NURSING
USER MANUAL

Version 4.0
April 1997
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Department of Veterans Affairs
Technical Service
Clinical Applications Product Line
Preface

Nursing is a component of the Department of Veterans Affairs VISTA (Veterans Health Information Systems and Technology Architecture) program. It comprises software which is used to:

1) Plan and document nursing care provided to the veteran patient.
2) Support nursing administration by providing data/information for nursing organizational decision-making purposes.
3) Provide and summarize data for performance improvement.
4) Provide aggregate data/information for nursing research endeavors.
5) Support nurse educators by providing data/information for the tracking of mandatory programs and staff education.

The Nursing Focus Group and nursing application developers designed this manual to explain the functionality of the package to the nursing application coordinator(s), provide information to resolve any operational issues and elucidate the flexibility of the software package. This manual can also be used as reference to assist IRMS (Information Resource Management Service) staff in the technical support of the application.
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Introduction

Nursing is a component of the Department of Veterans Affairs VISTA program. It is comprised of multiple modules (i.e., Administration, Clinical, Education, Performance Improvement, and Research). The current software release has been approved by the Nursing Focus Group with the assistance of the Alpha/Beta test sites and the many colleagues who use the software on a daily basis.

Administration:

1) Personnel management information (demographic and professional data of nursing staff),
2) Resource management/analysis tracking for reports on budgeting DRGs, overtime usage, patient care hours, supply equipment projections, and staffing hours, and
3) Mandatory reports (i.e., AMIS 1106, AMIS 1106a, Annual Report).

Clinical:

1) Patient classification,
2) Patient assessment,
3) Nursing care plans which are system focused and contain both nursing problems and medical diagnoses,
4) Patient care assignments,
5) Clinical protocols/guidelines for care,
6) Patient education material,
7) Discharge planning, and
8) Other patient related medical record data.

Education:

1) Education reports (i.e., mandatory inservice attendance, continuing education attendance, authorized absence/funding analysis), and
2) Student affiliation information (i.e., scheduling of student clinical labs, affiliation agreements).

Performance Improvement:

1) QA problem tracking system,
2) Infection control trends,
3) Patient incident analysis,
4) Employee accident analysis,
5) Continuous care monitors (clinical data), and
6) Administrative monitors (e.g., safety equipment).
Research:

1) Resource listing of VA nurse researchers, and
2) Additional functionalities as defined by the Nursing Focus Group.

Prior to implementing the software, review appropriate sections of this manual for new applications and modifications to previous releases. Also, if the Nursing software is not on-line at your facility, the nursing ADP coordinator, and all nursing personnel responsible for supporting the package, should pay special attention to the chapter on Package Management in this manual.

Functional Description of Version 4.0:

The nursing software includes the following functionalities:

Administration:

1) Tracks staff information including: personal/demographic data, previous professional experience, work assignments, grade, licensure, certification, professional education, end of probationary period, and military reserve status.
2) Uses a Position Control file to monitor past, current, and future nursing positions, future vacancies, reason for vacancy, start/stop dates for the position, and the level of employee filling the position. When a registered nurse's assignment is changed, the professional experience in the staff record is automatically updated.
3) Generates management reports on employees including: academic and professional degrees, grade statistics, age trends, gender trends, license renewals, certification statistics, active reservist lists, LPN and RN NPSB tracking, and proficiency tracking.
4) Provides resource management reports on ward/service FTEE statistics as well as ward and bed section workload/variance reports. The option which prints current workload reports can generate data on both the current and next tours of duty. Future releases will contain turnover statistics and additional workload reports.
5) Accumulates daily statistics on the number of patients treated in the following bed sections: hemodialysis, drug/alcohol patients, recovery room and domiciliary.
6) Generates daily, monthly, quarterly, and yearly AMIS Reports: 1106b (FTEE Budgeted/Actual), 1106 (Patient Classification), and 1106a (Manhours).
7) Provides workload statistics based on AMIS data.
8) Provides a telephone list of employees by service or location.
9) Provides miscellaneous patient acuity reports.

Education:

1) Tracks employee continuing education data.
2) Prints an AA/Funding Requests Report which indicates money authorized for C.E. attendance by specified year.

3) Tracks mandatory inservice information for multiple years. Information on program attendance can be provided by last attendance date or for three full fiscal years. Deficiency reports are available for the current or past three fiscal years.

Clinical:

1) Contains a patient classification system which generates reports by bed section and ward.

2) Includes nationally developed standard nursing care plans for initiating patient care plan generation.

3) Allows nurses to generate a patient care plan based on patient problems, identified goals, and specified nursing interventions. The software accommodates evaluation and resolution dates for problems, identifies target and met dates for goals, and discontinuation dates for interventions/orders.

4) Produces two types of assignment worksheets for each patient (brief and complete). The brief worksheet does not display selected care plan information.

5) Contains an option for printing a ward census by room and provides information on current patient location.

6) Generates reports for unclassified patients and provides a function for classifying unclassified patients only.

7) Allows a staff nurse to update a patient's nursing ward location and/or nursing AMIS bed section to insure accurate patient classification entries.

8) Allows users to enter vital signs, height, and weight on patients. Cumulative reports by patient or ward can be generated as well as latest patient information. Graphic reports of patient vital signs, blood pressures, weights and pulse oximetry/respirations are also provided.

9) Allows users to generate Intake and Output reports, an End of Shift Report, and a Health Summary Report by patient or ward.

Performance Improvement:

1) Contains options for reviewing patient classification and tracking errors.

2) Allows nursing QA staff and ADP coordinators to revise erroneous AMIS data.

3) Tracks units with no manhours data.

Package Management:

1) Allows sites to modify data (e.g., service positions, salary, grade/step codes, mandatory inservices, certifications, nursing locations, tour of duty) in specified nursing files.

2) Accommodates additional site-specific standard care plans.

3) Provides special ADP Coordinator functions for executing nursing options which affect patient acuity, manhours, FTEE status, etc., when TaskMan is off-line.
4) Provides ADP Coordinator options for admitting/transferring/discharging patients within the Nursing system when the MAS System is off-line. This feature ensures that patient information will be updated and available to nursing providers. When the package is off-line due to the installation of a new version, the software will automatically update the patients in the Nursing system by admitting and discharging patients before the system is made available to the user.

For additional information refer to the Release Notes, Version 4.0.
Section 1 Package Management
Chapter 1 Implementation and Maintenance

Description:

The intent of this section is to outline a method for the nursing ADPAC to implement the application. It is important to read and fully understand this section before continuing.

Virgin Installation of Software:

The following steps should be followed when the Nursing software is installed in an environment where no previous installation of the Nursing application has taken place. If a previous version of the Nursing application has been installed, refer to the Non-Virgin Installation of Software instructions found later in this chapter.

Step 1: Setting up the software environment

The Information Resources Management Service staff must install the software using the installation notes in either a test environment or the production (VAH) directory. Data entered into the test environment CANNOT be transferred into the production environment.

Additional Information:

Nursing V. 4.0 requires that the following VISTA packages must be loaded in order to fully use the package:

a. VA FileMan V. 21 or greater,
b. Kernel V. 8.0 or greater,
c. Kernel Toolkit V. 7.3 or greater,
d. PIMS V. 5.3 or greater,
e. PAID V. 4.0 or greater (optional),
f. Dietetics V. 4.6 or greater (optional),
g. Health Summary V. 2.7 or greater (optional),
h. Intake and Output V. 4.0,
i. Vitals/Measurements V. 4.0,
j. Text Generator V. 3.0.
**Recommendation:**

A limited amount of data should be entered into the test directory so the users may become familiar with the application and to establish an acceptable training data base.

The following steps MUST BE COMPLETED before the Nursing software can become operational.

*******Steps 2 THRU 5 MUST BE COMPLETED IN EXACT ORDER**********

**Step 2: Associating nursing units with MAS wards**

A comparison listing of ALL nursing locations (units) and ALL MAS ward locations (i.e., MAS location contained in File #42, the Ward Location file) must be compiled. This information will be required by the nursing application coordinator when entering data in the NURS Location (#211.4) file (refer to the Nursing User Manual, Maintenance of Administrative Site Files chapter). Information on File #42 should be provided by either the PIMS application coordinator or the IRMS staff. The NURS Location file's data must account for all MAS ward names in File #42. The data in the NURS Location file establishes a cross-reference file which is accessed in all modules of the Nursing software.

**Recommendation:**

Create the following comparison table for all nursing units.

<table>
<thead>
<tr>
<th>Nursing Location</th>
<th>MAS Location</th>
<th>Explanation of Nursing and MAS Locations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1E</td>
<td>1E</td>
<td>No discrepancy in nursing and MAS terminology.</td>
</tr>
<tr>
<td>1W</td>
<td>1W, 1NW, 1S</td>
<td>Nursing 1W is divided into multiple MAS locations.</td>
</tr>
<tr>
<td>ER</td>
<td></td>
<td>The ER is NOT a MAS ward location. It is a designated nursing assignment location only.</td>
</tr>
<tr>
<td>9S</td>
<td>9W</td>
<td>9W is considered a single MAS location but 9M is comprised of two (2) nursing locations.</td>
</tr>
</tbody>
</table>
The MASONLY location is used for two (2) purposes:

1) To associate all closed or inactive MAS wards with a nursing location.

2) To identify active MAS wards (with patients) where nursing has no patient care responsibility.

**Note:** All MAS wards in File #42 must be identified and associated with a nursing location in File #211.4. In both of the examples, the Patient Care Status field of the MASONLY unit should be "inactive" and the Ward Status field should be "active".

**Note:** MASONLY is pronounced "M-A-S-ONLY".

Diagram: This schematic depicts the relationship between the NURS Location (211.4), the Hospital Location (#44) and the Ward Location (#42) files.
The NURS Location file points to entries in the Hospital Location file from its (.01) name field.

The entries in the Hospital Location file pointed to by the NURS Location file are not inserted by the PIMS software. They are added by the Nursing application, and have the characters NUR appended in front to identify them. Due to a special look up and output transform, the NUR characters do not appear to the user during VA FileMan look-ups on the NURS Location file. However, these characters will appear to the user on look-ups on the Hospital Location file. This pointer relationship has been built because of a decision made by the Data Base Integration Committee (DBIC) to reduce the number of free text location files.

The NURS Location file points to entries in the Ward Location file from the MAS Ward (#.01) subfield of the MAS Ward (#2) field. These entries are the normal Ward Location file entries. This pointer relationship is needed by the Nursing software to identify the appropriate nursing location of a patient when the patient is admitted through ADT (the admission, discharge, transfer module of PIMS).

The Hospital Location and Ward Location files point to each other via the Ward Location file pointer (#42) and Hospital Locations file pointer (#44) fields respectively. This pointer relationship was set up via a decision by the DBIC to relate these two files to each other.

**Example:** This example shows how this pointer relationship is used for a typical set of locations.

<table>
<thead>
<tr>
<th>NURS LOCATION</th>
<th>HOSPITAL LOCATION</th>
<th>WARD LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>3AS</td>
<td>NURS 3AS</td>
<td>3A</td>
</tr>
<tr>
<td></td>
<td>3A</td>
<td>3S</td>
</tr>
<tr>
<td></td>
<td>3S</td>
<td></td>
</tr>
</tbody>
</table>

The nursing location of 3AS points to the hospital location NUR 3AS from the Name (#.01) field and the ward locations 3A and 3S from the MAS Ward (#2) field. The hospital location NUR 3AS does not point to the Ward Location file. The hospital location 3A points to the ward location 3A and vice versa. The hospital location 3S points to the ward location 3S and vice versa.

**Step 3:** Population of the NURS Parameters (#213.9) file.

This file is edited through the Site Parameter File option which is located in the Administrative Site File Functions Menu. Detailed information on this file is found in the chapter on Maintenance of Administrative Site Files in the Nursing User Manual. There are several specific issues that you need to address in the Parameter file before you enter data in the NURS Location file:

1. Define your facility as single vs. multi-divisional facility.
2. Identify that your facility has organized under a product line structure.

3. Enter the name of the CNO printer. The CNO printer is a device used to print specific tasked reports and should remain on-line at all times.

4. Enter a professional percentage value which will represent the default percentage of professional personnel assigned to a unit. This parameter is used for the calculation of workload required staffing when the professional percentage field is not defined for a specific NURS Location file entry.

5. Enter cutoff times for the day, evening, and night shift (preferably the end of each shift) which is used by the AMIS Acuity Batch Job as cutoff times for classification of patients for these shifts.

Additional IRMS related package management information is contained later in this chapter.

**Step 4:** Populate the Facility field of the NURS AMIS 1106B FTEE (#213.2) file.
Using the FTEE Service Budget (1106b) File, Edit option, update the Facility field of the NURS AMIS 1106B FTEE (#213.2) file by entering the names of the institutions (divisions) associated with your facility. The Administrative and Resource Management Reports use this file to display a list of institutions when a ‘?’ is entered at the Facility prompt. At this time you do not have to enter the FTEE associated with each facility or institution.

**Step 5:** Add data to Product Line file through the Product Line File Edit option in the Administrative Site File Functions option. This file has been exported with one entry, Nursing, that may not be deleted by any user. The application coordinator must add additional entries to this file if management wants to assign staff and locations to product lines. Entries in this file may relate to true product lines (e.g., medicine, surgery, mental health, primary care), programs, or the traditional services (e.g., nursing, social work, pharmacy) to produce reports that are meaningful to the users.

**Step 6:** Population of the NURS Location file (#211.4)
This file is edited through the Nursing Location File, Edit option which is located in the Administrative Site File Functions Menu. The process for entering information into this file can be found in the Maintenance of Administrative Site Files chapter in the Nursing User Manual. When editing this file, consider the following:

1. Enter data into the NURS Location file from the list of nursing locations compiled in Step 2 above.
a. If you are a multi-divisional facility, you must enter the name of the institution associated with the unit location. If you are a single facility, it is recommended that you enter the facility’s name at the Institution prompt.

b. If management wants reports by product line, enter the product line associated with the unit. Remember that the product line prompt does not display unless you have entered ‘yes’ in the NURS Parameter file product line field.

c. The Patient Care Status field should be INACTIVE for all units until a decision is made to bring the Nursing software up (i.e., actively use the software) on an individual unit. Only then should the Patient Care Status field be changed to ACTIVE using the Ward Activation Patient Update option. Before activating the status of this field, please review the information on the Ward Activation Patient Update option in the Maintenance of Clinical Site Files chapter.

d. All units, regardless of patient care status, must be entered into the Nursing Location file.

2. When the NURS Location file is completed, enter the Ward Activation Patient Update option located in the Clinical Site File Functions menu. This option runs a background job which checks that all MAS wards have been: a) associated with a nursing locations(s), and b) cross-referenced. The software displays the message, Checking to see if every MAS Ward has a corresponding NURSING unit, and if no problem exists, the "Select UNIT:" prompt appears. The user may enter an up-arrow (^) here to exit the option until units are ready to be populated with patients (refer to Step 6 below). If this background job identifies non-associated MAS ward(s), it displays the ward name(s) and the user must identify a relationship with a nursing unit.

**Step 7:** Population of the NURS Service Position file (#211.3)
This file is edited through the Service Position File, Edit option which is located in the Administrative Site File Functions Menu. The process for entering information into this file can be found in the Maintenance of Administrative Site Files chapter in the Nursing User Manual. In setting up this file, the application coordinator should assign all none nursing employees to an appropriate product line and associate them with the service category of ‘other’. Staff in traditional nursing roles, such as, registered nurse and nursing assistant, may be assigned to any product line but should be given the service category of registered nurse, licensed practical nurse and nursing assistant. Data in this file must be entered prior to entering names into the NURS Staff (#210) file.
Step 8: Population of the NURS Staff file (#210)
This file is edited through the Staff Record Edit option which is located in the Administration Records, Enter/Edit Menu. A detailed explanation for entering information into this file can be found in Section 2 of the Nursing User Manual. Before the process of entering nursing employee names into the NURS Staff (#210) file can begin, the names of all current employees must reside in the New Person (#200) file. There is a laygo parameter located in the NURS Site Parameter (#213.9) file (Nursing New Person File Access field) that can be turned on to permit the storing of new nursing staff names in File #200. It is suggested that if this feature is turned on, IRMS staff provide training to the nursing application coordinator on procedures for entering new names into File #200.

Step 9: Population of the NURS Patient file (#214)

1. Patients are admitted through the PIMS application, however, patients are not automatically admitted into the Nursing software until the following actions have been taken:
   
a. The editing of the NURS Location file (#211.4) has been completed (Step 3).

b. The Ward Activation Patient Update option has been run for a specific nursing location. This option kicks off a routine which automatically assigns patients to appropriate nursing units in the Nursing software. Once a unit has been activated, all subsequent hospital admissions and transfers to the activated unit(s) are updated in the nursing software.

   Note: The Patient Care Status field in the NURS Location file is changed to ACTIVE by the action of the option's routine. The process of patient movement on that ward continues until the unit is inactivated or until 6.2. (below) occurs.

2. When either the nursing software or the PIMS software is down (unavailable to the user), patients are not triggered into the Nursing software. In these circumstances, a back up option, Admit/Transfer Patient (Nursing Package Only), has been provided. This option should be available to the nursing ADP coordinator and other key nursing staff on all tours of duty.

   When the PIMS software goes back on-line, the nursing application coordinator should run the Ward Deactivation Patient Update and the Ward Activation Patient Update options (in that order) to validate the patient census on all nursing units.

3. When additional wards are added to the nursing application repeat the ward activation option. Multiple units may be activated at once.
4. In Multiple CPUs:
   a. The routines NURSCPL, NURSAMSG and NURSAWCK used in triggering the patient into the Nursing software, must reside in all CPUs using the PIMS software.
   b. The UCI translation table (in each CPU) must contain the NUR* and GMR* Globals.

5. When patients are initially admitted to a newly activated unit the following steps should be taken:
   a. A MAS bed census be printed.
   b. A nursing bed census be printed through the Ward Census Print (NURSPP-LOCWRD) option.
   c. A comparison be made of patients residing on the ward from both reports. If discrepancies are present, correct them using the Admit/Transfer Patient (Nursing Package Only) option.

**Step 10:** Populating other site configurable files

Review the following files. The edit/modify options associated with these files are located in the Administrative Site File Functions, Clinical Site File Functions, and QI Site Files menus of the Nursing application. The process and purpose for entering and editing data in these files is described later in this Package Management section. The specific edit option is listed with the file.

**Administrative Site Files:**

1. NURS Pay Scale (#211.1) file
   Edit using the Load Grade/Step Codes option.

2. NURS Clinical Background (#211.5) file
   Edit using the Clinical Background File, Edit option.

3. NURS Tour of Duty (#211.6) file
   Edit using the Tour of Duty File, Edit option.

4. NURS AMIS 1106b FTEE (#213.2) file
   Edit using the FTEE Service Budget (1106b) File, Edit option.

5. NURS Privilege (#212.6) file
   Edit using the Privilege File Edit option.
6. NURS Vacancy/Transferred Reasons (#211.9) file
   Edit using the Vacancy Reason File Edit option.

7. NURS Certification (#212.2) file
   Edit using the Certification File, Edit option.

Clinical Site File Functions:

8. GMRV Vital Category (120.53) file
   Display entries using the Display Vitals Category/Qualifier/Synonym Table option.

9. GMRV Vital Qualifier (#120.52) file
   Edit using the Enter/Edit Vitals Qualifiers option.

10. GMRY Intake Items (#126.8) file
    Edit using the Intake Items option.

11. GMRY Input Type (#126.56) file
    Edit using the Intake Type option.

12. GMRY IV Catheter (#126.74) file
    Edit using the IV Catheter option.

13. GMRY IV DC'ed Reason (#126.76) file
    Edit using the IV DC'ed Reason option.

14. GMRY IV Site (#126.7) file
    Edit using the IV Site option.

15. GMRY IV Site Description (#126.72) file
    Edit using the IV Site Description option.

16. GMRY NUR IV Solution (#126.9) file
    Edit using the IV Solution option.

17. GMRY Output Subtype (#126.6) file
    Edit using the Output Subtype option.

18. GMRY Output Type (126.58) file
    Edit using the Output Type option.

19. GMRY NUR Shift/Other (126.95) file
    Edit using the Shift Starting Hour and Other Parameters option.

---

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20. Aggregate Term (#124.2) file
   Edit using the Patient Plan of Care, Site Configuration option.

QI Site Files:
21. NURQ Standard of Care/Practice (#151) file
   Edit using the QI Summary Standards of Care/Practice File option.

22. NURQ Frequency (#154) file
   Edit using the QI Summary Frequency File option.

23. NURQ Rationale (#153) file
   Edit using the QI Summary Rationale File option.

Step 11: Tasking required background jobs

Notify the Site Manager to QUEUE the following jobs via TaskMan:

1. The NURAAM-ACU (Nursing Acuity/Separation-Activation Run) option is queued to
   run daily after midnight as a background job requiring no device selection.

This option (NURAAM-ACU) must be queued to run after midnight, daily. This job totals
acuity data for each unit for the night, day, and evening shifts and stores the data in the NURS
1106 Manhours (#213.4) file. This job also activates/ separates employees to/from active status
based on the vacancy date in the NURS Position Control (#211.8) file. When this option fails to
run to completion, an alert is sent to the NURS-ADP mail group and the option must be run
manually from the Special Functions menu. Patient classification is no longer disabled when this
option fails to run to completion. Night shift acuity totals are based on patient classifications
entered between 00:01 and the cutoff time of the night shift as indicated in the NURS Parameter
(#213.9) file. If no classifications are entered on the night shift, the latest classification for the
patient's unit on the job run date is used. If there are no classifications on the patient's current
unit, no acuity is counted for the night shift. Day shift acuity is based on classifications entered
between 00:01 and 15:00 (3:00pm). If a patient is discharged/transferred between 14:45 and
15:00 (2:45 - 3:00pm) and has a current classification for the run date, the acuity is credited to
the unit where the patient resided prior to the discharge or transfer. The evening shift acuity
totals are based on patients in the hospital at midnight who have been classified any time during
the day. When run manually, this job checks the last time it ran to completion and runs for all
days between the last time it ran (noted in File #213.9) and the day before the current day. The
data generated by this job is used for the following reports:

- AMIS workload statistics and summary reports
- patient category total reports (AMIS and midnight)
• separation/activation report
• unclassified patients report (AMIS and midnight)
• current unclassified patient reports

Data for the report, Workload Statistics Report (Current), is not dependent on the NURAAM-ACU option.

Note: When this job is run and there are MAS ward locations that do not have a matching nursing location, the user will get a mail message. The sender of the message will be the name of the person who queued the job to run.

2. The NURAMN-MANCK (Nursing Batch Job Status Check) option is queued to run daily at 06:00 hours as a background job requiring no device selection. If this option finds that the Nursing Acuity/Separation-Activation Run (NURAAM-ACU) did not run to completion, an alert is sent to the appropriate personnel in the NURS-ADP mail group. It is then necessary to run the Manual Nursing Acuity/Separation Run under the Special Functions menu.

**Step 12: Tasking optional background jobs**

The following optional reports may be queued (TO THE CNO PRINTER) at the discretion of the Nursing ADP Coordinator:

1. The NURAAM-UNCBAT (Batch Run of Unclassified AMIS 1106 Patients) option prints the unclassified AMIS 1106 patient list. To run this option manually, use the Unclassified AMIS 1106 Patients option under the Special Functions menu.

2. The NURAAM-MD-UNCBAT (Batch Run of Unclassified Midnight Patients) option prints the unclassified midnight patient list. To run this option manually, use the Unclassified Midnight Patients option under the Special Functions menu.

3. The NURAED-BATSEP-QUEUE (TaskManager Activation/Separation Report option prints daily position control changes on employees. The data for the reports (unclassified AMIS 1106 patients, unclassified midnight patient and position control changes) are generated by the Nursing Acuity/Separation-Activation Run (NURAAM-ACU) option. The NURAED-BATSEP-QUEUE option should be queued to run approximately two (2) hours after the NURAAM-ACU option is scheduled to ensure availability of the required data. To run this option manually, use the Employee Activation/Separation Report option under the Special Functions menu.
4. The NURAPR-RES-CURWKL-QUEUE (TaskManager Workload Statistic Report (Current) option prints current workload statistics information. To run this option manually, use the Workload Statistics Report (Current) option under the Resource Management Reports menu.

5. Add appropriate members to the NURS-ADP mail group. When setting up this mail group make sure the TYPE field is marked PUBLIC. The members of the group are notified when:

   a. The alert, NURS-CLASSIFICATION, is forwarded to the mail group NURS-ADP if the Nursing Acuity/Separation-Activation Run did not run or aborted prior to completion.

   b. The alert NURS SEPARATION/ACTIVATION is forwarded to the mail group NURS-ADP if the Nursing Acuity/Separation-Activation Run did not run or aborted prior to completion. The alerts are sent when appropriate by the option, NURAMN-MANCK.

**Step 13: Printer issues**

Users may print graphic reports on a dot matrix printer, but plotted data is not connected by lines. Linear graphic reports can be printed using the Kyocera F-800A laser printers; HP LaserJet III, LaserJet 4, LaserJet 5; and HP compatible printers. When using a programmable graphic laser printer the setups need to be checked, to insure the correct format on the printed page.

The following special printer setup is for Kyocera type printers:

   a. Ensure the existence of a Kyocera entry in the Terminal Type file. This device compresses print and has a margin width of 132 characters. This entry may be exported by Kernel, or you may have to set up your own entry.

      1) The Name (#.01) field should begin with the characters P-KYOCERA e.g., P-KYOCERA-P16. This is important as the software will not recognize the device as a Kyocera printer if this Terminal Type entry is not set up properly.

      2) The Right Margin (#1) field must be 132.

   b. Create a Device file entry for the Kyocera printer.

      1) The Name (#.01) field should contain the word KYOCERA. This isn't required, but will make selection of this device by users easier.

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2) Sub-Type (#3) field should point to a Terminal Type entry that fits the characteristics defined above in (a-1).

3) Margin Width (#9) field should be 132.

c. In the Kyocera printer, PRESCRIBE Macro Buffer Size (H0)=99.
   To reprogram your printer,
   1) Type: !R! RES; FRPO H0, 99; EXIT; on your terminal/input device.
   2) Print this code on your Kyocera printer (using appropriate print commands). This may be done through a mail message.
   3) Turn off the printer for a few seconds, then place the printer back on line (by turning it on). The printer will then be ready to print the linear graphic reports (e.g., SF511).

The following special printer setup is for HP LASERJET III, HP LASERJET 4 and HP LASERJET 5 printers:

a. Ensure the existence of a HP LASERJET entry in the Terminal Type file. This device compresses print and has a margin width of 132 characters. This entry may be exported by Kernel, or you may have to set up your own entry.

   1) The Name (#.01) field should begin with the characters P-HPLASER e.g., P-HPLASER-L180. This is important as the Vitals/Measurements software will not recognize the device as an HP LASERJET printer if this Terminal Type entry is not set up properly.

   2) The Right Margin (#1) field must be 132.

b. Create a Device file entry for the HP LASERJET printer.

   1) The Name (#.01) field should contain the word HPLASER. This isn't required, but will make selection of this device by users easier.

   2) Sub-Type (#3) field should point to a Terminal Type entry that fits the characteristics defined above in (b-1).

   3) Margin Width (#9) field should be 132.

   4) Suppress Form Feed at Close (#11.2) field should be set to YES.

Note: If the printer is not set up correctly, it will effect the printed output. KYOCERA and HPLASER are key words in the routine to identify which printer is being used, and IRMS must edit the Device file so the word KYOCERA or HPLASER appears in the name of the device (e.g., KYOCERA-PORT).
The IRMS staff should assign the CNO Printer in every CPU using the Nursing application. This printer is used to alert nursing management of unusual actions (e.g., NURSPATIENT3, TWO has not been admitted into the NURSING System by PIMS because the MAS ward does not have a corresponding NURSING LOCATION). The CNO Printer should be on-line and accessible at all times.

**Step 14: Package Management/Special Security Measures**

1. The nursing ADP coordinator(s) must be given the VA FileMan security code of "n". This access allows the application coordinator to view all nursing employee information.

2. Assign an appropriate PAID Education Tracking key (PRSE SUP and PRSE TRAIN) to nursing personnel. The PRSE SUP key should be given to any nursing educator/instructor. The PRSE TRAIN key should be assigned to nursing staff (exclusive of management staff) who have nursing unit staff education responsibilities. **Note:** Only assign one key to each nursing employee.

3. No additional security measures are required other than those implemented through Menu Manager and the package routines.

4. No additional licenses are necessary to run the software.

5. Confidentiality of staff and patient data and the monitoring of this confidentiality is no different than with any other paper reference.

**Step 15: Operating in multiple CPUs**

When operating the PIMS and nursing application in multiple CPUs refer to steps 6.4, 8, 9 and 10 above.
Step 16: Assigning menus

<table>
<thead>
<tr>
<th>Menu</th>
<th>Menu Text</th>
<th>Staff Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURS-SYS-MGR</td>
<td>Nursing System Manager's Menu</td>
<td>Nursing</td>
</tr>
<tr>
<td>NURS-ADM</td>
<td>Administrator's Menu</td>
<td>ADP Coordinator</td>
</tr>
<tr>
<td>NURS-ED</td>
<td>Nursing Educator's Menu</td>
<td>Administration Staff</td>
</tr>
<tr>
<td>NURS-QA</td>
<td>QA Coordinator's Menu</td>
<td>Q.A. Coordinator</td>
</tr>
<tr>
<td>NURS-HN</td>
<td>Head Nurse's Menu</td>
<td>All Head Nurses</td>
</tr>
<tr>
<td>NURS-RN</td>
<td>Staff Nurse Menu</td>
<td>All Staff Nurses</td>
</tr>
</tbody>
</table>

Non-Virgin Installation of software:

Follow steps 1 through 16 under Virgin Installation of software (refer to page 1 of this chapter) to complete the installation of Version 4.0.

Site Configurable Files/Fields

1. The NURS Parameters (#213.9) file.

The data elements in the NURS Parameters file can be modified by the site. Below is a list of these data elements.
<table>
<thead>
<tr>
<th>Field</th>
<th>Name</th>
<th>Data contained</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>CNO PRINTER</td>
<td>name of the printer</td>
<td>Device receiving all exception reports for the Nursing package. This printer should remain on-line at all times.</td>
</tr>
<tr>
<td>3</td>
<td>NURSING OFFLINE/</td>
<td>switch stating whether Nursing</td>
<td>This field can be used to bring the Nursing system off-line if needed.</td>
</tr>
<tr>
<td></td>
<td>ONLINE</td>
<td>System is:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1: OFF-LINE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0: ON-LINE</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>NURSING NEW PERSON FILE</td>
<td>switch stating whether Nursing</td>
<td>This field determines the Nursing system’s access to the NEW PERSON File (#200).</td>
</tr>
<tr>
<td></td>
<td>ACCESS</td>
<td>System has:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>0: NO ACCESS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TO THE NEW PERSON FILE</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1: ACCESS</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>TO THE NEW PERSON FILE</td>
<td></td>
</tr>
<tr>
<td>7.1</td>
<td>DAY SHIFT ACUITY TIME</td>
<td>military time of 4 characters in</td>
<td>Time at which the acuity totals are calculated for the day shift for the Workload Statistics Report (Current).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>length</td>
<td></td>
</tr>
<tr>
<td>7.2</td>
<td>EVENING SHIFT ACUITY TIME</td>
<td>military time of 4 characters in</td>
<td>Time at which the acuity totals are calculated for the evening shift for the Workload Statistics Report (Current).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>length</td>
<td></td>
</tr>
<tr>
<td>7.3</td>
<td>NIGHT SHIFT ACUITY TIME</td>
<td>military time of 4 characters in</td>
<td>Time at which the acuity totals are calculated for the night shift for the Workload Statistics Report (Current).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>length</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>PROFESSIONAL PERCENTAGE</td>
<td>percentage from 1 to 100 with no</td>
<td>The percentage of professionals to non-professionals for a given nursing location. This value will be used if the corresponding field in the NURS Location File (#211.4) has no data.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>decimal place</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>PRODUCT LINE</td>
<td>Y=Yes</td>
<td>Indicates whether or not FTEE data in the NURS Position Control file (#211.8) is associated with product lines besides Nursing.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N=No</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>MULTI-DIVISIONAL</td>
<td>Y=Yes</td>
<td>Indicates whether or not the facility is multi-divisional.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N=No</td>
<td></td>
</tr>
</tbody>
</table>

The site may need to modify the content of the Nursing Care Plan (i.e., Patient Plan of Care) sent out with the Nursing package. To do this, the site would have to use the Patient Plan of Care, Site Configuration (NURCFE-CARE) option. The site will be able to make local modifications to the content of the prime document without having to worry about a subsequent release of that application overwriting them.

Site Configurable Output

There are no site configurable sort or print templates in Version 4.0 of the Nursing package. The sort and print templates in the package are not subject to modification. The nursing application coordinator has been given certain FileMan options, from which site specific outputs could be generated using Option 2 (PRINT FILE ENTRIES). Any additional templates created should be named with the following convention:

NURS-Site Number (3 digit code assigned to each site)-Choose (P for print templates, S for sort templates)-Template name

ex.  NURS-578-P-MANDATORY INSERVICE (print template)
     NURS-578-S-STAFF SORT (sort template)

Resource Requirements

The minimal hardware requirements for the Nursing software are two CRTs and one printer per nursing location. In addition to this, the following statistics regarding the disk storage requirements of the Nursing software were compiled by the Alpha/Beta test sites.
### Package Management

<table>
<thead>
<tr>
<th>Globals</th>
<th>Type of Data</th>
<th>Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDs</td>
<td></td>
<td>340 blocks</td>
</tr>
<tr>
<td>NURSA</td>
<td>AMIS data classification</td>
<td>3-4 blocks/nursing location</td>
</tr>
<tr>
<td>NURC</td>
<td>Care plan data</td>
<td>2-12 blocks/patient</td>
</tr>
<tr>
<td>NURQ</td>
<td>QI Summary</td>
<td>1-18 blocks/patient</td>
</tr>
<tr>
<td>NURSF</td>
<td>Staff data</td>
<td>.86 blocks/staff</td>
</tr>
</tbody>
</table>
| NURSF(213.1)| Nursing pointer files         | block size is dependent upon class of hospital:  
|            |                                  | Class I - 296               |
|            |                                  | Class II - 256              |
|            |                                  | Class III - 111             |
|            |                                  | Class V - 98                |
| GMR       | Patient data for the Vitals/ Measurements, and Intake and Output Modules | 50-75 blocks/patient        |
| GMRD      | Static data for the Vitals/ Measurements, and Intake and Output Modules | 1200-1400 blocks depending on the global efficiency |
| Routines  |                                  | approx. 800k                |

### Technical Errors

1. ADT Functions of MAS System abort with <NOSYS> error.
   
a. When the CPU containing the Nursing system is down, the MAS system aborts with a <NOSYS> error. To correct this problem:
   
   1) Take the Nursing system off-line using the Nursing Offline/Online Switch in the NURS Parameters (#213.9) file.
2) After the CPU is brought up again the Nursing system should be placed on-line, and all patient movements in MAS should be put into the Nursing system. The best way of updating the patient movements is to run the Ward Deactivation Patient Update (NURSPT-WRDINA) option followed by the Ward Activation Patient Update (NURSPT-WRDACT) option after placing the Nursing system on-line.

2. User gets a warning message that the Nursing Acuity/Separation-Activation Run (NURAAM-ACU) option has not run to completion.

a. Four fields in the NURS Parameters file (#213.9) exist to help in debugging and recovery of errors encountered by this task (see Site Configurable Files/Fields).

1) Date AMIS Job Last Run Field (#6.1) - The date in this field is the date the Nursing Acuity/Separation-Activation Run (NURAAM-ACU) option last ran normally to completion.

2) AMIS Job Completion Field (#6.4) - This is a set of codes that denotes whether the last running of the NURAAM-ACU option ran to completion. One denotes the job finished normally, and zero denotes that the job terminated abnormally.

3) AMIS Ward Last Processed Field (#6.5) - This field contains an internal entry number in the NURS Location file (#211.4). This is the location that was last processed by the NURAAM-ACU option.

4) AMIS Patient Last Processed Field (#6.6) - This is an internal entry number in the Patient file (#2). This is the patient that was last processed by the NURAAM-ACU option.

b. The first thing that should be attempted is to run the Manual Nursing Acuity/Separation Run (NURAAM-ACUMAN) option. The fields referenced above, will cause the NURAAM-ACUMAN option to begin processing from where the NURAAM-ACU option left off.

c. If while running the NURAAM-ACUMAN option an error occurs, the Site Manager should check the following global node:

\[^{DIC}(213.9,1,"DATE")=A\^{\#}B\^{\#}C\^{\#}D\^{\#}E\^{\#}F\]

where:

A is the data in field 6.1 and should be equal to a FileMan date for today's date.

B is the data in field 6.4 and should be equal to the number 1.

C is the data in field 6.8 and should be equal to the number 1.
D is the data in field 6.92 and should be equal to the number 1.

E is the data in field 6.93 and should be equal to the number 1.

F is the data in field 56. If there is a value in this field it means the acuity job is currently running or possibly errored out before completion.

For example:

\(^{\text{DIC}(213.9,1,"DATE")} = 2970220^{\text{1}^{\text{0}^{\text{0}^{\text{1}^{\text{0}^{\text{1}^{\text{0}^{\text{0}^{\text{0}}}}}}}}}}\)

The problem probably lies in bad data or cross-references in the NURS Patient file (#214) or NURS Classification file (#214.6) and should be repaired on an individual basis.

3. Patients are not being automatically admitted to, or discharged in the Nursing package.

a. Check the ANURS cross-reference on field .1 of File 2. If it is not correctly defined, delete the erroneous data and correctly define the cross-reference using the following procedure in programmers mode:

```
>D KILLXREF^NURSCUTL
>D SETXREF^NURSCUTL
```

The xref should appear as follows:

\(^{\text{DD}(2,1,1,IEN,0)} = 2^{\text{ANURS}^{\text{MUMPS}}}
^{\text{DD}(2,1,1,IEN,1)} = S \ % X = X , X = \ "NURSCPL" \ X \ ^{\%ZOSF("TEST")} S \ X = % X
D: $T \ EN 1^{\text{NURSCPL}}
^{\text{DD}(2,1,1,IEN,2)} = S \ % X = X , X = \ "NURSCPL" \ X \ ^{\%ZOSF("TEST")} S \ X = % X
D: $T \ EN 2^{\text{NURSCPL}}\)
Chapter 2  Maintenance of Administrative Site Files

NURSFL-MENU

Administrative Site File Functions

Description:

This menu is assigned to the nursing ADP coordinator. The menu contains options which edit site file information used primarily in the administration module. These site files contain information which is defined by individual medical centers.

Additional Information:

Information stored through the Nursing Location File, Edit and the Site Parameter File options are used in the clinical, education, and performance improvement modules.

Recommendations:

1. Prior to entering data into these files, the user needs to:
   a. Identify the data which will populate the file.
   b. Identify who will have the capability to edit the data.

2. The nursing ADPAC should limit the number of users having access to these options.

Menu Display:

Select Nursing System Manager's Menu Option: 5  Nursing Features (all options)

1. Administration Records, Enter/Edit ...
2. Administration Records, Print ...
3. Administrative Site File Functions ...
4. Nursing Education Reports, Print ...
5. Patient Care Data, Enter/Edit ...
6. Patient Care Data, Print ...
7. Clinical Site File Functions ...
8. QI Data, Enter/Edit ...
9. Quality Performance Reports ...
10. QI Site Files ...
11. Special Functions ...
Select Nursing Features (all options) Option: 3  Administrative Site File Functions

1  AMIS 1106 Acuity Edit
2  Privilege File Edit
3  Certification File, Edit
4  FTEE Service Budget (1106b) File, Edit
5  Load Grade/Step Codes
6  Nursing Location File, Edit
7  Print Existing Location File Entries
8  Service Position File, Edit
9  Tour of Duty File, Edit
10  Vacancy Reason File Edit
11  Site Parameter File
12  Clinical Background File, Edit
13  Product Line File Edit

Menu Access:

The Administrative Site File Functions option is accessed through the Nursing Features (all options) menu.
**NURAAM-ACUED**

**AMIS 1106 Acuity Edit**

**Description:**

This option permits editing of acuity totals stored in the NURS AMIS 1106 Manhours (#213.4) file for the Night, Day, and Evening Shifts. Editing of acuity may be required when the system is off-line, for omissions, etc.

**Additional Information:**

Data in NURS AMIS 1106 Manhours (#213.4) file is used to generate the patient category totals for the quarterly AMIS 1106 and the AMIS workload reports. When classification information is entered through this option, the required FTEE in the Workload Statistics Reports is automatically updated. The same formula is used whether it is original or edited data. The Batch Run of Unclassified AMIS 1106 Patients (NURAAM-UNCBAT) option is a report (maybe queued) which identifies patients who were not classified for the previous day. Only totals for bed sections and categories may be entered for a given location. Individual patients may not be classified retrospectively. The AMIS 1106 Acuity Edit option may be given to nurse managers to maintain unit specific acuity data. The NURS AMIS 1106 Manhours (#213.4) file points to the New Person (#200) file and the NUR AMIS Ward (#213.3) file.

**Restrictions:**

Classification totals can be edited for only the last 120 days. Data may only be entered into category levels specific to that bed section.

**Menu Display:**

Select Nursing Features (all options) Option: 3  Administrative Site File Functions

1  AMIS 1106 Acuity Edit
2  Privilege File Edit
3  Certification File, Edit
4  FTEE Service Budget (1106b) File, Edit
5  Load Grade/Step Codes
6  Nursing Location File, Edit
7  Print Existing Location File Entries
8  Service Position File, Edit
9  Tour of Duty File, Edit
10 Vacancy Reason File Edit
Maintenance of Administrative Site Files

11 Site Parameter File
12 Clinical Background File, Edit
13 Product Line File Edit

Screen Prints:

Select Administrative Site File Functions Option: **1** AMIS 1106 Acuity Edit

Select DATE that patient was classified: **8/14/86** (AUG 14, 1986)

Enter the classification date when the acuity was either entered in error or omitted.

Select Shifts(s) (Enter [N]ight [D]ay [E]vening or [A]ll Shifts): **A**

Answer with appropriate shifts.

Select UNIT that needs correction: **6W**

Enter the ward/unit name where the acuity needs correcting or new data should be entered.

Select NURSING BED SECTION that needs correction: **SURGICAL**  /  <RET>

Enter the name of the nursing AMIS bed section associated with the acuity. The following is a list of choices:

- ALCOHOL AND DRUG TREATMENT
- DOMICILIARY
- HEMODIALYSIS
- INTENSIVE CARE
- INTERMEDIATE CARE
- MEDICAL (EXCLUDE SCI)
- MEDICAL (SCI)
- NURSING HOME CARE UNIT
- PSYCHIATRIC
- RECOVERY ROOM
- SURGICAL

After the date, ward, shift(s) and Amis bed section is entered, four possible scenarios can result:

**Example 1:** The software looks for existing data and then displays the (totaled) information by category. The appropriate categories for the bed section display.

```
CATEGORY 1: 2/ / <RET> Type a whole number between 0 and 99999
CATEGORY 2: 0/ / 1
CATEGORY 3: 15/ / <RET>
CATEGORY 4: 1/ / 2
```
Example 2: If no data has been entered for a nursing unit with an AMIS bed section identified in the NURS Location file, the software displays prompts for the appropriate categories.

CATEGORY 1: 0//3 Type a whole number between 0 and 99999
CATEGORY 2: 0//1
CATEGORY 3: 0//15
CATEGORY 4: 0//2

Example 3: When classification data must be entered on a date for a nursing unit with an AMIS bed section which is not identified (with that unit) in the NURS Location file, the software will display:

...Editing (name of shift) for (name of ward)... 
THIS COMBINATION YOU HAVE SELECTED DOES NOT EXIST, 
WOULD YOU LIKE TO ADD THIS AS NEW DATA? Yes//<RET>

The appropriate categories for the bed section displays.

Category 1: 0//<RET>
Category 2: 0//4

Example 4: When the NURAAM-ACU (Nursing Acuity/Separation Run) option does not run because TaskMan is down, the user will also see the display,

THIS COMBINATION YOU HAVE SELECTED DOES NOT EXIST, 
WOULD YOU LIKE TO ADD THIS AS NEW DATA? Yes//

for all nursing units. You will not find any data for units which classified patients on the previous day. If TaskMan is down, you will then have to manually run the above option by selecting the Manual Nursing Acuity/Separation Run (NURAAM-ACUMAN) option found in the Special Functions (NURSSP-MENU) menu.

After you have finished entering omitted acuity information, you can exit this option by entering return at the following prompts.

Select UNIT that needs correction: <RET>
Select DATE that patient was classified: <RET>

Menu Access:

The AMIS 1106 Acuity Edit option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.
NURSFL-PRIV

Privilege File Edit

Description:

This option allows the user to enter or edit the names of clinical privileges in the NURS Privilege (#212.6) file. This file is pointed to by the NURS Staff (#210) file. To add or edit privileges for an individual staff member refer to the Status and Position (NURAED-STF-STAT/POS) option under the Staff Record, Edit option.

Additional Information:

Each site may set up a list of privileges to be used. A date granted is entered with an individual's staff record.

Menu Display:

Select Nursing Features (all options) Option: 3 Administrative Site File Functions

1 AMIS 1106 Acuity Edit
2 Privilege File Edit
3 Certification File, Edit
4 FTEE Service Budget (1106b) File, Edit
5 Load Grade/Step Codes
6 Nursing Location File, Edit
7 Print Existing Location File Entries
8 Service Position File, Edit
9 Tour of Duty File, Edit
10 Vacancy Reason File Edit
11 Site Parameter File
12 Clinical Background File, Edit
13 Product Line File Edit

Screen Prints:

Select Administrative Site File Functions Option: 2 Privilege File Edit

Enter Privilege: Requests consultation/referrals
Are you adding "Requests consultation/referrals" as a new NURS PRIVILEGE (the 1ST)? No// Y (YES)
Enter a name of a privilege, a number associated with a privilege, or enter the name of a new privilege. Answer must be 3-50 characters in length.

Name: Requests consultation/referrals Replace <RET>

Enter Privilege:<RET>

You may enter another privilege.

**Menu Access:**

The Privilege File Edit option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.
NURAFL-CERT

Certification File, Edit

Description:

This option permits a service to enter and modify the NURS Certification (#212.2) file. A basic list of certifications is included in the software but as new certifications are recognized, that information may be added to this file. Certifications other than nursing selected certifications may be added to this file.

Additional Information:

For information on entering certifications into the employee records, refer to National Certification (NURAED-STF-CERT) under the Staff Record, Edit option. Certification information is printed on the Staff Record Report (NURAPR-STF) and the Certification Reports (NURAPR-CERTF). The NURS Staff (#210) file points to the NURS Certification (#212.2) file.

Menu Display:

Select Nursing Features (all options) Option: 3  Administrative Site File Functions

1  AMIS 1106 Acuity Edit
2  Privilege File Edit
3  Certification File, Edit
4  FTEE Service Budget (1106b) File, Edit
5  Load Grade/Step Codes
6  Nursing Location File, Edit
7  Print Existing Location File Entries
8  Service Position File, Edit
9  Tour of Duty File, Edit
10  Vacancy Reason File Edit
11  Site Parameter File
12  Clinical Background File, Edit
13  Product Line File Edit

Screen Prints:

Select Administrative Site File Functions Option: 3  Certification File, Edit

Select Type of Certification: RN,CNAA
Are you adding 'RN,CNAA' as a new NURS CERTIFICATION (the 13TH)? No// Y (Yes)
An example of a listing of certifications exported in the file is displayed below.

<table>
<thead>
<tr>
<th></th>
<th>Certification Type</th>
<th>Certification Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>RNC ADULT NURSE PRACTITIONER</td>
<td>AMERICAN NURSES ASSOCIATION</td>
</tr>
<tr>
<td>2</td>
<td>RN,CS C.S. IN MED/SURG NURSING</td>
<td>AMERICAN NURSES ASSOCIATION</td>
</tr>
<tr>
<td>3</td>
<td>RN,CS C.S. IN ADULT PSYCH. &amp; MENTAL HEALTH NSG.</td>
<td>AMERICAN NURSES ASSOCIATION</td>
</tr>
<tr>
<td>4</td>
<td>RNC COMMUNITY HEALTH NURSE</td>
<td>AMERICAN NURSES ASSOCIATION</td>
</tr>
<tr>
<td>5</td>
<td>RNC GERONTOLOGICAL NURSE</td>
<td>AMERICAN NURSES ASSOCIATION</td>
</tr>
<tr>
<td>6</td>
<td>RNC GERONTOLOGICAL NURSE PRACT.</td>
<td>AMERICAN NURSES ASSOCIATION</td>
</tr>
<tr>
<td>7</td>
<td>RNC MEDICAL-SURGICAL NURSE</td>
<td>AMERICAN NURSES ASSOCIATION</td>
</tr>
<tr>
<td>8</td>
<td>RNC PSYCH. AND MENTAL HEALTH NURSE</td>
<td>AMERICAN NURSES ASSOCIATION</td>
</tr>
<tr>
<td>9</td>
<td>RN,CNA NURSING ADMINISTRATION</td>
<td>AMERICAN NURSES ASSOCIATION</td>
</tr>
<tr>
<td>10</td>
<td>CRRN CERTIFIED REHABILITATION R.N.</td>
<td>ASSOCIATION OF REHABILITATION NURSES</td>
</tr>
<tr>
<td>11</td>
<td>CIC CERTIFIED INF. CONTROL PRACT.</td>
<td>ASSOCIATION OF PRACTITIONERS IN INFECTION CONTROL</td>
</tr>
<tr>
<td>12</td>
<td>CCRN CRITICAL CARE NURSE</td>
<td>AMERICAN ASSOCIATION OF CRITICAL CARE NURSES ETC.</td>
</tr>
</tbody>
</table>

Additional certification names can be entered into the file. Names must be 2-8 characters in length. Initials (abbreviation) identify the type of certification.

**ABBREVIATION:** RN,CNAA/\ <RET>  

You may edit the information at this prompt.

**NAME OF CERTIFICATION:** NURSING ADMINISTRATION ADV.

Enter the full name or type of certification. This must be 3-50 characters in length.

**NAME OF CERTIFYING AGENCY:** AMERICAN NURSES ASSOCIATION

This is the name of national organization granting certification and it is 1-50 characters in length.

**ABBREVIATED NAME OF AGENCY:** ANA

Enter the abbreviated name or initials of the certifying organization. The entry is 2-8 characters in length.

**Select Type of Certification:** <RET>  

You may enter another type of certification.

**Menu Access:**

The Certification File, Edit option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.
NURAFL-BFU

FTEE Service Budget (1106b) File, Edit

Description:

This option permits a user to enter data on budgeted/ceiling FTEE for each of the twenty AMIS 1106b categories. FTEE data is stored by institution or division. The data in this file pertains to total Nursing FTEE and is not affected by medical center product lines.

Additional Information:

The facility and FTEE information in this file is used to print the AMIS 1106b (NURAPR-RES-FTEE) Report. Institution names are also used in every Nursing Administration Module report that sorts by facility or division. The NURS AMIS 1106B FTEE (#213.2) file points to the Institution (#4) file; no other file points to File #213.2. This file must contain complete and correct information to print accurate variance between budgeted and actual FTEE for each facility. At a multi-divisional hospital this option is intended to only be given to the ADPAC at the legacy site for that ADPAC to enter the budgeted data for the additional sites.

Recommendations:

The data in this file should be reviewed at least quarterly.

Menu Display:

Select Nursing Features (all options) Option: 3 Administrative Site File
Functions

1 AMIS 1106 Acuity Edit
2 Privilege File Edit
3 Certification File, Edit
4 FTEE Service Budget (1106b) File, Edit
5 Load Grade/Step Codes
6 Nursing Location File, Edit
7 Print Existing Location File Entries
8 Service Position File, Edit
9 Tour of Duty File, Edit
10 Vacancy Reason File Edit
11 Site Parameter File
12 Clinical Background File, Edit
13 Product Line File Edit

1 Patch NUR*4*32 March 2000
Screen Prints:

Select Administrative Site File Functions Option: 4 FTEE Service Budget (1106b) File, Edit

Note:

1. No up-arrow (^) is allowed during entry.
2. You are entering FTEE Ceiling Totals assigned by Management for Nursing Service Personnel Quarterly Report 10-1106b (AMIS).
3. The date displayed is the last date budgeted entries were made.
4. Enter the date of current budgeted entries.
5. All numeric entries must be between 0 and 99999.

This is an example of entering the name of a new facility and associated budgeted FTEE in to the NURS AMIS 1106 FTEE (#213.2) file.

You will be entering FTEE Ceiling Totals assigned by Management for Nursing Service Personnel Quarterly Report 10-1106b (AMIS)

Select FACILITY: PERR

1   PERRY POINT               MD                    VAMC      641
2   PERRY POINT               MD                    CIVH      641DM
3   PERRY POINT               MD                    VCSFC     641DS
4   PERRY POINT               MD                    USAH      6419AA
5   PERRY POINT, MD                                           641

CHOOSE 1-5: 1

Are you adding 'PERRY POINT' as a new NURS AMIS 1106B FTEE (the 3RD)? No// Y (Yes)

The facility prompt appears only if the Multi-Divisional field of the NURS Parameter (#213.9) file is marked ‘Yes’. Answer with appropriate facility name (pointer to Institution file).

Date displayed is date of last budget entries. Enter date of current budget entries.


This is the date associated with the following data.

(01) BUDGETED RN: 145

Total number of (budgeted/ceiling) FTEE designated as RN positions.

(02) BUDGETED LPN: 60

Total number of (budgeted/ceiling) FTEE designated as LPN/LVN positions.
(03) BUDGETED NA: 100

Total number of (budgeted/ceiling) FTEE designated as NA positions.

(04) BUDGETED CLERICAL: 6

Total number of (budgeted/ceiling) FTEE designated as 'clerical' positions.

(05) BUDGETED ADMIN OFFICER: 0

Total number of (budgeted/ceiling) FTEE designated as 'administrative officer' positions.

(06) BUDGETED CLIN SPECIALIST: 3

Total number of RN (budgeted/ceiling) FTEE designated as 'clinical specialist' positions.

(07) BUDGETED RN PRACTITIONER: 4

Total number of RN (budgeted/ceiling) FTEE designated as 'nurse practitioner' positions.

(08) BUDGETED INFECT. CONTROL: 3

Total number of RN (budgeted/ceiling) FTEE designated as 'infection control' positions.

(09) BUDGETED PUBLIC HEALTH: 3

Total number of RN (budgeted/ceiling) FTEE designated as 'public health' positions.

(10) BUDGETED STAFF NURSE: 112

Total number of RN (budgeted/ceiling) FTEE designated as 'staff nurse' positions.

(11) BUDGETED CHIEF NURSE: 1

Total number of RN (budgeted/ceiling) FTEE designated as 'chief nurse' positions.

(12) BUDGETED ASST CHIEF NURSE: 3

Total number of RN (budgeted/ceiling) FTEE designated as 'asst chief nurse' positions.

(13) BUDGETED ASSOC CHIEF N.S.: 1

Total number of RN (budgeted/ceiling) FTEE designated as 'associate chief for N.S.' positions.

(14) BUDGETED SUPERVISOR: 2

Total number of RN (budgeted/ceiling) FTEE designated as 'supervisor' positions.
(15)  BUDGETED HEAD NURSE: 5
Total number of RN (budgeted/ceiling) FTEE designated as 'head nurse' positions.

(16)  BUDGETED OTHER NURSE: 2
Total number of RN (budgeted/ceiling) FTEE designated for special positions not identified in fields 6 thru 15 or 17 thru 20.

(17)  BUDGETED NURSE RESHR: 1
Total number of RN (budgeted/ceiling) FTEE designated as 'nurse researcher' positions.

(18)  BUDGETED ASSOC CHIEF/RESH: 1
Total number of RN (budgeted/ceiling) FTEE designated as 'associate chief/research' positions.

(19)  BUDGETED ASSOC CHIEF/EDU: 1
Total number of RN (budgeted/ceiling) FTEE designated as 'associate chief/education' positions.

(20)  BUDGETED INSTR/EDU: 3
Total number of RN (budgeted/ceiling) FTEE designated as 'instructor/education' positions.

Select FACILITY: <RET>

Note:

Fields 06-20 must total field 01. If the tally is incorrect, the following message will be displayed.

The number of RN's BUDGETED must equal the sum of categories 06 thru 20 (e.g. Clin Specialist, Nurse Practitioner, etc.)

Want the computer to enter the total FTEE (15) for categories 06 thru 20 into the Budgeted RN (01) field? YES// <RET>

The user can let the computer make the correction or can go back and edit the categories.

Menu Access:

The FTEE Service Budget (1106b) File, Edit option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.
NURAFL-GS-COD

Load Grade/Step Codes

Description:

This option permits the service to enter and modify the NURS Pay Scale (#211.1) file which contains grade/step codes used in Salary Reports (NURAPR-SAL) and the NURS Staff (#210) file. New grade/step codes must be entered into NURS Pay Scale (#211.1) file using the option Load Grade/Step Codes (NURAFL-GS-COD).

Additional Information:

This information is printed in the Staff Record Report. The NURS Pay Scale (#211.1) file is pointed to by the NURS Staff (#210) file.

Menu Display:

Select Nursing Features (all options) Option: 3 Administrative Site File Functions

1 AMIS 1106 Acuity Edit
2 Privilege File Edit
3 Certification File, Edit
4 FTEE Service Budget (1106b) File, Edit
5 Load Grade/Step Codes
6 Nursing Location File, Edit
7 Print Existing Location File Entries
8 Service Position File, Edit
9 Tour of Duty File, Edit
10 Vacancy Reason File Edit
11 Site Parameter File
12 Clinical Background File, Edit
13 Product Line File Edit

Screen Prints:

Select Administrative Site File Functions Option: 5 Load Grade/Step Codes

Select GRADE/STEP Code: R/S1/1
Are you adding 'R/S1/1' as a new NURS PAY SCALE (the 21ST)? Y (YES)
Enter Grade/Step Code.
examples:
R/E1/5 = Registered Nurse, ENTRY1, Step 5
N/4/7 = Nursing Assistant,GS4,Step 7
R/E1/5 = Registered Nurse, ENTRY1, Step 5
N/4/7 = Nursing Assistant,GS4,Step 7

The following is a list of choices:

<p>| | | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>R/E1/1</td>
<td>2</td>
<td>R/E1/2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>R/E1/4</td>
<td>5</td>
<td>R/E1/5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>R/E1/7</td>
<td>8</td>
<td>R/E1/8</td>
<td>9</td>
</tr>
<tr>
<td>10</td>
<td>R/E1/10</td>
<td>11</td>
<td>R/E1/11</td>
<td>12</td>
</tr>
<tr>
<td>13</td>
<td>N/A/3</td>
<td>14</td>
<td>R/A/4</td>
<td>15</td>
</tr>
<tr>
<td>16</td>
<td>R/A/6</td>
<td>17</td>
<td>R/A/7</td>
<td>18</td>
</tr>
<tr>
<td>19</td>
<td>R/A/9</td>
<td>20</td>
<td>R/A/10</td>
<td></td>
</tr>
</tbody>
</table>

There is no specific pattern which you must follow to enter a grade/step code. It is suggested that the service decide upon a pattern, so interpretation of reports is easier. The code indicates the employee's service category, grade, and step level.

**Example:**  R/E1/5; registered nurse/entry1 grade 1/step 5.
Service category abbreviations (exported with this package) are:
   C = clerical,
   R = registered nurse,
   L = licensed practical nurse/licensed vocational nurse,
   N = nursing assistant,
   O = other category (i.e., trainee, etc.).

Refer to the glossary for more information on Service Category.

GRADE/STEP CODE: R/S1/1// <RET>

You may edit grade/step code.

Select GRADE/STEP Code: <RET>

You may enter another grade/step code.

**Menu Access:**

The Load Grade/Step Codes option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.
NURSFL-LOC

Nursing Location File, Edit

Description:

This option permits the entry of a new administration location or clinical unit and the editing of associated data. The file contains demographic and budgeted FTEE information for wards/units, clinics, and other nursing assignment locations. Data must be updated when budgeted/ceiling FTEE changes are made by nursing administration.

Additional Information:

1. Information in this file is used throughout the nursing software (e.g., classification, staff file, manhours, patient plan of care, vitals, census, location comparison FTEE reports). The NURS Location (#211.4) file is pointed to by: the NURS Staff (#210) file, the NURS Position Control (#211.8) file, the NURS AMIS Daily Exception Report (#213.5) file, the NURS Patient (#214) file, and the NURS Classification (#214.6) file. The NURS Location file points to the Hospital Location (#44), NURS Product Line (#212.7), NURS Clinical Background (#211.5), and the NURS AMIS Ward (#213.3) files.

Budgeted staff service positions, and their associated FTEE data, although entered through this option, are stored in the NURS Position Control (#211.8) file. This budgeted service position information is used to print the FTEE Comparison (1106b) Report. The budgeted Service Category data displayed in the FTEE Comparison (1106b) Report is calculated from the service position information.

It is important that the Product Line field be completed when FTEE is assigned to services other than Nursing. Upon installation of the software, each location’s Product Line field is initialized with the service name of Nursing when no value is found stored in the field. The Product Line field is displayed only when the Product Line field of the NURS Parameter file contains a value of ‘yes’. Inactivating the Patient Care Status field and/or the Ward status field does not affect the inclusion of data in the AMIS manhours, classifications and workload reports.

NOTE: The NURS Location (#211.4) file must contain an MASONLY entry that has a ward status of active and a patient care status of inactive. All MAS ward locations should be associated with an active nursing unit or MASONLY.

Menu Display:

Select Nursing Features (all options) Option: 3  Administrative Site File Functions

1     AMIS 1106 Acuity Edit
2     Privilege File Edit

1  Patch NUR*4*2  October 1997
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<table>
<thead>
<tr>
<th></th>
<th>Function Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Certification File, Edit</td>
</tr>
<tr>
<td>4</td>
<td>FTEE Service Budget (1106b) File, Edit</td>
</tr>
<tr>
<td>5</td>
<td>Load Grade/Step Codes</td>
</tr>
<tr>
<td>6</td>
<td>Nursing Location File, Edit</td>
</tr>
<tr>
<td>7</td>
<td>Print Existing Location File Entries</td>
</tr>
<tr>
<td>8</td>
<td>Service Position File, Edit</td>
</tr>
<tr>
<td>9</td>
<td>Tour of Duty File, Edit</td>
</tr>
<tr>
<td>10</td>
<td>Vacancy Reason File Edit</td>
</tr>
<tr>
<td>11</td>
<td>Site Parameter File</td>
</tr>
<tr>
<td>12</td>
<td>Clinical Background File, Edit</td>
</tr>
<tr>
<td>13</td>
<td>Product Line File Edit</td>
</tr>
</tbody>
</table>

Screen Prints:

Select Administrative Site File Functions Option: 6  Nursing Location File, Edit

Example 1: Adding new information associated with an existing location.

Select NURSING UNIT NAME: CCU

Are you adding 'NUR CCU' as a new HOSPITAL LOCATION? No// Y (Yes)

The addition of ‘NUR’ is required in the Hospital Location File and is added automatically by the Nursing application.

HOSPITAL LOCATION INSTITUTION: BAL

1   BALTIMORE, MD             MD                              512
2   BALTIMORE-RO              MD                              313

CHOOSE 1-2: 1 NUR CCU

This field points to the Institution file. Answer with INSTITUTION NAME, or STATION NUMBER.

Are you adding 'CCU' as a new NURS LOCATION (the 37TH)? No// Y (Yes)

After entering the location as a new entry, the user may edit the above information.

NAME: CCU// <RET>
HOSPITAL LOCATION INSTITUTION: BALTIMORE, MD// <RET>
PRODUCT LINE: MEDICINE

1Answer with product line name that is found in the NURS Product Line (#212.7) file. The Product Line prompt displays when a user has entered ‘yes’ into the Product Line field in the NURS Parameter (#213.9) file. Data in this field is used to associate a location with a product line, service, or program. Administrative location reports use this field to sort by product line.

PATIENT CARE STATUS: I INACTIVE

---

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The following is an example of the on-line help.

**Explanation of the Patient Care Flag/Status**

Does Nursing provide patient care on this ward?

A Patient Care Status flag of "A" (ACTIVE) indicates that direct patient care is being provided on the Nursing location. This field will contain an "I" (Inactive) if no patient care activity is present or if the location is used for other Nursing education and administrative functions.

The Ward Activation (NURSPT-WRDACT) and Ward Deactivation (NURSPT-WR邓A) Options should be used to update this field. Editing of this field via any other means may cause the NURS Patient File to contain incorrect data.

For additional help on how this field should be set please type MORE.

<table>
<thead>
<tr>
<th>RELATED HELP FRAME</th>
<th>KEYWORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>1</td>
<td>MORE</td>
</tr>
</tbody>
</table>

* - Recently viewed help frame

Select HELP SYSTEM action or <return>:

Choose from:

A ACTIVE
I INACTIVE

**NOTE:**
Since this is a new ward, the user would enter an inactive (I) status because Patient Care Status should be activated through the Ward Activation Patient Update (NURSPT-WRDACT) option.

WARD STATUS: A ACTIVE

The following is an example of the on-line help.

**Explanation of the ward status/inactive flag.**

Is this location used by the Nursing package?

The Ward Status field indicates active and inactive locations in the Nursing System. To designate this field as "A" (ACTIVE), enter an "A" in the Ward Status field. If this location has been closed and all Nursing activities (e.g., patient care, Nursing education and administration functions) have ceased, then enter an "I" for "Inactive" in the Ward Status field.

For additional help on how this field should be set please type MORE.

<table>
<thead>
<tr>
<th>RELATED HELP FRAME</th>
<th>KEYWORD</th>
</tr>
</thead>
<tbody>
<tr>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>1</td>
<td>MORE</td>
</tr>
</tbody>
</table>

* - Recently viewed help frame
Select HELP SYSTEM action or <return>:

The ward status field has an entry of ‘I’ (Inactive) when the unit is closed, that is, when the location is not used for patient care or as an administrative staff location.

At this time, the user is asked if they want to associate MAS wards with the location. This relationship is used to place an inpatient assigned to a MAS ward onto a Nursing location.

There are no MAS wards associated with this Nursing unit. Would you like to (A) dd new MAS wards or (B)y pass this prompt (A/B): A// ADD NEW ENTRIES

Enter ‘A’ if a MAS ward should be associated with this location.

Select MAS ward to add: CCU

Answer with ward location name.

Select MAS ward to add: <RET>

Below is a listing of associated MAS wards
1. CCU

Would you like to (A) dd new MAS wards, (D)elete existing locations from the above listing or (B)ypass this prompt (A/D/B): B// BYPASS PROMPT

The user is asked if they want to associate an AMIS bedsection with the location. This relationship is used to display an appropriate patient classification pattern when staff classify a patient.

There are no AMIS bed sections associated with this Nursing location. Would you like to (A) dd new AMIS bed sections or (B)y pass this prompt (A/B): A// ADD NEW ENTRIES

Select AMIS bed section to add: INTENSIVE CARE

Answer with appropriate AMIS ward bed section. The following is a list of choices:
ALCOHOL AND DRUG TREATMENT
DOMICILIARY
HEMODIALYSIS
INTENSIVE CARE
INTERMEDIATE CARE
MEDICAL (EXCLUDE SCI)
MEDICAL (SCI)
NURSING HOME CARE UNIT
PSYCHIATRIC
RECOVERY ROOM
SURGICAL
Select AMIS bed section to add: <RET>

<table>
<thead>
<tr>
<th>AMIS Bed section</th>
<th>Associated MAS ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. INTENSIVE CARE</td>
<td></td>
</tr>
</tbody>
</table>

Would you like to (A)dd new AMIS bed sections, (D)elete existing AMIS bed sections from the above listing, (E)dit the associated MAS ward relationship, or (B)ypass this prompt (A/D/E/B): B// <RET> BYPASS PROMPT

Other examples of editing entries for locations and MAS wards can be found at the end of this option’s explanation.

**PROFESSIONAL PERCENTAGE:** 100

This number indicates the percentage of professional nursing personnel assigned to a unit.

1The professional percentage for a location is calculated by dividing the budgeted RN positions into the total budgeted RN, LPN, NA positions.

\[
\text{RN Budgeted FTEE} \div \text{Total Budgeted RN, LPN, NA} = \text{Professional Percentage}
\]

2Entering data here and not through the Site Parameter file makes this entry unit specific. The workload data is calculated using this value and not the value stored in the NURS Parameter file.

**UNIT EXPERIENCE:** CARDIAC INTENSIVE CARE

3This field contains the area of concentration, administrative or clinical, associated with this location. The data in this field is required for the batch run to adjust FTEE after Separation (NURAED-BATSEP) and Status and Position (NURAED-STF-STAT/POS) options to automatically trigger positions that are no longer active into the Experience field of the NURS Staff (#210) file.

Data is selected from the entries in the Clinical Background (#211.9) file. An example of entries which might be found in this file is found below.

CARDIAC INTENSIVE CARE
DRUG DEPENDENCY
MED/SURG
MEDICAL
NEURO-SURGERY
NEUROLOGY
NURSING ADMINISTRATION
NURSING EDUCATION
O.R.

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PLASTIC SURGERY
PSYCHIATRY
REHAB MEDICINE
RENAL/GU
SPINAL CORD INJURY
SURGICAL

1. Select SERVICE POSITION: **HN**  HEAD NURSE  NURSING
   Are you adding 'HN' as a new POSITION BUDGETED (the 1ST for this NURS POSITION)? No// **Y** (Yes)
   BUDGETED FTEE: **1**

2. Select SERVICE POSITION: **RN**
   1. RN  STAFF NURSE  NURSING
   2. RN-SURG  STAFF NURSE  NURSING
   CHOOSE 1-2: **1**
   Are you adding 'RN' as a new POSITION BUDGETED (the 2ND for this NURS POSITION)? No// **Y** (Yes)
   BUDGETED FTEE: **20**

3. Select SERVICE POSITION: <RET>

You may enter another service position.

On wards that have other staff positions, continue adding service positions and corresponding budgeted FTEE as appropriate.

Select NURSING UNIT NAME: <RET>

**Example 2:** MAS step-down unit incorporated into an intensive care unit.

Any time an MAS ward is added or deleted, the user must DEACTIVATE the location first, edit the MAS location, and then ACTIVATE the nursing location through the Ward Deactivation Patient Update (NURSPR-WRDIINA) and the Ward Activation Patient Update (NURSPRT-WRDACT) options.

Select MAS ward to add: **3M**

The MAS stepdown unit 3M consolidated into CCU.

Select MAS ward to add: <RET>

You may enter another MAS ward.

Below is a listing of associated MAS wards

1. **3M**

   Would you like to (A)dd new MAS ward, (D)elete existing locations from the above listing or (B)ypass this prompt (A/D/B): **B** DELETE EXISTING ENTRIES

---

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3. Patch NUR*4*2 October 1997
Example 3: Deleting an existing entry.

Select the number(s) of the entries you wish to delete (1-2): 2

Below is a listing of associated MAS wards
1. 3M
Would you like to (A)dd new MAS wards, (D)elete existing units from the above listing or (B)ypass this prompt (A/D/B): B// <RET> BYPASS PROMPT

Example 4: Adding a new AMIS bed section to the NURS Location file SICU entry:

<table>
<thead>
<tr>
<th>AMIS Bed section</th>
<th>Associated MAS ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PSYCHIATRIC</td>
<td>3S</td>
</tr>
</tbody>
</table>

Would you like to (A)dd new AMIS bed sections, (D)elete existing AMIS bedsections from the above listing, (E)dit the associated MAS ward relationship, or (B)ypass this prompt (A/D/E/B): B// A ADD NEW ENTRIES

Note:

1. New AMIS bed section(s) may be entered for existing NURS locations but the user must also associate an AMIS bed section with the appropriate MAS ward in order for the (AMIS) modules to function properly.

2. When an AMIS bed section is added or deleted, the user must DEACTIVATE and ACTIVATE the nursing location through the Ward Deactivation Patient Update (NURSPR-WRDNIA) and the Ward Activation Patient Update (NURSPT-WRDACT) options. This updates the existing patient's location/bedsections.

Example 5: Edit AMIS bed section relationship:

Would you like to (A)dd new AMIS bed sections, (D)elete existing AMIS bed sections from the above listing, (E)dit the associated MAS ward relationship, or (B)ypass this prompt (A/D/E/B): B// E EDIT RELATIONSHIP

---

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After entering the bed section the user can then associate the new (or old) bed section with an
MAS ward.

Select associated MAS ward: **3M**

AMIS BED SECTION: SURGICAL

Select associated MAS ward: **<RET>**

<table>
<thead>
<tr>
<th>AMIS Bed section</th>
<th>Associated MAS ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PSYCHIATRIC</td>
<td>3S</td>
</tr>
<tr>
<td>2. SURGICAL</td>
<td>3M</td>
</tr>
</tbody>
</table>

**Example 6:** Delete existing AMIS bed section entries:

Would you like to (A)dd new AMIS bed sections, (D)elete existing AMIS
bed sections from the above listing, (E)dit the associated MAS ward or
(B)yypass this prompt (A/D/E/B)[:D DELETE EXISTING ENTRIES

Select the number(s) of the entries you wish to delete (1-2): **2**

<table>
<thead>
<tr>
<th>AMIS Bed section</th>
<th>Associated MAS ward</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PSYCHIATRIC</td>
<td>3S</td>
</tr>
</tbody>
</table>

Would you like to (A)dd new AMIS bed sections, (D)elete existing AMIS
bed sections from the above listing, (E)dit the associated MAS ward
relationship, or (B)yypass this prompt (A/D/E/B): **B** // <RET> BYPASS PROMPT

**Example 7:** Inactivation of a nursing location:

Select NURSING UNIT NAME: **2B**

NAME: 2B//@

Deleting a Nursing Unit

A NURSING UNIT CANNOT BE DELETED!!

To simulate a deletion:

1. Run the WARD DEACTIVATION PATIENT UPDATE OPTION (NURSPT WRDINA) to:

   a) remove patients from the unit of the simulated deletion and

   b) set the PATIENT CARE STATUS field of this nursing location to inactive.

---

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12. Set the WARD STATUS field of this nursing location to (I) inactive.

3. Assign the corresponding MAS location(s) for the inactivated unit to a new or existing nursing location. Please note that all MAS locations that cannot be associated with an active nursing unit, should be assigned to the active location of MASONLY.

4. Delete the MAS location entry(s) for the old/original nursing location being deactivated.

5. Deactivate nursing locations which are receiving the MAS location referenced in step 3 (except MASONLY). Reactivate these wards using the Ward Activation Patient Update option (NURSPT-WRDACT). This process will place all patients from the closed unit on their new locations in the Nursing System.

Menu Access:

The Nursing Location File, Edit option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.

---

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CLOSING/EDITING AN EXISTING NURSING LOCATION

Select: Ward Deactivation Patient Update Option

Select: Print Existing Location File Entries option and print for selected locations.

Edit Location Through the Nursing Location File

Every MAS Ward has a corresponding Nursing Location

No

Yes

Select locations to be deactivated.

Edit selected Location(s) through the Nursing Location File, Edit option.

Patient Care Status field and status of all patient(s) assigned are set to INACTIVE.

Ward Status: Active Means that it has an active Administrative Function.

Add/Edit/delete all associated MAS Wards with this Nursing Location whether active or inactive.

Add/Edit/Delete AMIS bedsections.

No

Every MAS Ward has a corresponding Nursing Location

Yes

Select: Ward Activation Patient Update option and select location(s) to be Activated.

Associated MAS bedsection with Nursing bedsection.
NURSLO-PRINT

Print Existing Location File Entries

Description:

1. This option prints a report listing all information associated with a location stored in the NURS Location (#211.4) file. (e.g., ward and patient care status; corresponding MAS ward(s) and AMIS bedsection(s); and budgeted FTEE information).

Additional Information:

2. This option prints 3 different reports:
   - Status/bed section information
   - Status/bed section report with budgeted FTEE
   - Budgeted FTEE only

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Data can be edited through the Nursing Location File, Edit option. Budgeted service position FTEE information is stored in the Position Control (#211.8) file. The budgeted service position FTEE and its associated service category (reflected in File 211.8) is used to calculate the total budgeted service category FTEE. This report indicates if staff entries in the NURS Position Control file are associated with a unit. This information is found under the Staff Flag heading.

Menu Display:

Select Nursing Features (all options) Option: 3  Administrative Site File Functions

1. AMIS 1106 Acuity Edit
2. Privilege File Edit
3. Certification File, Edit
4. FTEE Service Budget (1106b) File, Edit
5. Load Grade/Step Codes
6. Nursing Location File, Edit
7. Print Existing Location File Entries
8. Service Position File, Edit
9. Tour of Duty File, Edit
10. Vacancy Reason File Edit
11. Site Parameter File

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Screen Prints:

Select Administrative Site File Functions Option: 7 Print Existing Location File Entries

Status/bed section information.

1. Status/bed section information (80 column)
2. Status/bed section report with budgeted FTEE (132 column)
3. Budgeted FTEE only (80 column)

Select Reporting Option: 1

1 Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing locations in the facility. When an individual unit is selected, the user is prompted with 'Another Nursing Unit'. A specified group of nursing units may be requested at the same time.

DEVICE: Enter appropriate device

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>AMIS</th>
<th>MAS</th>
<th>CARE</th>
<th>WARD</th>
<th>BED</th>
<th>MAS</th>
<th>BED</th>
<th>STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>STATUS</td>
<td>STATUS</td>
<td>SECTION</td>
<td>WARD</td>
<td>SECTION</td>
<td>FLAG</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
|---------------------------------------------------------------
| FACILITY: BUTLER
PRODUCT LINE: PRIMARY CARE

4EA      | ACTIVE | ACTIVE | MED | 4E | MED | YES
PRODUCT LINE: SURG

MICU     | ACTIVE | ACTIVE | ICU | MED | ICU | ICU | 51 | MED | NO

Enter RETURN to continue or '^' to exit: <RET>
### EXISTING LOCATION REPORT

<table>
<thead>
<tr>
<th>PATIENT NAME</th>
<th>AMIS STATUS</th>
<th>MAS STATUS</th>
<th>SECTION</th>
<th>WARD</th>
<th>SECTION</th>
<th>FLAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FACILITY: HINES**

**PRODUCT LINE: NURSING**

<table>
<thead>
<tr>
<th>WARD</th>
<th>AMIS STATUS</th>
<th>MAS STATUS</th>
<th>SECTION</th>
<th>WARD</th>
<th>SECTION</th>
<th>FLAG</th>
</tr>
</thead>
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<td>10W</td>
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<td>ACTIVE</td>
<td>REC</td>
<td>51</td>
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<td>NO</td>
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<td>11W</td>
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<td>ACTIVE</td>
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<td>1 WEST</td>
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<td>NO</td>
</tr>
<tr>
<td>13E</td>
<td>ACTIVE</td>
<td>ACTIVE</td>
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<td>1 EAST</td>
<td>PSY</td>
<td>NO</td>
</tr>
<tr>
<td>15E</td>
<td>ACTIVE</td>
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<td>MED</td>
<td>1 NORTH</td>
<td>SUR</td>
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<td>15W</td>
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<td>MED</td>
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</tr>
<tr>
<td>3C</td>
<td>INACTIV</td>
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<td>SUR</td>
<td></td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td>4E</td>
<td>ACTIVE</td>
<td>ACTIVE</td>
<td>ATC</td>
<td>4E</td>
<td>ATC</td>
<td>NO</td>
</tr>
<tr>
<td>51A</td>
<td>ACTIVE</td>
<td>ACTIVE</td>
<td>PSY</td>
<td>51</td>
<td>PSY</td>
<td>NO</td>
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<tr>
<td>5E</td>
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<td>ACTIVE</td>
<td>MED</td>
<td>5E</td>
<td>MED</td>
<td>NO</td>
</tr>
<tr>
<td>6E</td>
<td>ACTIVE</td>
<td>ACTIVE</td>
<td>HEM</td>
<td></td>
<td></td>
<td>NO</td>
</tr>
<tr>
<td>6W</td>
<td>INACTIV</td>
<td><strong>INACTIV</strong></td>
<td>MED</td>
<td>7W</td>
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<tr>
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<td><strong>INACTIV</strong></td>
<td>INT</td>
<td>8E</td>
<td>INT</td>
<td>NO</td>
</tr>
<tr>
<td>DU</td>
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<td>ACTIVE</td>
<td>HEM</td>
<td>DIALYSIS</td>
<td>HEM</td>
<td>NO</td>
</tr>
<tr>
<td>MASONLY</td>
<td>INACTIV</td>
<td>ACTIVE</td>
<td>MED</td>
<td>SUR</td>
<td>NHC</td>
<td>2ND FL</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>

---

Status/bed section report with budgeted FTEE.

1. Status/bed section information (80 column)
2. Status/bed section report with budgeted FTEE (132 column)
3. Budgeted FTEE only (80 column)

Select Reporting Option: 2

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

---

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Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility. When an individual nursing unit is selected, the user is prompted with 'Another Nursing Unit'. A specified group of Nursing units may be requested at the same time.

DEVICE: Enter appropriate device (report must go to a 132 col. device)

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>AMIS</th>
<th>MAS</th>
<th>MAS</th>
<th>STAFF</th>
<th>PROF</th>
<th>UNIT</th>
<th>SERVICE</th>
<th>BUDG</th>
<th>SERVICE</th>
<th>BUDG</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME</td>
<td>STATUS</td>
<td>STATUS</td>
<td>SECTION</td>
<td>WARD</td>
<td>SECTION</td>
<td>FLAG</td>
<td>%</td>
<td>TYPE</td>
<td>CATEGORY</td>
<td>FTEE</td>
</tr>
<tr>
<td>FACILITY: BUTLER</td>
<td></td>
<td></td>
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<tr>
<td>PRODUCT LINE: NURSING</td>
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<tr>
<td>3S</td>
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<td>ACTIVE</td>
<td>PSY</td>
<td>MED</td>
<td>3M</td>
<td>NUR 10E</td>
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<td>SURGICAL</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>NUR 3S</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>FACILITY: HINES</td>
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<tr>
<td>PRODUCT LINE: NURSING</td>
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</table>

Budgeted FTEE only

1. Status/bed section information (80 column)
2. Status/bed section report with budgeted FTEE (132 column)
3. Budgeted FTEE only (80 column)

Select Reporting Option: 3

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility. When an individual nursing unit is selected, the user is prompted with 'Another Nursing Unit'. A specified group of Nursing units may be requested at the same time.

DEVICE: Enter appropriate device (report must go to a 132 col. device)

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Budgeted FTEE only

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2. Status/bed section report with budgeted FTEE (132 column)
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Select Reporting Option: 3

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility. When an individual nursing unit is selected, the user is prompted with 'Another Nursing Unit'. A specified group of Nursing units may be requested at the same time.

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2. Status/bed section report with budgeted FTEE (132 column)
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Select Reporting Option: 3

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility. When an individual nursing unit is selected, the user is prompted with 'Another Nursing Unit'. A specified group of Nursing units may be requested at the same time.

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Budgeted FTEE only

1. Status/bed section information (80 column)
2. Status/bed section report with budgeted FTEE (132 column)
3. Budgeted FTEE only (80 column)

Select Reporting Option: 3
Select PRODUCT LINE (Press return for all product lines): <RET>

1Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all units in the facility. When an individual unit is selected, the user is prompted with 'Another Nursing Unit'. A specified group of nursing units may be requested at the same time.

DEVICE: HOME// Enter appropriate device

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</table>

Enter RETURN to continue or '"' to exit: <RET>

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1 Patch NUR*4*2 October 1997
2 Patch NUR*4*2 October 1997
This report may be used by the package ADPAC to identify erroneous location entries by comparing the printed information with other management records and discussing the data with management staff. Corrections are entered through the Nursing Location File, Edit (NURSFL-LOC) option.

**Menu Access:**

The Print Existing Location File Entries option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.

---

1 Patch NUR*4*2  October 1997
NURAFI-SPO

Service Position File, Edit

Description:

1. This option allows users to enter and modify data in the NURS Service Position (#211.3) file. Information stored in this file includes the service position name and abbreviation, priority sequence number, (associated) product line, (associated) service category, and an AMIS position that is linked to registered nurse positions only.

Additional Information:

2. This data is used in the Status and Position option of the Staff Record Edit and Staff Record Report, the Administrative Reports, and the Nursing Education Reports.

Service positions for non-nursing staff (i.e., personnel not generally associated with the traditional nursing service) are to be assigned a service category of ‘Other’. This category type can be further defined in the Other Service Category field. Management may use this ‘other service category’ when printing selected administration reports for non-nursing staff. The Other Service Category field does not appear if the product line is nursing.

The NURS Staff (#210) file, the NURS Position Control (#211.8) file and the NURS AMIS Daily Exception Report (#213.5) file (where Employee Activation/Separation Report data is stored) points to the NURS Service Position (#211.3) file. This file points to the NURS AMIS Position (#211.7) file and the NURS Product Line (#212.7) file.

Menu Display:

Select Nursing Features (all options) Option: 3 Administrative Site File Functions

<table>
<thead>
<tr>
<th>Option</th>
<th>Function</th>
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<tr>
<td>1</td>
<td>AMIS 1106 Acuity Edit</td>
</tr>
<tr>
<td>2</td>
<td>Privilege File Edit</td>
</tr>
<tr>
<td>3</td>
<td>Certification File, Edit</td>
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<tr>
<td>4</td>
<td>PTM 1106 Service Budget (1106b) File, Edit</td>
</tr>
<tr>
<td>5</td>
<td>Load Grade/Step Codes</td>
</tr>
<tr>
<td>6</td>
<td>Nursing Location File, Edit</td>
</tr>
<tr>
<td>7</td>
<td>Print Existing Location File Entries</td>
</tr>
<tr>
<td>8</td>
<td>Service Position File, Edit</td>
</tr>
<tr>
<td>9</td>
<td>Tour of Duty File, Edit</td>
</tr>
<tr>
<td>10</td>
<td>Vacancy Reason File Edit</td>
</tr>
<tr>
<td>11</td>
<td>Site Parameter File</td>
</tr>
<tr>
<td>12</td>
<td>Clinical Background File, Edit</td>
</tr>
</tbody>
</table>

1. Patch NUR*4*2 October 1997
2. Patch NUR*4*2 October 1997
Screen Prints:

Select Administrative Site File Functions Option: 8 Service Position File, Edit

Select Service Position abbreviation: HN
Are you adding 'HN' as a new NURS SERVICE POSITION (the 68TH)? No// Y (Yes)

Answer with appropriate service position abbreviation.

ABBREVIATION: HN
NAME: HEAD NURSE
PRIORITY SEQUENCE: 200
PRODUCT LINE: NURSING
SERVICE CATEGORY: RN REGISTERED NURSE
AMIS POSITION: 35 (HEAD NURSE)

Exit       Save       Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

The following is an explanation for each prompt:

ABBREVIATION:

1 Enter an abbreviation for a service position.

NAME:

Answer with name of service position/title.

PRIORITY SEQUENCE:

This number will determine the order in which a service position will print out on a report. A service position with a priority sequence of 200 will sort and print before a service position with a priority sequence of 900. These numbers do not affect the data stored in the staff record.

1 Patch NUR*4*2 October 1997
There are some restrictions on this numbering system:
1. Service positions with priority sequences of less than 100 will not print on reports. This is to enable the user to add a service position that is not desired in the prints.
2. No two service positions can have the same priority sequence.

PRODUCT LINE:

1. Enter the name of a service, program, or product line associated with the service position. The product line name may be associated with a traditional service name (e.g., nursing, chaplain, respiratory therapy), or a clinical center/product line (e.g., medicine, mental health). In some instances, a product line reference, of Patient Care Services is appropriate. This field is editable only when the product line in the NURS Parameter file contains an entry of ‘yes’. When the Site Parameter file’s product line contains a value of ‘no’, the field displays but the data cannot be edited.

SERVICE CATEGORY:

2. This field stores the name of an appropriate 'service category' that is related to the 'service position'. The first six choices on the list below are categories of nursing personnel used to complete the FTEE Comparison (1106b) Report. The category 'other' is used when associating staff with other medical center product lines, fenced positions, etc.

The following is a list of choices:

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<thead>
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<th>Code</th>
<th>Description</th>
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<td>S</td>
<td>SE SUMMER EMPLOYEE</td>
</tr>
<tr>
<td>A</td>
<td>AO ADMIN., OFFICER</td>
</tr>
<tr>
<td>O</td>
<td>OT OTHER</td>
</tr>
</tbody>
</table>

AMIS POSITION:

The following positions (from 26-40) are to be associated with a 'RN' service category only. Pointer to NURS AMIS POSITION FILE (#211.7).

The following is a list of choices:

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<tr>
<th>Position</th>
<th>Description</th>
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<td>27</td>
<td>(NURSE PRACTITIONER) NURSE PRACTITIONER</td>
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<tr>
<td>28</td>
<td>(INFECTION CONTROL) INFECTION CONTROL NURSE</td>
</tr>
<tr>
<td>29</td>
<td>(PUBLIC HEALTH) PUBLIC HEALTH COORDINATOR</td>
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<tr>
<td>30</td>
<td>(STAFF NURSE) STAFF NURSE</td>
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1 Patch NUR*4*2 October 1997
2 Patch NUR*4*2 October 1997
34 (SUPERVISOR)  SUPERVISOR
35 (HEAD NURSE)  HEAD NURSE
36 (OTHER NURSE)  OTHER THAN STAFF NURSE
37 (NURSE RE Sharma)  NURSE RESEARCHER
38 (ASSOC CHIEF/RESHR)  ASSOC. CHIEF/RESEARCH
39 (ASSOC CHIEF/EDU)  ASSOC. CHIEF/EDUCATION
40 (INSTR/EDU)  INSTRUCTOR

Select Service Position abbreviation: <RET>

1 You may enter additional service position abbreviations as appropriate, to complete your entries.

Menu Access:

The Service Position File, Edit option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.

1 Patch NUR*4*2  October 1997
NURAFL-TOD

Tour of Duty File, Edit

Description:

1. This option allows users to enter and modify shift data stored in the NURS Tour of Duty (#211.6) file.

Additional Information:

2. The data is used in the Status and Position (NURAED-STF-STAT/POS) option under the Staff Record Edit and reflected in the Staff Record Report. This file is pointed to by the NURS Position Control (#211.8) file, and the Seclusion/Restraint (#615.2) file.

Menu Display:

Select Nursing Features (all options) Option: 3 Administrative Site File Functions

1. AMIS 1106 Acuity Edit
2. Privilege File Edit
3. Certification File, Edit
4. FTEE Service Budget (1106b) File, Edit
5. Load Grade/Step Codes
6. Nursing Location File, Edit
7. Print Existing Location File Entries
8. Service Position File, Edit
9. Tour of Duty File, Edit
10. Vacancy Reason File Edit
11. Site Parameter File
12. Clinical Background File, Edit
13. Product Line File Edit

Screen Prints:

Select Administrative Site File Functions Option: 9 Tour of Duty File, Edit
Enter Tour of Duty: 11:00AM-7:00PM
Are you adding '11:00AM-7:00PM' as a new NURS TOUR OF DUTY (the 4TH)? No//Y

Y (YES)

Enter appropriate tour of duty.

TOUR OF DUTY: 11:00AM-7:00PM// <RET>

1. Patch NUR*4*2 October 1997
2. Patch NUR*4*2 October 1997
MEAL INDICATOR: Y YES

1This field indicates whether or not a meal time factor is included in the tour of duty. "Yes" means a meal time is provided. "No" means a meal time is not provided.

Enter Tour of Duty: <RET>

2You may enter another tour of duty, as appropriate, to complete the entries in this file.

Menu Access:

The Tour of Duty File, Edit option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.
Maintenance of Administrative Site Files

NURAFL-VAC

Vacancy Reason File Edit

Description:

This option provides enter/edit capability for the NURS Vacancy/Transferred Reasons (#211.9) file.

Additional Information:

This data is used in the Status and Position option under the Staff Record Edit to track the reason for position vacancies. Vacancy reasons are indicated on the Employee Activation/Separation Report option under the Special Functions option. This file is pointed to by the NURS Position Control (#211.8), and the NURS AMIS Daily Exception Report (#213.5) files. File #213.5 stores the Employee Activation/ Separation Report data.

Menu Display:

Select Nursing Features (all options) Option: 3  Administrative Site File Functions

1  AMIS 1106 Acuity Edit
2  Privilege File Edit
3  Certification File, Edit
4  FTEE Service Budget (1106b) File, Edit
5  Load Grade/Step Codes
6  Nursing Location File, Edit
7  Print Existing Location File Entries
8  Service Position File, Edit
9  Tour of Duty File, Edit
10  Vacancy Reason File Edit
11  Site Parameter File
12  Clinical Background File, Edit
13  Product Line File Edit

Screen Prints:

Select Administrative Site File Functions Option: 10  Vacancy Reason File Edit

---

1 Patch NUR*4*2  October 1997
Enter Vacancy Reason Code: **UTR**

Are you adding 'UTR' as a new NURS VACANCY/TRANSFERRED REASON FILE (the 11TH)? No// **Y**

This is an abbreviation or code for the vacancy/transferred reason. Entries in this field describe why the position is available/or unfilled.

The following is a list of choices:
- COP  CONTINUATION OF PAY
- EXL  EXTENDED LEAVE
- LWO  LEAVE WITHOUT PAY
- PTR  POSITION TRANSFER
- RES  RESIGNED
- RET  RETIRED
- SUM  SUMMER STUDENT
- TER  TERMINATED
- TRA  TRANSFERRED
- WOP  LEAVE WITHOUT PAY-JOURNALIZED

**DESCRIPTION:** **UNIT TRANSFER**

1. The answer must be 3-30 characters in length. This is the free text description or meaning of the code for the vacancy transferred reason.

**STATUS:** **A**

2. This field will help to build a relationship between statuses in the NURS Staff file, and vacancy reasons in the NURS Position Control file. The following is a list of choices:
   - A  ACTIVE  (active record)
   - I  INTERMITTENT  (active record)
   - R  INACTIVE  (closed record; inactive)

3. When an employee’s status in the NURS Position Control file is active, appropriate data in the employee’s NURS Staff and NURS Position Control record are reflected in management reports.

Enter Vacancy Reason Code: **<RET>**

You may enter another vacancy reason.

**Menu Access:**

The Vacancy Reason File Edit option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.

---

1 Patch NUR*4*2  October 1997  
2 Patch NUR*4*2  October 1997  
3 Patch NUR*4*2  October 1997
NURSFL-SITE

Site Parameter File

Description:

This option allows the user to edit the NURS Parameters (#213.9) file which contains: 1) the name of the CNO printer, 2) a nursing-wide default value for the professional percentage used in determining required FTEE in the workload statistics reports, 3) the time of day when acuity is aggregated for the workload statistics reports, 4) a product line indicator that allows storage and printing of data in the Administration Module by product line, service, or specialty other than Nursing, 5) a multi-divisional indicator that allows storage and printing of data in the Administration Module by division or facility, 6) a switch to allow the site manager to bring the Nursing application off-line, and 7) a switch to allow the site manager to turn on/off access to the New Person file.

Additional Information:

The CNO printer is used to print a message stating that an inpatient cannot be entered into the Nursing application due to an invalid MAS ward. This usually happens when a cross-reference between the MAS ward and unit is lost (corrupted cross-reference) or because no unit is associated with the patient’s MAS ward. The warning message that appears on the CNO printer contains the name of the patient and the following statement:

\[
\text{<Patient's Last name,First Name> has not been admitted into the Nursing System by MAS, because <ward name> (MAS ward) does not have a corresponding nursing location.}
\]

If the CNO printer is not defined, the user is notified that the patient is not in the system when classification is attempted. The CNO printer may also be used to print management reports that are queued to run daily as a TaskMan job.

The Professional Percentage field is a REQUIRED field; the application coordinator must enter a value. If the professional percentage field has no value and there is no entry associated with each unit in the NURS Location file’s Professional Percentage field, the following message displays when a workload report is printed:

\[
^1\text{This field defaults the percentage of professional personnel assigned to a unit if the professional percentage field is not defined in the NURS Location file. This data is used in the calculation of unit workload statistics.}
\]

\(^1\text{Patch NUR*4*2 October 1997}\)
The following prompt is presented.

**PROFESSIONAL PERCENTAGE:**

The user enters a percentage at the prompt and the value is stored in the NURS Parameter file.

Data stored in the Professional Percentage field calculates the FTEE number displayed under the REQ (required) columns in all workload statistics reports.

An entry in the Product line field is used to display (when the field value = yes) or hide (when field value = no) the, ‘Select PRODUCT LINE (Press return for all product lines):’ prompt in the Staff Record Report, Salary Reports, Telephone Number Listings, Nursing Education Reports, Administrative, and Resource Management reports. The following enter/edit options are also affected by the data in the Product Line field:

- Service Position File, Edit
- Nursing Location File, Edit
- Staff Record Edit
- Location Edit, Employee

The options, Service Position File, Edit and Nursing Location File, Edit allow users to associate product lines with service positions and units. Product line information is displayed through the Staff Record Edit and Location Edit, Employee options.

The Multi-Divisional field is used to display (when the field value = yes) or hide (when the field value = no) an institution or facility prompt in the Staff Record Report, Salary Reports, Telephone Number Listings, Nursing Education Reports, Administrative, and Resource Management reports. Also affected by the data in the Multi-Divisional field are the following enter/edit options:

- Nursing Location File, Edit
- FTEE Service Budget (1106b) File, Edit
- Staff Record Edit
- Location Edit, Employee

1\(^\text{The Nursing Location File, Edit and FTEE Service Budget (1106b) File, Edit options allow users to associate a facility with a unit and service position budgeted FTEE information. Facility or division data is displayed in the Staff Record Edit and Location Edit, Employee options.**}

---

1 Patch NUR*4*2  October 1997
The following is a flow chart to assist the user in setting up the Site Parameter File:

Menu Display:

Select Nursing Features (all options) Option: 3  Administrative Site File Functions

Patch NUR*4*2  October 1997
Screen Prints:

Select Administrative Site File Functions Option: 11 Site Parameter File

CNO PRINTER: 121

This field contains the name of the device used to print notices, exception reports, and selectively queued TaskMan reports. This printer should be on at all times.

PROFESSIONAL PERCENTAGE: 50/ <RET>

This field indicates a ratio of professional staff (defined as registered nurses) to other care givers assigned to a unit when a similar field in the NURS Location file is not defined. It must be completed for the software to calculate the required FTEE in the workload statistics reports. A default of 50 is distributed with the software.

The next three fields identify the times the system calculates all current workload statistics and the AMIS night workload statistics reports. Time must be entered as 4 NUMBERS REPRESENTING MILITARY TIME (e.g., 08:00 or 15:00). It is suggested that the shift acuity time be a time at the end of the shift.

DAY SHIFT ACUITY TIME: 1530

The time that the acuity totals are calculated for the day shift current workload statistics report.

EVENING SHIFT ACUITY TIME: 2330

The time that the acuity totals are calculated for the evening shift current workload statistics report.
**NIGHT SHIFT ACUITY TIME:** 0730

The time that the acuity totals are calculated for the night shift. Both AMIS and current workload statistics reports are based on the night shift acuity time.

**PRODUCT LINE: YES// <RET>**

1 This field should contain a value of ‘Yes’ when FTEE data in the NURS Position Control (#211.8) file is associated with multiple services/product lines. NO indicates that all FTEE is associated with Nursing Service.

**MULTI-DIVISIONAL: YES// <RET>**

This field should contain a value of ‘Yes’ when the facility/medical center is multi-divisional. NO indicates the facility is a single institution.

**NURSING OFFLINE/ONLINE: ON-LINE// <RET>**

2 This switch allows the site manager to place the Nursing application off-line without bringing down the entire system. The user will see this prompt only if they have programmer access.

Choose from:
1 OFF-LINE
0 ON-LINE

**NURSING NEW PERSON FILE ACCESS: ACCESS TO NEW PERSON FILE // <RET>**

3 This field allows the Site Manager to turn on/off access to the New Person (#200) file. The user will see this prompt only if they have programmer access. When the field value is ‘1’, the Demographic Data option of the Staff Record Edit option allows users to enter data into File #200.

Choose from:
1 ACCESS TO NEW PERSON FILE
0 NO ACCESS TO NEW PERSON FILE

**Menu Access:**

The Site Parameter File option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.

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1 Patch NUR*4*2 October 1997
2 Patch NUR*4*2 October 1997
3 Patch NUR*4*2 October 1997
NURAFL-CLBK

Clinical Background File, Edit

Description:

This option allows a service to define and modify data in the NURS Clinical Background (#211.5) file. This data identifies (previous or current) areas of clinical/professional experience. This file is not limited to entries pertaining to clinical experience but may also include data relevant to administration, education, informatics, and so on. This file is pointed to by the NURS Location (#211.4) file.

Additional Information:

Previous clinical experience can be associated with staff entered in the NURS Staff (#210) file. This information can be retrieved in the Staff Record Report.

Menu Display:

Select Nursing Features (all options) Option: 3 Administrative Site File Functions

1 AMIS 1106 Acuity Edit
2 Privilege File Edit
3 Certification File, Edit
4 FTEE Service Budget (1106b) File, Edit
5 Load Grade/Step Codes
6 Nursing Location File, Edit
7 Print Existing Location File Entries
8 Service Position File, Edit
9 Tour of Duty File, Edit
10 Vacancy Reason File Edit
11 Site Parameter File
12 Clinical Background File, Edit
13 Product Line File Edit

Screen Prints:

Select Administrative Site File Functions Option: 12 Clinical Background File, Edit

---

1 Patch NUR*4*2 October 1997
Enter Type of Background/Experience: **Neurology**

Are you adding 'Neurology' as a new NURS CLINICAL BACKGROUND (the 16TH)?

No/// Y

Answer with area of professional experience.

The following is a list of choices:

1. O. R.
2. MEDICAL
3. SURGICAL
4. REHAB MEDICINE
5. NURSING ADMINISTRATION
6. NURSING EDUCATION
7. SPINAL CORD INJURY
8. PSYCHIATRY
9. DRUG DEPENDENCY
10. SICU
11. MICU
12. CCU
13. PLASTIC SURGERY
14. RENAL/GU
15. NEURO-SURGERY

Description: Neurology///< RET>

Answer with description of area of professional experience.

**Menu Access:**

The Clinical Background File, Edit option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.
NURAFL-PROD-LINE

Product Line File Edit

Description:

1This option allows the user to update the NURS Product Line (#212.7) file. The user can add new product lines, programs, or services, or edit existing entries. All entries, except for the nursing entry, are editable.

Additional Information:

2Entries in this file are used to complete the Product Line field of the NURS Location (#211.4) file and the NURS Service Position (#211.3) file. Data in the Product Line file may relate to product lines (e.g., medicine, surgery, mental health, primary care), programs, or the traditional services (e.g., nursing, social work, pharmacy). If a facility retains the traditional service organizational structure, nursing might be the only required entry in this file.

Since the Product Line file is pointed to by the NURS Location (#211.4) file, entries in the product line field of the NURS Location file can be used to associate a product line (e.g., mental health, nursing, patient care services) with a location. The NURS Service Position (#211.3) also is pointed to by the product line field in the NURS Service Position field, therefore, a product line (e.g., nursing, social work, chaplaincy, primary care, mental health) can be associated with a service position.

Menu Display:

Select Nursing Features (all options) Option: 3 Administrative Site File Functions

1 AMIS 1106 Acuity Edit
2 Privilege File Edit
3 Certification File, Edit
4 FTEE Service Budget (1106b) File, Edit
5 Load Grade/Step Codes
6 Nursing Location File, Edit
7 Print Existing Location File Entries
8 Service Position File, Edit
9 Tour of Duty File, Edit
10 Vacancy Reason File Edit
11 Site Parameter File
12 Clinical Background File, Edit
13 Product Line File Edit

---

1 Patch NUR*4*2 October 1997
2 Patch NUR*4*2 October 1997
Screen Prints:
Select Administrative Site File Functions Option: 13  Product Line File Edit
Select PRODUCT LINE NAME: AMBULATORY CARE
Enter the name of the product line/program/service.
NAME: AMBULATORY CARE// <RET>
Select PRODUCT LINE NAME: <RET>

Menu Access:

The Product Line File Edit option is accessed through the Administrative Site File Functions option of the Nursing Features (all options) menu.
Chapter 3  Maintenance of Clinical Site Files

NURSCL-MENU

Clinical Site File Functions

Description:

This is the main menu for editing information in the clinical site files.

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1    Administration Records, Enter/Edit ...
2    Administration Records, Print ...
3    Administrative Site File Functions ...
4    Nursing Education Reports, Print ...
5    Patient Care Data, Enter/Edit ...
6    Patient Care Data, Print ...
7    Clinical Site File Functions ...
8    QI Data, Enter/Edit ...
9    Quality Performance Reports ...
10   QI Site Files ...
11   Special Functions ...

Select Nursing Features (all options) Option: 7 Clinical Site File Functions

1    Standard Patient Plan of Care Print
2    Patient Plan of Care, Site Configuration
3    Ward Activation Patient Update
4    Ward Deactivation Patient Update
5    Selected V/M Site File Functions ...
6    Configure I/O Files (ADP Coordinator Only) ...

Menu Access:

The Clinical Site File Functions option is accessed through the Nursing Features (all options) menu.
NURCFP-CARE

Standard Patient Plan of Care, Print

Description:

This option is part of the patient plan of care module and allows the user to view/print the data which makes up the patient plan of care guideline database (aggregate terms). This option enables the user to print any patient plan of care guideline within the database; data is stored in the Aggregate Term (#124.2) file.

Additional Information:

Guidelines can be accessed through the following pathways:

1. Medical Diagnostic Categories and medical diagnoses,
2. Health care and system deficits, and
3. Optional care plans based on:
   a. frequently identified medical diagnosis/procedures,
   b. nursing procedures,
   c. nursing specialty areas, and
   d. locally developed patient plans of care

If Medical Diagnoses are selected, the first level displays the Medical Diagnostic Categories (MDCs), the second level lists the associated medical diagnoses, and the third shows nursing problems and associated information (outcomes, interventions, related problems, defining characteristics, and related factors). When Nursing Problems are selected, the user can produce a list of health care and system deficits which access specific nursing problems and associated information (outcomes, interventions, related problems, defining characteristics, and related factors). When selecting Optional Care Plans, the user may see a combined list of medical diagnoses and nursing/medical procedures which leads directly to the care plan guidelines established through the clinical work group of the Nursing Focus Group.

Menu Display:

Select Nursing Features (all options) Option: 7 Clinical Site File Functions

1. Standard Patient Plan of Care Print
2. Patient Plan of Care, Site Configuration
3. Ward Activation Patient Update
4. Ward Deactivation Patient Update
5. Selected V/M Site File Functions ...
6. Configure I/O Files (ADP Coordinator Only) ...
Screen Prints:

Select Clinical Site File Functions Option: 1 Standard Patient Plan of Care, Print

Would you like to list the contents of:
1. Medical Diagnoses
2. Nursing Problems
3. Optional Care Plans

Enter action:

Example: Selection Short Cut.

This option contains an abbreviated approach for selecting from the lists contained in each section. When entering an action, you may select the entire list of MDCs, medical diagnoses, nursing problems, health care/system deficits, etc., before all the selections have displayed on the terminal. The user will be guided by the help prompt by entering a ? and following the action prompt indicating CHOOSE FROM by typing the number of entries listed. For example:

Enter action: 1

The user may select 1, or more, or all entries. At the next prompt type an ^ to stop the listing. The user views a minimal number of screens from which to select information rather than the entire listing.

...SORRY, I'M WORKING AS FAST AS I CAN...

The following is a list of the Medical Diagnostic Categories:

Would you like to list the contents of:
1. Cardiovascular
2. Endocrine
3. Gastrointestinal
4. GU/Renal
5. HEENT
6. Immune (Cancer, AIDS, Transplant, Arthritis)
7. Integument
8. Musculo-Skeletal/Orthopedic
9. Neurologic
10. Nutrition/Metabolic
11. Other
12. Plastic Surgery
13. Psychosocial
14. Pulmonary

Example: Printing specific MDC's and all related medical diagnoses.

Content Format: Medical Diagnostic Categories
Associated Medical Diagnoses
Would you like to list the contents of:
1. Medical Diagnoses
2. Nursing Problems
3. Optional Care Plans
Enter action: 1

...SORRY, I'M WORKING AS FAST AS I CAN...

Would you like to list the contents of:
1. Cardiovascular
2. Endocrine
3. Gastrointestinal
4. GU/Renal
5. HEENT
6. Immune (Cancer, AIDS, Transplant, Arthritis)
7. Integument
8. Musculo-Skeletal/Orthopedic
9. Neurologic
10. Nutrition/Metabolic
11. Other
12. Plastic Surgery
13. Psychosocial
14. Pulmonary
Enter action: 3

To choose a list of associated medical diagnoses for an MDC select 1

Would you like to print:
1. Medical DX only
2. Medical DX/Problems only
3. Selected Medical DX/Problems
Enter action: 1

...SORRY, I'M WORKING AS FAST AS I CAN...

The following is a display of a specific MDC (Gastrointestinal) and associated medical diagnoses:

DEVICE: HOME//Enter appropriate response
Patient Plan of Care Content by Medical Diagnoses

Gastrointestinal

Cholecystectomy
Diverticulitis
Esophageal Varices
Esophagitis/Esophageal Reflux/Esophageal Stricture
Fecal Diversion (Ileostomy, Colostomy)
Gastric Resection/Gastrectomy
Gastroenteritis/Gastritis
Gastrointestinal Hemorrhage
Hemmorhoids/Anal Fissure/Pilonidal Cyst
Hemmorhoidectomy
Herniorrhaphy
Intestinal Surgery
Liver Failure/Cirrhosis
Mallory-Weiss Syndrome
Pancreatitis
Peritonitis
Surgical Procedures of the GI Tract
Ulcers/Pepitic

Enter RETURN to continue or "^" to exit: <RET>

Example: Printing specific MDC and all related medical diagnoses and nursing guidelines.

Format Content: Medical Diagnosis

  Associated Medical Diagnoses
  Associated Nursing Problems

Would you like to list the contents of:
  1. Medical Diagnoses
  2. Nursing Problems
  3. Optional Care Plans
Enter action: 1

...SORRY, I'M WORKING AS FAST AS I CAN...
Would you like to list the contents of:
1. Cardiovascular
2. Endocrine
3. Gastrointestinal
4. GU/Renal
5. HEENT
6. Immune (Cancer, AIDS, Transplant, Arthritis)
7. Integument
8. Musculo-Skeletal/Orthopedic
9. Neurologic
10. Nutrition/Metabolic
11. Other
12. Plastic Surgery
13. Psychosocial
14. Pulmonary
Enter action: 7

Would you like to print:
1. Medical DX only
2. Medical DX/Problems only problems = nursing guidelines
3. Selected Medical DX/Problems
Enter action: 2

...SORRY, I'M WORKING AS FAST AS I CAN...

The following is a list of a specific MDCs, associated medical diagnoses, and related nursing guidelines contained in the software:

DEVICE: HOME//Enter appropriate response
Integument

Burns

Activity Intolerance
Airway Clearance, Ineffective
Anxiety
Breathing Pattern, Ineffective
Cardiac Output, Decreased (Electrical Factors)
Cardiac Output, Decreased (Mechanical Factors)
Constipation
Coping, Ineffective Family
Coping, Ineffective Individual
Fear
Fluid Volume Deficit (Actual/Potential)
Gas Exchanged, Impaired
Infection Potential
Injury Potential
Mobility, Impaired Physical
Nutrition, Alteration in:(Less Than Required)
Pain, Acute
Pain, Chronic
Powerlessness
Self Concept, Disturbance In
Sexual Pattern, Altered
Skin Integrity, Impairment Of (Actual)
Tissue Integrity, Impaired
Tissue Perfusion, Alteration In
Pressure Sores

Infection Potential
Nutrition, Alteration in:(Less Than Required)
Skin Integrity, Impairment Of (Actual)
Tissue Integrity, Impaired

Example: Printing MDCs, associated medical diagnoses, and specific guidelines (factors, interventions, orders and defining characteristics).

Format Content: Medical Diagnostic Categories
Associated Medical Diagnoses
Nursing Problems and/or
Outcomes and/or
Interventions and/or
Etiologies and/or
Related Problems and/or
Defining Characteristics

Would you like to list the contents of:
1. Medical Diagnoses
2. Nursing Problems
3. Optional Care Plans
Enter action: 1
...HMMM, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

Would you like to list the contents of:
1. Cardiovascular
2. Endocrine
3. Gastrointestinal
4. GU/Renal
5. HEENT
6. Immune (Cancer,AIDS,Transplant,Arthritis)
7. Integument
8. Musculo-Skeletal/Orthopedic
9. Neurologic
10. Nutrition/Metabolic
11. Other
12. Plastic Surgery
13. Psychosocial
14. Pulmonary
Enter action: 1,2
Would you like to print:
1. Medical DX only
2. Medical DX/Problems only
3. Selected Medical DX/Problems
Enter action: 3

This produces a combined listing of medical diagnoses for the above selected MDCs (Cardiovascular and Endocrine).

...SORRY, I'M WORKING AS FAST AS I CAN...

Would you like to list the contents of:
1. Abdominal Aortic Aneurysm Repair
2. Acute Myocardial Infarction
3. Addison's Disease (Adrenal Insufficiency)
4. Adrenalectomy
5. Angina/Chest Pain
6. Aortobifemoral Bypass Graft
7. Arterial Insufficiency
8. Atherosclerosis
9. Cardiac Surgery Post-Operative (CABG, Valve Replacement)
10. Cardiac Tamponade
11. Cardiogenic Shock
12. Cardiomyopathy
13. Carotid Artery Endarterectomy
14. Cushing's Disease
15. Diabetes Insipidus
16. Diabetes Mellitus
17. Digoxin Toxicity
18. Dysrhythmias
19. Endocarditis
20. Heart Failure
21. Hypertension
Enter action (<RET> to see more): 1,2

The user may select limited medical diagnoses from the list of diagnoses associated with the MDCs.

Would you like to list the contents of:
22. Hyperthyroidism (Graves' Disease)
23. Hypothyroidism
24. Parathyroidectomy
25. Pericarditis
26. Peripheral Vascular Surgery Procedures
27. Pulmonary Embolus
28. Thrombophlebitis (DVT)
29. Thyroidectomy
30. Valvular Heart Disease
31. Vein Ligation and Stripping
Enter action: <RET>

...SORRY, THIS MAY TAKE A FEW MOMENTS...

Based on the above list, the user may print all nursing problems or select specific guidelines.
Enter type of information you want printed:
1. All Nursing Problems in Selection
2. Selected Nursing Problems from Selection

Enter action: 2

By entering 2, the user can then select specific nursing care guidelines.

...HMMM, THIS MAY TAKE A FEW MOMENTS...

Select from the following Problems:
1. Anxiety
   - Acute Myocardial Infarction
Notice that the parent for this problem displays here (Acute Myocardial Infarction). This happens for all parents that have the classification of Medical Diagnoses/Procedure.

2. Cardiac Output, Decreased (Electrical Factors)
   - Abdominal Aortic Aneurysm Repair
   - Acute Myocardial Infarction
3. Cardiac Output, Decreased (Mechanical Factors)
   - Abdominal Aortic Aneurysm Repair
   - Acute Myocardial Infarction
4. Coping, Ineffective Family
   - Acute Myocardial Infarction
5. Coping, Ineffective Individual
   - Acute Myocardial Infarction
6. Fear
   - Abdominal Aortic Aneurysm Repair
   - Acute Myocardial Infarction
7. Fluid Volume Deficit (Actual/Potential)
   - Abdominal Aortic Aneurysm Repair
   - Acute Myocardial Infarction
8. Fluid Volume Excess (Actual/Potential)
   - Acute Myocardial Infarction
9. Gas Exchange, Impaired

Enter action (<RET> to see more): 1,2

Select from the following Problems:
10. Infection Potential
    - Abdominal Aortic Aneurysm Repair
11. Knowledge Deficit
    - Acute Myocardial Infarction
12. Knowledge Deficit [specify]
    - Abdominal Aortic Aneurysm Repair
13. Noncompliance/Nonadherence [specify]
    - Acute Myocardial Infarction
14. Pain, Chest
    - Abdominal Aortic Aneurysm Repair
    - Acute Myocardial Infarction
15. Spiritual Distress
    - Acute Myocardial Infarction
16. Tissue Perfusion, Alteration In
   - Abdominal Aortic Aneurysm Repair
   - Acute Myocardial Infarction
Enter action: <RET>

...SORRY, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

The user can then choose portions of the guidelines to be printed:

For each care plan, which data should be printed:
1. Nursing Problems/Outcomes
2. Nursing Problems/Interventions
3. Nursing Problems/Etiologies
4. Nursing Problems/Related Problems
5. Nursing Problems/Defining Characteristics
6. All of the above
7. Nursing Problems Only

Enter action: 1

Only the associated patient outcomes are printed under the problem/guideline.

DEVICE: HOME//Enter appropriate response

The following is a customized report reflecting specific information. The user can generate various reports by simply changing the sort parameters within this option.
Cardiovascular

Abdominal Aortic Aneurysm Repair

Cardiac Output, Decreased (Electrical Factors)

Goals/Expected Outcomes
- avoids metabolic death
- avoids toxicity/allergic reactions to drugs
- limits myocardial infarction area
  - 12 lead EKG findings
    - Q waves [specify location]
    - ST segment elevation [specify location]
    - T wave depression [specify location]
- level of energy
- maintains cardiac output
- capillary filling WNL
- lab data (e.g. BUN, creatinine) is normal or baseline
- normal skin color
- skin warm to touch
- vital signs WNL or returns to baseline
- maintains therapeutic levels of antiarrhythmic agents
- returns to and maintains NSR or pacing rhythm

[Extra Goal]

Acute Myocardial Infarction

Anxiety

Goals/Expected Outcomes
- identifies 3 precipitating events to anxiety
- identifies 3 signs and symptoms of anxiety
- identifies 3 sources of support
- reports decrease in signs/symptoms of anxiety
- sleeps for 4-5 hours without awakening
- verbalizes 3 activities that promote feelings of comfort

[Extra Goal]

Cardiac Output, Decreased (Electrical Factors)

Goals/Expected Outcomes
- avoids metabolic death
- avoids toxicity/allergic reactions to drugs
- limits myocardial infarction area
  - 12 lead EKG findings
    - Q waves [specify location]
    - ST segment elevation [specify location]
    - T wave depression [specify location]
- level of energy
- maintains cardiac output
- lab data (e.g. BUN, creatinine) is normal or baseline
- normal skin color
- skin warm to touch
- vital signs WNL or returns to baseline
maintains therapeutic levels of antiarrhythmic agents
returns to and maintains NSR or pacing rhythm
[Extra Goal]

Endocrine

...HMMM, LET ME THINK ABOUT THAT A MOMENT...

The following is a list of health care and system deficits:

Would you like to list the contents of:
1. Activities of Daily Living
2. Circulatory System
3. Cognitive-Sensory Area
4. Elimination
5. Health Management
6. Integumentary (Skin)
7. Musculoskeletal/Neurological
8. Nutrition-Metabolic Area
9. Psycho-Social Area
10. Respiratory System
11. Sexual Functioning/Reproductive System
12. Sleep/Rest
13. Spiritual Needs
Enter action: 1,2

If the user wants all, enter 1-13.
...HMMM, THIS MAY TAKE A FEW MOMENTS...

Enter type of information you want printed:
1. All Nursing Problems in Selection
2. Selected Nursing Problems from Selection
Enter action: 2

This will produce a combined listing of nursing problems for the selected health care and system
deficits (Activities of Daily Living and Circulatory System). If the user selected all, no list
would appear.
...HMMM, LET ME PUT YOU ON 'HOLD' FOR A SECOND...
Select from the following Problems:
1. Activity Intolerance
2. Cardiac Output, Decreased (Electrical Factors)
3. Cardiac Output, Decreased (Mechanical Factors)
4. Coping, Ineffective Family
5. Fluid Volume Deficit (Actual/Potential)
6. Fluid Volume Excess (Actual/Potential)
7. Home Maintenance Management, Impaired
8. Hyperthermia
9. Hypothermia
10. Knowledge Deficit
11. Pain, Acute
12. Pain, Chest
13. Pain, Chronic
14. Self-Care Deficit [Specify]
15. Tissue Integrity, Impaired
16. Tissue Perfusion, Alteration In

Enter action: 1

...SORRY, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

Based on the above list, the user may then print all or any combination of data associated with the patient plan of care guidelines.

For each care plan, which data should be printed:
1. Nursing Problems/Outcomes
2. Nursing Problems/Interventions
3. Nursing Problems/Etiologies
4. Nursing Problems/Related Problems
5. Nursing Problems/Defining Characteristics
6. All of the above
7. Nursing Problems Only

Enter action: 6

DEVICE: HOME//Enter appropriate device
Activities of Daily Living

Circulatory System

Activity Intolerance

Defining Characteristics
- abnormal heart rate or BP response to activity
- ECG changes reflecting arrhythmias or ischemia
- exertional dyspnea
- verbal report of fatigue or weakness

Etiology/Related and/or Risk Factors
- bed rest or immobility
- generalized weakness
- imbalance between oxygen supply and demand
- sedentary life-style

Goals/Expected Outcomes
- demonstrates increased control of dyspnea with activity
- demonstrates increased independence for self-care
- hemodynamically stable during activity
  - appropriate pulse rate for pt [specify range]
  - B/P
  - ear oximetry indicates oxygen saturation of 90% or greater
  - skin color and temperature WNL for pt
- verbalizes/demonstrates decreased fatigue with activity
- verbalizes/demonstrates physical conditioning techniques

Nursing Intervention/Orders
- administer bronchodilators as ordered
- administer oxygen/cannula at [specify] L/min or mask at [ ]%
- assess for signs of fatigue and weakness
- deteriorating personal appearance
- exertional dyspnea
- inability to be independent for self-care
- sleep pattern
- weight loss or gain
- initiate muscle strengthening/conditioning as indicated
- passive/active ROM q[frequency] hrs.
- plan activities to maximized medication/treatment benefits
- provide [number of] minutes of rest between activities
- pulse q[frequency] hrs
- refer for appropriate consults
- Chaplain Service
- Corrective Therapy
- Dietetic Service
- Occupational Therapy
- Physical Therapy
- Psychology Service
- Respiratory Therapy
- Social Work Service
- Speech Therapy
respiratory pattern q [frequency]
paradoxical breathing
respiratory altenans
respiratory rate during activities
skin color/texture during activities
teach patient
  coordinating breathing with activity
  pacing activities, exercise, rest
  relaxation therapy
  use of adaptive equipment to assist with ADLs
    shower hose
tub bench
use of Home Oxygen Therapy
using analgesics appropriately
using oral/inhaled bronchodilators (e.g., MDIs)
using pursed-lip breathing

[Extra Order]
Related Problems
  Comfort, Altered: Chest Pain
  Fluid Volume Deficit (Actual/Potential)
  Fluid Volume Excess (Actual/Potential)
  Gas Exchange, Impaired

Enter RETURN to continue or "^^" to exit: <RET>

Example: Printing optional patient plans of care.

Format Content: Optional Care Plans
  Nursing Problems and/or
    Outcomes and/or
    Interventions and/or
    Etiologies and/or
    Related Problems and/or
    Defining Characteristics

Would you like to list the contents of:
  1. Medical Diagnoses
  2. Nursing Problems
  3. Optional Care Plans

Enter action: 3

...EXCUSE ME, LET ME PUT YOU ON 'HOLD' FOR A SECOND...

The following is a list of combined medical diagnoses, patient problems, medical and nursing procedures:
Would you like to list the contents of:
1. Abdominal Aortic Aneurysm Repair
2. Acquired Immune Deficiency Syndrome (AIDS)
3. Acute Myocardial Infarction
4. Acute Respiratory Failure/Adult Resp Distress Syndrome
5. Alcohol/Drug Dependency Rehabilitation
6. Amputation (Rehabilitation)
7. Angina/Chest Pain
8. Aortobifemoral Bypass
9. Asthma/Chronic Obstructive Pulmonary Disease
10. Cancer of the Larynx
11. Cancer of the Lung
12. Cancer of the Lung (Surgical)
13. Cardiac Surgery
14. Cardiovascular Accident (Left Hemiplegia/Paresis)
15. Cardiovascular Accident (Right Hemiplegia/Paresis)
16. Cellulitis
17. Chemotherapy/Radiation Therapy
18. Cholecystectomy
19. Cirrhosis
20. Congestive Heart Failure
21. Depressive Neurosis

Enter action (<RET> to see more): <RET>

Would you like to list the contents of:
22. Diabetes Mellitus
23. Gastroenteritis/Gastritis
24. Gastrointestinal Hemorrhage (G.I. Bleed)
25. Generic Discharge Care Plan
26. Hemodialysis
27. Hepatitis
28. Hernia Repair
29. Hypertension
30. Manic Behavior
31. Ocular Disorder/Surgery (Cataracts)
32. Organic Disturbances
33. Pancreatitis
34. Parkinsons Disease
35. Pleural Effusion/Pneumothorax/Hemothorax/Empyema
36. Pneumonia/Pleurisy
37. Post Traumatic Stress Disorder
38. Pressure Ulcer
39. Psychoses/Schizophrenia
40. Pulmonary Edema
41. Pulmonary Embolus
42. Renal Failure

Enter action (<RET> to see more): <RET>
Would you like to list the contents of:
  43. Renal/Urinary Calculi
  44. Seizure Disorder
  45. Sleep Apnea
  46. Spinal Cord Injury (New Quadraplegia/Paraplegia)
  47. Spinal Headache
  48. Substance Abuse Withdrawal/Detoxification
  49. Transient Ischemic Attacks
  50. Transurethral Resection/Benign Prostatic Hypertrophy
  51. Traumatic Brain Injury
  52. Tuberculosis
  53. Urinary Tract Infection
Enter action: 1-53
...SORRY, JUST A MOMENT PLEASE...

This example will display all nursing problems.

Enter type of information you want printed:
  1. All Nursing Problems in Selection
  2. Selected Nursing Problems from Selection
Enter action: 1
...EXCUSE ME, HOLD ON...

For each care plan, which data should be printed:
  1. Nursing Problems/Outcomes
  2. Nursing Problems/Interventions
  3. Nursing Problems/Etiologies
  4. Nursing Problems/Related Problems
  5 Nursing Problems/Defining Characteristics
  6. All of the above
  7. Nursing Problems Only
Enter action: 6

The above generates a printed report for all care plan guidelines under the Optional Patient Plan of Care category.

**Menu Access:**

The Standard Patient Plan of Care Print option is accessed through the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCFE-CARE

Patient Plan of Care, Site Configuration

Description:

This option is part of the patient plan of care module and allows the nursing ADP Coordinator to add and modify entries to the Aggregate Term file. The aggregate terms are the strings of text which comprise the care plan guideline data base. Data is stored in the Aggregate Term (#124.2) file.

Additional Information:

The examples indicated in this section provide information about adding data to the standardized patient plans of care within the Aggregate Term file. All terms contained in the standard patient plans of care must contain specific/unique information for the purpose of adding a term in an existing plan or creating a new plan. The following is a glossary of terms which a user should review before attempting to modify the existing data.

Name: The name of the term (e.g., Coping, Ineffective Family, Goals/Interventions, blood gases [frequency]) entered in the file.

Term Definition: Used to differentiate between aggregate terms that have associated lower levels and those that do not.

Type of Term: Used to identify an aggregate term has a lower level associated with it.

Frame: A frame has two or more selectable terms related to it.

Term: A term is the lowest level in the hierarchy of the patient plan of care; there is nothing under a term to further describe or modify it.

Classification: These classifications distinguish the difference between aggregate terms.

Goal NURSC

Used to identify a goals/expected outcome frame or term which should have an associated date for review or met action.

Goals/Expected Outcomes NURSC

Used to identify a major level under a nursing problem or medical dx/procedure for categorizing measurable patient outcomes/goals.
Clinical Site Files

Medical Dx/Procedure  NURSC
   Used to identify a major level under a medical section for identifying medically related patient problems.

Medical Section  NURSC
   Correlates to the nursing section within the care plan hierarchy; this level is immediately under a prime document and contains a listing of medical diagnoses/procedures.

Nursing Intervention  NURSC
   Identifies a nursing order or intervention.

Nursing Problem  NURSC
   Identifies a patient problem or NANDA term.

Nursing Section  NURSC
   Correlates to the medical section, or an area/system of nursing care.

Orderable  NURSC
   An intervention which has an associated date for tracking data in the system or discontinuing the order.

Prime Document  GMRG
   A classification type describing the highest level within the hierarchy.

Related Factor  NURSC
   Used to identify a major level under a nursing problem or medical dx/procedure for categorizing possible etiologies of the patient problem.

Related Problem  NURSC
   Used to identify a major level under a nursing problem or medical dx/procedure for indicating potentially related or influencing problems.

Lead Text:  Text that will precede the text of this frame/document in displays.

Trail Text:  Text that will follow the text of this frame/document in displays.

Max:  The maximum number of selections allowed under this frame/document.  A null entry means there is no maximum.

Min:  The minimum allowable selections to be made under this frame/document. Null entry means zero.
Format of Output: The way the frame/document is displayed. Tabular and brief tabular display in an outline format. Tabular uses lead and trail text, and brief tabular does not. Sentence format creates paragraphs using lead and trail text, and ends sentences with periods.

CHOOSE FROM:
S SENTENCE
T TABULAR Patient plan of care uses this exclusively.
B BRIEF TABULAR

ASK ADDITIONAL TEXT: A flag to determine whether Additional Text can be entered for an aggregate term.

CHOOSE FROM:
0 NO
1 YES

SUPPRESS MIN/MAX MESSAGE: This field determines whether the MIN and MAX messages should be suppressed for this frame. For example if the minimum number of selections for a frame is one, and no selections are picked on that frame, an error message indicating this will appear. This field will allow the site to prevent those messages from printing if desired.

CHOOSE FROM:
0 NO SUPPRESSION same as leaving field with no data
1 SUPPRESS MIN MESSAGE only code that needs to be used in Patient Plans of Care.
2 SUPPRESS MAX MESSAGE
3 SUPPRESS BOTH MESSAGES

Standard HELP Prompt:

Enter appropriate action, or type a '?' to see what you can do: ?

Edit choices

You may make the following choices at this prompt:
1. Enter 'A' to add more items for the correct term.
2. Enter 'T' to edit the information that is displayed in the header for the current term.
3. You may choose one of the items in the above list, and edit the information it contains by entering the item number from the list.
4. To delete a selection from the above list, enter a number followed by an '@'. E.g. 2@
5. Enter 'R' to redisplay the selection list.
6. You may change the display order of an item by entering the item number from the list followed by a 'D'. E.g. 1D will edit the display order of item number 1.
In discussing the details of this option, selective system prompts are omitted due to the redundancy of their presence (e.g., Are you adding 'XXX' as a new AGGREGATE TERM). Also, the Aggregate Term file is known as the 'file'.

The Patient Plan of Care, Site Configuration option should be given only to the ADP Coordinator or specific users who are responsible for adding and modifying the patient plan of care data base.

Future Plans:

Future enhancements to this portion of the patient plan of care module include reducing keystrokes for adding or editing to the aggregate term file.

Menu Display:

Select Nursing Features (all options) Option: 7 Clinical Site File Functions

1 Standard Patient Plan of Care Print
2 Patient Plan of Care, Site Configuration
3 Ward Activation Patient Update
4 Ward Deactivation Patient Update
5 Selected V/M Site File Functions ...
6 Configure I/O Files (ADP Coordinator Only) ...

Screen Prints:

Select Clinical Site File Functions Option: 2 Patient Plan of Care, Site Configuration

Upon entering this option, the first thing the user is able to do is to enter/edit all of the site parameters that pertain to the Standard Patient Plan of Care print and edit options. The following will be displayed:

PATIENT PLAN OF CARE HEADER: Patient Plan of Care
PATIENT PROBLEM HEADER: Diagnosis
GOALS/EXPECTED OUTCOMES HEADER: Standards of Care
INTERVENTIONS/ORDERS HEADER: Standards of Practice
DEFAULT EVALUATION DATE: T+7
DEFAULT TARGET DATE: T+7

Do you wish to edit any of this data? NO// YES

If this question is answered NO, the user will not see the next six prompts.
PATIENT PLAN OF CARE HEADER: Patient Plan of Care// <RET>

The data in this field allows the site to change the title of the report generated by the Patient Plan of Care, Print (NURCPP-CARE) option from Patient Plan of Care to whatever is desired. E.g. Patient Care Plan.

PATIENT PROBLEM HEADER: Diagnosis// <RET>

The data in this field allows the site to change the header Patient Problem for the report generated by the Patient Plan of Care, Print (NURCPP-CARE) option to whatever is contained in this field. If this field has no data, the Patient Problem heading will still print.

GOALS/EXPECTED OUTCOMES HEADER: Standards of Care// <RET>

The data in this field allows the site to change the Goals/Expected Outcomes heading on the report generated by the Patient Plan of Care, Print (NURCPP-CARE) option to whatever is contained in this field. If this field has no data then the heading Goals/Expected Outcomes will be used.

INTERVENTIONS/ORDERS HEADER: Standards of Practice
Replace <RET>

The data in this field allows the site to change the Nursing Interventions/Orders heading of the report generated by the Standard Patient Plan of Care, Print (NURCPP-CARE) option to whatever is contained in this field. If this field has no data, then the Nursing Interventions/Orders heading will be used.

DEFAULT EVALUATION DATE: T+7// <RET>

The data in this field represents the default evaluation date that is seen during the Standard Patient Plan of Care, Edit (NURCPE-CARE) option when an evaluation date for a problem is edited.

DEFAULT TARGET DATE: T+7// <RET>

The data in this field represents the default target date that is seen during the Standard Patient Plan of Care, Edit (NURCPE-CARE) option when an target date for a goal is edited.

This is the end of the site parameters. From this point on the user is editing the content of the Patient Plan of Care data.

Nursing Care Plan
Classification: PRIME DOCUMENT   Output Format: TABULAR
Type of Term: FRAME
Minimum number of selections: 1
   1. Medical Diagnoses
   2. Nursing Problems
   3. Optional Care Plans
Classification, output format, type of term, and minimum number of selections, are fields within the file for the term, patient plan of care, which identify attributes for that term. For the user's convenience this data is displayed. At this point we want to go lower in the care plan hierarchy under nursing problems to modify data, therefore, enter the number 2.

Enter appropriate action, or type a '?' to see what you can do: 2

Nursing Problems
   Output Format: TABULAR
   Type of Term: FRAME
   Minimum number of selections: 1
   1. Activities of Daily Living
   2. Circulatory System
   3. Cognitive-Sensory Area
   4. Elimination
   5. Health Management
   6. Integumentary (Skin)
   7. Musculoskeletal/Neurological
   8. Nutrition-Metabolic Area
   9. Psycho-Social Area
   10. Respiratory System
   11. Sexual Functioning/Reproductive System
   12. Sleep/Rest
   13. Spiritual Needs

Enter appropriate action, or type a '?' to see what you can do: 1

Activities of Daily Living
   Classification: NURSING SECTION   Output Format: TABULAR
   Type of Term: FRAME
   Minimum number of selections: 1
   1. Coping, Ineffective Family
   2. Home Maintenance Management, Impaired
   3. Self-Care Deficit [Specify]

Enter appropriate action, or type a '?' to see what you can do: 1

Coping, Ineffective Family
   Classification: NURSING PROBLEM   Output Format: TABULAR
   Type of Term: FRAME
   Minimum number of selections: 1
   1. Defining Characteristics
   2. Etiology/Related and/or Risk Factors
   3. Goals/Expected Outcomes
   4. Nursing Intervention/Orders
   5. Related Problems

Remember the HELP Prompt?

Enter appropriate action, or type a '?' to see what you can do: ?
   Edit choices
You may make the following choices at this prompt:
1. Enter 'A' to add more items for the correct term.
2. Enter 'T' to edit the information that is displayed in the header for the current term.
3. You may choose one of the items in the above list, and edit the information it contains by entering the item number from the list.
4. To delete a selection from the above list, enter a number followed by an '@'. E.g. 2@
5. Enter 'R' to redisplay the selection list.
6. You may change the display order of an item by entering the item number from the list followed by a 'D'. E.g. 1D will edit the display order of item number 1.

There are several methods which could be used to explain how terms are constructed within this file. It may be more meaningful to provide examples currently in the system, after which the user can apply them to site specific modifications. When adding new data to a level within the hierarchy, enter the letter A; to modify the attributes describing an existing term, enter the letter T. Since our purpose is to explain existing data, we will enter T.

**Example 1:** Reviewing attributes at the Nursing Problem level for an existing term.

Enter appropriate action, or type a '?' to see what you can do: **T**

NAME: Coping, Ineffective Family

Replace <RET>

TERM DEFINITION:
1>A usually supportive primary person (family member or close friend)
2>is providing insufficient, ineffective, or compromised support,
3>comfort, assistance, or encouragement that may be needed by the
4>client to manage or master adaptive tasks related to the client's
5>health challenge.

Edit? NO/ <RET>

TYPE OF TERM: FRAME/ <RET>

Since data is found under this problem, the type of term is 'frame'.

CLASSIFICATION: NURSING PROBLEM/ <RET>

LEAD TEXT: <RET>

Will seldom be completed at the problem level.

TRAIL TEXT: <RET>

Will seldom be used at the problem level.

FORMAT OF OUTPUT: TABULAR/ <RET>

Standard response for ALL care plan entries.

MIN: 1/ <RET>

Always enter '1'.
MAX: <RET>

Leave blank.

SUPPRESS MIN/MAX MESSAGE: <RET>

Leave blank.

ASK ADDITIONAL TEXT: <RET>

Can be bypassed at this level.

Remember if there had not been a Coping, Ineffective Family term in the file, and you wanted to add it under the problem, Activities of Daily Living, then the following would have taken place:

**Example 2:** Adding Nursing Problems.

Activities of Daily Living
Classification: NURSING SECTION   Output Format: TABULAR
Type of Term: FRAME
Minimum number of selections: 1
1. Home Maintenance Management, Impaired
2. Self-Care Deficit [Specify]

Enter appropriate action, or type a '?' to see what you can do: A

Select term to add: **Coping, Ineffective Family**

This entry would have been identified as not being in the system and you would have had to complete all field attributes as reviewed above. After completing the data entry the new term is displayed in alphabetical order. The list is automatically renumbered:

Activities of Daily Living
Classification: NURSING SECTION   Output Format: TABULAR
Type of Term: FRAME
Minimum number of selections: 1
1. Coping, Ineffective Family
2. Home Maintenance Management, Impaired
3. Self-Care Deficit [Specify]

Now that you have an understanding of the process for adding terms and their attributes to the file, the following examples describe the file attributes used for other segments of the patient plan of care.

**Example 3:** Adding Etiology/Related and/or Risk Factors.

In constructing a new patient problem, you will likely have to enter a new Etiology/Related and/or Risk Factors.
NAME: Etiology/Related and/or Risk Factors
TERM DEFINITION:
   1> <RET>
TYPE OF TERM: 2 FRAME
CLASSIFICATION: RELATED FACTOR
LEAD TEXT: <RET>
TRAIL TEXT: <RET>
FORMAT OF OUTPUT: T TABULAR
MIN: 1
MAX: <RET>
SUPPRESS MIN/MAX MESSAGE: <RET>
ASK ADDITIONAL TEXT: YES

Example 4: Adding Goals/Expected Outcomes.

In constructing a new patient problem, you will likely have to enter a new Goals/ Expected Outcomes.

NAME: Goals/Expected Outcomes
TERM DEFINITION:
   1> <RET>
TYPE OF TERM: 2 FRAME
CLASSIFICATION: GOALS/EXPECTED OUTCOMES
LEAD TEXT: <RET>
TRAIL TEXT: <RET>
FORMAT OF OUTPUT: T TABULAR
MIN: 1
MAX: <RET>
SUPPRESS MIN/MAX MESSAGE: <RET>
ASK ADDITIONAL TEXT: YES

Example 5: Adding Nursing Intervention/Orders.

In constructing a new patient problem, you will likely have to enter a new Nursing Intervention/Orders.

NAME: Nursing Intervention/Orders
TERM DEFINITION:
   1> <RET>
TYPE OF TERM: 2 FRAME
CLASSIFICATION: NURSING INTERVENTION
LEAD TEXT: <RET>
TRAIL TEXT: <RET>
FORMAT OF OUTPUT: T TABULAR
MIN: 1
MAX: <RET>
SUPPRESS MIN/MAX MESSAGE: <RET>
ASK ADDITIONAL TEXT: YES
Example 6: Adding Related Problems.

In constructing a new patient problem, you probably will have to enter a new Related Problems.

NAME: Related Problems
TERM DEFINITION:
  1> <RET>
TYPE OF TERM: FRAME// <RET>
CLASSIFICATION: RELATED PROBLEM// <RET>
LEAD TEXT: <RET>
TRAIL TEXT: see// <RET>
FORMAT OF OUTPUT: TABULAR// <RET>
MIN: 1// <RET>
MAX: <RET>
SUPPRESS MIN/MAX MESSAGE: <RET>
ASK ADDITIONAL TEXT: YES// <RET>

Example 7: Building terms with an associated date.

The user must "tell" the system that a date needs to be associated with a goal or an order. If a term does not need an associated date, then do NOT complete the Classification field (enter <RET> at the prompt).

GOAL EXAMPLE:

Within the patient plan of care, the following will appear as a list of goals on a particular Goals/Expected Outcomes frame:

Goals/Expected Outcomes
*****************************************************************************
  1. demonstrates realistic responses to stress  08/09/96(T)
    .
    .
To build a goal, add a new frame or term on the Goals/Expected Outcomes frame as described before, but make sure the Classification field equals GOAL. This will allow you to associate a target date with this goal.

NAME: demonstrates realistic responses to stress
TERM DEFINITION:
  1> <RET>
TYPE OF TERM: 3 TERM
CLASSIFICATION: GOAL

This classification should be used with every goal needing a target date.
demonstrates realistic responses to stress
Classification: GOAL Output format: TABULAR
Type of Term: TERM

Enter appropriate action, or type a '?' to see what you can do: <RET>

Goals/Expected Outcomes
Classification: GOALS/EXPECTED OUTCOMES Output Format: TABULAR
Type of Term: FRAME Ask Additional Text: YES
Minimum number of selections: 1
Trail Text: family demonstrates
1. demonstrates realistic responses to stress The date is associated with this term.
2. effective decision making skills
3. effective family coping skills
4. effective problem solving

ORDERS EXAMPLE:

Within the patient plan of care, the following will appear as a list of interventions on a particular Nursing Intervention/Orders:

Nursing Intervention/Orders
******************************************************************************
1. teach effective coping skills 08/09/90(T)
.
.
To build an intervention, add a new frame or term on the Nursing Intervention/Orders frame as described before, but make sure the Classification field equals ORDERABLE. This will allow you to discontinue interventions as appropriate.

NAME: teach effective coping skills
TERM DEFINITION:
1> <RET>
TYPE OF TERM: FRAME// <RET>
CLASSIFICATION: ORDERABLE// <RET>
LEAD TEXT: <RET>
TRAIL TEXT: <RET>
FORMAT OF OUTPUT: TABULAR// <RET>
MIN: 1// <RET>
MAX: <RET>
SUPPRESS MIN/MAX MESSAGE: <RET>
ASK ADDITIONAL TEXT: YES// <RET>

The resulting frame will look like the following:

teach effective coping skills
Example 8: Lead text.

In printing data, you might want an outcome to display:

Goals/Expected Outcomes
  family demonstrates effective decision making skills

Within the file, you need to set the attributes to provide the lead text. The lead text does not display through the edit routine but on the printed patient plan of care. Your file attribute display should resemble:

NAME:  effective decision making skills
Replace <RET>
TERM DEFINITION:
  1> <RET>
TYPE OF TERM: TERM//<RET>
CLASSIFICATION: GOAL//<RET>
LEAD TEXT:  family demonstrates
TRAIL TEXT: <RET>
FORMAT OF OUTPUT: TABULAR//<RET>

As you exit the entry, your finished display should appear as:

effective decision making skills
  Classification: GOAL
  Type of Term: TERM
  Lead Text: family demonstrates

The above principle can be used to display lead text for an etiology, related problem, or order. Trail text is the same as lead text with the exception that it appear at the end of the term for which it is defined and not the beginning.

Example 9: Adding selections which have no subselections.

This example adds a term to an order:

teach effective coping skills
  Classification: ORDERABLE  Output Format: TABULAR
  Type of Term: FRAME  Ask Additional Text: YES
  Minimum number of selections: 1

Enter appropriate action, or type a '?' to see what you can do: A
Select term to add: **assertiveness**

Are you adding 'assertiveness' as a new AGGREGATE TERM (the 6571ST)? Y

teach effective coping skills
    Classification: ORDERABLE   Output Format: TABULAR
    Type of Term: FRAME   Ask Additional Text: YES
    Minimum number of selections: 1
    1. assertiveness

Enter appropriate action, or type a '?' to see what you can do: 1

assertiveness

Enter appropriate action, or type a '?' to see what you can do: T
NAME: assertiveness
    Replace <RET>
TERM DEFINITION:
    
TYPE OF TERM: 3  TERM
CLASSIFICATION: <RET>
LEAD TEXT: <RET>
TRAIL TEXT: <RET>

**Menu Access:**

The Patient Plan of Care, Site Configuration option is accessed through the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURSPT-WRDACT

Ward Activation Patient Update

Description:

This option sets the patient care status field and the status of all patients assigned to the ward to ACTIVE. The activation of nursing wards should be done through this option; do NOT activate locations through the Nursing Location File, Edit (NURSFL-LOC) accessed through the Nursing Package Site File Function menu. Certain nursing options (e.g., classification edits and reports) will not function for a nursing location until it has been activated. This option should also be used when any MAS ward changes and nursing AMIS bed section changes are entered into the NURS Location (#211.4) file.

Additional Information:

Menu Display:

Select Nursing Features (all options) Option: 7 Clinical Site File Functions

1 Standard Patient Plan of Care Print
2 Patient Plan of Care, Site Configuration
3 Ward Activation Patient Update
4 Ward Deactivation Patient Update
5 Selected V/M Site File Functions ...
6 Configure I/O Files (ADP Coordinator Only) ...

Screen Prints:

Select Nursing Package Site File Functions Option: 3 Ward Activation Patient Update

On entering this option a background routine performs a check to see if all MAS ward locations have been associated with a nursing location.

Checking to see if every MAS Ward has a corresponding NURSING Unit

If everything is ok, then the following prompt appears:

Select UNIT: 13

Enter the name of the unit you wish to activate. Each location name must be entered separately.
CHOOSE 1-2: 1
Select UNIT: <RET>
Ward Activation and Patient entry for the following Nursing Unit(s):

13E

Done ...

Note: If all MAS ward locations do not have a corresponding nursing location the following report displays on your screen:

The following MAS Wards do not have corresponding Nursing Locations:
   51A
   CCU

Press return to continue: <RET>

After the system displays those wards which are not associated with a nursing location the user will exit the option. The system will not allow any nursing ward locations to be activated until the problem is resolved. Obtain the report from the option, Print Existing Location File Entries (located in the Nursing Package Site File Function menu). This report indicates current nursing locations and MAS ward relationships. Editing of these relationships is done by using the Nursing Location File, Edit option.

Menu Access:

The Ward Activation Patient Update option is accessed through the Clinical Site File Functions option of the Nursing Features (all options) menu.
**NURSPR-WRDINA**

**Ward Deactivation Patient Update**

**Description:**

This option sets the patient care status field and the status of all patients assigned to the ward to INACTIVE. The deactivation of nursing wards should be done through this option; do NOT deactivate locations through the Nursing Location File, Edit (NURSFL-LOC) option accessed through the Nursing Package Site File Function menu. This option should also be used when any MAS ward changes and nursing AMIS bed section changes are entered into the NURS Location (#211.4) file.

**Menu Display:**

Select Nursing Features (all options) Option: 7  Clinical Site File Functions

1      Standard Patient Plan of Care Print
2      Patient Plan of Care, Site Configuration
3      Ward Activation Patient Update
4      Ward Deactivation Patient Update
5      Selected V/M Site File Functions ...
6      Configure I/O Files (ADP Coordinator Only) ...

**Screen Prints:**

Select Nursing Package Site File Functions Option: 4  Ward Deactivation Patient Update

On entering this option a background routine performs a check to see if all MAS ward locations have been associated with a nursing location.

Checking to see if every MAS Ward has a corresponding NURSING Unit

If everything is ok, then the following prompt will appear:

Select UNIT: 5E
Select UNIT: <RET>

Ward Deactivation and Patient entry for the following Nursing Unit(s):

5E

Done ...

Note: If all MAS ward locations do not have a corresponding nursing location, the following report displays on your screen:
Checking to see if every MAS Ward has a corresponding NURSING Unit

The following MAS Wards do not have corresponding NURSING Units:
   4M

Press return to continue: <RET>

After the system displays those wards which are not associated with a nursing location, the user will exit the option. The system will not allow any nursing ward locations to be deactivated until the problem is resolved. Running the Print Existing Location File Entries option (located in the Nursing Package Site File Function menu) will assist you by indicating current nursing locations and MAS ward relationships. If editing is required, use the Nursing Location File, Edit option.

Menu Access:

The Ward Deactivation Patient Update option is accessed through the Clinical Site File Functions option of the Nursing Features (all options) menu.
**NURCPE-VIT FILECONF**

**Selected V/M Site File Functions**

**Description:**

This menu option is assigned to appropriate application coordinators (e.g., Vitals/Measurements, Nursing) and contains options that define vitals/measurement qualifiers and their synonyms. Files edited by these menu's options are the GMRV Vital Qualifier (#120.52) and GMRV Vital Category (#120.53) files.

**Additional Information:**

This menu lists options that give the flexibility to add a site, and a quality to the Detailed Blood Pressure option. Please refer to the examples in the following options to see how this function for documenting detailed blood pressure works.

The information edited in the above files is used in the following options:

1. Vitals/Measurement Data Entry
2. Vitals/Measurements Results Reporting

Which are located in specific Nursing application menu options.

**Menu Display:**

Select Selected V/M Site File Functions Option:

1. Standard Patient Plan of Care Print
2. Patient Plan of Care, Site Configuration
3. Ward Activation Patient Update
4. Ward Deactivation Patient Update
5. Selected V/M Site File Functions ...
6. Configure I/O Files (ADP Coordinator Only) ...

Select Clinical Site File Functions Option: 5  Selected V/M Site File Functions

1. Enter/Edit Vitals Qualifiers
2. Change Default Qualifiers for Temp./Pulse
3. Display Vitals Category/Qualifier/Synonym Table

---

1. Patch NUR*4*4 August 1997
2. Patch NUR*4*4 August 1997
**Menu Access:**

The Selected V/M Site File Functions option is accessed through the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCPE-VIT VMSITE

Enter/Edit Vitals Qualifiers

Description:

1This option is used by the application coordinator to create and edit hospital-wide qualifiers and synonyms associated with vital signs and other patient measurements captured in the Vitals/Measurements application. Data is stored in the GMRV Vital Qualifier (#120.52) file.

Additional Information:

2Qualifiers describe how patient vital signs and miscellaneous measurements were taken. These package qualifiers are categorized by location (e.g., right arm, left leg), position (e.g., lying, sitting, standing), method (e.g., cuff, Doppler, auscultate, assisted ventilator, T-piece), site (e.g., right, left), quality (e.g., actual, estimated), and cuff size (e.g., adult, small adult, pediatric). Synonyms are used as qualifier abbreviations and are appended to the measurement's numeric values on graphic reports. For your convenience, we have provided a report that lists the current vital types and their associated categories, qualifiers and synonyms found in the Vitals/Measurements application. This report can be printed by running the Display Vitals Category/Qualifier/Synonym Table option in the Vitals/Measurements Site Files Menu. Qualifier synonyms do not print on the Health Summary package reports.

Restrictions:

3A new qualifier category cannot be entered into the software by the package coordinator. Also, new qualifier categories cannot be associated with a different vital type without a software patch issued by the developer. Please note, that once a qualifier is associated with a category of a vital type, it cannot be deleted, ONLY edited.

1 Patch NUR*4*4 August 1997
2 Patch NUR*4*4 August 1997
3 Patch NUR*4*4 August 1997
Menu Display:

Select Vitals/Measurement Option: 4  Vitals/Measurements Site Files Menu

   1      Edit Vitals Site Parameter File
   2      Change Default Qualifiers for Temp./Pulse
   3      Enter/Edit Vitals Qualifiers
   4*4    Display Vitals Category/Qualifier/Synonym Table
   5      Edit Administration Schedules File
   6      Display Administration Schedule File
   7      Create Vital Measurement Quick Order Protocol

Screen Prints:

Select Vitals/Measurements Site Files Menu Option: 3  Enter/Edit Vitals Qualifiers
Enter/Edit Vital qualifiers for:

   7. Pulse Ox.  8. Height

The following is an example of setting up the software to identify and document that oxygen was administered when the pulse oximetry reading was taken. This is probably the most difficult relationship identified in the software. As you review other V/M entries, you will note that the category/qualifier and synonym relationships are more logically understood.

Select a number of vital type: 7  PULSE OXIMETRY

Enter the number of the vital type you wish to edit.

   1. METHOD

Enter the number of the qualifier category you wish to enter/edit. Since only one category is listed, enter '1'.

Select the number of the qualifier category for PULSE OXIMETRY that you want to enter/edit: 1

In this next step, the package coordinator associates the device (delivery method) used to administer the oxygen by typing the name of the vital qualifier, Venturi mask.
PULSE OXIMETRY has the following METHOD qualifiers:
   AEROSOL/HUMIDIFIED MASK
   FACE TENT
   MASK
   NASAL CANNULA
   NON RE-BREATHER
   PARTIAL RE-BREATHER
   T-PIECE
   TRACHEOSTOMY COLLAR
   VENTILATOR
Enter a Vital Qualifier: VENTURI MASK

Are you adding 'VENTURI MASK' as
   a new GMRV VITAL QUALIFIER (the 66TH)? No// Y (Yes)
QUALIFIER: VENTURI MASK// <RET> PO2

1 Enter the appropriate synonym (1-3 characters) for the qualifier. Remember, that if you are unsure of the correctness of the qualifier to the category, answer 'No' at this prompt. When 'Yes' is entered to this question, the user can only change the stored entry, not delete it.

SYNONYM: VM

The list of all qualifiers associated with the method category for pulse oximetry is re-displayed.

PULSE OXIMETRY has the following METHOD qualifiers:
   AEROSOL/HUMIDIFIED MASK
   FACE TENT
   MASK
   NASAL CANNULA
   NON RE-BREATHER
   PARTIAL RE-BREATHER
   T-PIECE
   TRACHEOSTOMY COLLAR
   VENTILATOR
   VENTURI MASK
Enter a Vital Qualifier: <RET>

2 At this prompt you may enter <RET> to return to the main menu, enter additional category (method) related qualifiers associated with the vital type, or edit existing qualifiers. Remember that no qualifiers may be deleted.

Menu Access:

The Enter/Edit Vitals Qualifiers option is accessed through the Selected V/M Site File Functions option of the Clinical Site File Functions option of the Nursing Features (all options) menu.

---

1 Patch NUR*4*4  August 1997
2 Patch NUR*4*4  August 1997
NURCPE-VIT VMQUALTY

Change Default Qualifiers for Temp./Pulse

Description:

This option is for the ADP coordinator to change hospital-wide default qualifiers for temperature and pulse. The default information is stored in the GMRV Vital Category (#120.53) file.

Additional Information:

The exported default for temperature is oral and for pulse, the default is radial. In a future release, the Vitals/Measurements Focus Group has requested the defaults be location based (i.e., wards, nursing units, clinics).

Menu Display:

Select Clinical Site File Functions Option: 5 Selected V/M Site File Functions

1 Enter/Edit Vitals Qualifiers
2 Change Default Qualifiers for Temp./Pulse
| 13 Display Vitals Category/Qualifier/Synonym Table

Screen Prints:

Select V/M Site File Functions Option: 2 Change Default Qualifiers for Temp./Pulse

TEMPERATURE has the following location qualifiers:

1 AXILLARY
2 CORE
3 ORAL
4 RECTAL
5 SKIN
6 TYMPANIC

To change the temperature default from oral to tympanic, the coordinator enters the number '6' behind the //. If no change in the default is required, enter <RET> behind the //.

Enter a number for TEMPERATURE default qualifier
or ^ to quit or @ to delete: ORAL// 6 TYMPANIC

---

1 Patch NUR*4*4 August 1997
PULSE has the following location qualifiers:

1  APICAL  
2  BILATERAL PERIPHERALS  
3  BRACHIAL  
4  CAROTID  
5  DORSALIS PEDIS  
6  FEMORAL  
7  OTHER  
8  PERIPHERAL  
9  POPLITEAL  
10  POSTERIOR TIBIAL  
11  RADIAL  
12  ULNAR

Enter an appropriate default qualifier for PULSE or <RET> to retain the present default.

Enter a number for PULSE default qualifier 
or ^ to quit or @ to delete: RADIAL// <RET>

Menu Access:

The Change Default Qualifiers for Temp./Pulse option is accessed through the Selected V/M Site File Functions option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
**NURCPE-VIT CAT/QUAL TABLE**

1. **Display Vitals Category/Qualifier/Synonym Table**

**Description:**

2. This option displays a list of categories, qualifiers and synonyms associated with individual vital types (e.g., blood pressure, temperature, pulse, respirations, weight, circumference/girth and pulse oximetry). Data comes from the GMRV Vital Qualifier (#120.52) file and the GMRV Vital Category (#120.53) file.

**Additional Information:**

3. Qualifiers describe how patient vital signs and miscellaneous measurements were taken. These package qualifiers are categorized by location (e.g., right arm, left leg), position (e.g., lying, sitting, standing), method (e.g., cuff, Doppler, auscultate, assisted ventilator, T-piece), site (e.g., right, left), quality (e.g., actual, estimated), and cuff size (e.g., adult, small adult, pediatric). Synonyms are used as qualifier abbreviations appended to Vitals/Measurements numeric values on graphic reports. Qualifier synonyms do not print on the Health Summary package reports. Data displayed in this report can be updated by the application coordinator through the Enter/Edit Vitals Qualifiers option in the Vitals/Measurements Site Files Menu.

**Menu Display:**

Select Clinical Site File Functions Option: 5 Selected V/M Site File Functions

1. Enter/Edit Vitals Qualifiers
2. Change Default Qualifiers for Temp./Pulse

4. 3 Display Vitals Category/Qualifier/Synonym Table

**Screen Prints:**

Select V/M Site File Functions Option: 3 Display Vitals Category/Qualifier/Synonym Table

DEVICE: Enter appropriate device (This report must be queued when sent to a printer.)
### Vitals/Measurements Category/Qualifier/Synonym Table

#### Qualifiers for BLOOD PRESSURE:

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>POSITION</th>
<th>METHOD</th>
<th>CUFF SIZE</th>
</tr>
</thead>
<tbody>
<tr>
<td>L ARM: LA</td>
<td>LYING: Ly</td>
<td>CUFF: Cu</td>
<td>ADULT: Ad</td>
</tr>
<tr>
<td>L LEG: LL</td>
<td>SITTING: Si</td>
<td>DOPPLER: Dop</td>
<td>LG ADULT: LgA</td>
</tr>
<tr>
<td>R ARM: RA</td>
<td>STANDING: St</td>
<td>NON-INVASIVE: N-I</td>
<td>PEDIATRIC: Ped</td>
</tr>
<tr>
<td>R LEG: RL</td>
<td></td>
<td>PALPATED: Pal</td>
<td>SM ADULT: SmA</td>
</tr>
</tbody>
</table>

#### Qualifiers for PULSE:

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>SITE</th>
<th>METHOD</th>
<th>POSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>APICAL: Ap</td>
<td>LEFT: Lt</td>
<td>AUSCULTATE: Aus</td>
<td>LYING: Ly</td>
</tr>
<tr>
<td>BILATERAL PERIPHERALS: BiP</td>
<td>RIGHT: Rt</td>
<td>DOPPLER: Dop</td>
<td>SITTING: Si</td>
</tr>
<tr>
<td>BRACHIAL: Bra</td>
<td></td>
<td>PALPATED: Pal</td>
<td>STANDING: St</td>
</tr>
<tr>
<td>CAROTID: Car</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DORSALIS PEDIS: DP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FEMORAL: Fem</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER: Oth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PERIPHERAL: Per</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POPLITEAL: Pop</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>POSTERIOR TIBIAL: PT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>RADIAL: Rad</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ULNAR: Uln</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Qualifiers for RESPIRATION:

<table>
<thead>
<tr>
<th>METHOD</th>
<th>POSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASSISTED VENTILATOR: AV</td>
<td>LYING: Ly</td>
</tr>
<tr>
<td>CONTROLLED VENTILATOR: CV</td>
<td>SITTING: Si</td>
</tr>
<tr>
<td>SPONTANEOUS: S</td>
<td>STANDING: St</td>
</tr>
</tbody>
</table>

#### Qualifiers for TEMPERATURE:

<table>
<thead>
<tr>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AXILLARY: A</td>
</tr>
<tr>
<td>CORE: C</td>
</tr>
<tr>
<td>ORAL: O</td>
</tr>
<tr>
<td>RECTAL: R</td>
</tr>
<tr>
<td>SKIN: S</td>
</tr>
<tr>
<td>TYPANIC: T</td>
</tr>
</tbody>
</table>

---

1 Patch NUR*4*4  August 1997
Qualifiers for WEIGHT:

<table>
<thead>
<tr>
<th>QUALITY</th>
<th>METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTUAL: A</td>
<td>BED: B</td>
</tr>
<tr>
<td>DRY: D</td>
<td>CHAIR: C</td>
</tr>
<tr>
<td>ESTIMATED: E</td>
<td>STANDING: St</td>
</tr>
</tbody>
</table>

Qualifiers for CIRCUMFERENCE/GIRTH:

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>SITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABDOMINAL: Abd</td>
<td>LEFT: Lt</td>
</tr>
<tr>
<td>ANKLE: Ank</td>
<td>RIGHT: Rt</td>
</tr>
<tr>
<td>CALF: Clf</td>
<td></td>
</tr>
<tr>
<td>HEAD: Hd</td>
<td></td>
</tr>
<tr>
<td>LOWER ARM: LrA</td>
<td></td>
</tr>
<tr>
<td>OTHER: Oth</td>
<td></td>
</tr>
<tr>
<td>THIGH: Thi</td>
<td></td>
</tr>
<tr>
<td>UPPER ARM: UpA</td>
<td></td>
</tr>
<tr>
<td>WRIST: Wri</td>
<td></td>
</tr>
</tbody>
</table>

Qualifiers for HEIGHT:

<table>
<thead>
<tr>
<th>QUALITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACTUAL: A</td>
</tr>
<tr>
<td>ESTIMATED: E</td>
</tr>
</tbody>
</table>

Qualifiers for PULSE OXIMETRY:

<table>
<thead>
<tr>
<th>METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>AEROSOL/HUMIDIFIED MASK: AM</td>
</tr>
<tr>
<td>FACE TENT: FT</td>
</tr>
<tr>
<td>MASK: M</td>
</tr>
<tr>
<td>NASAL CANNULA: NC</td>
</tr>
<tr>
<td>NON RE-BREATHER: NRB</td>
</tr>
<tr>
<td>PARTIAL RE-BREATHER: PRB</td>
</tr>
<tr>
<td>T-PIECE: TP</td>
</tr>
<tr>
<td>TRACHEOSTOMY COLLAR: TC</td>
</tr>
<tr>
<td>VENTILATOR: Ven</td>
</tr>
<tr>
<td>VENTURI MASK: VM</td>
</tr>
</tbody>
</table>

Menu Access:

The Display Vitals Category/Qualifier/Synonym Table option is accessed through the Selected V/M Site File Functions option of the Clinical Site File Functions option of the Nursing Features (all options) menu.

1 Patch NUR*4*4  August 1997
NURCPE-I/O-FILE EDIT

Configure I/O Files (ADP Coordinator Only)

Description:

This menu is provided for the Nursing ADP Coordinator to configure the following file entries: Input Subtype (#126.5), Input Type (#126.56), Output Type (#126.58), Output Subtype (#126.6), IV Site (#126.7), Intake Items (#126.8), NUR IV Solution (#126.9), NUR Shift/Other (#126.95), IV Site Description (#126.72), IV Catheter (#126.74) and IV DC’ed Reason (#126.72).

Additional Information:

The first area of concern is to ensure that you have the appropriate entries in the site specific files to use the software at your hospital, ambulatory care facility, or other VHA facility. When the application is installed, all files have a few entries to assist you with initially running the software, but you will have to enter appropriate facility related data in the site configurable files. You may always edit file data if that data does not apply to a specific site.

Menu Display:

Select Nursing Features (all options) Option: 7 Clinical Site File Functions

1 Standard Patient Plan of Care Print
2 Patient Plan of Care, Site Configuration
3 Ward Activation Patient Update
4 Ward Deactivation Patient Update
5 Selected V/M Site File Functions ...
6 Configure I/O Files (ADP Coordinator Only) ...

Select Clinical Site File Functions Option: 6 Configure I/O Files (ADP Coordinator Only)

1 Intake Type
2 Output Type
3 Output Subtype
4 Intake Items
5 IV Site
6 IV Solution
7 Shift Starting Hour and Other Parameters
8 IV Site Description
9 IV Catheter
10 IV DC’ed Reason

Patch NUR*4*4 August 1997
**Menu Access:**

The Configure I/O Files (ADP Coordinator Only) option is accessed through the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCPE-I/O-INPUT FILE1

Intake Type

Description:

This option is for the Nursing ADP Coordinator to configure the NON-IV intake type entries for the Input Type (#126.56) file. For example, PO, TUBE FEEDING, and OTHER are input types.

Additional Information:

This information is used in the following options:

- Enter/Edit Patient Intake
- Print I/O Summary by Patient (by Shift & Day(s))
- Print I/O Summary (Midnight to Present)
- Print I/O Summary (48 Hrs)
- 24 Hours Itemized Shift Report

The entries of the GMRY Input Type Name prompt cannot be deleted except by IRMS staff. A user may change the entry name by editing the information.

Menu Display:

Select Clinical Site File Functions Option: 6 Configure I/O Files (ADP Coordinator Only)

1. Intake Type
2. Output Type
3. Output Subtype
4. Intake Items
5. IV Site
6. IV Solution
7. Shift Starting Hour and Other Parameters
8. IV Site Description
9. IV Catheter
10. IV DC'ed Reason

Screen Prints:

Select Configure I/O Files (ADP Coordinator Only) Option: 1 Intake Type
Select GMRY INPUT TYPE NAME: **GAVAGE**
Are you adding 'GAVAGE' as a new GMRY INPUT TYPE (the 5TH)? No// Y (YES)

Enter appropriate input type name. The following is an example of possible choices associated with this field:
- IRRIGATION       3
- OTHER            4
- PO               1
- TUBE FEEDING     2

NAME: GAVAGE//<RET>
ORDER: 5

This field holds the listing order for the patient intake/output reports.

Select GMRY INPUT TYPE NAME: <RET>

**Menu Access:**

The Intake Type option is accessed through the Configure I/O Files (ADP Coordinator Only) option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCPE-I/O-OUTPUT FILE1

Output Type

Description:

This option is provided for the ADP Coordinator to configure the entries for the GMRY Output Type (#126.58) file. URINE, STOOL and DRAINS, for example, are major output types.

Additional Information:

This information is used in the following options:
- Enter/Edit Patient Output
- Print I/O Summary by Patient (by Shift & Day(s))
- Print I/O Summary (Midnight to Present)
- Print I/O Summary (48 Hrs)
- 24 Hours Itemized Shift Report

The entries of the GMRY Output Type Name prompt cannot be deleted except by IRMS staff. A user may change the entry name by editing the information.

Menu Display:

Select Clinical Site File Functions Option: 6 Configure I/O Files (ADP Coordinator Only)

1  Intake Type
2  Output Type
3  Output Subtype
4  Intake Items
5  IV Site
6  IV Solution
7  Shift Starting Hour and Other Parameters
8  IV Site Description
9  IV Catheter
10  IV DC'ed Reason

Screen Prints:

Select Configure I/O Files (ADP Coordinator Only) Option: 2 Output Type
Select GMRY OUTPUT TYPE: OTHER
Are you adding 'OTHER' as a new GMRY OUTPUT TYPE (the 6TH)? No// Y (YES)

Answer with the appropriate output type. The following is an example of possible choices found in this field:
- DRAINAGE 4
- EMESIS 3
- FECES 5
- N/G 2
- URINE 1

OUTPUT TYPE: OTHER//<RET>
ORDER: 6

This field holds the listing order for the patient intake/output reports.

Select GMRY OUTPUT TYPE:<RET>

Menu Access:

The Output Type option is accessed through the Configure I/O Files (ADP Coordinator Only) option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCPE-I/O-OUTPUT FILE2

Output Subtype

Description:

This option allows the ADP Coordinator to enter the entries for the GMRY Output Subtype (#126.6) file pointed to by the GMRY Patient I/O File (#126). VOID, FOLEY and STRAIGHT CATH, for example, are subtypes of URINE. This file allows package coordinators to identify specific types or methods of output type collection.

Additional Information:

This information is used in the following options:
   Enter/Edit Patient Output
   24 Hours Itemized Shift Report

The entries of the GMRY Output Subtype prompt cannot be deleted except by IRMS staff. A user may change the entry name by editing the information.

Restrictions:

Only URINE and DRAINAGE output types should have associated output subtypes.

Menu Display:

Select Clinical Site File Functions Option: 6 Configure I/O Files (ADP Coordinator Only)

1 Intake Type
2 Output Type
3 Output Subtype
4 Intake Items
5 IV Site
6 IV Solution
7 Shift Starting Hour and Other Parameters
8 IV Site Description
9 IV Catheter
10 IV DC’ed Reason
Screen Prints:

Select Configure I/O Files (ADP Coordinator Only) Option: 3  Output Subtype

Select GMRY OUTPUT SUBTYPE: CHEST TUBE,LEFT
  Are you adding 'CHEST TUBE,LEFT' as a new GMRY OUTPUT SUBTYPE (the 6TH)?
No//  Y (YES)

Answer with appropriate output subtype. The following is an example of possible choices found in the field:

  CHEST TUBE,RIGHT   DRAINAGE
  FOLEY   URINE
  SHEATH CATH   URINE
  STRAIGHT CATH   URINE
  VOID   URINE

  GMRY OUTPUT SUBTYPE OUTPUT TYPE: DRAINAGE
OUTPUT SUBTYPE: CHEST TUBE,LEFT//<RET>
OUTPUT TYPE: DRAINAGE//<RET>

Select GMRY OUTPUT SUBTYPE:<RET>

Menu Access:

The Output Subtype option is accessed through the Configure I/O Files (ADP Coordinator Only) option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCPE-I/O-INTAKE ITEMS

Intake Items

Description:

This option allows the ADP Coordinator to enter items into the GMRY Intake Items (#126.8) file pointed to by the GMRY Patient I/O File (#126). The entries in the 126.8 file are used to identify specific fluid intake items associated with detailed oral fluids, tube feeding preparations, irrigation solution, etc. The information collected is the name of the intake item (e.g., water), the volume of the fluid's container, and the input type associated with the intake item's name (e.g., po, irrigation).

Additional Information:

This information is used in the following options:
  Enter/Edit Patient Intake
  24 Hours Itemized Shift Report

The entries of the GMRY Intake Items Name prompt cannot be deleted except by IRMS staff. A user may change the entry name by editing the information.

Menu Display:

Select Clinical Site File Functions Option: 6 Configure I/O Files (ADP Coordinator Only)

1 Intake Type
2 Output Type
3 Output Subtype
4 Intake Items
5 IV Site
6 IV Solution
7 Shift Starting Hour and Other Parameters
8 IV Site Description
9 IV Catheter
10 IV DC'ed Reason

Screen Prints:

Select Configure I/O Files (ADP Coordinator Only) Option: 4 Intake Items
Select GMRY INTAKE ITEMS NAME: **SODA**
Are you adding 'SODA' as a new GMRY INTAKE ITEMS (the 14TH)? No// Y (YES)

Enter appropriate intake item.

NAME: SODA/<RET>
VOLUME: 360

Enter amount of intake item.

Select INPUT TYPE: **PO**
Are you adding 'PO' as a new INPUT TYPE (the 1ST for this GMRY INTAKE ITEMS)? No// Y (YES)

Enter appropriate input type.

Select INPUT TYPE:<RET>

Select GMRY INTAKE ITEMS NAME:<RET>

**Menu Access:**

The Intake Items option is accessed through the Configure I/O Files (ADP Coordinator Only) option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCPE-I/O-IV SITE

IV Site

Description:

This option allows the ADP Coordinator to enter IV sites into the GMRY IV Site (#126.7) file. The entries are names of anatomical sites such as right wrist, left hand, etc..

Additional Information:

This information is used to track the IV insertion site and assist with documentation of the site's status and surrounding skin integrity. Deletion of file data does not affect existing patient information.

Menu Display:

Select Clinical Site File Functions Option: 6 Configure I/O Files (ADP Coordinator Only)

1 Intake Type
2 Output Type
3 Output Subtype
4 Intake Items
5 IV Site
6 IV Solution
7 Shift Starting Hour and Other Parameters
8 IV Site Description
9 IV Catheter
10 IV DC'ed Reason

Screen Prints:

Select Configure I/O Files (ADP Coordinator Only) Option: 5 IV Site

Select GMRY IV SITE: WRIST,RT
Are you adding 'WRIST,RT' as a new GMRY IV SITE (the 12TH)? No// Y (YES)

Enter appropriate IV site.

IV SITE: WRIST,RT/<RET>
Select GMRY IV SITE:<RET>
Menu Access:

The IV Site option is accessed through the Configure I/O Files (ADP Coordinator Only) option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
Clinical Site Files

**NURCPE-I/O-IV SOL**

**IV Solution**

**Description:**

This option allows the ADP Coordinator to enter IV solutions into the GMRY NUR IV Solution (#126.9) file. There are three fields associated with this option that store information on the IV solution: name, the type of solution (hyperal, piggyback, admixture, blood/blood products, and intralipids), and the volume of the solution.

**Additional Information:**

The IV solutions added to this file include admixtures, hyperals, intralipids, piggybacks and blood/blood products. This data is used only when the Pharmacy IV module interface is not available, when patient IV orders have not been entered into OE/RR and processed by pharmacy, or if an API (Application Program Interface) has not been written for a specific package (e.g., Blood Bank). Deletion of file data does not affect existing patient I/O information.

**Menu Display:**

Select Clinical Site File Functions Option: 6 Configure I/O Files (ADP Coordinator Only)

1. Intake Type
2. Output Type
3. Output Subtype
4. Intake Items
5. IV Site
6. IV Solution
7. Shift Starting Hour and Other Parameters
8. IV Site Description
9. IV Catheter
10. IV DC'ed Reason

**Screen Prints:**

Select Configure I/O Files (ADP Coordinator Only) Option: 6 IV Solution

Select GMRY NUR IV SOLUTION NAME: **D10W (1000)**

Are you adding 'D10W (1000)' as a new GMRY NUR IV SOLUTION (the 31ST)? No//Y (YES)

Enter the name of an appropriate IV solution.
GMRY NUR IV SOLUTION TYPE: A ADMIXTURE

Enter appropriate IV solution type. The following is a list of choices:

H HYPERAL
P PIGGYBACK
A ADMIXTURE
B BLOOD/BLOOD PRODUCT
I INTRALIPIDS

NAME: D10W (1000)//<RET>
TYPE: ADMIXTURE/<RET>
VOLUME: 1000

Enter amount of IV solution.

Select GMRY NUR IV SOLUTION NAME:<RET>

Note: The IV module can accommodate multiple types of IV solutions. Additives added to the bag can be treated as an independent solution. Therefore, you can add the additive solution into the IV SOLUTION file. For example: enter KCL 20 meq at the NAME prompt, ADMIXTURE at the TYPE prompt and 10 at the VOLUME prompt.

Menu Access:

The IV Solution option is accessed through the Configure I/O Files (ADP Coordinator Only) option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCPE-I/O-NURSHIFT

Shift Starting Hour and Other Parameters

Description:

This option allows the application coordinator to edit specific Intake and Output parameters that are stored in the GMRY NUR Shift/Other (#126.95) file. These parameters include the starting hours for the night, day, and evening shift (tour of duty) which is used to calculate a patient's total intake and output for a specific time span. A default volume for heparin and saline locks is also stored in this file.

Additional Information:

In this version of Intake and Output, the application can only assign shift start times for the entire hospital. In a future version, the application's functionality will be modified to accommodate unique shift times for specific wards or units. Also, the displaying of data for units with two tours of duty within a 24 hour time frame will be explored. The data type for the shift start hours is entered in military time (e.g., 0800, 1600, and 2400). The default volume for the heparin or saline locks and ports is also a hospital-wide value in this version.

Menu Display:

Select Clinical Site File Functions Option: 6 Configure I/O Files (ADP Coordinator Only)

1 Intake Type
2 Output Type
3 Output Subtype
4 Intake Items
5 IV Site
6 IV Solution
7 Shift Starting Hour and Other Parameters
8 IV Site Description
9 IV Catheter
10 IV DC'ed Reason

Screen Prints:

Select Configure I/O Files (ADP Coordinator Only) Option: 7 Shift Starting Hour and Other Parameters

Select GMRY NUR SHIFT/OTHER NAME: HOSPITAL

The data selected at this prompt cannot be edited.
NIGHT: 2400
Enter start time of night shift. Use military time.

DAY: 0700
Enter start time of day shift. Use military time.

EVENING: 330??
Enter start time of evening shift. Use military time.

Note: The program did not accept this entry as valid. Only military time is accepted.

EVENING: 1530
ML'S FLUSH: 2/<RET>
Enter the amount of fluid required to flush the heparin lock or port.

Select GMRY NUR SHIFT NAME/OTHER:<RET>

Menu Access:
The Shift Starting Hour and Other Parameters option is accessed through the Configure I/O Files (ADP Coordinator Only) option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCPE-I/O-SITE DESCRP

IV Site Description

Description:

This option allows the ADP Coordinator to enter IV site descriptions into the GMRY IV Site Description (#126.72) file. This information describes the condition of the skin around the insertion site of the IV catheter, needle, etc.

Additional Information:

This information is used for documenting site maintenance. Information is printed on the 24 Hours Itemized Shift Report, the Intravenous Infusion Flow Sheet, and the Nursing application's End of Shift Report. Deleting information from the file does not affect existing patient I/O information.

Menu Display:

Select Clinical Site File Functions Option: 6 Configure I/O Files (ADP Coordinator Only)

1  Intake Type
2  Output Type
3  Output Subtype
4  Intake Items
5  IV Site
6  IV Solution
7  Shift Starting Hour and Other Parameters
8  IV Site Description
9  IV Catheter
10 IV DC'ed Reason

Screen Prints:

Select Configure I/O Files (ADP Coordinator Only) Option: 8 IV Site Description

Select GMRY IV SITE DESCRIPTION: WARM
Are you adding 'WARM' as a new GMRY IV SITE DESCRIPTION (the 8TH)? No// Y (YES)
Answer with IV site description. The following is a list of choices:
  - DRAINAGE
  - NO REDNESS/PAIN/SWELLING
  - NON TENDER
  - RED
  - SLOUGH
  - SWOLLEN
  - TENDER

DESCRIPTION: WARM/<RET>

Select GMRY IV SITE DESCRIPTION:<RET>

**Menu Access:**

The IV Site Description option is accessed through the Configure I/O Files (ADP Coordinator Only) option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCPE-I/O-IV CATH

IV Catheter

Description:

This option allows the ADP Coordinator to enter different types of IV catheters, needles, etc. into the GMRY IV Catheter (#126.74) file.

Additional Information:

This file contains a list of IV Instrumentation (i.e., needles, catheters, locks, butterflys, etc.) that might be used by clinicians to establish an IV infusion (continuous or intermittent) of fluids or drugs. Both the type of catheter and it's size should be contained in the IV catheter name (when appropriate). Refer to the example illustrated under Screen Prints. Deleting of data in this file does not affect existing patient I/O information.

Menu Display:

Select Clinical Site File Functions Option: 6 Configure I/O Files (ADP Coordinator Only)

1 Intake Type
2 Output Type
3 Output Subtype
4 Intake Items
5 IV Site
6 IV Solution
7 Shift Starting Hour and Other Parameters
8 IV Site Description
9 IV Catheter
10 IV DC'ed Reason

Screen Prints:

Select Configure I/O Files (ADP Coordinator Only) Option: 9 IV Catheter

Select GMRY IV CATHETER IV CATHETER TYPE/SIZE: BUTTERFLY-20
Are you adding 'BUTTERFLY-20' as a new GMRY IV CATHETER (the 11TH)? No// Y (YES)
Answer with IV catheter name. The following is a list of choices:

- ANGIO CATH-14
- ANGIO CATH-16
- ANGIO CATH-18
- ANGIO CATH-20
- ANGIO CATH-22
- BUTTERFLY-16
- BUTTERFLY-18
- NEEDLE 1 1/4 IN-14
- NEEDLE 1 1/4 IN-16
- NEEDLE 1 1/4 IN-18

Note: In this file when you configure the entries, FileMan will order either numerically or alphabetically depending on your entries. For instance if you enter catheter size first, such as 18 and the user selects 18, then all the 18 catheters will be displayed for the user to select from.

IV CATHETER TYPE/SIZE: BUTTERFLY-20/<RET>

Select GMRY IV CATHETER IV CATHETER TYPE/SIZE:<RET>

**Menu Access:**

The IV Catheter option is accessed through the Configure I/O Files (ADP Coordinator Only) option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
NURCPE-I/O-DC REASON

IV DC'ed Reason

Description:

This option allows the ADP Coordinator to enter and edit reasons for discontinuing an IV into the GMRY IV DC'ed Reason (#126.76) file.

Additional Information:

The information in this file can be edited (name change and data deleted) through this option. Editing of information will not affect existing patient I/O information.

Menu Display:

Select Clinical Site File Functions Option: 6  Configure I/O Files (ADP Coordinator Only)

1  Intake Type
2  Output Type
3  Output Subtype
4  Intake Items
5  IV Site
6  IV Solution
7  Shift Starting Hour and Other Parameters
8  IV Site Description
9  IV Catheter
10  IV DC'ed Reason

Screen Prints:

Select Configure I/O Files (ADP Coordinator Only) Option: 10  IV DC'ed Reason

Select GMRY IV DC'ED REASON NAME: WRONG PATIENT
Are you adding 'WRONG PATIENT' as a new GMRY IV DC'ED REASON (the 8TH)?
No// Y (YES)
Answer with IV DC'ed reason name. The following is a list of choices:
  ACCIDENTALLY D/C'D
  CLOTTED
  COMPLETE A BOTTLE
  INFUSED Note: INFUSED is the default.
  IV INFILTRATED
  ORDER EXPIRED/DC'D
  SITE CONDITION

NAME: WRONG PATIENT/<RET>

Select GMRY IV DC'ED REASON NAME:<RET>

Menu Access:

The IV DC'ed Reason option is accessed through the Configure I/O Files (ADP Coordinator Only) option of the Clinical Site File Functions option of the Nursing Features (all options) menu.
Chapter 4  Special Functions

NURSSP-MENU

Special Functions

Description:

This is the main menu used to run backup routines, add/delete patients, etc., in the nursing software. Data used in these options is obtained from the following files:

- NURS Patient (#214) file
- NURS AMIS Daily Exception Report (#213.5) file
- NURS AMIS 1106 Manhours (#213.4) file
- NURS Location (#211.4) file
- NURS Staff (#210) file
- NURS Position Control (#211.8) file

Additional Information:

This group of options should be assigned to the nursing ADP Coordinator and other individuals responsible for the operation of the nursing application.

Menu Display:

Select Nursing System Manager's Menu Option: 5  Nursing Features (all options)

1  Administration Records, Enter/Edit ...
2  Administration Records, Print ...
3  Administrative Site File Functions ...
4  Nursing Education Reports, Print ...
5  Patient Care Data, Enter/Edit ...
6  Patient Care Data, Print ...
7  Clinical Site File Functions ...
8  QI Data, Enter/Edit ...
9  Quality Performance Reports ...
10  QI Site Files ...
11  Special Functions ...

Select Nursing Features (all options) Option: 11  Special Functions
## Special Functions

1. Admit/Transfer Pt. (Nursing Pkg. Only)
2. Inactivate/Disch. Pt. (Nursing Pkg. Only)
3. Employee Activation/Separation Report
4. Manual Nursing Acuity/Separation Run
5. Unclassified AMIS 1106 Patients
6. Manhours Exception Print by Service
7. Unclassified Midnight Patients
8. Manhours Exception Print by Location
9. Position Control/Staff File Integrity Report

## Menu Access:

The Special Functions option is accessed through the Nursing Features (all options) menu.
NURSPT-ACT

Admit/Transfer Pt. (Nursing Pkg. Only)

Description:

This option can directly admit a patient into the VISTA Nursing System. It is to be used only in the event that the MAS software does not automatically admit a patient into the Nursing System. This option does not replace the MAS ADT function. When MAS ADT software is down the admission and transferring of patients does not occur. Nursing Staff, assigned this option enter patient(s) and their locations into the Nursing System for the purpose of classifying, AMIS tracking, and so on. When MAS ADT software comes back on-line and the patient movements have been entered, an MAS background job updates entries as needed. Data is obtained from the NURS Patient (#214) file.

Additional Information:

The patient entered must be in the Patient (#2) file, however, this patient does not have to be active (an in-patient) in MAS.

Menu Display:

Select Nursing Features (all options) Option: 11 Special Functions

1   Admit/Transfer Pt. (Nursing Pkg. Only)
2   Inactivate/Disch. Pt. (Nursing Pkg. Only)
3   Employee Activation/Separation Report
4   Manual Nursing Acuity/Separation Run
5   Unclassified AMIS 1106 Patients
6   Manhours Exception Print by Service
7   Unclassified Midnight Patients
8   Manhours Exception Print by Location
9   Position Control/Staff File Integrity Report

Screen Prints:

Select Special Functions Option: 1 Admit/Transfer Pt. (Nursing Pkg. Only)

Select PATIENT NAME: NURSPATIENT,ONE 12-28-44 000522146 SC VETERAN

Enter patient name.

NURSPATIENT, ONE has been admitted into the NURSING SYSTEM.
NURSING LOCATION: NUR 10E/ 3E

Enter appropriate nursing location.

NURSING BED SECTION: SURGICAL/ <RET>

Enter appropriate bedsection.

**Example:** If the patient has no previous entry in the Patient file then the following occurs:

Select PATIENT NAME: NURSPATIENT,TWO

Patient not admitted with MAS -- notify MAS

**Note:**
Patients entered in error through this option may be discharged through the Inactivate/Disch. Pt. (Nursing Pkg. Only) (NURSPT-INAC) option.

**Menu Access:**

The Admit/Transfer Pt. (Nursing Pkg. Only) option is accessed through the Special Functions option of the Nursing Features (all options) menu.
NURSPT-INAC

Inactivate/Disch. Pt. (Nursing Pkg. Only)

Description:

This option inactivates a patient's record from the Nursing System and tracks discharge time from the ward. It does not replace the ADT (MAS) function but is to be used when the MAS ADT software is not running. When patients are discharged through this option, they will not appear in either the AMIS or midnight unclassified patients report. The discharge date and time can be edited through this option. Data is obtained from the NURS Patient (#214) file.

Menu Display:

Select Nursing Features (all options) Option: 11  Special Functions

1  Admit/Transfer Pt. (Nursing Pkg. Only)
2  Inactivate/Disch. Pt. (Nursing Pkg. Only)
3  Employee Activation/Separation Report
4  Manual Nursing Acuity/Separation Run
5  Unclassified AMIS 1106 Patients
6  Manhours Exception Print by Service
7  Unclassified Midnight Patients
8  Manhours Exception Print by Location
9  Position Control/Staff File Integrity Report

Screen Prints:

Select Special Functions Option: 2  Inactivate/Disch. Pt. (Nursing Pkg. Only)

Select PATIENT NAME: NURSPATIENT,THREE  03-19-41  000320231  SC VETERAN

Enter patient name.

DATE/TIME DISCHARGED: NOW// <RET>  (AUG 22,1986 14:18)

Enter date/time patient was discharged.

NURSPATIENT, THREE is discharged from the Nursing System.

Example:

If the patient's discharge date/time (from the nursing location) were incorrectly entered, the following prompts would allow the user to edit the data. The date and time does not have to be identical with that stored by MAS.
Special Functions

Select PATIENT NAME: NURSPATIENT,FOUR 01-27-49 000788766 SC VETERAN

PATIENT HAS ALREADY BEEN DISCHARGED FROM THE NURSING SYSTEM. DO YOU WANT TO CHANGE THE DISCHARGE DATE? NO// Y (YES) DATE/TIME DISCHARGED: OCT 1,1986// 10/02 (OCT 2,1986)

Time is optional.

If for any reason the patient's discharge was canceled, the patient can be readmitted through the option, Admit/Transfer Pt. (Nursing Pkg. Only). This option is held by selected users (as identified by the nursing ADP Coordinator).

Select PATIENT NAME: <RET>

Menu Access:

The Inactivate/Disch. Pt. (Nursing Pkg. Only) option is accessed through the Special Functions option of the Nursing Features (all options) menu.
NURAED-BATSEP

Employee Activation/Separation Report

Description:

1. This report prints a staff activation/separation listing on demand or when queued for a specific date by a user. A report by day may be printed for any of the last 30 days. Data comes from the NURS AMIS Daily Exception Report (#213.5) file.

Additional Information:

Employee activation/separation data is entered through the Staff Record Edit option. This report is dependent upon whether the Nursing Acuity/Separation Batch Job has run to completion. The Employee Activation/Separation Report can be queued to print daily through the TaskManager Activation/Separation Report (NURAED-BATSEP-QUEUE) option.

Future Plans:

This report will print for a specified date range.

Menu Display:

Select Nursing Features (all options) Option: 11 Special Functions

1. Admit/Transfer Pt. (Nursing Pkg. Only)
2. Inactivate/Disch. Pt. (Nursing Pkg. Only)
3. Employee Activation/Separation Report
4. Manual Nursing Acuity/Separation Run
5. Unclassified AMIS 1106 Patients
6. Manhours Exception Print by Service
7. Unclassified Midnight Patients
8. Manhours Exception Print by Location
9. Position Control/Staff File Integrity Report

Screen Prints:

Select Special Functions Option: 3 Employee Activation/Separation Report

Select Date of Staff Activation/Separation Report: T-1// <RET> (JAN 29, 1992)

Enter appropriate date.

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Special Functions

Select FACILITY (Press return for all facilities): <RET>

Enter appropriate facility.

DEVICE: HOME//Enter appropriate response

ON THE REPORT DATE, ASSIGNMENTS FOR THE FOLLOWING EMPLOYEES WERE ACTIVATED/SEPARATED. THE STATUS INDICATORS WERE MODIFIED APPROPRIATELY:

<table>
<thead>
<tr>
<th>NAME</th>
<th>ACT/SEP</th>
<th>LOCATION</th>
<th>ST/VAC DT</th>
<th>POSITION</th>
<th>REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSNURSE, ONE</td>
<td>ACT</td>
<td>3AM</td>
<td>JAN 29, 1992</td>
<td>RN</td>
<td></td>
</tr>
<tr>
<td>NURSNURSE, TWO</td>
<td>ACT</td>
<td>3S</td>
<td>JAN 29, 1992</td>
<td>RN</td>
<td></td>
</tr>
<tr>
<td>NURSNURSE, THREE</td>
<td>SEP</td>
<td>MED 4I</td>
<td>JAN 29, 1992</td>
<td>LPN 3</td>
<td>TRANSFERRED</td>
</tr>
<tr>
<td>NURSNURSE, FOUR</td>
<td>ACT</td>
<td>3AM</td>
<td>JAN 29, 1992</td>
<td>RN</td>
<td></td>
</tr>
</tbody>
</table>

TOTAL EMPLOYEES SEPARATED/ACTIVATED: 4

The above report indicates that three employees were assigned to new locations (two to 3AM and one to 3S) on 1/29/92 and all assumed staff nurse positions. Another action shows that an LPN left the MED 4I ward on 1/29/92 for another assignment.

If no employee assignment or position changes were processed then the following report would print:

<table>
<thead>
<tr>
<th>NAME</th>
<th>ACT/SEP</th>
<th>LOCATION</th>
<th>ST/VAC DT</th>
<th>POSITION</th>
<th>REASON</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NO EMPLOYEES SEPARATED/ACTIVATED ON JAN 29, 1992

Menu Access:

The Employee Activation/Separation Report option is accessed through the Special Functions option of the Nursing Features (all options) menu.
NURAAM-ACUMAN

Manual Nursing Acuity/Separation Run

Description:

This option compiles the Patient Category Totals-AMIS 1106, Patient Category Totals-Midnight Acuity, manhour AMIS workload totals for the day and evening shifts, and Employee Activation/Separation Reports when TaskMan is down. It is a back-up for NURAAM-ACU (Nursing Acuity/Separation Run) option. This option should be run when members of the NURS-ADP mail group receive an alert stating that the batch job did not run or aborted prior to completion. Be sure that all appropriate staff are added to the NURS-ADP mail group (i.e., IRMS support staff, ADPAC, backup). Data comes from the NURS AMIS 1106 Manhours (#213.4) file, and the NURS Location (#211.4) file.

Additional Information:

Lost nursing acuity/separation data may be entered though the AMIS 1106 Acuity Edit option. This option should be assigned to appropriate supervisory staff.

Restrictions:

This option recovers classification totals from the date the last nursing acuity/separation batch job was run.

Menu Display:

Select Nursing Features (all options) Option: 11 Special Functions

1  Admit/Transfer Pt. (Nursing Pkg. Only)
2  Inactivate/Disch. Pt. (Nursing Pkg. Only)
3  Employee Activation/Separation Report
4  Manual Nursing Acuity/Separation Run
5  Unclassified AMIS 1106 Patients
6  Manhours Exception Print by Service
7  Unclassified Midnight Patients
8  Manhours Exception Print by Location
9  Position Control/Staff File Integrity Report

Screen Prints:

Select Special Functions Option: 4 Manual Nursing Acuity/Separation Run
Special Functions

******************************************************************************
******************************************************************************
*****                                                                    ****
*****                                                                    ****
*****                   ** WARNING -- SPECIAL RUNNING **                 ****
*****                                                                    ****
*****           THE PURPOSE OF THIS OPTION IS TO UPDATE THE NURSING      ****
*****           PACKAGE ACUITY-EMPLOYEE ACTIVATION/SEPARATION COUNTS     ****
*****           THIS ROUTINE SHOULD BE RUN IF TASKMAN IS INOPERABLE      ****
*****                                                                    ****
*****           CONTACT THE NURSING ADP COORDINATOR TO CONFIRM THAT THE  ****
*****           ACUITY (AMIS 1106) UPDATE WILL BE RUN TONIGHT VIA        ****
*****           TASKMAN.                                                 ****
*****                                                                    ****
*****                                                                    ****
******************************************************************************
******************************************************************************
Press RETURN to continue, or "^" to exit:

... BACKUP/NURSING ACUITY - EMPLOYEE SEP/ACT RUN .........................
..........................................................................
..........................................................................
..........................................................................
..........................................................................

If TaskMan had run this option as scheduled then the user would see:

...BACKUP/NURSING ACUITY - EMPLOYEE SEP/ACT RUN...
BATCH JOB ALREADY COMPLETED

Menu Access:

The Manual Nursing Acuity/Separation Run option is accessed through the Special Functions
option of the Nursing Features (all options) menu.
NURAAM-UNC

Unclassified AMIS 1106 Patients

Description:

1This option prints a daily listing of patients not classified by 3 pm, based on the patient's MAS location and date/time of admission, transfer, and discharge.

Additional Information:

2Patients in this report are not included in the Patient Category Totals-AMIS 1106 Reports. This option is a manual back-up to the NURAAM-UNCBAT (Batch Run of Unclassified AMIS 1106 Patients) option which is the TaskMan job that queues the unclassified listing to the CNO printer. The report is produced by the information generated from the NURAAM-ACU (Nursing Acuity/Separation Run) option or the NURAAM-ACUMAN (Manual Nursing Acuity/Separation Run) option. Unlike the NURAAM-UNCBAT option which only prints data from the last batch run, data for a specified date (through this option) can be retrieved for no more than the last 30 days. Data is stored in the NURS AMIS Daily Exception Report (#213.5) file.

This report is dependent upon whether the Nursing Acuity/Separation Batch Job has run to completion, and will not print until the batch job has finished its run. Location data is sorted in alphabetical order.

Menu Display:

Select Nursing Features (all options) Option: 11 Special Functions

1 Admit/Transfer Pt. (Nursing Pkg. Only)
2 Inactivate/Disch. Pt. (Nursing Pkg. Only)
3 Employee Activation/Separation Report
4 Manual Nursing Acuity/Separation Run
5 Unclassified AMIS 1106 Patients
6 Manhours Exception Print by Service
7 Unclassified Midnight Patients
8 Manhours Exception Print by Location
9 Position Control/Staff File Integrity Report

Screen Prints:

Select Special Functions Option: 5 Unclassified AMIS 1106 Patients
Select date of AMIS Exception report: T-1/ <RET> (OCT 08, 1996)

Enter appropriate date.

---
1 Patch NUR*4*2 October 1997
2 Patch NUR*4*2 October 1997
Special Functions

Select FACILITY (Press return for all facilities): <RET>

Enter appropriate facility.

DEVICE: Enter appropriate response

| UNIT: 2AS |
|------------------|--|----------|------------------|
| NURSPATIENT, FIVE -9394 | NOT CLASSIFIED | N/A |
| NURSPATIENT, SIX -3333  | NOT CLASSIFIED | N/A |
| NURSPATIENT, SEVEN -0987 | NOT CLASSIFIED | N/A |
| NURSPATIENT, EIGHT -4321 | NOT CLASSIFIED | N/A |
| NURSPATIENT, TWO -5612   | NOT CLASSIFIED | N/A |
| NURSPATIENT, NINE -2043  | NOT CLASSIFIED | N/A |
| NURSPATIENT, TEN -2322   | NOT CLASSIFIED | N/A |
| NURSPATIENT1, ONE -7382  | NOT CLASSIFIED | N/A |
| NURSPATIENT1, TWO -9467  | NOT CLASSIFIED | N/A |
| NURSPATIENT1, THREE -3411 | NOT CLASSIFIED | N/A |
| NURSPATIENT1, FOUR -9922 | NOT CLASSIFIED | N/A |

| UNIT: MICU |
|------------------|--|----------|------------------|
| NURSPATIENT1, FIVE -8989 | CLASS. NOT CURRENT | N/A |
| MAR 01, 1999@14:10 |
| NURSPATIENT1, SIX -2343 | CLASS. NOT CURRENT | N/A |
| MAR 01, 1999@14:10 |
| NURSPATIENT1, SEVEN -2222 | CLASS. NOT CURRENT | N/A |
| MAR 01, 1999@14:10 |

Definition of ERROR and ABSENCE column codes:

1. CLASS. NOT CURRENT - Last classification does not fall in the AMIS time frame of 12MN to 3PM.
2. NOT ADMITTED - Patient not admitted through the MAS ADT function.
3. NOT CLASSIFIED - Patient has never been classified since admission.
4. N/A - Not applicable (patient is not on any form of leave).
5. LEAVE - On authorized leave.
6. AWOL - Absent without leave.
7. ERROR - Patient was admitted through the NURSPT-ACT (Patient Admit/Transfer) option rather than through the MAS Package.

Menu Access:

The Unclassified AMIS 1106 Patients option is accessed through the Special Functions option of the Nursing Features (all options) menu.

---

1 Patch NUR*4*24 May 1999
NURAMN-STA

Manhours Exception Print by Service

Description:

This option provides a report of all wards by shift that have no manhours data entered for a specific date or date range, by service. Information listed assists the service in correcting the omitted manhours. Data comes from the NURS AMIS 1106 Manhours (#213.4) file, and the NURS Location (#211.4) file.

Additional Information:

Manhours data can be entered through the option, Manhours Edit, AMIS 1106 (NURAMN-MANED).

Menu Display:

Select Nursing Features (all options) Option: 11 Special Functions

1 Admit/Transfer Pt. (Nursing Pkg. Only)
2 Inactivate/Disch. Pt. (Nursing Pkg. Only)
3 Employee Activation/Separation Report
4 Manual Nursing Acuity/Separation Run
5 Unclassified AMIS 1106 Patients
6 Manhours Exception Print by Service
7 Unclassified Midnight Patients
8 Manhours Exception Print by Location
9 Position Control/Staff File Integrity Report

Screen Prints:

Select Special Functions Option: 6 Manhours Exception Print by Service

Select FACILITY (Press return for all facilities): <RET>

Enter appropriate facility.

Start With DATE: 9/15 (SEP 15, 1996)

Enter starting date of report.
Go to DATE: SEP 15, 1996/ <RET> (SEP 15, 1996)

Enter ending date of report. The date displayed as the default is the start date. You may enter another date which must be a time between the start date and today's date minus 1.

DEVICE: HOME/ Enter appropriate response

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>SHIFT</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEP 15, 1996</td>
<td></td>
</tr>
<tr>
<td>3AM</td>
<td>DAY</td>
</tr>
<tr>
<td>3AM</td>
<td>EVENING</td>
</tr>
<tr>
<td>3AM</td>
<td>NIGHT</td>
</tr>
<tr>
<td>3S</td>
<td>EVENING</td>
</tr>
<tr>
<td>5E</td>
<td>DAY</td>
</tr>
<tr>
<td>9E</td>
<td>DAY</td>
</tr>
<tr>
<td>9E</td>
<td>EVENING</td>
</tr>
<tr>
<td>9E</td>
<td>NIGHT</td>
</tr>
<tr>
<td>AS</td>
<td>DAY</td>
</tr>
<tr>
<td>AS</td>
<td>EVENING</td>
</tr>
<tr>
<td>AS</td>
<td>NIGHT</td>
</tr>
<tr>
<td>SICU</td>
<td>DAY</td>
</tr>
<tr>
<td>SICU</td>
<td>EVENING</td>
</tr>
<tr>
<td>SICU</td>
<td>NIGHT</td>
</tr>
</tbody>
</table>

Menu Access:

The Manhours Exception Print by Service option is accessed through the Special Functions option of the Nursing Features (all options) menu.
NURAAM-MD-UNC

Unclassified Midnight Patients

Description:

1. This option prints a daily listing of patients not classified by midnight.

Additional Information:

2. This option is a manual back-up to the TaskMan job NURAAM-MD-UNCBAT option which may be queued to print the unclassified listing on the CNO printer. The report is produced by the information generated from the NURAAM-ACU (Nursing Acuity/Separation Run) option or the NURAAM-ACUMAN (Manual Nursing Acuity/Separation Run) option. Unlike the NURAAM-MD-UNCBAT option which only prints data from the last batch run, data (through this option) can be retrieved for no more than the last 30 days. Data is stored in the NURSAMIS Daily Exception Report (#213.5) file.

The Unclassified Midnight Patients report is dependent upon whether the Nursing Acuity/Separation Batch Job has run to completion. Location data is sorted in alphabetical order.

Menu Display:

Select Nursing Features (all options) Option: 11 Special Functions

1. Admit/Transfer Pt. (Nursing Pkg. Only)
2. Inactivate/Disch. Pt. (Nursing Pkg. Only)
3. Employee Activation/Separation Report
4. Manual Nursing Acuity/Separation Run
5. Unclassified AMIS 1106 Patients
6. Manhours Exception Print by Service
7. Unclassified Midnight Patients
8. Manhours Exception Print by Location
9. Position Control/Staff File Integrity Report

Screen Prints:

Select Special Functions Option: 7 Unclassified Midnight Patients
Select date of MIDNIGHT ACUITY Exception report: T-1// <RET> (APR 08, 1990)

Enter appropriate date.

Select FACILITY (Press return for all facilities): <RET>

Enter appropriate facility.
Special Functions

DEVICE: Enter appropriate response

<table>
<thead>
<tr>
<th>UNIT</th>
<th>PATIENT NAME - SSN LAST FOUR</th>
<th>ERROR</th>
<th>ABSENCE</th>
<th>CLASSIFIED</th>
</tr>
</thead>
<tbody>
<tr>
<td>2AS</td>
<td>NURSPATIENT, FIVE - 9394</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT, SIX - 3333</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT, SEVEN - 0987</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT, EIGHT - 4321</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT, TWO - 5612</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT, NINE - 2043</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT, TEN - 2322</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT1, EIGHT - 7382</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT1, TWO - 9467</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT1, THREE - 3411</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT1, FOUR - 9922</td>
<td>NOT CLASSIFIED</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>MICU</td>
<td>NURSPATIENT1, FIVE - 8989</td>
<td>CLASS. NOT CURRENT</td>
<td>N/A</td>
<td>MAR 01, 1999@14:10</td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT1, SIX - 2343</td>
<td>CLASS. NOT CURRENT</td>
<td>N/A</td>
<td>MAR 01, 1999@14:10</td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT1, SEVEN - 2222</td>
<td>CLASS. NOT CURRENT</td>
<td>N/A</td>
<td>MAR 01, 1999@14:10</td>
</tr>
<tr>
<td></td>
<td>NURSPATIENT, SIX - 3333</td>
<td>CLASS. NOT CURRENT</td>
<td>N/A</td>
<td>MAR 01, 1999@14:10</td>
</tr>
</tbody>
</table>

Definition of ERROR and ABSENCE column codes:

1. CLASS. NOT CURRENT - Last classification does not fall in the AMIS time frame of 12MN to 3PM.
2. NOT ADMITTED - Patient not admitted through the MAS ADT function.
3. NOT CLASSIFIED - Patient has never been classified since admission.
4. N/A - Not applicable (patient is not on any form of leave).
5. LEAVE - On authorized leave.
6. AWOL - Absent without leave.
7. ERROR - Patient was admitted through the NURSPT-ACT (Patient Admit/Transfer) option rather than through the MAS Package.

Menu Access:

The Unclassified Midnight Patients option is accessed through the Special Functions option of the Nursing Features (all options) menu.

---

1 Patch NUR*4*24  May 1999
NURAMN-STA-LOC

Manhours Exception Print by Location

Description:

This option provides a report, by user selected location, of dates and shifts which have no manhours data. Data comes from the NURS AMIS 1106 Manhours (#213.4) file, and the NURS Location (#211.4) file.

Additional Information:

This option can be given to the head nurse.

Menu Display:

Select Nursing Features (all options) Option: 11 Special Functions

1  Admit/Transfer Pt. (Nursing Pkg. Only)
2  Inactivate/Disch. Pt. (Nursing Pkg. Only)
3  Employee Activation/Separation Report
4  Manual Nursing Acuity/Separation Run
5  Unclassified AMIS 1106 Patients
6  Manhours Exception Print by Service
7  Unclassified Midnight Patients
8  Manhours Exception Print by Location
9  Position Control/Staff File Integrity Report

Screen Prints:

Select Special Functions Option: 8 Manhours Exception Print by Location

Select Nursing Unit: 3AM

Start With DATE: T-3 (JUN 11, 1990)

Enter starting date of report.

Go to DATE: JUN 11, 1990// T-1 (JUN 13, 1990)

Enter ending date of report. The date displayed as the default is the start date. You may enter another date which must be a time between the start date and today's date minus 1.

DEVICE: HOME//Enter appropriate response
### Menu Access:

The Manhours Exception Print by Location option is accessed through the Special Functions option of the Nursing Features (all options) menu.
NURS-COMP

Position Control/Staff File Integrity Report

Description:

1This option is an exception report that identifies discrepancies between the NURS Staff (#210) file and the NURS Position Control (#211.8) file, which could affect the accuracy of many of the administrative reports. The following is a list of discrepancies that are identified by this report and the corrective action that may be taken to correct the discrepancies:

a. Staff record has no corresponding New Person (#200) file entry.
   IRM should repoint the record in question to the appropriate New Person (#200) file entry, or delete the record through FileMan (^DIK), or delete the record through the FileMan Enter/Edit Option.

b. Staff record contains missing/invalid data in the Name field .01.
   IRM should enter a valid New Person (#200) file pointer in the staff record, or delete the record through FileMan (^DIK), or delete the record through the FileMan Enter/Edit Option.

c. Staff record has missing/invalid Status data in field 5.5.
   The user should enter status data in the staff record using the Status/Position [NURAED-STF-STAT/POS] option of the Staff Record Edit [NURAED-STF-MENU] menu.

d. Staff record is missing the 'B' index entry.
   IRM should set the 'B' index for the record in question using EN1^DIK.

e. Staff Employee has 'ACTIVE' status and no active file 211.8 assignment(s).
   User should inactivate staff record, or enter an assignment for the employee in question using the Status/Position option of the Staff Record Edit.

f. Staff Record has 'B' index entry and no data on zeroth node.
   IRM should kill the erroneous 'B' index entry using the KILL command.

g. File (#211.8) contains duplicate assignment entries for an employee.
   IRM should identify the inappropriate assignments and inactivate them by entering a vacancy date via the global edit utility, or delete the assignments with the KILL command from programmer mode.

1 Patch NUR*4*6 January 1998
1h. File (#211.8) contains assignments with no corresponding staff record. IRM should enter the data for the staff record using the Status and Position option of the Staff Record Edit, or delete the assignments from the position control file using the KILL command from programmer mode.

i. File (#211.8) contains active assignments for inactive nursing locations. The user should inactivate the assignments using the Status and Position option of the Staff Record Edit.

After correction of the aforementioned discrepancies this report should be re-run until the message 'No discrepancies were found between the 210 and 211.8 files.' is generated.

Additional Information:

SPECIAL NOTE: NEVER delete a duplicate entry in the New Person file but modify the employee's name by entering a ZZ or X as leading characters before the last name. FileMan cannot guarantee that pointers will be correctly updated.

Menu Display:

Select Nursing Features (all options) Option: 11 Special Functions

1 Admit/Transfer Pt. (Nursing Pkg. Only)
2 Inactivate/Disch. Pt. (Nursing Pkg. Only)
3 Employee Activation/Separation Report
4 Manual Nursing Acuity/Separation Run
5 Unclassified AMIS 1106 Patients
6 Manhours Exception Print by Service
7 Unclassified Midnight Patients
8 Manhours Exception Print by Location
9 Position Control/Staff File Integrity Report

Screen Prints:

Select Special Functions Option: 9 Position Control/Staff File Integrity Report

2 This option generates an exception report that identifies the following discrepancies between the NURS Staff (#210) and the NURS Position Control (#211.8) Files:

---

1 Patch NUR*4*6 January 1998
2 Patch NUR*4*6 January 1998
a. Staff record has no corresponding New Person (#200) file entry.
b. Staff record contains missing/invalid data in the Name field .01.
c. Staff record has missing/invalid Status data in field 5.5.
d. Staff record missing the 'B' index entry.
e. Staff Employee has 'ACTIVE' status and no active file 211.8 assignment(s).
f. Staff Record has 'B' index entry and no data on zeroth node.
g. File (#211.8) contains duplicate assignment entries for an employee.
h. File (#211.8) contains assignments with no corresponding staff record.
i. File (#211.8) contains active assignments for inactive nursing locations.

Do you want the discrepancy report queued to a printer?
Enter Yes or No: NO/<RET>

Checking the NURS Staff (#210) File.................................
................................................................................
................................................................................
Checking the NURS Position Control (#211.8) File.....

NURS POSITION CONTROL/NURS STAFF File Integrity Report JAN 21, 1998 PAGE: 1
RECORD#     NAME
DISCREPANCY  
--------------------------------------------------------------------------------
2         NURSNURSE, FIVE
STAFF RECORD MISSING THE 'B' INDEX ENTRY.
8         NURSNURSE, SIX.
STAFF RECORD HAS ACTIVE STATUS AND NO CURRENT FILE 211.8 ASSIGNMENT(S).
10        ** INVALID NAME DATA **
STAFF RECORD HAS NO CORRESPONDING NEW PERSON (#200) FILE ENTRY.
STAFF RECORD CONTAINS MISSING/INVALID STATUS DATA.
15        ** INVALID NAME DATA **
STAFF RECORD HAS NO CORRESPONDING NEW PERSON (#200) FILE ENTRY.
STAFF RECORD CONTAINS MISSING/INVALID DATA IN NAME FIELD.
STAFF RECORD MISSING THE 'B' INDEX ENTRY.
192       ** INVALID NAME DATA **
STAFF RECORD HAS NO CORRESPONDING NEW PERSON (#200) FILE ENTRY.
297         NURSNURSE, SEVEN
STAFF RECORD HAS ACTIVE STATUS AND NO CURRENT FILE 211.8 ASSIGNMENT(S).
8912       NURSNURSE, EIGHT
STAFF RECORD HAS ACTIVE STATUS AND NO CURRENT FILE 211.8 ASSIGNMENT(S).
9999999   POSTMASTER
STAFF RECORD HAS `B' INDEX ENTRY AND NO DATA ON ZEROTH NODE.

Enter RETURN to continue or '^' to exit: <RET>
The following assignments are duplicates in the NURS Position Control (211.8) File. To deactivate a specific assignment use the global root ^NURSF(211.8, and the global reference indicated for that assignment:

69,1,11,0) NURSNURSE,ONE RN MICU 1 02/05/91
69,1,12,0) NURSNURSE,ONE RN MICU 1 02/05/91
Enter RETURN to continue or '^' to exit: <RET>

The following assignments have no corresponding Nurs Staff (#210) File entry. To remove the assignment use the global root ^NURSF(211.8, and the global reference indicated for that assignment:

31,1,29,0) NURSNURSE,NINE RN SICU 1 07/17/90
31,1,25,0) NURSNURSE,FIVE HN SICU 1 01/01/94
Enter RETURN to continue or '^' to exit: <RET>

The following active employees are assigned to inactive nursing locations. To deactivate or edit a specific assignment use the Status and Position Option [NURAED-STF-STAT/POS] of the Staff Record Edit:

NURSNURSE,TEN RN 11W .1 07/17/90
NURSNURSE1,ONE RN 10W .8 07/17/90
NURSNURSE1,TWO RN 10W 0 07/17/90
NURSNURSE1,THREE NUR PRACT 3M 0 07/17/90
NURSNURSE1,FOUR CLER 10E 1 07/17/90
NURSNURSE1,FIVE NA 5 3M .5 07/17/90
NURSNURSE1,SIX RN 15E .1 11/26/93
NURSNURSE1,SEVEN INFEC C RN 11W .7 07/17/90
NURSNURSE1,EIGHT RN 10E .8 07/17/90
NURSNURSE1,NINE CNS/T 6E 1 08/29/95
NURSNURSE1,TEN RN 10W .1 07/17/90
Enter RETURN to continue or '^' to exit: <RET>

If no discrepancies are found, a message stating that there are no discrepancies is printed.

Menu Access:

The Position Control/Staff File Integrity Report option is accessed through the Special Functions option of the Nursing Features (all options) menu.

---

1 Patch NUR*4*6 January 1998
Chapter 5 Warnings and Messages

This section contains explanations of warnings and messages generated by the nursing software.

Classification Warning Message

A message is displayed on the terminal when a user wishes to classify a patient and the tasked background batch job, NURAAM-ACU (NURSING ACUITY/ SEPARATION RUN), has not run. The warning is shown when the user enters any classification edit; it does not affect the options associated with hemodialysis and recovery room counts. The following is an example of the warning displayed when classifying by ward:

Select Classification, Edit Patient Option: 2 Classify Patients by Ward

ENTER UNIT YOU WANT TO SEARCH: 3S

The classification routine begins to display the names of the patients on the unit/ward.

Begin updating patient classifications.

NURSPATIENT1, NINE OK? YES//<RET>

The software then completes a check on the background job. If the job does not run to completion, the warning displays.

********************************************************************************
*****                                                                      *****
*****                                                                      *****
*****                    NOTIFY NURSING ADP COORDINATOR                    *****
*****                                                                      *****
*****                  THIS CALL MUST BE MADE IMMEDIATELY                  *****
********************************************************************************

The user should then notify the nursing ADP Coordinator or supervisor.
Warnings and Messages

NURSPATIENT1, TEN OK? YES// ^

**** ROUTINE FINISHED ****

Action: The nursing ADP Coordinator/designee should initiate the steps below.
Users must wait until the following process has been completed before on-line classification can be resumed.

a. Select: Nursing Systems Manager's Menu (NURS-SYS-MGR)
b. Select: Nursing Features (all options)
c. Select: Special Functions
d. Select: Manual Nursing Acuity/Separation Run

Select Special Functions Option: 4 Manual Nursing Acuity/Separation Run

Press RETURN to continue, or "^" to exit: <RET>

DEVICE: HOME//Enter appropriate response

... BACKUP/NURSING ACUITY - EMPLOYEE SEP/ACT RUN ............................
................................................................................
................................................................................
................................................................................
................................................................................
...

After this message, press return to continue. Refer to Maintenance of Clinical Site Files chapter for additional information.
**Patient Not Admitted Due to Invalid MAS Ward**

If the relationship (cross-reference) between the MAS ward and nursing location is lost or does not exist in the NURS Location (#211.4) file, the following message appears.

```
NURSPATIENT2, ONE has not been admitted into the Nursing System by MAS, because 3E (MAS ward) does not have a corresponding nursing unit.
```

If the CNO printer field in the NURS Parameters file exists the above message will be printed on the CNO printer. If the CNO printer field is not defined, Nursing staff will be notified that the patient is not in the system when classification is attempted.

Refer to Package Management chapter of the User Manual or the Technical Manual for further information regarding the CNO printer.

**Action:** Determine if the Nursing Location file should be modified. Refer to Maintenance of Administrative Site files chapter.
Patient Not Admitted With MAS

The following message is displayed when the patient's name has not been entered in the Patient (#2) file:

Select PATIENT NAME: NURSPATIENT2, TWO

Patient not admitted with MAS -- notify MAS

Action: Notify MAS that the patient has not been entered in the Patient (#2) file.
Patient Is Not Active In The Nursing System

The following message is displayed when a patient does not have an active status in the Nursing System. Either MAS has not admitted the patient into the MAS System, or there was a problem with the MAS Nursing System interface.

Select PATIENT NAME: NURSPATIENT2, THREE 02-25-36 000334455

Patient is not active in the Nursing system -- notify Nursing ADP Coordinator

Action: Notify MAS if the patient has not been admitted through their package. Admission into the nursing software will be automatic at the time of the MAS admission. If the MAS software is down or admission into the nursing software must be expedited, the nursing ADP Coordinator may enter the patient into the nursing software through the Admit/Transfer Pt. (Nursing Pkg. Only) option (refer to Special Functions chapter).
Warnings and Messages

**Incomplete User/Person Data**

The following message may appear while attempting to run a report which contains nursing personnel data:

```
****INCOMPLETE USER/NEW PERSON DATA--NOTIFY NURSING ADP COORDINATOR****
```

Action: The Nursing ADP Coordinator must contact IRMS to have the New Person entries for the employee reviewed for missing information.
**Incomplete Nursing Data**

The following message may appear while attempting to run a report which contains nursing employee data:

```
****INCOMPLETE NURSING DATA--NOTIFY NURSING ADP COORDINATOR****
```

Action:

a. The Nursing ADP coordinator or designee must create or modify the Staff Record of the person who had this problem. Enter the Staff Record, Enter/ Edit option and verify that the employee has a record, primary position, and location.

b. If the employee's record is complete (i.e., service position and primary location are present), then ask an IRMS staff member to check the New Person (#200) file for the existence of a duplicate entry.

SPECIAL NOTE: NEVER delete a duplicate entry in the New Person file but modify the employee's name by entering a ZZ or X as leading characters before the last name. FileMan cannot guarantee that pointers will be correctly updated.
Warnings and Messages

Incomplete Service Position Data

The following message may appear while attempting to run a report which contains personnel data:

****INCOMPLETE SERVICE POSITION DATA--NOTIFY ADP COORDINATOR****

Action: The Nursing ADP Coordinator must check the NURS Service Position File (#211.3) to establish if all the data fields describing the service position have been completed. In most cases the AMIS position field will be lacking the appropriate information to run the report. Refer to Maintenance of Administrative Site Files chapter for additional information.
Nursing Alerts

Two alerts have been added to alert members of the NURS-ADP mail group that the manhours or AMIS classification batch job did not run or aborted prior to completion. The alerts appear as follows:

a. The AMIS Acuity-Sep/Act Batch job for MAY 3, 1995* was not completed.

b. The Nursing Sep/Act batch job for MAY 3, 1995* was not completed.

* Data in italics is representative of the information displayed in the alerts.
Warnings and Messages
Chapter 6 IRMS Options

NURS-EXP

NURS Staff Experience Integrity Check/Fix

Description:

This option checks, cleans and re-crossreferences the Nurstaff Experience Sub-File.

Additional Information:

This option can only be invoked by IRMS staff. Before running this option the user must stop
journaling of the ^NURS(210, global, make a backup of the NURS Staff (#210) file, and turn the
Nursing Package off-line. This option does the following:

1. Clean NURS Staff 210 sub-file 22.5.
2. Change pointer code on zero node to freetext.
3. Delete zero nodes that have no entries or cross-references.
4. Populate missing .01 fields that have a cross-reference.
5. Convert pointers in .01 fields to freetext.
6. Convert lower case entries to upper case.
7. Delete experiences that are not in the Experience File.
8. Match up entries and cross-references, eliminating duplicate
cross-references.
9. Re-crossreference sub-file 22.5.

Menu Display:

This option can only be invoked by IRMS staff.

Screen Prints:

>^ ^NURSEXP  NURS Staff Experience Integrity Check/Fix

This option checks the integrity of the NURS Staff File's Experience sub-file
in field 22.5, and makes the following error corrections when necessary:
IRM Options

a. Converts pointer values in the Name field to free text values.
b. Removes records with no data or cross-references.
c. Rebuilds missing Name entries that have a valid 'B' index entry.
d. Converts lower case Name entries to upper case.
e. Deletes experience entries missing from the NURS Clinical Background File.
f. Deletes duplicate cross-references.

Enter RETURN to continue or '^' to exit: <RET>

Checking Experience sub-file for deficiencies, fixing where necessary.
............................................................................
............................................................................
................................
Done...

Enter RETURN to continue or '^' to exit:

**Menu Access:**

This option can only be invoked by IRMS staff.
**NURS-PURG**

**Classification File Purge**

**Description:**

This option deletes or purges data, from the NURS Classification (#214.6) and NURS Review Classification (#214.7) classification globals, for a user specified date not later than six months. The nursing ADP Coordinator or IRMS (after conferring with nursing) can invoke this option to free computer disc space. Once it has been run the data is erased from Files #214.6 (NURS Classification) and #214.7 (NURS Review Classification). The Nursing Focus Group recommends that six months of data be retained, but this may be modified by IRMS based on the service/medical center policy. This purge function does not delete data from the 213.1 or 213.4 files which store acuity totals for quarterly AMIS and workload statistics reports. Data comes from the NURS Staff (#210) file, and the NURS Position Control (#211.8) file.

**Additional Information:**

This option can only be invoked by IRMS staff.

**Menu Display:**

This option can only be invoked by IRMS staff.

**Screen Prints:**

```>D EN1^NURSADEL  Classification File Purge
Has Nursing been contacted before purging data from files 214.6 and 214.7? YES/<RET>

Has journaling of ^NURSA global been stopped? YES/<RET>

Note: Journaling keeps a record of every set and kill. This information is unnecessary and does not need to be stored as it consumes disc space. Therefore, IRMS should be notified to turn off journaling.


Are you sure you want to delete data older than DEC 22, 1996? YES/<RET> (YES)```
Purging 214.6 data ..........  

Purging 214.7 data ..........  
Reindexing File 214.6  
.............................................................................  
.............................................................................  
.............................................................................  
.............................................................................  
.............................................................................  
.............................................................................  
Reindexing File 214.7  
.............................................................................  
.............................................................................  
.............................................................................  

Purge is completed, journaling for the ^NURSA global should be restarted!

Note: An alert is sent when purge is completed.

Menu Access:

This option can only be invoked by IRMS staff.
Chapter 7 Maintenance of Performance Improvement Site Files

NURQA-SITEFILE

QI Site Files

Description:

This section explains the options which edit the QI Summary site files. Entries are stored in the NURQ Standards of Care/Practice (#217.1) file, the NURQ Rationale (#217.2) file and the NURQ Frequency (#217.3) file.

Additional Information:

This information is used in creating and editing a QI summary record. Refer to Section 5 for additional information.

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1 Administration Records, Enter/Edit ...
2 Administration Records, Print ...
3 Administrative Site File Functions ...
4 Nursing Education Reports, Print ...
5 Patient Care Data, Enter/Edit ...
6 Patient Care Data, Print ...
7 Clinical Site File Functions ...
8 QI Data, Enter/Edit ...
9 Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Option: 10 QI Site Files

1 QI Summary Standards of Care/Practice File
2 QI Summary Frequency File
3 QI Summary Rationale File

Menu Access:

The QI Site Files option is accessed through the Nursing Features (all options) menu.
NURQA-PT-ESCP

QI Summary Standards of Care/Practice File

Description:

This option allows the user to enter specific nursing Standards of Care and Practice into the NURQ Standards of Care/Practice (#217.1) file.

Additional Information:

Standards of Care and Practice are associated with each QI Summary record. Refer to Section 5 for additional information.

Menu Display:

Select Nursing Features (all options) Option: 10 QI Site Files

1 QI Summary Standards of Care/Practice File
2 QI Summary Frequency File
3 QI Summary Rationale File

Screen Prints:

Select QI Site Files Option: 1 QI Summary Standards of Care/Practice File
Select NURQ STANDARDS OF CARE/PRACTICE NAME OF STANDARD: THE PATIENT WILL NOT HAVE ANY COMPLICATIONS
Are you adding 'THE PATIENT WILL NOT HAVE ANY COMPLICATIONS' as a new NURQ STANDARDS OF CARE/PRACTICE (the 8TH)? No// Y (YES)

Answer with name of standard of care or practice.

NAME OF STANDARD: THE PATIENT WILL NOT HAVE ANY COMPLICATIONS//<RET>

You may edit name of standard.

TYPE OF STANDARD: CARE

Identify the standard as a standard of Care or Practice.
Enter "c" for CARE or "p" for PRACTICE.

SERVICE: NURSING SERVICE

Enter the service associated with this standard.
**Menu Access:**

The QI Summary Standards of Care/Practice File option is accessed through the QI Site Files option of the Nursing Features (all options) menu.
NURQA-PT-FRE

QI Summary Frequency File

Description:

This option allows the user to edit data in the NURQ Frequency (#217.3) file. The frequency data describes the time frame used to collect and report QI Summary report information.

Additional Information:

This information is used in creating and editing a QI Summary record. Refer to Section 5 for additional information.

Menu Display:

Select Nursing Features (all options) Option: 10 QI Site Files

1  QI Summary Standards of Care/Practice File
2  QI Summary Frequency File
3  QI Summary Rationale File

Screen Prints:

Select QI Site Files Option: 2 QI Summary Frequency File
Select NURQ FREQUENCY: BIWEEKLY
Are you adding 'BIWEEKLY' as a new NURQ FREQUENCY (the 8TH)? No//Y (YES)

Answer with appropriate frequency.

The following is a list of choices:
ANNUALLY
BIMONTHLY
DAILY
MONTHLY
QUARTERLY
SEMIANNUALLY
WEEKLY

FREQUENCY: BIWEEKLY//<RET>

You may edit frequency.
Menu Access:

The QI Summary Frequency File option is accessed through the QI Site Files option of the Nursing Features (all options) menu.
NURQA-PT-RAT

QI Summary Rationale File

Description:

This option allows the user to edit data in the NURQ Rationale (#217.2) file. The rationale data describes the rationale used to collect and report QI Summary report information.

Additional Information:

This information is used in creating and editing a QI Summary record. Refer to Section 5 for additional information.

Menu Display:

Select Nursing Features (all options) Option: 10 QI Site Files

1 QI Summary Standards of Care/Practice File
2 QI Summary Frequency File
3 QI Summary Rationale File

Screen Prints:

Select QI Site Files Option: 3 QI Summary Rationale File
Select NURQ RATIONALE: HIGH COST
  Are you adding 'HIGH COST' as a new NURQ RATIONALE (the 4TH)? No// Y (YES)

Answer with appropriate rationale.

The following is a list of choices:
  HIGH RISK
  HIGH VOLUME
  PROBLEM PRONE

RATIONALE: HIGH COST// <RET>

You may edit rationale.

Menu Access:

The QI Summary Rationale File option is accessed through the QI Site Files option of the Nursing Features (all options) menu.
Section 2 Administration
Chapter 1 Package Operation

Having completed the instructions for implementing the software as indicated in the Package Management section, you are now ready to use the options. The content contained in the following sections provides information on all software options which can be assigned to nursing personnel. This information includes the name, description or purpose of the option, screen prints, menu access, and other information that supports the use of the options.

Remember that on-line help is available when questions arise. The user can type ? or ??, after any prompt to get a help message that generally tells the user what to do. In some instances, a specific list of possible responses is displayed. All field names in the Nursing application have descriptions associated with them. Help is also available at the menu level by typing a ??, ???, or ?OPTION.

For the purpose of summarizing multiple types of reports and their sort sequences we have modified the display of the reports in this manual. After a sample report is displayed (e.g., certification reports by location and service category), the manual then displays another example (e.g., certification reports by service and service category). What is not displayed is the user’s exit from the report and the return back to the menu.
Chapter 2 Staff Record

NURAED-STF-MENU

Staff Record Edit

Description:

The Staff Record Edit option allows the service to track employee data by storing demographic, service related and professional information in an individual’s electronic record. Staff data comes from the NURS Staff (#210) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file.

Additional Information:

This information is used to compile hospital nursing reports, AMIS 1106b reports, and other VACO nursing reports. Refer to the Staff Record Report, Administration Reports, AMIS, FTEE/Workload Reports for additional information. The Employee Location Edit option edits selected nursing position control information in the Staff Record.

These options should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and other key nursing personnel identified by the Chief, Nursing Service.

Menu Display:

Select Nursing Features (all options) Option: 1  Administration Records, Enter/Edit

Location Edit, Employee
Manhours Edit, AMIS 1106a
Staff Record Edit ...

Screen Prints:

Select Administration Records, Enter/Edit Option: Staff Record Edit

Select Nursing Service Staff Name: NURSNURSE, ONE

If your IRMS allows you to add new personnel to the New Person file then the following prompt is displayed:
Are you adding ‘NURSNURSE, ONE’ as a new NEW PERSON?  Y (Yes)

A “Soundex” cross-reference checks for potential duplicates. This helps to avoid duplicate entries.

Checking SOUNDEX for matches.
NURSNURSE2, ONE
Do you still want to add this entry: NO// Y (Yes)

NEW PERSON SSN: 000607942

Enter SSN of employee. Answer must be 9 numerics in length.

The following data is entered in a new employee's NURS Staff file record. You must complete all prompts. If the data is not entered, you may receive the message,

*****INCOMPLETE NURSING DATA--NOTIFY NURSING ADP COORDINATOR*****

when running certain reports. Before the reports can be printed, the employee's record(s) must be completed.

If the employee has already been entered into the New Person file, then only the following prompts are displayed:

Are you adding ‘NURSNURSE, ONE’ as a new NURS STAFF (the 172ND)? No// Y (YES)

PRIMARY POSITION START DATE: T (JAN 04, 1991)

Enter starting date for the primary position.

PRIMARY DUTY LOCATION: NHCU ACTIVE

Enter NURS location name.

PRIMARY SERVICE POSITION: RN STAFF NURSE

Enter NURS service position abbreviation, name, or priority sequence.

After entering the above data, the employee's appointment status and FTEE must be entered through the Status and Position option of the Staff Record Edit menu. Refer to the Status and Position option for additional information.

The Staff Record Edit menu below, allows the user to enter employee information by subject area.
1 Demographic Data
2 Personnel Data
3 Status and Position
4 License
5 Probationary Period/Promotion
6 Annual Review/NPSB
7 Professional Education
8 Professional Experience
9 National Certification
10 Military Status
ALL Edit All Employee Data

On the following pages, the entry of status and position data into the staff record is reviewed.
**NURAED-STF-DEMO**

**Demographic Data**

**Description:**

This option allows editing of the employee's demographic data (i.e., name, address, SSN, phone). Data is stored in the NURS Staff (#210) file.

**Additional Information:**

This information is reflected in the Staff Record Report, Gender Reports, and telephone listings. This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, nurse managers and others as identified by the Chief, Nursing Service.

**Menu Display:**

1  Demographic Data
2  Personnel Data
3  Status and Position
4  License
5  Probationary Period/Promotion
6  Annual Review/NPSB
7  Professional Education
8  Professional Experience
9  National Certification
10 Military Status
ALL  Edit All Employee Data

**Screen Prints:**

Select Staff Record Edit Option: 1  Demographic Data

EMPLOYEE: NURSNURSE, ONE  RN  
SSN:  If the SSN had not been previously entered then this field would remain blank until the information is entered.

Nursing Employee Demographic Data Edit.

NAME: NURSNURSE, ONE// <RET>

Enter name of employee. Answer must be 3-30 characters in length.
SEX: F  FEMALE

Enter gender of employee.

DOB: 6/6/61  (JUN 6, 1961)

Enter date of birth of employee.

SSN: 000607942  NURSNURSE, ONE

Enter SSN of employee. Answer must be 9 numerics in length.

The next set of prompts pertains to home address. Based on the information in the record you have to make one of the following choices:

1. If home address information has not previously been entered you are prompted to enter the address data.
2. If information has been previously entered, the address is displayed with the prompt.

Do you wish to edit the home address (Y/N) Y

Based on the user response, you may bypass the editing of the address field by answering N (NO), or edit the data (see below) by answering Y (YES).

STREET ADDRESS 1: 6234 STEWART DRIVE

Enter first line of street address. Answer must be 2-50 characters in length.

STREET ADDRESS 2 AND 3 can be used at the discretion of the user.

STREET ADDRESS 2: <RET>

Enter second line of street address. Answer must be 2-50 characters in length.

STREET ADDRESS 3: <RET>

Enter third line of street address. Answer must be 2-50 characters in length.

CITY: WILLOWBROOK

Enter employee's city. Answer must be 2-30 characters in length.

STATE: ILLINOIS

Enter employee's state.

ZIP CODE: 45634

Enter employee's ZIP CODE or ZIP+4.
The next group of prompts pertain to the mailing address:

1. If mailing address information has not previously been entered, then you are prompted with:

   Do you want the mailing address the same as the home address? NO/

   If you answer Y (Yes) then the home address is automatically entered in the file.

2. If N (NO) was entered as the response, the user receives prompts to enter mailing address.

3. If mailing address information has been previously entered,

   Do you wish to edit the mailing address (Y/N) Y

   (for yes) is displayed as the default. If you enter N (NO), the mailing address prompts are not displayed until you reenter the option. If you answer Y, then the following fields are displayed:

   MAILING ADDRESS: P.O. BOX 456

   Enter first line of mailing address. Answer must be 2-50 characters in length.

   MAILING ADDRESS 2 AND 3 can be used at the discretion of the user.

   MAILING ADDRESS 2: <RET>

   Enter second line of mailing address. Answer must be 2-50 characters in length.

   MAILING ADDRESS 3: <RET>

   Enter third line of mailing address. Answer must be 2-50 characters in length.

   MAILING CITY: WILLOWBROOK

   Enter city of mailing address. Answer must be 2-30 characters in length.

   MAILING STATE: ILLINOIS

   Enter state where mailing address is located.

   MAILING ZIP CODE: 35423-4567

   Enter ZIP CODE or ZIP+4 of mailing address.

The next section displays prompts for telephone number:
Select TELEPHONE NUMBER: **555-6543**

Enter employee's telephone number.

**OWNER OF TELEPHONE NUMBER: S SELF**

Indicates owner of the phone number (i.e., self, relative, neighbor or other). The following is a list of choices:

- **S** Self
- **R** Relative
- **N** Neighbor
- **O** Other

Select TELEPHONE NUMBER: `<RET>`

You may enter another telephone number.

**Example: Editing Telephone Number**
The telephone number is a multiple field; only the most recent entry displays. The entry of a new phone number at the 'Select TELEPHONE NUMBER' prompt (refer to prompt below) does not delete the telephone number displayed. Enter a ? (question mark) to see the individual's phone numbers and select the number you want deleted. When that phone number displays, enter an @ to delete the entry (see below).

Select TELEPHONE NUMBER: **555-6081// <RET>`

Enter telephone number.

```
TELEPHONE NUMBER: 555-6081// @
SURE YOU WANT TO DELETE THE ENTIRE '555-6081' TELEPHONE NUMBER? Y
```

Select TELEPHONE NUMBER: `<RET>`

The last section in this option identifies people to contact if an emergent situation arises:

Select NAME OF EMERGENCY CONTACT: **NURSSPOUSE, ONE**

Enter name of 'emergency contact'.

**RELATIONSHIP TO STAFF MEMBER: HUSBAND**

Indicates relationship of 'emergency contact' to employee.

**E-ADDRESS: 6021 STEWART DRIVE**

Enter street number and street name of 'emergency contact'.

**E-CITY: WILLOWBROOK**

Enter city of 'emergency contact'.
Staff Record

E-STATE: **ILLINOIS**

Enter state of 'emergency contact'.

E-ZIP CODE: **45634**

Enter zip code of 'emergency contact'.

E-TELEPHONE NUMBER: **555-1234**

Enter telephone number of 'emergency contact'.

Select NAME OF EMERGENCY CONTACT: <RET>

You may enter another 'emergency contact'.

**NURAED-STF-PER**

**Personnel Data**

**Description:**

This option allows the service to track minimal employee personnel data (e.g., VA start date, computation date). Data is stored in the NURS Staff (#210) file.

**Additional Information:**

Currently this section does not point to a personnel package and data must be entered by nursing. Information is printed in the Staff Record Report. This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and others as identified by the Chief, Nursing Service.

**Menu Display:**

1  Demographic Data
2  Personnel Data
3  Status and Position
4  License
5  Probationary Period/Promotion
6  Annual Review/NPSB
7  Professional Education
8  Professional Experience
9  National Certification
10 Military Status
ALL Edit All Employee Data

**Screen Prints:**

Select Staff Record Edit Option: 2  Personnel Data

EMPLOYEE: NURS NURSE, ONE   RN  
SSN: 000607942

Employee Personnel Data.

1SERVICE COMPUTATION DATE: MAY 5,1980  (NO EDITING)

This uneditable field contains the 'service computation date' for this employee. Service Computation Date includes all federal and military service time.

---

1 Patch NUR*4*22  March 1999
Staff Record

VA EMPLOYMENT STARTING DATE: 5/5/80  (MAY 5, 1980)

Enter the employee's VA employment starting date.

STATION ENTRY ON DUTY DATE: 5/5/80  (MAY 5, 1980)

Enter the employee's EOD (entry on duty) date for this facility, (i.e., VAMC, OPC etc.) EOD date within the VA system.

VETERAN PREFERENCE:  1  NONE

Enter the Employee Veteran Preference code. A number 0 - 6. The following is a list of choices:

<table>
<thead>
<tr>
<th></th>
<th>NO SERVICE</th>
<th>(no military service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>NONE</td>
<td>(military experience; no preference)</td>
</tr>
<tr>
<td>1</td>
<td>5 PT.</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>10 PT. DISAB.</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>10 PT. COMP</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>10 PT. OTHER</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>10 PT./30% COMP</td>
<td></td>
</tr>
</tbody>
</table>
**NURAED-STF-STAT/POS**

**Status and Position**

**Description:**

This option contains a position control function which allows nursing management to track employees' past, present, and future positions. Data is stored in the NURS Staff (#210) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file.

**Additional Information:**

This option doesn't allow duplicate assignments. The information is currently reflected in the AMIS 1106b Reports, FTEE Reports, Grade Reports, and the Staff Record Report. Facilities can, through VA FileMan, generate a turnover report. This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and others as identified by the Chief, Nursing Service.

**Future Plans:**

A future version of the nursing software will contain management turnover reports.

**Menu Display:**

1. Demographic Data
2. Personnel Data
3. Status and Position
4. License
5. Probationary Period/Promotion
6. Annual Review/NPSB
7. Professional Education
8. Professional Experience
9. National Certification
10. Military Status
   ALL Edit All Employee Data

**Screen Prints:**

Select Staff Record Edit Option: 3 Status and Position

EMPLOYEE: NURSNURSE, ONE RN
SSN: 000607942
Employee's Status and Position.

**STATUS:** A ACTIVE

Enter employee's status. The following is a list of choices:

- **A** ACTIVE (active/open record)
- **I** INTERMITTENT (active/open record)
- **R** INACTIVE (inactive/closed record)

This field indicates if an employee holds a present position in Nursing Service and "flags" the staff record as being opened. If the record is active/open, current employee information is used in all appropriate Nursing Service reports.

Prior to editing the position of the employee, the software allows the user to display assignments stored in the employee's record. By selecting (C), current and future positions are displayed; (P) displays past positions. When the record contains no data, a prompt indicates that information is not available.

**Example:** Current Assignment Listing for an Employee

Would you like to see this employee's (C)urrent or (P)ast positions: C/<RET>?

Enter a 'C' to see current positions, or a 'P' to see past positions.

<table>
<thead>
<tr>
<th>LOCATION/PRODUCT LINE</th>
<th>POSITION/PRODUCT LINE</th>
<th>DUTY</th>
<th>START DATE</th>
<th>VACANCY DATE</th>
<th>FTEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 SICU</td>
<td>RN</td>
<td>11:00PM-7:30AM</td>
<td>11/19/91</td>
<td></td>
<td>.2</td>
</tr>
<tr>
<td>NURSING</td>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 (P) 9E</td>
<td>RN</td>
<td>6:00A-2:30</td>
<td>02/05/91</td>
<td></td>
<td>.5</td>
</tr>
<tr>
<td>NURSING</td>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PRIMARY SERVICE POSITION:** STAFF NURSE
**PRIMARY SVC. POS. PRODUCT LINE:** NURSING
**PRIMARY LOCATION PRODUCT LINE:** NURSING
**PRIMARY FACILITY:** HINES
**TOTAL ASSIGNMENT FTEE:** .7

The current positions/assignment listing shows:

1. The location of all current positions/assignments and flags the primary assignment location.
2. The corresponding service position for each assignment.
3. The FTEE.
4. The tour of duty.
5. The starting date of the position.
6. The vacancy or closing date of the position.

---

1 Patch NUR*4*3 January 1998
1At the bottom of the assignment listing, another display shows the employee's status, primary service position and the total FTEE for all currently held, open, positions. If the Product Line and Multi-Divisional fields in the NURS Parameters (#213.9) file are set to 'Yes', the product lines for the employee’s primary unit and the product line for the employee’s primary service position as well as the employee’s primary facility are displayed.

After the assignments and positions are displayed, the following prompt indicates that you can enter new positions, delete errors, and close existing assignments.

Enter selection or type ? for help: ?

Display of help Information:

Selecting Assignments

WHEN MAKING SELECTIONS, A RANGE OF NUMBERS CAN BE SELECTED BY USING A HYPHEN AND MULTIPLE SELECTIONS CAN BE MADE BY SEPARATING THEM BY COMMAS.

E.G. 1 1-2 1,3 1-2,4-5 1,3-4 ARE EXAMPLES OF VALID SELECTIONS.

TO EDIT POSITIONS, SELECT THE NUMBER(S) OF THE ASSIGNMENT(S) TO BE EDITED. THE EXAMPLE ABOVE SHOWS VALID SELECTIONS.

TO DELETE POSITIONS, SELECT THE NUMBER(S) OF THE ASSIGNMENT(S) TO BE DELETED AND FOLLOW THAT SELECTION BY AN @.

E.G. 1@ 1-2@ 1@,3@ 1-2@,4-5@ 1@,3-4@ ARE EXAMPLES OF VALID SELECTIONS.

TO ADD NEW POSITIONS ENTER AN 'N' INTO THE SELECTION LIST.

EDITING, DELETING AND ADDING POSITIONS CAN BE DONE THE SAME IN SELECTION.

E.G. 1@,2,N 1-2@,3@ 1,N 2@,N ARE EXAMPLES OF VALID SELECTIONS.

Press return to continue or "^" to exit <RET>

2When entering new positions or editing data, you are asked to identify if the position is a primary assignment. There must be one primary assignment or position per employee; supervisory responsibility is associated with this primary position. Other information tracked is the location of the position, service position, starting and vacancy dates, tour of duty for each assignment, the FTEE, and a vacancy reason if the vacancy date is completed.

Example: Entering a New Position

Enter selection or type ? for help: N

Would you like to add a new assignment? YES// <RET> (YES)

Indicate if you would like to enter a new assignment.

---

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
Is this a primary assignment? NO// Y (YES)

Indicate if this is a primary assignment by answering yes or no.

LOCATION: SICU

Associate a nursing location with this position.

DATE PROFICIENCY IS DUE: 1-1-92 (JAN 1, 1992)

Enter date on which registered nurse's proficiency/annual narrative is due.

NAME OF EVALUATOR: NURSEVAL, ONE

Enter name of person evaluating this proficiency. The Name of Evaluator points to the NEW PERSON (#200) file.

SERVICE POSITION: RN STAFF NURSE

Enter a service position for this employee. Service position is a required field.

STARTING DATE: T+1 (NOV 19, 1991)

Enter starting date for employee.

ASSIGN TOUR OF DUTY: 8:00AM-4:00PM

Enter appropriate tour of duty for this position.

FTEE: 1

Enter the amount of FTEE assigned to this employee for this position. Type a number between 0 and 1, 3 decimal digits.

VACANCY DATE: <RET>

Enter the appropriate date for closing this position; it cannot be a date older than the start date.

Would you like to add a new assignment? NO// <RET> (NO)

You have the option to add another position for this employee. If you do not wish to make another entry, press return. A summary is displayed of all current positions (i.e., the location of the new position; the service position (a primary assignment position); the FTEE; tour of duty, and the start and vacancy date of the assignment). At the bottom of the assignment listing, another display shows employee's status, primary service position and the total FTEE for all present positions (not future positions). If the Product Line and Multi-Divisional fields in the NURS Parameters (#213.9) file are set to 'Yes', the product lines for the employee’s primary unit and the product line for the employee’s primary service position as well as the employee’s primary facility are displayed. When editing the total FTEE for any staff member, it cannot exceed 1. If new positions are entered and the total FTEE exceeds 1, the system displays:

1 Patch NUR*4*28 August 1999
2 Patch NUR*4*3 January 1998
DUE TO CHANGES THAT HAVE BEEN MADE, THE TOTAL FTEE WOULD BE GREATER THAN 1 FOR THIS EMPLOYEE. PLEASE RETRY THE CHANGE.

You can not have duplicate service positions on the same location. If a new position is entered and it has a duplicate service position for the same location, the system displays:

DUE TO CHANGES THAT HAVE BEEN MADE, DUPLICATE SERVICE POSITIONS ON THE SAME LOCATION EXIST FOR THIS EMPLOYEE. PLEASE RETRY THE CHANGE.

You can not have duplicate duty tours on the same location. If a new position is entered and it has a duplicate duty tour for the same location, the system displays:

DUE TO CHANGES THAT HAVE BEEN MADE, DUPLICATE DUTY TOURS ON THE SAME LOCATION EXIST FOR THIS EMPLOYEE. PLEASE RETRY THE CHANGE.

All newly added positions are invalidated. The positions must be reentered and the FTEE correctly adjusted.

Making changes now - hold a minute

<table>
<thead>
<tr>
<th>LOCATION/PRODUCT LINE</th>
<th>POSITION/PRODUCT LINE</th>
<th>DUTY</th>
<th>START DATE</th>
<th>VACANCY DATE</th>
<th>FTEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>SICU</td>
<td>RN</td>
<td>8:00AM-4:00PM</td>
<td>11/19/91</td>
<td></td>
<td>.2</td>
</tr>
</tbody>
</table>

NURSING NURSING

STATUS: ACTIVE
PRIMARY SERVICE POSITION: STAFF NURSE
PRIMARY SVC. POS. PRODUCT LINE: NURSING
PRIMARY LOCATION PRODUCT LINE: NURSING
PRIMARY FACILITY: HINES
TOTAL ASSIGNMENT FTEE: 1

Enter selection or type ? for help: <RET>

At the above prompt you may change information displayed, delete data, or add new positions.

Example: Editing a Current Position

Currently the employee holds the following assignments, and will be leaving the 3S position on 1/15/92. This position must be closed out by associating a vacancy date and a vacancy reason with the 3S position:

1 Patch NUR*4*33 June 2000
2 Patch NUR*4*3 January 1998
3 Patch NUR*4*3 January 1998
<table>
<thead>
<tr>
<th>LOCATION/PRODUCT LINE</th>
<th>POSITION/PRODUCT LINE</th>
<th>DUTY TOUR</th>
<th>START DATE</th>
<th>VACANCY DATE</th>
<th>FTEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3S</td>
<td>RN</td>
<td>6:00A-2:30</td>
<td>02/05/91</td>
<td></td>
<td>.5</td>
</tr>
<tr>
<td>NURSING</td>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9E</td>
<td>RN</td>
<td>6:00A-2:30</td>
<td>02/05/91</td>
<td></td>
<td>.5</td>
</tr>
<tr>
<td>NURSING</td>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

STATUS: ACTIVE
PRIMARY SERVICE POSITION: STAFF NURSE
PRIMARY SVC. POS. PRODUCT LINE: NURSING
PRIMARY LOCATION PRODUCT LINE: NURSING
PRIMARY FACILITY: HINES
TOTAL ASSIGNMENT FTEE: 1

Enter selection or type ? for help: 1

EDITING POSITION 1

Is this a primary assignment? NO// <RET> (NO)

Enter 'Yes' if this is a primary assignment, or 'No' if this is not a primary assignment.

LOCATION: 3S// <RET>

Enter appropriate location.

DATE PROFICIENCY IS DUE: JAN 1, 1992// <RET>

Enter date on which registered nurse's proficiency/annual narrative is due.

NAME OF EVALUATOR: NURSEVAL, ONE// <RET>

Enter name of person evaluating this proficiency. The Name of Evaluator points to the NEW PERSON (#200) file.

SERVICE POSITION: RN// <RET>

Enter appropriate service position.

STARTING DATE: FEB 5, 1991// <RET>

Enter starting date.

ASSIGN TOUR OF DUTY: 6:00A-2:30// <RET>

Enter the employee's assigned tour of duty.

---

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*28 August 1999
FTEE: .5// <RET>

Enter amount of FTEE for this employee for this position.

VACANCY DATE: 1/15/92  (JAN 15, 1992)

Enter vacancy date for this position.

VACANCY REASON: PTR  POSITION TRANSFER

Enter reason why position is vacant or why employee transferred.

The reason must be an entry in the Vacancy/Transferred Reasons file. New vacancy reasons may be added using the Vacancy Reason File Edit option in the Administrative Site File Functions menu. A status of active or inactive is linked to each vacancy reason and updates the Staff file appropriately when the batch job runs after midnight.

The following is a list of choices:

- COP Continuation of Pay
- EXL Extended Leave
- LWO Leave Without Pay
- PTR Position Transfer
- RES Resigned
- RET Retired
- SUM Summer Student
- TER Terminated
- TRA Transferred
- UTR Unit Transfer
- WOP Leave Without Pay-Journalized

Making changes now - hold a minute

After the vacancy date is entered the system stores the information in the staff record and the changes are printed for the user's review.

<table>
<thead>
<tr>
<th>LOCATION/PRODUCT LINE</th>
<th>POSITION/PRODUCT LINE</th>
<th>DUTY TOUR</th>
<th>START DATE</th>
<th>VACANCY DATE</th>
<th>FTEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>21</td>
<td>3S</td>
<td>RN</td>
<td>6:00A-2:30</td>
<td>02/05/91</td>
<td>.5</td>
</tr>
<tr>
<td>NURSING</td>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 (P)</td>
<td>9E</td>
<td>RN</td>
<td>6:00A-2:30</td>
<td>02/05/91</td>
<td>.5</td>
</tr>
<tr>
<td>NURSING</td>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

STATUS: ACTIVE
PRIMARY SERVICE POSITION: STAFF NURSE
PRIMARY SVC. POS. PRODUCT LINE: NURSING
PRIMARY LOCATION PRODUCT LINE: NURSING
PRIMARY FACILITY: HINES
TOTAL ASSIGNMENT FTEE: 1

---

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
Enter selection or type ? for help: <RET>

You may then exit from the position control file by entering <RET>, add a new position for the employee by entering N, or edit an existing position by entering a number.

Example: Past Position Function
To review past positions held by the employee, select P. The display indicates the location, the service position of each assignment, the primary assignment, the FTEE of each position, tour of duty, the start and vacancy dates.

Would you like to see this employee's (C)urrent or (P)ast positions: C// P
From what date would you like to list the positions: MAR 23, 1966// <RET>
(MAR 23, 1966)

Enter a date which is greater than or equal to the Station Entry on Duty date.

1 The default information provided by the system is the Station Entry On Duty Date (refer to the Personnel Data option of the Staff Record, Edit).

<table>
<thead>
<tr>
<th>LOCATION/</th>
<th>POSITION/</th>
<th>DUTY</th>
<th>START</th>
<th>VACANCY</th>
<th>FTEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRODUCT LINE</td>
<td>PRODUCT LINE</td>
<td>TOUR</td>
<td>DATE</td>
<td>DATE</td>
<td></td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------</td>
<td>------</td>
<td>-------------</td>
<td>-----------</td>
<td>------</td>
</tr>
<tr>
<td>1</td>
<td>MED 4I</td>
<td>RN</td>
<td>03/02/91</td>
<td>03/22/91</td>
<td>.2</td>
</tr>
<tr>
<td>NURSING</td>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 (P)</td>
<td>NHCU</td>
<td>RN</td>
<td>07/17/90</td>
<td>01/30/91</td>
<td>1</td>
</tr>
<tr>
<td>NURSING</td>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The following information displays the employee's present position:

STATUS: ACTIVE
PRIMARY SERVICE POSITION: STAFF NURSE
PRIMARY SVC. POS. PRODUCT LINE: NURSING
PRIMARY LOCATION PRODUCT LINE: NURSING
PRIMARY FACILITY: HINES

After the past positions are displayed on the screen, the user may edit and delete past positions through the past position pathway. The user cannot enter a new or reactivate a past position at this level. New past assignments can be put into the system by entering the current pathway only.

This section identifies miscellaneous information:

**Edit/Modify Grade Step Code:** Use the Load Grade/Step Codes option in the Administrative Site File Functions menu to edit grade/step codes.

---

1 Patch NUR*4*3 January 1998
MI REVIEW GROUP: RN
HOSPITAL (NO EDITING)

SALARY: 45995.00 (NO EDITING)

MI Review Group and Salary are uneditable: The MI review group data comes from the PAID Education Tracking module, and salary data also comes from PAID. Users are not permitted to change this data through this option.

GRADE/STEP CODE: R/N1/2

Enter an appropriate grade/step code. The following are examples of Grade/Step Codes:

1. R/NI1/5 = Registered Nurse, Nurse Intermediate, Level 1, Step 5
   N/4/7 = Nursing Assistant, GS4, Step 7

UNIFORM ALLOWANCE: Y (YES)

Indicate whether or not an employee is receiving a uniform allowance.

Select PRIVILEGES: Orders routine blood work
Are you adding 'Orders routine blood work' as a new PRIVILEGES (the 1ST for this NURS STAFF)? No// Y (YES)

Enter appropriate Nurs privilege name. The following is a list of choices:

Orders EKG, non invasive x-rays
Requests consultation/referral

Additional privileges can be added to the Privilege file through the Privilege File Edit option in the Administrative Site File Functions menu.

DATE GRANTED: 1/8/91 (JAN 08, 1991)

Enter date this privilege was granted.

COMMENTS:<RET>
  1><RET>

Enter any comments you may have.

Select PRIVILEGES: <RET>

You may enter another privilege here, or enter <RET> to exit.

---

1 Patch NUR*4*3 January 1998
NURAED-STF-LIC

License

Description:

This option tracks license data for an employee. It is used to supplement the license information provided by the Human Resources Management Service. Data is stored in the NURS Staff (#210) file.

Additional Information:

The information is reflected in the Staff Record Report, and the License Reports. This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and others as identified by the Chief, Nursing Service.

Menu Display:

1. Demographic Data
2. Personnel Data
3. Status and Position
4. License
5. Probationary Period/Promotion
6. Annual Review/NPSB
7. Professional Education
8. Professional Experience
9. National Certification
10. Military Status
ALL    Edit All Employee Data

Screen Prints:

Select Employee's Staff Record Edit Option: 4  License

EMPLOYEE: NURSNURSE, ONE RN
SSN: 000607942

License.

Select STATE ISSUING LICENSE: WYOMING

Enter name of state issuing license. License is a multiple field. An employee may have more than one license entered.
PROFESSIONAL LICENSE NUMBER: 33322

Enter license number printed on the individual's professional license.


Enter expiration date of license.

VERIFIED BY: NURSUSER, ONE

Enter the person's name who verified the license.

Select STATE ISSUING LICENSE: KANSAS

You may make another entry.
NURAED-STF-PROB

Probationary Period/Promotion

Description:

This option edits the employee's data regarding probationary periods and promotions. Data is stored in the NURS Staff (#210) file.

Additional Information:

This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and others as identified by the Chief, Nursing Service.

Menu Display:

1 Demographic Data
2 Personnel Data
3 Status and Position
4 License
5 Probationary Period/Promotion
6 Annual Review/NPSB
7 Professional Education
8 Professional Experience
9 National Certification
10 Military Status
ALL Edit All Employee Data

Screen Prints:

Select Staff Record Edit Option: 5 Probationary Period/Promotion

EMPLOYEE: NURSNURSE, ONE RN
SSN: 000607942

Probationary Period/Promotion.

END OF PROBATIONARY PERIOD: (MAY 05, 1982)

Enter date on which employee's probationary period ends. This date may be obtained from Personnel or from the Service Record Card (SRC).

Select DATE OF PROMOTION: 6/6/86 JUN 6, 1986
Are you adding 'JUN 6, 1986' as a new DATE OF PROMOTION (the 1ST for this NURS STAFF) No/ Y

Enter date of employee's promotions.
**TYPE OF PROMOTION: S  WITHIN GRADE STEP INCREASE**

Enter type of latest promotion. The following is a list of choices:

- **S**  Within Grade Step Increase
- **G**  Promotion to Next Grade
- **A**  Special Advancement for Achievement
- **P**  Special Advancement for Performance
- **E**  Advancement to Next Level
- **N**  Not Promoted at this Time

Select DATE OF PROMOTION: <RET>

You may enter a new date of promotion.

---

1 Patch NUR*4*20  November 1998
NURAED-STF-NPSB

Annual Review/NPSB

Description:

This option tracks the employee's multiple proficiency dates and the Nurse Professional Standards Board review dates. Data is stored in the NURS Staff (#210) file.

Additional Information:

Information is reflected in the Staff Record Report, the NPSB Reports, and the Proficiency Reports. The Name of Evaluator field points to the New Person (#200) file. This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and others as identified by the Chief, Nursing Service.

Menu Display:

1 Demographic Data
2 Personnel Data
3 Status and Position
4 License
5 Probationary Period/Promotion
6 Annual Review/NPSB
7 Professional Education
8 Professional Experience
9 National Certification
10 Military Status
ALL Edit All Employee Data

Screen Prints:

Select Staff Record Edit Option: 6 Annual Review/NPSB

EMPLOYEE: NURS NURSE, ONE RN
SSN: 000607942

Annual Review/NPSB.

Select DATE PROFICIENCY IS DUE: 5/5/86 MAY 5, 1986
Are you adding 'MAY 5, 1986' as a new DATE PROFICIENCY IS DUE (the 1ST for this NURS STAFF)? No// Y (YES)
Enter date on which registered nurse's proficiency/annual narrative is due. The DATE PROFICIENCY IS DUE is a multiple field and may have multiple dates entered. For example: 4 month and 9 month evaluations during orientation or any other date for tracking of evaluations may be entered.

**NAME OF EVALUATOR:** NURSEVAL, TWO

Enter name of person evaluating this proficiency. The Name of Evaluator points to the NEW PERSON (#200) file.

**TENTATIVE DATE FOR BOARD ACTION:** 5-5-86  (MAY 05, 1986)

Enter the targeted date the employee is scheduled for review by the Nurse Professional Standards Board.

**DATE WORK COPY SENT OUT:** 5-6-86  (MAY 06, 1986)

Enter the date the work copy/notice for the nurse's proficiency or annual narrative is sent to the evaluator.

**DATE PROF RETURNED FOR TYPING:** 5-9-86  (MAY 09, 1986)

Enter the date on which the nurse's written proficiency/annual narrative is returned by the evaluator for typing.

**ACTUAL DATE OF BOARD ACTION:** 5/12/86  (MAY 12, 1986)

Enter date on which the standards board actually reviewed the employee.

**DATE OF NEXT BOARD ACTION:** 5/12/87  (MAY 12, 1987)

Enter the next date on which the standards board will review the employee.

Select DATE PROFICIENCY IS DUE: <RET>

You may enter another proficiency date.

---

1 Patch NUR*4*21  January 1999
**NURAED-STF-EDUC**

**Professional Education**

**Description:**

This option edits the employee's professional education data. Data comes from the NURS Staff (#210) file.

**Additional Information:**

The information is reflected in the Staff Record Report, Academic Degree and Nursing Degree Reports. This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and others as identified by the Chief, Nursing Service.

**Menu Display:**

1  Demographic Data  
2  Personnel Data  
3  Status and Position  
4  License  
5  Probationary Period/Promotion  
6  Annual Review/NPSB  
7  Professional Education  
8  Professional Experience  
9  National Certification  
10 Military Status  
ALL  Edit All Employee Data  

**Screen Prints:**

Select Staff Record Edit Option: 7  Professional Education

EMPLOYEE: NURSNURSE, ONE   RN  
SSN: 000607942  

Employee's Professional Education.

Select PROFESSIONAL EDUCATION: 4  Bachelor's degree in Nursing   BSN  

Enter name of degree. The following is a list of choices:

1  Nursing diploma   DIP  
2  Associate degree in Nursing   AD  
3  Associate degree   AA  
4  Bachelor's degree in Nursing   BSN  
5  Bachelor's degree   BA
Professional Education field points to NURS EDUCATION file (#212.1).

MAJOR: NURSING

When a nursing degree is entered in the PROFESSIONAL EDUCATION field, NURSING is automatically entered as the major. However, if a non-nursing degree is entered you may select from the 50-entry NURS COLLEGE MAJOR list. See second example of professional education entry below.

Major is a pointer to the NURS COLLEGE MAJOR (#212.3) file.

COLLEGE/UNIVERSITY: U. OF MINNESOTA

Enter name of the college/university granting the degree.

YEAR: 1976 (1976)

Enter year the degree was obtained.

You may make another professional education entry.

Select PROFESSIONAL EDUCATION: <RET>
FACULTY: N NO

This field documents that the employee is a faculty member at a college, university, or other educational facility. Enter a yes or no. If yes is entered, the following prompt displays:

Select TYPE OF APPOINTMENT:
NURAED-STF-EXP

Professional Experience

Description:

This option edits the employee's professional experience data. The professional experience field may contain both non VA experience and station experience. Data is stored the NURS Staff (#210) file.

Additional Information:

Data describing non VA experience can be directly entered through this option. As the Status and Position option of the Staff Record closes a position by passing the vacancy date, the information is automatically stored in the NURS Staff file provided the tasked option, NURAAM-ACU, completes its daily run. If the NURAAM-ACU (Nursing Acuity/ Separation Run) option does not run to completion, the data will be stored when the NURAAM-ACUMAN (Manual Nursing Acuity/ Separation Run) option is selected by the nursing application coordinator.

Information can be accessed through the Staff Record Report. This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and others as identified by the Chief, Nursing Service.

Menu Display:

1 Demographic Data
2 Personnel Data
3 Status and Position
4 License
5 Probationary Period/Promotion
6 Annual Review/NPSB
7 Professional Education
8 Professional Experience
9 National Certification
10 Military Status
ALL Edit All Employee Data

Screen Prints:

Select Staff Record Edit Option: 8 Professional Experience

EMPLOYEE: Nursnurse, One RN
SSN: 000607942
Professional Experience.

Select PROFESSIONAL EXPERIENCE: Psychiatry

Enter professional experience. All professional experience. Pointer to NURS CLINICAL BACKGROUND file (#211.5).

Note: The entry of additional NURS CLINICAL BACKGROUNDS (professional experience) is done using the Clinical Background File, Edit option in the Administrative Site File menu. LAYGO access is not allowed. The following is a list of choices:
  - CCU
  - Drug Dependency
  - MICU
  - Medical
  - ETC.

LAST ASSIGNMENT LOCATION: DOCTOR'S HOSPITAL

Enter name of facility, agency, or unit which employed individual.

TITLE/POSITION: RN STAFF NURSE

Enter name of title/position held during this period of employment. Pointer to NURS SERVICE POSITION file (#211.3). The following is a list of choices:
  - ACGNS/LTC ACNS FOR NURSING HOME CARE
  - ACNS ASSOC CHIEF, NURSING SERVICE
  - ACNS SEC ACNS SECRETARY
  - ACNS/E SEC ACNS/E SECRETARY
  - ETC.

The entry of additional SERVICE POSITIONS must be done through the Service Position File, Edit option of the Nursing Package Site File menu. LAYGO access is not allowed.

DATE STARTED: 5/1/80 (MAY 01, 1980)

Enter beginning date of employee's assignment.

DATE ENDED: 5/1/83 (MAY 01, 1983)

Enter ending date of employee's assignment.

Professional Experience is a multiple field. In order to enter a duplicate professional experience " " must be entered around the professional experience. See example below.

Select PROFESSIONAL EXPERIENCE: "Psychiatry"

You may enter another professional experience entry.
NURAED-STF-CERT

National Certification

Description:

This option edits the employee's national certification information including expiration date. Data is stored in the NURS Staff (#210) file and the Certification (#212.2) file.

Additional Information:

Information is reflected in the Staff Record Report and the Certification Reports. This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and others as identified by the Chief, Nursing Service.

Menu Display:

1  Demographic Data
2  Personnel Data
3  Status and Position
4  License
5  Probationary Period/Promotion
6  Annual Review/NPSB
7  Professional Education
8  Professional Experience
9  National Certification
10  Military Status
ALL  Edit All Employee Data

Screen Prints:

Select Staff Record Edit Option: 9 National Certification

EMPLOYEE: NURSNURSE, ONE   RN
SSN: 000607942

Employee's National Certification.

National Certification is a multiple field. Since there are numerous certifications with the same abbreviation of RNC. Use the "RNC" entry to force a duplicate entry.
Enter the employee's certification abbreviation, then select the appropriate certification entry if more than one entry is displayed.

**ORIGINAL CERTIFICATION DATE:** 2/2/85 (FEB 2, 1985)

Enter the date of initial certification.

**DATE CERTIFICATION EXPIRES:** 2/2/88 (FEB 2, 1988)

Enter the expiration date. This is not a multiple field, the date must be changed upon employee recertification.

Select NATIONAL CERTIFICATION: <RET>

You may make another national certification entry.
NURAED-STF-MIL

Military Status

Description:

This option tracks the employee's previous military experience. The Branch of Service (#23) file containing service names is pointed to through this option. Data is stored in the NURS Staff (#210) file.

Additional Information:

Information is used in the Staff Record Report and Military Reports. This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and others as identified by the Chief, Nursing Service.

Menu Display:

1  Demographic Data
2  Personnel Data
3  Status and Position
4  License
5  Probationary Period/Promotion
6  Annual Review/NPSB
7  Professional Education
8  Professional Experience
9  National Certification
10 Military Status
ALL  Edit All Employee Data

Screen Prints:

Select Staff Record Edit Option: 10 Military Status

EMPLOYEE: NURSNURSE, ONE   RN
SSN: 000607942

Employee's Military Status.

One of several possibilities may occur:
1. If veteran preference (previously entered in the Personnel Data option) is no service the following is displayed:

NO MILITARY EXPERIENCE, THEREFORE NO FURTHER UPDATING REQUIRED

Press return to continue

2. If no previous veteran preference information was entered, the following is displayed:

MILITARY EXPERIENCE? Answer YES or NO

a. If the question is answered NO then no service is automatically entered.
b. If the question is answered YES then the following is displayed:

VETERAN PREFERENCE: 1 NONE

Enter the veterans preference. The following is a list of choices:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>NO SERVICE (no military service)</td>
</tr>
<tr>
<td>1</td>
<td>NONE (military experience; no preference)</td>
</tr>
<tr>
<td>2</td>
<td>5 PT.</td>
</tr>
<tr>
<td>3</td>
<td>10 PT. DISAB.</td>
</tr>
<tr>
<td>4</td>
<td>10 PT. COMP</td>
</tr>
<tr>
<td>5</td>
<td>10 PT. OTHER</td>
</tr>
<tr>
<td>6</td>
<td>10 PT./30% COMP</td>
</tr>
</tbody>
</table>

The next prompt is military status and indicates if the employee is an active reservist or retired from the military.

Select MILITARY STATUS: R RETIRED/DISCHARGED

Enter military status. The following is a list of choices:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>R</td>
<td>RETIRED/DISCHARGED</td>
</tr>
<tr>
<td>A</td>
<td>ACTIVE RESERVE</td>
</tr>
<tr>
<td>IRR</td>
<td>INDIVIDUAL READY RESERVE</td>
</tr>
<tr>
<td>IMA</td>
<td>INDIVIDUAL MOBILIZATION AUGMENTEE</td>
</tr>
</tbody>
</table>

3. If the veteran preference indicates a level of preference then the following appears:

Select MILITARY STATUS: A (ACTIVE RESERVE)

BRANCH OF SERVICE: NAVY
Enter name of 'service branch' if active-reservist. Pointer to BRANCH OF SERVICE file (#23). The following is a list of choices:

1  ARMY  
2  AIR FORCE  
3  NAVY  
4  MARINE CORPS  
5  COAST GUARD  
6  OTHER  
7  MERCHANT SEAMAN  
8  B.E.C.  
9  USPHS  
10  NOAA

Select MILITARY STATUS:  <RET> You may enter another military status.
NURAED-STF-ALL

Edit All Employee Data

Description:

This function allows the user to enter/edit employee data in the Staff Record without returning to the menu between major sections. Data comes from the NURS Staff (#210) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file.

Additional Information:

This option should be restricted to select users such as the nursing ADP Coordinator, nurse recruiter, nursing office staff, and others as identified by the Chief, Nursing Service.

Menu Display:

1. Demographic Data
2. Personnel Data
3. Status and Position
4. License
5. Probationary Period/Promotion
6. Annual Review/NPSB
7. Professional Education
8. Professional Experience
9. National Certification
10. Military Status
ALL  Edit All Employee Data

Screen Prints:

Select Staff Record Edit Option: ALL  Edit All Employee Data

Note: Between each section you are prompted with the question
DO YOU WISH TO CONTINUE TO THE NEXT SECTION? YES/
At the end of any section you may exit this loop by answering NO to this question.

Menu Access:

The Staff Record Edit option is accessed through the Staff Record Edit option of the Administration Records, Enter/Edit option of the Nursing Features (all options) menu, and the Administrator's Menu.
NURAED-STF-LOC

Location Edit, Employee

Description:

This option can be used in lieu of the Status and Position (NURAED-STF-STA/POS) option in the Staff Record Edit (NURAED-STF-MENU) option. It can be used when an employee is reassigned to a different clinical area, position/title, or has a change in FTEE. Staff data comes from the NURS Staff (#210) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file.

Additional Information:

This option doesn't allow duplicate assignments. This option should be restricted to select users such as the Nursing ADP Coordinator, nurse recruiter, nursing office staff and others as designated by the Chief, Nursing Service.

Menu Display:

Select Nursing Features (all options) Option: 1 Administration Records, Enter/Edit

Location Edit, Employee
Manhours Edit, AMIS 1106a
Staff Record Edit ...

Screen Prints:

Select Administration Records, Enter/Edit Option: Location Edit, Employee

Select Nursing Service Staff Name: NURSNURSE,ONE 000607942
...OK? YES// <RET> (YES)

Would you like to see this employee's (C)urrent or (P)ast positions: C// <RET>
<table>
<thead>
<tr>
<th>LOCATION/PRODUCT LINE</th>
<th>POSITION/PRODUCT LINE</th>
<th>DUTY</th>
<th>START DATE</th>
<th>VACANCY DATE</th>
<th>FTEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>SICU</td>
<td>RN</td>
<td>11:00PM-7:30AM</td>
<td>11/19/91</td>
<td>.2</td>
</tr>
<tr>
<td>SUEG</td>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 (P) 9E</td>
<td>RN</td>
<td>6:00A-2:30</td>
<td>02/05/91</td>
<td>.5</td>
<td></td>
</tr>
<tr>
<td>CRITICAL CARE</td>
<td>SURGERY2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

STATUS: ACTIVE
PRIMARY SERVICE POSITION: STAFF NURSE
PRIMARY SVC. POS. PRODUCT LINE: NURSING
PRIMARY LOCATION PRODUCT LINE: NURSING
PRIMARY FACILITY: HINES
TOTAL ASSIGNMENT FTEE: .7

Enter selection or type ? for help: <RET>

If the Product Line and Multi-Divisional fields in the NURS Parameters (#213.9) file are set to 'Yes', the Primary Product Line and Primary Facility for the position will appear at the bottom of the report also.

You may exit at this prompt by entering <RET> or add a new position, edit or delete an existing position.

No other prompts found in the Status and Position option of the Staff File Edit appear through this option.

**Menu Access:**

The Location Edit, Employee option is accessed through the Administration Records, Enter/Edit option of the Nursing Features (all options) menu, and the Administrator's Menu.

---

1 Patch NUR*4*3 January 1998
NURAPR-STF

Staff Record Report

Description:

This option prints a staff record report (demographic, service related, and professional information) for an individual nursing employee. Data comes from the NURS Staff (#210) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file.

Additional Information:

1. If the Product Line and Multi-Divisional fields in the NURS Parameters (#213.9) file are set to 'Yes', the Primary Product Line for location and service position, and Primary Facility for the position will appear in the report. Editing of this data is accomplished using the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Security:

Security has been provided on the Staff Record Report. This security screens data and displays prompts that can be viewed by Nursing employees based on their AMIS Position:

a. The Chief, Nursing Service and the Nursing ADP Coordinators can access all data.
b. The Associate/Assistant Chief(s) and Supervisors can access data of personnel subordinate to their position.
c. Head Nurses have access only to data specific to their ward.
d. Everyone else can only view their own data.

One exception to the above security is phone number data. Head Nurses and higher can see all phone numbers.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Patch NUR*4*3 January 1998
Screen Prints:

Select Administration Records, Print Option: 4  Staff Record Report

Select Nursing Staff Name:  NURSNURSE,ONE  000607942  RN  ...OK? Yes// <RET>  (Yes)

DEVICE: HOME// Enter appropriate response

INDIVIDUAL STAFF REPORT
----------------------------------------
NAME: NURSNURSE, ONE  SSN: 000-60-7942  DATE: MAY 11, 1995
DOB: JUN 6, 1961  AGE: 33  SEX: FEMALE

CURRENT FTEE INFORMATION
----------------------------------------
LOCATION/ POSITION/       DUTY            START      VACANCY     FTEE
PRODUCT LINE  PRODUCT LINE    TOUR            DATE       DATE
----------------------------------------
1  MICU       RN            11:00AM-5:30PM  11/19/91                .4
SUEG       NURSING
2 (P)  CCU       RN            7:00PM-5:30AM   02/05/91                .5
CRITICAL CARE  SURGERY2

STATUS: ACTIVE
PRIMARY SERVICE POSITION: STAFF NURSE
PRIMARY SVC. POS. PRODUCT LINE: SURGERY2
PRIMARY LOCATION PRODUCT LINE: CRITICAL CARE
PRIMARY FACILITY: HINES
TOTAL ASSIGNMENT FTEE: .9
MI REVIEW GROUP: RN
SALARY: 45995.00

GRADE/STEP: R/N2/4
UNIFORM ALLOWANCE: YES

----------------------------------------

1 Patch NUR*4*3  January 1998
<table>
<thead>
<tr>
<th><strong>ADDRESS/TELEPHONE</strong></th>
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<tbody>
<tr>
<td><strong>HOME ADDRESS INFORMATION</strong></td>
</tr>
<tr>
<td>------------------------</td>
</tr>
<tr>
<td>STREET: 6234 STEWART DRIVE</td>
</tr>
<tr>
<td>CITY: WILLOWBROOK</td>
</tr>
<tr>
<td>STATE: ILLINOIS</td>
</tr>
<tr>
<td><strong>MAILING ADDRESS INFORMATION</strong></td>
</tr>
<tr>
<td>---------------------------</td>
</tr>
<tr>
<td>STREET: PO BOX 456</td>
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<td>CITY: WILLOWBROOK</td>
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<td>STATE: ILLINOIS</td>
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<td><strong>TELEPHONE NUMBER INFORMATION</strong></td>
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<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>NUMBER: 555-6543</td>
</tr>
<tr>
<td>OWNER: SELF</td>
</tr>
<tr>
<td>OTHER OWNER:</td>
</tr>
<tr>
<td><strong>EMERGENCY CONTACT INFORMATION</strong></td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td>NAME: NURSSPOUSE, ONE</td>
</tr>
<tr>
<td>RELATIONSHIP: HUSBAND</td>
</tr>
<tr>
<td>STREET:</td>
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<td>CITY:</td>
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<tr>
<td>STATE:</td>
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<tr>
<td>PHONE NUMBER: 555-1234</td>
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<table>
<thead>
<tr>
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<tr>
<td>STATION ENTRY ON DUTY DATE: MAY 5, 1980</td>
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<tr>
<td>SERVICE COMPUTATION DATE: MAY 5, 1980</td>
</tr>
<tr>
<td>VA STARTING DATE: MAY 5, 1980</td>
</tr>
<tr>
<td>END OF PROBATIONARY PERIOD: MAY 5, 1982</td>
</tr>
<tr>
<td>DATE OF PROMOTION: JUN 6, 1986</td>
</tr>
<tr>
<td>TYPE: WITHIN GRADE STEP INCREASE</td>
</tr>
</tbody>
</table>
**EVALUATIONS/BOARD REVIEWS**

1. **DATE PROFICIENCY/NARRATIVE IS DUE: MAY 5, 1986**
   - **NAME OF EVALUATOR:** NURSEVAL, THREE
   - **DATE WORK COPY SENT OUT:**
   - **DATE PROF RETURNED FOR TYPING:**
   - **TENTATIVE DATE FOR BOARD ACTION:**
   - **ACTUAL DATE OF BOARD ACTION:** MAY 12, 1986
   - **DATE OF NEXT BOARD ACTION:** MAY 12, 1987

2. **DATE PROFICIENCY/NARRATIVE IS DUE: MAY 5, 1996**
   - **NAME OF EVALUATOR:** NURSEVAL, FOUR
   - **DATE WORK COPY SENT OUT:** MAY 5, 1996
   - **DATE PROF RETURNED FOR TYPING:** MAY 5, 1996
   - **TENTATIVE DATE FOR BOARD ACTION:** MAY 5, 1996
   - **ACTUAL DATE OF BOARD ACTION:** MAY 5, 1996
   - **DATE OF NEXT BOARD ACTION:** MAY 5, 1987

3. **DATE PROFICIENCY/NARRATIVE IS DUE: MAY 6, 1996**
   - **NAME OF EVALUATOR:** NURSEVAL, FIVE
   - **DATE WORK COPY SENT OUT:** MAY 6, 1996
   - **DATE PROF RETURNED FOR TYPING:** MAY 6, 1996
   - **TENTATIVE DATE FOR BOARD ACTION:** MAY 6, 1996
   - **ACTUAL DATE OF BOARD ACTION:** MAY 6, 1996
   - **DATE OF NEXT BOARD ACTION:** MAY 6, 1987

**PROFESSIONAL LICENSE INFORMATION**

- **STATE: WYOMING**
  - **LICENSE NUMBER:** 33322
  - **EXPIRATION DATE:** APR 4, 1987
  - **VERIFIED BY:** NURSEVAL, THREE

- **STATE: KANSAS**
  - **LICENSE NUMBER:** 657654
  - **EXPIRATION DATE:** JUL 7, 1985
  - **VERIFIED BY:** NURSEVAL, THREE

**PROFESSIONAL EDUCATION**

- **HIGHEST NURSING DEGREE:** Bachelor's degree in Nursing
- **HIGHEST ACADEMIC DEGREE:** Master's degree
- **DEGREE:** Bachelor's degree in Nursing
- **MAJOR:** NURSING
- **COLLEGE/UNIVERSITY:** U. OF MINNESOTA
- **YEAR COMPLETED:** 1976

---

1 Patch NUR*4*21 January 1999
DEGREE: Master's degree
MAJOR: EDUCATION
COLLEGE/UNIVERSITY: U OF MINNESOTA
YEAR COMPLETED: 1976
FACULTY: NO

-------------------------------
NATIONAL CERTIFICATION
-------------------------------

NAME OF CERTIFICATION: C.S. IN MED/SURG NURSING
CERTIFYING AGENCY: AMERICAN NURSES ASSOCIATION
DATE OF CERTIFICATION: FEB 2,1988
DATE OF EXPIRATION: FEB 2,1996

NAME OF CERTIFICATION: CRITICAL CARE NURSE
CERTIFYING AGENCY: AMERICAN ASSOCIATION OF CRITICAL CARE NURSES
DATE OF CERTIFICATION: MAY 5,1992
DATE OF EXPIRATION: MAY 7,1993

-------------------------------
PROFESSIONAL EXPERIENCE
-------------------------------

LOCATION: NHCU
TYPE OF EXPERIENCE: REHAB MEDICINE
TITLE/POSITION: HN
DATE PREVIOUS ASSIGNMENT STARTED: AUG 1,1991
DATE PREVIOUS ASSIGNMENT ENDED: SEP 30,1991

LOCATION: NHCU
TYPE OF EXPERIENCE: REHAB MEDICINE
TITLE/POSITION: RN
DATE PREVIOUS ASSIGNMENT STARTED: JAN 1,1996
DATE PREVIOUS ASSIGNMENT ENDED: JAN 1,1990

LOCATION: NHCU
TYPE OF EXPERIENCE: REHAB MEDICINE
TITLE/POSITION: RN
DATE PREVIOUS ASSIGNMENT STARTED: JAN 1,1996
DATE PREVIOUS ASSIGNMENT ENDED: JAN 1,1990

LOCATION: NHCU
TYPE OF EXPERIENCE: REHAB MEDICINE
TITLE/POSITION: RN
DATE PREVIOUS ASSIGNMENT STARTED: JAN 1,1996
DATE PREVIOUS ASSIGNMENT ENDED: JAN 1,1990

-------------------------------
MILITARY EXPERIENCE
-------------------------------

MILITARY EXPERIENCE: (RETIRED/DISC)
MILITARY EXPERIENCE: (ACT RESV)     BRANCH OF SERVICE: NAVY
PRIVILEGES
----------

PRIVILEGE: Develop plan of care
DATE GRANTED: JUL 7, 1990
COMMENTS: THIS PRIVILEGE MUST BE REVIEWS ON 4/2/91.

Select Nursing Staff Name: <RET>

Menu Access:

The Staff Record Report option is accessed through the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-STFLOC

Individual Staff Position/Location

Description:

This option prints a staff position/location report for an individual nursing employee. Data comes from the NURS Staff (#210) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file.

Additional Information:

This report only displays on the screen, it cannot be sent to a printer. If the Product Line and Multi-Divisional fields in the NURS Parameters (#213.9) file are set to 'Yes', the Primary Product Line and Primary Facility for the position will appear in the report. Editing of this data is accomplished using the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Screen Prints:

Select Administration Records, Print Option: 6 Individual Staff Position/Location

Select Nursing Staff Name: NURSNURSE, O
...OK? Yes// <RET> (Yes)
<table>
<thead>
<tr>
<th>LOCATION/PRODUCT LINE</th>
<th>POSITION/PRODUCT LINE</th>
<th>DUTY</th>
<th>START DATE</th>
<th>VACANCY DATE</th>
<th>FTEE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (P) 3S NURSING</td>
<td>RN NURSING</td>
<td>2:30PM-11:00PM</td>
<td>08/01/91</td>
<td>09/30/91</td>
<td>1.000</td>
</tr>
<tr>
<td>2 NHCU NURSING</td>
<td>RN NURSING</td>
<td></td>
<td>03/01/91</td>
<td>01/20/97</td>
<td>0.200</td>
</tr>
<tr>
<td>3 (P) MICU NURSING</td>
<td>RN NURSING</td>
<td>7:00AM-5:30PM</td>
<td>02/05/91</td>
<td>01/20/97</td>
<td>0.500</td>
</tr>
<tr>
<td>4 (P) MICU NURSING</td>
<td>RN NURSING</td>
<td>7:00AM-7:30PM</td>
<td>02/05/91</td>
<td></td>
<td>1.000</td>
</tr>
<tr>
<td>5 3S NURSING</td>
<td>RN NURSING</td>
<td></td>
<td>01/17/91</td>
<td>01/18/91</td>
<td>0.200</td>
</tr>
<tr>
<td>6 3S NURSING</td>
<td>RN NURSING</td>
<td></td>
<td>01/01/91</td>
<td>01/02/91</td>
<td>0.200</td>
</tr>
<tr>
<td>7 SICU NURSING</td>
<td>RN NURSING</td>
<td></td>
<td>01/01/88</td>
<td>01/01/96</td>
<td>0.100</td>
</tr>
</tbody>
</table>

STATUS: ACTIVE
PRIMARY SERVICE POSITION: STAFF NURSE

Press return to continue: <RET>

Menu Access:

The Individual Staff Position/Location option is accessed through the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu.
Chapter 3 Administration Reports

NURAPR-LOC-SER

Administrative Reports

Description:

The Administrative Reports option prints the location, service, and specific individual reports, such as age, grade, and nursing degree, which are generated based on the information in the NURS Staff (#210) file. Staff data reflecting assignment location, service position, and service category is found in the NURS Position Control (#211.8) file. The specifications for these reports were provided by the Nursing Focus Group and test sites.

Additional Information:

Some reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

The following totals are categorized by Product Line and/or Facility when appropriate.

Total Number of Assignments - This is the total number of positions/assignments in Nursing Service.

Total Number of Personnel - This is the total number of employees holding positions/assignments in Nursing Service.

Subtotal = Total of FTEE

Subcount = Number of staff

\[
\text{Submean} = \frac{\text{Subtotal}}{\text{Subcount}}
\]

Many of the report options offer the 4 print options listed below.

1. Location and Service Category
2. Location and Service Position
3. Service and Service Category
4. Service and Service Position
Location reports allow the user to request one or more nursing units at a time or all units by pressing return. If the user enters a specific unit, the 'Another Nursing Unit' prompt appears. When the user selects all units for inclusion in the report, only active locations print.

When printing a report sorted by location, each unit is printed on a separate page.

A. Use the ? (question mark) to identify the sort capabilities within each of these print options.

B. The following legend shows which reports provide summary information, such as 'total number of assignments' and 'total number of personnel', and which reports only exit to the menu:

1  + Academic Degree Reports
2  - Age Reports
3  * Certification Reports
4  + Gender Reports
5  + Grade Reports
6  * License Reports
7  + Military Reports
8  * NPSB Reports
9  + Nursing Degree Reports
10 * Proficiency Reports
11 * Comb. Acad./Nurs. Degree Reports

* Reports with no summary information, typing an "^" returns to menu.
+ Reports with summary information and message "Press return to continue, 'T' for totals, or '^' to exit" at the bottom of each screen.
  Typing a "T" shows you summary information at the point you exit the report.
  Typing an "^" exits to the menu.
- Age report has summary information, typing an "^" shows summary information at the point you exit the report and then returns you to the menu.

Security:

Security has been provided on the Administration Reports. This security screens data and displays prompts that can be viewed by nursing employees based on their AMIS Position:

a. The Chief, Nursing Service and the Nursing ADP Coordinators can access all data.

b. The Associate/Assistant Chief(s) and Supervisors can access data of personnel subordinate to their position.
c. Head Nurses have access only to data specific to their unit.

d. Everyone else can only view their own data.

One exception to the above security is phone number data. Head Nurses and higher can see all phone numbers.

**Menu Display:**

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1. Administration Records, Enter/Edit ...  
2. Administration Records, Print ...  
3. Administrative Site File Functions ...  
4. Nursing Education Reports, Print ...  
5. Patient Care Data, Enter/Edit ...  
6. Patient Care Data, Print ...  
7. Clinical Site File Functions ...  
8. QI Data, Enter/Edit ...  
9. Quality Performance Reports ...  
10. QI Site Files ...  
11. Special Functions ...

Select Nursing Features (all options) Option: 2 Administration Records, Print

1. Administrative Reports ...  
2. Resource Management Reports ...  
3. Salary Reports ...  
4. Staff Record Report  
5. Telephone Number Listings ...  
6. Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports

1. Academic Degree Reports  
2. Age Reports  
3. Certification Reports  
4. Gender Reports  
5. Grade Reports  
6. License Reports  
7. Military Reports  
8. NFSB Reports  
9. Nursing Degree Reports  
10. Proficiency Reports  
11. Comb. Acad./Nurs. Degree Reports

Select Administrative Reports Option:
Menu Access:

The Administrative Reports option is accessed through the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-ADGREE

Academic Degree Reports

Description:

This option allows the user to generate location and service reports summarizing the highest academic degree held by nursing personnel. Data may be sorted by facility, product line, service category or service position. Staff data reflecting assignment location, service position, and service category is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

Additional Information:

Editing of data is accomplished using the Staff Record Edit option in Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports
Administration Reports

1. Academic Degree Reports
2. Age Reports
3. Certification Reports
4. Gender Reports
5. Grade Reports
6. License Reports
7. Military Reports
8. NPSB Reports
9. Nursing Degree Reports
10. Proficiency Reports
11. Comb. Acad./Nurs. Degree Reports

Screen Prints:
Select Administrative Reports Option: 1 Academic Degree Reports

Sort by:
1. Location and Service Category
2. Location and Service Position
3. Service and Service Category
4. Service and Service Position

Choose a sort parameter set between 1 and 4: 1 Location and Service Category

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility. When an individual nursing unit is selected, the user is prompted with 'Another Nursing Unit'. A specified group of Nursing units may be requested at the same time.

NURSING Service Categories
---------------------------
1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-CLERICAL)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)
OTHER Service Categories
-----------------------------
  8. OTHER VOLUNTEER
  9. RD
 10. STUDENT NURSE
 11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

Select ACADEMIC DEGREE (Press return for all degrees): <RET>

Enter appropriate academic degree, or press return for all degrees.

DEVICE: HOME//Enter appropriate response
<table>
<thead>
<tr>
<th>NO.</th>
<th>LOCATION</th>
<th>SERVICE</th>
<th>EMPLOYEE</th>
<th>NAME</th>
<th>HIGHEST ACAD. DEGREE</th>
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<tbody>
<tr>
<td>1</td>
<td>3S</td>
<td>RN</td>
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<tr>
<td>1</td>
<td>3S</td>
<td>RN</td>
<td>NURSNURSE2,TWO</td>
<td>DNSC</td>
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<tr>
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<td>3S</td>
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<td>1</td>
<td>7E</td>
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<td>7E</td>
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<tr>
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<tr>
<td>3</td>
<td>NHCU</td>
<td>RN</td>
<td>NURSNURSE3,ONE</td>
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<td>NURSING OF RN</td>
<td>RN</td>
<td>NURSNURSE1,THREE</td>
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<tr>
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<td>NURSING OF RN</td>
<td>RN</td>
<td>NURSNURSE2,THREE</td>
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</table>

**NURSING NUMBER OF ASSIGNMENTS**: 13

**NURSING NUMBER OF PERSONNEL**: 11

**BALTIMORE, MD NUMBER OF ASSIGNMENTS**: 13

**BALTIMORE, MD NUMBER OF PERSONNEL**: 11

Press return to continue, "T" for totals, or "^" to exit: <RET>
HINES ACAD. EDUC. PROFILE BY LOCATION/SVC. CATEGORY FEB 24, 1997 PAGE: 3

<table>
<thead>
<tr>
<th>NO.</th>
<th>LOCATION</th>
<th>SERVICE</th>
<th>EMPLOYEE</th>
<th>HIGHEST NAME</th>
<th>HIGHEST ACAD. DEGREE</th>
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<tbody>
<tr>
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<td>2AS</td>
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<tr>
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<td>PHD</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>4ICU</td>
<td>LPN</td>
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<td></td>
</tr>
<tr>
<td>1</td>
<td>4ICU</td>
<td>RN</td>
<td>NURSNURSE3, FIVE</td>
<td>DNSC</td>
<td></td>
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<tr>
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<td>MA</td>
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</tr>
<tr>
<td>1</td>
<td>4M</td>
<td>RN</td>
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<td>MSN</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>SICU</td>
<td>CK</td>
<td>NURSNURSE3, EIGHT</td>
<td>DNSC</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>SICU</td>
<td>RN</td>
<td>NURSNURSE2, FOUR</td>
<td>BSN</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>SICU</td>
<td>RN</td>
<td>NURSNURSE3, NINE</td>
<td>BSN</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>SICU</td>
<td>RN</td>
<td>NURSNURSE3, TEN</td>
<td>MA</td>
<td></td>
</tr>
<tr>
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<td>SICU</td>
<td>RN</td>
<td>NURSNURSE3, ONE</td>
<td>MA</td>
<td></td>
</tr>
<tr>
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NURSING NUMBER OF ASSIGNMENTS 12
NURSING NUMBER OF PERSONNEL 12

DIETETICS SERVICE

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<th>HIGHEST NAME</th>
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<tbody>
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DIETETICS SERVICE NUMBER OF ASSIGNMENTS 1
DIETETICS SERVICE NUMBER OF PERSONNEL 1

HINES NUMBER OF ASSIGNMENTS 13
HINES NUMBER OF PERSONNEL 13

TOTAL NUMBER OF ASSIGNMENTS 30
TOTAL NUMBER OF PERSONNEL 28

Enter RETURN to continue or '^' to exit: <RET>
Choose a sort parameter set between 1 and 4:  2 Location and Service Position

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.

Select ACADEMIC DEGREE (Press return for all degrees): <RET>

Enter appropriate academic degree, or press return for all degrees.

DEVICE: HOME//Enter appropriate response
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<tr>
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<td>NURSNURSE2, FOUR</td>
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NURSING NUMBER OF PERSONNEL: 11

BALTIMORE, MD NUMBER OF ASSIGNMENTS: 13
BALTIMORE, MD NUMBER OF PERSONNEL: 11

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NURSING NUMBER OF ASSIGNMENTS: 13
NURSING NUMBER OF PERSONNEL: 12

DIETETICS SERVICE

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DIETETICS SERVICE NUMBER OF ASSIGNMENTS: 1
DIETETICS SERVICE NUMBER OF PERSONNEL: 1

HINES NUMBER OF ASSIGNMENTS: 14
HINES NUMBER OF PERSONNEL: 13
Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: 3  Service and Service Category


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

NURSING Service Categories
--------------------------
1.  R (RN-REGISTERED NURSE)
2.  L (LPN-LIC. PRACTICAL NURSE)
3.  N (NA-NURSING ASSISTANT)
4.  C (CK-CLERICAL)
5.  S (SE-SUMMER EMPLOYEE)
6.  A (AO-ADMIN. OFFICER)
7.  O (OT-OTHER)

OTHER Service Categories
------------------------
8.  OTHER VOLUNTEER
9.  RD
10. STUDENT NURSE
11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

Select ACADEMIC DEGREE (Press return for all degrees): <RET>

Enter appropriate academic degree, or press return for all degrees.

DEVICE: HOME//Enter appropriate response
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<tr>
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NURSING NUMBER OF ASSIGNMENTS: 13
NURSING NUMBER OF PERSONNEL: 11

BALTIMORE, MD NUMBER OF ASSIGNMENTS: 13
BALTIMORE, MD NUMBER OF PERSONNEL: 11

Press return to continue, "T" for totals, or "^" to exit: <RET>
### HINES

**ACADEMIC EDUCATION PROFILE BY SERVICE CATEGORY**  
Feb 24, 1997  
Page: 3

<table>
<thead>
<tr>
<th>No.</th>
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<th>Name</th>
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<td>RN</td>
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Nursing Number of Assignments: 12  
Nursing Number of Personnel: 12  

**Dietetics Service**

<table>
<thead>
<tr>
<th>No.</th>
<th>Employee Category</th>
<th>Name</th>
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Dietetics Service Number of Assignments: 1  
Dietetics Service Number of Personnel: 1

Hines Number of Assignments: 13  
Hines Number of Personnel: 13  

Total Number of Assignments: 30  
Total Number of Personnel: 28

Enter RETURN to continue or '^' to exit: <RET>
Administration Reports

Choose a sort parameter set between 1 and 4: 4  Service and Service Position


Select Reporting Option: 1

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.

Select ACADEMIC DEGREE (Press return for all degrees): <RET>

Enter appropriate academic degree, or press return for all degrees.

DEVICE: HOME//Enter appropriate response

ACADEMIC EDUCATION PROFILE BY SERVICE POSITION  APR 15, 1997  PAGE: 1

<table>
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<tr>
<th>SERVICE NO.</th>
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<th>EMPLOYEE NAME</th>
<th>HIGHEST ACAD. DEGREE</th>
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<td>NUMBER OF PERSONNEL</td>
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<tr>
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</table>
Menu Access:

The Academic Degree Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-AGE

Age Reports

Description:

This option prints location and service reports which provide a count of nursing personnel within specified age groups (age 18 and older). Data may be sorted by facility, product line, service category or service position. The age is determined by the date of birth field in the New Person (#200) file. Staff data reflecting assignment location, service position, and service category is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

Additional Information:

Editing of data is accomplished using the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports
Screen Prints:

Select Administrative Reports Option: 2 Age Reports

Sort by:

1. Location and Service Category
2. Location and Service Position
3. Service and Service Category
4. Service and Service Position

Choose a sort parameter set between 1 and 4: 1 Location and Service Category

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units): <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

NURSING Service Categories
-----------------------------
1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-CLERICAL)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)
OTHER Service Categories
------------------------
  8. OTHER VOLUNTEER
  9. RD
 10. STUDENT NURSE
 11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

START with DATE OF BIRTH (Press return for all dates of birth): <RET>

Enter appropriate date of birth, or press return for all dates of birth.

DEVICE: HOME//Enter appropriate response
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**NURSING**

**WARD LOCATION: 3S**

**SERVICE CATEGORY: LPN**

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**SERVICE CATEGORY: NA**

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**SUB-TOTAL:** 3 0 0 0 0 0 0 0 0

**SERVICE CATEGORY: RN**

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**WARD SUB-TOTAL:** 14 0 0 0 1 0 2 0

Press return to continue, or "^" to exit: <RET>
Choose a sort parameter set between 1 and 4: 2 Location and Service Position

Select appropriate facility or press return for all facilities.

Select appropriate product line(s) or press return for all product lines.

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

Enter appropriate service position, or press return for all service positions.
Start with DATE OF BIRTH (Press return for all dates of birth): <RET>

Enter appropriate date of birth, or press return for all dates of birth.

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Press return to continue, or "^" to exit: <RET>
HINES
NURSING SERVICE AGE PROFILE BY LOCATION/SVC POSITION    FEB 24, 1997    PAGE: 10
NAME    NO DOB 18-20 21-29 30-39 40-49 50-59 60-69 70+
---------------------------------------------------------------------

DIETETICS SERVICE
---------------------

WARD LOCATION: CNH

SERVICE POSITION: DIET/VOL

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SUB-TOTAL:  2  0  0  1  2  0  0  0
WARD SUB-TOTAL:  2  0  0  1  2  0  0  0
DIETETICS SERVICE SUB-TOTAL:  2  0  0  1  2  0  0  0
HINES SUB-TOTAL:  30  0  1  5  3  2  2

ASSIGNMENTS FINAL TOTAL:  82  0  1 11 14  5  5  3
PERSONNEL FINAL TOTAL:  70  0  1 11 14  4  4  3

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4:  3 Service and Service Category

Select Reporting Option:  2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.
NURSING Service Categories
-----------------------------
1.  R (RN-REGISTERED NURSE)
2.  L (LPN-LIC. PRACTICAL NURSE)
3.  N (NA-NURSING ASSISTANT)
4.  C (CK-CLERICAL)
5.  S (SE-SUMMER EMPLOYEE)
6.  A (AO-ADMIN. OFFICER)
7.  O (OT-OTHER)

OTHER Service Categories
------------------------
8.  OTHER VOLUNTEER
9.  RD
10. STUDENT NURSE
11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

Start with DATE OF BIRTH (Press return for all dates of birth): <RET>

Enter appropriate date of birth, or press return for all dates of birth.

DEVICE: HOME//Enter appropriate response

BALTIMORE, MD
NURSING SERVICE AGE PROFILE BY SERVICE CATEGORY FEB 24,1997 PAGE: 1
NAME NO DOB 18-20 21-29 30-39 40-49 50-59 60-69 70+
-----------------------------------------------
NURSING
--------

SERVICE CATEGORY: CK

NURSNURSE6, TWO X
NURSNURSE6, THREE X
NURSNURSE6, FOUR X

SUB-TOTAL: 1 0 0 2 0 1 0 0
NURSNURSE6, FIVE X
NURSNURSE6, SIX X
NURSNURSE6, SEVEN X

Press return to continue, or "^" to exit: <RET>
HINES
NURSING SERVICE AGE PROFILE BY SERVICE CATEGORY   FEB 24,1997   PAGE: 15
NAME
NO DOB 18-20 21-29 30-39 40-49 50-59 60-69 70+
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Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: 4 Service and Service Position


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.
Start with DATE OF BIRTH (Press return for all dates of birth): <RET>

Enter appropriate date of birth, or press return for all dates of birth.

DEVICE: HOME//Enter appropriate response

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Baltimore, MD

Nursing Service Age Profile by Service Position   Feb 24, 1997   Page: 1

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Enter RETURN to continue or '^' to exit: <RET>
Menu Access:

The Age Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-CERTF

Certification Reports

Description:

This option prints location and service reports reflecting the national certifications held by registered nurses, the agency granting the certification, and the date of its expiration. Data may be sorted by facility, product line, service category or service position. Staff data reflecting assignment location, service position, and service category is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

Additional Information:

Editing of staff certification information is accomplished using the Staff Record Edit option in the Administration Records, Enter/Edit menu. Basis certification data (e.g., name of certification sponsoring agency) is edited using the Certification File, Edit option in the Administrative Site File Functions menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2  Administration Records, Print

1  Administrative Reports ...  
2  Resource Management Reports ...  
3  Salary Reports ...  
4  Staff Record Report  
5  Telephone Number Listings ...  
6  Individual Staff Position/Location

Select Administration Records, Print Option: 1  Administrative Reports
Screen Prints:

Select Administrative Reports Option: 3 Certification Reports

Sort by:

1. Location and Service Category
2. Location and Service Position
3. Service and Service Category
4. Service and Service Position

Choose a sort parameter set between 1 and 4: 1 Location and Service Category

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

Select CERTIFICATION NAME (Press return for all certification names): <RET>

Enter appropriate nursing certification name, or press return for all nursing certification names.

Start With DATE CERTIFICATION EXPIRES (Press return for all dates): <RET>

Enter certification expiration date, or press return for all expiration dates.

DEVICE: HOME//Enter appropriate response
### Administration Reports

**Baltimore, MD**

**Certification Profile by Location/Svc. Category**

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<td>ANA</td>
<td>JUN 08, 1996</td>
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<td>ARN</td>
<td>MAR 07, 1987</td>
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Choose a sort parameter set between 1 and 4: 2 Location and Service Position

Select Facility (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select Product Line (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select Nursing Unit (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

Select Service Position (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.
Select CERTIFICATION NAME (Press return for all certification names): <RET>

Enter appropriate nursing certification name, or press return for all nursing certification names.

Start With DATE CERTIFICATION EXPIRES (Press return for all dates): <RET>

Enter certification expiration date, or press return for all expiration dates.

DEVICE: HOME//Enter appropriate response

Baltimore, MD

CERTIFICATION PROFILE BY LOCATION/SVC. POSITION FEB 24, 1997 PAGE: 1
NAME CERTIFICATION AGENCY EXPIRES
-----------------------------------------------
NURSING
---------
LOCATION: 3S
SERVICE POSITION: RN
NURSNURSE4,EIGHT GERONTOLOGICAL NURSE PRACT. ANA DEC 04, 1987

Enter RETURN to continue or '^' to exit: <RET>
HINES
CERTIFICATION PROFILE BY LOCATION/SVC. POSITION           FEB 24, 1997  PAGE: 9

NAME                    CERTIFICATION                       AGENCY  EXPIRES
--------------------------------------------------------------------------------
NURSING
--------
LOCATION:  SICU
SERVICE POSITION: HN

NURSNURSE3,NINE         ADULT NURSE PRACTITIONER            ANA     JAN 01, 1996
SERVICE POSITION: CARD RN

NURSNURSE3,TEN          NURSING ADMINISTRATION              ANA
SERVICE POSITION: RN

Enter RETURN to continue or '^' to exit: <RET>

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Select CERTIFICATION NAME (Press return for all certification names): <RET>

Enter appropriate nursing certification name, or press return for all nursing certification names.

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### Hines Certification Profile by Service Position

**FEB 27, 1997 PAGE: 3**

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<td>ANA</td>
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</table>

Enter RETURN to continue or '^' to exit: <RET>

### Menu Access:

The Certification Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-GENDER

Gender Reports

Description:

This option prints location and service reports which provide a count of employees by gender. Data may be sorted by facility, product line, service category or service position. Staff data reflecting assignment location, service position, and service category is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

Additional Information:

Editing of data is accomplished using the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports

1 Academic Degree Reports
2 Age Reports
3 Certification Reports
4 Gender Reports
5 Grade Reports
6 License Reports
7 Military Reports
8 NFSB Reports
9 Nursing Degree Reports
10 Proficiency Reports
11 Comb. Acad./Nurs. Degree Reports
Screen Prints:

Select Administrative Reports Option: 4 Gender Reports

Sort by:

1. Location and Service Category
2. Location and Service Position
3. Service and Service Category
4. Service and Service Position

Choose a sort parameter set between 1 and 4: 1 Location and Service Category

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units): <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

NURSING Service Categories
--------------------------
1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-CLERICAL)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)

OTHER Service Categories
------------------------
8. OTHER VOLUNTEER
9. RD
10. STUDENT NURSE
11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.
Select GENDER (Press return for both male and female): <RET>

Enter appropriate gender, or press return for both.

DEVICE: HOME//Enter appropriate response

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NURSING NUMBER OF PERSONNEL 58
Administration Reports

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BALTIMORE, MD NUMBER OF MALES 18
BALTIMORE, MD NUMBER OF FEMALES 40
BALTIMORE, MD NUMBER OF PERSONNEL 58

Press return to continue, "T" for totals, or "^" to exit: <RET>

-------------------------------------------------------------------------------------------------------------(last page of report)

HINES

GENDER BY LOCATION AND SERVICE CATEGORY       FEB 24, 1997      PAGE: 3

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NURSING NUMBER OF ASSIGNMENTS 42
NURSING NUMBER OF PERSONNEL 42

AMBULATORY CARE

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AMBULATORY CARE NUMBER OF ASSIGNMENTS 2
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**DIETETICS SERVICE**

- Number of Assignments: 5
- Number of Personnel: 5

**HINES**

- Number of Assignments: 49
- Number of Males: 15
- Number of Females: 34
- Number of Personnel: 49

**TOTAL**

- Number of Assignments: 123
- Number of Males: 33
- Number of Females: 76
- Number of Personnel: 109

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: 2 Location and Service Position

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.
Select GENDER (Press return for both male and female): <RET>

Enter appropriate gender, or press return for both.

DEVICE: HOME// Enter appropriate response

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NURSING NUMBER OF ASSIGNMENTS 42
NURSING NUMBER OF PERSONNEL 42
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**DIETETICS SERVICE**

- **NUMBER OF ASSIGNMENTS**: 5
- **NUMBER OF PERSONNEL**: 5

**HINES**

- **NUMBER OF ASSIGNMENTS**: 47
- **NUMBER OF MALES**: 14
- **NUMBER OF FEMALES**: 33
- **NUMBER OF PERSONNEL**: 47

**TOTAL**

- **NUMBER OF ASSIGNMENTS**: 121
- **NUMBER OF MALES**: 32
- **NUMBER OF FEMALES**: 75
- **NUMBER OF PERSONNEL**: 107

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: **3**  
Service and Service Category


Select Reporting Option: **2**

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.
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1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-CLERICAL)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)

OTHER Service Categories
------------------------
8. OTHER VOLUNTEER
9. RD
10. STUDENT NURSE
11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

Select GENDER (Press return for both male and female): <RET>

Enter appropriate gender, or press return for both.

DEVICE: HOME//Enter appropriate response
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BALTIMORE, MD NUMBER OF MALES                    18
BALTIMORE, MD NUMBER OF FEMALES                  40
BALTIMORE, MD NUMBER OF PERSONNEL                58

Press return to continue, "T" for totals, or "^" to exit: <RET>

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AMBULATORY CARE

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AMBULATORY CARE NUMBER OF ASSIGNMENTS               2
AMBULATORY CARE NUMBER OF PERSONNEL                2
**Dietetics Service**

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**Dietetics Service Number of Assignments:** 5

**Dietetics Service Number of Personnel:** 5

---

**Hines Number of Assignments:** 49

**Hines Number of Males:** 15

**Hines Number of Females:** 34

**Hines Number of Personnel:** 49

---

**Total Number of Assignments:** 123

**Total Number of Males:** 33

**Total Number of Females:** 76

**Total Number of Personnel:** 109

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: 4  Service and Service Position


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select Facility (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select Product Line (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.
Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.

Select GENDER (Press return for male and female): <RET>

Enter appropriate gender, or press return for both.

DEVICE: HOME//Enter appropriate response

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NURSING NUMBER OF ASSIGNMENTS 62
NURSING NUMBER OF PERSONNEL 58

BALTIMORE, MD NUMBER OF ASSIGNMENTS 62
BALTIMORE, MD NUMBER OF MALES 18
BALTIMORE, MD NUMBER OF FEMALES 40
BALTIMORE, MD NUMBER OF PERSONNEL 58

Press return to continue, "T" for totals, or "^" to exit: <RET>

HINES
GENDER BY SERVICE POSITION FEB 24, 1997 PAGE: 3

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NURSING NUMBER OF ASSIGNMENTS 42
NURSING NUMBER OF PERSONNEL 42
### DIETETICS SERVICE

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**DIETETICS SERVICE NUMBER OF ASSIGNMENTS**: 5

**DIETETICS SERVICE NUMBER OF PERSONNEL**: 5

**HINES NUMBER OF ASSIGNMENTS**: 47

**HINES NUMBER OF MALES**: 14

**HINES NUMBER OF FEMALES**: 33

**HINES NUMBER OF PERSONNEL**: 47

**TOTAL NUMBER OF ASSIGNMENTS**: 121

**TOTAL NUMBER OF MALES**: 32

**TOTAL NUMBER OF FEMALES**: 75

**TOTAL NUMBER OF PERSONNEL**: 107

Enter RETURN to continue or '^' to exit: <RET>

**Menu Access:**

The Gender Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-GRADE

Grade Reports

Description:

This option prints location and service reports which summarize the number of employees within all grade levels. Data may be sorted by facility, product line, service category or service position. Staff data reflecting assignment location, service position, and service category is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

Additional Information:

Editing of grade/step codes is accomplished for an individual employee through the Staff Record Edit option in the Administration Records, Enter/Edit menu. Salary comes from the PAID Employee (#450) file, and cannot be edited through the nursing software.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

  1    Administrative Reports ...  
  2    Resource Management Reports ...  
  3    Salary Reports ...  
  4    Staff Record Report  
  5    Telephone Number Listings ...  
  6    Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports
1      Academic Degree Reports
2      Age Reports
3      Certification Reports
4      Gender Reports
5      Grade Reports
6      License Reports
7      Military Reports
8      NPSB Reports
9      Nursing Degree Reports
10     Proficiency Reports
11     Comb. Acad./Nurs. Degree Reports

Screen Prints:

Select Administrative Reports Option: 5 Grade Reports

Sort by:

    1. Location and Service Category
    2. Location and Service Position
    3. Service and Service Category
    4. Service and Service Position

Choose a sort parameter set between 1 and 4: 1 Location and Service Category

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

NURSING Service Categories
----------------------------------
1.  R (RN-REGISTERED NURSE) 
2.  L (LPN-LIC. PRACTICAL NURSE) 
3.  N (NA-NURSING ASSISTANT) 
4.  C (CK-CLERICAL) 
5.  S (SE-SUMMER EMPLOYEE) 
6.  A (AO-ADMIN. OFFICER) 
7.  O (OT-OTHER)
OTHER Service Categories
------------------------
  8. OTHER VOLUNTEER
  9. RD
 10. STUDENT NURSE
 11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

Select GRADE/STEP CODE (Press return for all grade/step codes): <RET>

Enter appropriate grade/step code, or press return for all grade/step codes.

DEVICE: HOME//Enter appropriate response
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**DIETETICS SERVICE**

---

**NUMBER OF ASSIGNMENTS**

### DIETETICS SERVICE

- **NUMBER OF ASSIGNMENTS**: 5
- **NUMBER OF PERSONNEL**: 5

### HINES

- **NUMBER OF ASSIGNMENTS**: 49
- **NUMBER OF PERSONNEL**: 49

**TOTAL**

- **NUMBER OF ASSIGNMENTS**: 118
- **NUMBER OF PERSONNEL**: 114

Enter RETURN to continue or '^' to exit: `<RET>`

Choose a sort parameter set between 1 and 4: 

**Location and Service Position**

Select **FACILITY** (Press return for all facilities): `<RET>`

Select appropriate facility or press return for all facilities.

Select **PRODUCT LINE** (Press return for all product lines): `<RET>`

Select appropriate product line(s) or press return for all product lines.

Select **NURSING UNIT** (Enter return for all units) : `<RET>`

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter `<RET>` for all nursing units in the facility.

Select **SERVICE POSITION** (Press return for all service positions): `<RET>`

Enter appropriate service position, or press return for all service positions.

Select **GRADE/STEP CODE** (Press return for all grade/step codes): `<RET>`

Enter appropriate grade/step code, or press return for all grade/step codes.

**DEVICE**: HOME//Enter appropriate response
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NURSING NUMBER OF ASSIGNMENTS: 66
NURSING NUMBER OF PERSONNEL: 58

---
**Administration Reports**

Baltimore, MD number of assignments: 66
Baltimore, MD number of personnel: 58

Press return to continue, "T" for totals, or "^" to exit: <RET>

---

Hines
Grade profile by location and service position

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Nursing number of assignments: 43
Nursing number of personnel: 42
Administration Reports

DIETETICS SERVICE
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1    CNH    DIET/VOL  NURSNURSE5,EIGHT   C/4/3
1    CNH    DIET/VOL  NURSNURSE5,SIX      R/2-2/2
1    CNH    DIET/VOL  NURSNURSE6,ONE      R/A/5

---------------------------------
DIETETICS SERVICE NUMBER OF ASSIGNMENTS  5
DIETETICS SERVICE NUMBER OF PERSONNEL    5
---------------------------------
HINES NUMBER OF ASSIGNMENTS              48
HINES NUMBER OF PERSONNEL                47
---------------------------------
TOTAL NUMBER OF ASSIGNMENTS              121
TOTAL NUMBER OF PERSONNEL                112

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: 3   Service and Service Category


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.
NURSING Service Categories
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  1. R (RN-REGISTERED NURSE)
  2. L (LPN-LIC. PRACTICAL NURSE)
  3. N (NA-NURSING ASSISTANT)
  4. C (CK-CLERICAL)
  5. S (SE-SUMMER EMPLOYEE)
  6. A (AO-ADMIN. OFFICER)
  7. O (OT-OTHER)

OTHER Service Categories
-------------------------
  8. OTHER VOLUNTEER
  9. RD
 10. STUDENT NURSE
 11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

Select GRADE/STEP CODE (Press return for all grade/step codes): <RET>

Enter appropriate grade/step code, or press return for all grade/step codes.

DEVICE: HOME//Enter appropriate response
### Administration Reports

**BALTIMORE, MD**

**GRADE PROFILE BY SERVICE CATEGORY**  
**FEB 24, 1997**  
**PAGE: 1**

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**NURSING NUMBER OF ASSIGNMENTS**  
62

**NURSING NUMBER OF PERSONNEL**  
58

**BALTIMORE, MD NUMBER OF ASSIGNMENTS**  
62

**BALTIMORE, MD NUMBER OF PERSONNEL**  
58

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Nursing number of personnel: 42
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Dietetics Service Number of Assignments: 5
Dietetics Service Number of Personnel: 5

Hines Number of Assignments: 49
Hines Number of Personnel: 49

Total Number of Assignments: 118
Total Number of Personnel: 114

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: 4 Service and Service Position


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select SERVICE POSITION (Press return for all service positions): <RET>

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Select GRADE/STEP CODE (Press return for all grade/step codes): <RET>

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NURSING NUMBER OF ASSIGNMENTS 66
NURSING NUMBER OF PERSONNEL 58
Administration Reports

BALTIMORE, MD NUMBER OF ASSIGNMENTS 66
BALTIMORE, MD NUMBER OF PERSONNEL 58

Press return to continue, "T" for totals, or "^" to exit: <RET>

---------------------------------------------(last page of report)

HINES
GRADE PROFILE BY SERVICE POSITION FEB 24, 1997 PAGE: 3

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NURSING NUMBER OF ASSIGNMENTS 43
NURSING NUMBER OF PERSONNEL 42
DIETETICS SERVICE
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1     DIET/VOL   NURSNURSE5, NINE
1     DIET/VOL   NURSNURSE5, EIGHT               C/4/3
1     DIET/VOL   NURSNURSE5, SIX                 R/2-2/2
2     DIET/VOL   NURSNURSE5, SEVEN               R/2-2/2
1     DIET/VOL   NURSNURSE6, ONE                 R/A/5

DIETETICS SERVICE NUMBER OF ASSIGNMENTS           5
DIETETICS SERVICE NUMBER OF PERSONNEL             5
---------------------------------
HINES NUMBER OF ASSIGNMENTS                      48
HINES NUMBER OF PERSONNEL                        47
---------------------------------
TOTAL NUMBER OF ASSIGNMENTS                     121
TOTAL NUMBER OF PERSONNEL                       112

Enter RETURN to continue or '^' to exit: <RET>

Menu Access:

The Grade Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-LICENSE

License Reports

Description:

This option prints location and service reports, which summarize information on state licenses held by employees. Information includes employee name, social security number, expiration date of license, state issuing license, and professional license number. Data may be sorted by facility, product line and state. Staff information reflecting assignment location is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

Additional Information:

Licenses aren't associated with the category of personnel, therefore, all licenses will show on the report for an employee with an active status. For example, if a current RN holds a current RN license, and previously held an LPN license, both licenses appear on the report.

Editing of data for an individual is accomplished through the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1      Administrative Reports ...
2      Resource Management Reports ...
3      Salary Reports ...
4      Staff Record Report
5      Telephone Number Listings ...
6      Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports
行政报告

1. 学术学位报告
2. 年龄报告
3. 认证报告
4. 性别报告
5. 等级报告
6. 许可报告
7. 军事报告
8. NPSB 报告
9. 护理学位报告
10. 熟练度报告
11. 综合学术/护理学位报告

屏幕打印：

选择行政报告选项：6 许可报告

按 (1) 位置或 (2) 服务：1 位置

选择设施（按所有设施返回）：<RET>

选择合适的位置或按所有设施返回。

选择产品线（按所有产品线返回）：<RET>

选择合适的产品线或按所有产品线返回。

选择护理单元（按所有单元返回）：<RET>

选择一个活跃的护理单元，由 Ward Status 字段的 NURS Location File, Edit 选项定义。您也可以按<RET>键选择所有护理单元。

NURSING 服务类别
-------------------------
1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-Clerical)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)

OTHER 服务类别
-------------------------
8. OTHER VOLUNTEER
9. RD
10. STUDENT NURSE
11. ALL

选择服务类别：11

输入合适的服务类别。你可以选择一个或多个服务类别进行排序。

April 1997      Nursing V. 4.0 User Manual
Administration  3.71
Administration Reports

Start With DATE LICENSE EXPIRES (Press return for all dates): <RET>

Enter license expiration date, or press return for all expiration dates.

Select STATE (Press return for all states): <RET>

Enter state, or press return for all states.

DEVICE: HOME//Enter appropriate response

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<th>NAME</th>
<th>SVC</th>
<th>CAT.</th>
<th>SSN</th>
<th>DATE OF ISS.</th>
<th>LICENSE</th>
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HINES

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(last page of report)
LOCATION: CNH

NURSNURSE6,ONE      VOLUNT  000-22-2222  JAN 01, 1999 IL  93749357
NURSNURSE5,EIGHT     VOLUNT  000-62-8440

Enter RETURN to continue or '^' to exit: <RET>

License Report By (1) Location or (2) Service: 2  Service

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

NURSING Service Categories
--------------------------
1.  R (RN-REGISTERED NURSE)
2.  L (LPN-LIC. PRACTICAL NURSE)
3.  N (NA-NURSING ASSISTANT)
4.  C (CK-CLERICAL)
5.  S (SE-SUMMER EMPLOYEE)
6.  A (AO-ADMIN. OFFICER)
7.  O (OT-OTHER)

OTHER Service Categories
------------------------
8.  OTHER VOLUNTEER
9.  RD
10. STUDENT NURSE
11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service category.

Start With DATE LICENSE EXPIRES (Press return for all dates): <RET>

Enter license expiration date, or press return for all expiration dates.

Select STATE (Press return for all states): <RET>

Enter state, or press return for all states.

DEVICE: HOME//Enter appropriate response
## Administration Reports

### BALTIMORE, MD

**LICENSE PROFILE**

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<th>LIC. NUMBER</th>
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**LICENSE PROFILE**

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Enter RETURN to continue or '^' to exit: <RET>
Menu Access:

The License Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-MILITARY

Military Reports

Description:

This option prints location and service reports summarizing the military experience of employees. Data may be sorted by facility, product line, service category or service position. Staff data reflecting assignment location, service position, and service category is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

Additional Information:

Editing of data for an individual is accomplished through the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports

1 Academic Degree Reports
2 Age Reports
3 Certification Reports
4 Gender Reports
5 Grade Reports
6 License Reports
7 Military Reports
8 NFSB Reports
9 Nursing Degree Reports
10 Proficiency Reports
11 Comb. Acad./Nurs. Degree Reports
**Screen Prints:**

Select Administrative Reports Option: 7 Military Reports

Sort by:

1. Location and Service Category
2. Location and Service Position
3. Service and Service Category
4. Service and Service Position

Choose a sort parameter set between 1 and 4: 1 Location and Service Category

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

**NURSING Service Categories**

--------------------------
1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-Clerical)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)

**OTHER Service Categories**

------------------------
8. OTHER VOLUNTEER
9. RD
10. STUDENT NURSE
11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

Select MILITARY STATUS (Press return for retired and active reservists): <RET>

Enter appropriate military status, or press return for retired and active reservists.
Select MILITARY SERVICE BRANCH (Press return for all service branches): <RET>

Enter appropriate military service branch, or press return for all service branches.

DEVICE: HOME// Enter appropriate response

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NURSING NUMBER OF ASSIGNMENTS 15
NURSING NUMBER OF PERSONNEL 10

BALTIMORE, MD NUMBER OF ASSIGNMENTS 15
BALTIMORE, MD NUMBER OF PERSONNEL 10

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**NURSING**

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NURSING NUMBER OF ASSIGNMENTS 8
NURSING NUMBER OF PERSONNEL 8

HINES NUMBER OF ASSIGNMENTS 8
HINES NUMBER OF PERSONNEL 8

TOTAL NUMBER OF ASSIGNMENTS 25
TOTAL NUMBER OF PERSONNEL 19

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: 2  Location and Service Position

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.
Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.

Select MILITARY STATUS (Press return for retired and active reservists): <RET>

Enter appropriate military status, or press return for retired and active reservists.

Select MILITARY SERVICE BRANCH (Press return for all service branches): <RET>

Enter appropriate military service branch, or press return for all service branches.

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NURSING NUMBER OF ASSIGNMENTS: 15
NURSING NUMBER OF PERSONNEL: 14

BALTIMORE, MD NUMBER OF ASSIGNMENTS: 15
BALTIMORE, MD NUMBER OF PERSONNEL: 14

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Nursing Number of Assignments: 8
Nursing Number of Personnel: 7

Hines Number of Assignments: 8
Hines Number of Personnel: 7

Total Number of Assignments: 25
Total Number of Personnel: 23

Choose a sort parameter set between 1 and 4: 3 Service and Service Category


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.
Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

NURSING Service Categories
--------------------------
1. R (RN-REGISTERED NURSE)  
2. L (LPN-LIC. PRACTICAL NURSE)  
3. N (NA-NURSING ASSISTANT)  
4. C (CK-CLERICAL)  
5. S (SE-SUMMER EMPLOYEE)  
6. A (AO-ADMIN. OFFICER)  
7. O (OT-OTHER)

OTHER Service Categories
------------------------
8. OTHER VOLUNTEER  
9. RD  
10. STUDENT NURSE  
11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

Select MILITARY STATUS (Press return for retired and active reservists): <RET>

Enter appropriate military status, or press return for retired and active reservists.

Select MILITARY SERVICE BRANCH (Press return for all service branches): <RET>

Enter appropriate military service branch, or press return for all service branches.

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NURSING NUMBER OF ASSIGNMENTS: 29  
NURSING NUMBER OF PERSONNEL: 16

BALTIMORE, MD NUMBER OF ASSIGNMENTS: 29  
BALTIMORE, MD NUMBER OF PERSONNEL: 16

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**NURSING**

NURSING NUMBER OF ASSIGNMENTS: 8  
NURSING NUMBER OF PERSONNEL: 8

**DIETETICS SERVICE**

DIETETICS SERVICE NUMBER OF ASSIGNMENTS: 1  
DIETETICS SERVICE NUMBER OF PERSONNEL: 1

HINES NUMBER OF ASSIGNMENTS: 9  
HINES NUMBER OF PERSONNEL: 9

TOTAL NUMBER OF ASSIGNMENTS: 41  
TOTAL NUMBER OF PERSONNEL: 27

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4:  

Service and Service Position

Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.

Select MILITARY STATUS (Press return for retired and active reservists): <RET>

Enter appropriate military status, or press return for retired and active reservists.

Select MILITARY SERVICE BRANCH (Press return for all service branches): <RET>

Enter appropriate military service branch, or press return for all service branches.

DEVICE: HOME/\Enter appropriate response
### MILITARY PROFILE BY SERVICE POSITION

**FEB 24, 1997**

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**NURSING**

---

**NURSING NUMBER OF ASSIGNMENTS**: 29

**NURSING NUMBER OF PERSONNEL**: 16

**BALTIMORE, MD NUMBER OF ASSIGNMENTS**: 29

**BALTIMORE, MD NUMBER OF PERSONNEL**: 16

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## NURSING

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**NURSING**

- Number of Assignments: 9
- Number of Personnel: 8

## DIETETICS SERVICE

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<td>ARMY</td>
</tr>
</tbody>
</table>

**DIETETICS SERVICE**

- Number of Assignments: 1
- Number of Personnel: 1

**HINES**

- Number of Assignments: 10
- Number of Personnel: 9

**TOTAL**

- Number of Assignments: 42
- Number of Personnel: 27

Enter RETURN to continue or '^

<RET>
Menu Access:

The Military Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-NPSB

NPSB Reports

Description:

This option prints location, service, and individual reports of NPSB actions on RN/LPN/LVN employees. Data may be sorted by facility and product line. Staff data reflecting assignment location is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

Additional Information:

This report is 132 columns. Editing of data is accomplished for an individual employee through the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contains the value of 'yes'.

The reports sorted by service and location contain the latest proficiency and NPSB information for each RN and LPN. All assignment locations for these employees are printed in the service and location report. The individual report contains historical as well as the latest proficiency and NPSB information for the individual. Only the primary assignment location is reflected in the individual report.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1   Administrative Reports ... 
2   Resource Management Reports ... 
3   Salary Reports ... 
4   Staff Record Report 
5   Telephone Number Listings ... 
6   Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports

---

1 Patch NUR*4*3 January 1998
Screen Prints:

Select Administrative Reports Option: 8 NPSB Reports

By (1) Location (2) Service or (3) Individual: 1 Location

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units): <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

NURSING Service Categories
--------------------------
1.  R (RN-REGISTERED NURSE)
2.  L (LPN-LIC. PRACTICAL NURSE)
3.  ALL

Select SERVICE CATEGORY: 3

1 Enter appropriate service categories. You may select one or more service categories as sort parameter(s).

Start With ACTION DATE (Press return for all dates): <RET>

Enter appropriate action date, or press return for all action dates.

DEVICE: Enter appropriate response
### Nursing Service NPSB Profile by Location

**Baltimore, MD**

**FEB 28, 1997**

**Page: 1**

<table>
<thead>
<tr>
<th>NAME</th>
<th>SSN</th>
<th>LOCATION</th>
<th>CATEGORY</th>
<th>IS SENT OUT DATE</th>
<th>FOR TYPING DATE</th>
<th>TENTATIVE DATE FOR BOARD ACT.</th>
<th>ACTUAL DATE</th>
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<td>SEP 14, 1993</td>
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</table>

Enter RETURN to continue or ‘^’ to exit: <RET>

**NPSB Reports By (1) Location, (2) Service or (3) Individual:**

Select **FACILITY** (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select **PRODUCT LINE** (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

**NURSING Service Categories**

1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. ALL

Select **SERVICE CATEGORY:**

1. Enter appropriate service categories. You may select one or more service categories as sort parameter(s).

Start With **ACTION DATE** (Press return for all dates): <RET>

Enter appropriate action date, or press return for all action dates.

**DEVICE:** Enter appropriate response

---

1 Patch NUR*4*3 January 1998
### Administration Reports

#### NURSING SERVICE NPSB PROFILE BY LOCATION

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<th>SSN</th>
<th>LOCATION</th>
<th>CATEGORY</th>
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<th>FOR TYPING</th>
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<th>ACTUAL DATE</th>
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<td>SEP 16, 1993</td>
<td>SEP 15, 1993</td>
<td>SEP 14, 1993</td>
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Enter RETURN to continue or '^' to exit: <RET>

By (1) Location (2) Service or (3) Individual: 3 Individual

Select Nursing Staff Name: NURSNURSE,ONE 000607942 RN

...OK? YES// <RET> (YES)

#### DEVICE: Enter appropriate response

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Enter RETURN to continue or '^' to exit: <RET>

**Menu Access:**

The NPSB Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-NDGREE

Nursing Degree Reports

Description:

This option prints location and service reports summarizing the highest nursing degree held by registered nurses. Data may be sorted by facility, product line, service category or service position. Staff data reflecting assignment location, service position, and service category is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

Additional Information:

Editing of data for an individual employee is accomplished through the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports
1      Academic Degree Reports
2      Age Reports
3      Certification Reports
4      Gender Reports
5      Grade Reports
6      License Reports
7      Military Reports
8      NPSB Reports
9      Nursing Degree Reports
10     Proficiency Reports
11     Comb. Acad./Nurs. Degree Reports

Screen Prints:

Select Administrative Reports Option: 9 Nursing Degree Reports

Sort by:

1. Location and Service Category
2. Location and Service Position
3. Service and Service Category
4. Service and Service Position

Choose a sort parameter set between 1 and 4: 1 Location and Service Category

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of active nursing units as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

Select NURSING DEGREE (Press return for all nursing degrees): <RET>

Enter appropriate nursing degree, or press return for all nursing degrees.

DEVICE: HOME//Enter appropriate response
### Nursing Educ. Profile by Location/Svc. Category

**FEB 24, 1997**

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**Number of Assignments**

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**Number of Personnel**

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NURSING NUMBER OF ASSIGNMENTS: 27
NURSING NUMBER OF PERSONNEL: 27

HINES NUMBER OF ASSIGNMENTS: 27
HINES NUMBER OF PERSONNEL: 27

TOTAL NUMBER OF ASSIGNMENTS: 72
TOTAL NUMBER OF PERSONNEL: 68

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: 2 Location and Service Position

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.
Select NURSING UNIT (Enter return for all units): <RET>

Select the name of active nursing units as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.

Select NURSING DEGREE (Press return for all nursing degrees): <RET>

Enter appropriate nursing degree, or press return for all nursing degrees.

DEVICE: HOME//Enter appropriate response
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NURSING NUMBER OF PERSONNEL: 35

Baltimore, MD
NUMBER OF ASSIGNMENTS: 43

BALTIMORE, MD NUMBER OF PERSONNEL: 35

Press return to continue, "T" for totals, or "^" to exit: <RET>
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NURSING NUMBER OF ASSIGNMENTS: 28
NURSING NUMBER OF PERSONNEL: 27

HINES NUMBER OF ASSIGNMENTS: 28
HINES NUMBER OF PERSONNEL: 27

TOTAL NUMBER OF ASSIGNMENTS: 77
TOTAL NUMBER OF PERSONNEL: 68

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: 3 Service and Service Category

Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING DEGREE (Press return for all nursing degrees): <RET>

Enter appropriate nursing degree, or press return for all nursing degrees.

DEVICE: HOME//Enter appropriate response
NURSING EDUCATION PROFILE BY SERVICE CATEGORY

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<th>SERVICE</th>
<th>EMPLOYEE</th>
<th>HIGHEST NURSING DEGREE</th>
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<tbody>
<tr>
<td>1</td>
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NURSING NUMBER OF ASSIGNMENTS: 39
NURSING NUMBER OF PERSONNEL: 35

BALTIMORE, MD NUMBER OF ASSIGNMENTS: 39
BALTIMORE, MD NUMBER OF PERSONNEL: 35

Press return to continue, "T" for totals, or "^" to exit: <RET>
HINES
NURSING EDUCATION PROFILE BY SERVICE CATEGORY
FEB 24, 1997

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NURSING NUMBER OF ASSIGNMENTS: 27
NURSING NUMBER OF PERSONNEL: 27
HINES NUMBER OF ASSIGNMENTS: 27
HINES NUMBER OF PERSONNEL: 27
TOTAL NUMBER OF ASSIGNMENTS: 72
TOTAL NUMBER OF PERSONNEL: 68

Enter RETURN to continue or '^' to exit: <RET>

Choose a sort parameter set between 1 and 4: 4 Service and Service Position


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.
Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.

Select NURSING DEGREE (Press return for all nursing degrees): <RET>

Enter appropriate nursing degree, or press return for all nursing degrees.

DEVICE: HOME//Enter appropriate response
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NURSING NUMBER OF ASSIGNMENTS 43
NURSING NUMBER OF PERSONNEL 35

BALTIMORE, MD NUMBER OF ASSIGNMENTS 43
BALTIMORE, MD NUMBER OF PERSONNEL 35

Press return to continue, "T" for totals, or "^" to exit: <RET>
### Nursing Education Profile by Service Position

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**Nursing Number of Assignments:** 28  
**Nursing Number of Personnel:** 27

**Hines Number of Assignments:** 28  
**Hines Number of Personnel:** 27

**Total Number of Assignments:** 77  
**Total Number of Personnel:** 65

Enter RETURN to continue or '^' to exit: <RET>

## Menu Access:

The Nursing Degree Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-PROF

Proficiency Reports

Description:

This option prints location, service, and individual reports on actions taken to process the proficiencies/annual narratives of registered nurses. Data may be sorted by facility and product line. Staff data reflecting assignment location is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

Additional Information:

This report is 132 columns. Editing of data is accomplished for an individual employee through the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ... 
2 Resource Management Reports ... 
3 Salary Reports ... 
4 Staff Record Report 
5 Telephone Number Listings ... 
6 Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports

1 Academic Degree Reports 
2 Age Reports 
3 Certification Reports 
4 Gender Reports 
5 Grade Reports 
6 License Reports 
7 Military Reports 
8 NFSB Reports 
9 Nursing Degree Reports 
10 Proficiency Reports 
11 Comb. Acad./Nurs. Degree Reports
Screen Prints:

Select Administrative Reports Option: **10** Proficiency Reports

Proficiency Reports By (1) Location, (2) Service or (3) Individual: **1 Location**

Select FACILITY (Press return for all facilities): **<RET>**

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): **<RET>**

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : **<RET>**

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter **<RET>** for all nursing units in the facility.

Select DUE DATE (Press return for all dates): **<RET>**

Enter appropriate due date, or press return for all due dates.

DEVICE: **Enter appropriate response**

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Press return to continue or "^" to exit: **<RET>**

Proficiency Reports By (1) Location, (2) Service or (3) Individual: **2 Service**

Select FACILITY (Press return for all facilities): **<RET>**

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): **<RET>**

Select appropriate product line(s) or press return for all product lines.
Select DUE DATE (Press return for all dates): <RET>

Enter appropriate due date, or press return for all due dates.

DEVICE: Enter appropriate response

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<th>EVALUATOR</th>
<th>SENT OUT</th>
<th>FOR TYPING</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSNURSE2,THREE</td>
<td>000-64-3123</td>
<td>NURSING OF JUN 06, 1996</td>
<td>NURSNURSE2,NINE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE3,THREE</td>
<td>000-40-5678</td>
<td>SICU</td>
<td>JAN 01, 1990</td>
<td>NURSNURSE2,THREE</td>
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<tr>
<td>NURSNURSE2,THREE</td>
<td>000-64-3123</td>
<td>33</td>
<td>AUG 14, 1990</td>
<td>NURSNURSE11,NINE</td>
<td></td>
<td></td>
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<tr>
<td>NURSNURSE2,THREE</td>
<td>000-64-3123</td>
<td>NURSING OF AUG 14, 1990</td>
<td>NURSNURSE11,NINE</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>NURSNURSE2,THREE</td>
<td>000-64-3123</td>
<td>33</td>
<td>JUL 31, 1991</td>
<td>NURSNURSE2,NINE</td>
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<td></td>
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<td>NURSNURSE2,THREE</td>
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<td>NURSING OF JUL 31, 1991</td>
<td>NURSNURSE2,NINE</td>
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<tr>
<td>NURSNURSE2,THREE</td>
<td>000-64-3123</td>
<td>33</td>
<td>OCT 01, 1991</td>
<td>NURSNURSE1,ONE</td>
<td>AUG 30, 1993</td>
<td>SEP 10, 1993</td>
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<tr>
<td>NURSNURSE2,THREE</td>
<td>000-64-3123</td>
<td>NURSING OF OCT 01, 1991</td>
<td>NURSNURSE1,ONE</td>
<td>AUG 30, 1993</td>
<td>SEP 10, 1993</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>

Proficiency Reports By (1) Location, (2) Service or (3) Individual: 3 Individual

Select Nursing Staff Name: NURSNURSE,ONE 000607942 RN

...OK? YES// <RET> (YES)

DEVICE: Enter appropriate response

<table>
<thead>
<tr>
<th>NAME</th>
<th>SSN</th>
<th>LOCATION</th>
<th>DATE</th>
<th>DUE</th>
<th>EVALUATOR</th>
<th>SENT OUT</th>
<th>FOR TYPING</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSNURSE,ONE</td>
<td>000-60-7942</td>
<td>MICU</td>
<td>MAY 05, 1986</td>
<td>NURSNURSE2,THREE</td>
<td>MAY 05, 1996</td>
<td>MAY 05, 1996</td>
<td></td>
</tr>
<tr>
<td>NURSNURSE,ONE</td>
<td>000-60-7942</td>
<td>MICU</td>
<td>MAY 05, 1996</td>
<td>NURSNURSE1,ONE</td>
<td>MAY 05, 1996</td>
<td>MAY 05, 1996</td>
<td></td>
</tr>
<tr>
<td>NURSNURSE,ONE</td>
<td>000-60-7942</td>
<td>MICU</td>
<td>MAY 06, 1996</td>
<td>NURSNURSE4,THREE</td>
<td>MAY 06, 1996</td>
<td>MAY 06, 1996</td>
<td></td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>

Menu Access:

The Proficiency Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
**NURAPR-CDGREE**

**Comb. Acad./Nurs. Degree Reports**

**Description:**

This option prints location, service, and individual reports summarizing the highest academic and nursing degree held by employees. Data may be sorted by facility and product line. Staff data reflecting assignment location is found in the NURS Position Control (#211.8) file. All other data is found in the NURS Staff (#210) file.

**Additional Information:**

Editing of data for an individual employee is accomplished through the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

**Menu Display:**

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 1 Administrative Reports

1 Academic Degree Reports
2 Age Reports
3 Certification Reports
4 Gender Reports
5 Grade Reports
6 License Reports
7 Military Reports
8 NFSB Reports
9 Nursing Degree Reports
10 Proficiency Reports
11 Comb. Acad./Nurs. Degree Reports
Screen Prints:

Select Administrative Reports Option: 11  Comb. Acad./Nurs. Degree Reports

By (1) Location (2) Service or (3) Individual: 1  Location

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units): <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

NURSING Service Categories
------------------------------
1.  R (RN-REGISTERED NURSE)
2.  L (LPN-LIC. PRACTICAL NURSE)
3.  N (NA-NURSING ASSISTANT)
4.  C (CK-CLERICAL)
5.  S (SE-SUMMER EMPLOYEE)
6.  A (AO-ADMIN. OFFICER)
7.  O (OT-OTHER)

OTHER Service Categories
--------------------------
8.  OTHER VOLUNTEER
9.  RD
10.  STUDENT NURSE
11.  ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

DEVICE: HOME//Enter appropriate response
<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>CAT</th>
<th>SSN</th>
<th>DEGREE, CODE, PRIORITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSNURSE2,THREE</td>
<td>RN</td>
<td>000643123</td>
<td>Nursing diploma DIP 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bachelor's degree in Nursing BSN 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Doctoral degree PHD 4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bachelor's degree BA 2</td>
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<td></td>
<td></td>
<td></td>
<td>Associate degree in Nursing AD 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Master's degree in Nursing MSN 3</td>
</tr>
<tr>
<td>NURSNURSE4,EIGHT</td>
<td>RN</td>
<td>000311497</td>
<td>Bachelor's degree BA 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Nursing diploma DIP 0</td>
</tr>
<tr>
<td>NURSNURSE1,THREE</td>
<td>RN</td>
<td>000662610</td>
<td>Nursing diploma DIP 0</td>
</tr>
</tbody>
</table>

---HIGHEST NURSING DEGREE---
Master's degree in Nursing

---HIGHEST ACADEMIC DEGREE---
Doctoral degree

Enter RETURN to continue or '^' to exit: <RET>

By (1) Location (2) Service or (3) Individual: 2 Service

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.
OTHER Service Categories
------------------------
8. OTHER VOLUNTEER
9. RD
10. STUDENT NURSE
11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

DEVICE: HOME//Enter appropriate response

Baltimore, MD

Combined Educational Report by Service 2/24/97 Page: 1

Employee Name     Pos      SSN        Degree, Code, Priority
-------------------- ---  ---   ------  ----  --------
Service Category: LPN

NURS nurse6, six  LPN 7  000456789 Bachelor's degree in Nursing BSN 2

--Highest Nursing Degree--
Bachelor's degree in Nursing

--Highest Academic Degree--
Bachelor's degree in Nursing

Enter RETURN to continue or '^' to exit: <RET>

---------------------------------------------------------------------------------(last page of report)

Hines

Combined Educational Report by Service 2/24/97 Page: 4

Employee Name     Pos      SSN        Degree, Code, Priority
-------------------- ---  ---   ------  ----  --------
Service Category: LPN

NURS nurse3, four LPN 3  000073930 Associate degree in Nursing AD 1

--Highest Nursing Degree--
Master's degree in Nursing MSN 3

--Highest Academic Degree--
Master's degree in Nursing

Enter RETURN to continue or '^-' to exit: <RET>

By (1) Location (2) Service or (3) Individual: 3 Individual
Select Nursing Staff Name:  NURSNURSE,ONE  
000607942  RN

...OK? Yes// <RET> (Yes)

DEVICE: HOME//Enter appropriate response

COMBINED EDUCATIONAL REPORT BY INDIVIDUAL  2/24/97  PAGE: 1

SVC
EMPLOYEE NAME       POS       SSN       DEGREE, CODE, PRIORITY
--------------------      ---     ---       ------  ----  --------
NURSNURSE,ONE        RN       000607942 Bachelor's degree in Nursing  BSN  2
                         Master's degree  MA  3

--HIGHEST NURSING DEGREE--
Bachelor's degree in Nursing  

--HIGHEST ACADEMIC DEGREE--
Master's degree

Enter RETURN to continue or '^' to exit: <RET>

Menu Access:

The Comb. Acad./Nurs. Degree Reports option is accessed through the Administrative Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administrative Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-SAL

Salary Reports

Description:

The Salary Reports menu contains options for printing salary related reports. Data may be sorted by facility and product line. Salary data is obtained from the PAID Employee (#450) file. All other information on these reports is found in the NURS Staff (#210) file.

Additional Information:

When some of these reports are printed to the SCREEN (HOME) at the bottom of each page there may be a message:

1. "Press return to continue or "^" to exit"
   a. Continue - provides the next page of report, or exits to menu at end of report.
   b. ^ - will exit to the menu if not at the end of the report.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Security:

Security has been provided on the Salary Reports. This security screens data and displays prompts that can be viewed by Nursing employees based on their AMIS Position:

a. The Chief, Nursing Service and the Nursing ADP Coordinators can access all data.

b. The Associate/Assistant Chief(s) and Supervisors can access data of personnel subordinate to their position.

c. Head Nurses have access only to data specific to their ward.

d. Everyone else can only view their own data.

One exception to the above security is phone number data. Head Nurses and higher can see all phone numbers.
Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1 Administration Records, Enter/Edit ...
2 Administration Records, Print ...
3 Administrative Site File Functions ...
4 Nursing Education Reports, Print ...
5 Patient Care Data, Enter/Edit ...
6 Patient Care Data, Print ...
7 Clinical Site File Functions ...
8 QI Data, Enter/Edit ...
9 Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 3 Salary Reports

1 Salary Report For Entire Service
2 Individual Salary Report
| 3 Salary Report by Location/Svc. Category

Select Salary Reports Option:

Menu Access:

The Salary Reports option is accessed through the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu.

1 Patch NUR*4*21 January 1999
NURAPR-SAL-SER

Salary Report For Entire Service

Description:

This option prints an alphabetical service listing indicating the grade/step code and salary of all nursing employees. Data may be sorted by facility and product line. Salary data is obtained from the PAID Employee (#450) file. Employee name and grade/step data is found in the NURS Staff (#210) file.

Additional Information:

Salary data is displayed through the Staff Record Edit option in the Administration Records, Enter/Edit menu but is not editable. Salary data is only editable by personnel or Austin.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1    Administrative Reports ...
2    Resource Management Reports ...
3    Salary Reports ...
4    Staff Record Report
5    Telephone Number Listings ...
6    Individual Staff Position/Location

Select Administration Records, Print Option: 3 Salary Reports

1    Salary Report For Entire Service
2    Individual Salary Report
3    Salary Report by Location/Svc. Category

Screen Prints:

Select Salary Reports Option: 1 Salary Report For Entire Service

1 Patch NUR*4*21 January 1999
Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

DEVICE: HOME//Enter appropriate response

HINES

NURSING SERVICE STAFF SALARIES  FEB 24, 1997  PAGE: 1

<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>GRADE/STEP</th>
<th>SALARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSNURSE6,FOUR</td>
<td>R/E2/5</td>
<td>32190.00</td>
</tr>
<tr>
<td>NURSNURSE7,TWO</td>
<td>R/I/6</td>
<td>24478.00</td>
</tr>
<tr>
<td>NURSNURSE8,SIX</td>
<td>N/4/5</td>
<td>25843.00</td>
</tr>
<tr>
<td>NURSNURSE10,SEVEN</td>
<td>N/4/7</td>
<td>23190.00</td>
</tr>
<tr>
<td>NURSNURSE2,FIVE</td>
<td>R/E1/8</td>
<td>31702.00</td>
</tr>
<tr>
<td>NURSNURSE10,TEN</td>
<td>N/5/3</td>
<td>25458.00</td>
</tr>
<tr>
<td>NURSNURSE8,FOUR</td>
<td>N/1/4</td>
<td>32608.00</td>
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<tr>
<td>NURSNURSE3,EIGHT</td>
<td>R/S/5</td>
<td>14674.00</td>
</tr>
<tr>
<td>NURSNURSE,NINE</td>
<td>R/I/2</td>
<td>22564.00</td>
</tr>
<tr>
<td>NURSNURSE2,SIX</td>
<td>R/S/8</td>
<td>23853.00</td>
</tr>
<tr>
<td>NURSNURSE12,ONE</td>
<td>R/I/7</td>
<td>30321.00</td>
</tr>
<tr>
<td>NURSNURSE1,FIVE</td>
<td>N/3/9</td>
<td>28540.00</td>
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</table>

Enter RETURN to continue or '^' to exit: <RET>

**Menu Access:**

The Salary Report For Entire Service option is accessed through the Salary Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu.
NURAPR-SAL-IND

Individual Salary Report

Description:

This option prints a report of an individual employee's grade/step code and salary. Salary data is obtained from the PAID Employee (#450) file. Employee name and grade/step data is found in the NURS Staff (#210) file.

Additional Information:

Salary data is displayed through the Staff Record Edit option in the Administration Records, Enter/Edit menu but is not editable. Salary data is only editable by personnel or Austin.

Menu Display:

Select Nursing Features (all options) Option: 2  Administration Records, Print

1   Administrative Reports ...
2   Resource Management Reports ...
3   Salary Reports ...
4   Staff Record Report
5   Telephone Number Listings ...
6   Individual Staff Position/Location

Select Administration Records, Print Option: 3  Salary Reports

1   Salary Report For Entire Service
2   Individual Salary Report
13  Salary Report by Location/Svc. Category

Screen Prints:

Select Salary Reports Option: 2  Individual Salary Report

Select Nursing Staff Name: NURSNURSE12,TWO, TWO 000232222 RN
...OK? YES// <RET> (YES)

DEVICE: HOME//Enter appropriate response
### Menu Access:

The Individual Salary Report option is accessed through the Salary Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu.

```plaintext
Enter RETURN to continue or '^^' to exit: <RET>
```
Salary Report by Location/Svc. Category

Description:
This option generates a report of all employee salaries which can be sorted by product line, service category or location. The report supplies subtotals and average salary, for each location, service category, and facility when appropriate.

Additional Information:
Salary data is displayed through the Staff Record Edit option in the Administration Records, Enter/Edit menu but is not editable. Employees whose names are preceded by ‘***’ have no salary in the Employee (#450) file, and are not counted in the subtotals or totals of the report. Salary data is only editable by personnel or Austin. Salaries for employees with multiple assignments will display a prorated amount based on the FTEE for the selected location/service position.

Menu Display:
Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 3 Salary Reports

1 Salary Report For Entire Service
2 Individual Salary Report
3 Salary Report by Location/Svc. Category

Screen Prints:
Select Salary Reports Option: 3 Salary Report by Location/Svc. Category
Select PRODUCT LINE (Press return for all product lines): NURSING
Select an appropriate product line.

1 Patch NUR*4*21 January 1999
Select NURSING UNIT (Enter return for all units) : 2AS

Select an appropriate nursing unit.

Another NURSING UNIT: 4AS MEDICAL

You may select more than one.

Another NURSING UNIT: <RET>

NURSING Service Categories
--------------------------
1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-CLERICAL)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)

OTHER Service Categories
------------------------
8. ALL

Select SERVICE CATEGORY: 8

Enter appropriate service categories. You may select one or more service categories to sort by.

DEVICE: HOME//Enter appropriate response

............................................................

STAFF SALARIES BY LOCATION AND SERVICE CATEGORY DEC 14, 1998 PAGE: 1

<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>SERVICE CATEGORY</th>
<th>LOCATION</th>
<th>GRADE/STEP CODE</th>
<th>GRADE/STEP SALARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>** NURSNURSE12,THREE</td>
<td>LPN</td>
<td>2AS</td>
<td>R/A/5</td>
<td>21000.00</td>
</tr>
<tr>
<td>NURSNURSE12,FOUR</td>
<td>LPN</td>
<td>2AS</td>
<td>O/C/9</td>
<td>21000.00</td>
</tr>
</tbody>
</table>

------------------------

EMPLOYEES COUNTED 1.00
CATEGORY SUBTOTAL 21000.00
AVERAGE SALARY 21000.00

------------------------

EMPLOYEES COUNTED 1.00
UNIT SUBTOTAL 21000.00
AVERAGE SALARY 21000.00

Enter RETURN to continue or '^' to exit: <RET>

1 Patch NUR*4*21 January 1999
<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>SERVICE CATEGORY</th>
<th>LOCATION</th>
<th>CODE</th>
<th>SALARY</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSNURSE12,FIVE</td>
<td>RN</td>
<td>4AS MEDICA</td>
<td>O/AD/10</td>
<td>57890.00</td>
</tr>
<tr>
<td>NURSNURSE12,SIX</td>
<td>RN</td>
<td>4AS MEDICA</td>
<td>R/D/7</td>
<td>50000.00</td>
</tr>
<tr>
<td>** NURSNURSE12,SEVEN</td>
<td>RN</td>
<td>4AS MEDICA</td>
<td>R/D/10</td>
<td></td>
</tr>
</tbody>
</table>

EMPLOYEES COUNTED 2.00
CATEGORY SUBTOTAL 107890.00
AVERAGE SALARY 53945.00

EMPLOYEES COUNTED 2.00
UNIT SUBTOTAL 107890.00
AVERAGE SALARY 53945.00

EMPLOYEES COUNTED 3.00
PRODUCT LINE SUBTOTAL 128890.00
AVERAGE SALARY 42963.33

Enter RETURN to continue or '^' to exit: <RET>

Menu Access:

The Salary Report by Location/Svc. Category option is accessed through the Salary Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu.

---

1 Patch NUR*4*21 January 1999
NURAPR-PHONE

Telephone Number Listings

Description:

The Telephone Number Listings menu contains options for printing phone number reports. Data may be sorted by facility and product line. The phone number data is obtained from the NURS Staff (#210) file.

Additional Information:

Editing of data is accomplished for an individual employee through the Staff Record Edit option in the Administration Records, Enter/Edit menu.

When some of these reports are printed to the SCREEN (HOME) at the bottom of each page there may be a message:

1. "Press return to continue or "^" to exit"
   a. Continue - provides the next page of report, or exits to menu at end of report.
   b. ^ - will exit to the menu if not at the end of the report.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Security:

Security has been provided on the Telephone Number Listings Reports. This security screens data and displays prompts that can be viewed by Nursing employees based on their AMIS Position:

a. The Chief, Nursing Service and the Nursing ADP Coordinators can access all data.
b. The Associate/Assistant Chief(s) and Supervisors can access data of personnel subordinate to their position.
c. Everyone else can only view their own data.

One exception to the above security is phone number data. Head Nurses can see all phone numbers.
Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1  Administration Records, Enter/Edit ...
2  Administration Records, Print ...
3  Administrative Site File Functions ...
4  Nursing Education Reports, Print ...
5  Patient Care Data, Enter/Edit ...
6  Patient Care Data, Print ...
7  Clinical Site File Functions ...
8  QI Data, Enter/Edit ...
9  Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Option: 2 Administration Records, Print

1  Administrative Reports ...
2  Resource Management Reports ...
3  Salary Reports ...
4  Staff Record Report
5  Telephone Number Listings ...
6  Individual Staff Position/Location

Select Administration Records, Print Option: 5 Telephone Number Listings

1  Individual Phone Number
2  Phone (Home) Numbers by Location
3  Home Phone Number(s) For Entire Service

Select Telephone Number Listings Option:

Menu Access:

The Telephone Number Listings option is accessed through the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-PHONE-IND

Individual Phone Number

Description:
This option displays the phone number(s) of an individual nursing employee. The phone number data is obtained from the NURS Staff (#210) file.

Additional Information:
Editing of data is accomplished using the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Menu Display:
Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 5 Telephone Number Listings

1 Individual Phone Number
2 Phone (Home) Numbers by Location
3 Home Phone Number(s) For Entire Service

Screen Prints:
Select Telephone Number Listings Option: 1 Individual Phone Number

Select Nursing Staff Name: NURSNURSE10,FOUR 000888989 RN
...OK? YES/<RET> (YES)

DEVICE: HOME//Enter appropriate response
## Administration Reports

**TELEPHONE NUMBERS OF NURSING EMPLOYEES**

**MAR 14, 1986**

**PAGE: 1**

<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>SERVICE</th>
<th>TELEPHONE NUMBER</th>
<th>OWNER OF PHONE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSNURSE10, FOUR</td>
<td>RN</td>
<td>555-555-5634</td>
<td>SELF</td>
</tr>
<tr>
<td></td>
<td></td>
<td>555-555-1222</td>
<td>NURSUSER, TWO</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>

### Menu Access:

The Individual Phone Number option is accessed through the Telephone Number Listings option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Telephone Number Listings option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-PHONE-LOC

Phone (Home) Numbers by Location

Description:

This option prints a listing of employee home phone numbers by unit/location. Data may be sorted by facility, service position, and product line. The phone number data is obtained from the NURS Staff (#210) file. The unit/location data is contained in the NURS Position Control (#211.8) file.

Additional Information:

Editing of data is accomplished using the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2  Administration Records, Print

  1  Administrative Reports ...
  2  Resource Management Reports ...
  3  Salary Reports ...
  4  Staff Record Report
  5  Telephone Number Listings ...
  6  Individual Staff Position/Location

Select Administration Records, Print Option: 5  Telephone Number Listings

  1  Individual Phone Number
  2  Phone (Home) Numbers by Location
  3  Home Phone Number(s) For Entire Service

Screen Prints:

Select Telephone Number Listings Option: 2  Phone (Home) Numbers by Location
Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.

DEVICE: HOME//Enter appropriate response
<table>
<thead>
<tr>
<th>LOCATION</th>
<th>EMPLOYEE NAME</th>
<th>SERVICE POSITION</th>
<th>TELEPHONE NUMBER</th>
<th>OWNER OF PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3S</td>
<td>NURSNURSE2,TWO</td>
<td>NUR ADP</td>
<td>5553334</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE1,THREE</td>
<td>NUR RECRU</td>
<td>5557665</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE5,ONE</td>
<td>HN</td>
<td>5556432</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE4,NINE</td>
<td>RN</td>
<td>555-555-5555</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE4,TEN</td>
<td>RN</td>
<td>5555551111</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE4,EIGHT</td>
<td>RN</td>
<td>5557898</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE5,TWO</td>
<td>RN</td>
<td>5552223</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE5,THREE</td>
<td>RN</td>
<td>5554765</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE5,FOUR</td>
<td>RN</td>
<td>5554564</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE5,FIVE</td>
<td>RN</td>
<td>5553334</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE4,TWO</td>
<td>LPN 6</td>
<td>5550987</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE4,THREE</td>
<td>LPN 3</td>
<td></td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE4,FOUR</td>
<td>LPN 3</td>
<td>5555552</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE4,FIVE</td>
<td>NA 5</td>
<td>5554455</td>
<td>SELF</td>
</tr>
<tr>
<td>3S</td>
<td>NURSNURSE4,SEVEN</td>
<td>NA 1</td>
<td>5556667</td>
<td>SELF</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>
<table>
<thead>
<tr>
<th>LOCATION</th>
<th>EMPLOYEE</th>
<th>SERVICE</th>
<th>TELEPHONE</th>
<th>OWNER OF PHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIETETICS SERVICE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNH</td>
<td>NURSNURSE5,EIGHT</td>
<td>DIET/VOL</td>
<td>5558777</td>
<td></td>
</tr>
<tr>
<td>CNH</td>
<td>NURSNURSE5,NINE</td>
<td>DIET/VOL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNH</td>
<td>NURSNURSE6,ONE</td>
<td>DIET/VOL</td>
<td>555-3746</td>
<td>SELF</td>
</tr>
<tr>
<td>CNH</td>
<td>NURSNURSE5,SIX</td>
<td>DIET/VOL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CNH</td>
<td>NURSNURSE5,SEVEN</td>
<td>DIET/VOL</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>

Menu Access:

The Phone (Home) Numbers by Location option is accessed through the Telephone Number Listings option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Telephone Number Listings option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-PHONE-SER

Home Phone Number(s) For Entire Service

Description:

This option prints an alphabetical listing of home phone numbers for all nursing employees. Data may be sorted by facility and product line. The phone number data is obtained from the NURS Staff (#210) file. Service position data is obtained from the NURS Position Control (#211.8) file.

Additional Information:

Editing of data is accomplished using the Staff Record Edit option in the Administration Records, Enter/Edit menu.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 5 Telephone Number Listings

1 Individual Phone Number
2 Phone (Home) Numbers by Location
3 Home Phone Number(s) For Entire Service

Screen Prints:

Select Telephone Number Listings Option: 3 Home Phone Number(s) For Entire Service
Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

DEVICE: HOME//Enter appropriate response

Baltimore, MD

Telephone Numbers of Nursing Employees

<table>
<thead>
<tr>
<th>Employee Name</th>
<th>Service</th>
<th>Telephone Number</th>
<th>Owner of Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAVSNURSE6,FOUR</td>
<td>CLER</td>
<td>555-9356</td>
<td>SELF</td>
</tr>
<tr>
<td>NAVSNURSE7, TWO</td>
<td>COM H COOR</td>
<td>555-9365</td>
<td>SELF</td>
</tr>
<tr>
<td>NAVSNURSE6,SEVEN</td>
<td>LPN 3</td>
<td>555-9876</td>
<td>SELF</td>
</tr>
<tr>
<td>NAVSNURSE11, ONE</td>
<td>RN</td>
<td>555-0987</td>
<td>SELF</td>
</tr>
<tr>
<td>NAVSNURSE2, EIGHT</td>
<td>RN</td>
<td>555-4545</td>
<td>SELF</td>
</tr>
<tr>
<td>NAVSNURSE10, NINE</td>
<td>NA 5</td>
<td>555-2122</td>
<td>NEIGHBOR</td>
</tr>
<tr>
<td>NAVSNURSE8, SIX</td>
<td>NA 4</td>
<td></td>
<td>SELF</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>
<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>SERVICE POSITION</th>
<th>TELEPHONE NUMBER</th>
<th>OWNER OF PHONE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSNURSE9, ONE</td>
<td>NA 5</td>
<td>5556979</td>
<td>SELF</td>
</tr>
<tr>
<td>NURSNURSE3, TWO</td>
<td>RN</td>
<td>5550067</td>
<td>SELF</td>
</tr>
<tr>
<td>NURSNURSE9, TWO</td>
<td>NA 3</td>
<td>5559877</td>
<td>SELF</td>
</tr>
<tr>
<td>NURSNURSE10, FOUR</td>
<td>RN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE9, NINE</td>
<td>HN</td>
<td>5553333</td>
<td>SELF</td>
</tr>
<tr>
<td>NURSNURSE1, FOUR</td>
<td>CLER</td>
<td>5557866</td>
<td>SELF</td>
</tr>
<tr>
<td>NURSNURSE9, THREE</td>
<td>ALABAMA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE9, NINE</td>
<td>LPN 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE3, FIVE</td>
<td>RN</td>
<td>5555551000</td>
<td>SELF</td>
</tr>
<tr>
<td>NURSNURSE3, THREE</td>
<td>RN</td>
<td>5558754</td>
<td>SELF</td>
</tr>
<tr>
<td>NURSNURSE8, FIVE</td>
<td>NA 1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>

**Menu Access:**

The Home Phone Number(s) For Entire Service option is accessed through the Telephone Number Listings option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Telephone Number Listings option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
Chapter 4 Classification

NURAPC-MENU

Classification, Edit Patient

Description:

The Classification, Edit Patient option displays additional options for adding and editing patient classifications. Data is stored in the NURS Classification (#214.6) and the NURS Review Classification (#214.7) file until the Classification File Update (NURS-PURG) option is invoked. The Nursing Focus Group suggests that a minimum of six months of data be retained but this may be modified based on the service/medical center policy. Check with your Decision Support System (DSS) Site Manager prior to deleting classification data.

Additional Information:

The classifications or acuities are used in generating the Patient Category Totals-AMIS 1106 Reports and the AMIS and Current Workload Statistics Reports. Individual patient(s) AMIS classification cannot be edited but totals for a location and bedsection may. This is accomplished using the AMIS 1106 Acuity Edit option located in the Administrative Site File Functions menu. Classifications may be edited for the last 120 days.

General Information on Patient Classification.

1. Explanation of terms:

   Absence  A field in both the current unclassified and unclassified AMIS 1106 reports which indicates if a patient is on leave (LOA, pass, etc.), AWOL (absent without leave), Oth. Fac (patient is at another facility), and N/A (field does not apply; patient in hospital).

   Admission Date  The patient's last admission date to the facility; obtained from MAS data.

   Bed Section  The patient's current nursing AMIS bed section. The bed section for a patient may be edited using the Location/Bed Section, Edit Nursing option located in the Patient Care Data, Enter/Edit menu.

   Comments  The R.N.'s justification for changing the computed classification.

   (COMPUTER) or (USER) display  Indicates if the computer or user determined the patient's classification based on the factors selected.
Classification

Current Classification
The classification is a number depending upon the classification pattern used.

Factors
Factors are selected by the R.N. when classifying a patient.

Last Date/Time Classified
The most recent date and time the patient was classified.
This is automatically entered by the computer.

Last User to classify
Name of the R.N. classifier; automatically entered by the computer.

Patient
Patient's name is obtained from MAS data.

Room/Bed
Current room/bed number is obtained from MAS data.

SSN
Patient's social security number is obtained from MAS data.

Ward
The patient's current nursing location. The ward/location of a patient may be edited using the Location/Bed Section, Edit Nursing option located in the Patient Care Data, Enter Edit menu.

2. Warning messages:

a. Patient not admitted with MAS -- notify MAS:
   Occurs if the patient's name is not in the MAS Patient file or if there is no active admission in the MAS "Patient File".

b. Patient is not active in the Nursing System -- notify Nursing ADP Coordinator:
   Displayed if the patient was not entered into the Nursing System through MAS. If the MAS System is "down", contact the nursing ADP Coordinator or designee (refer to option "Admit/Transfer Pt. (Nursing Pkg. Only)" for additional information).

c. THIS PATIENT'S CLASSIFICATION HAS NOT BEEN UPDATED.: Occurs if an ^ was entered previous to completing data entry.

d. THIS PATIENT IS ON LEAVE, DO YOU STILL WISH TO CLASSIFY? NO// Displayed if the patient is on leave, AWOL or in another facility. Patients on pass are not counted in AMIS data and classifying is not necessary.

e. *** BAD ENTRY - TRY AGAIN ***:
   Indicates unacceptable character entry such as an alphanumeric character, symbol, or space.
Classification

f. *** FACTORS X,Y, or Z CANNOT BE USED TOGETHER ***:
   Inappropriate combination of factors used to classify a patient.

g. *** WHEN CHANGING THE CLASSIFICATION, COMMENTS MUST BE FILLED IN ***:
   Displays when the user tries to bypass the comment field after changing the classification calculated by the computer.

h. *** YOU MUST PICK ONE OF THE FACTORS ....***:
   Indicates data is missing and identifies missing entry.

i. **** NO FACTORS ENTERED - CLASSIFICATION NOT UPDATED ****:
   Displayed when a R.N. tries to bypass the "Enter Factors:" prompt of a patient never before classified.

j. **** ROUTINE FINISHED *****:
   Displayed when an ^ is entered or a time out occurs prior to completing classification; also prints after classifying a series of patients.

k. Classification Cannot Be Run
   A message is displayed on the terminal when a user wishes to classify a patient and the tasked background batch job, NURAAM-ACU (NURSING ACUITY/SEPARATION RUN), has not run. The warning is shown when the user enters any classification edit. This does not affect the options associated with hemodialysis and recovery room counts. The following is an example of the warning displayed when classifying by ward:

Select Classification, Edit Patient Option: 2 Classify Patients by Ward
ENTER UNIT YOU WANT TO SEARCH: 3S

The classification routine begins to display the names of the patients on the unit/ward.

Begin updating patient classifications.

NURSNURSE1,FOUR     OK? YES// <RET>

The software then completes a check on the background job. If the job does not run to completion, the warning displays.
The user may continue to classify patients, but should notify the nursing ADP coordinator or supervisor.

NURSSUPERVISOR, ONE OK? YES//

3. Example: Patient with no previous classification:

PATIENT CLASSIFICATION SURGICAL

Patient: NURSPATIENT2, FOUR SSN: 000-07-1694 Admission Date: 06/19/84
Ward: 3E Room/Bed: 322-3 Bed Section: Surgical
FACTORS:
1. Activity, independent
2. Bath, partial assist
3. Position, partial assist
4. Position, complete assist
5. Diet, partial assist
6. Diet, feed
7. IV, Add. q 6 h or more or TKO
8. Observe q 1-2 h
9. Observe almost constant

PATIENT: NURSPATIENT2, FOUR SSN: 000-07-1694
ENTER FACTORS: 1
Enter Classification: 1/＜RET＞

The patient's classification is computed as a 1; a ＜RET＞ indicates that the R.N. accepts the classification. If the R.N. had entered a ＜RET＞ after "Enter Factors:"
Enter Factors: <RET>

**** NO FACTORS ENTERED - CLASSIFICATION NOT UPDATED ****

PATIENT: NURSPATIENT2,FOUR    SSN: 000-07-1694

The prompt is again displayed for data entry. R.N.s may exit this program without classifying the patient by entering an ^.

4. Example: Editing a classification:

PATIENT CLASSIFICATION NURSING HOME CARE UNIT

Patient: NURSPATIENT2,FOUR   SSN: 000-07-1697   Admission Date: 06/19/84
Ward: 1B    Room/Bed: 322-3    Bed Section: NURSING HOME CARE UNIT

FACTORS:
1. Basic Hygiene/Bathing (Choose One) | 2. Nutrition/Feeding (Choose One)
   A. Self | D. Self
   B. Partial assist | E. Partial assist
   C. Complete assist | F. Complete assist
3. Elimination (Choose One)           | 4. Mobility (Choose One)
   G. Self | J. Self
   H. Partial assist | K. Partial assist
   I. Incontinent | L. Complete assist

5. Behavior/Orientation (Choose One)
   M. Alert/Oriented/Responsive
   N. Occasionally Disoriented/Confused
   O. Disoriented/Combative/Unresponsive

Current Classification: 3 Factors: B,E,I,K,O   (USER)
Computer's Classification for Factors would have been: 2
Comments: Special Test
Last user to classify: NURSUSER,THREE
Last date/time classified: 07/26/86@15:30

Do you wish to retain this as the current classification? YES// <RET> (YES)

The previous classification remains unchanged; only the name of the R.N. classifying the patient, and the date/time classified is updated.

If the response had been:

Do you wish to retain this as the current classification? YES// N   (NO)

PATIENT: NURSPATIENT2,FOUR   SSN: 000-07-1694

Choose one factor from each group separated by a comma. Factors are selected with or without commas.

Enter Factors: B,E,I,K,O// A,D,H,K,M
Enter Classification: 1// <RET>

R.N. classifying patient accepts computed classification.
If the R.N. wants to change the computed classification:

Enter Classification: 1// 2
Enter Comments: Special Test

Note:
The justification must be entered. If an ^ is entered after the prompt, **** THIS PATIENT'S CLASSIFICATION HAS NOT BEEN UPDATED **** would display).

If an ^ is entered at any of the following prompts, the patient's classification is not updated and a warning message will appear:

Do you wish to retain this as the current classification? YES// ^
This patient's classification has not been updated.

or

Enter Factors: B,E,I,K,O// ^
THIS PATIENT’S CLASSIFICATION HAS NOT BEEN UPDATED.

or

Enter Classification: 1// ^
THIS PATIENT'S CLASSIFICATION HAS NOT BEEN UPDATED.

or

Comments: ^
THIS PATIENT'S CLASSIFICATION HAS NOT BEEN UPDATED.

5. Example: Patients classified under "Alcohol and drug treatment":

Note:
The classification scale for Alcohol and Drug Treatment is a number between 1 and 4 and is based on your local classification system.

PATIENT CLASSIFICATION ALCOHOL AND DRUG TREATMENT
Patient: NURSPATIENT2,FIVE    SSN: 000337867    Admission Date: 10-20-86
Ward: 53E    Room/Bed: 5310-E    Bed Section: ALCOHOL AND DRUG TREATMENT

Current Classification: 2 (USER)
Last user to classify: NURSUSER,TEN
Last date/time classified: NOV 19,1986@08:14
Do you wish to retain this as the current classification? YES// N (NO)
Enter Classification: 2// <RET>
6. Statistics for domiciliary:

Clients are automatically tabulated at midnight and entered into the AMIS count as a category 1.

7. Example: Spinal cord injury, classification display:

Select PATIENT NAME: NURSPATIENT2,SIX     09-05-50     000555555  NSC VETERAN

PATIENT CLASSIFICATION MEDICAL (SCI)
Patient: NURSPATIENT2,SIX     SSN: 000-55-5555   Admission Date: 10/27/87
Ward: SCI 4M   Room/Bed: 403-2   Bed Section: MEDICAL (SCI)
FACTORS:
A. Activity, Independent
B. Bath/Shower, Set up, partial assist
C. Bath/Shower, Complete assist
D. Position/Transfer, Set up, standby or partial assist
E. Position/Transfer, Complete assist
F. Diet, Set-up, standby or partial assist
G. Diet, Complete assist
H. Bowel Care, Set up, standby or partial assist
I. Bowel Care, Complete assist
J. Monitor/Observe/Teach, 15-25 Min/Hr
K. Monitor/Observe/Teach, 30-45 Min/Hr
L. Constant Monitoring

Current Classification: 5   Factors: B,L  (COMPUTER)
Comments:
Last user to classify: NURSUSER,FOUR
Last date/time classified: JUL 20, 1996@07:42
Do you wish to retain this as the current classification? YES/<RET>

8. Examples of classification patterns:

The pattern is identified with correlating AMIS bed section and page number is indicated.

<table>
<thead>
<tr>
<th>Pattern</th>
<th>AMIS Bed Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Drug Treatment</td>
<td>Alcohol and Drug Treatment</td>
<td>4.6</td>
</tr>
<tr>
<td>Critical Care Patients</td>
<td>Intensive Care</td>
<td>4.10</td>
</tr>
<tr>
<td>Extended Care Patients</td>
<td>Intermediate Care OR</td>
<td></td>
</tr>
<tr>
<td>Medical/Surgical Patients</td>
<td>Nursing Home Care Unit)</td>
<td>4.12</td>
</tr>
<tr>
<td>Spinal Cord Injury</td>
<td>Medical (Excluding SCI) OR</td>
<td>4.4</td>
</tr>
<tr>
<td></td>
<td>Surgical Bed Section</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Medical (SCI)</td>
<td>4.7</td>
</tr>
</tbody>
</table>
Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1  Administration Records, Enter/Edit ...
2  Administration Records, Print ...
3  Administrative Site File Functions ...
4  Nursing Education Reports, Print ...
5  Patient Care Data, Enter/Edit ...
6  Patient Care Data, Print ...
7  Clinical Site File Functions ...
8  QI Data, Enter/Edit ...
9  Quality Performance Reports ...
10  QI Site Files ...
11  Special Functions ...

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

    Classification, Edit Patient ...
    Evaluation/Target Date & Order Status Edit
    Intake/Output Data Entry Menu ...
    Location/Bed Section, Edit Nursing
    Patient Plan of Care, Edit
    Vitals/Measurements Data Entry Menu ...

Select Patient Care Data, Enter/Edit Option: Classification, Edit Patient

1  Classify Patients Individually
2  Classify Patients by Ward
3  Hemodialysis Patients, Classify/Count
4  Recovery Room Patients, Classify/Count
5  Unclassified Patients, Edit

Select Classification, Edit Patient Option:

Menu Access:

The Classification, Edit Patient option is accessed through the Patient Care Data, Enter/Edit option of the Nursing Features (all options) menu, Head Nurse's Menu, and the Staff Nurse Menu.
NURAPC-INDPT

Classify Patients Individually

Description:

The Classify Patients Individually option allows a registered nurse to classify a single patient. Data is stored in the NURS Classification (#214.6) file.

Additional Information:

The only way to edit/correct an individual patient's classification is to reclassify that patient at the time the mistake is made. An individual patient cannot be retrospectively classified for a specific date/time. However, the acuity totals for a location, bedsection, date, and shift may be edited using the AMIS 1106 Acuity Edit option located in the Administrative Site File Functions menu for the past 120 days.

Menu Display:

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

    Classification, Edit Patient ...
    Evaluation/Target Date & Order Status Edit
    Intake/Output Data Entry Menu ...
    Location/Bed Section, Edit Nursing
    Patient Plan of Care, Edit
    Vitals/Measurements Data Entry Menu ...

Select Patient Care Data, Enter/Edit Option: Classification, Edit Patient

1  Classify Patients Individually
2  Classify Patients by Ward
3  Hemodialysis Patients, Classify/Count
4  Recovery Room Patients, Classify/Count
5  Unclassified Patients, Edit

Screen Prints:

Select Classification, Edit Patient Option: 1 Classify Patients Individually

Select PATIENT NAME: NURSPATIENT2,SEVEN 08-01-44 000777654 SC VETERAN
PATIENT CLASSIFICATION INTENSIVE CARE

Patient: NURSPATIENT2, SEVEN  SSN: 000-77-7654  Admission Date: 05/16/86
Ward: SICU  Room/Bed: 9I-2  Bed Section: INTENSIVE CARE

FACTORS:
A. Position, partial assist  | CHOOSE ONE OF
B. Position, complete assist  | THESE TWO
C. Physiological monitoring, more than q 2h  >
D. Physiological monitoring, q 1-2 h  > CHOOSE ONE OF
E. Physiological monitoring, q 1 h or less  > THESE THREE
F. Intravenous therapy, one IV
G. Intravenous therapy, 2 or more lines
H. Respiratory status, non-acute
I. Respiratory status, acute
J. Special procedures performed

Current Classification: 2  Factors: A, C, H  (USER)
Computer's Classification for Factors would have been: 1
Comments: ISOLATION
Last user to classify: NURSUSER, FIVE
Last date/time classified: JUL 21, 1986@14:53

Do you wish to retain this as the current classification? YES// <RET>  (YES)

Select PATIENT NAME: <RET>

Menu Access:

The Classify Patients Individually option is accessed through the Classification, Edit Patient option of the Patient Care Data, Enter/Edit option of the Nursing Features (all options) menu, Head Nurse's Menu, and the Staff Nurse Menu.
NURAPC-WRD

Classify Patients by Ward

Description:

The Classify Patients by Ward option allows the adding and editing of classifications for all patients on a selected ward/unit. Data is stored in the NURS Classification (#214.6) file.

Additional Information:

Classifications entered incorrectly can only be corrected by reclassifying the patient at the time the mistake was made. However, acuity totals for a location, bed section, date, and shift may be edited using the AMIS 1106 Acuity Edit option located in the Administrative Site File Functions menu for the past 120 days.

Menu Display:

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

Classification, Edit Patient ...
Evaluation/Target Date & Order Status Edit
Intake/Output Data Entry Menu ...
Location/Bed Section, Edit Nursing
Patient Plan of Care, Edit
Vitals/Measurements Data Entry Menu ...

Select Patient Care Data, Enter/Edit Option: Classification, Edit Patient

1      Classify Patients Individually
2      Classify Patients by Ward
3      Hemodialysis Patients, Classify/Count
4      Recovery Room Patients, Classify/Count
5      Unclassified Patients, Edit

Screen Prints:

Select Classification, Edit Patient Option: 2 Classify Patients by Ward
ENTER UNIT YOU WANT TO SEARCH: 1B
Begin updating patient classifications.

NURSPATIENT2,EIGHT  112-A  OK? YES// <RET>

NURSPATIENT2,EIGHT  12-10-25 000167561 NSC VETERAN
PATIENT CLASSIFICATION NURSING HOME CARE UNIT

Patient: NURSPATIENT2,EIGHT      SSN: 000-16-7561      Admission Date: 04/07/86
Ward: 1B      Room/Bed: 112-A      Bed Section: Nursing Home Care Unit

FACTORS:
1. Basic Hygiene/Bathing (Choose One)  |  2. Nutrition/Feeding (Choose One)
   A. Self                              |     D. Self
   B. Partial assist                    |     E. Partial Assist
   C. Complete assist                   |     F. Complete Assist
3. Elimination (Choose One)              |  4. Mobility (Choose One)
   G. Self                              |     J. Self
   H. Partial assist                    |     K. Partial Assist
   I. Incontinent                       |     L. Complete Assist
5. Behavior/Orientation (Choose One)
   M. Alert/Oriented/Responsive
   N. Occasionally Disoriented/Confused
   O. Disoriented/Combative/Unresponsive

Current Classification: 1    Factors: A,D,G,K,M    (COMPUTER)
Comments:
Last user to classify: NURSUSER,FIVE
Last date/time classified: JUL 25, 1986@14:21

Do you wish to retain this as the current classification? YES// N    (NO)

PATIENT: NURSPATIENT2,EIGHT      SSN: 000-16-7561
Enter Factors: A,D,G,K,M// A,D,H,L,M
Enter Classification: 1// <RET>

NURSPATIENT2,NINE          122-B  OK? YES// <RET>

NURSPATIENT2,NINE          09-01-54          000233333       SC VETERAN

Patient Classification Nursing Home Care Unit

Patient: NURSPATIENT2,NINE      SSN: 000-23-3333      Admission Date: 04/07/86
Ward: 1B      Room/Bed: 122-B      Bed Section: Nursing Home Care Unit

FACTORS:
1. Basic Hygiene/Bathing (Choose One)  |  2. Nutrition/Feeding (Choose One)
   A. Self                              |     D. Self
   B. Partial assist                    |     E. Partial Assist
   C. Complete assist                   |     F. Complete Assist
3. Elimination (Choose One)              |  4. Mobility (Choose One)
   G. Self                              |     J. Self
   H. Partial assist                    |     K. Partial Assist
   I. Incontinent                       |     L. Complete Assist
5. Behavior/Orientation (Choose One)
   M. Alert/Oriented/Responsive
   N. Occasionally Disoriented/Confused
   O. Disoriented/Combative/Unresponsive
Current Classification: 3   Factors: B,E,H,K,M  (USER)
Computer's Classification for Factors would have been: 2
Comments: ISOLATION
Last user to classify: NURSUSER,FIVE
Last date/time classified: JUL 25,1986@14:22
Do you wish to retain this as the current classification? YES// <RET>  (YES)

NURSPATIENT2,TEN OK? YES// <RET>

Continue as above until all patients have been classified.

To exit the loop or skip a patient review the following:

NURSPATIENT3,ONE OK? YES// N
Do you wish to stop looping through names? YES// <RET>

****ROUTINE FINISHED****

If no had been entered at the question:

NURSPATIENT3,ONE OK? YES//
Do you wish to stop looping through names? YES// N

The next name in the loop would appear and the patient (NURSPATIENT3,ONE) was skipped, therefore not classified.

Menu Access:

The Classify Patients by Ward option is accessed through the Classification, Edit Patient option of the Patient Care Data, Enter/Edit option of the Nursing Features (all options) menu, Head Nurse's Menu, and the Staff Nurse Menu.
**NURAPC-HEM**

**Hemodialysis Patients, Classify/Count**

**Description:**

The Hemodialysis Patients, Classify/Count option allows a R.N. to enter a patient's dialysis treatment (Inpatient or Outpatient) into the AMIS count. There is no classification for this category of patient. This information appears as a classification 1 and a count on the Patient Category Totals - AMIS 1106 Report, and AMIS Workload Statistics Report. Data is stored in the NURS Classification (#214.6) file.

**Additional Information:**

This count can be edited by using the AMIS 1106 Acuity Edit (NURAAM-ACUEDT) option in the Administrative Site File Functions menu for the past 120 days.

**Menu Display:**

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

Classification, Edit Patient ...  
Evaluation/Target Date & Order Status Edit  
Intake/Output Data Entry Menu ...  
Location/Bed Section, Edit Nursing  
Patient Plan of Care, Edit  
Vitals/Measurements Data Entry Menu ...

Select Patient Care Data, Enter/Edit Option: Classification, Edit Patient

1 Classify Patients Individually  
2 Classify Patients by Ward  
3 Hemodialysis Patients, Classify/Count  
4 Recovery Room Patients, Classify/Count  
5 Unclassified Patients, Edit

**Screen Prints:**

Select Classification, Edit Patient Option: 3 Hemodialysis Patients, Classify/Count
Select PATIENT NAME: NURSPATIENT3, TWO 08-08-51 000341143 SC VETERAN

The Nurse who performed the hemodialysis is from which unit: 6E

NURSPATIENT3, TWO HAS BEEN ADDED TO THE HEMODIALYSIS COUNT.

Select PATIENT NAME: <RET>

Menu Access:

The Hemodialysis Patients, Classify/Count option is accessed through the Classification, Edit Patient option of the Patient Care Data, Enter/Edit option of the Nursing Features (all options) menu, Head Nurse's Menu, and the Staff Nurse Menu.
NURAPC-RECRM

Recovery Room Patients, Classify/Count

Description:

The Recovery Room Patients, Classify/Count option allows the R.N. to enter names of patients present in the Recovery Room (or in a designated post anesthesia area/bed) at midnight into the AMIS count. This information appears as a classification 1 on all AMIS Classification Reports, however, it is a COUNT of the patient(s) at midnight. Data is stored in the NURS Classification (#214.6) file.

Additional Information:

This count can be edited by using the AMIS 1106 Acuity Edit option in the Administrative Site File Functions menu for the past 120 days.

Menu Display:

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

Classification, Edit Patient ...
Evaluation/Target Date & Order Status Edit
Intake/Output Data Entry Menu ...
Location/Bed Section, Edit Nursing
Patient Plan of Care, Edit
Vitals/Measurements Data Entry Menu ...

Select Patient Care Data, Enter/Edit Option: Classification, Edit Patient

1    Classify Patients Individually
2    Classify Patients by Ward
3    Hemodialysis Patients, Classify/Count
4    Recovery Room Patients, Classify/Count
5    Unclassified Patients, Edit

Screen Prints:

Select Classification, Edit Patient Option: 4 Recovery Room Patients, Classify/Count

Select PATIENT NAME: NURSPATIENT3,THREE  08-04-18  000848807  SC VETERAN
Recovery Room Location: **NUR 3AM**

NURSPATIENT3, THREE HAS BEEN ADDED TO THE RECOVERY ROOM COUNT.

Select PATIENT NAME: <RET>

**Menu Access:**

The Recovery Room Patients, Classify/Count option is accessed through the Classification, Edit Patient option of the Patient Care Data, Enter/Edit option of the Nursing Features (all options) menu, Head Nurse's Menu, and the Staff Nurse Menu.
NURAPC-UNCWRD

Unclassified Patients, Edit

Description:

The Unclassified Patients, Edit option allows the R.N. to classify all unclassified patients residing on a specific ward on a given day. The program displays all patients on the ward who have not been classified for the date entered. Data is stored in the NURS Classification (#214.6) file.

Additional Information:

Individual patient(s) AMIS classification cannot be edited but totals for a location and bedsection may. This is accomplished using the AMIS 1106 Acuity Edit option located in the Administrative Site File Functions menu. Classifications may be edited for the last 120 days.

Menu Display:

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

Classification, Edit Patient ...
Evaluation/Target Date & Order Status Edit
Intake/Output Data Entry Menu ...
Location/Bed Section, Edit Nursing
Patient Plan of Care, Edit
Vitals/Measurements Data Entry Menu ...

Select Patient Care Data, Enter/Edit Option: Classification, Edit Patient

1 Classify Patients Individually
2 Classify Patients by Ward
3 Hemodialysis Patients, Classify/Count
4 Recovery Room Patients, Classify/Count
5 Unclassified Patients, Edit

Screen Prints:

Select Classification, Edit Patient Option: 5 Unclassified Patients, Edit

ENTER UNIT YOU WANT TO SEARCH: 2AS
...SORRY, LET ME PUT YOU ON 'HOLD' FOR A SECOND...
NURSPATIENT1,TEN            OK? Yes// <RET>  (Yes)  NURSPATIENT1,TEN
04-05-25    000379530   SC VETERAN

PATIENT CLASSIFICATION MEDICAL (SCI)

Patient: NURSPATIENT1,TEN   SSN: 000-37-9530   Admission Date: 05/28/96
Ward: 2AS   Room/Bed:     Bed Section: MEDICAL (SCI)
FACTORS:
A. Activity, Independent
B. Bath/Shower, Set up, partial assist
C. Bath/Shower, Complete assist
D. Position/Transfer, Set up, standby or partial assist
E. Position/Transfer, Complete assist
F. Diet, Set-up, standby or partial assist
G. Diet, Complete assist
H. Bowel Care, Set up, standby or partial assist
I. Bowel Care, Complete assist
J. Monitor/Observe/Teach, 15-25 Min/Hr
K. Monitor/Observe/Teach, 30-45 Min/Hr
L. Constant Monitoring

Current Classification: 3   Factors: F,I  (COMPUTER)
Comments:
Last user to classify: NURSUSER, SIX
Last date/time classified: APR 26, 1995@11:56
Do you wish to retain this as the current classification? Yes// <RET>  (Yes)

NURSPATIENT3,FOUR            OK? Yes// <RET>  (Yes)  NURSPATIENT3,FOUR
10-10-23    000923680   NSC VETERAN

PATIENT CLASSIFICATION MEDICAL (SCI)

Patient: NURSPATIENT3,FOUR   SSN: 000-92-3680   Admission Date: 03/22/95
Ward: 2AS   Room/Bed:     Bed Section: MEDICAL (SCI)
FACTORS:
A. Activity, Independent
B. Bath/Shower, Set up, partial assist
C. Bath/Shower, Complete assist
D. Position/Transfer, Set up, standby or partial assist
E. Position/Transfer, Complete assist
F. Diet, Set-up, standby or partial assist
G. Diet, Complete assist
H. Bowel Care, Set up, standby or partial assist
I. Bowel Care, Complete assist
J. Monitor/Observe/Teach, 15-25 Min/Hr
K. Monitor/Observe/Teach, 30-45 Min/Hr
L. Constant Monitoring

Current Classification: 5   Factors: L  (COMPUTER)
Comments:
Last user to classify: NURSUSER, SIX
Last date/time classified: APR 26, 1995@11:59
Do you wish to retain this as the current classification? Yes// N  (No)
PATIENT: NURSPATIENT3,FOUR   SSN: 000-92-3680
Enter Factors: L// B,D,G
Enter Classification: 3// <RET>

NURSPATIENT3,FIVE OK? Yes// N (No)
Do you wish to stop looping through names? Yes// <RET> (Yes)

**** ROUTINE FINISHED ****

Menu Access:

The Unclassified Patients, Edit option is accessed through the Classification, Edit Patient option of the Patient Care Data, Enter/Edit option of the Nursing Features (all options) menu, Head Nurse's Menu, and the Staff Nurse Menu.
Classification

NURSPP-MENU

Patient Care Data, Print

Description:

This option provides the menu for classification, patient and clinical report options used by nursing personnel to provide patient care. These reports print data on classification, intake and output, vitals/measurements, end of shift information, plans of care, and other patient information.

Additional Information:

Data can be entered through any of the Patient Care Data, Enter/Edit options.

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1      Administration Records, Enter/Edit ...
2      Administration Records, Print ...
3      Administrative Site File Functions ...
4      Nursing Education Reports, Print ...
5      Patient Care Data, Enter/Edit ...
6      Patient Care Data, Print ...
7      Clinical Site File Functions ...
8      QI Data, Enter/Edit ...
9      Quality Performance Reports ...
10     QI Site Files ...
11     Special Functions ...

Select Nursing Features (all options) Option: 6 Patient Care Data, Print

1      Classification Report
2      Location of Individual Patient, Print
3      Patient Assignment Worksheet
4      Ward Census, Print
5      Current Unclassified Patient Print, by Location
6      Patient Plan of Care, Print
7      Vitals/Measurements Results Reporting ...
8      Intake/Output Results Reporting ...
9      End of Shift Report
10     Health Summary Report
11     V/M Graphic Reports
12     Patient Problems to be Evaluated

Select Patient Care Data, Print Option:
Menu Access:

The Patient Care Data, Print option is accessed through the Nursing Features (all options) menu, Administrator's Menu, Head Nurse's Menu, and the Staff Nurse Menu.
NURAPP-WRDCLAS

Classification Report

Description:

The Classification Report option prints all current patient classifications on a specified ward/unit. Data is obtained from the NURS Classification (#214.6) file.

Additional Information:

Data can be entered through any of the classification edits. This report will count any patient who was classified between 12:01 am and midnight on the date the report is requested. Patient category totals appear at the beginning of the report.

The total hospital report is sorted by facility when the multi-divisional field in the NURS Parameter (#213.9) file contains the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 6 Patient Care Data, Print

1 Classification Report
2 Location of Individual Patient, Print
3 Patient Assignment Worksheet
4 Ward Census, Print
5 Current Unclassified Patient Print, by Location
6 Patient Plan of Care, Print
7 Vitals/Measurements Results Reporting ...
8 Intake/Output Results Reporting ...
9 End of Shift Report
10 Health Summary Report
11 V/M Graphic Reports
12 Patient Problems to be Evaluated

Screen Prints:

Select Patient Care Data, Print Option: 1 Classification Report

Unit Classification

Press return if total hospital report is desired

Enter unit number if this is a unit report: 6W

1 Patch NUR*4*26 July 1999
Enter the number of copies of this report you wish to print.

DEVELOPMENT: HOME

UNIT PATIENT CLASSIFICATION REPORT

<table>
<thead>
<tr>
<th>PATIENT NAME/SSN</th>
<th>CLASS. FACTORS</th>
<th>DATE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENTS</td>
<td>I II III IV V</td>
<td>------------------</td>
<td>----------</td>
</tr>
<tr>
<td>CLASSIFIED</td>
<td>___ ___ ___ ___</td>
<td>___ ___ ___ ___</td>
<td>___ ___</td>
</tr>
<tr>
<td>CATEGORY TOTALS:</td>
<td>0 2 1 0 0 0</td>
<td>3</td>
<td>----------</td>
</tr>
</tbody>
</table>

UNIT: 6W
NURSING BED SECTION: INTENSIVE CARE

NURSPATIENT2, SEVEN 3 B E AUG 18, 1998@09:44 000-77-7654

NURSPATIENT3, SIX 2 A E F H AUG 18, 1998@09:21 000-37-2222

NURSPATIENT3, SEVEN 2 A C G I AUG 18, 1998@10:39 000-32-4567

Note:
If the total hospital report had been selected, then each ward would have been printed on a separate page.

Menu Access:

The Classification Report is accessed through the Patient Care Data, Print option of the Nursing Features (all options) menu, Administrator's Menu, Head Nurse's Menu, and the Staff Nurse Menu.
NURAPP-UNCLOC

Current Unclassified Patient Print, by Location

Description:

Current Unclassified Patient Print, by Location prints a report of all unclassified patients on a specific ward for a given day. Data is obtained from the NURS Classification (#214.6) file, and the NURS Patient (#214) file.

Additional Information:

Data can be entered through any of the Classification edits. The Current Unclassified Patient Print, by Location report has codes entered in the ABSENCE column. Below is a list of the definitions for the codes used.

1. N/A - (Not Applicable) Patient is not on leave.
2. LEAVE - Patient is on leave therefore cannot be classified.
3. ERROR - Either (a) Patient is admitted to unit through the Nursing package but not through MAS or (b) Nursing Package is down (off-line) when patient is discharged through MAS.

This report is dependent upon whether the Nursing Acuity/Separation Batch Job has run to completion.

Menu Display:

Select Nursing Features (all options) Option: 6 Patient Care Data, Print

1 Classification Report
2 Location of Individual Patient, Print
3 Patient Assignment Worksheet
4 Ward Census, Print
5 Current Unclassified Patient Print, by Location
6 Patient Plan of Care, Print
7 Vitals/Measurements Results Reporting ... 
8 Intake/Output Results Reporting ... 
9 End of Shift Report
10 Health Summary Report
11 V/M Graphic Reports
12 Patient Problems to be Evaluated
Screen Prints:

Select Patient Care Data, Print Option: 5 Current Unclassified Patients
Print, by Location

Enter UNIT you want to search: 51A

DEVICE: HOME/\Enter appropriate response

08/11/86 CURRENT UNCLASSIFIED PATIENT REPORT FOR LOCATION 51A PAGE: 1

<table>
<thead>
<tr>
<th>ROOM-BED</th>
<th>PATIENT</th>
<th>LAST CLASSIFIED</th>
<th>ABSENCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>5101-1</td>
<td>NURSPATIENT3, EIGHT</td>
<td>AUG 9,1986@16:25</td>
<td>LEAVE</td>
</tr>
<tr>
<td>5101-2</td>
<td>NURSPATIENT3, NINE</td>
<td>AUG 10,1986@16:26</td>
<td>N/A</td>
</tr>
<tr>
<td>5111-1</td>
<td>NURSPATIENT, FOUR</td>
<td>AUG 10,1986@16:27</td>
<td>N/A</td>
</tr>
<tr>
<td>5129-1</td>
<td>NURSPATIENT2, ONE</td>
<td>NOT CLASSIFIED YET</td>
<td>N/A</td>
</tr>
<tr>
<td>5129-2</td>
<td>NURSPATIENT3, TEN</td>
<td>AUG 10,1986@16:27</td>
<td>N/A</td>
</tr>
<tr>
<td>5129-3</td>
<td>NURSPATIENT4, ONE</td>
<td>AUG 10,1986@15:41</td>
<td>N/A</td>
</tr>
</tbody>
</table>

If all patients are classified, then the following is displayed:

08/11/86 CURRENT UNCLASSIFIED PATIENT REPORT FOR WARD 51A PAGE: 1

<table>
<thead>
<tr>
<th>ROOM-BED</th>
<th>PATIENT</th>
<th>LAST CLASSIFIED</th>
<th>ABSENCE</th>
</tr>
</thead>
</table>

ALL PATIENTS ON THIS UNIT ARE CLASSIFIED

Menu Access:

The Current Unclassified Patients Print, by Location is accessed through the Patient Care Data, Print option of the Nursing Features (all options) menu, Administrator's Menu, Head Nurse's Menu, and the Staff Nurse Menu.
NURAPR-RES

Resource Management Reports

Description:
This menu allows access to the print options related to FTEE, workload, and patient classification. Data is obtained from the NURS Classification (#214.6) file.

Additional Information:
Data can be entered through any of the classification edits, Nursing Location, FTEE Service Budget, and Manhours Edit files.

Menu Display:
Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1    Administration Records, Enter/Edit ...
2    Administration Records, Print ...
3    Administrative Site File Functions ...
4    Nursing Education Reports, Print ...
5    Patient Care Data, Enter/Edit ...
6    Patient Care Data, Print ...
7    Clinical Site File Functions ...
8    QI Data, Enter/Edit ...
9    Quality Performance Reports ...
10   QI Site Files ...
11   Special Functions ...

Select Nursing Features (all options) Option: 2 Administration Records, Print

1    Administrative Reports ...
2    Resource Management Reports ...
3    Salary Reports ...
4    Staff Record Report
5    Telephone Number Listings ...
6    Individual Staff Position/Location

Select Administration Records, Print Option: 2 Resource Management Reports
Classification

1. Current Unclassified Patient Print
2. Daily Patient Classification Summary By Ward
3. Individual Patient Classification Reports...
4. Patient Category Totals-AMIS 1106 Reports
5. Manhours Print
6. AMIS Workload Statistics Report
7. Workload Statistics Report (Current)
8. Patient Category Totals-Midnight Acuity Reports
9. FTEE Comparison (1106b) Report
10. FTEE Reports

Select Resource Management Reports Option:

Menu Access:

The Resource Management Reports option is accessed through the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-RES-UNCLAS

Current Unclassified Patient Print

Description:

Current Unclassified Patient Print, by Location prints a report of all unclassified patients on a specific ward for a given day. Data is obtained from the NURS Classification (#214.6) file, and the NURS Patient (#214) file.

Additional Information:

Data can be entered through any of the Classification edits. The Current Unclassified Patient Print, by Location report has codes entered in the ABSENCE column. Below is a list of the definitions for the codes used.

1. N/A - (Not Applicable) Patient is not on leave.
2. LEAVE - Patient is on leave therefore cannot be classified.
3. ERROR - Either (a) Patient is admitted to unit through the Nursing package but not through MAS or (b) Nursing Package is down (off-line) when patient is discharged through MAS.

This report can be automatically queued to run daily through the NURAPR-RES-UNCLAS-QUEUE (TaskMan Current Unclassified Patient Report) option.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 2 Resource Management Reports
Screen Prints:

Select Resource Management Reports Option: 1  Current Unclassified Patient Print

Select FACILITY (Press return for all facilities): HINES  IL  499

Enter appropriate facility or press return for all facilities.

Note: If you have answered ‘Yes’ to the Multi-Divisional prompt in the Site Parameter File option, you will get the above facility prompt. The name of the facility will show as a header in the report.

DEVICE: HOME//Enter appropriate response
Menu Access:

The Current Unclassified Patient Print option is accessed through the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu, and through the Classification Reports, Patient option of the Print Reports option of the QA Coordinator's Menu.

---

1 Patch NUR*4*20  November 1998
NURAPR-RES-WRDCLAS

Daily Patient Classification Summary by Ward

Description:

1The Daily Patient Classification Summary By Ward option prints a ward report summarizing the current classification (acuities) of patients in a selected facility, selected ward, or entire hospital, including patients for the current day. Data is obtained from the NURS Classification (#214.6) file.

Additional Information:

2Data can be entered through any of the classification edits. The total hospital report is sorted by facility when the multi-divisional field in the NURS Parameter (#213.9) file contains the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 2 Resource Management Reports

1 Current Unclassified Patient Print
2 Daily Patient Classification Summary By Ward
3 Individual Patient Classification Reports ...
4 Patient Category Totals-AMIS 1106 Reports
5 Manhours Print
6 AMIS Workload Statistics Report
7 Workload Statistics Report (Current)
8 Patient Category Totals-Midnight Acuity Reports
9 FTEE Comparison (1106b) Report
10 FTEE Reports

1 Patch NUR*4*26 July 1999
2 Patch NUR*4*26 July 1999
Screen Prints:

Example: 1

Select Resource Management Reports Option: 2  Daily Patient Classification Summary By Ward

Unit Classification

Press return if total hospital report is desired

Enter unit number if this is a unit report: 4E

1How many copies of this report are required: 1//<RET>

Enter the number of copies of this report you wish to print.

DEVICE: HOME//Enter appropriate response

2UNIT PATIENT CLASSIFICATION REPORT DATE: AUG 8,1998 PAGE: 1

<table>
<thead>
<tr>
<th>PATIENT NAME/SSN</th>
<th>CLASS.</th>
<th>FACTORS</th>
<th>DATE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSPATIENT3,NINE</td>
<td>4</td>
<td>D G</td>
<td>AUG 07,1998@11:52</td>
<td>SPECIAL TEST</td>
</tr>
<tr>
<td>000-33-3331</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSPATIENT3,FIVE</td>
<td>2</td>
<td>A F</td>
<td>AUG 07,1998@11:52</td>
<td>STRICT ISO.</td>
</tr>
<tr>
<td>000-46-9479</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSPATIENT2,ONE</td>
<td>2</td>
<td>B F</td>
<td>AUG 05,1998@11:52</td>
<td>SPECIAL TEST</td>
</tr>
<tr>
<td>000-58-3525</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
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<td>A F</td>
<td>AUG 03,1998@11:53</td>
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<td>000-33-3444</td>
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</table>

Example: 2

Select Resource Management Reports Option: 2  Daily Patient Classification Summary By Ward

Unit Classification

Press return if total hospital report is desired

Enter unit number if this is a unit report: <RET>

---

1 Patch NUR*4*26  July 1999
2 Patch NUR*4*22  March 1999
Select FACILITY (Press return for all facilities): **HINES**  IL  499

Enter appropriate facility or press return for all facilities.

**Note:** If you have answered ‘Yes’ to the Multi-Divisional prompt in the Site Parameter File option, you will get the above facility prompt, and the name of the facility will show as a header in the report.

**DEVICE:** HOME//Enter appropriate response

<table>
<thead>
<tr>
<th><strong>UNIT PATIENT CLASSIFICATION REPORT</strong></th>
<th><strong>DATE:</strong> AUG 9,1998</th>
<th><strong>Page:</strong> 1</th>
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<td><strong>HINES</strong></td>
<td><strong>UNIT: 4E</strong></td>
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<td>000-08-3729</td>
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</table>

**Menu Access:**

The Daily Patient Classification Summary By Ward option is accessed through the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu, and through the Classification Reports, Patient option of the Print Reports option of the QA Coordinator's Menu.

---

1 Patch NUR*4*22  March 1999
Individual Patient Classification Reports

Description:

The Individual Patient Classification Reports option is a menu displaying options for an individual patient's acuity data. Data is obtained from the NURS Classification (#214.6) file.

Additional Information:

Data can be entered through any of the classification edits.

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1  Administration Records, Enter/Edit ...
2  Administration Records, Print ...
3  Administrative Site File Functions ...
4  Nursing Education Reports, Print ...
5  Patient Care Data, Enter/Edit ...
6  Patient Care Data, Print ...
7  Clinical Site File Functions ...
8  QI Data, Enter/Edit ...
9  Quality Performance Reports...
10  QI Site Files ...
11  Special Functions ...

Select Nursing Features (all options) Option: 2 Administration Records, Print

1  Administrative Reports ...
2  Resource Management Reports ...
3  Salary Reports ...
4  Staff Record Report
5  Telephone Number Listings ...
6  Individual Staff Position/Location

Select Administration Records, Print Option: 2 Resource Management Reports
Classification

1  Current Unclassified Patient Print
2  Daily Patient Classification Summary By Ward
3  Individual Patient Classification Reports ...
4  Patient Category Totals-AMIS 1106 Reports
5  Manhours Print
6  AMIS Workload Statistics Report
7  Workload Statistics Report (Current)
8  Patient Category Totals-Midnight Acuity Reports
9  FTEE Comparison (1106b) Report
10 FTEE Reports

Select Resource Management Reports Option: 3  Individual Patient Classification Reports

Date/Time, Indiv. Classification Report By Ward & Date/Time, Indiv. Classification Report By

Select Individual Patient Classification Reports Option:

Menu Access:

The Individual Patient Classification Reports option is accessed through the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu, and through the Classification Reports, Patient option of the Print Reports option of the QA Coordinator's Menu.
NURAPR-RES-INDCLAS-DT

Date/Time, Indiv. Classification Report by

Description:

This option prints a report indicating an individual patient's daily classification (acuity) rating for a specific length of stay. Data is obtained from the NURS Classification (#214.6) file.

Additional Information:

Data can be entered through any of the classification edits.

Menu Display:

Select Nursing Features (all options) Option: 2  Administration Records, Print

  1  Administrative Reports ...
  2  Resource Management Reports ...
  3  Salary Reports ...
  4  Staff Record Report
  5  Telephone Number Listings ...
  6  Individual Staff Position/Location

Select Administration Records, Print Option: 2  Resource Management Reports

  1  Current Unclassified Patient Print
  2  Daily Patient Classification Summary By Ward
  3  Individual Patient Classification Reports ...
  4  Patient Category Totals-AMIS 1106 Reports
  5  Manhours Print
  6  AMIS Workload Statistics Report
  7  Workload Statistics Report (Current)
  8  Patient Category Totals-Midnight Acuity Reports
  9  FTEE Comparison (1106b) Report
  10  FTEE Reports

Select Resource Management Reports Option: 3  Individual Patient Classification Reports

  Date/Time, Indiv. Classification Report By Ward & Date/Time, Indiv. Classification Report By
### Screen Prints:

Select Individual Patient Classification Reports Option: **Date/Time, Indiv. Classification Report By**

Select **PATIENT NAME**: NURSPATIENT,FOUR  01-27-49     000788766 NSC VETERAN

Start date (time optional): **T-7// 5/1/86** (MAY 01,1986)

Go to date (time optional): **NOW//<RET>** (6/29/87@10:32)

**DEVICE**: HOME//Enter appropriate response

---

**JUN 29,1987**  INDIVIDUAL PATIENT CLASSIFICATION REPORT  PAGE: 1

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<th>DATE/TIME</th>
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<th>BED DATE/TIME</th>
<th>SECT</th>
<th>COMMENTS</th>
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<td>WOUND/SKIN ISOLATION</td>
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<td>JUL 8,1986@08:11</td>
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<td>PSY</td>
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<td>WOUND/SKIN ISOLATION</td>
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**CLASSIFICATION WARD 51A**

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### Menu Access:

The Date/Time, Indiv. Classification Report By option is accessed through the Individual Patient Classification Reports option of the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Individual Patient Classification Reports option of the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu, and through the Individual Patient Classification Reports option of the Classification Reports, Patient option of the Print Reports option of the QA Coordinator's Menu.
**NURAPR-RES-INDCLAS-WDT**

**Ward & Date/Time, Indiv. Classification Report By**

**Description:**

This option prints a report indicating an individual patient's daily classification (acuity) rating for a specific length of stay on a specific ward/unit. Data is obtained from the NURS Classification (#214.6) file.

**Additional Information:**

Data can be entered through any of the classification edits.

**Menu Display:**

Select Nursing Features (all options) Option: 2 Administration Records, Print

1. Administrative Reports ...
2. Resource Management Reports ...
3. Salary Reports ...
4. Staff Record Report
5. Telephone Number Listings ...
6. Individual Staff Position/Location

Select Administration Records, Print Option: 2 Resource Management Reports

1. Current Unclassified Patient Print
2. Daily Patient Classification Summary By Ward
3. Individual Patient Classification Reports ...
4. Patient Category Totals-AMIS 1106 Reports
5. Manhours Print
6. AMIS Workload Statistics Report
7. Workload Statistics Report (Current)
8. Patient Category Totals-Midnight Acuity Reports
9. FTEE Comparison (1106b) Report
10. FTEE Reports

Select Resource Management Reports Option: 3 Individual Patient Classification Reports

Date/Time, Indiv. Classification Report By
Ward & Date/Time, Indiv. Classification Report By
Screen Prints:

Select Individual Patient Classification Reports Option: **W**Ard & **D**ate/Time, **I**ndiv. **C**lassification Report By

Select **P**ATIENT **N**AME: **NURSPATIENT,FOUR** 01-27-49 000788766 **NSC** **V**ETERAN

Start date (time optional): T-7// 5/1/86 (MAY 01,1986)

Go to date (time optional): NOW// <RET> (6/27/87@10:32)

**ENTER UNIT**: 10E

**DEVICE**: HOME// **Enter appropriate response**

---

<table>
<thead>
<tr>
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<th>NO.</th>
<th>FACTORS</th>
<th>SECT</th>
<th>COMMENTS</th>
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<tr>
<td>JUL 8,1986@08:11</td>
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<td>PSY</td>
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<td>C G I</td>
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<td>JUL 10,1986@21:15</td>
<td>3</td>
<td>C G I</td>
<td>PSY</td>
<td>WOUND/SKIN ISOLATION</td>
</tr>
</tbody>
</table>

Menu Access:

The Ward & Date/Time, Indiv. Classification Report By option is accessed through the Individual Patient Classification Reports option of the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Individual Patient Classification Reports option of the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu, and through the Individual Patient Classification Reports option of the Classification Reports, Patient option of the Print Reports option of the QA Coordinator's Menu.
NURAPR-RES-MDPC

Patient Category Totals-Midnight Acuity Reports

Description:

This report summarizes midnight patient category totals. The acuity statistics are reflective of the patient classification on the unit/ward at midnight. Reports can be generated for a daily, monthly, quarterly, or annual period. Data is obtained from the NURS Classification (#214.6) file and stored in the NURS AMIS 1106 Manhours (#213.4) file by the Nursing Acuity/Separation Run option.

Additional Information:

The acuity information is entered through the appropriate Classification, Edit Patient option. This report is sorted by facility when the multi-divisional field in the NURS Parameter (#213.9) file contains the value of 'yes'.

Restrictions:

Data can be printed for daily, monthly, quarterly, and annual reports but only for a limited time. Data is purged by the tasked option NURAAM-ACU (Nursing Acuity/Separation-Activation Run). The restricted window for printing reports is summarized below:

Daily totals - 120 days
Monthly totals - 4 months
Quarterly totals - 5 quarters
Annual totals - 3 fiscal years

This report cannot be printed for the current day.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location
Select Administration Records, Print Option: 2 Resource Management Reports

1 Current Unclassified Patient Print
2 Daily Patient Classification Summary By Ward
3 Individual Patient Classification Reports ...
4 Patient Category Totals-AMIS 1106 Reports
5 Manhours Print
6 AMIS Workload Statistics Report
7 Workload Statistics Report (Current)
8 Patient Category Totals-Midnight Acuity Reports
9 FTEE Comparison (1106b) Report
10 FTEE Reports

Screen Prints:

Select Resource Management Reports Option: 8 Patient Category Totals-Midnight Acuity Reports

By (1) Location or (2) Service: 1 Location

Patient Classification Data

AMIS Report 10-1106 Segment 200

Select NURSING UNIT: 2AS

Select NURSING Bed Section (Press return for all bed sections):

Select report range:

- Daily
- Monthly
- Quarterly
- Annually

Enter Selection (D,M,Q or A): D

Start with DATE: 4-5 (APR 05, 1995)

Go to DATE: APR 05, 1995/ <RET> (APR 05, 1995)

DEVICE: HOME/ Enter appropriate response
**Midnight Acuity Daily Report for 04/05/95**

**PATIENT**

**Date:** 04/05/95  
**WARD:** 2AS  
**CATEGORY**  
**I**  
**II**  
**III**  
**IV**  
**V**  
**CLASS.**

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<tr>
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<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
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<td>7</td>
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<td>26</td>
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</table>

Would you like to run another report? NO// <RET>

By (1) Location or (2) Service:  
2 Service

Patient Classification Data

AMIS Report 10-1106 Segment 200


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): **HINES** IL 499

Enter appropriate facility or press return for all facilities.

**Note:** If you have answered ‘Yes’ to the Multi-Divisional prompt in the Site Parameter File option, you will get the above facility prompt. The name of the facility will show as a header in the report.

Please select whether this report is to show acuity by ward or bed section

Select U for Unit or B for Bed Section: U
Select report range:

- Daily
- Monthly
- Quarterly
- Annually

Enter Selection (D,M,Q or A): D

Start with DATE: T-7 (FEB 17, 1997)

Go to DATE: FEB 17, 1997// (FEB 17, 1997)

DEVICE: HOME// Enter appropriate response

---

Baltimore, MD

FEB 24, 1997 Report 10-1106 Segment 200 PAGE: 1
Cumulative Daily Patient Classification Data
AMIS Daily Report for 02/17/97

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Enter RETURN to continue or '^' to exit: <RET>
### Menu Access:

The Patient Category Totals-Midnight Acuity Reports option is accessed through the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
Chapter 5 AMIS

NURAMN-MANED

Manhours Edit, AMIS 1106a

Description:

The Manhours Edit, AMIS 1106a option allows a nurse to enter daily RN, LPN, and NA manhours. Data is stored in the NURS AMIS 1106 Manhours (#213.4) file.

Additional Information:

Manhours may be entered retrospectively or prospectively. This information is reflected in the Manhours Print report.

Restrictions:

Only Manhours "worked" in direct patient care may be entered.

Future Plans:

Manhours for "OTHER" Category will be incorporated in future versions.

Menu Display:

Select Nursing Features (all options) Option: 1  Administration Records, Enter/Edit

Location Edit, Employee
Manhours Edit, AMIS 1106a
Staff Record Edit ... 

Screen Prints:

Select Administration Records, Enter/Edit Option: Manhours Edit, AMIS 1106a
Select Nursing UNIT: 3AM
Select DATE: OCT 9, 1996// <RET> (OCT 09, 1996)  Current date is the default.
Select Shift(s) (Enter N - Night D - DAY E - Evening or A for All Shifts): A

...Editing NIGHT SHIFT for ward 3AM...

ACTUAL HOURS ON DUTY RN: 8
ACTUAL HOURS ON DUTY LPN: 0
ACTUAL HOURS ON DUTY NA: 16

ENTERED BY: The name of the user entering the data appears here.

...Editing DAY SHIFT for ward 3AM...

ACTUAL HOURS ON DUTY RN: 16
ACTUAL HOURS ON DUTY LPN: 4
ACTUAL HOURS ON DUTY NA: 24

ENTERED BY: The name of the user entering the data appears here.

...Editing EVENING SHIFT for ward 3AM...

ACTUAL HOURS ON DUTY RN: 16
ACTUAL HOURS ON DUTY LPN: 4
ACTUAL HOURS ON DUTY NA: 16

ENTERED BY: The name of the user entering the data appears here.

Select DATE: At this prompt you can enter another date and then enter or modify manhours data for the same ward. If you enter <RET>, you return to a menu.

Menu Access:

The Manhours Edit, AMIS 1106a option is accessed through the Administration Records, Enter/Edit option of the Nursing Features (all options) menu, Administrator's Menu, and the Head Nurse's Menu.
Patient Category Totals-AMIS 1106 Reports

Description:

Patient Category Totals-AMIS 1106 Reports option allows administrative nursing personnel to print location and service reports which summarize patient category totals. Data is aggregated from the NURS Classification (#214.6) file and the classification totals are stored in the NURS AMIS 1106 Manhours (#213.4) file.

Additional Information:

AMIS Patient category totals are based on the patient's location at 3:00 pm as indicated by the MAS package. When patients are transferred between 2:45 pm and 3:00 pm, classifications are assigned to the unit from where she/he is transferred. The acuity information is entered through the appropriate Classification, Edit Patient option. If nursing admitted the patient through the nursing software and classified the patient, MAS must indicate that the patient was on a location by 3:00 pm. This report is dependent upon whether the Nursing Acuity/ Separation-Activation Run option has completed.

This report is sorted by facility when the multi-divisional field in the NURS Parameter (#213.9) file contains the value of 'yes'.

Restrictions:

Data can be printed for daily, monthly, quarterly, and annual reports but only for a limited time. Data is purged by the tasked option NURAAM-ACU (Nursing Acuity/Separation-Activation Run). The restricted window for printing reports is summarized below:

Daily totals - 120 days
Monthly totals - 4 months
Quarterly totals - 5 quarters
Annual totals - 3 fiscal years

This report cannot be printed for the current day.
Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 2 Resource Management Reports

1 Current Unclassified Patient Print
2 Daily Patient Classification Summary By Ward
3 Individual Patient Classification Reports ...
4 Patient Category Totals-AMIS 1106 Reports
5 Manhours Print
6 AMIS Workload Statistics Report
7 Workload Statistics Report (Current)
8 Patient Category Totals-Midnight Acuity Reports
9 FTEE Comparison (1106b) Report
10 FTEE Reports

Screen Prints:

Select Resource Management Reports Option: 4 Patient Category Totals-AMIS 1106 Reports

By (1) Location or (2) Service: 1 Location

Patient Classification Data

AMIS Report 10-1106 Segment 200

Select Nursing Unit: 3AM

Select Nursing Bed Section (Press return for all bed sections): <RET>

Select report range:

- Daily
- Monthly
- Quarterly
- Annually

Enter Selection (D,M,Q or A): D
Start with DATE: T-1  (OCT 25, 1996)

Go to DATE: OCT 25, 1996// <RET> (OCT 25, 1996)

DEVICE: HOME//Enter appropriate response

OCT 26, 1996 AMIS Report 10-1106 Segment 200 PAGE: 1
Cumulative Daily Patient Classification Data
Daily Report for 10/25/96

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<tr>
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<th>CLASS.</th>
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<tr>
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<td>1</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7</td>
<td>3</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>19</td>
</tr>
</tbody>
</table>

Would you like to run another report? NO//<RET>

**Example:**

Service wide AMIS 1106 report.

By (1) Location or (2) Service: 2 Service

Patient Classification Data

AMIS Report 10-1106 Segment 200


Select Reporting Option: 1

Select FACILITY (Press return for all facilities): HINES IL 499

Enter appropriate facility or press return for all facilities.

**Note:** If you have answered ‘Yes’ to the Multi-Divisional prompt in the Site Parameter File option, you will get the above facility prompt, and the name of the facility will show as a header in the report.
Select report range:

- Daily
- Monthly
- Quarterly
- Annually

Enter Selection (D,M,Q or A): Q

Enter FISCAL YEAR: 96 (1996)

Enter QUARTER (Choose a number 1-4): 4

DEVICE: HOME//Enter appropriate response

APR 15, 1997 Report 10-1106 Segment 200 PAGE: 1
Cumulative Daily Patient Classification Data
AMIS Quarterly Report for 1996 Qtr. #4

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>CLASS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>BALTIMORE, MD TOTALS</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>CHICAGO (WESTSIDE), IL TOTALS</td>
<td>1104</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>
Cumulative Daily Patient Classification Data
AMIS Quarterly Report for 1996 Qtr. #4

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>I</th>
<th>II</th>
<th>III</th>
<th>IV</th>
<th>V</th>
<th>CLASS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALCOHOL AND DRUG TREATMENT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>DOMICILIARY</td>
<td>1104</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1104</td>
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<tr>
<td>INTENSIVE CARE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>INTERMEDIATE CARE</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MEDICAL (EXCLUDE SCI)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NURSING HOME CARE UNIT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>PSYCHIATRIC</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>RECOVERY ROOM</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>REPORT TOTAL</td>
<td>1104</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Would you like to run another report? NO// <RET>

**Menu Access:**

The Patient Category Totals-AMIS 1106 Reports option is accessed through the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-RES-MANHR

Manhours Print

Description:

This option allows the user to print reports which summarize the total RN, LPN, and NA patient care manhours worked. Reports can be generated for a daily, monthly, quarterly, or annual period for an indefinite period of time. The information is stored in the NURS AMIS 1106 Manhours (#213.4) file.

Additional Information:

1. On printed reports, the following information is printed in sequence:
   a. Manhours data for nursing units with no acuity data is printed first.
   b. If classification data is missing, the manhours data for those specific days are totaled and displayed at the top of the report. Refer to example below:

   OCT 26, 1996 Service Manhours Quarterly Report for 1996 Qtr. #4 PAGE: 1

   RN    LPN    NA
   -----------------------------
   TOTAL MANHOURS WHEN NO ACUITY DATA IS PRESENT:
   3AM 16.00  8.00  16.00
   3S  140.00  0.00   0.00
   OR  24.50  16.20   0.00
   SICU 190.00  0.00   0.00
   -------    -------    -------
   SUBTOTAL 370.50  24.20   16.00

2. If acuity is present and no manhours data was entered for a specific unit, the report reflects this in this format "0.00". Refer to example below:

   BEDSECTION: ALCOHOL AND DRUG TREATMENT AS
   0.00  0.00  0.00
   -------    -------    -------
   SUBTOTAL 0.00  0.00  0.00

3. On units/wards with split bedsections, manhours are calculated based on acuity ratios. The manhours on units with split bedsections are calculated at the time the manhours reports are printed.
4. If manhours data has not been entered for units that classify patients based on the AMIS bed section in File 211.4, nursing can print the dates of the missing entries through the following Special Functions options:

Manhours Exception Print by Service [NURAMN-STA]
Manhours Exception Print by Location [NURAMN-STA-LOC]

Units not associated with an AMIS bed section have their missing manhours data identified through the Manhours Print report [NURAPR-RES-MANHR].

The user can enter the missing information through the Manhours Edit, AMIS 1106a option.

This report is sorted by facility when the multi-divisional field in the NURS Parameter (#213.9) file contains the value of ‘yes’. This option can be run for past, current and future dates.

**Future Plans:**

This module will be continually enhanced in later versions to meet the AMIS reporting requirements.

**Menu Display:**

Select Nursing Features (all options) Option: 2  Administration Records, Print

1  Administrative Reports ...
2  Resource Management Reports ...
3  Salary Reports ...
4  Staff Record Report
5  Telephone Number Listings ...
6  Individual Staff Position/Location

Select Administration Records, Print Option: 2  Resource Management Reports

1  Current Unclassified Patient Print
2  Daily Patient Classification Summary By Ward
3  Individual Patient Classification Reports ...
4  Patient Category Totals-AMIS 1106 Reports
5  Manhours Print
6  AMIS Workload Statistics Report
7  Workload Statistics Report (Current)
8  Patient Category Totals-Midnight Acuity Reports
9  FTEE Comparison (1106b) Report
10  FTEE Reports
Screen Prints:

Select Resource Management Reports Option: 5 Manhours Print  

By (1) Location or (2) Service: 1 Location  

Nursing AMIS 1106 Patient Care Manhours Reports  

Select Nursing Unit: 10E  

Select Nursing Bed Section (Press return for all bed sections): <RET>  

Select report range:  

- Daily  
- Monthly  
- Quarterly  
- Annually  

Enter Selection (D,M,Q or A): D  

Start with DATE: T-1 (APR 22, 1997)  

Go to Date: Apr 22, 1997// <RET>  

DEVICE: HOME// Enter appropriate response  

APR 23, 1997 10E Manhours Daily Report for 04/22/97 PAGE: 1  

<table>
<thead>
<tr>
<th></th>
<th>RN</th>
<th>LPN</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>APR 22, 1997</td>
<td>----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>TOTAL MANHOURS WHEN NO ACUITY DATA IS PRESENT:</td>
<td>----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>10E</td>
<td>30.00</td>
<td>8.00</td>
<td>10.00</td>
</tr>
<tr>
<td>10E</td>
<td>0.00</td>
<td>15.00</td>
<td>2.00</td>
</tr>
<tr>
<td>10E</td>
<td>8.00</td>
<td>8.00</td>
<td>8.00</td>
</tr>
<tr>
<td></td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>SUBTOTAL</td>
<td>38.00</td>
<td>31.00</td>
<td>20.00</td>
</tr>
<tr>
<td>APR 22, 1997 TOTAL</td>
<td>----</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>38.00</td>
<td>31.00</td>
<td>20.00</td>
<td></td>
</tr>
<tr>
<td>REPORT TOTAL</td>
<td>38.00</td>
<td>31.00</td>
<td>20.00</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>  

Would you like to run another report? NO// <RET>  

Select Resource Management Reports Option: 5 Manhours Print
By (1) Location or (2) Service: 2 Service

Nursing AMIS 1106 Patient Care Manhours Reports


Select Reporting Option: 1

Select FACILITY (Press return for all facilities): <RET>

Select report range:

Daily
Monthly
Quarterly
Annually

Enter Selection (D,M,Q or A): q


Enter QUARTER (Choose a number 1-4): 2

DEVICE: HOME/ Enter appropriate response

| OCT 03, 1997 Service Manhours AMIS Quarterly Report for 1996 Qtr. #2 PAGE: 1 |
|---------------------------------------------------------------|-----|-----|-----|
| BALTIMORE, MD TOTALS | 144.00 | 64.00 | 72.00 |
| CHICAGO (WESTSIDE), IL TOTALS | 56.00 | 32.00 | 8.00 |
| HINES ISC TOTALS | 160.00 | 80.00 | 80.00 |

Enter RETURN to continue or '^' to exit: <RET>
<table>
<thead>
<tr>
<th>RN</th>
<th>LPN</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>16.00</td>
<td>8.00</td>
<td>8.00</td>
</tr>
<tr>
<td>56.00</td>
<td>32.00</td>
<td>24.00</td>
</tr>
<tr>
<td>40.00</td>
<td>16.00</td>
<td>24.00</td>
</tr>
<tr>
<td>16.00</td>
<td>8.00</td>
<td>8.00</td>
</tr>
<tr>
<td>---------</td>
<td>---------</td>
<td>--------</td>
</tr>
<tr>
<td>360.00</td>
<td>176.00</td>
<td>160.00</td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>

Would you like to run another report? NO// <RET>

**Menu Access:**

The Manhours Print option is accessed through the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.

---

1 Patch NUR*4*2 October 1997
NURAPR-RES-FTEEC

FTEE Comparison (1106b) Report

Description:

1. This option allows administrative nursing personnel to print an FTEE Comparison (1106b) Report which indicates ceiling (FTEE), positions (FTEE) filled, and a variance.

Additional Information:

2. Data under the ACTUAL column is aggregated, for both service and location reports, from the (active) staff positions in the NURS Position Control (#211.8) file. Budgeted FTEE in the service reports is obtained from the NURS AMIS 1106B FTEE (#213.2) file. In the location reports, budgeted FTEE data is obtained from the NURS Position Control (#211.8) file.

You may enter current employee information through the Staff Record Edit option and the Location Edit, Employee option. Information on budgeted FTEE printed in the service report, is entered through the FTEE Service Budget (1106b) File, Edit option. Budgeted FTEE information printed in the location reports, is entered through the NURS Location File, Edit option into the service position and associated budgeted FTEE fields for each location. Budgeted service position FTEE and its associated service category(s) (reflected in File #211.3) is used to calculate the total budgeted service category FTEE. If data is completely missing when running the service report, the following message displays:

*** YOU ARE MISSING DATA IN THE (FACILITY NAME) AMIS 1106B FTEE (213.2) FILE ENTRY. CONTACT THE NURSING APPLICATION COORDINATOR.

The report will then print for a facility or division having budgeted data. This report is sorted by facility only when the multi-divisional field in the NURS Parameter file contains the value of ‘yes’.

3. Effective with June 1997 data, AMIS Segment 202 was discontinued per TWX (Subject: Discontinuance of AMIS Segment 202 Nursing Service Code, VA Form 10-1106B (AMIS) and Report EM12, RCS 10-0034). The data is no longer required by the AMIS system. Cancellation of Section 203.00 Chapter 2, MP-6, Part VI, Supp. No. 1.2 will be forthcoming.

Menu Display:

Select Nursing Features (all options) Option: 2  Administration Records, Print

---

1. Patch NUR*4*2 October 1997
2. Patch NUR*4*2 October 1997
3. Patch NUR*4*2 October 1997
1      Administrative Reports ...
2      Resource Management Reports ...
3      Salary Reports ...
4      Staff Record Report
5      Telephone Number Listings ...
6      Individual Staff Position/Location

Select Administration Records, Print Option: 2 Resource Management Reports

1      Current Unclassified Patient Print
2      Daily Patient Classification Summary By Ward
3      Individual Patient Classification Reports ...
4      Patient Category Totals-AMIS 1106 Reports
5      Manhours Print
6      AMIS Workload Statistics Report
7      Workload Statistics Report (Current)
8      Patient Category Totals-Midnight Acuity Reports
9      FTEE Comparison (1106b) Report
10     FTEE Reports

Screen Prints:

Select Resource Management Reports Option: 9 FTEE Comparison (1106b) Report

By (1) Location or (2) Service: 1 Location

Select FACILITY (Press return for all facilities): HINES 499

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units): SICU
Another NURSING UNIT: <RET>

DEVICE: HOME//Enter appropriate response
### NURSING SERVICE BUDGETED/ACTUAL FTEE BY WARD

<table>
<thead>
<tr>
<th>TITLE</th>
<th>BUDGETED FTEE</th>
<th>ACTUAL FTEE</th>
<th>VARIANCE</th>
<th>MAR 03, 1997</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WARD: SICU</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 NURSING SUPERVISOR DAY</td>
<td>0.000</td>
<td>0.400</td>
<td>0.400</td>
<td></td>
</tr>
<tr>
<td>HEAD NURSE</td>
<td>1.000</td>
<td>1.500</td>
<td>0.500</td>
<td></td>
</tr>
<tr>
<td>CARDIAC CATH NURSE</td>
<td>0.500</td>
<td>0.300</td>
<td>-0.200</td>
<td></td>
</tr>
<tr>
<td>STAFF NURSE</td>
<td>10.000</td>
<td>5.600</td>
<td>-4.400</td>
<td></td>
</tr>
<tr>
<td>WARD TOTAL = 11.500</td>
<td>7.800</td>
<td>-3.700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RN TOTAL = 11.500</td>
<td>7.800</td>
<td>-3.700</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPN TOTAL =</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NA TOTAL =</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADMIN TOTAL =</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CLERICAL TOTAL =</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER TOTAL =</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**This option returns to the menu at this point.**

By (1) Location or (2) Service: 2 Service

Select FACILITY (Press return for all facilities): HINES IL 499

Enter appropriate facility or press return for all facilities.

THIS REPORT WILL COMPARE THE BUDGETED FTEE TOTALS ENTERED IN THE NURS AMIS 1106B FTEE (#213.2) FILE AGAINST TODAY’S CURRENT FTEE ENTRIES FOR AMIS SEGMENT 202 (1106B)

DEVICE: HOME//Enter appropriate response

---

1. Patch NUR*4*2 October 1997
2. Patch NUR*4*2 October 1997
## Menu Access:

The FTEE Comparison (1106b) Report option is accessed through the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.

### Table: FTEE Comparison Report

<table>
<thead>
<tr>
<th>POSITION</th>
<th>BUDGETED</th>
<th>ACTUAL</th>
<th>VARIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN (01)</td>
<td>141.00</td>
<td>34.15</td>
<td>-106.84</td>
</tr>
<tr>
<td>LPN (02)</td>
<td>60.00</td>
<td>7.70</td>
<td>-52.30</td>
</tr>
<tr>
<td>NA (03)</td>
<td>100.00</td>
<td>6.20</td>
<td>-93.80</td>
</tr>
<tr>
<td>CLERICAL (04)</td>
<td>6.50</td>
<td>2.30</td>
<td>-4.20</td>
</tr>
<tr>
<td>ADMIN OFFICER (05)</td>
<td>1.00</td>
<td>0.00</td>
<td>-1.00</td>
</tr>
<tr>
<td>CLIN SPECIALIST (06)</td>
<td>3.00</td>
<td>0.00</td>
<td>-3.00</td>
</tr>
<tr>
<td>RN PRACTITIONER (07)</td>
<td>4.00</td>
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<td>-3.80</td>
</tr>
<tr>
<td>INFECT. CONTROL (08)</td>
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<td>0.00</td>
<td>-3.00</td>
</tr>
<tr>
<td>PUBLIC HEALTH (09)</td>
<td>3.00</td>
<td>0.40</td>
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</tr>
<tr>
<td>STAFF NURSE (10)</td>
<td>112.00</td>
<td>25.90</td>
<td>-86.10</td>
</tr>
<tr>
<td>CHIEF NURSE (11)</td>
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<td>0.80</td>
<td>-0.20</td>
</tr>
<tr>
<td>ASST CHIEF NURSE (12)</td>
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<td>0.00</td>
<td>-3.00</td>
</tr>
<tr>
<td>ASSOC CHIEF N.S. (13)</td>
<td>1.00</td>
<td>0.00</td>
<td>-1.00</td>
</tr>
<tr>
<td>SUPERVISOR (14)</td>
<td>2.00</td>
<td>0.40</td>
<td>-1.60</td>
</tr>
<tr>
<td>HEAD NURSE (15)</td>
<td>5.00</td>
<td>3.70</td>
<td>-1.30</td>
</tr>
<tr>
<td>OTHER NURSE (16)</td>
<td>0.00</td>
<td>1.15</td>
<td>1.15</td>
</tr>
<tr>
<td>NURSE RESHR (17)</td>
<td>1.00</td>
<td>0.00</td>
<td>-1.00</td>
</tr>
<tr>
<td>ASSOC CHIEF/RESH (18)</td>
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<td>0.00</td>
<td>-1.00</td>
</tr>
<tr>
<td>ASSOC CHIEF/EDU (19)</td>
<td>1.00</td>
<td>0.00</td>
<td>-1.00</td>
</tr>
<tr>
<td>INSTR/EDU (20)</td>
<td>1.00</td>
<td>1.60</td>
<td>0.60</td>
</tr>
</tbody>
</table>
Chapter 6 FTEE/Workload Reports

NURAPR-RES-AMISWKL

AMIS Workload Statistics Report

Description:

The AMIS Workload Statistics Report option prints location and service reports that utilize manhours and acuity data from the NURS AMIS 1106 Manhours (#213.4) file.

Additional Information:

Information is entered through the Classification, Edit Patient option and the Manhours Edit, AMIS 1106a option.

This report is sorted by facility when the multi-divisional field in the NURS Parameter (#213.9) file contains the value of 'yes'.

This report is dependent on whether the Nursing Acuity/Separation Batch Job has run to completion. The acuity data is calculated by the Nursing Acuity/Separation-Activation batch job which runs after midnight to accumulate totals for the previous day. The totals are based on classifications that are entered before the cutoff time designated for the Night/Day/ Evening Shift in the NURS Parameter File. For example we will use 0700 for Nights, 1500 for Days and 2300 for Evenings as the cutoff times.

a. For the night shift, any classification entered for an active patient before 0700 will be counted. Since this cutoff time is before 1500, if the patient's classification has not been updated by 0700, the previous classification for the current unit is used. If no previous classification for that unit is available the patient will not be counted.

b. For the day shift, the latest classification entered before 1500 (3pm) will be counted in the official AMIS totals. If there is no classification before 1500 on the run date the patient is not counted in the official AMIS totals and will appear on the unclassified patient report. Any changes (discharge, transfer, death, etc.) that occurs after the day shift cutoff time will have no effect on the day shift totals.

c. For the evening shift, the latest classification that occurs before midnight will be counted. If the patient has not been classified on their current unit on the run date, that patient will not be counted in the evening shift acuity totals and will be reflected as unclassified on the Unclassified Midnight Patient's report. Changes that occur after 1500 will be reflected in these and subsequent totals.
The Classification File Purge option, found under the Nursing System Manager's Menu, permanently deletes data from the NURS Classification #214.6 and the NURS Review Classification #214.7 files. It is recommended that a minimum of 6 months of data remain in these files. Refer to the Package Management section for additional information on the Classification File Purge option. Contact the DSS Site Manager prior to any purging of classification data.

AMIS/Current Workload Statistics Definitions:

1. Unit - Patient care location.
2. Bed Sect - AMIS bed section.
3. RN FTEE/LPN FTEE/NA FTEE
   a. (Req.) - Required.
      1. Required RN's defined by either the Professional Percentage in the Nursing Location File for each location or in the Site Parameter File as a default for the service.
      2. Required LPN/NA, the remaining percentage from RN is divided equally between LPN's and NA's.
   b. SOD - Staff on duty taken from manhours entered for specific unit, shift and service category.
   c. VAR - Variance of FTEE between required staff and staff on duty.
   d. PT/PRO - Percent productivity calculated by:

   \[
   \frac{\text{Required SOD}}{\text{Actual SOD}} = \frac{120}{4} = 120
   \]

   A percentage greater than 100 means understaffed.
   A percentage less than 100 means overstaffed.

   e. Patient Category - Total number of patients classified per patient category.
   f. PTOT - Patient category totals includes only patients classified, not necessarily the patient census.
   g. Data is reported by:
      1. Shift
      2. Bed section
      3. Unit
      4. Hospital
Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location

Select Administration Records, Print Option: 2 Resource Management Reports

1 Current Unclassified Patient Print
2 Daily Patient Classification Summary By Ward
3 Individual Patient Classification Reports ...
4 Patient Category Totals-AMIS 1106 Reports
5 Manhours Print
6 AMIS Workload Statistics Report
7 Workload Statistics Report (Current)
8 Patient Category Totals-Midnight Acuity Reports
9 FTEE Comparison (1106b) Report
10 FTEE Reports

Screen Prints:


By (1) Location or (2) Service: 1 Location

1. Summary Report

Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select UNIT: 3S

Enter appropriate ward.

Start With DATE: 10/24/96 OCT 24, 1996

Enter appropriate start date.

Go to Date: OCT 24, 1996// <RET> (OCT 24, 1996)
By (1) Location or (2) Service: **2 Service**

1. Summary Report

Select Reporting Option: **2**

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): **HINES  IL  499**

Enter appropriate facility or press return for all facilities.

**Note:** If you have answered ‘Yes’ to the Multi-Divisional prompt in the Site Parameter File option, you will get the above facility prompt, and the name of the facility will show as a header in the report.


Enter appropriate date.

Go to Date: OCT 24, 1996// <RET> (OCT 24, 1996)

The date range in the parenthesis indicates the time frame for the report based on the start date.

**DEVICE:** Enter appropriate response

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1 Patch NUR*4*20 November 1998
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1 Patch NUR*4*20 November 1998
Menu Access:

The AMIS Workload Statistics Report option is accessed through the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
NURAPR-RES-CURWKL

Workload Statistics Report (Current)

Description:

This option allows nursing management to print current and projected workload statistics reports for locations and the entire service. Projected reports may be printed for the next two shifts from the current tour of duty. This report uses data from the NURS AMIS 1106 Manhours (#213.4) file to calculate the current acuity and generate workload statistics.

Additional Information:

Information is entered through the Classification, Edit Patient option and the Manhours Edit, AMIS1106a option. This report is based on the total number of patients classified on a location for a current date/time. The PTOT (patient total) column is being calculated on the fly as the report is run. Using this option, the required staffing for the next two shifts can be forecasted based on the current acuity. The time frame for the current and future shift(s) is calculated on the information entered into the Day, Evening, and Night Shift Acuity Time fields in the NURS Parameter (#213.9) file. The current workload statistics report can be automatically queued to run daily through the NURAPR-RES-CURWKL-QUEUE (TaskManager Workload Statistic Report (Current)) option.

This report is sorted by facility when the multi-divisional field in the NURS Parameter (#213.9) file contains the value of ‘yes’.

Future Plans:

This module is under continuous enhancement to satisfy site specific requirements.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1 Administrative Reports ...
2 Resource Management Reports ...
3 Salary Reports ...
4 Staff Record Report
5 Telephone Number Listings ...
6 Individual Staff Position/Location
FTEE/Workload Reports

Select Administration Records, Print Option: 2 Resource Management Reports

1. Current Unclassified Patient Print
2. Daily Patient Classification Summary By Ward
3. Individual Patient Classification Reports ...
4. Patient Category Totals—AMIS 1106 Reports
5. Manhours Print
6. AMIS Workload Statistics Report
7. Workload Statistics Report (Current)
8. Patient Category Totals—Midnight Acuity Reports
9. FTEE Comparison (1106b) Report
10. FTEE Reports

Screen Prints:


By (1) Location or (2) Service: 1 Location

Enter UNIT: 2A

Enter appropriate ward.

Select (N)ight, (D)ay, or (E)vening shift: D//<RET>

Enter 'D' for Day, 'E' for Evening or 'N' for Night shift.

DEVICE: Enter appropriate response

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1 Patch NUR*4*20 November 1998
```
By (1) Location or (2) Service: 2 Service


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): HINES IL 499

Enter appropriate facility or press return for all facilities.

Note: If you have answered ‘Yes’ to the Multi-Divisional prompt in the Site Parameter File option, you will get the above facility prompt. The name of the facility will show as a header in the report.

Select (N)ight, (D)ay, or (E)vening shift: D/<RET>

Enter 'D' for Day, 'E' for Evening or 'N' for Night shift.

DEVICE: Enter appropriate response

1 Patch NUR*4*20 November 1998
### Staffing Variance Worksheet for Hines

**DATE:** JUN 05, 1996 | 09:55:24  
**Shift:** NIGHT

**Instructions:**
- **Column A:** Total FTEE on duty (from computer printout and staffing adjustments)
- **Column B:** Total FTEE required for workload (taken from computer print-out)
- **Column C:** Total Variance by FTEE (Column A - Column B = Column C)
- **Column D:** Percentage of Total Variance (Column A / Column B = Column D)

The letters **NSS** in **Column D** indicate that no staff are scheduled for this unit.

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Enter RETURN to continue or '^' to exit:

### Menu Access:

The Workload Statistics Report (Current) option is accessed through the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.

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1. Patch NUR*4*20  November 1998
NURAPR-FTEE

FTEE Reports

Description:

This option allows administrative nursing personnel to print statistical reports which summarize FTEE information. Data may be sorted by service category or service position. Data comes from the NURS Position Control (#211.8) file.

Additional Information:

Information is entered through the Staff Record, Edit and the Location Edit, Employee options. This report is sorted by facility when the multi-divisional field in the NURS Parameter (#213.9) file contains the value of 'yes'.

Note: Two asterisks found before the service category of an employee indicates that an active employee has a "0" FTEE.

Menu Display:

Select Nursing Features (all options) Option: 2 Administration Records, Print

1  Administrative Reports ...
2  Resource Management Reports ...
3  Salary Reports ...
4  Staff Record Report
5  Telephone Number Listings ...
6  Individual Staff Position/Location

Select Administration Print Option: 2 Resource Management Reports

1  Current Unclassified Patient Print
2  Daily Patient Classification Summary By Ward
3  Individual Patient Classification Reports
4  Patient Category Totals-AMIS 1106 Reports
5  Manhours Print
6  AMIS Workload Statistics Report
7  Workload Statistics Report (Current)
8  Patient Category Totals-Midnight Acuity Reports
9  FTEE Comparison (1106b) Report
10  FTEE Reports
Screen Prints:

Select Resource Management Reports Option: 10  FTEE Reports

Sort by:

1. Location and Service Category
2. Location and Service Position
3. Service and Service Category
4. Service and Service Position

Choose a sort parameter set between 1 and 4: 1  Location and Service Category

Select FACILITY (Press return for all facilities): HINES  IL  499

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): NURSING

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units) : <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

NURSING Service Categories
--------------------------
1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-CLERICAL)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)

OTHER Service Categories
-------------------------
8. OTHER VOLUNTEER
9. RD
10. STUDENT NURSE
11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

Select FTEE (Press return for all FTEE): <RET>

Enter appropriate FTEE, or press return for all FTEE.

DEVICE: HOME//Enter appropriate response
<table>
<thead>
<tr>
<th>SERVICE CATEGORY</th>
<th>FTEE</th>
<th>EMPLOYEE NAME</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LPN</td>
<td>1.000</td>
<td>NURSNURSE12,NINE</td>
<td>10E</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NA</td>
<td>1.000</td>
<td>NURSNURSE12,TEN</td>
<td>10E</td>
</tr>
<tr>
<td>NA</td>
<td>1.000</td>
<td>NURSNURSE13,ONE</td>
<td>10E</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NA</td>
<td>1.000</td>
<td>NURSNURSE13,THREE</td>
<td>OR</td>
</tr>
<tr>
<td>NA</td>
<td>1.000</td>
<td>NURSNURSE13,FOUR</td>
<td>OR</td>
</tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>NURSING TOTALS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HINES TOTALS</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.000</td>
<td></td>
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</tr>
<tr>
<td>REPORT TOTAL</td>
<td></td>
<td></td>
<td>51.000</td>
</tr>
<tr>
<td>COUNT-ASSIGNMENTS</td>
<td>84.000</td>
<td>PERSONNEL</td>
<td>54.000</td>
</tr>
<tr>
<td>MEAN-ASSIGNMENTS</td>
<td>0.600</td>
<td>PERSONNEL</td>
<td>0.900</td>
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Choose a sort parameter set between 1 and 4: 2 Location and Service Position

Select FACILITY (Press return for all facilities): HINES IL 499

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): NURSING

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units): <RET>

Select the name of an active nursing unit as defined by the Ward Status field of the NURS Location File, Edit option. You may also enter <RET> for all nursing units in the facility.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.

Select FTEE (Press return for all FTEE): <RET>

Enter appropriate FTEE, or press return for all FTEE.

DEVICE: HOME//Enter appropriate response

<table>
<thead>
<tr>
<th>NURSING</th>
<th>NURSNURSE13,FIVE</th>
<th>10E</th>
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<tbody>
<tr>
<td>FTEE PROFILE BY LOCATION AND SERVICE POSITION</td>
<td>HINES</td>
<td>FEB 5, 1986</td>
</tr>
<tr>
<td>SERVICE POSITION</td>
<td>FTEE</td>
<td>LOCATION</td>
</tr>
<tr>
<td>------------------------------</td>
<td>------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>CNA</td>
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<tr>
<td>SUBTOTAL</td>
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<td></td>
</tr>
<tr>
<td>SUBCOUNT</td>
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<td></td>
</tr>
<tr>
<td>SUBMEAN</td>
<td>1.000</td>
<td></td>
</tr>
</tbody>
</table>
Last page of report

<table>
<thead>
<tr>
<th>RN</th>
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<th>NURSNURSE13, THREE</th>
<th>OR</th>
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<tr>
<td>SUBTOTAL</td>
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<td>SUBCOUNT</td>
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</tr>
<tr>
<td>SUBMEAN</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NURSING TOTALS

| SUBTOTAL | 4.000 |
| SUBCOUNT | 4.000 |
| SUBMEAN  | 1.000 |

HINES TOTALS

| SUBTOTAL | 4.000 |
| SUBCOUNT | 4.000 |
| SUBMEAN  | 1.000 |

REPORT TOTAL

| 51.000 |

COUNT-ASSIGNMENTS | 84.000 | PERSONNEL | 54.000 |
MEAN-ASSIGNMENTS | 0.600 | PERSONNEL | 0.900 |

Choose a sort parameter set between 1 and 4: 3 Service and Service Category


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): HINES IL 499

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): NURSING

Select appropriate product line(s) or press return for all product lines.
NURSING Service Categories
-----------------------------
1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-CLERICAL)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)

OTHER Service Categories
------------------------
8. OTHER VOLUNTEER
9. RD
10. STUDENT NURSE
11. ALL

Select SERVICE CATEGORY: 11

Enter appropriate service categories. You may select one or more service categories to sort by.

Select FTEE (Press return for all FTEE): <RET>

Enter appropriate FTEE, or press return for all FTEE.

DEVICE: HOME//Enter appropriate response

HINES

FTEE PROFILE BY SERVICE CATEGORY               FEB 5,1986      PAGE: 1
SERVICE CATEGORY               FTEE   EMPLOYEE          LOCATION
---------------------------------     ------  ----------------------  -------
NURSING
---------------------------------     ------  ----------------------  -------
    CK     0.600   NURSNURSE13,EIGHT  CNO
    CK     1.000   NURSNURSE13,NINE  CNO
    CK     1.000   NURSNURSE13,TEN   CNO
    CK     1.000   NURSNURSE14,ONE   CNO
    CK     1.000   NURSNURSE14,TWO   CNO
    CK     1.000   NURSNURSE14,THREE  CNO
    CK     1.000   NURSNURSE14,FOUR   CNO

SUBTOTAL   6.600
SUBCOUNT   7.000
SUBMEAN    0.900
Choose a sort parameter set between 1 and 4: 4  Service and Service Position


Select Reporting Option: 2

Select 1 to print a summary report or 2 to print the entire report.

Select FACILITY (Press return for all facilities): HINES    IL    499

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): NURSING

Select appropriate product line(s) or press return for all product lines.

Select SERVICE POSITION (Press return for all service positions): <RET>

Enter appropriate service position, or press return for all service positions.
Select FTEE (Press return for all FTEE): <RET>

Enter appropriate FTEE, or press return for all FTEE.

DEVICE: HOME//Enter appropriate response

HINES

FTEE PROFILE BY SERVICE POSITION                   FEB 5,1986     PAGE: 1

<table>
<thead>
<tr>
<th>SERVICE POSITION</th>
<th>FTEE</th>
<th>EMPLOYEE NAME</th>
<th>LOCATION</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td>NURSNURSE14,SIX</td>
<td>CNO</td>
</tr>
<tr>
<td>CNS</td>
<td>1.000</td>
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</tr>
<tr>
<td>SUBTOTAL</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUBCOUNT</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUBMEAN</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACNS</td>
<td>1.000</td>
<td>NURSNURSE14,SEVEN</td>
<td>CNO</td>
</tr>
<tr>
<td>SUBTOTAL</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SUBMEAN</td>
<td>1.000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Menu Access:

The FTEE Reports option is accessed through the Resource Management Reports option of the Administration Records, Print option of the Nursing Features (all options) menu, and the Administrator's Menu. This option is also accessed through the Resource Management Reports option of the Administration Reports (Head Nurse) option of the Head Nurse's Menu.
Section 3 Clinical
Chapter 1 Patient/Ward Information

NURSPE-LOC/BED

Location/Bed Section, Edit Nursing

Description:

The Location/Bed Section, Edit Nursing option permits the user to correct the patient's nursing ward location and nursing AMIS bed section. The patient's nursing AMIS bed section determines the classification tool used to classify the patient via the Edit Patient Classification Menu options.

Additional Information:

All patient transfers are initiated through the Admission, Discharge, and Transfer (ADT) option. The registered nurse may need this option if the following conditions are present:

1. ADT is down.

2. The nursing location must be changed because the NURS Location (#211.4) file cannot complete the association between the MAS ward and the nursing location. This condition occurs when an MAS ward is associated with two nursing units.

3. A patient is temporarily housed on a nursing unit and is intentionally not admitted through the ADT option. For example, when a lodger and day surgery patient might be entered in the nursing software for the purpose of tracking workload.

4. A change in the patient's nursing unit (i.e., a patient movement) that has not been entered through the ADT option due to human resource constraints, lack of written orders, etc.

5. The MAS location to which the patient is assigned is associated with a nursing location that does not contain the patient's appropriate bed section.

NOTE: The change in the nursing AMIS bed section is temporary. The staff nurse might have to update the patient's bed section on a daily basis when the new nursing AMIS bed section is not found in the NURS Location (#211.4) file. It is recommended that the nursing application coordinator associate the bed section with the nursing unit until the patient is transferred (or it can remain as a permanent entry).

Only active nursing unit names, as defined by the Patient Care Status field in the NURS Location (#211.4) file, can be selected by the user.
Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1. Administration Records, Enter/Edit ...
2. Administration Records, Print ...
3. Administrative Site File Functions ...
4. Nursing Education Reports, Print ...
5. Patient Care Data, Enter/Edit ...
6. Patient Care Data, Print ...
7. Clinical Site File Functions ...
8. QI Data, Enter/Edit ...
9. Quality Performance Reports ...
10. QI Site Files ...
11. Special Functions ...

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

Classification, Edit Patient ...
Evaluation/Target Date & Order Status Edit
Intake/Output Data Entry Menu ...
Location/Bed Section, Edit Nursing
Patient Plan of Care, Edit
Vitals/Measurements Data Entry Menu ...

Screen Prints:

Select Patient Care Data, Enter/Edit Option: Location/Bed Section, Edit Nursing

Select PATIENT NAME: NURSPATIENT4,FIVE
Select Nursing Unit: NUR 9// 9A

Enter <RET> if the correct ward is displayed, or change the nursing unit to the correct name by entering the name of an active nursing unit. This will not affect the MAS location.

Nursing BED SECTION: SURGICAL// <RET>

This is the name of the nursing AMIS bed section associated with the patient. The patient's nursing AMIS bed section determines the classification tool used to classify the patient via the Edit Patient Classification menu options. This field points to the NURS AMIS Ward (#213.3) file. You may either select the default or enter the correct nursing bed section.

Menu Access:

This option is accessed through the Patient Care Data, Enter/Edit option of the Staff Nurse Menu, Head Nurse's Menu, and Nursing Features (all options) menu.
**NURSPP-LOCIND**

**Location of Individual Patient, Print**

**Description:**

The Location of Individual Patient, Print option displays the nursing unit, room/bed number, hospital leave status, bed section, and the acuity of an individual patient. Information is obtained from the following files or applications: nursing unit and (nursing) bed section is retrieved from the NURS Patient (#214) file, the room/bed number and hospital leave status are obtained through the ADT application, and acuity is stored in the NURS Classification (#214.6) file.

**Additional Information:**

This option displays the patient information on a (terminal or monitor) screen. The user cannot send the patient information to a printer.

**Menu Display:**

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1  Administration Records, Enter/Edit ...
2  Administration Records, Print ...
3  Administrative Site File Functions ...
4  Nursing Education Reports, Print ...
5  Patient Care Data, Enter/Edit ...
6  Patient Care Data, Print ...
7  Clinical Site File Functions ...
8  QI Data, Enter/Edit ...
9  Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Option: 6 Patient Care Data, Print
Patient/Ward Information

1. Classification Report
2. Location of Individual Patient, Print
3. Patient Assignment Worksheet
4. Ward Census, Print
5. Current Unclassified Patient Print, by Location
6. Patient Plan of Care, Print
7. Vitals/Measurements Results Reporting ...
8. Intake/Output Results Reporting ...
9. End of Shift Report
10. Health Summary Report
11. Vitals/Measurements SF 511
12. Patient Problems to be Evaluated

Screen Prints:

Select Patient Care Data, Print Option: 2 Location of Individual Patient, Print

Select PATIENT NAME: NURSPATIENT3,SIX 01-01-37 000372222 SC VETERAN

NAME: NURSPATIENT3,SIX 000-37-2222
UNIT: SICU
ROOM-BED: 314-17
ABSENCE: N/A
BED-SEC: ICU
ACUITY: 2

Menu Access:

This option is accessed through the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Nursing Features (all options) menu, and the Staff Nurse Menu. The Location of Individual Patient, Print option is also accessed through the Print Reports option of the QA Coordinator's Menu.
NURSPP-LOCWRD

Ward Census, Print

Description:

This option allows the user to print ward census by room/bed number. The patient name and the (nursing) bed section is obtained from the NURS Patient (#214) file, the ADT software supplies the room/bed and absence (hospital leave status) information, the social security information is obtained from the Patient (#2) file, and the acuity information is obtained from the NURS Classification (#214.6) file.

Additional Information:

The ward census is printed for active nursing units. Active nursing units are identified by the Patient Care Status field in the NURS Location (#211.4) file.

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1 Administration Records, Enter/Edit ...
2 Administration Records, Print ...
3 Administrative Site File Functions ...
4 Nursing Education Reports, Print ...
5 Patient Care Data, Enter/Edit ...
6 Patient Care Data, Print ...
7 Clinical Site File Functions ...
8 QI Data, Enter/Edit ...
9 Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Option: 6 Patient Care Data, Print
Screen Prints:

Select Patient Care Data, Print Option: 4 Ward Census, Print

1 Select PRODUCT LINE (Press return for all product lines): NURSING

Select appropriate product line(s) or press return for all product lines.

Select NURSING UNIT (Enter return for all units): NHCU

Enter the name of an active nursing unit or press return for all units.

2 How many copies of this report are required: 1// <RET>

Enter the number of copies of this report you wish to print.

DEVICE: HOME// Enter appropriate response
### Menu Access:

This option is accessed through the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Nursing Features (all options) menu, and the Staff Nurse Menu. The Location of Individual Patient, Print option is also accessed through the Print Reports option of the QA Coordinator's Menu.

---

1 Patch NUR*4*22  March 1999
Patient/Ward Information
Chapter 2 Patient Assignments

NURCPP-ASSWRK

Patient Assignment Worksheet

Description:

This option prints a patient assignment worksheet containing information that assists nursing staff in providing patient care. The information is printed in two formats, brief and complete (see below for additional information). Patient data is obtained from multiple VISTA applications including the Patient Information Management System (PIMS), Adverse Reactions Tracking (ART), and Nursing applications. Data comes from the NURS Classification (#214.6) file, and the NURS AMIS Ward (#213.3) file.

Additional Information:

The user has the ability to print multiple copies of the patient assignment work-sheet. In this version, the patient assignment worksheet is not interfaced with Order Entry/Results Reporting. Admitting diagnosis is a free text field in the MAS software which is generally entered at the time of admission.

Future Version:

In a future version of the nursing software, additional information such as patient diet and orders for vitals, treatments, and patient intake and output will be automatically displayed. This information will be obtained from multiple VISTA applications including Order Entry/Results Reporting.

Menu Display

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)
Patient Assignments

1      Administration Records, Enter/Edit ...
2      Administration Records, Print ...
3      Administrative Site File Functions ...
4      Nursing Education Reports, Print ...
5      Patient Care Data, Enter/Edit ...
6      Patient Care Data, Print ...
7      Clinical Site File Functions ...
8      QI Data, Enter/Edit ...
9      Quality Performance Reports ...
10     QI Site Files ...
11     Special Functions ...

Select Nursing Features (all options) Option: 6 Patient Care Data, Print

1      Classification Report
2      Location of Individual Patient, Print
3      Patient Assignment Worksheet
4      Ward Census, Print
5      Current Unclassified Patient Print, by Location
6      Patient Plan of Care, Print
7      Vitals/Measurements Results Reporting ...
8      Intake/Output Results Reporting ...
9      End of Shift Report
10     Health Summary Report
11     V/M Graphic Reports
12     Patient Problems to be Evaluated

Example: Brief Assignment Worksheet

The brief assignment worksheet displays minimal information on the patient and provides an area to enter written notes on patient care such as activity, TPR, etc. Patient information obtained from the MAS software includes SSN, admitting date, room/bed number, admitting diagnosis, and physician name.

Screen Prints:

Select Patient Care Data, Print Option: 3 Patient Assignment Worksheet
Do you want to:
   1. Print Brief Assignment Worksheet(s)
   2. Print Complete Assignment Worksheet(s)
Select 1 or 2: 1

Assignment Sheet by (U)nit, (S)elected ward rooms, or (P)atient? U

You may print this report by ward, selected ward rooms, or by patient.

Select Unit: 3AM
Enter the name of an active nursing unit as defined.

How many copies of this report are required? 1// <RET>

Enter the number of copies you wish to print.

DEVICE: HOME//Enter the appropriate response

SEP 17, 1996 PATIENT CARE ASSIGNMENT/WORKSHEET PAGE: 1
UNIT: 3AM Nursing location
TOUR: ___________
STAFF: ____________ ____________ ____________ ____________ ____________

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<th>ADM: NOV 20,1987@13:45</th>
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<td>SSN: 000-91-4057</td>
<td>PHYSICIAN: NURSPROVIDER,FIVE</td>
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<tr>
<td>CATEGORY: 1</td>
<td>FACTORS: (1)</td>
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<tr>
<td>ADMITTING DIAGNOSIS: SOB, POST MI</td>
<td>This information is a free text field in the MAS software and is generally entered at the time of admission.</td>
<td></td>
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<tr>
<td>REACTIONS: PENICILLIN</td>
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<tr>
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<td>SSN: 000-43-3441</td>
<td>PHYSICIAN: NURSPROVIDER,FIVE</td>
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<tr>
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<tr>
<td>REACTIONS: STRAWBERRIES</td>
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<tr>
<td>ADL</td>
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<td>BATH</td>
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<tr>
<td>REACTIONS:</td>
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</tr>
<tr>
<td>ADL</td>
<td>SAFETY</td>
<td>BATH</td>
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April 1997 Nursing V. 4.0 User Manual Clinical 2.3
If you had chosen (S)elected ward rooms, then the user would be prompted with a list of rooms for a specific location e.g.:

Ward 3AM has the following rooms:

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>ROOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>301</td>
</tr>
<tr>
<td>2.</td>
<td>302</td>
</tr>
</tbody>
</table>

Select the NUMBER(S) of the rooms:

Enter appropriate response and then send your report to a printer. If you had chosen (P)atients then you would be able to print an abbreviated assignment worksheet for any patient.

**Example: Complete Assignment Worksheet**

The complete assignment worksheet prints patient problems and interventions identified through the patient plan of care while retaining the brief assignment worksheet display. For additional information on Patient Plan of Care. Refer to Section 3.

Do you want to:
1. Print Brief Assignment Worksheet(s)
2. Print Complete Assignment Worksheet(s)
Select 1 or 2: 2

Assignment Sheet by (U)nit, (S)elected ward rooms, or (P)atient? P

You may print this report by ward, selected ward rooms, or by patient.

Select PATIENT NAME: NURSPATIENT3, THREE 08-04-18 000848807 SC VETERAN

How many copies of this report are required? 1//<RET>

Enter the number of copies you wish to print.

DEVICE: HOME//Enter appropriate response
SEP 17, 1996               PATIENT CARE ASSIGNMENT/WORKSHEET              PAGE: 1
UNIT: 3AM                 
TOUR: __________
STAFF: ____________  ____________  ____________  ____________  ____________
-----------------------------------------------------------------------------
RM/ BED: 301-1            BEDSECTION: MED     ADM: AUG 16,1996@09:00
NAME: NURSPATIENT3,THREE  SSN: 000-84-8807  PHYSICIAN: NURSNURSE4,ONE
CATEGORY: 1               FACTORS: (279)
ADMITTING DIAGNOSIS:
REACTIONS:
PATIENT PROBLEMS         EVALUATION DATE       NURSING INTERVENTIONS
Infection Potential (Specific JAN 07, 1997       I&O q 24HRS
   to Respiratory System)                           assess effects of
Injury Potential          FEB 05, 1997         assess knowledge base
Mobility, Impaired Physical     FEB 21, 1997     out of bed q DAILY STARTING
   8/17/96
Self-Care Deficit Specify  MAR 16, 1997         assess for signs of fatigue
   and
Skin Integrity, Impairment Of MAR 18, 1997       weakness
   (Potential)                                      assist patient to identify his
   Mobility
Spiritual Distress        APR 07, 1997         implement plan
   systems                                            incent spirometer q 2 HR
   determine ability to learn and
   oxygen numeric value% per flow
   rate teach prevention of
   infection

<table>
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<tr>
<th>ADL</th>
<th>SAFETY</th>
<th>BATH</th>
<th>DIET</th>
<th>BP</th>
<th>TPR</th>
<th>WT</th>
<th>TREATMENTS</th>
<th>I/O</th>
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Menu Access:
This option is accessed through the Patient Care Data, Print option of the Staff Nurse Menu,
Head Nurse's menu, and Nursing Features (all options) menu.
Patient Assignments
Chapter 3 Patient Plan of Care

Description:

The Patient Plan of Care module is used to create, edit, and print patient plans of care. It resides in the GMRG namespace and utilizes the Text Generator utility. The files used in the patient plan of care module include:

- **Aggregate Term (#124.2)** - This file includes all the terms or strings of text used, and includes entries such as problem, goals, and orders. Each entry within the file is referred to as an aggregate term.
- **GMR Text (#124.3)** - This file stores selected hierarchy/text for a patient.
- **New Person (#200)** - This file is pointed to for the user who evaluated, entered, and modified the patient plan of care.
- **NURS Care Plan (#216.8)** - This file stores all the patient plan of care data.

Additional Information:

A computerized patient plan of care is created in a manner similar to a handwritten patient plan of care. The user initially determines if the plan is to be built on identified nursing problems, medical diagnoses, or optional patient plans of care. All paths yield similar plans. After choosing the type of patient problem, the user continues selecting additional problems from frames or screens until all of the patient problems have been selected. Having identified a particular problem, the user is given a secondary frame with the following categories for selections:

1. Defining Characteristics
2. Etiology/Related and/or Risk Factors
3. Goals/Expected Outcomes
4. Intervention/Orders
5. Related Problems

Although the above is the standard list, some problems may not include selections for defining characteristics and related problems. For every item chosen from the Goals/Expected Outcomes frame, a target date must be assigned. As each outcome is reviewed, the software prompts for an updated target date that indicates when a particular goal should be reviewed or met. The next major screen is the Intervention/Orders frame which identifies potential or previously identified patient related orders. Upon exiting this screen, the user is asked if any of the orders are to be discontinued. If the user answers yes, then a listing of active orders for potential discontinuation are displayed. From that list, interventions can be selected and discontinued.
After completing the elements for a patient problem, the status of the problem is queried. Completion of this status field is required for the application to display an evaluation date field. A problem can either have the status of evaluate, resolved, suspended or unresolved at discharge. Associated with the status field is an evaluation date which has been established for reevaluating the problem and associated data. When the problem is resolved, suspended, or unresolved at discharge it is removed from the patient's CURRENT patient plan of care listing. The data can then be printed through a separate option. This information is accessible through a separate option and a COMPLETE patient plan of care is printed.

The patient plan of care module uses six options which will be explained briefly below:

- Patient Plan of Care, Edit [NURCPE-CARE] - This option allows the user to create/modify a patient's plan of care.
- Evaluation/Target Date & Order Status Edit [NURCPE-EVAL] - This option allows the user to modify existing problems in the patient's plan of care.
- Patient Plan of Care, Print [NURCPP-CARE] - This option allows the user to print a patient's plan of care.
- Patient Problems to be Evaluated [NURCPP-EVAL] - This option allows the user to print a list of those problems requiring evaluation in a patient's plan of care.
- Standard Patient Plan of Care Print [NURCFP-CARE] - This option is found under the Clinical Site File Functions option and is used to print plan of care data from the Aggregate Term file.
- Patient Plan of Care, Site Configuration [NURCFE-CARE] - This option is found under the Clinical Site File Functions option and is used to add/modify entries in the Aggregate Term file. These entries build the screens used to create the patient’s individualized plan of care through the Patient Plan of Care Edit, and the Evaluation/Target Date and Order Status Edit options. This option also allows the application coordinator to change specific site parameters (patient plan of care header, patient problem header, goals/expected outcomes header and the interventions/orders header) used in printing the patient’s plan of care through the Patient Plan of Care, Print option. Both the evaluation date and target date defaults used in the two edit options, may be changed through this option.

The ADP coordinator should have access to all six of the patient plan of care module options listed above. The end users should have the following options:

- Patient Plan of Care, Edit
- Evaluation/Target Date & Order Status Edit
- Patient Plan of Care, Print
- Patient Problems to be Evaluated
The Patient Plan of Care Site Configuration option is restricted to the package coordinator or certain individuals who are responsible for creating and modifying standard terms used in the Patient Plan of Care, Edit option.

There are additional features and symbols used in displays that will be explained later in this chapter. Several of these features are summarized below.

- A plus (+) printed in screen displays indicates an additional level of screen selections is associated with the text.
- Double asterisk’s (**) in screen displays denote that terms has been previously selected.
- A user may review the developed plan of care during it’s development by entering a ^P at a selection prompt.
- Commas entered after the last number at the ‘Select at least 1:’ prompt, prevent the review of selection screens. This is called a ‘trailing comma’.
- At a selection prompt following any list that includes the term, Additional Text, the user may enter an ‘A’ to add additional selections (e.g., outcomes, interventions) to the frame’s list of terms.
- Text within [ ] (otherwise known as Internal Text) allows users to enter additional information to clarify the outcome, order or other term.
- Appended text is additional information added to the end of a specific outcome or intervention.

**Future Plans:**

In a future version of the patient plan of care module, the program will be enhanced to facilitate ease of use in creating, editing, and printing patient and site specific patient plans of care. Also, critical pathways will be incorporated into the software's functionality.
Patient Plan of Care

NURCPE-CARE

Patient Plan of Care, Edit

Description:

The Patient Plan of Care, Edit option allows a user to create or modify a patient's plan of care.

Additional Information:

This information is retrieved through the Patient Plan of Care, Print option. Editing of screen displays in this option is accomplished through the Patient Plan of Care Site Configuration option.

Menu Display:

Select Nursing Features (all options) Option: 4  Patient Care Data, Enter/Edit

Classification, Edit Patient ...
Evaluation/Target Date & Order Status Edit
Intake/Output Data Entry Menu ...
Location/Bed Section, Edit Nursing
Patient Plan of Care, Edit
Vitals/Measurements Data Entry Menu ...

Example: Creating a Patient Plan of Care

Select PATIENT NAME: NURSPATIENT5,TEN  12-01-57   000222333   NSC VETERAN

There is no previous Nursing Care Plan for this patient.
Would you like to add one? YES// <RET> (YES)
Let me create a new record...

Sample of a frame displaying major or primary categories of patient problems

********************************************************************************
NURSPATIENT5,TEN   000-22-2333                     DEC 1,1957 (31)    PAGE: 1
Nursing Care Plan
********************************************************************************

+ 1. Medical Diagnoses
+ 2. Nursing Problems
+ 3. Optional Care Plans

The user selects a pathway from which to build the plan of care.

Select at least 1: 2
The next frame lists areas of health care patterns used to categorize nursing problems.

+ 1. Activities of Daily Living
+ 2. Circulatory System
+ 3. Cognitive-Sensory Area
+ 4. Elimination
+ 5. Health Management
+ 6. Integumentary (Skin)
+ 7. Musculoskeletal/Neurological
+ 8. Nutrition-Metabolic Area
+ 9. Psycho-Social Area
+10. Respiratory System
+11. Sexual Functioning/Reproductive System
+12. Sleep/Rest
+13. Spiritual Needs

Select at least 1: 7

This frame lists specific patient problems associated with the above health care areas.

+ 1. Disuse Syndrome, Potential For
+ 2. Injury Potential
+ 3. Mobility, Impaired Physical
+ 4. Skin Integrity, Impairment Of (Potential)

Select at least 1: 2

The next frame is a primary display following a patient problem frame. At this level a user can begin to plan specific goals, interventions, etc. for a patient.

The user has decided to document related problems, risk factors, outcomes, and interventions.
Injury Potential

+ 1. Defining Characteristics
+ 2. Etiology/Related and/or Risk Factors
+ 3. Goals/Expected Outcomes
+ 4. Nursing Intervention/Orders
+ 5. Related Problems

Select at least 1: 2-4

The documentation process begins with the etiology and risk factors.

1. adverse effects of chemicals/drugs
2. biological
3. chemical
4. clothing
5. cognitive deficit
6. developmental
7. individual/environment conditions which impose a risk
8. infestation
9. knowledge deficit [specify]
10. loss of motor ability from disease/injury/aging/restraints
11. medical protocols
12. nonadherence/noncompliance
13. people provider

Please make the appropriate selections from this screen before continuing onto the next screen. Select at least 1: 11
14. perceptual deficit
15. physical restraints/barriers
16. physiologic
17. psychologic perception
18. self-mutilation
19. sensory loss from disease/injury/aging/restraints
20. unfamiliar setting

Additional Text:

Select at least 1: <RET>  (Since the selection was made in previous screen, the user enters <RET> and continues to the goal/outcome frame).

The following frame displays goals which have been entered in the standard patient plan of care data base for this problem. Please note that the ADP coordinator will be able to modify this list through the Patient Plan of Care, Site Configuration option provided within the package.

*****************************************************************************
NURSPATIENT5,TEN  000-22-2333                     DEC 1,1957 (31)    PAGE: 1
PATIENT PROBLEM: Injury Potential

Goals/Expected Outcomes
*****************************************************************************

1. remains free from injuries
2. verbalizes how to prevent injury
3. [Extra Goal]

Select at least 1: 1

'remains free from injuries'
has no target date information.

Enter a date which is greater than or equal to today's date.

TARGET DATE: T+5/\  <RET>  (JUL 01, 1996)

As noted above in the screen display, for every goal selected, the user is prompted to select an associated target date.

The next screen reviews the patient plan of care selections as the user leaves the frames connected with goals. Previously selected goals are highlighted and preceded by a double asterisk (**). This applies to all previously selected choices in the patient plan of care screen displays.
Patient Plan of Care

PATIENT PROBLEM: Injury Potential

Goals/Expected Outcomes

**    1. remains free from injuries                              07/01/96
  (T)
  2. verbalizes how to prevent injury
  3. [Extra Goal]

Select at least 1: <RET>

The following frame lists associated interventions. Again, this data can be modified by the ADP coordinator through a site file option. Note selection 6 and 8 in this frame have a plus sign (+) before them. The plus sign indicates that another screen of selections displays to further define this aggregate term.

Nursing Intervention/Orders

1. assure understanding of informed consent
2. identify and eliminate potential sources of injury
3. inspect for external factors which produce injury q [freq.]
4. observe for adverse effects of chemical agents/treatments
5. protect with restraints [specify]
+ 6. provide physically safe environment
+ 7. provide restraint care q[frequency]
+ 8. refer for appropriate consults
  9. teach patient regarding health maintenance
10. teach S/O regarding potential for injury
11. [Extra Order]

Select at least 1: 6-7,9-10

The following screen displays additional information from previous screens as indicated by the + sign and allows the user to further define the patient plan of care intervention, "provide a physically safe environment". An example of appended and additional text is also shown.
**NURSPATIENT5,TEN  000-22-2333  DEC 1,1957 (31)  PAGE: 1**

**PATIENT PROBLEM: Injury Potential**

provide physically safe environment

**1. bedrails**
2. call light
3. eliminate source of infestation
4. isolation
5. night light
6. prosthetic devices
7. remove constrictive clothing
8. safety restraints

Additional Text:
Select at least 1: 1;UP AT NIGHT,5,A

Text was appended to the term, bedrails, by entering a semicolon (;) to the number associated with the selection and then previous to entering another intervention, a comma (,) was inserted after the text, ‘UP AT NIGHT’.

ADDITIONAL TEXT

**************

Additional Text for 'provide physically safe environment': Remove clutter around patient environment

The additional text is typed in as a free text entry.

**NURSPATIENT5,TEN  000-22-2333  DEC 1,1957 (31)  PAGE: 1**

**PATIENT PROBLEM: Injury Potential**

provide physically safe environment

**1. bedrails UP AT NIGHT**
2. call light
3. eliminate source of infestation
4. isolation
**5. night light**
6. prosthetic devices
7. remove constrictive clothing
8. safety restraints

Additional Text: Remove clutter around patient environment

Select at least 1: <RET>

The following prompt (selection 7 on the Nursing Intervention/Orders screen) queries the user to enter a time frame for restraint care.
INTERNAL TEXT for 'provide restraint care [frequency]'
Internal Text Number 1: frequency// 2h

Internal text or text within [ ] is typed in as a free text entry.

Once again, the interventions are reviewed as the user leaves the orders frame(s). The user can see that selections 6, 7, 9, and 10 are asterisked and that restraint care should be provided every 2 hours.

*****************************************************************************
NURSPATIENT5,TEN 000-22-2333 DEC 1,1957 (31) PAGE: 1
PATIENT PROBLEM: Injury Potential

Intervention/Orders
*****************************************************************************

1. assure understanding of informed consent
2. identify and eliminate potential sources of injury
3. inspect for external factors which produce injury q [freq.)
4. observe for adverse effects of chemical agents/treatments
5. protect with restraints [specify]
** + 6. provide physically safe environment
** + 7. provide restraint care q [2h]
+ 8. refer for appropriate consults
** + 9. teach patient regarding health maintenance
** + 10. teach S/O regarding potential for injury
11. [Extra Order]

Select at least 1: <RET>

Do you wish to discontinue any order(s)? NO// <RET>

This prompt always displays when leaving intervention/order screens so that a user can select orders to be discontinued.

If Yes was entered, active orders for discontinuation would have been listed.

Upon returning to this level of the patient plan of care the user is preparing to exit this patient problem and establish an evaluation date.

*****************************************************************************
NURSPATIENT5,TEN 000-22-2333 DEC 1,1957 (31) PAGE: 1
Injury Potential
*****************************************************************************

+ 1. Defining Characteristics
** + 2. Etiology/Related and/or Risk Factors
** + 3. Goals/Expected Outcomes
** + 4. Nursing Intervention/Orders
+ 5. Related Problems
Select at least 1: <RET>

Since this is a new problem, the user is asked to enter: 1) a status and 2) an evaluation date for this problem.

'Injury Potential'
has no previous evaluation.

The following are codes and definitions used in documenting the problem's current status:
   A if problem is still ACTIVE
   R if problem is RESOLVED
   S if problem has been SUSPENDED (a problem is still an issue but not currently being addressed)
   U if problem was UNRESOLVED @ DISCHARGE

PROBLEM STATUS: Active// <RET>

A reevaluation due date is entered for the problem.

DATE PROBLEM TO BE RE-EVALUATED: T+5// <RET> (JUL 01, 1996)

The next three screens are displayed in review as a user exits the plan of care module.

***************************************************************************
NURSPATIENT5,TEN 000-22-2333 DEC 1,1957 (31) PAGE: 1
Musculoskeletal/Neurological
***************************************************************************
+ 1. Disuse Syndrome, Potential For
** + 2. Injury Potential 07/01/96(E)
+ 3. Mobility, Impaired Physical
+ 4. Skin Integrity, Impairment Of (Potential)

Select at least 1: <RET>

***************************************************************************
NURSPATIENT5,TEN 000-22-2333 DEC 1,1957 (31) PAGE: 1
Nursing Problems
***************************************************************************
Patient Plan of Care

+ 1. Activities of Daily Living  
+ 2. Circulatory System  
+ 3. Cognitive-Sensory Area  
+ 4. Elimination  
+ 5. Health Management  
+ 6. Integumentary (Skin)  
** + 7. Musculoskeletal/Neurological  
+ 8. Nutrition-Metabolic Area  
+ 9. Psycho-Social Area  
+10. Respiratory System  
+11. Sexual Functioning/Reproductive System  
+12. Sleep/Rest  
+13. Spiritual Needs

Select at least 1: <RET>

*****************************************************************************  
NURSPATIENT5,TEN   000-22-2333                    DEC 1,1957 (31)    PAGE: 1  
*****************************************************************************  

Nursing Care Plan  
*****************************************************************************  

+ 1. Medical Diagnoses  
** + 2. Nursing Problems  
 + 3. Optional Care Plans  
Select at least 1: <RET>

As a final step, the user is asked if a printed copy of the patient plan of care just edited should be generated. At any point in creating/editing a patient plan of care, the user can enter a caret P (^P) to print a current [C] patient plan of care without exiting.

Would you like to print a copy of this Nursing Care Plan? YES// <RET>

DEVICE: HOME//Enter appropriate response

The above information is only a cursory overview of the steps taken to develop a patient plan of care. Read the accompanying documentation for further details. The user should pay particular attention to the editing of text (i.e., appended, internal, and additional text).

Selecting a Patient plan of care to Edit

There are two ways to edit an existing patient plan of care.

Example: Adding a new plan for a patient with no previous plans.

Select PATIENT NAME: NURSPATIENT6,ONE  04-30-41  000432192  NSC VETERAN
There is no previous Patient Plan of Care for this patient. Would you like to add one? YES/<RET> (YES)
Let me create a new record...

*****************************************************************************
NURSPATIENT6,ONE  000-43-2192                         APR 30,1941 (48)
PAGE: 1

Nursing Care Plan
*****************************************************************************

+ 1. Medical Diagnoses
+ 2. Nursing Problems
+ 3. Optional Care Plans

Select at least 1:

Example: Choosing a previously developed patient plan of care.

The second possibility is the patient may have one or more plans already in the system. In this case a list of those patient plans of care (the date/time they were created, and who created them) is displayed.
The following is an example of a multiple and single plan of care selection display:

The following is a list of previous Nursing Care Plans

1. JUN 23, 1996@07:57:39    NURSNURSE14,EIGHT
2. JUN 21, 1996@08:03:34    NURSNURSE14,NINE

OR

The following is a list of previous Nursing Care Plans

1. JUN 21, 1996@08:03:34    NURSNURSE14,NINE

If the user does not want to use one of the listed patient plans of care, a new one can be added. Although it is strongly suggested that only one plan of care be developed for a patient.

Example: Adding a new plan with plans already in existence.

Select PATIENT NAME: NURSPATIENT6,ONE  04-30-41  000432192  NSC VETERAN

The following is a list of previous Nursing Care Plans

1. JUN 21, 1996@08:03:34    NURSNURSE14,NINE

Enter Selection: ?
ENTER THE NUMBER OF THE SELECTION TO BE CHOSEN,
OR THE NUMBER FOLLOWED BY AN '@' TO DELETE A SELECTION,
OR THE LETTER 'N' TO ADD A NEW Nursing Care Plan.
Enter Selection: N
Let me create a new record...

**+ 1. Medical Diagnoses
+ 2. Nursing Problems
+ 3. Optional Care Plans

Select at least 1:

The user continues the process by entering appropriate responses.

**Example: Selecting an existing plan to edit.**

Select PATIENT NAME: NURSPATIENT6,ONE 04-30-41 000432192 NSC VETERAN

The following is a list of previous Nursing Care Plans

1. JUN 23, 1996@07:57:39 NURSNURSE14,EIGHT
2. JUN 21, 1995@08:03:34 NURSNURSE14,NINE

Enter selection: 2

**Example: Bypassing Screens/Trailing Comma**

This feature facilitates quicker editing of nursing care plan data, and when consistently used, the user is not "backed out" of the option, frame by frame as previously shown in the example, Creating a Patient Plan of Care. If a user types a comma at the end of a list of choices, referred to as a trailing comma, the review screen does not re-display after the choices are processed. The trailing comma is used at any level as demonstrated in this section.
Nursing Care Plan

+ 1. Medical Diagnoses
** + 2. Nursing Problems
+ 3. Optional Care Plans
Select at least 1: 2

Nursing Problems

+ 1. Activities of Daily Living
+ 2. Circulatory System
+ 3. Cognitive-Sensory Area
** + 4. Elimination
+ 5. Health Management
+ 6. Integumentary (Skin)
+ 7. Musculoskeletal/Neurological
+ 8. Nutrition-Metabolic Area
+ 9. Psycho-Social Area
+10. Respiratory System
+11. Sexual Functioning/Reproductive System
+12. Sleep/Rest
+13. Spiritual Needs

Select at least 1: 1,

Activities of Daily Living

+ 1. Coping, Ineffective Family
+ 2. Home Maintenance Management, Impaired
+ 3. Self-Care Deficit [Specify]

Select at least 1: 1

Note that a trailing comma was not used here. The effect of this is displayed later in the example.
Coping, Ineffective Family

+ 1. Defining Characteristics
+ 2. Etiology/Related and/or Risk Factors
+ 3. Goals/Expected Outcomes
+ 4. Intervention/Orders
+ 5. Related Problems

Select at least 1: 3,4,

A trailing comma is used here, and this screen is not reviewed after Goals and Interventions are added into the patient plan of care.

1. demonstrates realistic responses to stress
2. effective client coping skills
3. effective decision making skills
4. effective problem solving
5. [Extra Goal]

Select at least 1: 1,2,

'demonstrates realistic responses to stress'
has no target date information.
TARGET DATE: T+5// <RET> (FEB 12, 1997)

effective client coping skills'
has no target date information.
TARGET DATE: T+5// <RET> (FEB 12, 1997)

Since the trailing comma was entered in selection 3 from the Coping, Ineffective Family frame, the next entry processed will be selection 4. The Interventions/Orders frame is displayed next.
1. assess family's coping response
2. assist family to appraise stressors
3. assist family to develop plan to cope with stressors
+ 4. refer for appropriate consults
+ 5. teach effective coping skills
6. [Extra Order]

Select at least 1: 1,2,

Do you wish to discontinue any order(s)? NO// <RET>  (NO)

Trailing comma is used again, and therefore no other selection is processed for the Coping, Ineffective Family frame. The prompt for the evaluation date for Coping, Ineffective Family is asked as if we just entered <RET> at the Coping, Ineffective Family frame.

'Coping, Ineffective Family'
has no previous evaluation.

PROBLEM STATUS: Active// <RET>
DATE PROBLEM TO BE RE-EVALUATED: T+5// <RET> (FEB 12, 1997)

Since the user did not type a trailing comma on the Activities of Daily Living frame, it is reviewed or re-displayed upon exiting the option.

*****************************************************************************
NURSPATIENT6,TWO 000-13-0991 DEC 24,1922 (69) PAGE: 1
Activities of Daily Living
*****************************************************************************
** + 1. Coping, Ineffective Family 02/12/97 (E)
    + 2. Home Maintenance Management, Impaired
    + 3. Self-Care Deficit [Specify]

Select at least 1: <RET>

Since a trailing comma was entered on the problems frame, it is not reviewed, and the Nursing Care Plan frame comes up for review. The trailing comma supports an efficient process for documenting plans of care.

Example: Updating the Problems, Goals, and Orders Status

If a problem is resolved while editing a plan of care, all orders selected for that problem are discontinued and goals are met. These functions automatically occur when the problems are resolved.

In the following excerpt, the user resolves the problem, Coping, Ineffective Family.
Activities of Daily Living

** + 1. Coping, Ineffective Family 02/12/97 (E)
   + 2. Home Maintenance Management, Impaired
   + 3. Self-Care Deficit [Specify]

Select at least 1: 1

Coping, Ineffective Family

+ 1. Defining Characteristics
+ 2. Etiology/Related and/or Risk Factors
** + 3. Goals/Expected Outcomes
** + 4. Intervention/Orders
+ 5. Related Problems

Select at least 1: <RET>

Last evaluation for 'Coping, Ineffective Family'
Evaluation Date: FEB 12, 1997

PROBLEM STATUS: Active// Resolved (This problem was resolved on 2/12/97).

When a problem is given a status of suspended or unresolved at discharge, all goals and interventions associated with that problem are automatically discontinued.

Activities of Daily Living

** + 1. Coping, Ineffective Family 02/12/97 (R)
   + 2. Home Maintenance Management, Impaired
   + 3. Self-Care Deficit [Specify]

Select at least 1:

Once this problem has been resolved, print out the COMPLETE plan to show that all goals have been met for that problem and interventions are discontinued.

By (U)nit, (S)elected ward rooms, or (P)atient? P
The following is a list of previous Nursing Care Plans

1. JAN 11, 1997@13:27:14 NURSNURSE14,TEN

Enter Selection: 1

Enter a C for a current listing, or an A for a complete listing: A

This Report may be Queued to print on another device, freeing your terminal for other use.

DEVICE: HOME//Enter appropriate response

The following report indicates the problem was resolved on 2/10/97; the goals were automatically met and the orders were automatically discontinued on 2/10/97.

Coping, Ineffective Family

Goals/Expected Outcomes
- Demonstrates realistic responses to stress
- Effective client coping skills

Intervention/Orders
- Assess family's coping response
- Assist family to appraise stressors

Diagnosis: Reactions:
E-prob eval dt U-prob unresolved at discharge S-prob suspended
T-goal target dt R-prob resolved/order reinstated

NURSPATIENT6,TWO 000-13-0991 69 ASSE D [A] VAF 10-0043
Example: Optional Patient Plan of Care Entry

The optional patient plan of care pathway is an abbreviated process for defining patient plans of care.

Select PATIENT NAME: NURSPATIENT6,TWO 12-24-22 000130991 SC VETERAN

The following is a list of previous Nursing Care Plans

1. JAN 11, 1997@13:27:14 NURSNURSE14,TEN

Enter Selection: 1

********************************************************************************
NURSPATIENT6,TWO 000-13-0991 DEC 24,1922 (69) PAGE: 1
Nursing Care Plans
********************************************************************************

+ 1. Medical Diagnoses
** + 2. Nursing Problems
+ 3. Optional Care Plans

Select at least 1: 3

********************************************************************************
NURSPATIENT6,TWO 000-13-0991 DEC 24,1922 (69) PAGE: 1
Optional Care Plans
********************************************************************************

+ 1. Abdominal Aortic Aneurysm Repair
+ 2. Acquired Immune Deficiency Syndrome (AIDS)
+ 3. Acute Myocardial Infarction
+ 4. Acute Respiratory Failure/Adult Resp Distress Syndrome
+ 5. Alcohol/Drug Dependency Rehabilitation
+ 6. Amputation (Rehabilitation)
+ 7. Angina/Chest Pain
+ 8. Aortobifemoral Bypass
+ 9. Asthma/Chronic Obstructive Pulmonary Disease
+10. Cancer of the Larynx
+11. Cancer of the Lung
+12. Cancer of the Lung (Surgical)
+13. Cardiac Surgery
+14. Cerebrovascular Accident (Left Hemiplegia/Paresis)

Please make the appropriate selections from this screen before continuing onto the next screen. Select at least 1: <RET>
Optional Care Plans

+15. Cerebrovascular Accident (Right Hemiplegia/Paresis)
+16. Cellulitis
+17. Chemotherapy/Radiation Therapy
+18. Cholecystectomy
+19. Cirrhosis
+20. Congestive Heart Failure
+21. Depressive Neurosis
+22. Diabetes Mellitus
+23. Gastroenteritis/Gastritis
+24. Gastrointestinal Hemorrhage (G.I. Bleed)
+25. Generic Discharge Care Plan
+26. Hemodialysis
+27. Hepatitis
+28. Hernia Repair

Please make the appropriate selections from this screen before continuing onto the next screen. Select at least 1: <RET>

Optional Care Plans

+29. Hypertension
+30. Manic Behavior
+31. Ocular Disorder/Surgery (Cataracts)
+32. Organic Disturbances
+33. Pancreatitis
+34. Parkinsons Disease
+35. Pleural Effusion/Pneumothorax/Hemothorax/Empyema
+36. Pneumonia/Pleurisy
+37. Post Traumatic Stress Disorder
+38. Pressure Ulcer
+39. Psychoses/Schizophrenia
+40. Pulmonary Edema
+41. Pulmonary Embolus
+42. Renal Failure

Please make the appropriate selections from this screen before continuing onto the next screen. Select at least 1: <RET>
Optional Care Plans

+43. Renal/Urinary Calculi
+44. Seizure Disorder
+45. Sleep Apnea
+46. Spinal Cord Injury (New Quadriplegia/Paraplegia)
+47. Spinal Headache
+48. Substance Abuse Withdrawal/Detoxification
+49. Transient Ischemic Attacks
+50. Transurethral Resection/Benign Prostatic Hypertrophy
+51. Traumatic Brain Injury
+52. Tuberculosis
+53. Urinary Tract Infection

Select at least 1: 1,45

Continue editing as needed.

Example: Patient Plan of Care Entered in Error

If for some reason a patient plan of care should not have been entered into the system, it can be entered in error from the Patient Plan of Care, Edit option. Patient plans of care that have been entered in error can be viewed via the Patient Plan of Care, Print option.

Enter the number of the selection to be chosen, or the number followed by an '@' to delete a selection, or the letter 'N' to add a new Nursing Care Plan.

The following is a list of previous Nursing Care Plans

1. FEB 6, 1997@07:37:47 NURSNURSE14,TEN
2. JAN 11, 1997@13:27:14 NURSNURSE14,TEN

Enter Selection: 1@
ARE YOU SURE YOU WANT TO ENTER THIS Nursing Care Plan IN ERROR? Y (YES)

The following is a list of previous Nursing Care Plans

1. JAN 11, 1997@13:27:14 NURSNURSE14,TEN

Enter Selection: <RET>

Notice that the Feb 6, 1997@07:37:47 entry is no longer selectable.


**Menu Access:**

The Patient Plan of Care, Edit option can be accessed through the Patient Care Data, Enter/Edit option of the Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
Patient Plan of Care

**NURCPE-EVAL**

**Evaluation/Target Date & Order Status Edit**

**Description:**

This option provides an efficient method for updating specific patient plans of care such as status and evaluation dates of patient problems, status and target dates of goals, and the status of orders.

**Additional Information:**

This data can be retrieved through the Patient Plan of Care, Print option.

**Menu Display:**

Select Nursing Features (all options) Option: 5  Patient Care Data, Enter/Edit

Classification, Edit Patient ...
Evaluation/Target Date & Order Status Edit
Intake/Output Date Entry Menu ...
Location/Bed Section, Edit Nursing
Patient Plan of Care, Edit
Vitals/Measurements Data Entry Menu ...

**Screen Prints:**

Select Patient Care Data, Enter/Edit Option: EVALuation/Target Date & Order Status Edit

Select PATIENT NAME: NURSPATIENT6,THREE  01-19-25  000767111  NSC VETERAN

A list of all active patient problems in the database appears. The list shows when the plan for that problem was developed, and its last evaluation date.

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>DATE/TIME DEVELOPED</th>
<th>EVALUATION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Activity Intolerance (Circulatory System)</td>
<td>APR 11, 1996@16:01</td>
<td>JUL 06, 1996</td>
</tr>
<tr>
<td>2 Airway Clearance, Ineffective</td>
<td>APR 11, 1996@16:01</td>
<td>MAY 02, 1996</td>
</tr>
<tr>
<td>3 Coping, Ineffective Family</td>
<td>APR 11, 1996@16:01</td>
<td>MAY 02, 1996</td>
</tr>
<tr>
<td>4 Fluid Volume Deficit (Actual/Potential)</td>
<td>MAR 6, 1996@09:54</td>
<td>APR 16, 1996</td>
</tr>
<tr>
<td>5 Self-Care Deficit [EATING]</td>
<td>MAR 6, 1996@09:54</td>
<td>APR 16, 1996</td>
</tr>
</tbody>
</table>
ENTER THE PROBLEM(S) (BY NUMBER) TO BE EDITED (1-7): 1, 4

This response must be a list or range, e.g., 1,3,5 OR 2-4,8.
Enter RD to redisplay this list of selections.

Response should be no less than 1 and no greater than 7.

The only problem that needs to be evaluated today (7/6/96), and one that was not resolved in 1996, that continues to appear on the list for this patient.

Example: Documenting a 'MET' goal and adding a new goal.

Activity Intolerance (Circulatory System)

Last evaluation for 'Activity Intolerance (Circulatory System)'
Evaluation Date: JUL 6, 1996

PROBLEM STATUS: Active//<RET>
DATE PROBLEM TO BE RE-EVALUATED: T+7//<RET> (JUL 13, 1996)

*****************************************************************************
NURSPATIENT6,THREE 000-63-2111 JAN 19,1925 (68) PAGE: 1

Goals/Expected Outcomes
*****************************************************************************

** 1. demonstrates increased control of dyspnea with activity 07/06/93(T)
  2. demonstrates increased independence for self-care
  + 3. hemodynamically stable during activity
  4. verbalized/demonstrates decreased fatigue with activity

** 5. verbalizes/demonstrates physical conditioning techniques 07/06/93(T)
  6. [Extra Goal]

Select at least 1: 1, 5, 2

The first goal was met, while the second goal has a new target date of one week from today and we will be adding a new goal.

For 'demonstrates increased control of dyspnea with activity'
the most current target date is:
TARGET DATE: JUL 13, 1996
TARGET DATE: JUL 13, 1996//T (JUL 06, 1996)

If today's date is entered, the software asks the user if the goal is met.

Has this goal been met? NO// Y (YES)

'demonstrates increased independence for self-care'
has no target date information.
TARGET DATE: T+7//<RET> (JUL 13, 1996)
**Example: Extending a target date:**

For 'verbalizes/demonstrates physical conditioning techniques'
the most current target date is:
   TARGET DATE: JUL 6, 1996
   TARGET DATE: T+7/\ <RET> (JUL 13, 1996)

**Example: Discontinuing interventions/orders.**

There is only one order, a user can do anything on this screen that can be done from the Patient Plan of Care, Edit option.
14. [Extra Order]

Select at least 1: <RET>

Do you wish to discontinue any order(s)? NO// Y  (YES)

The orders are listed by number. The user selects the number of the order to be D/c'd.

Example: Changing the status of a problem.

The second problem 'Fluid Volume Deficit (Actual/Potential) was a part of an earlier plan but was not resolved at the patient's discharge. It is selected to show an example of changing a status to Unresolved at Discharge.

Fluid Volume Deficit (Actual/Potential)

Last evaluation for 'Fluid Volume Deficit (Actual/Potential)'
Evaluation Date: APR 16, 1996

PROBLEM STATUS: Active// Unresolved @ Discharge

No further information is edited for this problem. The same would be true if the status is changed to Suspended or Resolved.

Menu Access:

The Evaluation/Target Date & Order Status Edit option is accessed through the Patient Care Data, Enter/Edit option of the Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
**NURCPP-CARE**

**Patient Plan of Care, Print**

**Description:**

This option displays either current (active) patient problems or all problems associated with a particular patient. A current patient plan of care does not display resolved problems, met goals and discontinued orders, etc. A complete patient plan of care includes all information entered for a specific patient plan of care regardless of the status of the entries.

**Additional Information:**

The header on this report is site configurable through the Patient Plan of Care, Site Configuration option under the Clinical Site Files menu. This data is edited through the Patient Plan of Care, Edit, and the Evaluation/Target Date and Order Status Edit options.

**Report formats:**

A user has the option to print several reports:

1. A 80 column report can be printed on all ward printers.

2. A 132 portrait or landscaped (KARDEX style) patient plan of care can be generated if a laser or ink jet printer is available.

**Definitions:**

In reviewing the patient plan of care, please note the following:

1. Dates, not followed by parentheses, indicate when the problem, goal, or order, was initially entered.

2. Date (E) - a date established for re-evaluation for a problem.

3. Date (R) - resolution date for a problem or order reinstated.

4. Date (S) - date a problem was suspended.

5. Date (U) - date a problem was marked as unresolved at discharge.

6. Date (T) - a target date established for attaining and/or re-evaluating a goal.
7. Date (M) - a date on which a goal was met.

8. Date (@) - a date on which a problem, goal or order was removed from the patient plan of care; it is meant to indicate an error.

9. Date (DC) - date on which an intervention was discontinued or a goal was identified as unattainable.

**Menu Display:**

Select Nursing Features (all options) Option: 6 Patient Care Data, Print

1. Classification Report
2. Location of Individual Patient, Print
3. Patient Assignment Worksheet
4. Ward Census, Print
5. Current Unclassified Patient Print, by Location
6. Patient Plan of Care, Print
7. Vitals/Measurements Results Reporting ... 
8. Intake/Output Results Reporting ... 
9. End of Shift Report
10. Health Summary Report
11. Vitals/Measurements SF 511
12. Patient Problems to be Evaluated

**Screen Prints:**

Select Patient Care Data, Print Option: 6 Patient Plan of Care, Print

By (U)nit, (S)elected ward rooms, or (P)atient? P

Select PATIENT NAME: NURSPATIENT6,THREE 01-19-25 000632111 NSC VETERAN

The following information displays existing patient plans of care for the patient.

The following is a list of the Nursing Care Plans:

1. FEB 25, 1986@16:01:04 NURSNURSE15,ONE
2. JUN 14, 1986@12:12:04 NURSNURSE14,TEN

Enter Numerical Choice: 1

Enter a C for a current listing, or an A for a complete listing: A

This Report may be Queued to print on another device, freeing your terminal for other use.
Example: Complete Patient Plan of Care

### 132 Column Portrait Display

**JAN 17, 1997 09:12**

<table>
<thead>
<tr>
<th>Date/Stat/Init</th>
<th>Patient Problem</th>
<th>Goals/Expected Outcomes</th>
<th>Date/Stat/Init</th>
<th>Nursing Intervention/Orders</th>
<th>Date/Stat/Init</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/12/96(R)RM</td>
<td>Health Maintenance, Alteration in</td>
<td>Maintains a state of wellness as evidenced by on admission including</td>
<td>06/14/96 RM</td>
<td>- Relationships with other: -Level of -Tissue intact</td>
<td>06/24/96 RM</td>
</tr>
<tr>
<td>06/24/96(E)RM</td>
<td>- Maintains or regains optimal level of mobility</td>
<td>-Motions intact</td>
<td>06/25/96 RM</td>
<td>-Recent changes in</td>
<td>06/25/96 RM</td>
</tr>
<tr>
<td>06/14/96 RM</td>
<td>- Orientation to time, place</td>
<td>-Use of professional resources</td>
<td>07/02/96 (T)RM</td>
<td></td>
<td>07/12/96 (DC)RM</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>06/14/96 (M)RM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>07/02/96 (T)RM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>06/14/96 (T)RM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>06/24/96 (DC)RM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>06/24/96 (DC)RM</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>06/24/96 (DC)RM</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Diagnosis: BROKEN FOOT**

**Physician:** NURSPROVIDER, TWO

**Reactions:**
- E-prob eval at
- U-prob unresolved at discharge
- S-prob suspended
- T-goal target at
- DC-order/goal discontinued
- M-goal met
- R-entered in error
- S-prob resolved/order reinstated

**NURSPATIENT6, THREE**

*Note: The [A] in the footer indicates a complete plan.*

### Example: Patient Plan of Care

**80 Column Portrait Display**
Health Maintenance, Alteration in

Etiology/Related and/or Risk Factors
- Altered communication
- Development tasks impaired
- Ineffective family/individual coping
- Additional Text:

Goals/Expected Outcomes
- Maintains a state of wellness as evidenced by:
  07/12/96 (E) NURSNURSE14
  06/24/96 (E) NURSNURSE14
  06/14/96 NURSNURSE14
- Relationships with others
  07/12/96 (T) NURSNURSE14
  06/25/96 NURSNURSE14
- Tissue intact
  07/12/96 (T) NURSNURSE14
  06/25/96 NURSNURSE14
- Maintains or regains optimal level of mobility
  07/02/96 (T) NURSNURSE14
  06/14/96 NURSNURSE14
- Remains/regains orientation to time, place and space
  07/02/96 (M) NURSNURSE14
  06/14/96 NURSNURSE14
- Communicates within capacity
  07/12/96 (@) NURSNURSE14
  07/12/96 NURSNURSE14

Intervention/Orders
- Assess causative factors on admission including
  06/24/96 (DC) NURSNURSE14
  06/14/96 NURSNURSE14
- Level of dependence/independence
- Recent changes in lifestyle
- Ability to meet health maintenance needs
- Use of professional resources
- Assist to maintain and manage health care
  07/12/96 (DC) NURSNURSE14
  06/24/96 NURSNURSE14
  Including
  - Involve family/friends in care management
  - Develop patient plan of care with patient/family
- Promote wellness through patient/family knowledge of
  07/12/96 (@) NURSNURSE14
  06/24/96 NURSNURSE14
  - Specific diseases
- Promote wellness through past patterns of health care
  06/24/96 (DC) NURSNURSE14
  Including
  - Influences of family, cultural/peer groups, mass media

Diagnosis: BROKEN FOOT

Reactions:
- E-prob eval dt U-prob unresolved at discharge S-prob suspended
- T-goal target dt DC-order/goal discontinued M-goal met
- @-entered in error R-prob resolved/order reinstated
- NURSPATIENT6,THREE 000-63-2111 64 SICU PROT M [A] VAF 10-0043

Physician: NURSPROVIDER, TWO
Example: Current Patient Plan of Care

Notice that the current plan in the following example does not display any discontinued (D/C), met (M), or deleted (@) information:

By (U)nit, (S)elected ward rooms, or (P)atient? P

Note: The [C] indicates a current plan.

Select PATIENT NAME: NURSPATIENT6,TWO 12-24-22 000130991 SC VETERAN

The following is a list of previous Nursing Care Plans

1. JAN 11, 1997@13:27:14 NURSNURSE14,TEN

Enter Selection: 1

Enter a C for a current listing, or an A for a complete listing: C

This Report may be Queued to print on another device, freeing your terminal for other use.

DEVICE: HOME/Enter appropriate response
### Patient Plan of Care

**Date** | **R.N.**
---|---
02/07/96(R) | NURSNURSE14
02/07/96 | NURSNURSE14

**Coping, Ineffective Family**

**Goals/Expected Outcomes**

**Intervention/Orders**

**Stress Incontinence**

**Goals/Expected Outcomes**

- Acknowledges need for muscle/sphincter exercises
- Demonstrates pelvic floor muscle exercises

**Intervention/Orders**

- Discuss emotional aspects such as:
- Activities that increase risk
- Active isometric pelvic exercises 2 times per hour

**Diagnosis:**

**Physician:**

**Reactions:**

- E-prob eval dt
- U-prob unresolved at discharge
- S-prob suspended
- T-goal target dt
- R-prob resolved/order reinstated

**Menu Access:**

The Patient Plan of Care, Print option can be accessed through the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
Patient Plan of Care

NURCPP-EVAL

Patient Problems to be Evaluated

Description:

This option displays a list of active patient problems that need reviewing. The list may contain active patient problems from previous admissions. These problems can be obtained for a single patient, all patients in selected rooms, or all patients on a particular location.

Additional Information:

Data can be edited through the Patient Plan of Care, Edit option.

Menu Display:

Select Nursing Features (all options) Option: 8 Patient Care Data, Print

1 Classification Report
2 Location of Individual Patient, Print
3 Patient Assignment Worksheet
4 Ward Census, Print
5 Current Unclassified Patient Print, by Location
6 Patient Plan of Care, Print
7 Vitals/Measurements Results Reporting ...
8 Intake/Output Results Reporting ...
9 End of Shift Report
10 Health Summary Report
11 Vitals/Measurements SF 511
12 Patient Problems to be Evaluated

Select Patient Care Data, Print Option: 12 Patient Problems to be Evaluated

By (U)nit, (S)elected ward rooms, or (P)atient? P

Select PATIENT NAME: NURSPATIENT6,THREE 01-19-25 000632111 NSC VETERAN

DEVICE: HOME// Enter appropriate response
### Menu Access:

The Patient Problems to be Evaluated option can be accessed through the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
Chapter 4 Vitals/Measurements

NURSPE-VIT-MENU

Vitals/Measurements Data Entry Menu

Description:

This menu contains options which permit users to enter vitals/measurements or to correct errors in vitals/measurements. Data comes from the GMRV Vital Measurement (#120.5) file.

Additional Information:

Data can be retrieved through any of the Vitals/Measurements Results Reporting options.

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1 Administration Records, Enter/Edit ...
2 Administration Records, Print ...
3 Administrative Site File Functions ...
4 Nursing Education Reports, Print ...
5 Patient Care Data, Enter/Edit ...
6 Patient Care Data, Print ...
7 Clinical Site File Functions ...
8 QI Data, Enter/Edit ...
9 Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

Classification, Edit Patient ...
Evaluation/Target Date & Order Status Edit
Intake/Output Data Entry Menu ...
Location/Bed Section, Edit Nursing
Patient Plan of Care, Edit
Vitals/Measurements Data Entry Menu ...

Select Patient Care Data, Enter/Edit Option: Vitals/Measurements Data Entry Menu
Menu Access:

The Vitals/Measurements Data Entry Menu option is accessed through the Patient Care Data, Enter/Edit option of the Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
NURCPE-VIT-EDIT

Vitals/Measurement Data Entry

Description:

This option permits users to enter different types of patient vitals signs and selected measurements into the clinical patient record system. Vitals/Measurements data is stored in the GMRV Vital Measurement (#120.5) file.

Additional Information:

1. Various vitals and other measurement data can be retrieved through any of the Vitals/Measurements Results Reporting menu options. If data was entered in error, the user can correct the misinformation through the Edit a Vitals/Measurements Entered in Error option.

Patient vital signs can be entered by patient, selected room and bed and by ward location (i.e., Hospital Location (#44) file). When vitals are entered, both a date and a time are required as well as hospital location. Vital signs and other patient measurements are documented in the specific order indicated by the vital type (temperature, weight, pulse oximetry). Data representing each vital type entry is also separated by a hyphen: Temp-Pulse-Resp-B/P-Height-Weight. To omit entering a vital/measurement reading:

- Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
- Enter an * for the specific value when documenting the reason for omission.
- Enter a single * to document that all measurements were omitted and the reason for omission.

The software supports the documentation of measurement omissions by displaying three reasons (i.e., unavailable, pass, and refused) when an '*' is entered for a measurement value.

2. Pain tracking is included in the software, where a user can document the level of pain that the patient is experiencing by using the following pain scale:

<table>
<thead>
<tr>
<th>Value</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No pain</td>
</tr>
<tr>
<td>1</td>
<td>(Minimal discomfort/pain)</td>
</tr>
<tr>
<td>99</td>
<td>Unable to respond</td>
</tr>
<tr>
<td>10</td>
<td>(Worst imaginable pain)</td>
</tr>
</tbody>
</table>

3. Pedal Pulse can be entered for a patient as a 1 (pulse present) or a 0 (pulse absent). The pedal pulse is displayed on the Cumulative Vitals Report, the Print Vitals Entered in Error for a Patient, and the table portion of the Vital Signs Record.
Users may enter just the systolic value of Blood Pressure, (e.g., 120/, 120/D, or 120/P) for doppler and palpated methods. If no qualifier is entered, palpated is the default.

Qualifiers (alpha characters appended to the measurement’s numeric value) are used to provide additional information about the vital sign(s) and measurements taken by the clinician. Qualifiers are grouped by categories such as: location (e.g., right arm, left leg), position (e.g., lying, sitting, standing), method (e.g., cuff, Doppler, auscultate, assisted ventilator, T-piece), site (e.g., right, left), quality (e.g., actual, estimated), and cuff size (e.g., adult, small adult, pediatric). Vital types can be printed by category with their associated qualifiers and synonyms through the Display Vitals Category/Qualifier/Synonym Table option. When documenting patient vital signs and measurements, the user may see a listing of valid qualifiers by entering a ‘?’ or ‘??’. The application coordinator has the ability to add qualifiers and change other software parameters through the Vitals/Measurements Site Files Menu option.

Note: After entering vitals/measurements information for a patient, the software displays this data and asks you, "Is this correct? YES//". The user must answer YES to store the data after it is verified correct. If the user enters an ‘^’ at the prompt, the application does NOT store the data and displays 'DATA DELETED' on the screen. Of course, if NO is entered after the prompt, patient information is NOT stored and all vitals/measurements data must be re-entered.

Defaults: The software has defaults for each vital/measurement except for blood pressure. These defaults are displayed when the clinician validates the measurements entered. The following list summarizes the software’s defaults:

- Temperature - Oral
- Pulse - Radial
- Respiration - Spontaneous
- Height - Actual
- Weight - Actual

An application coordinator can change the temperature and pulse defaults through the Change Default Qualifiers for Temp./Pulse option.

Asterisks have two different meanings in the software.

1. When entering vitals/measurements information, the user may enter the * to prompt the software to display reasons for not documenting a measurement. The user then selects the most appropriate entry.

2. When an * appears in a report appended to a vitals/measurement entry, the value of the measurement is either higher or lower than the acceptable value defined in the GMRV Vitals Parameters (#120.57) file. These file values can be edited by the package coordinator through the Edit Vitals Site Parameter File option.

---

1 Patch NUR*4*27  June 1999
2 Patch NUR*4*4  August 1997
3 Patch NUR*4*4  August 1997
4 Patch NUR*4*4  August 1997

4.4 Nursing V. 4.0 User Manual Clinical
April 1997
All patient measurements are stored in the U.S. Customary System in File #120.5 and displayed in both U.S. customary units and metric equivalents. Small discrepancies between the entering and displaying of data is due to the conversion between scales.

Temperature scales are automatically defined by the software when a user does not append a 'F' or a 'C' to the numeric entry. A number that is larger than or equal to 45 will be considered as a Fahrenheit temperature, and any number less than 45 will be considered as a Centigrade temperature.

1The scales for weight and height cannot be automatically determined. Therefore, the user must enter the scale (U.S. customary unit or metric equivalent) associated with the weight and height.

Menu Display:

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

Classification, Edit Patient ...
Evaluation/Target Date & Order Status Edit
Intake/Output Data Entry Menu ...
Location/Bed Section, Edit Nursing
Patient Plan of Care, Edit
Vitals/Measurements Data Entry Menu ...

Select Patient Care Data, Enter/Edit Option: Vitals/Measurements Data Entry Menu

Vitals/Measurements Data Entry ...
Edit a Vital/Measurement Entered in Error

Screen Prints:

Select Vitals/Measurements Data Entry Menu Option: Vitals/Measurements Data Entry
ENTER DATE (TIME Required) VITALS WERE TAKEN: T88 (APR 04, 1993@08:00)

2The first prompt is a system parameter used to identify the date and time the vitals/measurements were taken; time is required. The date/time is stamped on every vital/measurement that is entered into the system. The Change Date/Time Taken option allows the user to identify a new date/time the measurements were taken, a different vital type, or a new selection of patients without leaving the Vitals/ Measurement Data Entry menu. This Change Date/Time Taken option is further explained later in this chapter.

1 Patch NUR*4*4 August 1997
2 Patch NUR*4*4 August 1997
Vitals/Measurements

1 TPR Pain
2 TPR B/P Pain
3 TPR B/P Ht. Wt. and Pain
4 TPR B/P Wt. and Pain
5 Temp, Detailed PR and B/P
6 Detailed B/P and Associated Pulse
7 Pulse
8 Weight
9 Circumference/Girth
10 Pulse Oximetry
11 CVP (Central Venous Pressure)
12 User Configurable Combination
13 Change Date/Time Taken
14 Pain

Select Vitals/Measurement Data Entry Option: 1 TPR Pain

Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient?
P

Example: Process for entering vitals for an individual patient:

Enter patient name.

Select PATIENT NAME: NURSPATIENT3,THREE -- 500-1 YES SC VETERAN

Enter appropriate hospital location.

Select Hospital Location: 4E// <RET>

To omit entering a vital/measurement reading:
Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
Enter an * for the specific value when documenting the reason for omission.
Enter a single * to document that all measurements were omitted and the reason for omission.

The temp-pulse-resp-pain are entered at this prompt.

Temp-Pulse-Resp-Pain: 102.1-70-24-2

The following is representative of the software's on-line help:
** Temperature: a number + a location qualifier(optional), e.g., 99.6A or 99.6AX (F AXILLARY) or 37R (C RECTAL).
Default: ORAL
AXILLARY, CORE, ORAL, RECTAL, SKIN, TYMPANIC

1 Patch NUR*4*25 May 1999
2 Patch NUR*4*23 February 1999
3 Patch NUR*4*25 May 1999
4 Patch NUR*4*4 August 1997
5 Patch NUR*4*25 May 1999
** Pulse: a number + a location qualifier (optional), e.g., 70A or 70AP
   (70 APICAL).
   Default: RADIAL
   APICAL, BILATERAL PERIPHERALS, BRACHIAL, CAROTID, DORALIS PEDIS,
   FEMORAL, OTHER, PERIPHERAL, POPLITEAL, POSTERIOR TIBIAL, RADIAL, ULNAR
** Respiration: a number (0-99 with no decimal places) + method qualifier
   (optional) e.g., 40C or 40c.
   Default: SPONTANEOUS
   ASSISTED VENTILATOR, CONTROLLED VENTILATOR, SPONTANEOUS
The entry should be in the following format:
   TTT.T-PPP-RR
To omit entering a vital/measurement reading:
Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
Enter an * for the specific value when documenting the reason for omission.
Enter a single * to document that all measurements were omitted and the reason for omission.

The data entry is one single string of alphanumeric characters with each measurement separated by a hyphen (-). The software redisplays the data as:

```
Temp.: 102.1 F  (38.9 C)* ORAL
Pulse: 70 RADIAL
Resp.: 24 SPONTANEOUS
1Pain: 2
```

Note the asterisk (*) following the value for temperature. An asterisk (*) following data indicates that the value is higher or lower than the acceptable values which are defined in the site configurable file GMRV Vitals Parameters (#120.57).

Is this correct? YES// <RET>

At this point the user can reject or accept the entry. This is the last chance to change any possible errors during data entry. The user is able to correct errors at a later time using the error correction option (Edit a Vital/Measurement Entered in Error) which will be discussed later in this chapter.

Do you want to enter other V/M data for this patient? No// <RET> (No)

Select PATIENT NAME: <RET>

This option also supports entering patient vital signs and measurements for all patients on a ward or unit and by selected hospital rooms on a unit. Navigating through the software to document measurements for all patients on a unit is described next.

---

1 Patch NUR*4*25  May 1999
Select the measurement(s) you want to enter.

Example: Entering vitals for all of the patients on a particular unit.

Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? A

Enter the appropriate ward/unit name.

Select Unit: SICU

Begin entering patient vitals.

NURSPATIENT7, FOUR          550-1  OK? YES//<RET>

The clinician may enter patient information in the format described for the individual patient or bypass an entry by entering <RET>. The software indicates that no data was entered. The name of the next patient is displayed.

Temp-Pulse-Resp-Pain: <RET>

NO DATA ENTERED

Do you wish to stop looping through names? YES//N (NO)

When the clinician enters a NO behind the patient's name, he may continue to the next patient by answering NO to the question 'Do you wish to stop looping through names?' or exit by entering YES.

NURSPATIENT6, FOUR          550-2  OK? N  (NO)

NURSPATIENT6, FIVE          560-1  OK? <RET> (YES)
**Vitals/Measurements**

1 Temp-Pulse-Resp-Pain: **100.2R-60A-34C-2**

- Temp.: 100.2 F  (37.9 C) RECTAL
- Pulse: 60* APICAL
- Resp.: 34* CONTROLLED VENTILATOR

2 Pain: 2

Is this correct? YES // <RET>

NURSPATIENT6,SIX 560-10 OK? YES // N (NO)

Do you wish to stop looping through names? YES // <RET>  (YES)

Enter return to continue <RET>

| 1 | TPR Pain |
| 2 | TPR B/P Pain |
| 3 | TPR B/P Ht. Wt. and Pain |
| 4 | TPR B/P Wt. and Pain |
| 5 | Temp, Detailed PR and B/P |
| 6 | Detailed B/P and Associated Pulse |
| 7 | Pulse |
| 8 | Weight |
| 9 | Circumference/Girth |
| 10 | Pulse Oximetry |
| 11 | CVP (Central Venous Pressure) |
| 12 | User Configurable Combination |
| 13 | Change Date/Time Taken |
| 14 | Pain |

5 Select Vitals/Measurement Data Entry Option: 3 TPR B/P Ht. Wt. and Pain

Example: Entering vital signs by selecting specific beds. The software prompts for entering information is identical with the previous two pathways, i.e., entering data by patient or by unit.

Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? S

Select Unit: SICU

Enter appropriate ward location.

Ward SICU has the following rooms:

1. 550-1
2. 550-2
3. 550-3
4. 550-4
5. 560-1
6. 560-10
7. 560-2
8. 570-1

---

1 Patch NUR*4*25 May 1999
2 Patch NUR*4*25 May 1999
3 Patch NUR*4*25 May 1999
4 Patch NUR*4*23 February 1999
5 Patch NUR*4*25 May 1999
Select the NUMBER(S) of the rooms: 5-6

Enter room or range of rooms to enter patient vitals.

Begin entering patient vitals.

NURSPATIENT6,FIVE 560-1 OK? YES// <RET>

The software loops through the patients located in Rooms 560-1 and 560-10 and the user enters the vitals/measurements values.

1  TPR Pain
2  TPR B/P Pain
3  TPR B/P Ht. Wt. and Pain
4  TPR B/P Wt. and Pain
5  Temp, Detailed PR and B/P
6  Detailed B/P and Associated Pulse
7  Pulse
8  Weight
9  Circumference/Girth
10 Pulse Oximetry
11 CVP (Central Venous Pressure)
12 User Configurable Combination
13 Change Date/Time Taken
14 Pain

Example: Entering detailed B/P and associated pulse.

Select Vitals/Measurement Data Entry Option: 6 Detailed B/P and Associated Pulse
Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? P
Select PATIENT NAME: NURSPATIENT3,THREE -- 500-1
YES
SC VETERAN
Select Hospital Location: 4E// <RET> 4E

To omit entering a vital/measurement reading:
Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
Enter an * for the specific value when documenting the reason for omission.
Enter a single * to document that all measurements were omitted and the reason for omission.

BP-Pulse: 120/70-60

---

1 Patch NUR*4*25 May 1999
2 Patch NUR*4*23 February 1999
3 Patch NUR*4*4 August 1997
The software displays selections for documenting detailed blood pressures. When a blood pressure is entered with a qualifier for Doppler or palpated and no diastolic reading, (e.g., 120/d), the method does not display and will not be editable. Each qualifier must be separated by a comma. The user is not required to enter qualifiers to proceed to the next prompt.

Qualifiers for BLOOD PRESSURE:

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>POSITION</th>
<th>METHOD</th>
<th>CUFF SIZE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 L ARM</td>
<td>5 LYING</td>
<td>8 CUFF</td>
<td>13 ADULT</td>
</tr>
<tr>
<td>2 L LEG</td>
<td>6 SITTING</td>
<td>9 DOPPLER</td>
<td>14 LG ADULT</td>
</tr>
<tr>
<td>3 R ARM</td>
<td>7 STANDING</td>
<td>10 INVASIVE</td>
<td>15 PEDIATRIC</td>
</tr>
<tr>
<td>4 R LEG</td>
<td></td>
<td>11 NON-INVASIVE</td>
<td>16 SM ADULT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12 PALPATED</td>
<td>17 THIGH</td>
</tr>
</tbody>
</table>

Select a number under each category (optional). Separate the numbers with ',': 1, 6, 8

L ARM  SITTING  CUFF

The software displays selections for documenting detailed pulse.

Qualifiers for PULSE:

<table>
<thead>
<tr>
<th>SITE</th>
<th>METHOD</th>
<th>POSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 LEFT</td>
<td>3 AUSCULTATE</td>
<td>6 LYING</td>
</tr>
<tr>
<td>2 RIGHT</td>
<td>4 DOPPLER</td>
<td>7 SITTING</td>
</tr>
<tr>
<td></td>
<td>5 PALPATED</td>
<td>8 STANDING</td>
</tr>
</tbody>
</table>

Select a number under each category (optional). Separate the numbers with ',': 1

LEFT

B/P: 120/70  L ARM SITTING CUFF
Pulse: 60* RADIAL  LEFT
Is this correct? YES/

After reviewing the entry, a user can reject or accept the data. This is the last chance to change any possible errors during data entry. The user is able to correct errors at a later time using the error correction option, Edit a Vital/Measurement Entered in Error, which will be discussed later in this chapter.

Enter another B/P? NO/

If YES is entered, the user can enter another B/P and pulse under the same time for a different position, location, etc..

---

1 Patch NUR*4*27  June 1999
2 Patch NUR*4*4  August 1997
3 Patch NUR*4*4  August 1997
4 Patch NUR*4*4  August 1997
Vitals/Measurements

1. TPR Pain
2. TPR B/P Pain
3. TPR B/P Ht. Wt. and Pain
4. TPR B/P Wt. and Pain
5. Temp, Detailed PR and B/P
6. Detailed B/P and Associated Pulse
7. Pulse
8. Weight
9. Circumference/Girth
10. Pulse Oximetry
11. CVP (Central Venous Pressure)
12. User Configurable Combination
13. Change Date/Time Taken

Example: Girth measurement.

Select Vitals/Measurement Data Entry Option: 9  Circumference/Girth
Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or
(P)atient? P
Select PATIENT NAME: NURSPATIENT3,THREE -- 500-1
YES
SC VETERAN

Select Hospital Location: 4E// <RET>

To omit entering a vital/measurement reading:
Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
Enter an * for the specific value when documenting the reason for omission.
Enter a single * to document that all measurements were omitted and the
reason for omission.

The following is representative of the software's on-line help:

** Circumference: a number + 'I' or 'C' (2 decimals allowed)
For example: 72.25I (inches)  147C (centimeters)
The entry should be in the following format:

NNN.NN

Circumference/Girth: 32.25I
Qualifiers for CIRCUMFERENCE/GIRTH:

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>SITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ABDOMINAL</td>
<td>10 LEFT</td>
</tr>
<tr>
<td>2 ANKLE</td>
<td>11 RIGHT</td>
</tr>
<tr>
<td>3 CALF</td>
<td></td>
</tr>
<tr>
<td>4 HEAD</td>
<td></td>
</tr>
<tr>
<td>5 LOWER ARM</td>
<td></td>
</tr>
<tr>
<td>6 OTHER</td>
<td></td>
</tr>
<tr>
<td>7 THIGH</td>
<td></td>
</tr>
<tr>
<td>8 UPPER ARM</td>
<td></td>
</tr>
<tr>
<td>9 WRIST</td>
<td></td>
</tr>
</tbody>
</table>

The user identifies the type of circumference.

Enter a number under each category, separate numbers with a ','.

DO NOT select SITE if this is a HEAD/ABDOMINAL girth measurement: 1 ABDOMINAL

Circumference/Girth: 32.25 IN (81.92 CM) ABDOMINAL
Is this correct? YES// Y

Example: Circumference of left lower arm.

1To omit entering a vital/measurement reading:
Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
Enter an * for the specific value when documenting the reason for omission.
Enter a single * to document that all measurements were omitted and the reason for omission.

Circumference/Girth: 12.25I

Qualifiers for CIRCUMFERENCE/GIRTH:

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>SITE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 ABDOMINAL</td>
<td>10 LEFT</td>
</tr>
<tr>
<td>2 ANKLE</td>
<td>11 RIGHT</td>
</tr>
<tr>
<td>3 CALF</td>
<td></td>
</tr>
<tr>
<td>4 HEAD</td>
<td></td>
</tr>
<tr>
<td>5 LOWER ARM</td>
<td></td>
</tr>
<tr>
<td>6 OTHER</td>
<td></td>
</tr>
<tr>
<td>7 THIGH</td>
<td></td>
</tr>
<tr>
<td>8 UPPER ARM</td>
<td></td>
</tr>
<tr>
<td>9 WRIST</td>
<td></td>
</tr>
</tbody>
</table>

Enter a number under each category, separate numbers with a ','.

DO NOT select SITE if this is a HEAD/ABDOMINAL girth measurement: 5,10 LOWER ARM LEFT

1 Patch NUR*4*4 August 1997
Circumference/Girth: 12.25 IN (31.12 CM)  LOWER ARM  LEFT
Is this correct? YES// <RET>

Do you want to enter other V/M data for this patient? No// <RET>  (No)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>TPR Pain</td>
</tr>
<tr>
<td>2</td>
<td>TPR B/P Pain</td>
</tr>
<tr>
<td>3</td>
<td>TPR B/P Ht. Wt. and Pain</td>
</tr>
<tr>
<td>4</td>
<td>TPR B/P Wt. and Pain</td>
</tr>
<tr>
<td>5</td>
<td>Temp, Detailed PR and B/P</td>
</tr>
<tr>
<td>6</td>
<td>Detailed B/P and Associated Pulse</td>
</tr>
<tr>
<td>7</td>
<td>Pulse</td>
</tr>
<tr>
<td>8</td>
<td>Weight</td>
</tr>
<tr>
<td>9</td>
<td>Circumference/Girth</td>
</tr>
<tr>
<td>10</td>
<td>Pulse Oximetry</td>
</tr>
<tr>
<td>11</td>
<td>CVP (Central Venous Pressure)</td>
</tr>
<tr>
<td>12</td>
<td>User Configurable Combination</td>
</tr>
<tr>
<td>13</td>
<td>Change Date/Time Taken</td>
</tr>
<tr>
<td>14</td>
<td>Pain</td>
</tr>
</tbody>
</table>

Example: Pulse Oximetry.

Select Vitals/Measurement Data Entry Option: 10  Pulse Oximetry
Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient?  P
Select PATIENT NAME: NURSPATIENT3,THREE  --  500-1
YES
SC VETERAN

Answer with patient name.

Select Hospital Location: 4E// <RET>  4E

Enter appropriate hospital location.

3To omit entering a vital/measurement reading:
Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
Enter an * for the specific value when documenting the reason for omission.
Enter a single * to document that all measurements were omitted and the reason for omission.

The following is representative of the software's on-line help:
** Pulse Oximetry: Enter the numeric value of the patients O2 saturation obtained via pulse oximetry. The value will be interpreted as a percentage. The entry should be in the following format:

NNN

---

1 Patch NUR*4*25  May 1999
2 Patch NUR*4*23  February 1999
3 Patch NUR*4*4  August 1997

4.14 Nursing V. 4.0 User Manual
Clinical
April 1997
PO2: 89

At this prompt the user may indicate that patient was receiving oxygen at the time the pulse oximetry reading was taken. If YES is entered, additional information on the flow rate, O2 concentration, and method of O2 administration can be entered.

Is the patient on supplemental oxygen? Yes// <RET> (Yes)

Enter a number between 0.5-20 for liters/minute, and/or 21-100 for percent of oxygen concentration. If you wish to enter both rates, separate the values with a ','. 

Enter the numeric value(s) for amount of supplemental oxygen provided (Separate values with a ','): 3.5,40

Oxygen is supplied by

1 AEROSOL/HUMIDIFIED MASK
2 FACE TENT
3 MASK
4 NASAL CANNULA
5 NON RE-BREATHER
6 PARTIAL RE-BREATHER
7 T-PIECE
8 TRACHEOSTOMY COLLAR
9 VENTILATOR
10 VENTURI MASK

Enter a number: 1

Pulse Ox.: 89 % with supplemental O2 40% 3.5 l/min
via AEROSOL/HUMIDIFIED MASK

Is this correct? YES// <RET>

Do you want to enter other V/M data for this patient? No// <RET> (No)

1 Patch NUR*4*4  August 1997
Vitals/Measurements

1. TPR Pain
2. TPR B/P Pain
3. TPR B/P Ht. Wt. and Pain
4. TPR B/P Wt. and Pain
5. Temp, Detailed PR and B/P
6. Detailed B/P and Associated Pulse
7. Pulse
8. Weight
9. Circumference/Girth
10. Pulse Oximetry
11. CVP (Central Venous Pressure)
12. User Configurable Combination
13. Change Date/Time Taken

Example: Central Venous Pressure (CVP).

Select Vitals/Measurement Data Entry Option: 11  CVP (Central Venous Pressure)
Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or
(P)atient?  P
Select PATIENT NAME: NURSPATIENT3,THREE  --  500-1
YES
Select Hospital Location: 4E/

To omit entering a vital/measurement reading:
Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
Enter an * for the specific value when documenting the reason for omission.
Enter a single * to document that all measurements were omitted and the
reason for omission.

The following is representative of the software's on-line help:
** Central venous pressure: a number for cmH2O measurement or a number + 'G' for mmHg
measurement (1 decimal allowed).
A negative number can be entered up to and including -13 cmH2O or -9.6 mmHg.
The entry should be in the following format:

CVP: 14G

CVP: 19.04 cmH2O (14.0 mmHg)
Is this correct? YES/

Do you want to enter other V/M data for this patient? No/

1 Patch NUR*4*25 May 1999
2 Patch NUR*4*23 February 1999
3 Patch NUR*4*4 August 1997

4.16 Nursing V. 4.0 User Manual April 1997
Example: User Configurable Combination.

Select Vitals/Measurement Data Entry Option: 12 User Configurable Combination

This option allows the users to create their own vital signs and measurements combination(s). Although these selections display all prompts that support documentation of detailed measurements, the user can bypass these prompts.

Select the combination of Vitals/Measurements you want to enter.

1 T
2 P
3 R
4 B/P
5 Wt
6 Ht
7 Circumference/Girth
8 Pulse Oximetry
9 Pain

Data on weight and height is documented on a patient.

Select from 1 to 9 (enter 1, 3-5 etc.) or ^ to exit: 5, 6
Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? P
Select PATIENT NAME: NURSPATIENT3,THREE -- 500-1
YES
SC VETERAN

Select Hospital Location: 4E// <RET>
To omit entering a vital/measurement reading:
Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
Enter an * for the specific value when documenting the reason for omission.
Enter a single * to document that all measurements were omitted and the reason for omission.

The following is representative of the software's on-line help:
** Weight: a number+L(l) or a number+K(k) + 2nd quality (optional) 2
decimals allowed, e.g., 120.25L or 120l (pounds),
45.25K or 45k (kilograms).
120L, 120LA, or 120K for actual weight.
Default: ACTUAL
ACTUAL, DRY, ESTIMATED
** Height: a number + ',' + qualifier (2 decimals allowed)
72I (inches) 147C or 147CM (centimeters)
5F10I;E or 5FT10IN;E or 5'10";E (for 5 feet 10 inches ESTIMATED)
Default: ACTUAL
ACTUAL, ESTIMATED
The entry should be in the following format:
WWW.WW-HH

Ht.-Wt.: 5'6";E-165.25LE

Qualifiers for WEIGHT:
METHOD
1 BED
2 CHAIR
3 STANDING

The user may enter a method indicating how the weight was taken or enter <RET> to display, and the then validate data.

Select a number under each category (optional).

Wt.: 165.25 LB (75.11 KG) ESTIMATED BED
Ht.: 5 FT 6 IN (167.64 CM) ESTIMATED
Is this correct? YES// <RET>

Do you want to enter other V/M data for this patient? No// <RET> (No)
1 TPR Pain
2 TPR B/P Pain
3 TPR B/P Ht. Wt. and Pain
4 TPR B/P Wt. and Pain
5 Temp, Detailed PR and B/P
6 Detailed B/P and Associated Pulse
7 Pulse
8 Weight
9 Circumference/Girth
10 Pulse Oximetry
11 CVP (Central Venous Pressure)
12 User Configurable Combination
13 Change Date/Time Taken
14 Pain

Example: Change Date/Time Taken.

Select Vitals/Measurement Data Entry Option: 7 Pulse

When information is entered using the All patients on a unit or the Selected Rooms on a unit pathway, the user may enter new data without exiting and re-entering the option by selecting (13) Change Date/Time Taken. This option prompts for a new date/time measurement was taken, a different vital type, and a new selection of patients. As an example, the user documents 6 am pulse readings for 2AS patients, then enters the Change Date/Time Taken option and documents 8 am weights.

Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? A
Select Unit: 2AS
Begin entering patient vitals.

NURSPATIENT3,FOUR  OK? YES/<RET>

To omit entering a vital/measurement reading:
Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
Enter an * for the specific value when documenting the reason for omission.
Enter a single * to document that all measurements were omitted and the reason for omission.

Pulse: 86

Qualifiers for PULSE:

<table>
<thead>
<tr>
<th>SITE</th>
<th>METHOD</th>
<th>POSITION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 LEFT</td>
<td>3 AUSCULTATE</td>
<td>6 LYING</td>
</tr>
<tr>
<td>2 RIGHT</td>
<td>4 DOPPLER</td>
<td>7 SITTING</td>
</tr>
<tr>
<td></td>
<td>5 PALPATED</td>
<td>8 STANDING</td>
</tr>
</tbody>
</table>

1 Patch NUR*4*25 May 1999
2 Patch NUR*4*23 February 1999
3 Patch NUR*4*4 August 1997
Select a number under each category (optional).
Separate the numbers with ',',: 1,3,7

LEFT  AUSCULTATE  SITTING

Pulse: 86 RADIAL  LEFT  AUSCULTATE SITTING
Is this correct? YES//<RET>
.
.
.

The user continues to enter 6 am pulse readings, until he selects the Change Date/Time Taken option to enter 8 am weights.

Do you wish to stop looping through names? YES//<RET>
Enter return to continue <RET>

1   TPR Pain
2   TPR B/P Pain
3   TPR B/P Ht. Wt. and Pain
4   TPR B/P Wt. and Pain
5   Temp, Detailed PR and B/P
6   Detailed B/P and Associated Pulse
7   Pulse
8   Weight
9   Circumference/Girth
10  Pulse Oximetry
11  CVP (Central Venous Pressure)
12  User Configurable Combination
13  Change Date/Time Taken
14  Pain

At the next prompt, the user enters, 13, to enter another date/time, new vital types and select patient(s).

Select Vitals/Measurement Data Entry Option: 13  Change Date/Time Taken
ENTER DATE (TIME Required) VITALS WERE TAKEN: T@8:00 (MAR 03, 1997@08:00)
Select Vitals/Measurement Data Entry Option: 8 Weight

Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? A

Select Unit: 2AS

Begin entering patient vitals.

NURSPATIENT3,FOUR OK? YES// <RET>

To omit entering a vital/measurement reading:
Enter 'N' or 'n' for the value when NOT documenting a reason for omission.
Enter an * for the specific value when documenting the reason for omission.
Enter a single * to document that all measurements were omitted and the reason for omission.

Wt.: 400L

Qualifiers for WEIGHT:

METHOD

1 BED
2 CHAIR
3 STANDING

Select a number under each category (optional).

Separate the numbers with ',': 2

CHAIR

Wt.: 400 LB (181.82 KG) ACTUAL CHAIR

Is this correct? YES// <RET>

The user continues to select the patients that have 8 am weight readings and exits when documentation is completed.

---

1 Patch NUR*4*25 May 1999
2 Patch NUR*4*23 February 1999
3 Patch NUR*4*4 August 1997
4 Patch NUR*4*4 August 1997
Example: Pain.

Select Vitals/Measurement Data Entry Option: 14  Pain
Vitals by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient?  P
Select PATIENT NAME:  NURSPATIENT3,THREE  --  500-1
YES
SC VETERAN

Select Hospital Location: 4E// <RET>  4E

Enter an * for the specific value when documenting the reason for omission. Enter a single * to document that all measurements were omitted and the reason for omission.

The following is representative of the software's on-line help:
** Pain:  Enter a numeric value. 0 for no pain. 1-10 for pain scale
10 is worst imaginable pain or enter 99 if the patient is unable to respond
For example: 99 or 5
The entry should be in the following format:
NN

Pain:  3

Pain:  3
Is this correct? YES// <RET>

Do you want to enter other V/M data for this patient? No// <RET>  (No)
Menu Access:

The Vitals/Measurements Data Entry option is accessed through the Vitals/Measurements Data Entry Menu option of the Patient Care Data, Enter/Edit option of the Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
**NURCPE-VIT-ERROR**

**Edit a Vital/Measurement Entered in Error**

**Description:**

This option allows users to correct errors in vitals/measurements. When data is edited, a new record is created, and the old record is marked entered in error. Vitals/measurements data is stored in the GMRV Vital Measurement (#120.5) file.

**Additional Information:**

Vitals/measurements data can be retrieved through the Print Vitals Entered in Error for a Patient option. The information entered through this option is also reflected in the Cumulative Vitals Report.

**Menu Display:**

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

   Classification, Edit Patient ...
   Evaluation/Target Date & Order Status Edit
   Intake/Output Data Entry Menu ...
   Location/Bed Section, Edit Nursing
   Patient Plan of Care, Edit
   Vitals/Measurements Data Entry Menu ...

Select Patient Care Data, Enter/Edit Option: Vitals/Measurements Data Entry Menu

   Vitals/Measurements Data Entry ...
   Edit a Vital/Measurement Entered in Error

**Screen Prints:**

Select Vitals/Measurements Data Entry Menu Option: Edit a Vital/Measurement Entered in Error

Select PATIENT NAME: NURSPATIENT3,THREE 08-04-18 000848807 SC VETERAN

Answer with patient name.
Select DATE (TIME optional) of this error: T (APR 04, 1993)

Enter an appropriate date. When the exact time is not remembered, the user may enter the date, and all entries for that date display.

CHOOSE FROM:

1  APR 4, 1993@08:00
BP: 120/80 (R ARM/LYING)
T: 102.1 F (38.9 C)* (ORAL)
R: 24 (SPONTANEOUS)
P: 70 (RADIAL)
2  APR 4, 1993@08:01
BP: 130/85 (L ARM/LYING)

Select VITAL/MEASUREMENT from the above list: 1

Enter the number of the measurement or group of measurements you want to enter in error.

A detailed summary of the data is provided.

*** DATA TO BE ENTERED IN ERROR ***
APR 4, 1993@08:00
BP: 120/80 R ARM/LYING
T: 102.1 F (38.9 C)* ORAL
R: 24 (SPONTANEOUS)
P: 70 RADIAL

Select a VITAL type record, or press return to correct DATE/TIME, PATIENT or set INVALID for the record: RESPIRATION

In this example, the respirations were incorrectly documented. The user must select an appropriate reason(s) from 1-4.

In this case, the invalid record selection (4) cannot be used in combination with 1, 2, or 3. The user receives the following prompt.

1  INCORRECT DATE/TIME
2  INCORRECT READING
3  INCORRECT PATIENT
4  INVALID VITAL/RECORD

The INVALID RECORD reason cannot be used in combination with any other selections.

The following are examples of identifying incorrect patient data using the above four selections:

INCORRECT DATE/TIME: changes the date/time that a vital measurement was taken for a patient.

1 Patch NUR423 Feb 1999
Select the reason(s) for entering this vital/measurement in error: 1
Enter new date/time vitals were taken: 9A (APR 04, 1993@09:00)

INCORRECT READING: changes the data for a vital/measurement that was taken for a patient. The following prompt displays only if a single/specific vital has been identified for editing.

Select the reason(s) for entering this vital/measurement in error: 2

NEW RESPIRATION: 20A

The corrected information is entered.

INCORRECT PATIENT: changes the patient for a particular vital measurement (e.g., the data was entered for the wrong patient).

Select the reason(s) for entering this vital/measurement in error: 3
Select the NEW Patient's name: NURSPATIENT6,THREE 01-19-25 000632111 NSC VETERAN

INVALID VITAL/RECORD: deletes the record without adding any new data. In actuality, the bad record is still in the computer, but is not a part of the current patient data.

Select the reason(s) for entering this vital/measurement in error: 4

If a combination of the above applies, choices can be selected at one time as described below.

Select PATIENT NAME: NURSPATIENT6,SIX 03-22-22 000969342 NSC VETERAN

Select DATE (TIME optional) of this error: T (APR 04, 1993)

Choose FROM:

1   APR 4, 1993@08:00
    BP: 120/80
    T: 100.4 F (38.0 C) (ORAL)
    R: 20 (SPONTANEOUS)
    P: 80 (RADIAL)
    HT: 5 FT 8 IN (172.72 CM)
    WT: 200 LB (90.91 KG) (ACTUAL)

Select VITAL/MEASUREMENT from the above list: 1

*** DATA TO BE ENTERED IN ERROR ***
APR 4, 1993@08:00
BP: 120/80
T: 100.4 F (38.0 C) ORAL
R: 20 (SPONTANEOUS)
P: 80 RADIAL
HT: 5 FT 8 IN (172.72 CM)
WT: 200 LB (90.91 KG) ACTUAL
Select a VITAL type record, or press return to correct DATE/TIME, PATIENT or set INVALID for the record: RESPIRATION

1 INCORRECT DATE/TIME
2 INCORRECT READING
3 INCORRECT PATIENT
4 INVALID VITAL/RECORD

Select the reason(s) for entering this vital/measurement in error: 1-3
Enter new date/time vitals were taken: 9A (APR 04, 1993@09:00)

NEW RESPIRATION: 24A
Select the NEW Patient's name: NURSPATIENT6,THREE 01-19-25
000632111
NSC VETERAN

Select DATE (TIME optional) of this error: T (APR 05, 1993)

CHOOSE FROM:

1 APR  5, 1993@08:00
BP: 130/80  (L ARM/LYING)
 T: 101.2 F (38.4 C)  (RECTAL)
 R: 20  (ASSISTED VENTILATOR)
 P: 80  (APICAL)

Select VITAL/MEASUREMENT from the above list: 1

*** DATA TO BE ENTERED IN ERROR ***
APR  5, 1993@08:00
BP: 130/80  L ARM/LYING
 T: 101.2 F (38.4 C)  RECTAL
 R: 20  ASSISTED VENTILATOR
 P: 80 APICAL

Select a VITAL type record, or press return to correct DATE/TIME, PATIENT or set INVALID for the record: <RET>

1 INCORRECT DATE/TIME
2 INCORRECT PATIENT
3 INVALID VITAL/RECORD

Select the reason(s) for entering these vital/measurements in error:

Menu Access:

The Edit a Vital/Measurement Entered in Error option is accessed through the
Vitals/Measurements Data Entry Menu option of the Patient Care Data, Enter/Edit option of the
Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.

---

1 Patch NUR*4*23  February 1999
2 Patch NUR*4*23  February 1999
Vitals/Measurements

NURSPP-VIT-MENU

Vitals/Measurements Results Reporting

Description:

This menu contains options which allow the users to print various types of vitals/measurements reports. Data printed on these reports is stored in the GMRV Vital Measurement (#120.5) file.

Additional Information:

1Data printed in these reports was entered through the Vitals/Measurement Data Entry option, or the Edit a Vital/Measurement Entered in Error option. All abnormal patient values are identified on the vitals/measurements reports by an asterisk (*). Patient vital signs and measurements can be printed by patient, selected room and bed and by ward location (i.e., entry in the Hospital Location (#44) file). All vitals/measurements data for a patient is reflected on the Cumulative Vitals Report and the Vital Signs Record (SF 511) graphic report. The division name is obtained from the Hospital Location (#44) file.

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1 Administration Records, Enter/Edit ...
2 Administration Records, Print ...
3 Administrative Site File Functions ...
4 Nursing Education Reports, Print ...
5 Patient Care Data, Enter/Edit ...
6 Patient Care Data, Print ...
7 Clinical Site File Functions ...
8 QI Data, Enter/Edit ...
9 Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Option: 6 Patient Care Data, Print
<table>
<thead>
<tr>
<th></th>
<th>Classification Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Location of Individual Patient, Print</td>
</tr>
<tr>
<td>3</td>
<td>Patient Assignment Worksheet</td>
</tr>
<tr>
<td>4</td>
<td>Ward Census, Print</td>
</tr>
<tr>
<td>5</td>
<td>Current Unclassified Patient Print, by Location</td>
</tr>
<tr>
<td>6</td>
<td>Patient Plan of Care, Print</td>
</tr>
<tr>
<td>7</td>
<td>Vitals/Measurements Results Reporting ...</td>
</tr>
<tr>
<td>8</td>
<td>Intake/Output Results Reporting ...</td>
</tr>
<tr>
<td>9</td>
<td>End of Shift Report</td>
</tr>
<tr>
<td>10</td>
<td>Health Summary Report</td>
</tr>
<tr>
<td>11</td>
<td>V/M Graphic Reports</td>
</tr>
<tr>
<td>12</td>
<td>Patient Problems to be Evaluated</td>
</tr>
</tbody>
</table>

Select Patient Care Data, Print Option: **7** Vitals/Measurements Results Reporting

<table>
<thead>
<tr>
<th></th>
<th>Latest Vitals Display for a Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Latest Vitals by Location</td>
</tr>
<tr>
<td>3</td>
<td>Cumulative Vitals Report</td>
</tr>
<tr>
<td>4</td>
<td>Print Vitals Entered in Error for a Patient</td>
</tr>
</tbody>
</table>

**Menu Access:**

The Vitals/Measurements Results Reporting option is accessed through the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
Vitals/Measurements

NURCPP-VIT-DISP

Latest Vitals Display for a Patient

Description:

This option prints the latest vitals/measurements for an individual patient. Patient data is retrieved from the GMRV Vital Measurement (#120.5) file.

Additional Information:

Data displayed in this report is entered through the Vitals/Measurement Data Entry option, or the Edit a Vital/Measurement Entered in Error option. This report includes vitals/measurements obtained as an outpatient, inpatient, or both. Only radial, brachial, and apical pulses appear on the report.

Menu Display:

Select Nursing Features (all options) Option: 6 Patient Care Data, Print

1. Classification Report
2. Location of Individual Patient, Print
3. Patient Assignment Worksheet
4. Ward Census, Print
5. Current Unclassified Patient Print, by Location
6. Patient Plan of Care, Print
7. Vitals/Measurements Results Reporting ...
8. Intake/Output Results Reporting ...
9. End of Shift Report
10. Health Summary Report
11. V/M Graphic Reports
12. Patient Problems to be Evaluated

Select Patient Care Data, Print Option: 7 Vitals/Measurements Results Reporting

1. Latest Vitals Display for a Patient
2. Latest Vitals by Location
3. Cumulative Vitals Report
4. Print Vitals Entered in Error for a Patient

---

1 Patch NUR*4*27 June 1999
Screen Prints:

Select Vitals/Measurements Results Reporting Option: 1 Latest Vitals Display for a Patient

Select PATIENT NAME: NURSPATIENT6,THREE 01-19-25 000632111

DEVICE: Enter appropriate response

MAR 25,1997 (11:21) LATEST VITALS REPORT PAGE 1

<table>
<thead>
<tr>
<th>4M1-A</th>
<th>NURSPATIENT6,THREE</th>
<th>112-33-4443</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temp.: (03/21/97@09:48) 99.4 F (37.4 C) (ORAL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulse: (03/21/97@09:48) 55* (RADIAL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resp.: (03/21/97@09:48) 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1Pulse Ox: (03/21/97@09:48) 99% with supplemental O2 3L/min 30% - VENTURI MASK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B/P: (03/13/97@09:28) 120/80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ht.: (03/20/97@10:39) 2 ft 10 in (86.36 cm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wt.: (03/20/97@10:39) 500 lb (227.27 kg) (ACTUAL, BED)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BMI: 305*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CVP: (03/21/97@09:48) 24 cmH2O (17.6 mmHg)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Circ/Girth: (01/23/97@08) 32.1 in (81.53 cm) (ABDOMINAL)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2Pain: (03/22/97@09:22) 5</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Press return to continue <RET>

Menu Access:

The Latest Vitals Display for a Patient option is accessed through the Vitals/Measurements Results Reporting option of the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.

1 Patch NUR*4*27 June 1999
2 Patch NUR*4*23 February 1999
NURCPP-VIT-WARD

Latest Vitals by Location

Description:

This option prints the latest vitals/measurements for all patients on a specific ward. Vitals data
for a patient is stored in the GMRV Vital Measurement (#120.5) file.

Additional Information:

1Data printed in this report is entered through the Vitals/Measurement Data Entry option, or the
Edit a Vital/Measurement Entered in Error option. Only radial, brachial, and apical pulses
appear on the report.

Menu Display:

Select Nursing Features (all options) Option: 6 Patient Care Data, Print

1 Classification Report
2 Location of Individual Patient, Print
3 Patient Assignment Worksheet
4 Ward Census, Print
5 Current Unclassified Patient Print, by Location
6 Patient Plan of Care, Print
7 Vitals/Measurements Results Reporting ...
8 Intake/Output Results Reporting ...
9 End of Shift Report
10 Health Summary Report
11 V/M Graphic Reports
12 Patient Problems to be Evaluated

Select Patient Care Data, Print Option: 7 Vitals/Measurements Results Reporting

1 Latest Vitals Display for a Patient
2 Latest Vitals by Location
3 Cumulative Vitals Report
4 Print Vitals Entered in Error for a Patient

Screen Prints:

Select Vitals/Measurements Results Reporting Option: 2 Latest Vitals by Location

1 Patch NUR*4*27 June 1999
4.32 Nursing V. 4.0 User Manual Clinical
April 1997
Select WARD LOCATION NAME: **MICU**

Enter appropriate ward name.

**DEVICE:** Enter appropriate response

---

**MAR 25, 1997 (11:22) VITALS REPORT FOR UNIT: MICU - HINES, IL**

NURSPATIENT6, SEVEN 000-13-3012

Temp.: (03/20/97@1) 99.6 F (37.6 C) (ORAL)
Pulse: (03/20/97@1) 88 (RADIAL)
Resp.: (03/20/97@1) 24
B/P: (07/17/96@14:58) 120/80

Press return to continue or "^" to quit <RET>

---

**MAR 25, 1997 (11:22) VITALS REPORT FOR UNIT: MICU - HINES, IL**

500-1 NURSPATIENT3, THREE

Temp.: (03/20/97@1) 100 F (37.8 C) (ORAL)
Pulse: (03/20/97@1) 55* (RADIAL)
Resp.: (03/20/97@1) 20
1Pulse Ox: (02/20/97@07) 89% with supplemental O2 3.5L/min 40%

B/P: (02/21/97@14:17) 120/70 (L ARM, LYING, CUFF)
Ht.: (02/20/97@08) 6 ft (182.88 cm) (ESTIMATED)
Wt.: (02/20/97@08) 200 lb (90.91 kg)
BMI: 27
CVP: (02/21/97@14:28) 19.04 cmH2O (14.0 mmHg)
Circ/Girth: (02/21/97@14:28) 32.25 in (81.92 cm) (THIGH)

2Pain: (03/22/97@09:22) 5

Press return to continue <RET>

---

**Menu Access:**

The Latest Vitals by Location option is accessed through the Vitals/Measurements Results Reporting option of the Patient Care Data, Print option of the Administrator’s Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.

---

1 Patch NUR*4*27 June 1999
2 Patch NUR*4*23 February 1999
NURCPP-VIT-CUM

Cumulative Vitals Report

Description:

This option prints vitals/measurement information for patients over a user specified period of time. Data comes from the GMRV Vital Measurement (#120.5) file.

Additional Information:

Data printed in the reports is entered into the database through the Vitals/ Measurement Data Entry option, or the Edit a Vital/Measurement Entered in Error option. Reports can be printed by individual patient, for all patients on a ward, or for patients in a specific hospital room/bed.

Restrictions:

Data prints in chronological order.

Menu Display:

Select Nursing Features (all options) Option: 6  Patient Care Data, Print

1  Classification Report
2  Location of Individual Patient, Print
3  Patient Assignment Worksheet
4  Ward Census, Print
5  Current Unclassified Patient Print, by Location
6  Patient Plan of Care, Print
7  Vitals/Measurements Results Reporting ...
8  Intake/Output Results Reporting ...
9  End of Shift Report
10  Health Summary Report
11  V/M Graphic Reports
12  Patient Problems to be Evaluated

Select Patient Care Data, Print Option: 7  Vitals/Measurements Results Reporting

1  Latest Vitals Display for a Patient
2  Latest Vitals by Location
3  Cumulative Vitals Report
4  Print Vitals Entered in Error for a Patient
Screen Prints:

Select Vitals/Measurements Results Reporting Option: 3 Cumulative Vitals Report

Print by patient.

Vitals by (A)ll patients on a ward, (S)elected Rooms on ward, or (P)atient? P

Select PATIENT NAME: NURSPATIENT6,THREE  01-19-25  000632111
NSC VETERAN

Enter patient name.

Start with DATE (TIME optional): JAN 3,1993@10:00//1/1/95  (JAN 01, 1995)

Enter an appropriate beginning date for this report. The default date is the date of admission for inpatients or T-7 for outpatients.

Go to DATE (TIME optional): NOW//<RET> (FEB 25, 1997@09:46)

Enter appropriate ending date for this report.

DEVICE: Enter appropriate response
07/05/95
14:00  
T: 97.7 F (36.5 C)  (ORAL)  
P: 89  (RADIAL)  
R: 20  
B/P: 145/90  (R ARM, SITTING)  
H: 72.00 in (182.88 cm)  
Wt: 225.00 lb (102.27 kg)  
Body Mass Index: 31

06/18/96
08:00  
P: 62  (RADIAL)  
R: 20  
B/P: 122/68  (R ARM, SITTING)

08:01  
B/P: 102/60* (L ARM, SITTING)

08:02  
B/P: 100/60* (R ARM, STANDING)

08:03  
B/P: 120/70 (L ARM, STANDING)

08:04  
B/P: 110/60* (R ARM, LYING)

08:05  
B/P: 110/70 (L ARM, LYING)

02/17/97
08:00  
T: 99.0 F (37.2 C)  (ORAL)  
P: 75  (LEFT, RADIAL, PALPATED, SITTING)  
R: 14  (SITTING)  
B/P: 120/70 (L ARM)  
H: 72.00 in (182.88 cm)  
Wt: 200.00 lb (90.91 kg) (ACTUAL, STANDING)  
Body Mass Index: 27

1Pulse Ox.: 92 % with supplemental O2 3.5L/min 30% via MASK

02/19/97
14:00  
T: 98.7 F (37.1 C)  (ORAL)  
P: 70  (LEFT, RADIAL)  
R: 20  (STANDING)  
B/P: 120/60* (L ARM, STANDING)  
H: 72.00 in (182.88 cm)  
Wt: 205.00 lb (93.18 kg) (ACTUAL, STANDING)  
Body Mass Index: 28

2Pulse Ox.: 98 % with supplemental O2 4L/min 25% via MASK

3Pain: 5

Patch NUR*4*27 June 1999
Patch NUR*4*27 June 1999
Patch NUR*4*23 February 1999
The following legend is printed on the bottom of the report.

*** (E) - Error entry

NURSPATIENT6,THREE     000-33-4443  NOV 4,1985  11 YRS MALE          VAF 10-7987j
Unit: 4E                        Room: 500-3
Division: Hines

Menu Access:

The Cumulative Vitals Report option is accessed through the Vitals/Measurements Results Reporting option of the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
Vitals/Measurements

**NURCPP-VIT-ERROR**

**Print Vitals Entered in Error for a Patient**

**Description:**

This option prints a report of all vitals/measurements entered in error for a particular patient for a specific date range. Data comes from the GMRV Vital Measurement (#120.5) file.

**Additional Information:**

Patient information printed in this report was entered into the database through the Edit a Vital/Measurement Entered in Error option.

**Menu Display:**

Select Nursing Features (all options) Option: **6** Patient Care Data, Print

1 Classification Report
2 Location of Individual Patient, Print
3 Patient Assignment Worksheet
4 Ward Census, Print
5 Current Unclassified Patient Print, by Location
6 Patient Plan of Care, Print
7 Vitals/Measurements Results Reporting ...
8 Intake/Output Results Reporting ...
9 End of Shift Report
10 Health Summary Report
11 V/M Graphic Reports
12 Patient Problems to be Evaluated

Select Patient Care Data, Print Option: **7** Vitals/Measurements Results Reporting

1 Latest Vitals Display for a Patient
2 Latest Vitals by Location
3 Cumulative Vitals Report
4 Print Vitals Entered in Error for a Patient

**Screen Prints:**

Select Vitals/Measurements Results Reporting Option: **4** Print Vitals Entered in Error for a Patient
Select PATIENT NAME: NURSPATIENT6,THREE 01-19-25 000632111

Enter patient name.

Start with DATE (TIME optional): T-7//1/1/97 (JAN 01, 1997)

Enter appropriate start date.

go to DATE (TIME optional): NOW//<RET> (FEB 25, 1997@12:37)

Enter appropriate end date.

DEVICE: HOME// Enter appropriate response

FEB 25,1997 (11:00) ENTERED IN ERROR VITAL/MEASUREMENT REPORT PAGE 1
Patient: NURSPATIENT6,THREE 000-33-4443

<table>
<thead>
<tr>
<th>Date Vit./Meas. taken</th>
<th>User who made error</th>
</tr>
</thead>
<tbody>
<tr>
<td>FEB 25, 1997@06:30   TEMPERATURE</td>
<td>NURSUSER,SEVEN</td>
</tr>
<tr>
<td>Reason: incorrect reading</td>
<td></td>
</tr>
<tr>
<td>(Revised) 102.1 F (38.9 C)* (ORAL)</td>
<td></td>
</tr>
<tr>
<td>(Bad data) 99 F (37.2 C) (ORAL)</td>
<td></td>
</tr>
<tr>
<td>FEB 25, 1997@06:30   TEMPERATURE</td>
<td>NURSUSER,SEVEN</td>
</tr>
<tr>
<td>Reason: incorrect reading</td>
<td></td>
</tr>
<tr>
<td>(Revised) 102.1 F (38.9 C)* (ORAL)</td>
<td></td>
</tr>
<tr>
<td>(Bad data) 102 F (38.9 C)* (ORAL)</td>
<td></td>
</tr>
<tr>
<td>FEB 25, 1997@06:30   PAIN</td>
<td>NURSUSER,SEVEN</td>
</tr>
<tr>
<td>Reason: incorrect reading</td>
<td></td>
</tr>
<tr>
<td>(Revised) 3</td>
<td></td>
</tr>
<tr>
<td>(Bad data) 5</td>
<td></td>
</tr>
</tbody>
</table>

Data might not appear in the Revised Data column under certain conditions, for example, when original data was associated with another patient.

**Menu Access:**

The Print Vitals Entered in Error for a Patient option is accessed through the Vitals/Measurements Results Reporting option of the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.

---

1 Patch NUR*4*23 February 1999
Vitals/Measurements

NURCPP-VIT-SF511

V/M Graphic Reports

Description:

1. This option provides the user with 5 different reports, the first is a report simulating the Standard Form 511 - Vital Signs Record (Vital Flow Sheet), second is a B/P Plotting Chart, third is a Weight Chart, fourth is a Pulse Oximetry/Respiratory Graph, and last is a Pain Chart. Patient information contained in this report is stored in the GMRV Vital Measurement (#120.5) file, and the GMRY Patient I/O (#126) file.

Additional Information:

2. The information printed in this report was entered through the Vitals/Measurements and the GMRY Intake and Output applications. All 24 hour intake and output totals are in cubic centimeters (i.e., milliliters). Reports can be printed by selected patient, for all patients on a ward, and for patients in a specific hospital room/bed. Refer to Printer Issues in the Package Management section for additional information on setting up Kyocera F-800A and Hewlett-Packard LaserJet printers for printing linear graphic reports. Users may print the graphic reports using a dot matrix printer, data plotted is not connected by lines. Only radial, brachial, and apical pulses are plotted on the graph, all pulses appear on the table below the graph in the Vital Signs Record. The reason for omission will display on all the graphic reports.

Menu Display:

Select Vitals/Measurement Option: 2 Vitals/Measurements Results Reporting

1. V/M Graphic Reports
2. Latest Vitals Display for a Patient
3. Latest Vitals by Location
4. Cumulative Vitals Report
5. Print Vitals Entered in Error for a Patient

Screen Prints:

Select Vitals/Measurements Results Reporting Option: 1 V/M Graphic Reports
1 Vital Signs Record
2 B/P Plotting Chart
3 Weight Chart
4 Pulse Oximetry/Respiratory Graph
5 Pain Chart

Select a number between 1 and 5: 1 Vital Signs Record// <RET>

Vitals by (A)ll patients on a ward, (S)elected Rooms on ward, or (P)atient? P

Enter the patient's name.

Select PATIENT NAME: NURSPATIENT6,THREE 01-19-25 000632111
NSC VETERAN

Enter appropriate start date.

Start DATE (TIME optional): T-7//4/1/97 (APR 01, 1997)

Enter appropriate end date.

Go to DATE (TIME optional): NOW//4/22/97 (APR 22, 1997)

DEVICE: Enter appropriate response

This report must be queued to a line printer or sent to a slave printer configured to print a 132 column report.

The following is an example of an SF511 (Vital Signs Record) graph sent to a dot matrix printer:

---

1 Patch NUR*4*23 February 1999
2 Patch NUR*4*4 August 1997
3 Patch NUR*4*4 August 1997
4 Patch NUR*4*4 August 1997
<table>
<thead>
<tr>
<th>Vitals/Measurements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date/Time</strong></td>
</tr>
<tr>
<td><strong>Pulse Temp/F/C</strong></td>
</tr>
<tr>
<td><strong>Temperature</strong></td>
</tr>
<tr>
<td><strong>Pulse</strong></td>
</tr>
<tr>
<td><strong>Respiration</strong></td>
</tr>
<tr>
<td><strong>Blood Pressure</strong></td>
</tr>
<tr>
<td><strong>Pulse Ox.</strong></td>
</tr>
<tr>
<td><strong>Respiration</strong></td>
</tr>
<tr>
<td><strong>Body Mass Index</strong></td>
</tr>
<tr>
<td><strong>Weight (lb)</strong></td>
</tr>
<tr>
<td><strong>Height (in)</strong></td>
</tr>
<tr>
<td><strong>Output (24 Hr) (cc)</strong></td>
</tr>
<tr>
<td><strong>Intake (24 Hr) (cc)</strong></td>
</tr>
<tr>
<td><strong>Pain</strong></td>
</tr>
</tbody>
</table>

1. Patch NUR*4*4  August 1997
2. Patch NUR*4*24  May 1999

The B/P Plotting Chart, Weight Chart, Pulse Oximetry/Respiratory Graph, and Pain Chart have basically the same appearance with different data. When printing these graphic reports to a Kyocera F-800A or a Hewlett-Packard LaserJet printer, the data on the graph will be connected with lines.
Menu Access:

The V/M Graphic Reports option is accessed through the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
Chapter 5 Intake and Output

NURCPE-I/O-EDIT

Intake/Output Data Entry Menu

Description:

This is the main menu for the Intake and Output (I&O) application. It contains options for: (1) documenting patient intake and output, (2) starting and discontinuing IV lines and fluids, (3) documenting IV care, and (4) printing various intake and output reports. Data is stored in the GMRY Patient I/O (#126) file.

Additional Information:

The options found in this menu should be assigned to appropriate nursing personnel in accordance with Nursing Service policy.

This information is used in the following options:
- Print I/O Summary by Patient (by Shift & Day(s))
- Print I/O Summary (Midnight to Present)
- Print I/O Summary (48 Hrs)
- 24 Hours Itemized Shift Report
- Intravenous Infusion Flow Sheet
- End of Shift Report

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)
Intake and Output

Select Nursing Features (all options) Option: 5 Patient Care Data, Enter/Edit

- Classification, Edit Patient ...
- Evaluation/Target Date & Order Status Edit
- Intake/Output Data Entry Menu ...
- Location/Bed Section, Edit Nursing
- Patient Plan of Care, Edit
- Vitals/Measurements Data Entry Menu ...

Select Patient Care Data, Enter/Edit Option: Intake/Output Data Entry Menu

1 Enter/Edit Patient Intake
2 Enter/Edit Patient Output
3 Start/Add/DC IV and Maintenance

Menu Access:

The Intake/Output Data Entry Menu option is accessed through the Patient Care Data, Enter/Edit option of the Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
NURCPE-I/O-INTAKE

Enter/Edit Patient Intake

Description:

This option allows the user to enter or edit patient intake records (e.g., oral, IV, and nasogastric). Data is stored in the GMRY Patient I/O (#126) file. Refer to Chapter 2, Maintenance of Site Files for editing associated files.

Additional Information:

Enter/Edit Patient Intake is the primary option used to enter patient intake. You will note that two (2) columns display after the patient's hospital location or patient's name is entered:

<table>
<thead>
<tr>
<th>1</th>
<th>PO</th>
<th>6</th>
<th>PO</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>IV Access</td>
<td>7</td>
<td>Tube Feeding</td>
</tr>
<tr>
<td>3</td>
<td>Tube Feeding</td>
<td>8</td>
<td>Irrigation</td>
</tr>
<tr>
<td>4</td>
<td>Irrigation</td>
<td>9</td>
<td>Other</td>
</tr>
<tr>
<td>5</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The column on the left side of the screen, permits a user to document only the total intake (in milliliters) associated with a specific intake type (PO, IV, etc.). The column on the right allows users to document the names of specific liquids, fluids, solutions, etc. associated with an intake type. The documenting of specific IV fluids is accomplished through the Start/Add/DC IV and Maintenance option explained later in this chapter. If a user does not document that an IV has been started on a patient through the Start/Add/DC IV and Maintenance option, the software will not allow the user to chart an IV intake amount through this option.

The Intake and Output application does NOT automatically calculate the IV intake totals; this data must be manually entered. Although the intake amount could be calculated based on the date/time the IV solution was hung, the variables adversely affecting the flow rate and producing an erroneous IV intake, counter indicate the automatic calculation of the intravenous intake.

The Enter/Edit Patient Intake option prompts you after you have entered the intake, to enter the patient's output. This was done to simplify the I&O process and save time. The prompt's response is defaulted to YES but you can answer N (for NO) if there is no output at this time.

This software does not prevent intake and output measurements from being entered for patients on leave status, (e.g., authorized, unauthorized) or those that are deceased. When the date and time the data was collected is later than the date/time the patient died or was placed on leave, the software displays a reminder. Following this message, the user may continue entering data.
A patient's I&O information is printed on the following reports:
  - Print I/O Summary by Patient (by Shift & Day(s))
  - Print I/O Summary (Midnight to Present)
  - Print I/O Summary (48 Hrs)
  - 24 Hours Itemized Shift Report

Information on a patient's detailed intake is printed on the 24 Hours Itemized Shift Report.

**Restrictions:**

Data can only be edited for the previous 48 hour period. Future data cannot be entered.

**Menu Display:**

Select Patient Care Data, Enter/Edit Option: Intake/Output Data Entry Menu

1 Enter/Edit Patient Intake
2 Enter/Edit Patient Output
3 Start/Add/DC IV and Maintenance

**Screen Prints:**

Select Intake/Output Data Entry Menu Option: 1 Enter/Edit Patient Intake by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? P

Select PATIENT NAME: NURSPATIENT6,THREE 01-19-25 000632111 NSC VETERAN

Enter patient name.

Select HOSPITAL LOCATION: If the patient is an outpatient, the hospital location prompt displays.

The following example demonstrates the use of the left column for documenting ingested items. More than one (1) entry can be entered by separating numbers by a comma (',') or a hyphen ('-') for a range of numbers.
Note: The following screen display can be edited through the Intake Type option (refer to Chapter 2).

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>PO</td>
</tr>
<tr>
<td>2</td>
<td>IV ACCESS</td>
</tr>
<tr>
<td>3</td>
<td>TUBE FEEDING</td>
</tr>
<tr>
<td>4</td>
<td>IRRIGATION</td>
</tr>
<tr>
<td>5</td>
<td>OTHER</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>PO</td>
</tr>
<tr>
<td>7</td>
<td>TUBE FEEDING</td>
</tr>
<tr>
<td>8</td>
<td>IRRIGATION</td>
</tr>
<tr>
<td>9</td>
<td>OTHER</td>
</tr>
</tbody>
</table>

Select from 1 to 9 (enter 1,3-5 etc.) or "^" to quit: 1

Enter intake: PO

No records in the database within the last 48 hours

Note: The system alerts the user when no information for this intake type has been recorded in the previous 48 hours. If entries are present the program displays data entered within the last 48 hours and a prompt which allows the user to edit, delete and add a new entry, (i.e., Select a number (i.e., 1 to edit; 1@ to delete or N to add; ^ to quit selection) 6).

Please enter a new DATE/TIME: T@0902 (DEC 28,1992@09:02:00)

Enter appropriate date/time.

Enter PO dated DEC 28,1992@09:02

Unit ml is not required.

TOTAL AMOUNT: 560

Enter the intake volume. Ml does not have to be entered after the volume.

Total PO intake for this time: 560 mls

Do you want to enter OUTPUT? Yes// <RET> (Yes)

Enter 'N' to exit if there is no output for this patient.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>URINE</td>
</tr>
<tr>
<td>2</td>
<td>N/G</td>
</tr>
<tr>
<td>3</td>
<td>EMESIS</td>
</tr>
<tr>
<td>4</td>
<td>DRAINAGE</td>
</tr>
<tr>
<td>5</td>
<td>FECES</td>
</tr>
<tr>
<td>6</td>
<td>OTHER</td>
</tr>
</tbody>
</table>

Select from 1 to 6 (enter 1,3-5 etc.) or "^" to quit: URINE/<RET>

Note: The above screen display can be changed/edited through the Output Type option.

Enter output: URINE

Urine is the default, but the user may enter another output type from the above list.

No records in the database within the last 48 hours
Note: The system alerts the user when no information for this output type has been documented in the previous 48 hours. If entries are present the program displays those entered within the last 48 hours.

Please enter a new DATE/TIME: N (DEC 28,1996@09:05:04)

Enter appropriate date/time.

Enter URINE dated DEC 28,1996@09:05
Unit ml is not required

1. VOIED
2. FOLEY CATHETER
3. SUPRAPUBLIC CATHETER

Note: The above screen display of urine subtypes can be adjusted by editing the Output Subtype file through the Configure I/O Files (ADP Coordinator Only) option.

You may document how the output was obtained by entering a urine output subtype (i.e., voided, foley catheter, suprapubic catheter). If you do not wish to enter a subtype, enter <RET>. The user is then asked to enter an amount that is a numeric entry; you do not have to enter cc/ml. If the actual amount cannot be determined, an estimated amount using S = small, M = medium, and L = large may also be entered.

Select a number for the URINE SUBTYPE(optional): 2
FOLEY CATHETER

Enter appropriate subtype.

Enter numeric value for measured output in cc/ml or enter S(mall), M(edium) or L(arge) for estimated output.

OUTPUT AMOUNT: 340

The following example demonstrates patient intake using specific entries (right column). This display can be changed by editing the intake type data through the Intake Type option (refer to chapter 2).

Select Patient Intake/Output Menu Option: 1 Enter/Edit Patient Intake by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? P

Select PATIENT NAME: NURSPATIENT6,THREE 01-19-25 000632111 NSC VETERAN

1      PO                                6     PO
2      IV ACCESS                         7     TUBE FEEDING
3      TUBE FEEDING                      8     IRRIGATION
4      IRRIGATION                        9     OTHER
5      OTHER

Detailed input from 6 to 9
Select from 1 to 9 (enter 1,3-5 etc.) or "^" to quit: 6,7
Enter intake: PO
   1. DEC 28,1996@09:02      Total: 560 mls

In this example, the software displays the previous oral intake (documented within the last 48 hours).

Select a number (i.e., 1 to edit; 1@ to delete or N to add; ^ to quit selection): N

You can edit the previous entry, delete the entry or enter 'N' for a new entry.

Please enter a new DATE/TIME: T@1115  (DEC 28,1996@11:15)

Enter appropriate date/time. Time can be entered for the past 48 hours or the present, but cannot be entered in the future.

A list of items from the Intake Items file is displayed.

SOUP     120   mls
ICE CREAM 50   mls
JELLO     75   mls
MILK      240  mls
TEA       150  mls
WATER     125  mls
COFFEE    150  mls
JUICE     125  mls
SODA      360  mls

Intake items are specific to the facility. The ADP coordinator is responsible for maintaining the Intake Items file through the Configure I/O Files (ADP Coordinator Only) option.

Enter PO dated DEC 28,1996@11:15
   Unit ml is not required.

Select INTAKE ITEM: SOUP

Enter appropriate intake item.

VOLUME: 120// 150

Enter amount ingested. The user may either accept the default by entering <RET> or enter a different amount.

Select INTAKE ITEM: MILK
   VOLUME: 240/<RET>
Select INTAKE ITEM:<RET>
The software displays a total intake volume associated with this oral intake type.

Total PO intake for this time: 390 mls

Enter intake: TUBE FEEDING

No records in the database within the last 48 hours
Please enter a new DATE/TIME: N (DEC 28,1996@11:15:20)

Enter appropriate date/time.

A list of items found in the Intake Items file is displayed.

- MILK 240 mls
- WATER 125 mls
- SOUP 180 mls
- SUSTACAL 240 mls

You may have more or less items listed, depending on what the ADP coordinator entered into the Intake Items file through the Configure I/O Files (ADP Coordinator Only) option.

Enter TUBE FEEDING dated DEC 28,1996@11:15
Unit ml is not required.
Select INTAKE ITEM: SOUP

Enter the tube feeding product.

VOLUME: 180// 300

Enter amount ingested.

Select INTAKE ITEM: WATER
VOLUME: 125// 60
Select INTAKE ITEM: <RET>

Total TUBE FEEDING intake for this time: 360 mls

Do you want to enter OUTPUT? Yes// N (No)

IV Access.

Under this option, the user is able to enter the amount of the IV solution left in the container at the end of the shift or at any time an IV intake total must be entered. The Start/Add/DC IV and Maintenance option does not automatically calculate an accurate amount of absorbed solution per shift.

Select Patient Intake/Output Menu Option: 1 Enter/Edit Patient Intake by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? P
Select PATIENT NAME: NURSPATIENT6,THREE 01-19-25 000632111 NSC VETERAN

Detailed input from 6 to 9
1    PO
2    IV ACCESS
3    TUBE FEEDING
4    IRRIGATION
5    OTHER
6    PO
7    TUBE FEEDING
8    IRRIGATION
9    OTHER

Select from 1 to 9 (enter 1,3-5 etc.) or "^" to quit: 2
Enter intake: IV ACCESS

1. D5W 1000 mls 1000 mls (A) LEFT HAND Started on FEB 11,1996@10:39

The software displays a list of the patient's IVs that were entered through the Start/Add/DC IV and Maintenance option.

Enter the number of the IV you wish to enter/edit INTAKE: 1
Enter IV INTAKE for D5W 1000 mls A LEFT HAND 1000 mls
Started @FEB 11,1996@10:39
Total amount absorbed: 0 mls

The software indicates the total IV intake previously documented through the option and associated with this IV.

No intake records for this IV line within the last 48 hours

If no IV intake was entered, the display appears on the screen.

Please enter a new DATE/TIME: @1500 (FEB 11, 1996@15:00:00)

Enter ADMIXTURE intake dated FEB 11,1996@15:00
Enter * for AMOUNT LEFT if amount of solution absorbed is unknown.
Unit mls is not required.

AMOUNT LEFT: 600

This is the amount of the IV solution left at 1500 hours or 3pm.

Intake for this period: 400 mls ? Yes/<RET> (Yes)

This is the amount of IV fluid absorbed from the 1000 ml bag from the time it was started at 10:39am this morning..

Do you want to enter OUTPUT? Yes// N (No)

Menu Access:

The Enter/Edit Patient Intake option is accessed through the Intake/Output Data Entry Menu option of the Patient Care Data, Enter/Edit option of the Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
NURCPE-I/O-OUTPUT

Enter/Edit Patient Output

Description:

This option allows user to enter or edit patient output records only. Patient data is stored in the GMRY Patient I/O (#126) file.

Additional Information:

This option only permits entry of OUTPUT. URINE and DRAINAGE are the only output types with associated output subtypes, (e.g., foley, voided), but entering data for these subtypes is optional.

Patient output information is printed in the following options:
- Print I/O Summary by Patient (by Shift & Day(s))
- Print I/O Summary (Midnight to Present)
- Print I/O Summary (48 Hrs)
- 24 Hours Itemized Shift Report

A report of a patient's detailed output is found on the 24 Hours Itemized Shift Report.

Restrictions:

Data can only be edited for the previous 48 hour period. Future data cannot be entered.

Menu Display:

Select Patient Care Data, Enter/Edit Option: Intake/Output Data Entry Menu

1   Enter/Edit Patient Intake
2   Enter/Edit Patient Output
3   Start/Add/DC IV and Maintenance

Screen Prints:

Select Intake/Output Data Entry Menu Option: 2   Enter/Edit Patient Output
by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? P

Select PATIENT NAME: NURSPATIENT6,EIGHT   04-25-38   000222111
If the patient is an outpatient and/or placed on a ward for 23 hour observation, the hospital location prompt displays.

Select HOSPITAL LOCATION: 1 EAST

1. URINE
2. N/G
3. EMESIS
4. DRAINAGE
5. FECES
6. OTHER

Select from 1 to 6 (enter 1,3-5 etc.) or "^" to quit: URINE/<RET>

Enter output: URINE
1. FEB 2,1996@08:00 245 mls VOIDED
2. FEB 1,1996@14:24 455 mls FOLEY CATHETER
3. FEB 1,1996@09:49 100 mls SUPRAPUBLIC CATHETER

Select a number (i.e., 1 to edit; 1@ to delete or N to add; ^ to quit selection): N

Please enter a new DATE/TIME: @0845 (FEB 02, 1996@08:45:00)

Enter date/time of output.

Enter URINE dated FEB 2,1996@08:45
Unit ml is not required

1. VOIDED
2. FOLEY CATHETER
3. SUPRAPUBLIC CATHETER

Select a number for the URINE SUBTYPE (optional): 1

Enter numeric value for measured output in cc/ml or enter S(mall), M(edium) or L(arge) for estimated output.

OUTPUT AMOUNT: S// 240

DELETING ERRORS: The entry number, followed by an @ deletes the entry as shown below.

Select Patient Intake/Output Menu Option: 2 Enter/Edit Patient Output by (A)ll patients on a unit, (S)elected Rooms on unit, or (P)atient? P

Select PATIENT NAME: NURSPATIENT6,EIGHT 04-25-38 000222111

If the patient is an outpatient, the hospital location prompt displays.

Select HOSPITAL LOCATION: 1 EAST
Intake and Output

1  URINE
2  N/G
3  EMESIS
4  DRAINAGE
5  FECES
6  OTHER
Select from 1 to 6 (enter 1,3-5 etc.) or "^" to quit: URINE/<RET>

Urine is the software's default response.

Enter output: URINE
1.   FEB 2,1996@08:45              240 mls   VOIDED
2.   FEB 2,1996@08:00              245 mls   VOIDED
3.   FEB 1,1996@14:24              455 mls   FOLEY CATHETER
4.   FEB 1,1996@09:49              100 mls   SUPRAPUBIC CATHETER

Select a number(i.e., 1 to edit; 1@ to delete or N to add; ^ to quit selection): 2@

Select the entry to be deleted.

Are you sure you want to delete this record? Yes/<RET>   (Yes)

URINE Entered on FEB 2,1996@08:00 has been deleted!!!

The user can reenter the date/time and enter the correct amount if appropriate.

Menu Access:

The Enter/Edit Patient Output option is accessed through the Intake/Output Data Entry Menu option of the Patient Care Data, Enter/Edit option of the Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
NURCPE-I/O-IV CARE

Start/Add/DC IV and Maintenance

Description:

This option contains seven protocols associated with intravenous therapy:
1. Start IV - Start a new IV line or heparin/saline lock/port.
2. Solution: Replace/DC/Convert/Finish Solution - DC current solution then replace a new solution to the selected IV line or convert the IV according to the user's choice.
3. Replace Same Solution - Replace the same solution to a selected IV.
4. D/C IV Lock/Port and Site - Remove IV/lock/port from a selected IV site.
5. Care/Maintenance/Flush - Check site condition, dressing change, tube change and flush.
6. Add Additional Solutions(s) - Add additional solution(s) without discontinuing an existing one.
7. Restart DC'd IV - Restart an IV which was DC'd due to infiltration or other reasons.
8. Adjust Infusion Rate - Adjust infusion rate for a selected IV.
9. Flush - Flush all IV line(s) for a selected infusion site.

Information on a patient's IV line, solutions hung and absorbed, IV site care, etc., are stored in the GMRY Patient I/O (#126) file.

Additional Information:

A patient's IV intake cannot be documented through the Enter/Edit Patient Intake option (IV ACCESS) until an IV has been started through the Start IV option. This software option does not automatically calculate the amount of fluid absorbed during a specific 8 hour shift. There are multiple variables influencing the fluid's absorption rate (such as positioning, pathway, etc.), therefore, the total IV volume absorbed per shift must be manually entered through the Enter/Edit Patient Intake option (IV ACCESS). When the intake of an IV is unknown, the nurse may document this unknown amount by entering an asterisk (*).

The patient data entered through this option is reflected in the following reports:
   - 24 Hours Itemized Shift Report
   - Intravenous Infusion Flow Sheet

Restrictions:

Data can only be edited for the previous 48 hour period. Future data cannot be entered.
Menu Display:

Select Patient Care Data, Enter/Edit Option: Intake/Output Data Entry Menu

1. Enter/Edit Patient Intake
2. Enter/Edit Patient Output
3. Start/Add/DC IV and Maintenance

Screen Prints:

The following pages contain separate examples of each option’s use. There is no continuity in IV displays between individual examples.

Select Intake/Output Data Entry Menu Option: 3 Start/Add/DC IV and Maintenance
Select PATIENT NAME: NURSPATIENT6,THREE 11-04-85 000334443
500-3 NO NSC VETERAN

When the patient is an outpatient, a Hospital Location prompt appears and the patient’s clinic or ward should be entered. If the patient is an inpatient, the location prompt does not appear.

1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

1a. Start IV using a single lumen catheter.

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 1

*** START IV ***

There is no IV running for this patient.

Start new IV

Please enter a new DATE/TIME: N (FEB 14, 1997@14:39:34)
Select from the following IV sites

1. HAND
2. WRIST
3. LOWER ARM
4. UPPER ARM
5. ANTECUBITAL
6. SUBCLAVIAN
7. JUGULAR
8. ANKLE/FOOT
9. LEG
10. FEMORAL
11. UMBILICAL
12. PEDAL
Enter a number with a qualifier L for LEFT/R for RIGHT, default (L)eft.
(e.g., 2R for RIGHT WRIST; 2 or 2L for LEFT WRIST): 3

LEFT LOWER ARM

The ADP coordinator can add entries to the display list through the Configure I/O Files option, specifically the IV Site option.

Select from the following IV CATHS

1. ANGIO CATH-14
2. ANGIO CATH-16
3. ANGIO CATH-18
4. ANGIO CATH-20
5. ANGIO CATH-22
6. BUTTERFLY-16
7. BUTTERFLY-18
8. NEEDLE 1 1/4 IN-14
9. NEEDLE 1 1/4 IN-16
10. NEEDLE 1 1/4 IN-18
11. BUTTERFLY-20
12. TRIPLE LUMEN CVP
13. RA-PA CATH
14. VENOUS INTRODUCER
15. HICKMAN LOCK
16. DOUBLE LUMEN PERIPHERAL
17. SUBCLAVIAN
18. DOUBLE LUMEN SUBCLAVIAN
19. DOUBLE LUMEN 1
20. TRIPLE LUMEN 1
21. ANGIOCATH-14

Select a number between 1 and 21: 3

The ADP coordinator can add entries to the display list through the Configure I/O Files option, specifically the IV Catheter option.

Select one of the IV types listed below
A - admixture
B - blood/blood product
H - hyperal
I - intralipid
P - piggyback
L - locks/ports
Please enter a character: A admixture

Active pharmacy IV order for the patient:
1.5% DEXTROSE; HEPARIN 1,000 U/ML .05 UNITS; AMPHOTERICIN-B 50MG... 1000 100 ml/hr

Select a number between 1 and 1: <RET>

Enter Return to bypass the pharmacy orders and to select an entry from the Nursing Solution file.

Select a(n) admixture from the following Nursing Solution file listing
Enter a number/name for your selection,  
Enter additional vitamins/electrolytes using a ; to separate,  
for example, 4; multivits): **13**

The ADP coordinator can add entries to the display list through the Configure I/O Files option, specifically the IV Solution option.

Amount of solution in mls in the container: 1000/<RET>
Enter a number for infusion rate (Example: 125 = 125 ml/hr): **50**
D5W.2%NS (1000) admixture 1000 mls 50 ml/hr Is it correct? Yes/<RET> (Yes)
D5W.2%NS (1000) (A) 1000 mls (02/14/97@14:39)  
Do you want to add another solution to this line? No/<Y> (Yes)
Select one of the IV types listed below  
A - admixture  
B - blood/blood product  
H - hyperal  
I - intralipid  
P - piggyback  
L - locks/ports  
Please enter a character: **P** piggyback

No pharmacy active IV order for this patient

Select a(n) piggyback from the following Nursing Solution file listing

1. OTHER 0 mls  
2. D5W (50) 50 mls
If you select 1 for OTHER, you are asked to enter the name of an IV solution. For example:

Enter a number/name for your selection,  
Enter additional vitamins/electrolytes using a ; to separate,  
for example, 4; multivits): **1**
Please SPECIFY the name of the solution
(maximum 75 characters): AMPICILLIN 1GM in NS.9%

The user may type in the name of any solution or blood/blood product that is not longer than 75 characters.

AMPICILLIN 1GM in NS.9%  ? Yes\<RET> (Yes)
Amount of solution in mls in the container: 0\<RET> 50
Enter a number for infusion rate (Example: 125 = 125 ml/hr): 100
AMPICILLIN 1GM in NS.9% piggyback 50 mls 100 ml/hr Is it correct ?
Yes\<RET> (Yes)
D5W.2%NS (1000) (A) 1000 mls (02/14/97@14:39)
AMPICILLIN 1GM in NS.9% (P) 50 mls (02/14/97@14:39)
Do you want to add another solution to this line? No\<RET> (No)

If you entered YES, you can enter more solutions to the same IV site.

1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

1b. Start IV using a multi-lumen catheter.

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 1

*** START IV ***

Current IV(s):

1. LEFT LOWER ARM - ANGIO CATH-18
   D5W.2%NS (1000) (A) 50 ml/hr Started on 02/14/97@14:39
2. LEFT LOWER ARM - ANGIO CATH-18
   AMPICILLIN 1GM in NS.9% (P) 100 ml/hr Added on 02/14/97@14:39

Start new IV

Please enter a new DATE/TIME: n (FEB 14, 1997@14:44:35)
Select from the following IV sites

1. HAND 7. JUGULAR
2. WRIST 8. ANKLE/FOOT
3. LOWER ARM 9. LEG
4. UPPER ARM 10. FEMORAL
5. ANTECUBITAL 11. UMBILICAL
6. SUBCLAVIAN 12. PEDAL
Select from the following IV CATHs

1. ANGIO CATH-14                        12. TRIPLE LUMEN CVP
2. ANGIO CATH-16                        13. RA-PA CATH
3. ANGIO CATH-18                        14. VENOUS INTRODUCER
4. ANGIO CATH-20                        15. HICKMAN LOCK
5. ANGIO CATH-22                        16. DOUBLE LUMEN PERIPHERAL
6. BUTTERFLY-16                         17. SUBCLAVIAN
7. BUTTERFLY-18                         18. DOUBLE LUMEN SUBCLAVIAN
8. NEEDLE 1 1/4 IN-14                   19. DOUBLE LUMEN 1
9. NEEDLE 1 1/4 IN-16                   20. TRIPLE LUMEN 1
10. NEEDLE 1 1/4 IN-18                  21. ANGIOCATH-14
11. BUTTERFLY-20

Select a number between 1 and 21: 20

The ADP coordinator can add entries to the display list through the Configure I/O Files option, specifically the IV Catheter option.

1  DISTAL
2  MEDIAL
3  PROXIMAL

Select the port number used for medication infusion or ^ to quit: 1

Select one of the IV types listed below
A - admixture
B - blood/blood product
H - hyperal
I - intralipid
P - piggyback
L - locks/ports

Please enter a character: a admixture

Pharmacy active IV order for the patient:
1.5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG... 1000 100 ml/hr

Select a number between 1 and 1: 1

Amount of solution in mls in the container: 1000// <RET>

Enter a number for infusion rate (Example: 125 = 125 ml/hr): 100// <RET>

5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG... admixture

1000 mls  100 ml/hr  Is it correct ? Yes// <RET>

(Yes)
The user could have added another solution to the distal port. After the documentation specific to the distal port is completed, the user is again prompted with the list of ports. Documentation of a solution associated with another port can then be entered.

1 DISTAL
2 MEDIAL
3 PROXIMAL

Select the port number used for medication infusion or ^ to quit: 3

Select one of the IV types listed below
A - admixture
B - blood/blood product
H - hyperal
I - intralipid
P - piggyback
L - locks/ports

Please enter a character: h hyperal

pharmacy active IV order for the patient:
1.DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;... 1000 100 ml/hr

Select a number between 1 and 1: 1
Amount of solution in mls in the container: 1000// <RET>
Enter a number for infusion rate (Example: 125 = 125 ml/hr): 100// <RET>
DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;... hyperal
1000 mls 100 ml/hr Is it correct ? Yes// <RET>
(Yes)

DISTAL
5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG... (A)
1000 mls (02/14/97@14:44)

PROXIMAL
DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;... (H)
1000 mls (02/14/97@14:44)

Do you want to add another solution to PROXIMAL port? No// <RET> (No)

1 DISTAL
2 MEDIAL
3 PROXIMAL

Select the port number used for medication infusion or ^ to quit: ^

Note: The users must ^ to exit, otherwise an ERROR ENTRY prompt displays.
1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

1c. Hanging a unit of blood or blood products.

Select from 1 to 9 (enter 1, 3-5 etc.) or <RET> to exit: 1

** START IV ***

The IV line supporting blood transfusions can be supported by starting an IV using normal saline (NS) and adding the blood/blood product to the main line.

Current IV(s):

1. LEFT SUBCLAVIAN - TRIPLE LUMEN 1   DISTAL
   LOCK/PORT   Converted on 02/14/97@15:03

2. LEFT SUBCLAVIAN - TRIPLE LUMEN 1   MEDIAL
   D5W.2%NS (500) (A) 30 ml/hr   Added on 02/14/97@14:53

3. LEFT SUBCLAVIAN - TRIPLE LUMEN 1   PROXIMAL
   DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;... (H)
   100 ml/hr   Added on 02/14/97@14:44

Start new IV

Please enter a new DATE/TIME: n  (FEB 14, 1997@15:05:23)

Select from the following IV sites

1. HAND                                 7. JUGULAR
2. WRIST                                8. ANKLE/FOOT
3. LOWER ARM                            9. LEG
4. UPPER ARM                            10. FEMORAL
5. ANTECUBITTAL                         11. UMBILICAL
6. SUBCLAVIAN                           12. PEDAL

Enter a number with a qualifier L for LEFT/R for RIGHT, default (L)eft.
(e.g., 2R for RIGHT WRIST; 2 or 2L for LEFT WRIST): 2r
RIGHT WRIST

The ADP coordinator can add entries to the display list through the Configure I/O Files option, specifically the IV Site option.
Select from the following IV CATHs

1. ANGIO CATH-14                        12. TRIPLE LUMEN CVP
2. ANGIO CATH-16                        13. RA-PA CATH
3. ANGIO CATH-18                        14. VENOUS INTRODUCER
4. ANGIO CATH-20                        15. HICKMAN LOCK
5. ANGIO CATH-22                        16. DOUBLE LUMEN PERIPHERAL
6. BUTTERFLY-16                         17. SUBCLAVIAN
7. BUTTERFLY-18                         18. DOUBLE LUMEN SUBCLAVIAN
8. NEEDLE 1 1/4 IN-14                   19. DOUBLE LUMEN 1
9. NEEDLE 1 1/4 IN-16                   20. TRIPLE LUMEN 1
10. NEEDLE 1 1/4 IN-18                  21. ANGIOCATH-14
11. BUTTERFLY-20

Select a number between 1 and 21: 1

The ADP coordinator can add entries to the display list through the Configure I/O Files option, specifically the IV Catheter option.

Select one of the IV types listed below
   A - admixture
   B - blood/blood product
   H - hyperal
   I - intralipid
   P - piggyback
   L - locks/ports

Please enter a character: a admixture

Pharmacy active IV order for the patient:
1.5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG... 1000 100 ml/hr

Select a number between 1 and 1: <RET>

Select a(n) admixture from the following Nursing Solution file listing

1. OTHER  0 mls                         15. D5W.2%NS (500)  500 mls
2. 1/2 NS (1000) 1000 mls               16. D5W.9NS (1000)  1000 mls
3. 1/2 NS (500)  500 mls                17. D5W.9NS (250)  250 mls
4. 10% DEXTRAN 40  500 mls              18. D5W.9NS (500)  500 mls
5. D10W (1000)  1000 mls                19. D5W1/2NS (1000) 1000 mls
6. D10W.9NS (1000) 1000 mls             20. D5W1/2NS (250)  250 mls
7. D10W1/2NS (1000) 1000 mls            21. D5W1/2NS (500)  500 mls
8. D5.2NS  1000 mls                     22. KCL 20MEQ (50)  50 mls
9. D5W (250)  250 mls                   23. LACTATED RINGERS (1000)  1000 mls
10. D5W (500)  500 mls                  24. NS  500 mls
11. D5W(1000) 1000 mls                 25. NS.9% (1000) 1000 mls
12. D5W.2%NS (100) 100 mls              26. NS.9% (250)  250 mls
13. D5W.2%NS (1000) 1000 mls            27. NS.9% (500)  500 mls
14. D5W.2%NS (250) 250 mls              28. SODIUM BICARBINATE 5%(500) 500 mls

Enter a number/name for your selection,
Enter additional vitamins/electrolytes using a ; to separate,for example, 4;multivits): 24
Intake and Output

Amount of solution in mls in the container: 500/<RET>
Enter a number for infusion rate (Example: 125 = 125 ml/hr): 30
NS admixture  500 mls  30 ml/hr  Is it correct? Yes/<RET>  (Yes)
   NS (A)  500 mls  (02/14/97@15:05)
Do you want to add another solution to this line? No/<RET>  (No)

To document the hanging of blood, use the Add Additional Solution(s) protocol.

1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

Select from 1 to 9 (enter 1, 3-5 etc.) or <RET> to exit: 6
*** ADD ADDITIONAL SOLUTION(S) ***

1. LEFT SUBCLAVIAN - TRIPLE LUMEN 1
   DISTAL
   LOCK/PORT (02/14/97@15:03)
   MEDIAL
   D5W.2%NS (500) (A)  500 mls  (02/14/97@14:53)
   PROXIMAL
   DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;... (H)
   1000 mls  (02/14/97@14:44)
2. RIGHT WRIST - ANGIO CATH-14
   NS (A)  500 mls  (02/14/97@15:05)

Select an IV site to add additional solutions: 2
Please enter a new DATE/TIME: n  (FEB 14, 1997@15:06:56)
Select one of the IV types listed below
   A - admixture
   B - blood/blood product
   H - hyperal
   I - intralipid
   P - piggyback
   L - locks/ports
   Please enter a character: b  blood/blood product

No pharmacy active IV order for this patient
Select a(n) blood/blood product from the following Nursing Solution file listing:

1. OTHER  0 mls
2. CRYOPRECIPITATE  150 mls
3. FRESH FROZEN PLASMA  100 mls
4. PACKED RBC  350 mls
5. PLATELETS  100 mls
6. WHOLE BLOOD  450 mls

Note: Only solutions designated as blood/blood products will display. If you are required to document the blood control #, select 1 (for Other) and enter the type of blood/product with the control #.

Enter a number/name for your selection, Enter additional vitamins/electrolytes using a ; to separate, for example, 4;multivits): 4
Amount of solution in mls in the container: 350 // <RET>
Enter a number for infusion rate (Example: 125 = 125 ml/hr): 100
PACKED RBC  blood/blood product  350 mls  100 ml/hr  Is it correct? Yes // <RET>
(Yes)
NS (A)  500 mls  (02/14/97@15:05)
PACKED RBC (B)  350 mls  (02/14/97@15:06)
Do you want to add another solution to this line? No // <RET>  (No)

If you entered YES, you can enter more solutions to the same IV site.

1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

2a. Discontinuing/converting an IV solution using Solution: Replace/DC/Convert/Finish Solution.

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 2
*** SOLUTION: REPLACE/DC/CONVERT/FINISH SOLUTION ***

All running IV's are listed.

1. LEFT SUBCLAVIAN - TRIPLE LUMEN 1  MEDIAL
   D5W.2%NS (500) (A) 30 ml/hr Added on 02/14/97@14:53

2. LEFT SUBCLAVIAN - TRIPLE LUMEN 1  DISTAL
   5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG... (A)
   100 ml/hr Started on 02/14/97@14:44
3. LEFT SUBCLAVIAN - TRIPLE LUMEN 1 PROXIMAL
   DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;... (H)
   100 ml/hr  Added on 02/14/97@14:44

Select a number to be discontinued: 2

Discontinued 5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG...
1000 mls (A) LEFT SUBCLAVIAN  started on FEB 14,1997@14:44

Select one of the following reasons for DCing or ^ to exit

1. ACCIDENTLY DC'ED
2. CLOTTED
3. DATA ENTRY ERROR
4. INFLICTED
5. INFUSED
6. ORDER CHANGED
7. ORDER EXPIRED/DC'ED
8. REMOVED BY PATIENT
9. RESTART, OUTDATED
10. SITE CONDITION
11. TRIPPED
12. WRONG PATIENT

Select a number between 1 and 12: INFUSED// 6

ORDER CHANGED
DATE/TIME DC'ED: NOW// <RET>  (FEB 14, 1997@15:03:01)

Enter solution left in the container on FEB 14,1997@15:03
   Enter * for AMOUNT LEFT if amount of solution absorbed is unknown.
   Unit mls is not required.

AMOUNT LEFT: 250

Enter the amount left in the IV bag/bottle.

Intake for this period: 750 mls  ? Yes// <RET>  (Yes)

The user validates the amount of the IV fluid absorbed.

Do you wish to
   Convert to lock/port
   Hang a new solution
Please enter the FIRST character for your selection or press return to continue: c
Convert to lock/port
Did you flush ? No// y  (Yes)
Intake and Output

1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

2b. Finishing a solution and discontinuing the IV using Solution: Replace/DC/Convert/Finish Solution.

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 2

*** SOLUTION: REPLACE/DC/CONVERT/FINISH SOLUTION ***

1. LEFT ANTECUBITTAL - ANGIO CATH-18
   D5W.2%NS (1000)  (A) 50 ml/hr  Started on 02/14/97@15:15

2. LEFT SUBCLAVIAN - TRIPLE LUMEN 1   PROXIMAL
   DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;...  (H)
   100 ml/hr  Added on 02/14/97@15:13

3. RIGHT WRIST - ANGIO CATH-14
   NS  (A) 30 ml/hr  Started on 02/14/97@15:05

4. LEFT SUBCLAVIAN - TRIPLE LUMEN 1   DISTAL
   LOCK/PORT   Converted on 02/14/97@15:03

5. LEFT SUBCLAVIAN - TRIPLE LUMEN 1   MEDIAL
   D5W.2%NS (500)  (A) 30 ml/hr  Added on 02/14/97@14:53

Select a number to be discontinued: 3

Discontinued NS 500 mls (A) RIGHT WRIST started on FEB 14,1997@15:05

Select one of the following reasons for DCing or ^ to exit

1. ACCIDENTLY DC'ED
2. CLOTTED
3. DATA ENTRY ERROR
4. INFILTRATED
5. INFUSED
6. ORDER CHANGED
7. ORDER EXPIRED/DC'ED
8. REMOVED BY PATIENT
9. RESTART, OUTDATED
10. SITE CONDITION
11. TRIPPED
12. WRONG PATIENT
Intake and Output

Select a number between 1 and 12: INFUSED//

ORDER CHANGED

DATE/TIME DC'ED: NOW// <RET> (FEB 14, 1997@15:17:55)

Enter solution left in the container on FEB 14, 1997@15:17
Enter * for AMOUNT LEFT if amount of solution absorbed is unknown.
Unit mls is not required.

AMOUNT LEFT: 300

Enter the amount left in the IV bag/bottle.

Intake for this period: 200 mls ? Yes// <RET> (Yes)

The user validates the amount of the IV fluid absorbed.

Do you wish to
  Convert to lock/port
  Hang a new solution

At the next prompt, the user may enter <RET> to document removal of the IV line/catheter.

Please enter the FIRST character for your selection or press return to continue: <RET>

The IV site has no more solutions hanging. Do you want to DC IV SITE? Yes// <RET>
(Yes)
1. NO REDNESS/PAIN/SWELLING
2. NON TENDER
3. TENDER
4. RED
5. SWOLLEN
6. DRAINAGE
7. SLOUGH
8. FRANK PUS
Select from 1 to 8 (enter 1,3-5 etc.) to describe the infusion site: 1
NO REDNESS/PAIN/SWELLING

1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

3. Replace same solution.
Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 3
*** REPLACE SAME SOLUTION ***

1. RIGHT WRIST - ANGIO CATH-14
   NS (A) 30 ml/hr  Started on 02/14/97@15:05

2. LEFT SUBCLAVIAN - TRIPLE LUMEN 1  DISTAL
   LOCK/PORT   Converted on 02/14/97@15:03

3. LEFT SUBCLAVIAN - TRIPLE LUMEN 1  MEDIAL
   D5W.2%NS (500) (A) 30 ml/hr  Added on 02/14/97@14:53

4. LEFT SUBCLAVIAN - TRIPLE LUMEN 1  PROXIMAL
   DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;... (H)
   100 ml/hr  Added on 02/14/97@14:44

Select a number to be discontinued: 4

Discontinued DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;...
1000 mls (H) LEFT SUBCLAVIAN  started on FEB 14,1997@14:44

Select one of the following reasons for DCing or ^ to exit

1. ACCIDENTLY DC'ED
2. CLOTTED
3. DATA ENTRY ERROR
4. INFILTRATED
5. INFUSED
6. ORDER CHANGED
7. ORDER EXPIRED/DC'ED
8. REMOVED BY PATIENT
9. RESTART, OUTDATED
10. SITE CONDITION
11. TRIPPED
12. WRONG PATIENT

Select a number between 1 and 12: INFUSED// 5
INFUSED
DATE/TIME DC'ED: NOW// <RET>  (FEB 14, 1997@15:23)

Enter solution left in the container on FEB 14,1997@15:13
   Enter * for AMOUNT LEFT if amount of solution absorbed is unknown.
   Unit mls is not required.

AMOUNT LEFT: 0// <RET>

Enter the amount left in the IV bag/bottle.
Intake and Output

Intake for this period: 1000 mls  ? Yes// <RET>  (Yes)

The user validates the amount of the IV fluid absorbed.

Adding DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;...  (H)
1000 mls

Infusion rate(ml/hr) 100 // <RET>
New infusion rate is 100
VOLUME: 1000// <RET>

1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

4. DC IV/lock/port and site.

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 4
*** DC IV/LOCK/PORT AND SITE ***

1. LEFT LOWER ARM - ANGIO CATH-18
   D5W.2%NS (1000) (A) 1000 mls  (02/14/97@14:39)
   AMPICILLIN 1GM in NS.9%  (P)   50 mls  (02/14/97@14:39)

2. LEFT SUBCLAVIAN - TRIPLE LUMEN 1
   DISTAL
   5% DEXTROSE;EPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG...  (A)
   1000 mls  (02/14/97@14:44)
   MEDIAL
   D5W.2%NS (500) (A)  500 mls  (02/14/97@14:53)
   PROXIMAL
   DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;...  (H)
   1000 mls  (02/14/97@14:44)

Note: The IV solutions and locks/ports are associated with the IV site. The locks/ports are treated just like solutions. The following protocols: (infiltrated, infused, and order changed) display IV lines by IV site. The user is asked to enter the number of the IV site to be discontinued and all solutions/locks/ports associated with this IV site sill be DC'ed after the user provides additional closing information (i.e., fluid left/absorbed).

Select an IV site to discontinue: 1

LEFT LOWER ARM
   D5W.2%NS (1000) (A) 1000 mls  (02/14/97@14:39)
   AMPICILLIN 1GM in NS.9%  (P)   50 mls  (02/14/97@14:39)
Please enter DATE/TIME: NOW// (FEB 14, 1997@14:59:45)

Select one of the following reasons for DCing or ^ to exit

1. ACCIDENTLY DC'ED
2. CLOTTED
3. DATA ENTRY ERROR
4. INFILTRATED
5. INFUSED
6. ORDER CHANGED
7. ORDER EXPIRED/DC'ED
8. REMOVED BY PATIENT
9. RESTART, OUTDATED
10. SITE CONDITION
11. TRIPPED
12. WRONG PATIENT

Select a number between 1 and 12: INFUSED// 6
ORDER CHANGED

Discontinued D5W.2%NS (1000) 1000 mls (A) LEFT LOWER ARM started on FEB 14,1997@14:39

Enter solution left in the container on FEB 14,1997@14:59 Enter * for AMOUNT LEFT if amount of solution absorbed is unknown. Unit mls is not required.

AMOUNT LEFT: 900

Enter the amount left in the IV admixture bag/bottle.

Intake for this period: 100 mls ? Yes// <RET> (Yes)

The user validates the amount of the IV fluid absorbed.

Now the user will document the amount of piggyback solution remaining.

Discontinued AMPICILLIN 1GM in NS.9% 50 mls (P) LEFT LOWER ARM started on FEB 14,1997@14:39

Enter solution left in the container on FEB 14,1997@14:59 Enter * for AMOUNT LEFT if amount of solution absorbed is unknown. Unit mls is not required.

AMOUNT LEFT: 0// <RET>

Enter the amount left in the IV bag/bottle.

Intake for this period: 50 mls ? Yes// <RET> (Yes)

The user validates the amount of the IV fluid absorbed.
Intake and Output

1. NO REDNESS/PAIN/SWELLING
2. NON TENDER
3. TENDER
4. RED
5. SWOLLEN
6. DRAINAGE
7. SLOUGH
8. FRANK PUS

Select from 1 to 8 (enter 1,3-5 etc.) to describe the infusion site: 1

NO REDNESS/PAIN/SWELLING

Do you want to restart the DC'd IV? Yes/\n\n1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

5. Documenting IV site care, tubing change and flushing of lines.

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 5

*** CARE/MAINTENANCE/FLUSH ***

1. LEFT LOWER ARM - ANGIO CATH-18
   D5W.2%NS (1000) (A)  1000 mls  (02/14/97@14:39)
   AMPICILLIN 1GM in NS.9% (P)  50 mls  (02/14/97@14:39)

Note: This protocol displays solutions/locks/ports discontinued within 24 hours.

Select IV site for care/maintenance/flush: 1

Please enter date/time: NOW//  (FEB 14, 1997@14:43:57)
1. NO REDNESS/PAIN/SWELLING
2. NON TENDER
3. TENDER
4. RED
5. SWOLLEN
6. DRAINAGE
7. SLOUGH
8. FRANK PUS

Select from 1 to 8 (enter 1,3-5 etc.) to describe the infusion site: 1

NO REDNESS/PAIN/SWELLING

DRESSING CHANGED: <RET>

LEFT LOWER ARM - ANGIO CATH-18
1. D5W.2%NS (1000) (A) 1000 mls (02/14/97@14:39)
2. AMPICILLIN 1GM in NS.9% (P) 50 mls (02/14/97@14:39)

Enter the number(s) of the line associated with the TUBING CHANGE: <RET>

The user will notice that all of the patient's IV sites were displayed and when the IV's were DC'ed. If a previous IV site indicated a problem, this protocol can be used to document the condition of the site. The prompts are the same, but the user must enter <RET> at the TUBING CHANGE prompt.

6. Add additional solutions.

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 6

This example shows an admixture add to the medial port of a multi-lumen catheter.

*** ADD ADDITIONAL SOLUTION(S) ***

1. LEFT LOWER ARM - ANGIO CATH-18
   D5W.2%NS (1000) (A) 1000 mls (02/14/97@14:39)
   AMPICILLIN 1GM in NS.9% (P) 50 mls (02/14/97@14:39)
2. LEFT SUBCLAVIAN - TRIPLE LUMEN 1
   DISTAL
   5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG... (A)
   1000 mls (02/14/97@14:44)
   PROXIMAL
   DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;...
   (H) 1000 mls (02/14/97@14:44)

Select an IV site to add additional solutions: 2
Please enter a new DATE/TIME: n (FEB 14, 1997@14:53:19)

1 DISTAL
2 MEDIAL
3 PROXIMAL

Select the port number used for medication infusion or ^ to quit: 2
Intake and Output

Select one of the IV types listed below
A - admixture  
B - blood/blood product  
H - hyperal  
I - intralipid  
P - piggyback  
L - locks/ports
Please enter a character: a admixture

pharmacy active IV order for the patient:
1.5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG... 1000 100 ml/hr

Select a number between 1 and 1: <RET>

Since the solution was an ordered item, the user will select from the GMRY NUR IV Solution (#126.9) file.

Select a(n) admixture from the following Nursing Solution file listing

1. OTHER  0 mls  
2. 1/2 NS (1000)  1000 mls  
3. 1/2 NS (500)  500 mls  
4. 10% DEXTRAN 40  500 mls  
5. D10W (1000)  1000 mls  
6. D10W.9NS (1000)  1000 mls  
7. D10W1/2NS (1000)  1000 mls  
8. D5.2NS  1000 mls  
9. D5W (250)  250 mls  
10. D5W (500)  500 mls  
11. D5W(1000)  1000 mls  
12. D5W.2%NS (100)  100 mls  
13. D5W.2%NS (1000)  1000 mls  
14. D5W.2%NS (250)  250 mls  
15. D5W.2%NS (500)  500 mls  
16. D5W.9NS (1000)  1000 mls  
17. D5W.9NS (250)  250 mls  
18. D5W.9NS (500)  500 mls  
19. D5W1/2NS (1000)  1000 mls  
20. D5W1/2NS (250)  250 mls  
21. D5W1/2NS (500)  500 mls  
22. KCL 20MEQ (50)  50 mls  
23. LACTATED RINGERS (1000)  1000 mls  
24. NS  500 mls  
25. NS.9% (1000)  1000 mls  
26. NS.9% (250)  250 mls  
27. NS.9% (500)  500 mls  
28. SODIUM BICARBINATE 5%(500)  500 mls

Enter a number/name for your selection,
Enter additional vitamins/electrolytes using a ; to separate,
for example, 4;multivits): 15

Amount of solution in mls in the container: 500// <RET>
Enter a number for infusion rate (Example: 125 = 125 ml/hr): 30
D5W.2%NS (500)  admixture  500 mls  30 ml/hr  Is it correct ? Yes// <RET>
(Yes)
DISTAL
5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG... (A) 1000 mls (02/14/97@14:44)
MEDIAL
D5W.2%NS (500) (A)  500 mls (02/14/97@14:53)
PROXIMAL
DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;... (H) 1000 mls (02/14/97@14:44)
Do you want to add another solution to MEDIAL port? No// <RET> (No)
1. DISTAL
2. MEDIAL
3. PROXIMAL

Select the port number used for medication infusion or ^ to quit: ^

Since the user wishes to exit, an ^ is entered.

1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

7. Restart DC'd IV.

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 7
*** RESTART DC'd IV ***

Select one of the following IV(s) to restart

1. 5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG... (A) 1000 ml 100 ml/hr
   started on FEB 14,1997@14:44
   DC'd on FEB 14,1997@15:03  250 ml left
   DC reason: ORDER CHANGED
2. D5W.2%NS (1000) (A) 1000 ml 50 ml/hr
   started on FEB 14,1997@14:39
   DC'd on FEB 14,1997@14:59  900 ml left
   DC reason: ORDER CHANGED

Note: An IV can't be restarted for one or more of the following reasons:
   1. The specific item has been running over 24 hrs.
   2. The solution has been discontinued for over 8 hrs.
   3. The remaining solution is under 5 mls.
   4. The reason for discontinuation is 'INFUSED'.

Please enter your choice: 2

After the IV solution is selected, the user must validate the information displayed.

Amount of solution in mls in the container: 900/<RET>
Enter a number for infusion rate (Example: 125 = 125 ml/hr): 50/<RET>
D5W.2%NS (1000) admixture 900 mls 50 ml/hr Is it correct? Yes/<RET> (Yes)
The software then prompts for IV site and catheter information to complete the restart cycle.

Please enter a new DATE/TIME: n (FEB 14, 1997@15:47)
Select from the following IV sites

1. HAND 7. JUGULAR
2. WRIST 8. ANKLE/FOOT
3. LOWER ARM 9. LEG
4. UPPER ARM 10. FEMORAL
5. ANTECUBITALL 11. UMBILICAL
6. SUBCLAVIAN 12. PEDAL

Enter a number with a qualifier L for LEFT/R for RIGHT, default (L)eft.
(e.g., 2R for RIGHT WRIST; 2 or 2L for LEFT WRIST): 5
LEFT ANTECUBITALL

The ADP coordinator can add entries to the display list through the Configure I/O Files option, specifically the IV Site option.

Select from the following IV CATHs

1. ANGIO CATH-14 12. TRIPLE LUMEN CVP
2. ANGIO CATH-16 13. RA-PA CATH
3. ANGIO CATH-18 14. VENOUS INTRODUCER
4. ANGIO CATH-20 15. HICKMAN LOCK
5. ANGIO CATH-22 16. DOUBLE LUMEN PERIPHERAL
6. BUTTERFLY-16 17. SUBCLAVIAN
7. BUTTERFLY-18 18. DOUBLE LUMEN SUBCLAVIAN
8. NEEDLE 1 1/4 IN-14 19. DOUBLE LUMEN 1
9. NEEDLE 1 1/4 IN-16 20. TRIPLE LUMEN 1
10. NEEDLE 1 1/4 IN-18 21. ANGIOCATH-14
11. BUTTERFLY-20

Select a number between 1 and 21: 3

The ADP coordinator can add entries to the display list through the Configure I/O Files option, specifically the IV Catheter option.

Select one of the following IV(s) to restart

1. 5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG... (A) 1000 ml 100 ml/hr
   started on FEB 14,1997@14:44
   DC'd on FEB 14,1997@15:03    250 ml left
   DC reason: ORDER CHANGED

Please enter your choice: <RET>
1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

8. Adjust infusion rate.

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 8

*** ADJUST INFUSION RATE ***

This protocol lists each IV solution seperately.

1. LEFT SUBCLAVIAN - TRIPLE LUMEN 1 MEDIAL
   D5W.2%NS (500)  (A) 30 ml/hr Added on 02/14/97@14:53

2. LEFT SUBCLAVIAN - TRIPLE LUMEN 1 DISTAL
   5% DEXTROSE;HEPARIN 1,000 U/ML .05 UNITS;AMPHOTERICIN-B 50MG...  (A)
   100 ml/hr Started on 02/14/97@14:44

3. LEFT SUBCLAVIAN - TRIPLE LUMEN 1 PROXIMAL
   DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;...
   100 ml/hr Added on 02/14/97@14:44

4. LEFT LOWER ARM - ANGIO CATH-18
   D5W.2%NS (1000)  (A) 50 ml/hr Started on 02/14/97@14:39

5. LEFT LOWER ARM - ANGIO CATH-18
   AMPICILLIN 1GM in NS.9%  (P) 100 ml/hr Added on 02/14/97@14:39

Select the number of solution & rate to be adjusted: 5

   AMPICILLIN 1GM in NS.9%  50 mls (P) LEFT LOWER ARM started on FEB
   14,1997@14:39

Please enter Date/Time: NOW// <RET> (FEB 14, 1997@14:58:12)
Infusion rate(ml/hr) 100// 60
COMMENT: <RET>

The nurse may enter in this comment field any additional documentation, 1-50 characters in length, supporting the rate change.
1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

9. Flushing the IV line, lock or port.

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: 9
*** FLUSH ***

1. LEFT SUBCLAVIAN - TRIPLE LUMEN 1
   DISTAL
   LOCK/PORT (02/14/97@15:03)
   MEDIAL
   D5W.2%NS (500) (A)  500 mls  (02/14/97@14:53)
   PROXIMAL
   DEXTROSE 5%;AMINOSYN 7%;SODIUM CHLORIDE (2.5 MEQ/ML) 40 MEQ;... (H)
   1000 mls  (02/14/97@14:44)
2. RIGHT WRIST - ANGIO CATH-14
   NS (A)  500 mls  (02/14/97@15:05)
   PACKED RBC (B)  350 mls  (02/14/97@15:06)

Select IV site to flush: 2

Please enter DATE/TIME: NOW// <RET> (FEB 14, 1997@15:10:18)

1. Start IV
2. Solution: Replace/DC/Convert/Finish Solution
3. Replace Same Solution
4. DC IV/Lock/Port and Site
5. Care/Maintenance/Flush
6. Add Additional Solution(s)
7. Restart DC'd IV
8. Adjust Infusion Rate
9. Flush

Select from 1 to 9 (enter 1,3-5 etc.) or <RET> to exit: ^

Menu Access:

The Start/Add/DC IV and Maintenance option is accessed through the Intake/Output Data Entry Menu option of the Patient Care Data, Enter/Edit option of the Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
**NURSPP-I/O-MENU**

**Intake/Output Results Reporting**

**Description:**

This is the main menu for all patient intake and output reports. Patient data is stored in the GMRY Patient I/O (#126) file.

**Additional Information:**

This information can be edited through the following options:

- Enter/Edit Patient Intake
- Enter/Edit Patient Output
- Start/Add/DC IV and Maintenance

A report that has a default for the date will start with T-3 and go to NOW. These date ranges of course can be changed by the user when printing a report.

Table 1 provides a reference to printing parameters for the reports using the option numbers listed in the menu below to correspond with Table 1.

<table>
<thead>
<tr>
<th>OPTION</th>
<th>DATE RANGE</th>
<th>WARD</th>
<th>SELECTED RM</th>
<th>PATIENT</th>
<th>SCREEN PRT</th>
<th>ITEMIZED</th>
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<td>YES</td>
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<td>YES(IV)</td>
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</table>

Table 1

Note: For Intake to be itemized 'DETAILED INPUT' in the 'Enter/Edit Patient Intake' option must be used. IV solution's will display names from the IV option.

**Menu Display:**

Select Nursing System Manager's Menu Option: **5** Nursing Features (all options)
Intake and Output

1 Administration Records, Enter/Edit ...
2 Administration Records, Print ...
3 Administrative Site File Functions ...
4 Nursing Education Reports, Print ...
5 Patient Care Data, Enter/Edit ...
6 Patient Care Data, Print ...
7 Clinical Site File Functions ...
8 QI Data, Enter/Edit ...
9 Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Option: 6 Patient Care Data, Print

1 Classification Report
2 Location of Individual Patient, Print
3 Patient Assignment Worksheet
4 Ward Census, Print
5 Current Unclassified Patient Print, by Location
6 Patient Plan of Care, Print
7 Vitals/Measurements Results Reporting ...
8 Intake/Output Results Reporting ...
9 End of Shift Report
10 Health Summary Report
11 V/M Graphic Reports
12 Patient Problems to be Evaluated

Select Patient Care Data, Print Option: 8 Intake/Output Results Reporting

1 Print I/O Summary by Patient (by Shift & Day(s))
2 Print I/O Summary (Midnight to Present)
3 Print I/O Summary (48 Hrs)
4 24 Hours Itemized Shift Report
5 Intravenous Infusion Flow Sheet

Menu Access:

The Intake/Output Results Reporting option is accessed through the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
NURCPP-I/O-SUM

Print I/O Summary by Patient (by Shift & Day(s))

Description:

This option summarizes patient intake/output by major category and shift for a period of time as defined by the user. Patient data is stored in the GMRY Patient I/O (#126) file.

Additional Information:

Patient information displayed in the report has been entered through the following options:
- Enter/Edit Patient Intake
- Enter/Edit Patient Output
- Start/Add/DC IV and Maintenance

The aggregation of I&O data by shift is determined from the shift start time information stored in the GMRY NUR Shift/Other (#126.95) file.

Menu Display:

Select Patient Care Data, Print Option: 8 Intake/Output Results Reporting

1 Print I/O Summary by Patient (by Shift & Day(s))
2 Print I/O Summary (Midnight to Present)
3 Print I/O Summary (48 Hrs)
4 24 Hours Itemized Shift Report
5 Intravenous Infusion Flow Sheet

Screen Prints:

Select Intake/Output Results Reporting Option: 1 Print I/O Summary by Patient (by Shift & Day(s))
Enter start DATE for report: T-3// 12/11 (DEC 11, 1996)

Enter appropriate start date.

Go to DATE: NOW// <RET> (DEC 12, 1996@12:09)

Enter appropriate end date.
**Intake and Output**

Select **PATIENT NAME**: **NURSPATIENT3,THREE** 08-04-18 000848807 SC VETERAN

Enter patient name.

**DEVICE**: Enter appropriate response

---

**PATIENT INTAKE/OUTPUT SUMMARY**

DEC 11, 1996 - DEC 12, 1996 @12:09

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12/11/96

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TOTAL INTAKE MEASURED: 2350
TOTAL OUTPUT MEASURED: 1300

---

12/12/96

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</table>

TOTAL INTAKE MEASURED: 2735
TOTAL OUTPUT MEASURED: 1350

---

**NURSPATIENT3,THREE 000-84-8807 AUG 4, 1918 (73 YRS) MALE**

**UNIT**: SICU  RM/BED: 560-2
**DIVISION**: HINES, IL

Note: In the above report, only the first 5 characters of the intake and output types print in the header.

**Menu Access:**

The Print I/O Summary by Patient (by Shift & Day(s)) option is accessed through the Intake/Output Results Reporting option of the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
NURCPP-I/O-CURRENT

Print I/O Summary (Midnight to Present)

Description:

This option summarizes the current day's intake and output information for all patients on a ward, in a selected room on a ward, and individual patients. Patient data is stored in GMRY Patient I/O (#126) file.

Additional Information:

The aggregation of I&O data by shift is determined from the shift start time information stored in the GMRY NUR Shift/Other (#126.95) file.

The information displayed in the report has been entered through the following options:
   Enter/Edit Patient Intake
   Enter/Edit Patient Output

Menu Display:

Select Patient Care Data, Print Option: 8  Intake/Output Results Reporting

1  Print I/O Summary by Patient (by Shift & Day(s))
2  Print I/O Summary (Midnight to Present)
3  Print I/O Summary (48 Hrs)
4  24 Hours Itemized Shift Report
5  Intravenous Infusion Flow Sheet

Screen Prints:

Select Intake/Output Results Reporting Option: 2  Print I/O Summary (Midnight to Present)
By (A)ll patients on a ward, (S)elected Rooms on ward, or (P)atient? S

Select WARD LOCATION NAME: SICU

Enter appropriate ward location.
Intake and Output

Ward SICU has the following rooms:

<table>
<thead>
<tr>
<th>NUMBER</th>
<th>ROOM</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>301</td>
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<tr>
<td>2.</td>
<td>302</td>
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<tr>
<td>3.</td>
<td>550</td>
</tr>
<tr>
<td>4.</td>
<td>560</td>
</tr>
<tr>
<td>5.</td>
<td>570</td>
</tr>
</tbody>
</table>

Select the NUMBER(S) of the rooms: 4

Enter the number(s) associated with the rooms you want, separated by commas or hyphens if there is more than one room (e.g., 1-3,5 would be entries 1,2,3 and 5).

DEVICE: Enter appropriate response

PATIENT INTAKE/OUTPUT SUMMARY (CURRENT)
DEC 12, 1991                      WARD: SICU                  PAGE: 1
INPUT                                    |OUTPUT
| IV | BLOOD | PARNT |     |     |     |     |     |     |     |     |     |     |
|FLUID|PRDCT|NUTRI|PO | TUBE |IRRIG|OTHER|URINE|N/G | EMESI|DRAIN|FECES|OTHER|
-------------------------------------------------------------------------------
RM/BED : 560-1      NURSPATIENT6,FIVE       593-48-2726
N:                                       |
0| 0| 0| 0| 0| 0| 0| 0| 0| 0| 0| 0| 0|
D:                                       |
0| 0| 0| 0| 0| 0| 0| 0| 0| 0| 200| 0| 0| 20| 0| 0|
E:                                       |
0| 0| 0| 0| 0| 0| 0| 0| 0| 650| 0| 0| 0| 0| 0| 0|
TOTAL:                                   |
0| 0| 0| 0| 0| 0| 0| 0| 0| 850| 0| 0| 20| 0| 0| 0|
TOTAL INTAKE MEASURED: 0
TOTAL OUTPUT MEASURED: 870
-------------------------------------------------------------------------------
RM/BED : 560-2      NURSPATIENT3,THREE        000-84-8807
N:                                       |
450| 0| 0| 0| 0| 0| 0| 500| 0| 0| 0| 0| 0|
D:                                       |
300| 0| 0| 300| 0| 30| 0| 250| 0| 0| 50| 0| 0| 0|
E:                                       |
400| 0| 0| 0| 0| 0| 0| 0| 350| 0| 0| 0| 0| 0| 0|
TOTAL:                                   |
1150| 0| 0| 300| 0| 30| 0| 1100| 0| 0| 50| 0| 0| 0| 0|
TOTAL INTAKE MEASURED: 1480
TOTAL OUTPUT MEASURED: 1150
-------------------------------------------------------------------------------
NURSPATIENT3,THREE     000-84-8807    AUG 4,1918 (73 YRS)         MALE
UNIT: SICU               RM/BED: 560-2
DIVISION: HINES, IL
Menu Access:

The Print I/O Summary (Midnight to Present) option is accessed through the Intake/Output Results Reporting option of the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
Intake and Output

**NURCPP-I/O-48HRS**

**Print I/O Summary (48 Hrs)**

**Description:**

This option summarizes patient intake/output for the previous and current day. Patient data is stored in the GMRY Patient I/O (#126) file.

**Additional Information:**

The aggregation of I&O data by shift is determined from the shift start time information stored in the GMRY NUR Shift/Other (#126.95) file. Patient I&O may be printed for all patients on a ward, for patients in selected rooms, and for individual patients.

The information displayed in the report has been entered through the following options:

- Enter/Edit Patient Intake
- Enter/Edit Patient Output

**Menu Display:**

Select Patient Care Data, Print Option: 8  Intake/Output Results Reporting

1  Print I/O Summary by Patient (by Shift & Day(s))
2  Print I/O Summary (Midnight to Present)
3  Print I/O Summary (48 Hrs)
4  24 Hours Itemized Shift Report
5  Intravenous Infusion Flow Sheet

**Screen Prints:**

Select Intake/Output Results Reporting Option: 3  Print I/O Summary (48 Hrs)
By (A)ll patients on a ward, (S)elected Rooms on ward, or (P)atient? P
Select PATIENT NAME: NURSPATIENT3,THREE 08-04-18 000848807 SC VETERAN

Enter patient name.

DEVICE:  Enter appropriate response
### Intake and Output

**PATIENT INTAKE/OUTPUT SUMMARY (48 HRS)**

DEC 11, 1991 - DEC 12, 1991  
WARD: SICU  

<table>
<thead>
<tr>
<th>INPUT</th>
<th>OUTPUT</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV</td>
<td>BLOOD</td>
</tr>
<tr>
<td>FLUID</td>
<td>PRDCT</td>
</tr>
<tr>
<td></td>
<td>NUTRI</td>
</tr>
<tr>
<td></td>
<td>PO</td>
</tr>
<tr>
<td></td>
<td>TUBE</td>
</tr>
<tr>
<td></td>
<td>IRRIG</td>
</tr>
<tr>
<td>OTHER</td>
<td>URINE</td>
</tr>
<tr>
<td>OTHER</td>
<td>N/G</td>
</tr>
<tr>
<td></td>
<td>EMESI</td>
</tr>
<tr>
<td></td>
<td>DRAIN</td>
</tr>
<tr>
<td></td>
<td>FECES</td>
</tr>
<tr>
<td></td>
<td>OTHER</td>
</tr>
</tbody>
</table>

---

**RM/BED: 560-2  
NURSPATIENT3, THREE  
000-84-8807**

**12/11/91**

<table>
<thead>
<tr>
<th>N:</th>
<th>400</th>
<th>0</th>
<th>100</th>
<th>250</th>
<th>0</th>
<th>0</th>
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<th>500</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
<th>0</th>
</tr>
</thead>
<tbody>
<tr>
<td>D:</td>
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<td>0</td>
<td>100</td>
<td>300</td>
<td>0</td>
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<tr>
<td>E:</td>
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<td>1300</td>
<td>0</td>
<td>0</td>
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<td>0</td>
</tr>
</tbody>
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**TOTAL INTAKE MEASURED: 2350**  
**TOTAL OUTPUT MEASURED: 1300**

---

**12/12/91**

<table>
<thead>
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<th>0</th>
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<tbody>
<tr>
<td>D:</td>
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<td>0</td>
<td>80</td>
<td>300</td>
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<td>250</td>
<td>0</td>
<td>50</td>
<td>0</td>
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<td>0</td>
</tr>
<tr>
<td>E:</td>
<td>525</td>
<td>0</td>
<td>0</td>
<td>200</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<tr>
<td>TOTAL:</td>
<td>1575</td>
<td>0</td>
<td>110</td>
<td>1020</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
<td>50</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**TOTAL INTAKE MEASURED: 2735**  
**TOTAL OUTPUT MEASURED: 1350**

---

**NURSPATIENT3, THREE  
000-84-8807  
AUG 4, 1918 (73 YRS)  
MALE**

**UNIT: SICU  
RM/BED: 560-2**

**DIVISION: HINES, IL**

---

**Menu Access:**

The Print I/O Summary (48 Hrs) option is accessed through the Intake/Output Results Reporting option of the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
**NURCPP-I/O-SHIFT AND EVENT**

**24 Hours Itemized Shift Report**

**Description:**

This option produces itemized patient intake and output reports by shift for a period of time as defined by the user. Patient data is stored in the GMRY Patient I/O (#126) file.

**Additional Information:**

The aggregation of I&O data by shift is determined from the shift start time information stored in the GMRY NUR Shift/Other (#126.95) file. Patient I&O may be printed for all patients on a ward, for patients in selected rooms, and for individual patients.

The information displayed in the report has been entered through the following options:
- Enter/Edit Patient Intake
- Enter/Edit Patient Output
- Start/Add/DC IV and Maintenance

**Menu Display:**

Select Patient Care Data, Print Option: 8 Intake/Output Results Reporting

1. Print I/O Summary by Patient (by Shift & Day(s))
2. Print I/O Summary (Midnight to Present)
3. Print I/O Summary (48 Hrs)
4. 24 Hours Itemized Shift Report
5. Intravenous Infusion Flow Sheet

**Screen Prints:**

Select Intake/Output Results Reporting Option: 4 24 Hours Itemized Shift Report
Enter start DATE for this report: T-3// <RET> (FEB 23, 1997)

Enter appropriate start date.

Go to DATE: NOW// <RET> (FEB 26, 1997@10:25:25)

Enter appropriate end date.
By (A)ll patients on a ward, (S)elected Rooms on ward, or (P)atient? P

Select PATIENT NAME:  NURSPATIENT3,NINE  08-08-88  000333331  102A-1

Enter patient name.

DEVICE: Enter appropriate response

PATIENT INTAKE/OUTPUT REPORT BY SHIFT AND EVENT TYPE
----------------------------------------------------
FEB 23, 1997 - FEB 26, 1997

02/25/97
DAY:
ITEMIZED IV INTAKE
08:00
SALINE LOCK started Site: LEFT LEG IV cath: HICKMAN LOCK
Discontinued on 03/17/94 @ 08:01
HEPARIN LOCK added Site: LEFT LEG
Discontinued on 03/17/94 @ 12:33
LEFT LEG: NO REDNESS/PAIN/SWELLING, dressing changed
HICKMAN LOCK tubing changed
12:33
HEPARIN LOCK added Site: LEFT LEG Rate: 2 ml/hr
Discontinued on 03/17/94 @ 12:34
12:34
SALINE LOCK added Site: LEFT LEG
Discontinued on 03/17/94 @ 12:35
HEPARIN LOCK added Site: LEFT LEG
Discontinued on 03/17/94 @ 12:36
12:36
HEPARIN LOCK added Site: LEFT LEG Rate: 2 ml/hr

*** DAY shift total:
Intake: Output:

---------------------
Summary for: 02/25/97
Intake: Output:
Total intake measured: 0 mls
Total output measured: 0 mls

Menu Access:

The 24 Hours Itemized Shift Report option is accessed through the Intake/Output Results Reporting option of the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
Intake and Output

NURCPP-I/O-IVFLOW

Intravenous Infusion Flow Sheet

Description:

This option prints intravenous flow sheets by ward, room or by individual patient. Data is stored in the GMRY Patient I/O (#126) file.

Additional Information:

The information displayed in the report has been entered through the following option:
   Start/Add/DC IV and Maintenance

Menu Display:

Select Patient Care Data, Print Option: 8 Intake/Output Results Reporting

1   Print I/O Summary by Patient (by Shift & Day(s))
2   Print I/O Summary (Midnight to Present)
3   Print I/O Summary (48 Hrs)
4   24 Hours Itemized Shift Report
5   Intravenous Infusion Flow Sheet

Screen Prints:

Select Intake/Output Results Reporting Option: 5 Intravenous Infusion Flow Sheet
Enter start DATE for this report: T-3//2/1 (FEB 01, 1993)

Enter appropriate start date.

Go to DATE: NOW// 2/18 (FEB 18, 1993)

Enter appropriate end date.

by (A)ll patients on a ward, (S)elected Rooms on ward, or (P)atient? P
Select PATIENT NAME: NURSPATIENT6,NINE

Enter patient name.

** THIS REPORT NEEDS 132 COLUMNS - PORT/LAND **
DEVICE: Enter appropriate response
Menu Access:

The Intravenous Infusion Flow Sheet option is accessed through the Intake/Output Results Reporting option of the Patient Care Data, Print option of the Administrator's Menu, Head Nurse's Menu, Staff Nurse Menu, and the Nursing Features (all options) menu.
Intake and Output
Chapter 6 Miscellaneous Reports

NURSPP-SHIFT

End of Shift Report

Description:

This report contains patient problems, latest vitals and intake information for a selected nursing tour. Patient data comes from the NURS Patient (#214) file, NURS Classification (#214.6) file, NURS Care Plan (#216.8) file, and the GMRY Patient I/O (#126) file.

Additional Information:

1 The application coordinator must enter the nursing shift parameters in the GMRY NUR Shift/Other (#126.95) file before running this report. The time period of the shift uses the hours stored in this file. Users can edit the shift hour using the Shift Starting Hour and Other Parameters option. This report can be printed by ward, selected room(s), or by individual patient. When the user wishes to print a report at the beginning of a shift, they must select the previous shift to print patient information. Included in this report is the name and pager numbers of the provider and attending physician. The code after the pager number indicates either a voice pager (V), or a digital pager (D).

Menu Display:

Select Nursing Features (all options) Option: 6 Patient Care Data, Print

1 Classification Report
2 Location of Individual Patient, Print
3 Patient Assignment Worksheet
4 Ward Census, Print
5 Current Unclassified Patient Print, by Location
6 Patient Plan of Care, Print
7 Vitals/Measurements Results Reporting ...
8 Intake/Output Results Reporting ...
9 End of Shift Report
10 Health Summary Report
11 V/M Graphic Reports
12 Patient Problems to be Evaluated

1 Patch NUR*4*2 October 1997
Screen Prints:

Select Patient Care Data, Print Option: **9** End of Shift Report
Select shift for the report

N - night
D - day
E - evening

Please enter the character of your choice: **D**

By (U)nit, (S)elected unit rooms, or (P)atient? **U**

Print by unit.

Select Unit: **SICU**

1. by room-bed
2. by alphabetical
3. by bed

Enter a number: 1//<RET>

How many copies of this report are required: 1//<RET>

THIS REPORT REQUIRES AN 132 COLUMN DEVICE - LAND!

DEVICE: Enter appropriate response

<table>
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<tr>
<th>JUL 22,1997@09:30</th>
<th>END-OF-SHIFT REPORT UNIT: SICU</th>
<th>TOUR: 6:00-15:00</th>
<th>PAGE:1</th>
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<tbody>
<tr>
<td>ROOM</td>
<td>BED</td>
<td>NAME</td>
<td>SSN</td>
</tr>
<tr>
<td>-------</td>
<td>-----</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>4M1-A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSPATIENT6,THREE</td>
<td>03/20/97@08:56</td>
<td></td>
<td>P:73-LEFT RADIAL</td>
</tr>
<tr>
<td>500-33-4443</td>
<td>11 yrs. MALE</td>
<td></td>
<td>R:23-SPONTANEOUS LYI</td>
</tr>
<tr>
<td>Specialty: CARDIAC CARE</td>
<td>NURSNURSE15,TWO</td>
<td></td>
<td>T:101.3-TYMpanic</td>
</tr>
<tr>
<td>UNIT</td>
<td>(A)</td>
<td></td>
<td>6/5/97 7:00 am</td>
</tr>
<tr>
<td>Diet: REGULAR</td>
<td>555-5555 (V)</td>
<td></td>
<td>BF:136/60*-L ARM LYI</td>
</tr>
<tr>
<td></td>
<td>DR. PILL</td>
<td></td>
<td>140/62-9 ARM LYING</td>
</tr>
<tr>
<td></td>
<td>(P)</td>
<td></td>
<td>5/28/97 11:32 am</td>
</tr>
<tr>
<td></td>
<td>555-4567 (V)</td>
<td></td>
<td>WT:235.1 lb-ACTUAL</td>
</tr>
<tr>
<td></td>
<td>555-5911 (D)</td>
<td></td>
<td>5/7/97 9:13 am</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>WT:66 in-ACTUAL</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>PM:3</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Menu Access:

The End of Shift Report option is accessed through the Patient Care Data, Print option of the Staff Nurse Menu, Head Nurse's menu, and Nursing Features (all options) menu.

---

1 Patch NUR*4*24  May 1999
NURSPP-HLTHSUM

Health Summary Report

Description:

This option allows the user to print the Health Summary reports by nursing ward, room-bed for the selected unit, or by patient. Patient data comes from the NURS Patient (#214) file.

Additional Information:

This report can be printed by unit, selected room(s), or by individual patient.

Menu Display:

Select Nursing Features (all options) Option: 6 Patient Care Data, Print

1 Classification Report
2 Location of Individual Patient, Print
3 Patient Assignment Worksheet
4 Ward Census, Print
5 Current Unclassified Patient Print, by Location
6 Patient Plan of Care, Print
7 Vitals/Measurements Results Reporting ...
8 Intake/Output Results Reporting ...
9 End of Shift Report
10 Health Summary Report
11 V/M Graphic Reports
12 Patient Problems to be Evaluated

Screen Prints:

Select Patient Care Data, Print Option: 10 Health Summary Report

Print by patient.

Select Health Summary Type: YUILI

Answer with health summary type name.

By (U)nit, (S)elected unit rooms, or (P)atient? P

Select PATIENT NAME: NURSPATIENT6, TEN 08-20-22 000840786 SC VETERAN

Answer with patient name.
DEVICE: Enter appropriate response

09:24 04/16/97

********************* CONFIDENTIAL TEST REPORT SUMMARY *********************
NURSPATIENT6,TEN 000-82-8534 4E 500-1 DOB: 05/24/21

** DECEASED JAN 3, 1994@15:00 **

------------- DI - DIETETICS (max 5 occurrences or 1 year) -------------
No data available

------------- VS - Vital Signs (max 10 occurrences or 5 years) -------------

<table>
<thead>
<tr>
<th>Measurement</th>
<th>DT</th>
<th>TEMP (F(C))</th>
<th>PULSE</th>
<th>RESP</th>
<th>BP</th>
<th>HT (IN(CM))</th>
<th>WT (LB(KG))</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/03/97</td>
<td>10:58</td>
<td>100(37.8)</td>
<td>60</td>
<td>20</td>
<td>130/40</td>
<td>60(152.40)</td>
<td></td>
</tr>
<tr>
<td>02/27/97</td>
<td>10:57</td>
<td>97(36.1)</td>
<td>98</td>
<td>22</td>
<td>140/60</td>
<td>180(81.82)</td>
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</tr>
<tr>
<td>02/26/97</td>
<td>13:41</td>
<td>99(37.2)</td>
<td>66</td>
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</table>

-------- SVS - VITAL SIGNS SELECTED (max 5 occurrences or 5 years) --------

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<td>100(37.8)</td>
<td>60</td>
<td>20</td>
<td>130/40</td>
<td>300(136.36)</td>
<td>60(152.40)</td>
</tr>
<tr>
<td>02/27/97</td>
<td>10:57</td>
<td>97(36.1)</td>
<td>98</td>
<td>22</td>
<td>140/60</td>
<td>180(81.82)</td>
<td></td>
</tr>
<tr>
<td>02/26/97</td>
<td>13:41</td>
<td>99(37.2)</td>
<td>66</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

-------- TRF - TRANSFUSION RECORD (max 5 occurrences or 1 year) --------
No data available

-------- DVS - VITAL SIGNS DETAILED (max 10 occurrences or 5 years) --------
No data available

Printing this report for all patients on a unit or for all patients in a room follows the same process as described above.

**Menu Access:**

The Health Summary Report option is accessed through the Patient Care Data, Print option of the Staff Nurse Menu, Head Nurse's menu, and Nursing Features (all options) menu.
Section 4 Nursing Education Reports
Chapter 1 Nursing Education Reports

NURSE-PR-MENU

Nursing Education Reports, Print

Description:

This menu allows the user to print mandatory training class deficiency reports, 3 year training, and class reports for mandatory, continuing education, ward/unit, and other training classes. The training data for each nursing employee is stored in the PRSE Student Education Tracking (#452) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file. Active status and employee names are found in the NURS Staff (#210) file.

Additional Information:

There are no data entry options for the Nursing Education module. All data entry for the nursing education reports is accomplished via the Education Tracking module of PAID version 4.0. Refer to the PAID 4.0 User Manual for further information. Assigned Mandatory Review Groups may be viewed through the Staff Record (edit/print) option.

Reports can be printed in either an 80 column or 132 column format. The 80 column format prints only the first 25 characters of the class name on the report. The 132 column format prints the entire class name on the report.

The following of calendar/fiscal year, using 1995 as an example:
Calendar year (1995) starts with is an example January (1995) and goes to December (1995). Fiscal year (1995) starts with October of the previous year (1994) and goes to September 30th of the current year (1995). The title of the report reflects the type of report as well as the date range selected (i.e., FY 1997, CY 1997, 01/01/97-03/01/97).

1Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of "yes". Three of the reports (Training Report by Unit/Svc. Category, 3 Yr. Training Report by Unit/Svc. Category, and Mandatory Deficiency Report by Unit/Svc. Category) can be sorted by unit or service category.

Security:

The security within the Nursing Education reports options screens the data viewed by nursing employees based on their AMIS Position.

1 Patch NUR*4*3 January 1998
Nursing Educator's Menu

a. The Chief, Nursing Service and the Nursing ADP Coordinators can access all data.
b. The Associate/Assistant Chief(s) and Supervisors can access data of personnel subordinate to their positions.
c. Head Nurses have access only to data specific to their ward.
d. Staff can only view their own data.

An additional level of security has been provided through the Education Tracking software. Assign ONE of the following security keys to individuals that require access not included in nursing security:

1. **PRSE SUP:** Assigned to all employees within the service.
2. **PRSE TRAIN:** Assigned to nursing staff responsible for decentralized or unit training (based on their assigned unit).

Due to these changes, Nursing Education no longer needs the FileMan security access of "n". If the nursing ADPAC holds the PRSE CORD key, the ADPAC can access all nursing service training records (equivalent to "n").

**Menu Display:**

Select Nursing System Manager's Menu Option: **5** Nursing Features (all options)

1. Administration Records, Enter/Edit ...
2. Administration Records, Print ...
3. Administrative Site File Functions ...
4. Nursing Education Reports, Print ...
5. Patient Care Data, Enter/Edit ...
6. Patient Care Data, Print ...
7. Clinical Site File Functions ...
8. QI Data, Enter/Edit ...
9. Quality Performance Reports ...
10. QI Site Files ...
11. Special Functions ...

Select Nursing Features (all options) Option: **4** Nursing Education Reports, Print

---

1 Patch NUR*4*3 January 1998
1 Training Report by Unit/Svc. Category
2 Individual Training Report
3 3 Yr. Training Report by Unit/Svc. Category
4 Individual 3 Yr. Training Report
5 Mandatory Deficiency Report by Unit/Svc. Category
6 Individual Employee Deficiency Report
7 AA/Funding Requests Report (132 Col)
8 CE Training Attendance Summary Report (132 Col)

Select Nursing Education Reports, Print Option:

Menu Access:

The Nursing Education Reports, Print option is accessed through the Nursing Features (all options) menu, the Nursing Educator's Menu, and the Administrator's Menu. The Head Nurse's Menu contains all of the Nursing Education reports except for the AA/Funding Requests Report (132 col). The Individual Employee Deficiency Report and the Individual 3 Yr. Training Reports are also accessed through the Staff Nurse Menu.
NURSE-PR-MILOC

1Training Report by Unit/Svc. Category

Description:

2This option allows the user to print reports on programs or classes, sorted by nursing unit or service category, that are attended by nursing employees. The training data for each nursing employee is stored in the PRSE Student Education Tracking (#452) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file. Active status and employee names are found in the NURS Staff (#210) file.

Additional Information:

3Reports display data for a fiscal/calendar year or a selected date range; a specific type or all types of training; for one or more unit(s), or service categories, or the whole hospital; and for a single class or all classes. At the date range prompt, select the latest year you want to include in the report. Each unit report is printed on a separate page. At the end of each report, the following information is provided:

    Total Attendees: The number of "unique" individuals who attended any class over the selected period of time.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 4 Nursing Education Reports, Print

41 Training Report by Unit/Svc. Category
   2 Individual Training Report
   3 3 Yr. Training Report by Unit/Svc. Category
   4 Individual 3 Yr. Training Report
   5 Mandatory Deficiency Report by Unit/Svc. Category
   6 Individual Employee Deficiency Report
   7 AA/Funding Requests Report (132 Col)
   8 CE Training Attendance Summary Report (132 Col)

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
3 Patch NUR*4*3 January 1998
4 Patch NUR*4*3 January 1998
Screen Prints:

1 Select Nursing Education Reports, Print Option: 1 Training Report by Unit/Svc. Category

1. Unit
2. Service Category

Sort By: 1 Unit

Sort by either unit or service category.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select one of the following:

C Calendar Year
F Fiscal Year
S Selected Date Range

Select a Sort Parameter: Calendar Year

Select the time period for this report.

2 Select Calendar Year: 1997// 1996

This response must be a year, i.e., 1995.

Select one of the following:

M Mandatory Training
C Continuing Education
O Other/Miscellaneous
W Ward/Unit-Location Training
A All

Select Sort Parameter(s): Mandatory Training

Select what type of classes you want on the report. You can only enter one code.

Select NURSING UNIT (Enter return for all units): <RET>

Enter a single unit name or enter 'return' for all nursing units.

---

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
Select TRAINING CLASS (Press return for all classes): <RET>

Enter a single training class or enter ‘return’ for all classes.

DEVICE: HOME/Enter an appropriate device

<table>
<thead>
<tr>
<th>Date</th>
<th>Class</th>
<th>Attended</th>
<th>Hours</th>
<th>Presenter</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRITICAL CARE</td>
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<td></td>
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</tr>
<tr>
<td>Unit: CCU</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>BLOOD ADMINISTRATION</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,THREE RN</td>
<td>10/25/96</td>
<td>0.80</td>
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<td></td>
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<tr>
<td>Total Attendees: 1</td>
<td></td>
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<tr>
<td>CPR</td>
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<td></td>
</tr>
</tbody>
</table>

Press RETURN to continue or '^' to exit: <RET>

<table>
<thead>
<tr>
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<th>Hours</th>
<th>Presenter</th>
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<tr>
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<tr>
<td>Unit: 7W</td>
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</tr>
<tr>
<td>RADIATION HAZARD (continued)</td>
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<tr>
<td>NURSNURSE15,THREE RN</td>
<td>10/25/96</td>
<td>2.00</td>
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<tr>
<td>Total Attendees: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: <RET>

Sort By: 2 Service Category

Sort by either unit or service category.

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
3 Patch NUR*4*3 January 1998
Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select one of the following:

C  Calendar Year
F  Fiscal Year
S  Selected Date Range

Select a Sort Parameter: Calendar Year

Select the time period for this report.

Select Calendar Year: 1997// 1996

This response must be a year, i.e., 1995.

Select one of the following:

M  Mandatory Training
C  Continuing Education
O  Other/Miscellaneous
W  Ward/Unit-Location Training
A  All

Select Sort Parameter(s): Mandatory Training

Select what type of classes you want on the report. You can only enter one code.

NURSING Service Categories
-----------------------------
1.  R (RN-REGISTERED NURSE)
2.  L (LPN-LIC. PRACTICAL NURSE)
3.  N (NA-NURSING ASSISTANT)
4.  C (CK-CLERICAL)
5.  S (SE-SUMMER EMPLOYEE)
6.  A (AO-ADMIN. OFFICER)
7.  O (OT-OTHER)

OTHER Service Categories
------------------------
8.  ANALYST
9.  PATIENT CARE
10. PHYSICIAN
11. RECREATION
12. ALL

---

1 Patch NUR*4*3 January 1998
Select SERVICE CATEGORY: **12**

Enter the appropriate service category or select ‘All’ service categories.

Select TRAINING CLASS (Press return for all classes): **<RET>**

Enter a single training class or enter ‘return’ for all classes.

DEVICE: HOME//

Enter an appropriate device

<table>
<thead>
<tr>
<th>Date</th>
<th>Class/Employee</th>
<th>Attended</th>
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<td>BALTIMORE</td>
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<tr>
<td>MANDATORY TRAINING REPORT BY SVC. CATEGORY/CLASS FOR CY 1996 OCT 25, 1997 Page: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
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<tr>
<td>Service Category: RN</td>
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<tr>
<td>BLOOD ADMINISTRATION</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>NURSNURSE15,THREE 10E</td>
<td>10/25/96 1.00</td>
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HINES


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<td>Service Category: RN</td>
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</tr>
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<td>RADIATION HAZARD (continued)</td>
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<tr>
<td>NURSNURSE15,THREE 10E</td>
<td>10/25/96 2.00</td>
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<tr>
<td>Total Attendees: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Enter RETURN to continue or '^' to exit: **<RET>**
Menu Access:

The Training Report by Unit/Svc. Category option is accessed through the Nursing Education Reports, Print option of the Nursing Educator's Menu, the Nursing Features (all options) menu, the Head Nurse's Menu, and the Administrator's Menu.
NURSE-PR-MIND

Individual Training Report

Description:

This option allows an individual nursing employee to view and print his/her own educational record of attended courses. The training data for each nursing employee is stored in the PRSE Student Education Tracking (#452) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file. Active status and employee names are found in the NURS Staff (#210) file.

Additional Information:

1. Reports display data for a fiscal/calendar year; and for a specific type or all types of training. At the date range prompt, select the latest year you want to include in the report.

The security on this option is based on the user's service position. Please refer to Security section of this chapter for more information. At the end of each report a count of the total program hours is displayed which may be total CEUs, total Contact Hrs, and/or total Class Hours.

Menu Display:

Select Nursing Features (all options) Option: 4 Nursing Education Reports, Print

21 Training Report by Unit/Svc. Category
2 Individual Training Report
3 3 Yr. Training Report by Unit/Svc. Category
4 Individual 3 Yr. Training Report
5 Mandatory Deficiency Report by Unit/Svc. Category
6 Individual Employee Deficiency Report
7 AA/Funding Requests Report (132 Col)
8 CE Training Attendance Summary Report (132 Col)

Screen Prints:

Select Nursing Education Reports, Print Option: 2 Individual Training Report

---

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998

1.10 Nursing V. 4.0 User Manual Nursing Education Reports April 1997
Select one of the following:

M  Mandatory Training
C  Continuing Education
O  Other/Miscellaneous
W  Ward/Unit-Location Training
A  All

Select Sort Parameter(s): All

Select what type of classes you want on the report. You can only enter one code.

Select one of the following:

C  Calendar Year
F  Fiscal Year
S  Selected Date Range

Select a Sort Parameter: Calendar Year

Select the time period for this report.

Select Calendar Year: 1997/<RET>

This response must be a year, i.e., 1995.

Select Nursing Staff Name: NURSNURSE15,FOUR  000678901     HN

...OK? YES/<RET> (YES)

Enter the name of the person associated with the record. The security on this prompt is based on
the user's service position. Please refer to Security section of this chapter for more information.

DEVICE: HOME/<Enter an appropriate device>

INDIVIDUAL COMPLETE TRAINING REPORT FOR CY 1997  02/25/97 PAGE: 1

CLASS                      CLASS LOCATION         DATE(S)                CLASS HOURS
PRESENTER                  SVC REASON
--------------------------------------------------------------------------------
Employee Name: NURSNURSE15,FOUR  RN
PROTECTED NEEDLE           CHICAGO          08/31/97 -08/31/97     2.00
NURSNURSE15,FOUR
CEUs: 1.00                  Contact Hrs: 2.00

Total CEUs = 1.00          Total Contact Hrs = 2.00   Total Class Hrs = 2.00

Press RETURN to continue or '^' to exit: <RET>
Menu Access:

The Individual Training Report option is accessed through the Nursing Education Reports, Print option of the Nursing Educator's Menu, the Nursing Features (all options) menu, the Head Nurse's Menu, the Staff Nurse Menu, and the Administrator's Menu.
NURSE-PR-MI3LC

3 Yr. Training Report by Unit/Svc. Category

Description:

This option allows the user to print training reports on nursing employees for an identified 3 year period. The training data for each nursing employee is stored in the PRSE Student Education Tracking (#452) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file. Active status is found in the NURS Staff (#210) file. Employee names are found in the NURS Position Control (#211.8) file.

Additional Information:

Reports display data for a fiscal or calendar year; a specific type or all types of training; for one or more unit(s), or service categories, or the whole hospital; and for a single class or all classes. At the date range prompt, select the latest year you want to include in the report. Each unit report is printed on a separate page. Assigned Mandatory Review Groups may be viewed through the Staff Record (edit/print) option.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 4 Nursing Education Reports, Print

1  Training Report by Unit/Svc. Category
2  Individual Training Report
3  3 Yr. Training Report by Unit/Svc. Category
4  Individual 3 Yr. Training Report
5  Mandatory Deficiency Report by Unit/Svc. Category
6  Individual Employee Deficiency Report
7  AA/Funding Requests Report (132 Col)
8  CE Training Attendance Summary Report (132 Col)
Screen Prints:

1 Select Nursing Education Reports, Print Option: **3** 3 Yr. Training Report by Unit/Svc. Category

1. Unit
2. Service Category

Sort By: **1** Unit

Sort by either unit or service category.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

   Select one of the following:
   
   C  Calendar Year
   F  Fiscal Year

Select a Sort Parameter: **Calendar Year**

Select the time period for this report.

Select Latest Calendar Year: **1997**// <RET>

This response must be a year, i.e., 1995.

Select NURSING UNIT (Enter return for all units): <RET>

Enter a single unit name or enter 'return' for all nursing units.

   Select one of the following:
   
   M  Mandatory Training
   C  Continuing Education
   O  Other/Miscellaneous
   W  Ward/Unit-Location Training
   A  All

Select Sort Parameter(s): **Mandatory Training**

Enter the code for a single training type.

---

1 Patch NUR*4*3 January 1998
Select TRAINING CLASS (Press return for all classes): <RET>

Enter a single class name or press 'return' to print all classes.

DEVICE: HOME// Enter an appropriate device

<table>
<thead>
<tr>
<th>BALTIMORE</th>
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</thead>
<tbody>
<tr>
<td>3 CY MANDATORY TRAINING REPORT BY UNIT</td>
</tr>
<tr>
<td>Unit: CCU</td>
</tr>
<tr>
<td>CRITICAL CARE</td>
</tr>
<tr>
<td>NURSNURSE15, THREE RN</td>
</tr>
<tr>
<td>BLOOD ADMINISTRATION</td>
</tr>
<tr>
<td>CPR</td>
</tr>
<tr>
<td>AUG 14</td>
</tr>
<tr>
<td>FIRE SAFETY</td>
</tr>
<tr>
<td>OBSTRUCTED AIRWAY</td>
</tr>
<tr>
<td>RADIATION HAZARD</td>
</tr>
</tbody>
</table>

Press RETURN to continue or '^' to exit: <RET>

[last page of report]

<table>
<thead>
<tr>
<th>WEST LOS ANGELES</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 CY MANDATORY TRAINING REPORT BY UNIT</td>
</tr>
<tr>
<td>Unit: CHEMO</td>
</tr>
<tr>
<td>CRITICAL CARE</td>
</tr>
<tr>
<td>NURSNURSE15, FIVE</td>
</tr>
<tr>
<td>FIRE SAFETY</td>
</tr>
<tr>
<td>PROTECTIVE DEVICES</td>
</tr>
</tbody>
</table>

Press RETURN to continue or '^' to exit: <RET>

Sort By: 2 Service Category

Sort by either unit or service category.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

---

1 Patch NUR*4*3 January 1998
Select appropriate product line(s) or press return for all product lines.

Select one of the following:

C   Calendar Year
F   Fiscal Year

Select a Sort Parameter: Calendar Year

Select the time period for this report.

Select Latest Calendar Year: 1997/<RET>

This response must be a year, i.e., 1995.

NURSING Service Categories
--------------------------
1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-CLERICAL)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)

OTHER Service Categories
------------------------
8. ANALYST
9. PATIENT CARE
10. PHYSICIAN
11. RECREATION
12. ALL

Select SERVICE CATEGORY: 12

Enter the appropriate service category or select ‘All’ service categories.

Select one of the following:

M   Mandatory Training
C   Continuing Education
O   Other/Miscellaneous
W   Ward/Unit-Location Training
A   All

Select Sort Parameter(s): Mandatory Training

Enter the code for a single training type.

Select TRAINING CLASS (Press return for all classes): <RET>

Enter a single class name or press 'return' to print all classes.
1DEVICE: HOME//Enter an appropriate device

BALTIMORE
3 CY MANDATORY TRAINING REPORT BY SVC. CATEGORY          OCT 25,1997 PAGE: 1

--------------------------------------------------------------------------------
Service Category: RN

-----
NURSING

-----
NURSNURSE15,THREE   RN
BLOOD ADMINISTRATION                                      OCT 25
CPR                                                   AUG 25
FIRE SAFETY                                            OCT 25
OBSTRUCTED AIRWAY                                      OCT 25
RADIATION HAZARD                                       OCT 25

Press RETURN to continue or '^' to exit: <RET>

---------------------------------------------------------------------------------(last page of report)

WEST LOS ANGELES
3 CY MANDATORY TRAINING REPORT BY SVC. CATEGORY          OCT 25,1997 PAGE: 11

--------------------------------------------------------------------------------
Service Category: RN

-----
NURSING

-----
NURSNURSE15,FIVE
FIRE SAFETY                                            SEP 30
PROTECTIVE DEVICES                                     SEP 21

Press RETURN to continue or '^' to exit: <RET>

Menu Access:

2The 3 Yr. Training Report by Unit/Svc. Category option is accessed through the Nursing Education Reports, Print option of the Nursing Educator's Menu, the Nursing Features (all options) menu, the Head Nurse's Menu, and the Administrator's Menu.

---
1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
NURSE-PR-MI3I

Individual 3 Yr. Training Report

Description:

This option allows an individual nursing employee to view and print his/her own educational record that covers 3 years of attended courses. The training data for each nursing employee is stored in the PRSE Student Education Tracking (#452) file, and the PAID Employee (#450) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file. Active status and employee names are found in the NURS Staff (#210) file.

Additional Information:

1. Reports display data for a fiscal or calendar year; and for a specific type or all types of training. At the date range prompt, select the latest year you want to include in the report.

The security on this option is based on the user's service position. Please refer to Security section of this chapter for more information. At the date range prompt, select the latest year you want to include in the report.

Menu Display:

Select Nursing Features (all options) Option: 4 Nursing Education Reports,
Print

2 1  Training Report by Unit/Svc. Category
2  Individual Training Report
3 3 Yr. Training Report by Unit/Svc. Category
4  Individual 3 Yr. Training Report
5  Mandatory Deficiency Report by Unit/Svc. Category
6  Individual Employee Deficiency Report
7  AA/Funding Requests Report (132 Col)
8  CE Training Attendance Summary Report (132 Col)

Screen Prints:

Select Nursing Education Reports, Print Option: 4 Individual 3 Yr. Training Report

---

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
Select one of the following:

C  Calendar Year
F  Fiscal Year

Select a Sort Parameter: Calendar Year

Select the time period for this report.

Select Latest Calendar Year: 1997/<RET>

This response must be a year, i.e., 1995.

Select one of the following:

M  Mandatory Training
C  Continuing Education
O  Other/Miscellaneous
W  Ward/Unit-Location Training
A  All

Select Sort Parameter(s): All

Select what type of classes you want on this report.

Select Nursing Staff Name: NURSNURSE15,FOUR 000678901 HN

...OK? YES/<YES>

Enter the name of the person associated with the report. The security on this prompt is based on the user's service position. Please refer to Security section of this chapter for more information.

DEVICE: HOME/<Enter an appropriate device>

3 CY INDIVIDUAL COMPLETE TRAINING REPORT FEB 25, 1997 PAGE: 1


-------------------------------------------------------------------------------------------------

Employee Name: NURSNURSE15,FOUR RN

CPR                     JAN 13
CPR 2                    APR 02
INFECTION CONTROL       AUG 18
BIOETHICS               JAN 17
BLOOD ADMINISTRATION    APR 14
BUDGET                  AUG 13

Press RETURN to continue or '^' to exit: <RET>

Menu Access:

The Individual 3 Yr. Training Report option is accessed through the Nursing Education Reports, Print option of the Nursing Educator's Menu, the Nursing Features (all options) menu, the Head Nurse's Menu, the Staff Nurse Menu, and the Administrator's Menu.
NURSE-PR-MIDEF

| Optional Deficiency Report by Unit/Svc. Category

Description:

This option allows the user to print a report of required classes not attended by the employee. Courses not attended as required are designated as deficiencies. Attendance data used to calculate this report is stored in the PRSE Student Education Tracking (#452) file. This data is checked against required classes located in the employee's record in the Paid Employee (#450) file and the class information existing in the PRSE Program/Class file (#452.1). The MI class name must be found in File #452.1. If the name has been deleted from this file then the MI class will never appear on this report. The training data for each nursing employee is stored in the PRSE Student Education Tracking (#452) file, and the PAID Employee (#450) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file. Active status is found in the NURS Staff (#210) file. Employee names are found in the NURS Position Control (#211.8) file.

Additional Information:

Reports display data for a fiscal or calendar year; for one or more unit(s), or service categories, or the whole hospital; and for a single class or all classes. At the date range prompt, select the latest year you want to include in the report. Only the names of current employees (as indicated in File #450) are reflected in this report.

The percentage of compliance for all MI classes is calculated through the following formula:

\[
\frac{\text{# of individuals who attended all required MI classes assigned to Nursing service}}{\text{# of individuals (in File #450) assigned to Nursing service and to an MI Class}}
\]

In calculating the percentage of compliance for review groups, the percentage is based on attendance at all classes for the selected time frame, for active employees only. The individual is otherwise counted as deficient no matter how many classes were attended in the review group.

If an individual class is selected, the percentage is calculated as follows:

\[
\frac{\text{# of individuals who attended the selected class}}{\text{# of individuals (in File #450) who are required to attend the selected class}}
\]
Some employees who are deficient in classes may not show up on the report. This is because the deficiency reports currently do not project deficiencies for a time period, but take into account the last time the employee attended the class and the required frequency of attendance. If a report is requested for calendar year 1997, the required frequency for attending this class is yearly, and the employee last attended the class in June 1996, they are not required to attend the class again until June 1997. Even though they have not attended the class in calendar year 1997, they will not show up on the deficiency report until after June 1997. The exception to this is if the employee has never attended the class before, they would show up on a report for calendar year 1997 as deficient. Another exception to this would be classes with no required frequency for re-attendance which means attendance was only required one time. Employees attending this class will no longer be flagged as deficient after attending the class once. Also, when a class is assigned to an employee the date assigned is recorded in the employee record. If a future date is placed in this field the employee is not required to attend the class until after the date the class is assigned. So what needs to be considered for each required class are the following:

1. Date class was last attended.
2. Required frequency for re-attendance.
3. Date class was assigned to the employee.

Note: If an employee is not assigned a mandatory training review group and/or a required class, the deficiency reports will indicate a compliance of 100%. In a future version, a message will print stating that the employee is not assigned to any review group or to any required class. It is suggested that all supervisors be given the Employee Mandatory Training Group/Class Report option for the purpose of identifying staff who are not assigned appropriate training review group(s) or required classes.

1Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'. This report can also be sorted by unit or service category.

This report also includes an anniversary date, which is the next date an employee is scheduled to take a class.

Menu Display:

Select Nursing Features (all options) Option: 4 Nursing Education Reports, Print

---

1 Patch NUR*4*3 January 1998
Nursing Educator's Menu

1. Training Report by Unit/Svc. Category
2. Individual Training Report
3. 3 Yr. Training Report by Unit/Svc. Category
4. Individual 3 Yr. Training Report
5. Mandatory Deficiency Report by Unit/Svc. Category
6. Individual Employee Deficiency Report
7. AA/Funding Requests Report (132 Col)
8. CE Training Attendance Summary Report (132 Col)

Screen Prints:

2 Select Nursing Education Reports, Print Option: 5 Mandatory Deficiency Report by Unit/Svc. Category

1. Unit
2. Service Category

Sort By: 1 Unit
Sort by either unit or service category.

Select FACILITY (Press return for all facilities): <RET>
Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>
Select appropriate product line(s) or press return for all product lines.

Select one of the following:

C Calendar Year
F Fiscal Year

Select a Sort Parameter: Calendar Year

Select the time period for this report.

3 Select Calendar Year: 1997// 1996

This response must be a year, i.e., 1995.

Select TRAINING CLASS (Press return for all classes): BIOETHICS
BIOETHICS 08-27-92

Enter a single class name or press 'return' for all classes.

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
3 Patch NUR*4*3 January 1998
Select NURSING UNIT (Enter return for all units): <RET>

Enter a single unit name or press 'return' for all nursing units.

DEVICE: HOME// Enter an appropriate device

```
1BALTIMORE

MANDATORY DEFICIENCY REPORT BY UNIT FOR CY 1996 10/27/97 PAGE: 1

EMPLOYEE NAME ANNIVERSARY CLASS

CRITICAL CARE

Unit: 15E

% Compliance: 60

NURSNURSE2, TWO RN 2/24/96 BIOETHICS

Enter RETURN to continue or '^

(last page of report)

MANDATORY DEFICIENCY REPORT BY UNIT FOR CY 1996 10/27/97 PAGE: 4

EMPLOYEE NAME ANNIVERSARY CLASS

CRITICAL CARE

Unit: 15W

% Compliance: 30

NURSNURSE15, SIX RN 3/12/96 BIOETHICS
NURSNURSE15, SEVEN RN 1/22/96 BIOETHICS

Enter RETURN to continue or '^

Sort By: 2 Service Category

Sort by either unit or service category.

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

1 Patch NUR*4*3 January 1998
Select one of the following:

- C Calendar Year
- F Fiscal Year

Select a Sort Parameter: Calendar Year

Select the time period for this report.

Select Calendar Year: 1997/\ 1996

This response must be a year, i.e., 1995.

Select TRAINING CLASS (Press return for all classes): BIOETHICS

BIOETHICS 08-27-92

Enter a single class name or press 'return' for all classes.

NURSING Service Categories
--------------------------
1. R (RN-REGISTERED NURSE)
2. L (LPN-LIC. PRACTICAL NURSE)
3. N (NA-NURSING ASSISTANT)
4. C (CK-CLERICAL)
5. S (SE-SUMMER EMPLOYEE)
6. A (AO-ADMIN. OFFICER)
7. O (OT-OTHER)

OTHER Service Categories
------------------------
8. ANALYST
9. PATIENT CARE
10. PHYSICIAN
11. RECREATION
12. ALL

Select SERVICE CATEGORY: 12

Enter the appropriate service category or select ‘All’ service categories.

DEVICE: HOME/\ Enter an appropriate device

---

1 Patch NUR*4*3 January 1998
Menu Access:

The Mandatory Deficiency Report by Unit/Svc. Category option is accessed through the Nursing Education Reports, Print option of the Nursing Educator's Menu, the Nursing Features (all options) menu, the Head Nurse's Menu, and the Administrator's Menu.

---

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
NURSE-PR-DEMP

Individual Employee Deficiency Report

Description:

This option allows the user to print required classes not attended by a specific nursing employee. Mandatory or required courses not attended are designated as deficiencies. The training data for each nursing employee is stored in the PRSE Student Education Tracking (#452) file, and the PAID Employee (#450) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file. Active station and employee names are found in the NURS Staff (#210) file.

Additional Information:

1 Reports display data for a fiscal or calendar year. At the date range prompt, select the latest year you want to include in the report. This option does not display projected deficiencies (i.e., those classes that technically are not yet identified as deficient but still have to be taken at a future time during the fiscal or calendar year). The employee's attendance at MI classes is checked against required classes located in the employee's record in the Paid Employee (#450) file, and the class information existing in the PRSE Program/Class (#452.1) file. The MI class name must be found in File #452.1. If the name has been deleted from this file then the MI class will never appear on this report.

The security on this option is based on the user's service position. Please refer to Security section of this chapter for more information. If the employee has no SSN or is not in the Paid Employee (#450) file the following message appears:

No SSN found for this person, or no entry for this person is found in the PAID Employee (#450) file.

2 This report also includes an anniversary date, which is the next date an employee is scheduled to take a class.

Menu Display:

Select Nursing Features (all options) Option: 4 Nursing Education Reports, Print

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
<table>
<thead>
<tr>
<th></th>
<th>Training Report by Unit/Svc. Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Individual Training Report</td>
</tr>
<tr>
<td>2</td>
<td>3 Yr. Training Report by Unit/Svc. Category</td>
</tr>
<tr>
<td>3</td>
<td>Individual 3 Yr. Training Report</td>
</tr>
<tr>
<td>4</td>
<td>Mandatory Deficiency Report by Unit/Svc. Category</td>
</tr>
<tr>
<td>5</td>
<td>Individual Employee Deficiency Report</td>
</tr>
<tr>
<td>6</td>
<td>AA/Funding Requests Report (132 Col)</td>
</tr>
<tr>
<td>7</td>
<td>CE Training Attendance Summary Report (132 Col)</td>
</tr>
</tbody>
</table>

**Screen Prints:**

Select Nursing Education Reports, Print Option: 6 Individual Employee Deficiency Report

Select one of the following:

C Calendar Year
F Fiscal Year

Select a Sort Parameter: Calendar Year

Select the time period for this report.

Select Calendar Year: 1997// 1996

This response must be a year, i.e., 1995.

Select EMPLOYEE NAME: NURSNURSE15,FOUR 000678901

Enter the name of the person associated with the report. The security on this prompt is based on the user's service position. Please refer to Security section of this chapter for more information.

DEVICE: HOME//Enter an appropriate device

---

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
3 Patch NUR*4*3 January 1998

April 1997 Nursing V. 4.0 User Manual
Nursing Education Reports 1.27
### INDIVIDUAL EMPLOYEE DEFICIENCY REPORT FOR CY 1996

<table>
<thead>
<tr>
<th>EMPLOYEE NAME</th>
<th>UNIT</th>
<th>ANNIVERSARY DATE</th>
<th>CLASS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSN1SE15, FOUR RN</td>
<td>10E</td>
<td>4/4/96</td>
<td>ACLS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10/5/96</td>
<td>ADP SECURITY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3/26/96</td>
<td>ANNUAL REVIEW REVISITED</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1/17/96</td>
<td>BIOETHICS</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6/2/95</td>
<td>BLOOD ADMINISTRATION</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4/18/96</td>
<td>COMPUTER SECURITY</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1/13/96</td>
<td>CPR</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5/5/96</td>
<td>EEO/SEXUAL HARRESSMENT</td>
</tr>
</tbody>
</table>

Press RETURN to continue or '^' to exit: <RET>

### Menu Access:

The Individual Employee Deficiency Report option is accessed through the Nursing Education Reports, Print option of the Nursing Educator's Menu, the Nursing Features (all options) menu, the Head Nurse's Menu, the Staff Nurse Menu, and the Administrator's Menu.

---

1 Patch NUR*4*3 January 1998
2 Patch NUR*4*3 January 1998
NURSE-PR-AAF

AA/Funding Requests Report (132 Col)

Description:

This option allows the user to print a report of authorized absence/funding requests. The training data for each nursing employee is stored in the PRSE Student Education Tracking (#452) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file. Active status is found in the NURS Staff (#210) file. Employee names are found in the NURS Position Control (#211.8) file.

Additional Information:

Reports display C. E. data (both local and non-local) for a fiscal/calendar year or a selected date range; and for a single nursing employee or all nursing employees.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 4 Nursing Education Reports, Print

| 1 | Training Report by Unit/Svc. Category |
| 2 | Individual Training Report            |
| 3 | 3 Yr. Training Report by Unit/Svc. Category |
| 4 | Individual 3 Yr. Training Report     |
| 5 | Mandatory Deficiency Report by Unit/Svc. Category |
| 6 | Individual Employee Deficiency Report |
| 7 | AA/Funding Requests Report (132 Col)  |
| 8 | CE Training Attendance Summary Report (132 Col) |

Screen Prints:

Select Nursing Education Reports, Print Option: 7 AA/Funding Requests Report (132 Col)

Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

1 Patch NUR*4*3 January 1998
Nursing Educator's Menu

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select one of the following:

C    Calendar Year
F    Fiscal Year
S    Selected Date Range

Select a Sort Parameter: Calendar Year

Select the time period for this report.

Select Calendar Year: 1997// 1995

This response must be a year, i.e., 1995.

Select Nursing Staff Name (Press return for entire nursing staff): <RET>

Enter the name of the person associated with the report, or press return for all nursing staff. The security on this prompt is based on the user's service position. Please refer to the Security section of this chapter for more information.

DEVICE: Enter an appropriate device

This report must be sent to a 132 column device

<table>
<thead>
<tr>
<th>EMPLOYEE</th>
<th>CLASS</th>
<th>UNIT</th>
<th>DATE</th>
<th>LOCATION</th>
<th>AA</th>
<th>AA</th>
<th>FUNDS</th>
<th>FUNDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURGERY2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,FOUR RN CCU 01/28/95 MANAGER'S SEXUAL HARASSMENT CLA CHICAG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,FOUR RN CCU 02/03/95 CREATIVE TEACHING CHICAG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,FOUR RN CCU 02/03/95 BASIC LIFE SUPPORT CHICAG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,FOUR RN CCU 02/03/95 ADVANCED LIFE SUPPORT CHICAG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,FOUR RN CCU 02/13/95 IV CERTIFICATION CHICAG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,FOUR RN CCU 02/14/95 PATIENT ABUSE CHICAG</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Press RETURN to continue or '^' to exit: <RET>
<table>
<thead>
<tr>
<th>EMPLOYEE</th>
<th>CLASS</th>
<th>DATE</th>
<th>LOCATION</th>
<th>AA</th>
<th>AUT</th>
<th>FUNDS</th>
<th>FUNDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSNURSE15,EIGHT</td>
<td>RN</td>
<td>01/12/95</td>
<td>BIOETHICS</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,EIGHT</td>
<td>RN</td>
<td>02/14/95</td>
<td>BASIC LIFE SUPPORT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,EIGHT</td>
<td>RN</td>
<td>02/27/95</td>
<td>ADP SECURITY</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,EIGHT</td>
<td>RN</td>
<td>03/20/95</td>
<td>INTAKE/OUTPUT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,EIGHT</td>
<td>RN</td>
<td>03/20/95</td>
<td>PATIENT ABUSE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NURSNURSE15,NINE</td>
<td>BN</td>
<td>03/20/95</td>
<td>ADVANCED LIFE SUPPORT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Comment:** NOTHING

**Total Funding Requested:** $960.00

**Total Funding Authorized:** $510.00

Enter RETURN to continue or '^' to exit: <RET>

**Menu Access:**

The AA/Funding Requests Report (132 Col) option is accessed through the Nursing Education Reports, Print option of the Nursing Educator's Menu, the Nursing Features (all options) menu, and the Administrator's Menu.
NURSE-PR-CES

C.E. Training Attendance Summary Report (132 Col)

Description:

This option allows the user to print 132 column reports on continuing education programs or classes attended by nursing employees. The training data for each nursing employee is stored in the PRSE Student Education Tracking (#452) file. Staff data reflecting assignment location and service category is found in the NURS Position Control (#211.8) file. Active status is found in the NURS Staff (#210) file. Employee names are found in the NURS Position Control (#211.8) file.

Additional Information:

Reports display data for local or non-local continuing education classes. At the end of each report the following information is provided:

- Class total: The total number of classes over a period of time (local or non-local).
- Total Attended: The number of unique people who attended a class.
- Total Presentation: The number of occurrences of a class.

Reports can be sorted and printed by facility and/or product line when the appropriate fields (multi-divisional and product line) in the NURS Parameter (#213.9) file contain the value of 'yes'.

Menu Display:

Select Nursing Features (all options) Option: 4 Nursing Education Reports,
Print

1 Training Report by Unit/Svc. Category
2 Individual Training Report
3 3 Yr. Training Report by Unit/Svc. Category
4 Individual 3 Yr. Training Report
5 Mandatory Deficiency Report by Unit/Svc. Category
6 Individual Employee Deficiency Report
7 AA/Funding Requests Report (132 Col)
8 CE Training Attendance Summary Report (132 Col)

Screen Prints:

Select Nursing Education Reports, Print Option: 8 C.E. Training Attendance Summary Report (132 Col)

1 Patch NUR*4*3 January 1998
Select FACILITY (Press return for all facilities): <RET>

Select appropriate facility or press return for all facilities.

Select PRODUCT LINE (Press return for all product lines): <RET>

Select appropriate product line(s) or press return for all product lines.

Select CONTINUING EDUCATION PROGRAM (Press return for all Programs): <RET>

Enter a specific class name or press 'return' for all classes.

Select one of the following:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>L</td>
<td>Local CE Classes</td>
</tr>
<tr>
<td>N</td>
<td>Non-Local CE Classes</td>
</tr>
</tbody>
</table>

Select Local or Non-Local CE PROGRAMS (Press Return for all classes): <RET>

Enter the code (L=Local, N=Non-Local) for a specific type of CE report or press 'return' for both types of CE classes.

Start With CLASS DATE (Press return for all dates): <RET>

Enter the date range for the report.

DEVICE: Enter an appropriate device

<table>
<thead>
<tr>
<th>CLASS</th>
<th>CONTACT</th>
<th>DATES</th>
<th>HRs</th>
<th>CEU's</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>SURGERY2</td>
<td></td>
<td>10/21/94-10/21/94</td>
<td>8.00</td>
<td>0.0</td>
<td>7.20</td>
</tr>
</tbody>
</table>

Press RETURN to continue or '^' to exit: <RET>
## C.E. Training Attendance Summary Report

**Date:** FEB 25, 1997  
**Page:** 38

<table>
<thead>
<tr>
<th>Class</th>
<th>Dates</th>
<th>Hrs</th>
<th>CEU's</th>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>NURSING</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-local ADP Security</td>
<td>03/16/94-03/16/94</td>
<td>8.00</td>
<td>0.00</td>
<td>NURSPRESENTER, ONE</td>
</tr>
<tr>
<td>Total Presentation: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Attended: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake/Output</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenter: RHODEISLAND BROS.</td>
<td>04/07/94-04/07/94</td>
<td>8.00</td>
<td>0.00</td>
<td>NURSPRESENTER, TWO</td>
</tr>
<tr>
<td>Total Presentation: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Attended: 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Non-local Classes:** 18

Enter RETURN to continue or '^' to exit: <RET>

### Menu Access:

The C.E. Training Attendance Summary Report (132 Col) option is accessed through the Nursing Education Reports, Print option of the Nursing Educator's Menu, the Nursing Features (all options) menu, and the Administrator's Menu.
Section 5 Performance Improvement
Performance Improvement
Chapter 1 QA Patient Classification

NURSQE-REVCL-MENU

Review/Edit Patient Classification

Description:

This menu displays special review/edit options related to patient classification. Data is stored in the NURS Review Classification (#214.7) file.

Additional Information:

This menu is appropriate for supervisors and nursing performance improvement staff.

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1 Administration Records, Enter/Edit ...
2 Administration Records, Print ...
3 Administrative Site File Functions ...
4 Nursing Education Reports, Print ...
5 Patient Care Data, Enter/Edit ...
6 Patient Care Data, Print ...
7 Clinical Site File Functions ...
8 QI Data, Enter/Edit ...
9 Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Option: 8 QI Data, Enter/Edit

AMIS 1106 Acuity Edit
Manhours Edit, AMIS 1106a
QI Summary Enter/Edit ...
Review/Edit Patient Classification ...

Select QI Data, Enter/Edit Option: Review/Edit Patient Classification

Individual Patient, Review/Edit
Ward, Review/Edit Classifications By
Menu Access:

The Review/Edit Patient Classification option is accessed through the QI Data, Enter/Edit option of the Nursing Features (all options) menu and the QA Coordinators menu.
NURAPC-REVIND

Individual Patient, Review/Edit

Description:

This option allows a supervisor or nursing QA staff member to review the classification of a patient for the correct day. Reclassification of an individual patient is also permitted. Data is stored in the NURS Review Classification (#214.7) file.

Additional Information:

This menu is appropriate for supervisors and nursing performance improvement staff. Data is retrieved through a user generated VA FileMan report.

Menu Display:

Select Nursing Features (all options) Option: 8  QI Data, Enter/Edit

  AMIS 1106 Acuity Edit
  Manhours Edit, AMIS 1106a
  Review/Edit Patient Classification ...

Select QI Data, Enter/Edit Option: Review/Edit Patient Classification

  Individual Patient, Review/Edit
  Ward, Review/Edit Classifications By

Screen Prints:

Select Review/Edit Patient Classification Option: Individual Patient, Review/Edit

Select PATIENT NAME: NURSPATIENT6,THREE 11-04-85 000223333
NSC VETERAN

  PATIENT CLASSIFICATION INTENSIVE CARE

Patient: NURSPATIENT6,THREE SSN: 000-22-3333  Admission Date: 01/03/93
Unit: MICU Room/Bed: 500-3 Bed Section: INTENSIVE CARE
QA Patient Classification

FACTORS:
A. Position, partial assist  | CHOOSE ONE OF
B. Position, complete assist | THESE TWO
C. Physiological monitoring, more than q 2 h  >
D. Physiological monitoring, q 1-2 h       > CHOOSE ONE OF
E. Physiological monitoring, q 1 h or less  > THESE THREE
F. Intravenous therapy, one IV
G. Intravenous therapy, 2 or more lines
H. Respiratory status, non-acute
I. Respiratory status, acute
J. Special procedures performed

Current Classification: 1  Factors: A,C  (COMPUTER)
Comments:
Last user to classify: NURSUSER,EIGHT
Last date/time classified: JUL 31, 1995@14:23
Last reviewed by:
Last date/time reviewed:

Do you wish to override this classification? No// Y  (Yes)

PATIENT: NURSPATIENT6,THREE  SSN: 000-22-3333
Enter Factors: A,C// A,D,H
Enter Classification: 2// <RET>

Menu Access:

The Individual Patient, Review/Edit option is accessed through the Review/Edit Patient Classification option of the QI Data, Enter/Edit option of the Nursing Features (all options) menu and the QA Coordinators menu.
**NURAPC-REVWRD**

**Ward, Review/Edit Classifications By**

**Description:**

This option allows a supervisor or nursing QA staff member to review the classification of patients on a given day by ward. Reclassification of an individual patient is also permitted. Data is stored in the NURS Review Classification (#214.7) file.

**Additional Information:**

This menu is appropriate for supervisors and nursing performance improvement staff. Data is retrieved through a user generated VA FileMan report.

**Menu Display:**

Select Nursing Features (all options) Option: **8** QI Data, Enter/Edit

AMIS 1106 Acuity Edit
Manhours Edit, AMIS 1106a
QI Summary Enter/Edit ...
Review/Edit Patient Classification ...

Select QI Data, Enter/Edit Option: **Review/Edit Patient Classification**

Individual Patient, Review/Edit
Ward, Review/Edit Classifications By

**Screen Prints:**

Select Review/Edit Patient Classification Option: **Ward, Review/Edit Classifications By**
ENTER LOCATION YOU WANT TO SEARCH: **MICU**
Begin updating patient classifications.

NURSPATIENT7,ONE OK? YES// <RET> NURSPATIENT7,ONE 01-01-53
000448888 EMPLOYEE

PATIENT CLASSIFICATION INTENSIVE CARE

Patient: NURSPATIENT7,ONE SSN: 000-44-8888 Admission Date: 08/23/89
Unit: MICU Room/Bed:   Bed Section: INTENSIVE CARE
FACTORS:
A. Position, partial assist | CHOOSE ONE OF
B. Position, complete assist | THESE TWO
C. Physiological monitoring, more than q 2 h >
D. Physiological monitoring, q 1-2 h > CHOOSE ONE OF
E. Physiological monitoring, q 1 h or less > THESE THREE
F. Intravenous therapy, one IV
G. Intravenous therapy, 2 or more lines
H. Respiratory status, non-acute
I. Respiratory status, acute
J. Special procedures performed

Current Classification: 2 Factors: B,C,G (COMPUTER)
Comments:
Last user to classify: NURSUSER,EIGHT
Last date/time classified: JUL 31, 1995@14:23
Last reviewed by:
Last date/time reviewed:

Do you wish to override this classification? No// Y (Yes)

PATIENT: NURSPATIENT7,ONE SSN: 000-44-8888
Enter Factors: B,C,G// A,D,G
Enter Classification: 2// <RET>

NURSPATIENT7,TWO OK? YES/ <RET>

The program continues as above. All patients on the ward can be reviewed without exiting the option. If the user wishes, he/she may:

1. Discontinue the loop after classifying a patient by entering an ^ after the patient's name:
   NURSPATIENT7,THREE OK? YES// ^
   **** ROUTINE FINISHED ****

2. Skip the review of a patient and continue to the next patient:
   NURSPATIENT7,ONE OK? YES// N
   Do you wish to stop looping through names? YES// N
   NURSPATIENT7,TWO OK? YES// <RET>
   NURSPATIENT7,TWO 01-23-47 000345645 SC VETERAN

3. Discontinue classifying a patient at any time by entering an ^ behind any // within the program.
Menu Access:

The Ward, Review/Edit Classifications By option is accessed through the Review/Edit Patient Classification option of the QI Data, Enter/Edit option of the Nursing Features (all options) menu and the QA Coordinators menu.
Chapter 2 Rank Listing of Patient Problems

NURCRP-CP RANK LISTING

Rank Listing of Care Plan Data

Description:

This option displays a listing of patient problems and/or nursing orders (interventions) that have been selected for patients on one or more locations, over a date range. Data is stored in the NURS Care Plan (#216.8) file.

Additional Information:

Patient problems are displayed in rank order by frequency and the most frequently selected problem appears first in the report. Under the patient problems is a list of orders associated with the problem, sorted in rank order by frequency. For selected patients the first letter of the last name and last four digits of the SSN appear with each problem and order.

Information is entered through the Patient Plan of Care, Edit option.

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1 Administration Records, Enter/Edit ...
2 Administration Records, Print ...
3 Administrative Site File Functions ...
4 Nursing Education Reports, Print ...
5 Patient Care Data, Enter/Edit ...
6 Patient Care Data, Print ...
7 Clinical Site File Functions ...
8 QI Data, Enter/Edit ...
9 Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Option: 9 Quality Performance Reports

QI Summary, Print
Rank Listing of Care Plan Data
Screen Prints:

Select Quality Performance Reports Option: Rank Listing of Care Plan Data
Start with Date (Time Optional): 1-1-95 (JAN 01, 1995)
Go to Date (Time Optional): 5-30-95 (MAY 30, 1995)

Select Nursing Unit: MICU
Another Nursing Unit: SICU
Another Nursing Unit: 2AS

You may deselect from the list by typing a minus sign, -, followed by the location name. E.g., -2AS would delete 2AS from the list of locations already selected.

Another Nursing Unit: -2AS
Another Nursing Unit: <RET>

REPORT IDENTIFIER: INTENSIVE CARE UNITS

This is a free-text prompt printed in the header to identify this report.

Would you like statistics by:
1. Admitting Location for a particular admission
2. All Locations the Patient was on during a particular admission.
Choose 1 or 2: 1

Select one of the following:

1 Nursing Diagnoses Only
2 Combination Nursing Diagnoses/Interventions
3 Interventions Only

Select which data is to be displayed in this report: 2 Combination Nursing Diagnoses/Interventions

DEVICE: HOME//Enter appropriate response
<table>
<thead>
<tr>
<th>Rank</th>
<th>Freq</th>
<th>Problem</th>
<th>Report Identifier: INTENSIVE CARE UNITS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7</td>
<td>Activity Intolerance</td>
<td>A9581,J3421,M9536,T3333,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>refer for appropriate consults</td>
<td>M9536,T3333,</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>administer bronchodilators as ordered</td>
<td>T3333,</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>passive/active ROM q{frequency}hrs.</td>
<td>T3333,</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>teach patient</td>
<td>T3333,</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>respiratory rate during activities</td>
<td>T3333,</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>Coping, Ineffective Family</td>
<td>A6408,A9581,M9536,T3333,</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>refer for appropriate consults</td>
<td>A6408,M9536,T3333,</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>assist family to appraise stressors</td>
<td>M9536,T3333,</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>assess family's coping response</td>
<td>T3333,</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>assist family to develop plan to cope with stressors</td>
<td>M9536,</td>
</tr>
</tbody>
</table>
## Rank Listing of Patient Problems

<table>
<thead>
<tr>
<th>Rank</th>
<th>Freq</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>5</td>
<td>Airway Clearance, Ineffective</td>
</tr>
<tr>
<td></td>
<td></td>
<td>M9536,T3333,</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>refer for appropriate consults</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>administer bronchodilators as ordered</td>
</tr>
<tr>
<td>1</td>
<td>4</td>
<td>out of bed q[frequency]</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>weight q[frequency]</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>elevate head of bed</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>I&amp;O q[frequency]</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>mouth care q[frequency]</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>humidity as indicated</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>assess respiratory rate and pattern/breath sounds</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>TPR q[frequency]</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>B/P q[frequency]</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>ABGs/pulse oximetry q[frequency]</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>cardiac rhythm q[frequency]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rank</th>
<th>Freq</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>4</td>
<td>Home Maintenance Management, Impaired</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A9581,D9539,M9536,T3333,</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>refer for appropriate consults</td>
</tr>
<tr>
<td>2</td>
<td>1</td>
<td>assess causative/contributing factors</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>reduce or eliminate causative/contributing factors</td>
</tr>
</tbody>
</table>
### Rank Listing of Patient Problems

<table>
<thead>
<tr>
<th>Rank</th>
<th>Freq</th>
<th>Intervention</th>
</tr>
</thead>
</table>
| 3    | 4    | Self-Care Deficit [Specify]  
|      |      | B6094,M9536,T3333, |
| 1    | 3    | refer for appropriate consults  
|      |      | B6094,M9536,T3333, |
| 2    | 1    | determine person's usual eating pattern  
|      |      | T3333, |
| 2    | 1    | position person in upright, comfortable eating position  
|      |      | B6094, |
| 2    | 1    | provide bathing time and routine to encourage independence  
|      |      | B6094, |
| 2    | 1    | provide adaptive equipment  
|      |      | B6094, |
| 2    | 1    | [Extra Order]  
|      |      | B6094, |
| 2    | 1    | facilitate patient control over activity  
|      |      | T3333, |
| 2    | 1    | assess and utilize support systems [specify]  
|      |      | T3333, |
| 4    | 3    | Breathing Pattern, Ineffective  
|      |      | M9536,T3333, |
| 1    | 3    | refer for appropriate consults  
|      |      | M9536,T3333, |
| 1    | 3    | administer bronchodilators as ordered  
|      |      | M9536,T3333, |
| 1    | 3    | out of bed q[frequency]  
|      |      | M9536,T3333, |
| 2    | 2    | I&O q[frequency]  
|      |      | M9536,T3333, |
| 2    | 2    | weight q[frequency]  
|      |      | M9536,T3333, |
| 2    | 2    | provide for relief of pain  
|      |      | M9536,T3333, |
| 2    | 2    | document use of accessory muscles q [ ]  
|      |      | M9536,T3333, |
| 3    | 1    | assess respiratory rate and pattern/breath sounds  
|      |      | T3333, |
| 6    | 1    | Social Isolation  
|      |      | T3333, |
| 1    | 1    | sit quietly with patient if (s)he is not verbalizing  
|      |      | T3333, |
| 6    | 1    | Sensory/Perception Alteration due to Toxic Substance  
|      |      | T3333, |
| 1    | 1    | involve in 1:1 and groups discussing consequences use/abuse  
|      |      | T3333, |
Menu Access:

The Rank Listing of Care Plan Data option is accessed through the Quality Performance Reports option of the Nursing Features (all options) menu and the Print Reports option of the QA Coordinators menu.
Chapter 3 QI Summary

NURQA-PT-MENU

QI Summary Enter/Edit

Description:

This section explains the options which create the QI Summary data. Entries are stored in the QI Summary file (#217). The Performance Improvement Summary is a module which allows users to create and print monthly/quarterly QI reports, track nursing, non-nursing, and interdisciplinary performance measures, and also integrate data entered into the Survey Generator. Survey Generator is a package that creates questionnaires, totals results, and tracks percentages for threshold evaluation. Together, the Survey Generator and QI Summary report are used for tracking and reporting any performance measures, including chart audits, and discharge summary audits.

Performance Improvement Summary is found in the NURQ namespace. File numbers are in the range of 217 to 217.4. The files are as follows:

217 - NURQ QI SUMMARY: This file contains all of the QI Summary data.
217.1- NURQ STANDARDS OF CARE/PRACTICE: This file contains a list of all the standards of care and standards of practice.
217.2 - NURQ RATIONALE: This file contains all of the rationale data.
217.3 - NURQ FREQUENCY: This file contains all of the frequency data.

Additional Information:

Performance measures are pulled from information (questions) in the Survey Generator. If a double question mark (??) is entered at this prompt,

Select PERFORMANCE MEASURE: ??

You will be presented with the performance measures (questions) from the identified survey.

Example:

Select PERFORMANCE MEASURE: ??

CHOOSE FROM:

1 Is the IV fluid infusing as ordered?
2 Is the bag and IV tubing properly labeled and dated?
3 Was the tubing changed every 48 hours?
4 Was the dressing changed every 24 hours?
5 Was the site appearance charted every shift?
6 Was the site changed every 72 hours or documentation given why it wasn't?
7 Is there a signature for every initial?
There is no jumping allowed in this module. Data can be printed through the QI Summary Print option.

**NOTE:** If you want your survey results to be differentiated by location on the QI Summary report, you must make sure that Nursing Location is a required demographic on the survey. If this is not done, prior to allowing users to participate in the survey, your results will be skewed. The following example shows how to make Nursing Location a required demographic on a survey:

```
Survey Generator Manager Menu

1  Create/Edit a Survey
2  Copy an Survey
3  Print a Survey
4  Release/Disable a Survey for Participation
5  Count Survey Participants
6  Delete a Survey, Questions and Responses
7  Clear a Survey of Responses
8  Generate Survey Statistics
9  Print Statistics by a Demographic Data Item
10 Print all Survey Responses Individually
11 Export a Survey
12 Import a Survey
13 Populate the Demographic Reference File
14 Fix a Survey Response

Select Survey Generator Manager Menu Option: 1 Create/Edit a Survey

Create/Edit/Maintain a Survey v 2.0

Select one of the following:

C Create a New Survey
B Edit Basic Survey data
D Add or Edit Demographic Survey Fields
E Edit All Questions Sequentially
I Add/Edit Individual Questions
P Print a Survey
Q Quit (also uparrow, or <RETURN>)

Selection: D Add or Edit Demographic Survey Fields
Survey Name Selection

Survey NAME: ANY SURVEY       By: NURSNURSE11,FIVE

Subject: ANY SURVEY
Add/Edit Demographic Questions

By: NURSNURSE11,FIVE

Select DEMOGRAPHIC DATA ITEM: NURSING LOCATION

DEMOGRAPHIC DATA ITEM: NURSING LOCATION// <RET>
TYPE: P   POINTER
FILE: 211.4   NURS LOCATION
IS THIS A REQUIRED ANSWER?: Y   YES

Subject: ANY SURVEY
Add/Edit Demographic Questions

By: NURSNURSE11,FIVE

Select DEMOGRAPHIC DATA ITEM: <RET>

Create/Edit/Maintain a Survey

Select one of the following:

C    Create a New Survey
B    Edit Basic Survey data
D    Add or Edit Demographic Survey Fields
E    Edit All Questions Sequentially
I    Add/Edit Individual Questions
P    Print a Survey
Q    Quit (also uparrow, or <RETURN>)

Selection: <RET>
Survey Generator Manager Menu

1. Create/Edit a Survey
2. Copy an Survey
3. Print a Survey
4. Release/Disable a Survey for Participation
5. Count Survey Participants
6. Delete a Survey, Questions and Responses
7. Clear a Survey of Responses
8. Generate Survey Statistics
9. Print Statistics by a Demographic Data Item
10. Print all Survey Responses Individually
11. Export a Survey
12. Import a Survey
13. Populate the Demographic Reference File
14. Fix a Survey Response

Select Survey Generator Manager Menu Option:

Restrictions:

There is no security in the package keeping one service from looking at another services data in the QI routines or in the Survey Generator. You can print anyones' data, but you can only edit your own data. This version of the QI Summary module is compatible with the Survey Generator V. 2.0.

Future Plans:

This package will be enhanced as JCAHO requirements change.

Recommendations:

The QI Summary Report is meant to work in conjunction with the Survey Generator. By using the Survey Generator, you can develop appropriate performance measures to use in monitors and audits. The survey generator will provide you with basic tabulations and statistics which you will use in the QI Summary Report. Once a 'Survey' is created, the performance measures will point to the QI Summary Report - Performance Measure. For specifics on the use of the Survey Generator please refer to the Survey Generator Version 2.0 User Manual.
Definitions:

QI: Quality Improvement also called CQI (Continuous Quality Improvement) and TQI (Total Quality Improvement) is an approach to quality management that builds upon traditional performance improvement methods by:

* Emphasizing the organization and systems, rather than individuals.
* Using objective data with which to analyze and improve processes.
* The ideal that systems and performance can always improve even when high standards appear to have been met.
* This is also called Performance Improvement or Quality Management.

Standards of Care: A written value that defines patient expectations. Standards of Care reflect the Clinical functions of an organization as they are directed to the patient who receives the service. Example: The patient can expect skin integrity to be maintained.

Standards of Practice: A written value that defines the rules, actions, or conditions of practitioners who provide patient care. Standards of Practice reflect the professional functions of the organization as they are directed to the staff who delivers the service. Example: The RN will assist the patient in maintaining skin integrity by assessing the patient, providing an environment conducive to skin integrity and treating skin breakdown when it occurs according to procedure.

Key Functions: Also called "Important Functions" or "Important Aspects of Care" are a goal directed interrelated series of processes that are believed to have a significant effect on the probability of desired patient outcomes (high-risk function, high-volume function, and problem-prone function). Examples: Patient care, education of patients and family, continuum of care, patient rights, assessment.

Indicator (Performance Measure): "A measurement used to monitor and evaluate the quality of important governance, management, clinical and support functions" (Joint Commission) Performance measures do not measure the quality of care, but the practices of individuals, the rules and regulations of the organization, the timeliness of treatment, the use of medical technology and the function of all health care team members. Performance measures point to issues of care that need further investigation. Examples: * Was a Skin Risk Assessment (10-0096) completed? Yes/No.  *The acute med/surg unit has a 2% or less incidence of skin breakdown for pts. per quarter.
Type of Indicator/Performance Measure - Performance measures can be of 3 types:

- **Structure** - assesses the environment in which the care occurs, including qualifications and numbers of providers.
- **Process** - assesses an important and discrete activity that is carried out, either to directly care for the patient or to support patient care.
- **Outcome** - assesses what happens or does not happen to a patient following a process.

Definition of Terms: Part of Performance Measure Development that comes after you have identified the Important Function (Key Function or Important Aspect of Care) and the Performance Measure Statement. It defines the terms in your performance measure statement to provide consistency for reviewers.

Example:

I. **Important Aspect of Care (Key Function):**
   Assessment

II. **Performance Measure Statement:**
   Patients will be assessed within 8 hours of admission.

III. **Definition of Terms:**
   A. **Patients** - any inpatient with a LOS longer than 24 hours.
   B. **Assessed** - 1) Have data gathered regarding chief complaint; physical signs and symptoms; history of medical problems, surgeries, procedures; allergies; psychologic and social status; and ability, need, and readiness to learn and 2) conclusions drawn by a registered nurse, physician, and social worker.
   C. **Within 8 hours of admission** - within 8 hours of the patient's arrival in the nursing unit.

**Menu Display:**

Select Nursing System Manager's Menu Option: **5** Nursing Features (all options)

1. Administration Records, Enter/Edit...
2. Administration Records, Print...
3. Administrative Site File Functions...
4. Nursing Education Reports, Print...
5. Patient Care Data, Enter/Edit...
6. Patient Care Data, Print...
7. Clinical Site File Functions...
8. QI Data, Enter/Edit...
9. Quality Performance Reports...
10. QI Site Files...
11. Special Functions...
Select Nursing Features (all options) Option: 8  QI Data, Enter/Edit

AMIS 1106 Acuity Edit
Manhours Edit, AMIS 1106a
QI Summary Enter/Edit ...
Review/Edit Patient Classification ...

Select QI Data, Enter/Edit Option: QI Summary Enter/Edit

1  Disciplines
2  Important Functions
3  Data
4  Performance Measures
5  Receiver of Results
6  References
7  Other QI Summary Data
8  Edit All QI Summary Data

Menu Access:

The QI Summary Enter/Edit option is accessed though the QI Data, Enter/Edit option of the Nursing Features (all options) option, or through the QA Coordinator menu option.
NURQA-PT-ALL

Edit All QI Summary Data

Description:

This option allows the user to enter/edit all of the QI Summary data for the survey. Data comes from the QI Summary (#217) file which has pointers to the Standards of Care/Practice (#217.1) file, Rationale (#217.2) file, and Frequency (#217.3) file.

Additional Information:

This data can be edited all at one time through option 8, or each section can be edited individually through options 1-7. Data can be printed through the QI Summary Print option.

Menu Display:

Select Nursing Features (all options) Option: 8  QI Data, Enter/Edit

AMIS 1106 Acuity Edit
Manhours Edit, AMIS 1106a
QI Summary Enter/Edit ...
Review/Edit Patient Classification ...

Select QI Data, Enter/Edit Option: QI Summary Enter/Edit

1  Disciplines
2  Important Functions
3  Data
4  Performance Measures
5  Receiver of Results
6  References
7  Other QI Summary Data
8  Edit All QI Summary Data

Screen Prints:

Select QI Summary Enter/Edit Option: 8  Edit All QI Summary Data
Select SURVEY: PATIENT RIGHTS

Answer with the survey name.
DISCIPLINES: HEAD NURSE

Enter name of person(s) or units responsible for this report.

SERVICE: NURSING

Enter the name of the service associated with this survey.

DATA SOURCE:
INTERVIEW WITH COGNITIVELY INTACT PATIENTS
Edit? NO

Enter the name of the source from which the data was collected.

SAMPLE SIZE: 27

Answer with number of observations.

METHODOLOGY:
PATIENT INTERVIEW
Edit? NO

Enter the method with which the data was collected.

FREQUENCY: SEMIANNUALLY

Enter how often this information is reported, i.e. monthly, quarterly, etc. This is a pointer to the Frequency (#217.3) file. The following is a sample list of entries:

ANNUALLY
BIMONTHLY
BIWEEKLY
DAILY
MONTHLY
QUARTERLY
SEMIANNUALLY
WEEKLY

MONITORING PERIOD: YEAR

Answer with the period of time data was collected, i.e. June, 1992; April-June, 1992; etc.

Select RECEIVER OF RESULTS: CHIEF OF NURSING SERVICE

Answer with the name of the person(s) or committees this information is communicated to.

RECEIVER OF RESULTS: CHIEF OF NURSING SERVICE

You may edit this entry.
DATE COMMUNICATED: MAR 02, 1995  

Enter date this information was given to another group or supervisor.

Select RECEIVER OF RESULTS: 

You may make another entry.

REFERENCES:  
SEVERAL ARTICLES HAVE BEEN WRITTEN CONCERNING PATIENT RIGHTS  
Edit? NO  

Answer with any references you may have.

OTHER:  
PATIENTS WERE SURVEYED REGARDING THEIR KNOWLEDGE OF RIGHTS. NEEDS IDENTIFIED INCLUDED THE RIGHT TO REFUSE TREATMENT.  
Edit? NO  

Enter any additional data you may have. The field 'Other' is an extra field that may be used by the service to track additional information not contained in other segments of this module.

Select LOCATION: NUR CCU  

Enter the location you wish to enter data for.

Select IMPORTANT FUNCTIONS: ETHICS/PATIENT RIGHTS  

Answer with high priority functions, processes, treatments, and activities that have the greatest impact on patient care, occur most frequently, affect the largest number of patients or produce risk problems.

IMPORTANT FUNCTIONS: ETHICS/PATIENT RIGHTS  
Replace

You may edit this entry.

Select STANDARDS OF CARE: THE PATIENT WILL NOT HAVE ANY COMPLICATIONS  

Enter patient expectations describing the kinds of care the patient can expect to receive from nurses.

Select STANDARDS OF PRACTICE: THE NURSE WILL PROVIDE EDUCATION TO THE PATIENT  

Enter nurses expectations -- what the nurse does to meet the patient expectations.
Select IMPORTANT FUNCTIONS: <RET>

You may enter more than one.

Select PERFORMANCE MEASURE: 1 Did you receive a copy of the Patient's Bill of Rights when you arrived on the nursing unit?

Answer with one of the questions from the survey.

PERFORMANCE MEASURE: Did you receive a copy of the Patient's Bill of Rights when you arrived on the nursing unit?
Replace <RET>
TYPE OF INDICATOR: OUTCOME// <RET>

Enter either Structure, Process or Outcome. Structure (an indicator that assesses the environment in which care occurs); Process (indicator that assesses an important and discrete activity that is carried out, either to directly care for the patient or to support patient care); Outcome (indicator that assess what happens or does not happen to a patient following a process).

DEFINITION OF TERMS:
  COGNITIVELY INTACT: AWARE OF THEIR ACTIONS
  Edit? NO// <RET>

Enter the definition of any terms used in this data entry.

Select RATIONALE: STUDY ON HOW NURSES ARE SAFEGUARDING PATIENT'S RIGHTS// <RET>

Answer with reason for looking at this indicator. High Risk (causes great risk to patient); High Volume (occurs frequently); Problem Prone (causes problems for patients and staff). The following is a sample list of entries:

    HIGH RISK
    HIGH VOLUME
    PROBLEM PRONE

METHOD OF DETERMINING VARIANCE: HISTOGRAM// <RET>

Enter mechanism to determine when further evaluation must be triggered.

CONCLUSIONS:
  STAFF HAS INCREASED AWARENESS OF PATIENT RIGHTS
  Edit? NO// <RET>

Enter any conclusions you have about this indicator.

RECOMMENDATION/ACTION: EDUCATE PATIENTS REGARDING RIGHTS
Replace <RET>

Describe the recommendations and actions taken on this performance measure.
PERSON/GROUP TAKING ACTION: PROJECT COORDINATOR

Enter name of person(s) responsible for implementing the action.

DATE IMPLEMENTED: MAR 02, 1995

Enter date when action is initiated.

EFFECTIVENESS OF ACTION TAKEN: ACTIONS TAKEN WERE EFFECTIVE IN IMPROVING PATIENT CARE

Answer with how effective the actions were that were taken. The following is a list of choices:

1. NO ACTIONS TAKEN
2. ACTIONS TAKEN WERE EFFECTIVE IN IMPROVING PATIENT CARE
3. ACTIONS TAKEN WERE PARTIALLY EFFECTIVE IN IMPROVING PATIENT CARE
4. ACTIONS TAKEN WERE NOT EFFECTIVE IN IMPROVING PATIENT CARE

Select PERFORMANCE MEASURE:

You may enter another performance measure.

Menu Access:

The Edit All QI Summary Data option is accessed through the QI Summary Enter/Edit option of the QI Data, Enter/Edit option of the Nursing Features (all options) option, or the QA Coordinators menu option.
NURSQA-PR-MENU

Quality Performance Reports

Description:

This section explains the option which prints the QI Summary data. Data comes from the QI Summary file (#217) and the QA Forms file (#748).

Additional Information:

Data is entered through the QI Summary Enter/Edit option.

Menu Display:

Select Nursing System Manager's Menu Option: 5 Nursing Features (all options)

1 Administration Records, Enter/Edit ...
2 Administration Records, Print ...
3 Administrative Site File Functions ...
4 Nursing Education Reports, Print ...
5 Patient Care Data, Enter/Edit ...
6 Patient Care Data, Print ...
7 Clinical Site File Functions ...
8 QI Data, Enter/Edit ...
9 Quality Performance Reports ...
10 QI Site Files ...
11 Special Functions ...

Select Nursing Features (all options) Options: 9 Quality Performance Reports

QI Summary, Print
Rank Listing of Care Plan Data

Menu Access:

The Quality Performance Reports option is accessed through the Nursing Features (all options) menu.
NURQA-PT-10PRINT

QI Summary, Print

Description:

This option allows the user to print all of the QI Summary data for a particular survey, including the statistics for that survey. Data comes from the QI Summary (#217) file and the QA Forms (#748) file.

Additional Information:

Data is entered through the QI Summary Enter/Edit option.

Menu Display:

Select Nursing Features (all options) Option: 9  Quality Performance Reports

    QI Summary, Print
    Rank Listing of Care Plan Data

Screen Prints:

Select Quality Performance Reports Option: QI Summary, Print
Select SURVEY: PATIENT RIGHTS

Answer with the survey name.

Select UNIT (Enter return for all units): CCU

Enter location of survey.

DEVICE: HOME//Enter appropriate device
A. DISCIPLINES: HEAD NURSE, NURSING SERVICE

B. DATA:
   1. DATA SOURCE:
      INTERVIEW WITH COGNITIVELY INTACT PATIENTS
   2. SAMPLE SIZE: 27
   3. METHODOLOGY:
      PATIENT INTERVIEW
   4. FREQUENCY: SEMIANNUALLY
   5. MONITORING PERIOD: YEAR
   6. SURVEY STATISTICS:
      1) Did you receive a copy of the Patient's Bill of Rights when you arrived on the nursing unit?
         12 participants or 40.0% responded NO
         18 participants or 60.0% responded YES
      2) Were the rules of your unit discussed with you? (meals passes laundry)
         13 participants or 43.3% responded NO
         17 participants or 56.7% responded YES
      3) Does the nursing staff provide you with privacy?
         3 participants or 10.0% responded BLANK-BYPASSED.
         6 participants or 20.0% responded NO
         21 participants or 70.0% responded YES
      4) Does the nursing staff treat your personal property with respect?
         6 participants or 20.0% responded BLANK-BYPASSED.
         2 participants or 6.7% responded NO
         22 participants or 73.3% responded YES
      5) Do you know about living wills and medical durable power of attorney?
         5 participants or 16.7% responded NO
         25 participants or 83.3% responded YES
      6) Do you know why you are in the hospital? (request a specific diagnosis/answer)
         3 participants or 10.0% responded BLANK-BYPASSED.
         3 participants or 10.0% responded NO
         24 participants or 80.0% responded YES
QI SUMMARY: PATIENT RIGHTS

7) Do you know what medications you are taking?
   - 1 participant or 3.3% responded BLANK-BYPASSED.
   - 5 participants or 16.7% responded NO
   - 24 participants or 80.0% responded YES

8) Do you usually know what your plan of care is?
   - 2 participants or 6.7% responded BLANK-BYPASSED.
   - 7 participants or 23.3% responded NO
   - 21 participants or 70.0% responded YES

9) Do the nurses treat you with respect?
   - 4 participants or 13.3% responded NO
   - 26 participants or 86.7% responded YES

10) What is the name of the nurse caring for you?
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - Correct response
    - Free text response:
      - No
QI SUMMARY: PATIENT RIGHTS

free text response: N

free text response: No

free text response: No

free text response: No

free text response: No

free text response: No

free text response: No

free text response: No

free text response: No

free text response: No

free text response: No

free text response: N

free text response: No

free text response: No

free text response: No

free text response: No

free text response: NURSNURSE1

free text response: NURSNURSE2

free text response: NURSNURSE3

Total responses: 30
QI Summary

HINES 12-16-92 PAGE: 4
QI SUMMARY: PATIENT RIGHTS

C. RECEIVER OF RESULTS:
   SUPERVISOR/COORDINATOR
       DATE COMMUNICATED: 12-16-92
   CHIEF OF NURSING SERVICE
       DATE COMMUNICATED: 12-16-92
   HEAD NURSE
       DATE COMMUNICATED: 12-16-92

D. REFERENCES:
   SEVERAL ARTICLES HAVE BEEN WRITTEN CONCERNING PATIENT RIGHTS

E. OTHER:
   PATIENTS WERE SURVEYED REGARDING THEIR KNOWLEDGE OF RIGHTS. NEEDS
   IDENTIFIED INCLUDED THE RIGHT TO REFUSE TREATMENT.

ENTERED BY: NURSUSER, NINE

F. LOCATION INFORMATION:

**********
1. CCU
   A. SURVEY STATISTICS:

      No statistics data for this ward

   B. IMPORTANT FUNCTIONS:

      | STANDARD FUNCTION | ASSOC. OF CARE | STANDARD FUNCTION | ASSOC. OF PRACTICE |
      |-------------------|---------------|-------------------|---------------------|
      ETHICS/PATIENT    | THE PATIENT WILL NOT HAVE ANY COMPLICATIONS | NURSING          | THE NURSE WILL PROVIDE EDUCATION TO THE PATIENT |

C. PERFORMANCE MEASURE:

Did you receive a copy of the Patient's Bill of Rights when you arrived on the nursing unit?

<table>
<thead>
<tr>
<th>QUESTION #1</th>
<th>QUESTION #2</th>
<th>QUESTION #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>OUTCOME</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. TYPE OF INDICATOR: OUTCOME
2. DEFINITION OF TERM:

   COGNITIVELY INTACT:
   AWARE OF THEIR ACTIONS

3. RATIONALE:

   STUDY ON HOW NURSES ARE SAFEGUARDING PATIENT’S RIGHTS
Question #4 | Question #5 | Question #6
---|---|---
1. TYPE OF INDICATOR: | | |
2. DEFINITION OF TERM: | | |
3. RATIONALE: | | |
4. METHOD OF DETERMINING VARIANCE: | | |
5. CONCLUSIONS: | | |
6. RECOMMENDATION/ACTION: | | |
7. PERSON/GROUP TAKING ACTION: | SANDY THOMAS | |
8. DATE IMPLEMENTED: | | 12/14/92 |
9. EFFECTIVENESS OF ACTION TAKEN: | | |

Enter RETURN to continue or `^^` to exit: <RET>
Glossary

AA  Authorized absence of staff member from duty.

Access Code  A unique sequence of characters known by and assigned only to the user, the system manager and/or designated alternate(s). The access code (in conjunction with the verify code) is used by the computer to identify authorized users.

Acuity  Patient classification or category rating from 1 through 5.

Administration Schedule  This is a common abbreviation for a schedule. A schedule is the frequency for which an action is to take place, such as every eight hours (Q8H) or every other day (QOD).

ADP Coordinator/ADPAC/Application Coordinator  Automated Data Processing Application Coordinator. The person responsible for implementing a set of computer programs (application package) developed to support a specific functional area such as nursing, PIMS, etc.

ADT  Admission, Discharge, Transfer (PIMS option).

AMIS  Automated Management Information System.

Application  A system of computer programs and files that have been specifically developed to meet the requirements of a user or group of users. Examples of VISTA applications are the PIMS and nursing modules.

Archive  The process of moving data to some other storage medium, usually a magnetic tape, and deleting the information from active storage in order to free-up storage space on the system.

Audit Trail/Logging Features  The use of automated software procedures to determine if the security controls implemented for protection of computer systems are being circumvented and to identify the potential source of the security breach.

Backup Procedures  The provisions made for the recovery of data files and program libraries and for restart or replacement of ADP equipment after the occurrence of a system failure.

Baud Rate  The rate at which data is being transmitted or received from a computer. The baud rate is equivalent to the number of characters per second times 10.

Block  The unit of storage transferred to and from disk drives, typically 512, 1024, or 2048 bytes (characters).
Glossary

Boot  The process of starting up the computer.

Bulletin  A canned message that is automatically sent by MailMan to a user when something happens to the data base.

Byte  A unit of computer space usually equivalent to one character.

C.E.  Continuing education.

CIOFO  Chief Information Office Field Office, formerly known as Information Resource Management Field Office, and Information Systems Center.

CNO  Central nursing office (e.g., CNO printer).

Contingency Plan  A plan which assigns responsibility and defines procedures for use of the backup/restart/recovery and emergency preparedness procedures selected for the computer system based on a risk analysis for that system.

CORE  A collection of VA developed programs (specific to PIMS, Pharmacy Service, and Laboratory Service) which are run at VA Medical Centers.

CPRS  Computerized Patient Record System.

CPU  Central Processing Unit, the core of a computer system.

CRT  Cathode Ray Tube, similar to a TV monitor but used in computer systems for viewing data. Also called a Video Display Terminal (VDT).

Current Employee  A nursing employee with the status of 'active' or 'intermittent' as identified in the NURS Staff (#210) file.

Currently Employed  See 'Current Employee'.

Cursor  A visual position indicator (e.g., blinking rectangle or an underline) on a CRT that moves along with each character as it is entered from the keyboard.

Data Dictionary  A description of file structure and data elements within a file.

Device  A hardware input/output component of a computer system (e.g., CRT, printer).

Disk  A magnetic storage device used to hold information.

Edit  Used to change/modify data typically stored in a file.
EOD   Enter on Duty. The date on which an individual began his/her employment.

Field   A data element in a file. For example, FTEE and SEX are fields in the NURS Staff file (#210).

File   An area where data is stored for retrieval at a later time. A computer record of related information (e.g., Staff (DB) File, Patient file, Prescription file).

File Manager or FileMan   Within this manual, File Manager or FileMan is a reference to VA FileMan. FileMan is a set of M routines used to enter, edit, print, and sort/search related data in a file; a database.

Focus Group   Previously referred to as the Expert Panel, or SIUG (Special Interest User Group). A committee which advises programmers about the development of a particular system/package.

FTEE   Full time employee equivalent.

Global   An M term used when referring to a file stored on a storage medium, usually a magnetic disk. In the nursing software, for example, nursing employee data is stored in one global, and patient data is stored in another global.

GMRV   This signifies the General Medical Record namespace assigned to the Vitals/Measurements application.

GMRY   This signifies the General Medical Record namespace assigned to the Intake and Output application.

Grade/Step   The salary grade and its related step.

Hardware   The physical or mechanical components of a computer system such as CPU, CRT, disk drives, etc.

I&O   Intake and Output.

Intake /Output Type   The type denotes from where the intake or output is derived, i.e., oral, intravenous, etc.


IV   Intravenously; by intravenous injection.
Glossary

Kernel   A set of software utilities. These utilities provide data processing support for the application packages developed within the VA. They are also tools used in configuring the local computer site to meet the particular needs of the hospital. The components of this operating system include: MenuMan, TaskMan, Device Handler, Log-on/Security, and other specialized routines.

Kilobyte   More commonly known as Kbyte or K. A measure of storage capacity equivalent to 1024 characters.

LAYGO   An acronym for Learn As You Go. A technique used by FileMan to acquire new information as it goes about its normal procedure. It permits a user to add new data to a file.

M   Formerly known as MUMPS. Massachusetts (General Hospital) Utility Multi-Programming System. This is the programming language used to write all VISTA applications.

M.I.   Mandatory Inservice.

MailMan   An electronic mail, teleconferencing, and networking system.

Megabyte   A measure of storage capacity; approximately 1 million characters. Abbreviated as Mbyte or Meg.

Memory   A storage area used by the computer to hold information.

Menu   A set of options or functions available to users in editing, formatting, generating reports, etc.

Menu Manager   A part of the Kernel that allows each site to manage the various options or functions available to individual users.

ML   Milliliters; a unit of volume used in the Intake and Output application.

Modem   An electronic device which converts computer signals to enable transmission through a telephone.

Module   A component of the nursing software application that covers a single topic or a small section of a broad topic.

Namespace   A naming convention followed in the VA to identify various applications and to avoid duplication. The namespace is used as the prefix for all routines and globals used by the application. The nursing software uses NUR as its namespace.

NPSB   Nurse Professional Standards Board.
Nursing Unit   A nursing location which is found in the NURS Location (#211.4) file.

Operating System   The innermost layer of software that communicates with the hardware. It controls the overall operation of the computer such as assigning places in memory, processing input and output. One of its primary functions is interpreting M computer programs into a language the system can understand.

Option   A functionality that is invoked by the user. The information defined in the option is used to drive the menu system. Options are created, associated with others on menus, or given entry/exit actions. For example, the NURS-SYS-MGR is the main menu for the Nursing application.

Package   Otherwise known as an application. A set of M routines, files, documentation and installation procedures that support a specific function within VISTA (e.g., the ADT and Intake and Output applications).

Password   A protected word or string of characters that identifies or authenticates a user, a specific resource, or an access type (synonymous with verify code).

Patient Plan of Care   Previously referred to as Nursing Care Plans. The following is a list of terms related to Patient Plan of Care:

Additional Text   Appears as an individual selection for the five basic components of the care plan. It is free text, ranging from 1-245 characters and can be used to clarify or individualize a patient's plan of care. Additional Text does not highlight and no '**' precedes it when selected. Example: ADDITIONAL TEXT: Hard of Hearing.

Aggregate Term   An aggregate term is an element. Throughout the hierarchy of Patient Plan of Care when a selection is made in the development of a patient care plan, that selection is an element/aggregate term. In the Patient Plan of Care site configuration file the same holds true. When prompted with "Select Term to Add," you are adding an element/aggregate term, to that level of the Patient Plan of Care hierarchy. Aggregate terms may be either a Frame or a Term. An example of an aggregate term may be any of the following: altered cardiovascular status, Goals/Expected Outcomes, A-line patent, PA line.

Appended Text   Text that is entered by the user at the end of an element to further clarify the context of the patient data. (For example, if you choose to append the text for SIGNS AND SYMPTOMS OF INFECTION, you could add the terms REDNESS, SWELLING, DRAINAGE, etc., for clarification.).
Classification   A characteristic assigned to one or more aggregate terms in order to link the proper contributing factor (Etiology, Goals/Expected Outcomes, Interventions or Related Factors) or parent (Patient Specific Problems). The TERM 'wine with meals' is an Intervention, therefore, the classification is ORDERABLE and is displayed with Treatment Interventions/Orders.

Contributing Factor   One of the 5 basic components of a patient plan of care. The 5 contributing factors are:
1. Defining Characteristics
2. Etiology/related and/or risk factors
3. Goals/expected outcomes
4. Intervention/orders
5. Related problems.

Defining Characteristics   Subjective/objective signs and symptoms indicative of a condition corresponding to a given Nursing Diagnosis. It is a contributing factor as well as a classification for "Defining Characteristics".

Element   A component or an essential part. It can be a TERM or FRAME and comprises the selections used to create a Patient Plan of Care. Example: below the knee amputation or altered cardiovascular status.

Frame   This is an element that is general and allows specific items or elements to be selected. A frame contains more selections or terms. Example:
+ A-line (FRAME)
1. Calibrate and monitor on Adm. & PRN (TERM)
2. Maintain good position of extremity.

Goal   A classification used to identify a Goal and/or Expected Outcome. A goal can be measurable or the final outcome of a problem. When used as date for reference or action 'Met' is associated with it.

Goal/Expected Outcome   Has two purposes:
1. It is a contributing factor (major level), as well as;
2. A classification for the "contributing factor" Goals/Expected Outcomes.

Internal Text   This is text that can be entered by the user to clarify the meaning of an element. Left and right brackets, [ ], indicate the user will be asked to insert additional text to clarify the element. E.g., V/S q[ ]h, 4 is inserted and text appears as V/S q[4]h.

Intervention   The classification for the contributing factor 'Intervention/ Orders'. It links all orders or interventions. Previously, this was named Nursing Interventions.
Glossary

Lead Text  See Glossary Term under Patient Plan of Care "Text".

Max  The maximum number of selections that can be selected under a frame. This is normally left blank, when creating a site specific Patient Plan of Care there is no limit to the selections that can be made.

Min  The minimum number of selections that can be selected under a frame. The number one (1) is always entered when creating a site specific Patient Plan of Care indicating that at least one (1) selection must be made or the frame will not be included in the care plan.

Orderable  A classification that is used to link a name and/or frame to Intervention/Order. Orderable allows you to track the date of initiation and the date of discontinuation.

PPC  Patient Plan of Care (Previously called Nursing Care Plan).

Prime Document  A classification for the highest level of PPC.

Related Factor  The classification for the contributing factor for Related Problems.

Related Problem  One of the 5 basic contributing factors of the PPC.

Site Configurable  A term used to refer to features in the system that can be modified to meet the needs of each site. The site configuration option allows ADP coordinators to add to "already existing" medical diagnoses/nursing problems.

Tabular  The output format for PPC in which the frame and/or document is displayed. There are 3 types of output format, but only tabular is used with PPC.

Term  An element used to designate a specific/singular thought or idea. Ex., calibrate and monitor on Adm. & PRN.

Text  Lead and trail text are fields which should be used to provide additional information to FRAMES and TERMS usually associated with Intervention/Orders and Nursing Goals/Outcomes. This information, though useful, might exceed the frame's or term's 60 character field.
1. **Lead Text (for Terms)** An example of lead text: The aggregate term under an Intervention should be "assess, monitor and document respiratory rate during activities". The key intervention is "respiratory rate during activities" but for clarity you need to include assess, monitor, and document. Therefore, you can build the aggregate term "respiratory rate during activities" under the frame Intervention/Orders and place the text "assess, monitor, and document" into the lead text field.

2. **Trail Text (for Terms)** Example: The aggregate term under Intervention might be "assess for signs of fatigue and weakness" but you also need to note that the patient should be monitored and that the information must be documented. Therefore, by adding: "monitor and document" as trail text to the aggregate term, the following intervention can be displayed on the care plan: "assess for signs of fatigue and weakness; monitor and document."

3. **Lead and/or Trail Text (for Frames)** Lead and/or Trail Text can be used in a FRAME so that you do not have to keep typing the same word or phrase to TERMS listed under FRAME. Ex. When a user selects the FRAME "refer for appropriate consult", he/she is asked to select the appropriate consult(s). When the Care Plan is printed the word "specifically" is printed following the element. "Specifically" is listed as a Trail Text in the site configuration file. The print would look like "refer for appropriate consult specifically (Physical Therapy, Chaplain)".

**PIMS** Patient Information Management System previously known as the MAS Package.

**PO** Per orum; refers to an item consumed orally or through the mouth.

**Pointer** A special type of FileMan data that takes its value from another file. This is a method of joining files together and avoiding duplication of information.

**Port** An outlet in the back of the computer into which terminals can be connected.

**Printer** A device for printing (on paper) data which is processed by a computer system.

**Program** A set of M commands and arguments, created, stored, and retrieved as a single unit in M.

**Protocol** A single entry point referencing multiple routine entry points to execute several inter related, required processes which perform specific functions. When multiple protocols are associated with a single procedure (i.e., intravenous lines or IV lines), they are found grouped under a single option.
Glossary

Purge  The deletion of data from a file.

Qualifier  A word that gives a more detailed description of an item.

Queuing  The scheduling of a process/task to occur at a later time. Queuing is normally done if a task uses up a lot of computer resources.

Required Field  A field which the user must complete by entering requested data.

Response Time  The average amount of time the user must wait between the time the user responded to a question at the terminal and the time the system responds by displaying data and/or the next question.

Restart/Recovery Procedures  The actions necessary to restore a system's data files and computational capability after a system failure or penetration.

<RET>  Carriage return.

Routine  A set of commands and arguments, created, stored, and retrieved as a single unit in M.

Risk Analysis  An analysis of system assets and vulnerabilities to establish an expected loss from certain events based on estimated probabilities of the occurrence of such events.

Security Key  A function which unlocks specific options and makes them accessible to an authorized user.

Security System  A part of Kernel that controls user access to the various computer applications. When a user signs-on, the security system determines the privileges of the user, assigns security keys, tracks usage, and controls the menus or options the user may access. It operates in conjunction with MenuMan.

Sensitive Information  Any information which requires a degree of protection and which should be made available only to authorized users.
Glossary

Service Category  A term used within the nursing software to categorize employees into six generic groups:
   (1) registered nurse
   (2) licensed practical nurse
   (3) nursing assistant
   (4) clerical staff
   (5) administrative officer/assistant
   (6) other
The sixth category, other, can be used when (a) the first (1-5) categories are inappropriate, and/or (b) the FTEE should not be included in the above five FTEE category counts.

Service Position  A term used within the nursing software to categorize employees based on job descriptions. Examples of service positions are: staff nurse, LPN 5, NA 4, supervisor, clerk typist, etc.

Site Configurable  A term used to refer to features in the system that can be modified to meet the needs of each site.

Software  A generic term referring to a related set of computer programs. Generally, this refers to an operating system that enables user programs to run.

Subroutine  A part of a program which performs a single function.

1Synonym  A qualifier abbreviation appended to vitals/measurements numeric values on graphic reports.

Task Manager or TaskMan  A part of Kernel which allows programs or functions to begin at specified times or when devices become available. See Queuing.

Telecommunications  Any transmission, emission, or reception of signs, signals, writing, images, sounds or other information by wire, radio, visual, or any electromagnetic system.

Terminal  A device used to send and receive data from a computer system (i.e., keyboard and CRT, or printer with a keyboard).

TIU  Text Integration Utility.

Type(s) of Training  A specific category of training class or program as defined in the PAID Education Tracking module. The categories are defined as mandatory training, continuing education, other/miscellaneous, and ward/unit-location training.

UCI  User Class Identifier. The major delimiter of information structure within the operating system.

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1 Patch NUR*4*4  August 1997
Glossary

User  A person who enters and/or retrieves data in a system, usually utilizing a CRT.

Utility  An M program that assists in the development and/or maintenance of a computer system.

VDT  Video Display Terminal. Also called a Cathode Ray Tube (CRT).

Verify Code  A unique security code which serves as a second level of security access. Use of this code is site specific; sometimes used interchangeably with a password.

VISTA  Veterans Health Information Systems and Technology Architecture.

Ward/Unit Location  See Nursing Unit.
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