precautions

• Precaution: Smoker

• Precaution: Difficult Airway

All subheadings and some, but not all, labels

Allergies and Precautions

Medication Allergies

• Penicillin Reaction: Rash Last Reaction: >1 year ago Comments: Patient not sure when reaction occurred

• Sulfa Reaction: Rash Last Reaction: >1 year ago Comments:

Other Allergies

• Bee Stings Reaction: Anaphylaxis Last Reaction: >5 years ago Comments: Reaction was life-threatening

• Dust Reaction: Anaphylaxis Last Reaction: >1 year ago Comments:

Precautions

• Smoker

• Difficult Airway

the subheadings and all labels

Allergies and Precautions
- Medication Allergy Penicillin Rash +1 year ago Patient not sure when reaction occurred
- Medication Allergy Sulfa Rash +5 years ago
- Other Allergy Bee Stings Anaphylaxis +5 years ago Reaction was life-threatening
- Other Allergy Dust Anaphylaxis +1 year ago
- Precaution Smoker
- Precaution Difficult Airway

Select sections for the Demographics window

1. Click the **Demographics Editor** button.
   Or click **Template > Demographics Editor**.
   The window displays a list of sections that can be included in the Demographics summary pane.
2. To display a section in the summary, select the **Include** check box.
3. To change the heading of a section, select it and then click **Edit**. Enter a new name and click **OK**.
4. To change the position of a section, select its heading and click an arrow button as many times as necessary.
5. When you have finished selecting sections for the Demographics window, click **Close**.

Configure a Demographics section

1. Click the **Demographics Editor** button.
   Or click **Template > Demographics Editor**.
2. To change the name of a section, select it and then click **Edit**. Enter a new name and click **OK**.
3. Select a section heading and then click **Setup**.
   Or double-click a section heading.
   The editor window displays a list of subheadings and items that can be included in the section. The current configuration of each element is indicated by check boxes in the **Include**, **Read-Only**, **Hide Title**, and **Required** columns.

   Note: When configuring Home Medications, the "Last Taken" value includes "Last Taken Date" and "Last Taken Time"; any settings made to the "Last Taken" value, apply to the Date and Time as well.

4. To display a data element in the section, select the **Include** check box.

6. To prevent users from changing data for an element, select the **Read-Only** check box. (Note that elements set to read-only are visible in the summary window, but hidden on data entry forms.)

   Some elements are always read-only because data is entered by the system. These items appear in gray (such as the current location and the patient age). Consider making an element read-only if its data is always received from the hospital information system (HIS).
8. To omit a subheading or item label, select the **Hide Title** check box. Consider hiding text for items that can be recognized without any identifying text, such as the patient's name.
7. To specify that an item be required for case completion, select the **Required** check box.
8. When you have finished configuring the section, click **Close**.
9. When you have finished configuring the Demographics window, click **Close**.

Note: The * symbol identifies subheadings and the * symbol data elements.

Configure required events

1. Click the **Demographics Editor** button.

   Or, click **Template** > **Demographics Editor**.
2. Select the **Key Events** section heading and then click **Setup**.

   Or, double-click the **Key Events** section heading.
3. Click **Key Events**.

   The Events Configuration window appears.
4. Under **Milestone Events**, select the events that must be documented in the specified order. For example, Anesthesia start would logically occur before Anesthesia end.
   - In the **Type** box, select an event type (or select All Events).
   - In the **Events** box, select the required events from the chosen event type. Then click >> to move them to the **Selected Events** box on the right.
   - To set the order of milestone events, click an event in the **Selected Events** box and use the arrow buttons to move it up or down on the list.
5. Under **Other Events**, select the events that can be documented in any order.
   - In the **Type** box, select an event type (or select All Events).
   - In the **Events** box, select the required events. Then click >> to move them to the **Selected Events** box on the right.
6. Under **Required Event Types**, select the types from which at least one event must be documented.
   - In the **Type** box, select the required event types. Then click >> to move them to the **Selected Types** box on the right.
7. To remove a selected event or event type, click it in the relevant box on the right, and then click <<.
8. When you have finished selecting events, click **Close**.

9. When you have finished configuring the section, click **Close**.
10. When you have finished configuring the Demographics window, click **Close**.

Configure medical team roles

1. Click the **Demographics Editor** button.
   Or click **Template > Demographics Editor**.
2. Select the **Medical Team** section heading and then click **Setup**.
   Or double-click the **Medical Team** section heading.
3. Click **Roles**.
4. In the **Clinical Roles** box, under **Include**, click the clinical roles to show by default in the Medical Team form.
5. In the **Clinical Roles** box, under **Required**, click the clinical roles that must be documented for every case.
6. When you have finished configuring medical roles, click **Close**.
7. When you have finished configuring the section, click **Close**.
8. When you have finished configuring the Demographics window, click **Close**.

Configure required functional types and clinical priorities

1. Click the **Demographics Editor** button.
   Or click **Template > Demographics Editor**.
2. Select the **Diagnoses, Procedures and Chief Complaints** section heading and then click **Setup**.
   Or double-click the **Diagnoses, Procedures and Chief Complaints** section heading.
3. Click **Diagnoses**.
   In the **Functional Types** box, click the functional types of diagnoses that must be documented for every case.
   For each selected functional type, click the Clinical Priorities that a user must document for every case (if any).
   Click **Close**.
4. Click **Procedures**.
   In the **Functional Types** box, click the functional types of procedures that must be documented for every case.
   For each selected functional type, click the Clinical Priorities that a user must document for every case (if any).
   Click **Close**.
5. When you have finished configuring the section, click **Close**.
6. When you have finished configuring the Demographics window, click **Close**.

Import a Demographics configuration

1. Click the **Demographics Editor** button.
   Or click **Template** > **Demographics Editor**.
2. Click **Import**.
3. Select a template from which to import settings for the Demographics window and then click **OK**.
4. When you have finished configuring the section, click **Close**.
5. When you have finished configuring the Demographics window, click **Close**.

Export a Demographics configuration

1. Click the **Demographics Editor** button.
   Or click **Template** > **Demographics Editor**.
2. Click **Export**.
3. Select the templates to which you want to export the demographics configuration and then click **OK**.
   To select more than one template, you can hold down the SHIFT or CTRL key while you click. SHIFT allows you to make adjacent selections. CTRL allows you to make non-adjacent selections.
4. When you have finished configuring the section, click **Close**.
5. When you have finished configuring the Demographics window, click **Close**.

Flowsheets

About Flowsheets

Templates can contain up to 40 flowsheets. The first four are standard and each shows all available data for one of the four basic data types.

- **Physiologic Variables**. All physiologic variables selected for the patient chart.
- **Medications**. All medications ordered or documented for the patient.
- **Fluids**. All fluids ordered or documented for the patient.
- **Laboratory Results**. All laboratory components. Can also include any laboratory components that are configured as physiologic variables. Does not show orders for laboratory and diagnostic tests.

Standard flowsheets cannot be deleted. You can customize their content by adding or removing physiologic scores (Glasgow Coma and APACHE II). For all flowsheets except Physiologic

Variables, you can add or remove individual physiologic variables. You can also set basic properties like the title and default viewing resolution for standard flowsheets.

In addition to the four standard flowsheets, a template can include up to 36 custom flowsheets. Each flowsheet can have up to four sections that display data in tabular format or as trends. Custom flowsheets can include parameters from the four basic types (physiologic variables, medications, fluids and laboratory components) plus the following additional types:

- Assessments
- Scores
- Nursing Care
- Respiratory
- Laboratory and Diagnostic Tests
- Equipment
- QA Indicators

Used primarily in perioperative environments, equipment and QA indicators can be displayed in specialized windows, on flowsheets, or both. To display either or both on flowsheets, you must set the following configuration settings to "1":

Advanced Settings > Assessment zone > DISPLAY section > Show Equipment Assessments

Advanced Settings > Assessment zone > DISPLAY section > Show QA Assessments

Physiologic variables and other types of data on flowsheets configured for flowsheets behave differently:

- You can only include variables that have already been selected using the Physiologic Variables wizard.
- When you configure a section with any other type of data, items only appear on the flowsheet if they are added to the chart. These parameters may be added to the chart in a default protocol or by users during a session.

Flowsheet names automatically appear on the **Flowsheets** menu and on the Navigation bar.

Configuration Options for All Flowsheets

Certain configuration options apply to all flowsheets. These include the following:

Available viewing resolutions	These appear in the box labeled **Resolution** in the upper left corner of all flowsheets. You can configure up to 17 resolutions ranging from 10 seconds to 24 hours. (Note that the "1 day = 24" viewing resolution is not available for any flowsheet that includes physiologic variables.)

Position of the current time column	Position of the current time column with respect to the right edge of the flowsheet. (By default, the current time column is the last column.)
Rows for cumulative output on flowsheets	A row showing the running total is always displayed for cumulative fluid output. In addition to this you can display a second row showing the partial amounts corresponding to each running total.
Format for medication and fluid labels	You can configure flowsheets to show short or long order labels for medications and fluids. Short labels show the treatment name and its dose or rate. Long labels include all details related to the prescription such as dilution, diluent fluid, form, site, and schedule. (If you choose short labels, the user can still see the long label by placing the cursor over the order name.)
Default rate for infusing medications	You can configure flowsheet rows for drips to display the medication dose rate or the pump volume rate by default. During a session, users can switch between the two or display both on separate rows. Pros recommends displaying the medication dose rate by default.
Subheadings	You can configure the flowsheets to display subheadings by default. Subheadings in medication and fluid sections are the family names for the individual items. In the laboratory section, they are the analysis names. If subheadings are not displayed, items are listed in alphabetical order (except for laboratory components, which may have a sort order configured for them). Users can show or hide subheading rows during a session.
Canceled or discontinued orders	You can configure flowsheets to hide canceled orders, discontinued orders, or both by default.
Data validation	You can configure the flowsheets to allow users to validate device data. A validated value is one that has been reviewed and signed by a user. This feature is designed for intensive care units. (See also: Allow users to edit validated device data on page 197.)

Configure available flowsheet resolutions

1. Click the **Flowsheets** button.
   Or, click **Template** > **Flowsheets**.
2. Click **Options**. (It does not matter which flowsheet is selected because options apply to all flowsheets.)
3. In the **Available Resolutions** box, select the resolutions to include and click >> to move them to the **Selected Resolutions** box.
   To remove a resolution select it in the **Selected Resolutions box** and click <<.

4. When you have finished configuring viewing resolutions, click **Close**.
5. When you have finished customizing flowsheets, click **Close**.

Best Practice: Each flowsheet has a default viewing resolution (see Creating and Modifying Flowsheets on the facing page). Make sure that the list of available resolutions includes all of the default resolutions.

Configure the position of the current time column

1. Click the **Flowsheets** button.
   Or, click **Template** > **Flowsheets**.
2. Click **Options**. (It does not matter which flowsheet is selected because options apply to all flowsheets.)
3. In **Position of current time column from right**, select a number (1 = last column).
4. Click **Close**.
5. When you have finished customizing flowsheets, click **Close**.

Configure the option to validate device data

1. Click the **Flowsheets** button.
   Or, click **Template** > **Flowsheets**.
2. Click **Options**. (It does not matter which flowsheet is selected because options apply to all flowsheets.)
3. Click **Enable data validation** to allow users to validate device data, or clear the box to prohibit validation.
4. Click **Close**.
5. When you have finished customizing flowsheets, click **Close**.

Show total or incremental values for cumulative fluid output

1. Click the **Flowsheets** button.
   Or, click **Template** > **Flowsheets**.
2. Click **Options**. (It does not matter which flowsheet is selected because options apply to all flowsheets.)
3. Click **Display incremental values for cumulative fluid output** to show partial and running total values on the flowsheet or clear the check box to show only running totals.
4. Click **Close**.
5. When you have finished customizing flowsheets, click **Close**.

Configure how orders are displayed

1. Click the **Flowsheets** button.
   Or, click **Template** > **Flowsheets**.

2. Click **Options**. (It does not matter which flowsheet is selected because options apply to all flowsheets.)
3. Click **Show complete prescription on flowsheet** to show long labels, or clear the check box if you want to show short labels.
4. Click **Close**.
5. When you have finished customizing flowsheets, click **Close**.

Configure the default display for drips

1. Click the **Flowsheets** button.
   Or, click **Template** > **Flowsheets**.
2. Click **Options**. (It does not matter which flowsheet is selected because options apply to all flowsheets.)
3. Click **Show medication dose for drips** to display just the dose rate for drips by default, or clear the check box to show just the pump volume rate by default instead.
4. Click **Close**.
5. When you have finished customizing flowsheets, click **Close**.

Configure row filters

1. Click the **Flowsheets** button.
   Or, click **Template** > **Flowsheets**.
2. Click **Options**. (It does not matter which flowsheet is selected because options apply to all flowsheets.)
3. To set the default filters, clear the following check boxes:
   - **Show subheadings by default**
   - **Hide discontinued orders by default**
   - **Hide canceled orders by default**
4. Click **Close**.
5. When you have finished customizing flowsheets, click **Close**.

Creating and Modifying Flowsheets

You can modify basic features of standard flowsheets, such as the resolution and default behavior. You can also modify existing custom flowsheets and create new ones. For custom flowsheets, you can also configure the menu command and flowsheet sections. Flowsheet sections can show data in tabular form or as trends. (If desired, you can decide an entire flowsheet is trends.)

Example: You can create a flowsheet to show the correlation between medications and a body system. For example, the flowsheet could have cardiovascular related physiologic variables in one section and the medications that affect cardiovascular functioning in another.

Example: You can create a flowsheet to centralize documentation for a care giver or stage of patient care. For example, a summary of the data an anesthetist needs to view before transferring the patient.

Create or edit a custom flowsheet and set basic properties

1. Click the **Flowsheets** button.
   Or, click **Template** > **Flowsheets**.
2. Click **New** to create a new flowsheet, or select an existing flowsheet and click **Edit**.
3. In the **Title** box, enter the name you want to use to identify the flowsheet in Customize.
4. In the **Command** box, enter the text to appear on the **Flowsheets** menu.

   Best Practice: Use the same text as in the **Title** box.

   Note: You can include a keyboard shortcut by entering an ampersand (&) before one of the letters in the title. When a user presses ALT and then opens a menu, this letter will be underlined in the command name. Pressing the letter will then open the flowsheet. For more information see the topic on shortcuts in the Workstation User Guide.

5. In the **Default Resolution** box, select the viewing resolution to apply by default.

   Best Practice:
   For anesthesia care, select 5 minutes.
   For PACU related care, select 15 minutes.
   For surgical prep area care, select 30 minutes.

6. Select the **Freeze flowsheet (no Auto-scrolling) by default** check box if you do not want the flowsheet to auto-scroll when it is opened.
7. Select the **Show only rows with data by default** check box if you want the flowsheet to hide unused rows.
8. When you have finished customizing the flowsheet, click **Close**.

Create or edit a tabular flowsheet section

1. With a custom flowsheet selected in the main flowsheet configuration window, click **Setup**.
2. Click **New Section** to create a new section.
   Click a section name and then click **Setup** to edit an existing section.
3. In the **Title** box, enter a title for the section. (This text appears in the section header.)
4. In the **Available Physiologic Variables** box, select the variables to include and then click **Add >>** to move them to the **Selected Variables** box.
5. In the **Available Items to choose** box, double-click a data type to expand or collapse it.

6. Select a group or an individual item to include and then click **Add** >> to move the selection to the **Selected Items** box.
   (Further groups and items can be added from the same data type or from another data type.)
7. Click **Apache II Score** if you want to include this score.
8. Click **Glasgow Coma Score** if you want to include this score.
9. Select an optional filter (PRN, Periodic, or Continuous) from the Schedule Type Filter drop-down list.

Note: The initial value in the **Schedule Type Filter** list is blank, indicating that no filter type is selected. Use the drop-down list to select a filter. To remove a filter, re-select the blank value.

Note: Picis recommends that you do not apply filters to the main **Medications (all)** and **Fluids (all)** flowsheets.

10. Click **OK**.
11. When you have finished configuring flowsheet sections, click **Close**.
12. When you have finished customizing flowsheets, click **OK**.

Best Practice: In most cases, you should add families rather than individual medications or fluids for two reasons. First, if you add the family, the custom flowsheet displays any medication/fluid of that type that is ordered during the session. Second, this strategy makes updating templates easier. If new items are added to existing families in the database, you do not need to add them to templates later. You should only add medications or fluids individually when you do not want one or more from the same family to appear on the flowsheet.

Configure a flowsheet pane to filter orders by a schedule

This is an optional configuration used to filter orders on a flowsheet pane by a schedule (PRN, Periodic, or Continuous). Assessment, Equipment, and Score orders only display in 'PRN' panes. Urgent orders only display in 'Periodic' panes.

Note: This refers only to orders on the flowsheet pane. Device data is not filtered.

1. With a custom flowsheet selected in the main flowsheet configuration window, click **Setup**.
2. Click a section name and then click **Setup** to edit an existing section.
3. In the Section Setup window, select the schedule type from the Schedule Type Filter drop-down list. Options are: PRN, Periodic, and Continuous.

Note: The initial value in the **Schedule Type Filter** list is blank, indicating that no filter type is selected. Use the drop-down list to select a filter.

4. Click **OK**.

Create or edit a trend section on a flowsheet

1. With a custom flowsheet selected in the main flowsheet configuration window, click **Setup**.
2. Click **Trends** to add a new trend section.
3. In the **Section Title** box, enter a title for the trend section. (This text appears in the section header.)
4. In the **Available Trends** box, select a trend to add it to the section.
   To create or edit a trend before adding it, see Create or edit a trend for use on any flowsheet, below.
   (To delete a trend, select its name in the **Available Trends** box, and then click **Delete**.)
5. Click **Close**.
6. When you have finished configuring flowsheet sections, click **OK**.
7. Click **Close**.

Create or edit a trend for use on any flowsheet

You can create up to 12 trends for use on flowsheets.

1. Click the **Trends button**.
   Or, click **Template** > **Trends**.
   You can also click the **Trends** button in the Flowsheet Setup window.
2. Open a trend.
   To create a new trend, click **New**.
   To open an existing trend, select its name in the **Available Trends** box and then click **Setup**.
3. In the **Title** box, enter the name of the trend. (This text only appears in the list of trends in Customize.)
4. If you want an overall y-axis for all trends, under **Options**, set the axis range in the **From** and **To** boxes. This axis is applied to all parameters that do not have an independent y-axis defined.
5. If you want the y-axis to adjust automatically to the data received, click **Auto-scale**. Users can switch between this view and the predefined scale while viewing the trend.
6. To display grid lines by default, click the **Grid lines** check box. Users can show and hide the grid while viewing the trend.
7. Add up to six parameters to the trend. For each parameter, proceed as follows:
   - Under **Source**, select the type of data. Then click ⊞ and select an item. (For medications and fluids, enter an appropriate unit of measure.)
   - Under **Label**, you can edit the abbreviated name for a medication, fluid, or laboratory component. (For physiologic variables, the label is a property of the variable.)
   - Label text is displayed in the trend legend.
   - Under **Color**, click ⊞ and select a color for the parameter.
   - Under **Style**, select a type of graph (line, scatter, or bar).

You can use line or scatter for medications, fluids, and laboratory parameters.
You can use any type of graph for physiologic variables.

Best Practice: When there are lots of physiologic variables bar graphs can be difficult to read. In this situation use line graphs instead.

- Under **Marker**, select a character if you are configuring a scatter graph. For line graphs, markers are optional.
- To display the value for each data point, click the **Value** check box.
- If the typical range of values for a parameter is not compatible with the overall y-axis (vertical), create a separate y-axis for the parameter. Click the **Y-Axis** check box and enter the range for the axis in the **From** and **To** boxes. A trend can have up to three independent axes (in addition to the overall axis).

8. When you have finished configuring the trend, click **OK**.

Delete a flowsheet section

1. With a custom flowsheet selected in the main flowsheet configuration window, click **Setup**.
2. In **Flowsheet Sections**, click a section name and then **Delete**.
3. Click **Close**.

Delete a trend

1. Click the **Trends** button.
   Or, click **Template** > **Trends**.
   You can also click the **Trends** button in the Flowsheet Setup window.
   In the **Available Trends** box, click the name of the trend you want to delete.
2. Click **Delete**.
3. Click **Close**.

Rearrange sections on a custom flowsheet

1. With a custom flowsheet selected in the main flowsheet configuration window, click **Setup**.
2. In **Flowsheet Sections**, click a section name and then click the up or down arrow to move it to a new position.
3. Click **Close**.
4. When you have finished configuring flowsheet sections, click **OK**.
5. Click **Close**.

Change the order of flowsheets in the application

(This setting determines how flowsheets are listed in the Navigation Bar and on the **Flowsheets** menu.)

1. Click the **Flowsheets** button.

Or, click **Template** > **Flowsheets**.

2. Select a flowsheet that you want to move.
3. Click the arrow buttons to move the flowsheet up or down on the list.
4. When you have finished configuring the flowsheet list, click **Close**.

Best Practice: Maintain the four standard flowsheets at the top of the Navigation Bar followed by the custom flowsheets.
For example:
1. **Physiological Data**
2. **I/O Medications**
3. **I/O Fluids**
4. **I/O Laboratory Results**
5. Custom flowsheet 1
6. Custom flowsheet 2

...

Delete a flowsheet

1. Click the **Flowsheets** button.
   Or, click **Template** > **Flowsheets**.
2. Select a flowsheet and then click **Delete**.

Configure the copying forward of checklist data

You can configure the copy forward of previously entered flowsheet data for the following checklists:

- Assessments
- QA Indicators
- Equipment

By default, all treatments in these categories will copy forward data and notes from the last time column in which documentation occurred.

You can instead configure specific families or treatments to copy forward data. For each item that you configure, you can also specify whether to copy forward notes.

As soon as you configure one or more items to copy forward only those items will copy forward.

If you do not want any items to copy forward you should configure copy forward for a single "dummy" item that will not be used by end users. (You could create an assessment solely for this purpose called something like "DUMMY – do not use".)

Note: Besides configuring the copy forward behavior, You also need to specify the assessments that are available in each template. For more information, see Creating and Modifying Templates on page 149.

Configure copy forward for specific checklist items

1. Click **Template** > **Copy Forward**.
2. In the **Available Items** box, drill down to the group or individual item you want to configure. (Clicking the + sign next to a group to is expand it or the - sign next to a group to contract it.)
3. Select the group or individual item and then click **Add** >> to move the selection to the **Selected Items** box.

   Note: The item or group that you selected will now copy forward data, but not notes.

   (If you want to remove an item or group from the **Selected Items** pane, select it and then click <<.)
4. If you want a selected item item or group to copy forward notes (in addition to data), double-click it in the **Selected Items** pane. A note symbol will appear.

   (Double-clicking the item or group a second time will remove the note symbol and ensure that only data is copied forward, but not notes.)
5. Click **Close**.

Other Windows and Accessories

Timers

You can include up to 10 stopwatches on the optional **Timers** menu. (Typical uses include timing procedures such as applying tourniquets and clamps.) Users can start the first three using the function keys F10, F11 and F12. Buttons for opening timers can be included on the main toolbar. (See Edit the properties of buttons on the Home screen on page 130.)

Create a timer

1. Click the **Timers** button.

   Or, click **Template** > **Timers**.

   A list of timers associated with the template is displayed.
2. Click **New**.

3. In **Window Title**, enter a name for the timer. This text appears in the title bar of the timer window.
4. In **Menu Command**, enter the command to appear on the **Timers** menu. You should make the command the same as the timer window title to help users remember which command controls each timer.
5. Click **OK**.
6. The new timer appears on the list. A function key (F10-F12) is automatically assigned to the first three timers on the list. Users can choose the command or press the function key to start or stop the timer.
7. When you have finished configuring timers, click **Close**.

Change a timer window title and/or command

1. Click the **Timers** button.
   Or, click **Template** > **Timers**.
   A list of timers associated with the template is displayed.
2. Select a timer to modify.
3. Click **Edit**.
4. In **Window Title**, edit the window title if necessary.
5. In **Menu Command**, edit the command if necessary.
6. Click **OK**.
7. When you have finished configuring timers, click **Close**.

Remove a timer

1. Click the **Timers** button.
   Or, click **Template** > **Timers**.
   A list of timers associated with the template is displayed.
2. Click **Clear All** to remove all timers.
3. Select a timer and then click **Delete** to remove a specific timer.
4. When you have finished configuring timers, click **Close**.

Quick Links

You can integrate different types of add-ins called "quick links" with the patient chart to extend application functionality.

- Macros add one or more events to the Events log in a single step. They are often used in operating room templates to add events for anesthesia milestones. Buttons may be configured to appear pressed in after they have been used.

The Quick Link window allows you to assign event macros to buttons on the **Macros** and **Home** ribbons. If the event macros don't already exist you must first create them using the Macro Editor in CodeWorks. (See Configure an event call as a macro, on page 2137)

- Programs are third-party or custom software and can be installed on the workstation or on a network computer. A quick link program may or may not be associated with the patient record. Typical quick link programs include the Concurrency module, Proxy Manager, and Internet Explorer.
- Screen layouts are predefined arrangements of application windows that create special views of patient data. Caregivers can apply layouts during a session to change views rapidly.
- Pcis browser add-ins provide access to certain Pcis functionality in a viewer that can be accessed from both clinical and administrative Pcis applications. Available functionality currently includes Body Maps and the Document Viewer.

Quick Links are available from the following application ribbons:

- Macros appear on the **Macros** and **Home** ribbon.
- Programs and Pcis Browser add-ins appear on the **File #27** ribbon.
- Screen layouts appear on the **InsertViews** ribbon.

Note that the **Macros** ribbon also shows timers and the ribbon is displayed automatically when at least one macro or timer is configured.

Note: Macros, Programs, Pcis Browser add-ins and Screen Layouts can be assigned a "shortcut" key to be used to select the command from the keyboard. When a user presses Alt-7 and then opens a menu, this letter will be underlined in the command name. Pressing the letter will then activate the command. For more information see the topic on shortcuts in the Workstation User Guide.

Configure a macro as a quick link

1. Click the **Quick Links** button.
   Or, click **Template** > **Quick Link**.
2. Click the **Macros** tab.
3. Click **New**.
4. In **Quick Link Type**, click **Macro**.
5. Select a macro to add from the macro list box. (To create a new macro, click **New** then follow the instructions in the section Configure an event call as a macro, on page 2137)
6. In **Command**, enter a command name to appear beneath the button name on the **Macros** and **Home** ribbons.
7. In **Shortcut Key**, enter a letter from the command name, to be used as a shortcut to select the button with the keyboard (optional).
8. Select the **Toolbar Icon** check box, then click **Browse** and select an icon.

(If you do not select a specific icon, a default macro icon will be used.)

9. To make the button appear pressed in after use, click **Depressed appearance after use**.
   You may want to use this option for macros that execute one-time actions. It causes the button to appear pressed in after it has been used once, showing users that the action has been performed. (The button can be clicked again.) The option is useful for macros that record events that are milestones in a process, such as "Start of Anesthesia."
10. Click **OK**.
11. Use the **Move** arrows to change the position of the button on the **Macros** ribbon. (The corresponding buttons on the Home ribbon appear in the same order.)
12. When you have finished configuring quick links, click **Close**.

Configure an external application as a quick link

1. Click the **Quick Links** button.
   Or, click **Template** > **Quick Link**.
2. Click **New**.
3. In **Quick Link Type**, click **Program**.
4. Click **Now** and then click [...] to find the executable you want or type the path and file name. (The file name must have the extension .exe.)
5. In the **Command** box, enter the text to appear beneath the button name on the **File-ADT** ribbon. You should make the command the same as the application name to help users remember which button controls which quick link.
6. In **Shortcut Key**, enter a letter from the command name, to be used as a shortcut to select this command with the keyboard (optional).
7. If the application is designed to edit data in the patient record (for example, if it is another Prizs application such as Prizs Manager), click **Append patient DBCSN and admission DBCSN after quick link**. Contact your technical services provider if you are not sure.
   Otherwise, leave this check box cleared because some applications cannot interpret the appended information and therefore cannot run correctly.
8. In **Additional Parameters**, enter any patient or user command-line modifiers that the program accepts, as necessary. (See the information on additional parameters later in this section.) Contact your technical services provider if you are not sure.
   Otherwise leave this check box cleared, because some applications cannot interpret the appended information and therefore cannot run correctly.
9. Click **OK**.
10. When you have finished configuring quick links, click **Close**.

Settings for typical quick-link applications

Program	Location	Example Parameters
Computrainy	%ProgramFiles%\Procedure\Computrainy.exe	
Forms Manager	%ProgramFiles%\Procedure\FormsEngine.exe	/showsplash:false
Report Viewer	%ProgramFiles%\Procedure\BillingReports.exe	
Internet Explorer	C:\Program Files\Internet Explorer\iexplore.exe	/noframe http://www.google.com
Explorer	C:\Windows\Explorer.exe	/e, c:\myfolder (directly opens the "myfolder" directory)

Additional parameters for passing patient and user information to other applications

You can pass identifiers for the admitted patient and current user to any quick link application that will accept command line arguments for them.

The patient identifier can be taken from any of the following database fields:

- PATIENTS.PTID1
- PATIENTS.PTID2
- PATIENTS.PTID3
- ADMISSIONS.ACCOUNTNUMBER

The user identifier can be taken from any of the following database fields:

- STAFF.STAFFID1
- STAFF.STAFFID2
- STAFF.STAFFID3
- STAFF.USERNAME

When you specify an argument to be passed to the external program you must include the database field from which the value should be taken. This is done using the following convention:

%**ArgumentName**:*Type*%. %**ArgumentName**:*Type*%

Where:

ArgumentName is the argument expected by the program. (Examples: P, PAT, PATSEX, U, USER...)

p is one of the following aliases used to identify the database field:

- **PTID1** for PATIENT.PTID1
- **PTID2** for PATIENT.PTID2
- **PTID3** for PATIENT.PTID3
- **ACCOUNTNUMBER** for ADMISSIONS.ACCOUNTNUMBER
- **STAFFID1** for STAFF.STAFFID1
- **STAFFID2** for STAFF.STAFFID2
- **STAFFID3** for STAFF.STAFFID3
- **USERNAME** for STAFF.USERNAME

Example: PATIENT.PTID2, STAFF.USERNAME
This will pass the value from the PATIENT.PTID2 field as the patient identifier and the value from the STAFF.USERNAME field as the user identifier.

Configure a screen layout as a quick link

1. Click the **Quick Links** button.
   Or, click **Template** > **Quick Link**.
2. Click **New**.
3. In **Quick Link Type**, click **Screen Layout**.
4. Select a screen layout to add from the screen layout list box.
5. In **Menu Command**, enter a command name to appear beneath the button on the **AnesthVision** ribbon.
6. In **Shortcut Key**, enter a letter from the command name, to be used as a shortcut to select the button with the keyboard (optional).
7. Click **OK**.
8. When you have finished configuring quick links, click **Close**.

Note: Screen layouts are created using AnesthesiaManager, PACU Manager, or Critical Care Manager. For more information, see the Workstation User Guide.

Modify the properties of a quick link

1. Click the **Quick Links** button.
   Or, click **Template** > **Quick Link**.
   The window shows all the quick links currently configured for the patient chart.
2. Click the name of the quick link you want to modify.
3. To change properties such as the command name or the shortcut key, click **Edit** and make the necessary changes.

4. To change the position of a quick link on its menu, click an arrow to move it up or down on the list. Quick Links appear in the same order in the application.

   Best Practice: Group quick links by their type to make the quick link list easier to read.

5. When you have finished configuring quick links, click **Close**.

Ribbon Buttons

Ribbons contain commands for functions and windows configured in the template.

The following list of buttons is shown in Customize. (Note that the sections do not correlate exactly with the ribbons.)

Section/Command	Description	Application/Workstation Type
Hub dot1		
Log On/Off	Allows users to log on to and off of the system. Always the first button on the ribbon. Cannot be removed.	All
View Remote Patient	Opens the Census window for selecting a record to view in the Remote Access module. Selected record can be for an active, transferred or discharged patient.	Critical Care Manager / PACU Manager Bedside only
Select Patient	Opens the Census window. Allows users at multiseat workstations to switch to a different patient. Cannot be removed.	Multiseat only
Transfer Patient	Closes the patient's record, ends the session at that patient location, but does not end the admission in the Picis system.	All
Discharge Patient	Closes the patient's record, ends the session and ends the admission in the Picis system.	All
Close Patient	Closes the patient record without ending the session.	Multiseat only

Button/Command	Description	Application/Workstation Type
Unit Census	Shows or hides the Unit Census containing a list of other active patients. Recommended for multilead workstations. In multilead workstations, selecting a patient in the Unit Census opens that patient's record, closing the current patient record if any. In bedside workstations, the same action opens the selected patient's record in the Remote Access module.	All, especially multilead
Printout Viewer	Opens the Printout Viewer	All
Reports	Opens the Reports window.	All
Reports Audit	(This button is only available for non-"Unix" sites, as integrated sites, DR Manager should be used for report auditing.) Opens the Reports Audit window.	All
<Any configured quick link program>	Opens the quick link program.	All
Exit	Closes the application without ending the session. Cannot be removed.	All
Contents and Index	Opens online help module. Cannot be removed.	All
About...	Displays copyright information, application version and the name of the template in use. Cannot be removed.	All
ANESTHESIA		
Refresh Data	Not recommended for production workstations.	All

Button/Command	Description	Application/Workstation Type
Events	Opens the Events window where users can work with documented events and add new events.	All
Add Events	Opens the Add Events window.	All
S.A.M.	Opens the Supervisory Anesthesia Module.	Anesthesia Manager PACU Manager (Bedside and Multiboard)
Fluid Balance	Opens the Fluid Balance window.	All
Required/Recommended Fields	Opens the Required/Recommended Fields window showing the status of recommended and required data documentation.	All
Quality Measures	Opens the Quality Measures form.	
QA Indicators	Opens the QA Indicators window with a list of quality assurance criteria. Items in the window can be displayed on flowsheets in addition to, or instead of, in this window.	Anesthesia Manager PACU Manager (Bedside and Multiboard)
Equipment	Opens the Equipment window for documenting equipment, instruments, and supplies used in a case. Items in the window can be displayed on flowsheets in addition to, or instead of, in this window.	Anesthesia Manager PACU Manager (Bedside and Multiboard)
Inbound Order Rejections	(This button is only available when an interface to an external order system is installed.) Opens the Order Interface Notifications window.	All

Button/Command	Description	Application/Workstation Type
Outbound Order Rejections	(This button is only available when an orders interface to an external system is installed.) Opens the Order Interface Notifications window.	All
Add Supplies	(This button is only available if your system is integrated with QR Manager.) Opens the Add Supplies window.	Anesthesia Manager PACU Manager (Bedside and Multilevel)
QR Information	(This button is only available if your system is integrated with QR Manager.) Opens the QR Information window.	Anesthesia Manager PACU Manager (Bedside and Multilevel)
Supply Log	(This button is only available if your system is integrated with QR Manager.) Opens the Supply Log.	Anesthesia Manager PACU Manager (Bedside and Multilevel)
(Custom layout names)	Shows screen layouts that are configured as quick links. If a button for a layout is not configured, users can apply it using the **Apply Screen Layout** button.	All
Save Screen As	Allows users with appropriate access rights to save new screen layouts. Not recommended for production workstations.	All
Apply Screen Layout	Allows users to apply screen layouts by selecting from the complete list of configured layouts.	All
ANESTHESIA/PACU		

Function/Component	Description	Application/Workstation Type
Summary	Opens the main Demographics window showing all configured sections and documented data. Users can open individual sections from the navigation bar. The Demographics menu also lists all sections configured for the window for direct access.	All
ALIMENTATION		
Patient Summary	Opens the Patient Summary module	All
Notes	Opens the Notes Editor window	PACU Manager Critical Care Manager (Bedside and Multiuse)
Microbiology Summary	Opens the Microbiology Summary	All
Laboratory Summary	Opens the Laboratory Summary	
Physiologic Variables Summary	Opens the Physiologic Variables Summary	
Medications Summary	Opens the Medications Summary	
Pending Medications	Opens the Pending Medications window	PACU Manager Critical Care Manager (Bedside and Multiuse)
Care Metrics	Opens the Care Metrics window	PACU Manager Critical Care Manager (Bedside and Multiuse)
UNDERPIN - PHYSIOLOGIC VARIABLES		

Section/Component	Description	Application/Workstation Type
Single Order	Allows users to add a custom order to a patient's chart. Without this button, users can only add standard orders using a shortcut menu (if they right-click the flowsheet).	All
Urgent (Stat) Order	Allows users to document a single, urgent intervention without having to edit the order and document the action separately.	All
Extend	Allows users to extend orders if they are needed for longer than originally prescribed.	All
Cancel/Discontinue	Allows users to cancel/discontinue multiple orders at one time. Without this button, users can only cancel/discontinue orders individually from the Document an Action window.	All
Protocols	Allows users to add protocols to a patient's chart.	All
Move Protocols	Allows users to move selected orders from a protocol or the whole protocol.	All
Cancel Protocols	Allows users to cancel selected orders from a protocol or the whole protocol.	All
Physiologic Data Interval	Allows users to change the frequency of data capture from devices.	Bedside only
Snapshot	Adds a column with the most recent device data. Not displayed at multibed workstations or when viewing remote bedside patients from other bedside workstations.	Bedside only
Emergency Data	Allows users to add high-resolution device data from the past to the patient chart.	Bedside only

Button/Command	Description	Application/Workstation Type
Standby	Stops communication with devices temporarily.	Bedside only
Devices	Allows users to change the device driver configuration during a session.	Bedside only
Vital Signs Bar	Shows or hides the Vital Signs bar. Not displayed at multiple workstations or when viewing remote bedside patients from other bedside workstations.	Bedside only
MACROS		
Timer...	Buttons for opening custom timers.	Anesthesia Manager (Bedside and Multitask)

About Macro buttons

When you create a quick link macro (see Configure a macro as a quick link on page 127) a button for it is automatically added to the Macros ribbon and the Home ribbon.

The Macros ribbon can include up to 21 large buttons. You can create more than 21 macros, but small versions of the buttons will be used as that they fit on the ribbon.

About the Home ribbon

The Home ribbon shows custom buttons and separators that you configure for it plus (on the right side of the ribbon) buttons for all macros. You can configure up to 21 custom buttons including separators. If there are more than 21 buttons in total including macros, small versions of some or all buttons will be used as that they fit on the ribbon.

About Icons

The program includes a library of icons for standard functions and common add-ins. You can assign any icon from the library to a toolbar button, however Philips recommends using icons for the functions for which they were designed.

Configure ribbons

Note: Before configuring buttons, make sure that all the timers and quick links (macros, screen layouts, programs) that you need are configured.

1. Click the **Ribbons** button.
   Or, click **Template** > **Ribbons**.
   The pane on the left displays ribbon headings and all possible commands for each ribbon. The symbol next to a button name indicates its current status.

-	Button is always on the ribbon (it cannot be removed).
✖	Button is not on the ribbon (it can be added).
✔	Button is on the ribbon (it can be removed).
✔	Button is on the ribbon and also appears on the **Home** ribbon. (The position and config. of the button on the Home ribbon can be set in the right pane.)

2. Double-click an entry to add /remove it to/from its ribbon.
3. To add a button to the **Home** ribbon, select it and then click ✔.
   a. In the window that appears, in **Tooltip**, enter the text to appear when the pointer is left over the button.
   b. Click **Browse** to select an icon for the button. The system prevents you from selecting the same icon for more than one button.
      The button appears at the bottom of the right pane.
   c. Select the button in the right pane and use the **Move** arrows to position it (the topmost button will appear to the far left on the ribbon).
4. When you have finished configuring buttons, click **Close**.

Note: The Log On/Off button appears automatically and cannot be removed or modified. The **Select Patient** button is only available at multilevel workstations. Similarly, the **View Remote Patient** button is only available at bedside workstations.

Edit the properties of buttons on the Home ribbon

1. Click the **Ribbons** button.
   Or, click **Template** > **Ribbons**.
2. On the right side of the window, select the button and then click **Edit**.
3. Edit the properties as necessary.
4. Click **OK**.
5. When you have finished configuring ribbons, click **Close**.

Remove buttons from the Home ribbon

1. Click the **Ribbons** button.
   Or, click **Template** > **Ribbons**.

2. On the right side of the window, select the button you want to remove.
3. Click **<<**.
4. Click **OK**.
5. When you have finished configuring ribbons, click **Close**.

Rearrange buttons on the Home ribbon

1. Click the **Ribbons** button.
   Or, click **Template** > **Ribbons**.
2. On the right side, select the button you want to move and use the **Move** arrows to position it.
3. When you have finished configuring ribbons, click **Close**.

Create/edit icons for ribbon buttons

Pivia provides a library of icons that can be added to ribbons. Icons are stored in the following location:

"\\Program Files\Pivia\Runtime\Resources"

You can add new icons to the library by placing graphic files in this folder. Graphic files must have the following characteristics:

- They must be in bitmap format.
- They must measure 32 x 32 pixels.
- The background color should be RGB 212, 208, 200 (so that it is transparent in the application).
- They must have a filename with the following format:

  [*YNAME*]_32x32.bmp

  Where *[YNAME]* is any valid Windows file name. In other words, spaces, hyphens, and the underline character are permitted.

Note: The "x" in "32x32" must be lower case. All other characters can be in any case.

Example:
14A_ElectricalHeadStart_32x32.BMP
Thin arrow_32x32.bmp
DualByNecessity_32x32.bmp

Note: If you change the icon of a pre-set toolbar button in a sample template, certain graphics in the Workstation User Guide will no longer reflect the actual toolbar arrangement of your template.

8

Workstation Configuration

About Workstation Settings

Workstation settings determine aspects of application behavior that are identical for every session, independent of the template used. Although Customize provides access to over 1000 configuration parameters, this manual only provides information about the ones you are likely to need in normal use. If you have questions about other parameters, contact your Pivia representative.

Workstation settings can be categorized as follows:

- **Basic workstation settings.** *(For more information, see* Basic Workstation Settings on the next page *)*
- **Advanced workstation settings.** *(For more information, see* The Advanced Settings Window on page 177 *and* The Configuration Editor on page 181 *)*
- **Proxy Manager settings.** *(For more information, see* Proxy Manager Configuration on page 211 *)*
- **Event lists and macros.** *(For more information, see* Event lists and Macros on page 212 *)*
- **Device Data Interruption settings.** *(For more information, see* Device Communication Failures on page 213 *)*
- **Various window configuration.** *(For more information, see* Various Windows on page 215 *)*

Basic Workstation Settings

The window for entering basic workstation settings provides access to a small number of important settings in a controlled manner. Settings are made using check boxes and option buttons.

Access Basic Workstation Settings

- On the **Workstation** menu, click **Basic Settings**.

Advanced Workstation Settings

Advanced workstation settings are accessed via two windows—the Configuration Editor and the Advanced Settings window.

- The Configuration Editor offers access to all workstation settings and includes enhanced functionality such as the ability to add new zones, sections and entries. Values are entered by typing them in fields.
- The Advanced Settings window offers access to a restricted group settings including those most frequently accessed. It does not have the enhanced capabilities of the Configuration Editor but it does show information about many of the settings and includes a user-friendly palette for entering color settings.

CAUTION Advanced settings should only be changed by someone with a thorough knowledge of the Pcis system. You are strongly advised not to edit or add undocumented settings. For help configuring undocumented parameters, please contact your technical support representative.

Access the Configuration Editor

- In the "Open" window, click **Open** next to **Configuration Editor**.

Access the Advanced Settings window

1. Open any template. (It does not matter which one because the settings affect the workstation not the template.)
2. Click **Workstation** > **Advanced Settings**.

Basic Workstation Settings

The following basic workstation settings are documented in this guide.

- Demographics fields to show on the Patient Bar and other demographics settings.

(For more information, see Demographics and Patient Bar Workstation Settings below.)

- The type of access to remote patients
  (For more information, see Access to Remote Patients on page 175.)
- The time till automatic log off occurs
  (For more information, see Automatic Log Off on page 175.)
- Whether or not patient data is displayed when no user is logged on
  (For more information, see Unattended Workstation Display on page 175.)
- How user names appear in the Log On window
  (For more information, see Log On window on page 180.)
- Possible reasons the user can select when discharging a patient
  (For more information, see Discharge Reasons on page 203.)

Demographics and Patient Bar Workstation Settings

You can set the demographics information to show beneath the patient name on the Patient Bar. The band can include any combination of the following: age, gender, weight, height, Body Surface Area (BSA), Body Mass Index (BMI), Length of Stay (LOS), and procedure. If the procedure has been modified the procedure shown will be the modified one, rather than the originally planned procedure.

Note: Only medical procedures with a functional type of "Pre-op" or "Surgical" are shown on the band.

Other workstation-level demographics settings can be found on the **Template** menu:

- The order of the patient's first, middle, and last names on the Patient Bar and title bar
- The time limit for completing demographics documentation after the end of the encounter. (After this period, only users with the "Manage Summary Unlock" right can edit data.)
- The types of data that can be copied forward from a previous admission record
- The ability to import home medications from an interface note

Note: Other settings on the Patient Bar are configured at the template level. For more information, see Patient Bar and Notifications Window on page 113.

Note: Other demographics settings are configured at the template level. For more information, see Demographics on page 126.

Select demographics fields to display on the Patient Bar

1. On the **Workstation** menu, click **Basic Settings**.
2. Under **Patient Bar fields**, select the demographics fields you want to display on the band.

2. Click **Close**.

Set the time limit for completing demographics documentation

1. Click the **Demographics Editor** button.
   Or on the **Template** menu, click **Demographics Editor**.
2. Click **Options**.
3. In the **Limit (in hours) for completing documentation** box, select the time limit for completing the case record.
   The default time period is 48 hours. Caregivers have this number of hours to complete documentation in the Demographics window for the encounter after a transfer or discharge. After this time all sections are locked. (Users with the "Manage Summary Unlock" right can override the lock.)
4. When you have finished setting options, click **Close**.
5. When you have finished configuring the Demographics window, click **Close**.

Note: The setting also affects the ability to modify these same sections using Privoy Manager. For reasons related to this, Picis recommends that when using perioperative integration, do not restrict the time available for completing documentation.

Set the format of the patient name on the Patient Bar and title bar

1. Click the **Demographics Editor** button.
   Or on the **Template** menu, click **Demographics Editor**.
2. Click **Options**.
3. Under **Name format**, click **First Middle Last**, **Last, First Middle**, or **Last Middle, First**.
4. When you have finished setting options, click **Close**.
5. When you have finished configuring the Demographics window, click **Close**.

Specify the data that can be copied forward from a previous admission record

1. Click the **Demographics Editor** button.
   Or on the **Template** menu, click **Demographics Editor**.
2. Click **Options**.
3. Under **Copy Forward**, select the data that can be copied forward.
   - **Patient Information**
   - **Hospital Information**
   - **Home Medications**

4. When you have finished setting options, click **Close**.
5. When you have finished configuring the Demographics window, click **Close**.

Specify if home medications data can be imported from an interface note

1. Click the **Demographics Editor** button
   Or on the **Template** menu, click **Demographics Editor**.
2. Click **Options**.
3. Under **Import Data from Interface Notes**, select the **Interface Home Medications** check box to allow this data to be imported.
4. Click **Close**.
5. When you have finished configuring the Demographics window, click **Close**.

Note that data from interface notes is always imported in "snapshot mode" as described in the following box.

About Snapshot mode

In Snapshot mode any existing entries in the record are removed and replaced with entries from the interface note.

Example. A patient record initially shows two home medications Paracetamol 500mg and Heparin. A clinician opens an interface note that shows that the patient now just takes Paracetamol 1 g. After data has been imported the record will only show a home medication of Paracetamol 1g (there will be no indication of Heparin).

Access to Remote Patients

You can configure the type of access to remote patients.

Workstation Type	Access Type	Result
Bedside	View Only	Full access to the patient at the local bedside workstation, view only access to all other patients.
Bedside	View/Chart	Full access to the patient at the local bedside workstation, full access to all multilisted patients and those admitted to bedside workstations.
Multilisted	View Only	Full access to patients admitted in multilisted units, view only access to all bedside patients.

Workstation Type	Access Type	Result
Multibed	ViewChart	Full access to patients admitted to multibed units, full access to all bedside workstations.

Note: Users only have access to patients that are listed in the Census window. Queries for the Census types in Census windows define the patients that are available at a workstation.

The access type determines the general level of access to patient records, access to specific functionality depends on system rights. (For more information, see System Rights on page 221.)

For information on how to set up multibed units and change the location type, see Create a unit/cot bed location for a multibed unit on page 255 and Modify a location on page 255.

Set the type of access to remote patients

1. On the **Workstation** menu, click **Basic Settings**.
2. Under **Remote Patient Access**, select the type of access to remote patients. The effect of this setting depends on whether you are configuring a bedside or multibed workstation.
3. Click **Close**.

Automatic Log Off

Automatic Log Off is the period of time that "clinical modules" at the workstation remain in a logged on state when the system is idle (no user input). At the end of this period, a 30 second countdown occurs during which a message is displayed to warn that you unsaved data will automatically be lost. When the countdown ends a user must log on again before working with the chart.

The value that you set also applies to Privoy Manager. At workstations where Privoy Manager is used as well as another module — Anesthesia Manager, Critical Care Manager, or PACU Manager — user input at the workstation in Privoy Manager resets the counter in the other modules, and vice versa.

Set the automatic log off interval

1. On the **Workstation** menu, click **Basic Settings**.
2. In the **Automatic Log Off** box, select an interval.
   To prevent the system from logging off automatically, set this to zero.
3. When you have finished setting time-related parameters, click **Close**.

Unattended Workstation Display

You can specify whether or not patient data is displayed when no user is logged on.

Note: This setting affects Proxy Manager as well as Anesthesia Manager, PACU Manager, and Critical Care Manager.

Hide patient data when user logs off

1. On the **Workstation** menu, click **Basic Settings**.
2. Select the **Hide patient data when no user is logged on** check box.
3. Click **Close**.

Remote Access Behavior

For more information on the types of patient record that can be viewed using Remote Access, see the Workstation User Guide.

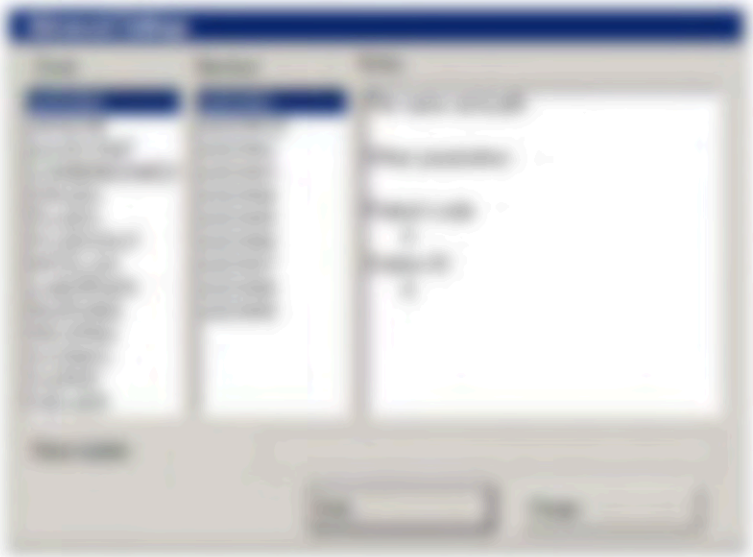
SETTING 0 – "Start Remote Access from main application"

Enabling this setting allows users to access patients via the Remote Access window and causes Remote Access to open when the internal patient context changes internally between Picis applications.

Best Practice: If you disable this setting, remove the "View Remote Patient" and "Unit Carousel" commands from their respective menus. (Even if you leave them they will not function.)

The Advanced Settings Window

The Advanced Setting window provides access to hundreds of settings, the majority of which never require changes. This manual describes the settings that are most commonly used. For help configuring other parameters, please contact your technical support representative.



(Note that the names of zones, sections and entries are not localized. They are always in English even for sites that install Pico software in another language.)

In this guide, settings are shown in the following format:

Entry, Section, Zone > default, example

Example Engine, CAN CONFIGURE, Scanner > default, engine

Open the Advanced Settings Window

- Click the **Advanced Settings** button
  Or, on the **Workstation** menu, click **Advanced Settings**.

Modify an entry

1. Select the **Zone**.
2. Select the **Section**.
3. Select the entry and click **Edit**, or double-click the entry.
4. Enter a new value and click **OK**.
5. When you have finished modifying entries, click **Close**.

Messages and Prompts

These settings govern messages and prompts shown to users.

Example "Are you sure you want to delete this data?"

Set whether the system will prompt users for confirmation

Registry: CURRENT_USER\Software\Cerner\Millennium\AdvancedSettings\ConfirmMessages

This parameter determines whether users must confirm their actions after completing certain tasks. It also controls prompts for fluid and medication administration.

Confirmation messages for the following actions can be suppressed:

- Creating treatments, standard orders, protocols, or schedules
- Deleting protocols, schedules, or standard orders
- Editing or renaming protocols
- Prescribing an order or protocol
- Removing orders from a protocol
- Discontinuing orders
- Copying orders
- Validating multiple orders
- Editing or undoing a validation

Values

0 = No confirmation prompts

1 = Confirmation prompts

Set whether the system will show the completion of tasks

Registry: CURRENT_USER\Software\Cerner\Millennium\AdvancedSettings\SuccessMessages

This parameter determines whether a message is displayed after certain tasks are successfully completed with OK Enter.

Example: "Protocol was successfully created."

Success messages can be suppressed in the following situations:

- When creating a treatment, protocol, or standard order
- When adding a protocol

Values

0 = No completion messages

1 = Completion messages

Show or hide the daylight saving time (DST) message

Registry: CURRENT_USER\Software\Cerner\Millennium\AdvancedSettings\DSTMessage

This parameter determines whether an information message is displayed whenever a user prescribes or extends an order that coincides with a clock change.

0 = Show DST messages

1 = Hide DST messages

Setting the Color of Certain Features

These settings govern the colors of certain features in the GUI.

CAUTION The colors in some user guide screenshots may no longer be valid for your site if you make changes.

Set the background color of out-of-range dose values

Inquiry, Screens, Right-click>Edit>Backgrounds > (Pane: personal)

This parameter determines the background color for the **Dose** control in the Document an Action/Review Documentation window when the value is outside the reference range.

Values

Any color

Set the background color of the window pane for adding memos

Inquiry, Screens, Memo > (Pane: personal)

This parameter determines the background color of the window pane for typing a memo. It applies to all types of memo. Note that it is only visible when the memo is created and does not affect existing memos.

Values

Any color

Note: Other color parameters in the AUTOTJOLOG section are obsolete and should not be altered.

Text Settings

CAUTION Although you are able to change text in the application interface using Advanced Settings, Picis recommends against doing so. **Customized text is not preserved during product upgrades**. In addition, Picis documentation refers to standard menu, command, and control names; changes may be confusing to users and complicate product support.

Bearing in mind the caution, this section is limited to text settings that Picis is often asked about. Sites changing these settings do so at their own risk and are encouraged to document both the original text (to revert back if needed) and the updated text (to easily re-enter it following a software update).

Change the text for Glasgow Coma Score criteria

[Company]_[ExampleTable]_[Text](Number)

Each Text(Number) entry corresponds to a score criteria. Change the text as required.

Example:

[Company]_[ExampleTable]_[Text3] = [Eyes: Open]

Values

Any text string.

Documenting and Viewing Data on Flowsheets

These settings govern how data is documented and viewed on flowsheets.

Set the sort order of treatments on flowsheets

[Type]_[CMTOrderOrTitle]_[ExpectTreatmentsInSortOrder] = 0

Determines the sort order of treatments. The behavior depends on whether family names are hidden or shown on the flowsheet.

When family names are hidden: 1 = alphabetically by treatment name. 0 = by index. (Sorting is alphabetical for treatments with the same index).

When family names are shown: 1 = alphabetically by family name and then treatment name. 0 = by family index and then treatment index. (Sorting is alphabetical for familiesOrtreatments with the same index).

Values

1 = Default. When family names are hidden, sorting is alphabetical by treatment name. When family names are shown, sorting is alphabetical by family name and then by treatment name.

0 = When family names are hidden, sorting is by the treatment index. (Sorting is alphabetical for treatments with the same index). When family names are shown, sorting is by family index and then treatment index. (Sorting is alphabetical for familiesOrtreatments with the same index).

Set the fields to show in order descriptions

[Any order type]_[CMTOrderOrTitle]_[ShowInLabel] = 0

This parameter determines whether the selected field name is shown in the order description on flowsheets. The list of possible fields depends on the order type.

Example

[illegible]

Values

0 = Field shown in order description

[illegible] = Field not shown in order description

Set the ability to modify doses in medication and fluid orders

[illegible]

This parameter determines whether users can alter the ordered dose of a medication or fluid on a flowsheet. If this option is active, the shortcut menu displayed when users right-click a medication or fluid name on a flowsheet includes the **Modify Order** command.

Values

0 = Users can modify doses

[illegible] = Users cannot modify doses

Set the ability to document a task with a dose/rate of zero

[illegible]

This parameter determines if users can validate tasks that have a dose or rate of zero. The setting affects medications and fluids.

Values

0 = Users can document tasks with a dose/rate of zero

[illegible] = Users cannot document tasks with a dose/rate of zero

Display the absolute dose for combined medications

[illegible]

This parameter determines if the calculated dose for weight-dependent orders is displayed or hidden.

Values

0 = Field shown

[illegible] = Field not shown

Set the default category for the Multi Validation window

[illegible]

This parameter determines the default value for the Multi Validation window.

Values

0 = All categories

1 = Assessments

2 = Combined Medications

3 = Equipment

4 = Fluids IN

5 = Fluids OUT

6 = Laboratory

7 = Medications

8 = Nursing Care

9 = Respiratory

10 = Scores

Set the time limit for the last validation for an order

Registry: CURRENTVERSION\...\SoftTrac\Software\Controls\Office\ClientCare = 24

This parameter sets the time period that controls the validations in the 'Document Multiple Actions' window (which can then be copied forward). The last validation that occurred within the configured period is shown for each window.

Values

Times in hours

Set the early documentation limit

Registry: CURRENTVERSION\...\Process Flows = 0

This parameter determines how long in advance of its scheduled time a user can document a task. (If a user documents a task early, the recorded time of documentation is the current time, not the original scheduled time.)

Values

Time in hours (**Minimum** = 1 hour, **Maximum** = 48 hours)

Set the order extension period

To extend an order, users need prescription rights.

Registry: INTERSYSHKEY_MACHINE\Software\Wow6432Node\InterSystems\CSP\7\Security\Account = 168 (7 days)

This parameter determines the period of time by which orders are extended. Orders are extended by either this fixed period or by the duration of the original order, whichever is shorter.

Values

Length of time in hours (Maximum = 720 hours (30 days))

Set the extend order time limit

To extend an order, users need prescription rights.

Registry: HKEY_CURRENT_USER\Software\PharmaCy\Pharmacy\Extend Order Time Limit

This parameter determines how long before or after its scheduled ending time a user can extend an order. When a user clicks the **Extend** command or button, only those orders for which an ending time falls within the configured number of hours from the current time is visible for selection.

Values

Length of time in hours (0 = orders cannot be extended.)

Note: To prevent users from accidentally extending an order twice, Pcis recommends that you use a value that is less than or equal to half the Order Extension Period.

Set a time limit for documenting tasks

Registry: CURRENT_USER\Software\PharmaCy\Pharmacy\Task Documentation Time Limit

If a scheduled task is documented late, the system prompts the user to shift the remaining tasks to later times or maintain the original times. This parameter defines how long after the scheduled time users can document tasks without the prompt appearing.

The default setting of 60 minutes is intended for users that document tasks as they perform them and is especially relevant for medications.

The value should be increased if caregivers tend to document actions more than one hour after performing them. For example, if all orders are documented at the end of the shift, an appropriate setting would be 480 minutes (8 hours). Set the interval even higher if users never reschedule when documenting late.

Values

Length of time in minutes

Set a documentation limit for finished orders

Registry: CURRENT_USER\Software\PharmaCy\Pharmacy\Finished Order Time Limit

This parameter determines the time limit for entering data after the end of a PRN order. The end is the scheduled end or the time at which it was discontinued.

Values

Length of time in hours

Set the default start time for orders

Registry: CURRENT_USER\Software\Logical\Epic > 1.0

This parameter determines the default time shown in the **Starting Time** control of the order window. It affects the following:

- Single orders
- Standard orders
- Protocols (as default protocols or prescribed during a session)

Values:

A negative value* = The number of minutes prior to the session start time.

0 = The actual time that the order is added.

1 = The starting time of the session.

*Values lower than -360 (e.g. -420) are not valid and will default to -360.

(See also: Round the default starting time for orders below.)

Round the default starting time for orders

Registry: DWORD/32b: Rounds_To_Minutes > 0

The Round_To_Minutes parameter is applied to orders when the default start time for such orders is the time that the order is added. This parameter determines whether the system uses the exact time (in hours, minutes and seconds) or rounds the time down to the nearest multiple of the parameter value.

Typical settings include 1, 5, 15, 30 and 60 minutes. For example, if this parameter is set to 15, the default starting time of 10:47:30 would be rounded down to the nearest multiple of 15, or 10:45.

Values:

0 = Exact time in hours, minutes and seconds.

1-60 = Multiple in minutes to which the default starting time is rounded.

(See also: Set the default start time for orders above.)

Set the default time for documenting a task

Registry: DWORD/32b: Show_Increment_Times_In_Code > 0

This parameter determines the default administration time supplied in the window that is shown when a user clicks a scheduled task. This can be the scheduled time for the task or the current time when the task marker was clicked.

Use the scheduled time if users document their work at the end of a shift. Use the current time if users document tasks as they perform them.

Values

0 = Scheduled time

1 = Current time

Set the ability to extend continuous orders

Registry: [illegible] Value name: [illegible] Value data: 0 or 1

Continuous orders have no fixed end point after documentation starts; users can continue to enter data indefinitely. For this reason, continuous orders are normally not included in the Extend Orders window. This parameter allows you to include these orders in the window so that users can validate their continuation. Extending such an order adds an automatic memo to the order.

Values

0 = Continuous orders cannot be extended (they are not listed in the Extend Order window).

1 = Continuous orders can be extended.

Set rights needed to cancel or discontinue orders

Registry: [illegible] Value name: [illegible] Value data: 0 or 1

This parameter determines the access rights required to cancel or discontinue an order. By default, users can cancel or discontinue an order if they have rights to document it. Changing this setting requires users to have the same rights as they would need to order the item. (See also "Purge orders to discontinue orders when transferring a patient on page 32 and "Prescription Validation Rights on page 208.")

Values

0 = Validation rights required to discontinue orders.

1 = Prescription rights required to discontinue orders.

Set IV base solution volumes

Registry: [illegible] Value name: [illegible] Value data: [illegible]

This parameter determines the default base solution volumes that are available in the window when documenting IV fluids.

Values

Series of volumes in ml separated by vertical bars (|).

Set the order description behavior of IV fluids

Registry: [illegible] Value name: [illegible] Value data: 0 or 1

Determines whether or not the order description shown on the flowsheet changes when base volume, additives, additive amount (dose or concentration), or pump rate are changed during documentation of a fluid with IV fluid ballasting.

Values

0 = Order description does not change. (Default)

1 = Order description changes to reflect the latest documented changes.

Example

Original prescribed order description: NaCl 0.9% 100 mL @ 10 mL/h // 10 mEq KCl intravenous Continuous

User documents a volume of 200 mL. Order description on flowsheet changes to the following: NaCl 0.9% 200 mL @ 10 mL/h // 10 mEq KCl intravenous Continuous

Set required ID number for blood bags

[illegible] CHECKSUM1234, CallCrossMatchRequired = 0

This parameter determines whether or not an ID number must be entered when a blood product is administered to a patient.

Values

0 = Not required

1 = Required

Set the number of decimal places in doses and volumes

DOSES, CHECKSUM1234, RoundedDecimalsForDoseAndVolume = 2

This parameter determines the number of decimal places that can be entered in a window control when prescribing or documenting medication or fluid orders. The parameter affects medication doses, fluid volumes, and pump rates. The system displays up to the number indicated, excluding trailing zeros.

Values

A number representing the decimal places.

Set the number of digits for rounding flowsheet values

DOSES, CHECKSUM1234, RoundingDecimalsForDisplay = 3

This parameter determines the number of digits to which values in flowsheet cells are rounded.

Values

A number representing the number of digits.

Set the ability to document doses outside the reference range

Registry: CCRP\CERNER\CRL\...\DoseRangeDefaultDocumentation = 0

The minimum and maximum doses specified in standard orders for medications and fluids can serve as reference values or limits. If the system is configured to use ordered doses as limits, users cannot document values outside this range. If it is configured to use them as reference values, the system identifies values that are outside of the range, but does allow users to document them.

Values

0 = Doses and volumes are fixed limits

1 = Doses and volumes are reference values only

Note: This parameter does not affect continuous medications.

Set the default fluid family shown when prescribing intermittent medication infusions

Registry: CCRP\CERNER\CRL\...\IVRegion\...\DefaultIVFluidFamilyCodeValue = 0

This parameter determines the fluid family that is shown by default when prescribing orders in the Single Order and Urgent (Stat) Order windows. Users can select "Diluted" and then choose a fluid from this family or another as part of a medication infusion.

Values

Any CMC65 from the FAMILY auxiliary table that is associated with a Fluid IV category. If left at the default value, the drop-down list will show "All Families" by default.

Set the default fluid shown when prescribing intermittent medication infusions

Registry: CCRP\CERNER\CRL\...\IVRegion\...\DefaultIVFluidItemId = 0

This parameter determines the fluid that is shown by default when prescribing orders in the Single Order and Urgent (St) Order windows. Users can select "Diluted" and then choose this fluid or another as part of a medication infusion.

Values

Any CMC65 from the TREATMENTS auxiliary table that is associated with a fluid family. If left at the default value, the drop-down list will not show any fluid by default.

Assessments, Scores, Equipment and QA Indicators

These settings govern the appearance and functionality of assessments, scores, equipment lists and QA indicators.

Set the assessments box height

Workstation\... \CCRP\APPL Section\...\Height of Frame = 20

This parameter determines the number of response options that can be displayed in the Assessments, QA Indicators, and Equipment windows. Increasing the number of items increases the height of the box (users must scroll to see assessment items that do not fit).

Values

Number of items (maximum = 40)

Set the assessments multi-selection symbol

Administrator, SYSTEM, Multi-Selection Configuration > F5

This parameter determines the flowsheet symbol used to indicate that more than one option has been selected in the Assessments, QA Indicators, and Equipment windows.

Values

Any character(s)

Set the assessments note symbol

Administrator, SYSTEM, Note Symbol > F5

This parameter determines the flowsheet symbol used to indicate that a note has been entered in the Assessments, QA Indicators, and Equipment windows.

Values

Any character

Set the barometric pressure for APACHE II

Activity COMPASSRESTORE, Maintenance > F2

The APACHE II score is based on various parameters, including the average barometric pressure. If your hospital is located in a region with an average barometric pressure that is different than the worldwide average at sea level (747 mm Hg), you should set the appropriate value.

Values

Local barometric pressure in mm Hg

Note: This setting does not affect derived physiologic variables (such as A-aDO2) that are calculated using the local barometric pressure. Barometric pressure value for derived physiologic variables must be entered directly in the relevant formula in the Clinic's Lotk database table. (See Derived Variables on page 2-21.)

Show equipment checklists on flowsheets

Administrator, SYSTEM, Show Equipment Assessments > F2

This parameter determines whether or not equipment items can appear on the flowsheets.

Values

0 = Equipment items cannot appear on flowsheets

1 = Equipment items can appear on flowsheets

Show QA indicators on flowsheets

Advanced\Q... 0 (OFF/0)... Show QA Indicators = 0

This parameter determines whether or not QA indicators can appear on the flowsheets. (This parameter does not affect the QA Indicators window.)

Values

0 = QA indicators cannot appear on flowsheets

1 = QA indicators can appear on flowsheets

Performance Options Related to the Database

These parameters control how the application interacts with the Proii database. The default values for these settings are configured for maximum performance - so that the application reads data from the server as infrequently as possible. However, if the network connection is not frequently, it may be necessary to increase the database interaction so that each workstation has enough data to work offline effectively.

Set the frequency of database access

Engine\... 1/10/1/1000/1/10... CacheRefreshFrequency = 0.0001220

This parameter determines the frequency with which the workstation automatically retrieves data from the main database.

The local workstation stores certain database tables in local memory after retrieving them from the main database the first time they are needed. New information in the main database is detected using PIMS, so that it can subsequently be retrieved by the workstation. In addition, the workstation automatically retrieves new information from time to time in case there is a problem with PIMS. The CacheRefreshFrequency parameter determines how often this occurs.

The parameter is expressed as the ratio of queries to data retrievals. With the highest possible ratio, 1:1, the workstation retrieves new data from the main database every time the application needs data. With the default ratio of 1:0.0001, the workstation retrieves new data from the main database once for every 10000 queries.

This setting has little effect on performance under normal conditions because the system communicates changes to the content of the main database to local workstations immediately.

Note: When this parameter is set via Advanced Settings the decimal separator for this parameter must always be a period (.) regardless of the language of the operating system or regional

settings. (If you instead set the parameter via the Configuration Editor (in Customize) you should use the decimal separator defined in the regional settings.)

Sample Values

1 = Data refreshed once for every query. (recommended setting when working with DB Editor).
0.1 = Data refreshed once for every 10 queries.
0.0001 = Data refreshed once for every 10000 queries (recommended setting for normal use).

Set screen refresh rate/scroll speed

Registry: [illegible] Result: [illegible] (1 = [illegible])

This parameter determines whether the application reads all orders on the chart during screen refreshes, or just those corresponding to the current time view.

Screen refreshes are faster when the system only needs to read a subset of the order list, but scrolling is slower because any change to the time view requires the system to read a new group of orders from the database.

Values

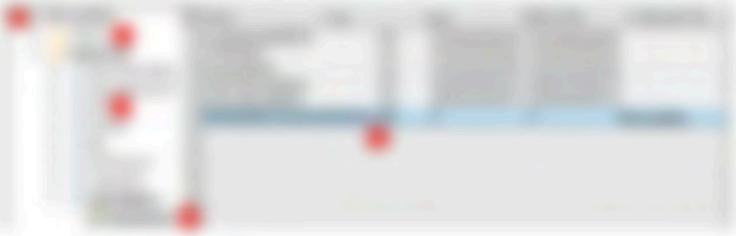
0 = System reads all scheduled orders during screen refreshes.

1 = System only reads schedules from shown interval.

The Configuration Editor

Using The Configuration Editor

The Configuration Editor window provides access to parameters that should only be changed by someone with a thorough knowledge of the system. The majority of settings never require changes. This manual describes the settings that are most commonly used.



1. Configuration set
2. Words

3. Zone
4. Section
5. Entry

Each entry belongs to an organizational unit called a "World". Worlds contain functional areas called "Zones". Zones contain "sections". Entries are found within sections. Click to the left of worlds and zones to show and hide the items below them. When you select a section the entries within it are listed in the right pane.

Note The names of worlds, zones, sections and entries are the same regardless of the installation language – they are never localized.

Bold formatting of a unit (world, zone, section or entry) indicates that the unit was edited in the current configuration set.

Most of the time you will use Customize to modify the values of existing entries. However, in some cases you may need to add a new entry, section or zone. There may be times when you need to delete or inactivate an existing entry, section or zone.

CAUTION The Configuration Editor has no "Save" button. changes you make are saved to the database instantly. If the configuration set you are editing is active the changes affect any machines linked to that configuration set.

Entry Details

Name	Type	Default Value	Value	Configuration Set
[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	[illegible]	[illegible]	[illegible]	
[illegible]	**[illegible]**	**[illegible]**	**[illegible]**	**[illegible]**

For each entry you can see the following information:

- **Bold formatting**. Indicates that the entry was edited in the current configuration set.
- **Type**. The entry type, such as integer (INT), string (STR) or list (LST).
- **Value**. The value for the entry in the current configuration set.
- **Default Value**. The default value for the entry from Pick default configuration.
- **Configuration Set**. This column is only relevant when the configuration set being viewed is "This machine configuration". The presence of text in this column indicates that the entry has

been edited in one or more of the configuration sets that affects the computer. The column shows the value from the last configuration set applied to the workstation.

> **Example.** For a particular setting, the default value is *A*. This value is changed to *A1* in the hospital configuration and to *C* in a configuration set that is applied to "Workstation 1". When viewing the setting in "This machine configuration" at Workstation 1 it will show the value *C* and the name of the configuration set where the value *C* was entered.

Note. Adding a comment to an entry is considered as an edit.

Note. The following actions will explicitly set the value in the current configuration set. This means that the value will not change if the entry is edited in a higher level configuration set:
- Opening an entry and clicking **OK** without actually changing anything.
- Re-entering a value that you previously edited in the same configuration set.

Example. For a particular setting the hospital configuration has a value of *A1*. In "This machine configuration" you double-click the entry and click **OK**. In the hospital configuration the value is later changed to *A2*. When you then open "This machine configuration" you see *A1*, not *A2*.

The Hospital Configuration

Edits made to the hospital configuration are not propagated to configuration sets – when viewing entries in a configuration set you see either the Pink default values or values that have been explicitly set in the configuration set; you do not see any values that were set in the hospital configuration. (Similarly, edits made to one configuration set are not propagated to any other configuration set.)

In contrast, when working with "This machine configuration" you will see edits made to all higher level configurations – the hospital configuration plus all configuration sets that are applied to the workstation. (In the case of conflicting values, the value from the last configuration set applied to the workstation is shown.)

> **Example.** A certain parameter has a Pink default value, *C*. In the hospital configuration you change this to *A*. This setting has not been edited in any configuration set or in the local workstation configuration. Method 1: When you look at the parameter in a configuration set applied to your machine you see the value *A*. When you look at the parameter in "This machine configuration" you see the value *A*.

Deleting and Inactivating Items

There may be times when you need to delete or inactivate an existing entry, section or zone in a configuration set. The differences between deleting and inactivating items are shown in the following table.

Inactivating	Deleting
Inactivated entries can be reactivated at any time.	Deleted entries cannot be reactivated; they can only be recreated.
You can inactivate any entity, section or cards.	The **Delete** command is enabled for items that were added or modified in the current configuration set. For items from the default configuration that have not been modified in the current configuration set, the command is grayed out.
After inactivating an item you cannot add a new item of the same name.	After deleting an added item you can add an item of the same name again.
An inactive item is effectively "turned off" at the current level and levels "above" it. **CAUTION** Depending on the setting, inactivating an item could cause the software to fail.	If you delete an item that was added to the configuration set it is removed from the configuration set (it is no longer visible in the Configuration Editor when editing the configuration set). If you click **Delete** to remove an item from the default configuration that has been edited the value will revert to the value passed down from the previous configuration set; the item itself will not be removed. **Example** For a particular setting, the hospital configuration has a value of H and "This machine configuration" has a value of M. No other configuration sets are applied to the workstation. When you delete this setting in "This machine configuration" the setting remains visible in Customize, but now shows the value H.
Inactive items are shown in italic, grey font.	

Exporting Settings to XML

You can export settings from a configuration set, world, zone or section to an XML file. The file will only contain entries that have been added or edited in the configuration set. (For example, if you were to create a configuration set and then export it without having made any changes to it the xml file would be empty.)

You can use the XML file in the following ways:

- Open the file in a suitable editor to view the settings that have been made for the configuration set.
- Import all settings from the file into another configuration set.

- Add and edit settings in the file using a suitable editor (taking care to maintain the expected structure), and then import all settings from the file into another configuration set.

Copying Settings Within and Between Configuration Sets

You can copy a zone, section or setting to another position in the same configuration set or to a different configuration set.

Example: You could copy the address section from the ICU template (**Routines** > **ICU_RT** > **Address**) to the MICU template (**Routines** > **MICU_RT** > **Address**).

Open the Configuration Editor

1. In the "Open" window, select the configuration set you want to work with in the **Configuration Set** box.

   Note: You can later change to another configuration set using the **Configuration Set** control at the top of the Configuration Editor window.

2. Next to **Configuration Editor**, click **Open**.

Note: By default, inactivated items are shown in italic, gray font. To hide such items from view, clear the **Show inactive items** check box at the bottom of the window.

Change the Configuration Set shown in the Configuration Editor

By default, the Configuration Editor opens the configuration set that you selected in the "Open" window after starting Customize.

- To change to another configuration set, click its name in the **Configuration Set** drop-down list in the top left of the Configuration Editor.

Enter or modify the value of an existing entry

1. In the Configuration Editor, select the **World** > **Zone** > **Section** containing the entry you want to modify.
2. Double-click the entry.
   A new window opens.
3. In **Value**, enter or modify the a value for the entry. Be careful not to use spaces before or after the value you enter.
4. Optional: In **Comment**, enter or modify a comment for the string.

   Note: Comments are only seen by other users of Customize; they do not appear in the main programs.

5. Click **OK**.

Add a new zone, section or entry

1. In the Configuration Editor, right-click the parent element and select **Add Zone**, **Add Section** or **Add Entry**, as appropriate.
2. Enter the name of the new element.
3. If the element is an entry, click **Type** and select the data type from the drop-down list.
   - String (if the value will be treated as text).
   - Boolean (if the value will be True or False).
   - List (if the value will be a multi-row list of items).
     (To add, edit or delete items in a list, right-click the list and select the relevant command.)
   - Color (if the value will be an RGB color specification).
   - Font (if the value will be a font specification).
   - Byte (if the value will be a number up to 8 bits long).
   - Integer (if the value will be a number up to 32 bits long).
   - Double (if the value will be a number up to 64 bits long).
4. Click **OK**.

Inactivate a zone, section or entry

(For more information, see Existing and Inactivating Items on page 153.)

1. In the Configuration Editor, double-click the element that you want to inactivate. (For zones and sections, you can also right-click the element and select **Edit Zone** / **Edit Section**.)
2. Select **Inactive**.
   (To make an entry "active", clear the **Inactive** check box.)
3. Click **OK**.

Delete a single zone, section or entry

(For more information, see Existing and Inactivating Items on page 153.)

1. In the Configuration Editor, right-click the element that you want to delete and select **Delete**.
2. At the confirmation prompt, click **Yes**.

Delete multiple zones, sections or entries

(For more information, see Existing and Inactivating Items on page 153.)

1. In the right pane of the Configuration Editor, hold down the SHIFT or CTRL key while you click the items you want to delete. SHIFT allows you to select adjacent items. CTRL allows you to select non-adjacent items.
2. Right-click and select **Delete**. (This command will be available if the selection includes any items that were added or modified in the current configuration set.)
3. At the confirmation prompt, click **Yes**.

Rename a zone or section

Note: When working with a configuration set you are unable to rename a zone or section that is part of the hospital configuration. When working with the hospital configuration you are unable to rename an item that is part of the Pivio default configuration. In both cases, if you try to rename an item a new item will be created instead with the name that you specify.

1. In the Configuration Editor, right-click the element you want to rename and select **Edit Zone**, or **Edit Section**, as appropriate.
2. Modify the name.
3. Click **OK**.

Rename an entry

Note: When working with a configuration set you are unable to rename an entry that is part of the hospital configuration. When working with the hospital configuration you are unable to rename an entry that is part of the Pivio default configuration. In both cases, the Rename command is unavailable.

1. In the Configuration Editor, right-click the entry, and select **Rename**.
2. In **Name**, type a new name.
3. Click **OK**.

Export all settings from a configuration set, world, zone or section

1. In the Configuration Editor, right-click the item from which you want to export settings and select **Export All**, **Export World**, **Export Zone** or **Export Section**, as appropriate, and then select **All Data**.
2. In **Filename**, type a name for the file or accept the default.
3. Click **Save**.

Export only the settings from a configuration set, world, zone or section that have been modified in the current configuration set

1. In the Configuration Editor, right-click the item from which you want to export settings and select **Export All**, **Export World**, **Export Zone** or **Export Section**, as appropriate, and then select **Only Changes**.
2. In **Filename**, type a name for the file or accept the default.
3. Click **Save**.

Import settings from an XML file

1. In the Configuration Editor, click **Import**.

Note: You do not need to select an element before importing - the XML file specifies the world, zone and section for every setting in it.

2. Browse to the XML file that you want to import settings from.
3. Click **Open**.

When you import settings from the XML file replace any identical settings in the current configuration set.

Note: Imported settings are not immediately obvious; you need to close and reopen the configuration editor window to see them.

Copy a zone, section or entry to another position in the current configuration set

1. In the Configuration Editor, right-click the zone, section or entry that you want to duplicate and click **Copy**.
2. Right-click the world, zone or section where you want to place the copied item and click **Paste**.

Note: If an item of the same name already exists you will be shown a message asking if you want to overwrite the file. You can click **Yes**, **No** or **Cancel**. Clicking **No** will create a copy of the item with the suffix '(1)'.

Copy a zone, section or entry to another configuration set

- In the Configuration Editor, right-click the zone, section or entry that you want to copy, select **Copy to** and then select the name of the configuration set you want to copy the entry to.

Note: If an item of the same name already exists you will be shown a message asking if you want to overwrite it. Clicking **No** will cancel the operation.

The item will be placed in the same structure as the item being copied.

Search for a setting

You can use the search facility to find worlds, zones, sections, settings and values.

1. In the Configuration Editor, click **Find**.

Note: You do not need to select an element before searching - the search will always commence with the first of the worlds.

2. In **Text to find**, type the text that you want to search for.

Note: The search finds matches that contain the text, not just exact matches.

Note: The search is case insensitive. If you enter "port" the search will also find elements containing "PORT".

3. If you want to search using regular expressions, click **Use regular expression** and make sure the **Text to find** field has a valid expression. (For more information on regular expressions, see http://en.wikipedia.org/wiki/Regular_expression.)
4. Click **Find Next**.
   If a match is found the world, zone, section or setting will be highlighted. Otherwise, a message will be shown.
5. To search for more matches, click **F3**.

Log On window

You can configure the way user names are shown in the Log On window.

User identifier

World	Zone	Section	Entry
Shego	Shego	Security	UseSiteRSPFormLogOn

Possible Values
0 (the default) - USERNAME is used for logging on
1 - BTSRTF01 is used for logging on
2 - BTSRTF02 is used for logging on
3 - BTSRTF03 is used for logging on

User visibility

World	Zone	Section	Entry
Shego	Shego	Security	ShowUserNameInLogon

Possible Values
TRUE - the typed username is visible
FALSE - the typed username appears as asterisks

Note: If **UseSiteRSPFormLogOn** is set to use a staff ID from the **ShowUserNameInLogon** parameter is not used (the typed ID is always visible regardless of the setting).

Drop-down list of usernames

World	Zone	Section	Entry
Image	Image	Security	ShowUserNameInCombo

Possible Values
"FALSE" – a drop-down list box of usernames is available; users can select a name from the list or type a name in the blank box. "FALSE" (default) – a drop-down list box of usernames is not available. Users must type usernames in the blank box.

Note: If **UseSoftPDFInfLogIn** is set to use a staff ID or if **ShowUserNameInLogon** is set to mask the user, then the **ShowUserNameInCombo** parameter is not used (a drop-down list is never shown) regardless of the setting.

Discharge Reasons

You can specify whether or not users are able to create discharge reasons "on-the-fly". When this parameter is set to "TRUE" the window shown when a patient is discharged will include an **Add Type** button that allows users to enter a new discharge reason.

Note: If an end user adds a new discharge reason while discharging a patient that discharge reason will then automatically be available to all workstations.

World	Zone	Section	Entry
Image	Add	Discharge Dialog	Allow add discharge reasons

Possible Values
"true" – to give users the ability to add a discharge type when discharging patients. "false" – to deny users the ability to add a discharge type when discharging patients.

For more information, see Discharge Reasons on page 291.

User Name in Title Bar

You can specify whether the Title Bar shows the username or actual name of the logged on user.

Wizard	Zone	Section	Entry
Widget	Widget	Security	ShowUserNameInTitle

Possible Values
True – The user name is shown in the Title bar
False – The user name is not shown in the Title bar

Change Password Button

You can configure whether or not the **Change Password** button is shown in logon windows. (If Directory Services Authentication is used it will never be present regardless of this setting.)

Wizard	Zone	Section	Entry
Widget	Widget	Security	AllowPasswordChange

Possible Values
1 – The Change Password button is available in logon windows.
0 – The Change Password button is not available in logon windows.

Clinical Note Export

The Clinical Notes System has the ability to export a read-only file with an automatically generated file name to a specified location and then notify the HIS via an HL7 message. You can configure the following:

- The shared network folder where files will be exported to
- The file format
- The naming convention for the file
- Whether the file is exported automatically when a note is finalized (or when an addendum is saved for a finalized note) or manually when the user clicks the **Send** button.

Configure the shared network folder for exported notes

Wizard	Zone	Section	Entry
NotesServices	NotesServices	PDFNotesExport	DestinationPath

Possible Values

A local or network path.

Example: \\cliniconPrdfile1\Notes\Exports

Example: C:\Server Note Files

Note: The user associated with the clinical notes service must have write privileges for this folder. (See the Clinicon Notes System Installation Guide for more information.)

Configure the naming convention for exported note files

Wizard	Zone	Section	Entry
NotesServices	NotesServices	PDFNotesExport	OutputFileNameFormat

Possible Values

Any combination of the following variables and "fixed" text.

Variable	Description
{Y4}	Proc. date (4K/2D)
{Mm/D}	Admission (4K/2D)
{Mm1}	Admission (D1)
{Mm2}	Admission (D2)
{Mm3}	Admission (D3)
{P4}	Patient (4K/2D)
{P1}	Patient (D1)
{P2}	Patient (D2)
{P3}	Patient (D3)
{TmN}	Template name
{Mid}	Note ID
{Tid}	Timestamp

Possible Values
Best Practice: To ensure unique file naming always use the timestamp variable.
Example: [FIELD:MRN]-[Full]

Configure the format for exported notes

Wizard	Zone	Section	Entry
NotesServices	NotesServices	PDFNotesExport	ExportToPDF

Possible Values
True – Notes are exported in PDF format.
False – Notes are exported in RPS format.

Configure automatic export of notes

Wizard	Zone	Section	Entry
NotesServices	NotesServices	PDFNotesExport	TemplatesToAutoExport

Possible Values
The name of each clinical note template for which you want notes based on the template to be automatically exported when finalized. Do not include the .rpt extension.
Note: To add, edit or delete items in a list, right-click the list and select the relevant command.
The **Send** button will be available for notes based on any templates not in the list. Users can then manually export the note if they want to.)

Maximum Patients per Anesthesiologist of Record (Concurrency)

You can specify the maximum number of patients that users of the Concurrency module are able to assign to an anesthesiologist of record. If an end user attempts to assign more patients a warning message will be shown and the user will be prompted for confirmation of the action.

Note: Regardless of the patient/anesthesiologist ratio there is never any limitation or warning message in the Medical Team demographics module when the anesthesiologist of record is

documented or in the Events window when the "Anesthesia Start" event is documented. The parameter only affects the reassignment of patients made using the Concurrency module.

World	Zone	Section	Entry
ChartPlus	Concurrency	Concurrency	MaxNumberConcurrentPatients

Possible Values
Any integer

Care Metrics

The Care Metrics window provides a physiologic display of certain ICU measures during an admission. There are sections for 'activities' (medical device data), treatments and antibiotics.

You configure the window for the workstation, as described here, and then add it to the templates you want to use. Patient Buttons, on page 123

World	Zone	Section	Entry
ChartPlus	ICUMetrics	Sections	Activities Treatments Antibiotics.txt

Possible Values
List items for the Activities entry must be CRL codes for the devices that you want to measure. (You can see a list of all CRL codes in the "Physiologic Variables" auxiliary database table using DB Editor.) The description after the pipe symbol (|) should be what you want to be shown in the Care Metrics window. It does not need to correspond with the description of the variable in the database, but Picis recommends that it does. List items for the Treatments entry must be DBCODE for the treatments that you want to see measurements for. (You can see all treatments in the "Treatment" auxiliary database table using DB Editor.) List items for the Antibiotics.txt entry must be DBCODE for the treatment families that you want to see measurements for. (You can see a list of all treatment families in the "Family" auxiliary database table using DB Editor.)

CaseCheck

- You can configure CaseCheck to log the user off when a patient record is closed.
- You can hide the **Print** button to prevent users from printing data.

Configure CaseCheck to log off when closing a record

World	Zone	Section	Entry
ChartPlus	CaseCheck	Configurations	LogoffAfterClosingPatient

Possible Values
True — CaseCheck will log off the user when a record is closed.
False — CaseCheck will not log off the user when a record is closed.

Show or hide the Print button in CaseCheck

World	Zone	Section	Entry
ChartPlus	CaseCheck	Configurations	ShowPrintScreenButton

Possible Values
True — The Print button is shown in CaseCheck.
False — The Print button is not shown in CaseCheck.

Microbiology Results Window Default Sort

Microbiology results are sorted by Time Collected by default. You can change the default sort order.

World	Zone	Section	Entry
ChartPlus	App	Microbiology	DefaultSortColumn

Possible Values
0 – to sort by the "Updated" column
1 – to sort by the "Test" column
2 – to sort by the "Collected" column
3 – to sort by the "Source" column

Configure laboratory data to show

You can specify how far back from the current date to show laboratory data.

Model	Zone	Section	Entry
ChartPlus	Labtests	General	LabTestDays

Possible Values
Any integer number of days. The default is 10 days.

(See also the similar setting for Prism Manager: Prism Manager Configuration, on page 221.)

For Anesthesia Manager and PACU Manager, a typical setting would be 10 days.

For Critical Care Manager, a typical setting would be 730 days (two years).

Best Practice: At workstations where users may need to see historic patient data for discharged patients, Philips recommends setting this parameter to its maximum value of 32000 days (nearly 88 years).

Template List

You can configure a template list to be shown to end users when they access records as follows:

- At a bedside workstation, when viewing the chart of a patient admitted at another bedside workstation or via a multibed workstation.
- At a multibed workstation, when viewing the chart of a patient admitted at a bedside workstation or via another multibed workstation.
- When viewing the chart of a patient who has been transferred.
- When viewing the chart of a patient who has been discharged.

World	Zone	Section	Entry
ChartPlus	App	ChartPlus	AllowTemplateSelectionOnRemoteView

Possible Values
True or False (default)

When set to True, the template selection window opens and lists all templates available in the database. The user selects a template to use for viewing the record.

When set to False, the template selection window does not open. Instead, the template applied is the one used for the last session of the record that is being opened. (If the template is not available to the local machine the default system template will open instead.)

External Order Notifications

You can configure whether or not to show notifications for new external orders in the Notifications window accessed from the Patient Bar). (For more information, see "Patient Bar and Notifications Window on page 112".)

Note: This is a template-specific setting.

World	Zone	Section	Entry
Realtime	Template_prefix_RT	Application	ShowInboxToPCISMedNotification

Example
For the General Anesthesia template you need to edit this setting in the GA_RT zone.

Possible Values
True – to show notifications.
False – to hide notifications.

The Default System Template

In a number of situations (described elsewhere in this guide) the default template is used. Settings for this template are found in the **Realtime** > **gen_rt** zone. You can customize these settings at any configuration level.

The best way to change the default template is by adding another template and basing the default template on this. (The only other way to edit it is by directly changing settings in the Configuration Editor.)

Base the default template on another template

1. Create/edit the template you want to use as a basis for the default template.
2. In the Configuration Editor, export the **Realtime** > **(zone name)** corresponding to the template.
3. Open the exported .XML file in a suitable editor and replace the zone name with pcs_0.
4. In the Configuration Editor, import the settings from the .XML file.

(The exporting and importing of settings is described in The Configuration Editor on page 31.)

Report Configuration at the Template Level

You can configure the folder locations where (Crystal Report) report files are located and where report PDFs are saved to. You can do this globally (using SM Editor) or locally (using Customizer). (For more information, see Reports on page 213)

Best Practice: Make the report file path different to the report save path.

World	Zones	Machine	Entry
Realtime	(template prefix)_ALL	CrystalReports	ReportsPath -the folder where report files are found). SavePath -the folder where reports will be saved to).

Possible Values
Any valid path to a shared folder **Note:** Regardless of whether a path is defined globally or locally, the path itself can be either local or remote. For example, a global setting could be "C:\Program\Files\Pros\Reports\Files" Users need "write" access to the report save path and "read" access to the report files path.

For global options related to reports, see Reports on page 1.

Report Configuration for Prosp Manager

File menu commands

You can configure the **Reports** and **Reports Audit** commands to appear on the **File** menu.

Note: Only non "Web" sites should configure the **Reports Audit** command to appear in Proxy Manager, for integrated sites, report auditing is performed using OR Manager.

World	Zone	Section	Entry
eKat	evalconfig	General	MRxICrystal: For the **Reports** command. MRxICrystalAudit: For the **Reports Audit** command.

Possible Values
True – The command is shown on the **File** menu. False – The command is not shown on the **File** menu.

Folder locations related to reports

You can configure the folder locations where report files are located and where report PDFs are saved to. You can do this locally, using Customize as described here, or globally, using OR Editor. For global options related to reports, see Reports on page 2139.

Best Practice: Make the report file path different to the report save path.

World	Zone	Section	Entry
eKat	evalconfig	CrystalReads	ReportsPath: the folder where report files are found. SavePath: the folder where reports will be saved to.

Possible Values
Any valid path to a shared folder. **Note**: Regardless of whether a path is defined globally or locally, the path itself can be either local or remote. For example, a global setting could be "C:\Program Files\Pros\Reports\Files" Users need "write" access to the report save path and "read" access to the report files path.

Patient Summary Export to the HIS

You can enable users to send streamlined Patient Summary reports to the HIS and configure the different possible report types. All report types are shown to end users in a drop-down list. Patient Summary reports are in XML format.

Add the "Export Report" command to the Patient Summary window

World	Zone	Section	Entry
ClientPlus	PPExport	General	EnPCsEnNtEtPrDtTrDe

Possible Values
True – The command is available in the Patient Summary.
False – The command is not available in the Patient Summary.

Create report types

1. Add a new section beneath **Chartplus** > **PPExport** to be used for the report type.

   Best Practice: Copy the section used by an existing report type.

2. Name the section "ExportReport*#*".
   Where *#* = 1, 2, 3 etc. (Report types appear in this order in the Patient Summary.)
3. If necessary, change the suffix in the name of other "ExportReport…" sections to adjust their order.
4. Select the section you created to see its entries in the right pane.
5. Double-click **Caption** and enter the name as you want it to appear in the Patient Summary.
6. Double-click each of the following entries and set them to True or False as appropriate. Data types set to True will be exported.
   CHARTSMTNDS - physiologic data tables and laboratory data tables
   FBALANCDS - fluid balance information
   PRSTSDSLIDS - medications, fluids and active protocols
   DIAGPROCDS - diagnoses and procedures
   NOTESDS - patient summary notes
   EVENTSDS - events
   ASSMNTCSRDSDS - assessments and scores

Auto-Adjust Fluid Volume Setting for Infusion Pumps

The infusion rate shown at an infusion pump matches the infusion rate shown in Anesthesia Manager. However, as far as the total infused volume is concerned, over time there may be a slight discrepancy between the value shown at the pump and in the application. (The discrepancy depends on the pump characteristics.) In such situations, with existing functionality, users can make

manual volume adjustments as necessary. Alternatively, devices using a suitably configured driver file have also been able to make automatic volume adjustments. You can set the required threshold for automatic volume adjustments.

The configuration is set using the Configuration Editor. **Note that this setting does not exist. It must be manually created as an entry of type "Double".**

WORKLD: VISUALCARE

ZONE: FLUIDS

SECTION: ADJUSTVOLUME

ENTRY: **Threshold**

VALUE: The threshold value in ml.

Note: If this configuration setting does not exist or it does exist but no value has been set for it then the program assumes a default value of 0.005. (Note that in previous releases, when this threshold was not configurable, the system used a value of 0.001.)

Example

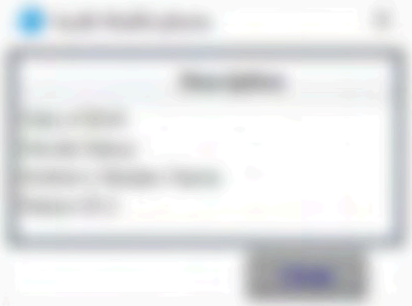
Value = 0.005 (ml)

Volume shown at pump	Cumulated volume calculated in program	Difference as a percentage	Auto adjust volume?
1ml	1.002	0.002	N
2ml	2.004	0.004	N
3ml	3.005	0.005	Y - new cumulated volume in program jumps back to 3ml.
4ml	4.002	0.002	N
5ml	5.004	0.004	N
6ml	6.005	0.005	Y - new cumulated volume program jumps back to 6ml.

Note: In order to use this functionality, a suitably configured driver file must exist for the infusion pump in question. At this time, such a driver is available for Braun infusion pumps. If your site would like to use this functionality with an infusion pump from another manufacturer, please consult your Picis representative.

Demographics Notification Icon

If demographics data is updated in the ADT the Notifications icon will turn red. A user can click the icon to open a window showing all unacknowledged notifications listed by type. Next to each type is a **View Details** button. Clicking this button effectively acknowledges the notification. In the case of Demographics, you can configure the behavior of the **View Details** button so that it either opens the Demographics module or opens a new window listing the fields that have changed.



Example of the window listing the fields that have changed

Configuration

The configuration is set at the template level using the Configuration Editor in Customize.

WORKLD: REAL/TIME

ZONE: TEMPLATE_BASE\Defaults

SECTION: APPLICATION

ENTRY: **ShowAuditNotifications**

VALUE: True or False

(Set VALUE to "True" to activate the new setting.)

Event Sets and Macros

Event sets are groups of events that are typically documented together during surgery. They are often used in operating room templates to document surgical milestones that are required for all patients, such as Start of anesthesia. Users can add an event set to the patient chart by choosing it in the Add Events window or running a macro.

You create event sets and event macros in the Event Sets and Macros window. Event sets and macros are independent of the template, after they are created, they can be included in any template. (See Edit an event set in the library on page 123 and Configure a macro as a quick link on page 127.)

The process for creating an event macro is the same as for creating an event set plus you can configure the macro to perform an action after adding the events, such as executing a menu command or applying a screen layout.

Note: If a supervisor event is included in an event set, it is only added to the Events Log if the event set is added to the patient chart by a user with the "SAM! View and Use" system right.

Create or edit an event set

1. On the **Workstation** menu, click **Event Sets and Macros**.
2. Click **New**, and enter a name for the event set.
   Or, select an event set to edit from the **Available Event Sets** box.
3. In the **Type** box, select an event type. Then select one or more events of that type in the **Available Events** box and click >>. Repeat this step if you want to add events of a different event type to the event set.
4. Use the **Move** arrows to move a highlighted event in the **Selected Events** box to a new position. Events are listed in this order in the Events Library.
5. To remove an event from an event set, click the event in the **Selected Events** box and then click **Delete**. (This does not delete the event from the database.)
6. Click **Save**.
7. When you have finished creating event sets and event macros, click **Close**.

Configure an event set as a macro

1. On the **Workstation** menu, click **Event Sets and Macros**.
   In the **Available Event Sets** box, select an event set.
2. Click **Next** >.
3. If you want the macro to allow users to enter a date and time for the events, click **Prompt for date and time when inserting events**.
4. You can configure the macro to perform an action after inserting the events.
   To apply a screen layout, click **Apply screen layout** and select a predefined screen layout from the list.
   To execute a command, click **Execute command** and select a command from the list. (Commands are only executed if they also appear on the corresponding menu. See Menus, Buttons, on page 30.)
5. Click **Save**.
6. When you have finished creating event sets and macros, click **Close**.

Delete an event set or macro

1. On the **Workstation** menu, click **Event Sets and Macros**.
2. In the **Available Event Sets** box, select the event set/macro you want to delete.

3. Click **Delete**.
4. Click **Close**.

Device Communication Failures

There may be occasions in which the program stops receiving device data during a session. This can occur because of problems with device connectivity or system configuration, or an internal error in the application. You can configure the system to notify users after a certain period with no new data from one or more devices. The application displays a warning identifying the port number and driver for each problematic device and can also send an e-mail message to support staff for help resolving the problem.

Configure the system for device communication failures

1. On the **Workstation** menu, click **Device Data Interruptions**.
2. In the **Intervals without data** box, enter the number of data collection intervals to wait before displaying a warning message in the application.

   This parameter determines how long the system waits to notify users after it stops receiving data from devices. The delay is based on the **Physiologic Data Interval** (frequency of automatic data collection). To calculate the length of the delay in minutes, multiply the **Physiologic Data Interval** by the value of this parameter.

   > **Example**: Using an **Intervals without data** setting of 3:
   > - If the **Physiologic Data Interval** is 1 minute, the delay would be 3 minutes.
   > - If the **Physiologic Data Interval** is 5 minutes, the delay would be 15 minutes.

3. In the **Message to display in application** box, you can edit the text of the message that users see.

   > **Note**: Do not press ENTER when typing the text; any text typed after you press enter does not appear when the message is shown.

4. If you want the system to notify support staff automatically by e-mail, do the following:
   a. Click **Notify support staff by e-mail**. (This enables the **Email Details** tab and the buttons at the bottom of the pane.)
   b. In **SMTP mail server**, specify the mail server.
   c. In **Seconds before automatic e-mail notification**, enter the delay before the system sends an e-mail message automatically.

      This parameter determines how long the system waits to send the e-mail message after displaying the indicator message. Users can either send the message manually from the indicator message window or wait for the system to send the message. Users can cancel a message when prompted to confirm the action.
   d. For each person who should receive a notification, click **New** and then enter the person's e-mail address.

- To edit or delete an email address, select it and then click **Edit** or **Delete** as appropriate.
- Click **Email Defaults** and type an **Email subject** and **Email body** as appropriate.

Note You can use the following variables in both the subject and body:
(facility) - The facility short name, followed by the full description in brackets.
(department) - The department description.
(workstation) - The computer name.
(user) - Full name of the logged in user.

5. When you have finished, click **Close**.

Note Connections to the SMTP server are anonymous (a mailbox is not needed).

Carenzo Windows

Overview

Picis provides a set of sample carenzo windows for selecting patients in Anesthesia Manager, PACU Manager, Critical Care Manager, Procs Manager, CareCheck, and the Printout Loader. The windows classify patients by admission status and allow users to display different patient groups. Selected patient records can be opened to document preoperative data, start a session, view data, or complete case documentation.

A window typically allows a user to select from different groups of patients, such as the following:

- Transfer patients. Patients who have been transferred from one bed and are awaiting admission to another.
- Discharged patients. Patients who have been discharged from the Picis system because they have left the hospital or been transferred to a non-Picis unit. These patients can be readmitted or viewed.
- Admitted patients. Patients currently admitted to beds. These patients can be viewed but cannot be admitted to a workstation.

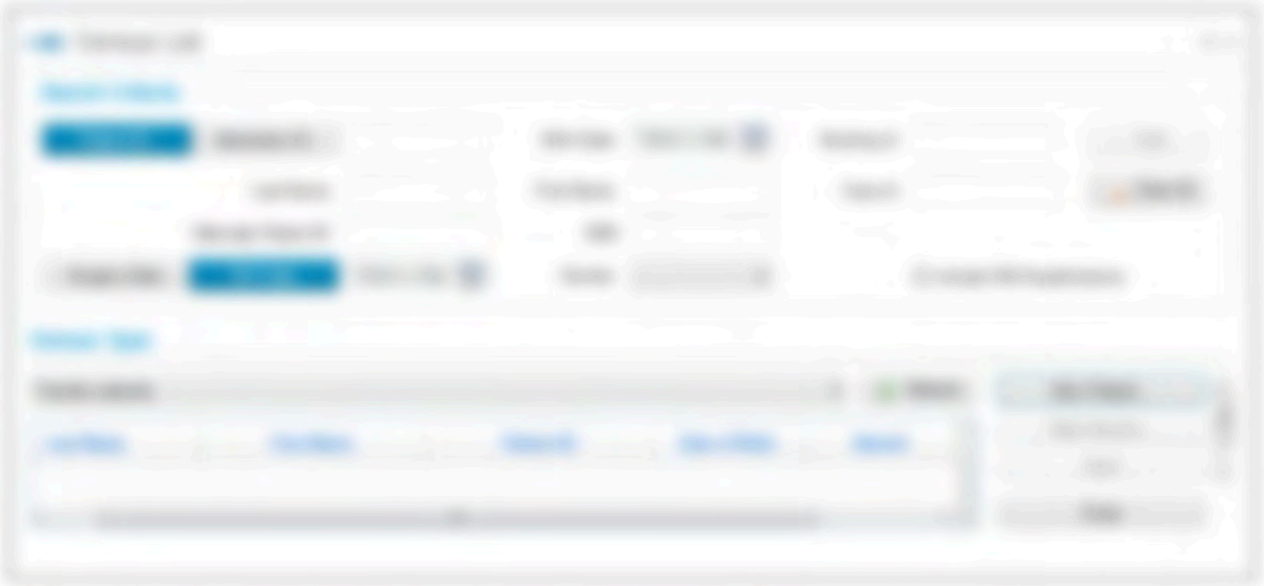


Figure 1: Example carevue window. (The buttons and colors/ headings depend on the selected Carevue Type. The actual window you see depends on how your hospital has configured the window.)

You configure carevue windows using ADT Administrator, as described in the next section.

ADT Administrator

If you belong to a user group with the 'Will Manage' right, you can use ADT Administrator to configure carevue windows for AnesthesiaManager, PRICU Manager, Critical Care Manager, Pump Manager, CareCheck and Printouts.

ADT Administrator serves two functions:

- It is used for ADT operations.
- It is used for configuring carevue windows.

This guide focuses solely on its use for configuring carevue windows. For information on using ADT Administrator for ADT operations, please see the Workstation User Guide.

Before customizing a carevue window, you should consider the following issues:

- The types of patients your users need access to and which type is used most frequently (for example, multibed, bedside, HIS, active, transferred, and discharged).
- Whether Philips receives patient data from the HIS or from user entry.
- What patient information should accompany the name (for example, Patient ID, room or bed number, attending physician, hospital department or unit name, diagnosis or procedure name, patient age).

- Desired sort order for the patient list (for example, last name, Patient ID, room or bed number, attending physician).
- ADT functions needed at the workstation (create new patients, import patients from the ADS, start a session with an existing patient, open a record for viewing only, transfer a patient, discharge a patient). Philips recommends omitting the Transfer and Discharge functions from census windows at bedside workstations to prevent users from ending sessions at other workstations. These functions would typically only be available at supervisor and multibed workstations.

Note: The Search Criteria section is present at the top of every census window and is not configurable.

Start ADT Administrator to configure a census list

1. Navigate to the "c:\Program Files\Philips\Patient" folder using Windows Explorer.
2. Double-click the file **ADT_Administrator.exe**.
3. Log in to **ADT_Administrator**.
4. Click the **C** button at the top of the window.
   Or, on the **Census List** menu, click **Configure**.
5. In the **Configuration Set** box, select a configuration set. The census list that you edit will be available at all workstations to which the selected configuration set is applied. (Select "This machine configuration" if you just want to apply the layout to the workstation that you are currently using.) For more information on configuration sets, see the System Configuration Guide.
6. In the **World** box, click the Philips "configuration world" that contains the census window. Then click the window name in the **Zone** box.
7. Click **OK**.

Application	World	Zone
Anesthesia Manager, PIICiX Manager and Critical Care Manager (local patient selection from a bedside workstation)	<World>	InternCensus
Anesthesia Manager, PIICiX Manager and Critical Care Manager (remote patient selection from a bedside workstation)	<World>	CiviTCensus
Anesthesia Manager, PIICiX Manager and Critical Care Manager (patient selection from a multibed workstation)	<World>	InternCensusMB

Application	World	Zone
Privoy Manager	Utility	PrivoyCentricus
CasesCheck	<World>	CasesCheckCentricus
ADT Administration	<World>	AdtCentricus
Printouts This centricus window affects the Forms Builder previews in Customizer and the Printouts Viewer application. **Best Practice:** By default, the centricus list for this window shows all patients that are admitted or were previously admitted and can take some time to load. Privo recommends that you create an additional centricus list with a reduced set of patients (such as "Currently Admitted Patients") and set it as the default centricus list for this window.	<World>	PrivCentricus

Creating Queries for the Patient Groups

Each patient group centricus type is associated with an SQL query that defines the selection criteria and the information to retrieve for each patient. The query for the most frequently used patient group can be configured as the default.

You can use the default centricus list queries that are provided or create your own. With the exception of the query used to search the HIS, you can also modify the centricus list queries that are provided.

⚠ **CAUTION:** You should not modify the "Search results (HIS)" query.

⚠ **CAUTION:** The "**Search results**" query must always include the following alias definitions in the FROM line:
- PATIENTS P
- ADMISSIONS A
- DISCHARGES D

You cannot use the alias letters P, A or D for any other tables.

There must be an SQL statement for each patient group that is available to users. There is no limit to the number of patient groups that can be created, but each window must have at least one.

An SQL statement defines the selection criteria for patients and the information to retrieve for them. The easiest way to create an SQL statement is to copy an existing query and modify it, or import a query from another census window. Do not attempt to write an SQL statement yourself unless you are a database administrator with extensive knowledge of Prism database structure.

Rules for creating and editing queries

A query can retrieve a list of patients (one row per patient) or a list of sessions for patients (with one row for each session).

- If you plan to use the census window for starting active sessions with patients (admitting them to a bed), the list should display one row per patient. The first field in the SQL statement must be the PATIENTCOMCID or ADMISSIONDMDBCID. This applies to the AdmCensus census window.
- If you plan to use the census window for selecting patient sessions to view (without an admission to the current workstation), the list should display one row for each session. The first field in the SQL statement must be the ADMISSIONDMDBCID. This applies to the census window at a bedside workstation when viewing remote patients (CmCTCensus) and to the census window at a multibed workstation (AdmCensus).

The first field in the SQL statement is used for record identification purposes only and is not displayed on the patient list.

The statement must include fields for all of the columns on the census list in the same order from left to right.

Create a new query

1. Open a census window as described in ACT Administrator on page 216.
2. Click **New**.
3. In the **Titles** box, enter a name for the patient group. This text is displayed in the **Census Type** box in the window.
4. If you want to apply the new query by default, select the **Default Query** check box.
5. Click **OK**.
6. In the **SQL Statement** box, write a SELECT statement that returns the desired information.
   Remember that the patient list displays query results for database fields in the same order, from left to right, as they are defined in the statement (excluding the PATIENTCOMCID or ADMISSIONDMDBCID field). For example, if the first field in the statement is the LAST NAME, the first column of the patient list shows this data.

Edit a query

1. Open a census window as described in ACT Administrator on page 216.
2. In the **Titles** box, click a query name and then click **Edit**.
   Or, double-click the query name.

3. In the **SQL Statement** box, edit the query to change the selection and grouping criteria, fields for patient and admission information, order of the columns, or the sort order for the list.

   Remember that the patient list displays query results for database fields in the same order, from left to right, as they are defined in the statement succeeding the PATIENTOBJECT or ADMISSIONOBJECT field. For example, if the first field in the statement is the LAST NAME, the first column of the patient list shows this data.

Copy a query

1. Open a census window as described in ADT Administrator on page 276.
2. In the **Titles** box, click a query name.
3. Click **Copy**.
4. Enter a name for this patient group. This text is displayed in the **Census Type** box in the window.
5. If you want to apply the new query by default, select the **Default Query** check box.
6. Click **OK**.

Import a query

1. Open a census window as described in ADT Administrator on page 276.
2. Click **Import**.
3. In the **World** box, click the Picis 'configuration world' that contains the census window with the query you want to import. Then click the window name in the **Zone** box.
4. Select a query and click **OK**. The query is imported.
5. Click **OK**.

Rename a query

1. Open a census window as described in ADT Administrator on page 276.
2. In the **Titles** box, click a query name and then click **Edit**.
   Or, double-click the query name.
3. In the **Title** box, edit the query name. This text is displayed in the **Census Type** box in the window.
4. Click **OK**.

Configure a query to be applied by default

1. Open a census window as described in ADT Administrator on page 276.
2. In the **Titles** box, click the name of the query you want to apply by default and then click **Edit**.
   Or, double-click the query name.
3. Select the **Default Query** check box.
4. Click **OK**.

Delete a query

1. Open a census window as described in ADT Administrators on page 215.
2. In the **Titles** box, click the name of the query you want to delete.
3. Click **Delete**. The query is deleted.
4. Click **OK**.

Customizing the Patient List

The patient list displays the query results in a multi-column list. To configure this part of the census window, you must do the following:

- For each query, create a column for each field that is displayed in the query results. (The first field in the SQL statement is used for record identification purposes only and is not displayed on the patient list.)
- Enter the text for each column heading.
- Set the width of each column.

Set up a patient list

1. Open a census window as described in ADT Administrators on page 215.
2. In the **Titles** box, click the name of the patient group.
3. Click the **New** button next to the **Columns** box.
4. In **Column Header**, enter the text to display above the column.
5. In **Column Width**, enter the width of the column in pixels.
6. Click **OK**.
7. Click **Test** to preview the results as often as you like. If you want to change the column header or adjust the width, click the column name and then click **Edit**.

Columns must be listed in the same order as the corresponding fields in the SQL statement.

Change the position of a column

1. Open a census window as described in ADT Administrators on page 215.
2. In the **Titles** box, click the name of the patient group.
3. In the **Columns** box, click the name of the column.
4. Click the **Down** or **Up** button to move the column to a new position.

Delete a column

1. Open a census window as described in ADT Administrators on page 215.
2. In the **Titles** box, click the name of the patient group.
3. In the **Columns** box, click the name of the column.

4. Click **Delete**.

Customizing Buttons and Other Controls

You can include buttons for up to 11 ADT functions in a canvaus window. Canvaus windows typically have buttons for a few basic functions. Canvaus windows for system diagnostics, such as the ADT Administration canvaus window, may include buttons for all of the major functions.

You can also customize the following elements in the canvaus window:

- Text displayed in the title bar of the window
- Text label above the Canvaus Type list box
- Text of the Close button
- Standard ADT functions

Add a button to a canvaus window

1. Open a canvaus window as described in ADT Administrator on page 215.
2. Under **Buttons**, click **Add**.
3. In **Button ID**, click the button identifier for the button you want to add.
4. In **Label**, enter the text to display on the button.
5. To configure the button as the default button for the window, select the **Default Button** check box.
   The default button can be activated in the canvaus window by pressing **Enter**.
6. Click **OK**.

See Button Reference on page 224 for information about the functions associated with each button.

Edit the text of a canvaus window button

1. Open a canvaus window as described in ADT Administrator on page 215.
2. Under **Buttons**, click the button name in the **Button ID** column.
3. Click **Edit**.
4. In **Label**, edit the text to display on the button.
5. To configure the button as the default button for the window, select the **Default Button** check box.
   The default button can be activated in the canvaus window by pressing **Enter**.
6. Click **OK**.

Change the order of buttons in a canvaus window

1. Open a canvaus window as described in ADT Administrator on page 215.
2. Under **Buttons**, click the button name in the **Button ID** column.
3. Click **Up** or **Down** to move the button to a new position on the list.

Buttons are displayed in the same order in the census window.

Delete a button from a census window

1. Open a census window as described in [ADT Administration on page 215].
2. Under **Buttons**, click the button name in the **Button ID** column.
3. Click **Delete**.

Customize text in a census window

1. Open a census window as described in [ADT Administration on page 215].
2. In **Caption**, enter the text to be displayed in the title bar of the Census List window.
3. Click **Workstation Settings**.
4. In **Census Type Label**, enter the text label for the Census Type list box.
5. In **Cancel Button Label**, enter the text label for the Cancel button.
6. Click **OK**.

Define text for field and button labels in all census windows

Text labels for fields and buttons are the same for all census lists on this workstation.

1. Open a census window as described in [ADT Administration on page 215] on page 1. (It does not matter which one because the settings you will make apply to all census lists at the workstation.)
2. Click **Workstation Settings**.
3. Enter the text to display for each field and button.
4. Click **OK**.

Testing and Saving Configured Census Windows

You can preview the census window while working. This allows you to verify that queries run successfully, that fields and columns match, and that text is clear to users.

When you are satisfied with a window, you can save it. You can also save a window with a different name to replace another census window.

Test the configuration

1. Click the name of a patient group by selecting its name in the **Census Type** box.
2. Click **Test**.

Note: Each patient group has a patient list. Remember to check the list for each group when testing a census window.

Save the window configuration

- If you are finished configuring the window, click **OK**.

  The configuration is saved automatically.

  If you want to save the changes without closing the window, click **Save**.

Save the window configuration for use with a different application

Note: Three of the buttons listed in the selection window are not currently supported: ReopenPatientButton, ReopenPreAdmittedPatientButton and CorrectButton.

1. After you have finished configuring the window, click **Save As**.
2. In the **World** box, click the appropriate Picis 'configuration world' for the application. Then click the window name in the **Data** box. (For a list of census windows, see [ADT Administrator, on page 2](#).)
3. Click **OK**.

Button Reference

This table shows the census window buttons that can be configured.

Button Identifier & Suggested Text	Description
NewPatientButton 'New Patient...'	Creates a new record and admits the patient to the workstation.
NewPreAdmitted 'New preadmission'	Creates a new record and sets the patient's admission status to 'PreadmitMed'.
AdmitPatientButton 'Start Selected Patient'	Admits the selected patient to the workstation.
PreAdmitButton 'Preadmission'	Starts a preadmission session with the selected patient.
TransferPatientButton 'Transfer'	Ends the patient's session and changes the patient's admission status to 'Transfer'.
DischargePatientButton 'Discharge'	Ends the patient session and discharges the patient from the Picis system.

Button Identifier & Suggested Text	Description
GetPatientButton "Open Chart"	Opens a patient record without changing the patient's admission status.
RefreshButton "Refresh"	Refreshes the list for the selected patient group.
BreakURLinkButton "Break Off-Link"	Breaks a booking/case link.
ChangePatientButton "Change Patient"	Changes the patient on an admission.
CreatePreAdmissionButton "Create Preadmission"	Creates a pre-admission record.
LinkPreAdmissionButton "Link Preadmission"	Links one pre-admission to another.
GetSuppsButton "Supply Log"	Opens the Supply Log.

Printout Viewer (workstation settings)

This section describes workstation-level printout settings. For template-level workstation settings, see Printouts (template settings) on page 111. The following settings are available:

Time options

- You can define the default day start time to be used when an end user selects "current day" as the period to be printed. This setting applies to all printout models.
- You can specify the viewing periods available for end users to select when creating a printout: Admission, Day, Shift, Encounter, and Custom. This setting applies to all printout models.
- You can specify the duration of user inactivity after which a printout model that is open for editing in the Customizes Printout Builder is automatically saved.

General printout settings

- For each printout model, you can define the output type (PDF and/or paper). For PDF printing, you can specify the filename format and network destination.

Default printout settings

- You can specify a default printout model and a default viewing period. These defaults are preselected when a user creates a printout.

Configure the start time for "current day" printing

1. Click **Workstation** > **Printout Viewer Configuration** > **General**.
2. Next to **Default start time for current day**, select **00:00** or **Start time of first shift**.

Configure the viewing periods available for end users

1. Click **Workstation** > **Printout Viewer Configuration** > **General**.
2. Next to **Included Viewing Periods**, select each viewing period that you want to be available.

Configure the autosave timeout for (Customize) Forms Builder users

1. Click **Workstation** > **Printout Viewer Configuration** > **General**.
2. Next to **Autosave (minutes inactive)**, enter a value. After this amount of user inactivity (in minutes), any printout model that is open for editing in the (Customize) Printout Builder will be automatically saved.

Note: This setting also applies to the configuration of quality measures.

Configure print output types

1. On the **Workstation** menu, click **Printout Viewer Configuration**.
2. Under **General Printout Settings**, select a printout model. (The list shows the printout models linked to the configuration set that you are currently editing.)
3. Under **Output Type**, select **Printer**, **Both**, or **File (PDF)**.
   If you select **Both** or **File (PDF)** you must also configure the filename format and network destination. You can also optionally configure the XML to be notified whenever the PDF is generated by selecting **Export to XML**.
4. Under **Filename Format**, type a format to use for filenames.
   Besides free text, use the following variables in order to create unique filenames.
   (Note that these variables are not case sensitive.)

   Identification variables
   {FOM} Print date (DEVD)

[AccID] Admission DBCID
[Acn1], [Acn2], [Acn3] Admission ID1, 2, 3
[AccNum] Account number
[FacName] Facility short name
[FacDesc] Facility description

Patient information variables

[PFn] First name
[PLn] Last name
[PMn] Middle name
[PID] Patient DBCID
[PI1], [PI2], [PI3] Patient id 1, 2, 3
[PDoB] Patient date of birth

Printout information

[PrN] Printout model name

User who printed

[UDB] Staff DBCID
[UIn] Initials
[UID] Username
[UFn] First name
[ULn] Surname

Times (From 'Timeframe' - To 'Timeframe' and 'Printed time')

[FsD], [FsM], [FsW] day, 1 to 31
[FsmI], [FsmS], [FsmN] month, 1 to 12
[FsyI], [FsyS], [FsyL] year, 0 to 99
[FsaI], [FsaS], [FsaL] year, 0000 to 9999
[FsH], [FsI], [FsS] hour, 00 to 23
[FsM], [FsN], [FsA] minute, 00 to 59

Example [FsD] - [FsM] - [FsaL] [FsH]:[FsM]:[FsS] would create a filename such as 30-01-2022 08:00:00.txt, used: [FsD]-[FsM]-[FsaL] [FsH]:[FsM]:[FsS].PDF

Note: By default, if a value does not exist for a variable it will be replaced by the string "(null)" in the filename. You can specify an alternative string to be used in such situations by placing a colon plus the alternative text before the final parenthesis of the variable convention.

Example: If you want the text "No Account" to be used whenever there is no value for the (AcctNum) variable, use the following expression: (AcctNum:No Account).

3. Under **Target Network Path**, type the path to a shared network folder where PDFs will be generated.

   Example: \\FrontServer\Pics\Printouts

   Note: Users need write access to the configured folder and it needs to be available when configuring. (The software will not let you save the configuration if it does not detect the share.)

4. Click **OK**.

Configure the default printout settings

1. Click **Workstation** > **Printout Viewer Configuration** > **General**.
2. Next to **Default Model**, select the model to use as the default.
3. Next to **Default Viewing Period**, select the viewing period to use as the default.

Note: If defaults are not set, end users will have to select the required model and viewing period when printing.

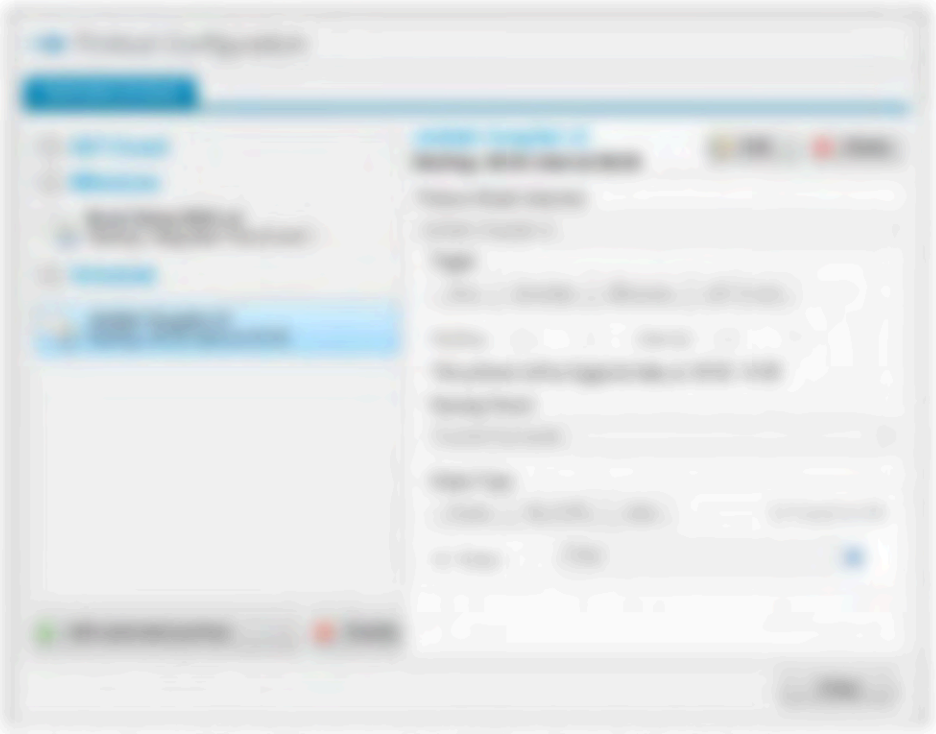
Automated Printouts (workstation settings)

You can configure printouts to be created automatically (sent to a printer, file or both) at specific times, with a specific schedule (e.g. every 4 hours) or when certain milestones or system NDT events occur. Each combination of settings is referred to as an automated printout instance.

Note: When printouts are created automatically, no window is shown to the user. For this reason, automatic printouts are also referred to as "silent printouts".

Create an automated printing instance

1. On the **Workstation** menu, click **Automated Printouts**.
   A window such as the following appears:



2. At the bottom of the left pane, click **Add automated printout**.

Enter settings in the right pane as required:

3. Under **Printout Model Selection**, select a printout type.
4. Under **Trigger**, select a trigger type (**Time**, **Schedule**, **Milestone** or **ADT Event**).
   The controls in the **Trigger** pane change according to the selection.

Time	In the **Starting** box, enter the time that you want the printout to be generated. You can either type the time in military time format (e.g. 14:30) or click the clock symbol and pick a time.

Schedule	In the **Starting** box, enter the time that you want the first printout of the day to be generated. You can either type the time in military time format (e.g. 14:30) or click the clock symbol and pick a time. In the **Interval** box, enter the interval between printouts in hours and minutes. Automated printouts will be created at the Starting time and then after each interval until the end of the day is reached. **Example:** If the Starting time is 4:30 and the Interval is 8, printouts will be created at 4:30, 12:30 and 20:30. **Note:** If you only want one printout per day, enter a large interval such that the end of the day will be reached before the next printout can occur. (Tip: Use an interval of "23:45".)
Milestone	Click in the **Milestone** drop-down box and select a milestone event.
ADT Event	Click in the **ADT Event** drop-down box and select an ADT event.

3. Under **Viewing Period**, select a date range to be printed.
   - Choose from a predefined range (such as Current Encounter, Since Admission or Current Day).
   - Choose Absolute to set specific start and end times. (For this setting, you can also specify the day relative to the current day ("0" = today, "-1" = yesterday etc.)
   - Choose Relative to print a period relative to the printout time, such as the last 4 hours. (For this setting, you can specify hours and minutes.)
5. Under **Output to**, select an output type (**Printer**, **File**, or **Printer & File**).
   The controls in the **Output to** pane change according to the selection. The settings are the same as those available when configuring the Printout Viewer. For more information, see Configure print output (pane) on page 228.
7. If you want the printout exported to the HIS, select **Export to HIS**.
8. Click **OK**.

View, edit, disable or delete an automated printing instance

1. On the **Workstation** menu, click **Automated Printouts**.
2. To view the configuration settings for an existing automated printout instance, select the instance in the left pane.
3. To edit the configuration settings for the selected instance, click **Edit**.
4. To disable the selected instance, click **Disable**. (You can re-enable it in the future by selecting the instance and clicking **Enable**.)
5. To delete the selected instance, click **Delete**.

9

Preop Manager Configuration

About Preop Manager Configuration

Customize contains a section for configuring the behavior and appearance of preoperative evaluations. You should perform such configuration after using DB Editor to create content in the database corresponding to forms for medical histories, physical examinations, risk assessments and anesthesia plans. For more information, see Preop Manager on page 230.

Note: Preop Manager configuration settings are not dependent on templates.

Note: If AnestiaNova Manager or PACU Manager are integrated with Picis PreOptimize™, then Preop Manager should not be used and you should not change any settings in the Preop Manager configuration.

Note: The automatic logoff period (the period of inactivity before the application logs off automatically) is controlled by a workstation setting for all the "clinical module" applications. For more information, see Automatic Log Off on page 179.

Open the Preop Manager configuration window

1. Start Customize. (See Starting and Quitting Customize on page 32.)
2. In **Configuration set**, select a configuration set. (See Configuration Sets and Workgroups on page 31.)

3. Next to **Prosp Manager Configuration**, click **Open**.

Prosp Evaluation Sections

This section covers the following functionality:

- Select sections to include and configure their order
- Change a section title
- Configure fields for form sections
- Lock sections after a patient discharge

Select sections to include and configure their order

(For a list of possible sections see the *Workstation User Guide*.)

1. Click the **Basic Configuration** tab.
   The current configuration is shown in the **Selected Sections** box.
2. To add a section to the summary, in the **Available Sections** box, click the section label, and then click >>.
3. To remove a section from the summary, in the **Selected Sections** box, click the section label, and then click <<.
4. Use the arrows to move a highlighted section in the **Selected Sections** box to a new position. Sections are shown in this order on the Prosp Manager summary.
5. When you have finished, click **Close**.

Note: The forms 'Copy Forward' and 'Previous Evaluations' are identical. The only reason to include both in Prosp Manager would be if they were used by different clinicians for both purposes and sites wanted to avoid retraining clinicians.

Change a section title

1. Click the **Basic Configuration** tab.
2. In the **Selected Sections** box, click the name of the section you want to edit.
3. Click **Edit** to open a window showing the existing title.
4. In the **Section Title** box, enter the new text.
5. Click **OK**.
6. Click **Close**.

Configure fields for form sections

1. Click the **Basic Configuration** tab.

2. In the **Selected Sections** box, click the name of the section you want to edit.
3. Click **Setup** to open a window showing all possible data elements for the section.
4. In the **Name** column, click the name of a field you want to configure.
   - To include the field in the section, select the **Include** check box.
   - To remove the field, clear the check box.
   - To configure the field to display data but not permit data entry, select the **Read-Only** check box. (You should only set a field as read-only if data for it will always be provided automatically from the HIS link or from Anesthesia Manager, PACU Manager or Critical Care Manager.)
   - To allow data entry, clear the check box.
   - To display the field data but not include a field label, select the **Hide Title** check box.
   - To display a label before the data, clear the check box.
   - To require users to document the item, select the **Required** check box.
   - To make the field optional, clear the check box.
   - To change the field label, click the **Edit** button, enter the new text and click **OK**.

Lock sections after a patient discharge

This setting controls whether or not the following sections are locked after the patient is discharged:

- Home Medications
- Surgical History
- Record Status
- Preop Instructions
- Risk Assessments
- Physical Exam
- Anesthesia Plan
- Tests & Results
- Past Medical History

Note that another setting determines whether sections shared with the Demographics module are locked. See [xx, the one, one, to completing discharge before documentation on page 1](#).

1. Click the **Basic Configuration** tab.
2. Select the **Lock sections on patient discharge** check box.
3. When you have finished configuring Preop Manager, click **Close**.

Note: Picis recommends that sites using perioperative integration allow editing of preop records for discharged patients.

Required Data

This section covers the following functionality:

- Configure required data related to diagnoses and procedures
- Configure required data in the anesthesia plan section
- Configure required data in the physical examination section
- Configure required data in the medical history section
- Prevent final signoff when required data is missing
- Prevent final signoff when required data is missing

Note: In Preop Manager, a red exclamation mark will be shown next to required data that has not been entered.

Configure required data related to diagnoses and procedures

In Preop Manager, users can specify the functional type (Preop, Surgical etc.) and clinical priority (primary, secondary or unknown) for each diagnoses and procedure that is entered.

In Customize, you can configure that a certain functional type is required. For example, if you configure that a 'Preop' functional type is required for Diagnoses, then at least one diagnosis must have the functional type, Preop.

You can also configure that a required functional type must be accompanied by a certain clinical priority in at least one diagnoses/procedure. For example, you can specify a functional type of 'Preop' together with a clinical priority of 'Primary'.

1. Click the **Basic Configuration** tab.
2. In the **Selected Sections** box, click the section that contains diagnoses and procedures.
3. Click **Setup**.
4. Click **Diagnoses** or **Procedures** (whichever you want to edit).
   A window appears showing each functional type and its possible clinical priorities.
5. To specify a required functional type, select the corresponding main check box. To furthermore specify that the functional type must be accompanied by a certain clinical priority, select the corresponding check box beneath it.
6. Click **Close**.

Example: The following example shows the functional types 'Surgical', 'Anesthesia' and 'Preop'. Beneath each functional type the user can select the associated clinical priority - 'Primary'.

"Secondary" or "Unknown"

- Surgical
  - Primary
  - Secondary
  - Unknown
- Anesthesia
  - Primary
  - Secondary
  - Unknown
- Preop
  - Primary
  - Secondary
  - Unknown

Configure required data in the anesthesia plan section

1. Click the **Basic Configuration** tab.
2. In **Selected Sections**, click the name of the anesthesia plan section.
3. Click **Setup**.
4. To require users to document the patient's ASA type, select the **ASA type required** check box.
5. In **Required Subsections**, select the check boxes next to the subsections that must be completed for every patient.
6. Click **Close**.

Configure required data in the physical examination section

1. Click the **Basic Configuration** tab.
2. In **Selected Sections**, click the name of the physical examination section.
3. Click **Setup**.
4. In **Required Subsections**, select the check boxes next to the subsections that must be completed for every patient.
5. Click **Close**.

Configure required data in the medical history section

1. Click the **Basic Configuration** tab.
2. In **Selected Sections**, click the name of the medical history section.

3. Click **Setup**.
4. In **Required Subsections**, select the check boxes next to the subsections that must be completed for every patient.
5. When you have finished configuring Preop Manager, click **Close**.

Prevent final signoff when required data is missing

1. Click the **Basic Configuration** tab.
2. Select the **All required data must be entered before final signoff** check box.
3. When you have finished configuring Preop Manager, click **Close**.

Quick Links, Toolbar Buttons and Menu Commands

This section covers the following functionality:

- Configure a quick link application for the Preop Manager toolbar
- Provide a toolbar button for printing preoperative patient instructions
- Provide a button for creating a template-based printout

Configure a quick link application for the Preop Manager toolbar

Note: You can use the buttons numbered from 1 to 0 to configure up to five add-ins. Each button allows you to configure one add-in. Click button 1 to configure the first add-in, then click button 2 for the second add-in, and so on.

1. Click the **General Settings** tab.
2. Under Add-in Configuration, click button 1 and then do the following:
   a. In **Location**, enter the path to and name of the executable file.
   b. Select a graphic for the toolbar button and click **OK**.
   c. Select the **Toolbar** bean check box and then click **Browse**.
   d. In **Tooltip**, enter the text to display when the user holds the cursor over the toolbar button.
3. To configure another add-in, click button 2 and repeat the steps in step 2. Use buttons 3, 4, and 5 for additional add-ins, as necessary.
4. Click **Close**.

Best Practice: If either Anesthesia Manager, PACU Manager or Critical Care Manager is also used at the workstation, configure a quick link for it (in Location, enter the path to the Cerner.exe file).

Provide a toolbar button for printing preoperative patient instructions

1. Click the **General Settings** tab.
2. Click **Include Patient Printout** button.
3. Click **Close**.

Provide a button for creating a template-based printout

1. Click the **General Settings** tab.
2. Click **Show Printout Viewer** button.
3. Click **Close**.

Note: Preop Manager always includes a **Print Evaluation** command on the **File** menu. This command is used to print the current preop summary. The formatting is controlled by an XSL style sheet and the content is preconfigured—it cannot be changed in Preop Manager. Users click this command in Preop Manager to select the printer.

Note: In contrast to **Print Evaluation**, **Open Printout Viewer** is used to create a printout with formatting and content defined by a printout template (just like printouts of the anesthesia record). If configured to be shown in Preop Manager it only appears on the main toolbar. When a user clicks the button the Printout Viewer window opens allowing the user to select a printout model to use for printing.

Configure the commands you want to appear on the File menu

You can configure the following menu commands to be shown on the **File** menu:

- New Patient
- OR Information
- New Evaluation

1. Click the **General Settings** tab.
2. Click the relevant **Show** checkbox(es).
3. Click **Close**.

Interface Notes

Note: If AnesthesiaManager or PACU Manager are integrated with Picis PreOptimize™, then Preop Manager should not be used and you should not change any settings in the Preop.

Manager configuration

You can set the ability to import the following data from an interface note into Prexp Manager:

- Home medications
- Past medical history
- Surgical history data
- Physical exam data (including vital signs)
- Test and results data

Note that data from interface notes is always imported in "snapshot mode" as described in the following box.

About Snapshot mode

In Snapshot mode any existing entries in the record are removed and replaced with entries from the interface note.

Example: In Prexp Manager, a patient record initially shows two home medications: Paracetamol 500mg and Nyquil. A clinician opens an interface note that shows that the patient now just takes Paracetamol 1 g. After data has been imported the prexp record will only show a home medication of Paracetamol 1g (there will be no indication of Nyquil).

Example: In Prexp Manager, a patient record initially shows an allergy to egg. A clinician opens an interface note that does not have any allergies. After data has been imported the Prexp Manager record will not show any allergies.

Configure the ability for users to import data from an interface note

1. Click the **Import Interface Notes** tab.
   - Click **Home Medications** to allow this data type to be copied from an interface note.
   - Click **Past Medical History** to allow this data type to be copied from an interface note.
   - Click **Surgical History** to allow this data type to be copied from an interface note.
   - Click **Physical Exam / PMT Vital Signs** to allow this data type to be copied from an interface note.
   - Click **Tests and Results** to allow this data type to be copied from an interface note.
2. Click **Close**.

Miscellaneous Prexp Manager Configuration

This section covers the following functionality:

- Choose the patient identification number to display in the title bar
- Configure laboratory data to show
- Configure the ability for users to copy data from one evaluation to the next
- Require users to log on before closing the application
- Enable printing an exit after a prexp record is edited

Choose the patient identification number to display in the title bar

1. Click the **General Settings** tab.
2. In **Patient ID Source**, select a source (database field) to use as the patient identifier in the Prexp Manager title bar. You can choose from the following:
   mrn1, mrn2, mrn3, accountnumber, user1, user2, or user3
3. When you have finished configuring Prexp Manager, click **Close**.

Note: The setting you make depends on the identification system used by your hospital and how the identifier database fields are used. For example, if you want to display the Medical Record Number and this is stored in the PTID1 field, you would choose PTID1.

Require users to log on before closing the application

1. Click the **Basic Configuration** tab.
2. Select or clear the **No logon required to exit Prexp Manager** check box.
3. Click **Close**.

This feature is intended for the situation where a user has been automatically logged off.

Configure laboratory data to show

This setting determines how far back from the current date to show laboratory data for.

1. Click the **General Settings** tab.
2. In **Days of laboratory data to display**, select how far back from the current date to show lab test data.
3. Click **Close**.

(See also the similar setting for Anesthesia Manager, PACU Manager and Critical Care Manager: Configure laboratory data to show on page 235.)

Configure the ability for users to copy data from one evaluation to the next

Note: This feature is only available for the Home Medications, Past Medical History and Physical Exam / PAT Vital Signs sections.

1. Click the **Copy Forward** tab.
2. Click **Home Medications**, to allow data from this section to be copied forward to the next evaluation.
3. Click **Past Medical History**, to allow data from this section to be copied forward to the next evaluation.
4. Click **Physical Exam / PAT Vital Signs**, to allow data from this section to be copied forward to the next evaluation.
5. Click **Close**.

Enable printing on exit after a preop record is edited

If a user edits a preop record, a printout of that record will be created when Preop Manager is closed.

1. Click the **Silent print** tab.
2. Select **Silent print on editing and closing a preop record**.
   a. In **Model**, select the printout type to use.
   b. Under **Output**, select the format for the printout.
      (Select To **file** *or* **Both** *to save an electronic record of each printout to a predefined network folder.*
3. Click **Close**.

The Preop Instructions Printout

Unlike other aspects of Preop Manager, the Preop Instructions Printout is configured using a html editor rather than Customize.

Customize the preoperative instructions printout

1. Open the following file in a HTML editor (or Microsoft Word and saving as html):
   "\\Program Files\\Procedure Resource\\en\\PREOPINST.html"
2. Customize the text.
   The document combines standard text with dynamic data from a patient's evaluation. Rewrite the standard text as needed. Use the following variables for dynamic data:
   #PATIENT NAME#: First and last name as shown in the header of the preoperative summary.

&PATIENT.ID# - Patient identification number displayed in the header of the preoperative summary.
&PLANNED.PROCEDURE# - Procedures documented in the form for diagnosis and procedures.
&DATE.OF.SURGERY# - Surgery date displayed in the demographics form.
&PATIENT.INSTRUCTIONS# - Instructions for the patient selected in the preoperative instructions form.
&PRESCRIPTIONS# - Instructions regarding medications selected in the home medications form.

3. Customize the look.
   Set formatting such as fonts, tabs etc.
   Insert pictures as desired (e.g. the Hospital logo).
4. Save the file.

Note: Do not change the margins of the html page itself as final margins are controlled by Internet Explorer settings, as described next.

Change the page margins

When the Prevu Instructions Printout is printed it will use the margins that are configured in Internet Explorer (**File** > **Page Setup**). The default margin size is 0.75 inches.

If a user changes the margins in Internet Explorer it will only affect printouts created by that user. Changes are saved to the following registry key:

HKEY_CURRENT_USER\Software\Microsoft\Internet Explorer\PageSetup

Change the default margin size for all users of a workstation

1. In the registry, create a key called PageSetup under HKEY_LOCAL_MACHINE with the entries that you want. The best way to do this is as follows:
   a) Set the margins you want in Internet Explorer (**File** > **Page Setup**).
   b) Open the registry and export the following registry key:
   HKEY_CURRENT_USER\Software\Microsoft\Internet Explorer\PageSetup
   (When you export a key it creates a "reg" file in the folder that you designate.)
   c) Open the reg file in Notepad, replace the text "CURRENT_USER" with the text "LOCAL_MACHINE" and save the file.
   d) Double-click the reg file in Explore. This will load the new key back into the registry.
2. Delete the PageSetup key for the current user. (This will ensure that settings from the Local Machine key are used when creating a printout).
3. Instruct users not to change page setup settings in Internet Explorer. (Otherwise a new PageSetup key will be created in the registry for the current user and the settings will override

the local machine settings. Alternatively, you can enforce this to some extent by creating a logon script to delete the PageSetup key for the current user each time a user logs on.

10

DB Editor

DB Editor Overview

The CAR database contains all of the clinical content and many configuration parameters for Preop Manager, Anesthesia Manager, PACU Manager, and Critical Care Manager. Each hospital creates a custom database during implementation. DB Editor provides access to certain database tables and parameters after installation of the software.

Hospitals use DB Editor to work with the following items:

- Flowsheet content including physiologic variables, medications, fluids, care activities, scores, nursing assessments.
- Note templates.
- Content for the perioperative QA Indicators and Equipment windows.
- Events.
- Standard orders, protocols and schedules for orders.
- Content for user selections in Demographics and Preop Manager windows, plus lists of the most frequently used diagnoses, procedures, and allergies for quick selection.
- Content for preoperative evaluations.
- Hospital department names.
- Preop Manager, Anesthesia Manager, PACU Manager and Critical Care Manager workstation and task locations.

- Configuration parameters related to audit trails

Starting and Quitting DB Editor

Note that other Proto programs at the same workstation should be shut down while DB Editor is being used.

You must have the system right *DB Editor* to work with this application. In addition, you need specific access rights to work with different types of database content:

Database content	System right needed to edit content
Clinical content	Orders: Supervisor Options
Users, user groups, prescription validation rights	User Accounts: Maintenance

Note: Only a database administrator with extensive knowledge of the Proto system should use DB Editor. Changes made using this tool affect the behavior of the entire Proto system immediately. Any unwanted changes must be reversed manually.

When working with DB Editor, you are advised to set the *CacheRefreshProbability* to 1 using Customize, as described in the section Set the frequency of database access on page 33. Restore the parameter to its normal setting when you are finished using DB Editor.

Start DB Editor

1. Click **Start** > **All Programs** > **Proto Products <version>** > **DB Editor**.
2. Enter a valid user name and password to log on to the system.

Note: If your system is configured to use Directory Services Authentication, the **Change Password** button is disabled and a control for choosing the **Domain** may be present.

Quit DB Editor

- Click **Quit**.

Changes are saved automatically.

DB Editor Interface

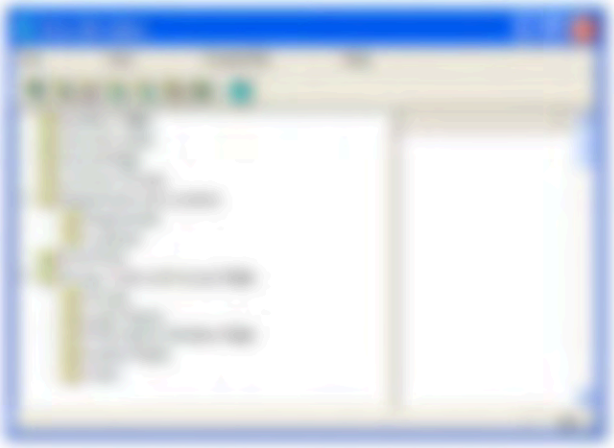


Figure 2: The DB Editor interface for a standalone "clinical module" system.

The left side of the application window shows folders containing items that can be modified. The right side of the window shows the contents of the selected folder. If you double-click an item on the right side of the window, a wizard starts or a table for editing the item opens.

DB Editor divides database content in five main folders:

- **Auxiliary Tables**. Standard items that a user selects from lists when entering information in application windows and custom forms. (If the system is configured for perioperative integration many tables are hidden — the functionality can instead be found in OR Manager).
- **Clinical Content**. Entries related to care activities that can be documented for a patient. These include medications, fluids, assessments and scores, protocols, and all components associated with them.
- **Clinical Roles**. Possible functions that a medical team member can perform in a surgical procedure and the attending types associated with each type.

  (For more information, see Clinical Roles on page 203.)
- **Common Choices**. Lists of the diagnoses, procedures, medications, and allergies that are used most frequently in different care areas. Windows prepare a short list with only these items for quick selection. Users can "drill down" to search for less frequently used items if needed.
- **Departments and Locations**. Hospital departments that use the Picis system, and locations that represent specific workstations or beds.

  (For more information, see Hospital Departments and Patient Locations on page 207.)

- **Groups, Users and Access Rights**: User groups, users, system rights, and prescription/validation rights. If your system is configured for perioperative integration, this folder is not present — the functionality can instead be found in DR Security Manager.

  (For more information, see Program Users on page 201.)

CAUTION: DB Editor has no "Save" button; edits are saved to the database instantly.

Auxiliary Database Tables

The **Auxiliary Tables** section provides access to key database tables. These tables were initially populated before installation of the software, or by sending test data from other information systems during implementation. DB Editor lets you add new items, edit existing items, and (for some tables) disable unnecessary items. (For a full list of auxiliary tables, see Auxiliary Database Tables on page 230.)

Indexing

Tables with an **Index** column allow you to control the order in which items appear in Pharm Manager, Anesthesia Manager, PACU Manager and Critical Care Manager. If some items in a table are indexed and others are not, the manner in which items appear depends on the application. In Pharm Manager, items that are not indexed are shown alphabetically at the top of windows and the indexed items are shown below. By contrast, in Anesthesia Manager, PACU Manager and Critical Care Manager, indexed items are shown at the top of windows and the non-indexed items are shown below.

Note: To set the sort order for laboratory items, see Laboratory and Diagnostic Tests on page 301.

Reserved tables

The following tables are included in DB Editor for informational purposes only. They should not be edited:

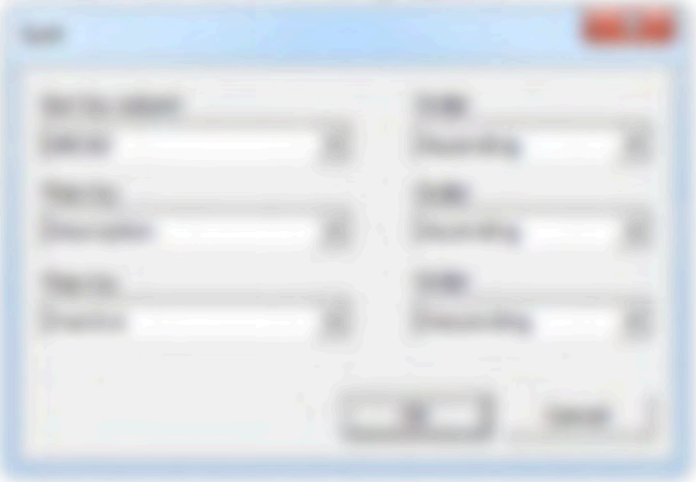
- ADT States
- Anesthesia Plan Types
- Application Roles
- Categories
- Concept Identifiers (Clinical Data Interfaces)
- Configuration Status Types

- Distribution Status Types
- Family Behavior
- Order Modification Types
- Order Task Status
- Order Types
- Score Groups
- Unit Times

What you can do

Sort entries in a table

1. Click **Sort**.
   A window such as the following appears:



   In **Sort by values**, select the column to sort by.
2. To apply a second sort within the already sorted results, select the second column to sort by in the top **Then by** box.
3. To apply a third sort within the already sorted results, select the third column to sort by in the bottom **Then by** box.
4. Items are listed in ascending alphabetical order by default. To change the sort order, click the drop-down arrow in the **Order** box for the sort and select Ascending or Descending as required.
5. Click **OK**.

Note about Ascending sort

Any empty (blank cell) entries are listed first. Thereafter, ordering is alphabetical. Symbols and numbers are considered before letters.

The first time you sort the sorting is case sensitive, with uppercase letters being considered first. For example, the entry "Beam" would be listed above "arm" and "1 BRF" would be listed above "1 cm". If you were to sort a second time (without changing any of the sort options), the sorting would be case insensitive.

Add an entry to a table

1. In the **Auxiliary Tables** folder, double-click the name of the table.
2. Click **Add**.
3. Click a cell and type the new item. Click anOnt to save the new cell data. (You must do this before you can select another cell.) Complete all columns in the row.
   Some tables include columns with entries from other tables. For example, the Units table includes a column that links each entry to an item on the UnitTypes table. Information is entered in these columns by selecting from a drop-down list that appears when you click the cell.
4. When you have finished adding entries, click **Close**.

Delete an entry from a table

1. In the **Auxiliary Tables** folder, double-click the name of the table.
2. Select the entry to delete.
3. Click **Delete**.

Note: In some tables, you can disable entries without deleting them. These tables include a column labeled **Inactive**. Selecting **Inactive** removes the entry from applications. Clearing the check box restores them. Items in tables can also be deleted, but this action is permanent.

Modify an entry in a table

1. In the **Auxiliary Tables** folder, double-click the name of the table.
2. Click a cell to edit.
3. To replace the existing entry, enter new text. To edit the entry, press F2 and edit the text. To cancel either operation, click cOn.
4. Click **Close**.

Disable a table entry to remove it from applications

1. In the **Auxiliary Tables** folder, double-click the name of the table.
2. Select an entry to disable.
3. Select the check box in the **Inactive** column.
   Not all tables have this column.
4. Click **Close**.

Note: In some tables, you can disable entries without deleting them. These tables include a column labeled **Inactive**. Selecting **Inactive** removes the entry from applications. Clearing the check box restores them. Items in tables can also be deleted, but this action is permanent.

11

OE Editor and System Configuration

Access Rights and Users

There are two types of access rights:

- Rights associated with application functionality are called 'system rights' and are part of the software; you cannot create new system rights or delete existing ones.
- Rights associated with clinical content are called 'Prescription/Validation rights.' A group of predefined rights are provided; you can create new rights using OE Editor. So that 'cards' implies, these rights control access to treatments and orders in the database.

System Rights

The following system rights can be granted to user groups.

System right	What you can do with this right
Add to Fluid Balance	Exclude an order from the fluid balance when prescribing or first documenting (cataloging) it. (By default, all fluid orders are added to the Fluid Balance.)
Adt Manage	Use the following features in ADT Administration: • Preadmit, admit, transfer or discharge a patient.

System right	What you can do with this right
	• Undo a discharge • Configure sensus lists **Note:** To start ADT Administrator users need the "Diagnostic Tools" right plus either the "Anesthesia Manager User", "PACU Manager User" or "Critical Care Manager User" right.
Allow to Change Doses During Take Req	Modify the dose when documenting a rate bag of continuous Combined Medication.
Anesthesia Manager User	• Start Anesthesia Manager. • View flowsheets. • View prescription and documentation (validation) data for orders. (You do not need prescription or validation rights for the order concerned.) • View cell, order and time column memos. (See also the "Clinical Modules User" right.) • Close Anesthesia Manager at multiseat workstations. (Note that this right does not allow you to close Anesthesia Manager at bedside workstations - for that you need the "Clinical modules user" right.) • Close Remote Access at bedside workstations. • Start ADT Administrator. (You also need the "Diagnostic Tools" right for this.)
Body Map Admin	Use the Body Map Administrator tool to create body map templates.
Body Map Edit	Create and edit body maps.
Body Map View	View body maps.
CaseCheck	Start CaseCheck and access all functionality.
Clinical modules user	Access all data and functionality in Anesthesia Manager, Critical Care Manager, and PACU Manager **except the following**, for which additional rights are needed: • Patient Summary. • Demographics window.

System right	What you can do with this right
	• Printouts (of patient charts). • Device configuration. • Ability to edit and delete certain events and physiologic data. • SAM module. • Ability to document APACHE II and Glasgow Coma Scores. • Concurrency module. • Ability to link to preadmissions. • Ability to create and edit certain clinical database content via the **Orders** menu. • Ability to move and resize windows. • Copy-forward functions. • Chase Anesthesia Manager at bedside workstations.
Concurrency	Use the Concurrency module and access all functionality.
Configuration Management	Use Customize to perform the following tasks: • Create and edit configuration sets. • Create logical workgroups and assign computers to them. • Assign configuration sets to workgroups. • Create screen layouts (using Anesthesia Manager, PACU Manager or Critical Care Manager). For more information, see the *Workstation User Guide*. • Create and configure various windows using ADT Administrator. (To start Customize, you also need the Customize right.)
Critical Care Manager View	See one for "Anesthesia Manager View"
Customize	Start Customize and edit the local workstation configuration. (To access other features, you need the Configuration Management right.)
DB Editor	Start and use DB Editor (users must also have the right "Orders Supervisor Options" to work with items in the Clinical Content folder and the right "User Accounts Maintenance" to work with items in the Groups, Users, and Access Rights folder).

System right	What you can do with this right
Delete Clinical Notes	Delete a draft note.
Demogr. <window name> edit	Enter or modify data in the relevant Demographics window. (See also the Preop Home Medications use right.)
Demogr. <window name> view	View data in the relevant Demographics window. (See also the Preop Home Medications view right.)
Demogr. Configure	Use the Demographics Editor > Customize.
Demogr. copy hospital admission data into the Demogr. hospital information form	Copy the hospital admission data from a previous admission into the hospital information form.
Demogr. Patient identification view	View patient identification data. Copy the account number and ADMID1 value from a previous admission into a patient demographics information form.
Demogr. previous admissions copy forward view	View previous admissions in the Demographics module that are copy forward eligible.
Demogr. Print	Print the Demographics window.
Demogr. Summary unlock	Unlock the Demographics summary for an encounter.
Diagnostic Tools	Start and use utilities in the Pro\Diagnostics folder. **Note:** To start ADT Administrator users need the "Diagnostic Tools" right plus either the "Anesthesia Manager View", "PACU Manager View" or "Critical Care Manager View" right. Users can change patients, link preadmissions, break links to DB Manager records and close (end) preadmissions. Users who also have the "ADT Manage" right can access additional functions. (See the one for this right for more details.)
Document. Viewer task	Start the Document. Viewer, view all files and upload files.

System right	What you can do with this right
Document Viewer View	Start the Document Viewer and view all files.
Edit Clinical Notes	Edit/finalize a draft note that was created by another user (users do not need rights to edit or finalize their own notes).
Edit Devices	Configure devices from within Anesthesia Manager, PACU Manager, or Critical Care Manager.
Edit Events	Add, modify, or delete events for the following: - a remote patient when the access type is "View/Chart" - a patient with transfer or discharged status.
Edit RTD	Add, modify, or delete physiologic data for the following: - a patient in transfer or discharged status - a remote patient when the access type is "View/Chart".
Edit Supply Price	View and edit prices in the Supply Log and Add Supply window.
eView Acknowledge lab notifications	(Not currently used. Reserved for future use.)
eView Edit General announcements	(Not currently used. Reserved for future use.)
eView Edit System announcements	(Not currently used. Reserved for future use.)
eView Edit System threshold settings	(Not currently used. Reserved for future use.)
eView view	(Not currently used. Reserved for future use.)
Eventligence Mapping Tool Edit	(Not currently used. Reserved for future use.)
Integrated Data Report use	Enable the "Reviewed" option in the "Post-discharge Edited Shared Fields" report (in the Report Viewer).
Integrated Data Report view and	View and print the "Post-discharge Edited Shared Fields" report (in Report Viewer).

System right	What you can do with this right
print	
Mapping Tool Admin	Use all Mapping Tool functionality including the ability to remove locks.
Mapping Tool Use	Use all Mapping Tool functionality except the ability to remove locks.
Orders Supervisor Options	Create and edit treatments, schedules, standard orders, protocols, and other clinical databases content. **Note:** Supervisors with this right can validate any order and edit validations made by other users even if the supervisor does not have validation rights for the order concerned. **Note:** The right also allows you to document an override reason and comments for an externally prescribed order that has a medication interaction.
Order Inbound Error Acknowledge	Acknowledge errors related to the ABCIn/NS order interface. Users without this right can view a list of errors but cannot acknowledge them.)
Order Outbound Error Acknowledge	Acknowledge errors related to the OUTBOUND order interface. Users without this right can view a list of errors but cannot acknowledge them.)
PACU Manager View	Gain row for "Anesthesia Manager View"
Patient Summary Add Notes	Add notes in the Add Notes tab of the Patient Summary.
Patient Summary Save Reports	Save Patient Summary reports.
Patient Summary View	View and print the Summary view of the Patient Summary.
Pharmacy Report View and Print	Start Report Viewer. View and print the pharmacy billing exception report.
Picis Hub	Start and use the Picis Hub.
Proxy window name - use	Enter or edit data in the relevant Proxy Manager window.

System right	What you can do with this right
Pmsg: narrative owner: view	View data in the relevant Pmsg Manager window. Note that the Pmsg: Home Medications view right is also needed to view data for Home Medications in the Demographics module in Anesthesia Manager, PACU Manager and Critical Care Manager.
Pmsg: and Demogr: Interface form: view	View the interface form from Pmsg Manager or the Demographics module.
Pmsg: Home Medications: edit	Enter or edit data in the Home Medications window in Pmsg Manager and in the Demographics module in Anesthesia Manager, PACU Manager and Critical Care Manager. Copy data from a previous admission or an interface note into the Home Medications window.
Pmsg: Manager: view	Start Pmsg Manager. (Additional rights are needed to view and edit data.)
Pmsg: Order, Task: edit	Enter or edit data in the Tasks and Results window in Pmsg Manager. Copy data from an interface note into the Tasks and Results window.
Pmsg: Physical Exam: edit	Enter or edit data in the Physical Exam window in Pmsg Manager. Copy data from a previous admission or interface note into the Physical Exam window.
Pmsg: Review of Systems: edit	Enter or edit data in the Past Medical History window in Pmsg Manager. Copy data from a previous admission or interface note into the Past Medical History window.
Pmsg: Supervisor	Not used. Reserved for future versions.
Pmsg: Surgical History: edit	Enter or edit data in the Surgical History window in Pmsg Manager. Copy data from an interface note into the Surgical History window.
PreOptimize	Access PreOptimize buttons and commands in Pmsg Manager, Anesthesia Manager and PACU Manager.
Printouts	Start and use the Printout Loader. This right is needed when creating printouts directly by starting the Printout Loader or when printing from Anesthesia Manager, PACU Manager, or Critical Care Manager. It is not needed for printing the Pmsg Manager Summary, Demographics window or Patient Summary.

System right	What you can do with this right
Profile Event Pair Conflict Manual Override	Override an event pair conflict for the 'Anesthesia Start' event. This right allows you to proceed with adding the event to the Events Log. (Other conflicting events are not added.)
Profile exception manual override	Set or un-set the 'manual override' flag for an exception record that the user has the right to view in the Report Viewer.
Profile report all audit	View and print all exception and concurrency reports in the Report Viewer.
Profile report view & print	Start Report Viewer. View and print exception and concurrency reports in which the user is a recorded anesthesia provider.
QRP Mapping Tool	Start the Mapping Tool that is used to configure Quality Reports.
QRP measure set owner	Open the relevant quality report.
QuickQuery	No longer used.
Reports Menu	View, print and save reports.
Reports Audit Menu	View an audit trail showing who has viewed, printed and saved reports.
R1 Access	Document the Glasgow Coma and APACHE II scores.
SAM view and use	Use the Supervisory Anesthesia Module.
Security Report Print & View	Start Report Viewer. View and print 'audit trail' reports.
Send Supply	Activate 'Send Supplies function in Anesthesia Manager, so that the documented Anesthesia Manager supplies can be sent to OR Manager from the Anesthesia Manager Supply Log.
SummaryHome screen: View	Not used.
SummaryHome screen: audit	Not used.
Summary, Previous Evaluation Audit	Not used.
Supply: Use	Access the Supply Log and Add Supplies window.

System right	What you can do with this right
	Users can have Item Supply and Edit Supply Price rights without having the Supply Use right. In such cases, users can send supplies or edit price information without having the rights to edit other parts of the supply.
Synaptical Mapping	(Not currently used. Reserved for future use.)
Unlock Clinical Notes	Unlock a clinical note that is open for editing by another user.
User Accounts Maintenance	Access the "Groups, Users and Access Rights" folder in DB Editor.
VIP Access	Enable/disable the 'VIP' flag on patient records.
Windows Control	Move and resize windows in Anesthesia Manager, PACU Manager, and Critical Care Manager.
Withdrawn Consent Access	Select/clear the "Withdrawn Consent" flag in patient records.

Note: One of the following rights is required to start Report Viewer:
- Profile report view & print
- Pharmacy report view & print
- Security Report Print & View

Prescription/Validation Rights

Each treatment and order in the database has two rights associated with it:

- A "prescription" right for prescribing (adding one or more scheduled tasks to the patient chart). The prescription right is also needed for revising or extending an order.
- A "validation" right for documenting completion of a task related to the order.
- Depending on the system configuration, either the prescription right or the validation right is needed in order to cancel or discontinue the order (for more information, see For rights needed to cancel or discontinue orders, on page 230).

  Note: No rights are needed for the automatic discontinuation/cancelation of orders that occurs when a patient is discharged.

You can use Prescription/Validation rights in two ways:

- To limit access to treatments in order to prevent some users from working with them.

- To associate specific treatments with certain types of clinicians in order to hide all other treatments for these clinicians.

Prescription/validation rights allow you to control who can add and document different items on a patient chart. These rights reflect the needs of different types of users and hospital policies and procedures. Rights are assigned to treatments and standard orders.

Rights are also assigned to user groups. Users in a group can work with all database items that share the same prescription/validation rights. Users only see the items to which they have access when ordering. This allows you to limit access to items and filter them so that specialists see only the ones that they need.

A set of default rights is provided. Custom rights are created during database installation and assigned to treatments and standard orders before the database is generated. New rights can be added to an installed database. This can be done using DB Editor, as described in this guide.

Example of how prescription/validation rights are used

For example, to allow only doctors to add any standard narcotic order to a patient chart but allow both doctors and nurses to document its administration, the following rights structure can be used:

- A prescription/validation right called "Narcotics, order" and another called "Narcotics, document".
- Standard orders for all narcotics with the Order Access set to "Narcotics, order" and the Validation Access set to "Narcotics, document".
- A user group called "Doctors" with the prescription/validation right "Narcotics, order". All doctors are members of this user group.
- A user group called "Nurses" with the prescription/validation right "Narcotics, document". All nurses are members of this user group.

Standard Order: Morphine 1-30 mg Intravenous Bolus or PRN	
Order Access: Narcotics, prescribe	Validation Access: Narcotics, document

The Narcotics, prescribe right is needed to order morphine.

The Narcotics, document right is needed to document that morphine has been given.

Group	RIS Right
Doctors	Narcotics, prescribe Narcotics, document
Nurses	Narcotics, document

View Prescription/validation rights

- To see the list of existing rights, do the following:
  - In the **Groups, Users and Access Rights** folder, open the **Prescription/Validation Rights** subfolder. All prescription and validation rights are displayed on the right side of the window.
- To view the rights associated with a treatment, do the following:
  - In the **Auxiliary Tables** folder, double-click **Treatment**.

Create a new Prescription/validation right

1. On the **Create/Edit** menu, click **Prescription/Validation Rights**.
2. Click **New**.
3. Enter a name for the prescription/validation right.
4. Click **OK**.

You can now assign this right to user groups and to new treatments and standard orders.

Program Users

If you are installing the system for the first time, user names were entered when the database was installed. After installation, you can use DB Editor to create groups for those users and assign system and Prescription/Validation rights to the groups. You can also use DB Editor for maintenance tasks such as adding and deleting users, resetting passwords, and modifying user groups.

Create a new user

1. Click
   Or, on the **Create/Edit** menu, click **User Profiles**.
2. Enter the following information:
   User's first and last names. (You must not leave either of these blank.)
   User Name. Any unique combination of numbers or letters, to log on to the system.
   Initials. The user's initials appear on printouts to identify the user who entered a particular event.
   User ID and **Other User ID** (optional). Identification numbers, such as the social security number or any other number the hospital associates with a staff member. You must enter at least one user ID.
   Staff Type. Select an entry from the staff classification list.
   Select **Active** to indicate that the user is currently authorized to use the system.

3. To define professional categories for the user, select an attending type in the **Available Attending Types** list and click >> to add it to the **Selected Attending Types** list. To select more than one user, you can hold down the SHIFT or CTRL key while you click. SHIFT allows you to make adjacent selections. CTRL allows you to select non-adjacent users.

   To remove an attending type from the list, in **Selected Attending Types**, click the attending type. Then click <<.
4. To add the user to groups, select a group in the **Available User Groups** list and click >>.
5. To create a password for the user, click **Set Password**, enter and confirm the new password, then click **OK**.

   Note: Passwords should only contain alphanumeric characters. Prisms may be further restrictions depending on the global password settings. For more information, see Password Characteristics on page 2111.

   To let the user enter a new password at the next log on, leave these controls blank.

   Although a user can use a provided password to access applications, he or she should be encouraged to change it when next logging on to an Prism application (by clicking **Change Password** in the logon window).
6. Click **Exempt from Lockout**, if you do not want the user to be restricted to a maximum number of failed logon attempts. (See Password Characteristics on page 2111.)
7. Click **OK**.

Modify a user profile

1. In the **Groups, Users and Access Rights** folder, open the **Users** subfolder. All users are displayed on the right side of the window.
2. Double-click the user you want to modify.
3. Enter the following information:

   User's first and last names.

   User Name. Any unique combination of numbers or letters, to log on to the system.

   Initials. The user's initials identify the person adding an item to the Events Log.

   User ID and **Other User ID** (optional). Identification numbers, such as the social security number or any other number the hospital associates with a staff member. You must enter at least one user ID.

   Staff Type. Select an entry from the staff classification list.

   Select **Active** to indicate that the user is currently authorized to use the system.
4. To define professional categories for the user, select an attending type in the **Available Attending Types** list and click >> to add it to the **Selected Attending Types** list. To select more than one user, you can hold down the SHIFT or CTRL key while you click. SHIFT allows you to make adjacent selections. CTRL allows you to select non-adjacent users.

   To remove an attending type from the list, in **Selected Attending Types**, click the attending type. Then click <<.

5. To add the user to groups, select a group in the **Available User Groups** list and click >>.
6. Click **Expiry from Lockout**. If you do not want the user to be restricted to a maximum number of failed logon attempts. (See Password Parameters on page 270.)
7. Click **OK**.

Reset a user's password

1. In the **Groups, Users and Access Rights** folder, open the **Users** subfolder. All users are displayed on the right side of the window.
2. Double-click the user you want to modify.
3. Click **Set Password**.
4. To assign a new password to the user, enter it in the **New Password** and **Confirm New Password** boxes.

   To let the user enter a new password at the next log on, leave these controls blank.

   > **Note**: Passwords should only contain alphanumeric characters. (There may be further restrictions depending on the global password settings. For more information, see Password Parameters on page 270.)

   Although a user can use a provided password to access applications, he or she should be encouraged to change it when next logging on to a Pcvs application (by clicking **Change Password** in the logon window).
5. Click **OK**.

Unlock a user who has been locked out

A user becomes locked out when he or she has exceeded the configured number of unsuccessful logon attempts. (See Password Parameters on page 270.)

1. In the **Groups, Users and Access Rights** folder, open the **Users** subfolder. All users are displayed on the right side of the window.
2. Double-click the user you want to unlock.
3. Click **Unlock User**.
4. Click **OK**.

Delete (inactivate) a user

1. In the **Groups, Users and Access Rights** folder, open the **Users** subfolder. All users are displayed on the right side of the window.
2. Double-click the user you want to remove.
3. Clear the **Active** check box. (Users cannot be permanently erased from the system.)
4. Click **OK**.

User Groups

Users acquire their access rights from the groups they belong to. In non-integrated sites, a user can belong to more than one group.

Figure 2: For non-integrated sites, a user can belong to more than one user group. User 3 belongs to user group A as well as user group B, and therefore has the rights of both groups.

Clinical Roles

Users of Anesthesia Manager and PACU Manager typically need to document who performed certain key functions in a case. The Attending Type classifies staff members by their medical specialties. A staff member with a particular Attending Type can play different roles in a specific procedures. For example, a surgeon might fill any of the following roles: Primary Surgeon, Scheduled Surgeon, Surgical Resident. In Picis products these are known as Clinical Roles.

If your hospital does not use OR Manager, you can perform the following tasks using DB Editor:

Create a new clinical role below
Modify the attending types associated with a clinical role below
Delete a clinical role below

If your system is configured for perioperative integration with OR Manager, these tasks are performed using OR Security Manager.

Create a new clinical role

1. Click
   Or, on the **Create/Edit** menu, click **Clinical Roles**.
2. In the **Description** box, enter the name of the role.
3. In the **Available Attending Types** box, click the types that can perform the role in a procedure. Then click >>.
4. Click **OK**.

Modify the attending types associated with a clinical role

1. Click
   Or, on the **Create/Edit** menu, click **Clinical Roles**.
2. In the **Description** box, enter the name of the role.
3. In the **Available Attending Types** box, click the types that you want to associate with the role. Then click >>.
4. In the **Selected Attending Types** box, click the types that you want to disassociate from the role. Then click <<.
5. Click **OK**.

Delete a clinical role

1. Click
   Or, on the **Create/Edit** menu, click **Clinical Roles**.
2. Clear the **Active** check box.
3. Click **OK**.

Attending Types

You can create attending types or edit the names of existing ones. Certain attending types are required by the system and cannot be deleted.

You can view and edit attending types in the Attending Types auxiliary table. For systems that are integrated with OR Manager, this table is not available in DB Editor; you should instead use Security Manager.

Note: For a patient's anesthesiologist to appear in the Concurrency module in Anesthesia Manager, the attending type of the anesthesiologist must be documented on the Medical Team section as the type that has DBCID identifier 2.[redacted]. By default, this type is named "Anesthesiologist".

Logon Reports

For sites using perioperative integration with OR Manager, logon reports are generated using OR Security Manager.

DB Editor allows system administrators to generate a logon report for all users or for a chosen user. The following can be specified when creating a report:

- The user (or "all users").
- The period covered by the report.
- The applications for which logon details should be shown.
- The actions to appear on the report: successful logons, unsuccessful logons and unlocking other users.

(Reports also show the computer location where each action occurred.)

Create a logon report

1. In the **Groups, Users and Access Rights** folder, open the **Logon Reports** subfolder. All users are displayed on the right side of the window.
2. Double-click the user for which you want to create a report. (To create a report for all users, double-click **All Pride users**.)
   The Logon Report window appears. The user is selected by default in the drop-down list at the bottom of the window. You can change the user selection here, if necessary.
3. Enter the period to be covered by the report (in the **From** and **To** boxes).
4. Select the actions to appear on the report (**Successful Log On**, **Unsuccessful Log On**, **Unlock user**).
5. Under **Application**, check the Pride applications for which you want to see logon details. (To see details for all applications, choose **Select All**.)
6. Click **Apply** to generate the report (on screen).
7. To print the report, click **Print**.

8. Click **Close**.

Hospital Departments and Patient Locations

DB Editor allows you to work with patient locations and hospital departments. Locations are entries in the database that correspond to nurse/wards for patients and PCA workstations. Each workstation and patient location is associated with a department. Hospital departments were created when the database was installed.

Entries for bedside and multibed workstations are added to the LOCATIONS table in the database automatically during software setup.

Note: New locations are placed in the "Not Assigned" workgroup by default. (For more information on workgroups, see Creating and Editing Workgroups on page 2-1.)

There are three types of locations:

- A bedside workstation is both a workstation and a patient location. The workstation can be used to admit only to this location.
- A multibed workstation is a workstation but not a patient location. multibed workstations allow caregivers to work with multiple patients who are admitted to multibed locations.
- A multibed patient bed is a patient location without a workstation. Users select a patient location when admitting a patient in a multibed unit.

After implementation, you can use DB Editor to enter patient beds linked to multibed workstations, and to modify and delete items.

For more information on workstation types, see the Workstation User Guide.

Create a department

1. Click
   Or, on the **Create/Edit** menu, click **Departments**.
2. Click **New**.
3. Enter the department name and click **OK**.

Note: After creating a department, you can link it to a facility. This is done in the Departments auxiliary table. (Due to technical reasons you cannot create the department directly in the Departments table.) For more information, see Facilities on page 2-11.

Note: If your hospital uses eVitae you must assign a department type to the department as described next.

Assign a department type to the department

Note: Department types are only used by eVitae. For a department to be accessible in eVitae it must have a department type of ICU, OR or PACU. The department type is not shown in any of the applications.

1. In the **Auxiliary Tables** folder, double-click **Departments**.
2. Under **Type Description**, select the department type from the drop-down list.
3. Click **Close**.

Change a department name

1. Click
   Or, on the **Create/Edit** menu, click **Departments**.
2. Double-click the department names to change.
3. Enter a new name.
4. Click **OK**.

Create a patient bed location for a multibed unit

1. On the **Create/Edit** menu, click **Locations**.
2. In **Description**, enter the name of the bed location, such as "PACU Bed 001."
   Descriptions should not be repeated within a department.
   The description helps database administrators and DB Editor users identify the location—it does not appear in end user applications.
3. In **Initials**, enter a short version of the bed name, such as "001."
   The initials identify the bed in the Unit Census and the ADT window.
4. In **Location Type**, click **Multibed patient bed**.
   Note that this type of location does not have a computer name.
5. Click **Next**.
6. Select a department.
7. Click **Next**.
8. Confirm the information and click **Finish**.

View Location Information

- In the **Departments and Locations** folder, open the **Locations** subfolder.

For each location, you can see the following information:

- **Description**
- **Computer Name** (if this is blank it indicates a multihost patient bed)
- **Initiate**
- **Identifier** (a system-generated identification number for the location)
- **Machine Type**
  - PCIM = PCIM server
  - CVI = "clinical workstation"

> **Note:**
> - Machine Type is set by the Config Tool when it is run at a machine. (The tool is always run during an installation or upgrade.)
> - Multihost patient beds do not have a **Machine Type**.
> - Machines with Machine Type "CVI" are available for selection when setting up workgroups in Customize. (For more information, see Creating and Editing Workgroups on page 2-1.)
> - For Citrix XenApp connections, the computer name is that of the device connected to the Citrix XenApp server not the name of the Citrix XenApp server itself. The machine type for such connections is "CVI".

To see the following information, you must double-click the location and click **Next** to move through the wizard:

- **Location Type** (Bedside, Multihost or Multihost patient bed)
- **Department**

Modify a location

1. In the **Departments and Locations** folder, open the **Locations** subfolder.
2. Double-click the location to change.
3. Edit the information as necessary.
4. Click **Next**.
5. Select a new department if necessary.
6. Click **Next**.
7. Confirm the information and click **Finish**.

> **Note:** You cannot modify a location that has a patient linked to it.

> **Note:** You cannot inactivate or delete a location.

> **Note:** You should not repeat a computer name that is already associated with another location.

Miscellaneous System Settings

Template Encounter Type

Templates are classified by their encounter type. Templates for induction, intraoperative, and postoperative care units might have an encounter type called Perioperative. Templates for different intensive care units (CVICU, SICU, MICU, PICU, and NICU) might share one called Critical Care. Each hospital creates and names the encounter types it needs.

Encounter types appear in the dvcmtreatmentmodeenum table. They consist of two forms of the name (Description and Label) and a property called "ICU". If the ICU property is set to 1, the encounter type is intensive care. If the property is set to 0, the encounter type is not intensive care. The ICU property affects the following aspects of the application:

- The Common Choice lists that contain the most commonly used diagnoses, procedures, medications and allergies for quick selection. Powerchart, Anesthesia Manager, PARIS Manager, and Critical Care Manager include lists for preoperative, perioperative, and critical care data. (You can edit lists with DB Editor. For more information, see Common Choices for Diagnoses, Procedures, and Allergies on page 301.)
- Whether data collected during an encounter can be used to calculate the APACHE II score. This score requires data from the first 24 hours of a patient's stay in an intensive care unit. This score can only be calculated using data collected with a template classified as ICU-related (ICU property =1); data collected with a non-ICU template during a session in an ICU cannot be used.

The encounter type name is displayed in application interfaces as follows:

- The **Description** appears in Customize and in the Printout Loader window.
- The **Label** appears in the application (in the time bar, trends, and the Fluid Balance window).

Most hospitals need only the default encounter types provided. You can modify their names and, if needed, create new types. You cannot delete entries from this table.

Create or modify an encounter type

1. In the **Auxiliary Tables** folder, double-click **Environment Type Groups**.
2. To create a new encounter type, click **Add** and then **OK**.
   To change an existing type, click the cell containing the text or property that you want to modify.
3. Under **Description**, enter or change the name of the encounter type, and then press ENTER.
4. Under **Label**, enter or modify the label for the encounter type, and then press ENTER.
5. Under **ICU**, enter 1 if the encounter type is for use in intensive care. If it is not, enter 0.
6. When you have finished creating and modifying encounter types, click **Close**.

Change the encounter type for a template

1. In the **Auxiliary Tables** folder, double-click **Environment Types**.
2. Locate the template name on the list.
3. In the **Group** column, select the new encounter type for the template.

Facilities

Facilities are used by Pcis programs to determine the behavior of various windows and supply billing.

You combine facilities in "facility groups". (The facility group to which the workstation belongs is called the Home facility group.) The login behavior and access to patient records depends on the workstation type (desktop or multiseat) as described in the *Workstation User Guide*. A facility can only belong to one facility group.

You can also use an alternative to or in addition to using facility groups to use customize various list queries to show patient records from a specific facility or facilities. (For more information, see Census Windows on page 2-12.)

Note: Census windows will only show records associated with facilities for which the user has access rights.

Creating and modifying facility groups and facilities

Best Practice: Create facility groups before you create facilities. (When creating a facility you can then specify the facility group that it belongs to.)

Create or rename a facility group

1. In the **Auxiliary Tables** folder, double-click **Facility Groups**.
2. To create a new facility, click **Add** and then **OK**.
3. Under **Description**, enter or change the name of the facility group, and then press ENTER.
4. When you have finished creating or renaming facility groups, click **Close**.

Create or edit a facility

When creating a facility, you must associate it with a time zone.

CAUTION: After setting the time zone for a facility, you should not change it.

Facilities cannot be deleted but their descriptions can be changed. Before a facility can be inactivated, all of its mapped departments must first be un-mapped so that they can be attached to another facility.

Create or modify a facility

1. In the **Auxiliary Tables** folder, double-click **Facilities**.
2. To create a new facility, click **Add** and then **OK**.
   To change an existing facility, click the cell containing the text or property that you want to modify.
3. Under **Description**, enter or change the name of the facility, and then press ENTER.
4. Under **Short Name**, enter or modify the short name for the facility, and then press ENTER.
5. Under **Facility Group**, select a facility group for the facility, and then press ENTER.
6. Under **Time Zone**, select a time zone for the facility from the drop-down menu.
7. When you have finished creating and modifying facilities, click **Close**.

After creating facilities, you should map departments to them.

Map a department to a facility

1. In the **Auxiliary Tables** folder, double-click **Departments**.
2. Under **Facility**, select the facility from the drop-down list.
3. When you have finished mapping departments to facilities, click **Close**.

Facilities and Supply Billing

Note: Supply billing is only available for sites that integrate with OR Manager. For more information, see the *Workstation User Guide*.

Facilities are linked to stocks as follows:

- When mapping events with stocks, the Customize user must first select a facility before accessing the stock inventories associated with it. (For more information on event-stock mapping, see [Event Mapping on the Inventory page](#).) The link between facilities and inventories is configured in OR Manager. (For more information, see the *OR Manager Configuration Guide*.)
- You can configure a default "use area" for each facility.

  Each stock item can be assigned a "use area" in the Supply Log. Use areas are used by some sites to define additional billing codes for stocks. For example, "Cardiovascular OR" and "General OR" could be different cost centers getting supplies from the same inventory.

  When stock is added to the Supply Log manually or automatically via an associated event, it will be assigned the default use area associated with the facility in which it is added. If no default use area is defined for the facility, the Use Area field will be left empty for this item in the Supply Log. For manually-added stock, you can change the Use Area in the Add Supply window while adding the item. For both manually-added and automatically-added stock, you can change the Use Area for an item in the Supply Log any time after it has been added.

Set the default use area for a facility

1. Under **Supplies** > **Facility Use Area**, double-click the name of the facility in the right pane.
2. Under **Select Use Area**, select a use area that you want to be shown by default in the Use Area drop-down list of the Add Supplies window. If you leave this blank then
3. **Facility**, select the facility from the drop-down list.
4. When you have finished mapping departments to facilities, click **Close**.

Event Mapping

It is possible to associate stock items with Events in order to support Supply Log functionality. If and when a mapped event is added to the Events Log in AnesthesiaManager the associated stocks get added to the Supply Log automatically.

Map events to stock items

1. On the **Create/Edit** menu, click **Event Stocks**.
2. In the **Event Type** box, select an event type.
3. Under **Events**, click an event and then click **Next**.
4. In the **Facility** box, select a facility.
5. In the **Inventory** box, select an inventory.
   The stock for that inventory appears in the left pane below.
6. Select one or more stock items from the left pane and click > to move them to the Selected Stocks pane.
7. Click **OK**.

Audit Trail

Privoy Manager, AnesthesiaManager, PACU Manager and Critical Care Manager create audit trails of major user actions based on the log on. You can configure these programs to create a more extensive audit trail to help comply with HIPAA requirements for protecting patient data.

The settings affect all the aforementioned applications and apply to all departments in the hospital. By default, a complete audit trail is enabled.

Configure the type of audit trail

1. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
2. In the **Value** column, click the cell next to the **Disable creation of System Events Audit Trail** option.
3. Enter **0** for a complete audit trail.
   Enter **1** for a limited audit trail that does not record the following actions:
   - Census list viewing.

- Successful or unsuccessful user log on
- User log off
- Start and end of an interruption in device data reception
- Warning message about device data interruption
- Successful or unsuccessful automatic or manual e-mail message about device data interruption
- Creating a printout
- Opening a patient record
- Opening a VIP patient record (regardless of the **Show warning message when accessing VIP records** setting. For more information, see Privacy Messages on page 257.)

4. Press Enter.

Password Parameters

For standalone "clinical module" sites, password options are set using DB Editor, as described in this section.

For sites using perioperative integration (with OR Manager), password options are set using OR Security Manager. (Password settings in DB Editor are either unavailable or ignored.)

You can configure the following password settings:

- The number of consecutive failed logon attempts before a user is locked out.

  Attempts are tracked independently of the application. For example, two attempts to log in to Privia Manager, followed by an attempt to log in to Anesthesia Manager, will lock a user out of the system. When users are locked out of one application, they are locked out from all Privia applications.

  DB Editor can be used to "unlock" any users that have been locked out. (See Unlock a User Who Has Been Locked Out on page 253.)

  You can make specified users exempt from being locked out. (See Create a New User on page 251 and Modify a User Profile on page 252.)
- The period after which user passwords expire. (Users must change their passwords before this period finishes to continue using the system.)
- The advance notice that users receive before their passwords are due to expire.
- Whether passwords must contain both numbers and letters.
- The minimum and maximum length of a password.
- The ability to reuse previous passwords.

See also: Directory Services Authentication on page 279

Set the number of logon attempts before users are locked out

1. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
2. In the **Value** column, click the cell next to **Max number of failed logons before user is logged out**.
3. Enter a number. Unless a user is exempt, he or she is locked out after this number of unsuccessful consecutive logon attempts. (A value of "0" means that users are never locked out, no matter how many failed logon attempts they make.)
4. Press Enter.

Set the password expiration period

1. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
2. In the **Value** column, click the cell next to **Password expiration period in days**.
3. Enter the duration of user passwords in days. Passwords expire after this period. (A value of "0" means that passwords never expire.)
4. Press Enter.

Set the advance notice for password expiration

1. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
2. In the **Value** column, click the cell next to **Show warning message x days before password expires**.
3. Enter the number of days notice given to a user before their password expires. (A value of "0" means that no notice is given.)
4. Press Enter.

Set whether passwords must contain both numbers and letters

1. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
2. In the **Value** column, click the cell next to **Password must be alphanumeric**.
3. Enter "1" if passwords must contain both numbers and letters, otherwise enter "0".
4. Press Enter.

Note: You can also set this option in the Password Configuration window (**File > Password Configuration**).

Set the minimum and maximum lengths that passwords can have

1. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
2. In the **Value** column, click the cell next to **Password minimum length** and enter a value.
3. In the **Value** column, click the cell next to **Password maximum length** and enter a value.
4. Press Enter.

Note: You can also set this option in the Password Configuration window (**File > Password Configuration**).

Set the ability to reuse previous passwords

1. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
2. In the **Value** column, click the cell next to **Password reuse count restriction** and enter a value.
3. Users can reuse an old password after this many password changes.

   Example: The setting is 3. A user has the password dog then later changes it to cat then later changes it to mouse. We want password can be dog again.

4. Press Enter.

Note: You can also set this option in the Password Configuration window (**File > Password Configuration**).

Directory Services Authentication

User authentication credentials can be maintained in a Directory Services server (DS) repository, such as Microsoft Active Directory. In general, when DSA authentication is enabled passwords cannot be set for users and the **Change Password** button does not appear in login windows of Pivia applications. For full details, see the appendix on DSA in the *OR Security Manager User Guide*.

LDAP Filtering

When a user enters login credentials the LDAP Repository or LDAP server is searched for matches. LDAP filtering can be used to narrow the focus of the search.

You must configure the LDAP filter using LDAP syntax standards. For more information on these standards, see the Microsoft Developers Network (MSDN) Web site for the article *Search Filter Syntax (Windows)*.

Link: http://msdn.microsoft.com/en-us/library/aa746475(VS.85).aspx

Or

Search the MSDN for article "aa746475 (v.85)".

For all filters, the **ldapfilter** parameter uses a variable to automatically pass the user name that is entered in the login window to the LDAP authentication system.

Example:
(&(objectClass=user)(sAMAccountName=%U))
The user enters Pivotstar in the Username field of the Logon window.

(Result: The variable %1 is automatically replaced by Provision and this username is passed to the LDAP authentication system.

In addition to the user name, the parameter can also be configured to pass a domain that is entered during login.

Note: Inactive users are ordinarily included in searches. You can use the parameter to filter them out.

The parameter can also be configured based on additional **objectClass** attributes in the LDAP Repository, such as department, facility, status, role, etc. the filter can be customized based on the attributes that appear in a particular site's LDAP Repository.

Combinations of criterion can be created using operators to define conditions and further specify a search. Some common operators are listed in the table below.

=	Equal to
<=	Less than or equal to
>=	Greater than or equal to
&	And
|	Or
!	Not

By default, the `userPrincipalName` setting is blank. A configuration must be defined to avoid an error occurring when attempting to log in. The minimum required configurations are as follows:

Active Directory
(sAMAccountName=%1)

Sun One Directory
(uid=%1).

Note: An authentication will only be allowed if the filtered search returns one matching result. null or multiple results will return an authentication error.

Example
Filter for a single object: (objectClass=user) will return all users.

Example
Filter containing two objects: (&(objectClass=user)(department=IT))

Example
Filter for all users excluding disabled accounts: (&(objectClass=user)(!(userAccountControl:1.2.840.113556.1.4.803:=2)))

Use Directory Services Authentication (DSA) for password validation

1. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
2. In the **Value** column for **LdapAuthEnabled**, enter '1' to use Directory Services Authentication for controlling access to Picis applications. (A value of '0' means that the feature is not used.)
3. In the **Value** column for **LdapDirectoryPath**, enter the LDAP path to the directory that stores the Picis identity credentials.
4. In the **Value** column for **LdapAuthenticationType**, enter one of the three authentication types below.

   None. Clear text passwords are passed over an unsecured communication channel.

   Secure. This is the default and uses NTLM or Kerberos depending on the underlying security providers supported by the operating system.

   SSL. Authentication is performed over a secure communication channel using a server certificate. The DSA server must be enabled to use SSL and the server certificate must be installed as 'Trusted' in all client machines via group policy.
5. In the **Value** column for **LdapAuthEnginDomain**, enter the domain to be used for authentication. If a value is entered, users will not be able to enter a domain when logging on. If this field is left blank, users will be able to choose a domain when logging on and their credentials will be authenticated against it.
6. In the **Value** column for **AuthenticationByPassIdentities**, enter the usernames of any users who are allowed to bypass DSA security, separated by commas. Security for these users will be maintained in DB Editor.
7. In the **Value** column for **LdapFilter**, enter a filter using the appropriate syntax. (This setting cannot be left blank.)
8. Press Enter.

Reports

When an end user opens the Reports window they are shown a list of report files (RPT files) that exist in a predefined folder. (For information on creating and installing report files, see *Crystal Templates (RPT files) in use (CE)*.) The folder where report files are installed can be defined globally, or at a local level (for Picis Manager, the workstation level; for Anesthesia Manager, PACU Manager, and Critical Care Manager, the application template level). A local level setting overrides the global setting.

Example
The global report path setting is "\\Server01\Reports\Files".
One template has a report path setting of "C:\Program Files\Picis\Reports\Files"; when this template is used, the reports available to the user depend on the report files installed locally in this folder.
Another template has no report path setting; when this template is used the reports available to the user depend on the report files installed at the Server01 machine.

The default location that reports are saved to can also be defined globally or at a local level. As with the report file location, a local level setting overrides the global setting.

Regardless of whether a path is global or in a template, it can be either local or remote. For example, a global setting could be "C:\Program Files\Pro\Reports\Files" - users need "write" access to the report save path and "read" access to the report files path.

Best Practice: Make the report file path different to the report save path.

Besides file paths there are two more global configuration options available for reports:

- You can configure whether users are able to change the location where reports are saved to.
- You can configure whether a notification should be sent to the IAS when a report is saved. (If you enable this setting, the path for saving reports must be a shared network folder.)

Best Practice: If you enable the IAS notification, disable the ability for users to change the location where reports are saved to.

Configure folder locations for reports at a global level

1. Start DB Editor.
2. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
3. In the **Value** column, click the cell next to **CrystalHook: ReportsPath** and enter or modify the path where report files (RPT files) are located.
4. In the **Value** column, click the cell next to **CrystalHook: SavePath** and enter or modify the path where reports (PDFs) will be saved.
5. Press Ctrl+S.

Configure the ability for users to change the folder that reports are saved to

1. Start DB Editor.
2. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
3. In the **Value** column, click the cell next to **CrystalHook: Prompt Save** and enter `1` to allow changing the folder or `0` to disallow it.
4. Press Ctrl+S.

Configure the system to notify the IAS when a report is saved

1. Start DB Editor.
2. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
3. In the **Value** column, click the cell next to **CrystalHook: Notify IAS** and enter `1` to enable IAS notification or `0` to disable it.
4. Press Ctrl+S.

Discharge Reasons

You can configure the list of discharge reasons that appear in the drop-down list of the window that is shown when discharging a patient.

Note: There is also a workstation parameter that controls whether users of a workstation can add a new discharge reason to the system when they discharge a patient. A new discharge reason entered by a user is automatically available to all workstations. For more information, see (1) page 224.

Create a discharge reason

1. In the **Auxiliary Tables** folder, double-click **Discharges**.
2. Click **Add**.
3. In the **Description** column, type the discharge reason.
4. Press ENTER.

Modify a discharge reason

1. In the **Auxiliary Tables** folder, double-click **Discharges**.
2. Click the row that you want to change.
3. Click **Delete** to permanently remove the entry, or click **Inactive** to deactivate it, or click F2 in the **Description** column and edit the text.
4. Press ENTER.

Standard Coding

The Content Library Installer allows you to map certain items in the database to standard codes that hospitals can use for data analysis in third-party software. You can view the coding in the following auxiliary tables in OB Editor:

- Standard Coding for Assessment Items
- Standard Coding for Events
- Standard Coding for Event Types
- Standard Coding for Physiologic data
- Standard Coding for Score Items
- Standard Coding for Treatments

For detailed information regarding Standard Content and the Content Library Installer tool, see the Content Library Guide.

Mappings are read-only; codes cannot be added, deleted, or edited by users in DB Editor. However, Prize staff have the ability to insert and modify mappings on request. (Mappings can never be deleted.)

The columns for each mapping appear as follows:

DBCODE	Short name*	External Standard Code 1	External Standard Code 2
DBCODEs of the mapped items	Names of items from the database. For physiologic data, CML codes are shown. For treatments the long name is shown followed by the family name in parenthesis.	An alphanumeric code of up to 30 characters.	An alphanumeric code of up to 30 characters.

Privacy Messages

You can configure the following "privacy" messages:

- A message to be shown in the Log On window of Prize applications.
- A message to be shown when users open VIP patient records.
- A message to be shown when users open the records of patients who have withdrawn consent for the hospital to access their data.

For standalone "clinical modules" sites, privacy messages are set using DB Editor, as described in this section.

For sites that integrate with OR Manager, privacy messages are set using OR Security Manager. (The settings are unavailable in DB Editor.)

DB Editor provides default message text that can be used for US English installations. (Note that the text is not automatically localized if the installation language is not US English.)

Configure a message to be shown in the Log On window on application startup

1. Click **Create/Edit** > **Security Options**.
2. Select **Show privacy message when application starts**.
3. Enter/edit the required text in the top pane.
4. Click **OK**.

Configure a message to be shown when VIP patient records are accessed

1. Click **Create/Edit** > **Security Options**.
2. Select **Show warning message when accessing VIP records**.
3. Enter/edit the required text in the middle pane.

4. Click **OK**.

Note: Enabling this setting also creates an audit trail of user access to VIP patient records. For more information, see the Report Viewer Guide.

Configure a message to be shown when "Withdrawn Consent" records are accessed

1. Click **Create/Edit** > **Security Options**.
2. Select **Show warning message when accessing patient records whose consent was withdrawn**.
3. Enter/edit the required text in the bottom pane.
4. Click **OK**.

Note: Enabling this setting also creates an audit trail of user access to "withdrawn consent" patient records. For more information, see the Report Viewer Guide.

12

08 Editor and Clinical Content

Clinical Auxiliary Tables

The following table shows the main auxiliary tables for clinical content.

TABLE	CONTENT
Allergies	List of possible allergies that a patient might have.
Allergy Types	Allergy classifications. Examples: Food, Environmental.
Analyses	Laboratory analyses for the 'Enter/Edit Laboratory Results' window.
Assessment Items	Items for each assessment.
Components (Laboratory)	Laboratory components for the 'Enter/Edit Laboratory Results' window.

DB Editor and Clinical Context

Clinical Auxiliary Tables

TABLE	CONTENT
Environment Type Groups	Types of encounters that can comprise a patient admission. Typically these are the names of care areas in the hospital (perioperative, critical care). Text appears in time bar of flowsheets to identify the encounter corresponding to data. The ICU property affects the 'common choices' available and the ability to calculate the APACHE II score. For more information, see: Create or modify an encounter type on page 273 Common Choices for Diagnoses, Procedures, and Allergies on page 324
Environment Types	Template name, prefix, and encounter type. Typically these are the names of hospital units within care areas or clinical environments. Data is added to this table automatically when a template is created in Customize. Text appears in the time bar on flowsheets to identify the session corresponding to data.
Event Types	Drop-down list entries for types of events in the Events window and the Event Sets and Macros window in Customize. Event types can be added, edited, and deleted in DB Editor.
Events	Event entries available for selection in Customize. New entries are added in Customize. Existing entries can be edited and deleted in DB Editor.
Family	Treatment families and their categories. New entries are added using a wizard in the Clinical Context section of DB Editor and cannot be edited or deleted from this Auxiliary Table. The only data that can be edited is the Index property that allows you to determine the order of families in windows and on flowsheets. **Note:** In this table, the **Index** value determines the position of a family with respect to other families of the same family behavior. (For this reason, the same index value can appear multiple times, for different family behaviors.) **Best Practice:** First sort entries by Family Behavior. Then, for each family behavior, add an index value for those families that you want to appear in a certain order. **Note:** Family names should not start with a space (except for the "All Families" entry, which should not be edited.)

TABLE	CONTENT
Form Types	Classifications for forms in which medications can be administered. Only used for standard orders.
Forms	Drop-down list entries for forms in which medications can be administered. Available for selection when creating orders.
Laboratory Data Status	Status descriptions for laboratory test results in the Laboratory Summary window. Only used when there is a link to a hospital laboratory system. Data is typically supplied by the laboratory system.
Laboratory Sources	Sources for laboratory test results in the Laboratory Summary window. For example, 'blood'. Only used when there is a link to a hospital laboratory system. Data typically supplied by the laboratory system.
NoteTypeBlocks	Sections (blocks) for Patient Summary note types.
NoteTypes	Patient Summary note types.
Part Components	Table that links the Components and Parts tables. (A part could be a group of components used in one or more analyses. In practice, parts and the analysis are the same.)
Parts	Table that links the Analyses and Components tables. Part names are typically identical to Analysis names. The part name is not used anywhere else.
Physiologic Variables	Physiologic variable descriptions, labels, comments, and units. Formulas for derived variables. (Existing entries can be modified, but new entries cannot be added.) Labels cannot be entered in formulas for derived variables in the Physiologic Variables auxiliary database table in DB Editor). Instead, CNL codes must be used. Note that you can use the Formula Checker tool to create/edit a formula and check its syntax with labels showing, as long as you switch the display to show CNL codes before copy/pasting the formula to the Physiologic Variables database table.
Route Types	Classifications for administration routes of medications and fluids. Used for filtering appropriate routes for different forms of medication.
Routes	Drop-down list entries for administration routes of medications and fluids. Used when creating orders.

TABLE	CONTENT
Treatment	Treatment names for medications, fluids, laboratory tests, assessments, scores, IDR indications, equipment lists, nursing care activities, and respiratory care. Data is entered using a wizard in the Clinical Content section of IW Editor. You can modify entries and change the Prescription/Validation rights associated with them but you cannot add new ones. You can remove entries from the system by selecting the **Inactive** check box. **Note**: The "Add to Fluid Balance" setting for treatments is not displayed in this table because this setting can only be modified in standard orders. **Note**: Inactivating a treatment will inactivate any standard orders based on it.
Standard Orders	Lists individual medications for standard orders. The "Add to Fluid Balance" check box must be selected in order to modify the particular medication. **Note**: If you inactivate a standard order it will be removed from all protocols that it is in.
Unit Types	Classifications of units of measure for internal use.
Units	Drop-down list entries for units of measure used in medication and fluid orders and with physiologic variables. Each entry has a symbol, conversion factor and unit type. The conversion factor and unit type determine the way in which the unit contributes to the Fluid Balance. A unit will contribute to the Fluid Balance if it satisfies the following criteria: - It has a unit type of "volume" - Its conversion factor is not zero. The contribution depends on the ratio of the conversion factor to the conversion factor of the "ml" unit (usually "1"). For example, suppose we have a unit called "Mouth unit" and the "ml" unit has a conversion factor of 1. If "Mouth unit" has a conversion factor of 2 it means that for every "Mouth unit" that is documented 2 ml of fluid is added to the Fluid Balance.

Note that the Treatments auxiliary table allows you to edit treatments that already exist. You can use this table to change a treatment's name and/or the rights associated with it. You cannot use

this table to create a treatment or to change the category a treatment belongs to (Food vs. Medication, etc.).

CAUTION There is nothing to prevent you from inadvertently creating two or more treatments with the same description.

Related Topics

Sort entries in a table on page 207
When you have finished adding entries, click Close. on page 208
Delete an entry from a table on page 208
Modify an entry in a table on page 208

Auxiliary Table Usage by Functional Area

Standard Orders

Form Types

Forms

Route Types

Routes

Standard Orders

Treatment

Unit Types

Units

Note Besides using auxiliary tables, standard orders also use schedule configurations and prescription/validation rights.

Events

Event Types

Events

Patient Summary

NoteTypeBlocks

NoteTypes

Content for Flowsheets

Using DB Editor to Edit Content

The CARI database provides all of the items that users select when documenting patient data on flowsheets. After initial database installation you can use DB Editor to add new content and edit existing content.

All items on flowsheets, except laboratory analyses, are listed in the Treatment table. New items can be created using the Treatment wizard in the Clinical Content folder. After an item has been created, you can edit the name, change access rights, and remove the item from applications. You can set the sort order of items in the Assessments and Equipment categories to control how they are listed in application windows.

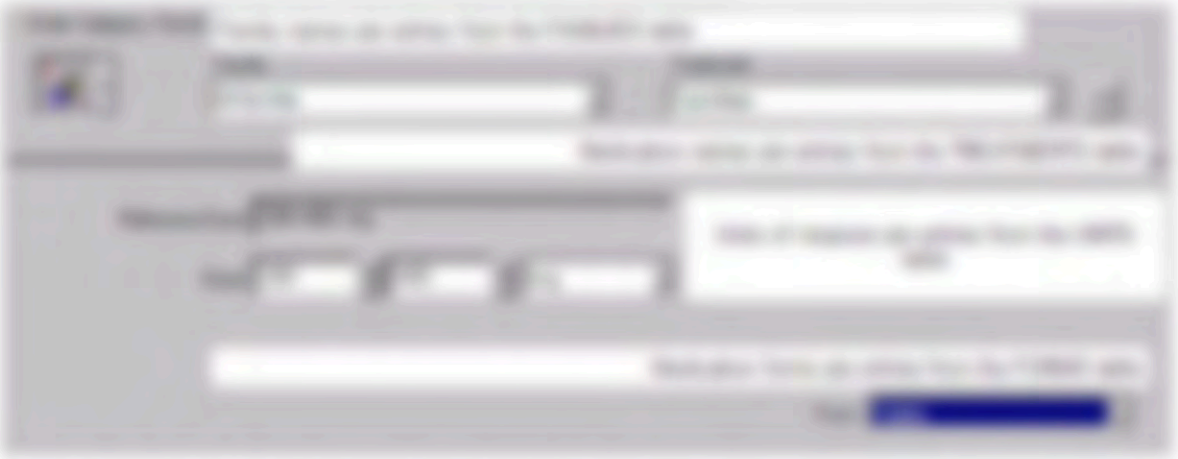


Figure 4: This window displays custom content from the database.

Medication and Fluid Treatments

Entries for documenting administration medications and fluids make up a large part of the Treatment table.

- Medication treatments include all oral, topical, inhaled, and infused drugs, except those that are delivered in drips. The table does not include medications available for documenting home medications in Proxy Manager or medication allergies.
- Fluids include all items that affect a patient's fluid balance: drips, blood products, colloids, crystalloids, and products for enteral and parenteral nutrition. Fluids also include items for documenting fluid loss, such as urine, fluids from drains, and blood.

- Additives are special treatments that are available only for creating admixtures with items in the IV Fluids category. Additives cannot be administered alone or with other types of fluids. Examples of typical additives include electrolytes, vitamins, minerals, and certain medications.

Note: To create treatments you use the Treatments window of the Clinical Content folder. However, to edit or delete treatments you use the Treatment auxiliary table (see Auxiliary Databases Tables on page 2707).

Create a medication

1. In the **Clinical Content** folder, double-click **Treatments**.
2. In **Order Category**, click Medications and then click **Next** >> to go to the next step in the wizard.
3. In **Family**, enter a new family name or select an existing family for the medication.
4. In **Treatment**, enter the name of the medication.
   (Take care not to enter any spaces at the start of the name.)
5. Set the access rights required to order and document the item:
   - In **Prescription Access**, select the Prescription/Validation right required to add, modify, discontinue, cancel, and extend the item.
   - In **Validation Access**, select the Prescription/Validation right required to move, reschedule, and document data about administration on a patient's chart.

   Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.
6. Click **Save**.

Create a blood product, drip or other fluid

1. In the **Clinical Content** folder, double-click **Treatments**.
2. In **Order Category**, click **Fluids IV** and then click **Next** >> to go to the next step in the wizard.
3. In **Behavior**, optionally, select one of the following:
   Blood Products, for whole blood, plasma and blood derivatives.
   Drips, for medications that are infused continuously.
   IV Fluids, for colloids, crystalloids, solutions for enteral and parenteral nutrition, base solutions for intravenous admixtures, and fluids for oral intake.
   If you omit this step, the **Family** box below shows the entire list of fluid intake families. If you enter a behavior, the **Family** box shows only the relevant families.
4. In **Family**, enter a new family name or select an existing family for the fluid.
5. In **Treatment**, enter the name of the fluid.
6. Set the access rights required to order and document the item:
   - In **Prescription Access**, select the Prescription/Validation right required to add, modify, discontinue, cancel, and extend the item.

- In **Validation Access**, select the Prescription/Validation right required to move, reschedule, and document data about administration on a patient's chart.

Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.

7. Click **Save**.

Create a bodily fluid entry for documenting output

1. In the **Clinical Content** folder, double-click **Treatments**.
2. In **Order Category**, click **Fluids OUT** and then click **Next** > to go to the next step in the wizard.
3. In **Behavior**, optionally, select one of the following:

   Blood OUT: for sources of blood loss.

   Fluids OUT: for other types of bodily fluids.

   Urine: for urine and ultrafiltrate.

   If you omit this step, the **Family** box below shows the entire list of fluid output families. If you enter a behavior, the **Family** box shows only the relevant families.
4. In **Family**, enter a new family name or select an existing family for this fluid.
5. In **Treatment**, enter the name of the fluid.
6. Set the access rights required to order and document the item:
   - In **Prescription Access**, select the Prescription/Validation right required to add, discontinue, cancel, and extend the item.
   - In **Validation Access**, select the Prescription/Validation right required to document data about administration on a patient's chart.

   Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.
7. Click **Save**.

Create a fluid additive

1. In the **Clinical Content** folder, double-click **Additives**.
2. Click **New**.
3. In **Additive**, enter the name of a new additive or select an existing one.
4. In **Dose**, enter the minimum and maximum doses and the corresponding unit of measure.
5. In **Default Concentration**, optionally, enter the default concentration as a percentage or part per million. Users can document other concentrations during a session.

   This setting is used only when a user selects the **Include additives in volume** option when documenting a fluid containing the additive.

   Note that the concentration refers to the additive dissolved in a solution that is added to the base fluid and not the concentration of the additive in the base fluid itself.
6. In **User Access**, select the prescription/validation right that a user must have in order to add the additive to a fluid.

7. Click **OK**.

Laboratory and Diagnostic Tests

Three types of flowsheet entry are available for laboratory work:

- **Physiologic variables**. Items supplied by devices, such as blood gas analyzers, or analyzed within the unit and represented as physiologic variables. If no device supplies data, users can enter data manually.

  This type of configuration can also be used to facilitate data entry if there is no link to the laboratory system. Data appears on flowsheets and can be included in the Patient Summary and printouts but does not appear in the Laboratory Summary.

  For example: Creatinine (Creat), Arterial O2 saturation (Sat_A), Hematocrit (Hct), Serum sodium (Na_Ser)

- **Laboratory analytes and components**. Analytes are the names of standard tests that include one or more components. The hospital's laboratory system typically provides data through a link. If no link exists, users can enter results manually. Data appears on flowsheets and can also be viewed in the Laboratory Summary window and included in the Patient Summary and printouts.

  For example: Chemistry 1, CBC, Liver Function Test

- **Diagnostic and laboratory activities**. Tasks that caregivers can schedule for a patient. After being completed, the flowsheet reflects the time and caregiver that performed the task. Tasks are not shown in the Laboratory Summary although related laboratory results may be.

  For example: Cardiac risk panel, CBC, cultures, X-rays, EKG, urinalysis, Pulmonary function test

Configuration Instructions

Physiologic variables. To associate a physiologic variable with data from a "laboratory device" see Devices and Physiologic Variables on page 119

Laboratory analytes and components. See Laboratory Analytes and Components on the next page.

Diagnostic and laboratory activities. See the following procedure.

Create a task for diagnostic tests or laboratory activity

1. In the **Clinical Content** folder, double-click **Treatments**.
2. In **Order Category**, click **Laboratory** and then click **Next** > to go to the next step in the wizard.
3. In **Family**, enter a new family name or select an existing family for the item.
4. In **Treatment**, enter the name of the task.
   (Take care not to enter any spaces at the start of the name.)
5. Set the access rights required to order and document the item.

- In **Prescription Access**, select the Prescription/Validation right required to add, discontinue, cancel and extend the item.
- In **Validation Access**, select the Prescription/Validation right required to reschedule and document data about administration on a patient's chart.

Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.

8. Click **Save**.

Note: Items entered in this way allow users to schedule and document the completion of tasks related to laboratory and diagnostic tests. The entries are not designed for documenting the results of tests.

Laboratory Analyses and Components

If there is a link to the hospital's laboratory information system, this system usually populates the database with analysis and component names automatically as it sends data. This typically takes place during testing of the link using sample data. Items appear in alphabetical order on Flowsheets until they are "indexed".

Manually add an analysis to the database

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Analyses** in the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. On the new row, enter the name of the new analysis.
5. In the **Index** column, enter a number corresponding to the position of the item relative to others in the section and then press Enter.

   Best Practice: Include a zero before single-digit numbers (01, 01, 02, ...).

   This step is optional. If you leave the index blank, sections appear in the order they were entered.
6. Click **Close**.
7. Double-click **Ports** in the list of database tables on the right side of the main window.
8. Click the **Add** button to add a new row to the table.
9. On the new row, enter the same name as you entered on the Analyses table.
   Example: CBC
10. On the same row, in the **Analysis** column, select the name you entered on the Analyses table.
    Example: CBC

Manually add laboratory components to the database

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.

2. Double-click **Components_(Laboratory)** in the list of database tables on the right side of the main window.
3. Click the **Add** button and enter the name of a component on the new row. Repeat this for each component in the analysis.
   For example, Red Blood Cells.
4. When you have finished entering component names, click **Close**.

Manually add components to an analysis

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Parts_Components** in the list of database tables on the right side of the main window.
3. Click the **Add** button and select the name of the analysis in the Part column.
   Example: CBC.
4. On the same row, click in the **Component** column and select the name of a component in the analysis.
   For example, Red Blood Cells.
5. Continue adding new rows and selecting components until the analysis is complete.
6. Click **Close**.

About the sort order for analyses and components

Regardless of whether analyses and components are added automatically or manually they need to be manually indexed to set their sort order on flowsheets. (Indexing means assigning an index number.)

When analysis names are shown to the user (**Show subheadings by default** option selected), they appear in the order determined by their indexes. their components appear underneath in the order determined by their indexes.

When analysis names are not shown to the user (**Show subheadings by default** option cleared), components appear in the order determined by their indexes.

In both cases, items that do not have indexes are displayed in alphabetical order at the end of the list.

For example:

With subheadings	No subheadings
Laboratory Results	Laboratory Results
Hematology	Urine Rbc
	WBC
	RBC

DB Editor and Clinical Content

Content for Flowsheets

Mnh subheadings	Nc subheadings
Chemistry	HGB
Urinalysis	Albumin

Analysis indexes: Hematology (1), Chemistry (2), Urinalysis (3).
Component indexes: Urine Alb (1), BMD (10), RBC (11), HGB (12), Albumin (26).

Note: An analysis can be a single component.

Note: A component can appear in more than one analysis. In such situations some trial and error is involved in setting the index because an index number that works well for one analysis may not work well for another (a component can only have one index number).

Note: In the Laboratory Summary and the Enter Laboratory Data windows, the list of analyses always appears in alphabetical order. Components for a selected analysis appear in the order determined by their indexes.

Note: Proxy Manager only shows components, not analyses. Components appear in the order determined by their indexes.

Recommended workflow for setting indexes

1. Obtain a separate printout of each analysis from the hospital laboratory system (each showing its components).
2. Determine the components and analyses that should appear in a particular order on flowsheets.
3. Put the printouts for analyses in the order that makes sense clinically. Write #1 at the top of the first, #2 at the top of the second etc. Skip numbers to make it easier to insert or change items later.
4. On the printout for each analysis, determine the order of components that makes sense clinically. Write #1 next to the first, #2 next to the second etc. Skip numbers to make it easier to insert or change items later. Whenever you index a component check all other analyses that this component may appear in and give that component the same index number on the printouts for those analyses.
5. Using a word processor or spreadsheet application, enter the index numbers in two tables, such as the following.

Component	Index
pH	1
pCO2	9
pO2	10
Na	15
K	20
Cl	25
pH(T)	30
pT	35

Analysis	Index
Arterial Blood Gases	1
Arterial Blood Gases	
Arterial Blood Gases	
Chemical 7	5
Chemical 7	
Chemical 7	
Coagulation	10
Coagulation	

Example indexes for components and analyses

8. Send test data from the laboratory information system for the components that need indexing before sending data for other components. This makes it easier to find the components you need in database tables.
7. In DB Editor, add the index numbers in the Code/Index/1 and Res/Ind/1 auxiliary tables using the spreadsheet you created as a guide.
8. If the laboratory link is left to automatically create analyses and components you should review the auxiliary tables in DB Editor now and then to see if any changes to index numbers are needed.

Nursing Care, Respiratory and Ventilator Treatments

In PACU Manager and Critical Care Manager, clinicians may want to include nursing and respiratory therapy activities in the care plan. Caregivers are notified when required tasks are due and they can document that the tasks were performed. You can create new activities and edit existing entries on the Treatments table in the Auxiliary Tables section.

Note: Treatment names that contain non-alphanumeric characters may not display properly on the flowsheet.

Create a nursing care treatment

1. Click **Clinical Content** on the left side of the main window in DB Editor.
2. Double-click **Treatments** on the list on the right side of the main window.
3. In **Order Category**, select **Nursing Care** and then click **Next** > to go to the next step in the wizard.
4. In **Family**, enter a new family name or select an existing family for the item.
5. In **Treatment**, enter the name of the activity.
   (Take care not to enter any spaces at the start of the name.)
6. Set the access rights required to order and document the item.

- In **Prescription Access**, select the Prescription/Validation right required to add, discontinue, cancel, and extend the item.
- In **Validation Access**, select the Prescription/Validation right required to reschedule and document data about administration on a patient's chart.

Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.

7. Click **Save**.

Create a respiratory therapy treatment

1. Click **Clinical Content** on the left side of the main window in OB Editor.
2. Double-click **Treatments** on the list on the right side of the main window.
3. In **Order Category**, select **Respiratory** and then click **Next** > to go to the next step in the wizard.
4. In **Behavior**, optionally, click **Respiratory Therapy**.

   If you omit this step, the **Family** box below shows the families of all respiratory items. If you select a behavior, the **Family** box shows only the relevant families.
5. In **Family**, enter a new family name or select an existing family for this item.
6. In **Treatment**, enter the name of the therapy.

   (Take care not to enter any spaces at the start of the name.)
7. Set the access rights required to order and document the item.
   - In **Prescription Access**, select the Prescription/Validation right required to add, discontinue, cancel, and extend the item.
   - In **Validation Access**, select the Prescription/Validation right required to reschedule and document data about administration on a patient's chart.

   Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.
8. Click **Save**.

Create a ventilator-related treatment

1. Click **Clinical Content** on the left side of the main window in OB Editor.
2. Double-click **Treatments** on the list on the right side of the main window.
3. In **Order Category**, select **Respiratory** and then click **Next** > to go to the next step in the wizard.
4. In **Behavior**, optionally, select Ventilators.

   If you omit this step, the **Family** box below shows the families of all respiratory items. If you select a behavior, the **Family** box shows only the relevant families.
5. In **Family**, enter a new family name or select an existing family for this item.
6. In **Treatment**, enter the name of the activity.

   (Take care not to enter any spaces at the start of the name.)

7. Set the access rights required to order and document the item:
   - In **Prescription Access**, select the Prescription/Validation right required to add, discontinue, cancel, and extend the item.
   - In **Validation Access**, select the Prescription/Validation right required to document data about administration on a patient's chart.

   Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.
8. Click **Save**.

Checklists for Assessments, QA Indicators, and Equipment

The checklist format is shared by three types of items:

- Nursing assessments for evaluating aspects of a patient's condition in critical care and post-anesthesia environment. Assessments are designed to appear on flowsheets.

  Note: No standard flowsheet exists for this type of data. If users document assessments, you must create a custom flowsheet and configure it to include assessments.

- QA indicators collect data related to quality assurance requirements for surgery patients. These items are designed for a specialized window of the same name.

  Note: Items can be added as single orders or as part of a default protocol configured for the template. Depending on the workstation configuration, QA indicators may or may not appear on flowsheets. (For more information, see Assessments, Events, Equipment and QA Indicators on page 291.)

- Equipment lists collect data about equipment and supplies used during the procedure. These items are designed for a specialized window of the same name.

  Note: Equipment can be added as single orders or as part of a default protocol configured for the template. Depending on the workstation configuration, equipment lists may or may not appear on flowsheets. (For more information, see Assessments, Events, Equipment and QA Indicators on page 291.)

The checklists that you create are added to the Treatments table. During the process of creating a checklist you associate one or more items with the checklist. After creating the checklist, you can edit or add checklist items via the Assessment Items table.

Note: Assessment and equipment items cannot be deleted from the database.

Create an assessment checklist

1. Click **Clinical Content** on the left side of the main window in DB Editor.
2. Double-click **Assessments** on the right side of the main window.

3. In **Order Category**, select **Assessments** and then click **Next** > to go to the next step in the wizard.
4. In **Behavior**, click **Non-QA Assessment**.
   (If you omit this step, the **Family** box below will also show the families of QA indicators. If you select a behavior, the **Family** box shows only the relevant families.)
5. In **Family**, enter a new family name or select an existing family for the assessment.
6. In **Treatment**, enter the name of the assessment.
   (Take care not to enter any spaces at the start of the name.)
7. Set the access rights required to order and document the item.
   a. In **Prescription Access**, select the Prescription/Validation right required to add, discontinue, cancel, and extend the item.
   b. In **Validation Access**, select the Prescription/Validation right required to document data about administration on a patient's chart.

   Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.
8. Click **Next** > to go to the next wizard step.
9. For each checklist item, do the following.
   a. In **Description**, enter the item name.
   b. In **Code**, enter the abbreviation or code for the item.
   c. Click **Add**.

   Example
   Treatment: Wounds Time
   Checklist Items: Bandage, Placed, Right
   Codes: BDGE, PLCE, RHD

When adding assessment items in this way, the **Description** is limited to 30 characters and the **Code** to 10 characters. (If you instead add or edit assessment items directly in the Assessment Items table, the **Description** limit is 128 characters and the **Code** limit is 16 characters.)

Checklist items appear in the order in which you entered them. You can change the order by editing the Index property in the Administrator > Order table. See Edit a checklist assessment's QA indicators, assessment, on page 370.

Create a QA indicator checklist

1. Click **Clinical Content** on the left side of the main window in DB Editor.
2. Double-click **Assessments** on the right side of the main window.
3. In **Order Category**, select **Assessments** and then click **Next** > to go to the next step in the wizard.
4. In **Behavior**, click **QA Assessment**.

(If you omit this step, the **Family** box below will also show the families of nursing assessments. If you select a behavior, the **Family** box shows only the relevant families.)

5. In **Family**, enter a new family name or select an existing family for the item.
6. In **Treatment**, enter the name of the item.

   (Take care not to enter any spaces at the start of the name.)
7. Set the access rights required to order and document the item.
   - In **Prescription Access**, select the Prescription/Validation right required to add, discontinue, cancel, and extend the item.
   - In **Validation Access**, select the Prescription/Validation right required to document data about administration on a patient's chart.

   Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.
8. Click **Next** > to go to the next wizard step.
9. For each checklist item, do the following:
   - In **Description**, enter the item name.
   - In **Code**, enter the abbreviation or code for the item.
   - Click **Add**.

   Example
   Treatment: Problems
   Checklist items: None, Adverse drug reaction, Dental injury, Eye injury, Headache

When adding assessment items in this way, the **Description** is limited to 30 characters and the **Code** to 10 characters. (If you instead add or edit assessment items directly in the Assessment Items table, the **Description** limit is 128 characters and the **Code** limit is 16 characters.)

Items appear in the order in which you entered them. You can change the order by editing the Index property in the Assessment Finish table. See Edit a checklist assessment's UR indicators, equipment, or the next page.

Create a new equipment checklist

1. Click **Clinical Content** on the left side of the main window in DB Editor.
2. Double-click **Assessments** on the right side of the main window.
3. In **Order Category**, select **Equipment** and then click **Next** > to go to the next step in the wizard.
4. In **Family**, enter a new family name or select an existing family for the item.
5. In **Treatment**, enter the name of the item.

   (Take care not to enter any spaces at the start of the name.)
6. Set the access rights required to order and document the item.
   - In **Prescription Access**, select the Prescription/Validation right required to add, discontinue, cancel, and extend the item.

- In **Validation Access**, select the Prescription/Validation right required to document data about administration on a patient's chart.

Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.

7. Click **Next** > to go to the next wizard step.
8. For each checklist item, do the following:
   - In **Description**, enter the item name.
   - In **Code**, enter the abbreviation or code for the item.
   - Click **Add**.

Example
Treatment: ANY Equipment
Checklist items: Capnography, EKG, Gas analyzer, IABP, O2 analyzer, Pulse oximeter

When adding assessment items in this way, the **Description** is limited to 30 characters and the **Code** to 10 characters. (If you instead add or edit assessment items directly in the Assessment Items table, the **Description** limit is 128 characters and the **Code** limit is 16 characters.)

Items appear in the order in which you entered them. You can change the order by editing the Index property in the Antoinetta® Finish table. See Edit a checklist (assessments, I/O indicators, equipment) above.

Edit a checklist (assessments, I/O indicators, equipment)

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Assessment Items** on the list of database tables on the right side of the main window.
3. To add a new item to the list, click the **Add** button and enter the name of an item on the new row. Then press Enter.

   To edit the name of an item, change the text in the **Description** column.

   To change the order of items on the list, renumber them in the **Index** column.

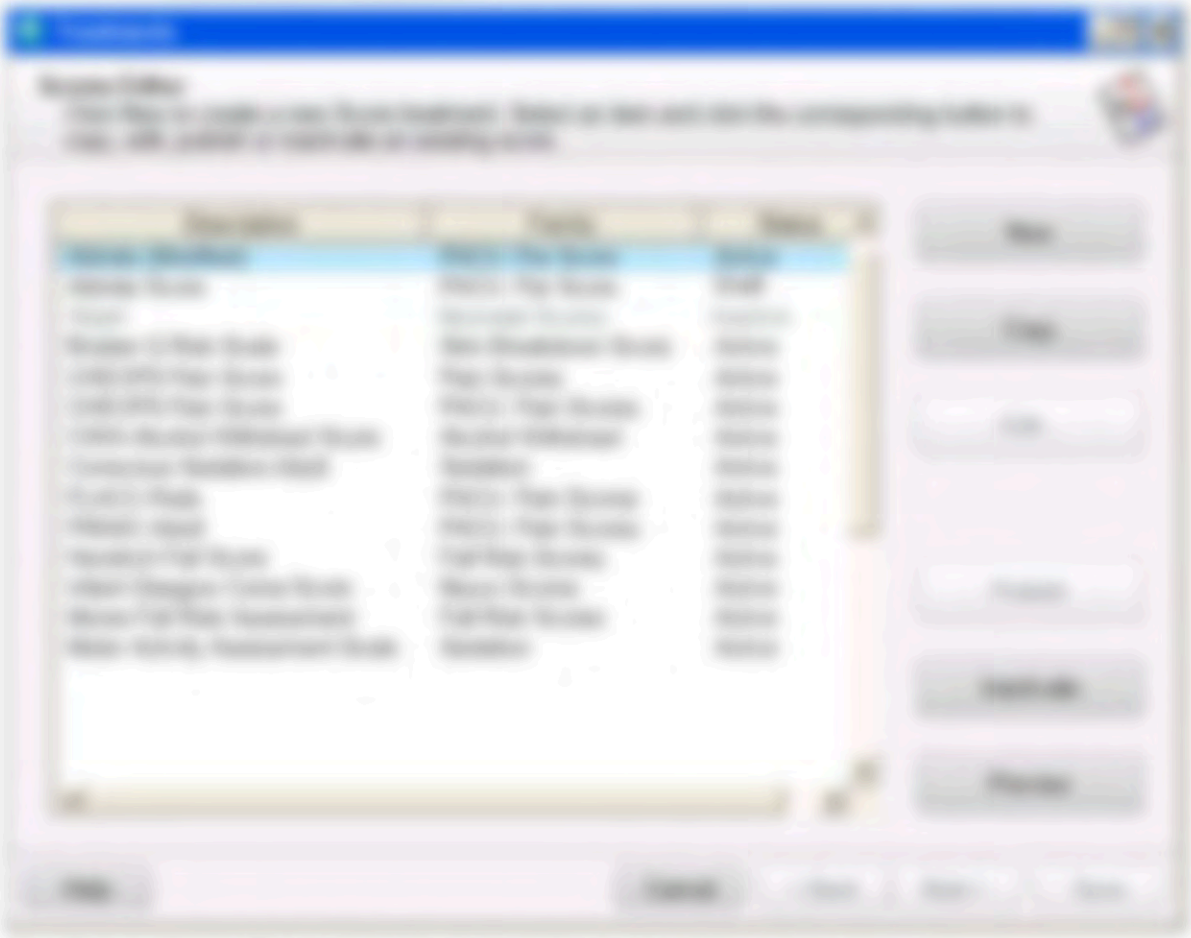
   If you want to delete an item, contact your database administrator.
4. When you have finished entering checklist items, click **Close**.

Scores

Two special preconfigured scores are provided for use in critical care environments, APACHE II and Glasgow Coma Scale. These scores are hardcoded in the software and not accessible via the Scores Editor.

You can also create your own scores using the Scores Editor. (If your hospital uses standard Picis database content, your system will already have scores like TISS, APS/APP, Aldrete, or Braden Risk Scale.)

After creating and publishing scores, you need to make them available on flowsheets. For information, see Flowsheets on page 1401.



The Scores Editor. The buttons depend on the status of the selected score.

What you should know

- When you first create a score its status is "draft". You can only edit or delete a score that has this status.
- When a new score is ready to be used you can "activate" it. Activating a score for the first time is called "publishing".
- If a published score is no longer needed you can hide it from end users by inactivating it (it cannot be permanently deleted).

  You can also reactivate an inactive score.

- You can create a score by copying an existing score and editing it. The suffix "copy" is added to the name.
- You can preview the score to see how it will look to end users.

Score Items

A score consists of one or more groups. Within each group there may be radio buttons (enabling the end user to select a single item) or check boxes (enabling the end user to select one or more items). When you create a score you define the group names and behavior, the items within each group and the points associated with each item.

You specify each item in a group as either custom or calculated.

Custom items are free text conditions that are not related to any other data on the patient chart. For example, "Reflex response: cough". If an end user selects such an item (indicating that the condition is met) the points associated with the item are added to the total score.

Calculated items, on the other hand, add points to the total score automatically when data that is already on the patient's chart satisfies predefined conditions. When configuring such items you can choose from the following data types:

- Demographics (age and gender)
- Physiologic variables
- Laboratory components

For calculated items, you can specify a single condition (for example, "age > 65") or multiple conditions. With multiple conditions, you can specify that the points be added to the total score when all conditions are met (for example, "age > 65" AND "heart rate > 100") or when any of the conditions is met (for example, "age > 65" OR "heart rate > 100").

Button Reference

Button	Purpose
New	Create a score from scratch.
Copy	Create a score based on a copy of another score.
Edit	Edit a draft score. **Note:** The availability of this button depends on the status of the selected score. It is grayed out for scores that have been published (regardless of whether they are active or inactive).

Button	Purpose
Publish / **Activate**	Publish a draft score or activate an inactivated score. **Note:** The label and availability of this button depend on the status of the selected score. For draft scores, the label is "Publish". for published scores that have been inactivated, the label is "Activate". for published scores that are currently active, the button is grayed out.
Inactivate / **Delete**	Delete a draft score or inactivate an active score. **Note:** The label and availability of this button depend on the status of the selected score. For draft scores, the label is "Delete". for published scores that are currently active, the label is "Inactivate". for published scores that have been inactivated, the button is grayed out.
Preview	Preview a score to see how end users will see it.

Publish, delete, inactivate, activate or preview a score

1. Click **Clinical Content** on the left side of the main window in DB Editor.
2. Double-click **Scores** in the list on the right side of the main window.
   The Scores window appears.
3. Select a score in the left pane.
4. To publish a draft score, click **Publish**. (The score will become activated.)
5. To delete a draft score, click **Delete**.
6. To inactivate an active score, click **Inactivate**.
7. To reactivate an inactive score, click **Activate**.
8. To preview a score in the same way end users will see it, click **Preview**.
9. To close the window, click **Cancel**.

   Note: Any changes you have made are preserved. The button is labeled "Cancel" because the same button is used to cancel while editing a score.

Create a draft score from scratch

1. Click **Clinical Content** on the left side of the main window in DB Editor.
2. Double-click **Scores** in the list on the right side of the main window.
   The Scores window appears.
3. Click **New**.
   A new window appears.

4. In **Family**, enter a new family name or select an existing family for this item.
5. In **Treatment**, enter the name of the score.
   (Take care not to enter any spaces at the start of the name.)

   Note: If you attempt to create a score using a treatment name that already exists within the selected family a red outline will appear around the Treatment box and you will be unable to save any changes.

6. Set the access rights required to order and document the item.
   - In **Prescription Access**, select the Prescription/Validation right required to add, discontinue, cancel, and extend the item.
   - In **Validation Access**, select the Prescription/Validation right required to document data about administration on a patient's chart.

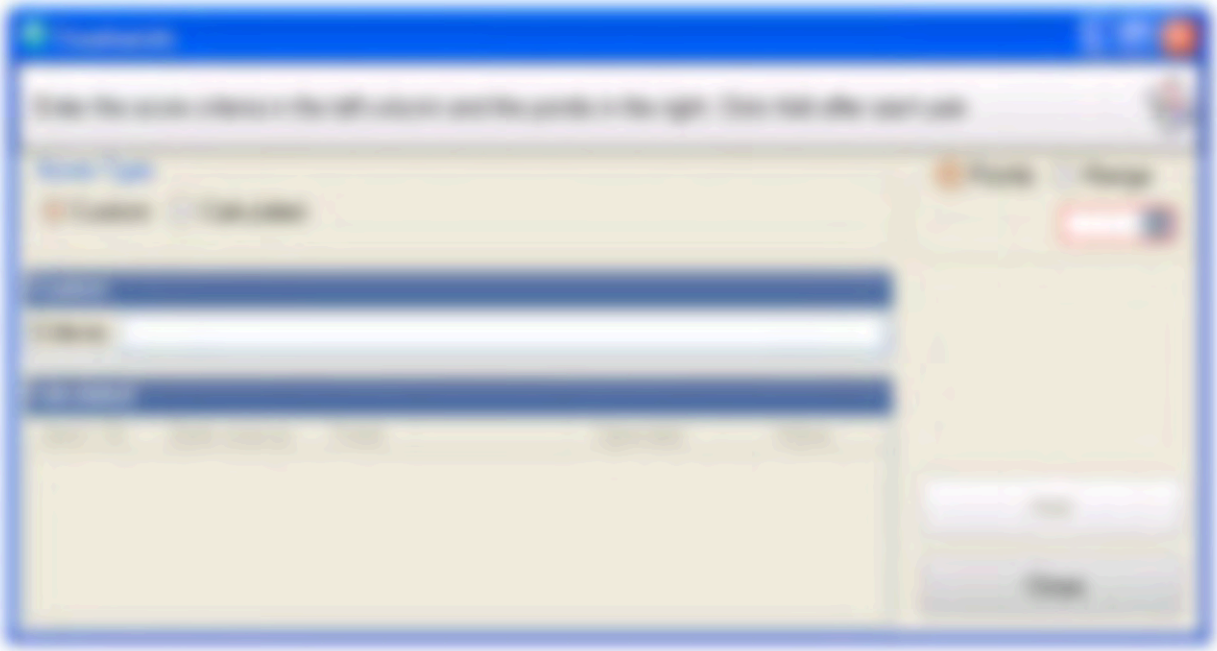
   Note: Rights assigned to treatments only affect custom orders based on those treatments. Standard orders are assigned their own rights.

   Note: You will not be able to save the score unless you have selected access rights for it.

7. Click **Next** > to go to the next wizard step.
   The Scores Editor window appears.
   The top of the Scores Editor shows an empty header of the first group.

8. Click the edit button in the group header.
   An empty, row for the first item appears below the header as follows:

9. In the white box, enter a name for the group.
10. To create a group of radio buttons, click **Single Selection**. to create a group of check boxes, click **Multiple Selection**.
11. To create an item in the group, click the edit button in the empty row for the new item.
    The following window appears:



To create a custom item...

12. Click **Custom**.
    a. In **Criteria**, enter the criteria name.
    b. If you want to associate a fixed number of points with the criteria, click **Points** and enter a number in the box below. Note that negative values are permitted.
    c. If you want users to select the points from a range that is associated with the criteria, click **Range**. A second box appears below. Enter the start of the range in the left box and the end of the range in the right box. Note that negative values are permitted.
    d. Click **Add**.

To create a calculated item...

13. Click **Calculated**.

    An empty row appears in the "Calculated" section.

    You can enter as many conditions in this section as you wish. The And / Or setting for each condition determines whether the points are added when all conditions are met or when any condition is met. The setting you choose (AND or OR) must be the same for all conditions.

> **Note:** If an item only has one condition it does not matter whether you select AND or OR.

a. Under **Anatlas**, select ANES or OR, as required.
b. Under **Data source**, select either Demographics, Physiologic or Laboratory.
c. Under **Field**, select a field from the data source that you specified.
d. Under **Operator**, enter a mathematical operator (equals, greater than, less than, or not equal).
e. Under **Value**, enter the comparison value.
f. If you want to associate a fixed number of points with the item, click **Points** and enter a number in the box below. Note that negative values are permitted.
g. If you want users to select the points from a range that is associated with the item, click **Range**. A second box appears below. Enter the start of the range in the left box and the end of the range in the right box. Note that negative values are permitted.
h. Click **Add**.

14. When you have finished entering items for a group, click in the group header.
A new empty header appears for the next group and an icon appears to the left of the group indicating its type.

 Multiple Selection

Single Selection

15. Add more groups as needed, in the same way as described for the first group.
16. When you are done, click **Save**.

Best Practice: Preview the score before publishing it.

Create a score based on an existing score

1. Click **Clinical Content** on the left side of the main window in DB Editor.
2. Double-click **Scores** in the list on the right side of the main window.
The Scores window appears.
3. Select a score and click **Copy**.
4. Follow the procedure for editing a draft score, from step 3 onwards.

Edit a draft score

1. Click **Clinical Content** on the left side of the main window in DB Editor.
2. Double-click **Scores** in the list on the right side of the main window.
The Scores window appears.
3. Select a score and click **Edit**.

A new window appears.

4. Edit **Friendly**, **Treatment**, **Prescription Access** and **Validation Access** as required and then click **Next** to go to the next wizard step.

   The Scores Editor window appears.

   For more information on the functionality in this window, see Create a draft score from scratch on page 203.

5. Edit the score as follows:

   Edit group names by clicking the edit button in the group header and modifying the text in the white box.

   Edit group types by toggling between **Single Selection** and **Multiple Selection**.

   Delete a group by clicking the black cross in the group header.

   Edit a group item by clicking the edit button next to it. (For more information on the window that opens, see Create a draft score from scratch on page 203.)

   Delete a group item by clicking the black cross next to it.

6. When you have finished editing, click **Save**.

Best Practice: Preview the score before publishing it.

Schedules for Orders

Schedules determine when and how items on the chart can be documented. They can be used to create standard orders and custom orders.

A schedule can indicate a specific time for administration (such as 7:00 AM), a frequency (such as every 4 hours), or the duration of a continuous activity (such as administration of a drip). It also indicates the length of time to remain active on the chart (such as for 72 hours).

You can create schedules to use with the four basic types of order:

- **Periodic-Absolute**. Concrete times for administering, plus a duration for the order. For example, 7:00 AM and 7:00 PM for three days.

  (Only "on the hour" times are permitted.)

- **Periodic-Relative**. Frequency for administering, plus a duration for the order. For example, every four hours for 24 hours.

- **PRN**. Administration as necessary. The order may be unrestricted, or there may be a minimum interval between administration times. For example, whenever necessary over the next 8 hours, but not more often than once every hour.

  PRN orders are appropriate for optional actions or actions that cannot be scheduled.

- **Continuous**. Processes that are started and then take place steadily over a fixed period of time. For example, over the next three hours.

OB Editor and Clinical Content

Content for Flowsheets

Schedules for periodic relative and PRN orders are created in the same way. users make this choice between periodic and PRN when they select a schedule for the treatment.

CAUTION When creating schedules you must test them thoroughly to ensure that tasks are created at the times expected. Testing should include extending an order to make sure it extends as expected.

Note You can delete schedules, but you cannot edit them.

Schedule Reference

Order Type	Frequency	Duration	Examples
Periodic-Absolute	Times of the day to the nearest whole hour between 0 (midnight) and 23 (11:00 PM), separated by commas. (Times must be entered consecutively. For example, "5, 8, 10" is allowed but "5, 10, 8" is not.)	Total duration (any negative integer to represent days)	At 7 am and 7 pm for 24 h Freq. = 1, 19 Duration = -1 At midnight and 4 hrs for 96 h Freq. = 0, 16 Duration = -2
Periodic-Relative	Frequency in minutes	Total duration (hours)	Every 3 h for 24 h Freq. = 180 Duration = 24
Unrestricted PRN (Administration optional)	As often as necessary.	Total duration of order on chart (hours)	48 Hour Below Freq. = 0 Duration = 48
Restricted PRN (Administration optional.)	As often as necessary, with a minimum interval (in minutes) between administrations.	Total duration of order on chart (hours)	As often as every 4 h for 48 h Freq. = 240 Duration = 48

Order Type	Frequency	Duration	Examples
Continuous	No effect as necessary. Administration is optional.	Total duration of order (hours). Item is shown on the chart for this period of time, but does not end until stopped.	Continuously for 48 h Daily, 1 - 7 Duration = 48

Useful Schedules

A "Now" schedule is a relative periodic schedule that can be used to place a single (not) task on the flowsheet. Such schedules are used for items involving a single action that will be performed and documented in one step such as laboratory tests, scales and assessments that will be performed once. If your database does not already include such a schedule you can create one using a frequency of 0? and a duration of 1.

For assessments that users need to be able to perform repeatedly over a week, use a continuous schedule (frequency - 1) and a duration of 168 (1 - 7 x 24).

More About Absolute Schedules

There are several points to keep in mind when creating absolute schedules:

- You cannot create a schedule for specific days of the week, such as "every Thursday". (For this you would need to create a weekly schedule and users would need to prescribe it to start on a Thursday.)
- The system calculates the time of the first task in a schedule by adding hours to midnight of the start date when the order is prescribed.
- The system calculates the times of subsequent tasks in the schedule by adding hours to the date and time of the first task in the schedule.
- When an absolute order is extended, the system replicates the schedule exactly as it was created. Therefore, the time of the first (extended) task will be calculated from midnight of the date the order is extended rather than adding hours to the date and time of the last task.

Example: If you want to create a schedule for a recurring order that begins at 8 AM every week and repeats weekly for 3 weeks, you have the following options:
- Create a relative schedule that has an interval of 7 days. The user would then start the order on the correct day by changing the start date. The order will extend using the 7 day interval.
- Create an absolute schedule with a frequency as described below:
  - Frequency - 192, 360, 528. Duration - 1.
  - Frequency for the first task - 192 hours (8 days plus 8 hours). The date and time of the first task is 8 AM, 8 days after the start date.
  - Frequency for the second task - 360 hours (7 days added to the first task). The date and time of

the second task is 6 AM, 1 days after the first task.
> Frequency for the third task: 4HR hours (14 days added to the first task). The date and time of the third task is 6 AM, 14 days after the first task.When this type of schedule is extended, it will cause the fourth task (the first extended task) to be created 6 days and 6 hours after midnight on the date the order is extended, creating this new task on the 7th day at 6 AM. The system will continue to create tasks on the same day of the week as the original tasks.

Note: When using this type of schedule, users must be trained to change the start date when the order is first prescribed so that it begins on the current date. In our example, creating the order by leaving the start date as 'today' will create the first task 6 days and 6 hours from today. (If today is Tuesday, this order will start next week on Monday at 6 AM.) Instead, when prescribing such orders, users should change the start date to the day after the order is actually prescribed.

Create a Periodic or PRN schedule

1. In the **Clinical Content** folder, double-click **Schedules**.
2. Click **New**.
3. In the **Description** box, enter the schedule name.
4. In the **Frequency** box, enter the specific administration times (absolute schedules) or the interval between tasks (relative schedules).

   For **absolute** schedules, enter one or more administration times using whole numbers between 0 (midnight) and 23 (11 PM hrs). Separate multiple times with commas. For example, an entry of 8, 12, 18 would place order markers at 8 AM hrs, 12 PM noon and 6 PM hrs on the chart.

   For **relative** schedules, enter the interval between administration times in minutes. If the schedule is used with a Periodic order, not cells appear on the chart at this interval. If the schedule is used with a PRN order, no actions are marked on the chart. (To create a schedule for unrestricted PRN orders, enter 1. For restricted PRN orders, caregivers can document actions as needed, but must wait between validations for the interval that you specify.)
5. In the **Duration** box, for all schedules except Periodic-Absolute, enter the length of time in hours that the item should remain on the chart.

   For Periodic-Absolute schedules, enter a negative number to indicate the number of days that the item should remain on the chart. For example, an entry of -3 combined with the previous example of 8, 12, 18 would create a schedule for 8 AM hrs, 12 PM hrs and 6 PM hrs every day for three days.
6. Click **Save**.
7. When you have finished creating schedules, click **Close**.

Create a Continuous schedule

1. In the **Clinical Content** folder, double-click **Schedules**.
2. Click **New**.
3. In the **Description** box, enter the schedule name.

4. In the **Frequency** box, enter `1`.
5. In the **Duration** box, enter a length of time in hours.
   This parameter determines how long an order with this schedule remains active on a flowsheet as indicated by starting and ending points. Documentation must start between the two points. Once started, items remain active until stopped by a caregiver.
6. Click **Save**.
7. When you have finished creating schedules, click **Close**.

Delete a schedule

1. In the **Clinical Content** folder, double-click **Schedules**.
2. Select the schedule and click **Delete**.

Standard Orders

A standard order combines a treatment with a schedule and other administration information that can be added to the patient chart together. (For example, Nystatin/Amphotericin, 500 mg oral tablet, every six hours, if the patient is in pain.). Standard orders can be grouped in protocols to further document the ordering process.

In the case of medications and fluids, the administration information includes the dose and may also indicate a form (for example tablet) and a route (for example oral). The dose may define an exact amount or a range.

Additionally, the order may state that a medication is diluted in a specified volume of a particular fluid. If such an order uses a periodic schedule, the duration of each administered dose may be included (for example, `every four hours for twenty minutes`). These orders are called intermittent medication infusions.

Best Practice: If your site uses infusion pumps, create a standard order for each fluid that will be used with the pump, taking care to include the minimum required information. units with a time factor such as ml/hr or mg/kg/hr, a base solution greater than 0 ml, and, for medication infusions, a dilution.

Create or modify a standard order

1. In the **Clinical Content** folder, double-click **Standard Orders**.
2. Click **New** to create a new standard order.
   Or, select an order and click **Edit**.
3. Follow the wizard instructions to enter the necessary information.
   Order Category: Category for the treatment.
   Family: Custom family for the treatment.
   Treatment: Action to be performed.

Administration Information. For treatments in the Fluids In, and Medications categories, this includes information like the dose, medication form and medication route. For Medications, the administration information includes details of the fluid in which the medication is diluted (if any). For the Respiratory category, it includes the ventilator settings or respiratory therapy options.

Note: For Fluids, the **Add to Fluid Balance** setting determines whether or not the **Add to Fluid Balance** box is selected by default when an end user documents the order.

Schedule Type: Periodic, PRN, or **Continuous**. See the section Schedules for Orders on page 111 for an explanation of the three types. For In fluids administered using a pump (like IV drips), only the continuous schedule type can be selected. For medication infusions, only the Periodic or PRN schedule types can be selected.

Standard Schedules. Library of custom schedules in the hospital database.

Task Type: Bolus or **Duration**. You can only select a duration for periodic orders. (The maximum duration possible is 99 hours). Continuous orders do not have a task type.

Condition (Optional). Any specific condition that must be met before the caregiver administers the order.

Notes (Optional). Any other information a user needs when administering the order.

Prescription Access. Prescription/validation right a user must have to order, modify, discontinue, cancel, or extend the standard order. Only drips, medications, intermittent infusion, and combined medications can be modified.

Validation Access. Prescription/validation right a user must have to move, modify, or reschedule the standard order. Only fluids in, medications, intermittent infusion, combined medications, and nursing care orders can be moved.

Auto-Select Order. Option that causes the standard order to be selected automatically when a user selects the treatment in the Single Order window.

Note: It is possible to set more than one standard order as the default. The one shown by default is the last one configured.

4. Click **Finish**.

Delete (inactivate) a standard order

1. In the **Clinical Content** folder, double-click **Standard Orders**.
2. Select the order.
3. Click **Delete**.

   The order will become inactivated and appear with a gray background. It can be reactivated by selecting it and clicking **Undo Deletion**. (If an entry is gray but the **Undo Deletion** button is not available, it means the underlying treatment has been inactivated.)

Note: When a standard order is deleted it is removed from any protocols that it is in. If reactivated, it will be added again to the protocols it was in before.

Standard Orders for Combined Medications

You can also create standard orders that contain more than one medication component. (You would usually do this if your pharmacy prefers to combine separate medication orders in this way.) For example, a prescription for Morphine @ 25 mcg/kg/h could be combined with a prescription for Midazolam @ 40 mcg/kg/h, by mixing suitable doses of each in a calculated volume of saline. Medication components are shown on the Medications flowsheet and Fluid components on the Fluids flowsheet.

As with normal standard orders, you can create combined medication orders for PRN, Periodic, and continuous orders.

Creating a combined order for PRN and Periodic orders is fairly straightforward because they are not time-based - you specify the dose for each of the medication components, and if applicable, the fluid volume of the medication components infused. Fields in the configuration window are not interdependent, so when you enter data in one field, data in the other fields does not change.

Creating a combined order for continuous orders requires more thought because the individual dose rates, solvent amounts, solvent fluid volume, and pump rate are interconnected. (Note that continuous combined medication orders can only be given as a rate - bag levels are not supported.)

The interrelated fields are as follows:

- **Dose** (actually a dose rate. This is the prescribed dose.)
- **Solvate** (the available doses)
- **Fluid volume** (the diluent volume)
- **Pump rate**

When you edit data in one field, the data in one or more other fields may be recalculated. Recalculated fields are shown with a green background.

Although you are able to fix the pump rate and have doses, solvate and diluent fluid volume recalculated accordingly, you would not really want to do this when creating a standard order. Instead, make sure that the **Fixed rate** check box is cleared.

For continuous standard orders with the **Fixed rate** check box cleared, the window behaves as follows:

Editing this field	Recalculates these fields
Dose	Dose (for other components) Pump Rate
Fluid Volume	Pump Rate

Adding this field	Recalculates these fields
Include	Include (for other components) Pump Rate
Pump Rate	Dose (for all components)

(Other than having the ability to add more than one medication, standard orders for combined medications are configured like normal standard orders.)

Create or modify a Periodic or PRN standard order for combined medications

1. In the **Clinical Content** folder, double-click **Standard Orders for combined medications**.
2. Click **New** to create a new standard order.
   Or, select an order and click **Edit**.
3. Click a Schedule Type (**Periodic** or **PRN**) and select a schedule from the drop-down list.
4. For Periodic orders, choose **Bolus** or **Duration** (for an intermittent medication infusion). If you chose Duration, enter the infusion time in hours and minutes. (PRN orders are always bolus.)
5. Click **Next**.
6. For each medication component that you want to add, proceed as follows:
   a. Click **New Row**.
   b. Click the **Name** field and select the medication name from the drop-down list.
   c. Click the left **Dose** field and enter a dose.
   d. Click the right **Dose** field and select a unit from the drop-down list.
7. If the components are infused with a diluent fluid, proceed as follows:
   a. Select **Infusion**. (If you previously selected a schedule with Duration, Infusion is selected already.)
   b. Enter a value for **Fluid volume**.
   c. Select a **Diluent Family** from the drop-down list.
   d. Select a **Diluent Fluid** from the drop-down list.
8. In **Form**, enter the medication form.
9. In **Route**, enter the medication route.
10. Click **Next**.
11. (Optional) In **Condition**, enter any specific condition that should be met before the caregiver administers the order (such as "for pain").
12. Click **Next**.
    (Optional) In **Memo**, enter any other information a user needs when administering the order.
13. Click **Next**.

In **Prescription Access**, select the Prescription/validation right a user must have to order, modify, discontinue, cancel, or extend the standard order.

In **Validation Access**, select the Prescription/validation right a user must have to reschedule a task, move orders, or validate (document) administration of the standard order.

14. Click **Finish**.

Create or modify a Continuous standard order for combined medications

1. In the **Clinical Content** folder, double-click **Standard Orders for combined medications**.
2. Click **New** to create a new standard order.
   Or, select an order and click **Edit**.
3. Under **Schedule Type**, click **Continuous** and select a schedule from the drop-down list.
4. Click **Next**.
   There are a number of ways to create a new order, but Pcds recommends the following workflow.
5. Make sure that **Fixed rate** is not selected.
6. For each medication component that you want to add, proceed as follows:
   - Click **New Row**.
   - Click the **Name** field and select the treatment name from the drop-down list.
   - Click the left **Dose** field and enter a dose.
   - Click the right **Dose** field and select a unit from the drop-down list.
   - Click the right **Solute** field and select a unit from the drop-down list. (Do not select the Solute amount yet.)
7. Select a **Diluent Family** from the drop-down list.
8. Select a **Diluent Fluid** from the drop-down list.
9. Enter a value for **Fluid Volume**.
10. In the right **Pump rate** field, select a unit from the drop-down list. (Do not select a pump rate.)
11. For one medication component only, click the left **Solute** field and enter a solute amount.
    When you do this, the solute amounts for the other components are calculated automatically.
12. Check that all values are appropriate. If you want to edit any values, consider how the fields are interrelated, as previously described in this section.
13. In **Form**, enter the medication form.
14. In **Route**, enter the medication route.
15. Click **Next**.
16. (Optional) In **Condition**, enter any specific condition that should be met before the caregiver administers the order (such as "for pain").
17. Click **Next**.
    (Optional) In **Notes**, enter any other information a user needs when administering the order.
18. Click **Next**.

In **Prescription Access**, select the Prescription/validation right a user must have to order, modify, discontinue, cancel, or extend the standard order.

In **Validation Access**, select the Prescription/validation right a user must have to reschedule a task, move an order, or validate document administration on the standard order.

Select **Auto-Select Order** if you want the standard order to be selected automatically when a user selects the treatment in the Single Order window.

Note: It is possible to set more than one standard order as the default. The one shown by default is the last one configured.

10. Click **Finish**.

Delete (inactivate) a standard order for combined medications

1. In the **Clinical Content** folder, double-click **Standard Orders for Combined Medications**.
2. Select the order.
3. Click **Delete**.

Note: The order will become inactivated. It can be reactivated by selecting it and clicking **Undo Deletion**. (If an entry is inactivated but the **Undo Deletion** button is not available it means an underlying treatment has been inactivated.)

Note: When a standard order is deleted it is removed from any protocols that it is in. If reactivated, it will be added again to the protocols in was in before.

Protocols

Protocols are groups of standard orders that can be added to a patient chart together. Users can modify the protocols for different situations by adding and removing unneeded orders without changing the protocol in the database.

After creating protocols, you can associate them with templates in two ways: you can define a default protocol for the template that populates flowsheets automatically with basic orders at the start of a session, and you can specify a 'protocol library' for the template, from which users can choose protocols manually during a session.

See also: Configure a default protocol on page 126

Create a protocol

1. In the **Clinical Content** folder, double-click **Protocols**.
2. Click **New**.
   The left box shows the standard orders available.

3. You can filter the list in the left box by **Category**, **Family**, or by text that you enter in the **Search** box (only matches containing the text will be shown).
4. You can sort the list in the left box by name (**Sort by name**) or by the index value assigned to the underlying treatment in the Treatments auxiliary database table (**Sort by index**).
5. In the left box, select a standard order and click >> to add it to the protocol.

   Note: To select multiple items, hold down CTRL while you click them.

6. When you have finished adding standard orders to the protocol, click **Save As**.
7. Enter a name for the protocol.
8. Click **OK**.
9. Click **Close**.
10. When you have finished creating protocols, click **Close**.

Modify a protocol

1. In the **Clinical Content** folder, double-click **Protocols**.
2. Select a protocol and click **Edit**.
3. You can filter the list in the left box by **Category**, **Family**, or by text that you enter in the **Search** box (only matches containing the text will be shown).
4. You can sort the list in the left box by name (**Sort by name**) or by the index value assigned to the underlying treatment in the Treatments auxiliary database table (**Sort by index**).
5. To add an order to the protocol, select it in the left box and click >>. To remove an order from the protocol, select it in the right box and click <<.
6. When you have finished editing the set, click **OK**.
7. When you have finished creating protocols, click **Close**.

Delete a protocol

1. In the **Clinical Content** folder, double-click **Protocols**.
2. Select a protocol and click **Delete**.
3. When you have finished working with protocols, click **Close**.

Rename a protocol

1. In the **Clinical Content** folder, double-click **Protocols**.
2. Select a protocol and click **Rename**.
3. Enter the new name and click **OK**.
4. When you have finished working with protocols, click **Close**.

Physiologic Variables

Physiologic variable are stored in the database. You cannot delete or add variables to this table with DB Editor. If you need a variable that is not in the table, contact your system administrator.

You can configure the label, full name, comment, and units. Other properties such as 'copy forward' behavior, math function, and artifact limits are configured in templates.

For more information on configuring variable properties, see Configuring Physiologic Variables, on page 123.

Set the properties of physiologic variables

1. In the **Auxiliary Tables** folder, double-click **Physiologic Variables**.
2. Locate the variable on the table and click the cell containing the property you want to customize.
3. Press Enter after making each change.

Variable properties include the following:

Label	Abbreviation of up to six characters for the variable name. This is the default abbreviation for trends.
Description	Full name of the variable. This appears on flowsheets.
Comment	Optional additional information that can be viewed by users in the Variable Properties window. If a comment is included, the variable name has a memo symbol beside it.
Unit	Optional unit of measure applicable to the data.
Formula	Formula for calculating data if the variable is derived.
Derived	Indicates that the variable is derived. See Derived Variables, below.

Note: The label and description of each variable must be unique.

Derived Variables

A derived variable obtains its data from calculations performed on data from other physiologic variables or database constants, using a formula. For example, Derived Mean Pulmonary Pressure (dMPAi) uses data from the variables Pulmonary Diastolic Pressure (DPAi) and Pulmonary Systolic Pressure (SPAi) as follows:

$$dMPAi = (SPAi + (DPAi \times 2)) / 3$$

Derived variables behave similarly to other physiologic variables: data is added to flowsheet columns at the configured interval and included in snapshots and emergency data blocks.

Calculations use the most recent data available for the source variables and constants. To calculate data for a derived variable, the template must include all of the source variables. The CIMI database includes approximately 90 derived variables. You can create new derived variables using arbitrary variables.

CAUTION The database includes a number of derived variables by default. The formulas for these variables are provided for example purposes only and may not be appropriate to all sites. If a site wants to use a derived variable it must first check that its formula conforms with the site's standard of practice (and edit the formula accordingly if it does not).

Formulas for derived variables

A formula can contain the following elements:

- Arguments. Physiologic variables, represented by their Child-Link codes or labels, and database constants.

  Enclose variable labels in square brackets ([ ]). Precede Child-Link codes with a pound symbol (#001). Physiologic variable labels are case-sensitive.

  Three database constants are provided: #BSA1 (Mosteller), #BSA2 (DuBois), and #BSA3 (Haycock). Data for #BSA1 and #BSA2 are entered by users on the demographics form. #BSA3 is calculated internally using #BSA1 and #BSA2.

- Numeric floating point constants: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, .

  The decimal separator should be the same as that specified in Regional Settings (either a single period or comma).

ARITHMETIC OPERATORS		
+	Addition	1 + 2
-	Subtraction	3 - 1
-	Negation	-5
*	Multiplication	2 * 3
/	Division	1 / 2
^	Exponentiation	4 ^ 2

COMPARISON OPERATORS		
=	Equal to	(=99) → (Pos:99)
>	Greater than	(=99) → (Pos:99)
<	Less than	(=99) → (Pos:99)
> =	Greater than or equal to	(=99) → = (Pos:99)
< =	Less than or equal to	(=99) → = (Pos:99)
< >	Not equal to	(=99) → < (Pos:99)

FUNCTIONS	
IF	IF (Condition, Value_if_True, Value_if_False) Returns the value of the second or third argument, based on the value of Condition as follows: If Condition is any value except for zero, Value_if_True is returned. If Condition is equal to zero, Value_if_False is returned.
ISEMPTY	ISEMPTY (Expression) Returns 1 if Expression has an EMPTY value and 0 otherwise. See Prevent errors with IF, ISERR, and ISEMPTY on the facing page.
ISERR	ISERR (Expression) Returns 1 if Expression has an ERROR value and 0 otherwise. See Prevent errors with IF, ISERR, and ISEMPTY on the facing page.

Interpret the errors returned by formulas

Formulas and expressions within formulas can return error values instead of data. If the entire formula returns an error value, the flowsheet cell is left blank.

A formula or expression can return the following error values:

- **EMPTY**: Returned when a physiologic variable or database constant that has no value is used as a function argument.

  This occurs when a physiologic variable used in the expression is not present on the flowsheet or when no data is available for it.

  It also occurs when no value is available for a database constant used in the expression.

- **#DIV/0!**: Returned when an invalid arithmetic operation occurs, such as division by zero or when a negative value is raised to a non-integer power.
- **#NUM!**: Returned when the final result of a calculation is less than -9.99E or greater than 9E+99.

  Also returned when the absolute value of any expression in the formula is less than 1E-307 or greater than 9.99999999999999E+307.

If an expression returns several types of error values, the error value having the highest priority is displayed. Error values have the following priority, from highest to lowest:

#NUM!

#DIV/0!

#NAME?

Prevent errors with IF, ISERR, and ISNAPTY

The ISERR and ISNAPTY functions can detect #DIV/0! and #NAME? error values. The IF function can be combined with these functions to prevent the whole formula from returning an error.

For example, the following formula substitutes the value for PULSE whenever data is unavailable for the sporadic variable PULSE:

```
IF ( ISNAPTY ( PULSE ) , PULSE , PULSE )
```

Tip: You can use physiologic variables that are not part of the patient chart as temporary values to simplify other formulas.

How expressions are evaluated

Expressions enclosed in parentheses are evaluated before being used further in the formula.

Spaces are ignored unless they appear in one of the following:

- Physiologic variable labels
- Chart-x Link codes
- Database constants
- Function names (for example, IF)
- Operators (for example, <=)

Operations are performed in the following order:

- Negation
- Exponentiation
- Multiplication and division
- Addition and subtraction
- Comparison

Operators having the same precedence, for example addition and subtraction, are evaluated from left to right.

Circular references in formulas

A formula cannot contain a circular reference.

For example:

```
AA = [PVU30]

PVU30 = IF ( [AA] > 60, 60, [AA] )
```

The first expression uses PVU30 to obtain Heart Rate. The second expression uses Heart Rate to obtain PVU30. Neither of the expressions can be calculated.

A circular reference can involve more than two expressions:

A = [" B
B = [" C
C = [" A

The first expression uses B to obtain A. The second expression uses C to obtain B. The third expression uses C to obtain A. None of these expressions can be calculated.

Note: If a circular reference is present in the Physiologic Variables auxiliary table, you may not see any physiologic variables at all in Customize or Anesthesia Manager/PACU Manager/Critical Care Manager. DB Editor does not warn you if you have entered a circular reference.)

Sample formulas for derived variables

Example 1: HR vs PVU30

```
x = IF ( [HR] > [PVU30], [HR], [PVU30] )
```

If Heart Rate is greater than PVU30, then x equals Heart Rate. If not, x equals PVU30.

Example 2: Body Surface Area (BSA)

```
x = IF ( [Weight] < 10, [Weight] * 0.75 * 0.0034, IF ( [Weight] < 20.99, [Weight] *
0.46 * 0.0061, IF ( [HEIGHT] [WEIGHT], WEIGHT, [Weight] * 0.425 * [HEIGHT] * 0.725 *
0.007184 ) ) )
```

Note: Your hospital unit may use a different formula for BSA.

If Weight is less than 10 kg, x = (Weight ^ 0.75) * 0.0034.

If Weight is less than 20.99 kg, x = (Weight ^ 0.46) * 0.0061.

Note that these expressions do not contradict each other because they are calculated from left to right and the second expression is only used if the first is false. The second expression really means "if Weight is between 10 kg and 20.86 kg"

If Weight is greater than 20.86 kg, and a value of Height is not available, x = Height = null.

If Weight is greater than 20.86 kg, and a value of Height is available, x = (Weight * 0.425) * (Height ^ 0.725) * 0.007184.

Note that Weight appears in brackets because it is a physiologic variable. Height does not because it is a database constant.

Example 3: Body Mass Index (BMI)

```
BMI = (703) * (kg.get) / (cm.get) ^ (kg.get)
```

Configure a derived variable

Note: Only configure a variable as a derived variable if data from the variable will never be provided by a device.

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Physiologic Variables** on the list of database tables on the right side of the main window.
3. Locate the variable on the table. To sort variables by any column, click a column heading.
4. In the **Formula** column, enter the formula for calculating data for the variable. Then press Enter.
5. In the **Derived** column, select the check box.
   The variable appears in the Derived Variables window in Customize the next time you open that application.

Specialized Windows

Demographics

Content available for documenting patient demographics can be found in the Auxiliary Tables section.

TABLE	CONTENT
Medications	Medications that users can select as home medications or medication allergies.
Preferred Language	A list of languages in which patients may prefer to communicate. (Click the **Default** column next to a language to make it the default language in drop-down lists within the applications.) **Note:** You can also set the default preferred language in the Configuration Parameters auxiliary table (by specifying its code).
Route Types	Types for locating items in the Routes table. Not used elsewhere.
Routes	Administration routes for medications and fluids. Drop-down list entries available when creating orders. (Including standard orders created in DB Editor.)

Common Choices for Diagnoses, Procedures, and Allergies

Common choices are abbreviated lists of diagnoses, procedures, and allergies that include the most frequently documented items in a particular care area. Common choice lists are associated with controls in the Demographics and Privoy Manager windows. Items may be displayed in drop-down list controls or the upper half of the Search window. Users can search the entire list in the database if a needed item is not found on a common choices list.

You can modify the contents of a list, but you cannot create new ones. The list displayed in a session depends on the template used with the patient. Templates are classified by their encounter type as either ICU or non-ICU. Critical Care Manager uses ICU templates and Anesthesia and PACU Manager use non-ICU templates.

Note: Common Choices lists are originally empty. (They are not included in the initial installation.)

Critical Care Manager:

- ICU - Diagnoses - Demographics
- ICU - Procedures - Demographics

(Used when the ICU property for the encounter type is set to Y.)

Anesthesia and PACU Manager:

- PERIOP - Diagnoses - Demographics
- PERIOP - Procedures - Demographics

(Used when the ICU property for the encounter type is set to N.)

Proxy Manager:

- PRECIP - Diagnoses - Proxy Manager Demographics
- PRECIP - Medications - Proxy Manager Medications
- PRECIP - Procedures - Proxy Manager Demographics
- PRECIP - Procedures - Proxy Manager Surgical History
- ALL - Medications - Medication Allergies

Copy an existing common choices list

1. In the **Common Choices** folder, double-click the name of the list you want to replace with the imported list.
2. Click **Import Common Choices**.
3. Select the list you want to copy.
4. Click **OK**.
   Please note that this action cannot be undone. The items on the imported list replace any items in the Common Choices box.
5. You can customize the list by adding and removing items, and changing their order.
6. To save the list and continue working, click **Apply**.
7. To print the list, click **Print**.
8. When you have finished, click **OK**.

Add items to a common choices list

1. In the **Common Choices** folder, double-click the name of the list you want to modify.
2. For diagnosis and procedure common choice lists only:
   a. In the **Group** box, select a code group to display its items in the **Source** box. The possible code groups are as follows:

All	Shows all items from all groups.
CPT	For procedures only. Shows items with CPT codes. (This option will not be present if your system does not have CPT codes or it they have expired.)
Hospital Defined	Shows any hospital-specific items your hospital has configured (from the V_MEDICAL/V_PROCEDURE or V_DIAGNOSIS table of the CAR database as appropriate).
ICD9	Shows items with ICD-9 codes. (This option will not be present if your system does not have ICD-9 codes or it they have expired.)
ICD10	Shows items with ICD-10 codes. (This option will not be present if your system does not have ICD-10 codes or it they have expired.)
Shared	For procedures only. Shows items required by the system such as "unknown".

   a. In the **Type** box, select a clinical category, such as "certified" or "transplant", to display its items in the **Source** box.
3. If necessary, limit the selection to items that contain specific text by entering the text in the **Containing Text** box and clicking **Find**.
4. In the **Source** box, click the check box next to each item you want to add to the **Common Choices** box. Items with a check mark are added automatically.
5. To save the list and continue working, click **Apply**.
6. To print the list, click **Print**.
7. When you have finished, click **OK**.

Change the order of common choices

1. In the **Common Choices** folder, double-click the name of the list you want to modify.
2. To change the position of an item on the list, click it in the **Common Choices** box and then click the ↑ or ↓ button.

   Use the ⇑ or ⇓ buttons to move the item to the top or bottom of the list.
3. To sort the items in alphabetical order, click **ABC**.
4. To save the list and continue working, click **Apply**.
5. To print the list, click **Print**.
6. When you have finished, click **OK**.

Remove an item from a common choices list

1. In the **Common Choices** folder, double-click the name of the list you want to modify.
2. In the **Common Choices** folder, click the item that you want to remove.
3. Click <-**Remove**.
4. To save the list and continue working, click **Apply**.
5. To print the list, click **Print**.
6. When you have finished, click **OK**.

Events and SAM Windows

Although the database stores event names and the Events table is accessible using DB Editor, you should use Customize to add new events. You can use DB Editor to edit, delete or configure the following properties of existing events:

- Events and event types. You can edit the names of events and event types in the corresponding Auxiliary Tables. Do not change the settings in the Event Categories column of the Event Types table.

  You can delete individual events and entire event types by selecting the **Inactive** check box on a list.

Note: After inactivating an event you should use Customize to remove it from all the event sets in which it is found.

Note: For Professional Fee billing, you must make sure that the following events are active: 'Anesthesia Start', 'Anesthesia Finish', and 'Staff Billing Login'.

- Symbols for events. When an event with a symbol is documented, the symbol appears in the Wire bar. The symbol can be any single character from the ISO Latin1 character set.

  Note that by default, the symbol for the 'microbiology result' automatic system event is 'M'.
- Events for anesthesia supervisors. These events can only be documented by anesthesia supervisors. If a non-supervisor administers anesthesia, the supervisor typically enters these events using the SuperUsers, Anesthesia Module (SAM).
- Event pairs. You can create event pairs consisting of two events: a start event and an end event. Users are prevented from documenting an end event unless the associated start event has already been documented. An event check for an event pair is performed when a start event is added.

Note: The Professional Fee billing system requires an event pair consisting of the Anesthesia Start and Anesthesia End events.

Create or modify an event symbol

1. In the **Auxiliary Tables** folder, double-click **Events**.
2. In the row corresponding to the event, enter the desired character in the **Symbol** column, and then press ENTER.
3. When you have finished creating and modifying events, click **Close**.

Designate an event for use in SAM

1. In the **Auxiliary Tables** folder, double-click **Events**.
2. In the row corresponding to the event, click **Supervisor**.
3. When you have finished, click **Close**.

Note: Only members of a user group with the system right 'SAM view and edit' can document these events.

Create an event pair

1. On the menu, click **Event Pairs**.
2. In **Event: Start**, select the event that must be documented first.
3. In **Event: End**, select the event that must be documented second.
4. Click **OK**.

Note: An event can only appear in one event pair. The **OK** button is unavailable if one or both of the selected events already belong to an event pair.

Edit an event pair

1. Click **Event Pairs**.
2. Select the event pair that you want to edit.
3. In **Event Start**, select the event that must be documented first.
4. In **Event End**, select the event that must be documented second.
5. Click **OK**.

Note: An event can only appear in one event pair. The **OK** button is unavailable if one or both of the selected events already belong to an event pair.

Delete an event pair

1. Click **Event Pairs**.
2. Select the event pair that you want to edit.
3. Click **Delete**.
4. Click **OK**.

Patient Summary

The Patient Summary is configured using Customize. You can use DB Editor to create and configure types of notes that users can add to summary reports. You create note types by adding entries to the NoteTypes table.

Sometimes clinicians prefer to exclude certain types of notes from the summary. These note types can be configured as hidden. Hidden notes appear only on the Notes tab. You can also configure certain note types to be temporary. After the patient discharge, the system retains these notes for a certain period of time and then deletes them. You can configure the period of time to retain the notes.

After you have created a note type, you can define its content by creating note blocks on the NoteSysBlocks table. Note blocks are blank sections with headings that appear in a defined sequence.

Create or modify a note type

1. In the **Auxiliary Tables** folder, double-click **NoteTypes**.
2. To create a new note type, click **Add** and then **OK**.
   To change an existing type, click the cell containing the text or property that you want to modify.
3. Under **Description**, enter or change the name of the note type, and then press ENTER.

4. Under **Index**, enter a number, and then press ENTER. The number determines the position of the note type in drop-down lists in the patient summary.
5. Click **InActive**, if you do not want notes based on this note type to be seen on the Current Report tab.
6. Click **Discharge**, if you want notes based on this note type to be deleted after the patient is discharged. (Under **Days to delete after discharge**, enter a number, and then press ENTER, to set the number of days after discharge the notes should be deleted.)
7. When you have finished creating and modifying note types, click **Close**.

Add auxiliary note blocks to a note type

1. In the **Auxiliary Tables** folder, double-click **NoteTypeBlocks**.
2. To create a new note block, click **Add** and then **OK**.
   To change an existing block, click the cell containing the text or property that you want to modify.
3. Under **Description**, enter or change the name of the note block, and then press ENTER.
4. Under **NoteTypes**, select the note type in which you want to place the note block.
5. Under **Index**, enter a number, and then press ENTER. The number determines the position of the note block within the note type. (If there is only one note block in the note type, its index should be "1".)
6. When you have finished creating and modifying note blocks, click **Close**.

Note: You cannot use the same note block in two or more note types; you must create separate note blocks for use with each note type, even if they have the same name (Description).

Anesthesiologist Required for Supply Billing

If your system integrates with OR Manager, the patient chart may include a Supply Log for recording stocks used during anesthesia administration. You can configure whether or not the anesthesiologist must first be documented for supplies to be submitted. (The anesthesiologist associated with the transmitted supply is the first Medical Team member for the encounter that has a clinical role of Anesthesia Attending or Anesthesiologist.)

Configure whether or not an anesthesiologist is required for supply billing

1. In the **Auxiliary Tables** folder, double-click **Configuration Parameters**.
2. In the **Value** column, click the cell next to the **Anesthesiologist required in Supply Billing** option.
3. Enter **0** if supplies can be transmitted without an anesthesiologist being documented.
   Enter **1** if supplies can only be transmitted when an anesthesiologist is documented.
4. Press ENTER.

Rule-Based Notifications for Sepsis

Configuration

Rule-Based Notifications for sepsis are configured using Customize and DB Editor. For more information, see Rule-Based Notifications for Sepsis on page 20.

Configure a list of symptoms and risk factors

1. Open DB Editor.
2. In the **Auxiliary Tables** folder, double-click the **Rule Symptoms** table.
3. To edit a description, type the new text in the **Description** cell.
4. To add a new list item, click **Add** and then type the text in the **Description** cell.
5. Click **ENTER** to save the new cell data. (You must do this before you can select another cell.)
6. When you have finished adding entries, click **Close**.

Powp Manager

Overview

Content for certain windows in Powp Manager can be customized at a global level using DB Editor.

- **Allergies** and **Diagnoses and Procedures**. You can customize the "common choices" lists associated with diagnoses, procedures, and allergies. These lists provide abbreviated selections of the items most commonly documented in the care area.

  See Common Choices for Diagnoses, Procedures, and Allergies on page 225.

- **Post Medical History**. Areas of in the patient's medical history to be covered in the evaluation. When created, new entries appear automatically in the corresponding window in Powp Manager. You can designate some sections as required for all patients.

  For example, Neurological, Cardiovascular, Anesthesia History, Family History, Alcohol, tobacco and drug use.

  See Create a section in the medical history on page 232 and Add a finding to a medical history section on page 233.

- **Physical Exam**. Body systems to be examined. When created, new entries appear automatically in the corresponding window. You can designate some sections as required for all patients.

  For example, Airway and Neck, Pulmonary, Cardiovascular, Musculoskeletal, Skin.

  See: Create a section in the physical examination on page 222 and Create a finding for a physical examination section on page 223.

- **Anesthesia Plan**. Techniques, equipment and issues to discuss with the patient. When created, new entries appear automatically in the corresponding window in Prasys Manager. You can designate some sections as required.

  For example, Anesthesia Technique, Additional Equipment, Risks Discussed with Patient.

  See: Edit a finding in an anesthesia plan section on page 224.

- **Risk Assessments**. Lists of risk factors with possible findings for each. Each factor is associated with a number of points. The total score may include recommendations.

  For example:

  Risk factor: Ischemic Heart Disease

  Findings: Pathologic Q waves, Angina stable, Angina unstable, Coronary artery disease, etc.

  The Body System Exams auxiliary table contains the names of the risk factors; the Body System Exam Items auxiliary table contains the findings for each factor.

  See: Create a risk factor for a risk assessment on page 226 and Create a finding for a risk factor on page 228 Create a new risk assessment form on page 231

  Note: The table that stores the names of risk assessment types is not accessible with DB Editor; a database tool such as Microsoft SQL Management Studio must be used. For more information, see Create a risk assessment type on page 226.

- **Home Medications**. The status of a medication in the patient's current regime of medication.

  For example, Active, Inactive, Unknown.

  The Prasys Statuses (Medications) auxiliary table supplies options for the **Status** column in this form.

  See: Auxiliary Database Tables on page 245.

- **Prasys Instructions**. Information given to patient on what to do in preparation for surgery. When created, new entries appear automatically in the corresponding window.

  For example, STOP eating solid food or drinking milk or non-clear juices 8 hours before your hospital arrival time.

  The Prasys Instruction Types auxiliary table supplies the types and the Prasys Instructions auxiliary table supplies options for this window.

  See: Create a perioperative instruction on page 234.

- **Record Status**. List of possible statuses for an evaluation. Users set the status manually. The status is displayed at the top of the evaluation summary and can be used in queries in the Census window.

  For example: Ready for doctor, Needs follow-up, Ready for surgery, Surgery canceled

  The Proxy Record Status auxiliary table supplies the statuses.

  See: Create an evaluation status on page 215

- **Signatures**. Up to eight different types of signatures for caregivers responsible for completing or reviewing all or part of an evaluation. For each signature type you can specify if using it should change the status of the entire evaluation to Final. After a final signature certain sections will become locked if the configuration option is set. Users can then only enter addenda to an evaluation, but not change the data in the affected sections.

  For example: LPN/LVN or Resident, Attending Review

  The Signoff Types auxiliary table supplies options for this window.

  See: Create a signature type for signing evaluations on page 216

- **Addenda**. Notes that caregivers can add to an evaluations, typically after it has been signed as final. Caregivers can enter free text or use standard comments.

  For example: Agree with the above assessment with the following exceptions: All available information reviewed, patient is ready for surgery.

  The Common Text auxiliary table contains all available standard comments.

  See: Create a standard comment for addenda on page 216

Medical History Section

Create a section in the medical history

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Body System Exams** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. Enter the name of the section and then press Enter.
5. In the **Body System Exam Type** column select **Review of systems** and then press Enter.
6. In the **Index** column, enter a number corresponding to the position of the section relative to others in the window and then press Enter.

   Best Practice: Include a zero before single-digit numbers (01, 01, 02,).

   This step is optional. If you leave the index blank, sections appear in the order they are entered.
7. When you have finished adding sections, click **Close**.

Add a finding to a medical history section

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Body System Exam Items** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. Enter the name of a review finding and then press Enter.
5. In the **Body System Exam** column select the name of the corresponding section and then press Enter.
6. In the **Index** column, enter a number corresponding to the position of the item relative to others in the section and then press Enter.

   Tip: Include a zero before single-digit numbers (05, 01, 02, ...).

   This step is optional. If you leave the index blank, sections appear in the order they are entered.
7. In the **Exam Assessments** column, select the appropriate status (Normal, Abnormal, Deferred) and then press Enter.
8. When you have finished creating items, click **Close**.

Physical Examination Section

Create a section in the physical examination

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Body System Exams** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. Enter the name of the section and then press Enter.
5. In the **Body System Exam Type** column, select **Physical exam** and then Enter.
6. In the **Index** column, enter a number corresponding to the position of the section relative to others in the window and then press Enter.

   Tip: Include a zero before single-digit numbers (05, 01, 02, ...).

   This step is optional. If you leave the index blank, sections appear in the order they are entered.
7. When you have finished adding section names, click **Close**.

Create a finding for a physical examination section

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Body System Exam Items** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. Enter the name of a review finding and then press Enter.

5. In the **Body System Exam** column, select the name of the corresponding section and then press Enter.
6. In the **Index** column, enter a number corresponding to the position of the item relative to others in the section and then press Enter.
   Tip: Include a zero before single-digit numbers (05, 01, 02, ...).
   This step is optional. If you leave the index blank, sections appear in the order they are entered.
7. In the **Exam Assessments** column, select the appropriate status (Normal, Abnormal, Deferred) and then press Enter.
8. When you have finished creating items, click **Close**.

Anesthesia Plan Section

Add a finding to an anesthesia plan section

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Anesthesia Plans** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. Enter the name of the item and then press Enter.
5. In the **Index** column, enter a number corresponding to the position of the item relative to others in the section and then press Enter.
   Tip: Include a zero before single-digit numbers (05, 01, 02, ...).
   This step is optional. If you leave the index blank, sections appear in the order they are entered.
6. In the **Anesthesia Plan Type** column, select the name of the corresponding section and then press Enter.
7. When you have finished creating items, click **Close**.

Preoperative Instructions Section

Create a preoperative instruction

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Procip Instructions** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. Enter the instruction and then press Enter.
5. When you have finished adding instructions, click **Close**.

Record Status Section

Create an evaluation status

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Proxy Record Status** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. In the **Description** column, enter the instruction and then press Enter.
5. When you have finished adding instructions click **Close**.

Signatures Section

Create a signature type for signing evaluations

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Signoff Types** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. In the **Description** column, enter a status and then press Enter.
5. In the **Index** column, enter a number corresponding to the position of the item relative to others in the window and then press Enter.

   Tip: Include a zero before single-digit numbers (00, 01, 02, ...).

   This step is optional. If you leave the index blank, sections appear in the order they are entered.
6. In the **Final** column, select a checkbox if you want the signature type to be considered as a final signoff. (Depending on the configuration, a final signoff may lock certain sections.)
7. When you have finished adding statuses click **Close**.

Note that no more than eight signature types should be configured.

Addenda Section

Create a standard comment for addenda

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Comment Text** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. Enter a standard comment in the **Description** column and then press Enter.
5. In the **Index** column, enter a number corresponding to the position of the item relative to others on the list and then press Enter.

   Tip: Include a zero before single-digit numbers (00, 01, 02, ...).

This step is optional. If you leave the index blank, sections appear in the order they are entered.

6. In the **Fields** column, select ASSESSED,ASSESS, and then press Enter.
7. When you have finished adding comments, click **Close**.

Risk Assessment Sections

Create a risk assessment type

To add a new risk assessment type, a database administrator must edit the database directly using an appropriate tool (such as Microsoft SQL Server Management Studio).

1. In the database table BODYSYSTEMEXAMTYPES, add a new row.
2. One of the body system exam types has the description "Unknown". copy the DBCDE for this entry to the new exam type and change the final digit to X, where X=1, 2, 3 etc. Do not use a value used by another exam type. the DBCDE must be unique.
3. In the **BODYSYSTEMEXAMTYPEDESC** column, type a description for the new exam type (this is the description shown in DB Editor).
4. In the **BODYLISTED** column, type 'Y'.
5. In the **GRAF** column, type 'Y'.

Create a risk factor for a risk assessment

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Body System Exams** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. Enter the name of the section and then press Enter.
5. In the **Body System Exam Type** column, select a risk assessment type and then press Enter.
   The risk factor will appear in any form based on the selected risk assessment type.
6. In the **Index** column, enter a number corresponding to the position of the section relative to others in the window and then press Enter.
   Tip: Include a zero before single-digit numbers (05, 01, 02, ...).
   This step is optional. If you leave the index blank, sections appear in the order they are entered.
7. In the **Points** column, enter the score associated with the risk factor. (Note that the maximum score you can have for a risk factor is 999.) The score is taken into account when at least one finding is documented for the risk factor. See also: Create a recommendation for the total risk assessment score on the Scoring page.
8. When you have finished adding section names, click **Close**.

Create a finding for a risk factor

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.

2. Double-click **Body_System Exam Items** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. In the **Description** column, enter the name of the finding and then press Enter.
5. In the **Body_System Exam** column, select the name of the corresponding section and then press Enter.
6. In the **Index** column, enter a number corresponding to the position of the item relative to others in the section and then press Enter.

   Tip: Include a zero before single-digit numbers (00, 01, 02, ...).

   This step is optional. If you leave the index blank, sections appear in the order they are entered.
7. In the **Exam Assessments** column, select **Finding** and then press Enter.
8. When you have finished creating findings, click **Close**.

Create a recommendation for the total risk assessment score

1. Click **Auxiliary Tables** on the left side of the main window in DB Editor.
2. Double-click **Risk_Assessment_Recommendations** on the list of database tables on the right side of the main window.
3. Click the **Add** button to add a new row to the table.
4. In the **Minimum** column, enter the lowest value in the score range for the recommendation and then press Enter.
5. In the **Maximum** column, enter the highest value in the score range and then press Enter.
6. In the **Recommendation** column, enter a recommendation of up to 255 characters and then press Enter.
7. When you have finished creating recommendations, click **Close**.

The recommendations you shape at the bottom of a form if the combined score for all risk factors (sections) on that form falls within the configured range.

Note that a recommendation applies to all risk assessments having the relevant score. To create an individual recommendation for each risk assessment, you must make sure the score for each risk factor is such that the combined score can only possibly apply to the assessment in question.

Example: Suppose you have two assessments, each with four risk factors: you give a score of 1 to each risk factor in the first assessment, giving a possible total score of 0, 1, 2, 3 or 4; you give a score of 10 to each risk factor in the second assessment, giving a possible total score of 0, 10, 20, 30 or 40. (The only score that can never be unique is 5.)

Create a new risk assessment form

The form will appear on the Navigation Bar and as a section of the Summary. Each form essentially consists of the following elements:

- A new section in the **eval** > **evalconfig** zone in Customize. (The easiest way to create this is by copying an existing risk assessment form section.)

  Settings in the section determines the following:
  - The vertical position of the form name on the Navigation Bar and Summary.
  - The risk assessment type. (To create a new type, see Create a risk assessment form on page 13.)
- A label for the form and the text to show in the status bar when the form is selected. These are specified in the following XML file using an XML editor:

  %ProgramFiles%\InterSystems\Ensemble\{Language}.xml

  Note: You have to distribute this file to all workstations that will need the new risk assessment form.
- Risk factors, findings and recommendations for the risk assessment type that you specified, using DB Editor.

1. Create a section for the new form in Customize

Prior to commencing the configuration you should obtain the DBCID of the risk assessment type on which the form will be based. A database administrator will need to identify this DBCID in the [redacted] table of the LIVR database using an appropriate tool (such as Microsoft SQL Server Management Studio).

The following procedure requires the Configuration Editor in Customize. For more information on using the Configuration Editor, see The Configuration Editor on page 33.

1. Open the Configuration Editor in Customize.
2. In the **eval** > **evalconfig** zone, copy the section of an existing risk assessment form and paste it into the same zone.

   A prompt will ask if you want to overwrite the existing section.
3. Click **No**.

   A new section will be created.
4. Rename the section however you like (the name only appears in Customize) and select the new section to see its entries in the right pane.
5. Double-click **Caption** and enter an identifier for that caption. Do not use spaces.

   Note: The identifier only appears in Customize and the language xml file, not in Proxy Manager. You must ensure it is not used in any other sections in the **eval** > **evalconfig** zone.

   Best Practice: Prefix the caption with "RAF:" to reduce the likelihood of conflict with an existing setting. For example, "RAF:Pulmonary".

8. Double-click **HelpCaption** and enter an identifier for the status bar text. The text must exactly match the text you entered for **Caption**, but with "StatusBarText" at the end. For example, "MAP.PatientsStatusBarText"

   Note: The identifier only appears in Customize and the language.xml file, not in Prezy Manager.

7. Double-click **XML** and locate theDBKSID number.

   Example
   ...<Protocol TYPE="**[redacted]**">...</Protocol TYPE>...

8. Replace the DBKSID with that of the risk assessment type that was provided by the database administrator.
9. Select the **eval** > **evalconfig** > **VerticalMenu**1 section to see its entries in the right pane.
10. Double-click **MenuItems** and add a list entry with the exact name of the new section you created for the form. Add the entry in the position that you want the form to appear on the Navigation Bar and Summary.
11. Double-click **AllowedMenuItems** and add a list entry with the exact name of the new section you created for the form. The position of the entry in the list is not important.

5. Create a label and status bar text for the new form

1. In Explorer, browse to the following folder:
   "c:\Program Files\InProcision\"
2. Locate the XML language file used by your installation and open it in a text editor or xml editor.

   Example: For US English installations, the file is USA.xml.

3. Search for **Zone Name="EntityCONFIG"**
4. Add the following text beneath the EntityCONFIG zone:
   <Entity Name="[Caption]" Type="STR" Value="[Form Label]" />
   Where [Caption] is the exact text you entered in Customize for the Caption entry, and [Form Label] is the text you want to see in Prezy Manager for the form (on the Navigation Bar, Summary, and form title bar).
5. Add the following text beneath the EntityCONFIG zone:
   <Entity Name="[HelpCaption]" Type="STR" Value="[Status Bar Text]" />
   Where [HelpCaption] is the exact text you entered in Customize for the HelpCaption entry, and [Form Label] is the text you want to see in Prezy Manager for the form (on the Navigation Bar, Summary, and form title bar).
6. Save and close the file.

6. Create risk factors, findings and recommendations for the new form

- Create risk factors, findings and recommendations for the form as needed. For more information see the following sections:
  - Create a risk factor for a risk assessment on page 226
  - Create a finding for a risk factor on page 228
  - Create a recommendation for the total risk assessment score on page 227

Auxiliary Tables Associated with Preop Manager

Note: Some of these tables are also associated with Anesthesia Manager, PACU Manager and Critical Care Manager.

TABLE	CONTENT
Allergies	List of possible allergies that a patient might have.
Allergy Types	Allergy classifications. Examples: Food, Environmental
Anesthesia Plan Types	Titles for the four 'Anesthesia Checklist' in Preop Manager (Anesthesia Plan section).
Anesthesia Plans	Entries for the 'Anesthesia Checklist' tables in Preop Manager form for documenting the anesthesia plan.
Anesthesia Types	Drop-down list entries for Preop Manager form for documenting the patient's surgical history.
Body System Exam Items	Entries for the 'Findings' tables in the forms for documenting physical examinations, medical history and risk assessments.
Body System Exams	Entries for the Preop Manager forms for documenting physical examinations, medical history and risk assessments. (New exams only appear in Preop Manager when items are added for them in the Body System Exam Items table.)
Common Text	Drop-down list entries for predefined comments in Addenda section.
Complications	Drop-down list entries for complications in past surgeries in the Surgical History section.
Home Medication Frequencies	Drop-down list entries for documenting medications being taken by patient at time of evaluation in the Home Medications section.

TABLE	CONTENT
Proxy Relevant Medications	Drug-down list entries for possible preoperative relevant for home medications.
Order Task	Diagnostic tests in the Tasks and Results section.
Risk Assessment Recommendations	Predefined recommendations associated with ranges of possible scores for a risk assessment. The text appears in the Risk Assessment form after completion of the assessment.
Route Types	Classifications that make administration routes easier to find in DB Editor fast used elsewhere.

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DB Editor and Clinical Content

Proxy Manager

13

DB Editor and Note Templates

About Publishing Note Templates

To enable a note template for use at workstations, it must be published using the Notes Manager window in DB Editor. Clinicians can then create notes based on the template.

Note that the term 'publishing' is used in two ways in the Prizi Notes System:

1. Publishing a template from InfoPath to a designated network folder to make it available to Notes Manager.
2. Publishing a template from Notes Manager to the database so that it becomes enabled for use at workstations.

This guide discusses publishing from Notes Manager. For information on publishing from InfoPath and on the Prizi Notes System in general, please see the *Template Design Guide for Notes*.

Accessing Notes Manager

All users with access to DB Editor can access the Notes Manager window.

1. Open DB Editor.
2. Under **File**, click **Notes Manager**, or click the Notes Manager toolbar icon.

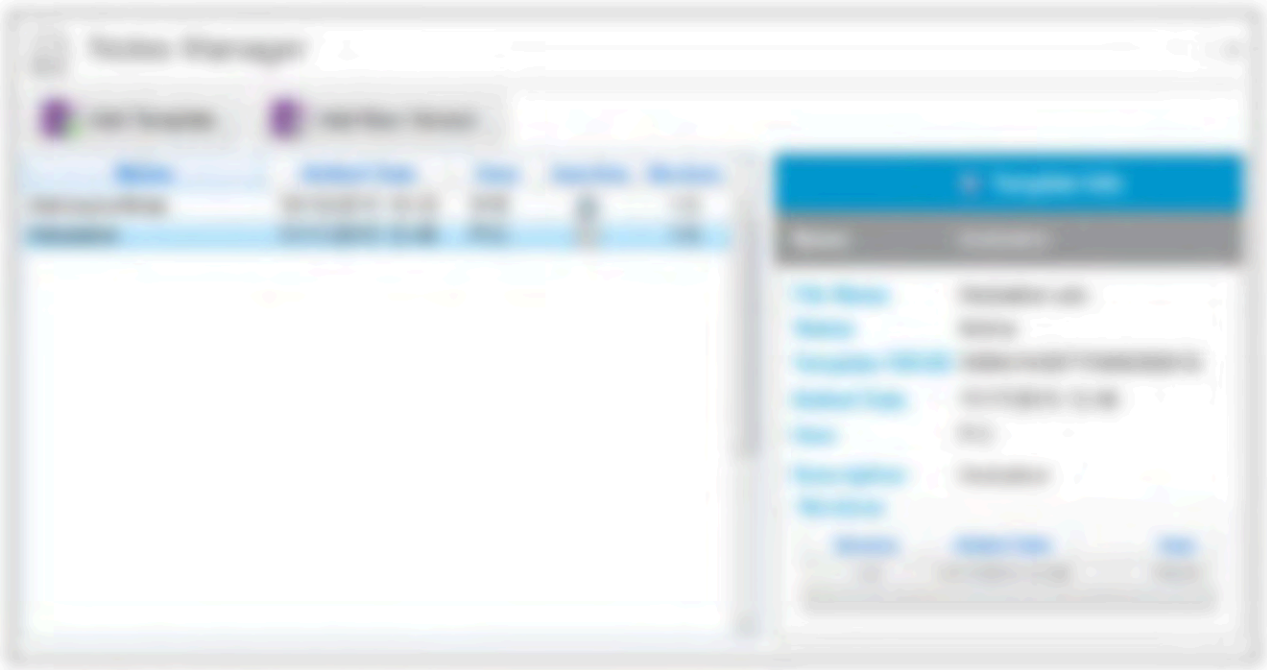


Figure 6 The Notes Manager window

Publishing a New Note Template

Publishing a note template makes it available in the Notes Editor window at workstations.

Note: Any template that you publish is displayed in Notes Editor even if you later inactivate it.

1. On the Notes Manager tool bar, click **Add Template**, and specify the requested information:
   - **File path**: click the folder icon and browse to the shared network folder where the template files are stored. (Template files have the extension `.ntxt`.) Select the template file that you want to make available.
     For more information, see the Template Design Guide for the Pilot Notes System.
   - **Name**: enter a name to identify the template to end users in Notes Editor. (Different versions of a template share the same Name.)
   - **Description**: enter a description for the template. This description is shown in the tooltip for the template in Notes Editor.
2. Click **OK**.
   Notes Manager uploads the template to the database. After uploading finishes, the new template is shown in the Notes Manager template list.

Versioning an Existing Note Template

You can create a new version of an existing template.

- A Notes Editor user can only create new notes with the latest version of a template.
- Notes created with the old version remain accessible for editing and viewing in Notes Editor.

Versioning a template is a two stage process: first you publish a new version of the template using InfoPath, and then you use Notes Manager to make the new version available at workstations.

Stage 1

1. Open the existing template in InfoPath design mode (for example, MyTemplate.xsn).
2. Update the template as required.
3. Under **File**, click **Save As** and type a new name to save the template. For example, MyTemplate_v2.xsn.

   Note: The new version template file name must be unique. It cannot have the same file name as any template already in the Prize Notes System.
4. Publish the new template from InfoPath.

Note: For the required version of InfoPath, see the Release Notes.

Stage 2

1. In the Notes Manager list of templates, select the template you want to upgrade.
2. On the Notes Manager tool bar, click **Add New Version**. The Template Properties window appears.
3. At the **File path** prompt, click the folder icon.
4. Browse to the new version of the template file in the shared network folder (for example, MyTemplate_v2.xsn) and select it.

   The name is not editable - it is the same name as the template you want to upgrade.
5. Enter a **Description** and click **OK**.
   - The added template file is published to the database.
   - After the upload completes, the new template version appears in the Notes Manager template list.

Note: If you click **Add Template** instead of **Add New Version** in the tool bar, the new version of your template is added as a new template in Notes Manager. If this happens, you must inactivate the old template version so that end-users cannot create new notes from it.

For more information, see the Template Design Guide for Notes.

Inactivating a Template

If you no longer want users to be able to create notes from a particular template, you should inactivate it. Inactivating a template does not affect notes that have already been started with that template. Draft notes can still be edited, saved, and finalized. Final notes can still be viewed and have comments appended to them.

Note: Any template that you publish is displayed in Notes Editor even if you later inactivate it.

1. In the Notes Manager list of templates, select the template you want to inactivate.
2. Select **Inactive** for the chosen template.

Common Choice Lists for Notes

A note template can include sections for showing data from physiologic variables or laboratory components. When creating a note the end user selects a 'common choice' list and data is retrieved for the items in that list.

'Common choice' lists are defined in OB Editor.

To create a common choice list for notes, on the **Create/Edit** menu, click **New Common Choice**.

Note: You cannot rename a common choice list after it has been created.

To edit a common choice list for notes, click the **Common Choices** folder in the main window. The right pane shows all common choice lists. Common choice lists for notes begin with 'ALL.NOTES'. Double-click the common choice list that you want to edit.

Note: Although common choice lists for notes are accessed via the Common Choices folder just like the lists for diagnoses, procedures and allergies, they are created differently and behave differently.
- Common choice lists for notes are available in all environments.

...End users select the list itself rather than an item from the list. Data is shown for all items from that list and new items cannot be added "on-the-fly".

Physiologic Variables

To create a common choice list of physiologic variables, click **Physiologic** at the top of the Common Choices window. You must specify one of the variables in the list as a "reference variable". The note will show the data for all variables from the database column that has the last value for the reference variable.

- The left pane lists the available items. The right pane lists items that have been selected for the common choice list.

  To select an entry, click the **Select** check box next to it. (As item moves to the right pane. (Items are added to this pane in the order they are selected.)
- The bottom right box shows the "reference variable". To define a reference variable, highlight an entry in the right pane and then click **Select**.
- **Remove**. Removes the selected item from the right pane. (You can also remove an item by clearing the check box for it.)
- **Clear**. Removes all items from the right pane.
- **Up and Down arrows**. Establish the sort order on the right pane. This dictates the order in which the data is displayed in the note.
- **Save**. Saves the common choice list and closes the window.
- **Cancel**. Closes the window without saving.

Laboratory Components

To create a common choice list of laboratory components, click **Laboratory** at the top of the Common Choices window.

- The left pane lists the available items. The right pane lists items that have been selected for the common choice list. To select an entry, click the **Select** check box next to it. the item moves to the right pane. (Items are added to this pane in the order they are selected.)
- **Remove**: Removes the selected item from the right pane.
- **Clear**: Removes all items from the right pane.
- **Up and Down arrows**: Establish the sort order on the right pane. This dictates the order in which the data is displayed in the note.
- **Save**: Saves the common choice list and closes the window.
- **Cancel**: Closes the window without saving.

Appendix A: Report Templates (RPT files)

Creating Report Templates

Note: Besides creating your own Crystal Report templates Prism has a number of standard templates available for purchase. Please contact your Prism representative for more information.

Report templates should be created using Crystal Reports 11.5 by implementation staff who are experienced with the Prism database structure and with Crystal Reports.

At run time the following application parameters are passed to the report document and can therefore be used as standard filters in report templates as needed.

- AdmissionID(text)
- Admit1 (only if the report is opened from AnesthesiaManager, PACU Manager or Critical Care Manager. Note that this parameter does not always exist for an admission.)
- EncounterID(text)
- PatientID(text)
- ProcDetailID(text)
- Prn1
- StaffID(text)
- Staff#1
- UserName

- PrevqEffectd (when the report is opened from Prevq Manager)

To be able to use the application parameters, a set of parameter fields must be created with the exact names specified above. (Henceforth, these will be referred to as "Prvtx parameter fields".) DBKIDfx must be configured as type "numeric"; all other Prvtx parameter fields must be configured as type "string". After a Prvtx parameter field has been created you can "bind" it to a report element. When you bind a parameter it acts as a filter for the data returned by that element.

Note: You must not place Prvtx parameter fields in the report layout directly; they should not be used as visual layout design elements.

Reports can have as many subreports as needed. However, subreports beneath a subreport are not supported. (This is a Crystal Reports limitation.)

A report can only link to a single database. If links to multiple databases are needed a subreport must be created for each.

Links to the following databases are supported:

- CAR (the default if no database is specified)
- PDM
- IDB
- TMS
- QMO
- DRM
- EAT_BCS
- EAT_AIS
- EAT_DB
- EAT_CC
- EAT_DB_AIS
- EAT_DB_STG
- RRQ

Reports will link to the CAR database unless one of the other databases is instead specified in a parameter field named DATABASE. If the DATABASE parameter field exists then at run-time Crystal Reports will look in the specified database for tables, stored procedures and views used in the report.

Reports and subreports can have different DATABASE configurations. For example, the report may have a parameter field named DATABASE that points to the PDM database while a subreport has a parameter field named DATABASE that points to the DRM database.

Pivot parameter fields can be used with stored procedures. The parameter fields must be defined within the stored procedure itself - they get added to Field Explorer automatically when the stored procedure is added to the report. In stored procedures, Pivot parameter fields must be declared as type VARCHAR(8K) and explicitly cast prior to their use. The parameter fields must be used using the following syntax:

SET @**parameter** = CONVERT(VARCHAR(8K),[x,y,...])[@**parameter**],'|')[x,y,...]

(Note that the quotes at the end are as follows: single quote then double quote then single quote then comma then space then two single quotes).

The following example shows a stored procedure in which the Pivot parameter field **PatientStock** is first declared, then cast, and then used:

CREATE PROCEDURE sp_GetTestProcedure
(@**PatientStock** VARCHAR(8K))
AS
SET NOCOUNT ON
SET @**PatientStock** = CONVERT(VARCHAR(8K),[x,y,...])[@**PatientStock**],'|')[x,y,...]
SELECT * FROM Patient WHERE Stock IN (@**PatientStock**)

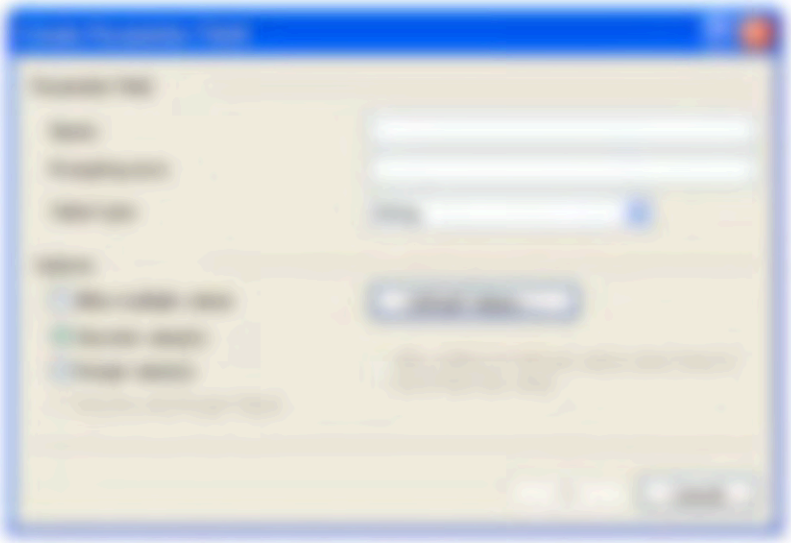
Parameter fields that have been added to the report as part of a stored procedure appear in Field Explorer with an @ character at the beginning of the name. Because of this it is completely valid to have the same parameter appear twice in Field Explorer, like this:

(This screenshot shows the English language version of Crystal Reports. Your version may be localized.)

The following procedures for creating Pivot parameter fields and binding them to report elements provide basic guidance only. For more information on creating a report, please consult the documentation/help that comes with Crystal Reports.

Create a Pivot parameter field

1. In the Field Explorer, right-click **Parameter Fields** and select **New**.
   A window such as the following opens:



(This screenshot shows the English language version of Crystal Reports. Your version may be localized.)

2. In **Name**, type the exact name expected by the application (see the list near the beginning of this section). For example, PatientAbout.
3. In **Value type**, select "Number" if the parameter is a DBKEY, otherwise select "String".
4. Leave the other settings at their default values and click **OK**.

Use a Pivio parameter field in a report

1. Right-click the entity that you want to limit to a Pivio parameter field and then click **Select Expert**.
2. In the window that opens, click **Show Formula**.
   A new pane appears at the bottom of the window.
3. Click **Formula Editor**.
4. In the left pane of the window that appears, click **Record Selection**.
5. In the right pane, enter the formula for the report element.
6. Add the Pivio parameter field as a filter for the data retrieved by the formula.
   To do this add an equals sign to the right of the formula followed by
   If the parameter field is a DBKEY it must be used with the cdbl function, as shown in the following example:
   cdbl( ) = **cdbl**( )
   In this example **cdbl**( ) is the existing to the database field and to the context parameter field.

Note: A tick appears next to the name of a parameter in the Field Explorer when it is used in a report.

Link a report or sub-report to a specific database

1. Open the report or sub-report.
2. In the Field Explorer, right-click **Parameter Fields** and select **New**.
3. In **Name**, type DATABASE.
4. In **Value type**, select "String".
5. Click **Default Values**.
6. In the window that appears, type the database name (for example, CRMD) in the left pane under **Select an order value** and click > to move the value to the right pane.

   Note: You should only define a single value.
7. Click **OK** to return to the original window.
8. Leave the other settings at their default values and click **OK**.

Installing Reports

To be available to end users, reports (RPT files) must be installed either locally at the workstations that need them or in a shared network folder. For more information, see Reports on page 219.

Note: The report names that end users see are the filenames but without the RPT extension.

A

Appendix A: Report Templates (RPT files)

Installing Reports

B

Appendix B: Global Configuration Parameters

About Global Configuration Parameters

The following table lists the parameters in the Configuration Parameters auxiliary table in CM Editor. Most parameters are described in this guide. In such cases, cross references are included. Parameters related to specific interfaces are described in the interface documentation.

(Entries are sorted by their CMOVE database identifier number.)

Configuration Parameter	Where is it described?
AGT_OutAccount	Documentation for the AGT_OutAccount interface
AreaPhoneLength required in Supply Billing	Not used in this version
AuthenticationByPasswordAllow	Directory Services Authentication on page 275
CCCBK admission key	Not used in this version
CCCBK admission key field	Not used in this version
CCCBK booking key	Not used in this version
CCCBK case key	Not used in this version

B

Appendix B: Global Configuration Parameters

About Global Configuration Parameters

Configuration Parameter	Where is it described?
CCOW: encounter key	Not used in this version.
CCOW: patient key	Not used in this version.
CCOW: patient key: field	Not used in this version.
CCOW: user key	Not used in this version.
CCOW: user key: field	Not used in this version.
CDI: eClinicalr Data Interface: Outbound	Not used in this version.
CrystalReports: Notify: ASE	Reports on page 279
CrystalReports: Prompt: Save	Reports on page 279
CrystalReports: Reports: Path	Reports on page 279
CrystalReports: Save: Path	Reports on page 279
Default: preferred: language: code	Demographics on page 322
Demo: Mode: Indicator	For internal use only. Do not modify.
Disable: creation: of System Events: Audit: Trail	Audit Trail on page 271
DNS: Server	(Not currently used. Reserved for future use.)
Enable: BreakGlass: button	For internal use only. Do not modify.
Enable: ChangePatient: button	For internal use only. Do not modify.
Enable: ClosePrelnfoession: button	For internal use only. Do not modify.
Enable: LinkPrelnfoession: button	For internal use only. Do not modify.
Hours: to: disable: Note: editing: after: Admission: End	(Not currently used. Reserved for future use.)
Interaction: checking: Display: Allergy: Reactions: option	Not used in this version.
Interaction: checking: enabled	Not used in this version.

Configuration Parameter	Where is it described?
interaction checking severity level	Not used in this version.
ldap filter setting	Directory Services Authentication on page 279
ldapAuthEnabled	Directory Services Authentication on page 279
ldapAuthenticationType	Directory Services Authentication on page 279
ldapAuthSingleDomain	Directory Services Authentication on page 279
ldapDirectoryPath	Directory Services Authentication on page 279
Max number of failed logons before user is locked out	Password Parameters on page 279
Name of the integrated DR Manager .fdr file	Not used in this version.
Password expiration period in days	Password Parameters on page 279
Password maximum length	Password Parameters on page 279
Password minimum length	Password Parameters on page 279
Password must be alphanumeric	Password Parameters on page 279
Password reuse count restriction	Password Parameters on page 279
PCM Administrator Listener	PCM documentation
PCM XLT run Remoting endpoint	Technical Reference Guide
Pentaj integration	Not used in this version.
Prompt for LockPostAdmission during Admit	For internal use only. Do not modify.
ShareFrom Node Web Viewer	(Not currently used. Reserved for future use.)
ShareFrom Site for Node Templates	(Not currently used. Reserved for future use.)

Appendix B: Global Configuration Parameters

About Global Configuration Parameters

Configuration Parameter	Where is it described?
SharedPoint Site Library for Notes	(Not currently used. Reserved for future use.)
SharedPoint Site Library for Provider Notes	(Not currently used. Reserved for future use.)
Show warning message for patient access. N=Never, A=Always, U=For UP patients only.	This parameter has been replaced by new functionality and is now obsolete. (The value has no effect.) For the new related functionality, see Privacy Messages on page 251.
Show warning message n days before password expires	Password Parameters on page 279
Temporary password expiration period in hours	Password Parameters on page 279
Use MedMech passwords	Documentation for MedMech integration
HSTA Namespace (obsolete)	This parameter was intended for VA sites running version 5.1 only and is now obsolete.

C

Appendix C: Auxiliary Database Tables

List of Auxiliary Database Tables

The list below shows all tables in the Auxiliary Tables section of DB Editor.

- Admission Types*
- ADT Status
- Anxiety Classes
- Allergies*
- Allergy Types*
- Ambulatory Status*
- Analytes
- Analytes (Microbiology)
- Anesthesia Plan Types
- Anesthesia Plans
- Anesthesia Types
- Application Roles
- Applications
- ASA Types*

C

Appendix C: Auxiliary Database Tables

List of Auxiliary Database Tables

- Assessment Items
- Attending Types*
- Blood Groups
- Body System Exam Items
- Body System Exams
- Categories
- Category Types
- Chief Complaints*
- Clinical Priorities*
- Common Text
- Complications
- Components (Laboratory)
- Components (Microbiology)
- Concept Identifiers (Clinical Data Interface)
- Configuration Parameters
- Countries*
- Departments
- Diagnoses*
- Diagnosis Functional Types*
- Diagnosis Types*
- Discharges
- Environment Type Groups
- Environment Types
- Ethnicities*
- Event Types
- Events
- Facilities
- Facility Groups
- Family
- Family Behavior
- Form Types

- Forms
- Group Mappings
- Home Medication Frequencies
- Home Medication Status
- Insurance Companies*
- Insurance Company Types*
- Kin Type*
- Laboratory Data Status
- Laboratory Rooms
- Laboratories*
- Markets*
- Medical Procedure Functional Types*
- Medical Procedure Types*
- Medical Procedures*
- Medications*
- NoteTypeBlocks
- NoteTypes
- Order Task Status
- Order Task
- Order Types
- Part Components
- Parts
- Periods*
- Physiologic Variables
- Precautions*
- Precaution Types*
- Preferred Language*
- Prep Instruction Types
- Prep Instructions
- Prep Record Status
- Prep Statuses (Medications)

C

Appendix C: Auxiliary Database Tables

List of Auxiliary Database Tables

- Races*
- Reaction Types*
- Reactions*
- Religions*
- Risk Assessment Recommendations
- Route Types*
- Routes*
- Score Groups
- Sexes*
- Signoff Types
- Sites*
- Source of consent*
- Staff Types*
- Standard Coding for Assessment Items
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- Standard Orders
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Appendix D: Supported CNE Codes & Laboratory Components for Rule Based Sepsis Notifications

This appendix shows the supported laboratory components and CNE codes (for physiologic variables) that can be used in a hospital's sepsis rule. For more information, see Rule Based Notifications for Sepsis on page 31 and Rule Based Notifications for Sepsis on page 218.

Each section provides a list of CNE codes that can be used for the variables in question. Within each list the codes are ranked. If data is provided for more than one CNE code, the notification system uses the highest ranking CNE code.

Note: Short and Long Names are included for reference purposes only. Exact names depend on the configuration at each hospital.

Heart Rate - Pulse

1. 801 HR Heart Rate
2. 804 PULSE Pulse Rate from IMBP
3. 803 PULSOX Pulse Rate Pulse Oximeter
4. 802 PULSE Pulse Rate BP Training
5. 805 PULSEV Pulse Rate from CVP
6. 806 HRIMBP Heart Rate IMBP
7. 807 HRd Heart Rate Duplicate
8. 820 PULSE1 Pulse Rate 1 (Invasive)
9. 826 PULSE2 Pulse Rate 2 (Invasive)
10. 187 PULSE2 Pulse Rate from Sp02 Duplicate

Appendix D: Supported CNL Codes & Laboratory Components for Rule-Based Sepsis Notifications

11. 3843 LabPR Lrt Pulse Rate
12. 3846 MBPR MPR Pulse Rate
13. 4136 PULS_B BAP Pulse Rate
14. 4141 PULS_T TAP Pulse Rate
15. 4132 FAPR Fm Pulse Rate
16. 4135 ApPR Aortic Pulse Rate

Systolic Pressure

1 1. 3110 NISBP Non-Invasive Syst. Art. P
2. 3131 SPa Systolic Pressure (Art.)
3. 3861 SPa2 Systolic Pressure (Art.) 2
4. 3863 SPa3 Systolic Pressure (Art.) 3
5. 3320 SPu Systolic Pressure (Pul)
6. 3172 NISBPD Non-Invasive Syst. Art. P dup
7. 3864 pAWTS pAWT Systolic, PIGGS
8. 3430 B_3115 BAP Systolic, Channel
9. 3186 CNAPS Cont Non-invasive Art Pres Systolic
10. 4036 FmArtS Femoral Arterial Pressure (Systol.)
11. 3001 LnACu Umbilical Arterial Catheter system
12. 3114 NISBPh Non-Invasive Syst. P sPa
13. 3186 CNAPS Cont Non-invasive Art Pres Systolic

Mean Arterial Pressure

1. 3115 NIMBP Non-Invasive Mean Art. P
2. 3112 MAP Mean Arterial Pressure
3. 3862 MAP2 Mean Arterial Pressure 2

Oxygen Saturation

1. 130 SpO2 Pulse Art. O2 Saturation
2. 867 SpO2D Pulse Art. O2 Saturation dup
3. 870 SpO2_2 Pulse Art O2 Saturation_2
4. 3031 ROSR Regional O2 Saturation Right Ch 1
5. 3071 ROSL Regional O2 Saturation Left Ch 2

6. 474: 4532-3 Regional O2 Saturation-Ch 3
7. 478: 4532-4 Regional O2 Saturation-Ch 4

Respiratory Rate

1. 389: Resp_cnt# Monitor Respiratory Rate per min
2. 100: Resp_cr Vent Resp Rate/min (total)
3. 106: SPR Spontaneous Resp. Rate
4. 183: Intake Vent Resp Rate/min Setting
5. 867: SpFreq Spontaneous Frequency
6. 478: Respiratory Rate Actual

FiO2

1. 136: FiO2 Inspired Oxygen %
2. 137: FiO2cc Inspired O2 Non Ventilated
3. 116: FiO2/5 FiO2 Set
4. 891: SetO2/2 O2 concentration - set
5. 180: O2_F1 O2 Flow

Temperature

1. 348: Temp1? Temporal Temperature
2. 351: TMP1 Temperature Site 1
3. 352: TMP2 Temperature Site 2
4. 353: TMP3 Temperature Site 3
5. 354: TMP4 Temperature Site 4
6. 338: TMP5 Temperature Site 5
7. 352: TMP6 Temperature Site 6
8. 340: CTMP Core Temperature
9. 350: TMP Temperature
10. 355: BLTMP Blood Temperature
11. 356: TcTMP Transcutaneous Temp
12. 357: RcTMP Rectal Temperature
13. 352: TMPTYM Tympanic Temperature
14. 358: TMPBLA Bladder Temperature

Appendix D: Supported CWL Codes & Laboratory Components for Rule-Based Sepsis Notifications

15. ISIP: TMPAX: Axillary Temperature
16. IBIO: TMPNCo: Temperature Nasal-Core
17. IBIS: TMPNP: Temperature Nasal-Pharyngeal
18. IAB: Temp: Temporal

Laboratory Results

For the following Laboratory Components below, the results provided as Lab Components will be used:

- Lactate: (with CBKXR: [redacted])
- PaO2/Q: (with CBKXR: [redacted])
- WBC: (with CBKXR: [redacted])
- Band Neutrophils: (with CBKXR: [redacted])

Best Practice

Associate these components with a new analyte called "Sepsis"

1. In the Analyte table, add the analyte "Sepsis"
2. In the Parts table, add the part "Sepsis", associating it with the "Sepsis" analyte.
3. In the Part Components table, add the following rows:

PART	COMPONENT
Sepsis	Lactate
Sepsis	Band Neutrophils
Sepsis	WBC
Sepsis	PaO2/Q

Appendix E: Localization

About Localization

Philips provides versions of Philips Manager, Anesthesia Manager, PACU Manager, Critical Care Manager, and their associated configuration tools in various languages.

The text "strings" needed for these languages are already included in the installation, but need to be enabled by setting a configuration set parameter.

Note: Diagnostic tools are only available in English.

After installing the software and enabling the language, some elements of the system still appear in English prior to modifying templates. To achieve a 100% localized installation, certain items in the default templates must be translated or removed.

You can switch between supported languages using the Configuration Editor. (See The Configuration Editor on page 10-1.)

Wizard	Screen	Section	Entry
LPQWIN	Processor	Language	Extensions

Possible Values
Any supported 2-letter language identifier
Example: For Spanish installs, enter SPA
The list of supported languages depends on the software version. Please consult the Release Notes for more information.

Template Items to Translate

The following items correspond to parts of the patient chart that are defined in the sample custom templates.

- Names of custom flowsheets and trends. (Names for the four standard flowsheets are part of the standard interface.)

  See: Create or edit a custom flowsheet and set basic properties on page 130 **and** Create or edit a trend for use on any flowsheet on page 134

- Names for custom screen layouts.

  See: Quick Links on page 139

- Names of timers, quick link programs and macros.

  See: Change a timer window title and/or command on page 194, Configure a macro as a quick link on page 121, **and** Configure an external application as a quick link on page 139

- Tooltips for all buttons.

  See: Edit the properties of buttons on the Home ribbon on page 196

- Titles, section headings and description text for all flowsheets.

  See: Create or edit a custom flowsheet and set basic properties on page 130, **and** Create or edit a custom flowsheet and set basic properties on page 130

- Trend titles and the labels for physiologic variables in the legend.

  See: Create or edit a trend for use on any flowsheet on page 134

- Names of Note Types in the Patient Summary.

  See: Create or modify a note type on page 249

- The printout for preoperative instructions in Preop Manager.

  See: Preop Manager Configuration on page 251

Appendix F: Improving Access to Picos Products

Configuring Easy Access to Picos Products

You can add Picos application icons to the bottom of the screen to make the products more accessible.

Add a Picos application icon to the taskbar

- Click **Start**, find and right-click the application's icon and then click **Pin to Taskbar**.

  – or –

- Drag the program's shortcut from the desktop or Start menu to the taskbar.

See the operating system help file for more information.

G

Appendix G: Locally-Stored Configuration Settings

About Locally-Stored Configuration Settings

Configuration Sets are stored in the database. This includes all templates and most workstation settings. However, some configuration settings continue to be stored locally at each workstation as follows:

Setting Type	Files	Notes
"Language Files" for localized GUI text	%ProgramFiles%\Pro\bin\<Language Extension>.xml **Example:** Spanish GUI text is stored in the file sPro.xml.	There is one XML file for each supported language. The XML file used by the workstation depends on a "Language" setting. (For more information, see the Workstation Installation Guide.)

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Appendix G: Locally-Stored Configuration Settings

About Locally-Stored Configuration Settings

Setting Type	Files	Notes
Device drivers	Device driver files are in the following folder: %ProgramFiles%\Pro2\Drivers.net\Device	
Perfect Trace settings	%ProgramFiles%\Pro2\storage\ptusersettings.config	
XB Editor settings	%ProgramFiles%\Pro2\bin\XBTouchUp.xml	**CAUTION:** These settings should only be changed by Pro2 staff
Other application settings	For example, files with the extension CONFIG in the following folder: %ProgramFiles%\Pro2\bin	Some setting files are intended for use by Pro2 staff only. **CAUTION:** You should only change settings that are documented here or in another Pro2 guide.

Appendix H: The Export Tool for Quality Measures

The Export Tool allows the user to export data from all quality measure form submissions in the hospital for a specific form versions and date range. Data is exported as a single XML file that conforms to AQI's NACOR XML 2019 schema and Relaxng rules.

The tool is installed on all workstations and can be used by staff with the "Export Tool User" right.

Required Patient Chart Data for AQI NACOR submissions

For AQI Nacor reporting, the following data is required in all patient charts for which quality measure data is submitted. (This data must be present in the chart at the time the form is submitted.)

- Sex
- DOB
- At least one Medical Team member with the following data:
  - Staff ID (1 to 9 digit numeric value). This corresponds to the "Other User ID" field in the DB Editor window for configuring user profiles.
  - Staff ID (1 to 10 digit numeric value). This value cannot be entered via Picis software. It must be entered directly in the CIHI database using SQL Server Management Studio (STAFF table, STAFFCD column).
  - Attending Type cased in the case) or Clinical Role

    The attending type or clinical role must be one of the following: Anesthesiologist, Certified Anesthesiologist Assistant, Certified Registered Nurse Anesthetist, Fellow Anesthesiologist, Surgeon, Advanced Practice Nurse, Physician Assistant, Registered Nurse, Resident Anesthetist, Student Registered Nurse Anesthetist, Dentist or Oral Surgeon, Podiatrist, Dentist Anesthesiologist, Dentist Anesthesiologist Resident

H

Appendix H: The Export Tool for Quality Measures

Attending type is checked first. If a match to a valid name is found it is used; otherwise, the clinical role is used.

(Note that the report includes data for all medical team members.)

- At least one Anesthesia Start – Anesthesia Finish event pair.
- At least one event of type AnesthesiaType documented between the Anesthesia Start and Anesthesia Finish events.
  The event must have one of the following descriptions: Neuraxial, General Anesthesia, Monitored Anesthesia Care, Peripheral Nerve Block, No Anesthesia Provided, Unknown
- ASA Type (which can be "Unknown").
- Insurance Company.
  The Insurance Company must be one of the following: Commercial, Government: Medicare Fee for Service – Part A, Government: Medicare Fee for Service – Part B, Government: Medicare Fee for Service – Part C, Government: Medicaid, Government: Military/Veterans, Government: Other, Worker's Compensation, Self-Pay, Charity, Other, Unknown

Note: Insurance Company data is entered in the Billing section of the Demographics module. If an actual insurance company name is entered, this is exported in the report as Unknown.

Best Practice: At workstations where Quality Measure forms will be submitted, set the MACCRA required data types as "Required".

Note: Required data that is automatically present in all patient charts is not listed here. For the full specification, please visit the ASA website.

Optional Patient Chart Data for ASA MACCRA submissions

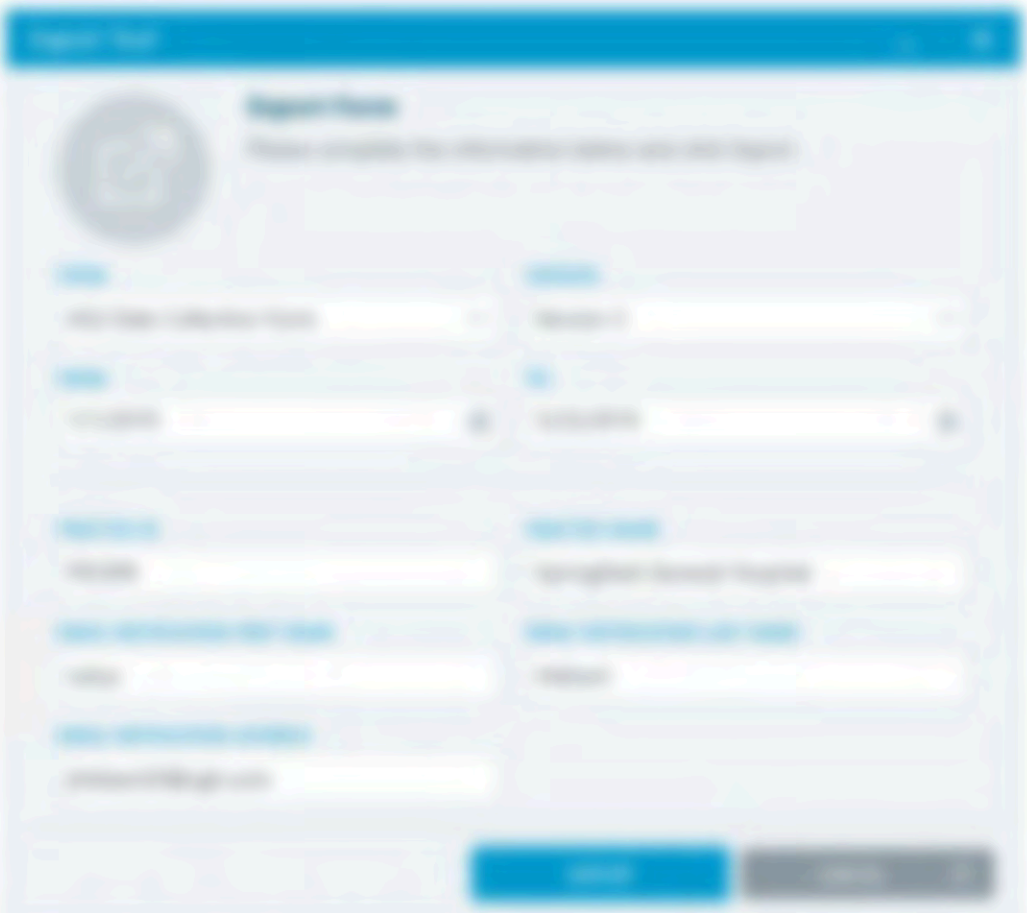
The following data will form part of the report, but is optional.

- City
- ZIP Code
- Admissions Height
- Admissions Weight

Using the Export Tool

Start the Export Tool

1. Navigate to the "bin" folder of the Prizz installation using Windows Explorer.
2. Double-click the file **ExportTool.exe**.
3. Log in to the Export Tool.



Example of the Export Tool window

Notes:

- All fields in the window are mandatory.

H

Appendix H: The Export Tool for Quality Measures

- The "Form" field is populated with all forms for which there has been at least one submission (including deleted forms).
- After selecting a form, the "Version" field is populated with all versions of the selected form for which there has been at least one submission.
- The "From" and "To" fields define the date range for the export.
  The report includes every form submission associated to an encounter that ended within the selected date range.

  Example: A form is submitted on January 10 and the same encounter ends on January 15. In the Export Tool, the "To" field is set to January 12. Result: The submitted form is not included in the XML report.

Create a NAACCR-compliant XML report

1. Select a **Form**.
2. Fill in all other fields.
3. Click **Export**.
4. Browse to the folder where you want to save the file.
5. Click **Save**.

The report is saved with a NAACCR-compliant filename.

Example: PELVIS2.XML_20200704PT124614.1_20180814EL001.NAACCR.xml

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