Note this document was generated from an archived project with the trial version of MadCap Flare, so text is scrambled.

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 *Releare Notes* for date of lanufacture.

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CE 0123

Unipue Device Identifher (UDI)	For UDI infoqmation, refer to thd *Release Notes*.

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1

Introduction

Overview

This manual describes the configuration of [illegible] Manager, Anesthesia Manager, PACU Manager and Critical Care Manager. [illegible] You can customize [illegible] application and the contents of the database to support the practices of individual departments or caregivers.

This 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 [illegible] database and for maintaining application security in systems that do not integrate with [illegible].

  > **Note:** [illegible] is the name that is the database used by [illegible] Manager, Critical Care Manager, Anesthesia Manager and PACU Manager.

- **ADT Administrator:** For configuring Census List windows for the different applications. [illegible] 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.

[illegible]

[illegible]

What's New

New in Picis 10C

[illegible]

For more information, see:

[illegible]

[illegible]

Background Concepts

Orders Integration

[illegible]

Multibed Workstations

[illegible]

[illegible]

[illegible]

Note: [illegible]

Remote Access Type

[illegible]

[illegible]

2

Customize

Customize Overview

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

- Creating "opinion models"
- Cloning 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 printouts for configuration sets.)

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

Nomenclature

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

Application Templates are settings used by Anaesthesia 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 Anaesthesia 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 Product > 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** is present.

Exit Customize

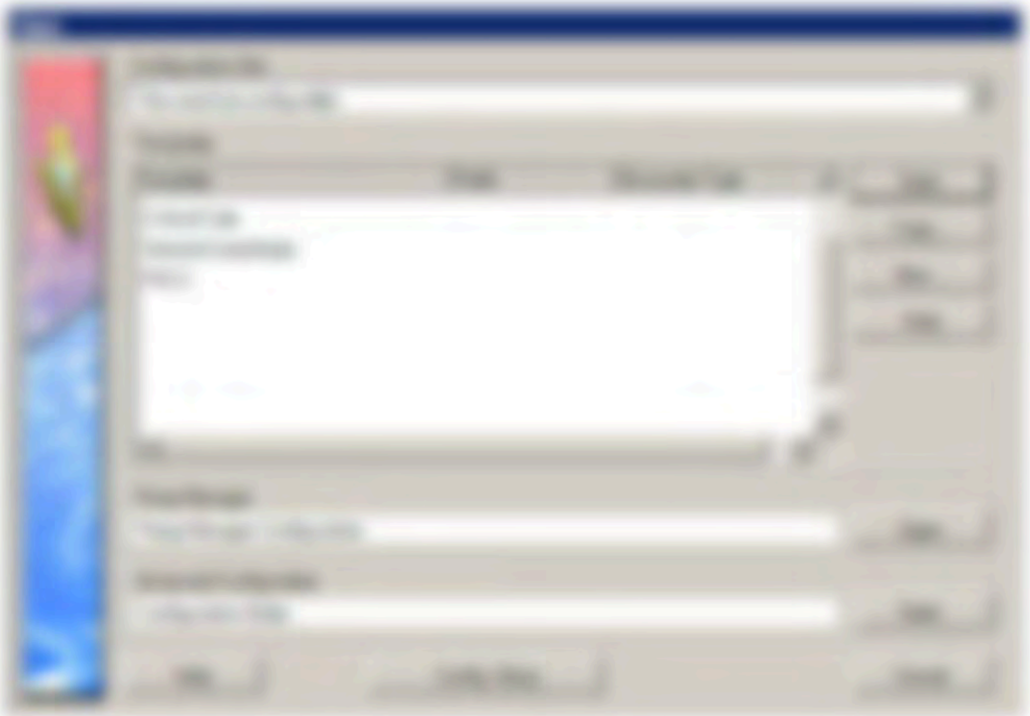
- On the **File** menu, click **Exit**.

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 27.

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



[illegible]

Element	Description of use
Configuration Set	[illegible]

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 act on machines linked to the selected configuration set. Note that besides template-specific settings opening any templates 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 on machines linked to the selected configuration set. For more information, see Hiding Templates on page [illegible]. **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 [illegible] on page [illegible].
Proxy IP login "Open" button	After selecting a configuration set, you can click this button to edit Proxy IP login 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 [illegible].
- Create a new template. For more information, see Working With Templates on page [illegible].
- Create a copy of a template. For more information, see Working With Templates on page [illegible].
- Edit workstation settings. For more information, see Workstation Configuration on page [illegible].
- Edit Proxy Manager settings. For more information, see Proxy Manager Configuration on page [illegible].

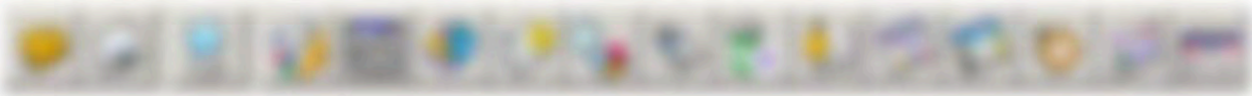
> **Note:** Prior to any of these actions you must first select an appropriate configuration set from the drop-down list.

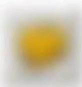
Setting up workgroups and configuration sets - what you can do

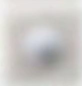
- Create workgroups and assign computers to them. For more information, see Creating and Editing Workgroups on page [illegible].
- Create/edit configuration sets and assign them to workgroups. For more information, see Creating, Editing and Assigning Configuration Sets on page [illegible].

The Customize Toolbar

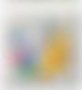
After opening a new or existing template the following toolbar is available:



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

 Saves any changes made to the open template and sorted list settings.

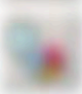
 Advanced Settings window. (For more information, see The Advanced Settings Window on page [illegible].)

 Configure Test Parameters (opens to the Preferences tab).

 Physiologic Variables

 Protocols

 Events

 Fluid Balance

 Patient Summary

 Medication Summary

 Demographics Editor

 Trends

 Flowsheets

 Timers

 Quick Links

 [illegible]

3

Configuration Sets and Workgroups

About Configuration Sets and Workgroups

Configuration sets

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

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

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

1. Picis default configuration.

   Contains all required entries with their respective default values. The Picis default configuration cannot be edited.

2. Hospital configuration.

   Used for general hospital settings that differ from the Picis 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 Customize.

[illegible]

Note: [illegible]

Note: [illegible]

[illegible]

Note: [illegible]

Configuration set versions

[illegible]

[illegible]

Note: [illegible]

⚠ **CAUTION:** [illegible]

The Hospital Configuration

[illegible]

Best Practice: [illegible]

"This Machine Configuration"

[illegible]

a. [illegible]
b. [illegible]
c. [illegible]
d. [illegible]

Workgroups

[illegible] **Workgroups** [illegible]

- [illegible]
- [illegible]

Note: [illegible]

Note: [illegible]

Note: [illegible]

Examples

[illegible]

Example 1

Configuration set	Value of [illegible]
[illegible] default	[illegible]
[illegible]	[illegible]
Configuration Set A	not set
Configuration Set B	not set
Local [illegible]	not set

Result: The value "X" gets applied to the workstation.

Example 2

Configuration set	Value of a certain parameter
Philips default	X
Hospital	H
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
Philips default	X
Hospital	H
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
Philips default	X
Hospital	H
Configuration Set A	A
Configuration Set B	B
Local workstation	W

Result: The value "W" 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 [illegible] system right is required for these tasks.

For information on creating and editing configuration sets, see [illegible] Configuration Sets on page [illegible].

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

Best Practice: Create a workgroup named [illegible] for [illegible] workstations that are no longer used. Do not assign any configuration sets to this workgroup.

Best Practice: Create a workgroup named [illegible] for [illegible] workstations that only have [illegible] programs installed. Do not assign any configuration sets to this 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 View the computer/workgroup assignments on the previous page.
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 View the computer/workgroup assignments on the previous page.
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.

6. 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 View the computer/workgroup assignments on page [illegible].
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 View the computer/workgroup assignments on page [illegible].
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:

- View 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
- Download a configuration set
- Edit a configuration set

- [illegible]
- [illegible]

[illegible]

Note: [illegible]

Best Practice: [illegible]

Best Practice: [illegible]

Best Practice: [illegible]

CAUTION: [illegible]

View configuration sets and their assignments to workgroups

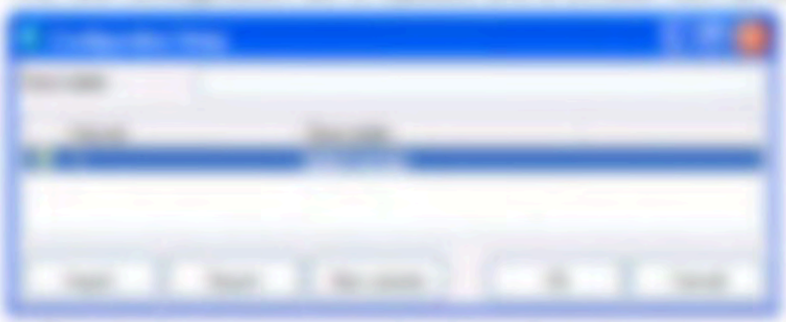
1. In the "Open" window, click **Config. Setup**.
2. Click the **Configuration Sets [illegible] Workgroups** tab.
   [illegible]
3. [illegible]
4. Click **Close**.

Create a configuration set

1. In the "Open" window, click **Config. Setup**.
2. [illegible]
3. [illegible]
4. Click **Add**.

5. To start with a blank configuration set (based on the Pivot 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 View 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 [illegible].
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 pages 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 [illegible].
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 [illegible].
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 option 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 to workgroups on page [illegible].
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 session 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 linked, you will be given a warning message indicating that any edits you make will affect any [illegible] linked to the configuration set.

  You have the following options:
- Edit a template. For more information, see What You Can Configure on page [illegible].
- Create a new template. For more information, see Working With Templates on page [illegible].
- Create a copy of a template. For more information, see Working With Templates on page [illegible].
- Edit workstation settings. For more information, see Workstation Configuration on page [illegible].
- Edit Privacy Manager settings. For more information, see Privacy Manager Configuration on page [illegible].

Note

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

- **Use Graphical 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 [illegible] Administrator to create sensor lists and link them to configuration sets. For more information, see** [illegible] on page [illegible].

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 View configuration sets and their assignments to workgroups on page [illegible].
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 >>.

   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: [illegible] 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 sets in 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're applied.
7. Click **Close**.

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

- [illegible] Workgroup
  - 1 - HR Dept Configuration Set
  - 2 - [illegible] Configuration Set
- [illegible] Workgroup
  - 1 - HR Dept Configuration Set
  - 2 - [illegible] Configuration Set

Remove configuration sets from workgroups

1. In the "[illegible]" 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 [illegible].
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.

5. 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.

6. 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 set to "CW". If it is set to this value, 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 version 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 if 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 values 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 XY you edited, proceed to the next step.

6. Close the end user application concerned. In Windows Explorer, search for the file [illegible].xml 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 listing of templates that are not applicable to the workgroup that the workstation belongs to. Contact your System Administrator for more information.

4

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 [illegible].)

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 type.
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

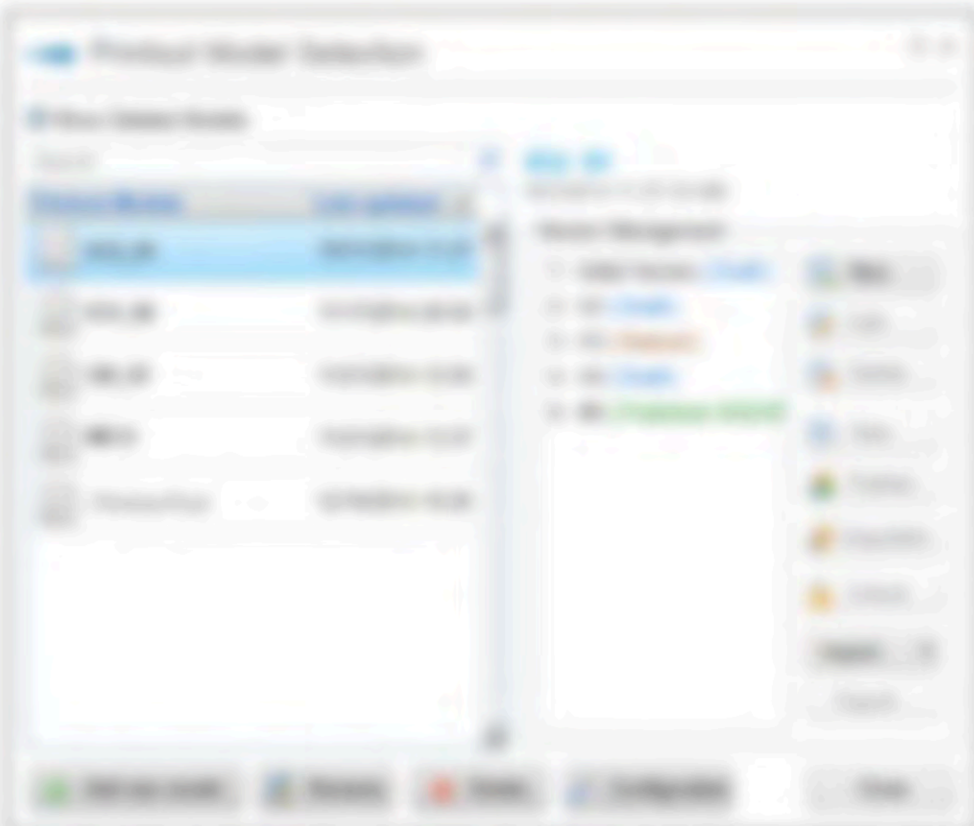
Open the Printout Builder

1. Start Customize, as described in [illegible].
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 is automatically retired when V5 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 the 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 colum header "**Last updated**". (Click the heading 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 CustomView it can take several minutes to open.

Note: Even if you do not make any edits yet you must save the model then 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 hidden link between the model and any configuration sets that it is applied to is retained. 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**.

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 OPMX (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 open 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 (OPMX) 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 properly.

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 (OPMX) 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 as 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"). In 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 Customizer users at other workstations from simultaneously editing the same version. These 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 or locks (for example, if a user's machine crashes or if a user logs off work station 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 undone.

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 **View**.

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

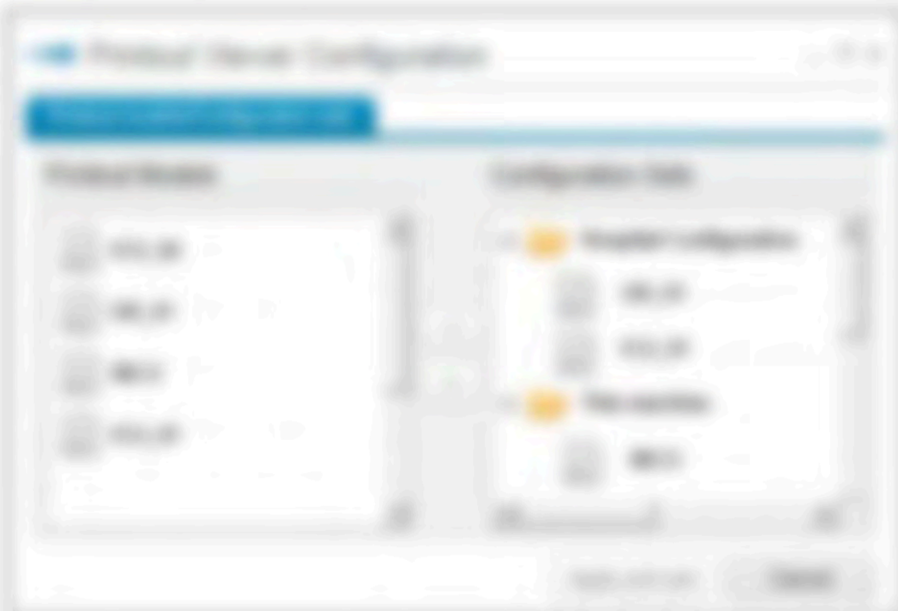
1. Select the version in the right pane.
2. Click **Unlock**.

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 [illegible] 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 [illegible] to remove the selected model from the configuration set.
4. Click **Apply and exit**.
   If an automated printout instance is associated with the model (see [illegible] on page [illegible]) 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 extent of the Printout Builder autosave feature. For more information, see [illegible].

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

- **Top**: Ribbons with pagination 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 To
Home	Opening, saving, renaming, publishing and previewing a printout model Create/deleting library query blocks Creating/deleting library images
Printout	Naming printout sessions Configure 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 [illegible]. (For information on containers, see [illegible] page [illegible].)

Blocks are broadly categorized by their type.

Basic Blocks

Barcode — a barcode generated from a specified patient identification field

Field — 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

Vital Signs

Admission Data — Data that is usually entered in the HIS before the Picis session starts

Adm. Ht/Wt/BSA/IBW/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

Lab/ordering

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 73.)

Query blocks

Query-based blocks that your site has set up.

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.

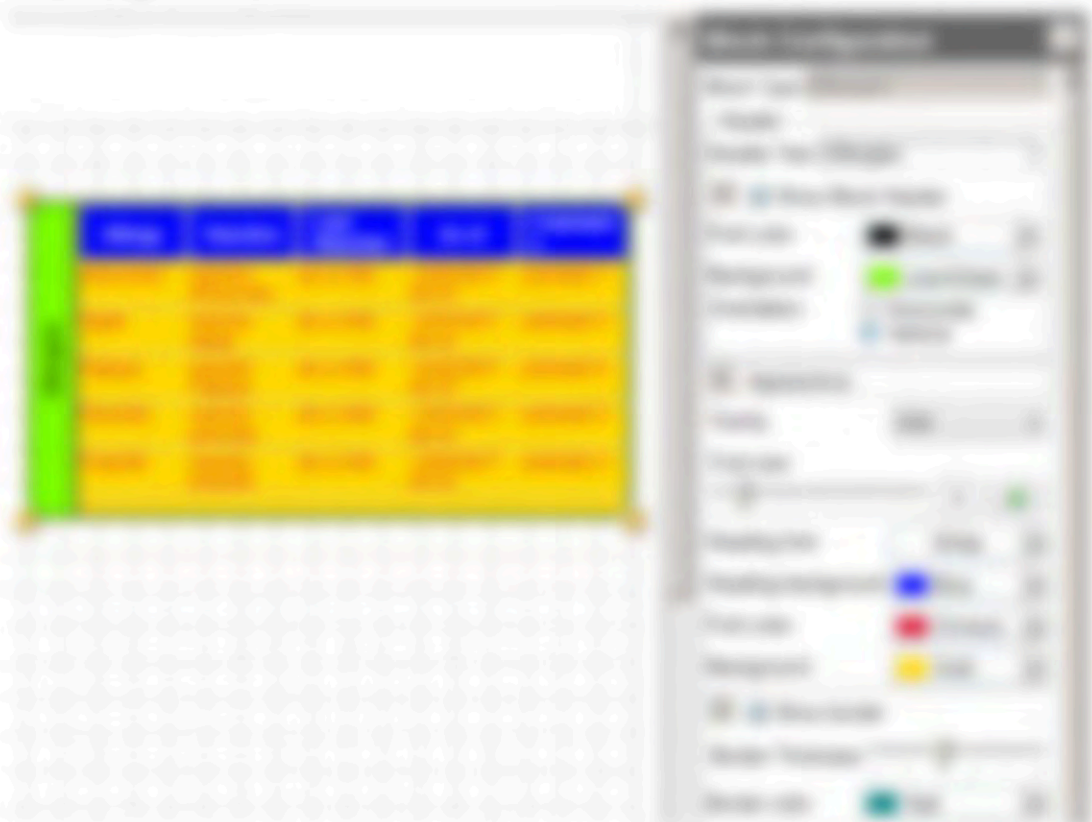
Note: For containers, the font size controls the font size used by all blocks within the container except those for which a specific font size has been set locally in the properties of the block.

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

Formatting controls



Notes:

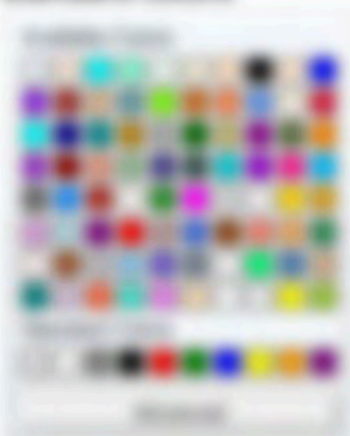
- If you specify a particular font size for a block it will no longer respond to font size changes set for the whole printout (or for the container if the block is in a container). You can reset the font size back to the default by clicking this button: After you do this, the block will resume responding to font size of type made at the container and printout levels.

- For more information on colour 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 lies horizontally across the top of the block or vertically down its left side.

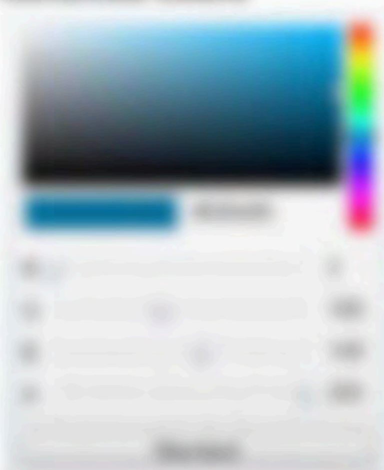
Other Controls

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:** If an 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:** If an entry has comma-separated values (as in the case above) but no line breaks, entries are separated by semi-colons.
Columns	Select the columns that you want to show for the block.
Ordering	Select any fields that you want to display in the block and use the Up and Down arrows to change the order in which you want to display them.

Standard colors



Advanced colors



Column widths

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
- Field Reference
- Fluids In
- Fluids Out
- Image
- Label
- Laboratory
- Medication Details
- Medications
- Notes
- Physiological Variables
- Query Blocks
- Required Events
- Required Events
- Sepsis Notifications
- Trends
- Waveforms
- [illegible]

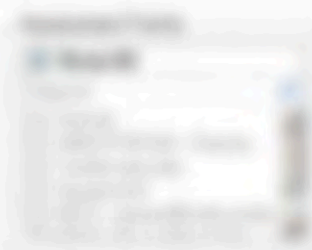
Allergies

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

Anesthesia Plan

Anesthesia Plan Type	[illegible] **Show All**.
Columns	[illegible]

Assessments

Assessment Fields - Show All - Bearing	[illegible] **Show All**. [illegible] **Search** [illegible]	

Barcode

Format ID	[illegible] - Account Number - [illegible] - [illegible]
Show value in text format	[illegible]

Body Systems

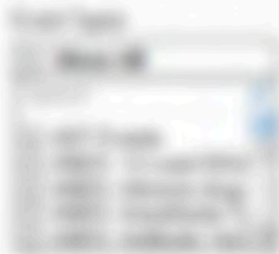
Body Systems Eval Type	[illegible] **Show All**.
Columns	[illegible]

Demographics

Ordering	[illegible]

Events

Group by Event Type	[illegible]
Event Types - **Show All** - **Search**	[illegible]



Field

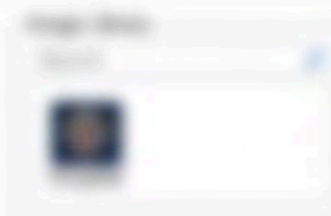
Alignment	Specify the text alignment: left aligned, center aligned or right aligned.
Field Library	Select the fields that you want to show on the printout. Name Page number Printed date Printout PTSD1, PTSD2, PTSD3 Total pages User

Fluid Balance

Family Behavior	[illegible]

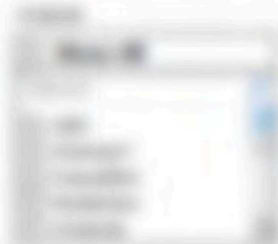
Fluids In

Only print documented fluids	[illegible]
Interval in minutes	[illegible]
Family Behavior	[illegible]
Number of columns	[illegible]
Width	[illegible]
Show dose for drips	[illegible]
Show dose on drips (Total)	[illegible]



	[illegible]

Laboratory

Analysis **– Show All** **– Search**	[illegible]	

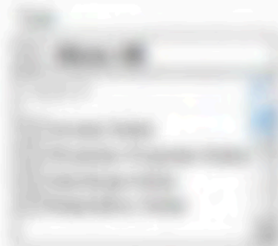
Medication Details

Columns	[illegible]

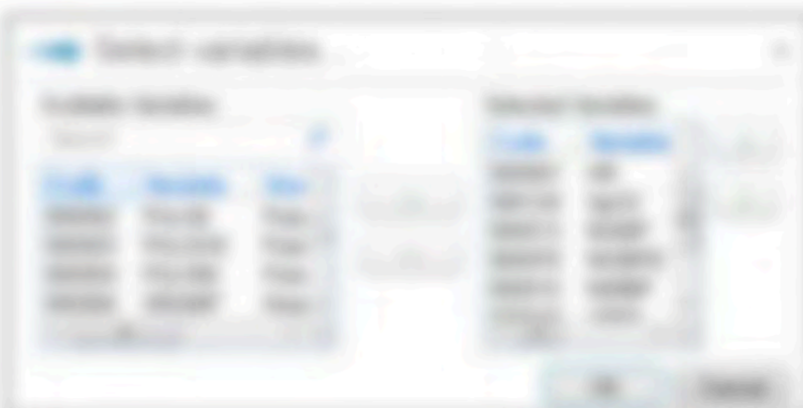
Medications

Include absolute dose for patient weight	[illegible]
Intervals in minutes	[illegible]
Form	[illegible]
Number of columns	[illegible] **Note:** [illegible]
Width	[illegible]
Only print undocumented medications	[illegible] [illegible]

Notes

Type - **Show All** - **Search**	Select the Patient Summary note types you 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 [illegible] by name [illegible]. If 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 lists to show specific variables (as [illegible]). If you start typing in the **Search** field the pane will display only the variables whose names start with the typed text. **Selecting items**

	You can hold down the SHIFT key and click the first and last item 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, then 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, 20, 30, 60 or 120. **Note:** Columns show the last value received in the time period that they represent (rather than the mean value).
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 as 60 minutes and 24 time columns per page. Ordinarily, the printout covers a whole day on each page that the block is printed. However, if a printed block on a page includes any snapshots 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

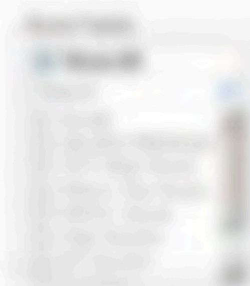
Columns Header	To change a column header: 1. Click **Columns** and select the column identifier. 2. In **Header**, type the text you want as the column header.
Edit SQL	Select to edit the SQL query code, change the column widths or [illegible]

	[illegible]

Required Events

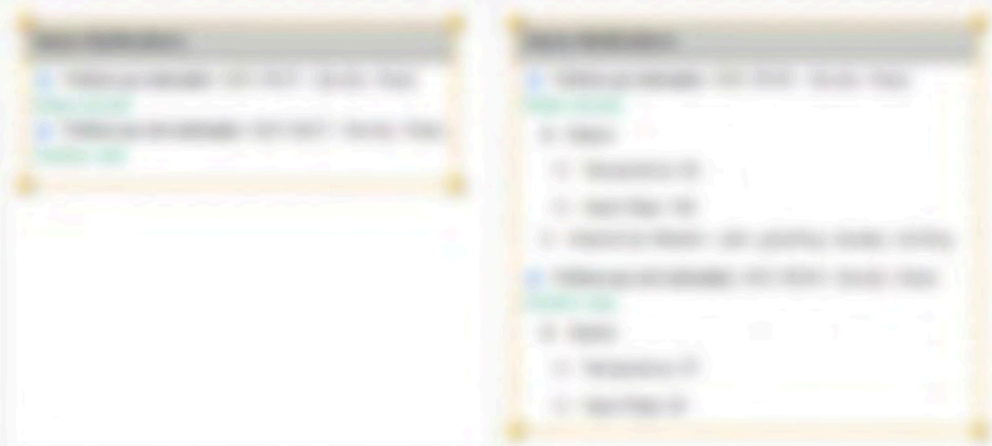
Show	[illegible]

Scores

Show Score Items	[illegible]
Score Family - **Show All** - **Search**	[illegible] 

Reports Notifications

Show Notification Details	[illegible] **Checkbox cleared** / **Checkbox selected**



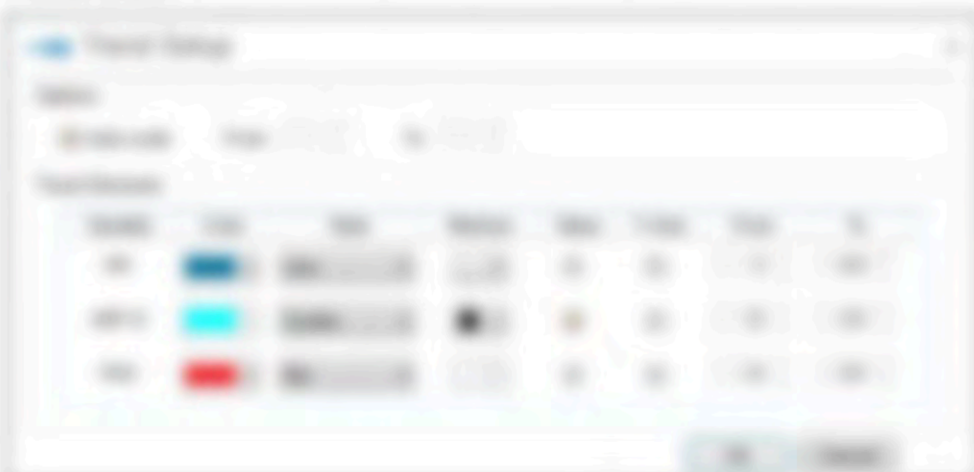
Notific Items	This section is reserved for future use.
- **Show All**	For this release, **Show All** and **Rapid Notifications** should always be selected.
- **Accept**	

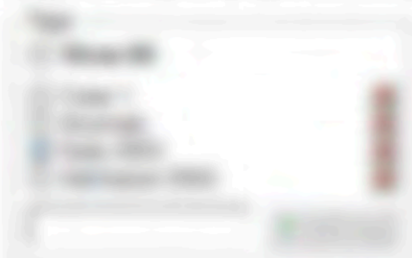
Trends

The **Interval for minutes**, **Number as columns**, and **Select variables** options behave the same as those of the same name for the Physiologic 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.



Tags	This section allows you to create tags, which end users can assign to waveform snapshots in [illegible] 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 or [illegible] with that tag to be displayed on 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**.
- Alternately, 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 on 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 Details 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 clipboard
	Zoom in
	Zoom out
	Reset zoom to 100%
	Zoom to fit the page width
	Zoom to see one full page
	Zoom to see two pages

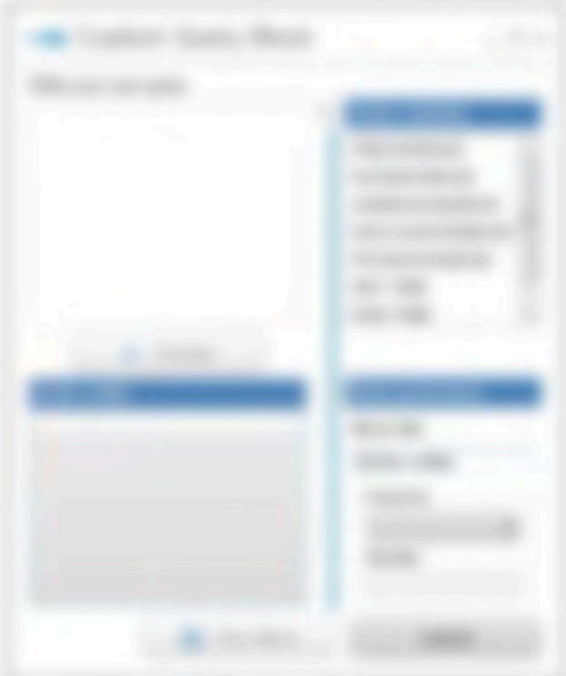
Creating Library Items

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 to 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 XML file.)



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 [illegible] column names from the patient's [illegible] in the selected timeframe:

```
[illegible]
```

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

[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]

Note: When copy/pasting make sure that special characters like quotation marks and [illegible] are retained.

For sites upgrading from Excel-based printouts only: Create custom query blocks from an [illegible] file

1. On the **Home** ribbon, under **Standard Library**, click **Query Blocks > Import [illegible] file**.
2. Browse for an (Excel) printout [illegible] file and click **Open**.

   A window appears showing the blocks from the [illegible] 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 XM file block that you imported. These blocks contain SQL code from the XM 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, TIF. 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 logo 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 (or fs) 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 (values 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 Blocks, Tables, Section Layouts and Containers on page 53.)

> **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-stamped, such as fluids and medications.

Every 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 tab ( ).

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 tile.

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 **Move 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 every 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)

  c. Click and hold down the mouse button while you "drag" the line to resize the footer and then release the button.
3. 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, so 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 Types on page 7.

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 [illegible].) Please also note 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 [illegible] 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 on 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.

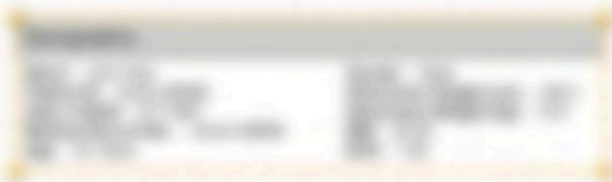
For blocks/containers in continuous layouts or in autofit containers, you can only change the vertical position of the block with respect to other blocks. (In other words, you can change the order in which the blocks appear.) The horizontal position is fixed.

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 our 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 tab:

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 (time) 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
Physiological Tables	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
Diagnoses	Low
Events	High
Precautions	Low
Procedures	Low
Scores	Medium

[illegible]

[illegible]

[illegible]

Example

[illegible]

Layout Type

There are two layout types:

- Fixed
- Continuous

Fixed Layout

[illegible]

EXAMPLES: FIXED 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 as 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 fit the most of the page by avoiding empty space and repeated data. Such layout can include non-fixed blocks and fixed containers.

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

Containers

Fixed Containers

Adding a fixed container to a fixed layout section

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 change to fit their contents but stay in 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

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

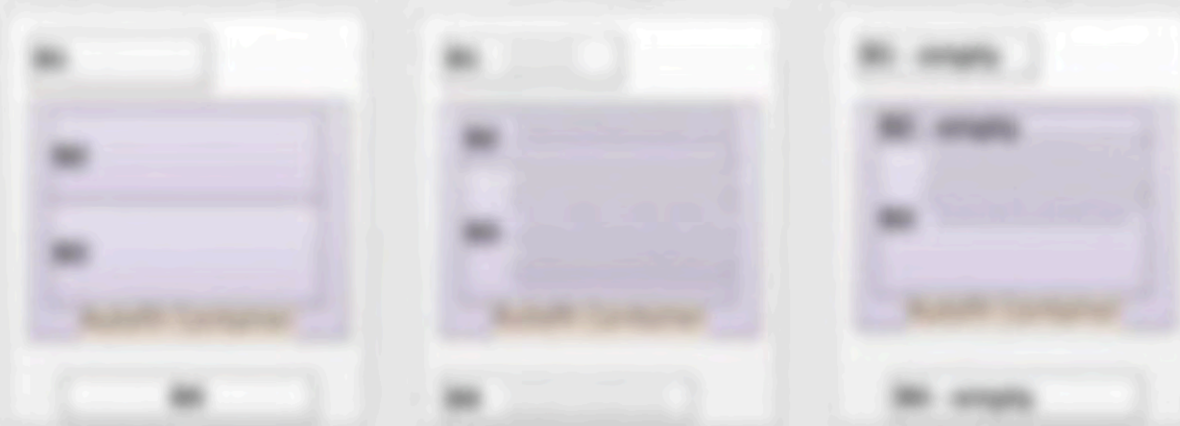
Auto-fit Containers

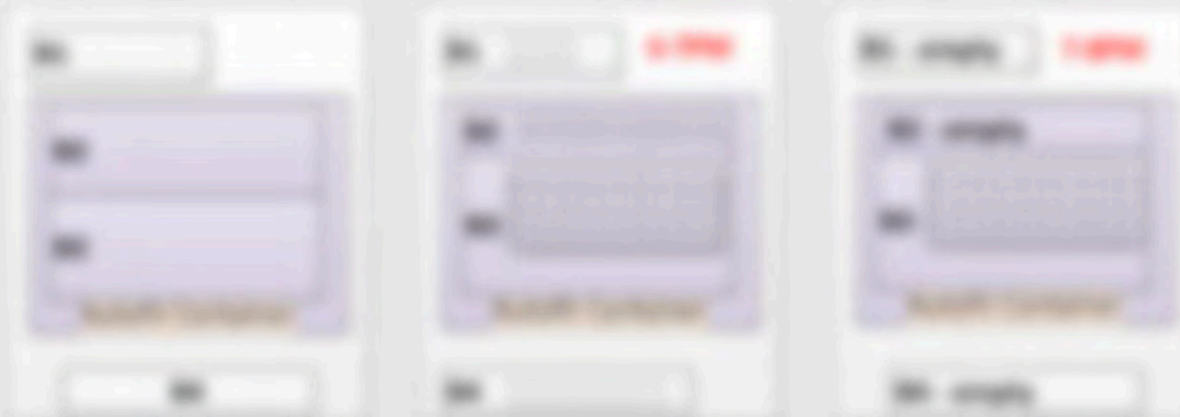
You can add an autofit container to a fixed layout.

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





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 these blocks is the same as for creating [illegible] models. For more information, see [illegible] on page [illegible].)
5. Rearrange sections as required.
6. Preview the model.
7. Publish the model.
8. Users submit forms as they work with patient data.
9. The hospital uses the Export Tool to create NACOR-compliant XML reports, if needed.

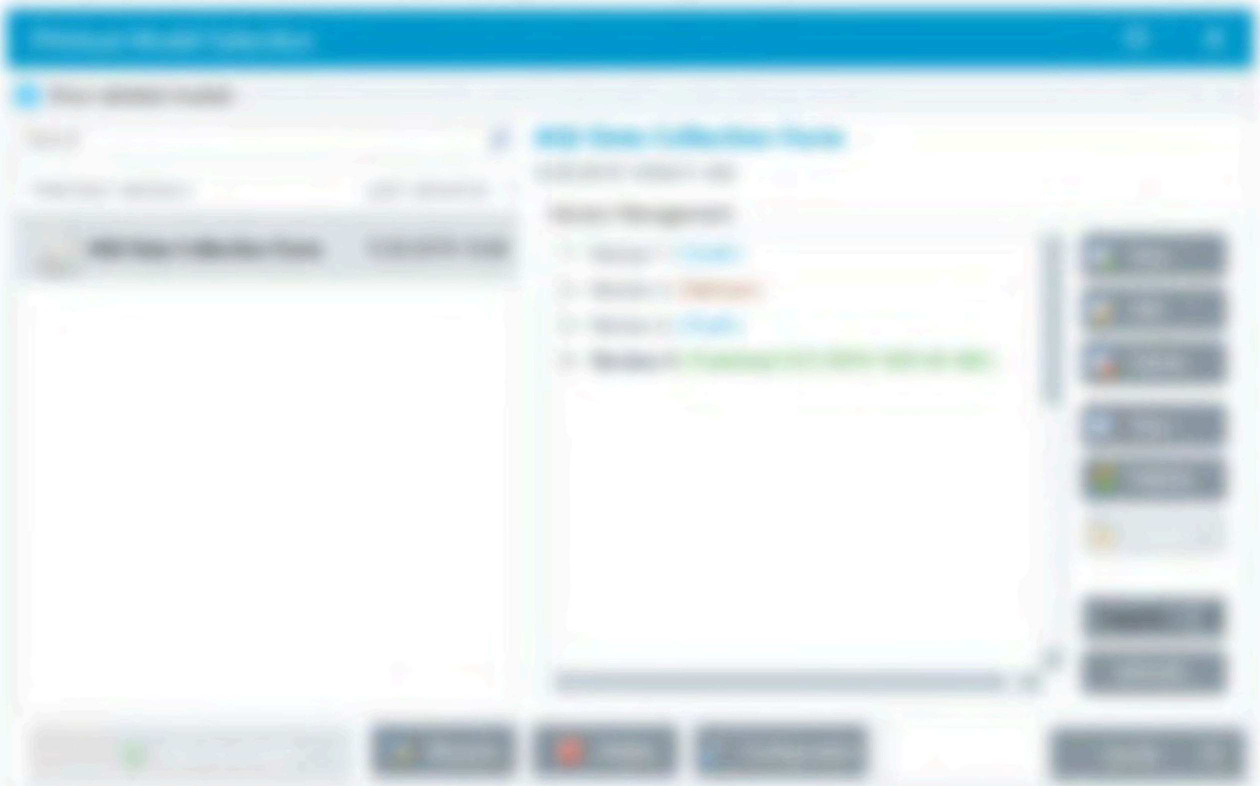
This section covers the creation and publication of quality measure forms.

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 [illegible].

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, V1 was the first published version. This version was automatically retired when V4 was published.)

This window is similar to the window used for configuring printout models. However, unlike printout 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 Printout 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 Pivot 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 Quitting Customize on page
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 .QFMX.

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 .QFMX 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 (.FRM) 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: [illegible]

[illegible]

[illegible]

[illegible]

Create a new version

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

[illegible]

Open a version for editing

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

Delete a version

Note: [illegible]

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

Preview a version

[illegible]

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

Quality Measures Library

editor, locate the rows corresponding to the measures that you want to retain. ...copy those rows to the bottom of the BSV 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 edit 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 is 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 layout area.

[illegible]

- [illegible] **Properties**.
- [illegible] **Block Configuration** [illegible]

Editing Measure Blocks

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

Appearance properties are the same as those common to many printed blocks and described in [illegible]

The following settings are specific to Measure blocks:

[illegible]

There are three ways to proceed:

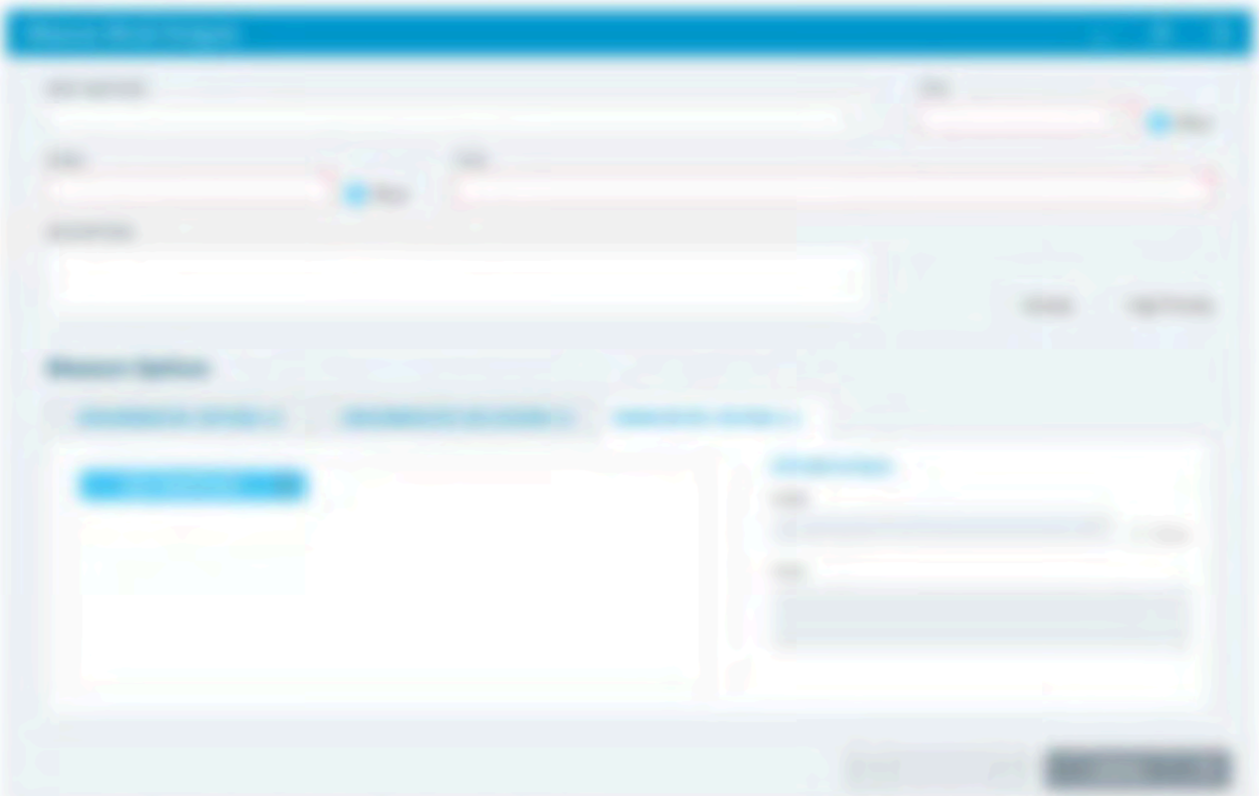
- In **Base Measure**, [illegible]
- In **Base Measure**, [illegible] **Edit Measure** [illegible]
- Click **Edit Measure** [illegible]

Note: [illegible]

Best Practice: [illegible]

The Measure Block Designer window

[illegible]



Mandatory fields are shown with a red outline.

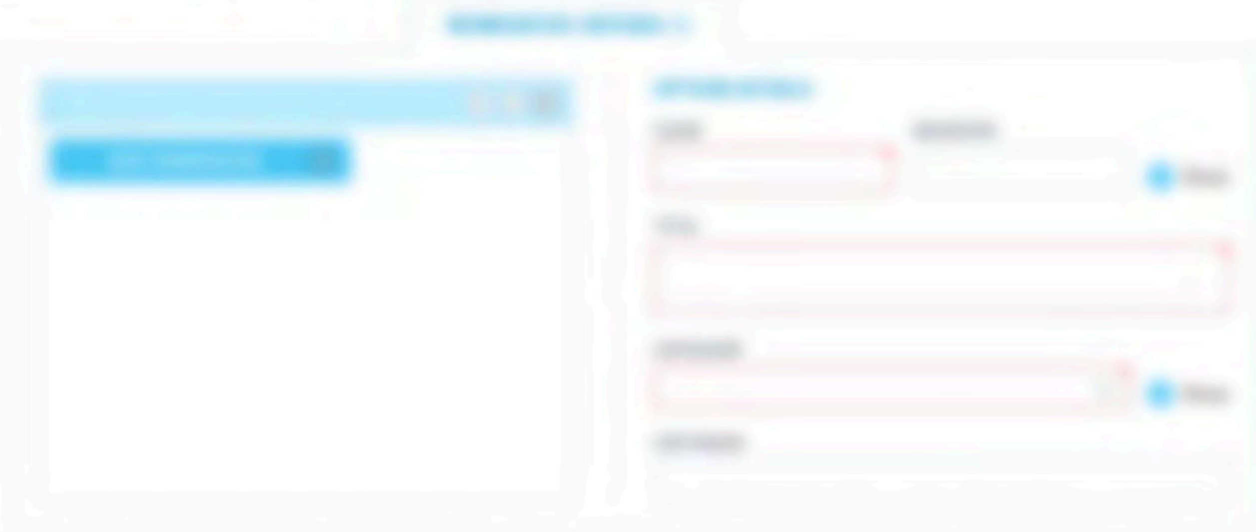
For a general discussion of the terminology used in this window, see the section on Quality Measures in the Clinician User Guide.

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.
Base Measure	For new measures, this field is blank. When editing an existing measure, this field shows the name of the measure you are editing.

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 appears on the form after the title. **Example:** [illegible]
Code	A code that your hospital and relevant external agencies use to identify the [illegible] measure. **Example:** [illegible]
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

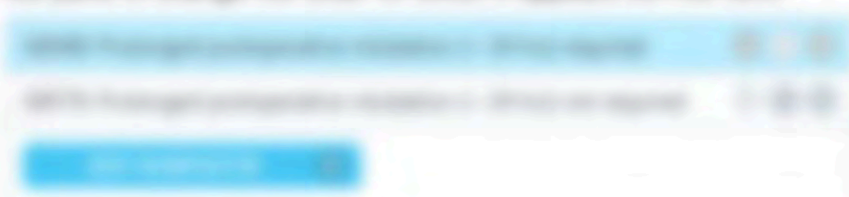
After you click **Add Numerator**, the tab changes as follows:



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 ↑/↓ 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 **Criterion** box allows you to create "composite measures" in which numerators are grouped together with a common meaning.

Example of a form with numerator options grouped together.

To group numerators together under a heading, for each numerator that you want to group, enter the same heading text in the **Criterion** box. Note that the heading text you enter must be exactly the same (including spaces and capitalization) 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.

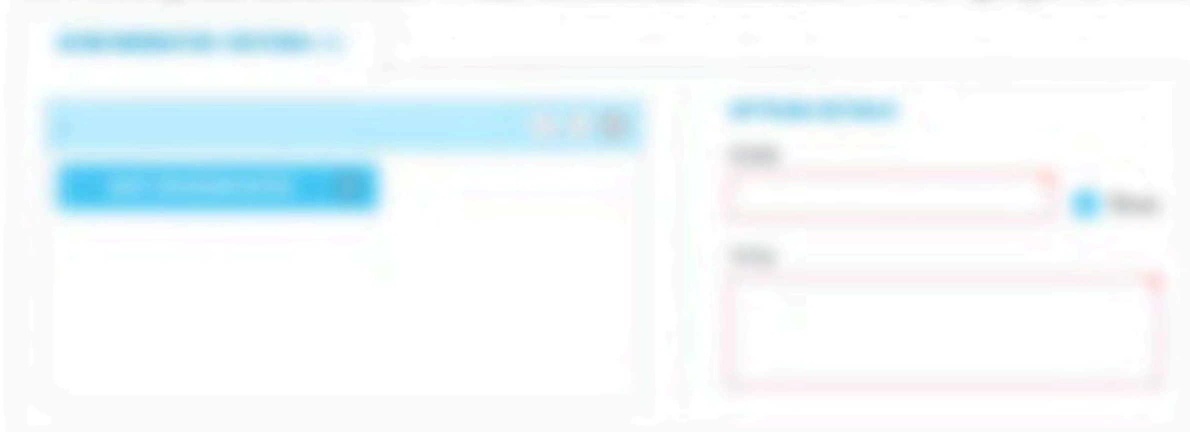
Best Practice: Keep criteria of the same group next to each other on the Numerator Criteria tab.

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 Mode Designer is identical.

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



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

For a UI 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 numerator criteria.

6

Rule-Based Notifications for Sepsis

Rule Criteria

Configuration

- Using [illegible] Editor and Customize, ensure that items required by the rules are present on one or more flowsheets. A full list of required [illegible] and laboratory components can be found in [illegible] on page [illegible].
- 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 [illegible] after a notification has been acknowledged.
- In Customize, at the template level, add a new index – "Sepsis" – to flowsheets so that users can view or add documentation related to the notification. (Users perform the initial documentation in the Sepsis [illegible] 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 **[illegible] > [illegible] > RuleBasedNotification > [illegible]** 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 **[illegible] > [template_prefix] > APPLICATION > [illegible]** to True.
4. Close Customize.

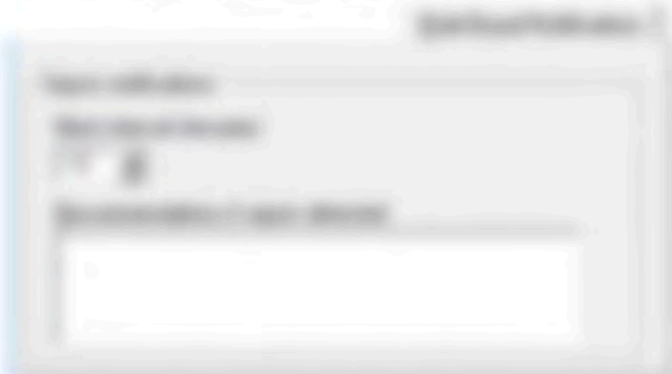
Note: After activating sepsis notification functionality in a template, for the functionality to become available for current patient sessions, you must discharge and readmit any patients admitted to workstations where the template is in use.

Note: The algorithm only uses [illegible] that correspond to the timeframe of the [illegible] admission. [illegible] data from times prior to the [illegible] 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 is to be shown again.

   Note: Only values between 1 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. The use of this check may lead to 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 remotely views a patient admitted to workstation B, the Sepsis Screening window will show recommendations configured for workstation A, not workstation B.

   Best Practice: For easy template, use the same recommendation text at all worked items 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, for SOFA or APACHE II scores.
• End users cannot edit the score or modify 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 > Flowsheet**.

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 **Sepsis notifications**.
6. Click **OK**.
7. Click **Close** twice to return to the last window.

7

Application Template Configuration

About Application Templates

[illegible]

Note: [illegible]

[illegible]

Note: [illegible]

[illegible]

- [illegible]

- [illegible]
- [illegible]
- [illegible]

[illegible]

[illegible]

Note: [illegible]

[illegible]

How eView Uses Templates

[illegible]

- Patient Summary
- Shifts for the Fluid Balance

Note: [illegible]

Templates, Sessions and Encounters

[illegible]

[illegible]

[illegible]

[illegible]

Sample Templates

[illegible]

Encounter Type [illegible]	Template Name	Prefix
Bring back to OR (3)	Bring back as General Anesthesia	[illegible]
	Bring back as PACU	[illegible]
	Bring back to ICU Anesthesia	[illegible]
General Anesthesia (6)	Surgical Prep Area	[illegible]
	Cardiovascular Anesthesia	[illegible]
	PACU	[illegible]
	General Anesthesia	[illegible]
	Sedation/Conscious	[illegible]
	Epidural/Regional/Spinal	[illegible]
ICU (1)	PACU	[illegible]
	Critical Care	[illegible]
Neonatal ICU (1)	NICU	[illegible]

[illegible]

[illegible]

Flowsheets	[illegible]
Macros	[illegible]
Modules	[illegible]
Patient Summary	[illegible]
[illegible]	[illegible]

[illegible]

Working With Templates

Creating Custom Templates

[illegible]

1. [illegible]
2. [illegible]

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

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

The template name is displayed on the title bar on [illegible] and in the [illegible] window [illegible] a session.

Each template has a prefix and encounter type associated with it. The prefix is part of the [illegible] for the template settings and also appears in the "About" window in [illegible]. The encounter type is the care area associated with the template. It appears in various places, such as the title bar (in parentheses) and controls various aspects of the program behavior. (For more information, see [illegible] on page [illegible].)

You can create new templates from scratch (based on the default install time settings in the **Realtime** > **PGS_AT** [illegible]) 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) [illegible] 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 [illegible] 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 required.
- 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, [illegible] 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**.

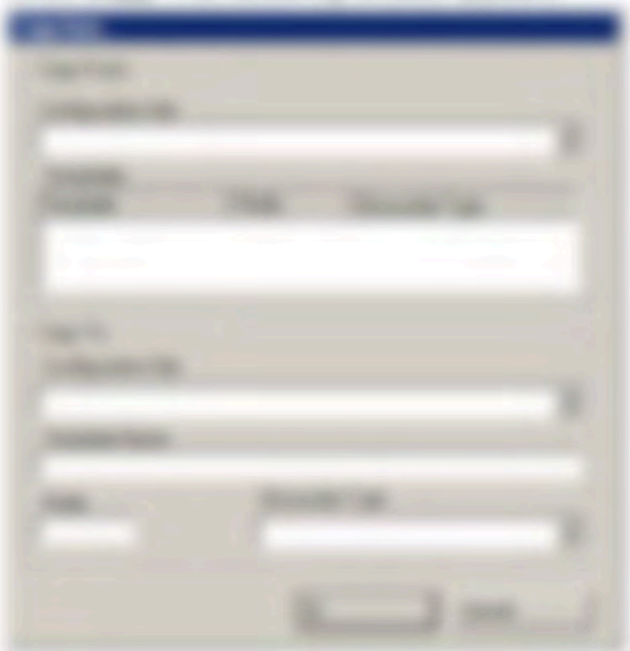
- In **Description**, enter a name for the template.
- In **Prefix**, enter an alphanumeric abbreviation of up to five characters.
- In **Encounter Type**, select a care type with which to associate the template.

3. Click **OK**.

Note: If your site uses or plans to use [illegible], you must also 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 "Tools" 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 Analytics, 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 Database Tables on page [illegible].

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 Database Tables on page [illegible].
- 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 (last). 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 listed.

Workstation "Beta" has configuration set B applied to it (last). 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 hidden. 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

- [illegible]

Note: [illegible]

Hide a template for a configuration set – preferred method

[illegible]

Hide a template for a configuration set – advanced method

[illegible]

Menu	Area	Section	Entry
[illegible]	[illegible]	[illegible]	[illegible]

Possible Values
[illegible] **Note:** [illegible]

Best Practice: [illegible]

[illegible]

Example:
[illegible]

> Although Configuration Set B includes Template 3 it is not available at the sorted list on either the @ST window or the Customize "Types" window because it has been hidden by Configuration Set B.

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 session tab DBOID from the HiddenReservedTypes 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 [illegible] and Patient Summary on page [illegible].)
- Required data for acuity rules.

  (See: Configure a Demographics section on page [illegible] and Configure required functional types and clinical priorities on page [illegible].)
- 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 [illegible].)
- Custom flowsheets.

  (See: Flowsheets on page [illegible].)
- Form 1 of the Fluid Balance window.

  (See: Fluid Balance Window on page [illegible].)
- Printouts.

  (See: Printouts (template settings) on page [illegible].)
- Available toolbar, accessories, and "quick links" in the application.

  (See: Quick Links on page [illegible] and Charts on page [illegible].)
- Configuration on the toolbar, Vital Signs bar, and Patient Bar.

  (See: Status Buttons on page [illegible], Vital Signs Bar on page [illegible], and Patient Bar and Applications Window on page [illegible].)
- Clinical content available to users for documenting patient care.

  (See: Protocols on page [illegible] or Events on page [illegible].)

- Screen 1 pods and macros
  (See [illegible] and [illegible].)

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). The [illegible] to ensure that all required information has been documented. (See also [illegible].)
- 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 [illegible]. For more details and information about [illegible], see the appendix on [illegible] 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 scrolled). [illegible]

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 **Configure User 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 **Configure User 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 upon 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 upon 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 transfer** check box. [illegible] 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 HIS.

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 units. See also Configuration Options for All Departments on page [illegible].)
- Change the color that identifies edited values on flowsheets. The default color is red. If users might confuse a red value with indication of low, for example, you can use another color.
- Set the default status for indications. Indications identify values that are outside of configured indication limits for a variable.

Allow users to edit device data

1. Click the **Configure Parameters** button.
   Or, click **Template > Configuration Parameters > Preferences**.
2. Select the **Device data can be edited** check box.
3. When you have finished editing data-edit 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 [illegible].

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 [illegible] 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 indications for physiologic variables

Note: 'Notifications' are indications that [illegible] 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 [illegible]. (See Configure variable properties on page [illegible].)

In addition, selecting the **Notifications On** check box enables the following: [illegible]

- Users can set notification [illegible] 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 notification limit appears outlined in red on flowsheets and in the Physiologic Variables Summary.

Note: 'Notifications' are visible indications. 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**: [illegible]
- **Emergency Data Reserve**: [illegible]
- **Daily Shifts**: [illegible]

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: 15-30 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: [illegible]

Note: [illegible]

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, [illegible]

> **Best Practice:** Philips recommends that you set the value to the maximum of [illegible] hours and only decrease the setting if you experience history problems at [illegible].

5. 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 [illegible].

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. This window allows the user to transfer or discharge the patient. (This 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, as 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	Details
 **Notifications icon**	The icon is always displayed. (The colour changes according to the notification status.)
 **Potential Interactions icon**	The icon is displayed when interaction checking is enabled for the entire system (in [illegible]).
 **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
 **[illegible] data**	Enable when your system has a HIS or Laboratory link.

Alert 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 site template. For more information, see Demographics and Patient Bar Workstation Settings on page [illegible].
- 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.)
- 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 [illegible] 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 [illegible] 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 **Show Details** button. For more information, see [illegible] on page [illegible].

Configure the Allergies/Precautions box

1. Click the **Configuration Parameters** button and then click **Allergies/Precautions**.
   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 [illegible] window regardless of the configuration of the Allergies/Precautions box.

Note: The system right for [illegible] is needed to [illegible] the Allergies box from the Patient [illegible].

Enable the Pending Tasks icon

1. Click the **Configuration Parameters** button.
   Or, click **Template > Configuration Parameters > Preferences**.
2. Select the **Display [illegible]** 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 notification** 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 [?].

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 [?] 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 [?] 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 discussed in detail in Demographics on page [illegible]. 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 the 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 variables
- 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 [illegible] Administrator.)

Configure required or recommended data

1. Click **Template > Required/Recommended Field Configuration**.
2. To expand a section, click the icon 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 the 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

[illegible]

Configuration files

[illegible]

Physical connection

[illegible]

Menus

[illegible]

Template Configuration

[illegible]

Enable the Waveforms tab in Customize at workstations

[illegible]

Auto Snapshots

[illegible]

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

- The delay after the session/alarm start before the snapshot capture initiates. The value can be between 1 and 6 minutes (the default is 3 minutes).
- The duration of the capture. The value can be between 5 and 120 seconds (the default is 8 seconds).
- A comment for the captured waveform.

Default Resolution

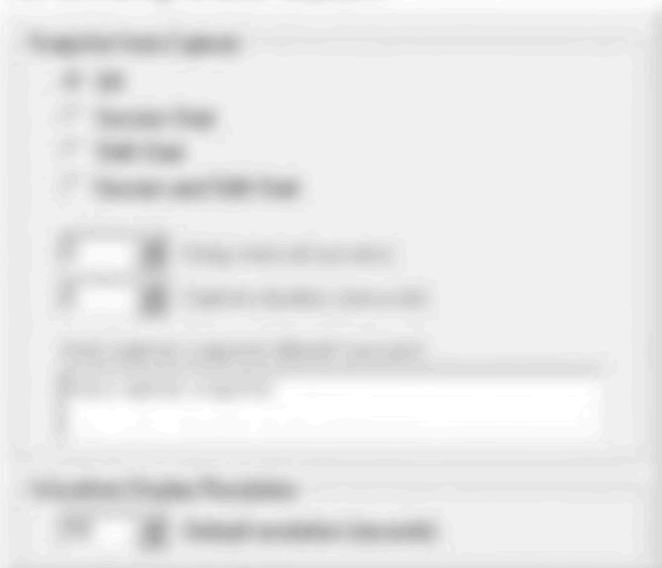
The default waveform resolution controls the time range shown when a user opens the Waveforms window. You can set it to between 4 and 40 seconds. The default installation setting is 10 seconds, meaning the window shows 10 seconds of data. Users can change the resolution on the fly.

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 (mins)**, 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. [illegible]

Devices and Physiologic Variables

About Physiologic Variables

[illegible]

[illegible]

[illegible]

Note: [illegible]

Note: [illegible]

About Derived Physiologic Variables

Note: [illegible]

[illegible]

1. [illegible]

2. Click **Next** twice 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 the window, by using the arrows next to the variable's name.

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

Configuring Physiologic Variables

Best Practice: Allow any medical device in the hospital that is capable of connecting to the program to 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, "%ProgramFiles%\Picis\Devices\Drivers\Devices").
(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 tab.

You can modify an existing configuration by going to the corresponding wizard step and making needed changes. Variables selected using the 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

Step	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 Flowsheet	Create and add any needed custom variables using [illegible]. 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 (such as patient weight, height and [illegible]).	Template

Derived variables get their data using the associated formula in the database. You can view the database formula when you edit 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 [illegible].
   (Click [illegible] to remove a device driver from a port.)
4. Click **Next** [illegible] 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 variable that have been configured as derived variables. Doing so would result in bad data. (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 **Devices and Variables** box on the left shows the drivers configured for the acquisition along with their port numbers.

   > **Note:** A green check mark next to a variable in the list 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 >>** you can expand the list of variables for the driver to see those that will be selected.

5. To select a single variable from a device, click the variable name beneath the driver name.
6. To remove a variable from the selection, do the following:
7. Drag the variable name to the left pane.

   Or, click the variable 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 **Click to Link 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 **Templates > 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 **Chart Link Library** box, double-click any variable you want to add. (If you need to create a custom variable, choose an available "Wildcard Variable" (codes 001 through 700).)

   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 any 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 005) is present.

Adjust the order of variables on the flowsheet

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

   Or, click **Templates > 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 **Templates > 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:** It's ok to enable this setting for variables that are configured to allow data to be copied forward.
Copy Forward	Data for the variable is entered manually, but 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 obtained 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: DATA RECEIVED DURING INTERVAL LAST VALUE AVERAGE 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 for 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 for the time frame that the flowsheet column represents.

Variable Property	Description
Notification Limits	[illegible]
Artifact Limits	[illegible] **Best Practice:** [illegible]
Format	[illegible]

Review the physiologic variables list

1. Click the **Physiologic Variables** button.
   Or, click **Template > Physiologic Variables**.
2. Click **Next >>** [illegible]
   [illegible] **Restore** [illegible]
   Click **<< Previous** [illegible]
3. Click **Next >>** [illegible] **Close**.

APACHE II Score

[illegible] APACHE [illegible]

- Heart Rate [illegible]
- Mean Arterial Pressure [illegible]
- Rectal Temperature [illegible]
- Resp Rate [illegible]
- FiO2 [illegible]

- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]

[illegible]

[illegible]

Vital Signs Bar

[illegible]

[illegible]

Choose what to display on the Vital Signs bar

1. Click the **Physiologic Variables** button.
   Or, click **Templates > Physiologic Variables**.
2. [illegible]
3. In the **Chart Variables** area, [illegible]

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 variables 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 related 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 as configured. (See Configure Orders on page [illegible].)

Each template can have a different protocol library.

Protocols can include orders from any of the treatment categories in the database: Medication, Fluid Intake, Fluid Output, Laboratory Components, Respiratory, Assessment, QA Indicators, Equipment, Scores, and Nursing Care.

You can associate up to three protocols with a template:

Default	Anesthesia Manager, ICCA 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.

[illegible]

[illegible]

Configure a default protocol

1. Click the **Protocols** button.
   Or, click **Templates > Protocols**.
2. In **[illegible]**, 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, [illegible]
   [illegible]
4. Click **Close**.

Events

What you can configure

Add one or more events to the events library

1. Click the **Events** button.
   Or, click **Templates > 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 2 and 3 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 Fee billing, you must make sure that your templates includes the events "Anesthesia Start", "Anesthesia Finish", and "Staff Begin 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 events 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 with 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 [illegible] you should not remove shared events, such as Anesthesia Start, Anesthesia End, and Anesthesia Type.

4. Click **Delete**. (This removes the event from the library, leaving it available for later addition, 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 [illegible] 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 [illegible] event, click **Prompt for confirmation when deleting events**.
5. To prevent deletion of events that occurred too far back in time, enter a [illegible] 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 [illegible] on page [illegible].
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 **SAM** 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 on the template.

Fluid Balance Window

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

- Bar graph with multiple time views ([illegible], Day, [illegible], Admission, and optionally, [illegible] 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 [illegible] 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 device to appear on the bypass fluids pie chart, it must belong to a fluid family that is designated as bypass. You can configure any fluid family in the [illegible] as for bypass. It is [illegible] to include the word "bypass" in the name of bypass fluids, as shown in the following example.

Fluids In
- Blood Products
- Blood Products (Bypass)
- Medication Infusions
- Meds Gtts Infusions (Bypass)
- Other Fluids
- Other Fluids (Bypass)

Fluids Out
- Blood Loss
- Blood Loss (Bypass)
- Other Fluid Loss
- Other Fluid Loss (Bypass)
- Urine
- Urine (Bypass)

If you cannot find suitable fluid I-Views in the datasets, 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 charts**.
3. Click **Bypass Rules**.
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. Data Sheet

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 clinician in the Patient Summary module
Events	Events from either the selected viewing period or the last 12 hours, dependent 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 note tables on page [illegible].)

- 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 [illegible].)

- You can allow users to send streamlined reports to the [illegible] and configure [illegible] different possible report types. This is a workstation setting.

  (See: Patient Summary Export to the [illegible] on page [illegible].)

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 **Room 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 [illegible].

   The **<Starting date> to <Ending date>** viewing period allows users to define a custom viewing period.
5. To create a new 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 [illegible]).
   - 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** list then click <<. (Note that you cannot remove the [illegible] viewing period.)
7. Set the order of viewing periods for both the tab report and room:
   - 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 **Numbers**, click an identification number.
3. Choose sections to include on the report:
   - In the **Current Configuration** box, under the 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 **D to 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 **Tables ID** box with a default identification code (T1, T2, 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 last (most recent) values obtained 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 variable 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 sporadic 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 (DBPA), Systolic Blood Pressure (SBPA), Respiratory Rate (RR)

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

	[illegible]	[illegible]	[illegible]	[illegible]
CO	[illegible]	[illegible]	[illegible]	[illegible]
HR	[illegible]	[illegible]	[illegible]	[illegible]
DBPA	[illegible]	[illegible]	[illegible]	[illegible]
SBPA	[illegible]	[illegible]	[illegible]	[illegible]
RR	[illegible]	[illegible]	[illegible]	[illegible]

Add a laboratory table

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

1. Click the **Patient Summary** button.
   Or, click **Jump to > 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 (xtab01, xtab02, 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 analysis on the list, 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, clear the check box next to the table name. (Click the check box a second time to restore 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 Analyses** box, select the parameters you want to add to the table. Then click **Add >>**.
6. In the **Selected Variables** or **Selected Analyses** 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 title for the table you want to delete.
4. Click **Delete**.
5. Click **Close**.

Configure the patient summary for export to the HIS

This is configured at the workstation level using Configuration Editor. See Patient Summary Export to the HIS on page [illegible].

Medication Summary

The Medication Summary shows all medication doses administered in a time period and the total dose 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 **Templates > Medication Summary**.
2. In the **Sort Medications by** box, select a default sort 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 lower 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 Design: 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 Worklist 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 use criteria from the American Recovery and Reinvestment Act of 2009 (ARRA).

RACE (US)	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 Supply Log, configure any data type as needed for defining as required. (See the Workstation User Guide for more information.)

These settings are configured via the **Templates > Demographics Editor** window.

> **Note:** The **Options** button in the **Templates > 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 [illegible].

> **Note:** For information on further configuration options specific to CaseChek, see CaseChek on page [illegible].

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 are visible, but not all labels:

Allergies and Precautions
Medication Allergies
> Penicillin Reaction: Rash Last Reaction: >1 yr 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

No 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.

5. To prevent users from changing data for an element, select the **Read Only** check box. (Show that elements are read-only are visible in the summary window, but hidden on data entry forms.)

   Some elements are always read-only but use 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).
6. 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 appear 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 diagnosis 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 procedure 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 this 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 this 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 collected 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 you configured as physiologic variables. Does not show orders for laboratory and diagnostic tests.

Standard flowsheets cannot be deleted. You can customize their contents 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 [illegible] custom flowsheets. Each flowsheet can have up to four sections that display data in tabular format or as graphs. Custom flowsheets can include variables from the four basic types (physiologic variables, medications, fluids and laboratory components) plus the following additional types:

- Assessments
- Scores
- Nurses' 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 "Y":

Advanced Settings > Assessment zone > DISPLAY section > Show Equipment Assessments

Advanced Settings > Assessment zone > DISPLAY section > Show QA Assessment

Physiologic variables and other types of data on flowsheets configured [illegible] behave differently:

- You can only include variables that have already been selected using the Physiologic Variables tab.
- 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 16 hours. (Note that the "1 day x 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 row, 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 filler, form, site, and regimen. (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. Even if it appears, users can switch between the two or display both on separate rows. Philips 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 it uses. 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.
Set 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 151.)

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. Check **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. Check **Show complete orderable on flowsheet** to show full 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 cancelled 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 events. (If desired, you can decide an entire flowsheet to [illegible].)

Example: You can create a flowsheet to show the correlation between medications, on 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 given or state of patient care. For example, a summary of the data an anesthetist needs to note 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 [illegible].
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, the 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 [illegible] Usage Guide.

5. In the **Default Resolution** box, select the viewing resolution to apply by default.

   Best Practice:
   For anesthesia care, select [illegible] minutes.
   For PACU-related care, select [illegible] minutes.
   For surgical prep area care, select [illegible] minutes.

6. Select the **Freeze flowsheet (no Auto-scrolling) by default** check box if you do not want the flowsheets 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, [illegible] then click **Select** 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. On 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 or 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: Philips recommends that you do not apply filters to the in **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 updated 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 Wound orders only display in "PRN" panes. Urgent orders only display in "Periodic" panes.

Note: This affects only on 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: [illegible]

4. Click **OK**.

Create or edit a trend section on a flowsheet

1. [illegible] click **Setup**.
2. Click **Trends** [illegible]
3. [illegible]
4. [illegible]
5. Click **Close**.
6. [illegible] click **OK**.
7. Click **Close**.

Create or edit a trend for use on any flowsheet

[illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]
   - [illegible]

- 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 [illegible] to 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 in 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 every 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 **Flowsheet** 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 on the Navigation Bar, followed by the custom flowsheets.
For example:
• **Physiological Data**
• **IV Medications**
• **IV Fluids**
• **Laboratory Results**
• Custom flowsheet 1
• 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, [illegible] treatments in [illegible] categories will copy forward [illegible] 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

Configure copy forward for specific checklist items

1. Click **Templates > Copy Forward**.

Other Windows and Accessories

Timers

Create a timer

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 items 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 to annotating more detail key 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 as buttons on the **Macros** and **Home** ribbons. If the event macros don't already exist you must first create them using the [illegible] Editor in Customize. (See [illegible])

- Programs are third-party or custom software. [illegible] 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 [illegible], [illegible] and Internet Explorer.
- Screen layouts are predefined arrangements of application windows that create special views of patient data. [illegible] can apply layouts during a session to change views rapidly.
- [illegible] add-ins provide access to [illegible] function [illegible] in a viewer [illegible] can be accessed from both clinical and administrative [illegible] 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 [illegible] add-ins appear on the **File-EXT** ribbon.
- Screen layouts appear on the **Insert/View** ribbon.

Note that the **Macros** ribbon only shows when and the ribbon is displayed automatically when at least one macro or [illegible] is configured.

Note: Macros, Programs, [illegible] 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 and then opens a menu, the 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 [illegible].)
6. In **Comment**, enter a comment note to appear beneath the button name on the **Macros** and **Home** ribbons.
7. In **Shortcut Key**, enter a letter from the comment note, 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 last once, showing users that the action has been performed. (The button can be clicked again.) The option is useful for or ones 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 **New** 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 **Quick Link** ribbon. You should make the command the same as the application name to help users remember which button connects which quick link.
6. In **Shortcut Key**, enter a letter from the command name, to be used as a shortcut to select the control tab with the keyboard (optional).
7. If the application is destined to add data to the patient record (for example, if it is another Picis application such as Picis Manager), click **Append patient MRN and admission MRN to the quick link**. Contact your technical services provider if you are not sure.

   Otherwise, leave the check box cleared because some applications cannot interpret the appended information and therefore cannot run correctly.

8. In **Additional Parameters**, enter any options or user command-line modifiers that the program accepts. (If necessary, see the information on additional parameters later in this section.) Contact your technical services provider if you are not sure.

   Otherwise leave the 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
Concurrency	%ProgramFiles%\Picis\bin\Concurrency.exe	
Proxy Manager	%ProgramFiles%\Picis\bin\FormsEngine.exe	[illegible]
Report Viewer	%ProgramFiles%\Picis\bin\BillingReports.exe	
Internet Explorer	C:\Program Files\Internet Explorer\iexplore.exe	-nohome 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**>=%a%, <**ArgumentName**>=%a%

Where:

ArgumentName is the argument expected by the program. (Examples: ID, PAT, PATIENT, or USER.)

a is one of the following aliases used to identify the database field:

- **PTID1** for PATIENTS.PTID1
- **PTID2** for PATIENTS.PTID2
- **PTID3** for PATIENTS.PTID3
- **ACCNUMBER2** for ADMISSIONS.ACCOUNTNUMBER
- **STAFFID1** for STAFF.STAFFID1
- **STAFFID2** for STAFF.STAFFID2
- **STAFFID3** for STAFF.STAFFID3
- **USERNAME** for STAFF.USERNAME

Example: PID=%PTID2%, U=%USERNAME%
This will pass the value from the PATIENTS.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 **Import/View** 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're finished configuring quick links, click **Close**.

Note: Screen layouts are created using Gravitiview manager, PACS 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 Links**.
   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 so it is the quick link that 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 appear in Customize. (Note that the sections do not correlate exactly with the ribbons.)

Button/Context tab	Description	Application/Workstation Type
FILE tab		
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 Review 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 multibed workstations to switch to a different patient. Cannot be removed.	Multibed only
Transfer Patient	Closes the patient's record, ends the session at the patient location, but does not end the admission in the Prism system.	All
Discharge Patient	Closes the patient's record, ends the session and ends the admission in the Prism system.	All
Close Patient	Closes the patient record without ending the session.	Multibed only

Button/Custom id	Description	Application/Workstation Type
Unit Census	[illegible]	All, especially multibed
Printout Viewer	Opens the Printout viewer	All
Reports	Opens the Reports window	All
Reports Audit	[illegible] Opens the Reports Audit window	All
[illegible]	[illegible]	All
Exit	Closes the application without ending the session. Cannot be removed.	All
Contents / 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
[illegible]		
Default Data	Not recommended for production workstations.	All

Button/Control Id	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 OBCU Manager (Bedside and Multibed)
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 Multibed)
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 Multibed)
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/Control id	Description	Application/Workstation Type
Outbound Order Notifications	(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 [illegible].) Opens the Add Supplies window.	Anesthesia Manager [illegible] Manager (Bedside and Multibed)
MR Information	(This button is only available if your system is integrated with [illegible] Manager.) Opens the MR Information window.	Anesthesia Manager PACU Manager (Bedside and Multibed)
Supply Log	(This button is only available if your system is integrated with [illegible] Manager.) Opens the Supply Log.	Anesthesia Manager PACU Manager (Bedside and Multibed)
[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 Layouts** button.	All
Save Screen As	Allows users with appropriate [illegible] rights to save new screen layouts. Not recommended on production workstations.	All
Apply Screen Layout	Allows users to apply screen layouts by selecting from the complete list of configured layouts.	All
DEMOGRAPHICS		

[illegible]	Description	Application/Workstation Type
Summary	Opens the [illegible] Demographics window showing all configured sections and documented data. Users can open individual sections which the navigation tab. The Demographics menu also lists [illegible] sections configured for the window for direct access.	All
SUMMARIES		
Patient Summary	Opens the Patient Summary module	All
Notes	Opens the Note Editor window	PICU Manager Critical Care Manager (Bedside and Multibed)
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	PICU Manager Critical Care Manager (Bedside and Multibed)
Care Metrics	Opens the Care Metrics window	PICU Manager Critical Care Manager (Bedside and Multibed)
ORDERS - PHYSIOLOGIC VARIABLES		

Button/Control Id	Description	Application/Workstation Type
Single Order	[illegible]	All
Urgent (Stat) Order	[illegible]	All
Extend	[illegible]	All
Cancel/Discontinue	[illegible]	All
Protocols	[illegible]	All
Move Protocol	[illegible]	All
Cancel Protocol	[illegible]	All
Physiologic CI to Interval	[illegible]	Bedside only
Snapshot	[illegible]	Bedside only

Section/Control (a)	Description	Application/Workstation Type
Emergency [illegible]	Allows users to [illegible] high-resolution device data [illegible] to the patient chart	Bedside only
Standby	Stops communication with devices temporarily	Bedside only
Devices	Allows users to change the device layout configuration during a session	Bedside only
Vital Signs Bar	Shows or hides the Vital Signs bar [illegible]	Bedside only
MACROS		
[illegible]	Buttons for [illegible]	[illegible] (Bedside and Multiseat)

About Macro buttons

[illegible]

About the Home ribbon

[illegible]

About Icons

[illegible]

Configure ribbons

Note: Before configuring buttons, make sure that all the timers and quick links (macros, scratch 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 on each ribbon. The symbol next to a button name indicates the 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 tooltip of the button on the Home ribbon can be set in the right pane.)

2. Double-click an entry to add/remove a button to the 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 Key On/Off button appears automatically and cannot be removed or modified.
The **Select Patient** button is only available at multibed workstations. Similarly, the **View Remote P-Vent** 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 arrows to position it.
3. When you have finished configuring ribbons, click **Close**.

Create/edit icons for ribbon buttons

Pivot provides a library of icons that can be added to ribbons. Icons are stored in the following location:

%ProgramFiles%\Pivot\Resources\

You can add new icons to the library by placing graphic files in the 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:

  STRING_32x32.bmp

  Where STRING is any valid Windows file name. In other words, spaces, hyphens, and the underline characters are permitted.

Note: The 'x' in '32x32' must be lower case. All other characters can be in any case.

Example
100_RecordAnotherSomething_32x32.BMP
Third arrow_32x32.bmp
QualityAssurance_32x32.bmp

Note: As 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 at your hospital.

8

Workstation Configuration

About Workstation Settings

[illegible]

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 conds, sections and simples. 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 as the Configuration Editor but it does have 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 [illegible] 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 [illegible].)
- The time till automatic log offs occurs
  (For more information, see Automatic Log Off on page [illegible].)
- Whether or not patient data is displayed when no user is logged on
  (For more information, see Unattended Workstation Display on page [illegible].)
- How user names appear in the Log On window
  (For more information, see Log On window on page [illegible].)
- Possible reasons the user can select when discharging a patient
  (For more information, see Discharge Reasons on page [illegible].)

Demographics and Patient Bar Workstation Settings

You can set the demographics information to show beneath the patient name on the Patient Bar. This 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 original 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 "Demographics Summary Unlocked" right can edit data.)
- The types of data that can be copied forward from a previous admission record
- The ability to import home meds 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 [illegible].

Note: Other demographic settings are configured at the template level. For more information, see Demographics on page [illegible].

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.

3. 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 module for the encounter after a transfer or discharge. After this time all sections are locked. (Users with the "Demogr Summary Unlock" offer can override this lock.)
4. When you have finished setting options, click **Close**.
5. When you have finished configuring the Demographics window, click **Close**.

Note: This setting also affects the ability to modify these same sessions using Praxis M-tags. For reasons related to this, Picis recommends that sites 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 select 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 node

1. Click the **Demographics Editor** button
   Or, on the **Template** menu, click **Demographics Editor**.
2. Click **Options**.
3. Under **Import Data from Interface Nodes**, 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 nodes 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 node.

Example: A patient's record initially shows two home medications: Paracetamol 500mg and Heparin. A clinician opens an interface node 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
Remote	View Only	Full access to the patient at the local bedside workstation; view-only access to all other patients.
Remote	View/Chart	Full access to the patient at the local bedside workstation; full access to all unfixed patients (not those admitted on bedside workstations).
Multibed	View Only	Full access to patients admitted in multibed units; view-only access to bedside patients.

Workstation Type	Access Type	Result
[illegible]	[illegible]	[illegible]

Note: [illegible]

[illegible]

[illegible]

Set the type of access to remote patients

1. On the **Workstation** menu, click **Basic Settings**.
2. [illegible]
3. [illegible]

Automatic Log Off

[illegible]

[illegible]

Set the automatic log off interval

1. On the **Workstation** menu, click **Basic Settings**.
2. [illegible]
3. [illegible]

Unattended Workstation Display

[illegible]

Note: This setting affects [illegible] Managers as well as [illegible] Manager, [illegible] Manager, and [illegible] 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.

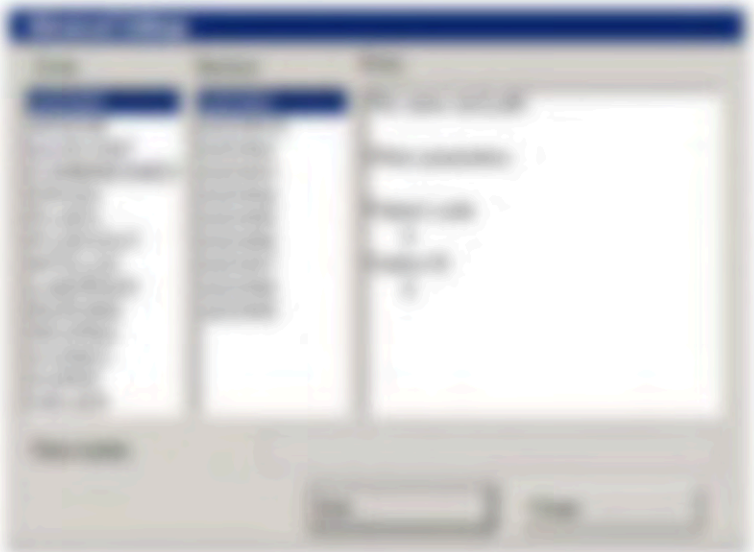
SETTING 2 — "[illegible] Remote Access from main application?"

Enabling this setting allows users to access patients via the Remote Access window and causes Remote Access to close when the [illegible] patient context changes internally between [illegible] applications.

Best Practice: If you disable this setting, remove the 'View Remote Patient' and 'View Census' commands from their respective menus. (Even if you retain them they will not function.)

The Advanced Settings Window

The Advanced Settings window provides access to hundreds of settings, the majority of which never require changes. This manual describes the settings that you most commonly use. 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 their software in another language.)

In this guide, settings are shown in the following format:

[illegible]

Example: [illegible]

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 file?"

Set whether the system will prompt users for confirmation

[illegible]

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
- Exiting or ordering a validation

Values

0 = No confirmation prompts

1 = Confirmation prompts

Set whether the system will show the completion of tasks

[illegible]

This parameter determines whether a message is displayed after certain tasks are successfully completed with [illegible].

Example: "Protocol was successfully created."

Success messages can be suppressed in the following situations:

- When creating a treatment, protocol, or standard order
- When editing a protocol

Values

0 = No completion messages

1 = Completion messages

Show or hide the daylight saving time (DST) message

[illegible]

[illegible]

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:** [illegible]

[illegible]

[illegible]

Values

Any color

[illegible]

[illegible]

Values

Any color

> **Note:** [illegible]

Text Settings

> **CAUTION:** [illegible]

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

[illegible]

Each Text[Number] entry corresponds to a GCS criteria. Change the text as required.

Example

[illegible]

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

[illegible]

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 families/treatments 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 families/treatments with the same index.)

Set the fields to show in order descriptions

[illegible]

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

1 = Field shown in order description

0 = 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 that displays when users right-click a medication or fluid name on a flowsheet includes the **Modify Order** command.

Values

1 = Users can modify doses

0 = 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. This setting affects medications and fluids.

Values

1 = Users can document tasks with a dose/rate of zero

0 = 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

1 = Field shown

0 = 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

[illegible]

This parameter sets the time period that controls the validations in the "Document Multiple Actions" window (which can [illegible] be copied forward). The last validation that occurred within the configured period is shown for each window.

Values

Time in Hours

Set the early documentation limit

[illegible]

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 = 47 hours)

Set the order extension period

To extend an order, users need prescription rights.

[illegible]

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.

[illegible]

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, [illegible] 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

[illegible]

If a scheduled task is documented late, the system prompts the user to shift the remaining [illegible] 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 [illegible] 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 reorganize when documenting late.

Values

Length of time in minutes

Set a documentation limit for finished orders

[illegible]

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

[illegible]

This parameter determines the default time shown in the **Starting Time** column of the order window. It affects the following:

- Single orders
- Standard orders
- Protocols [illegible]

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. -400) 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

[illegible]

The Round_To_Minute 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, 10, [illegible] and 60 minutes. For example, if the parameter is set to 15, the default starting time of [illegible] would be rounded down to the nearest multiple of 15, or [illegible].

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

[illegible]

This parameter determines the default administration time supplied in the window [illegible] 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

[illegible]

Continuous orders have no fixed end point after documentation starts; users can continue to order [illegible] indefinitely. For this reason, continuous orders are normally not included in the Extend Orders window. This parameter allows you to include [illegible] orders in the window so that users can validate their continuation. Extending such an order [illegible] an automatic [illegible] 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

[illegible]

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 the setting requires users to have the same rights as they would need to order the item. [illegible]

Values

0 = Validation rights required to discontinue orders

1 = Prescription rights required to discontinue orders

Set IV base solution volumes

[illegible]

This parameter determines the default base solution volumes that [illegible] 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

[illegible]

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 behavior.

Values

1 = Order description does not change. (Default)

0 = Order description changes to reflect the latest documented changes.

Example

Original prescribed order description: [illegible]

User documents a volume of [illegible]. Order description on flowsheet changes to the following: [illegible]

Set required ID number for blood bags

[illegible]

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

[illegible]

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

[illegible]

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

[illegible]

[illegible]

Values

0 = Doses and volumes are hard limits

1 = Doses and volumes are reference values only

Note: This parameter does not affect continuous infusions.

Set the default fluid family shown when prescribing intermittent medication infusions

[illegible]

[illegible]

Values

[illegible]

Set the default fluid shown when prescribing intermittent medication infusions

[illegible]

[illegible]

Values

[illegible]

Assessments, Scores, Equipment and QA Indicators

These settings govern the appearance and functionality of assessments, scores, equipment [illegible] and QA indicators.

Set the assessments box height

[illegible]

This parameter determines the number of response options that can be displayed in the Assessments, I&O Indications, 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 = [illegible])

Set the assessments multi-selection symbol

[illegible]

This parameter determines the flowsheet symbol used to indicate that more than one option has been selected in the Assessments, I&O Indications, and Equipment windows.

Values

Any character(s)

Set the assessments note symbol

[illegible]

This parameter determines the flowsheet symbol used to indicate that a note has been entered in the Assessments, I&O Indications, and Equipment windows.

Values

Any character

Set the barometric pressure for APACHE II

[illegible] CONFIGURATION, [illegible]

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 (760 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; the barometric pressure value for derived physiologic variables must be entered directly in [illegible] in the [illegible] database table. (See [illegible] on page [illegible].)

Show equipment checklists on flowsheets

[illegible]

This parameter determines whether or not equipment items can appear on the flowsheet.

Values

0 = Equipment items cannot appear on flowsheets

1 = Equipment items can appear on flowsheets

Show QA indicators on flowsheets

[illegible]

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

[illegible]

Set the frequency of database access

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

Note: [illegible]

settings. (If you instead set the parameter via the Configuration Editor (for Customizer) 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
0.001	= Data refreshed once for every 1000 queries (recommended setting for normal use)

Set screen refresh rate/scroll speed

[illegible]

This parameter determines whether the application reads all orders on the chart during screen refreshes, or just those corresponding to the current time slot.

Screen refreshes are faster when the system only needs to read a subset of the order list, but scrolling is slower because any change in the time view requires the system to read a new group of orders from the database.

Values

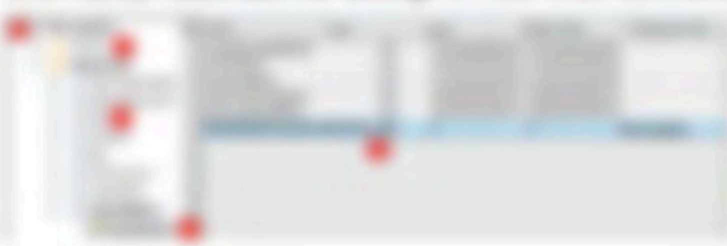
0 = System reads all schedule orders during screen refreshes

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. World
3. Zone
4. Section
5. Entry

[illegible]

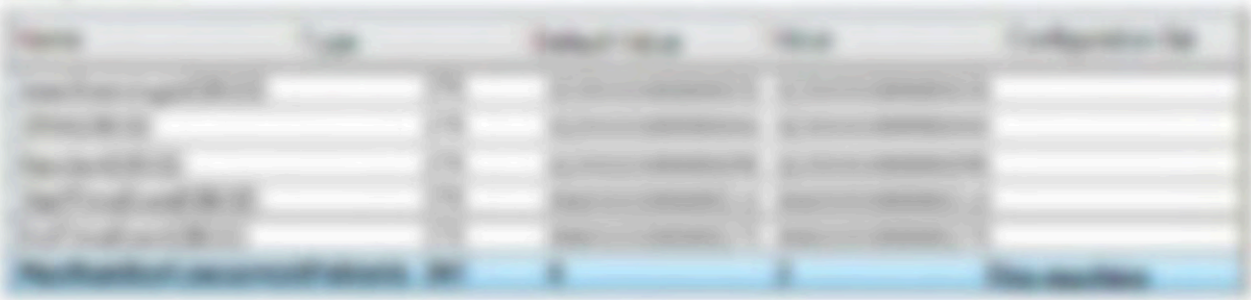
Note: [illegible]

[illegible]

[illegible]

CAUTION: [illegible]

Entry Details



For each entry you can see the following information:

- **Bold formatting.** [illegible]
- **Type.** [illegible]
- **Value.** [illegible]
- **Default Value.** [illegible]

- **Configuration No.** [illegible]

> **Example:** [illegible]

Note: Adding a comment to an entity is considered as an edit.

Note: [illegible]

[illegible]

The Hospital Configuration

[illegible]

[illegible]

> **Example:** [illegible]

Deleting and Inactivating Items

[illegible]

[illegible]

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 zone.	The **Delete** command is enabled for items that were added or modified in the current configuration set. For items from the default certification 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 "below" it. ⚠ **CAUTION:** Depending on the setting, inactivating an item can cause the editor to fail. Inactive items are shown in italic, grey font.	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 certification set. If you use **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 [illegible]. In "This machine configuration" has a [illegible]. No other configuration sets are applied to the workstation. When you delete the option in "This machine configuration" the setting remains visible in Customize, but now shows the value [illegible].

Exporting Settings to XML

You can export settings from a certification set, world, zone or section to an XML file. The file will only contain entries that have been added or edited in this 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 certification 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 [illegible] 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:** [illegible] **[illegible]** to the [illegible] template **[illegible]**.

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. [illegible] **Configuration Editor**, click **Open**.

> **Note:** By default, inactivated items are shown in italic, grey 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 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 setting.

   > **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.)
   - Colour (if the value will be an RGB colour 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 Deleting and inactivating items on page [illegible].)

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 Deleting and inactivating items on page [illegible].)

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 Deleting and inactivating items on page [illegible].)

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 Prov default configuration. In both cases, as 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 Prov 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, 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 site 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 visible; 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 expressions** 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
[illegible]	[illegible]	Security	UseRealRDPForLogOn

Possible Values
0 (the default): USERNAME is used for logging on
1: STAFFID1 is used for logging on
2: STAFFID2 is used for logging on
3: STAFFID3 is used for logging on

User visibility

World	Zone	Section	Entry
[illegible]	[illegible]	Security	ShowUserNameInLogon

Possible Values
TRUE – the typed username is visible
FALSE – the typed username appears as asterisks

Note: If UseRealRDPForLogOn is set to use a staff ID then the ShowUserNameInLogon parameter is not used (the typed ID is always visible regardless of the option).

Drop-down list of usernames

World	Zone	Section	Entry
Shop	Shop	Security	ShowUserNameCombo

Possible Values
TRUE – 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 **[illegible]** is set to use a [illegible] or if **[illegible]** is use to mark the user, then the **ShowUserNameCombo** 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 the 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 in all workstations.

World	Zone	Section	Entry
Clin [illegible]	Adt	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 [illegible].

User Name in Title Bar

You can specify whether the Title Bar shows the username or actual name of the logged on user.

Model	Zone	Section	Entry
[illegible]	[illegible]	[illegible]	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.)

Model	Zone	Section	Entry
[illegible]	[illegible]	[illegible]	[illegible]

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

World	Zone	Section	Entry
NotesService	NotesService	FSDNotesExport	DestinationPath

Possible Values
A local or network path
Example: [illegible]
Example: [illegible]

Note: The user associated with the clinical notes service must have write privileges for this folder. (See the Clinical Notes System Installation Guide for more information.)

Configure the naming convention for exported note files

World	Zone	Section	Entry
NotesService	NotesService	FSDNotesExport	OutputFileNamePattern

Possible Values
Any combination of the following variables and "fixed" text:

Variable	Description
[illegible]	[illegible] date DDMMYY
[illegible]	Admission DDMMYY
[illegible]	Admission ID1
[illegible]	Admission ID2
[illegible]	Admission ID3
[illegible]	Patient DDMMYY
[illegible]	Patient ID1
[illegible]	Patient ID2
[illegible]	Patient ID3
[illegible]	Template name
[illegible]	Note ID
[illegible]	Timestamp

Possible Values
Best Practice: To ensure unique file naming always use the timestamp variable.
Example: [illegible]

Configure the format for exported notes

Module	Area	Section	Entry
NotesService	NotesService	PDFNotesExport	ExportToPDF

Possible Values
True – Notes are exported in PDF format. False – Notes are exported in XPS format.

Configure automatic export of notes

Module	Area	Section	Entry
NotesService	NotesService	PDFNotesExport	TemplatesToAutoExport

Possible Values
The name of each clinical note template for which you want notes based on the templates to be automatically exported when finalized. Do not include the 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 template not in the list. Users can then manually export the note if they want to.)

Maximum Patients per Anaesthesiologist of Record (Concurrency)

You can specify the maximum number of patients that users of the Concurrency module are able to assign to an anaesthesiologist 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/anaesthesiologist ratio there is never any limitation or warning message in the Record Team demographics module when an anaesthesiologist of record is [illegible]

[illegible]

Module	Zone	Section	Entry
ChartPlus	[illegible]	[illegible]	[illegible]

Possible Values
Any integer

Care Metrics

[illegible]

Module	Zone	Section	Entry
ChartPlus	[illegible]	Sections	Activities Treatments [illegible]

Possible Values
[illegible]
[illegible]
[illegible]

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
ChartPro	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
ChartPro	CaseCheck	Configurations	[illegible]

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
ChartPro	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.

Weight	Zone	Section	Entry
ChartPlus	LabData	General	LabTestDays

Possible Values
Any integer number of days. The default is [illegible] days.

(See also the similar setting for Proxy Manager: "Proxy Manager Configuration" on page [illegible].)

For Anesthesia Manager and PACU Manager, a typical setting would be [illegible] 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 on discharged patients, Philips recommends setting this parameter to its maximum value of [illegible] days (nearly [illegible] 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 at 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	OpenPlus	[illegible]

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 in 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 [illegible] on page [illegible].)

Note: This is a template-specific setting.

World	Zone	Section	Entry
Realtime	(Template_prefix)_IP	Application	[illegible]

Example
For the General Anesthesia template you need to set this setting in the GA_IP 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** > **gau_ip** zone. You can customize these settings at any configuration level.

The best way to change the default template is by editing 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. Use Setup to edit the templates 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 [illegible].
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 [illegible].)

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 DB Editor or locally using Customizer. (For more information, see Reports on page [illegible].)

Best Practice: Make the report file path different to the report save path.

World	Zone	Section	Entry
Realtime	[template profile_ID]	CrystalReport	ReportsPath: the folder where report files are stored. 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 "[illegible]". 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 [illegible].

Report Configuration for Proxy Manager

File menu commands

You can configure the **Reports** and **Reports Audit** commands to appear on the **File** menu.

Note: [illegible] **Reports Audit** [illegible]

World	Zone	Section	Entry
[illegible]	[illegible]	[illegible]	[illegible] **Reports** [illegible] [illegible] **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 [illegible] [illegible] [illegible]

Best Practice: [illegible]

World	Zone	Section	Entry
[illegible]	[illegible]	[illegible]	[illegible] (the folder where report files are found) [illegible] (the folder where reports will be saved to)

Possible Values
Any valid path to a shared folder.
Note: [illegible]

Patient Summary Export to the HIS

You can enable users to send [illegible] Patient Summary reports to the HIS [illegible]

Patient Summary reports [illegible] in XML format.

Add the "Export Report" command to the Patient Summary window

Model	Zone	Section	Entry
ChartPlus	OPReport	General	EXPORTREPORTON

Possible Values
True — The command is available on the Patient Summary
False — The command is not available on the Patient Summary

Create report types

1. Add a new section beneath **Chartplus > OPReport** 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.

   CHARTDATAON: [illegible] data tables and laboratory data tables

   FBALANCEON: fluid balance information

   PROTOCOLSON: medications, fluids and action protocols

   DIAGPROCON: diagnoses and procedures

   NOTESON: patient summary notes

   EVENTSON: events

   ASSMSCORESON: assessments and scores

Auto-Adjust Fluid Volume Setting for Infusion Pumps

The infusion rate shown at an infusion pump matches the infusion rate shown for Anesthesia Manager. However, as far as the total infused volume is concerned, over time there may be a slight discrepancy between the [illegible] shown at the pump and in the application. (The discrepancy depends

[illegible]

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 "[illegible]".**

WORLD : [illegible]

ZONE : [illegible]

SECTION : [illegible]

ENTRY : **Threshold**

VALUE : The threshold [illegible]

Note: [illegible]

Example

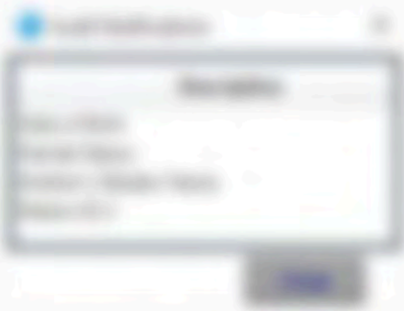
[illegible]

Volume shown at pump	Cumulated volume calculated in program	Difference [illegible] percentage	Auto adjust volume?
1st	[illegible]	[illegible]	N
2nd	[illegible]	[illegible]	N
3rd	[illegible]	[illegible]	[illegible]
4th	[illegible]	[illegible]	N
5th	[illegible]	[illegible]	N
6th	[illegible]	[illegible]	[illegible]

Note: [illegible]

Demographics Notification Icon

[illegible]



[illegible]

Configuration

[illegible]

WORLD: REALTIME

ZONE: TEMPLATE_SHORTNAME

SECTION: APPLICATION

ENTRY: **[illegible]**

VALUE: [illegible]

[illegible]

Event Sets and Macros

[illegible]

[illegible]

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 client command or applying a screen layout.

Note: If a supervisor review 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 'Edit View and Use' system right.

Create or edit an event set

1. On the **Workstation** menu, click **Event Sets and Macros**.
2. Click **New...** to 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 "Menu Buttons" on page 211.)
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 **Save**.
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 for 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:** Given 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 for 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:
   - Click **Notify support staff by e-mail**. (This enables the **Email Details** tab and the buttons at the bottom of the pane.)
   - In **SMTP mail server**, specify the mail server.
   - 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.
   - 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 Details** 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).

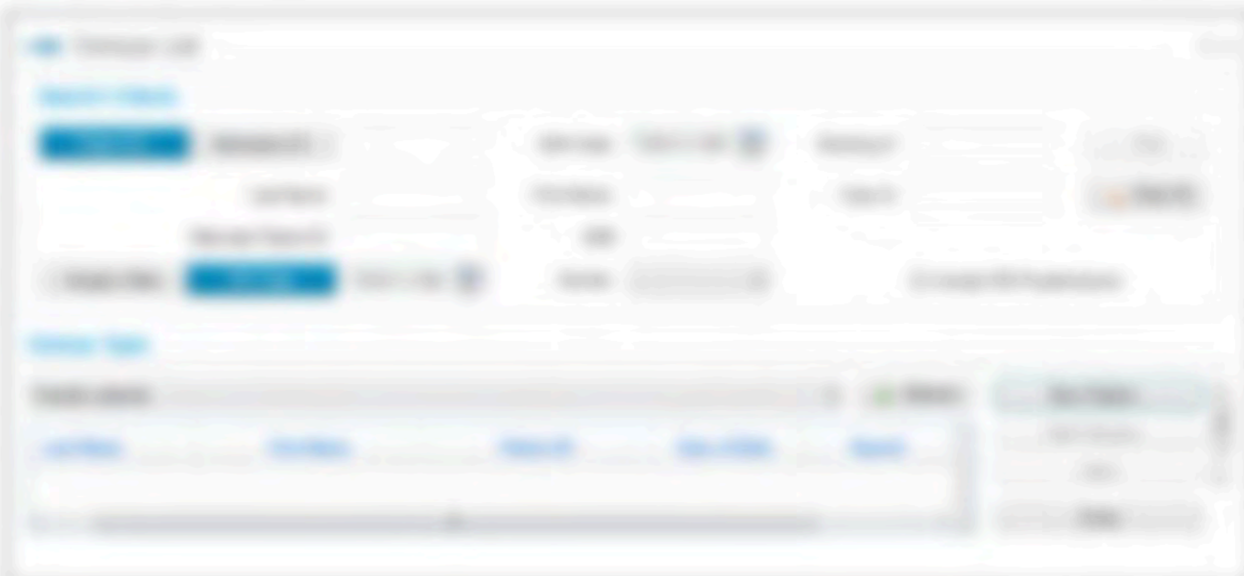
Census Windows

Overview

Picis provides a set of sample census windows for selecting patients in Anesthesia Manager, PABU Manager, Critical Care Manager, Picis Manager, CaseTracker, and the Producer Loader. The windows classify patients by admission status, to 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.



ADT Administrator

- [illegible] for the patient list (for example, [illegible] name, Patient ID, [illegible] attending physician).
- ADT functions [illegible] at the workstation (create new patients, import patients from the [illegible], [illegible] with an existing patient, [illegible] for viewing only, transfer a patient, discharge [illegible] patients). [illegible] Transfer and Discharge functions [illegible] census windows. [illegible] workstations [illegible]. These functions [illegible] only be available at supervisor [illegible].

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 [illegible] folder using Windows Explorer.
2. Double-click the file **ADT Administrator.exe**.
3. Log in to **ADT Administrator**.
4. Click the [illegible] button at the top of the window.
   Or, on the **Census List** menu, click **Configure**.
5. In the **Configuration Set** box, select [illegible] configuration set. The census list [illegible] will be available at all workstations to which the selected configuration set is applied. [illegible] configuration [illegible] if you just want to apply the layout to the workstation [illegible] you are currently using.) For more information on configuration sets, see [illegible] System Configuration Guide.
6. In the **World** box, click the [illegible] "configuration world" that contains the census window. Then click the window name in the **Zone** box.
7. Click **OK**.

Applies to	World	Zone
Anesthesia Manager, [illegible] Manager and Critical Care Manager (local patient selection from a bedside workstation)	[illegible]	[illegible]Census
Anesthesia Manager, [illegible] Manager and Critical Care Manager (remote patient selection from a bedside workstation)	[illegible]	[illegible]Census
Anesthesia Manager, [illegible] Manager and Critical Care Manager (patient selection from a [illegible] workstation)	[illegible]	[illegible]Census[illegible]

Application	World	Zone
Proxy Manager	[illegible]	ProxyCensus
[illegible]	[illegible]	[illegible]
ADT Administrator	[illegible]	AdtCensus
Printout This census window affects the Forms Builder preview in [illegible] and the [illegible] Viewer application. **Best Practice:** By default, the census list for this window shows all patients that are admitted or were previously admitted and can take some time to load. [illegible] recommends that you create an additional census list with a reduced set of patients (such as "Currently Admitted Patients") and set it as the default census list for this window.	[illegible]	PrtCensus

Creating Queries for the Patient Groups

Each patient group (census 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 census list queries that are provided or create your own. With the exception of the query used to search the [illegible], you can also modify the census list queries that are provided.

⚠ **CAUTION:** You should not modify the "Search results ([illegible])" query.

⚠ **CAUTION:** The "**Search results**" query must always include the following alias definitions in the FROM line:
• PATIENTS P
• ADMISSIONS A
• ENCOUNTERS E
You cannot use the alias letters P, A or E 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.

[illegible]

Rules for creating and editing queries

[illegible]

- [illegible]
- [illegible]

[illegible]

[illegible]

Create a new query

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]

Edit a query

1. [illegible]
2. [illegible]

3. In the **SQL Statement** box, edit the query to [illegible] the selection [illegible] grouping criteria, fields for patient and admission information, order as 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 (excluding the [illegible] or [illegible] 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 [illegible] on page [illegible].
2. In the **Titles** box, click a query name.
3. Click **Copy**.
4. Enter a name for the patient group. This text is displayed in the **Census Type** box in the window.
5. If you want to apply this new query by default, select the **Default Query** check box.
6. Click **OK**.

Import a query

1. Open a census window as described in [illegible] on page [illegible].
2. Click **Import**.
3. In the **Model** box, click the [illegible] "configuration world" that contains the census window with the query you want to import. Then click the window name in the **Done** 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 [illegible] on page [illegible].
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 title. 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 [illegible] on page [illegible].
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 title.
3. Select the **Default Query** check box.
4. Click **OK**.

Delete a query

1. Open a census window as described in [illegible] on page [illegible].
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, set up a column for every 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 every column heading.
- Set the width of each column.

Set up a patient list

1. Open a census window as described in [illegible] on page [illegible].
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 need 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 [illegible] on page [illegible].
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 [illegible] on page [illegible].
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 census window. Census windows typically fit as buttons for a few basic functions. Census windows for system diagnostics, such as the ADT Administrator census window, may include buttons for all of the major functions.

You can also customize the following elements in the census window:

- Text displayed in the title bar of the window
- Text label above the Census Type list box
- Text of the Close button
- Standard ADT functions

Add a button to a census window

1. Open a census window as described in ADT Administration 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 census 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 census window button

1. Open a census window as described in ADT Administration on page 215.
2. Under **Buttons**, click the button 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 census window by pressing **Enter**.
6. Click **OK**.

Change the order of buttons in 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 **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 [illegible].
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 [illegible].
2. In **Caption**, enter the text to be displayed in the title bar of the Census that 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 [illegible] on page [illegible]. It does not matter which one because the settings you will make apply to all census lists on 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 display, 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 line of a patient group by selecting its name in the **Census Type** box.
2. Click **Test**.

Note: If no patient group is in a patient list. Remember to check the test 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: Some of the buttons listed in the admission window are not currently supported: ReopenPatientButton, ReopenPreAdmittedPatientButton and CorrectButton.

1. After you have finished configuring the window, click **Save As**.
2. In the **Worlds** box, click the appropriate Pivot "configuration world" for the application. Then click the window name in the **Save** box. (For a list of census windows, see [illegible].)
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 adds the patient to the workstation.
NewPreAdmitted "New preadmission"	Creates a new record and sets the patient's admission status to "PreAdmitted".
AdmitPatientButton "Admit 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 Pivot system.

Button Identifier & Suggested Text	Description
FixPatientButton "Open Chart"	Opens a patient record without changing the patient's admission status.
RefreshButton "Refresh"	Refreshes the list for the selected patient group.
BreakERLinkButton "Break ER Link"	Breaks a background link.
ChangePatientButton "Change Patient"	Changes the patient on an admission.
ClosePreAdmissionButton "Close Preadmission"	Closes a pre-admission record.
LinkPreAdmissionButton "Link PreAdmission"	Links one pre-admission to another.
GetSupplyButton "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 [illegible]. 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 note that is open for editing in the (Customize) Printout Mode is automatically saved.

General printout settings

- For every printout model, you can define the output type (PDF and/or a [illegible]). 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 **[illegible]** 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 every 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 [illegible] to be notified whenever the PDF is generated by selecting **[illegible]**.
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
[illegible]: [illegible]

[illegible] Admission ID/ID
[illegible] Admission ID 1, 2, 3
(AccNum) Accession number
(FacName) Facility short name
(FacDesc) Facility description
Patient information variables
(PFn) First name
(PLn) Last name
(PMn) Middle name
(PId) Patient ID/ID
[illegible] Patient id 1, 2, 3
(PDoB) Patient date of birth
Printout information
(PrN) Printer model name
User who printed
(UID) User ID/ID
(UIn) Initial
(UN) Username
(UFn) First name
(ULn) Surname
Dates [illegible]
[illegible] day, 1 to 31
[illegible] month, 1 to 12
[illegible] year, 0 to 99
[illegible] year, 0000 to 9999
[illegible] hour, 00 to 23
[illegible] minute, 00 to 59
Example: [illegible] would equate to filename such as [illegible]

Note: By default, if a value does not exist for a variable it will be replaced by [illegible] [illegible]

Example: [illegible]

5. Under **[illegible] Network Path**, type the path to a shared network folder [illegible]

Example: [illegible]

Note: [illegible]

6. 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 [illegible] model and viewing period when printing.

Automated Printouts (workstation settings)

You can configure printouts to be created automatically [illegible]

Note: [illegible]

Create an automated printing instance

1. On the **Workstation** menu, click **Automated Printouts**.
   A window [illegible] 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 (at) you want the printout to be generated. You can either type the time in valid hh:mm format (e.g. 10:30) 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. 14:00) 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 4:00 and the interval is 8, printouts will be created at 4:00, 12:00 and 20:00. **Note:** If you only want one printout per day, enter a large interval so that the end of the day will be reached before the next printout can occur. (Tip: Use an interval of "23:59".)
Milestone	Click on the **Milestone** drop-down box and select a milestone event.
ADT Event	Click on the **ADT Event** drop-down box and select an ADT event.

5. 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 option, you can specify hours and minutes.)
6. 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 [illegible].
7. If you want the printout exported to the HIS, select **Export as 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 MR 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 231.

Note: Preop Manager configuration settings are not dependent on templates.

Note: If Anesthesia Manager or PACU Manager are integrated with Preop Preferences™, 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 modular" applications. For more information, see Automatic Log Off on page 173.

Open the Preop Manager configuration window

1. Start Customize. (See Starting and Quitting Customize on page 111.)
2. In **Configuration set**, select a configuration set. (See Configuration Sets and Workgroups on page 117.)

3. Next to **Preop Manager Configuration**, click **Open**.

Preop 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 Preop Manager summary.
5. When you're finished, click **Close**.

Note: The forms 'Copy Forward' and 'Previous Evaluations' are identical. The only reason to include both in Preop Manager would be if they were used by different clinicians for both purposes and were wanted to avoid confusing 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 [illegible] module are locked. See [illegible]

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 Prexy 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 Prexy Manager, users can specify the functional type (Prexy, Surgical etc.) and clinical priority (primary, secondary or unknown) for each diagnosis and procedure that is entered.

In Customize, you can configure that a certain functional type is required. For example, if you configure that a 'Prexy' functional type is required for Diagnosis, then at least one diagnosis must have the functional type, Prexy.

You can also configure that a required functional type must be accompanied by a certain clinical priority in at least one diagnosis/procedure. For example, you can specify a functional type of 'Prexy' 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 see).
   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 below it.
6. Click **Close**.

Example: The following example shows the functional types 'Surgical', 'Anesthesia' and 'Prexy'. Beneath each functional type the user can select the associated clinical priority - 'Primary'.

"Secondary" or "Unknown"

- Surgical
  - Primary
  - Secondary
  - Unknown
- Anesthesia
  - Primary
  - Secondary
  - Unknown
- Proxy
  - 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're finished configuring Prep 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're finished configuring Prep Manager, click **Close**.

Quick Links, Toolbar Buttons and Menu Commands

This section covers the following functionality:

- Configure a quick link application for the Prep Manager toolbar
- Provide a toolbar button for printing preparation patient instructions
- Provide a button for creating a template-based printout

Configure a quick link application for the Prep Manager toolbar

Note: You can use the buttons numbered from 1 to 5 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:
   - In **Location**, enter the path to and name of the executable file.
   - Select a graphic for the toolbar button and click **OK**.
   - Select the **Toolbar Icon** check box and then click **Browse**.
   - 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 worked site, configure a quick link for it. In Location, enter the path to the Centricity 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: Proxy Manager always includes a **Print Evaluation** command on the **File** menu. This command is used to print the current proxy summary. The formatting is controlled by an XSL style sheet and the content is preconfigured; it cannot be changed in Proxy Manager. Users click this command in Proxy 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 (not the contents of the anesthesia record). If configured to be shown in Proxy 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 Anesthesia Manager or PACU Manager are integrated with Picis PreAdmission™, then Proxy Manager should not be used and you should not change any settings in the Proxy

Manager configuration

You can set the ability to import the following data from an interface note into Proxy Manager:

- Home medications
- Past medical history
- Surgical history [illegible]
- Physical exam [illegible] (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 Proxy Manager, a patient record initially shows two home medications: Paracetamol 500mg and [illegible]. A clinician opens an interface note that shows that the patient now just takes Paracetamol [illegible]. After data has been imported the proxy record will only show a home medication of Paracetamol [illegible]; there will be no indication of [illegible].

Example: In Proxy 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 Proxy Manager record will not show any allergies.

Configure the ability for users to import data from an interface note

1. Click the **Sport 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 / [illegible]**, 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 Preop 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 on exit after a preop 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 notice (database field) to use as the patient identifier in the Preop Manager title bar. You can choose from the following:
   [illegible]
3. When you have finished configuring Preop Manager, click **Close**.

Note: The setting you make depends on the identification system used by your hospital and how the identifier details (or 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 Preop 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 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 [illegible].

Configure the ability for users to copy data from one evaluation to the next

Note: The 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 **Done**.

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**.
   - In **Model**, select the printout type to use.
   - 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 **Done**.

The Preop Instructions Printout

Unlike other aspects of Preop Manager, the Preop Instructions Printout is configured using a text editor rather than Customize.

Customize the preoperative instructions printout

1. Open the following file in a HTML editor (or Microsoft® Word and save as html):
   "%ProgramFiles%\[illegible]\Resources\[illegible]\PREOPINST.htm"
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-PROCEDURES#: Procedures documented in the form for diagnoses / procedures.

#DATE-OF-SURGERY#: Surgery date displayed in the demographics form.

#PATIENT-INSTRUCTIONS#: Instructions for the patient selected in the preoperative instructions form.

#PREOP-MEDICATIONS#: Instructions regarding medications selected in the home medications form.

3. Customize the look.

   Set formatting such as bold, italic 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 their margins are controlled by Internet Explorer settings, as described next.

Change the page margins

When the Preop 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 in 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 Explorer. 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

[illegible]

[illegible]

- [illegible]
- Note templates
- [illegible]
- Events
- [illegible]
- [illegible]
- Content for preoperative evaluations
- Hospital department names
- [illegible]

- Configuration parameters related to audit trails

Starting and Quitting DB Editor

Note that other Picis 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.

If database content	System right needed to edit content
Clinical content	Order: Supervisor Options
Users, user groups, prescription/validation rights	Users Accounts Maintenance

Note: Only a database administrator with extensive knowledge of the Picis system should use DB Editor. Changes made using this tool affect the behavior of the entire Picis system immediately. Any unwanted changes must be reversed manually.

When working with DB Editor, you are advised to set the CacheRefreshPeriodicity to 1 using Customize, as described in the section Set the frequency of database access on page [illegible]. Restore the parameter to its normal setting when you are finished using DB Editor.

Start DB Editor

1. Click **Start > All Programs > Picis Pipelinks [illegible] > 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 **Exit**.

Changes are saved automatically.

DB Editor Interface

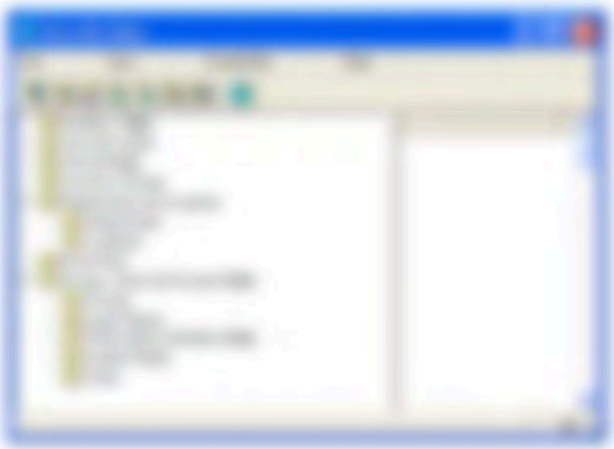


Figure 2 The DB Editor interface for a standalone "Virtual Install" system

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. [illegible]
- **Clinical Content**: Entries related to care activities that can be documented for a patient. These include medications, fluids, assessments and events, protocols, and all components associated with them.
- **Clinical Roles**: Possible functions that a surgical team member can perform in a surgical procedure and the attending types associated with each type.

  (For more information, see Clinical Roles on page [illegible].)
- **Common Choices**: Lists of [illegible] diagnoses, procedures, medications, [illegible] and allergies that [illegible] used most frequently in different care areas. [illegible]
- **Departments and Locations**: Hospital departments that use the [illegible] system, and locations that represent specific workstations or beds.

  (For more information, see Hospital Departments and Patient Locations on page [illegible].)

- **Groups, Users and Access Rights**: [illegible]

  [illegible]

CAUTION: [illegible]

Auxiliary Database Tables

The **Auxiliary Tables** [illegible]

Indexing

[illegible]

Note: [illegible]

Reserved tables

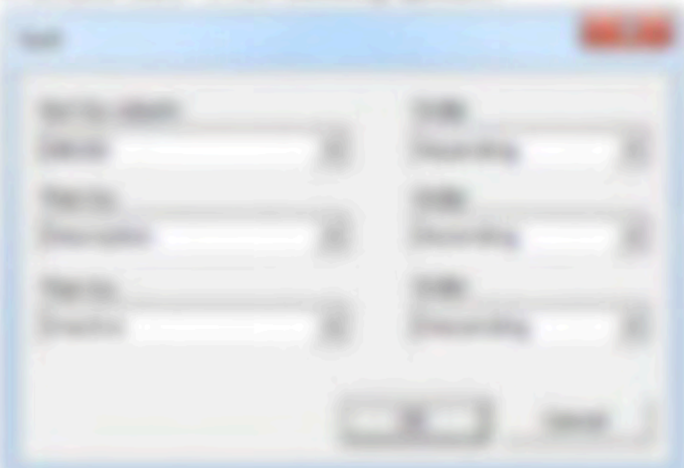
[illegible]

- ADT States
- Anesthetic Plan Types
- Application Roles
- Categories
- Concept Identifiers (Clinical IS to Interface)
- Configuration Status Types

- Distribution Status Types
- Family Behavior
- Order Modification Types
- Dispatcher Task Status
- Driver Types
- Route Scripts
- Unit Times

What you can do

Sort entries in a table

1. Click **Sort**.
   A window such as the following appears:
   
   In **Sort by column**, 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 [illegible] would be listed above [illegible] and [illegible] would be listed [illegible]. If you want to sort a second time without changing any of the sort options, the sorting would be [illegible].

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. [illegible] 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 [illegible] table includes a column that links each entry to an [illegible] in the [illegible] 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 to edit the text. To cancel either new text, click [illegible].
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 [illegible] entries without deleting them. These tables include columns labeled **[illegible]**. Selecting **[illegible]** removes the entry from [illegible] items. Clearing the check box restores them. Items in tables can also be deleted, but this action is permanent.

11

DB Editor and System Configuration

Access Rights and Users

There are two types of access rights:

- [illegible]
- [illegible]

System Rights

[illegible]

System right	What you can do with this right
[illegible]	[illegible]
ADT Manage	[illegible] - [illegible]

System right	What you can do with this right
	- Undo a discharge - Configure various lists **Note:** To start ACT 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 [illegible] Flag	Modify the dose when documenting [illegible] new bag of continuous Combined Meds too.
Anesthesia Manager User	- Start Anesthesia Manager - Use flowsheets - Order prescription and documentation (validation) data for [illegible]. (You do not need prescription or validation rights for the order concerned.) - View cell, order, [illegible] column matrix. (See also the "Clinical Modules Use" right.) - Close Anesthesia Manager at incharge workstations. (Note that this right does not allow you to close Anesthesia Manager at bedside workstations; for that you need the "Clinical modules use" right.) - Close Remote Access at bedside workstations. - Start ACT 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 use	Access all data and functionality for 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 pre-admissions • Ability to create and edit certain clinical database content in the Orders ribbon • Ability to move and resize windows • Copy-forward function • Close 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 sensor windows using AST Administrator (To start Customize, you also need the Customize right.)
Critical Care Manager View	Also use 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 "Order 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 folders.

System right	What you can do with this right
Delete Clinical Notes	Delete a draft note
Demographics [illegible] edit	Enter or modify data in the relevant Demographics window. [illegible]
Demographics [illegible] view	View data in the relevant Demographics window. [illegible]
Demographics Configure	Use the Demographics Editor in Customize.
Demographics copy hospital admission [illegible]	Copy the hospital admission [illegible] from a previous admission into the hospital information form.
Demographics Patient Identification view	View patient identification [illegible]. Copy the account number and [illegible] values from a previous admission into a patient demographic information form.
Demographics previous admissions [illegible]	View previous admissions in the Demographics [illegible] that are copy forward eligible.
Demographics Print	Print the Demographics window.
Demographics Summary [illegible]	[illegible] the Demographics summary for an encounter.
Diagnostic Tools	Start and use utilities in the [illegible] folder. **Note:** [illegible]
Document Viewer [illegible]	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 [illegible] files.
Edit Clinical Notes	Edit a 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 [illegible] 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 Pane	View and edit panes in the Supply Pkg and Add Supply windows
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.)
Intelligence 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 on the Report Viewer.
Integrated Data Report view and print	View and print the "Post-discharge Edited Shared Fields" report on Report Viewer.

System right	What you can do with this right
[illegible]	
Mapping Tool Admin	Use all Mapping Tool functionality including the ability to remove tables.
Mapping Tool User	Use all Mapping Tool functionality except the ability to remove tools.
Order Supervisor Options	Create and edit treatments, schedules, standard orders, protocols, and other clinical database content. **Note:** Supervisors with this right can validate any order and edit valid items made by other users even if the supervisor does not have validation rights for the order concerned. **Note:** This 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 relating to the INBOUND order interface. Users without this right can view a list of errors but cannot acknowledge them.
Order Outbound Error Acknowledge	Acknowledge errors relating to the OUTBOUND order interface. Users without this right can view a list of errors but cannot acknowledge them.
PACT Manager View	See row for "Anesthesia [illegible] 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.
[illegible]	Open and use the [illegible].
[illegible]	Enter or edit [illegible] in the relevant Group Manager window.

System right	What you can do with this right
Preop Individual Admit view	View data in the relevant Preop Manager window. Note that the Preop 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.
Preop and Demogr. Interface Form view	View the interface form from Preop Manager or the Demographics module
Preop Home Medications use	Enter or edit data in the Home Medications window in Preop 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.
Preop Manager use	Start Preop Manager. (Additional rights are needed to view and edit data.)
Preop Order Test use	Enter or edit data in the Tests and Results window in Preop Manager. Copy data from an interface note into the Tests and Results window.
Preop Physical Exam use	Enter or edit data in the Physical Exam window in Preop Manager. Copy data from a previous admission or interface note into the Physical Exam window.
Preop Review of Systems use	Enter or edit data in the Past Medical History window in Preop Manager. Copy data from a previous admission or interface note into the Past Medical History window.
Preop Supervisor	Not used. Reserved for future versions.
Preop Surgical History use	Enter or edit data in the Surgical History window in Preop Manager. Copy data from an interface note into the Surgical History window.
UserOptions	Access PreOptions buttons and commands in Preop 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 opening from Anesthesia Manager, PACU Manager, or Critical Care Manager. It is not needed for printing the Preop Manager Summary, Demographics window or Patient Summary.

System right	What you can do with this right
Profile Event Plan Conflict Manual Override	Override an event plan conflict for an 'Anesthesia Start' event. This right allows you to proceed with adding the event to the Events List. (Other conflicted events are not added.)
Profiles exceptions manual override	Set or un-set the 'manual override' flag for an exception (except that the user has the right to view in the Report Viewer).
Profiles report all of [illegible]	View and print all exception and concurrency reports in the Report Viewer.
Profiles report own to print	Start Reports Viewer. View and print exception and concurrency report in which the user is a recorded anesthesia provider.
QRP Mapping Tool	Start the Mapping Tool that is used to configure Quality Reports.
PRF measure [illegible]	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.
RT Scores	Document the Glasgow Coma and [illegible] 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.
Summary/Home screen view	Not used.
Summary/Stand screen audit	Not used.
Summary Provide Evaluation Audit	Not used.
Supply Use	Access the Supply flag and Add Supplies window.

System right	What you can do with this right
	Users can have Send 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 use other parts of the supply.
Surgical 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" View 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 use Report Viewer:
- Profiles 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 suggested tasks to the patient chart). The prescription right is also needed for timing 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 Are rights needed to cancel or discontinue orders? on page 281.)

  Note: No rights are needed for the automatic discontinuation/cancellation 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 those clinicians.

Prescription/validation rights allow you to control who can add and document different data 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 while ordering. This allows you to limit access to items and filter them so that specialists see only the ones that they order.

A set of default rights is provided. Custom rights are created during database installation and assigned to the items and standard orders before the database is [illegible]. 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 scheme can be used:

- A prescription/validation right called "Narcotics, order" and another called "Narcotics, document".
- Standard orders for all narcotics only 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 5-10 mg Intravenous Bolus or PRN	
Order Access	Validation Access
Narcotics, prescribe	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	P/V 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 1 was created when the database was installed. After installation, you can use OR Editor to create groups for these users and assign system and Prescription/Validation rights to the groups. You can also use OR 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 [illegible] record.
   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. There may be further restrictions depending on the global password settings. For more information, see Password Parameters on page 274.

   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 OB 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 Parameters on page 274.)
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 name.

   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 valid 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 **Exempt from Lockout**, if you do not want the user to be restricted to a maximum number of failed login attempts. (See Password Parameters on page 273.)
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 **New 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 contents 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 273.)

   Although a user can use a provided password to activate applications, he or she should be encouraged to change it when next logging on to a Proficy application (by clicking **Change Password** on the login 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 login attempts. (See Password Parameters on page 273.)

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

Clinical Roles

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, select 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.

[illegible]

Note: [illegible]

Logon Reports

[illegible]

[illegible]

- [illegible]
- [illegible]
- [illegible]
- [illegible]

([illegible])

Create a logon report

1. [illegible]
2. [illegible]

   [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]

6. Click **Close**.

Hospital Departments and Patient Locations

[illegible]

[illegible]

Note: [illegible]

There are three types of locations:

- [illegible]
- [illegible]
- [illegible]

[illegible]

[illegible]

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: [illegible]

For each location, you can see the following information:

- **Description**
- **Computer Name** (if this is blank it indicates a multibed patient bed)
- **Initials**
- **Identifier** (a system-generated identification number for the location)
- **Machine Type**
  - PCM = PCM server
  - CW = "clinical workstation"

Note:
· Machine Type is set by the Config Tool when it is run on a machine. (The tool is always run during an installation or upgrade.)
· Multibed patient beds do not have a **Machine Type**.
· Locations with Machine Type "CW" are available for selection when setting up workgroups in Customize. (For more information, see Creating and Editing Workgroups on page 2..)
· 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 "CW".

To see the following information, you must double-click the location and click **Next** to move through the wizard:

- **Location Type** (Bedside, Multibed or Multibed patient bed)
- **Department**

Modify a location

1. In the **Departments and Locations** folder, open the **Locations** window.
2. Double-click the location to change.
3. Edit the information as needed.
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

Create or modify an encounter type

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 Picis programs to determine the behavior of census 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 depend on the workstation type (bedside or midlevel) 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 joint facility groups: use customized census list queries to show patient records from a specific facility or facilities. (For more information, see Census Windows on page 213.)

Note: Census windows will only open 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 set up 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 [illegible] 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 [illegible].) 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.

  [illegible]

  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 taken. If no default use area is defined for the facility, the Use Area field will be left empty for that 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 is 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 Anesthesia Manager 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 **New**.
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

Proxy Manager, Anesthesia Manager, 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 while accessing VIP records** setting. For more information, see Privacy Warnings on page 257.)

6. Press Save.

Password Parameters

For standalone "clinical module" sites, password options are set using OR Editor, as described in this section.

For sites using enterprise integration with OR Manager, password options are set using OR Security Manager. (Password settings in OR 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 Pimsy 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 Picis applications.

  OR Editor can be used to "unlock" any users that have been locked out. (See Unlock a user who has been locked out on page 257.)

  You can make specific users exempt from being locked out. (See Create a new user on page 251 and Modify a user profile on page 253.)
- The period after which user passwords expire. (Users must change their passwords before the 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 275.

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 n 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: [illegible]

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 DS authentication is enabled, passwords cannot be set for users and the **Change Password** button does not appear in login windows of [illegible] applications. For full details, see the [illegible] 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 [illegible] of the search.

You can 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: [illegible]

Or

Search the MSDN for article [illegible]

For [illegible] filters, the **UserFilter** parameter has a variable to automatically pass the user name that is entered in the login window to the LDAP authentication system.

Example:
[illegible]
[illegible]

Result: The variable %1 is automatically replaced by [illegible] and this username is passed to the LDAP authentication system.

In addition to the user name, the parameter can [illegible] 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 criteria 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 [illegible] 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=ICU))

Example
Filter for all users excluding disabled accounts: (objectClass=user)(!(userAccountControl=2)[illegible]

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 [illegible] 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 [illegible] user credentials.
4. In the **Value** column for **LdapAuthenticationType**, enter one of the three authentication types below.

   None: Clear text passwords are passed over an unencrypted 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 **LdapAuthSingleDomain**, 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 as [illegible] in DB Editor.
7. In the **Value** column for **LdapFilter**, enter a filter with the appropriate syntax. (This setting cannot be left blank.)
8. Press [illegible].

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 sites, see [illegible] on page [illegible].) The folder where report files are installed can be defined globally or at a local level (for Proxy Manager, the workstation level; for [illegible] Manager, [illegible] Manager and [illegible] Manager, the application template level). A local level setting overrides the global setting.

Example
The global report path setting is "\\Server01\ReportFiles".
One template has a report path setting of "C:\ProgramFiles\[illegible]\ReportFiles": 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 on the Server01 machine.

The default locations 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:\ProgramFiles\FlowReportFiles". Users need "write" access to the report save path and "read" access to the report files path.

Best Practice: Keep the report file path different to the report save path.

Besides the 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 HIS 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 HIS 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 Enter.

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 Enter.

Configure the system to notify the HIS 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 HIS** and enter 1 to enable HIS notification or 0 to disable it.
4. Press Enter.

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 [illegible] on page [illegible].

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 DB Editor:

- Standard Coding for Assessment Items
- Standard Coding for Events
- Standard Coding for Event Types
- Standard Coding for Physiologic s
- 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, Philips staff have the ability to insert and modify mappings on request. (Mappings 1:1 never be deleted.)

The columns for each mapping appear as follows:

DBOID	Item name(s)	External Standard Code 1	External Standard Code 2
DBOIDs of the mapped items	Names of items from the database. For physiologic data, CSL codes are shown. For treatments the long name is shown followed by the tally name in parentheses.	An alphanumeric code of up to 30 characters.	An alphanumeric code of up to 30 characters.

Privacy Messages

You can configure the following "pop-up" messages:

- A message to be shown in the Log On window of Philips 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 module" sites, privacy messages are set using DB Editor, as described in this section.

For sites that interface with CR Manager, privacy messages are set using CR 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 this 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 upon application start-up**.
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

DB 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
Analytes	Laboratory analytes for the 'Enter/Edit Laboratory Results' window
Assessment Items	Items for each assessment
Components (Laboratory)	Laboratory components for the 'Enter/Edit Laboratory Results' window

TABLE	CONTENT
[illegible]	[illegible] For more information, see: [illegible] [illegible]
[illegible]	[illegible]
Event Types	[illegible]
Events	[illegible]
Family	[illegible] **Note:** [illegible] **Best Practice:** [illegible] **Note:** [illegible]

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 analyses are the same.)
Parts	Table that links the Analyses and Components tables. Part names are typically identical to Analyses 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 (as in DB Editor). Instead, CNL codes must be used. Note that you can use the Formulas Checker tool to [illegible] 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
Tx/ Intent	Treatment x-rays for medications, fluids, laboratory tasks, assessments, scores, [illegible], equipment ties, nursing care activities, and [illegible]. Data is entered using a wizard in the Clinical Content section of [illegible] 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 [illegible] orders. **Note:** Inactivating a treatment will inactivate [illegible] 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 [illegible] medication. **Note:** If you inactivate a standard order it will be removed from all protocols [illegible].
Unit Types	Classification 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 [illegible], 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 "[illegible] unit" and the "ml" unit has a conversion factor of 1. If "[illegible] unit" has a conversion factor of [illegible] it means that for every "[illegible] unit" that is documented [illegible] ml of fluid be added to the Fluid Balance.

Note that the Treatments auxiliary table allows you to edit treatments that already exist. You can use the 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 (Fluid IN, Medication, etc.).

⚠ **CAUTION:** There is nothing to prevent you from inadvertently creating two or more treatments with the same description.

Related Topics

Edit entries in a table on page [illegible]
When you have changed existing entries, click Close, on page [illegible]
Delete an entry from a table on page [illegible]
Modify an entry in a table on page [illegible]

Auxiliary Table Usage by Functional Area

Standard Orders

Form Types

Forms

Route Types

Routes

Standard Orders

Tcl Insert

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

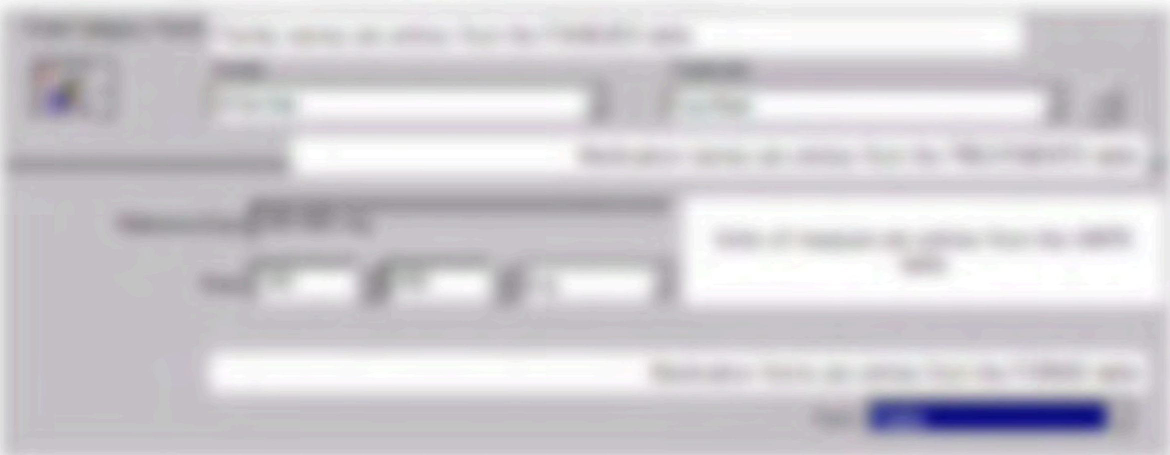
[illegible]

Content for Flowsheets

Using DB Editor to Edit Content

[illegible]

[illegible]



[illegible]

Medication and Fluid Treatments

[illegible]

- [illegible]

- 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 ongoing 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 set up treatments you use the Treatments window of the Clinical Content folder. However, to edit or delete treatments you use the Treatments auxiliary table (see Auxiliary Database Tables on page 255).

Create a medication

1. In the **Clinical Content** folder, double-click **Treatments**.
2. In **Order Category**, click Medication 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, verify, and extend the item.
   - In **Validation Access**, select the Prescription/Validation right required to move, reschedule and document data. Each administration on a patient's eFS.

   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 IN** and then click **Next** > to go to the next step in the wizard.
3. In **Behavior** (optional), 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 select 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, or extend the item.
- In **Validation Access**, select the Prescription/Validation right required to sign, 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 Catalog**, 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 ignores only the valid ID 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, 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, are 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 (Blood), Arterial O2 saturation (Sat_A), Hemoglobin (Hb), Serum sodium (Na_Ser).

- **Laboratory analyses and components**: Analyses are the names of ordered 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 7, CBC, Liver Function Test.

- **Diagnostic and laboratory activities**: Tasks that caregivers can organize for a patient. After being completed, the flowsheet reflects the time and caregiver that performed the task. Tasks are not shown on 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 [illegible].

Laboratory analyses and components: See Laboratory Analyses and Components on the next page.

Diagnostic and laboratory activities: See the following procedure.

Create a task for diagnostic tests or laboratory activity

1. On 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 task.
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 [illegible] and document the item:
   - In **Prescription Access**, select the Prescription/[illegible] right required to add, discontinue, cancel and [illegible] the item.
   - In **Validation Access**, select the Prescription/Validation right required to [illegible] and document data about administration on a patient's chart.

   Rights assigned to treatments only affect custom orders based on those treatments. [illegible] orders are assigned their own rights.
6. Click **Save**.

Note: Items entered in this way allow users to schedule and document the completion of tasks related to [illegible] 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, the 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 OR 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, 02, 03 ...).

   This step is optional. If you leave the index blank, analyses appear in the order they were entered.
6. Click **Close**.
7. Double-click **Parts** 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 (L Sorting)** in the list of database tables on the right side of the main window.
3. Click the **Add** button, and enter the name as 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 **Flash 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 Flash column.
   Example: CBC
4. On the same row, click in the **Component** column and select the name of a component in the list.
   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 in the grid (**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 in the grid (**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

[illegible]	[illegible]
Hematology	[illegible]
	WBC
	RBC
	HGB
Chemistry	Albumin
Urinalysis	

Analysis indexes: Hematology (1), Chemistry (2), Urinalysis (3)
Component indexes: [illegible], WBC (11), RBC (1?), HGB (1?), Albumin (20)

Note: An analysis can be a single component.

Note: [illegible]

Note: [illegible]

Note: [illegible]

[illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]

5. [illegible]

Component	Index
pH	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]

Analysis	Index
Arterial Blood Gases	[illegible]
[illegible] Blood Gases	
Arterial Blood Gases	
[illegible]	[illegible]
[illegible]	
[illegible]	
Coagulation	[illegible]
Coagulation	

Example indexes for components and analyses

6. [illegible]
7. [illegible]
8. [illegible]

Nursing Care, Respiratory and Ventilator Treatments

[illegible]

Note: [illegible]

Create a nursing care treatment

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
   [illegible]
6. [illegible]

- 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 the 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 Ventilation.

   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 the 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 rights 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 folder is shared by three types of items:

- Nursing assessments are evaluating aspects of a patient's condition in order to 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 [illegible].)

- Equipment lists collect data about equipment and supplies used during the procedure. These lists 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 [illegible].)

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 add or edit 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 OR 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 **Behaviour**, click **Non-QA Assessment**.
   (If you omit this step, the **Family** box below will also show the families of PA 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 **Tx Name**, 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:
   - In **Prescription Access**, select the Prescription/Valid Item right required to add, discontinue, cancel, and renew 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: Wound Care Checklist items: Normal, Flaccid, Rigid Codes: NOR, FLA, RIG

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 1?? characters and the **Code** limit is 10 characters.)

Checklist items appear in the order in which you entered them. You can change the order by editing the Index property in the Assessment Items table. See Edit a checklist assessment's QA indicators, assessments on page 3??.

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 [illegible] on a patient's [illegible].

   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: Problem
Checklist items: Illness, Adverse drug reaction, Dental injury, Eye injury, Head lice

When adding assessment items in this way, the **Description** is limited to [illegible] characters and the **Code** to [illegible] characters. (If you instead add or edit assessment items directly in the Assessment Items table, the **Description** limit is [illegible] characters and the **Code** limit is [illegible] characters.)

Items appear in the order in which you entered them. You can change the order by editing the Index property in the Assessment Items table. See Edit a checklist (assessments, lab indicators, equipment) on the next page.

Create a new equipment checklist

1. Click **Clinical Content** on the left side of the main window in OB 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 [illegible] right required to document data about administration on a patient's sheet.

Rights assigned to treatments only. [illegible] based on those treatments. [illegible]

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: [illegible] Equipment
Checklist items: Capnography, [illegible], Gas analyzer, [illegible] analyzer, Pulse oximeter

When [illegible] assessment items in this way, the **Description** is limited to [illegible] characters and the **Code** to [illegible] characters. (If you [illegible] assessment items directly in the Assessment Items table, the **Description** limit is [illegible] characters and the **Code** limit is [illegible] characters.)

Items appear in the order in which you entered them. You can change the order by editing the Index property in the [illegible] table. See [illegible].

Edit a checklist (assessments, QA indicators, equipment)

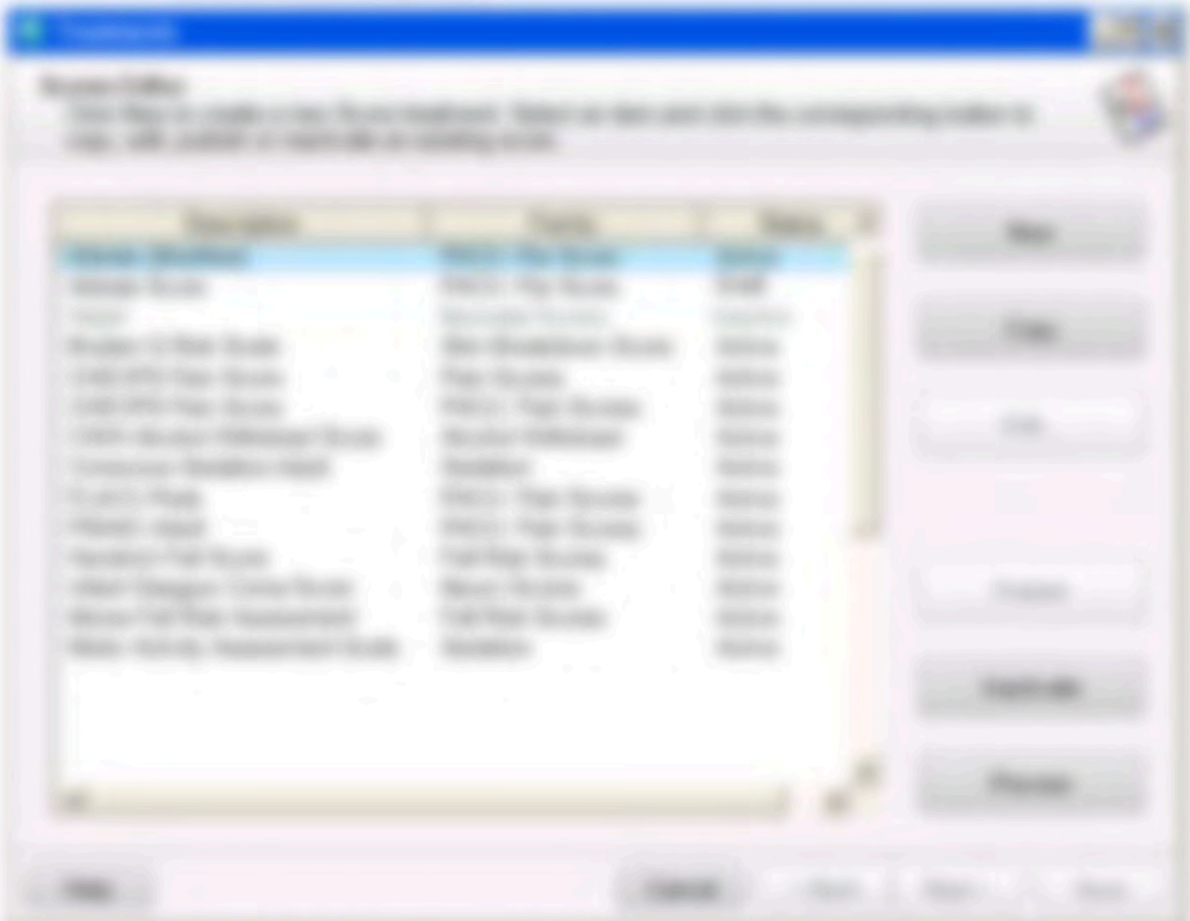
1. Click **Auxiliary Tables** on the left side of the main window in OR Editor.
2. Double-click **Assessment Items** on the list of database tables on the right side of the main window.
3. To add a new item to the list, click the **Add** button and enter the name of an item on the new row. Then press 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 [illegible] and Glasgow Coma Scale. These scores are hardcoded in the software and not accessible via the Scores Editor.

You can [illegible] create your own scores using the Scores Editor. (If your hospital uses standard [illegible] database content, your system will already have scores like TISS, [illegible], and [illegible].)

After creating and publishing scores, you need to make them available on flowsheets. For information, see Flowsheets on page [illegible].



The Scores Editor. The buttons depend on the status on the selected score.

What you should know

- When you first set up 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.

- [illegible]
- [illegible]

Score Items

[illegible]

- [illegible]
- [illegible]
- [illegible]

[illegible]

Button Reference

Button	Purpose
New	Create a score from scratch.
Copy	Create a score based on a copy of another score.
Edit	Edit a(n) [illegible] score. **Note:** [illegible]

Button	Purpose
Publish / Activate	Publish a draft score or activate an inactive 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.

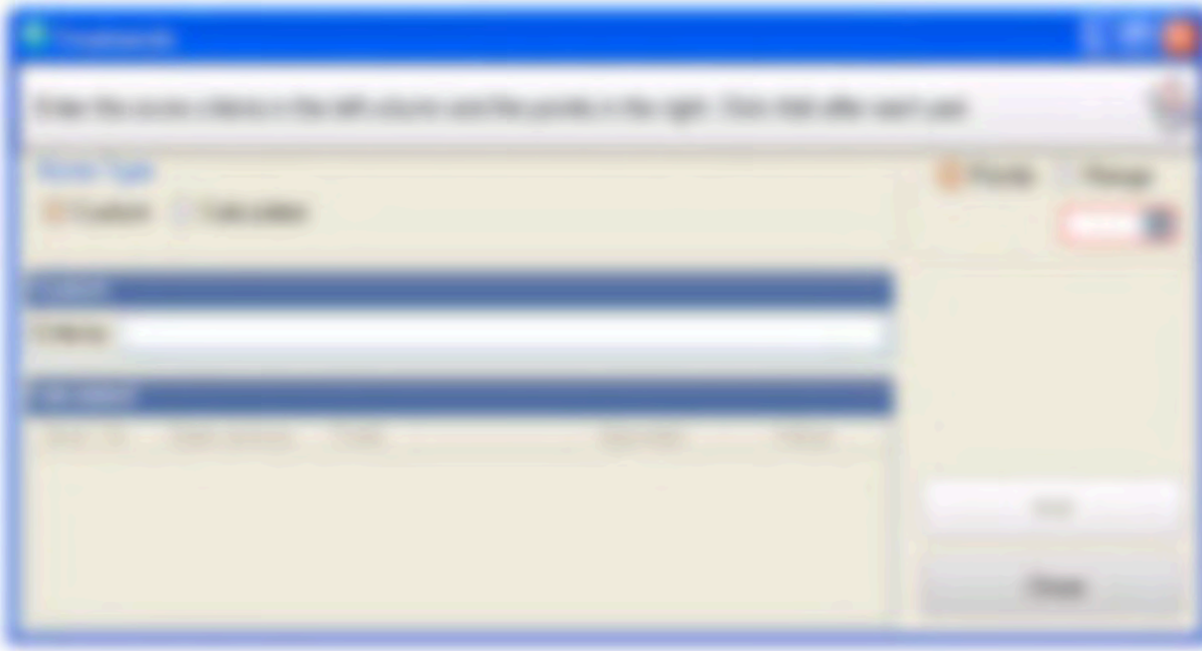
Publish, delete, inactivate, activate or preview a score

1. Click **Clinical Content** on the left side of the main window in OB 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 active.)
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 **Close**.

   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 OB 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.

a. Under **And/or**, select AND or OR, as required.
b. Under **Data source**, select either Demographics, Flowsheets or Laboratory.
c. Under **Field**, select a field from the data source that you specified.
d. Under **Operator**, enter a mathematical operator (equal to, 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 OB 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 OB 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 **Family**, **Treatment**, **Prescription Actions** and **Validation Access** as required and then click **Next** to go to the next wizard step.

   The Score Editor window appears.

   For more information on the functionality in this window, see [illegible] on page [illegible].

5. Edit the score as follows:

   Edit group names by clicking the edit button in the group header and modifying the text in the [illegible].

   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 [illegible] on page [illegible].)

   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 tasks 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 10 hours.

- **PRN**: Administration as needed. The order may be timelimited, 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 items 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.

Schedules for periodic relative and PRN orders are created in the same way; users make the 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 time expected. Testing should include [illegible] an order to [illegible] [illegible] is expected.

Note: You can delete schedules. [illegible]

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, 9, 18' is allowed but '9, 18, 5' is not.)	Total duration (any negative integer to represent [illegible])	[illegible] Freq. = [illegible] Duration = [illegible] [illegible] Freq. = [illegible] Duration = [illegible]
Periodic Relative	Frequency in minutes	Total duration (hours)	Every 2 h for 24 h Freq. = 120 Duration = 24
Unrestricted PRN (Administration optional)	As often as needed [illegible]	Total duration of order on chart (hours)	48-hour [illegible] Freq. = 0 Duration = 48
Restricted PRN (Administration optional)	As often as necessary, with a minimum interval (in minutes) between validations	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	As often as necessary; Administration is optional	Total duration of order (given). Item is shown on the chart for the period of time, but does not end until stopped.	Continuously for 48 h Freq = 1 Dur hrs = 48

Useful Schedules

[illegible]

More About Absolute Schedules

[illegible]

- [illegible]
- [illegible]
- [illegible]
- [illegible]

[illegible]

[illegible]

Note: [illegible]

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, [illegible]

   For **relative** schedules, [illegible]
5. In the **Duration** box, [illegible]

   [illegible]
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**.

Delete a schedule

Standard Orders

Create or modify a standard order

Administration information: For treatments in the Fluids In, and Medications categories, [illegible] includes information like the dose, medication form and medication route. For Medications, [illegible] 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 B [illegible]** 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 [illegible] for [illegible] explanation of the three types. For IV fluids administered using a pump [illegible] or for 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 48 hours). Continuous orders do not have a task type.

Condition (Optional): Any specific condition that must be met before the caregiver administers the [illegible].

Memo (Optional): Any other information a user needs when administering the order.

Prescription Access: Prescription/validation [illegible] a user must have to order, modify, discontinue, cancel, or extend the standard order. Only drips, medications, intermittent infusions and combined medications can be modified.

Validation Access: Prescription/validation right a user must have to [illegible], modify, or [illegible] the standard order. Only fluids in, medications, intermittent infusions, combined medications, and nursing care orders can be [illegible].

Auto-Select Order: Option that causes the standard order to be selected automatically when a user selects the treatment in the Single Orders 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.)

Standard Orders for Combined Medications

Editing this field	Recalculates these fields
Dose	Dose (for other components) Pump Rate
Diluent Volume	Pump Rate
Volume	Volume (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 other 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** (as 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 every 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.
7. If the components are infused with a diluent fluid, proceed as follows:
   - Select **Infusion**. (If you previously selected a schedule with Duration, Infusion is selected already.)
   - Enter a value for **Diluent volume**.
   - Select a **Diluent Family** from the drop-down list.
   - 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 **[illegible]**, enter any other information a user needs when administering the order.
13. Click **Next**.
In **Prescription Access**, select the [illegible] right a user must have to order, modify, discontinue, cancel, or extend the standard order.
In **Validation Access**, select the [illegible] right a user must have to reschedule a task, move orders, or validate [illegible] administration of the standard order.
14. Click **Finish**.

Create or modify a Continuous standard order for combined medications

1. In the **Clinical Content** tree, 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 [illegible] recommends the following workflow.
5. Make sure that **Fixed rate** is not selected.
6. For every 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 **[illegible]** field and select a unit from the drop-down list. (Do not select the [illegible] amount yet.)
7. Select a **[illegible] Family** from the drop-down list.
8. Select a **[illegible]** from the drop-down list.
9. Enter a value for **Fluid Volume**.
10. In the right **Pump [illegible]** field, select a unit from the drop-down list. (Do not select a pump rate.)
11. For one medication component only, click the left **[illegible]** field and enter a [illegible] amount.
When you do this, the [illegible] amounts for the other components are calculated automatically.
12. Check that all values are appropriate. If you need to edit any values, consider how the fields are [illegible], 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 Actions**, select the Prescription/validation right a user must have to reschedule a task, move an order, or validate document administration of the standard order.
   Select **Auto-Select Order** if you want the standard order to be selected automatically when a user selects the list item 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.

19. 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 back to the protocols it was in before.

Protocols

Protocols are groups of standard orders that can be added to a patient chart together. Users can tailor 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 flowsheet 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 to apply during a session.

See also: Configure a default protocol on page 3[illegible].

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 variables are stored in the database. You cannot delete or add variables to this table with OR 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 filter are configured in templates.

For more information on configuring variable properties, see Configuring Physiologic Variables on page [illegible].

Set the properties of physiologic variables

1. In the **Auxiliary Tables** folder, double-click **Physiologic Variables**.
2. Locate the variable in 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 also 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 gets a marker symbol beside it.
Unit	Default 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 variable constants using a formula. For example, Derived Mean Pulmonary Pressure (dMPA) uses data from the variables Pulmonary Diastolic Pressure (DPA) and Pulmonary Systolic Pressure (SPA) as follows:

dMPA = DPA + (SPA − DPA)/3

Derived variables behave similarly to other physiologic variables: data is listed in 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 CSR database includes approximately 30 derived variables. You can create new derived variables using additional 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 Mod-i-Link codes or labels, and database constants.

  Enclose variable labels in square brackets ([VAR]). Precede Chart-i-Link codes with a pound symbol (#0011). Physiologic variable labels are case-sensitive.

  Three database constants are provided: WEIGHT, HEIGHT, and BSA (Body Surface Area). Data for HEIGHT and WEIGHT are entered by users on the demographics flowsheet. BSA is calculated internally using HEIGHT and WEIGHT.

- 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	2 - 1
	Negation	-1
*	Multiplication	2 * 3
/	Division	1 / 2
^	Exponentiation	2 ^ 3

COMPARISON OPERATORS		
=	Equal to	{HR} = {PULSE}
>	Greater than	{HR} > {PULSE}
<	Less than	{HR} < {PULSE}
>=	Greater than or equal to	{HR} >= {PULSE}
<=	Less than or equal to	{HR} <= {PULSE}
<>	Not equal to	{HR} <> {PULSE}

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 an 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.

- **ERROR**: Returned when an invalid arithmetic operation occurs, such as division by zero or when a negative value is raised to a non-integer power.
- **INVALID**: Returned when the final result of a calculation is less than -9,999 or greater than 99,999.

  Also returned when the absolute value of any expression in the formula is less than 1E-308 or greater than 9.99999999999999E+308.

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:

INVALID

ERROR

EMPTY

Prevent errors with IF, ISERR, and ISEMPTY

The ISERR and ISEMPTY functions can detect ERROR and EMPTY 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 specific variable PULSE1:

```
IF ( ISEMPTY ( {PULSE1} ), {PULSE}, {PULSE1} )
```

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
- Clinical 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

Operations 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:

```
[illegible]
[illegible]
```

The first expression uses Pulse to obtain Heart Rate. The second expression uses Heart Rate to obtain Pulse. Neither of the expressions can be calculated.

A circular reference can involve more than two expressions:

A = 2 * B

B = 2 * C

C = 4 * A

The first expression uses B to obtain A. The second expression uses C to obtain B. The third expression uses A to obtain C. 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 PULSE

```
[illegible]
```

If Heart Rate is greater than Pulse, then x equals Heart Rate. If not, x equals Pulse.

Example 2: Body Surface Area (BSA)

```
[illegible]
```

Note: Your hospital unit may use a different formula for BSA.

If [illegible] is less than [illegible], x = [illegible]

If Weight is less than [illegible] kg, x = [illegible]

Note that these expressions do not contradict each other because they are calculated from left to right, so the second expression is only used if the first is false. The second expression really means "a Weight is between [illegible] kg and 29.99 kg."

If Weight is greater than 29.99 kg, and a value of Height is not available, a = Weight / null.

If Weight is greater than 29.99 kg, and a value of Height is available, a = (Weight [illegible]) / (Height [illegible]) [illegible]

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 = [illegible]
```

Configure a derived variable

Note: Only configure a variable as a derived variable if data from this 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** in the list of lookup tables on the left 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. Type your formula.
5. In the **Derived** column, select the check box.

   The variable appears in the Derived Variables window in Datamine 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 grouping 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 Essay 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 dataset as 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 1.)

Anesthesia and PACU Manager:

- PERIOP - Diagnoses - Demographics
- PERIOP - Procedures - Demographics

(Used when the ICU property for the encounter type is set to 0.)

Proxy Managers

- PREOP - Diagnoses - Proxy Manager Demographics
- PREOP - Medications - Proxy Manager Medications
- PREOP - Procedures - Proxy Manager Demographics
- PREOP - Procedures - Proxy Manager Surgical History
- IML - 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 in the imported list replace any items in the Common Choices list.
5. You can customize the list by adding or removing items, or 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 if they have expired.)
Hospital Defined	Shows any hospital-specific items your hospital has configured from the S_MEDICAL/PROCEDURES or S_DIAGNOSES table of the OR 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 if 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 if they have expired.)
Sh test	For procedures only. Shows items required by the system such as "Unknown".

c. In the **Type** box, select a clinical category, such as "cardiac" 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 CustomTool to add new events. You can use DB Editor to edit, delete or configure the following properties on 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 row.

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 Begin'.

- Symbols for events. When an event with a symbol is documented, the symbol appears in the time line. 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 Supervisory 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 for 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 type 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 for 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 type you want to edit.
3. Click **Delete**.
4. Click **OK**.

Patient Summary

The Patient Summary is configured using Customize. You can use OB 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 NoteTypeBlocks table. Note blocks are text 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 **isHidden** 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 the 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 sections (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 stock 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 is configured using Customize and OR Editor. For more information, see Rule-Based Notifications for Sepsis on page [illegible].

Configure a list of symptoms and risk factors

1. Open OR Editor.
2. In the **Auxiliary Tables** folder, double-click the **Rule Symptoms** table.
3. To edit a destination, 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**.

Preop Manager

Overview

Content for certain windows in Preop Manager can be customized at a global level using OR Editor.

- **Allergies** and **Diagnoses and Procedures**. You can customize the "common choice" lists associated with diagnoses, procedures, and allergies. These lists provide abbreviated selections of the items most commonly documented in the case area.

  See: Common Choices for Diagnoses, Procedures, and Allergies on page [illegible]

- **Past Medical History**. [illegible] of the patient's medical history to be covered in the [illegible]. When created, new entries appear automatically in the corresponding window in Preop 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 [illegible] and Add a finding to a medical history section on page [illegible].

- **Physical Exam**: Body systems to be examined. When created, new entries appear automatically in the corresponding window. You can designate sub-sections as required for all patients.

  For example: Ears and Neck, Pulmonary, Cardiovascular, Musculoskeletal, Skin.

  See: [illegible] and [illegible]

- **Anesthesia Plan**: Techniques, equipment and issues to discuss with the patient. When created, new entries appear automatically in the corresponding window in Preop Manager. You can designate some sections as required.

  For example: Analgesic Technique, Additional Equipment, Risks Discussed with Patient.

  See: [illegible]

- **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 sections; the Body System Exam Items auxiliary table contains the findings for each factor.

  See: [illegible] and [illegible]

  > **Note**: The table that stores the names of risk assessment types is not accessible via OR Editor; a database tool such as Microsoft SQL Management Studio must be used. For more information, see [illegible]

- **Home Medications**: The status of a medication in the patient's current regime of medication.

  For example: Active, Inactive, Unknown.

  The Preop Statuses (Medications) auxiliary table supplies options for the **Status** column in this form.

  See: Auxiliary Database Tables on page [illegible]

- **Preop Instructions**: Information given to patients 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 Preop Instruction Types auxiliary table supplies the types and the Preop Instructions auxiliary table supplies options for the window.

  See: Create a preoperative instruction on page [illegible]

- **[illegible] 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 [illegible] of the [illegible] window.

  For example: Ready for [illegible], [illegible] follow-up, Ready for surgery, Surgery [illegible].

  The [illegible] [illegible] Status auxiliary table supplies the statuses.

  See: [illegible] on page [illegible]

- **Signatures**: Up to [illegible] different types of signatures [illegible] responsible for completing or [illegible] [illegible] part of an evaluation. For each sign-type you can specify if using it [illegible] change the status of the entire evaluation to final. [illegible] a final signature certain sections will become locked if this configuration option is [illegible]. Users can then only enter addenda to an evaluation, but not change the data in the affected sections.

  For example: [illegible] or Resident, Attending Review

  The Signoff Types auxiliary table supplies options for this service.

  See: [illegible] on page [illegible]

- **Addenda**: Notes that caregivers can add to an evaluation, typically after it has been [illegible] as final. Caregivers can enter free text or use standard comments.

  For example: Agree with the [illegible] 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: [illegible] on page [illegible]

Medical History Section

Create a section in the medical history

1. Click **Auxiliary Tables** on the left side of the main window in OR 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 [illegible] before single digit numbers ([illegible]).

   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 [illegible] window in OB Editor.
2. Double-click **Body System Exam Item** 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 [illegible] finding and then press [illegible].
5. In the **Body System Exam** column select the [illegible] of the corresponding section and then press [illegible].
6. In the **Index** column, enter a number corresponding to the position of the item relative to others in the section and then press [illegible].
   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 the appropriate status (Normal, Abnormal, Deferred) and then press [illegible].
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 [illegible] window in OB 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 [illegible].
5. In the **Body System Exam Type** column, select **Physical [illegible]** and then [illegible].
6. In the **Index** column, enter a number corresponding to the position of the section relative to others in the window and then press [illegible].
   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. 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 OB 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 (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 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 OB Editor.
2. Double-click **Anesthesia Plans** 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. 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 (0, 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 OB Editor.
2. Double-click **Preop Instructions** 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. 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. Hit 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 **Common 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 UI 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 **Field** column, select [illegible] and then press Enter.
7. When you have finished editing 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 [illegible], add a new row.
2. One of the body system exam types has the description "Unknown"; copy the [illegible] for this entry to the new exam type and change the [illegible] digit to X, where X=0, 2, 3 etc. Do not use a [illegible] used by another exam type; the [illegible] must be unique.
3. In the **[illegible]** column, type a description for the new exam type (up to the description shown in DB Editor).
4. In the **[illegible]** column, type "[illegible]".
5. In the **[illegible]** column, type "[illegible]".

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 (00, 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 [illegible].) 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 [illegible] 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 Item** 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 (0, 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 are shown at the bottom of a form if the combined score for all risk factors (positives) 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, fixing 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 0.)

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 [illegible] > **evalconfig** zone in Customize. (The easiest way to create this is by copying an existing risk assessment form section.)

  Settings in the section determine 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 type on page [illegible].)
- A label for the form, and the text to show in the status bar while the form is selected. These are specified in the following XML file using an XML editor:

  [illegible]

  > **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 [illegible] of the risk assessment type on which the form will be based. A database administrator will need to identify the [illegible] in the [illegible] table in the [illegible] 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 [illegible].

1. Open the Configuration Editor in Customize.
2. In the **[illegible]** > **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 [illegible] 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 **[illegible]** > **evalconfig** zone.

Best Practice: [illegible]

6. Double-click [illegible]

Note: [illegible]

7. Double-click [illegible]

Example:
[illegible]

8. [illegible]
9. [illegible]
10. Double-click [illegible]
11. Double-click [illegible]

[illegible]

1. [illegible]
   [illegible]
2. [illegible]

Example: [illegible]

3. [illegible]
4. [illegible]
   [illegible]
   [illegible]
5. [illegible]
   [illegible]

Where [Help] (short) is the exact text you entered in Customize for the NavCaption entry and [Form Label] is the text you want to see in Preop Manager for the form (on the Navigation Bar, Summary and form title bar).

6. Save and close the file.

8. 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 [illegible]
  - Create a finding for a risk factor on page [illegible]
  - Create a recommendation for the total risk assessment score on page [illegible]

Auxiliary Tables Associated with Preop Manager

Note: Some of these tables are also associated with Anesthesia Manager, PACU Manager and Critical Care Manager.

TABLE	COMMENT
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 Checklists" 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 on 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 [illegible] comments in [illegible] section.

TABLE	CONTENT
Complications	Drop-down list entries for complications in past surgeries for the Surgical History section.
Home Medication Frequencies	Drop-down list entries for documenting medications being taken by patient at time of visit in the Home Medications section.
Preop Statuses (Medications)	Drop-down list entries for possible preoperative statuses for home medications.
Order Test	Diagnostic tests in the Tests 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 for completion on the assessment.
Note Types	Classifications that make administration issues easier to find in DB Editor. Not used elsewhere.

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 [illegible] 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 topic discusses publishing from Notes Manager. For information on publishing from InfoPath and on the [illegible] Notes System in general, please see the [illegible] 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.

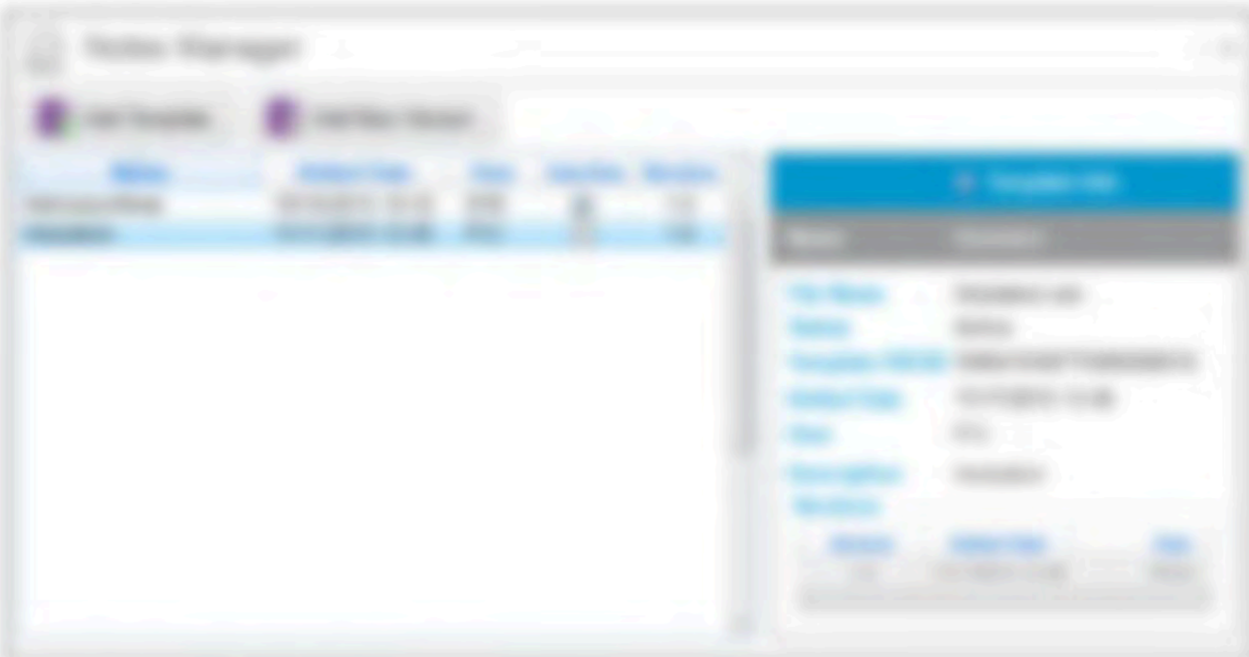


Figure 8: The Notes Manager window

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 '.[illegible]'.) Select the template file that you want to make available.
     For more information, see the Template Design Guide for the [illegible] System.
   - **Name:** enter a name to identify the template to any 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 are still 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 to organizations.

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 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 upload.
5. Enter a **Description** and click **OK**.
   - The added template file is published in the database.
   - When the upload completes, the new template version appears in the Notes Manager template list.

[illegible]

Inactivating a Template

[illegible]

Common Choice Lists for Notes

[illegible]

Physiologic Variables

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 in the right pane. This dictates the order in which the data is displayed in the note.
- **OK**: Saves the common choice list and closes the window.
- **Cancel**: Closes the window without saving.

A

Appendix A: Report Templates (RPT files)

Creating Report Templates

Note: Besides creating your own Crystal Report templates Picis has a number of stock templates available for purchase. Please contact your Picis representative for more information.

Report templates should be created using Crystal Reports 11.0 by implementation staff who are experienced with the Picis 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 selection filters in report templates as needed:

- AdmissionDbsid
- AdminID (only if the report is opened from Anesthesia Manager, PACU Manager or Critical Care Manager. Note that this parameter does not always exist w/o an admission.)
- EnvironmentDbsid
- PatientDbsid
- Product Dbsid
- Port
- StaffDbsid
- StaffId
- UserName

- [illegible]

[illegible]

Note: [illegible]

[illegible]

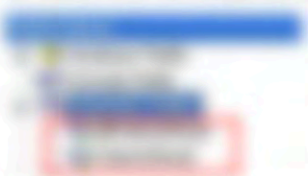
[illegible]

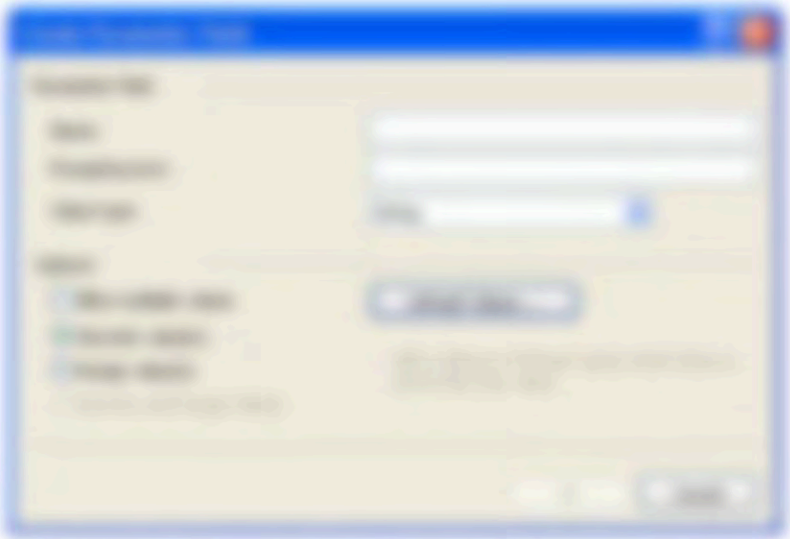
[illegible]

- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]
- [illegible]

[illegible]

[illegible]





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. For **Value type**, select "String".
5. Click **Default Values**.
6. In the window that appears, type the database rate (for example, ORA) in the left pane under **Select or enter 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 173.

Note: The report names that end users see are the filenames but without the RPT extension.

B

Appendix B: Global Configuration Parameters

About Global Configuration Parameters

The following tables lists the parameters in the Configuration Parameters system table in OM-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 OMOD database identifier number.)

Configuration Parameter	Where is it described?
ADT Outbound	Documentation for the ADT Outbound interface
Anaesthesiologist required in Supply Billing	Not used in this version
AuthenticateByPasswordAndMaster	Directory Services Authentication on page 275
CCOW admission key	Not used in this version
CCOW admission key field	Not used in this version
CCOW booking key	Not used in this version
CCOW case key	Not used in this version

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 (Clinical Data Interface) Outbound	Not used in this version.
CrystalHook Notify URL	Reports on page [illegible]
CrystalHook Prompt Page	Reports on page [illegible]
CrystalHook Reports Path	Reports on page [illegible]
CrystalProxy Save Path	Reports on page [illegible]
Default preferred language code	Demographics on page [illegible]
Demo Mode Indicator	For internal use only. Do not modify.
Disable creation of System Events Audit Trail	Audit Trail on page [illegible]
DSS Server	(Not currently used. Reserved for future use.)
Enable AssignOffline button	For internal use only. Do not modify.
Enable ChangePatient button	For internal use only. Do not modify.
Enable ClosePatientAdmission button	For internal use only. Do not modify.
Enable LinkPatientAdmission 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 button	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 [illegible]
LdapAuthEnabled	Directory Services Authentication on page [illegible]
LdapAuthenticationType	Directory Services Authentication on page [illegible]
LdapAuthSingleDomain	Directory Services Authentication on page [illegible]
LdapDirectoryPath	Directory Services Authentication on page [illegible]
Max number of failed logons before user is locked out	Password Parameters on page [illegible]
Name of [illegible] integrated OR Manager file [illegible]	Not used in this version.
Password expiration period in days	Password Parameters on page [illegible]
Password maximum length	Password Parameters on page [illegible]
Password minimum length	Password Parameters on page [illegible]
Password must be alphanumeric	Password Parameters on page [illegible]
Password reuse count restriction	Password Parameters on page [illegible]
[illegible] License	[illegible] documentation
[illegible] HL7 [illegible] endpoint	Technical Reference Guide
[illegible] integration	Not used in this version.
Prompt for [illegible] during Admit	For internal use only. Do not modify.
SharePoint Web Part Viewer	(Not currently used. Reserved for future use.)
SharePoint Site for Note Templates	(Not currently used. Reserved for future use.)
SharePoint Site Library for Notes	(Not currently used. Reserved for future use.)

Configuration Parameter	Where is it described?
SharePoint Doc Library for Private Notes	Not currently used. Reserved for future use.
Show warning message for patient access: 0=Never, 1=Always, 2=For VIP 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 [illegible].
Show warning message n days before password expires	Password Parameters on page [illegible]
Temporary password expiration period in hours	Password Parameters on page [illegible]
Use MediTech passwords	Documentation for MediTech integration
[illegible] Namespace (obsolete)	This parameter was intended for [illegible] version [illegible] 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 OR Editor.

- Admission Types
- ADS States
- Airway Classes
- Allergies
- Allergy Types
- Ambulatory Status
- Analyses
- Analyses (Microbiology)
- Anesthesia Plan Types
- Anesthesia Plans
- Anesthetic Types
- Application Roles
- Applications
- ASA Types

- Assessment Items
- Attending Types*
- Blood Groups
- Body System Exam Items
- Body System Exams
- Categories
- Category Types
- Chief Complaints*
- Clinic / Provider*
- Common Text
- Complications
- Components (Laboratory)
- Components (Microbiology)
- Context Identifiers (Clinical Data Interface)
- Configuration Parameters
- Counties*
- 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

- Fluids
- Group Mappings
- Home Medication Frequencies
- Home Medication Status
- Insurance Companies*
- Insurance Company Types*
- Kin Type*
- Laboratory Data Status
- Laboratory Sources
- [illegible]*
- [illegible]*
- Medical Procedure Functional Types*
- Medical Procedure Types*
- Medical Procedures*
- Medications*
- NoteTypeModes
- NoteTypes
- Order Tier Status
- Order Text
- Order Types
- Part Components
- Parts
- Payers*
- Physiologic Variables
- Precautions*
- Precaution Types*
- Preferred Language*
- Preop Instruction Types
- Preop Instructions
- Preop Record Status
- Presc Statuses (Medications)

- Races*
- Reaction Types*
- Reactions*
- Religions*
- Risk Assessment Recommendations
- Route Types*
- Routes*
- Score Groups
- Sexes*
- Signoff Type
- Sites*
- Source of consent*
- Staff Types*
- Standard Coding for Assessment Items
- Standard Coding for Event Types
- Standard Coding for Events
- Standard Coding for Physiologic Variables
- Standard Coding for Score Items
- Standard Coding for Treatments
- Standard Orders
- Treatments
- Unit Times
- Unit Types
- Units

D

Appendix D: Supported CNL Codes & Laboratory Components for Rule-Based Sepsis Notifications

This appendix shows the supported laboratory components and CNL codes for physiologic variables that can be used in a hospital's sepsis rule. For more information, see [illegible] and [illegible].

Each section provides a list of CNL 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 [illegible] code, the notification system uses the highest ranked CNL code.

Note: Short and long names are included for reference purposes only. These names depend on the configuration at each hospital.

Heart Rate / Pulse

1. [illegible] HR Heart Rate
2. [illegible] Pulse Rate from NIBP
3. [illegible] Pulse Rate Pulse Oximeter
4. [illegible] Pulse Rate BP [illegible]
5. [illegible] Pulse Rate from CVP
6. [illegible] Heart Rate [illegible]
7. [illegible] Heart Rate Duplicate
8. [illegible] Pulse Rate 1 [illegible]
9. [illegible] Pulse Rate 2 [illegible]
10. [illegible] Pulse Rate from SpO2 [illegible]

11. [illegible] Pulse Rate
12. [illegible]
13. [illegible] Pulse Rate
14. [illegible] Pulse Rate
15. [illegible]
16. [illegible] Pulse Rate

Systolic Pressure

1. [illegible]
2. [illegible] Systolic Pressure [illegible]
3. [illegible] Systolic Pressure [illegible]
4. [illegible] Systolic Pressure [illegible]
5. [illegible] Systolic Pressure [illegible]
6. [illegible]
7. [illegible]
8. [illegible]
9. [illegible]
10. [illegible]
11. [illegible]
12. [illegible]
13. [illegible]

Mean Arterial Pressure

1. [illegible]
2. [illegible] Mean Arterial Pressure
3. [illegible] Mean Arterial Pressure [illegible]

Oxygen Saturation

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible] Regional O2 Saturation [illegible]
5. [illegible] Regional O2 [illegible]

6. 774 pSO2-3 Regional O2 S location Ch 3
7. 776 pSO2-4 Regional O2 S location Ch 4

Respiratory Rate

1. 080 Sey_mM Monitor Respiratory Rate per min
2. 150 Rsp_cr Vent Resp Rate/min (total)
3. 157 SRR Spontaneous Resp. Rate
4. 160 Code Vent Resp Rate/min Setting
5. 861 SpFreq Spontaneous Frequency
6. 478 Respiratory Rate Actual

FiO2

1. 02 FiO2 Inspired Oxyfer %
2. 12F FiO2/cc Inspired O2 Non Humif bar
3. 116 FiO2/E FiO1 Set
4. 091 SetO2C O2 concentration, set
5. 160 O2_Fl O2 Flow

Temperature

1. 036 TempT Temporal Temperature
2. 051 TLP1 Temperature Site 1
3. 052 TMP2 Temperature Site 2
4. 053 TLP3 Temperature Site 3
5. 054 TMP4 Temperature Site 4
6. 056 TLP5 Temperature Site 5
7. 052 TMP6 Temperature Site 6
8. 049 CRMP Core Temperature
9. 050 TMP Temperature
10. 055 BLTMP Blood Temperature
11. 56 TcTMP Transcut Venous Temp
12. 057 RecTMP Rectal Temperature
13. 058 TMPTYL Tympanic Temperature
14. 058 TMPBLA Bladder Temperature

15. [illegible] TMPAX Axill ry Temperature
16. [illegible] TMPRCt Temperature Rectal Core
17. [illegible] TMPNP Temperature Nasal Pharyngeal
18. [illegible] Temp Temper1

Laboratory Results

For the following Laboratory Components below, the results provided as Lab Components will be used:

- Lactate (with OBX03 [illegible])
- PaCO2 (with OBX03 [illegible])
- WBC (with OBX03 [illegible])
- Band Neutrophils (with OBX03 [illegible])

Best Practice:

Associate these components with a new analysis called "Sepsis":

1. In the Analysis table, add the values "Sepsis".
2. In the Parts table, add the part "Sepsis", associating it with the "Sepsis" analysis.
3. In the Part Components table, add the following rows:

PART	COMPONENT
Sepsis	Lactate
Sepsis	Band Neutrophils
Sepsis	WBC
Sepsis	PaCO2

E

Appendix E: Localization

About Localization

[illegible]

[illegible]

Note: Diagnostic tools are only available in English.

[illegible]

[illegible]

[illegible]	[illegible]	[illegible]	Entry
[illegible]	[illegible]	[illegible]	Extension

Possible Values
Any supported 3-letter language identifier
Example: For Spanish locale, 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 [illegible] and Create or edit a trend for use on any flowsheet on page [illegible]
- Names for custom screen layouts.

  See: Quick Links on page [illegible]
- Names of timers, quick link programs and macros.

  See: Change a timer [illegible] on page [illegible], Configure a macro as a quick link on page [illegible], and Configure an external application as a quick link on page [illegible]
- Tooltips for all buttons.

  See: Edit the properties of buttons on the [illegible] ribbon on page [illegible]
- Titles, section headings and description text for all flowsheets.

  See: Create or edit a custom flowsheet and set basic properties on page [illegible] and Create or edit a custom flowsheet and set basic properties on page [illegible]
- Trend titles and the labels for physiologic variables in the legend.

  See: Create or edit a trend for use on any flowsheet on page [illegible]
- Names of Note Types in the Patient Summary.

  See: Create or modify a note type on page [illegible]
- The printout and preoperative instructions in Proxy Manager.

  See: Proxy Manager Configuration on page [illegible]

F

Appendix F: Improving Access to Picis Products

Configuring Easy Access to Picis Products

You can add Picis application icons to the bottom of the screen to make the products more accessible.

Add a Picis application icon to the taskbar

- Click **Start**, find and right-click an 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

[illegible]

Setting Type	Files	Notes
[illegible]	[illegible] **Example:** [illegible]	[illegible]

Setting Type	Files	Notes
Device drivers	Device driver files are in the following folder: %ProgramFiles%\[illegible]	
[illegible] Trace settings	%ProgramFiles%\[illegible].config	
[illegible] settings	%ProgramFiles%\[illegible]	CAUTION: These settings should only be changed by [illegible] staff
Other application settings	For example, files with the extension [illegible] in the following folder: %ProgramFiles%\[illegible]	Some setting files are intended for use by [illegible] staff only. CAUTION: You should only change settings that are documented here or in another [illegible] guide.

H

Appendix H: The Export Tool for Quality Measures

[illegible]

[illegible]

[illegible]

[illegible]

- [illegible]
- [illegible]
- [illegible]
  - [illegible]
  - [illegible]
  - [illegible]

    [illegible]

[illegible]

- 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: [illegible]
- ASA Type [illegible]
- [illegible] Company
  The Insurance Company must be one of the following: [illegible]

Note: [illegible]

Best Practice: [illegible]

Note: [illegible]

Optional Patient Chart Data for AP-NACOR submissions

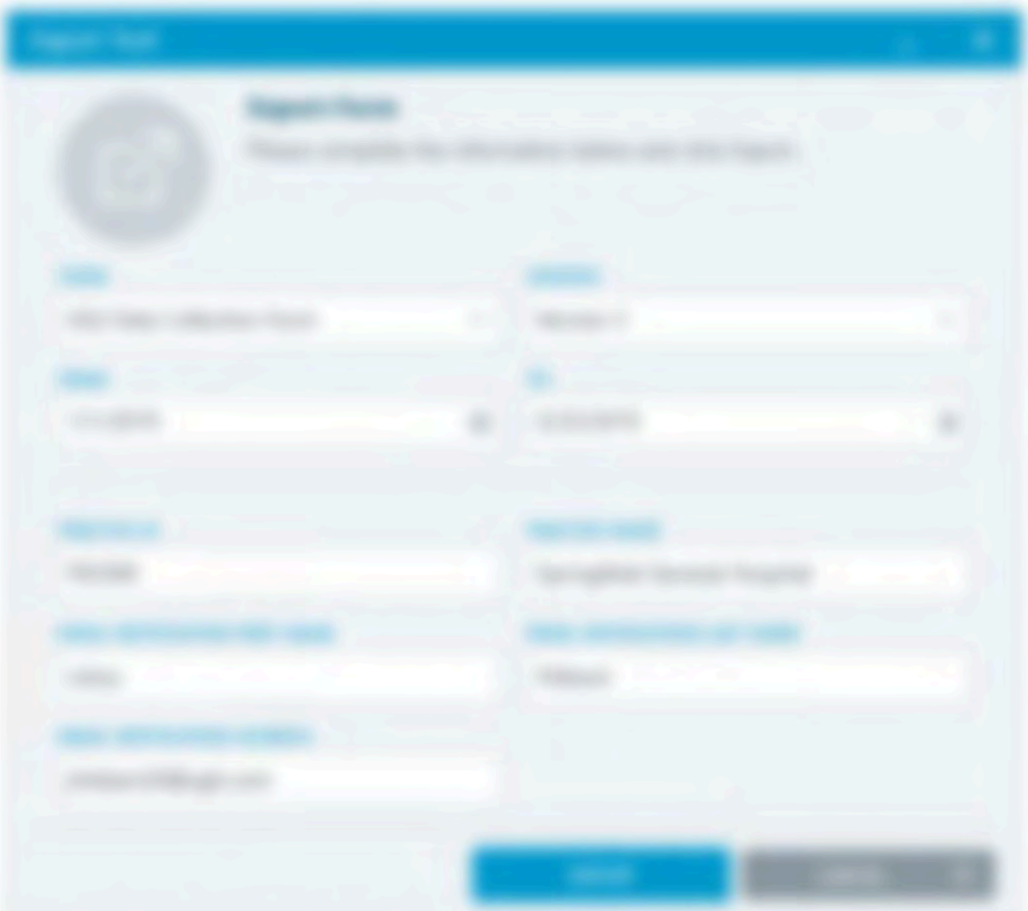
The following data will form part of the report, but is optional.

- City
- ZIP Code
- Admission Height
- Admission Weight

Using the Export Tool

Start the Export Tool

1. Navigate to the 'bin' folder of the Picis 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 this window are mandatory.**

- 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 1 and the same encounter ends on January [illegible]. In the Export Tool, the "To" field is set to January [illegible]. Result: The submitted form is not included on 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: [illegible]

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