NaviCare® WatchChild®

Obstetrical Data Management System

User Manual

LAB00197 rev. 11

Federal Communications Commission Notice

This equipment has been tested and found to comply with the limits for a Class A digital device, pursuant to part 15 of the Federal Communications Commission (FCC) rules. These limits are designed to provide reasonable protection against harmful interference when the equipment is operated in a commercial environment. This equipment generates, uses and can radiate radio frequency energy and, if not installed and used in accordance with the instruction manual, may cause harmful interference to radio communications. Operation of this equipment in a residential area is likely to cause harmful interference, in which case the user will be required to correct the interference at their own expense.

NOTE: Changes or modifications to equipment not expressly approved in writing by Hill-Rom could void the user's authority to operate the equipment.

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Preface

Description of Device

The NaviCare® WatchChild® Obstetrical Data Management System (NaviCare® WatchChild®) has the capability to record, store, and display fetal and maternal data from initial prenatal care and including antepartum testing. These tests are done through labor, delivery, and discharge. Specifically, data from fetal monitoring and maternal vital signs monitoring equipment can be recorded, stored, and displayed in NaviCare® WatchChild®. This is made possible with automation of the following areas:

- Admission/Discharge/Transfer (ADT)
- Labor and Delivery Charting
- Nursing Notes
- Physician's Notes
- Fetal Strip Display
- Obstetrical Statistical Trend Reports (e.g., patient admissions and discharges over time)

NaviCare® WatchChild® enables clinicians to simultaneously view a patient's fetal strip and clinical data. Interaction with NaviCare® WatchChild® is accomplished through a graphical user interface (GUI). Users can input data, select options and activate buttons on the screen by using a PC keyboard and mouse. In addition, a physician who has been granted access to the patient's NaviCare® WatchChild® record by the clinical facility can use a PC to access the patient's records remotely from any location that has authorized access to the NaviCare® WatchChild® server, and can remotely update the patient's record and fetal strip.

NaviCare® WatchChild® is offered with an optional write once, read many (WORM) optical disks archiving system, which replaces conventional paper storage.

Intended Use

NaviCare® WatchChild® is intended to be used as a complete Obstetrical Data Management System, which has the ability to record, store, and display data from fetal and maternal vital signs monitors. It manages patient information from the initial prenatal care to post-delivery discharge. NaviCare® WatchChild® organizes clinical data that would normally be provided on paper records or other clinical systems and devices. This system also serves as a decision support tool and serves as an electronic medical record.

Indications for Use

NaviCare® WatchChild® is indicated for use in a hospital/clinical environment.

CAUTION: Federal law restricts this device to be sold by or on the order of a licensed physician.

CAUTION: NaviCare® WatchChild® is not intended to be a diagnostic device. You must follow good clinical practices, your hospital's guidelines and policies for patient care, and other recognized acceptable standards such as the Association of Women's Health Obstetrics and Neonatal Nurses (AWHONN) and American College of Obstetrics and Gynecology (ACOG), which prescribe patient assessment intervals. Use of NaviCare® WatchChild® is not intended to replace clinical assessment and evaluation of the patient. Whenever there is any question of diagnosing fetal well being, a review of the fetal monitor strip is appropriate.

Who Should Read This Manual

This manual is intended for use by the following staff:

- Nurses (Labor & Delivery, Postpartum, Antepartum, Nursery, Mother-Baby)
- Perinatologists
- Pediatricians
- Family practitioners
- Anesthesiologists
- Obstetricians
- Certified nurse midwives
- Unit secretaries
- Medical records staff
- Clinical office staff
- Obstetric residents
- Nurse Managers and supervisors

Related Documentation

You may also refer to the following documents related to NaviCare® WatchChild®:

- *NaviCare® WatchChild® System Administrator Manual, (LAB00196)*
- *NaviCare® WatchChild® Training Manual, (LAB00200)*
- *NaviCare® WatchChild® HL7 Interface Specifications Manual, (LAB00241)*
- *NaviCare® WatchChild® Release Notes (LAB00318)*
- *NaviCare® WatchChild® Newborn Neonatal Data Management System User Manual, (LAB00691)*

Summary of Warning and Caution Statements

This section provides a summary of all the warning and caution statements included in this manual.

Chapter 1, "Description of Device"

CAUTION: Federal law restricts this device to be sold by or on the order of a licensed physician.

CAUTION: NaviCare® WatchChild® is not intended to be a diagnostic device. You must follow clinical practices, your hospital's guidelines and policies for patient care, and other recognized acceptable standards such as the Association of Women's Health Obstetrics and Neonatal Nurses (AWHONN) and American College of Obstetrics and Gynecology (ACOG), which prescribe patient assessment intervals. Use of NaviCare® WatchChild® is not intended to replace clinical assessment and evaluation of the patient.Whenever there is any question of diagnosing fetal well being, a review of the fetal monitor strip is appropriate.

Chapter 2, "Getting Started with NaviCare® WatchChild®"

CAUTION: Only the Single-Patient Surveillance screen has sufficient precision of the fetal strip to be used for assistance with decision support.

CAUTION: You must inform NaviCare® WatchChild® whether the monitored data belongs to the same patient in the bed or to a new patient. This verification helps to prevent the strip of a new patient from being merged to the strip of the previous patient in that bed.

Chapter 3, "Admitting a Patient"

CAUTION: If you admit a new patient when the **Admit Patient** button is red, the new patient's strip will be merged with the previous patient's strip data.

Chapter 9, "Transfer Patients and Merge, Move or Delete Monitoring Strips"

CAUTION: If the message "monitor is/was on but no patient admitted. Transfer to OUT to remove" is displayed on a bed, admitting a new patient to this bed will cause merging of the previous patient's strip with the new patient's strip. Transfer the strip to OUT before performing the patient transfer.

CAUTION:

CAUTION: Moving or deleting strip data can result in valid patient data being overwritten or deleted. Do not perform the procedure below unless you are absolutely certain that moved data will not overwrite valid data and that data being deleted is truly extraneous or invalid.

Chapter 11, Using Alerts.

WARNING: Alerts are not substitutes for the maternal physiological monitors or maternal fetal monitors connected to the patients. Failure to follow the established hospital protocol may result in serious injury or death for the patient or fetus.

WARNING: NaviCare® WatchChild® alerts are intended to alert the health care professionals of conditions beyond certain parameters. The alerts are not intended as diagnostic tools and are not substitutes for proper patient evaluation.

CAUTION: ALWAYS check all fetal heart rates when caring for multiple fetuses.

CAUTION: Maternal NIBP or SpO2 alerts will not be enabled unless a patient is admitted to NaviCare® WatchChild®.

CAUTION: ***ALWAYS*** check the workstation alert parameters after an interruption in service of NaviCare® WatchChild® and after admitting a patient to determine if the defined parameters are appropriate for that patient. If alerts have been re-defined for a patient, those parameters remain in effect for that patient whenever she is transferred or discharged. When a patient is newly admitted, the default parameters are in effect.

Chapter 19, “ADT Interface”,

CAUTION: To avoid attaching strips to the incorrect patient, the fetal monitor should be turned off when the patient is discharged. Leaving the monitors running once the patient is discharged could result in an incorrect merging of the fetal monitor strip.

CAUTION: When beds alert without a patient name in the bed, verify the strip belongs to correct patient.

CAUTION: To reduce the risk of strip issues, NWC prohibits ADT messages to remove patients from a bed when the monitor is on or if alerts are currently active on the bed.

Chapter 20, “Strip Analysis” .

WARNING: Strip analytics tools are provided for charting assistance only and are intended as recommendations only. Use of Strip analytics tools are not intended to replace clinical assessment and evaluation of the patient, nor be used as the sole source for decisions regarding patient care. Users must follow clinical practices, hospital guidelines and policies for patient care, and other recognized acceptable standards such as the Association of Women's Health Obstetrics and Neonatal Nurses (AWHONN) and American College of Obstetrics and Gynecology (ACOG).

WARNING: Strip analysis is not saved as a flowsheet record or in an audit trail It is not intended to be the sole source of analysis of fetal strip data. It is a tool to assist the user in documenting a fetal assessment.

Chapter 21, Troubleshooting Tips

CAUTION: Data retention and recovery may not be possible during an interruption in service to NaviCare® WatchChild®. To ensure that important medical record information is retained, always run fetal monitor paper when experiencing service delays or outages. Always revert to hospital standard practices for the completion and retention of patient medical data.

Conventions

Typographical

This guide uses the following typographic conventions:

Bold Type	Indicates a specific area within NaviCare® WatchChild®, or a command or function.
Italic Type	Indicates a special term, emphasis, or the title of a book.

`Monotype`	Indicates the specific text to type into a field.
Blue text	Indicates a cross-reference hyperlink. When viewing this manual on a PC, clicking the blue cross-reference will take you to the referenced location in the manual.

Icons

The following Icon Key shows the icons you may find in the text of this manual. When an icon appears, it indicates the following:

NOTE: This icon denotes a tip or note for more efficient operation of the system.

CAUTION: This icon denotes a caution statement. Caution statements indicate a potentially hazardous situation, which, if not avoided, may result in minor or moderate injury to the user or patient, or equipment damage.

WARNING: This icon denotes a warning statement. Warning statements indicate a potentially hazardous situation, which, if not avoided, may result in serious injury or death.

Cleaning NaviCare® WatchChild® Components

To assure proper functioning of NaviCare® WatchChild®, regular cleaning of the system components like keyboard, mouse, monitor, and so on, is necessary. It is advisable to keep fluids away from the workstation area to prevent possible spills that can damage the components.

Refer to the manufacturer’s user manuals on cleaning and maintenance of the system components.

Proper Disposal of Non-Functional Equipment

Follow the manufacturer's user manual for proper disposal of non-functional hardware components.

For non-functional Data Acquisition Servers (DASs) and instructions on proper disposal, contact NaviCare® WatchChild® Technical Support.

Usage Tips

Signatures

Several NaviCare® WatchChild® screens have a Signature button and/or field that enables — and in some cases requires — you to certify that you have personally performed the procedures recorded on that screen. However, signatures entered on screens are for NaviCare® WatchChild® accountability purposes only. Signatures in NaviCare® WatchChild® are not considered electronic legal document signatures in accordance with ASTM E1762-95 (E1762-95 Standard Guide for Electronic Authentication of Health Care Information, ASTM International, Volume 14.00, 2003).

General Shortcuts

- Press Tab on the keyboard after entering data in each field instead of pressing Enter. To go back to the previous field, press Shift+Tab.
- Press Tab to automatically calculate any number of fields such as the EDD, Age, and Labor Stages. Pressing Tab after entering data into these types of fields will calculate the value for the associated field.
- The F3 key is the same as selecting **OK**.
- The F4 key is the same as selecting **Cancel**.
- Pressing the F6 key while the cursor is in a field enables you to see the history of changes to that field, which serves as an audit trail.
- The F10 key activates the numeric keypad or a pop-up window, depending on the field.
- To close NaviCare® WatchChild®, go to the Census screen or a Single- or Multi-Patient Surveillance screen and then press the keyboard Ctrl-T keys. Ctrl-T places the screen within a standard Windows frame with an X (close) box in the upper-right corner. Selecting the X closes NaviCare® WatchChild®. (If you decide after pressing Ctrl-T that you do not want to close NaviCare® WatchChild®, press Ctrl-T again to remove the Windows frame.). The system can also be closed by pressing Alt+F4. If the system is not on the census board, Alt+F4 will need to be pressed again.

Screen Buttons

You will encounter the buttons shown at right on many NaviCare® WatchChild® screens. While OK and Cancel appear on most screens, Next and the two arrow buttons appear only in context, as described below.

Next	Appears on all screens where entered data is charted as a record in one or more flowsheets. Saves and charts data, clears the data entry fields and leaves the current screen up for charting another entry.
OK	Saves screen data changes or authorizes an action and takes you out of the current screen. Only use this button if you have changed the screen data.
Cancel	Deletes data that you have just entered but not yet saved and closes the current screen. Only use this button if you have not changed any screen data, or do not want to save any changes.
⇦	Appears only when a screen is part of a sequence of two or more related screens. The back arrow button takes you back to the previous screen in a sequence of related screens.
⇨	Appears only when a screen is part of a sequence of two or more related screens. The forward arrow button takes you to the next screen in a sequence of related screens.

System Function buttons, shown in Figure 1-1, are displayed across the bottom of the Census and Surveillance screens, above the status bar, and perform the functions described below:

Figure 1-1 *System Function Buttons and Status Bar*

Census Displays the Census screen, which lists all unit beds and basic information about each occupied bed. Bed numbers are color coded to visually indicate each patient's status according to the hospital's policy.

Archive Displays the Archive Retrieval screen, which provides access to archived patient records and enables the reverse discharge of a patient who has been discharged from NaviCare® WatchChild®.

View Strips Views selected single or multiple patient beds on a Surveillance screen.

Back Takes you back to the previous Surveillance screen.

Maternal Gives access to the Maternal Census screen, which shows the list of bed numbers and patients names with the most recent vital signs as captured from the Electronic Fetal Monitor or an approved Physiologic Monitor.

System Provides access to system administrative functions such as generating reports, setting user authorizations and configuring system parameters.

Newborn Opens the application to the NaviCare® WatchChild® Neonatal Record. This is only accessible within the Comprehensive Chart. There are two options for the Newborn Record – the Classic option will be described in this manual. The separate Newborn Application has its own operating manual.

Logout Logs a user off the system. The user's name is removed from the status box. The current screen remains displayed without patient identification, but the next user must log in before using the system.

Help Displays online help (by linking to the manuals and release notes) and a phone number for NaviCare® WatchChild® Technical Support.

The small grey status bar is located at the bottom of the screen below the System Function buttons, as shown in Figure 1-1. The status bar shows the following:

- Workstation IP address (left)
- User name (to the right of the workstation number)
- Status message (to the right of the user name)
- Current date and time (to the right of the status message)
- Number of alerts (to the right of the date and time). Click this number to manually open the Alert Management popup window to show all active alerts one by one (even alerts on hold at this workstation). For more information, see "Acknowledge, Close (hold), and Close All Alerts" on page 11-3.

Pop-up Fields

For drop-down fields with a single selection:

- For drop-down fields, when entering the first few letters of a doctor's or nurse's last name all names starting with those letters are displayed. If theirs is the only name beginning with those letters, the correct name is selected.
- On any field with drop-down menu choices, entering the first letter of an option selects the option or takes you to the portion of the list with options that start with that letter unless it is a multi-select drop down.
- Hover the cursor over the pop-up field to view a tool tip that displays the field's value.

Check Boxes

Throughout NaviCare® WatchChild®, you will encounter various screens with small check boxes filled with a question mark, as shown at right.

The question mark (?) in the check box indicates that you have either not answered the question or do not know the answer. An X (at right, top) indicates Yes and a blank check box (at right, bottom) indicates No.

To provide or change an answer, simply select the box to toggle it to the next state (**?** to blank, blank to **X**, or **X** to **?**). Select **Clear**, when available, to set all of the check boxes at once to blank. This indicates that the answer to all of the questions is No. You can then individually select the check boxes where you want to answer Yes.

Time and Date Fields

All NaviCare® WatchChild® screens containing date fields where you can specify a date offer two ways to specify the dates: Using shortcut keys or using the drop-down calendar feature. Both are described below.

Shortcut Keys

You can use the following shortcut keys to enter time and date:

- Type `N` or `T` to insert the current date or the current date and time; `N` and `T` both generate the same values.
- Type `Y` to insert yesterday's date or yesterday's date and time 24 hours prior to the current time.

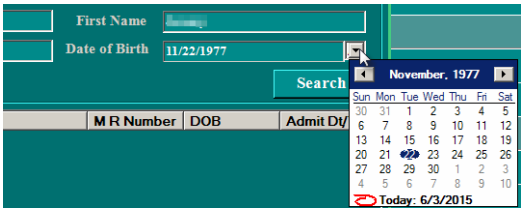
NOTE: The date format defaults to the long format of *mm/dd/yyyy* (for example, 06/01/2015), but your location may have been customized. For example, your date format can be configured to a long format of dd/mm/yyyy (for example, 01/06/2015), or to a short length (for example 6/1/15). The time should be entered using a twenty-four hour clock, for example, 2100 or 21:00 for 9 P.M. For mid-night, enter 0000 or 00:00.

- If you enter only a time into a date/time field, NaviCare® WatchChild® assumes the current date and inserts that date into the field.

- You may manually type the date in the field, with or without separators, and the format in the field will appear with configured separators. For example, typing 12062012 will look like 12/06/2012 in the field. However, if configured to short length (i.e. 6/6/12) you must use separators.

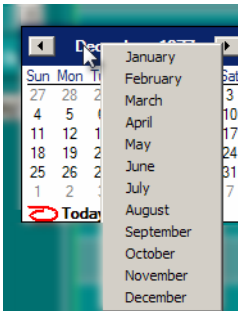
Drop-Down Calendar

1. Select the ▼ arrowhead. The Calendar pop-up opens, as shown below.

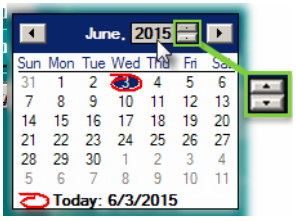


NOTE: The date on the drop down calendar is always in a *dd/mm/yyyy* format despite the configured date format in the field.

2. To select the month, select the ◄ or ► arrowheads to navigate to previous or subsequent months in the same year, respectively, or select the *current* month to display a dropdown list of months, as shown at right.



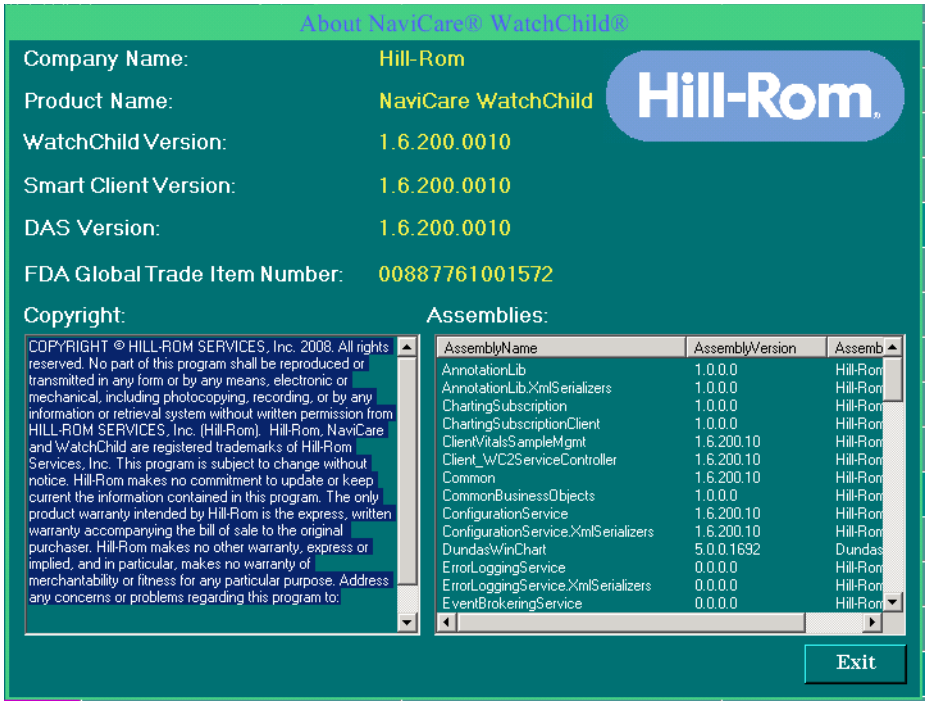
3. Select the month from the list.
4. To select the year, select the currently displayed year, for example, 2012 (the year shown below). Two buttons — ▲ and ▼ — appear next to the year, enabling you to increment up to the next or down to the previous year.



Determining Your NaviCare® WatchChild® Version

1. Select the **System** button. The System Functions Menu screen opens.
2. Select **About WatchChild**. The About WatchChild screen appears, similar to that shown in Figure 1-2.

Figure 1-2 *About WatchChild Screen*



Chapter 2

Getting Started with NaviCare® WatchChild®

This chapter covers the following information about NaviCare® WatchChild®:

Starting NaviCare® WatchChild®

1. Double-select the NaviCare® WatchChild® start icon on the workstation desktop. A Security screen for logging in appears, as shown in Figure 2-1.

Figure 2-1 *Security Screen*

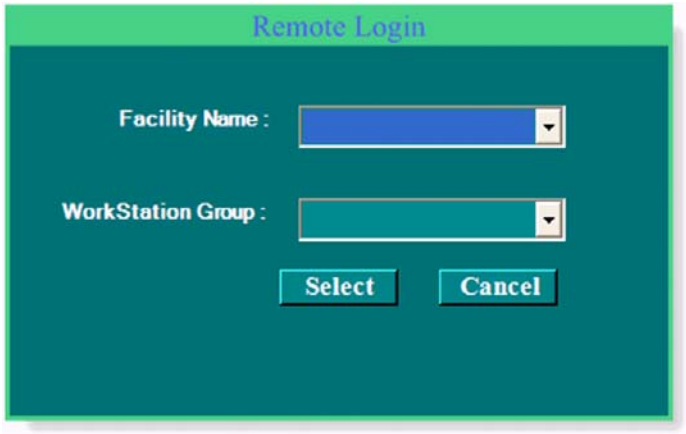
After the system is started, you can access NaviCare® WatchChild® screens, depending upon the level of privileges the system administrator has granted you. Many screens in NaviCare® WatchChild® require you to pass system security prior to gaining access to the screens. If a screen requires security, the same Security screen as above automatically appears.

The Security screen validates you and grants appropriate access to desired screens in NaviCare® WatchChild®. The Security screen also identifies you to the system so that the system can document any changes you make to the patient data in NaviCare® WatchChild®.

As a security measure, your user ID and password time-out if the workstation is idle for a specific time period or if you select **Logout**. In such a case, you must re-enter your user ID and password in order to resume work.

2. Enter your user ID and password in the fields provided, then select **OK**. Passwords are case sensitive. The Remote Login screen appears, as shown in Figure 2-2.

Figure 2-2 *Remote Login Screen*



3. Use the ▼ buttons at the end of the Facility Name and WorkStation Group fields to select the facility to which you are assigned and the WorkStation Group to which your workstation is attached, then select the **Select** button. The Remote Login screen closes and your location's default NaviCare® WatchChild® screen displays.

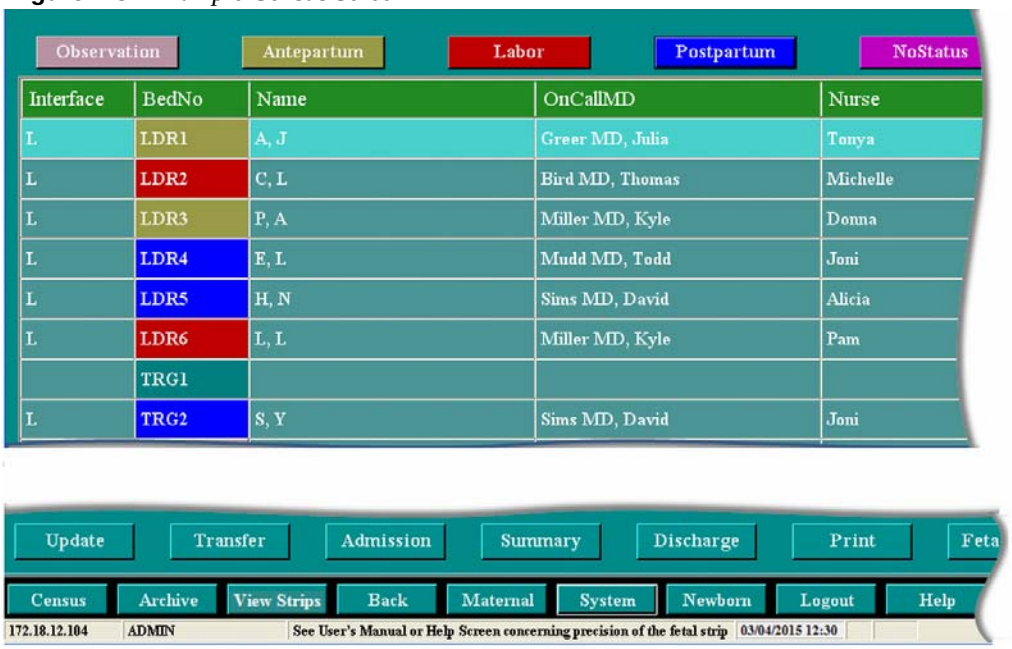
NOTE: The default screen that displays upon start-up is defined by the system administrator. The default screen is normally either the Multi-Patient Surveillance or the Census screen.

NOTE: This remote log in screen will not appear if the workstation has been configured.

Census and Surveillance Screens — Your Main Starting Points

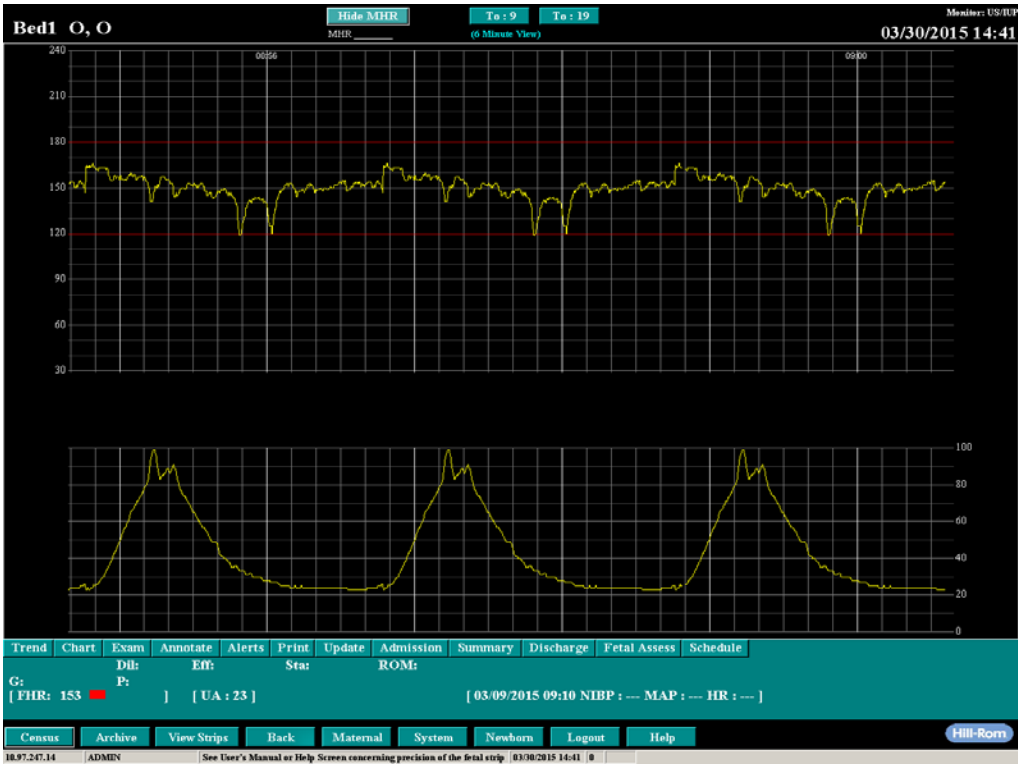
Your starting screen for many NaviCare® WatchChild® functions and procedures is either the Census screen or the Single- or Multi-Patient Surveillance screen. The Census screen shows you a list of all beds in your unit, a color-coded status of each bed, and columns of quick-reference information such as each patient's initials or name, the name of her obstetrician, nurse and other information. An example of a Census screen is shown in Figure 2-3 on page 2-3.

Figure 2-3 *Example Census Screen*



Surveillance screens show fetal heartbeat (top) and uterine activity (bottom) monitoring strips and provide access to various functions that are specific to strips, trends and charting. A Single-Patient Surveillance screen shows the monitoring strip for just one specific patient, and because the graph fills most of the screen, this is the most detailed monitoring view. Also, because the entire screen is available, more functions can be performed directly from this screen by selecting buttons. Figure 2-4 on page 2-4 shows an example of a Single-Patient Surveillance screen. This screen should be the start-up view from the patient's bedside PC monitor.

Figure 2-4 *Example of a Single-Patient Surveillance Screen*



CAUTION: Only the Single-Patient Surveillance screen has sufficient precision of the fetal strip to be used for assistance with decision support.

A Multi-Patient Surveillance screen shows the monitoring graphs of two or more patients. Monitoring for up to 30 patients can be displayed at one time, but the more patients being monitored on the screen, the smaller each monitoring strip must be, the less detailed the graphs and the fewer functions can be accessed directly via buttons from each patient's monitor. Figure 2-5 on page 2-5 shows an example of a Multi-Patient Surveillance screen with four beds displayed, two of which has ongoing fetal and maternal monitoring running and one of which is available to admit a new patient.

Figure 2-5 *Example of a Multi-Patient Surveillance Screen*

What is Monitored and Recorded

NaviCare® WatchChild® automatically records the following data from the fetal monitor when the monitor is on and connected to the patient:

- Fetal Heart Rate (FHR). It is sampled four times each second.
- Uterine Activity (UA). It is sampled once every second.

If maternal monitoring devices are connected, NaviCare® WatchChild® automatically records the following maternal data, which is entered into the patient's chart.

- Maternal non-invasive blood pressure (NIBP). NIBP vital signs are also annotated onto the fetal strip
- SpO2 (oxygen saturation)
- Maternal Heart Rate (HR)

When using the Phillips Avalon FM50 triplet monitor, regardless of the number of fetal tracings (single, twin, or triplet), the secondary wallplate (if applicable) will only monitor maternal physiological data; if another fetal monitor is connected to the secondary wallplate, there will not be any fetal data monitored. If a quad gestation needs to be monitored, (2) twin monitors must be used with (2) wallplates (primary and secondary).

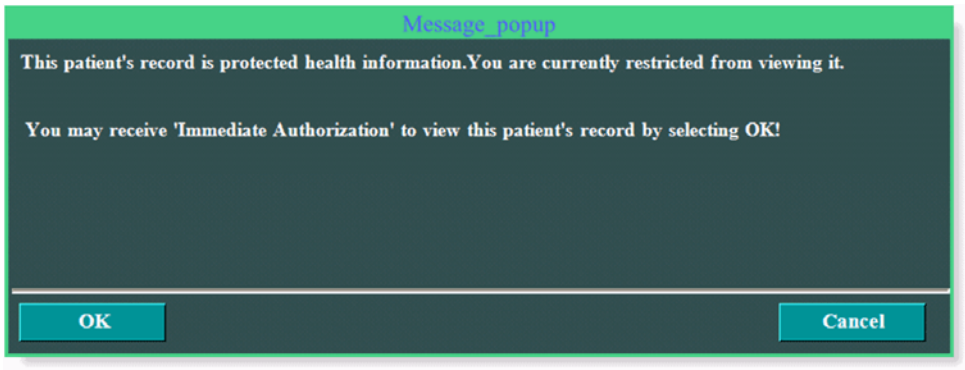
NOTE: If the patient is configured to have maternal alerts active, the alerts occur dependent on the configured "Maternal Re-Alert Delay," which is an admin-only setting. Vital signs may be recorded more often than alerts would be generated, even if the patient is out of bounds for a specific measurement.

User Access Restrictions

By default, users are allowed access privileges to most features and data for all patients. However, data access can be restricted for specific patients.

Some features that require additional authorization are the ability to acknowledge alerts (although all users can put alerts on "hold" by closing the alert management box), and the ability to activate/inactivate alerts for specific patients. If you are restricted from accessing a particular patient's records, the restricted message pop-up screen will display when you first attempt to access the patient's information, as shown in Figure 2-6.

Figure 2-6 *Restricted Message Pop-up Screen*



To obtain immediate authorization to view this patient's record, select **OK**.

NOTE: The authorization is valid until you log out, your user ID and password time-out, or the system logs you out automatically.

NOTE: Only patient initials will be displayed on the Census screen for patients whose data is restricted from view by the current user.

NOTE: Whenever you view a patient's record or enter any information about a patient, it is recorded in an audit trail and made available through the System Reports function. For more information on User Access Restrictions and restricting caregiver access to patient information, refer to the *NaviCare® WatchChild® System Administrator Manual, (LAB00196).*

NOTE: You can view alerts even when logged out, but your workstation needs to be configured to view alert popups to view them. To acknowledge alerts, you must be logged in and have the correct user privileges.

Using the Census Screen

The Census screen is a dynamic informational screen that shows you basic data about multiple patients during their visits. Most fields on this screen are updated automatically when data is charted elsewhere, for example, when data is updated on the Obstetric Admitting Record or Vaginal Exam screens. The Remarks field can be updated by selecting the **Update** button, which opens another screen that enables you to add or change remarks. None of the fields on the Census screen can be modified by entering data directly into the field.

The Census screen displays all beds connected to NaviCare® WatchChild® along with a summary of current information for each patient. If more beds exist than those displayed on the screen, a scroll bar appears on the right-hand side of the screen. To view patient beds that are not displayed on the screen, select the scroll bar and drag the bar either up or down. You can also scroll horizontally to see fields columns that are off the screen.

OUT Beds

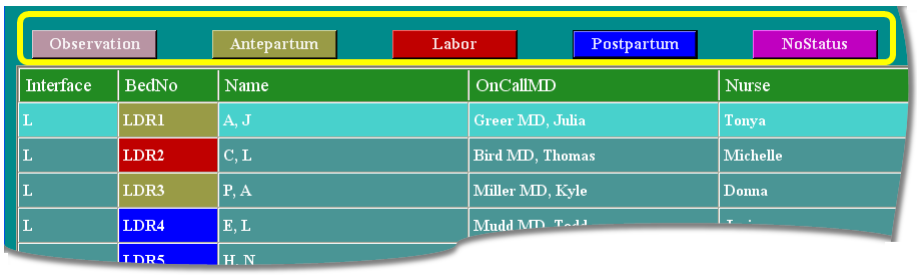
In addition to the actual patient beds, occupied or not, the Census screen always shows one or more OUT beds. These are “virtual” beds used for such things as admitting a patient for testing when she is not placed into an actual bed, discharging a patient, clearing old monitoring data from an actual bed prior to admitting a patient to that bed, and other situations where a place is needed for a patient’s data without the patient being in a real bed.

The Census screen will always contain at least one unoccupied OUT bed; if patient data is placed in that OUT bed, another vacant OUT bed is automatically added to the Census screen.

Status Buttons

In NaviCare® WatchChild®, each patient has a status even if that status is No Status. The five colored buttons displayed across the top of the screen (outlined in Figure 2-7) are Status setting buttons. The status of the patient is represented by the color in the **BedNo** (bed number) field for that patient, which matches the color of the corresponding Status button.

Figure 2-7 *Census Screen Status Buttons*



The only status buttons that are applied automatically are No Status and Retrieved. No status is the default when you first admit a patient. The Retrieved status gets automatically assigned when a patient is brought from archive by "Retrieve". After that, you change a patient's status by first selecting the appropriate bed and then selecting the applicable Status button. The background color of the bed number will change to that of the button you selected, indicating the status you chose.

The Status button colors can be configured for your hospital by your NaviCare® WatchChild® System Administrator. The following list displays the default meaning of each Status button.

Observation Admitted for observation

Antepartum Not in labor and has not delivered

Labor In active labor

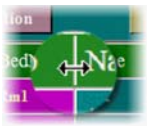
Postpartum Has delivered

No Status No assigned status

Retrieved Retrieved from archive. Appears in an outbed only.

The columns that show on the Census screen can be custom configured for your hospital. The following list displays the default columns:

- **Interface** (The interface column is a static feature but may be hidden if Interfaces were not purchased. See "HL7 Interface Options" on page 2-21 at the end of this chapter.)
- **BedNo** (bed number)
- **Name** (patient name)
- **OnCall MD** (obstetrician name)
- **Nurse** (nurse name)
- **Pedi** (pediatrician)
- **Remarks**
- **Gest** (gestation)
- **G/P** (gravida/parity)
- **Dil/Sta/Eff** (dilation/station/effacement)
- **Time of Last Exam**

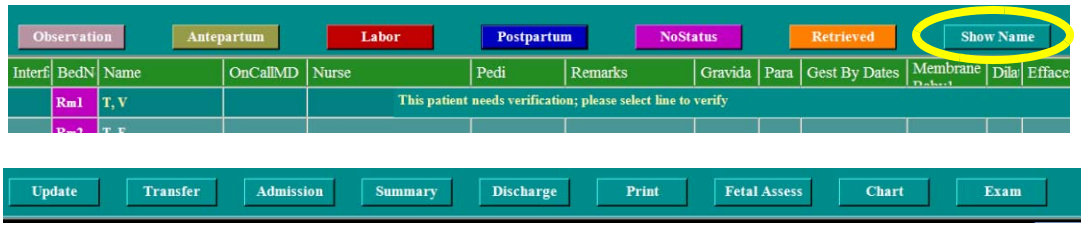


You can change the width of any columns to suit your needs. To do that: Use your computer mouse to hover the pointer over the boundary line between two column headings until the pointer becomes a double arrow, as shown at right, then select-drag left or right to change the columns' width. Column width changes remain until another user changes the widths again. The Census columns are Workstation specific so columns selected for the LDR environment may be different from the Census display for the MB/PP Unit, etc.

Census Function Buttons

You can access other functions that relate to specific beds and patients by selecting any Census screen function button, shown outlined in Figure 2-8. To use all but the Show Name button, first select a bed and then select the button for the function you want to perform. The Show Name button does not require bed selection.

Figure 2-8 *Census Screen Function Buttons*



The function of each button is as follows:

Show Name This button toggles to **Hide Name** when selected, then back to **Show Name** when **Hide Name** is selected. It is also the only Function button that does not require selection of a bed before selecting the button. By default, NaviCare® WatchChild® shows only patients' initials on the Census screen. To see full names, select **Show Name**, which then shows the full name of all patients and toggles the button to **Hide Name**. Select **Hide Name** to switch back to initials only and toggle the button back to **Show Name**.

Update Displays the Update Patient Information screen, shown in Figure 2-9, enabling you to enter a remark and modify some of the patient information displayed on the Census screen. If you mark an update as important, the message appears on the Census screen in yellow.

If the **Update** button is used on an empty bed, the Update Room Information screen displays, as shown in Figure 2-10, enabling you to type in a comment to display in the room's Remarks field, for example, *Lights are out* or *Call Maintenance*.

To remove an existing message on an empty bed, select the bed, select **Update** to display the Update Room Information screen, then erase the message and select **OK** to close the screen.

Figure 2-9 *Update Patient Information Screen*

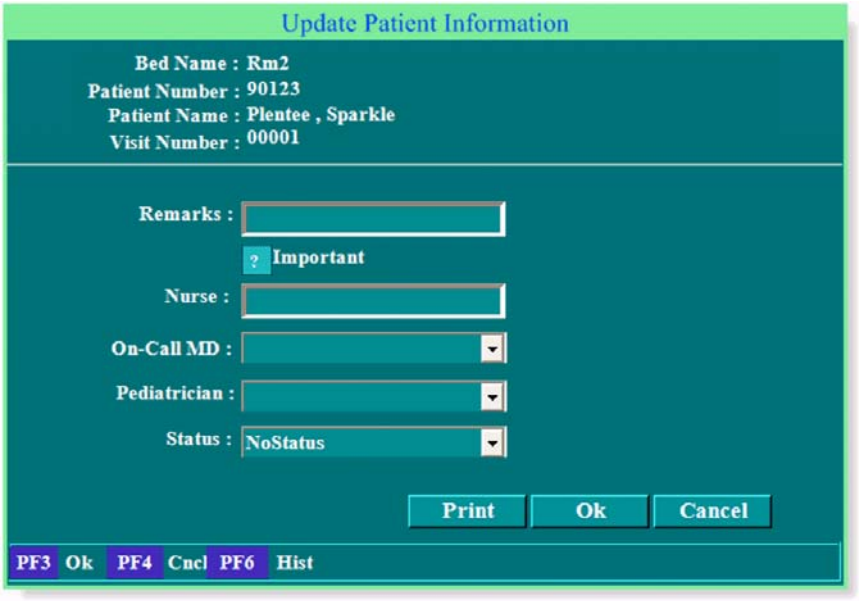
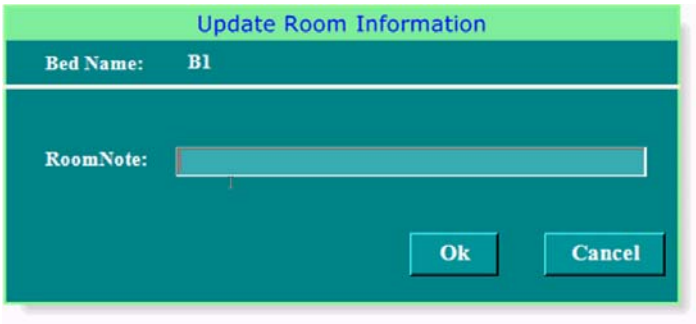


Figure 2-10 *Update Room Information Screen*



Transfer Select to transfer a patient to another bed, to an OUT bed, from an OUT bed to an active bed, or to merge patient monitoring strips. See Chapter 9, “Transfer Patients and Merge, Move or Delete Monitoring Strips” on page 9-1 for details on using this function.

Admission Displays the Admission Name Lookup screen if no patient is in the selected bed, or displays the Obstetric Admitting Record screen for the selected patient. See Chapter 3, “Admitting a Patient” on page 3-1 for detailed information about the admission process and the Obstetric Admitting Record.

Summary Displays the Labor and Delivery Summary screen. See Chapter 16, “Labor, Delivery, and Infant Summary” on page 16-1 for detailed information about the Labor and Delivery Summary screens.

Discharge Displays the Discharge Patient screen to discharge the patient from NaviCare® WatchChild®. See “Discharging a Patient” on page 3-13 for details.

Print Prints the Census screen. You may select the content of the printed screen within the pop-up window. All column widths are printed in the Excel default width.

Fetal Assess Displays the Uterine/Fetal Assessment screen. See Chapter 7, “Uterine/Fetal Assessment Screen” on page 7-1 for details on using this function.

Chart Displays the Chart screen. See Chapter 6, “Using the Chart Screen — Comprehensive Charting” on page 6-1 or Chapter 12, “Flowsheets Overview” on page 12-1, depending on which version of charting is installed.

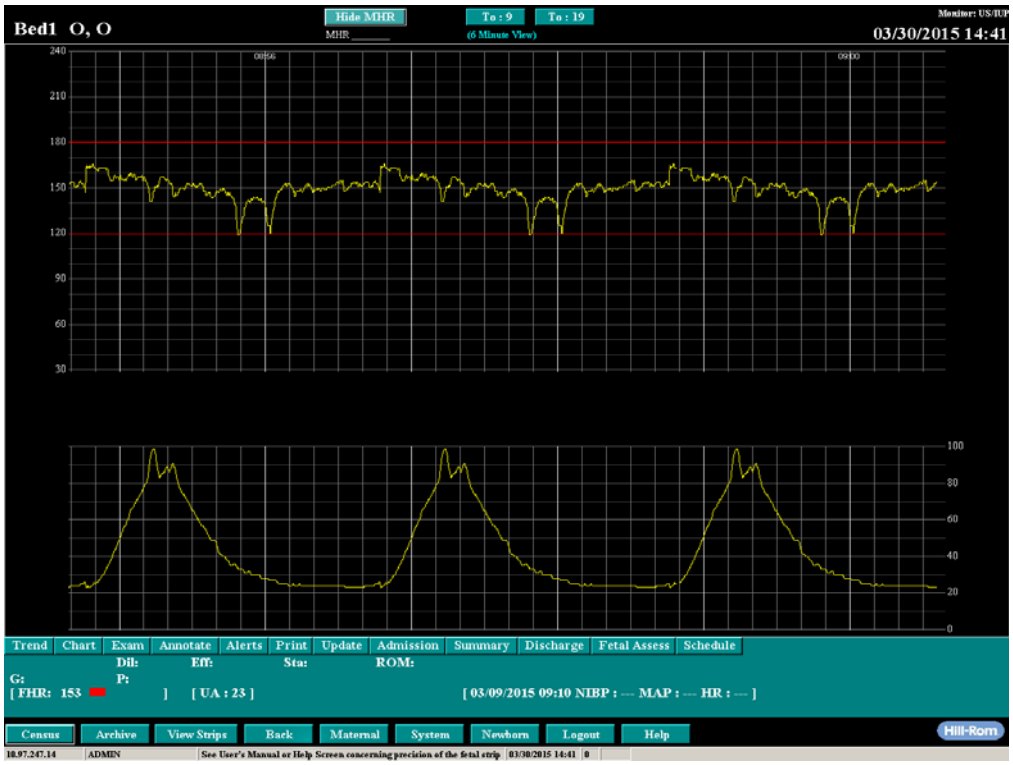
Exam Displays the Vaginal Exam screen. See Chapter 5, “Vaginal Examination Screen” on page 5-1 for details on using this function.

Selecting Patient Monitoring Strips from the Census Screen

You can select and view patient monitoring strips from the Census screen. Both Single- and Multi-Patient Surveillance screen strips show the fetal heart rate (upper half patient strip) and uterine contractions (lower half patient strip). To display the monitoring strip for a *single* patient:

1. Select the patient's bed.
2. Select the **View Strips** button, located at the bottom of the screen. The Single-Patient Surveillance screen for the selected patient displays, as shown in Figure 2-11 on page 2-11.

Figure 2-11 *Single-Patient Surveillance Screen*

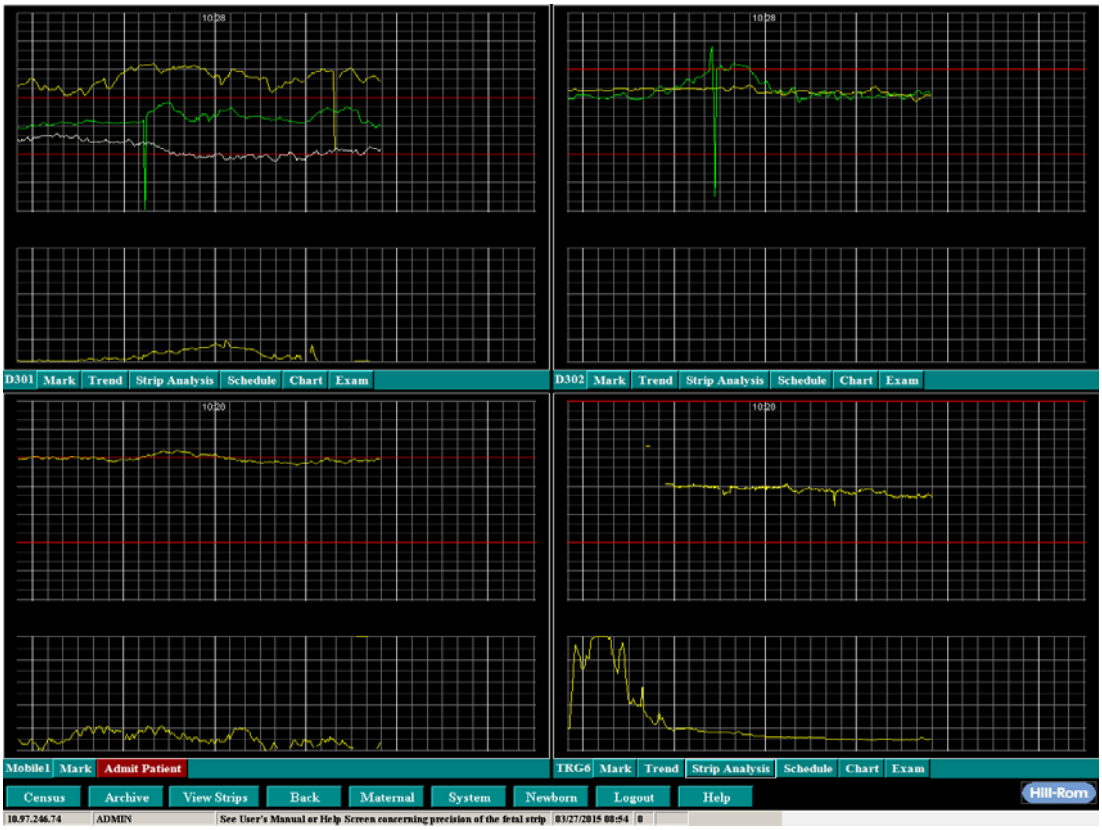


To display monitoring strips for *multiple* patients:

1. Select the beds whose strips you wish to view. To select adjacent beds from the screen, select-drag from the first to the last bed you wish to display from the list. To select non-adjacent beds, press and hold the keyboard Ctrl key and select each bed you wish to display.
2. When finished selecting beds, select the **View Strips** button, located at the bottom of the screen. The strips for as many beds as you selected are displayed on a Multi-Patient Surveillance screen, as shown in the four-patients example in Figure 2-12 on page 2-12. Notice that monitoring has only recently begun on the bed in the upper-right of the screen.

CAUTION: Only the Single-Patient Surveillance screen has sufficient precision of the fetal strip to be used for assistance with decision support.

Figure 2-12 *Multi-Patient Surveillance Screen Example*



3. To view fewer beds, select the **Mark** button for just the beds you wish to view, then select **View Strips**. Only those beds you marked will show on the screen.

4. If you wish to see the full-screen view (Single-Patient Surveillance) of any of the patients on the Multi-Patient Surveillance screen, simply select the strip (anywhere within the strip) you wish to see. That strip will then be presented on a Single-Patient Surveillance screen, which shows more detail than the Multi-Patient view. To return to the Multi-Patient view, select the **Back** button at the bottom of the screen.

Using the Maternal Census Screen

The Maternal Census screen shows only occupied beds and recent[1] values recorded by the maternal monitors attached to all patients.

Access the Maternal Census screen by selecting the **Maternal** button located at the bottom of the screen.

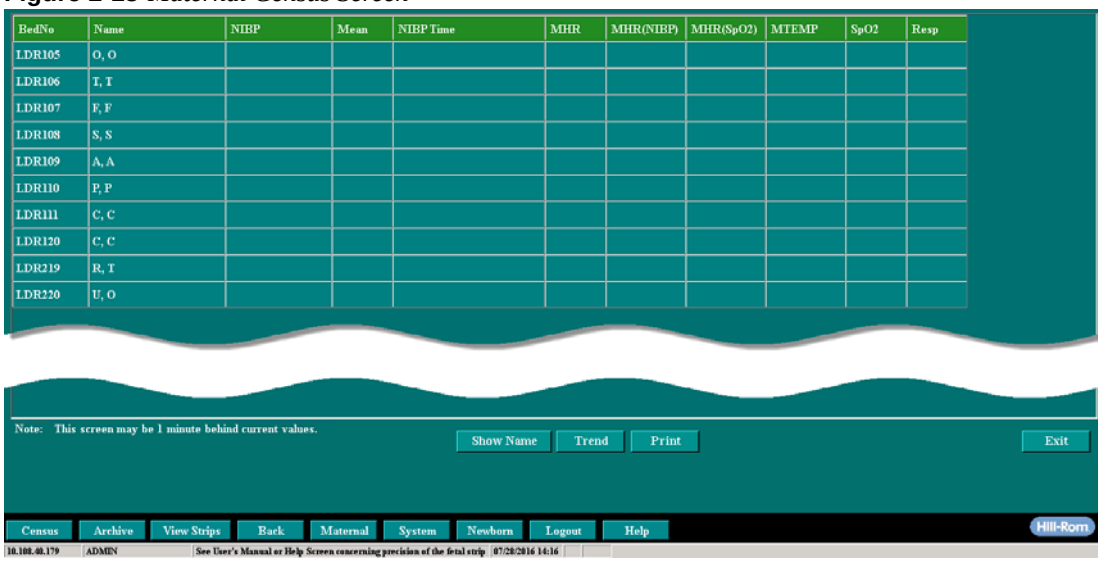
The Maternal Census screen displays the following recent data recorded by the maternal monitors:

- Room
- Name
- NIBP (non-invasive blood pressure)
- Mean (blood pressure)
- Time
- MHR (maternal heart rate)
- MHR(N)
- MHR(S)
- SpO2 (oxygen saturation)
- Resp (respiration)

NOTE: Refer to your maternal monitor manufacturer's manual for information regarding the time delay for transfer of data to NaviCare® WatchChild®, i.e., transfer time for an SpO2 reading.

1. In the Multi-Patient Surveillance, Census, View Strips, or Archive screens, select the **Maternal button** located at the bottom of the workstation screen. The Maternal Census screen for all patients appears, as shown in Figure 2-13.

Figure 2-13 *Maternal Census Screen*

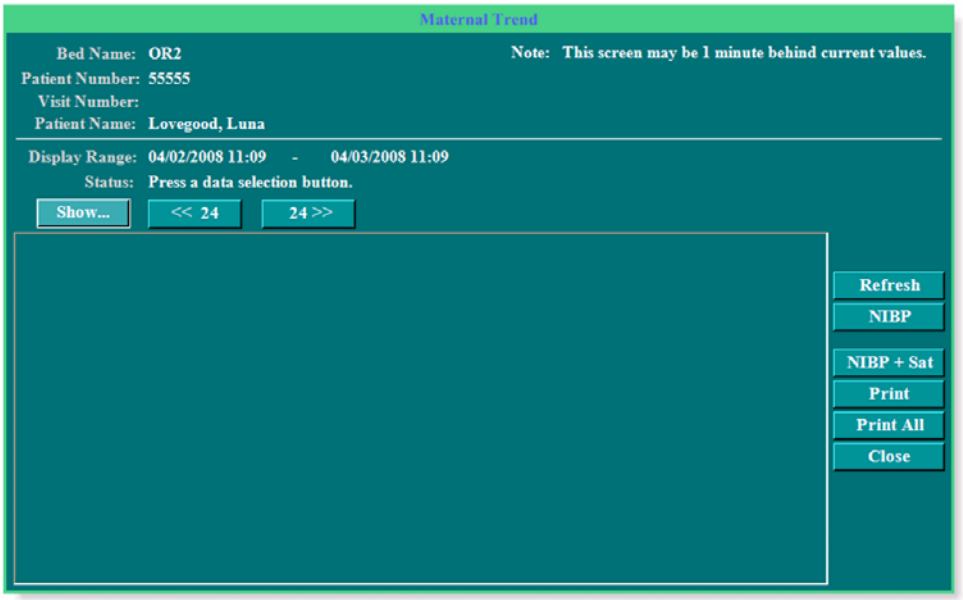


2. Select a patient from the list on the Maternal Census screen.

[1] Monitor values displayed on the Maternal Census screen normally run 1 to 1.5 minutes behind the values displayed on a Single-Patient Surveillance screen.

3. Select **Trend**. The Maternal Trend screen appears for the selected patient, as shown in Figure 2-14.

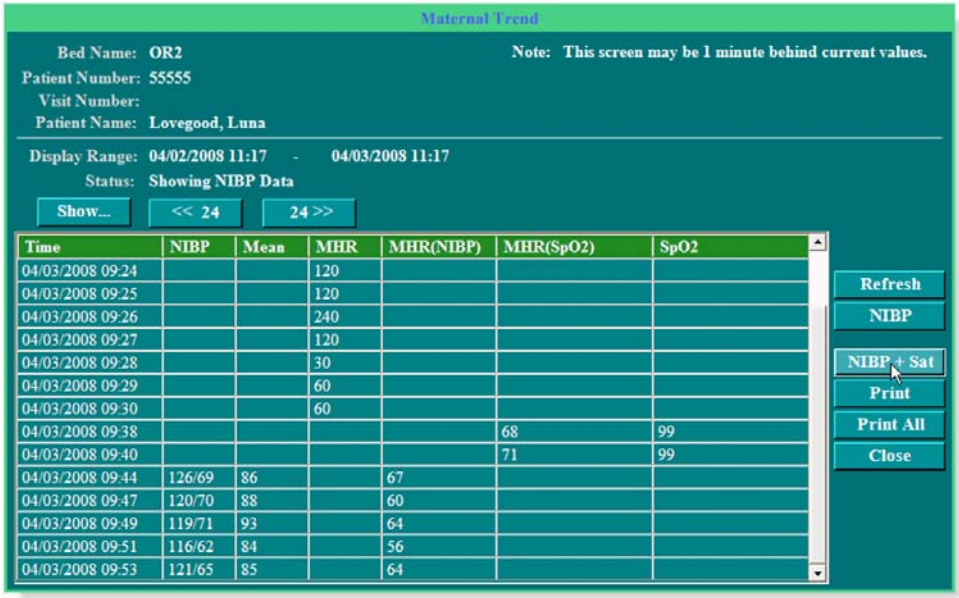
Figure 2-14 *Maternal Trend Screen*



The Maternal Trend screen can also be accessed by selecting **Trend** from the Single-Patient Surveillance screen and then selecting **Maternal**.

4. The trended maternal values for NIBP or NIBP+Sat can also be displayed. Select either **NIBP** or **NIBP+Sat** to select one of the values to view. The **NIBP** button displays the NIBP and maternal heart rate values with each NIBP taken, while the **NIBP+Sat** button displays both the NIBP values and the oxygen saturation values, as shown in Figure 2-15.

Figure 2-15 *Maternal Trend Screen with NIBP-Saturation Values*



The current display range is shown at the top of the screen in Figure 2-15 on page 2-14. Use any of the three buttons in the following list to select the range you want to view.

Show...	Select and enter the date and time for the period of values you want to view. However, there is a limit to the number of lines that can be displayed
<< 24 Hours	Select to view the values for the previous 24 hours after the current display date and time.
24 Hours >>	Select to view the values for the next 24 hours after the current display date and time.

5. Select **Show** to select the time and the date that you want to view in the Maternal Trends screen. The Show New Period of Time screen appears as shown in Figure 2-16.

Figure 2-16 *Show New Period of Time Screen*

6. Enter the date in the following format: *mm*/*dd*/*yyyy*

NOTE: Enter all four digits to specify the year when entering the date.

7. Enter the time in the following format: *hh*:*mm*.
8. Select **OK**.
9. Use the following buttons in the Maternal Trend screen:

Refresh	Select to refresh the Maternal Trend screen
Show Name	By default, NaviCare® WatchChild® shows only patient initials on the Census screen. Click **Show Name** to show the full name of all patients. The button label changes to **Hide Name**. Click **Hide Name** to show patient initials only and change the button label back to **Show Name**. This is the only Function button that can be used without selecting a bed.
Print	Select to print the NIBP or NIBP+Sat information currently displayed on the Maternal Trend screen.
Print All	Select to print all of the data for the selected patient. Use to print all data even if a portion is selected.

10. Select **Close** to exit the screen.

Using Surveillance Screens

Surveillance Screen Buttons

Table 2-1 describes all of the function buttons that can appear on a Single-Patient and/or Multi-Patient Surveillance screen when the screen is initially displayed, either for an empty bed or for a bed with an admitted patient. Which buttons are displayed at any one time depends on whether or not a bed is occupied and whether one bed or multiple beds are being monitored. (The buttons are listed in the order in which they appear on screens, left to right.)

Table 2-1 *Surveillance Screen Function Buttons (Sheet 1 of 2)* **S**=Single-Patient **M**=Multi-Patient

Button	S	M	Purpose
Mark		✓	Enables you to specify a subset of the displayed screens to view in the Multi-Patient Surveillance screen view, for example, to view only three of an initially displayed 12 screens. To use, select **Mark** for the screens you wish to view, then select **View Strips**.
Trend	✓	✓	Enables you to view previous areas of the monitoring strip to help you identify the labor trend. Also provides access to the Move/Delete strip functions. See Chapter 8, “Maternal/Fetal Strip Functions” on page 8-1.
Chart	✓	✓	Displays the Chart screen. See Chapter 6, “Using the Chart Screen — Comprehensive Charting” on page 6-1 or Chapter 12, “Flowsheets Overview” on page 12-1, depending on which version of charting is installed.
Exam	✓	✓	Displays the Vaginal Exam screen. See Chapter 5, “Vaginal Examination Screen” on page 5-1 for details on using this function.
Annotate	✓		Displays the Annotate Strip screen. See Chapter 10, “Annotating the Patient Monitoring Strip” on page 10-1 for details.
Alerts	✓		Displays the Set Up Patient Alert screen, enabling you to set alert parameters for just the specific patient. See “Specifying Patient-Specific Alert Parameters” on page 11-5 for details.
Print	✓		Enables you to print or fax all or a specified portion of a patient strip.
Update	✓		Displays the Update Patient Information screen. See a full description of the Update function on page 2-9.
Admission	✓		Displays the Obstetric Admitting Record screen. See“Filling In and Updating the Obstetric Admitting Record” on page 3-8 for detailed information about the Obstetric Admitting Record.
Summary	✓		Displays the Labor and Delivery Summary screen. See Chapter 16, “Labor, Delivery, and Infant Summary” on page 16-1 for detailed information about the Labor and Delivery Summary screens.

Table 2-1 *Surveillance Screen Function Buttons (Sheet 2 of 2)* **S**=Single-Patient **M**=Multi-Patient

Button	S	M	Purpose
Discharge	✓		Displays the Discharge Patient screen to discharge the patient from NaviCare® WatchChild®. See "Discharging a Patient" on page 3-13 for details.
Admit Patient	✓	✓	On screen only when no patient is admitted in the bed. Displays the Admission Name Lookup screen. See Chapter 3, "Admitting a Patient" on page 3-1.
Strip Analysis	✓	✓	A diagnostic tool that may be used by the clinician. See Chapter 20, "Strip Analysis" on page 20-1.
Schedule	✓	✓	A list of Fetal Assessments as scheduled by the facility (may be set by the hospital or NWC Tech Support).

Single-Patient Screen Views and Data Display

Time Spans

The default view of a Single-Patient Surveillance screen is the 6-minute view. In the 6-minute view, the graphs fill the screen and show six minutes of strip data. This is the most detailed strip view and is the only view that should be used to assist with decision support. However, you can change the view to show longer time spans.

There are one or two buttons at the top-center of the screen — one button for a monitor running at resolution 1024x768, two buttons for a monitor running at resolution 1280x1024. These buttons toggle to a different time span, depending on the button's label. The current view time span is shown in parentheses below the button(s), as shown at right.

A computer monitor running at a resolution of 1280x1024 can display time spans of 6, 9 and 19 minutes. The **To : 9** button switches the view time span to 9 minutes and toggles the button label to **To : 6**. The **To : 19** button switches the view time span to 19 minutes and toggles the button label to **To : 9**. A computer monitor running at a resolution of 1024x768 can display time spans of 7 and 14 minutes and the time span toggle button works the same way as on a 1280x1024 monitor, switching to the opposite time span with each selection of the button.

When you switch to a different time span view, the height of the strips also changes. This preserves the angle of the fetal heart rate and uterine activity graphing lines even though the amount of information being displayed has changed.

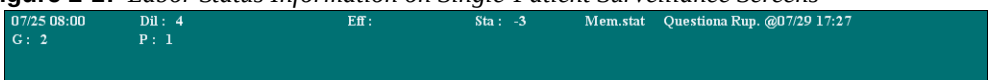
Maternal Heart Rate

Another button at the top of the screen, this one left of center, is the **Show MHR** button. This, too, is a toggle. Select it to show the maternal heart rate as a numeric value in a field below the button and as a graph line on the fetal heart rate graph. When you select **Show MHR**, the heart rate displays and the button toggles to **Hide MHR**. Select it again, and display of maternal heart rate data ends and the button toggles to **Show MHR**. MHR shows during a fetal alert even if you have selected **Hide MHR**.

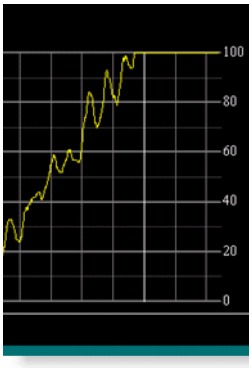
Labor Status Information

Labor status information is presented at the bottom of the Single-Patient Surveillance screen below the screen buttons, as shown in Figure 2-17. Dilation, effacement, station and membrane status information displays if it has been entered on the Vaginal Exam and Uterine/Fetal Assessment screens. Additional information such as fetal heart rate, uterine activity and oxygen saturation level are shown if sensor data is present.

Figure 2-17 *Labor Status Information on Single-Patient Surveillance Screens*



UA Values Above 100



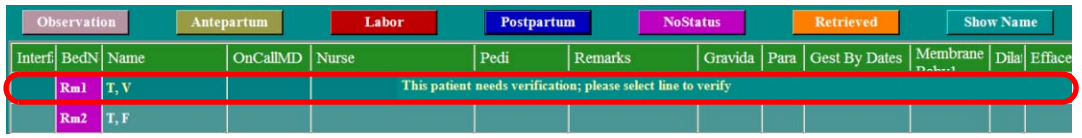
The Uterine Activity area of a Surveillance screen can graph values up to 100. If a uterine activity value reaches or exceeds 100, it is shown as a flat line at the 100 level, as illustrated by the sample at right. The value above 100 is actually being recorded by NaviCare® WatchChild® even though it cannot be graphed; it is shown in the Labor Status Information area beneath the graph.

To ensure that anyone reading the strip at a later time can tell at a glance what the actual value of the flat-lined area was. Consider annotating the strip with the value whenever you see a flat-at-100 reading.

Verifying Patient Information

When NaviCare® WatchChild® detects fetal data after the monitor is turned off for more than a specified period of time (the default is ten minutes), it flags the bed with the following message on the Census screen: *This patient needs verification; please select line to verify*, as shown in Figure 2-18.

Figure 2-18 *Census Screen with Patient Verification Message Line*



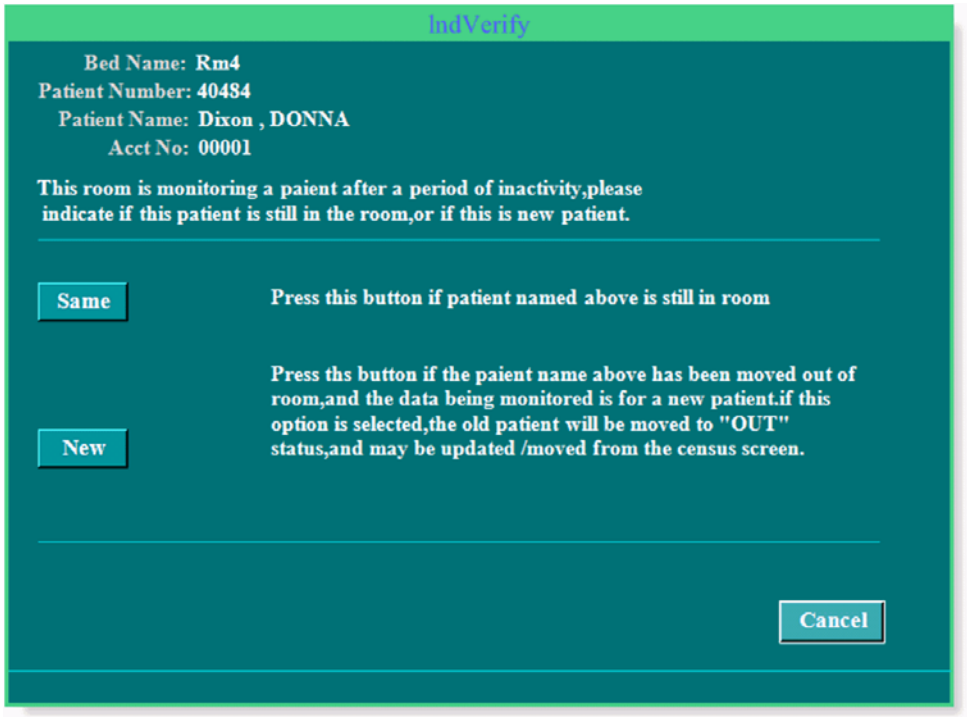
On the Single- or Multi-Patient Surveillance screen, a red button labeled **Verify Bed** is displayed, as shown in the segment from a Multi-Patient Surveillance screen in Figure 2-19 on page 2-19.

Figure 2-19 *Verify Patient Button on a Surveillance Screen*

To Verify a patient record:

1. Do one of the following, depending on whether you are on the Census screen or a Surveillance screen:
   - **From the Census screen** — Select the line for the patient requiring verification. The IndVerify screen appears, as shown in Figure 2-20 on page 2-20.
   - **From a Surveillance screen** — Select the **Verify Bed** button. The IndVerify screen appears, as shown in Figure 2-20 on page 2-20.

Figure 2-20 *IndVerify Screen*



2. Read the screen instructions, then select either the **Same** button or the **New** button, as appropriate to your patient.

CAUTION: You must inform NaviCare® WatchChild® whether the monitored data belongs to the same patient in the bed or to a new patient. This verification helps to prevent the strip of a new patient from being merged to the strip of the previous patient in that bed.

Logging Out of NaviCare® WatchChild®

Select the **Logout** button, just left of the Help button at the bottom of the screens. When you log out, your user name disappears from the status bar. An empty user name block in the status bar indicates that no one is currently logged on to the workstation. NaviCare® WatchChild® will prompt the next user to enter his or her user ID and password as soon as they try to use any function.

As a security measure, your user ID and password automatically time out if the workstation is idle for a specified period of time. (The default period of time is five minutes, but the NaviCare® WatchChild® System Administrator can customize this time period.)

After logout, the Census screen and Single-Patient Surveillance screen will display patients' initials to protect patient privacy. You must re-enter your user ID and password to regain access to patient data.

The timeout value is dependent on the location that the credentials are entered. If the user logs in to the NaviCare® Maternal client using the Maternal security screen, the Maternal and Newborn clients use the timeout period from the Maternal client (SecurityIdleTime). If the user logs in to the NaviCare® Newborn client using the Newborn security screen, the Maternal and Newborn clients use the timeout period from the Newborn client (default = 10 minutes).

Closing NaviCare® WatchChild® on Your PC

If you need to close NaviCare® WatchChild® (for example, to disconnect and move a mobile workstation), press the keyboard Ctrl-T buttons. The NaviCare® WatchChild® screen is placed within a standard Windows frame with an X (close) button in the upper-right corner. Select the **X** to close the window and NaviCare® WatchChild®.

HL7 Interface Options

NaviCare® WatchChild® provides four standard interfaces:

- ADT
- Pharmacy
- Laboratory
- Maternal Vital Signs/Annotations

When any of these are made available and data has been imported to a patient's record, a symbol appears in the Census screen Interface column next to the patient's Bed Number. Clicking a symbol in the Interface Column displays the appropriate screen.

Table 2-1 *Interface Column Symbols*

Symbol	Definition
*	Admitting Data has been imported from the Admission Office Software System.
L	The chart has unprocessed laboratory information received from the Laboratory HL7 System. This indicator is displayed if the patient matches the interface message on both its MRN and visit number as an "L".
P	The pharmacy has dispensed medications to the patient.

ADT Interface - Empty Bed

If the bed is empty (there is no name in the patient name field) clicking the "*" (asterisk) displays a pop-up screen that allows you to select the patient's name for that admission. Confirm with the patient identifiers (First Name, Last Name, Birth Date) that you are selecting the correct patient. When that patient is selected, the Admitting Record will be populated with the data pulled from the Admitting Office Record. It includes, but is not limited to:

- Patient First and Last Name
- Medical Record Number
- Visit Number
- Admitting Date and Time

Additional demographic information may be included. See "Auto ADT" on page 19-8 for more information on the maternal information that NaviCare® WatchChild® may accept.

ADT Interface - Occupied Bed

If there is already a patient's name on the Census screen and the Interface column displays "*":

1. Click the patient's name.
2. Click **Admission.**
3. From the Address-O-Graph in the upper left corner of the first screen, click the **Interface** button. A pop-up window appears with the patient's name.
4. Click the correct patient name.
5. Click **OK** and the data populates the appropriate fields in the patient's Admission Record.

Laboratory Interface

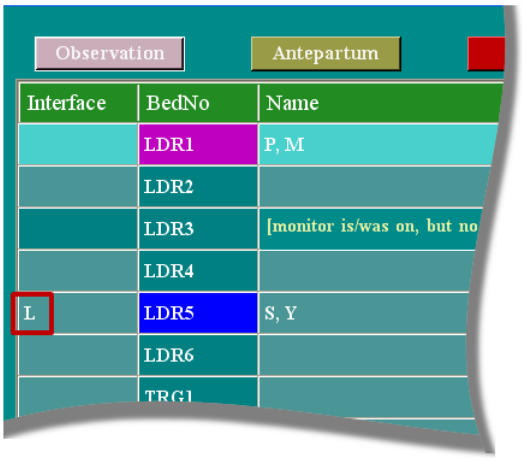
The Laboratory Interface provides doctors and nurses with a list of received laboratory orders, tests, and results; and allows them to review the results either individually or in groups. Reviewed laboratory results are converted into the Laboratory flowsheet records where they exist as a part of the patient's record.

A nurse or doctor may click directly on the "L" in the Census screen Interface column to open the Laboratory Results screen or click the **Lab** button on the patient's appropriate flowsheet (Prenatal, Outpatient, Ante/Intrapartum, and Postpartum). When this opens, it reveals lab data that has not been reviewed. Once reviewed, the data will be marked with the reviewer's signature and a date/time stamp.

To review laboratory results from the Census screen Interface column:

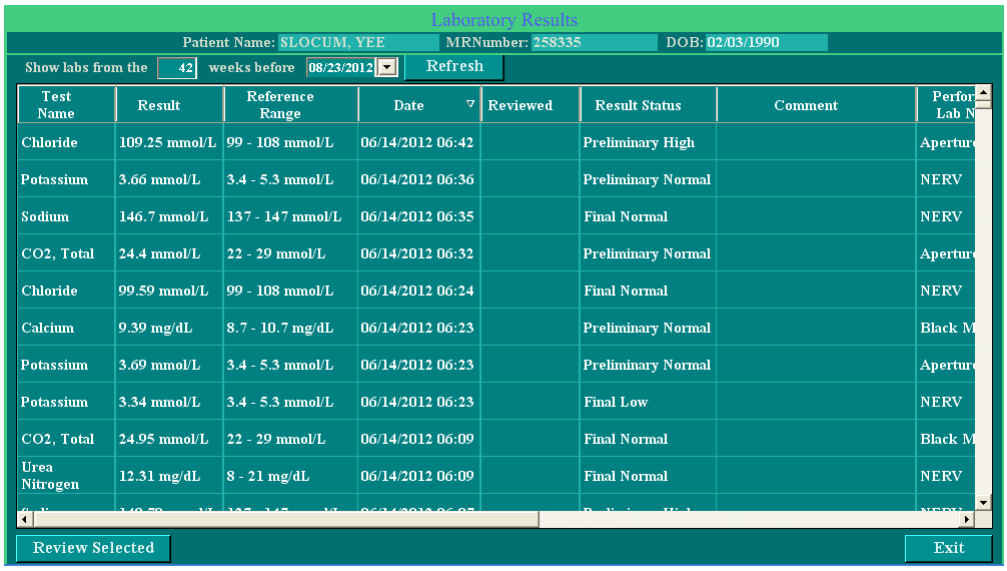
1. Click the "L".

Figure 2-21 *HL7 Census Interface Laboratory Results*



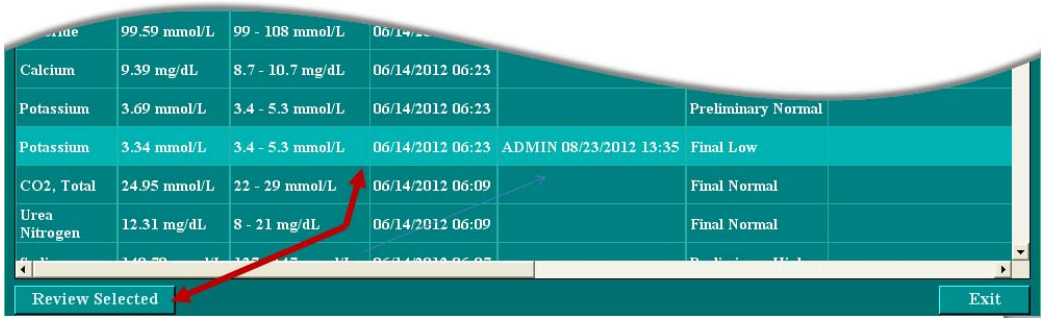
2. A Lab Results screen displays with all non-reviewed lab testing and results for that patient.

Figure 2-22 *Lab Results Screen*



3. Select the test or tests to incorporate into the patient's Laboratory flowsheet records and click **Review Selected**.

Figure 2-23 *Review Lab Results*



4. When all results are reviewed, the "L" will disappear from the Census screen Interface column.

Pharmacy Interface

The Pharmacy interface provides nurses with a list of medications ordered through the Computerized Physician Order Entry (CPOE) System, the hospital's pharmacy software, or some other designated Pharmacy and NaviCare® WatchChild® application. Once the message has been received an indicator appears in the Census screen Interface column.

Clicking the "P" directly from the Census screen Interface column opens the Pharmacy Dispensed screen displaying a list of dispensed drugs from the Pharmacy Department's software. Double clicking any of the medications displays the Medication/IV Administration screen. The medication selected is populated to all the appropriate fields within the record, other than the dosage given.

You may also achieve the same results by clicking the **Meds/IV** button from the patient's Outpatient, Ante/Intrapartum, or Postpartum flowsheets. Clicking the **Get Prescription from Interface** button from the Medication/IV Administration screen displays the Pharmacy Dispensed screen.

From the Medication/IV Administration screen, you may record the amount that you administered. Clicking the **Send Meds to Strip** button records the medication on the EFM Strip and clicking the **Send Meds to Delivery Summary** button records the medication in the Labor & Delivery Summary. See "Recording Medications and IV Information" on page 15-8 for more information.

Annotations and Vital Signs recorded on the EFM Strip may be outbound to the patient's EMR from NaviCare® WatchChild®. This data must have an approved field to accept the data within the record.

All Interface information between NaviCare® WatchChild® and another approved Electronic Medical Record has to be mapped by Interface Specialists within Hill-Rom and the hospital setting.

Chapter 3

Admitting a Patient

This chapter covers the following information:

Identifying an Available Bed

The presence and color of the **Admit Patient** button on the Multi-Patient Surveillance and the Single-Patient Surveillance screens indicates the availability of a bed and whether or not there is monitor data associated with that bed. Table 3-2 summarizes the meanings:

Table 3-2 *Admit Patient Button Indications*

This...	Indicates this...
No **Admit Patient** button	A patient is already admitted to the bed within NaviCare® WatchChild®.
	A red **Admit Patient** button indicates that there is monitor data associated with the bed, although no patient is currently admitted into the bed within NaviCare® WatchChild®. Either of two conditions can cause this: • A patient was physically placed into the bed and attached to monitors that are now sending data, but the patient has not yet been formally admitted using NaviCare® WatchChild®. If this is the case, admit the patient. • There is old monitoring (strip) data still associated with this bed from a previous patient, testing or demonstration. If this is the case, see "Clearing an Unidentified Strip Prior to Admission" on page 3-2 for instructions on removing the old data before admitting a new patient.
	A normal color **Admit Patient** button (same color as the other screen buttons) indicates that the bed is available for admitting a patient and there is no monitoring data currently associated with the bed.

Clearing an Unidentified Strip Prior to Admission

CAUTION: If you admit a new patient when the **Admit Patient** button is red, the new patient's strip will be merged with the previous patient's strip data.

If the **Admit Patient** button is red and the unidentified strip should *not* be merged with the new patient's data:

1. Label the strip by admitting a "patient" as `NoName` for the last name. Use the room number for the first name; for example, `LDR10`.
2. Transfer[1] this pseudo patient and strip to an OUT room, where it can remain until it can be properly identified and labeled.
3. Admit the real patient to the intended bed (see "Admitting a Patient to NaviCare® WatchChild®" on page 3-3).

[1] See "Transferring a Patient to Another Bed" on page 9-1.

Admitting a Patient to NaviCare® WatchChild®

You can admit a patient to NaviCare® WatchChild® from any of three different screens; where you start this procedure depends on which screen you use:

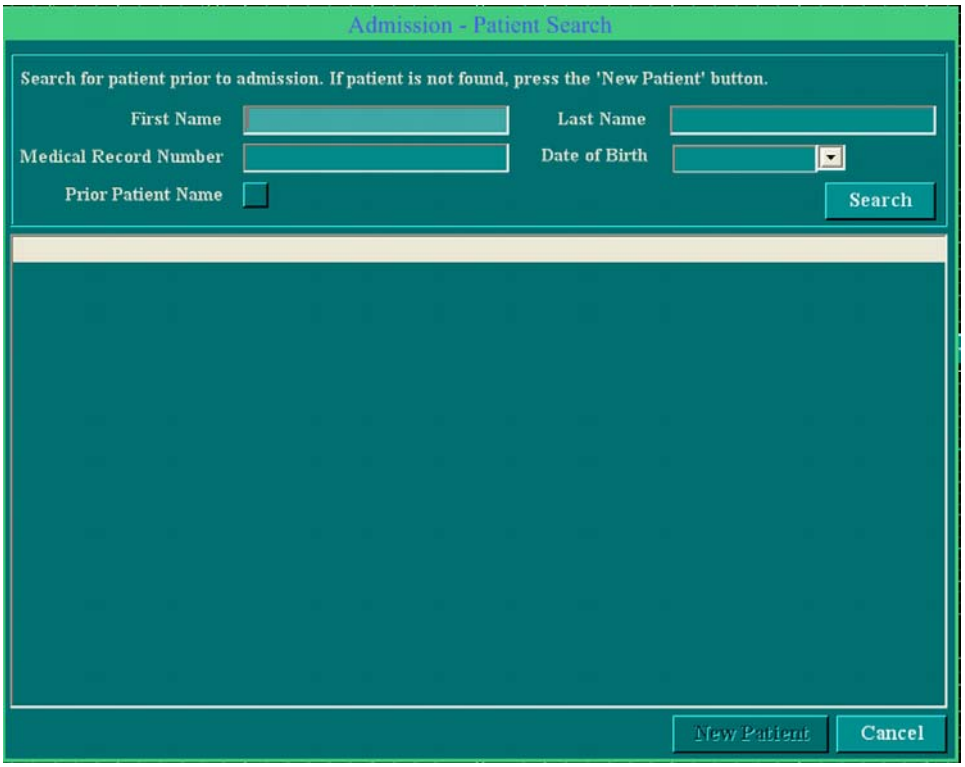
- Multi-Patient Surveillance screen — Begin this procedure from step 1.
- Single-Patient Surveillance screen — Begin this procedure from step 4 on page 3-4.
- Census screen — Begin this procedure from step 7 on page 3-4.

1. From the Multi-Patient Surveillance screen, locate an empty patient bed, indicated by the presence of an **Admit Patient** button, as shown in Figure 3-1.

Figure 3-1 *Multi-Patient Surveillance with Admit Patient Button*

2. Select the **Admit Patient** button. The Admission Patient Search screen opens, as shown in Figure 3-2 on page 3-4.

Figure 3-2 *Admission Patient Search Screen*



3. Skip to step 9.
4. Display a Single-Patient Surveillance screen from either the Multi-Patient Surveillance or Census screens.
5. Select the **Admit Patient** button. The Admission Name Lookup screen appears, as shown in Figure 3-2.
6. Skip to step 9.
7. If you are not already viewing the Census screen, display it by selecting the **Census** button.
8. Select the empty bed where the patient is to be admitted, then select the **Admission** button. The Admission Name Lookup screen appears, as shown in Figure 3-2.
9. On the Admission Name Lookup screen, enter one of the following into the **Enter name or number or date** field:
   - All or the first few letters of the patient's name in the format specified on the screen, or...
   - All or the first few digits of the patient's medical record number (MRN), or...
   - The patient's date of birth in the numeric format *mm/dd/yy* or *mm/dd/yyyy*
10. Select **Search**. A list of all matching names is displayed, along with their MRNs. Notice that the **New Patient** button has become active on the screen.

    In most cases, a patient's information will be listed because she was admitted to the hospital prior to being sent to your Labor & Delivery unit; the hospital information system will have already made her admittance information available to NaviCare® WatchChild®. However, there will occasionally be instances when a patient arrives at your unit prior to her hospital admittance information reaching NaviCare® WatchChild®.

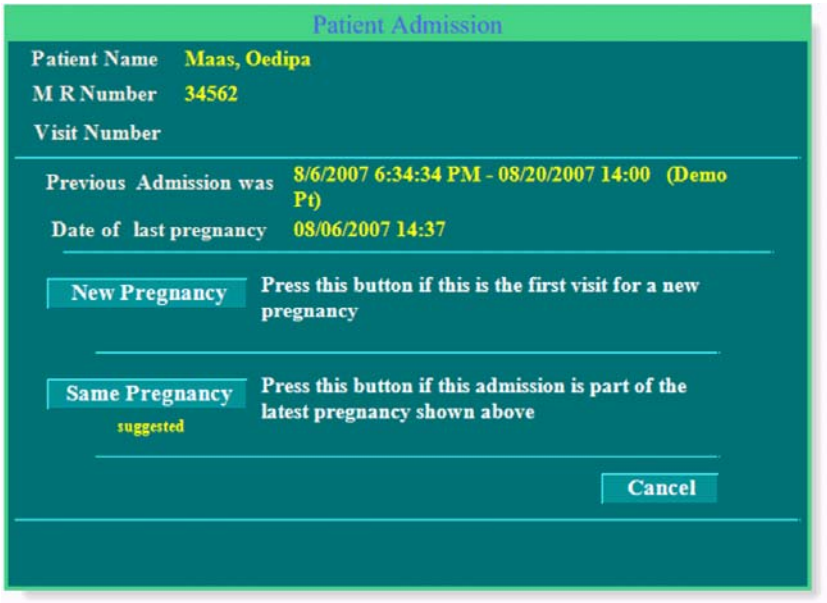
11. Does your patient's name appear in the displayed list?

    If Yes: Proceed to step 12 on page 3-5.

    If No: Skip to step 15 on page 3-6.

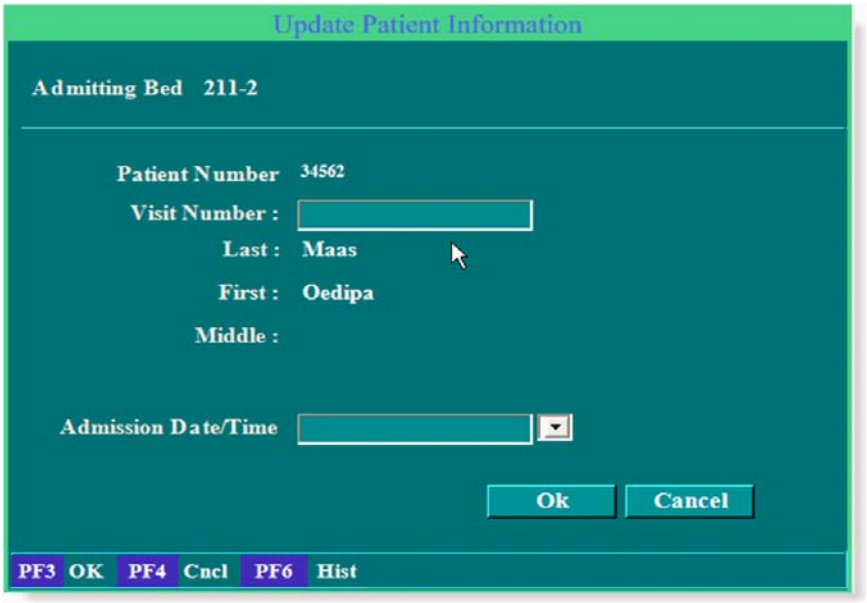
12. Select the patient from the name list. The Patient Admission screen appears, as shown in Figure 3-3.

Figure 3-3 *Patient Admission Screen*



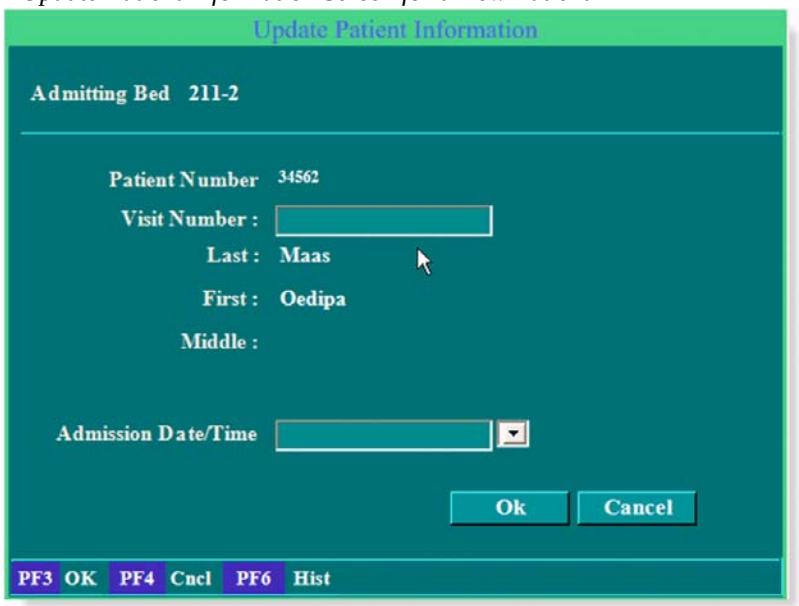
13. Select **New Pregnancy** or **Same Pregnancy**. (NaviCare® WatchChild® suggests which button to select, based on an analysis of any previous visit and pregnancy information.) The Update Patient Information screen appears, as shown in Figure 3-4. If you selected **New Pregnancy**, the screen appears as shown below, with the **Visit Number** field, also known as the account number, in need of input.

Figure 3-4 *Update Patient Information Screen*



14. At the first opportunity after your patient is settled in, proceed to "Filling In and Updating the Obstetric Admitting Record" on page 3-8. *End of this procedure.*
15. Select **New Patient**. The Update Patient Information screen appears, as shown in Figure 3-5.
16. If the **Visit Number** field is available for input, type in a visit number (sometimes referred to as the account number).
17. In the **Admission Date/Time** field, specify the date and time that you are admitting the patient to the bed (see "Time and Date Fields" on page 1-9 for tips on shortcuts and calendar usage), and then select **OK** to admit the patient and close the Update Patient Information screen.

Figure 3-5 *Update Patient Information Screen for a New Patient*



NOTE: If you entered numeric information such as a date for your search, that will appear in the **Patient Number** field; delete it from the field. If you entered alphabetic information, it appears in the **Last** name field.

18. Whether or not you must enter a medical record number and visit number depends on your facility's policies regarding manual entry of that information when the information is not available to NaviCare® WatchChild® from the hospital information system. Depending on local procedures, either enter a valid medical record number (an MRN) and visit number in their respective fields, or leave those fields blank and proceed to the next step.

NOTE: A patient cannot be discharged from NaviCare® WatchChild® unless she has an MRN and a visit number. These numbers are generated by the hospital Admissions department (usually).

19. Enter the patient's last name, first name and middle name or initial in their respective fields.
20. In the **Admission Date/Time** field, specify the date and time that you are admitting the patient to the bed (see "Time and Date Fields" on page 1-9 for tips on shortcuts and calendar usage).
21. Select **OK** to admit the patient to the bed and close the Update Patient Information screen.
22. At the first opportunity after your patient is settled in, proceed to "Filling In and Updating the Obstetric Admitting Record" on page 3-8.

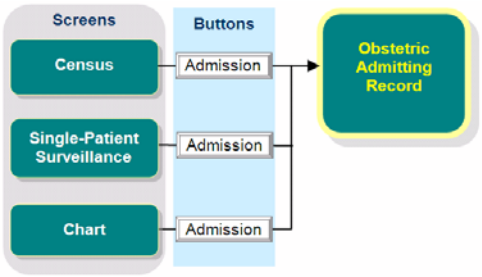
Filling In and Updating the Obstetric Admitting Record

■ “Obstetric Admitting Record — Comprehensive Charting” on page 4-1

To change the patient’s MRN, visit number or name, go to “Changing a Patient’s MRN, Visit Number or Name” on page 3-9.

1. You can access the Obstetric Admitting Record screen from either the Census screen, a Single-Patient Surveillance screen or the Chart screen, as illustrated in Figure 3-6.

Figure 3-6 *Accessing the Obstetric Admitting Record Screen*

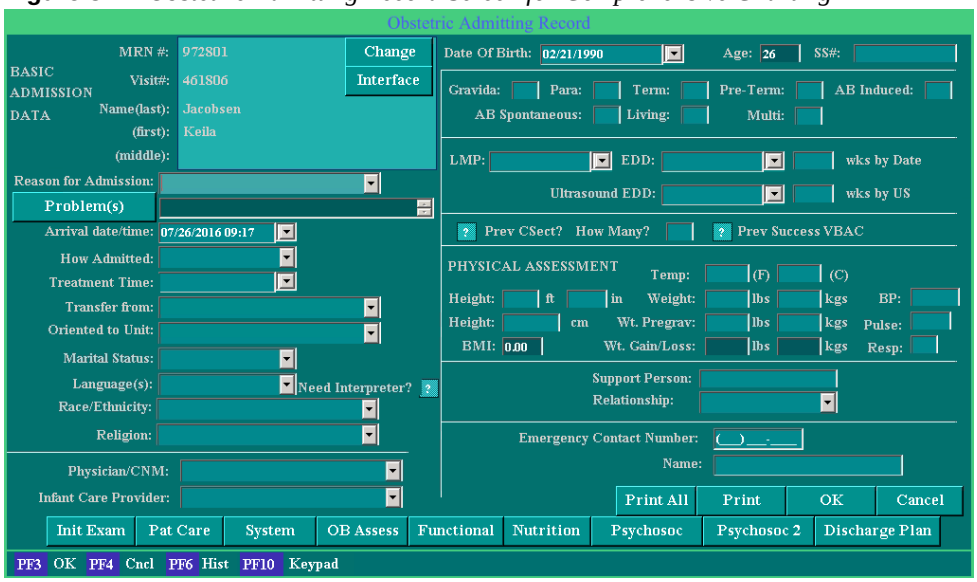


From the Census screen, first select the patient bed that corresponds to the Obstetric Admitting Record that you want to modify.

From the Chart screen, select a **Choose** button and specify the patient bed for which you want to fill in or update the Obstetric Admitting Record.

2. From either the Census, Single-Patient Surveillance or Chart screen, select the **Admission** button. The following screen appears, as shown in Figure 3-7:

Figure 3-7 *Obstetric Admitting Record Screen for Comprehensive Charting*



3. Go to “Obstetric Admitting Record — Comprehensive Charting” on page 4-1

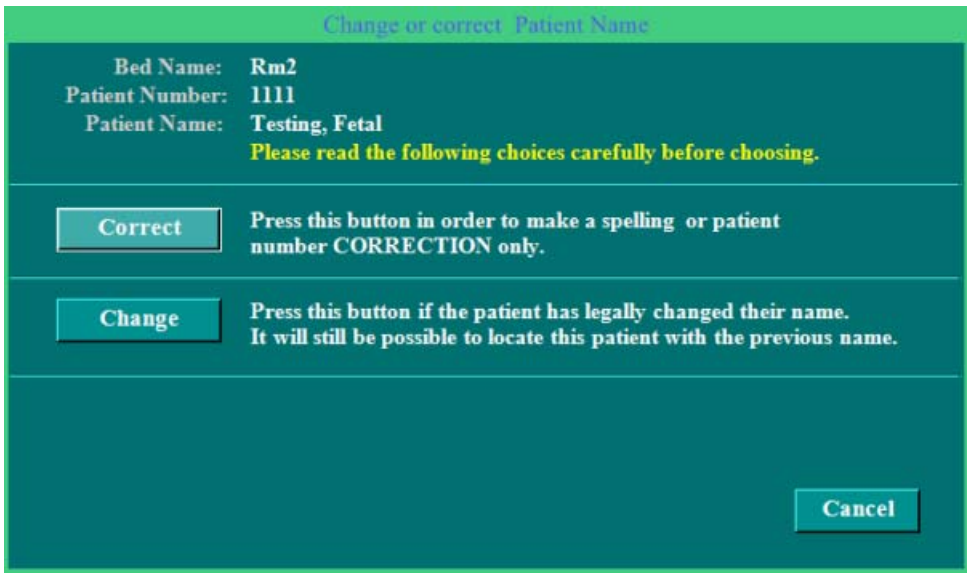
To change the patient’s MRN, visit number or name, go to “Changing a Patient’s MRN, Visit Number or Name” on page 3-9.

Changing a Patient's MRN, Visit Number or Name

The Change block on the Obstetric Admitting Record screen enables you to change the patient's MRN (medical record number, a.k.a. the patient ID), visit number (a.k.a. the visit number) and her name. To do that:

1. Select the **Change** button. The Change or Correct Patient Name screen appears, as shown in Figure 3-8.

Figure 3-8 *Change or Correct Patient Name*

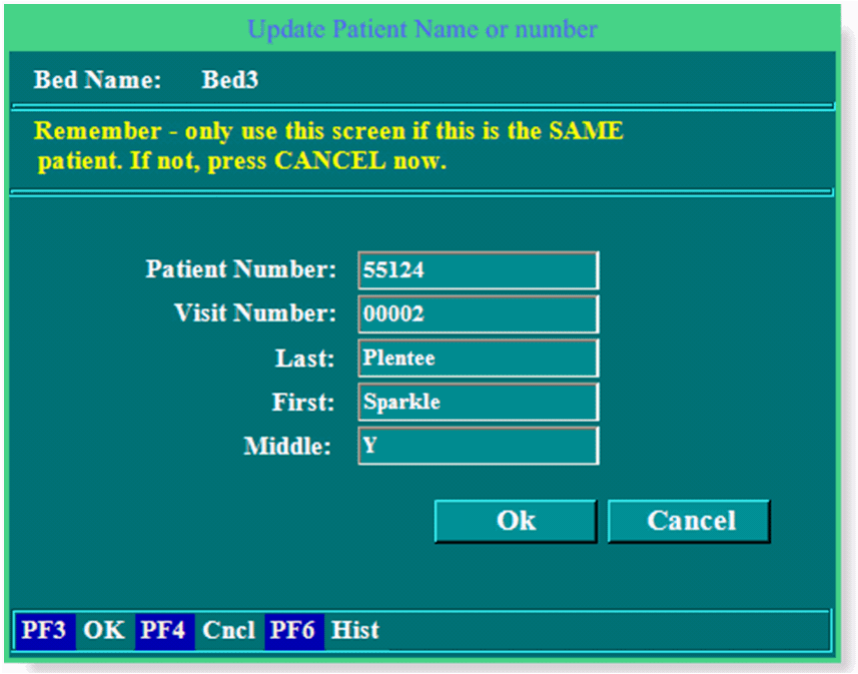


The buttons on this screen do the following:

- **Correct** and **Change:** Although the text associated with the **Correct** and **Change** buttons indicates that they are for different purposes, both buttons display the same screen — Update Patient Name or Number — and *appear* that they can be used to modify the information described for either of those buttons. However, behind the scenes (within the NaviCare® WatchChild® program) they actually perform different functions. Therefore, *always* select the **Correct** button to correct an MRN, visit number, or the spelling of the patient's name. *Always* select the **Change** button to update the patient's record with her legal name change.

  An example of the Update Patient Name or Number screen is shown in Figure 3-9 on page 3-10. If you select either **Correct** or **Change**, proceed to step 2 on page 3-10.

Figure 3-9 *Update Patient Name or Number Screen*



2. Make the needed changes on the Update Patient Name of Number screen, then select **OK**. Your changes are immediately applied to the Obstetric Admitting Record screen. *End of Procedure*.

Pre-Admitting a Patient

You can enter pre-admission information for a patient prior to the actual labor and delivery visit. The procedure is similar to admitting the patient, but the discharge procedure is slightly different.

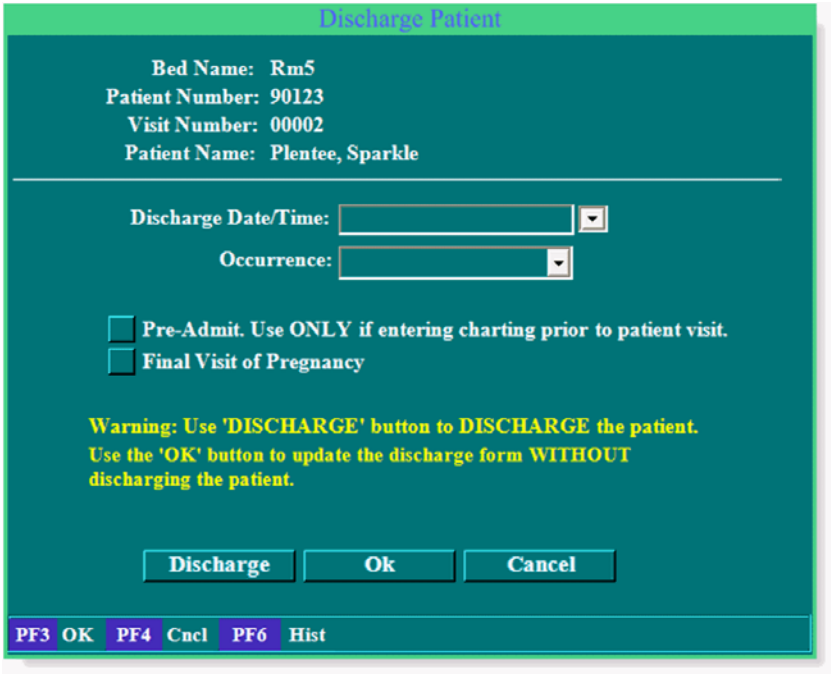
NOTE: You are not required to complete the medical record number, admission/discharge date and time fields, or occurrence for a pre-admission.

1. From the Multi-Patient Surveillance or Maternal screens, select **Census**. The Census screen appears, a portion of which is shown in Figure 3-10.

Figure 3-10 *Census Screen with Out bed Admission*

2. Select the OUT line or select any empty bed.
3. Select **Admission.** See "Admitting a Patient to NaviCare® WatchChild®" on page 3-3 and follow the procedure to admit the patient.
4. Enter pre-admission information on any of the charting screens, select **OK** on any screen on which you have entered data, and then return to the Census screen.
5. Select the pre-admitted patient.
6. Select **Discharge**. The Discharge Patient screen opens, as shown in Figure 3-11 on page 3-12.

Figure 3-11 *Discharge Patient Screen*



7. Type `N` into the **Discharge Date/Time** field to automatically enter the current date and time.
8. From the **Occurrence** field drop-down menu, select **Prenatal Visit**.
9. Select to X the **Pre-Admit** check box.
10. Select the **Discharge** button to discharge the pre-admitted patient.

    When it is later time to physically admit the patient for delivery, her pre-admission information will come up in the Obstetric Admitting Record search list. When her name is selected there, a message box pops up, allowing the admitter to use the pre-admission information previously entered.

Discharging a Patient

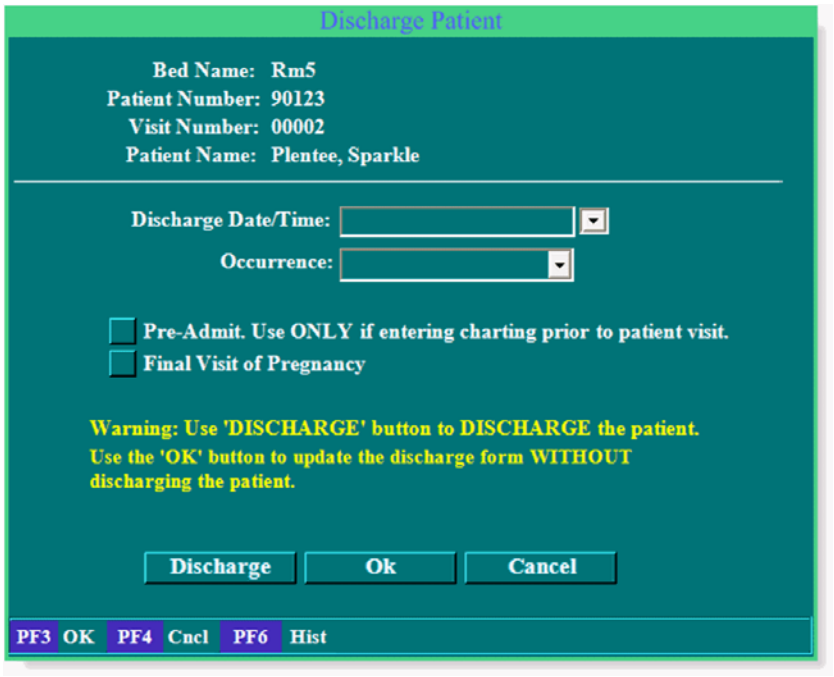
You can discharge a patient from either the Census screen or a Single-Patient Surveillance screen. To do that:

1. *From the Census* screen, select the patient to be discharged and then select **Discharge**.

   From the Single-Patient Surveillance screen, select **Discharge**.

   The Discharge Patient screen appears, as shown in Figure 3-12.

Figure 3-12 *Discharge Planning Screen*



2. Type `N` into the **Discharge Date/Time** field to automatically enter the current date and time.
3. From the **Occurrence** field drop-down menu, select the appropriate reason why the patient was admitted. In other words, select what occurred that led to the admission of the patient that you are now discharging.
4. Select the **Pre-Admit** or **Final Visit of Pregnancy** check box *only if appropriate* for this discharge.
5. If for any reason you are not quite ready to actually discharge the patient, select **OK**. Anything you entered or selected on the screen will be held and the screen closes. The next time you select **Discharge** for this patient on the Census or Single-Patient Surveillance screen, the Discharge Patient screen will display exactly as you left it, with your entries intact but not saved to the NaviCare® WatchChild® database.

   If you are ready to actually discharge the patient, select **Discharge**. The screen closes, the patient is removed from the bed, all of her patient data is saved and her patient record is queued for archiving according to the archive schedule established for your facility

Archived Records Retrieval

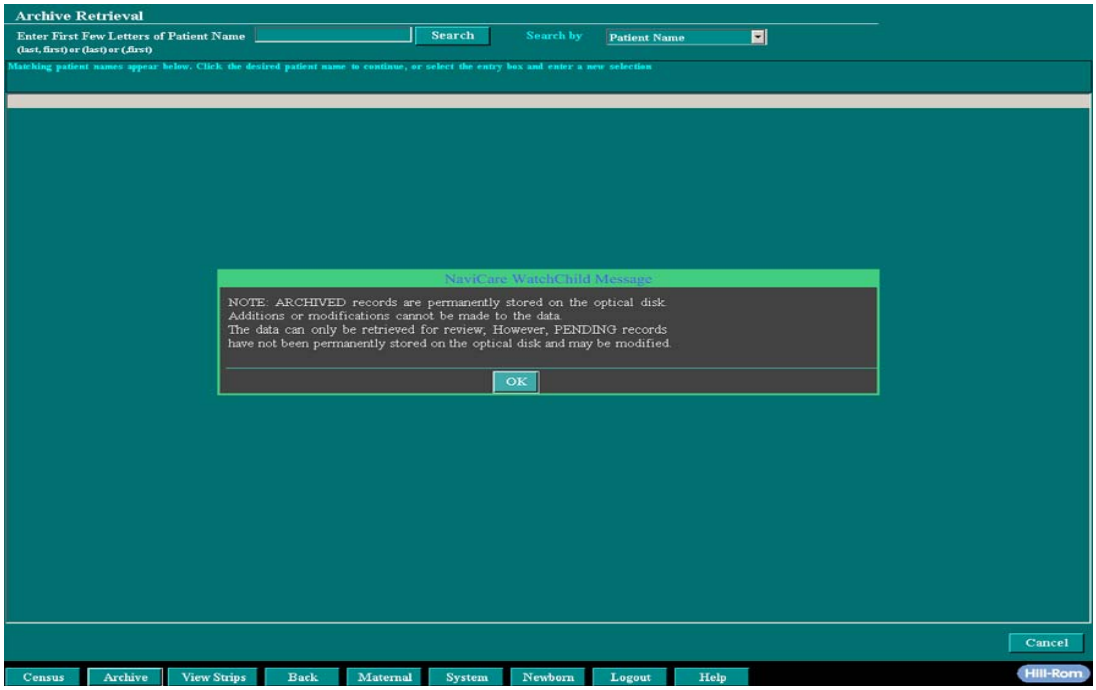
Archived NaviCare® WatchChild® data consists of stored patient fetal monitor strip(s) and any related charting on optical or other media for long-term storage. After a patient is discharged from NaviCare® WatchChild®, the patient's data remains in a *pending* state on the system hard drives until it moves to a different state: *review, closed,* or *archived*. A *pending* state is where the chart is in a *Hold* mode for 1 to 30 days based on the configuration set by the system administrator. During this time, the staff clinician may edit a record. In a *review* state, a patient visit can be edited by a user with adequate privileges, and is configurable for 1 to 365 days. While in a *closed* state, patient records can only be edited by NaviCare® WatchChild® technical support. A *closed* state can be configured to last anywhere from 42 to 1,600 weeks. An *archived* state is where the chart has been closed and a PDF archive is available for retrieval.

Each night, NaviCare® WatchChild® will automatically archive the patient data to the specific state (pending, review, or closed) for those patients who have been discharged according to hospital-specified time limit.

To retrieve the charting data:

1. In the Multi-Patient Surveillance, Census or Maternal screens, select **Archive**. The Archive Retrieval screen opens with a message indicating that the archived records are permanently stored on optical disk and additions or modification are not allowed to the data[1]. The Archive Retrieval screen with the message pop-up appears similar to that shown in Figure 3-13.

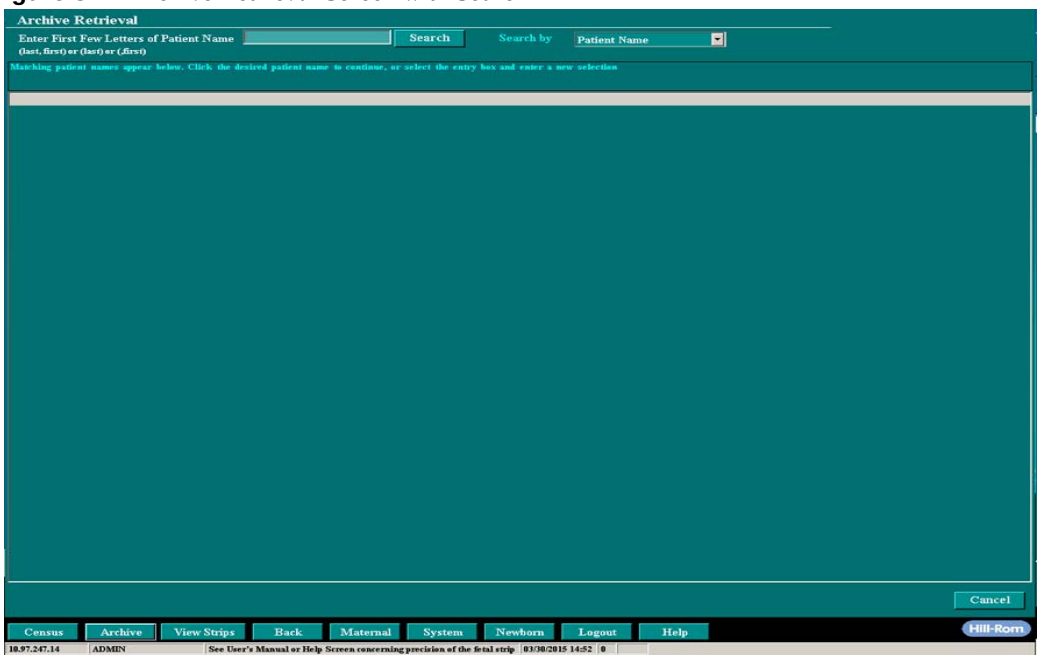
Figure 3-13 *Achieve Retrieval with message pop-up Screen*



[1] Whether or not modifications to the data are allowed depends upon the archive state.

2. Select **OK** to close the message pop-up screen. The Archive Retrieval refreshes as shown in Figure 3-14 on page 3-15, enabling you to search for a patient record.

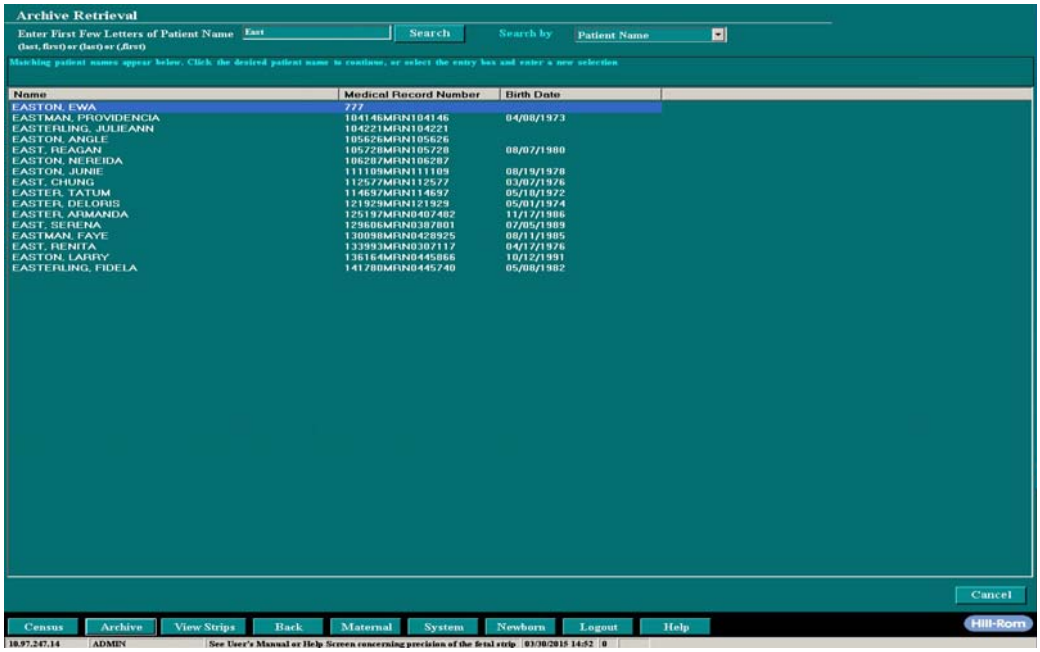
Figure 3-14 *Archive Retrieval Screen with Search*



3. From the **Search by** drop-down menu, select the type of search you wish to perform (Name, Date or MRN). The label for the search data entry field changes to match the type of search you selected.

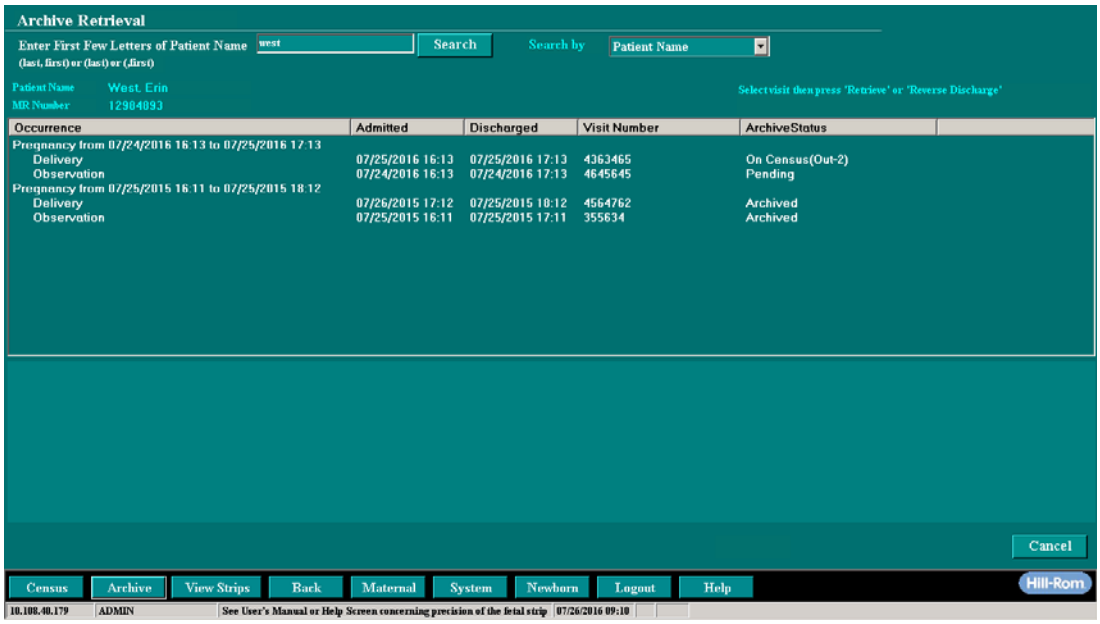
4. Select the **Search** button. If a record matching your entry cannot be found, a message pop-up appears and suggests another search criteria. If there are any matches to your search, they will be listed in the central window of the screen, as shown in Figure 3-15.

Figure 3-15 *Archive Retrieval Screen with Matching Names*



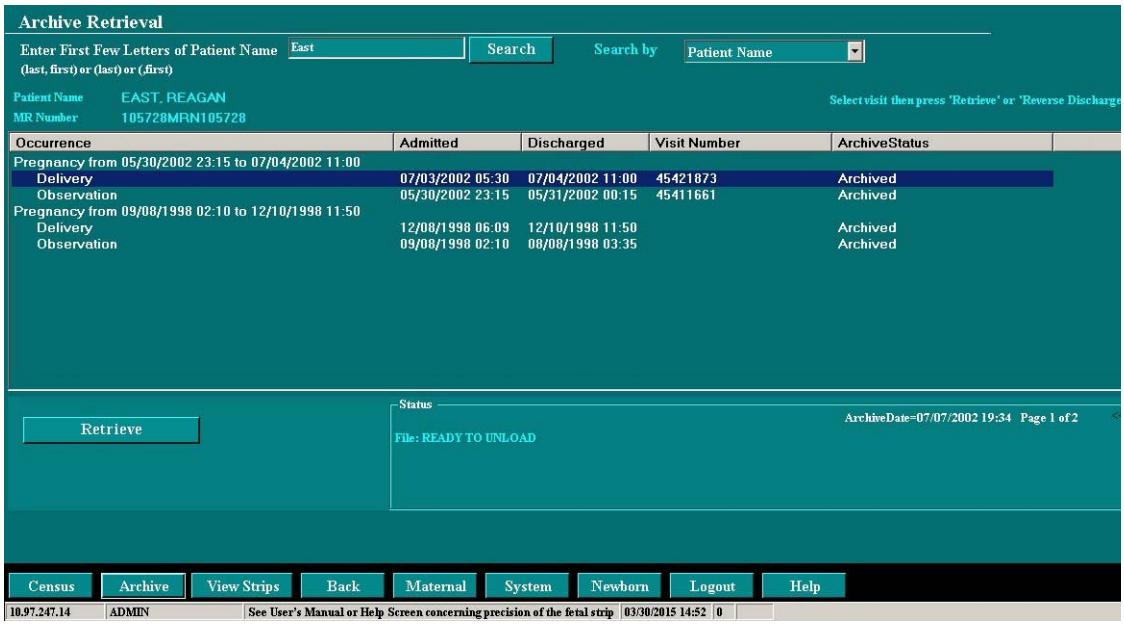
5. Select the patient's name in the list. The selected patient's details appear, as shown in Figure 3-16. A patient on the census has an ArchiveStatus of “On-Census (Out-2)”.

Figure 3-16 *Archive Retrieval Screen Listing Patient Visits*



6. Select a visit. (In the example above, that would be Observation.) The **Retrieve** and **Reverse Discharge** buttons appear, as shown in Figure 3-17. If the patient is on the census, the **Retrieve** and **Reverse Discharge** are hidden for that patient.

Figure 3-17 *Archive Retrieval Visit Selection*

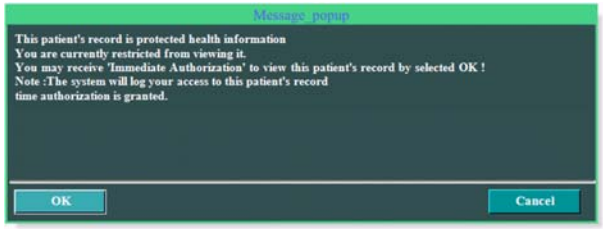


The **Retrieve** button draws the patient's data from the archive and places it in an Outbed on the Census screen, from where the patient's chart data can be accessed for viewing or printing. The patient will be in the retrieved status (designated by the associated color). Only the user who retrieves the patient or a System Administrator can access the chart. To retrieve the data, select the entry with the correct admission date, then select **Retrieve**.

The **Reverse Discharge** button uses the archived patient data to readmit the patient as an active patient, thus allowing edits to be made to the chart, and will place the patient in an Outbed with no status.

7. Select **Reverse Discharge**. (If you were restricted from viewing the patient at the time she was discharged, a "restricted patient information" message pop-up appears, as shown in Figure 3-18. If this happens, select **OK**.)

Figure 3-18 *Restricted Patient Information Message Pop-Up*



The patient is readmitted to an OUT bed and the screen changes to Single-Patient Surveillance.

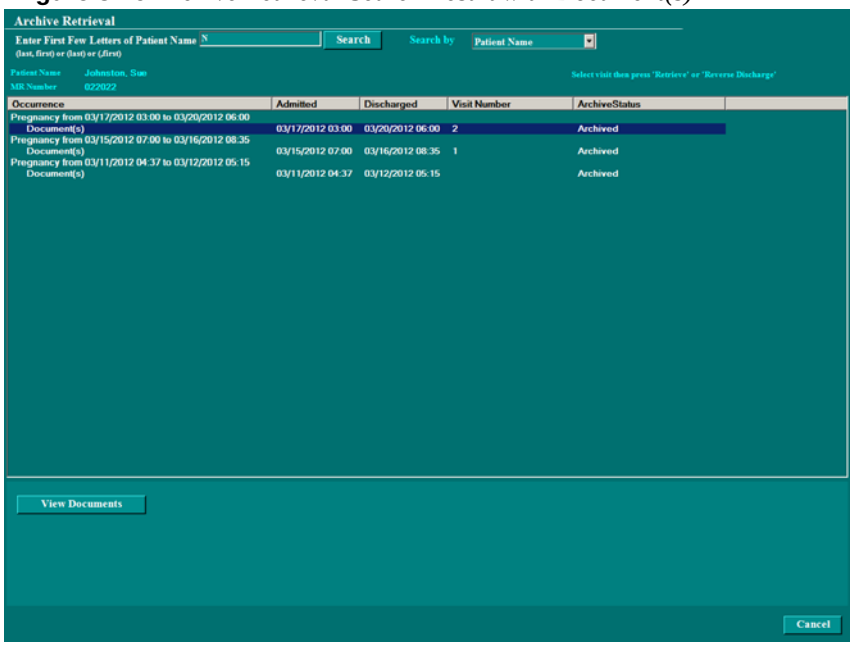
8. Select the **Census** button to switch to the Census screen.

9. Using the 'ctrl' key, select both the OUT bed containing the patient and an empty bed, then select **Transfer** to place the newly re-admitted patient into an actual bed, or leave the patient in an Outbed in order to update the chart before discharging the patient again.

To retrieve an archived document:

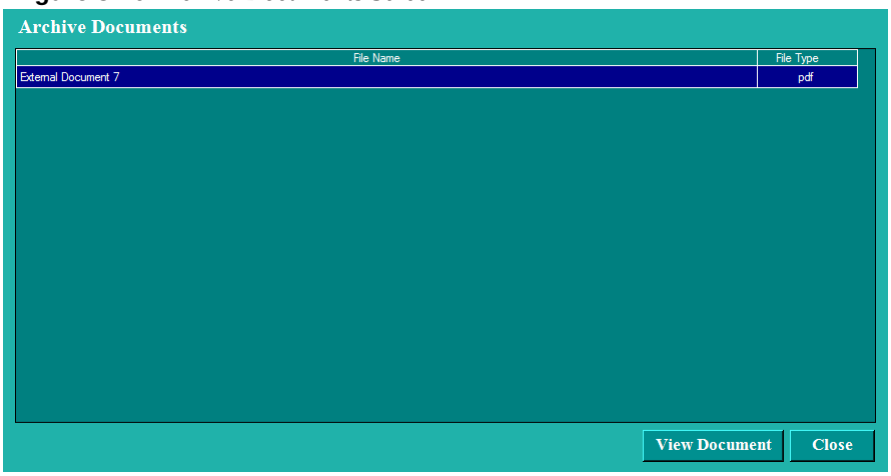
1. From an Archive Retrieval search result with an *Archive* status, click to select a *Document(s)* line, as shown in Figure 3-19.

Figure 3-19 *Archive Retrieval Search Result with Document(s)*



2. Click the **View Documents** button at the bottom of the page to access the Archive Documents screen as shown in Figure 3-20.

Figure 3-20 *Archive Documents Screen*



3. Select a document file name and click the **View Document** button.
4. The document displays on the screen with the option to save to disk or print.

Chapter 4

Obstetric Admitting Record — Comprehensive Charting

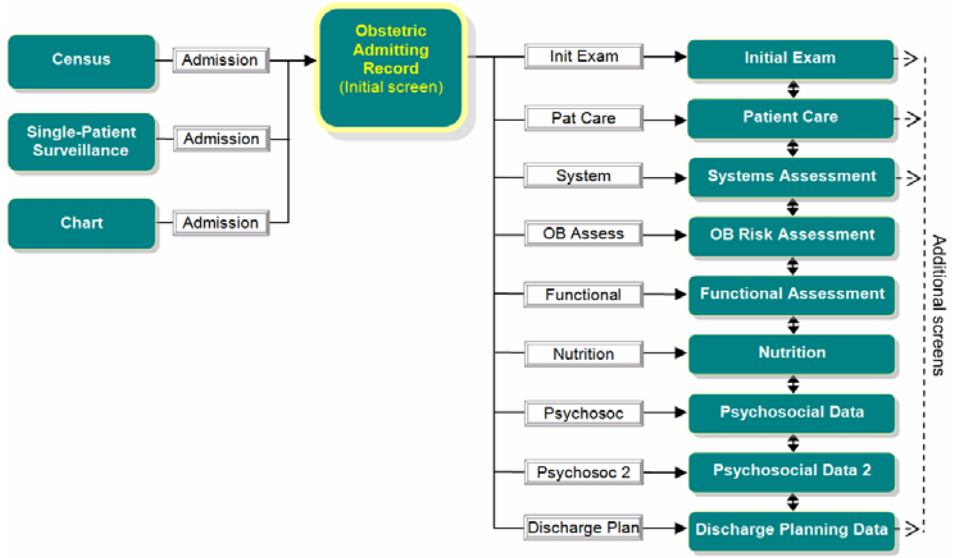
Overview and Navigation

The Obstetric Admitting Record consists of the initially-displayed Obstetric Admitting Flowsheet screen, plus nine additional admission screens accessible directly from the Obstetric Admitting Record tab. Additional screen levels are available from several of the first-level screens, and many of the second level screens provide access to additional screens. Some of the screens in the Obstetric Admitting Record are also accessible from other areas, for example, from the Chart and Prenatal Record screens.

You can enter patient data on all of the screens in a single data-entry session or on an as-needed or other basis, depending on your facility's policies, patient conditions and workload. The Obstetric Admitting Record screens enable you to record subjective, objective, assessment, patient history and plan information at either a patient's bedside or the nurses' station.

Figure 4-1 illustrates how the Obstetric Admitting Record and all of its first-level screens are accessed. Notice that each of the first-level screens is available directly from a corresponding button on the Obstetric Admitting Record screen.

Figure 4-1 *Obstetric Admitting Record*



Usage Notes:

- From each first-level screen you can move to the next or previous screen using arrow buttons, shown at right.

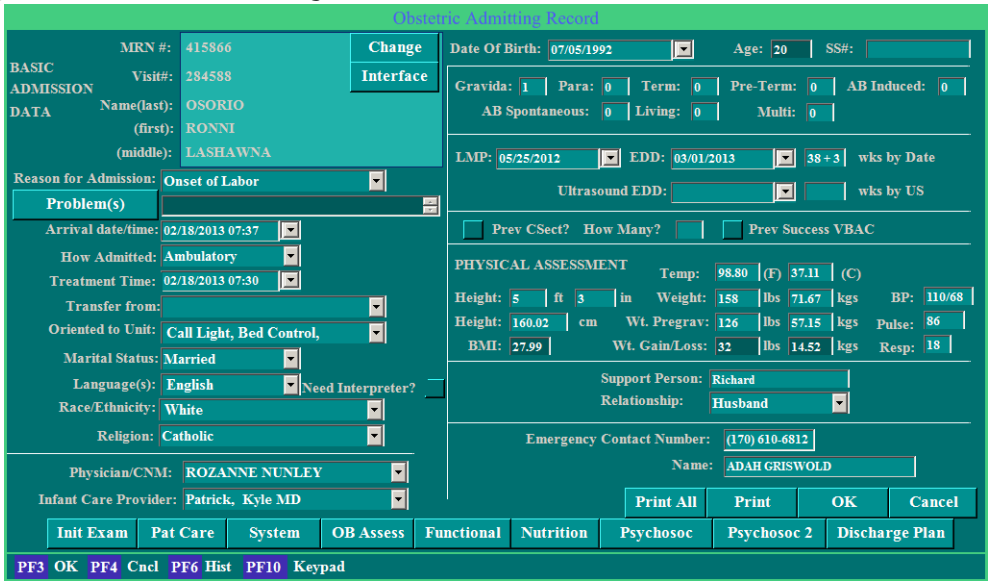
- When you select any button (except **Cancel**) that takes you to another screen, your changes to the current screen are automatically saved.
- The **OK** and **Cancel** buttons on all but the first screen will return you to the initial screen of the Obstetric Admitting Record.

Obstetric Admitting Record — Initial Screen

Use the following procedure to use the Obstetric Admitting Record screen.

1. If you have not already done so, display the Obstetric Admitting Record screen for your patient by following the procedure given in Chapter 3, "Admitting a Patient" on page 3-1 for a new patient, or refer to Figure 4-1 on page 4-1 to access the screen for an existing patient. The initial Obstetric Admitting Record screen is shown in Figure 4-2.

Figure 4-2 *Obstetric Admitting Record — Initial Screen*



Become familiar with the function of the following four screen buttons before proceeding to the next step:

Print All — Prints all of the Obstetric Admitting Record information from all of the screens, which includes the four prenatal screens.

Print — Prints all the screens except for the four prenatal screens.

OK — Saves all new or changed data on the current Obstetric Admitting Record screen and closes the current screen. This also functions to "seal" the Admitting Record (all screens) from future changes. Changes/editing may be made within the Admission Record; however, those changes will no longer flow forward to other fields within the NaviCare® WatchChild® complete Chart. Those changes or additional data must be entered manually.

Cancel Discards any changes you have made to the current screen and closes the screen.

Usage Notes:

- Any drop-down menu with **OK** and **Cancel** buttons at the bottom of the menu enables you to select multiple items from the menu.
- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item for this record only.

2. Do you need to change the patient's MRN (medical record number), visit number or name?

   If Yes, go to "Changing a Patient's MRN, Visit Number or Name" on page 3-9, follow the procedure there, then return here if there are other Obstetric Admitting Record changes that you want to make.

   If No, proceed to step 3, below.

3. To go to a different Obstetric Admitting Record screen, refer to Table 4-1 for which button takes you to which screen and where the usage information for that screen is located.

Table 4-1 *Obstetric Admitting Record Screens Access Buttons*

Button	Screen Displayed	Described in...
Problem(s)	Obstetric Admitting Problem(s)	"Obstetric Admitting Record - Problem(s) Screen" on page 4-4
Init Exam	Initial Exam	"Initial Exam Screen" on page 4-6
Pat Care	Patient Care	"Patient Care Screen" on page 4-16
System	Systems Assessment	"Systems Assessment Screen" on page 4-19
OB Assess	OB Risk Assessment	"OB Risk Assessment Screen" on page 4-35
Functional	Functional Assessment	"Functional Assessment Screen" on page 4-36
Nutrition	Nutrition	"Nutrition Screen" on page 4-41
Psychosoc	Psychosocial Data	"Psychosocial Data Screen" on page 4-43
Psychosoc 2	Psychosocial Data 2	"Psychosocial Data 2 Screen" on page 4-44
Discharge Plan	Discharge Planning Data	"Discharge Planning Data" on page 4-45

Fill in the following Obstetric Admitting Record initial screen fields (or verify prepopulated information) as appropriate to your patient and your facility's policies:

4. To save your entries, either select **OK** to save your changes and close the Obstetric Admitting Record screen, or select one of the other screen access buttons to save your entries thus far and go to another Obstetric Admitting Record screen. To exit without saving, select **Cancel**.

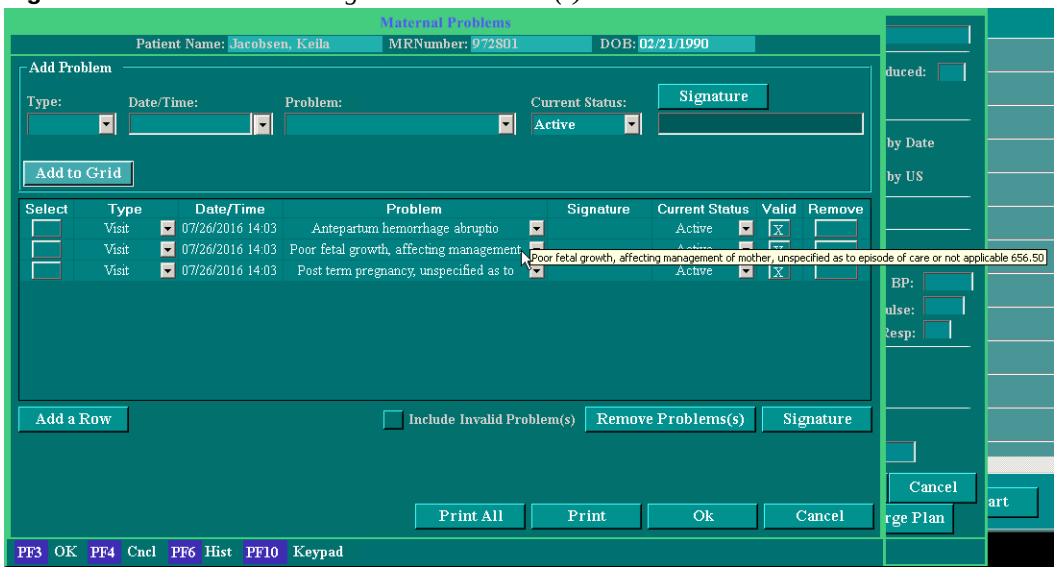
   Many fields in the Obstetric Admitting Record screen will flow to other sections of this Chart. One such field is the Gestational Age field that also populates the appropriate field on the Labor and Delivery Summary screen. See Chapter 16, "Labor, Delivery, and Infant Summary" on page 16-1 for information about this screen. When that field is noted on the Census screen, the patient's gestational age will increase with days of hospitalization.

Obstetric Admitting Record - Problem(s) Screen

Access the Problem(s) screen for your patient by clicking the **Problem(s)** button on the Obstetric Admitting Record — Initial Screen.

The Problem(s) screen displays, as shown in Figure 4-3.

Figure 4-3 *Obstetric Admitting Record - Problem(s) Screen*



Usage Notes:

- When you hover over a selected item in the reference list, a tool tip displays the full reference.
- To add patient problems, see "To add one or more problems (from the Add Problem section at the top):" on page 4-5 and "To add one or more problems (from the grid):" on page 4-5.
- To delete one, or more, problems from the grid; click the corresponding **Remove** box(es) and select the **Remove Problem(s)** button.
- To modify a newly added problem field in the grid, select a new choice from the drop-down list in the field.
- To view or hide invalid problems, check or clear the **Include Invalid Problem(s)** box.
- To save changes, click **OK**.

To add one or more problems (from the Add Problem section at the top):

1. Select the **Type** of problem (Admission, Discharge, Visit, or Chronic).
2. Select the date that the problem was recorded.
3. Select one or more **Problem** descriptions and click **OK** in the drop-down menu. To read a long reference, hover over the reference item and a tool tip will display the full reference.
4. Select the **Current Status** of the problem(s) (Active, Resolved, Referred, Assumed Resolved, Denied, Transitioned, Other).
5. Click the **Signature** button at the top of the screen to sign the problem.
6. Click the **Add to Grid** button.
7. Click **OK** to save the problem record.

To add one or more problems (from the grid):

1. Click the **Add a Row** button, near the bottom of the screen, for each problem to add.
2. For each row, select the **Type** of problem (Admission, Discharge, Visit, or Chronic).
3. For each row, select the date that the problem was recorded.
4. For each row, select a **Problem** description. To read a long problem reference, hover over the reference item and a tool tip will display the full reference.
5. For each row, select the **Current Status** of the problem (Active, Resolved, Referred, Assumed Resolved, Denied, Transitioned, Other).
6. For each row, the validate (check) box is marked valid by default.
7. Click the **Signature** button to sign the row.

   NOTE: You can sign multiple rows at the same time by placing an X in the **Select** box for the rows that you want to sign.

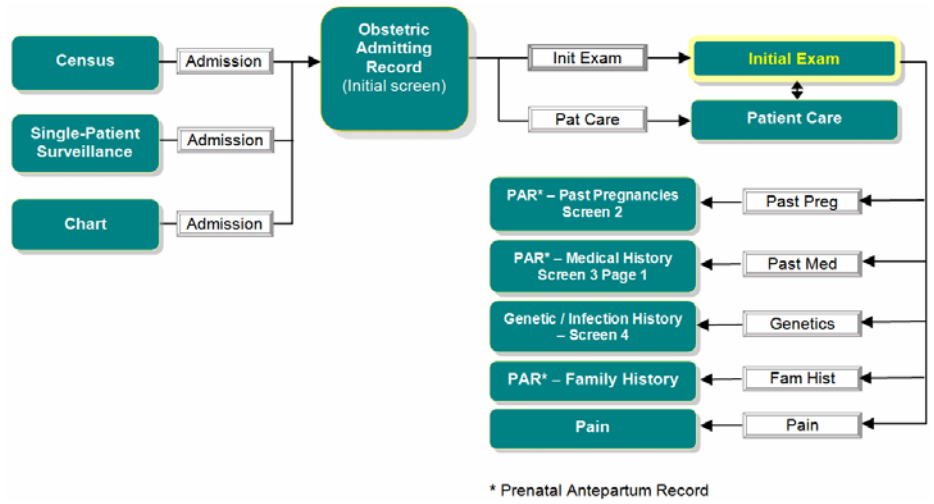
8. Click **OK** to save the problem record.

   NOTE: The only fields in the grid the clinician has the ability to modify after 'OK' has been clicked are the current status and the valid box fields.

Initial Exam Screen

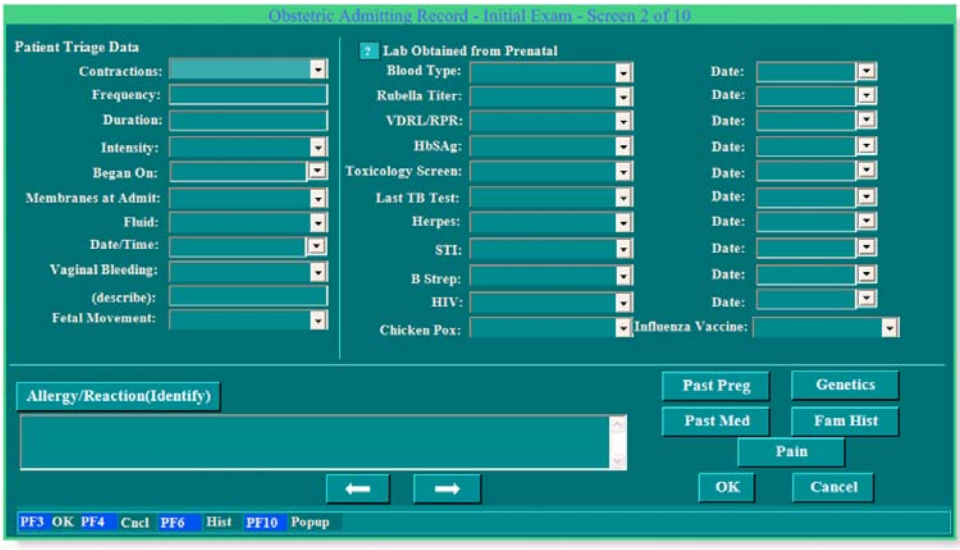
1. Access the Initial Exam screen for your patient via any of the paths illustrated in Figure 4-4. Notice that there are additional screens directly available from the Initial Exam screen by selecting buttons on the screen.

Figure 4-4 *Accessing the Initial Exam Screen*



The Initial Exam screen displays, as shown in Figure 4-5.

Figure 4-5 *Initial Exam Screen*



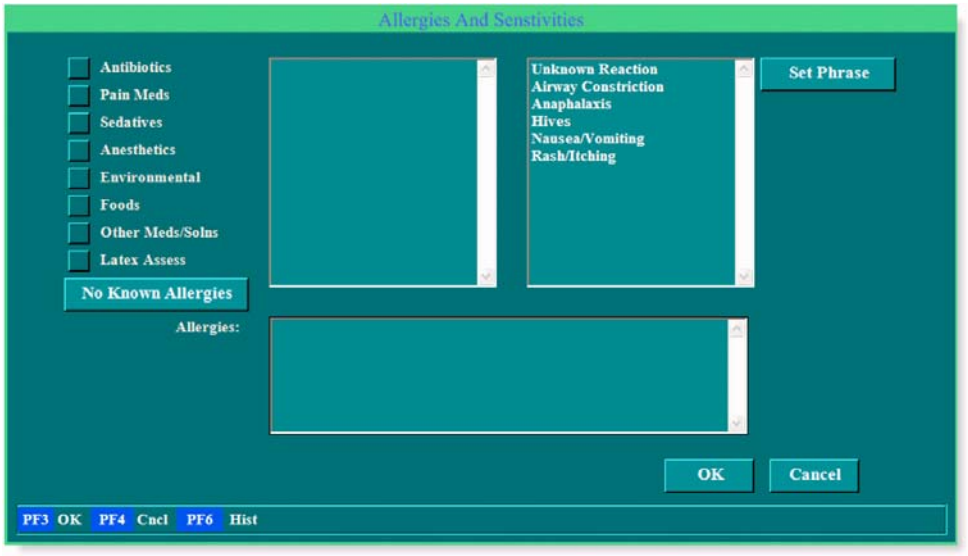
Add or update the screen field information on the Initial Exam screen. To go to one of the button-accessed screens, refer to Table 4-2 on page 4-7 for where the usage information for that screen is located.

Table 4-2 *Initial Exam Screen — Additional Screens* (PAR = Prenatal Antepartum Record)

Screen Name	Described in...
PAR - Past Pregnancies Screen 2	"Past Pregnancies Screen" on page 4-8
PAR - Medical History Screen 3 Page 1	"Medical History Screens" on page 4-10
Genetic / Infection History - Screen 4	"Genetic/Infection History Screen" on page 4-12
PAR - Family History	"Family History Screen" on page 4-13
Pain	"Pain Screen" on page 4-15

2. Fill in the following Initial Exam screen fields as appropriate to your patient and your facility's policies:
3. Select the **Allergy/Reaction(Identify)** button. The Allergies And Sensitivities screen appears, as shown in Figure 4-6.

Figure 4-6 *Allergies And Sensitivities Screen*



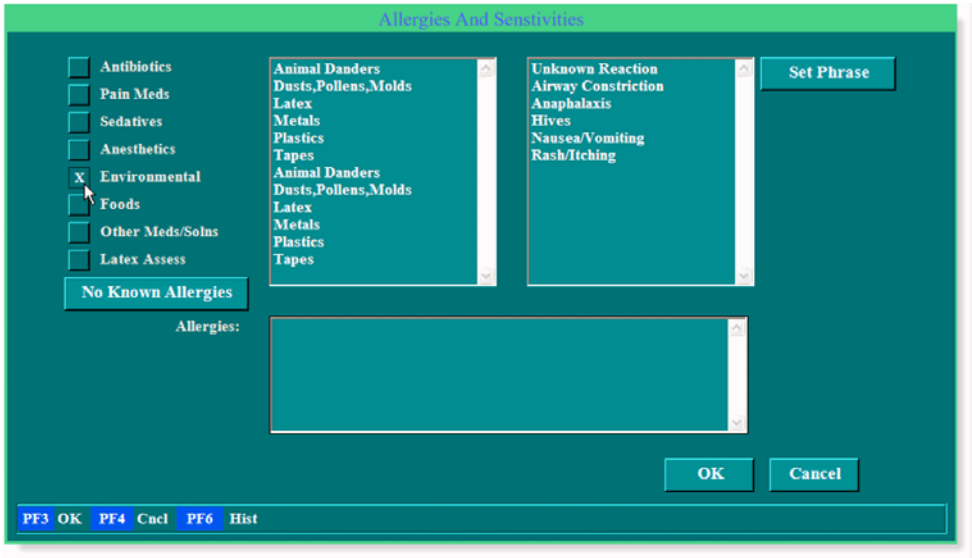
4. Does the patient have any known allergies?

   If Yes, proceed to step 5.

   If No, select the **No Known Allergies** button. The phrase *No Known Allergies* appears in the field below the button. Skip to step 7.

5. On the left of the screen is a list of allergy categories, each with a blank check box. Selecting a check box puts an X in it and, in the box to the right of the categories, generates a list of category-specific allergy triggers. To the right of that is a list of reactions. Figure 4-7 on page 4-8 shows an example with **Environmental** selected.

Figure 4-7 *Environmental Allergies*



6. Select a trigger, then select a reaction caused by the trigger, then select **Set Phrase**. The trigger and reaction appear in the **Allergies** field. You can select as many trigger-reaction combinations from as many categories as necessary. You can also manually type additional information into the **Allergies** field if there is no appropriate trigger-reaction combination. For example, the patient's only allergy may be to cats, which cause uncontrollable sneezing. As none of the category triggers or reactions is that specific, simply type `Cats: Uncontrollable sneezing` into the **Allergies** field.

   When you are done specifying allergies and sensitivities, select **OK** to save your changes and return to the Initial Exam screen. Notice that your allergies and sensitivities entries now appear in the box under the **Allergy/Reaction(Identify)** button.

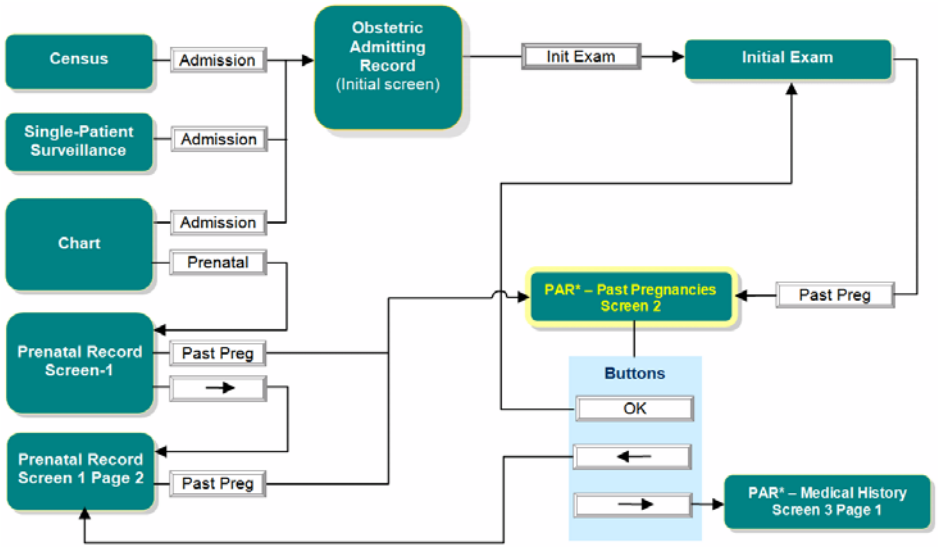
7. To save your entries, either select **OK** to save your changes and close the Initial Exam screen, or select one of the other screen access buttons to save your entries thus far and go to another screen. (See Table 4-2 on page 4-7 for where the button-accessible screens are described.) To exit without saving, select **Cancel**.

Past Pregnancies Screen

The Prenatal Antepartum Record - Past Pregnancies screen, shown in Figure 4-8, enables you to enter information about any past pregnancies. Access to the screen and the screens you can go to from there is illustrated in Figure 4-9 on page 4-9.

Figure 4-8 *Past Pregnancies Screen*

Figure 4-9 *Accessing the Past Pregnancies Screen*



The screen displays with basic patient information pulled from previous screens pre-loaded in the fields at the top of the screen. The lower half of the screen is for entering information about the previous pregnancies. One row of a data-gathering table is initially displayed, but you can add as many rows as there were pregnancies by selecting the **Add Row** button.

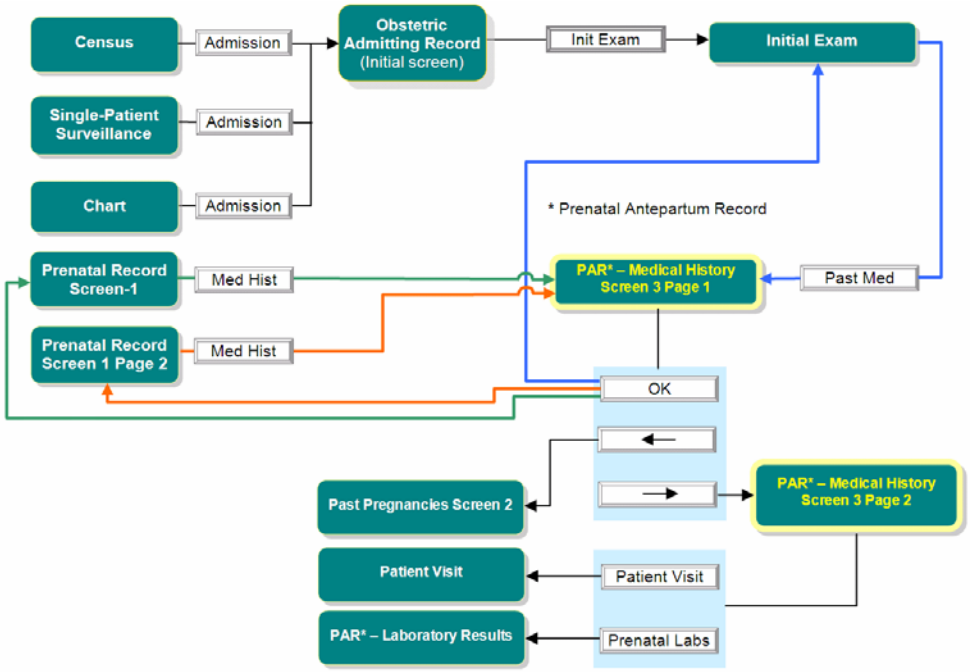
1. Update the screen fields.
2. To save your entries, either select **OK** to save your changes and close the Past Pregnancies screen, or select one of the other screen access buttons to save your entries thus far and go to another screen (see Figure 4-9 on page 4-9 for where each button takes you). To exit without saving, select **Cancel**.

Medical History Screens

The Prenatal Antepartum Record - Medical History screens (there are two screens; page 1 is shown in Figure 4-10) enable you to enter detailed information about the patient's medical history. Access to both of the Medical History screens and the screens you can access from each is illustrated in Figure 4-11 on page 4-10.

Figure 4-10 *Medical History Page 1 Screen*

Figure 4-11 *Accessing the Medical History Page 1 Screen*



The screen displays with basic patient information from previous screens pre-loaded in the fields at the top of the screen. The remainder of the screen is for entering medical history information. Notice the screen you return to after selecting **OK** on the Medical History Page 1 screen depends on which screen you came from, as illustrated by the blue, green and orange lines in Figure 4-11 on page 4-10.

1. The table lists fields by field groups, with each group of fields defined by its topic label. Each field group has the same set of check boxes and fields.

   Usage Notes:

   - **Positive** check box equates to Yes.
   - Selecting the check box to blank equates to No.
   - **Type** fields are limited to 20 characters, including spaces. **Treatment** fields are limited to 30 characters, including spaces.
   - Dates can be typed into the field in the form *mm/dd/yyyy* or selected from the drop-down calendar (see "Time and Date Fields" on page 1-9 for tips on using the calendar).

2. Select the ⇨ button to proceed to the Medical History Page 2 screen, shown in Figure 4-12.

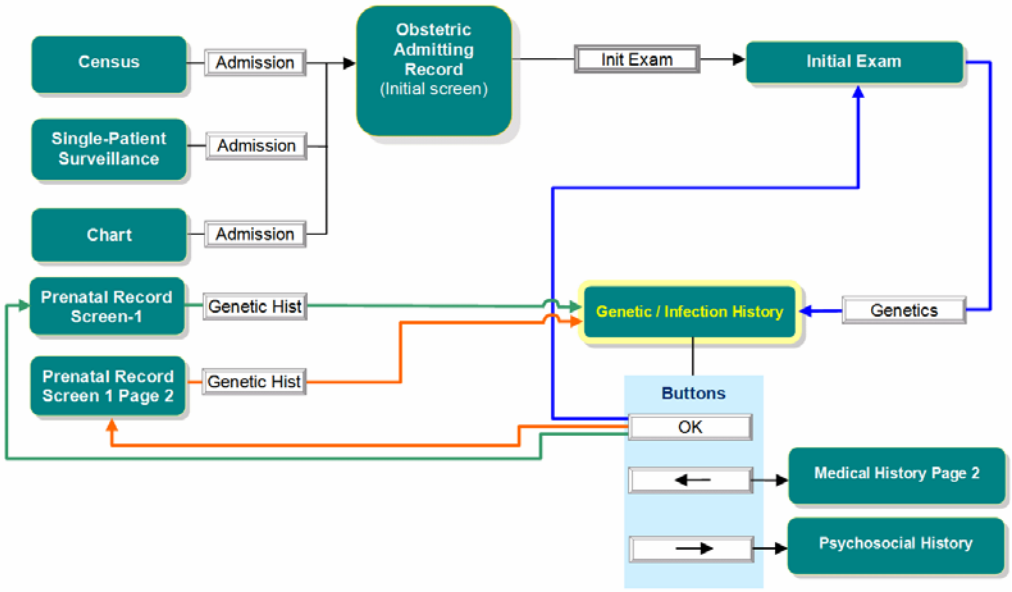
Figure 4-12 *Medical History Page 2 Screen*

3. To save your entries, select **OK** to save your changes and close the Medical History Page 2 screen. For another screen see Figure 4-11 on page 4-10 for where each button takes you. To exit without saving, select **Cancel**.

Genetic/Infection History Screen

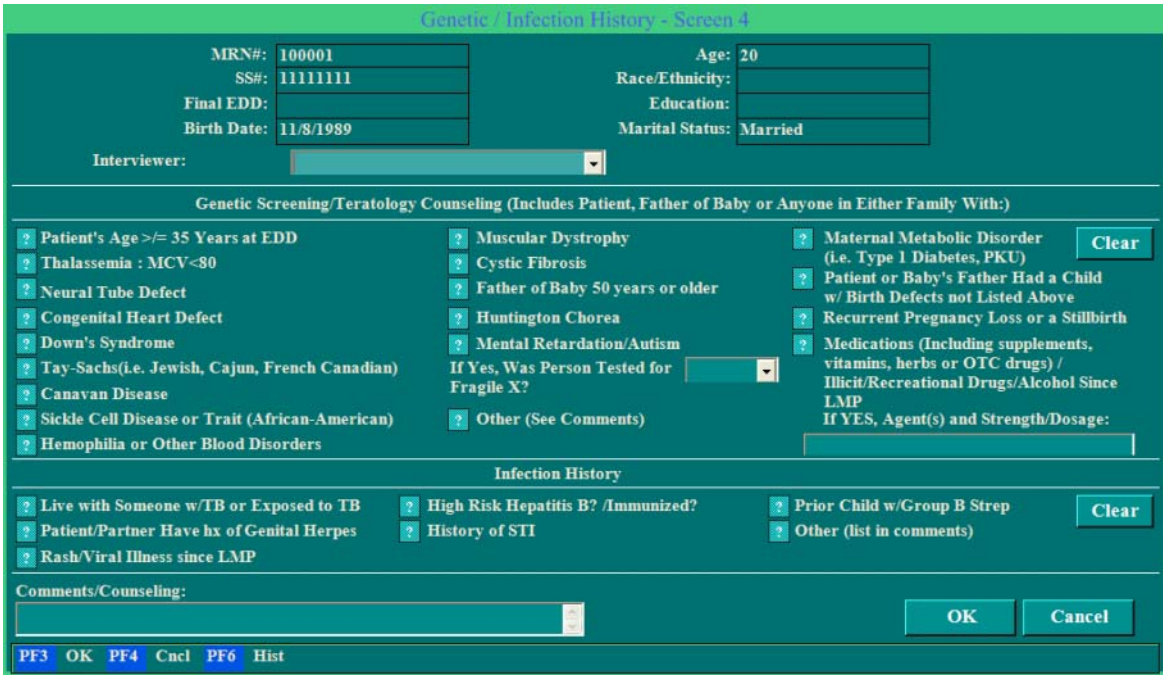
The Genetic/Infection History screen enables you to record information about family genetic factors and parental infections that could pose potential risks to the fetus. Access to the screen is illustrated in Figure 4-13.

Figure 4-13 *Accessing the Genetic / Infection History Screen*



1. Access the Genetic/Infection History screen, shown in Figure 4-14, via any of the paths illustrated above.

Figure 4-14 *Genetic/Infection History Screen*



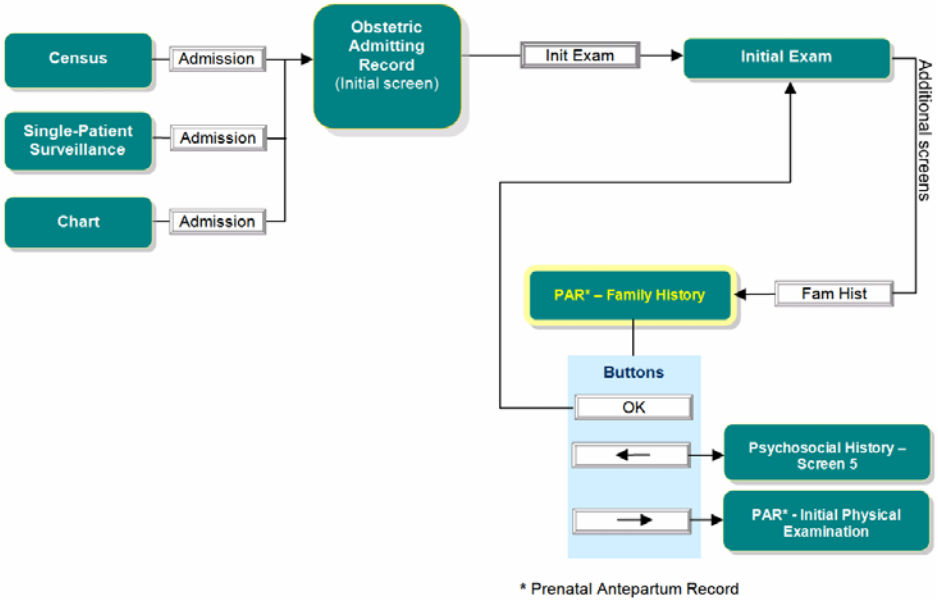
The screen displays with basic patient information from previous screens pre-loaded in the fields at the top of the screen. The remainder of the screen is for entering genetic/infection history information. You will return to the Initial Exam screen after selecting **OK** (Figure 4-13).

2. To save your entries, select **OK** to save your changes and close the Genetic/Infection History screen and return to the Initial Exam screen. (see Figure 4-13 on page 4-12 for where each button takes you).

Family History Screen

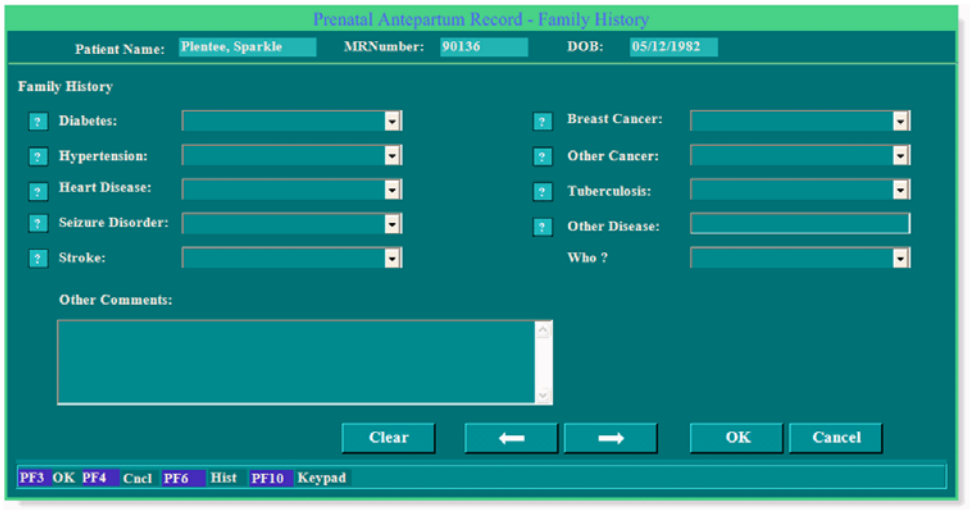
The Family History screen enables you to record information about family factors that can be potential risk factors for the patient. Access to the screen is illustrated in Figure 4-15.

Figure 4-15 *Accessing the Family History Screen*



1. Access the Family History screen, shown in Figure 4-16, via any of the paths illustrated above.

Figure 4-16 *Family History Screen*



Usage Notes:

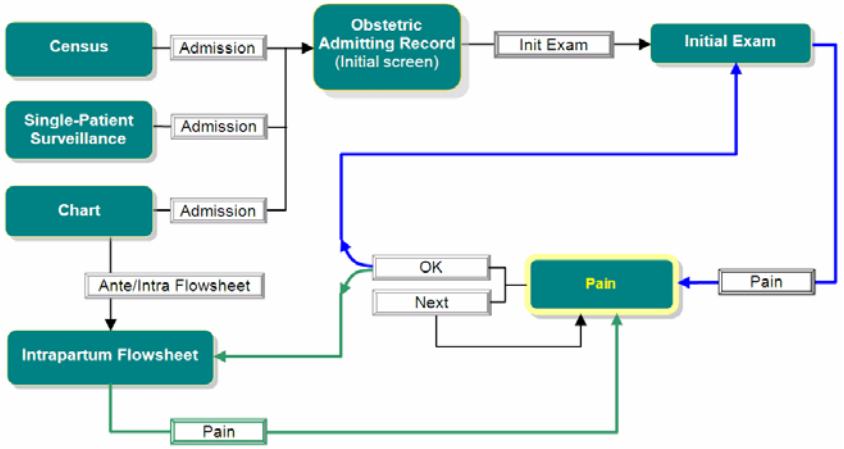
- Any drop-down menu with **OK** and **Cancel** buttons at the bottom of the menu enables you to select multiple items from the menu.
- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item.

2. If all of the check boxes contain a question mark (?), select the **Clear** button to clear the check boxes, then select to X (Yes) all conditions that apply.
3. For each checked (X'd) condition, select from the corresponding drop-down list all blood relatives who have or have had the condition. If you checked **Other Disease**, type the name of the disease into the corresponding text entry field, then select the applicable blood relative from the **Who?** drop-down menu.
4. In the **Other Comments** field, type any applicable clarifying information about any of the selected conditions.
5. To save your entries, select **OK** to save your changes and close the Family History screen and return to the Initial Exam screen. (see Figure 4-15 on page 4-13 where each button takes you). To exit without saving, select **Cancel**.

Pain Screen

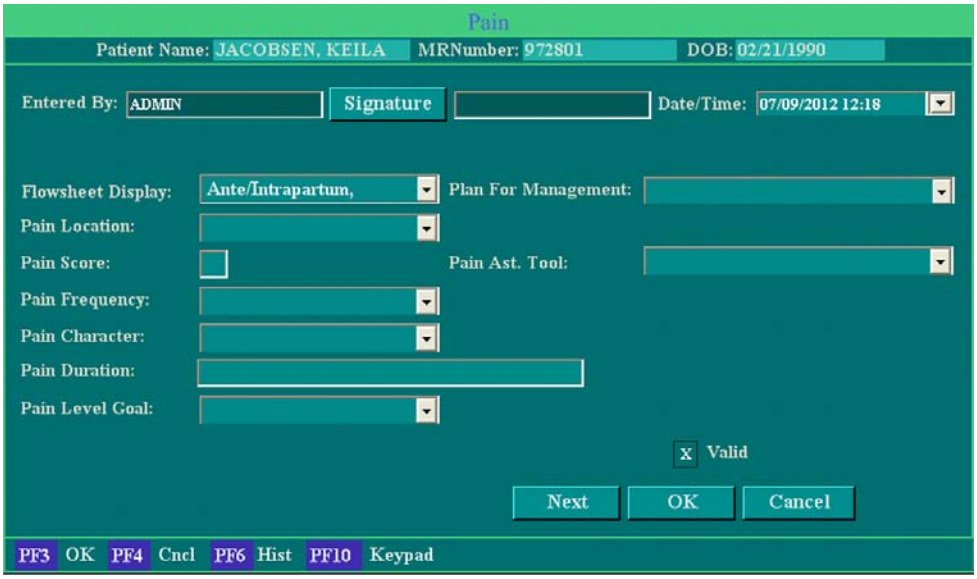
The Pain screen enables you to record the details of any pain that the patient is experiencing. Access to the screen is via any screen that has a **Pain** button; two of the paths are illustrated in Figure 4-17. Notice that the screen you return to when selecting **OK** on the Pain screen depends on how you got to the Pain screen, as illustrated by the blue and green lines in the diagram.

Figure 4-17 *Accessing the Pain Screen*



1. Access the Pain screen, shown in Figure 4-18 on page 4-15, via any of the paths illustrated above.

Figure 4-18 *Pain Screen*



Usage Notes:

- Select the **Signature** button when you have made entries on the screen and are sure the entries are accurate. **Signature** opens a pop-up screen with your user ID prepopulated. Enter your password. Passwords are case sensitive. Your assessment cannot be modified by any other user.

- If you open an existing entry by selecting **Edit** on the Flowsheet screen and that entry was signed by another user, the signature field will be red and you can only view the entry.
- The **Valid** check box indicates that the assessment entries are currently accurate; it is the default setting. If, on the Intrapartum Flowsheet screen, you determine that an assessment is no longer accurate, select **Edit** for that entry to open the entry's screen, then deselect (*blank*) the check box.
- The **Next** button opens a new Pain screen for entering additional assessments.
- Any drop-down menu with **OK** and **Cancel** buttons at the bottom of the menu enables you to select multiple items from the menu.
- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item.

2. Select **OK** to save your entries and return to the screen from which you accessed the Pain screen, or select **Next** to save your entries and open a clear Pain screen for entering another pain assessment.

Patient Care Screen

The Patient Care screen enables you to record information about the patient's current status that can aid in planning for both her prenatal and postpartum care.

1. Access the Patient Care screen for your patient via any of the paths illustrated in Figure 4-19. The Patient Care screen is shown in Figure 4-20 on page 4-17. Notice that there is one additional screen directly available from the Patient Care screen by selecting a button on the screen.

Figure 4-19 *Accessing the Patient Care Screen*

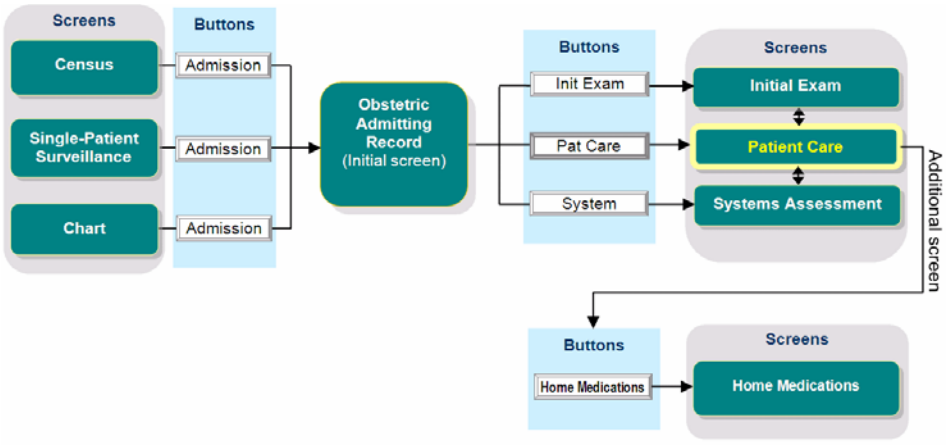
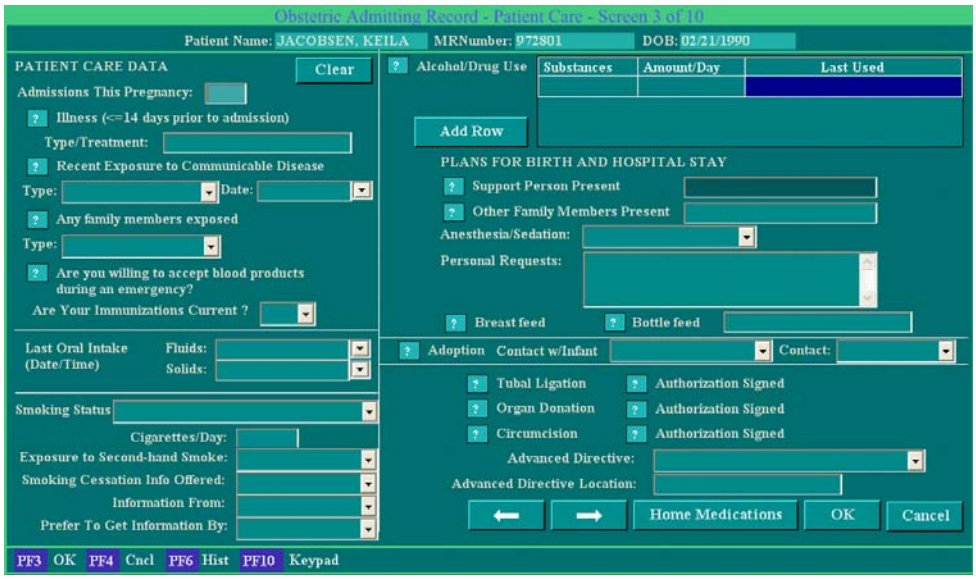


Figure 4-20 *Patient Care Screen*



2. Fill in the fields and check boxes as appropriate. Some of the information fields may be prepopulated with information previously recorded on other screens. Some prepopulated information can be modified if it is no longer accurate.

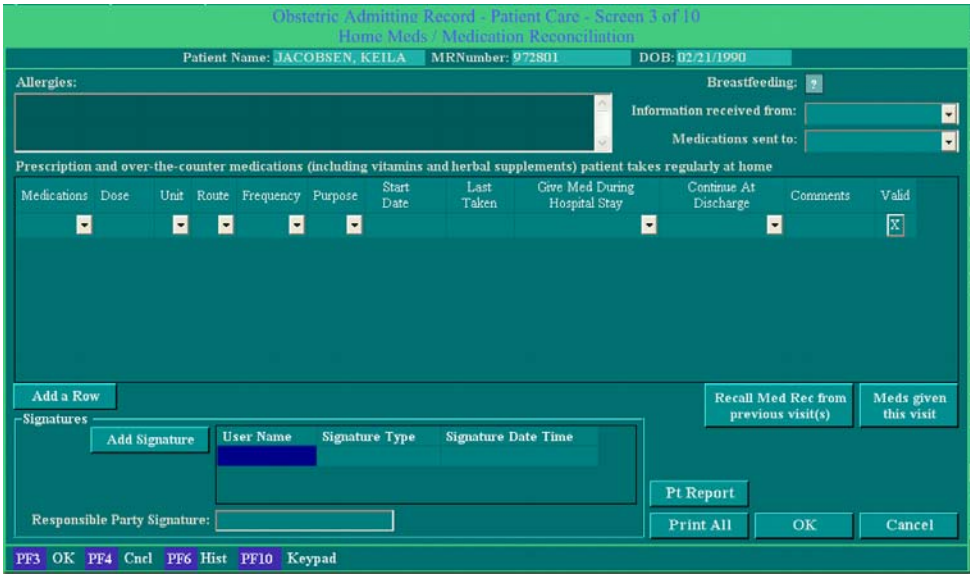
3. To save your entries, either select **OK** to save your changes and close the Patient Care screen, or select the ⇨ or ⇦ buttons to save your entries thus far and go to another screen. (See Table 4-2 on page 4-7 for where the button-accessible screens are described.) To exit without saving, select **Cancel**.

Home Medications Screen

This screen enables you to produce a complete listing of all medications that the patient takes at home, how much, how often, and related information. The screen is accessed by selecting the **Home Medications** button on the Patient Care and the Prenatal Flowsheet screens.

The Home Medications screen, shown in Figure 4-21, initially displays with only one row for entering information about a single medication. However, you can add as many additional rows as needed by selecting the **Add a Row** button. When all medications have been entered, the list can be printed.

Figure 4-21 *Home Medications Screen*



If there are additional home medications to record, select the **Add a Row** button to add rows, then repeat this procedure for each medication.

When you are finished entering medications, you can print the list if desired. Select **OK** to save the entries and return to the Patient Care screen.

Systems Assessment Screen

Access the Systems Assessment screen for your patient via any of the paths illustrated in Figure 4-22. The Systems Assessment screen is shown in Figure 4-23. Notice that there are two additional screens directly available from the Systems Assessment screen by selecting buttons on the screen.

Figure 4-22 *Accessing the Systems Assessment Screen*

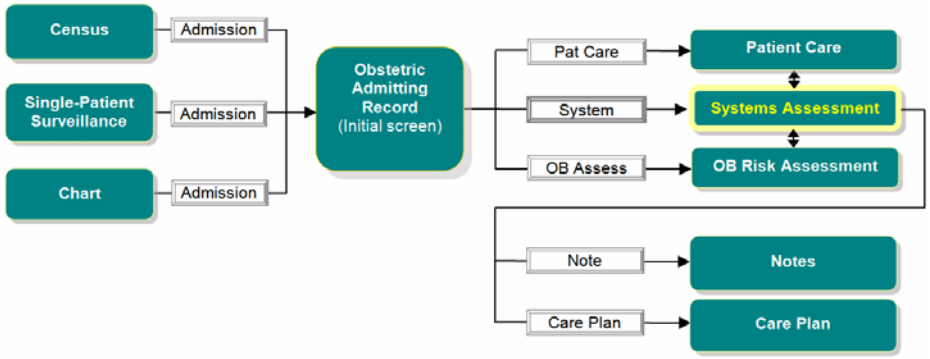
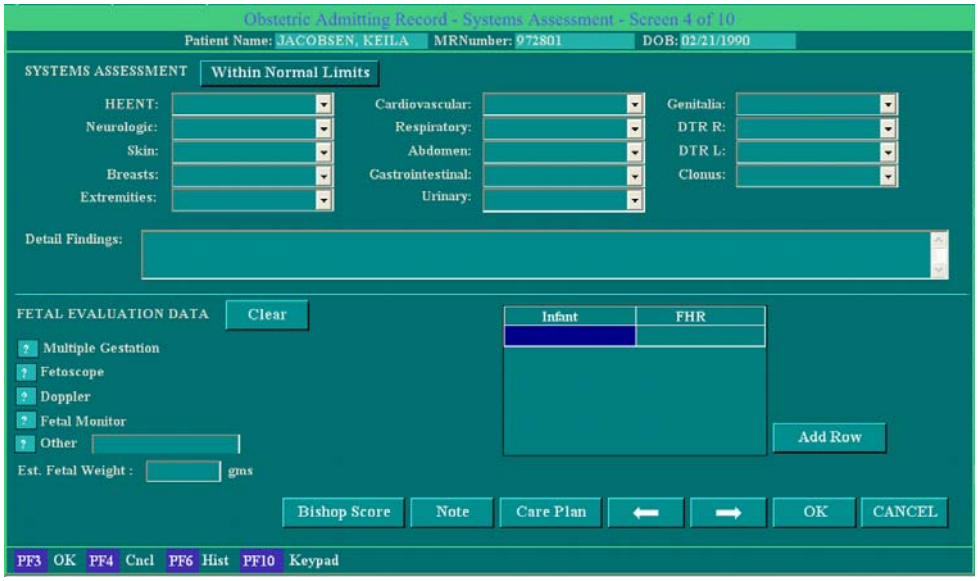


Figure 4-23 *Systems Assessment Screen (from Obstetric Admitting Record)*



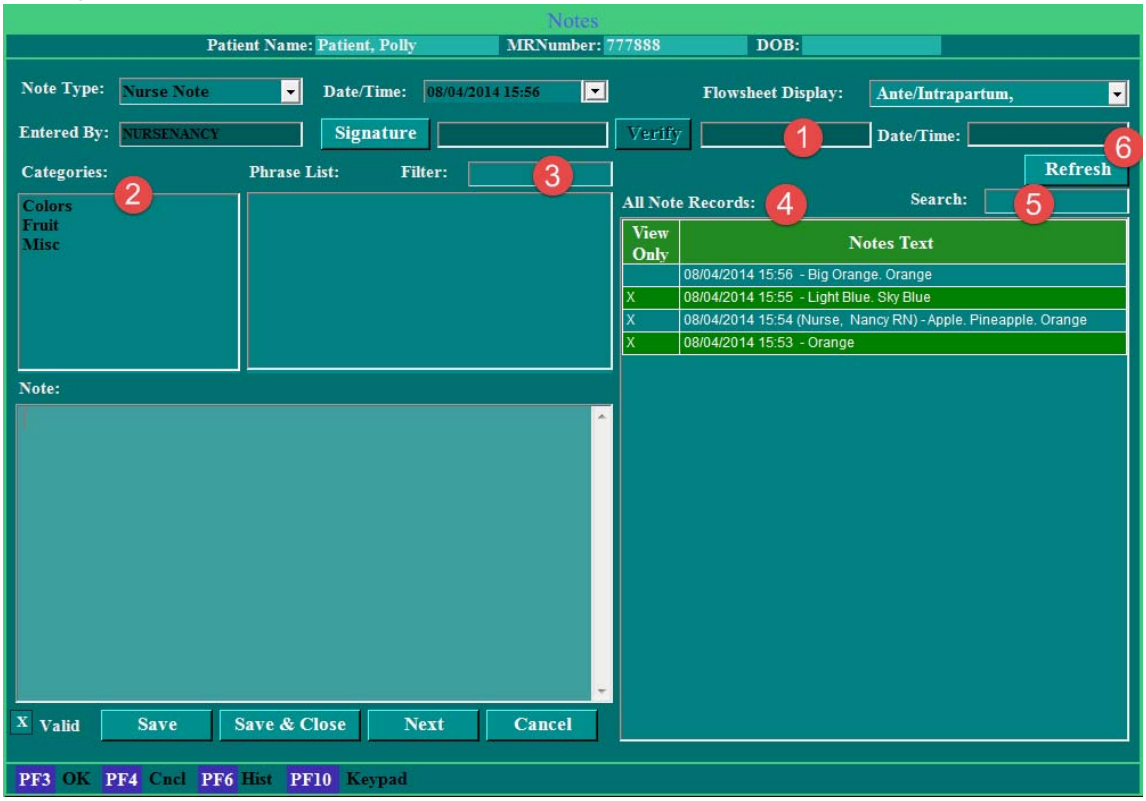
To save your entries, either select **OK** to save your changes and close the Systems Assessment screen, or select the ⇨ or ⇦ buttons to save your entries thus far and go to another screen. To exit without saving, select **Cancel**.

Notes Screen

The Notes screen is accessed from numerous places within NaviCare® WatchChild®. Notes can be opened from a record or flowsheet, or any screen containing a **Note** button.

Overview

Figure 4-24 *Notes Screen - Selected Features*



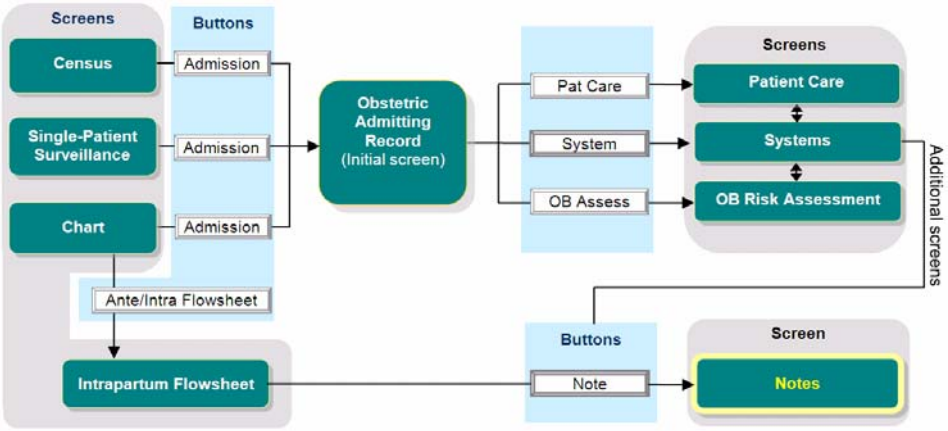
Selected features of the *Notes* screen:

1. **Verify.** Only authorized users can verify a note, the same person cannot sign and verify a note. Once a note is verified any edits to the verified note will remove the verification. The date/time auto-populates when the verify signature is added.
2. **Categories.** Phrases are organized into Categories, so the phrases can be more easily managed.
3. **Filter.** Phrase lists can be filtered to more easily find the specific phrases.
4. **All Note Records.** Viewing, creating, editing, signing, and verifying notes can all be done from one screen, including viewing the notes from previous visits for the current pregnancy.
5. **Search.** A search can be done for the list of notes in the current pregnancy; the search includes dates, notes text, and names of Signature and Verify users.
6. **Refresh.** Refreshes the **All Note Records** view when notes are added and/or edited from another workstation. The updates will appear once **Refresh** is selected, unless the additions and/or edits are done from the same workstation. Additions/edits done from the same workstation, automatically update the **All Note Records** view.

Accessing the Notes Screen

The Notes screen is accessed from numerous places within NaviCare® WatchChild®, only two of which are shown in Figure 4-25. Any screen containing a **Note** button takes you to the Notes screen, which enables you to enter notations that are specific to the screen from which you accessed Notes.

Figure 4-25 *Accessing the Notes Screen*



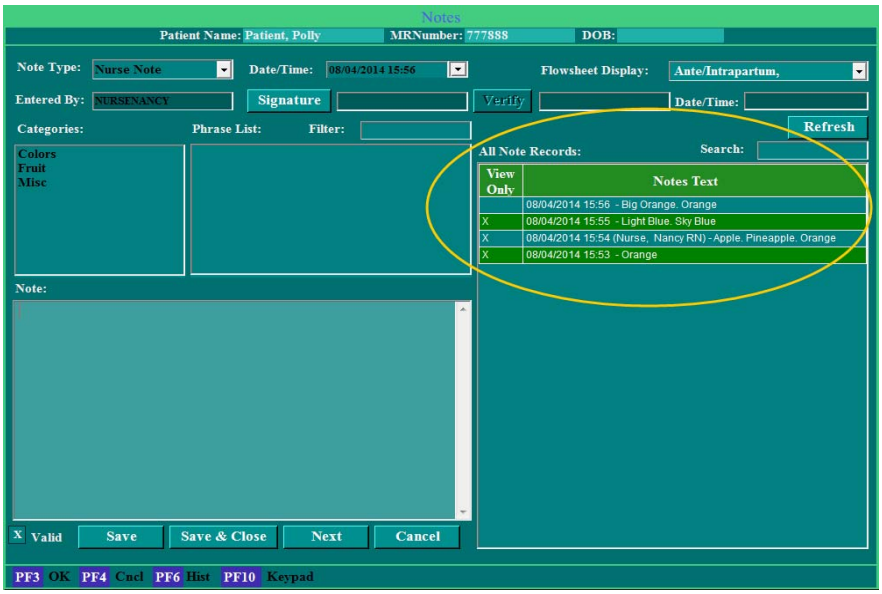
Usage Tips

- Select from the **Note Type** drop-down menu the type of note you are recording.
- Select from the **Flowsheet Display** drop-down menu the type of flowsheet to which this note applies.
- The **Note** field enables you to free-form type in your full note or select one or more predefined phrases from the **Phrase List** menu. You can combine free-form written note text with predefined phrases. To add predefined phrases, select as many as apply, then select the **Set Phrase** button.
- Select the **Signature** button only *after* you have made entries on the screen and are sure the entries are accurate. **Signature** opens a pop-up screen with your user ID prepopulated. Enter your password. Passwords are case sensitive. Once you have done that, your assessment on the screen cannot be modified by any other user. See Figure 4-36 on page 4-27.
- If you open an existing entry by selecting **Edit** on the Intrapartum Flowsheet screen and that entry was signed by another user, the signature field will be red and you can only view the entry.
- The **Valid** check box indicates that the note entries are currently accurate; it is the default setting. If, on the Intrapartum Flowsheet screen, you determine that a note is no longer accurate, select **Edit** for that entry to open the entry's Note screen, then deselect (*blank*) the check box.
- There are multiple options for saving a note:
  - The **Save** button saves the note without closing the Notes screen.
  - The **Save & Close** button saves the note and closes the Notes screen.
  - The **Next** button saves the current note and opens a new Notes screen for entering additional assessments.

View Notes

1. Select the desired patient.
2. Access the *Notes* screen by clicking the **Note** button on any record or flowsheet screen.
3. A list of all of the patient notes for the current pregnancy appears in the **All Note Records** section on the right side of the *Notes* screen:

Figure 4-26 *Notes Screen - All Note Records Area*

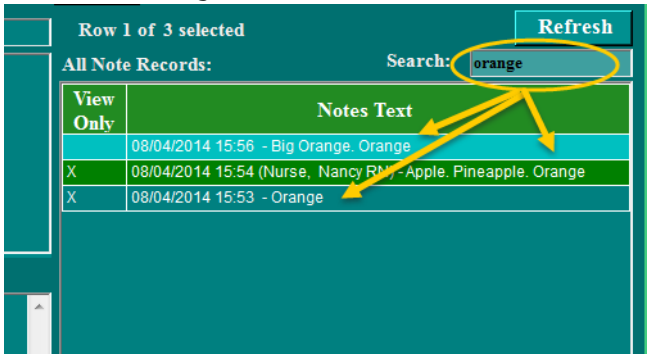


Search for Notes in the All Note Records section

1. To search for a specific note on the *Notes* screen, view the patient notes in the **All Note Records** section.
2. Type a term in the **Search** field at the top of the **All Note Records** section. This search can be for any information shown in this section, including dates, names, and the note text.

   The **All Note Records** section displays all the notes that contain the search term, see below:

Figure 4-27 *Notes Screen - Searching the All Note Records Section*



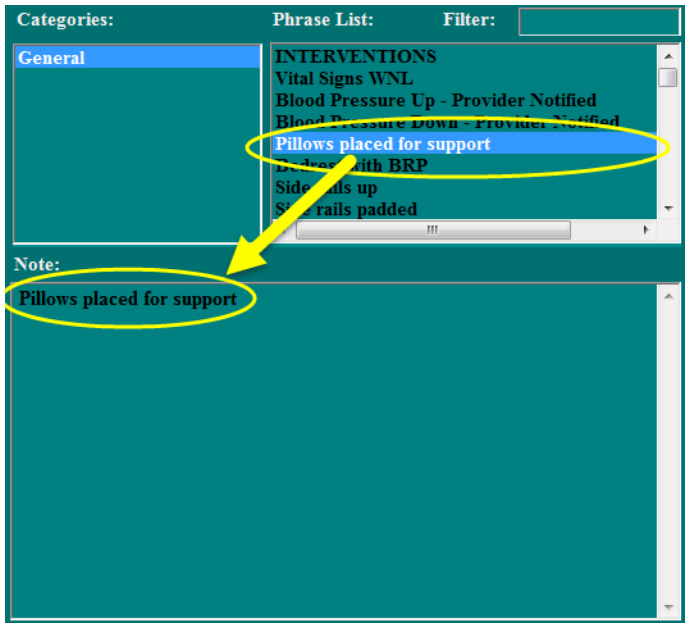
3. To view the full display for all of the notes again, delete the search term from the **Search** field.

Add a Note

1. Navigate to the desired flowsheet or record to enter a note.
2. Click the **Note** button from any record (where the button exists) or flowsheet screen.
3. Check to make sure the correct patient name and medical record number appear at the top of the Notes screen.
4. The **Note Type** dropdown defaults to *Nurse Note*, unless the logged in user signs in as a provider. (The **Note Type** defaults to *Nurse Note* for all users designated as either: *Nurse* or *Other* on the *User Maintenance* configuration screen; all users designated as *Provider* default to *Provider Note*.) Users have the option to change the default **Note Type** to another **Note Type**, *Provider Note* or *Consult Note*, if desired.
5. The **Date/Time** defaults to the current date and time, unless changed by the user.
6. In the **Flowsheet Display** dropdown, make sure the desired flowsheets are selected for the note. (The **Flowsheet Display** automatically defaults based on the system configuration for **Flowsheet Display**.)
7. **Entered By** defaults to the logged in user's name; this field cannot be changed.
8. Use **Categories** and **Phrase list** to add notes.
   a. Select the desired ***Category*** for the note.
   b. In the **Phrase list panel**, select a *phrase*. The text then appears in the **Note** field.

   For example, choose **Category** *General*, then click *Pillows placed for support*, the phrase is added in the **Note** field, (see below):

Figure 4-28 *Notes Screen - Phrase List*



   c. The **Phrase List** can be filtered, select **Filter** to find specific phrases.
9. Make sure the **Notes** field contains the desired information before saving the note. Free-text any additional information needed into the **Notes** field; free-text may be the entire or portion of the note). The populated Phrase list content in the **Notes** field can be edited or deleted.

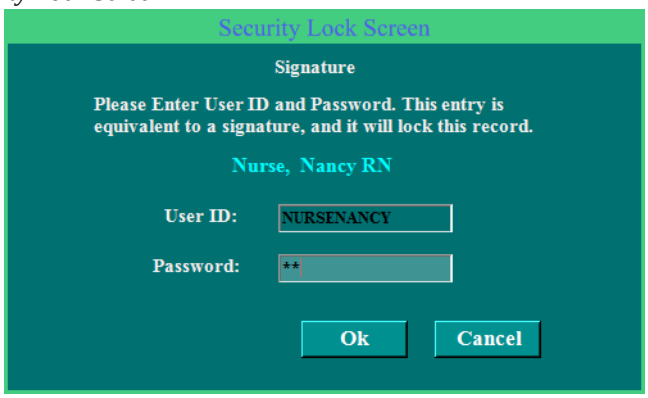
10. Verify the information in the note is complete and correct.

    If the information is not correct, the information can either be edited or canceled; click the **Cancel** button to discard the changes.

11. If desired/required, click the **Signature** button to sign the note.

    The Security Lock Screen popup appears:

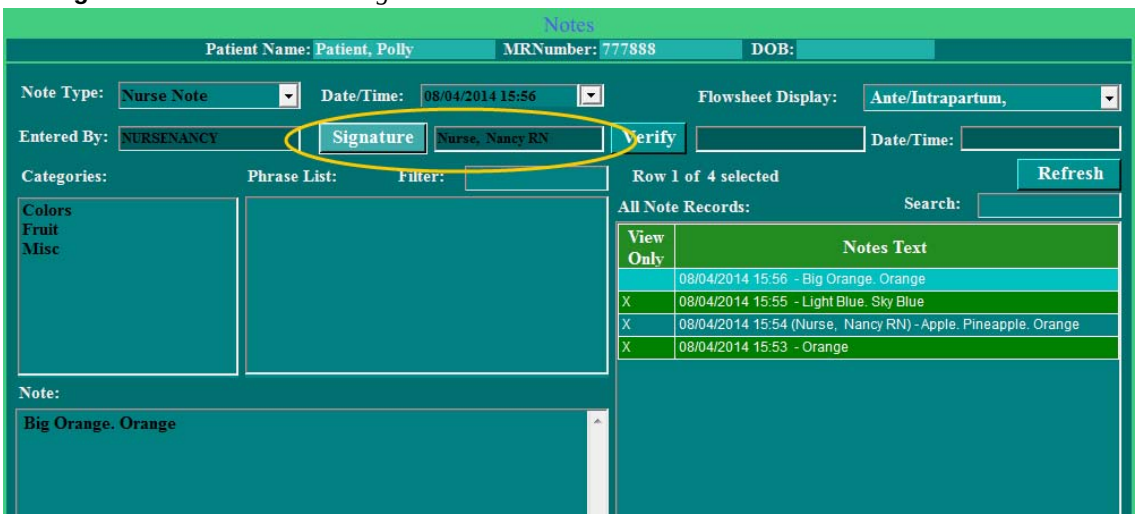
Figure 4-29 *Security Lock Screen*



12. Enter NaviCare® WatchChild® user *password*, and then click **OK**. Passwords are case sensitive.

    The Security Lock Screen popup closes, and the user name appears in the *Signature* field:

Figure 4-30 *Notes Screen - Signature Field*

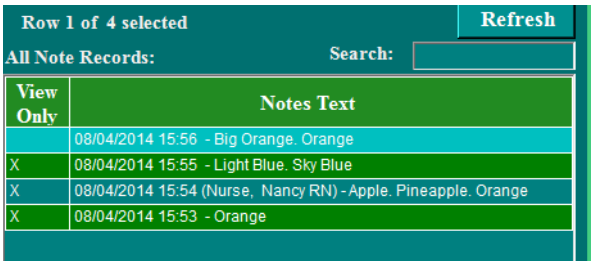


NOTE: Several NaviCare® WatchChild® screens have a **Signature** button and/or field that enables - and in some cases requires - users to certify the user personally performed the procedures/tasks on that screen; however, signatures entered on screens are for NaviCare® WatchChild® accountability purposes only. Signatures in NaviCare® WatchChild® are not considered electronic legal document signatures in accordance with ASTM E1762-95 (E1762-95 Standard Guide for Electronic Authentication of Health Care Information, ASTM International, Volume 14.00, 2003).
Always sign and/or verify notes in accordance with the facility-specific clinical guidelines and hospital policies.

13. Click **Save & Close**, or click **Next** to save the note and enter another one.

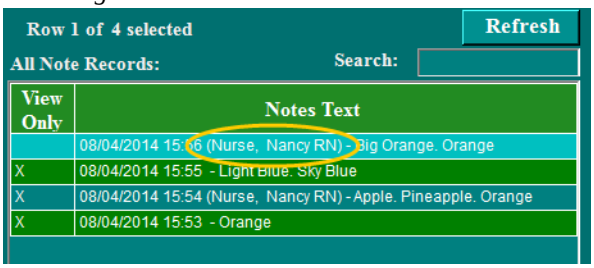
    Once the note is saved, the note is listed in the **All Note Records** section on the right side of the *Notes* screen.

Figure 4-31 *Notes Screen - Note Added to All Note Records*



If the user signed the note before saving, the user's name appears in the notes text for the *Note*:

Figure 4-32 *Notes Screen - Signed Note in All Note Records*

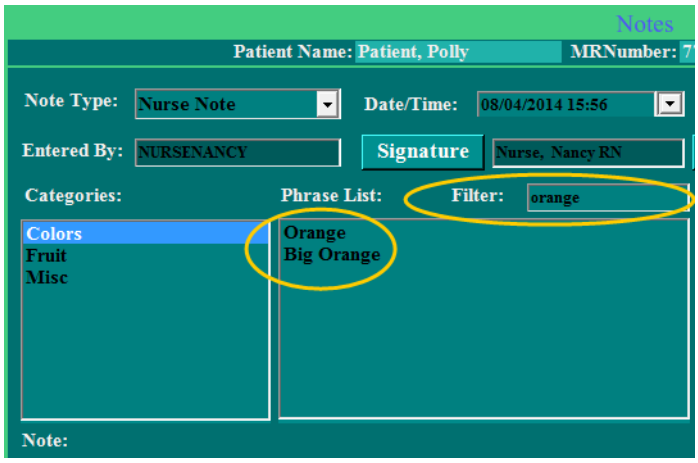


Filter Phrases for Notes

If there are many categories and phrases to choose from, users can use the **Filter** to find specific phrases.

1. Select a *Category* from the **Categories** box.
2. Enter a desired term to search for in the **Filter** field. The filtered list of phrases appears in the **Phrase List** box:

Figure 4-33 *Notes Screen - Filtered Phrase List*



3. To view all of the phrases again, delete the text in the **Filter** box.

Edit a Note

Users can only edit a note if:

- The note is from the current visit.
- The note has not been signed, or the note was signed by the logged in user.

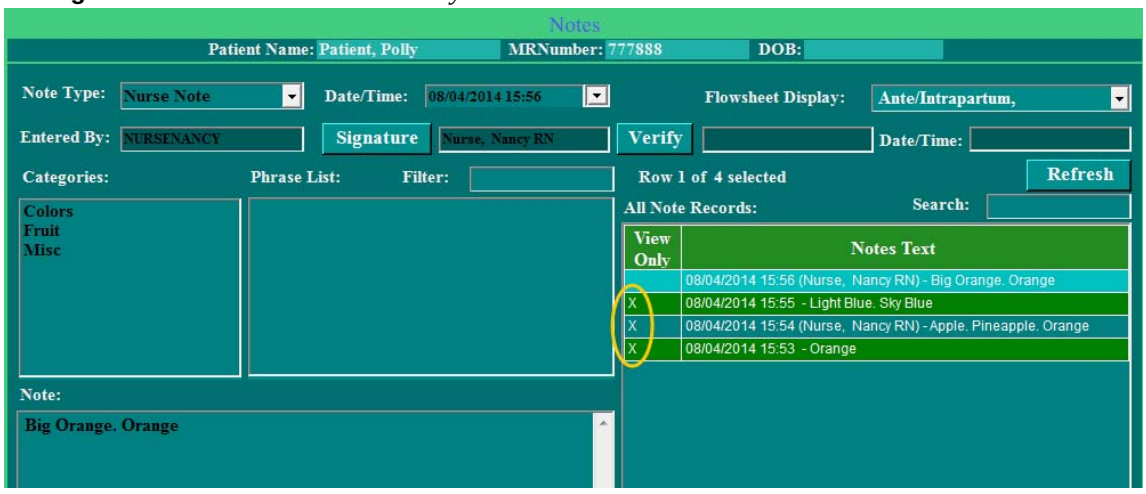
When a signed note has been verified, the user who signed the note can still edit the note and the **Verify** signature is removed.

1. Select the desired patient and then navigate to the *Notes* screen by clicking the **Note** button on any record (with access to Note) or flowsheet screen.

   A list of all of the patient notes for the current pregnancy appears on the right side of the *Notes* screen in the **All Note Records** section (see Figure 4-26 on page 4-22).

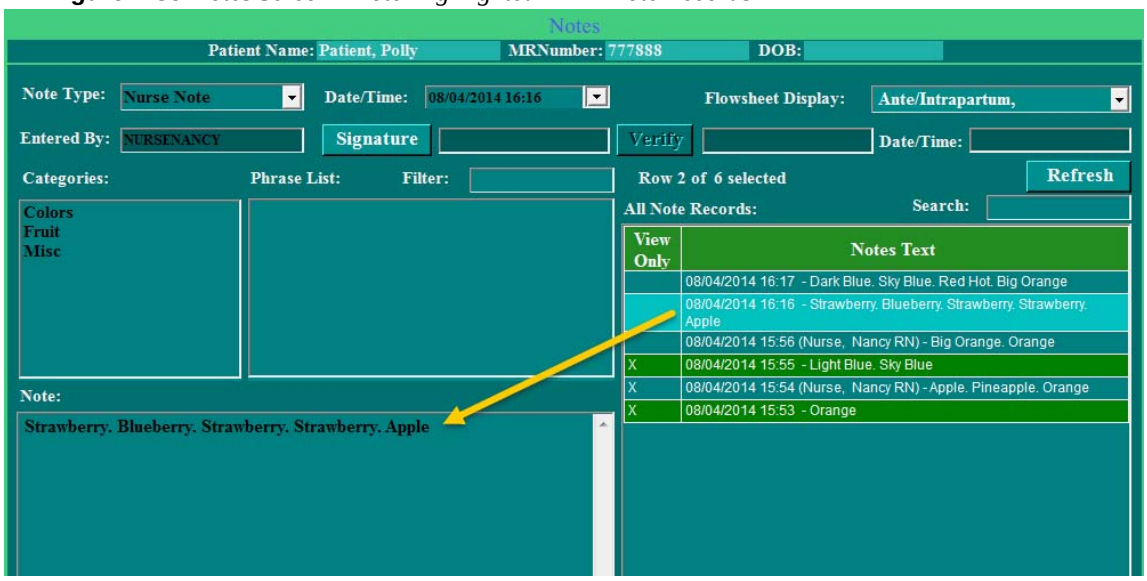
2. Notes from previous visits cannot be edited, and are shown with an **X** in the **View Only** column for that note:

Figure 4-34 *Notes Screen - View Only Column*



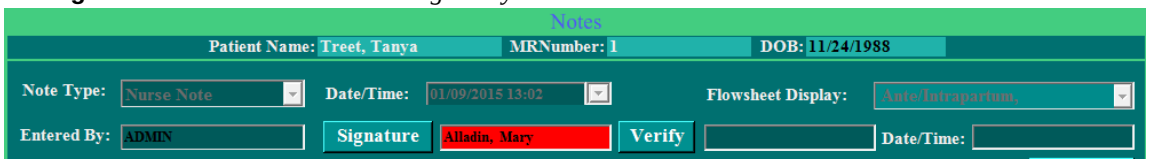
3. To edit a note, click the note in the **All Note Records** list. The note is highlighted indicating it has been selected:

Figure 4-35 *Notes Screen - Note Highlighted in All Note Records*



If a note has been signed by another user, it cannot be edited; clicking on the note, shows the note fields are dark gray (dithered), indicating the note is not editable, and the signature field also appears with a red background:

Figure 4-36 *Notes Screen - Note Signed by Other User*



4. Make the desired changes to the note.
5. Click **Refresh** to ensure the note has not been changed while the note has been opened.
6. Sign the note if it has not already been signed. (Notes can only be signed once.)

NOTE: Always click the **Refresh** button before signing, verifying, or saving a note. If another user has changed the note since it has been opened, the changes will appear in the body of the *Notes* screen and in the **All Note Records** section once **Refresh** has been selected.

7. Click **Save & Close**, or click **Next** to save the note and enter another one.

   Once the note is saved, it is listed in the **All Note Records** section on the right side of the *Notes* screen, reflecting any changes made to the note text.

Figure 4-37 *Notes Screen - Saved Note in All Note Records*

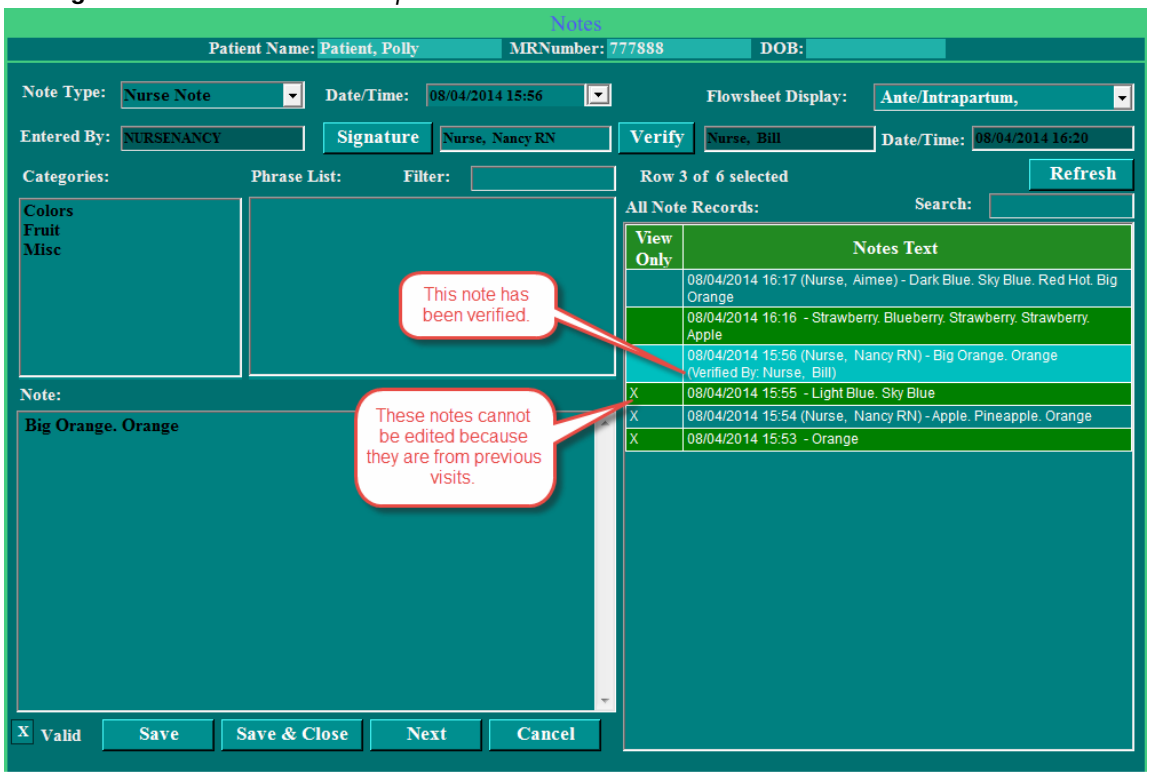
Edit a Verified Note

To edit a verified note, the signed user removes the verification. This means once the note is edited, it will have to be verified again by an authorized user.

1. Select the desired patient with a verified note and access the *Notes* screen by clicking the **Note** button on any record (with access to the button) or flowsheet screen.

   A list of all of the patient notes for the current pregnancy appears on the right side of the *Notes* screen in the **All Note Records** section. Verified notes are shown with the name of the user who verified the note(s), as shown below:

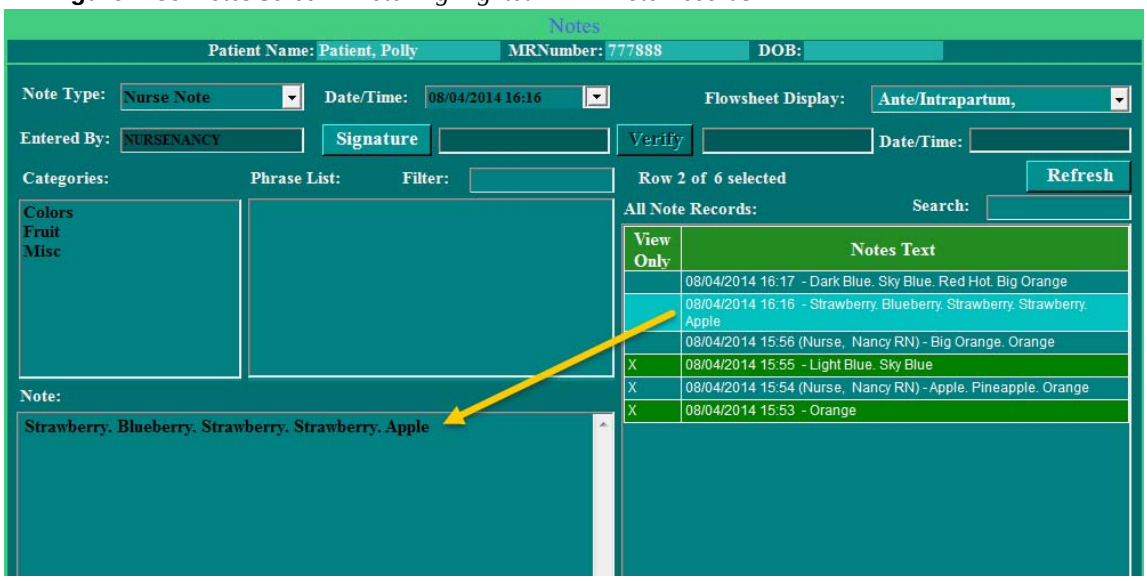
Figure 4-38 *Notes Screen - Verified Note*



Notes from previous visits cannot be edited, and are shown with an **X** in the **View Only** column for that note.

2. To edit a note, click the row for the note in the **All Note Records** list. The note is highlighted indicating it has been selected:

Figure 4-39 *Notes Screen - Note Highlighted in All Note Records*



If a note has been signed by another user, it cannot be edited, when the note is selected, the note fields are shown in dark gray (dithered) indicating it is not editable, and the signature field appears with a red background (see Figure 4-36 on page 4-27).

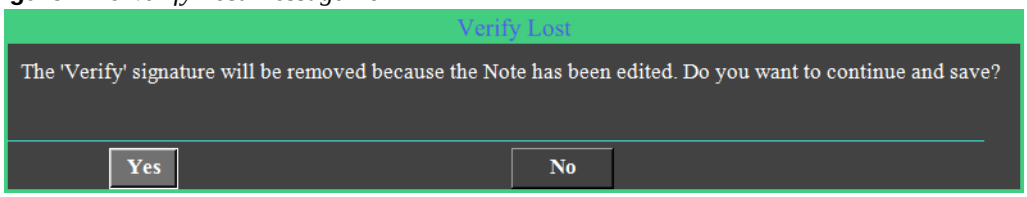
Make the desired changes to the note, if applicable.

3. Click **Refresh** to make sure another user at another workstation has not changed this note since it has been opened.

NOTE: Always click the **Refresh** button before signing, verifying, or saving a note. If another user at another workstation has changed the note since it has been opened, the changes will appear in the body of the *Notes* screen and in the **All Note Records** section.

4. Click the **Save** button. The **Verify Lost** popup message box appears:

Figure 4-40 *Verify Lost Message Box*



Click **Yes** to remove the verification and save the updated changes, or click **No** to cancel and discard the updated changes.

The saved note appears in the **All Note Records** section of the *Notes* screen, with the updated changes made to the note text. The verification signature is removed.

Sign a Note

NOTE: Always sign and verify patient notes in accordance with facility-specific clinical guidelines and hospital policies.

Only authorized users can sign notes. Once a note is signed, only the signed user, who entered the note, can edit it.

To sign a note:

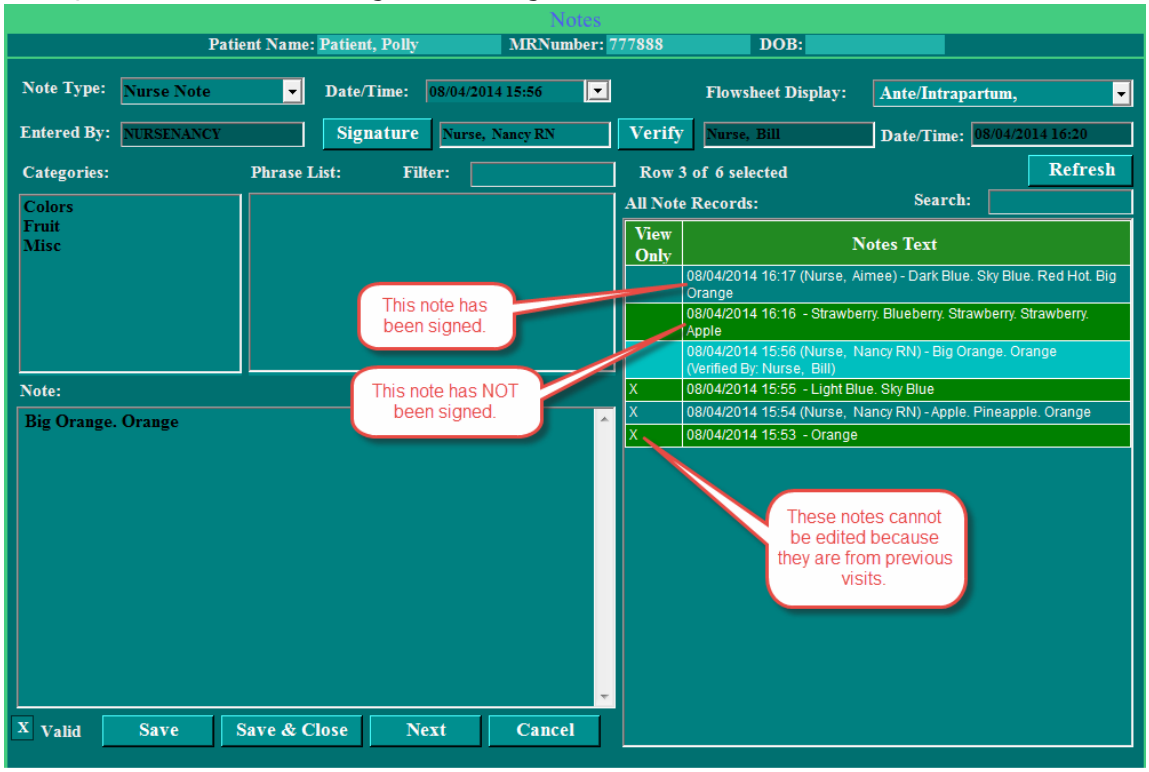
1. Select the desired patient and access the *Notes* screen by clicking the **Note** button on any record (with the button) or flowsheet screen.

   A list of all of the patient notes for the current pregnancy appears on the right side of the *Notes* screen in the **All Note Records** section:

2. To find unsigned notes, check for the most recent notes at top of the list.

   - *Unsigned Notes* do not include the name of the signer in parentheses after the date and time:

Figure 4-41 *Notes Screen - Signed and Unsigned Notes*



   - Select the desired note to sign in the **All Note Records** section. The selected note is shown as highlighted. (*Notes* for the current visit are shown without an **X** in the **View Only** column.)

3. Click the **Refresh** button. If another user at another workstation has changed the note since it has been opened, the changes will appear in the body of the *Notes* screen and in the **All Note Records** section.

NOTE: Always click the **Refresh** button before signing, verifying, or saving a note.

4. Click the **Signature** button. The **Security Lock Screen** appears.
5. Enter a *user ID* and *password*, and then click **OK**. Passwords are case sensitive.
6. Click **Save & Close**, or click **Next** to save the note and enter another one.

   The signed note appears in the **All Note Records** section of the *Notes* screen, with user name shown in parentheses after the date and time.

Verify a Note

NOTE: Once a note is verified, the verification is removed when the signed user edits the note again.
Always sign and verify patient notes in accordance with facility-specific clinical guidelines and hospital policies.

You can only *verify* a note if:

- the user is authorized to verify patient notes in NaviCare® WatchChild®.
- the user is not the same person who signed the note.
- the unverified note is for the current patient visit. (Notes from previous visits are locked and cannot be verified or edited in any way.)

To **verify** a note:

1. Select the desired patient and access the *Notes* screen by clicking the **Note** button on any record (with the button) or flowsheet screen.

   A list of all of the patient notes for the current pregnancy appears on the right side of the *Notes* screen in the **All Note Records** section.
2. To find unverified notes, check the most recent notes at top of the list.
   - Notes for the current visit are shown without an **X** in the **View Only** column.
   - Unverified Notes do not include the name of the verifier at the end of the Notes Text (see Figure 4-38 on page 4-28).
3. Click in the *Notes* text block to select the desired note to verify. The selected note is shown highlighted.

4. Click the **Refresh** button. If another user at another workstation has changed the note since it has been open, the changes will appear in the body of the *Notes* screen and in the **All Note Records** section.

NOTE: Always click the **Refresh** button before signing, verifying, or saving a note.

5. Click the **Verify** button. The **Security Lock Screen** appears.
6. Enter a *user ID* and *password*, and then click **OK**. Passwords are case sensitive.
7. Click **Save & Close**, or click **Next** to save the note and enter another one.

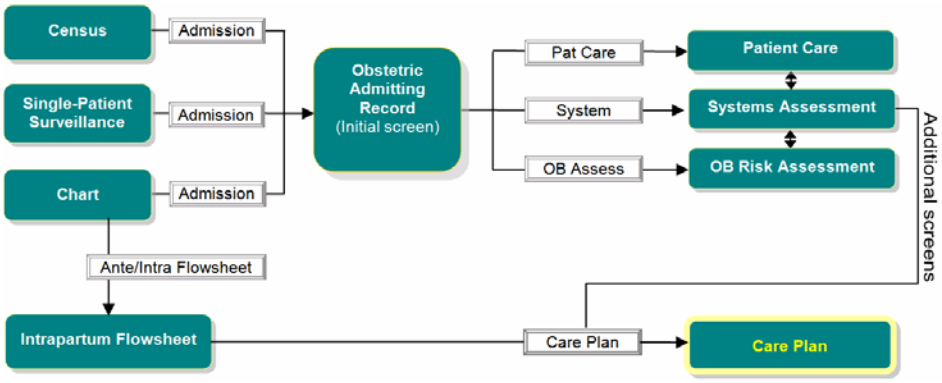
   The saved note appears in the **All Note Records** section of the *Notes* screen, with the user name as the verifier shown at the end of the note text.

Figure 4-42 *Notes Screen - Verified Note*

Care Plan

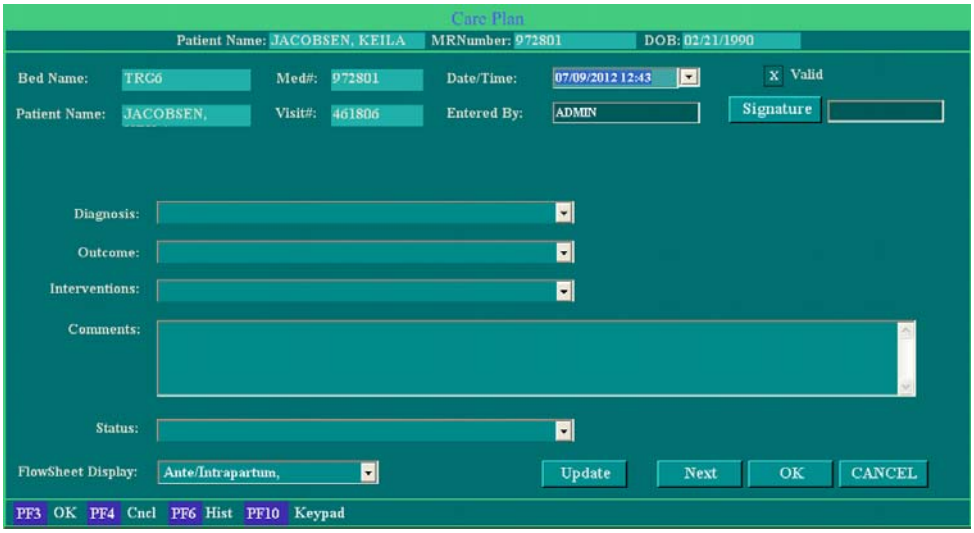
The Care Plan screen enables you to record problems that the patient may be experiencing or is in danger of experiencing and document the plan for resolving or preventing the problem. The screen is accessed via the paths illustrated in Figure 4-43.

Figure 4-43 *Accessing the Care Plan Screen*



1. Access the Care Plan screen, shown in Figure 4-44, via any of the paths illustrated above.

Figure 4-44 *Care Plan Screen*



Usage Notes:

- Select the **Signature** button only *after* you have made entries on the screen and are sure the entries are accurate. **Signature** opens a pop-up screen with your user ID prepopulated. Enter your password. Passwords are case sensitive. Once you have done that, your assessment on the screen cannot be modified by any other user.
- If you open an existing entry by selecting **Edit** on the Intrapartum Flowsheet screen and that entry was signed by another user, the signature field will be red and you can only view the entry.
- The **Valid** check box indicates that the Care Plan entries are currently accurate; it is the default setting. If, on the Intrapartum Flowsheet screen, you determine that a care plan is no

longer accurate, select **Edit** for that entry to open the entry's Care Plan screen, then deselect (*blank*) the check box.

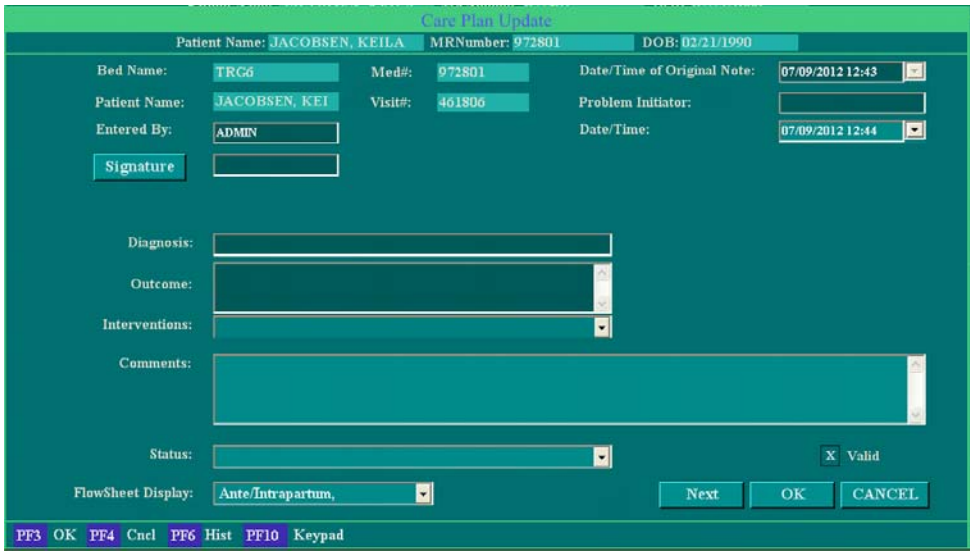
- The **Next** button opens a new Care Plan screen for recording additional problems and their resolutions.
- Any drop-down menu with **OK** and **Cancel** buttons at the bottom of the menu enables you to select multiple items from the menu.
- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item.

2. Select **Next** to save your entries and proceed to another Care Plan screen for entry of another care plan, or select **OK** to save your changes and return to the screen from which you accessed this screen.

Care Plan Update Screen

The Care Plan Update screen enables you to provide additional information or status on a previously defined care plan. The screen, shown in Figure 4-45, is accessed only by selecting the **Update** button on the Care Plan screen.

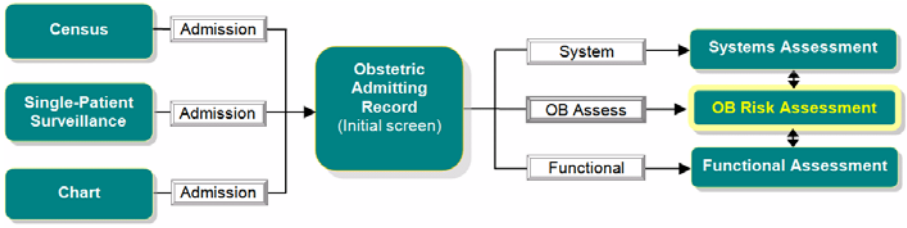
Figure 4-45 *Care Plan Update Screen*



OB Risk Assessment Screen

The OB Risk Assessment screen enables you record patient factors that may pose a risk to the mother or newborn during labor and/or delivery. Access to the screen is via any of the paths illustrated in Figure 4-46.

Figure 4-46 *Accessing the OB Risk Assessment Screen*



1. Access the OB Risk Assessment screen, shown in Figure 4-47, via any of the paths illustrated above.

Figure 4-47 *OB Risk Assessment Screen*

Usage Notes:

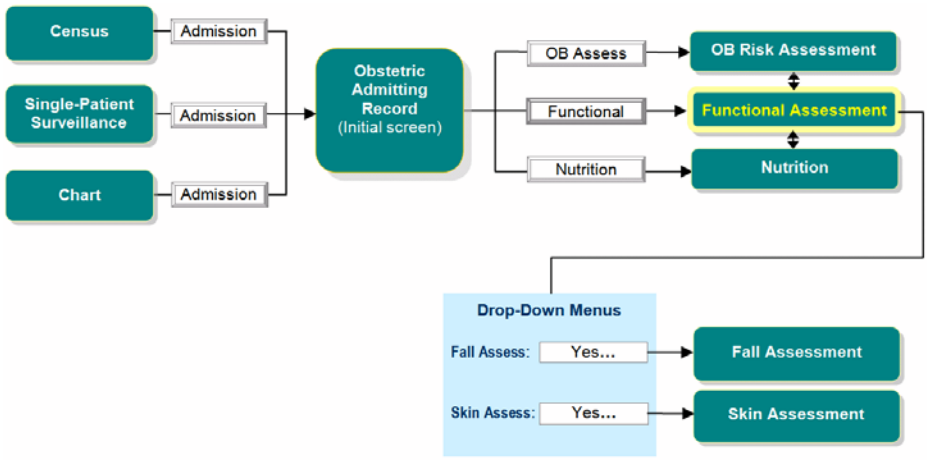
- The **Clear** button at the top of the screen sets all check boxes on the screen to *blank*, indicating No. Individual check boxes can then be selected to X (Yes) as necessary.
- Any drop-down menu with **OK** and **Cancel** buttons at the bottom of the menu enables you to select multiple items from the menu.
- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item.
- When a patient does not and has not had a listed condition, leave both the **Current** and **Prev** check boxes blank for that condition.

2. Enter patient information into each field. A *field group* is a labeled field with associated check boxes.
3. To save your entries, either select **OK** to save your changes and close the OB Risk Assessment screen, or select the ⇨ or ⇦ buttons to save your entries and go to another screen. To exit without saving, select **Cancel**.

Functional Assessment Screen

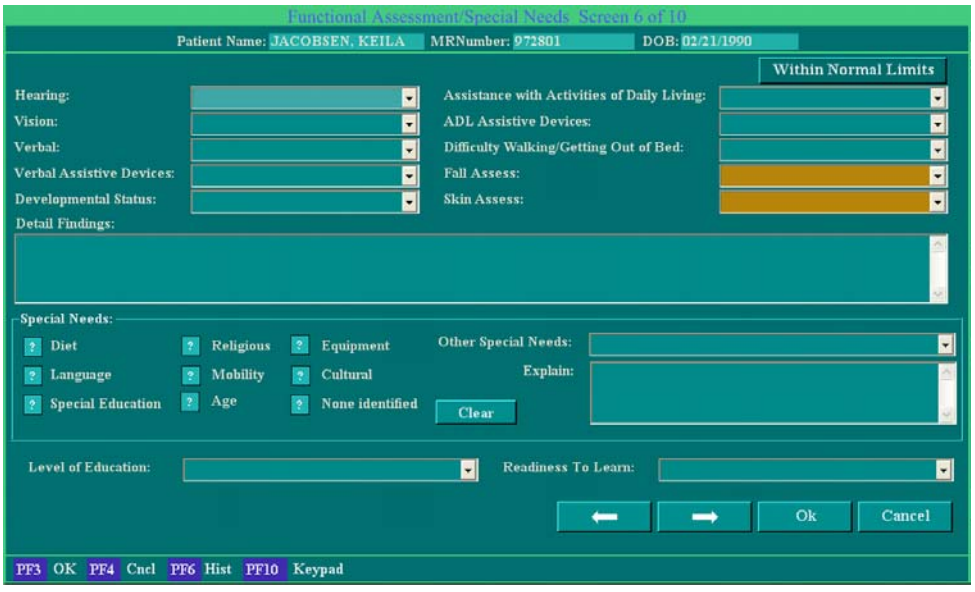
The Functional Assessment screen enables you to record your assessment of the patient's basic functional abilities. The screen is accessed via any of the paths illustrated in Figure 4-48.

Figure 4-48 *Accessing the Functional Assessment Screen*



1. Access the Functional Assessment screen, shown in Figure 4-49, via any of the paths above.

Figure 4-49 *Functional Assessment Screen*



Usage Notes:

- Any drop-down menu with **OK** and **Cancel** buttons at the bottom of the menu enables you to select multiple items from the menu.
- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item.

2. Select the ⇨ button to save the information and go to the Nutrition screen. Select the ⇦ button to save your changes and go to the OB Risk Assessment screen. Select **OK** to save your changes and close the screen. Select **Cancel** if you did not make any entries or to discard your changes.

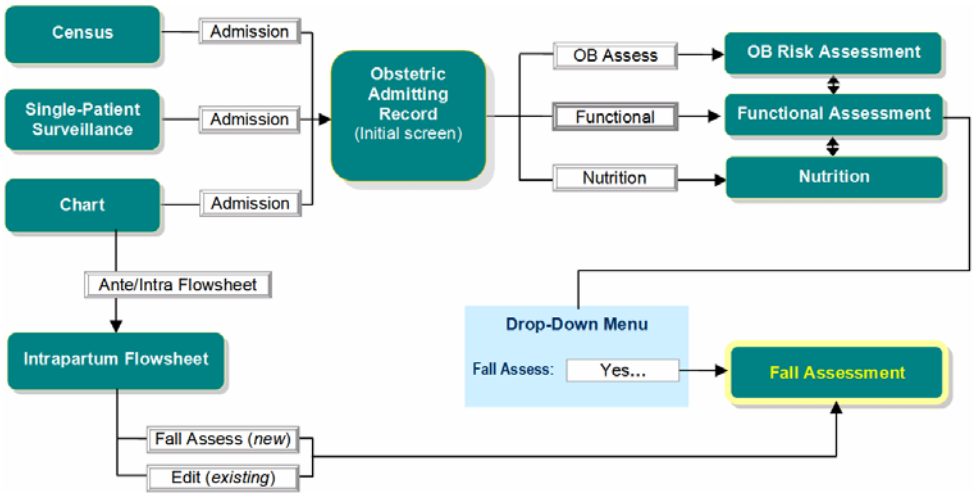
Fall Assessment Screen

The Fall Assessment screen is accessed by either of the following methods:

- From the Functional Assessment screen by selecting a "yes" answer option from the **Fall Assess** drop-down menu
- From the Intrapartum Flowsheet screen by selecting the **Fall Assess** button to open a new Fall Assessment screen, or an **Edit** button to open an existing Fall Assessment entry

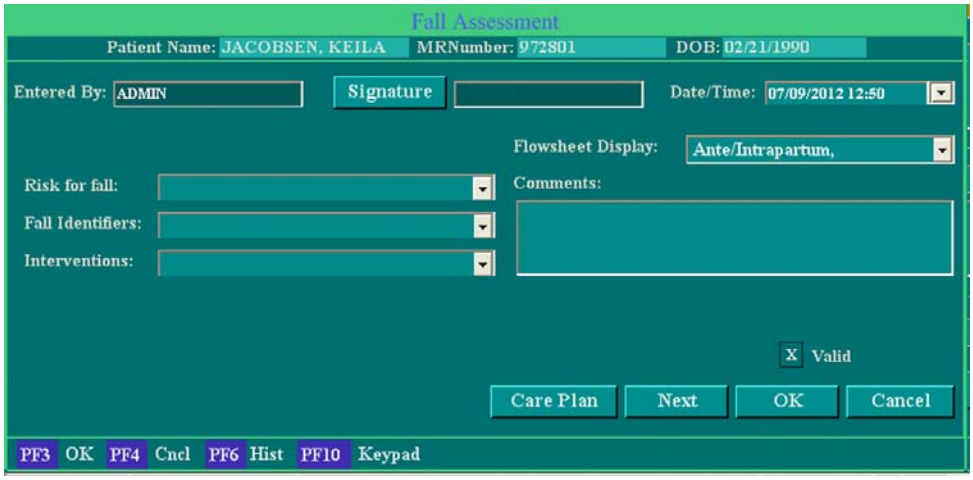
Both methods are illustrated in below in Figure 4-50.

Figure 4-50 *Accessing the Fall Assessment Screen*



1. Access the Fall Assessment screen, shown in Figure 4-51 on page 4-38, via any of the paths described above.

Figure 4-51 *Fall Assessment Screen*



Usage Notes:

- Select the **Signature** button only *after* you have made entries on the screen and are sure the entries are accurate. **Signature** opens a pop-up screen with your user ID prepopulated. Enter your password. Passwords are case sensitive. Once you have done that, your assessment on the screen cannot be modified by any other user.
- If you open an existing entry by selecting **Edit** on the Intrapartum Flowsheet screen and that entry was signed by another user, the signature field will be red and you can only view the entry.
- The **Valid** check box indicates that the assessment entries are currently accurate; it is the default setting. If, on the Intrapartum Flowsheet screen, you determine that an assessment is no longer accurate, select **Edit** for that entry to open the entry's Fall Assessment screen, then deselect (*blank*) the check box.
- The **Next** button opens a new Fall Assessment screen for entering additional assessments.

2. Use the drop-down menus for each field to fill in assessment data. You can select multiple options from each menu.
3. Enter any additional clarifying information into the **Comments** field.
4. If you wish to lock the entries on this screen so that they cannot be modified by other users, select the **Signature** button and enter your password when prompted to do so. Passwords are case sensitive. The user ID will autopopulate for the logged in user.
5. When you have completed your assessment, select **OK** to save your entries and close the screen, or select **Cancel** to discard your entries.

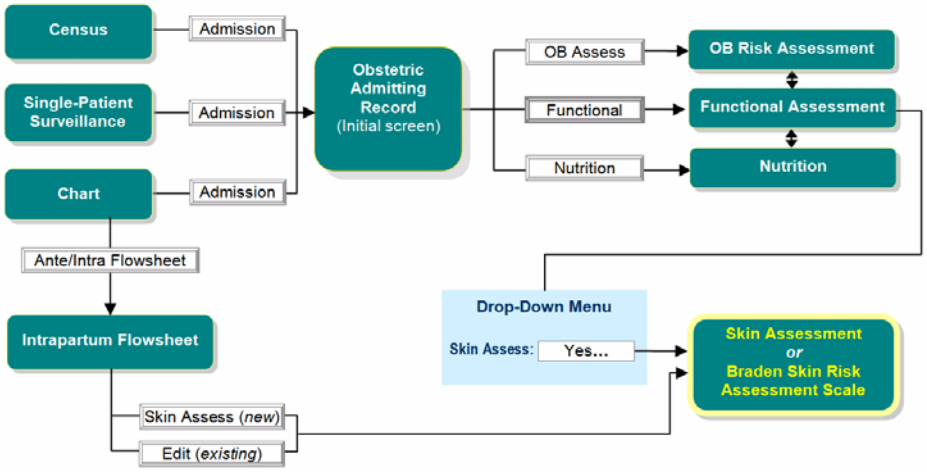
Skin Assessment Screen

NaviCare® WatchChild® can use one of two screens for recording skin assessment information. Which screen is used depends on a configuration parameter set by your NaviCare® WatchChild® System Administrator. The default setting is the Braden Skin Risk Assessment Scale. The Skin Assessment function is accessed by either of the following methods:

- From the Functional Assessment screen by selecting a “yes” answer option from the **Skin Assess** drop-down menu
- From the Intrapartum Flowsheet screen by selecting the **Skin Assess** button to open a new Skin Assessment screen, or an **Edit** button to open an existing Skin Assessment entry

Both methods are illustrated below in Figure 4-52.

Figure 4-52 *Accessing the Skin Assessment Screen*



1. Access the Skin Assessment function via any of the paths illustrated above. One of the following screens will appear, depending on your facility’s configuration: Braden Skin Risk Assessment Scale screen, shown in Figure 4-53 or Skin Assessment screen, shown in Figure 4-54 on page 4-40.

Figure 4-53 *Braden Skin Risk Assessment Scale*

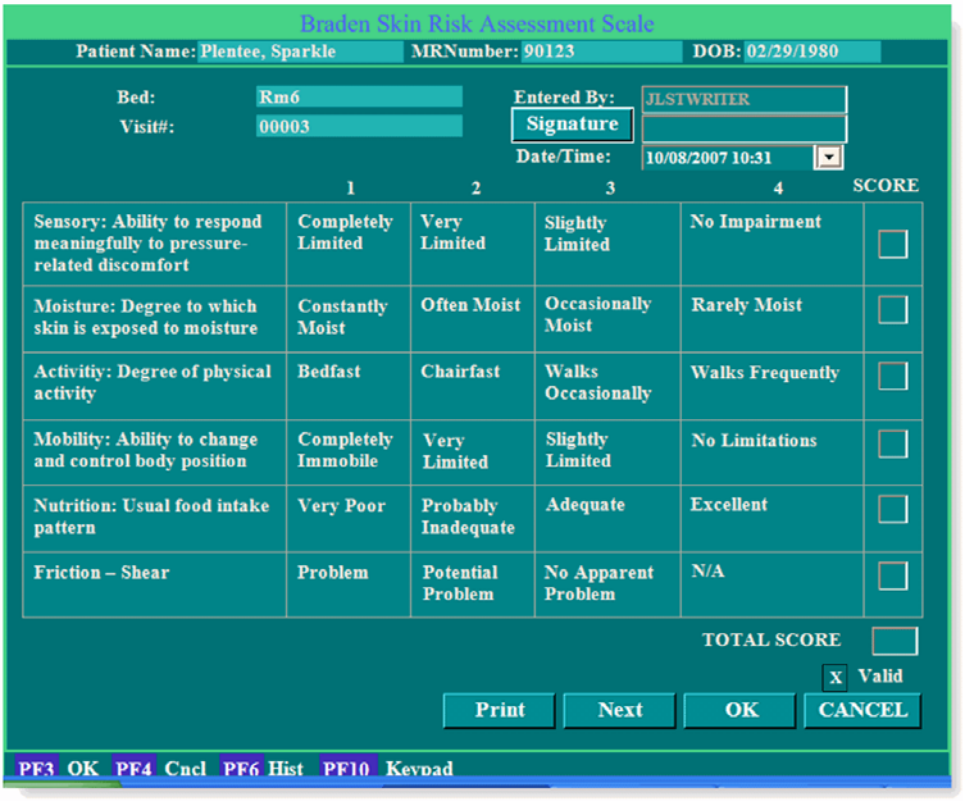
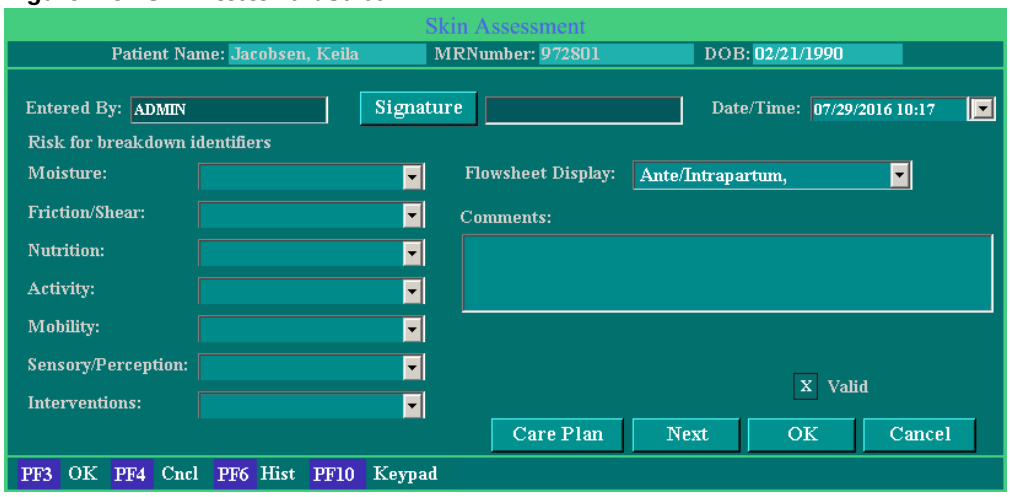


Figure 4-54 *Skin Assessment Screen*



Usage Notes:

- Select the **Signature** button only *after* you have made entries on the screen and are sure the entries are accurate. **Signature** opens a pop-up screen with your user ID prepopulated. Enter your password. Passwords are case sensitive. Once you have done that, your assessment on the screen cannot be modified by any other user.
- If you open an existing entry by selecting **Edit** on the Intrapartum Flowsheet screen and that entry was signed by another user, the signature field will be red and you can only view the entry.

- The **Valid** check box indicates that the assessment entries are currently accurate; it is the default setting. If, on the Intrapartum Flowsheet screen, you determine that an assessment is no longer accurate, select **Edit** for that entry to open the entry's Skin Assessment screen, then deselect (*blank*) the check box.
- The **Next** button opens a new skin assessment screen for entering additional assessments.

2. *For the Skin Assessment screen*:

   d. Use the drop-down menus for each field to fill in assessment data. You can select multiple options from each menu.

   e. Type any additional clarifying information into the **Comments** field.

   For the Braden Skin Risk Assessment Scale screen: Enter the score for each assessment category in the corresponding score field. The total score is automatically calculated.

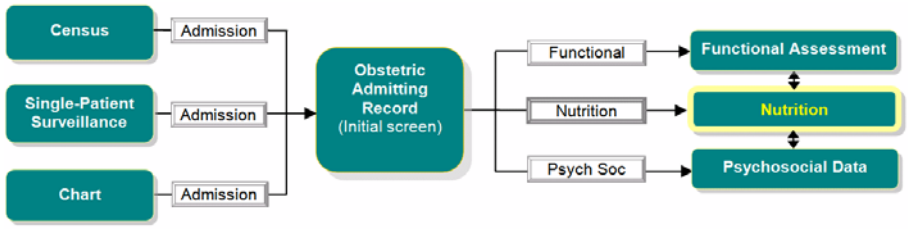
3. If you wish to lock the entries on this screen so that they cannot be modified by other users, select the **Signature** button and enter your password when prompted to do so. Passwords are case sensitive. The user ID will autopopulate for the logged in user.

4. When you have completed your assessment, select **OK** to save your entries and close the screen.

Nutrition Screen

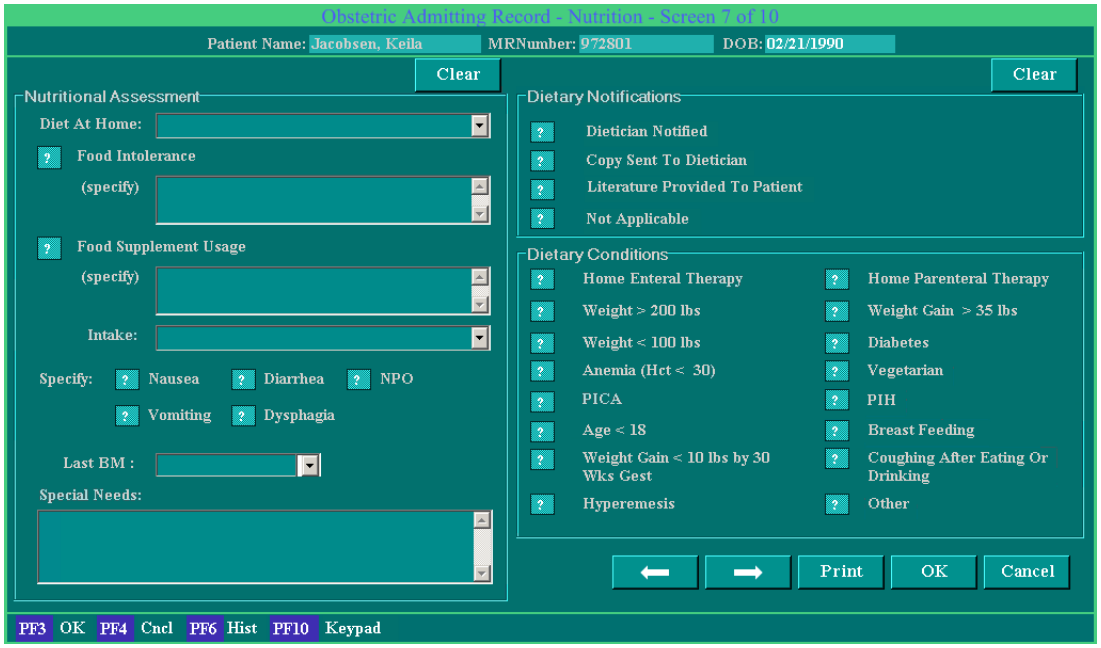
The Nutrition screen enables you to record your assessment of factors affecting the patient's nutrition. The screen is accessed via any of the paths illustrated in Figure 4-55.

Figure 4-55 *Accessing the Nutrition Screen*



1. Access the Nutrition screen, shown in Figure 4-56 on page 4-42, via any of the paths illustrated above.

Figure 4-56 *Nutrition Screen*

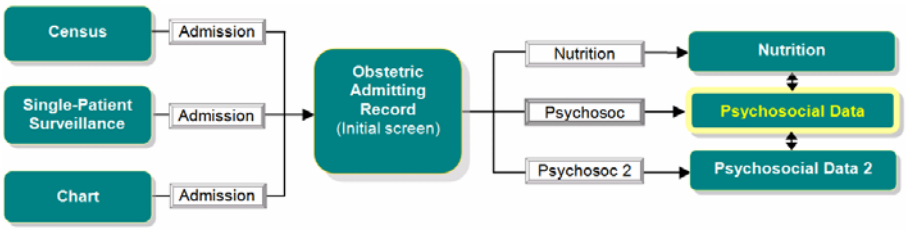


2. Look over the screen's check boxes and determine if most of the responses will be No. If so, select the **Clear** buttons to set all check boxes to *blank*, which will eliminate the need to select each check box to clear the question marks.
3. In the **Diet At Home** field, using the drop-down menu, select the patient's normal or recommended diet.
4. For the remainder of the screen, select to X (indicating Yes) all check boxes that apply to the patient. Where there are associated text or selection fields, enter details and make selections as appropriate.
5. When you have completed all entries you can select **Print** to produce a hardcopy of the information for the patient's dietician or at-home caregiver. When done, select one of the following:
   - **OK** to save the information and return to the Obstetric Admitting Record screen
   - ⇨ to save the information and go to the Psychosocial Data screen
   - ⇦ to save the information and go back to the Functional Assessment screen

Psychosocial Data Screen

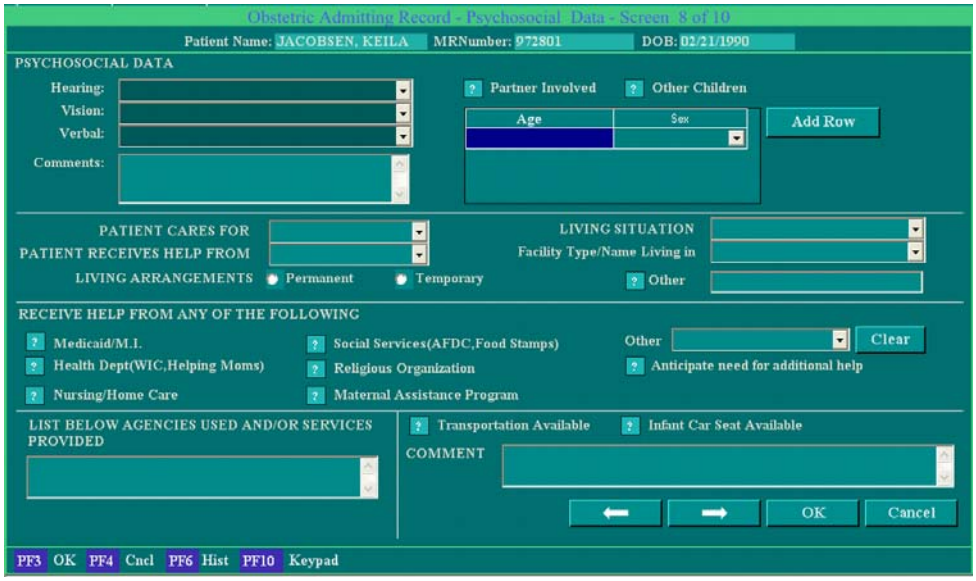
The Psychosocial Data screen enables you to record information about the patient's normal living conditions; this is the first of two screens that gather this type of information. The Psychosocial Data screen is accessed via any of the paths illustrated in Figure 4-57.

Figure 4-57 *Accessing the Psychosocial Data Screen*



1. Access the Psychosocial Data screen, shown in Figure 4-58, via any of the paths illustrated above.

Figure 4-58 *Psychosocial Data*



Usage Notes:

- Any drop-down menu with **OK** and **Cancel** buttons at the bottom of the menu enables you to select multiple items from the menu.
- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item.

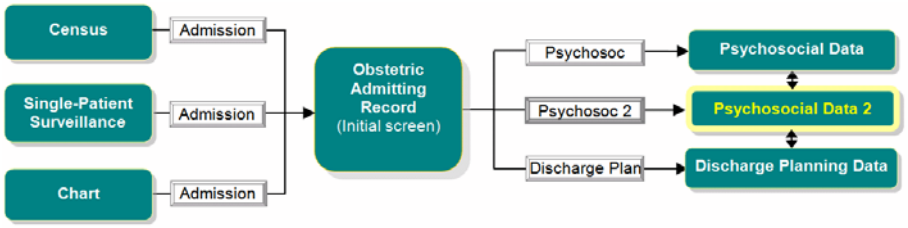
2. Enter the patient information into the screen fields and check boxes. Some fields may be pre-populated from entries previously made on other screens.
3. When you have completed all entries, select one of the following:

- ⇨ to save your entries and proceed to the Psychosocial Data 2 screen to continue entering related information (see "Psychosocial Data 2 Screen" below).
- ⇦ to save your entries and go back to the Nutrition screen.
- **OK** to save your entries and close the screen.

Psychosocial Data 2 Screen

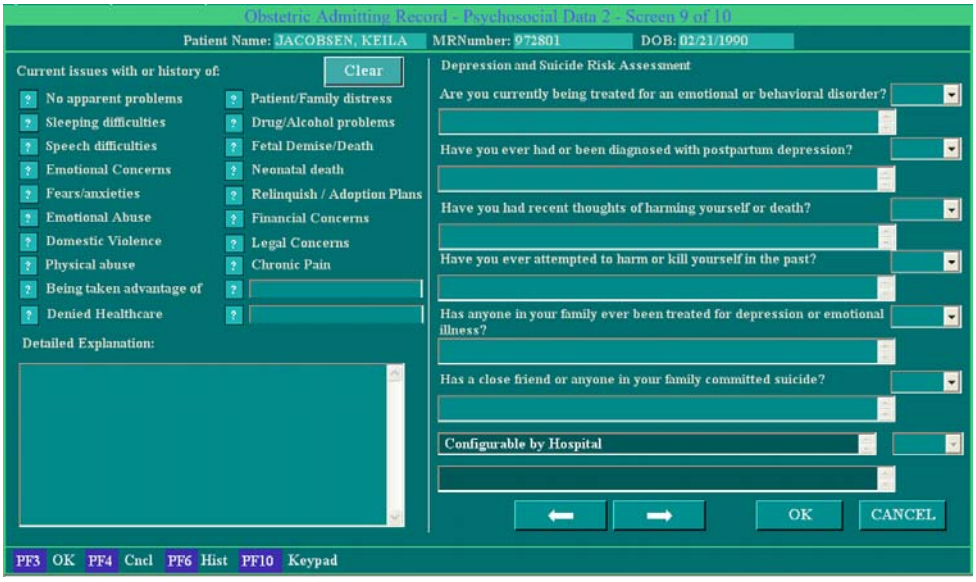
The Psychosocial Data 2 screen is the second of two screens that enable you to record information about the patient's normal living conditions. The Psychosocial Data 2 screen is accessed via any of the paths illustrated in Figure 4-59.

Figure 4-59 *Accessing the Psychosocial Data 2 Screen*



1. Access the Psychosocial Data 2 screen, shown in Figure 4-60 on page 4-44, via any of the paths illustrated above.

Figure 4-60 *Psychosocial Data 2 Screen*



Usage Notes:

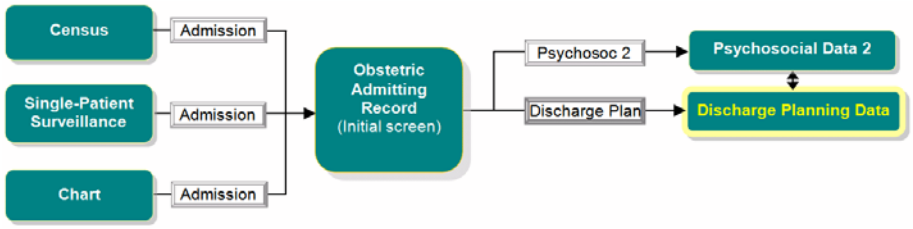
- Select the **Clear** button on each half of the screen to clear all check boxes, indicating No. You can then select to X (Yes) only those that apply to your patient.
- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item.

2. When you have completed all entries, select one of the following:
   - ⇨ to save your entries and proceed to the Discharge Planning screen (see "Discharge Planning Data" below).
   - ⇦ to save your entries and go back to the first Psychosocial Data screen.
   - **OK** to save your entries and close the screen.

Discharge Planning Data

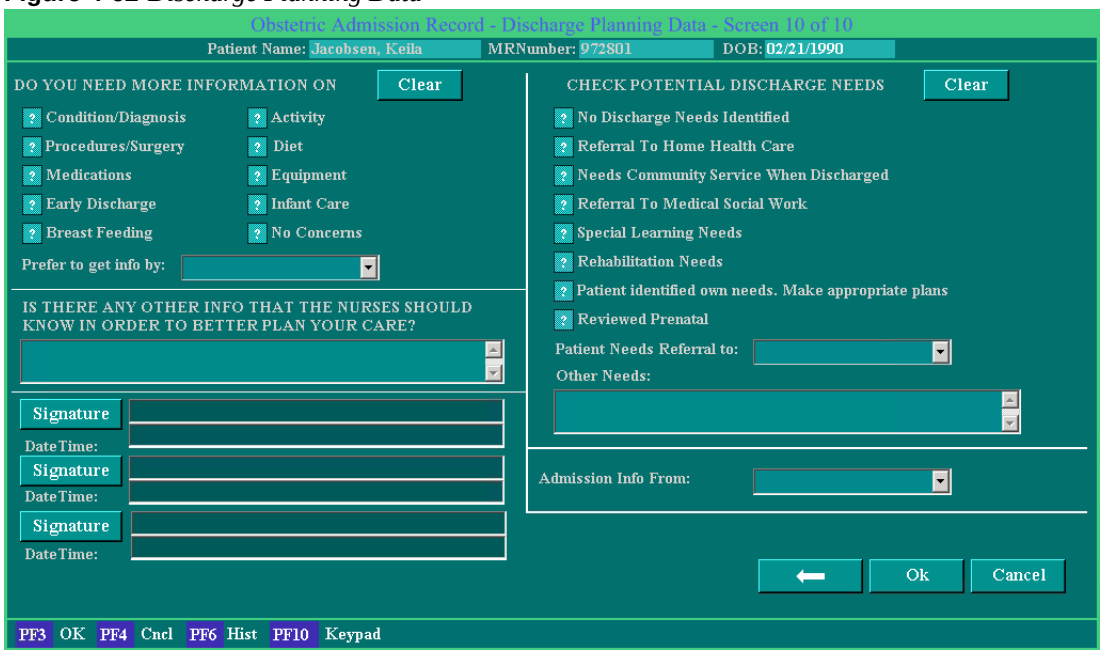
The Discharge Planning Data screen enables you to record any special needs the patient may have at the time of or shortly after discharge. The screen is accessed any of the paths illustrated in Figure 4-61.

Figure 4-61 *Accessing the Discharge Planning Screen*



1. Access the Discharge Planning Data screen, shown in Figure 4-62, via any of the paths illustrated above.

Figure 4-62 *Discharge Planning Data*



Usage Notes:

- Select the **Clear** button on each half of the screen to clear all check boxes, indicating No. You can then select to X (Yes) only those that apply to your patient.
- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item.

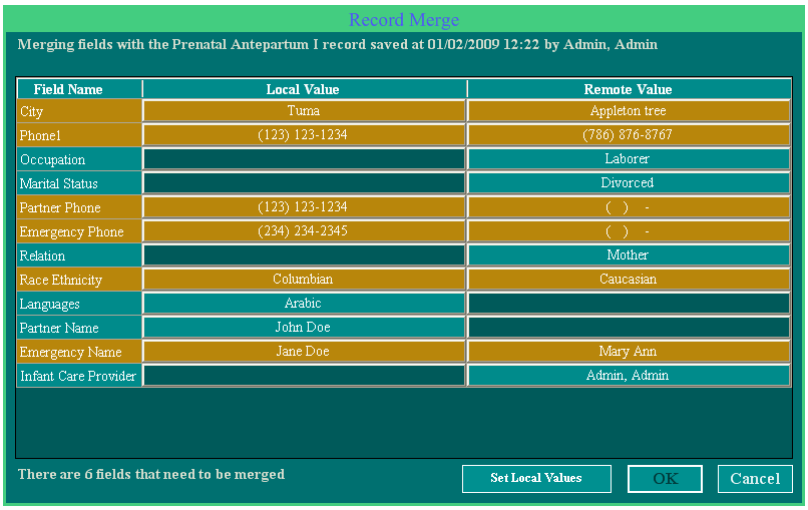
2. When you have completed all entries, select one of the following:
   - ⇦ to save your entries and go back to the Psychosocial Data 2 screen.
   - **OK** to save your entries and close the screen.

Record Merge

In the event two users are on the same chart, at the same time, documenting on the same fields, a record merge will be created. Record merge only occurs for charting screens (i.e. Admission Record, Labor Summary and Delivery Summary, OR Record, Postpartum profile, etc), not for flowsheet records.

If a merge is required, then a record merging screen will be presented to the user. This screen, shown in Figure 4-63, displays only the fields that are commonly changed between local changes and the other user's changes (remote).

Figure 4-63 *Record Merge Screen*



There are 3 colors on the record merge screen, Dark Green, Light Green, and Gold.

- Dark Green indicates not selected and the result will be that the dark green values will not be saved.
- Light Green indicates the value is currently selected and the result will be that the values will be saved.
- Gold indicates that a decision is required because two users have entered values into that same field. The user can manually select each field as desired. Once all fields are Light Green or Dark Green the OK button can be selected which will save the light green values.

Optionally, the user can select ‘Set Local Values’. This option automatically selects all gold local values. This is a quick way for users to select all of their changes plus any changes the other user entered.

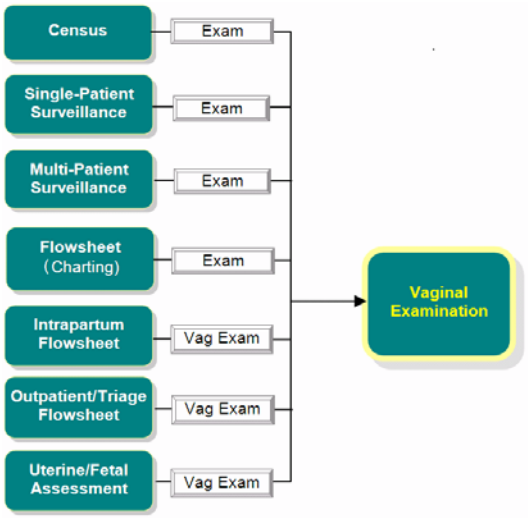
Chapter 5

Vaginal Examination Screen

Access and Data Entry

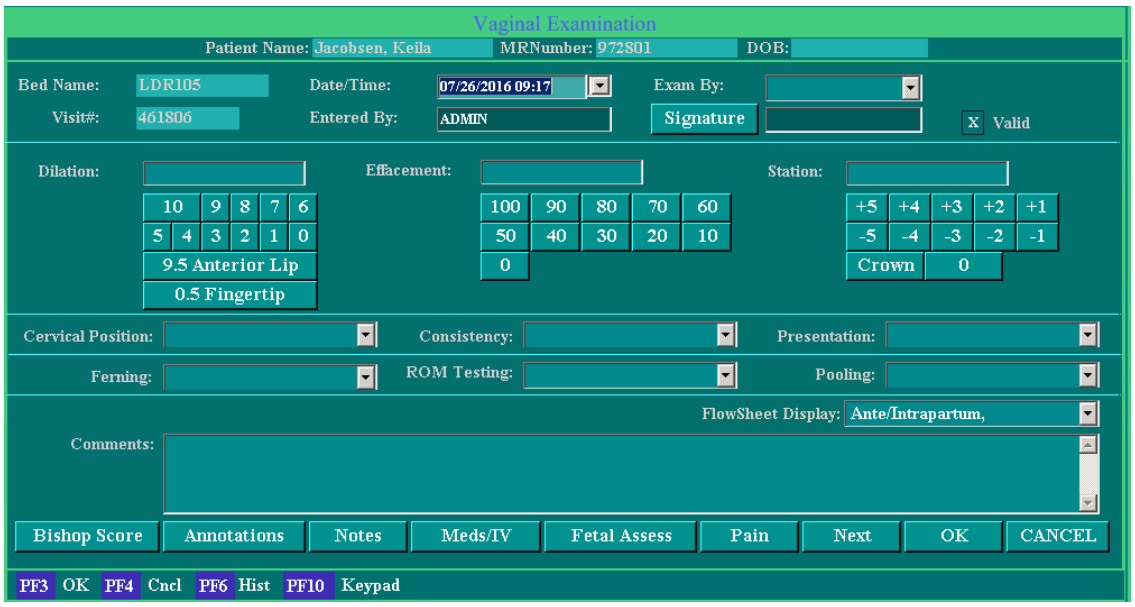
The Vaginal Examination screen is used for entering data on the monitor strip as an annotation and on flowsheets for the selected patient. The screen is accessed from several screens, as illustrated in Figure 5-1.

Figure 5-1 *Accessing the Vaginal Examination Screen*



1. Display the Vaginal Examination screen, shown in Figure 5-2, via any of the paths illustrated in Figure 5-1 on page 5-1.

Figure 5-2 *Vaginal Examination Screen*



Usage Notes:

- Entries on this screen are automatically annotated to the patient strip if the parameter config is set to ON.
- Dilation and Station values entered on this screen are used to plot the labor curve (see "Viewing the Labor Curve" on page 6-5 for details).
- The current date and time are automatically entered in the **Date/Time** field. The Date/Time may be changed to reflect the actual time completed. The patient strip will be annotated to the date and time you enter.

2. Select **Dilation**, **Effacement** and **Station** values from the corresponding buttons beneath each field.
3. Use the drop-down selection menus for **Cervical Position**, **Consistency**, and **Presentation** to enter data for those fields.
4. Use the drop-down selection menus for **Ferning**, **ROM Testing**, and **Pooling** to enter data for those fields.
5. Use the **Comments** data entry field to type any pertinent additional information about the exam.
6. To go to another screen without first closing the Vaginal Examination screen, select the appropriate button on the bottom of the screen. Table 5-3 on page 5-3 shows you which screen is displayed by each button and where to find usage information for the screen.
7. The Bishop Score screen may be accessed by one of the lower buttons on the Vaginal Examination screen. Open this screen and record the patient's status by clicking on the grid. The patient's score will appear on the Ante/Intrapartum Flowsheet under the **Bishop Score** option.

Table 5-3 *Buttons to Other Screens Reference*

Button	Screen Accessed	Described in...
Bishop Score	Bishop Score	“Vaginal Examination Screen” on page 5-1
Annotations	Annotate Strip	“Annotating a Patient Monitoring Strip” on page 10-1
Notes	Notes	“Notes Screen” on page 4-20
Meds/IV	Medications/IVs	“Recording Medications and IV Information” on page 15-8
Pain	Pain	“Pain Screen” on page 4-15

8. When you are done entering information, select **OK** to save your entries and close the screen or use the **NEXT** button to record another exam entry.

Chapter 6

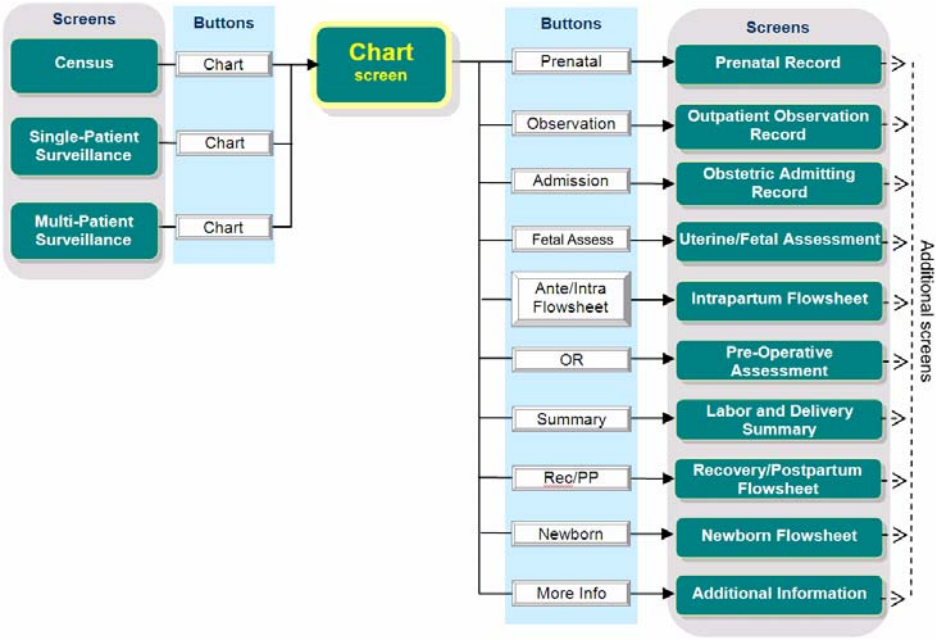
Using the Chart Screen — Comprehensive Charting

This chapter covers the following information for NaviCare® WatchChild® Chart screen for Comprehensive Charting:

Accessing the Chart Screen

The Chart screen provides access — directly or indirectly — to most of the NaviCare® WatchChild® Comprehensive Charting functions. Figure 6-1 shows an overview of how to get to the Chart screen and the first-level charting screens that you can access directly using Chart screen buttons.

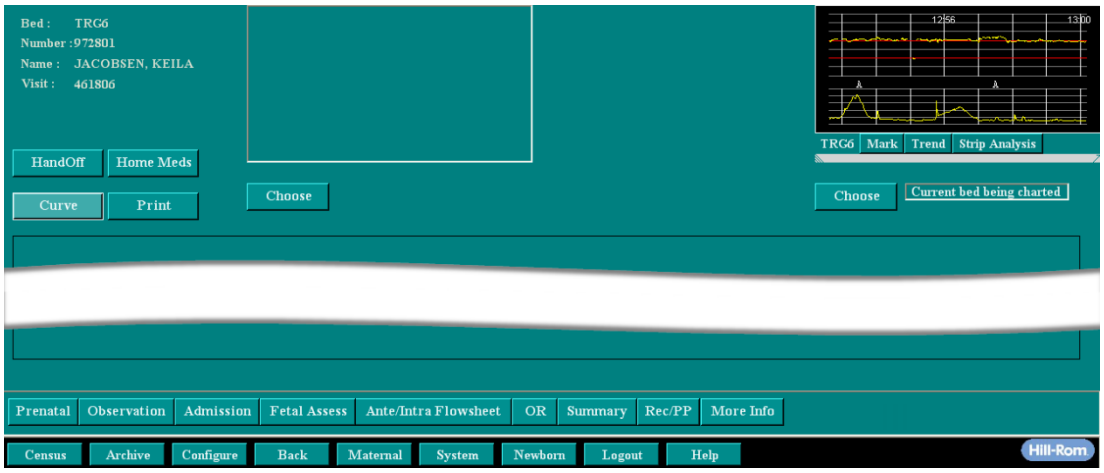
Figure 6-1 *Chart Screen Access and First-Level Screens*



To access the Chart screen:

1. From a Single- or Multi-Patient Surveillance screen for your patient, select the **Chart** button, or from the Census screen, select your patient and then select **Chart.** The Chart screen opens for the selected patient, as shown in Figure 6-2. The patient monitoring strip for the selected patient is displayed in the upper-right box. The Chart screen displays the bed number, medical record number, visit number, and name in the upper-left corner.

Figure 6-2 *Chart Screen*



2. Table 6-1 shows what each button does and where the results of each button is described:

Table 6-1 *Chart Screen Buttons and Their Screens*

Button	Screen or Function	Where Described
Handoff	Labor & Delivery Hand Off Communication	"Labor & Delivery Hand Off Communications" on page 6-7
Curve	Labor Curve	"Viewing the Labor Curve" on page 6-5
Print	Prints all charting information	"Print" on page 6-16
Choose	Specify another patient to monitor	"Choosing Another Patient from the Chart Screen" on page 6-4
Prenatal	Prenatal Record	Chapter 13, "Prenatal Record — Comprehensive Charting" on page 13-1
Observation	Outpatient/Observation Record	Chapter 14, "Using the Outpatient/Observation Record" on page 14-1
Admission	Obstetric Admitting Record	Chapter 4, "Obstetric Admitting Record — Comprehensive Charting" on page 4-1
Fetal Assess	Uterine/Fetal Assessment	Chapter 7, "Uterine/Fetal Assessment Screen" on page 7-1
Ante/Intra Flowsheet	Intrapartum Flowsheet	Chapter 15, "Using the Ante/Intrapartum and Outpatient/Triage Flowsheets" on page 15-1
OR	Pre-Operative Assessment and operative record	"Pre-Operative Assessment" on page 6-8
Summary	Labor and Delivery Summary	Chapter 16, "Labor, Delivery, and Infant Summary" on page 16-1
Rec/PP	Recovery/Postpartum Flowsheet	Chapter 17, "Recovery & Postpartum Records" on page 17-1
Newborn	Newborn Flowsheet	Chapter 18, "Newborn Profile and Initial Physical Examination" on page 18-4
More Info	Additional Information	"Additional Information Screen" on page 6-15
Bar Under Upper R Surveillance Strip	Expansion Bar	Allows you to grab and drag the black hatch marks to expand the strip view.

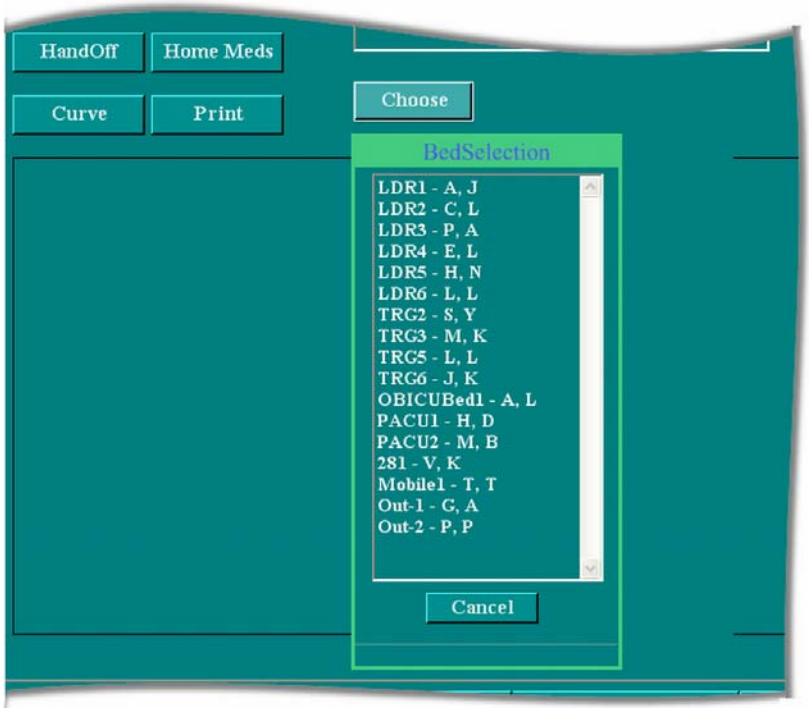
Choosing Another Patient from the Chart Screen

1. Open the Chart screen for the selected patient.

   The right box in the Chart screen displays the patient monitoring strip for the current patient being charted. The name and bed of the current patient being charted is displayed in the top-left corner of the screen. The buttons you select from the charting menu allow you to chart for the current patient.

2. To select another patient to view as the current patient being charted, select the left **Choose** button. The Bed Selection list box displays, as shown in Figure 6-3.

Figure 6-3 *Bed Selection Screen*



3. Choose the patient you want to display as the current patient being charted. The right box and upper left-hand corner information changes and displays the selected patient information.

   Any bed number you select will chart for the selected patient with her name displayed in the top-left corner of the screen.

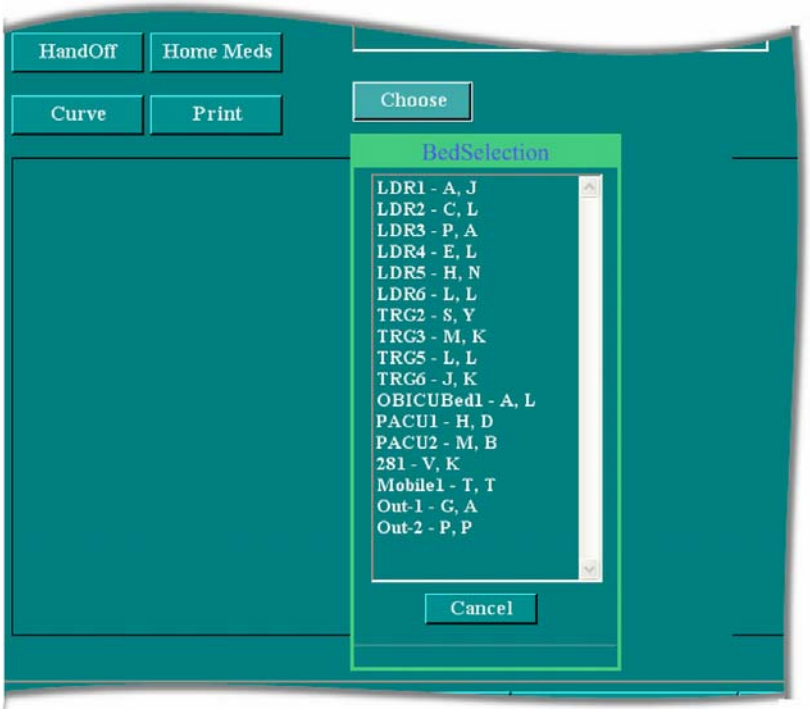
Surveillance of Two Patients from the Chart Screen

The top-middle box of the Chart screen allows users to view another patient monitoring strip in addition to the current patient being charted. However, any charting button you select allows you to chart only for the current patient being charted.

1. Display the Chart screen for the selected patient. The right box in the Chart screen displays the monitoring strip for the current patient being charted.

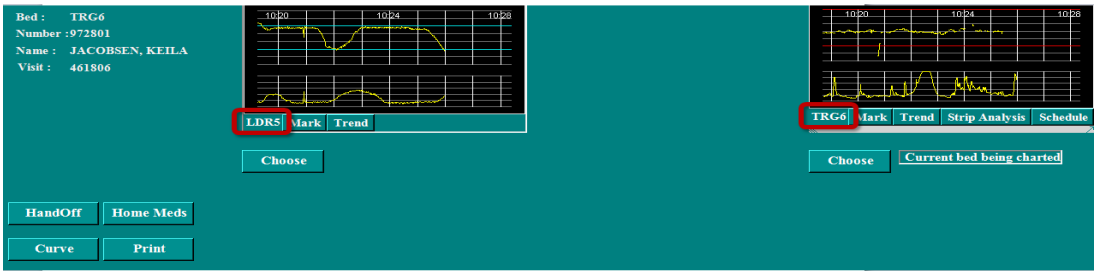
2. To select a second patient to monitor, select the **Choose** button located below the left box. The Bed Selection list box opens, as shown in Figure 6-4.

Figure 6-4 *Choosing a Second Bed to Monitor on the Chart Screen*



3. Select the patient whose monitoring strip you want to display in the left box. The Chart screen displays both the monitoring strip you selected and the monitoring strip for the current patient being charted, as shown in Figure 6-5.

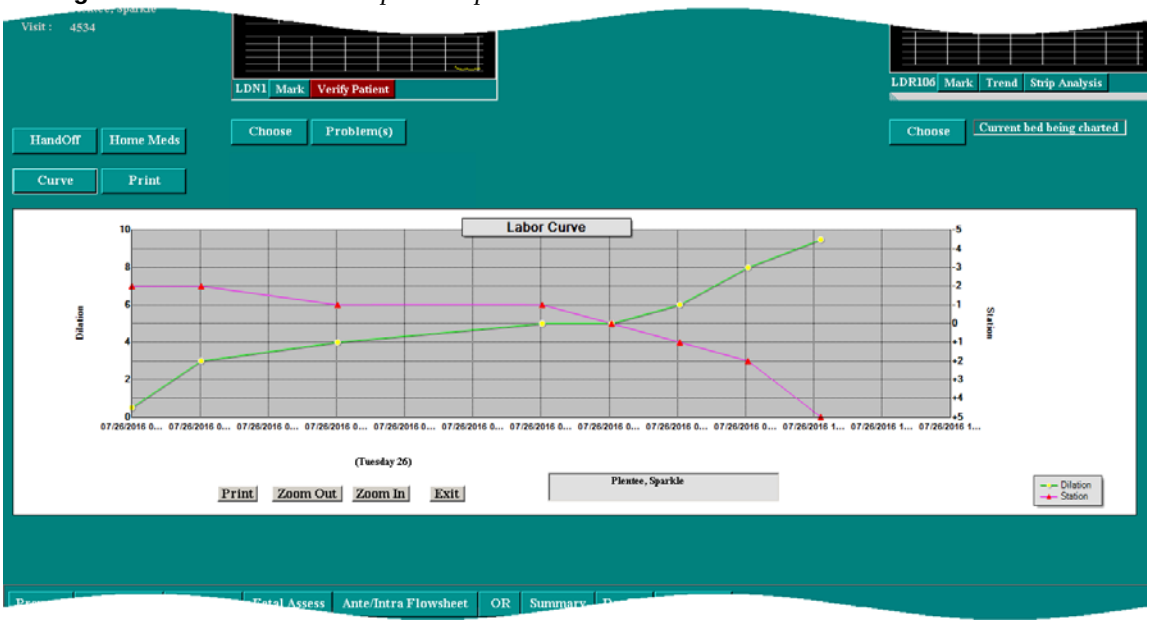
Figure 6-5 *Chart Screen with Two Patients Displayed*



Viewing the Labor Curve

You can view a graph showing the progression of labor by selecting the **Curve** button on the Chart screen. The Labor Curve graph, an example of which is shown in Figure 6-6 on page 6-6, displays in the central area of the Chart screen and gets its data from all of the examinations recorded on the Vaginal Exam screen. The default time span of the graph is 12 hours.

Figure 6-6 *Labor Curve Graph Example*



The buttons on the Labor Curve graph perform the following functions:

Print Prints the entire graph on your local printer.

Zoom Out Each selection of this button doubles the graph's displayed time span. For example, selecting **Zoom Out** expands the displayed default time span to 24 hours. Selecting it again expands the time span to 48 hours.

Zoom In Each selection of this button halves the graph's displayed time span. For example, selecting **Zoom In** halves the displayed default time span to 6 hours. Selecting it again halves the time span to 3 hours. With each halving, the most recent examination point remains in view.

Exit Closes the Labor Curve graph.

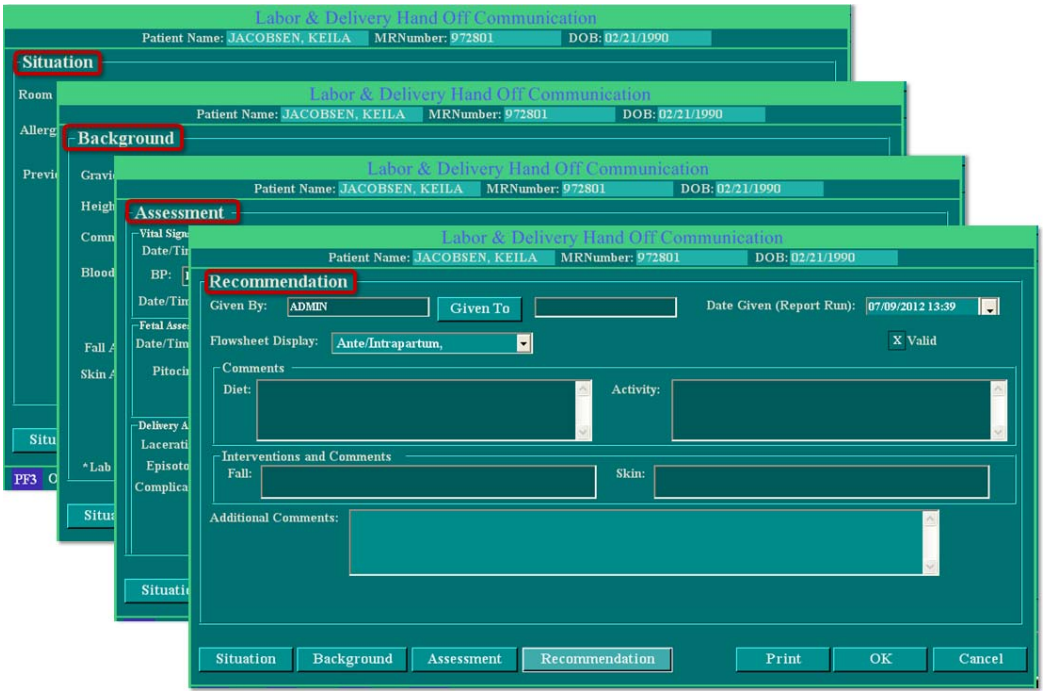
In addition to the zoom in and out feature, you can scroll the graph from side to side using the scroll bar at the bottom of the graph.

NOTE: Any vaginal exams performed while the Labor Curve graph is displayed will not appear on the graph in real time. You must close the graph (select the **Exit** button), then select **Curve** to reopen the Labor Curve graph. The Labor Curve graph will then show the exam.

Labor & Delivery Hand Off Communications

The Labor & Delivery Hand Off Communications screen, shown in Figure 6-7, is accessed by selecting the **Handoff** button on the Chart screen. It contains key data autopopulated from various charting and examination screens. Its purpose is to enable a smooth hand-off of a patient from one caregiver to another (for example, during a shift change) by providing a summary of the patient's status in the SBAR format as of the last examination. The four screens are display-only; they cannot be modified in any way. The user can have the person in which they are giving the report to sign the handoff tool to save it in the Ante/Intrapartum Flowsheet. If this is not signed from the same PC, it cannot be saved.

Figure 6-7 *Labor & Delivery Hand Off Communications Screen*



The following buttons provide additional hand-off screens (meaning that they are display-only) directly from this screen:

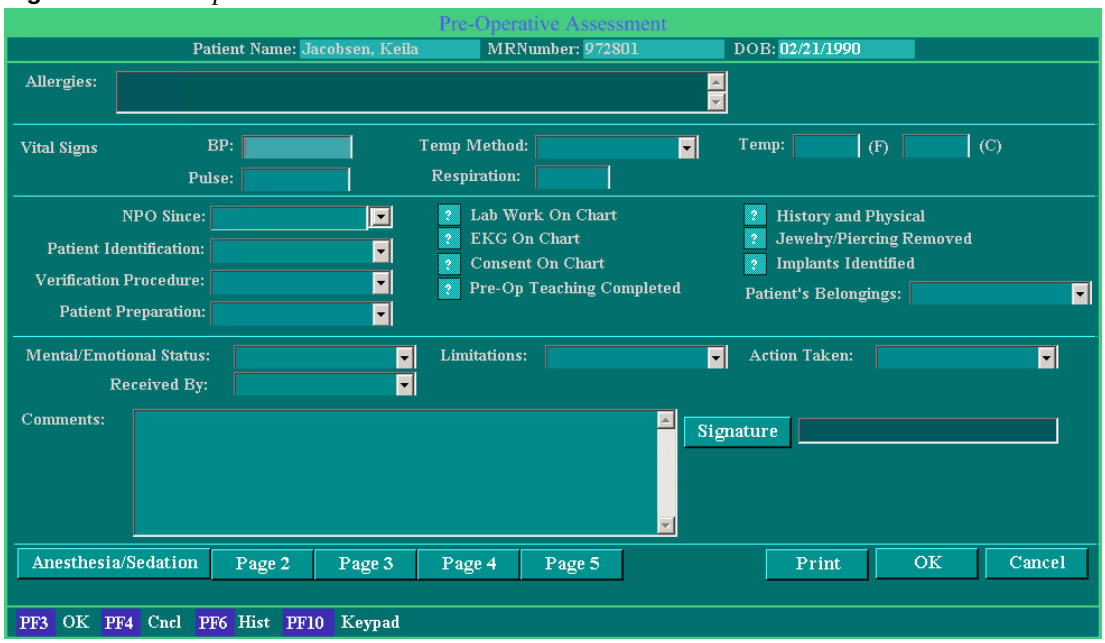
OB Assessment Displays the OB Risk Assessment screen (see "OB Risk Assessment Screen" on page 4-35 for usage information).

Special Needs Displays the first Psychosocial Data screen (see "Psychosocial Data Screen" on page 4-43for usage information).

Pre-Operative Assessment

The Pre-Operative Assessment screen, shown in Figure 6-8, enables you to record your assessment of a patient's readiness for surgery. This screen is accessible only via the **OR** button on the patient's Chart screen or from the Labor Summary Screen.

Figure 6-8 *Pre-Operative Assessment Screen*



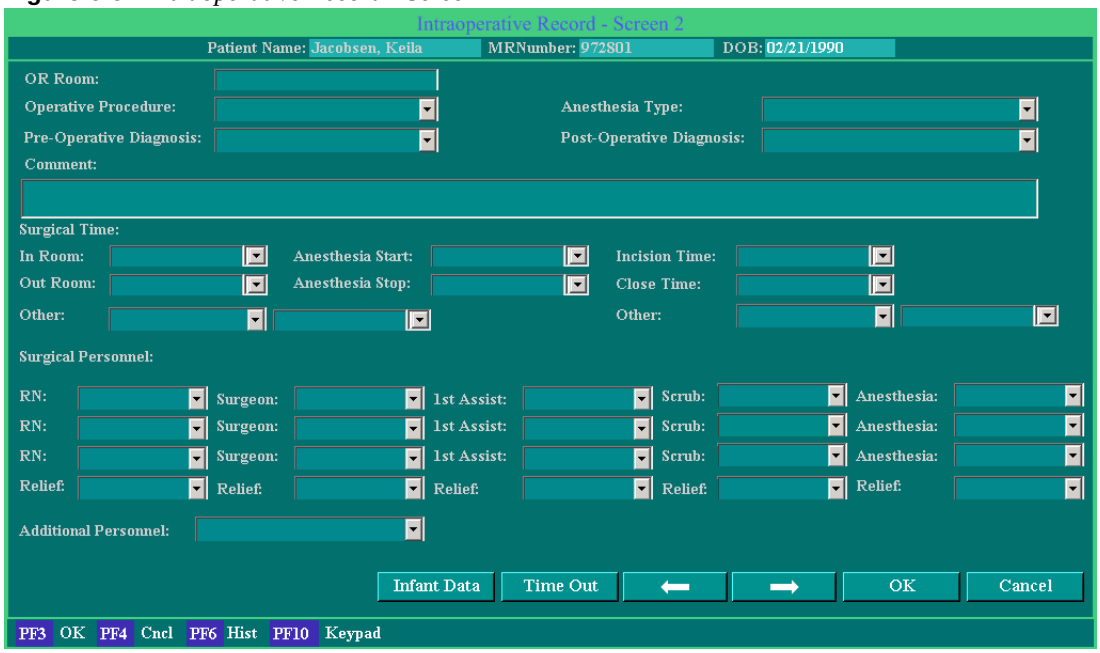
Usage Notes:

- Use the data entry fields, drop-down selection menus and check boxes to record your assessment information.When you are done recording pre-operative assessment information, select OK to save your entries if you do not plan to arrow forward and chart in the Intraoperative screens.
- To begin recording intraoperative information for your patient, select the ⇨ (arrow forward) button and see "Recording Intraoperative Information" on page 6-9" for usage information about the Intraoperative Record screens.
- Select **OK** to save your entries in the Intraoperative Screens 2 through 5 and close the screen. Intraoperative Screen 5 contains the Intraoperative Care Plan.

Recording Intraoperative Information

The Intraoperative Record - Screen 2, shown in Figure 6-9, is the first of four screens that enable you to compile a complete intraoperative record documenting the patient's surgical procedure. This screen is accessed only by selecting the ⇨ (Arrow Forward) on the Pre-Operative Assessment Screen.

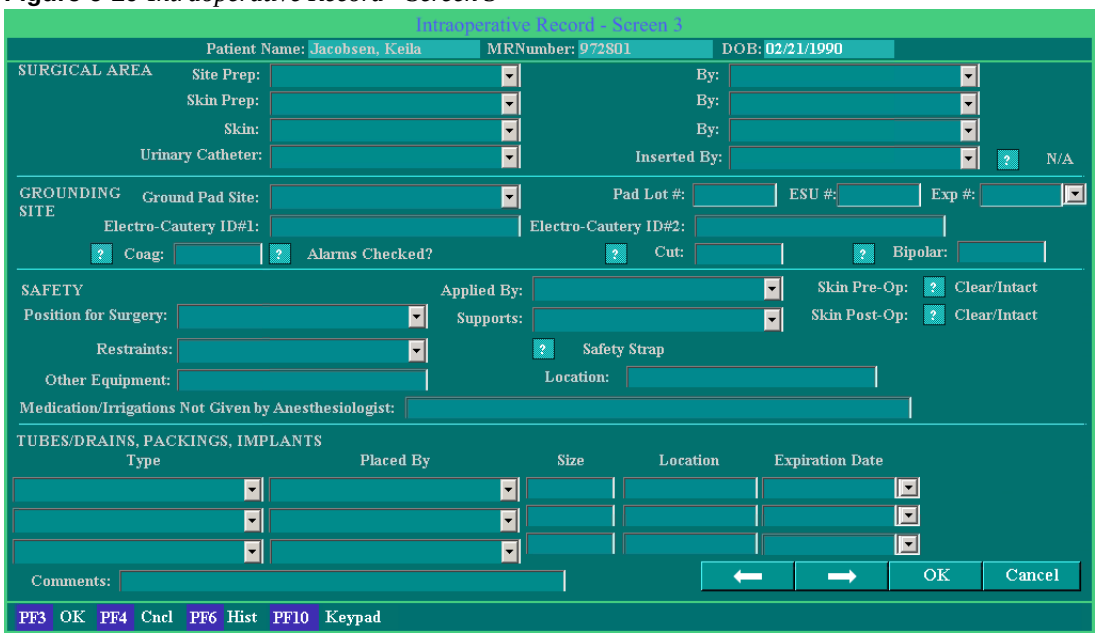
Figure 6-9 *Intraoperative Record - Screen 2*



Usage Notes:

- Use the data entry fields and drop-down selection menus to record necessary information.
- To continue to the next Intraoperative Record screen, shown in Figure 6-10 on page 6-10, select the ⇨ (arrow forward) button.
- To begin entering anesthesia-related information, select the **Anesthesia/Sedation** button and then see "Pre-Anesthetic/Sedation Evaluation" on page 6-12 for usage instructions.
- To view labor summary information, select the **Summary** button, and then see Chapter 16, "Labor, Delivery, and Infant Summary" on page 16-1 for more information.
- To record a procedure time out, select the **Time Out** button and then see "Procedure Time Out" on page 15-5 for more information.

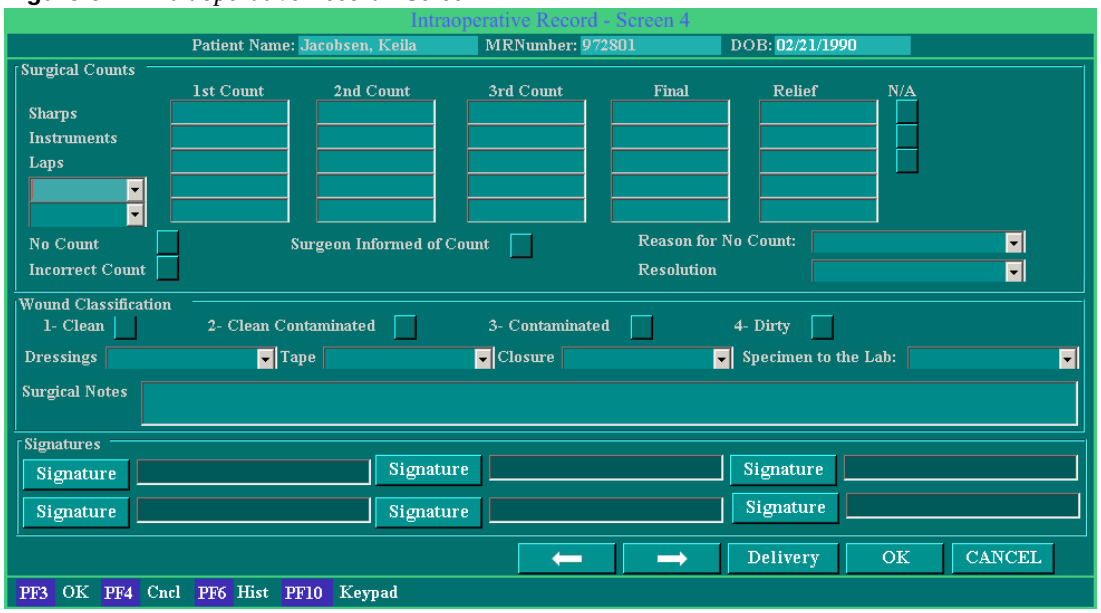
Figure 6-10 *Intraoperative Record - Screen 3*



Usage Notes:

- Use the data entry fields, drop-down selection menus and check boxes to record information about the surgical area, safety, grounding site and tubes/drains, packings and implants.
- To view labor summary information, select the **Summary** button, and then see Chapter 16, “Labor, Delivery, and Infant Summary” on page 16-1 for more information.
- To continue to the next Intraoperative Record screen, shown in Figure 6-11, select the ➪ (Arrow Forward).

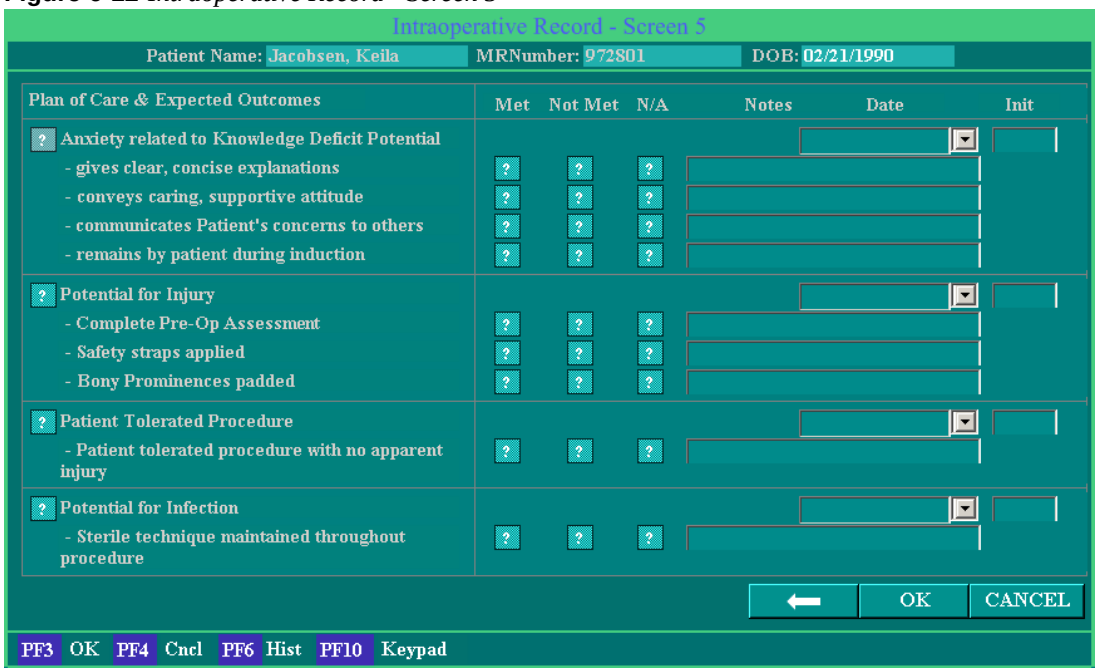
Figure 6-11 *Intraoperative Record - Screen 4*



Usage Notes:

- Use the data entry fields, drop-down selection menus and check boxes to record information about surgical counts and wound classification. The count fields are alphanumeric so both numbers and letters can be entered as applicable.
- To view labor summary information, select the **Summary** button, and then see Chapter 16, “Labor, Delivery, and Infant Summary” on page 16-1 for more information.
- To continue to the next (and final) Intraoperative Record screen, shown in Figure 6-12, select the ⇨ (Arrow Forward).

Figure 6-12 *Intraoperative Record - Screen 5*



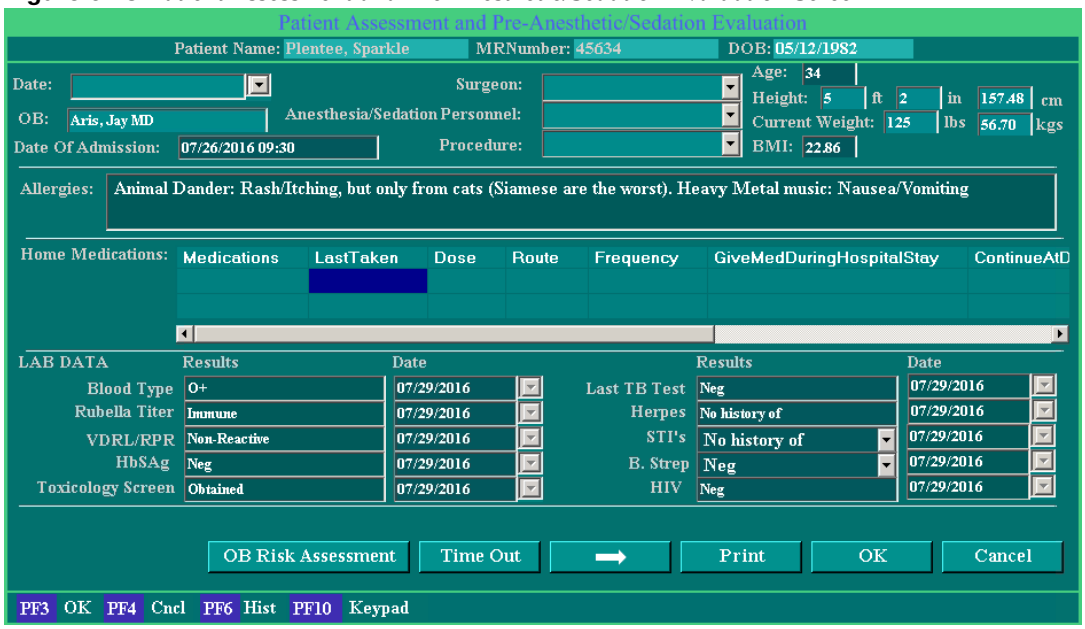
Usage Notes:

- Use the data entry fields, drop-down selection menus and check boxes to record plan of care and expected outcomes information.
- To view labor summary information, select the **Summary** button, and then see Chapter 16, “Labor, Delivery, and Infant Summary” on page 16-1 for more information.
- When you are done entering all intraoperative information, select **OK** to save all of your entries and close the screen.

Pre-Anesthetic/Sedation Evaluation

The Patient Assessment and Pre-Anesthetic/Sedation Evaluation screen, shown in Figure 6-13, is the first of four screens that enable you to view and record surgical anesthesia information for the patient's record. This screen is accessed only by selecting **Anesthesia/Sedation** on the Intraoperative Record - Screen 2 screen.

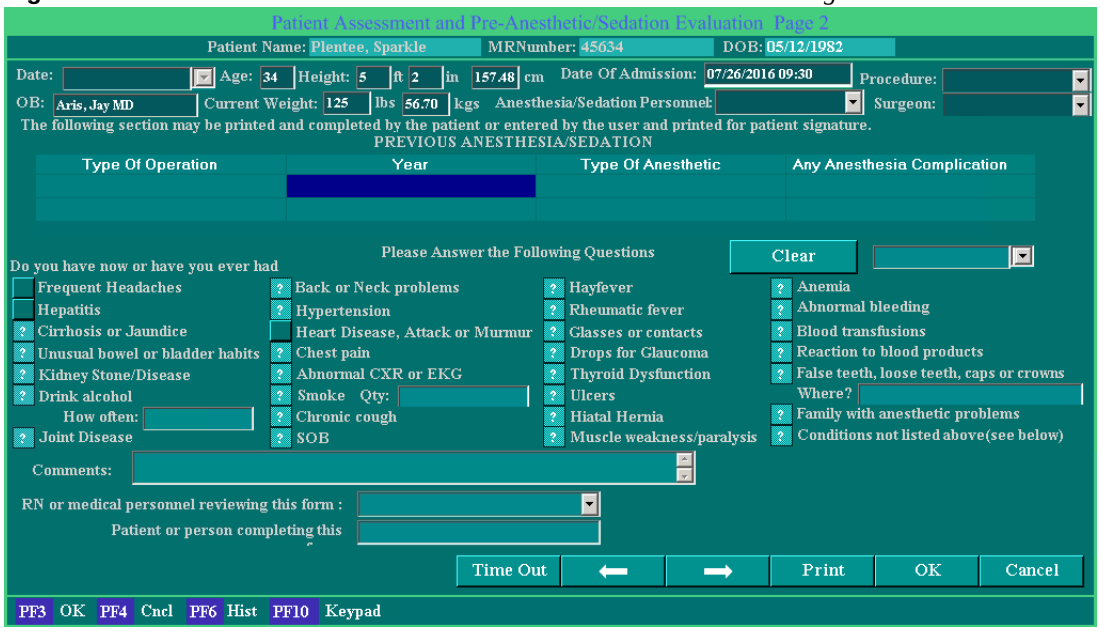
Figure 6-13 *Patient Assessment and Pre-Anesthetic/Sedation Evaluation Screen*



Usage Notes:

- Use the data entry fields and drop-down selection menus to enter **Date**, **OB**, **Surgeon**, **Anesthesia Personnel**, and **Procedure** information. All other fields on this screen are view-only and are automatically populated with data previously entered on other screens.
- To view the established Obstetric Risk Assessment information about the patient, select **OB Risk Assessment**.
- To view or modify the patient's pre-operative assessment, select the **OR** button and then see "Pre-Operative Assessment" on page 6-8 for more information.
- To record a procedure time out, select the **Time Out** button and then see "Procedure Time Out" on page 15-5 for more information.
- Select the ⇨ (Arrow Forward) to proceed to the Patient Assessment and Pre-Anesthetic/Sedation Evaluation Page 2 screen, shown in Figure 6-14 on page 6-13

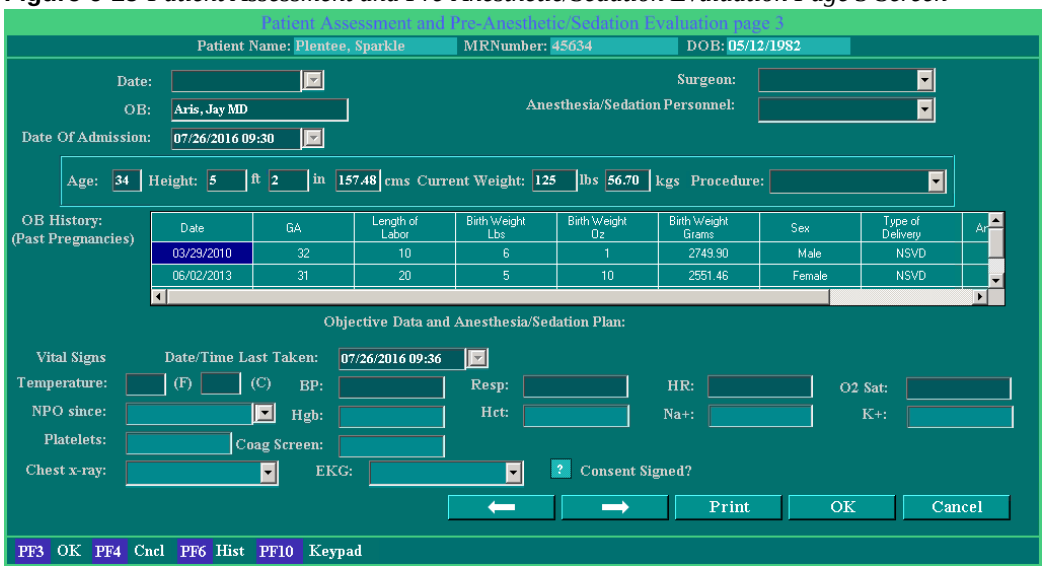
Figure 6-14 *Patient Assessment and Pre-Anesthetic/Sedation Evaluation Page 2 Screen*



Usage Notes:

- For the lower half of the screen, select the check boxes to X or *blank* as appropriate for your patient. If all answers will be No, select the **Clear** button.
- The field next to the **Clear** button is a date/time field. Enter or select the date that you are making the evaluation.
- Use the data entry fields and drop-down selection menus to provide all other information.
- To view or modify the patient's pre-operative assessment, select the **OR** button and then see "Pre-Operative Assessment" on page 6-8 for more information.
- To record a procedure time out, select the **Time Out** button and then see "Procedure Time Out" on page 15-5 for more information.
- To continue the pre-anesthesia evaluation, select the ⇨ (Arrow Forward) to proceed to the Patient Assessment and Pre-Anesthetic/Sedation Evaluation Page 3 screen, shown in Figure 6-15.

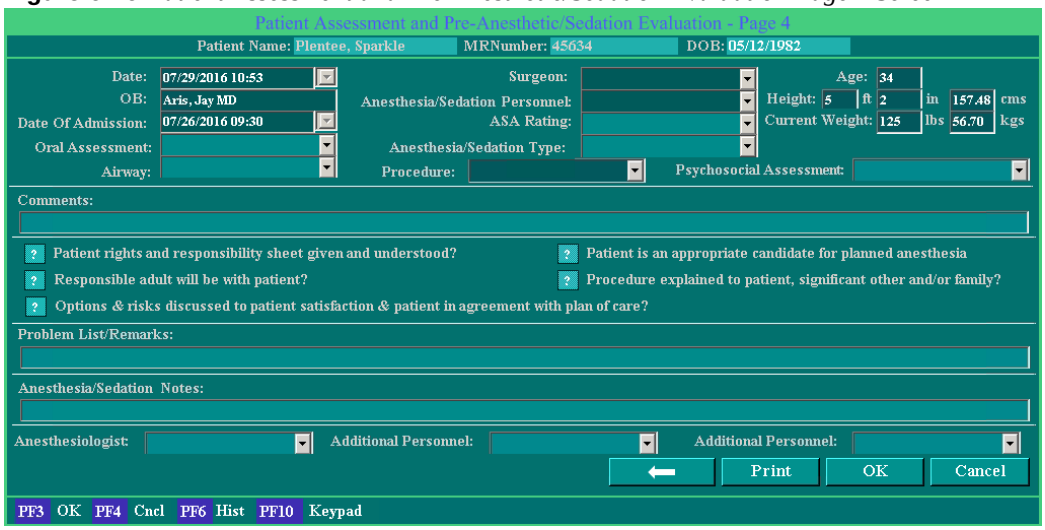
Figure 6-15 *Patient Assessment and Pre-Anesthetic/Sedation Evaluation Page 3 Screen*



Usage Notes:

- Many of the fields on this screen are view-only and are pre-filled with information previously entered on other screens
- Use the data entry fields and drop-down selection menus to enter non-prefilled data as appropriate to your patient.
- To continue entering pre-anesthetic evaluation information, select the ➪ (Arrow Forward) to proceed to the Patient Assessment and Pre-Anesthetic/Sedation Evaluation Page 4 screen, shown in Figure 6-16.

Figure 6-16 *Patient Assessment and Pre-Anesthetic/Sedation Evaluation Page 4 Screen*



Usage Notes:

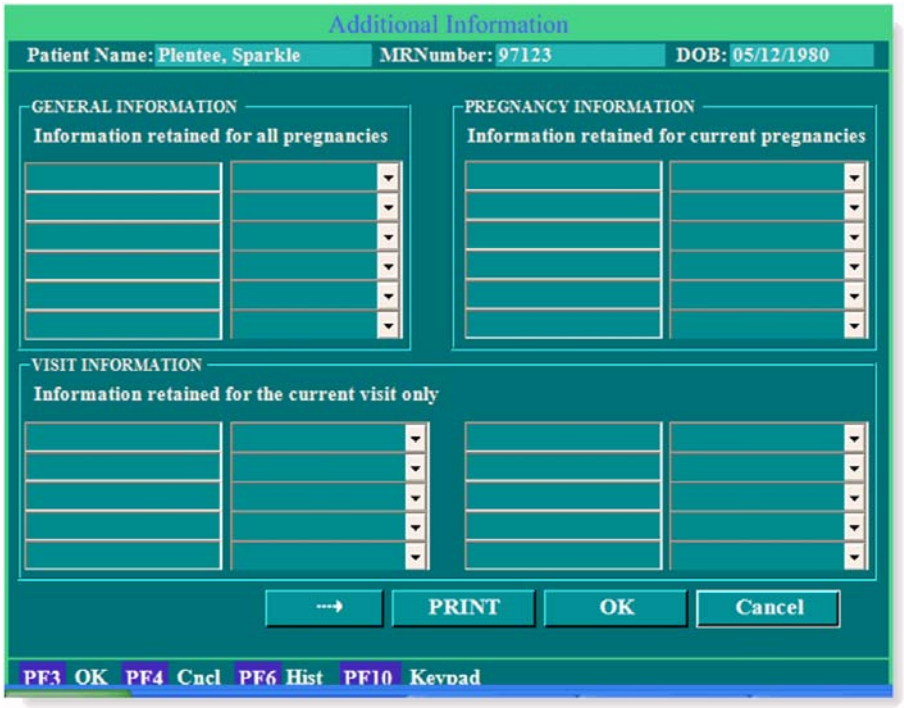
- Use the data entry fields, drop-down selection menus and check boxes to complete the pre-anesthetic evaluation.
- When you are done entering data on this screen, select **OK** to save your entries and close the screen.

Additional Information Screen

The Additional Information screen, a blank example of which is shown in Figure 6-17, is used to record hospital-specific information into the patient's record. NaviCare® WatchChild® supplies no default information for this screen other than the section headings and the menus selection of **Other**. The screen is accessed by selecting **More Info** on the Chart screen. Your **NaviCare®** WatchChild® System Administrator will populate the screen fields with the arrows and menus with any information mandated by your specific facility. The field label columns to the left side without arrows are entered by Tech Support.

The form for this is available from your NWC Clinical Application Specialist. When you have completed the form identifying what goes into each Header, fax it to NWC Tech Support and they will Hard Code that data into the left fields. The Hospital NWC System Administrator will then be able to develop the dropdown fields on the arrow side.

Figure 6-17 *Additional Information Screen*



Usage Notes:

- All of the drop-down selection menus have **Other** as a default selection. As with all other menus where **Other** is a selection option, selecting it opens a text entry field that enables you to type your own selection entry.
- The ⇨ (Arrow Forward) takes you to a second Additional Information screen that is identical to the first unless changed by your System Administrator. Selecting that button on the second screen takes you to a third, which is identical to the first and second unless modified by your System Administrator.

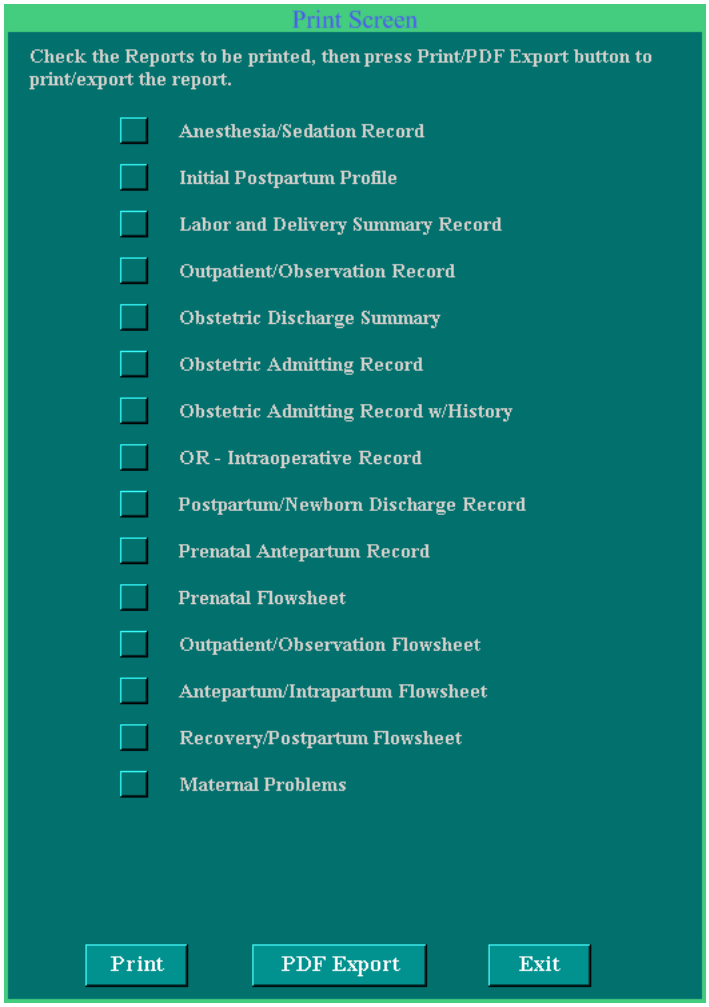
Print

The Print screen, shown in Figure 6-18, enables you to print the selected chart sections of a patient. This screen is accessible only via the **PRINT** button on the patient's Chart screen.

Usage Notes:

- Use the check boxes to select the chart sections to be printed.
- Select **Print** to print the sections or select the PDF Export feature. The PDF feature selection will require you to attach the info to a Word Document and save it to a file or the desktop.
- Select **Exit** to close the screen.

Figure 6-18 *Print Screen*



Chapter 7

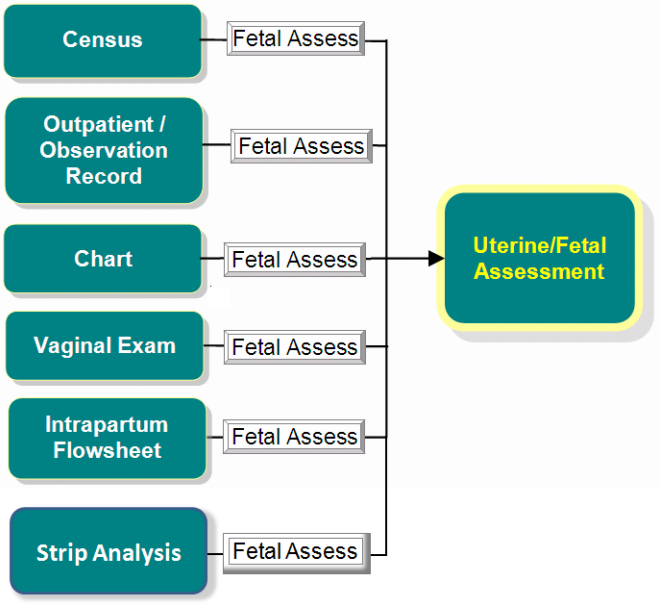
Uterine/Fetal Assessment Screen

The Uterine/Fetal Assessment screen gathers detailed information about uterine activity, vital signs, and fetal assessments.

Using the Uterine/Fetal Assessment Screen

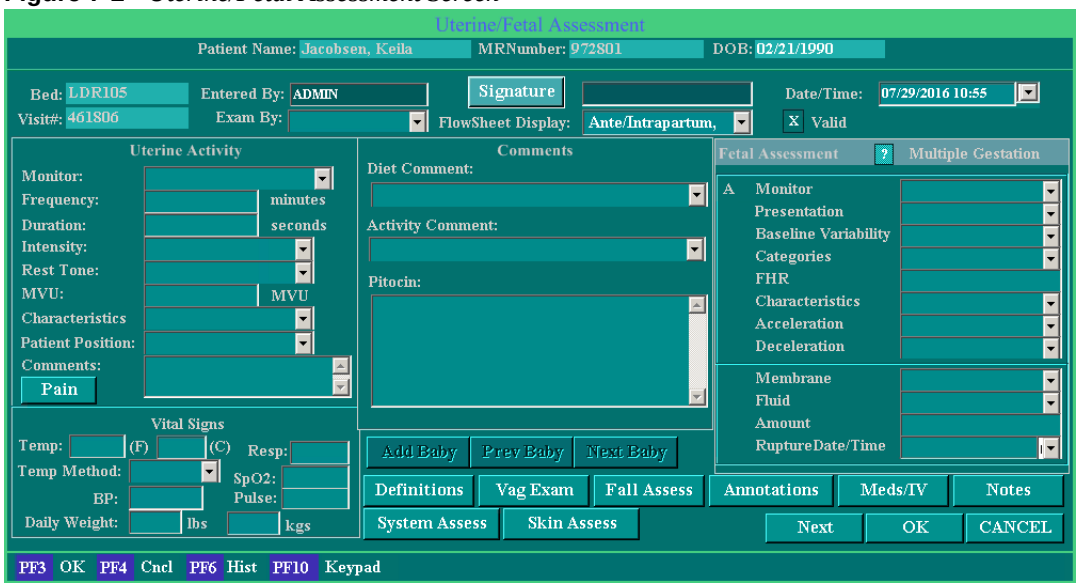
The Uterine/Fetal Assessment screen can be accessed from any of six other screens, as illustrated in Figure 7-1.

Figure 7-1 *Accessing the Uterine/Fetal Assessment Screen*



1. Access the Uterine/Fetal Assessment screen, shown in Figure 7-2 on page 7-2, via any of the paths illustrated in Figure 7-1.
2. In the **Exam By** field, select your name from the drop-down menu if you are the person performing the exam.
3. In the **Date/Time** field, enter the time and date that you perform the examination. If it is now, typing N or T into the field will automatically generate the current date and time.
4. Use the data entry fields and drop-down selection menus to enter maternal assessment information in the Uterine Activity and Vital signs blocks on the left of the screen.

Figure 7-2 *Uterine/Fetal Assessment Screen*



5. In the Fetal Assessment section of the screen, select to *blank* (for No) or X (for Yes) the **Multiple Gestation** check box. If you select to X, the **Add Baby** button is enabled allowing you to add up to 9 additional fetuses as shown in Figure 7-4 on page 7-3.

Figure 7-3 *Uterine/Fetal Assessment Screen for Multiple Gestations*

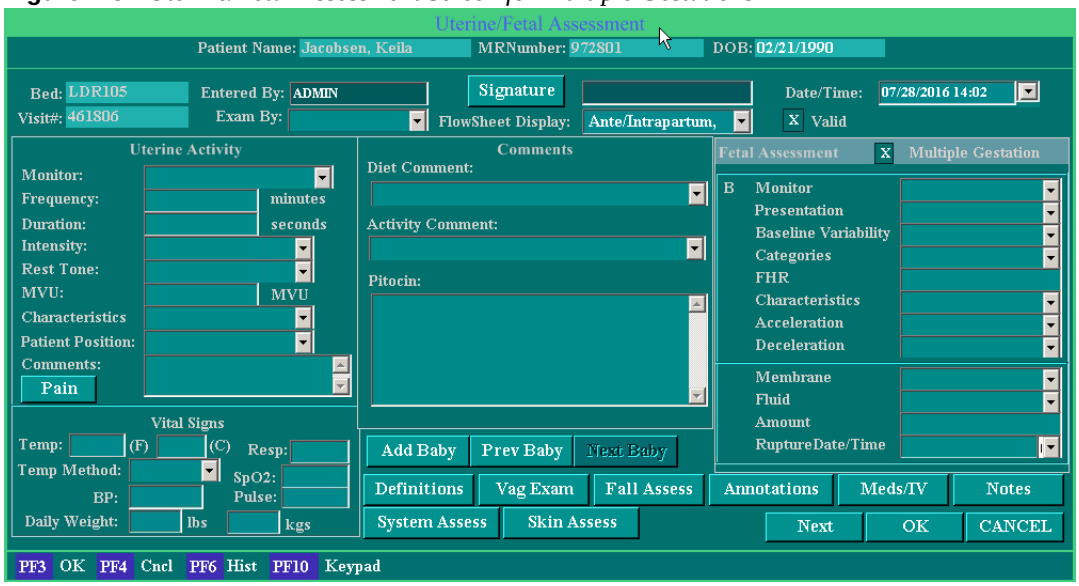
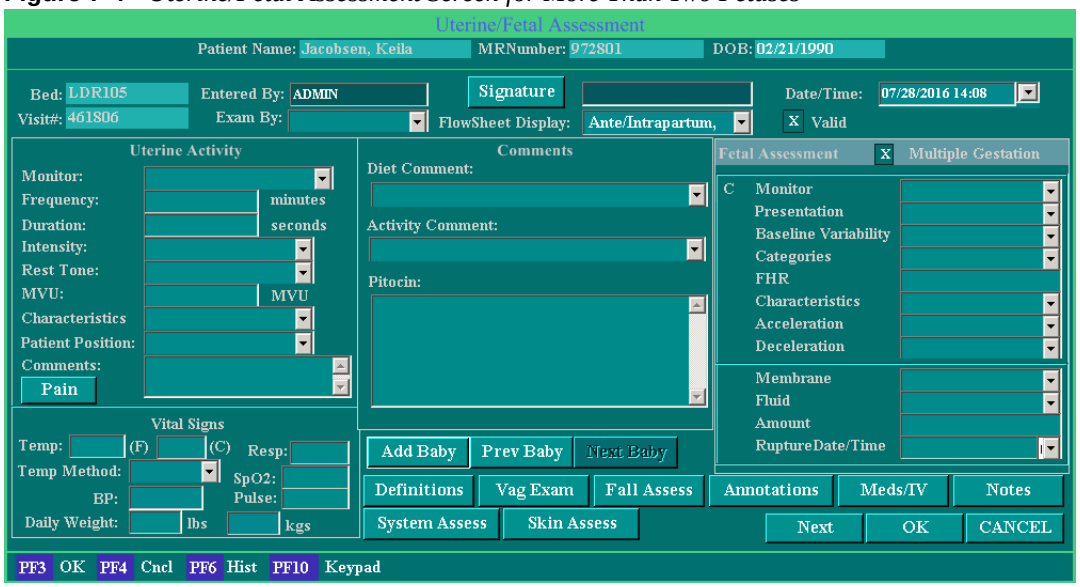


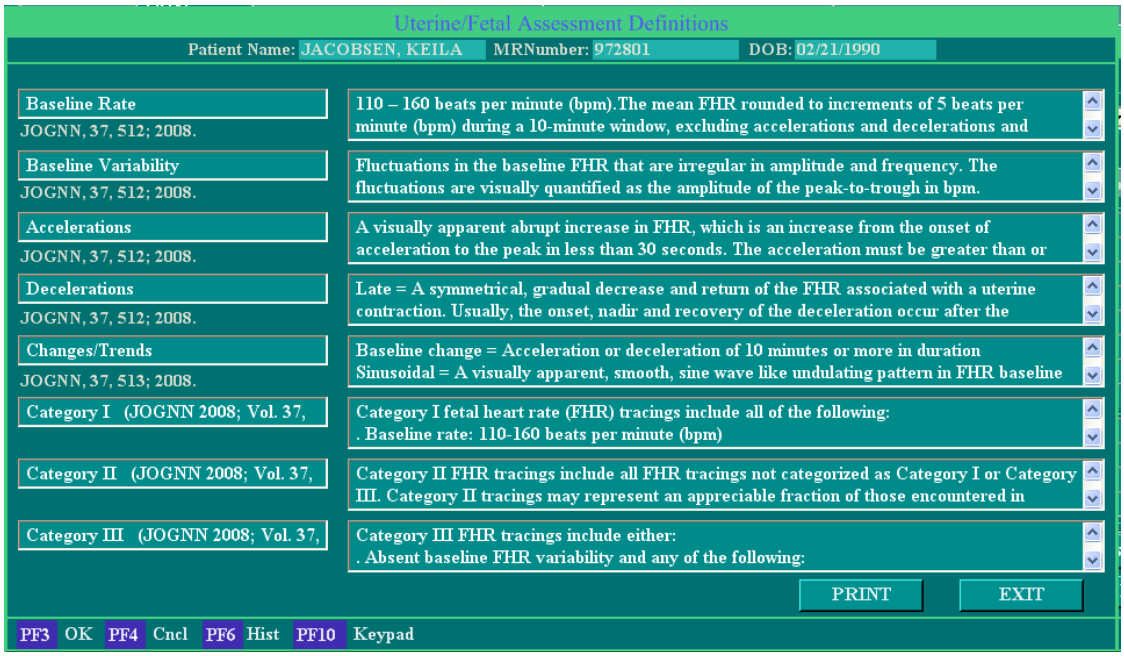
Figure 7-4 *Uterine/Fetal Assessment Screen for More Than Two Fetuses*



6. Use the data entry fields and drop-down selection menus to enter fetal assessment information.

   Your facility's formal definitions of fetal assessment fields can be found by selecting the **Definitions** button, which displays the Uterine/Fetal Assessment Definitions screen, shown in Figure 7-5. To modify or add definitions, contact NaviCare® WatchChild® Technical Support at 1-800-455-3720, Option 3, Option 2.

Figure 7-5 *Uterine/Fetal Assessment Definitions Screen*



Use the center portion of the screen to list the patient's diet, physical activity and Pitocin titration.

7. The buttons beside and below **Definitions** take you to other screens for entering additional assessment information. Table 7-1 on page 7-4 shows you which screen is displayed by each button and where to find usage information for each screen. Except for the **Definitions** button, selecting a button to go to another screen automatically saves your entries on the Uterine/Fetal Assessment screen before the next screen appears.

Table 7-1 *Uterine/Fetal Assessment Screens Access Buttons*

Button	Screen Accessed	Described in...
Vag Exam	Vaginal Examination	Chapter 5, "Vaginal Examination Screen" on page 5-1
Fall Assess	Fall Assessment	"Fall Assessment Screen" on page 4-37
Annotations	Annotate Strip	"Annotating a Patient Monitoring Strip" on page 10-1
Meds/IV	Medications/IVs	"Recording Medications and IV Information" on page 15-8
Notes	Notes	"Notes Screen" on page 4-20
System Assess	Systems Assessment	"Systems Assessment Screen" on page 4-19
Skin Assess	Skin Assessment	"Skin Assessment Screen" on page 4-38

Chapter
8

Maternal/Fetal Strip Functions

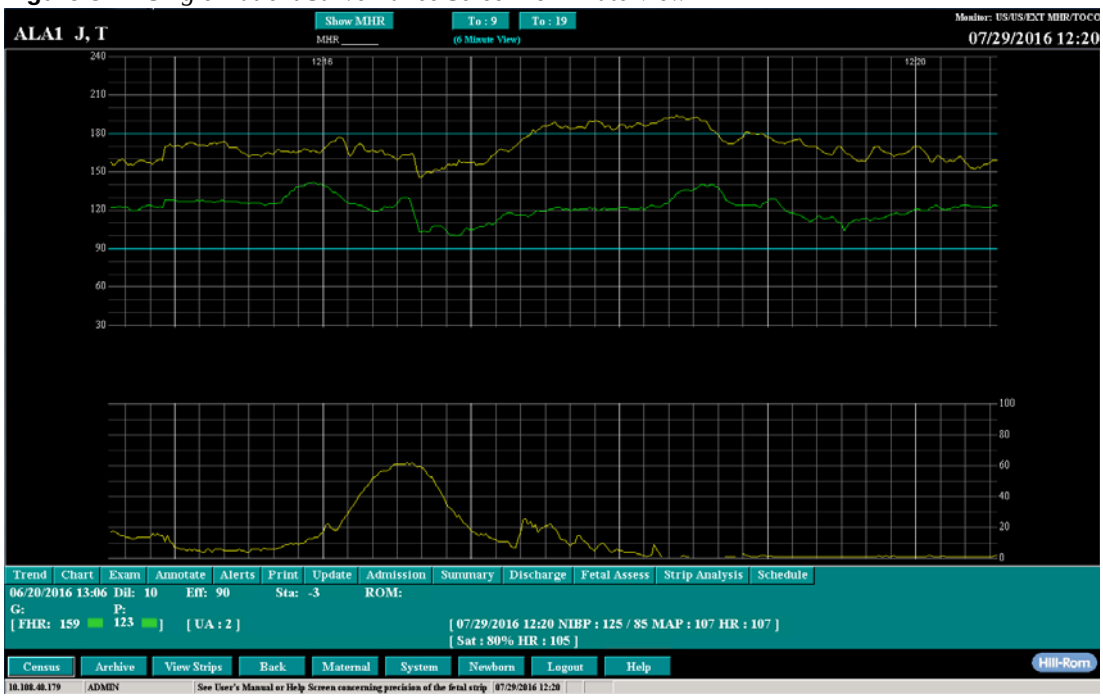
This chapter covers the following information for NaviCare® WatchChild®:

- "Maternal/Fetal Strip Basics"
- "Using the Trend Function"
- "Printing Patient Monitoring Strips"

Maternal/Fetal Strip Basics

To access a patient's maternal/ fetal strip, highlight the patient (bed) on the Census screen and click the **View Strips** button at the bottom of the screen.

Figure 8-1 *Single-Patient Surveillance Screen- 6 Minute View*



The Single Surveillance Strip shown in Figure 8-1 displays the components for twin fetuses. Baby A is represented by a yellow trace and Baby B by a green trace.

The following buttons appear at the top of the screen:

- **Show/Hide MHR** – If the mother has pulse oximetry, use this button to show or hide the maternal heart rate (MHR) on the strip. When displayed, the maternal pulse is represented by a white trace.
- **To: 6, To: 9, To: 19** – Use these buttons to select different minute views of the strip.

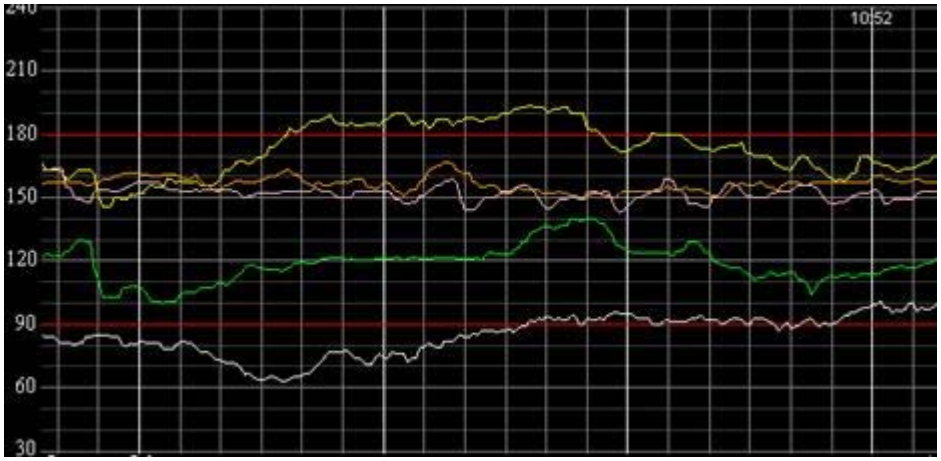
The bottom of the screen displays tabs that provide access to different areas of the maternal chart. Clinical data displays below the tabs. The color blocks in the lower left corner of the screen indicate the signal strength as follows:

- **Green** - strong signal
- **Yellow** - weak signal
- **Red** - no signal

Fetal Tracing Colors

NaviCare® WatchChild® has the ability to monitor and view up to 4 babies on the same strip. Each baby displays as a different color trace. The MHR, if shown, always displays as a white trace. Figure 8-2 shows the maximum 4 babies and MHR that can be monitored and displayed on the same strip.

Figure 8-2 *Single-Patient Surveillance Screen showing Quadruplets and Maternal Pulse*



The colors that display on the fetal monitor are determined by where the fetal/maternal monitor is plugged into the wall plate.

NOTE: Uterine contractions always appear as yellow.

Primary wall plate:

- The first cable port, farthest port on the left, (Baby A) is a yellow trace.
- The second port (Baby B) is a green trace.

Secondary wall plate:

- The first cable port (Baby C) is an orange trace.
- The second port (Baby D) is a pink trace.

NOTE: If using a Phillips Avalon FM50 triplet monitor, “NST1” is yellow, “NST2” is green, and “NST3” is orange.

Using the Trend Function

The **Trend** button is located below the patient monitoring strip viewing area and can be used to view the preceding monitoring strips. The Trend option allows you to see a patient monitoring strip from the beginning to the entire length of the strip or for just a specific period of time.

Using Trend from Single-Patient Surveillance

The Trend function enables you to view earlier areas of the patient strip to verify that the labor trend is progressing as expected or to identify potential problems.

1. In the Multi-Patient Surveillance screen, select a bed to be monitored or in the Census screen, select a bed and select **View Strips**. The Single-Patient Surveillance screen for the selected patient appears.
2. Select **Trend**. The buttons at the bottom of the screen change to a different set, as shown in Figure 8-3.

Figure 8-3 *Single-Patient Surveillance Screen Trend Buttons*

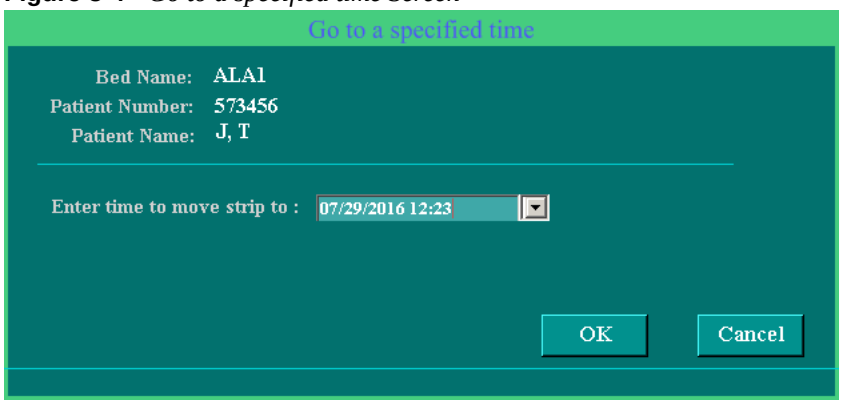
3. Use the buttons listed below to change the view of the monitoring strip as required:

Begin	Select to view the beginning of the monitoring strip.
End	Select to view the end of the monitoring strip.
Go To	Select to view a particular time on the monitoring strip. A window pops up requesting you to enter the specific date and time you want to view, as shown in Figure 8-4 on page 8-4.
Move/Delete	See “Move/Delete Strip Data” on page 9-5 for details on using this function.
Annotate	Select to enter a post-dated annotation or to mark an event indicating that an annotation will be made later. See “Annotating a Patient Monitoring Strip” on page 10-1 for usage information.
Print/Fax	Select to print or fax all or a part of the monitoring strip.
Maternal	Select to display the Maternal Trend screen. See “Using the Maternal Census Screen” on page 2-13 for more information about the Maternal Trend screen.

Arrows Select the left arrow to move the monitoring strip backward. Select the right arrow to move the monitoring strip forward. To move the strip, select and hold the arrow in the direction you wish to move. Select the tip of an arrow to allow the strip to autotrend or a shaded portion of an arrow to move at a slower pace (see Figure 8-5).

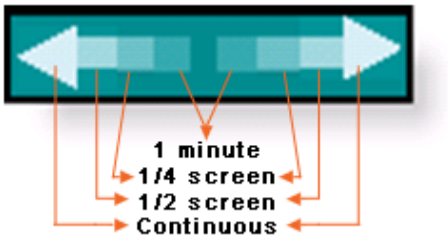
Cancel Select to exit the screen

Figure 8-4 *Go to a specified time Screen*



NOTE: Enter all the four digits to specify the year when entering the date.

Figure 8-5 *Arrows Speed*



Hovering towards the center of the arrows moves the strip slower.
The color intensity indicates the moving strip speed.
The brighter the arrow color, the faster the strip moves.
Extreme left/right autoadvances the strip.
To stop autotrending, click anywhere on the strip or arrow.

4. Select **OK** to go to the specified date and time in the Go to a Specified Time screen.
5. Select **Cancel** to return to normal viewing.

Using Trend from Multi-Patient Surveillance

As with the Single-Patient Surveillance screen, the Trend function enables you to view earlier areas of the patient strip to verify that the labor trend is progressing as expected or to identify potential problems. The **Trend** button enables you to review the previous fetal monitoring strip data.

When the **Trend** button on the Multi-Patient Surveillance screen is selected, the **Mark**, **Trend** and **Chart** buttons are replaced by the Left-Right arrow and the Cancel button. To use the Left-Right arrow button *speeds* feature, see Figure 8-5 above.

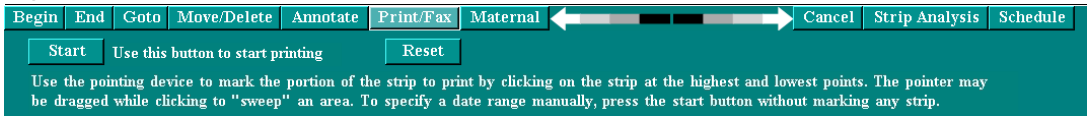
Printing Patient Monitoring Strips

For diagnostic and legal purposes, NaviCare® WatchChild® allows you to print the entire fetal monitoring strip or specific portions of the strip. The monitoring strip prints at the same scale as the paper strip on the fetal monitor. When you specify printing of the entire monitoring strip, a message box displays verifying whether you want to print the entire strip. When the monitoring strip prints, the following information is included on the monitoring strip:

- Patient name
- Patient ID
- Name of the user who prints the monitoring strip
- Print date and time
- Events
- Annotations

1. In the Multi-Patient Surveillance screen, select the patient or on the Census screen, select a bed and select **View Strips**. The Single-Patient Surveillance screen for the monitoring strip you want to print appears.
2. Select the **Print** button. The buttons at the bottom of the screen change to the same set used for the Trend function, as shown in Figure 8-6.

Figure 8-6 *Trend Buttons Set*



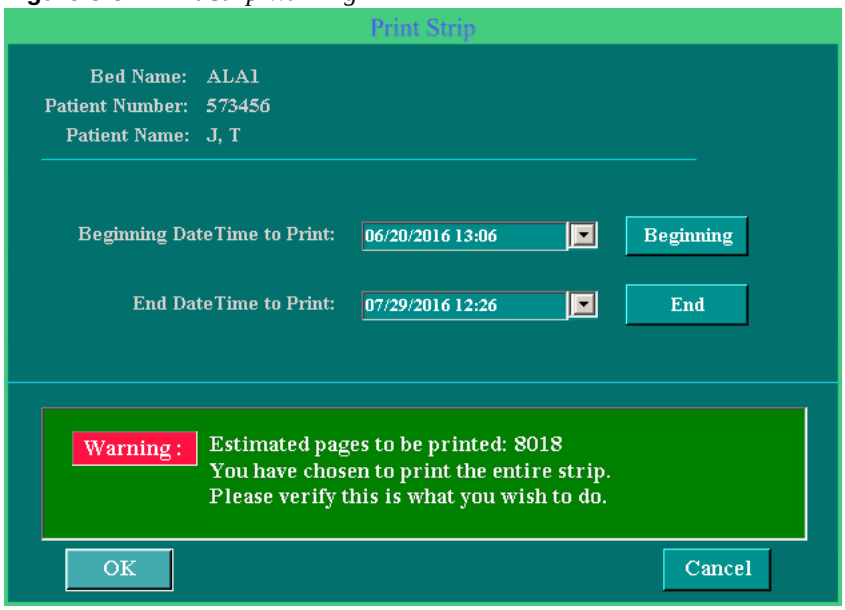
3. *To print just a portion of the strip,*
   a. Mark that portion you wish to print (see "Move/Delete Strip Data" on page 9-5 for instructions on how to mark a strip).
   b. Select **Print.** Two new buttons appear beneath the Trend function buttons, as shown in Figure 8-7 on page 8-5.
   c. Skip to step 7 on page 8-6.

   To print the entire strip, proceed to step 4 on page 8-5.
4. Select **Print**. Two new buttons appear beneath the Trend function buttons, as shown in Figure 8-7 on page 8-5.

Figure 8-7 *Start and Reset Strip Printing Buttons*

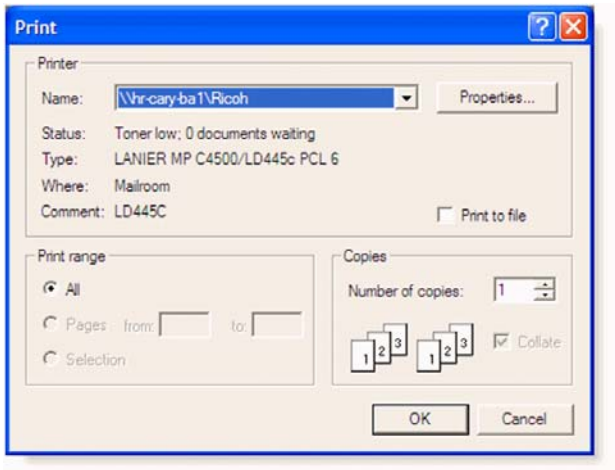
5. Select **Start**. The warning message pop-up shown in Figure 8-8 appears.

Figure 8-8 *Print Strip Warning*



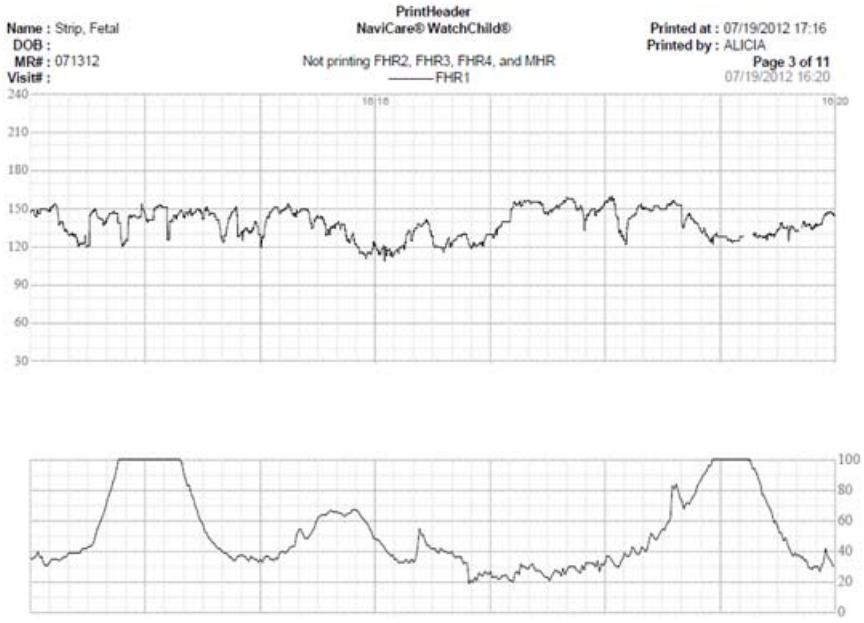
6. If you do not want to print the entire strip, select **Cancel**, then return to step 3 on page 8-5. Otherwise, select **OK**.
7. Select **Start** and proceed to the next step.
8. A standard Windows print dialog box appears, similar to that shown in Figure 8-9.

Figure 8-9 *Windows Print Dialog Box*



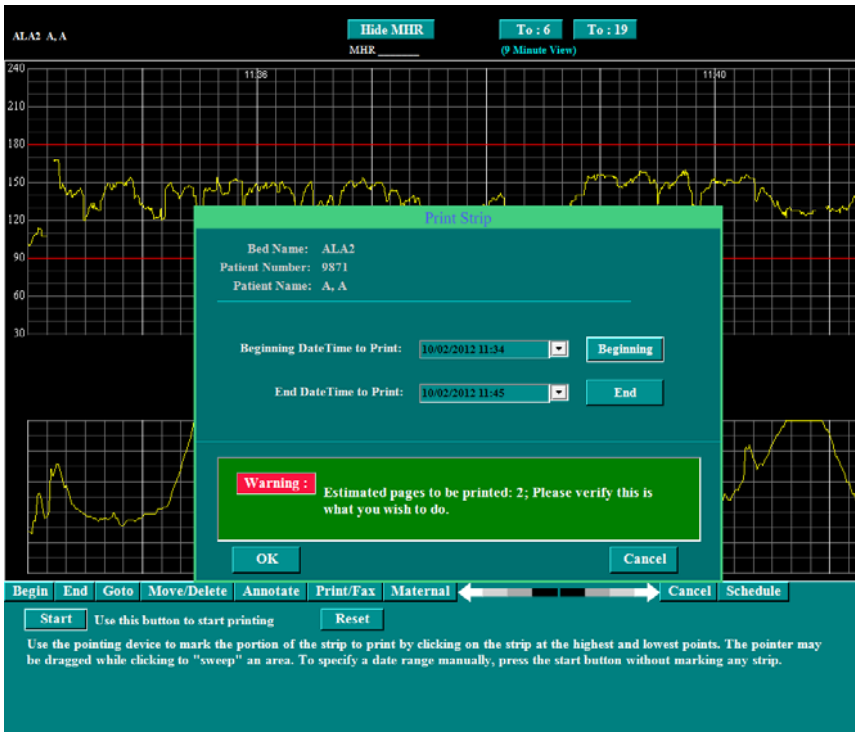
9. Select the destination printer if the default is not what you want.
10. Select **OK** to begin printing. Figure 8-10 on page 8-7 shows an example portion of a strip printout.

Figure 8-10 *Strip Printout Example*



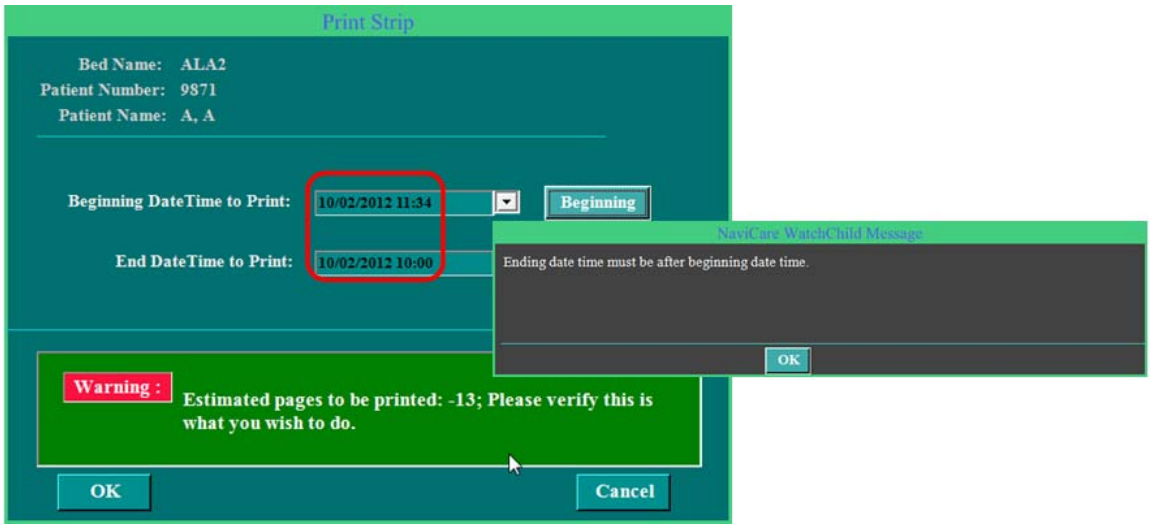
For printing a desired portion of the strip, a date/time range selection is available. 'Beginning Date/Time to print' and 'End Date/Time to print' fields are displayed after choosing the **Start** button; buttons (**Beginning** and **End**) are available to quickly populate beginning and end time fields of the strip as shown in Figure 8-11.

Figure 8-11 *Printing a Strip Portion*



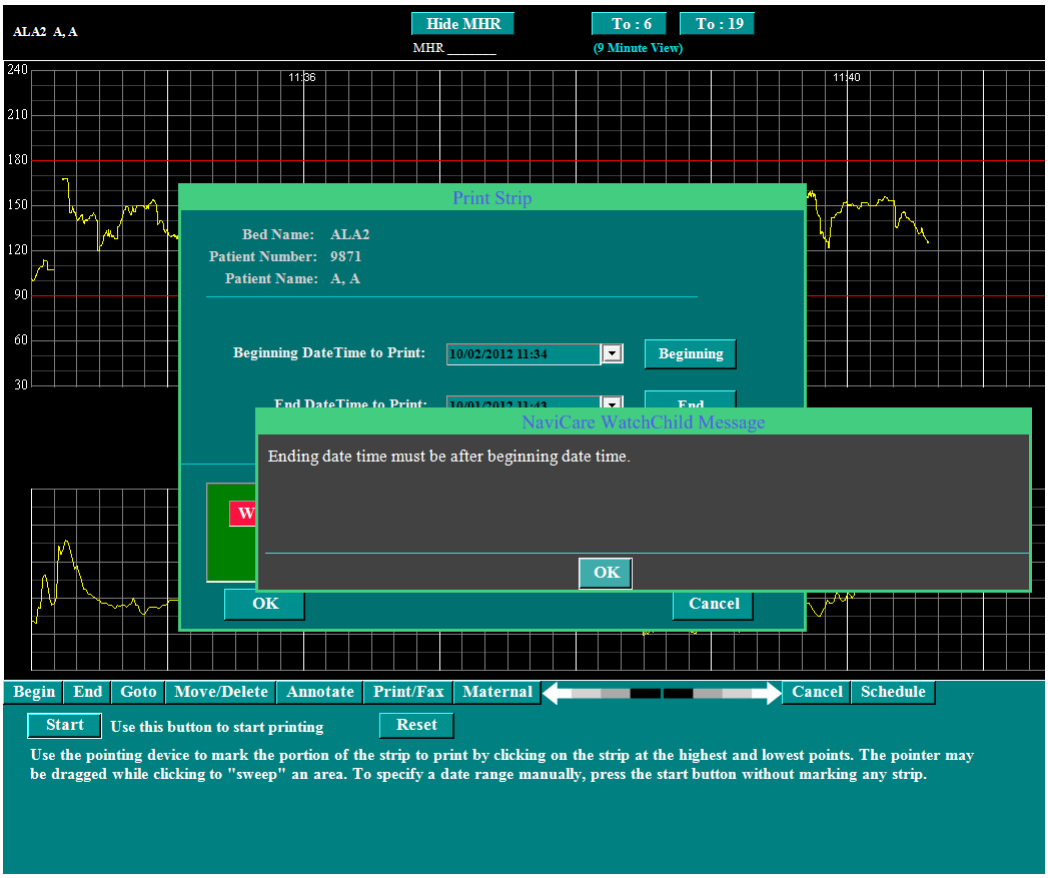
A message for ‘Estimated pages…’ that will be printed is displayed on the screen. You can accept the print by clicking **OK** or not accept the print by clicking **Cancel**.

Figure 8-12 *Estimated Pages Message*



If the ‘End DateTime to Print’ is before the ‘Beginning DateTime to Print’, an error message pop-up box appears.

Figure 8-13 *Error Message*



Chapter 9

Transfer Patients and Merge, Move or Delete Monitoring Strips

This chapter covers the following information for NaviCare® WatchChild®:

Transferring a Patient to Another Bed

A patient can be transferred from one bed to another bed. For example, a patient can be moved from her current bed to the operating room for a cesarean section and then to recovery or to postpartum after delivery. NaviCare® WatchChild® automatically annotates the patient monitoring strip at the time of the transfer. Transferring patients is always performed from the Census screen. NaviCare® WatchChild® also allows the patient and the patient data to be moved to a special holding bed that is created as required. These special beds have the prefix Out. Use these beds to hold patient charting for the following conditions:

- A particular bed is not yet established
- Not all of the patient's charting was completed before the patient was discharged from the hospital
- The patient is temporarily transferred to another location off the unit

An OUT bed can also be used to admit a patient for tests and charting updates when she is not actually being admitted for labor and delivery or if she is being admitted for labor and delivery before a labor bed is available. In all of these cases, the procedure of transferring her from a regular bed to and OUT bed and vice versa is the same.

1. On the Census screen, select the patient to be transferred, then press and hold the keyboard Ctrl key and select the bed into which the patient is being transferred. The transfer-to bed *must* be empty.
2. Select **Transfer** to complete the process of transferring the patient from one bed to another.

Merging Monitor Strips for the Same Patient

Use the Transfer function to merge two monitoring strips that belong to the same patient. For example, a patient is moved from Bed 1 to Bed 2 and is hooked up to the monitor in Bed 2. Before the patient is transferred to Bed 2 in NaviCare® WatchChild®, a monitoring strip will appear in Bed 1.

The patient's previous monitoring strip in Bed 1 can be merged with the current patient monitoring strip in Bed 2.

From the Census screen:

1. Select the patient's current bed.
2. Press and hold the keyboard Ctrl key and select the bed that contains the monitoring data from which the patient was transferred.
3. Select **Transfer**. A message pop-up screen opens asking you to verify the merge.
4. Select **OK** to merge the selected monitoring strips.

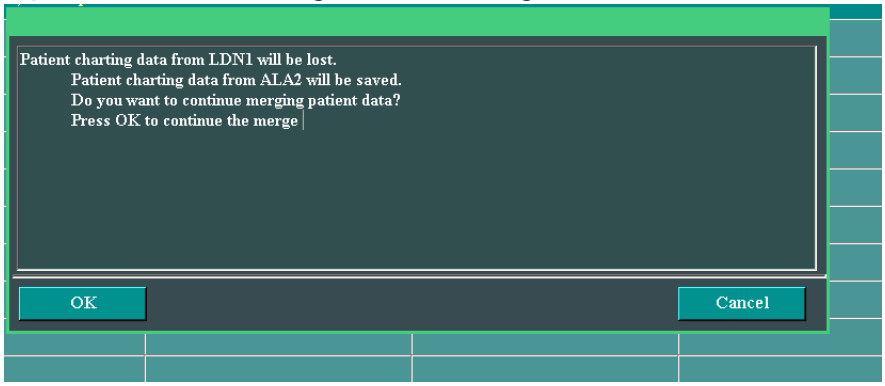
CAUTION: If the message "monitor is/was on but no patient admitted. Transfer to OUT to remove" is displayed on a bed, admitting a new patient to this bed will cause merging of the previous patient's strip with the new patient's strip. Transfer the strip to OUT before performing the patient transfer.

If there is any overlapping strip during the strip merge, the system creates a "Merge Strip Data" screen. There are two instances that could cause this to occur:

- the patient is mistakenly admitted into two rooms
- a patient is in one room and has to move to another room (i.e. room issues or to the OR)

In the rare situation where a patient is mistakenly admitted into two rooms and charting data exists for both rooms, a message alert appears indicating that patient data will be lost from the source bed (bed moving from) and the charting data will be saved on the destination bed (bed moving to).

Figure 9-1 *Patient Charting Data Alert Message*



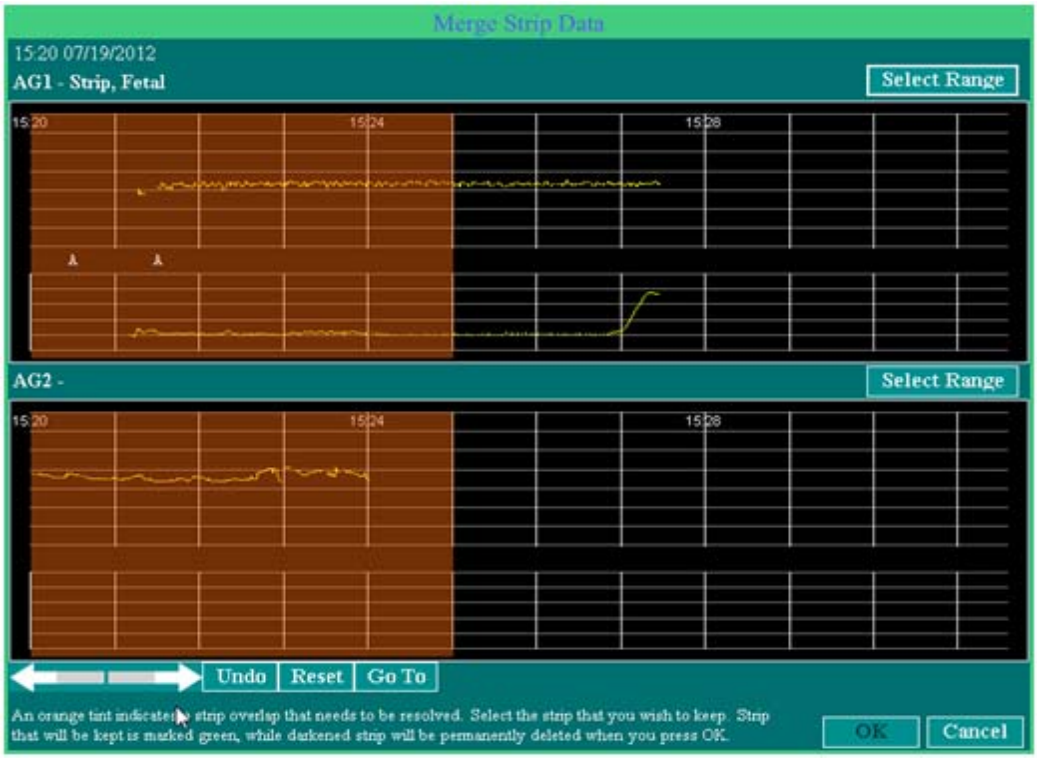
If this should occur, press **OK** to continue. The charting information is not truly lost, but rather placed into the charting history. The saved information will display on the screen.

A more common situation would be where a patient physically moves from one room to another room but was not transferred on the census board. The merge strip alert occurs when attempting to move the patient name to the new room resulting in two monitor strips for the same patient. In essence, the two strips will need to get "sewn" together.

To resolve this issue, perform the following steps:

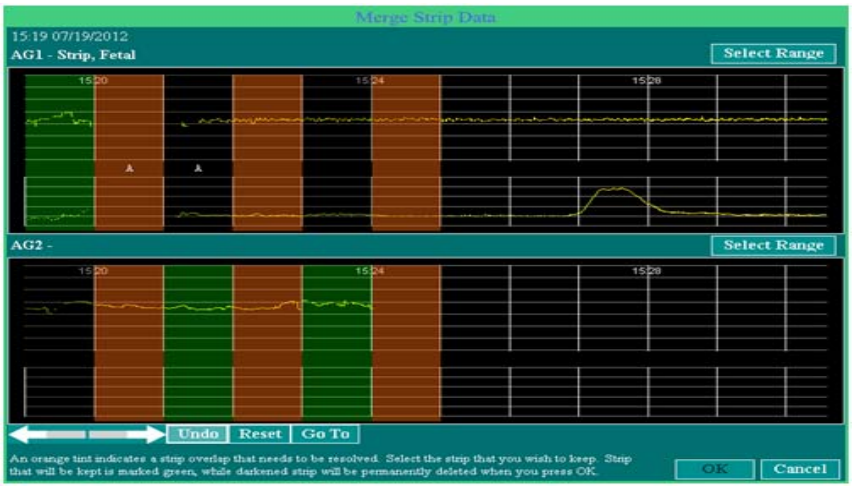
1. Any overlap detected by the system appears highlighted in orange and the following alert message appears at the bottom of the screen: "*An orange tint indicates a strip overlap that needs to be resolved. Select the strip that you wish to keep. Strip that will be kept is marked green, while darkened strip will be permanently deleted when you press OK*."

Figure 9-2 *Strip Overlap Alert Message*



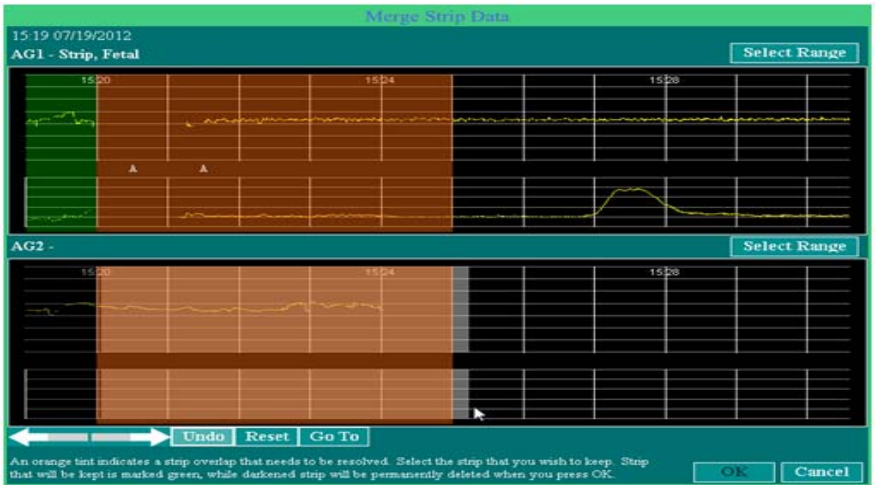
2. Until the conflict has been resolved, the **OK** button remains disabled.
3. Select the segments to keep and those to destroy. Portions of both strips can be selected, either by:
    - clicking the mouse on one-minute intervals and changing the orange tint to green (see Figure 9-3 on page 9-4)

Figure 9-3 *Selecting One Minute Segments*



- dragging the mouse across a selected range (see Figure 9-4)

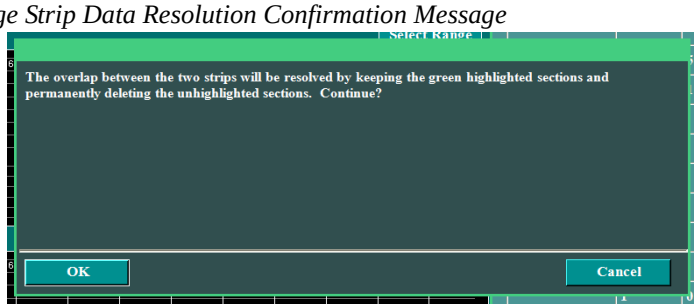
Figure 9-4 *Click and Drag the Mouse*



4. Once selected, segments change color from an orange tint to green and the 'OK' button becomes enabled. Press **OK**.

5. A confirmation pop up message appears stating that this step saves all selected (green highlighted) sections and permanently deletes all non-selected sections. Press **OK** to continue or **Cancel** to revise the selections.

Figure 9-5 *Merge Strip Data Resolution Confirmation Message*



Move/Delete Strip Data

You can move or delete selected strip data using the **Trend** button on the Single-Patient Surveillance screen.

NOTE: Moving or deleting strip data requires that the Role to which your user ID is associated is explicitly authorized to perform the function.

CAUTION: Moving or deleting strip data can result in valid patient data being overwritten or deleted. Do not perform the procedure below unless you are absolutely certain that moved data will not overwrite valid data and that data being deleted is truly erroneous or invalid.

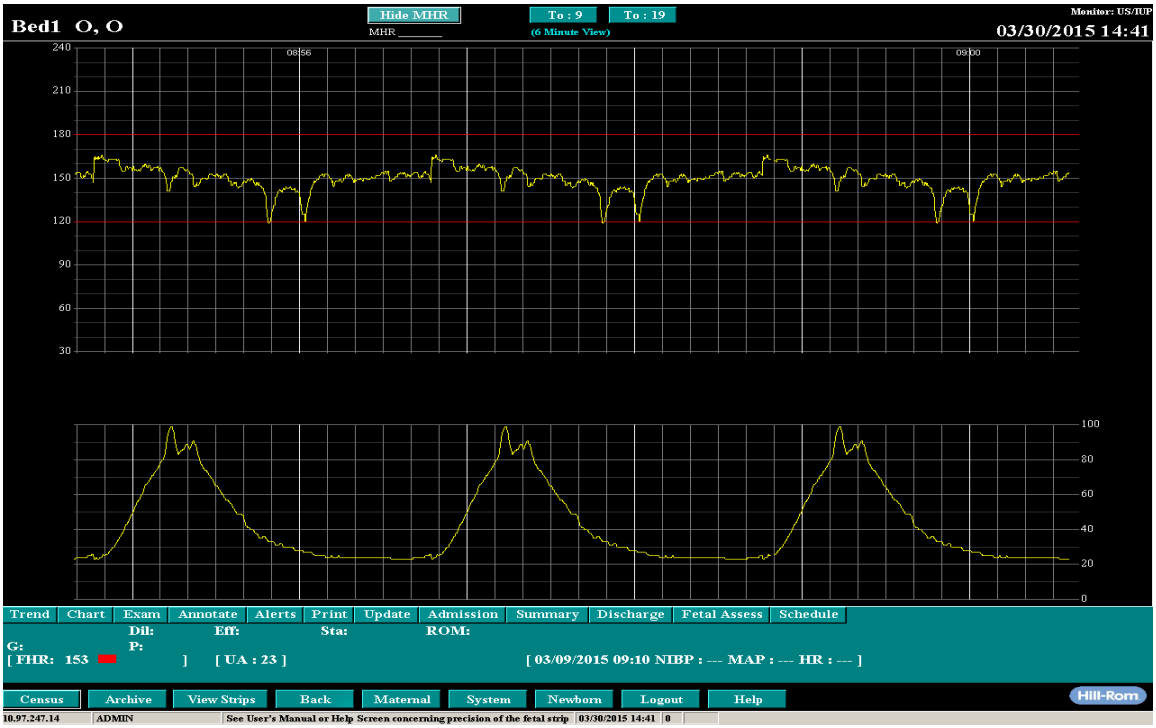
NOTE: Charts affected by the Move/Delete function are automatically annotated to document the move/delete that was done.

NOTE: Move/Delete strip functions cannot be done in a 6-minute or 7-minute view. The functions can be performed in either the 9, 14, or 19 minute views

Moving or Deleting Strip Data

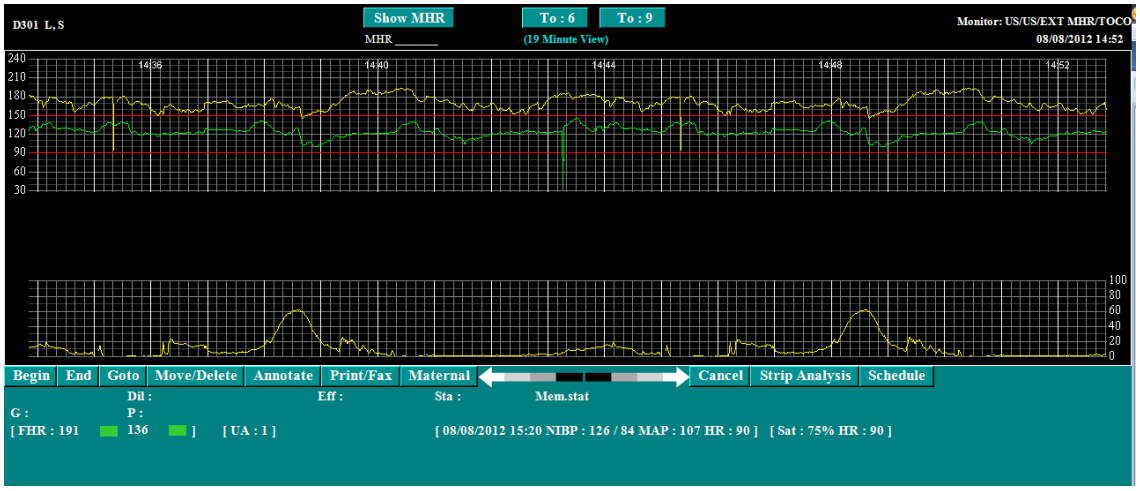
1. In the Multi-Patient Surveillance screen, select the screen for the desired patient. The Single-Patient Surveillance screen appears, as shown in Figure 9-6.

Figure 9-6 *Single-Patient Surveillance Screen*



2. Set the time span view to 9, 14 or 19 minutes, depending on the choices on your screen.
3. Select the **Trend** button. The buttons set at the bottom of the strip changes, as shown in Figure 9-7, which shows a 19-minute view.

Figure 9-7 *Single-Patient Surveillance Screen with Trend Buttons (19-minute view)*



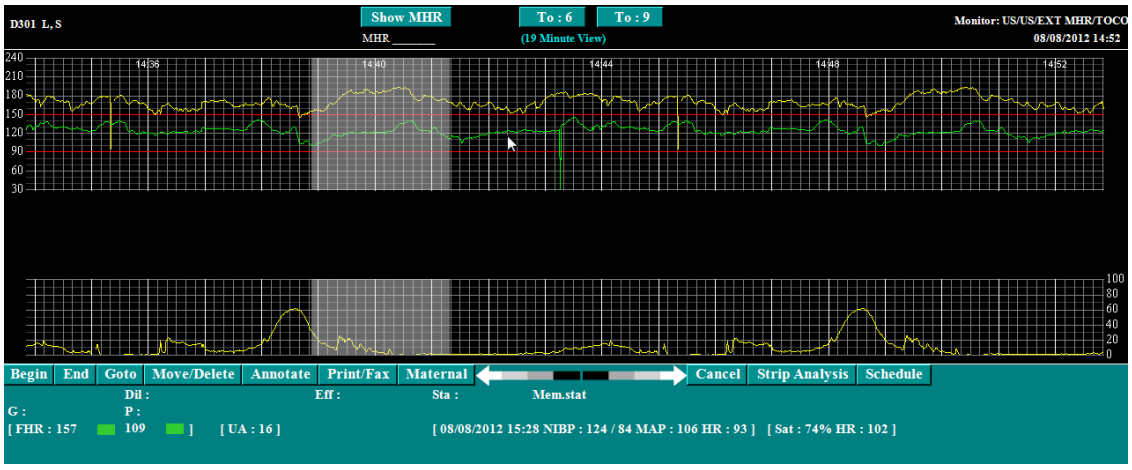
4. Select the strip at the highest and lowest points you desire to Move/Delete. This can be done by dragging and “sweeping” an area.

   The alternative way to select the entire monitoring strip is by selecting the **Begin** and **End** buttons.

   - **Begin** to move to the beginning of the monitoring strip.
   - **End** to move to the end of the monitoring strip.

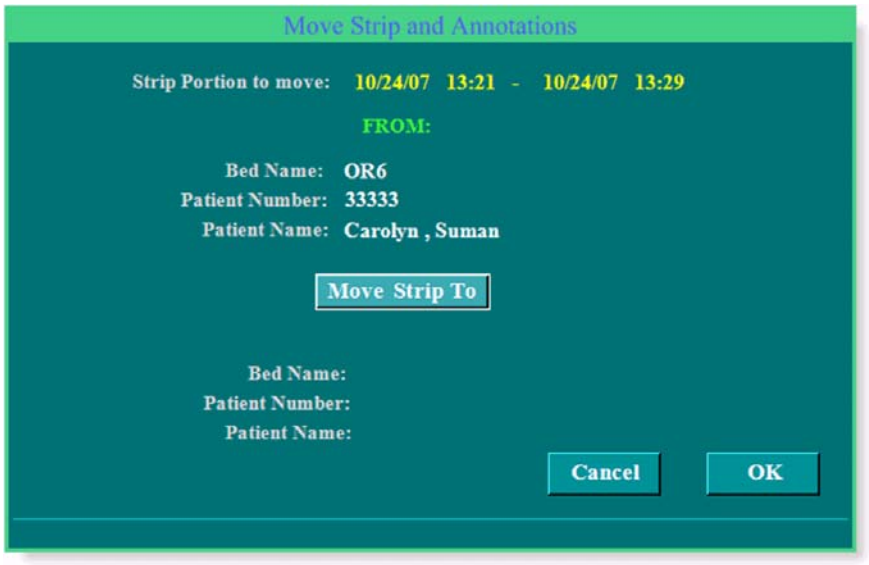
5. Select **Move/Delete**. The Move/Delete screen appears as shown in Figure 9-8.

Figure 9-8 *Single-Patient Surveillance Screen with Move Delete*



6. Select the **Move** button at the left of the screen. The Move Strip and Annotations screen appears as shown in Figure 9-9 on page 9-7. To delete strip data, select Delete; otherwise skip to step 10 on page 9-9.

Figure 9-9 *Move Strip And Annotations Screen*



7. Select **Move Strip To**. The Bed Selection screen appears, as shown in Figure 9-10.

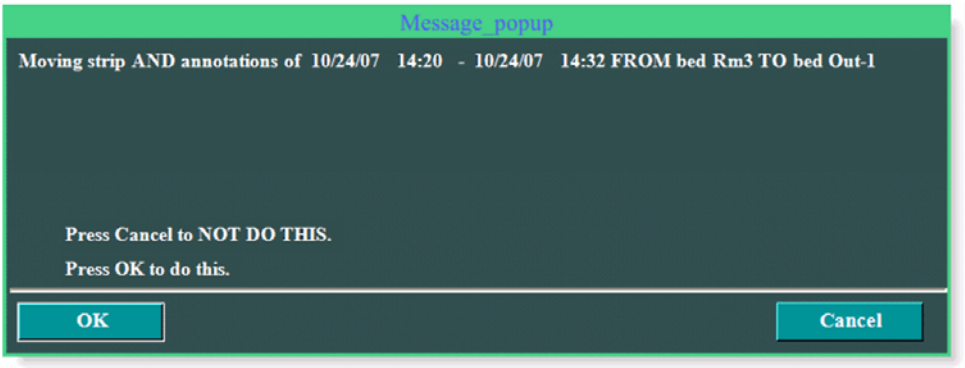
Figure 9-10 *Bed Selection Screen*

8. Select the bed to which you want to move the strip. The Bed Number, Patient Number and Patient Name fields in the Move Strip and Annotations screen become populated, as shown in Figure 9-11 on page 9-8.

Figure 9-11 *Move Strip And Annotations Screen with Patient Bed Details*

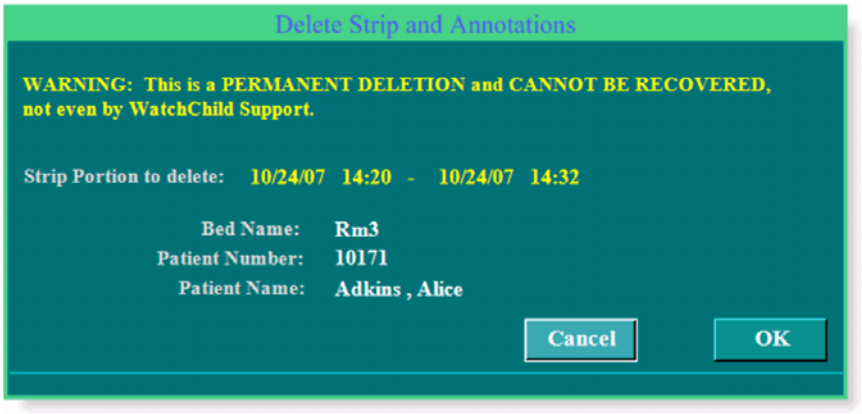
9. Select **OK** to move the strip. A message pop-up screen appears, informing you of what is about to happen and giving you the opportunity to cancel the move, as shown in Figure 9-12.

Figure 9-12 *Message Pop-up Screen for Moving Strip Annotations*



Skip to step 10 on page 9-9.

Figure 9-13 *Deletion Warning Message*



10. Select **OK** to complete the process and exit the screen.
11. Select the **Delete** button. A deletion warning message opens, as shown in Figure 9-13 on page 9-8, informing you of what is about to happen and giving you the opportunity to cancel the move.

Chapter 10

Annotating the Patient Monitoring Strip

This chapter covers the following information for NaviCare® WatchChild®:

NaviCare® WatchChild® enables nurses and physicians to enter annotations directly onto the patient monitoring strip. It also automatically registers the user ID of the person entering the annotation. A late entry will appear at the specified time on the strip with the actual entry time listed. The specification of what constitutes a *late* entry time is defined by the hospital through the parameter configurations (Options are for 0-3 hours).

NOTE: Because of the space constraints on the patient monitoring strip, annotations on the strip must be concise. If you annotate with large amounts of text, the space required for the annotation will cause it to display further away from the time of the event you are annotating.

Annotating a Patient Monitoring Strip

To open the Annotate Strip screen:

1. On the Multi-Patient Surveillance screen, select a bed to be monitored; on the Census screen, choose a bed and select **View Strips**. The Single-Patient Surveillance screen for the selected patient appears.
2. Select **Annotate**. The Annotate Strip screen appears with the time to the nearest minute. Right-clicking directly on the Single-Patient Surveillance screen will also bring up the Annotate Strip screen with the time entry exactly where you placed your cursor.

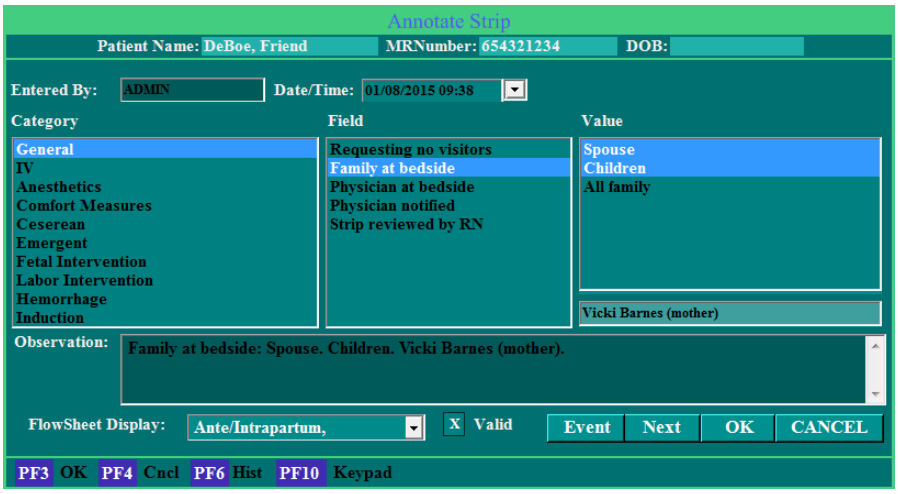
The appearance and functionality of the Annotate Strip screen depends on whether the option **Use Integrated Annotations** is enabled or disabled. The variations in the screen's appearance are illustrated in Figure 10-1 on page 10-2 and Figure 10-2 on page 10-3.

For information on enabling Integrated Annotations, see the *NaviCare® WatchChild® System Administrator Manual* (LAB00196).

A separate procedure is provided for entering annotations on each version of the screen.

Integrated Annotations Enabled

Figure 10-1 *Annotate Strip Screen with Integrated Annotations Enabled*



1. Enter annotations by selecting the category and sub-category you want to chart from in the left and middle boxes, and then selecting a value in the box on the right. (Some sub-categories may allow multiple values to be selected.)

NOTE: The **Date/Time** field is not updated until you click **Next**.

If free text annotation is enabled for the selected sub-category, you can type an annotation in the text box below the list of values.

The **Observation** box displays the annotation as it will appear on the monitoring strip.

2. Click **OK** to populate the annotation to the flowsheet and to set the annotation on the monitoring strip.
3. Click **Next** to enter another annotation to the monitoring strip.

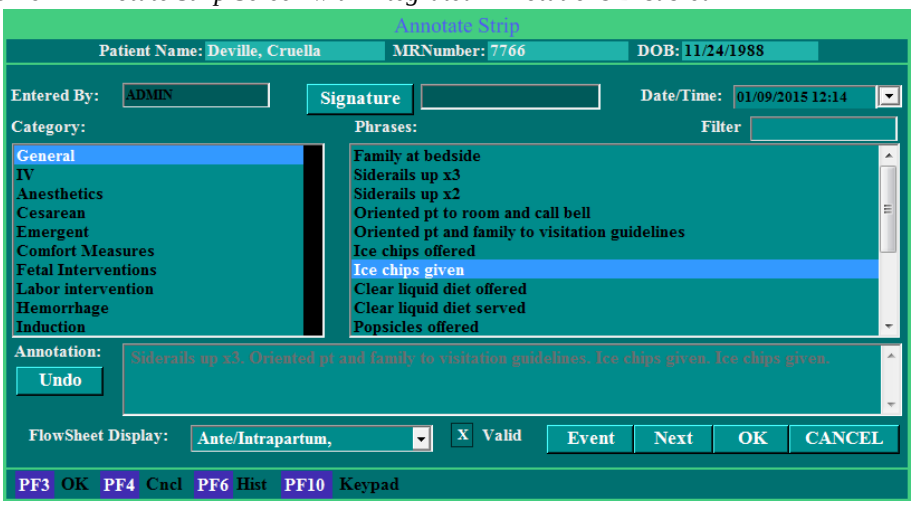
   The **Date/Time** field is updated to display the current date and time.
4. You can edit an annotation by using the EDIT function on the appropriate flowsheet or by clicking directly on the annotation on the Fetal Strip – this will bring the annotation screen up and will allow you to make corrections.

NOTE: The **Signature** box is not present on the Annotate Strip screen when Integrated Annotations are enabled. The integrated EMR might not support the flowsheet locking functionality provided by the Signature feature.

NOTE: If not all the expected annotation entries are displayed, check with your system administrator. The option **Multiple Allowed Per Minute** might be enabled, while your integrated EMR system might limit annotation entries to one per minute.

Integrated Annotations Disabled

Figure 10-2 *Annotate Strip Screen with Integrated Annotations Disabled*



1. Enter annotations by choosing the category you wish to chart from and then selecting one or more of the phrases in the list box, typing directly in the **Annotations** text box, or both.

   NOTE: To delete text, highlight the undesired word or phrase and press delete. If free text annotation is disabled click the **UNDO** button and the last entry will be deleted.

   After you select **OK**, the annotation will populate to the monitoring strip and create an annotation flowsheet record.

2. Optionally, sign the annotation by entering your signature in the **Signature** text box. A signed annotation cannot be edited or removed by another user.
3. Select **OK** to populate the annotation to the flowsheet and to set the annotation on the monitoring strip.
4. Select **Next** to enter another annotation to the monitoring strip.
5. Editing of annotations may be accomplished by using the EDIT function on the appropriate flowsheet or by clicking directly on the annotation on the Fetal Strip – this will bring the annotation screen up and will allow you to make corrections.

Making Late Annotations on the Patient Monitoring Strip

You can make annotations on a patient monitoring strip for an event (task, exam, values, etc.) that occurred at an earlier point in time. When making a late annotation, the user must change the date and time to the time desired for the annotation. The strip does not have to be displayed to make the annotation. The annotation is documented with the current date and time but the entry will show for the specific time the event occurred. If the strip still shows the time you want your annotation to display, you may right click directly on the strip and that time will appear on your annotation screen.

Correcting or Invalidating a Previous Annotation

After an annotation is added, it cannot be changed or invalidated if it is signed by another user. Only the owner of the signed annotation can change or invalidate that annotation. In case of any erroneous entries or an entry that is no longer valid, clear the **Valid** check box. This will also show the annotation has a line drawn through the documentation on the flowsheet and it will be removed from the fetal strip.

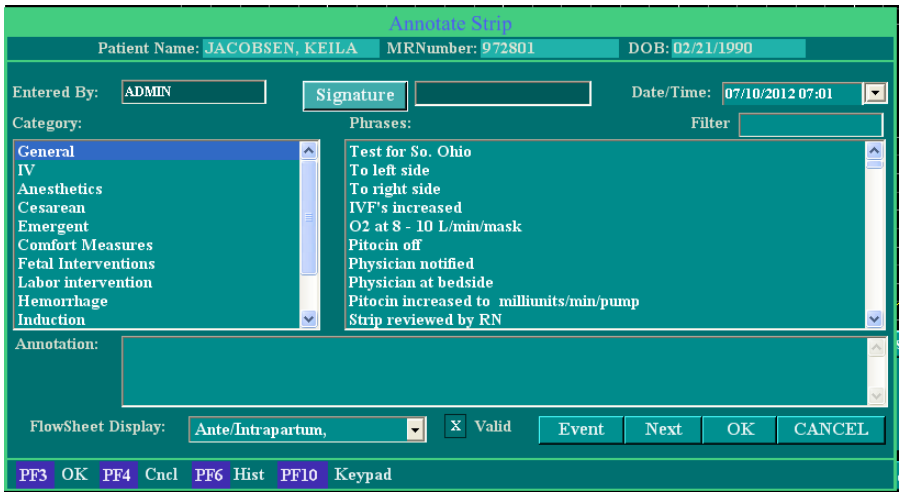
Marking an Event on the Patient Monitoring Strip

NaviCare® WatchChild® has another annotation feature, called Event. Use the Event function to mark a point on the strip where a complete annotation will be made later when time permits.

An event is marked with an arrow, the user ID of the person who entered the event, and the word Event. The Event appears on the patient monitoring strip at the time entered and indicates that a complete annotation will be made later as in Figure 10-4.

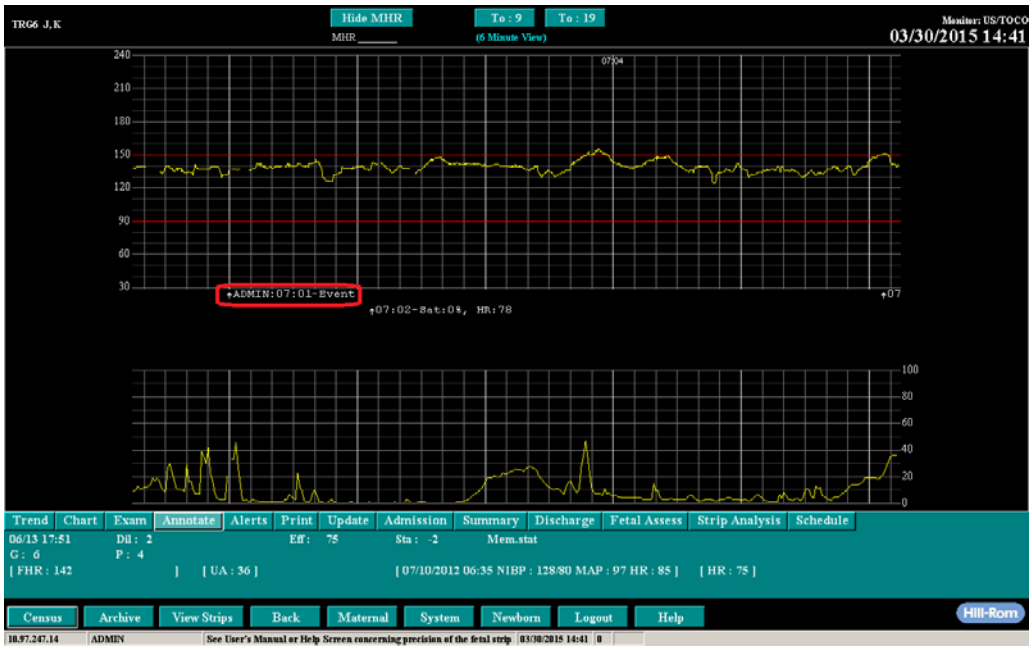
1. In the Multi-Patient Surveillance or Census screens, open a Single-Patient Surveillance screen for the selected patient.
2. Select **Annotate**. The Annotate Strip screen appears, as shown in Figure 10-3.

Figure 10-3 *Annotate Strip Screen with Event*



3. Select **Event** on the Annotate Strip screen. The Annotate Strip screen closes and the message `Event` and the *`user_ID`* are marked on the patient monitoring strip as shown in Figure 10-4.

Figure 10-4 *Example Event Annotation*



To go back and enter the annotation for the marked event, follow the steps in "Making Late Annotations on the Patient Monitoring Strip" on page 10-3.

Chapter 11

Using Alerts

This chapter covers the following topics:

NaviCare® WatchChild® can provide both audible and visual alerts for certain fetal and maternal conditions. The hospital may specify alert parameters that define the conditions that will trigger an alert or utilize the Hill-Rom default parameters.

The following section describes each type of alert.

WARNING: Alerts are not substitutes for the maternal physiological monitors or maternal fetal monitors connected to the patients. Failure to follow the established hospital protocol may result in serious injury or death for the patient or fetus.

WARNING: NaviCare® WatchChild® alerts are intended to alert the health care professionals of conditions beyond certain parameters. The alerts are not intended as diagnostic tools and are not substitutes for proper patient evaluation.

Alerts Overview

Fetal Alerts

The fetal heart rate (FHR) alerts use a "sliding time window" concept to trigger when the overall trend of the FHR is out of limits. The combination of the following settings for each FHR type determines when an alert is triggered for a patient:

- Alert Window Period (the time period for measuring the alert condition (i.e., number of seconds for use, alert limit and FHR detection algorithms)
- Alert FHR % (percentage of time during the Alert Window Period in which the out of limit alert condition must occur to trigger an alert)
- Re-Alert Delay (amount of time after an alert is acknowledged before the same alert can occur again for the same patient)
- FHR Low Alert Limit (defaults to 90 bpm but may be different at your facility)
- FHR High Alert Limit (defaults to 180 bpm but may be different at your facility)

- Also, if there is a period of blank data less than or equal to 5 seconds during the sliding window period, the blank data is considered as out of limits.

Multiple Fetus Alerts

When monitoring multiple fetuses, up to four, all of the fetal heart rates are visible on one fetal strip and each tracing is displayed in a different color. The fetal heart rate for each baby is evaluated against the defined fetal heart rate limits. When one fetal heart rate is found to be outside the limits, an alert is triggered. Navicare WatchChild continues to monitor alert conditions for all babies even if one is alerting. When the No Data alert feature is active and there is no data being collected on one fetus, an alert is triggered for that baby.

CAUTION: ALWAYS check all fetal heart rates when caring for multiple fetuses.

No Data alerts

By default, the No Data alert feature is NOT activated. If activated, NaviCare® WatchChild® will alert if the FHR is not detected when the fetal monitor is on. If the cords attaching the monitor to the patient are not connected to the fetal monitor, it will not alert for lack of data. The FHR No Data alert is triggered based on the combined settings for Alert Window Period, Alert FHR %, and Re-Alert Delay. The alert is disabled if the fetal monitor is turned off.

Re-Alert Delay

After an alert is triggered and acknowledged, NaviCare® WatchChild® will wait a hospital-specified amount of time before alerting again. The value can be left at the system default or a hospital-specified default, or can be configured. to a value in the range available for each alert.

NOTE: For specific information on default values and alert types, refer to the *NaviCare® WatchChild® System Administrator Manual, (LAB00196).*

Maternal Alerts

The default for NIBP, Saturation, and HR Alerts is OFF. If your facility sets maternal alerts to be active, by default the alert will be activated immediately upon an out-of-limits value. Subsequent alerts will only be triggered after the Maternal Re-Alert Delay time period has passed and a value is out-of-limits. This alert can be activated for individual patients by the hospital, when desired, if you choose not to have the alerts active by default.

CAUTION: Maternal NIBP or SpO2 alerts will not be enabled unless a patient is admitted to NaviCare® WatchChild®.

NOTE: Refer to your maternal monitor manufacturer's manual for information regarding time delay for transfer of data to NaviCare® WatchChild® i.e., SpO2 reading.

Acknowledge, Close (hold), and Close All Alerts

NaviCare® WatchChild® provides audible, visual, and pop-up alerts during specific fetal and maternal conditions. The type of alerts used is defined by the hospital and configured for each workstation or workstation group by your NaviCare® WatchChild® System Administrator.

NOTE: You will be prompted to log in to acknowledge an alert if you are not already logged in. (enter your **User ID** and **Password** and click **Ok** as prompted, passwords are case sensitive). If you do not have the proper level of privilege assigned, contact your system administrator.

NOTE: If you acknowledge an alert, the alert is acknowledged on all configured workstations. Closing an alert only puts it on "hold" on your workstation. Putting an alert on hold silences the alert and closes the alert popup window for the amount of time specified by the facility (Alert Hold Period).

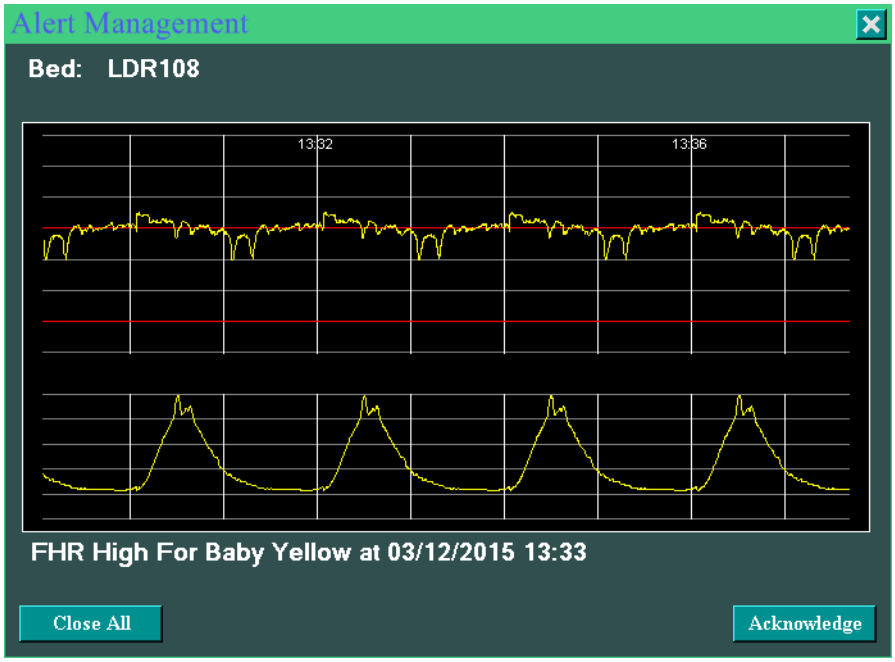
Visual Alerts

Visual alerts flash a red box around the alerting patient's bed row on the Census screen or Maternal Census screen and around the patient's strip window on a surveillance screen. Workstations in patient rooms are usually configured to receive only visual alerts.

Pop-up alert window

By default, an Alert Management window (shown in Figure 11-1 on page 11-4) displays when an alert on a patient occurs, even if that patient is not currently being viewed at that workstation, regardless of the patient information you are viewing at the time.The System Administrator can set a parameter that specifies pop-up alerts for all workstations, meaning that the pop-up alert will appear on the workstation whether the strip is currently being viewed or not. The monitor strip that is alerting will pop-up in a window on top of whichever screen is being viewed on the workstation and will give a brief description of the alert. Only one pop-up alert at a time is visible on a workstation.

Figure 11-1 *Pop-Up Alert Example*



You can close the alert temporarily or acknowledge the alert:

To temporarily close the alert:
Close the **X** in the upper right corner of the window to "close" the alert (put it on hold). When an alert is on hold, it is only for that workstation; the Alert Management popup window continues to display on other workstations. Also, even if an alert is on hold, the flashing red border around the strip remains. In essence closing the alert says "OK, I know you're there and I'll address the problem shortly if no one else gets to it first."

To temporarily close all alerts:
Click **Close All** to temporarily "hold" all currently active alerts on the workstation.

To Acknowledge the alert:
Click **Acknowledge** to turn the alert off. This removes the pop-up alert from every workstation and the flashing red border from around the strip and ends the audible alert sounds. In essence, Acknowledge says "I'm now addressing the cause of the alert." Only users qualified to address the alert should acknowledge the alert. If you are not logged in, you will be prompted to do so before acknowledging.

Audible Alerts

Workstations can be configured to alert audibly whenever an alert event occurs, but always in combination with visual and/or pop-up alerts. Acknowledging and resetting audible alerts is done the same way as for visual and pop-up alerts. Workstations at the Nurse's station or desk are usually configured to receive Audible alerts.

Manually view alerts

You can view a single active alert for a patient on single surveillance by left-clicking inside the red border around the strip area.

You can manually view all alerts by clicking the number of alerts located in the small gray status bar located at the bottom of the screen below the System Function buttons (shown as a **0** in Figure 1-1, this is the number to the right of the system date and time). Click this number to manually open the Alert Management popup window to show an active alert. This also "unholds" any alerts that have been on hold on your workstation. Note that "unholding" an alert causes the audible alert sound to restart, if your workstation is set to use audible alert sounds.

Each time you close an alert (by clicking the X in the upper right corner of the window) or acknowledge an alert, the next active alert appears in the Alert Management popup window. If there are no more active alerts, the window closes.

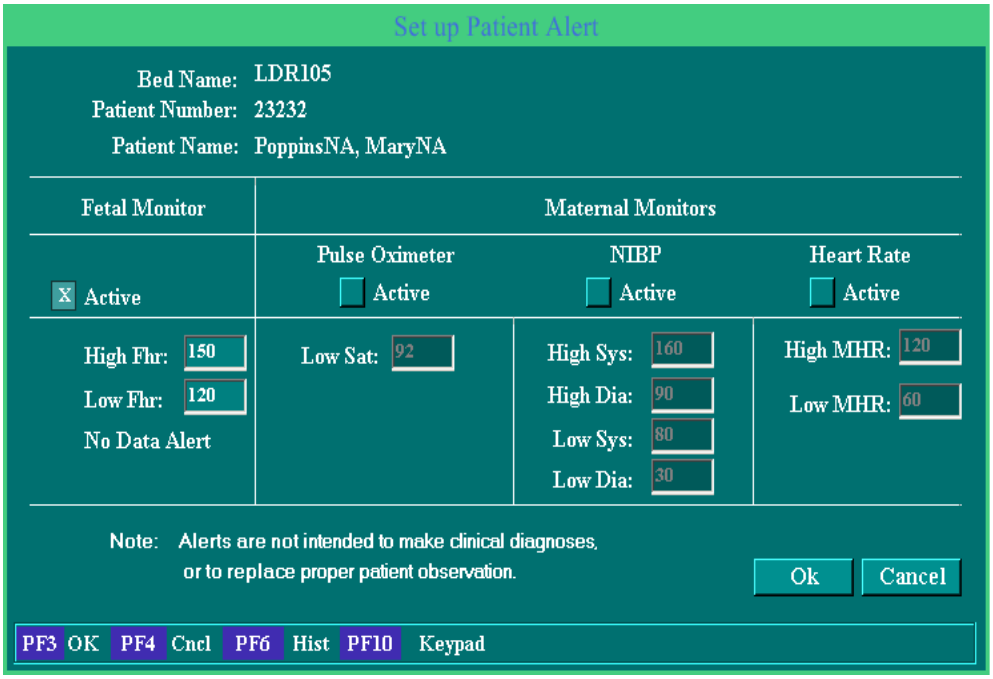
If your workstation is not configured to view popups, clicking the number of alerts in the status bar does not work. To manage alerts, use a workstation where alert popups are configured by the hospital. You can also acknowledge alerts for a bed by left-clicking on the strip area in the single surveillance view for the bed.

Specifying Patient-Specific Alert Parameters

To specify the parameters on an individual patient's alerts:

1. Display the Single-Patient Surveillance screen from the Multi-Patient Surveillance or Census screens.
2. Select **Alerts**. The Set Up Patient Alert screen appears, as shown in Figure 11-2 on page 11-6. The screen example shows the default NaviCare® WatchChild® settings.

Figure 11-2 *Set Up Patient Alert Screen*



3. Select the monitors to activate. Click to select Fetal, and Maternal Pulse Oximeter, NIBP (non-invasive blood pressure), and Heart Rate. Modify parameter values as appropriate for your patient.

4. Select **OK** to save your changes and close the screen.

CAUTION: ***ALWAYS*** check the workstation alert parameters after an interruption in service of NaviCare® WatchChild® and after admitting a patient to ensure that the parameters are appropriate for that patient. Patient-specific alert parameters remain in effect for that patient until she is transferred or discharged. When a patient is newly admitted, the default parameters are in effect.

Chapter 12

Flowsheets Overview

The Flowsheet function in NaviCare® WatchChild®, enables you to view the charting details gathered on many of the clinical and assessment screens in a table format on a single screen. In addition, you can edit the data displayed and you can access various charting screens directly from the flowsheet screen.

Flowsheet Types and Navigation

There are six different flowsheets in NaviCare® WatchChild®:

- **Basic** (only for the Basic Charting version of NaviCare® WatchChild®). This is a minimal version of the Intrapartum Flowsheet (see below)

For NaviCare® WatchChild®with Comprehensive Charting:

- **Prenatal**, see Chapter 13, “Prenatal Record — Comprehensive Charting” on page 13-1
- **Ante/Intrapartum** and **Observation/Triage**, see Chapter 15, “Using the Ante/Intrapartum and Outpatient/Triage Flowsheets” on page 15-1
- **Recovery/Postpartum**, see Chapter 17, “Recovery & Postpartum Records” on page 17-1
- **Newborn**, see Chapter 18, “Newborn Flowsheet” on page 18-1

Access to each flowsheet is as follows:

1. ***From the Census or Multi-Patient Surveillance*** screen, select the patient and then select **Chart**.

   From a Single-Patient Surveillance screen, select **Chart**.

   The Chart screen appears.

2. On the Chart screen, do one of the following, depending on which flowsheet you wish to display:

   - Basic Charting Intrapartum Flowsheet, select **Flowsheet**; this is the only available flowsheet in the Basic Charting version of NaviCare® WatchChild®
   - Prenatal Flowsheet, select **Prenatal** to display the Prenatal Record screen, and then select **Prenatal Flowsheet**
   - Intrapartum Flowsheet, select **Ante/Intra Flowsheet**
   - Outpatient/Triage Flowsheet, select **Observation** to display the Outpatient/Observation Record screen, and then select **Flowsheet**
   - Recovery/Postpartum Flowsheet, select **Rec/PP**
   - Newborn Flowsheet, select **Newborn**

   The selected flowsheet appears.

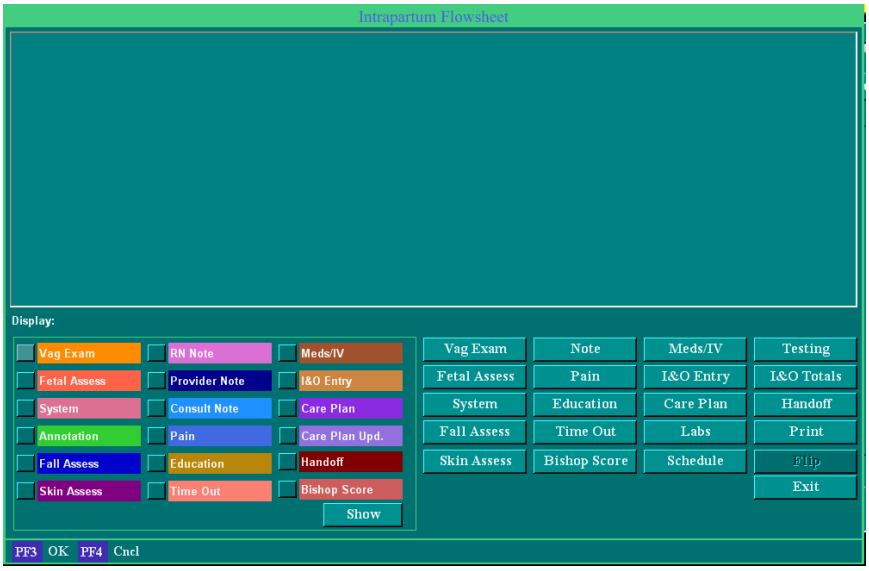
All of the flowsheets are used in the same manner:

- Each has multiple buttons that take you to screens that are associated with the type of flowsheet you are viewing
- The screens accessed using flowsheet buttons create flowsheet records that are added to the flowsheet table when you save your entered data and close the accessed screen
- Flowsheet tables initially display in a horizontal layout
- Table views can be flipped to display data in a vertical layout
- You can display as many or as few data types as you prefer
- You can print all displayed data

Displaying Flowsheet Data

Each flowsheet initially displays with a blank data table area (top half of the screen), as shown by the Intrapartum Flowsheet example in Figure 12-1.

Figure 12-1 *Intrapartum Flowsheet Screen*

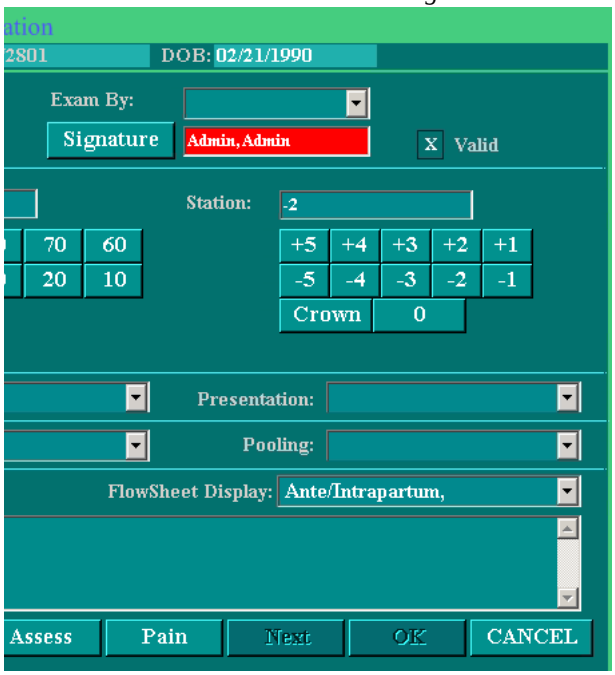


The data types selection area (lower-left quadrant of the screen) enables you to select the types of data you wish to display. What will be shown is all of the entries made thus far for the selected data type, for example, the results of each Vaginal Exam or Fetal Assessment. To see the data, select the check box next to each of the data types you wish to display, then select **Show**. Figure 12-2 on page 12-3 shows an Intrapartum Flowsheet screen with Vag Exam, Fetal Assess and Pain entries displayed.

Figure 12-2 *Intrapartum Flowsheet Screen with Data Displayed*

Notice the **Edit** buttons on the far left of the screen, one for each row, and the vertical and horizontal scroll bars on the right and bottom of the data table, respectively. Selecting an **Edit** button enables you to see the full entry screen on which the entry was made. For example, selecting **Edit** for a Vag Exam entry takes you to the Vaginal Examination screen for that specific entry. Once a record is signed, only the user who signed the record can edit the record; however, any user can view the record. If a user is viewing a record signed by another user, the signature field will be red and the 'ok' button is disabled, as shown in Figure 12-3, indicating the user can only view the record.

Figure 12-3 *Intrapartum Flowsheet Screen with Locked Signature*



As with a Census screen, you can change the width of any column to suit your needs. To do that: Use your computer mouse to hover the pointer over the boundary line between two column headings until the pointer becomes a double arrow, as shown at right, then select-drag left or right to change a column's width.

Flipping the Table View

You can change the orientation of the table data from horizontal to vertical and vice versa if you prefer to view the data differently than currently displayed. To do that, select the **Flip** button. Figure 12-4 shows the default and flipped views of the same screen.

Figure 12-4 *Flowsheet Normal and Flipped Views*

Notice that in the flipped view, the **Edit** buttons are now at the top of each column and what were column headers on the default (horizontal) view are now row labels on the left. The Edit buttons operate the same way regardless of the table orientation.

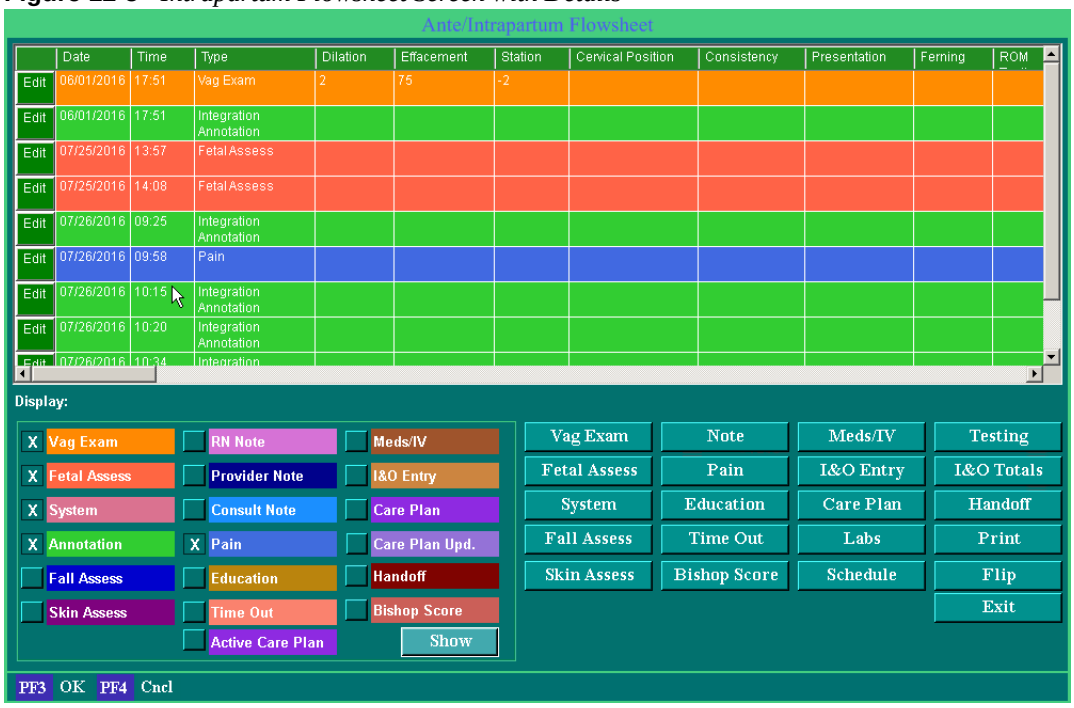
Printing Flowsheet Data

The procedure for printing flowsheets is the same for all of the flowsheets. This procedure uses the Intrapartum flowsheet as an example.

To print flowsheet data:

1. Check the boxes to display the details you want to view and print.
2. Select **Show**. The selected details appear, as shown in Figure 12-5 on page 12-5.

Figure 12-5 *Intrapartum Flowsheet Screen with Details*



3. Select **Print**. A standard Windows Print dialog box opens, enabling you to select a printer if the default is not where you want to print.
4. Select **OK** to print the flowsheet data.

Marking an Entry as Invalid

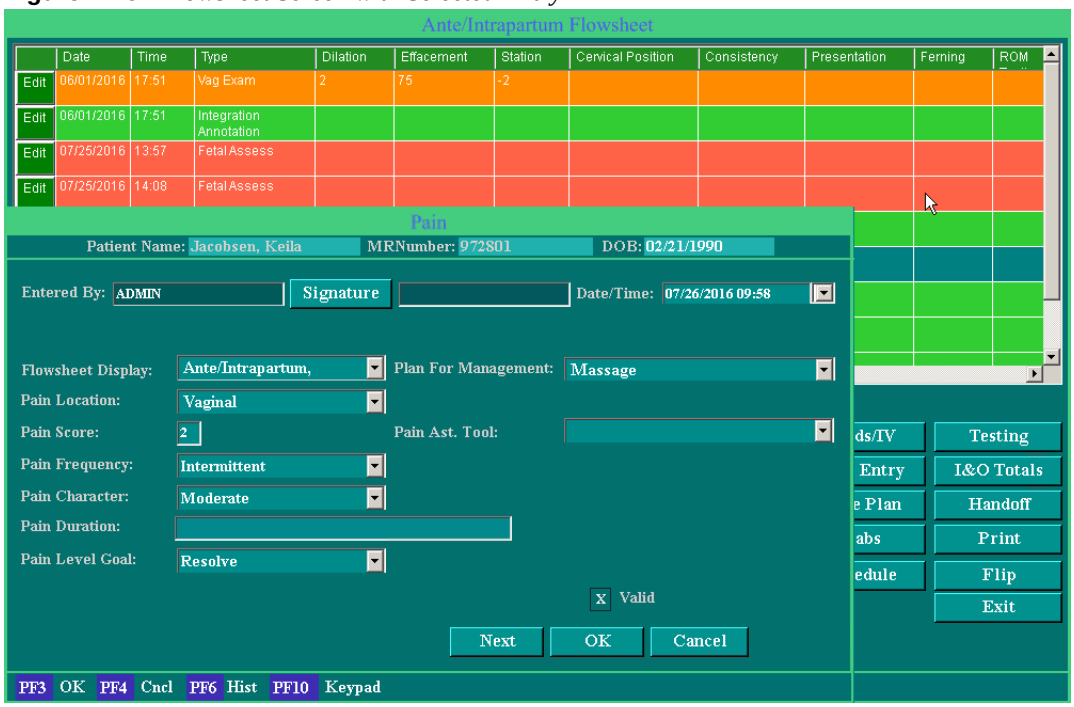
Flowsheet entries *cannot* be deleted. If a flowsheet entry was recorded incorrectly, it can be marked as “invalid” by selecting (unchecking) the **Valid** box on the source data screen *only if you were the person who entered the record.*

Since the **Valid** box defaults to a checked box, you can mark an entry as invalid by editing the source record screen and selecting the box to uncheck it.

To invalidate a flowsheet entry:

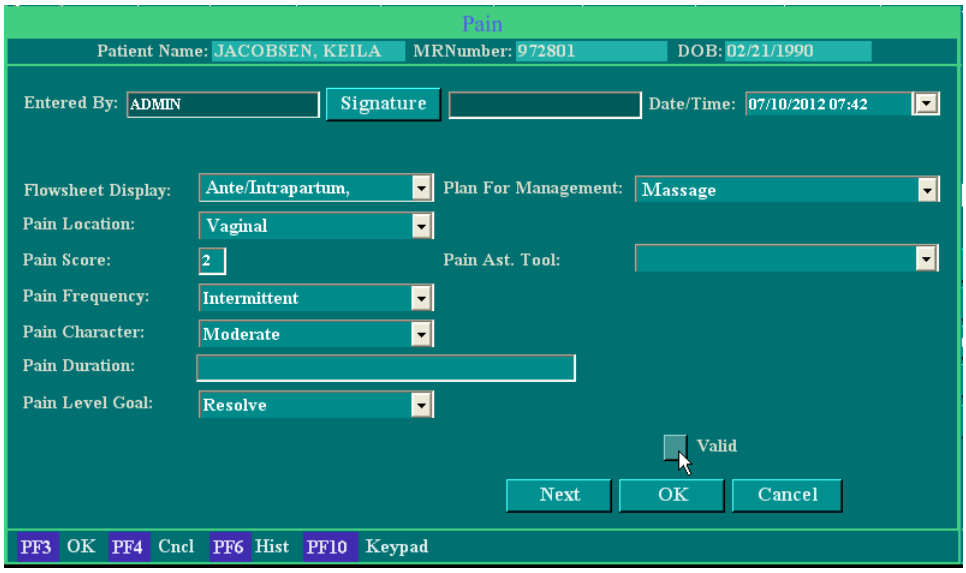
1. Display the flowsheet screen and show entries for the selected patient.
2. Locate and select **Edit** for the entry that you want to invalidate, as shown in Figure 12-6. The source record screen for the entry opens.

Figure 12-6 *Flowsheet Screen with Selected Entry*



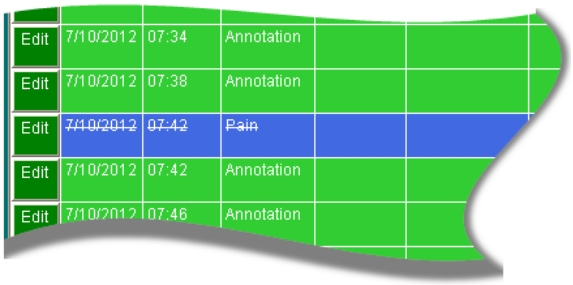
3. Select **Edit** for the selected entry. The selected screen displays.
4. Uncheck (select to *blank*) the **Valid** check box, as shown in Figure 12-7 on page 12-7.

Figure 12-7 *Valid Display Example*



5. Select **OK** to save the entry as an invalid entry. The entry on the flowsheet now has a line through all text in the entry, indicating that it is no longer valid, as shown in Figure 12-8.

Figure 12-8 *Invalid Flowsheet Entry Example*



Accessing Other Screens from Flowsheets

Each flowsheet screen contains buttons that give you direct access to screens that are related to the flowsheet you are viewing. Table 12-2 shows which screen is accessed for each button on each type of flowsheet and where that screen is described in this manual.

Table 12-2 *Flowsheet Screen Buttons-to-Other Screens Cross-Reference (Sheet 1 of 3)*

Button	Screen Accessed	Described in...
Basic Charting Flowsheet		
Annotations	Annotate Strip	"Annotating a Patient Monitoring Strip" on page 10-1
Fetal Assessment	Uterine/Fetal Assessment	Chapter 7, "Uterine/Fetal Assessment Screen" on page 7-1
Exam	Vaginal Examination	Chapter 5, "Vaginal Examination Screen" on page 5-1
Prenatal Flowsheet		
Pt Visit	Patient Visit	"Patient Visit Screens" on page 13-10
Note	Notes	"Notes Screen" on page 4-20
Home Meds	Home Medications	"Home Medications Screen" on page 4-18
Intrapartum Flowsheet* and *Outpatient/Triage Flowsheet		
Vag Exam	Vaginal Exam	Chapter 5, "Vaginal Examination Screen" on page 5-1
Fetal Assess	Uterine/Fetal Assessment	Chapter 7, "Uterine/Fetal Assessment Screen" on page 7-1
System	Systems Assessment	"Systems Assessment Screen" on page 4-19
Fall Assess	Fall Assessment	"Fall Assessment Screen" on page 4-37
Skin Assess	Skin Assessment	"Skin Assessment Screen" on page 4-38
Note	Notes	"Notes Screen" on page 4-20
Pain	Pain	"Pain Screen" on page 4-15
Education	Antepartum/Intrapartum Education Record	"Recording Patient Education Data" on page 15-3
Time Out	Procedure Time Out	"Procedure Time Out" on page 15-5

Table 12-2 *Flowsheet Screen Buttons-to-Other Screens Cross-Reference (Sheet 2 of 3)*

Button	Screen Accessed	Described in...
Bishop Score	Bishop Score	Chapter 5, "Vaginal Examination Screen" on page 5-1
Meds/IV	Medications/IVs	"Recording Medications and IV Information" on page 15-8
I&O Entry and **I&O Totals**	Intake/Output Entry Record and Intake and Output Totals	"Intake/Output Entry Record" on page 15-6
Care Plan	Care Plan	"Care Plan" on page 4-33
Labs	Laboratory Results	"Laboratory Results" on page 13-12
Testing	Antepartum Testing	"Recording Outpatient/Observation Testing Data" on page 14-3
I&O Totals	Intake and Output Totals and Intake/Output Entry Record	"Intake/Output Entry Record" on page 15-6
Recovery/Postpartum Flowsheet		
PP Profile	Initial Postpartum Profile	"Recording the Initial Postpartum Profile" on page 17-3
PP Exam	Postpartum Exam	"Recording Postpartum Examination Data" on page 17-4
Rec Exam	Recovery Exam	"Recovery Exam" on page 17-5
System	Systems Assessment	"Systems Assessment Screen" on page 4-19
PACU	PACU Care Record	"Recording PACU Care Record" on page 17-6
Fall Assess	Fall Assessment	"Fall Assessment Screen" on page 4-37
Note	Notes	"Notes Screen" on page 4-20
Pain	Pain	"Pain Screen" on page 4-15
Education	Postpartum Education Record	"Recording Postpartum Patient Education" on page 17-7
Time Out	Procedure Time Out	"Procedure Time Out" on page 15-5
Skin Assess	Skin Assessment	"Skin Assessment Screen" on page 4-38

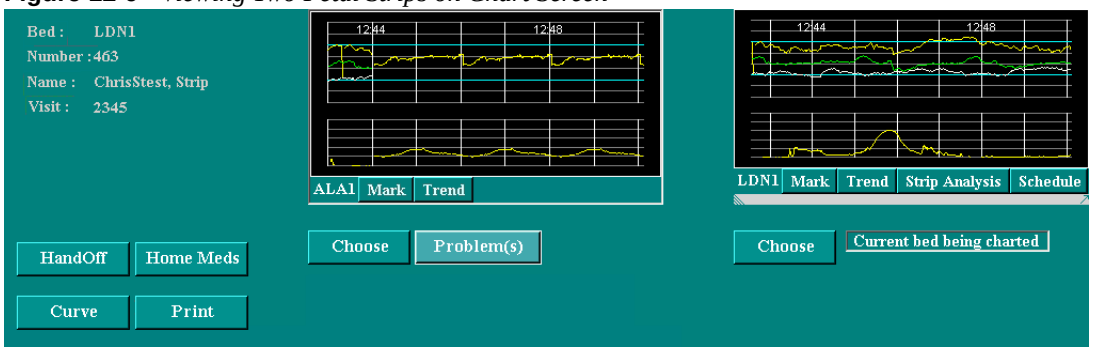
Table 12-2 *Flowsheet Screen Buttons-to-Other Screens Cross-Reference (Sheet 3 of 3)*

Button	Screen Accessed	Described in...
Meds/IV	Medications/IVs	"Recording Medications and IV Information" on page 15-8
I&O Entry and **I&O Totals**	Intake/Output Entry Record and Intake and Output Totals	"Intake/Output Entry Record" on page 15-6
Care Plan	Care Plan	"Care Plan" on page 4-33
DC/Ed	Postpartum/Newborn Discharge	"Postpartum Discharge" on page 17-8
Discharge	Obstetric Discharge Summary	"Creating an Obstetric Discharge Summary" on page 17-10
Newborn Flowsheet		
NB Profile	Newborn Profile	Chapter 18, "Newborn Profile and Initial Physical Examination" on page 18-4
NB Exam	Newborn Examination	"Adding and Recording Newborn Examination Data" on page 18-6
System	Systems Assessment	"Recording Newborn System Assessment" on page 18-7
Education	Antepartum/Intrapartum Education Record	"Recording Postpartum Patient Education" on page 17-7
Note	Notes	"Notes Screen" on page 4-20
Pain	Newborn Pain	"Recording Newborn Pain Assessment" on page 18-8
Meds/IV	Newborn Medications/IVs	"Newborn Medications" on page 18-9
Care Plan	Care Plan	"Care Plan" on page 4-33
DC/Ed	Newborn Discharge Summary	"Newborn Medications" on page 18-9

Viewing Fetal Strips from the Chart Screen

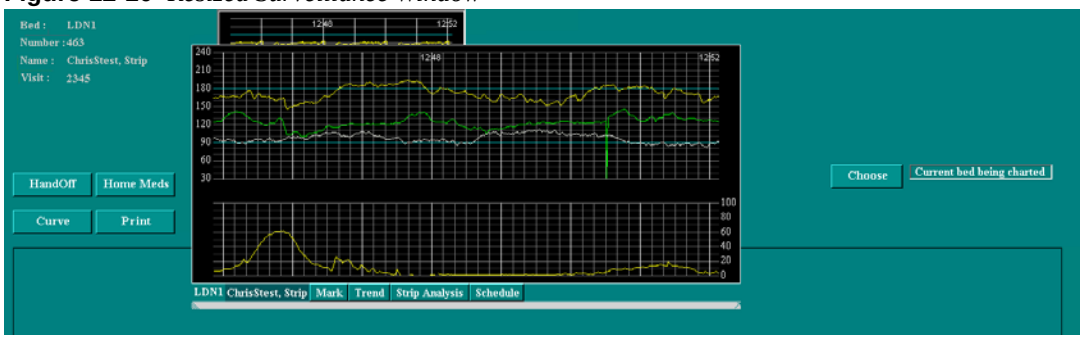
Users have the ability to view up to two strips while documenting in the chart screen, no matter which flowsheet is displayed. The user will always be documenting on the strip in the upper right corner, which has a label that reads "current bed being charted" as indicated in Figure 12-9 on page 12-11. Users can view the same strip in both windows if there is a desire to trend in one window view and see real time strip data in the other window.

Figure 12-9 *Viewing Two Fetal Strips on Chart Screen*



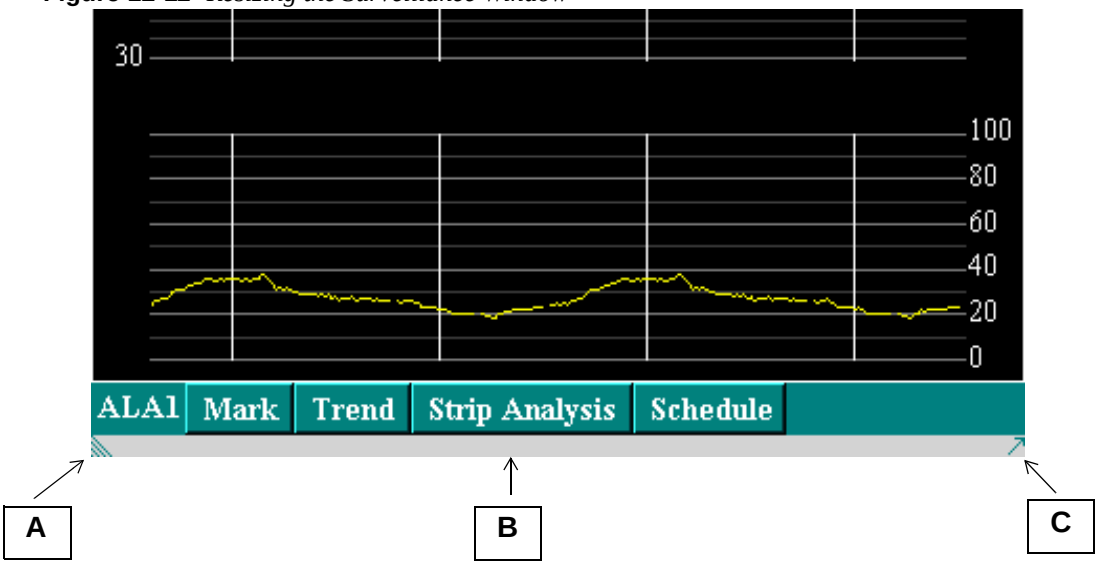
Users have the ability to resize the (right) surveillance window on the charting screens. As shown in Figure 12-10, this allows users to see a larger representation of the surveillance strip while charting on the patient. Users can trend forward and back in a similar manner to the single-surveillance screen. However, in order to enable auto-trend mode, the user must hold the right mouse button for 1 second. Right-clicks that are less than a second move the surveillance strip manually in that direction.

Figure 12-10 *Resized Surveillance Window*



To resize the surveillance window, referring to Figure 12-10 on page 12-11, place the cursor at the bottom left corner (A) of the window drag bar and drag to the desired size. To reset the window back to its original size and location, double-click the drag bar middle (B) or select the button on the bottom right of the surveillance window (C).

Figure 12-11 *Resizing the Surveillance Window*



Single clicking the surveillance window results in viewing a Single Surveillance screen only if there are no charting windows open. The surveillance windows are not active when an alert or message box is present on the screen. Users must respond to an alert or message before the surveillance windows can become active again.

The charting window and surveillance window are interchangeable. Users can resize the surveillance window to a desired height and width that best suits their needs. Refer to Figure 12-12 and Figure 12-13 for different resizing examples.

Figure 12-12 *Large Charting Screen with Small Surveillance Screen*

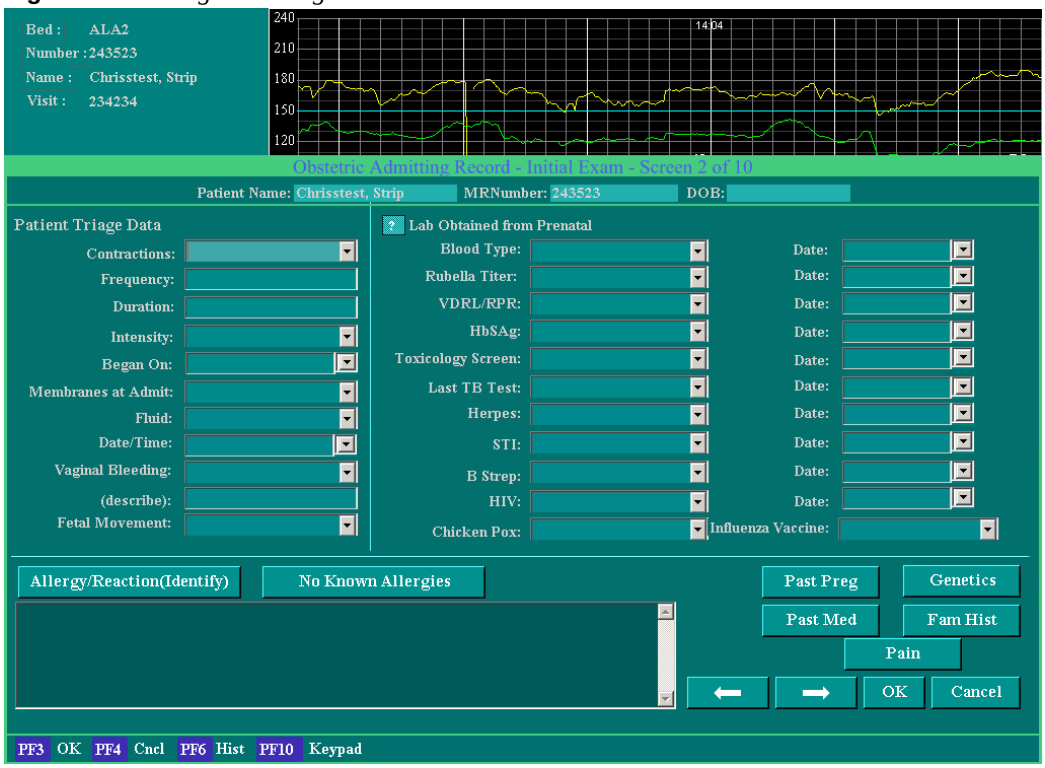
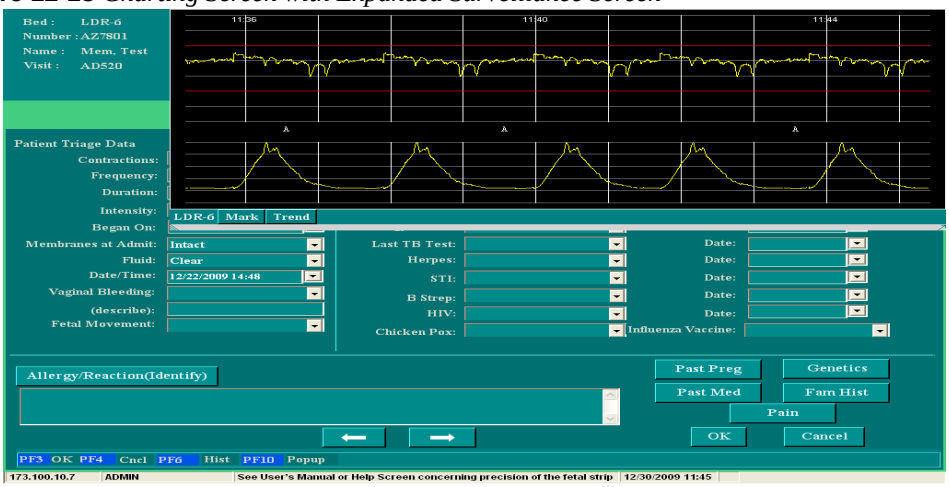
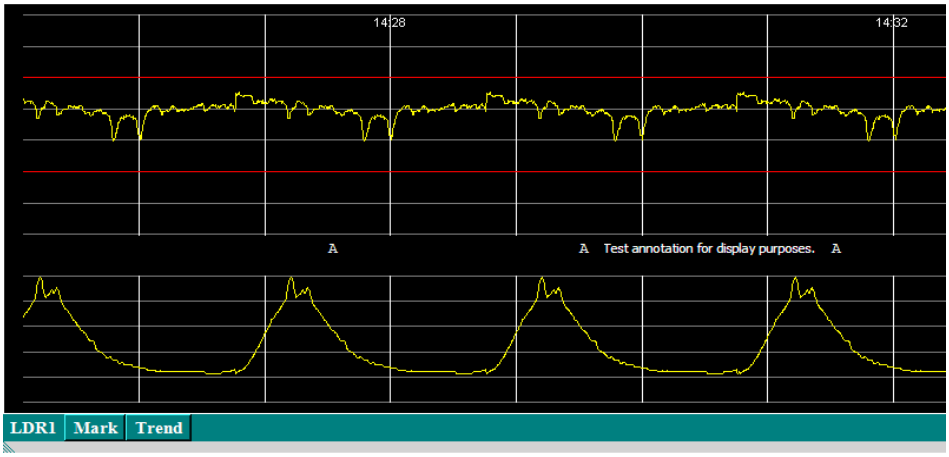


Figure 12-13 *Charting Screen with Expanded Surveillance Screen*



Annotations appear on the surveillance window as an "A". Move the mouse over the “A” to expand the annotation text as shown in Figure 12-14. Hovering over any "A" on the strip view displays the annotation for that specific time.

Figure 12-14 *Expanding Surveillance Screen Annotation Text*



Chapter 13

Prenatal Record — Comprehensive Charting

The Prenatal Record and its associated screens enables clinicians to manage the prenatal period for both the mother and the fetus, providing easy access to all of the prenatal information from a single reference point from the Chart screen by selecting the **Prenatal** button.

The Prenatal Record screens can be used for recording key information that will then be immediately available in NaviCare® WatchChild® when your patient is physically admitted to the hospital for labor and delivery. Some of the screens directly accessed from the Prenatal Admitting Record are the same as those directly accessed from the Obstetric Admitting Record.

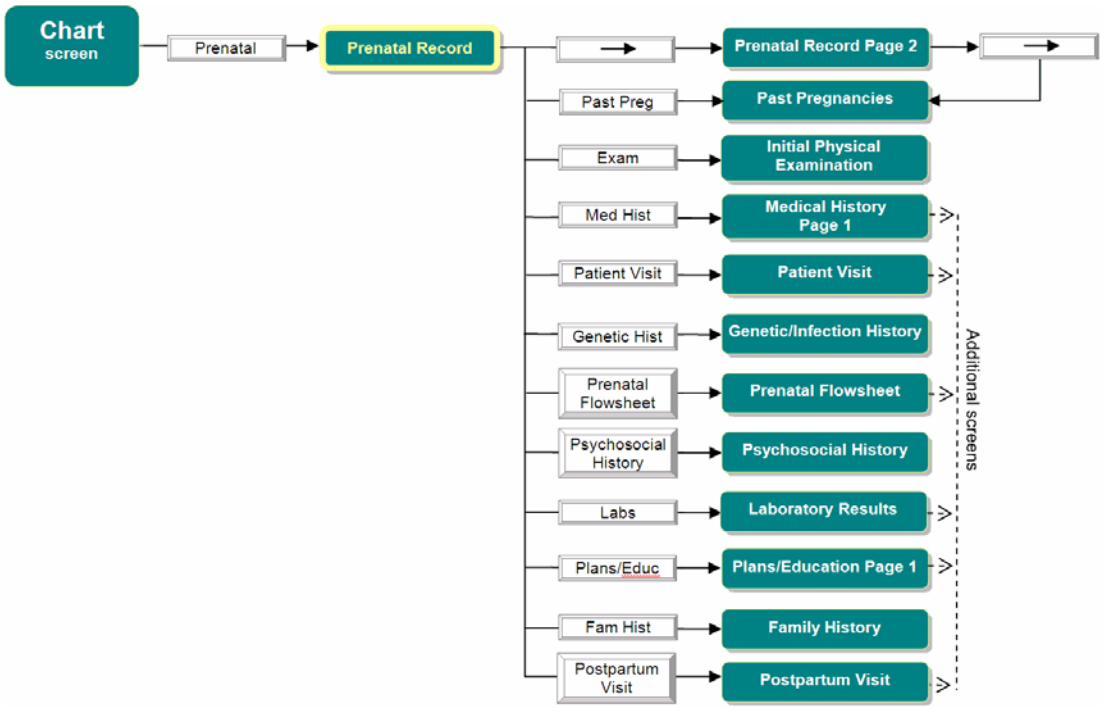
Overview and Navigation

The Prenatal Record consists of the initially-displayed Prenatal Record screen, plus eleven additional screens accessible directly from the Prenatal Record screen. Four of the screens (Genetics, Past Pregnancies, Family History, and Past Medical are accessible both directly and indirectly from Screen 2 of the Admission Section.

You can enter patient data on all of the screens in a single data-entry session or on an as-needed basis, depending on your facility's policies, patient conditions and workload. The Prenatal Record screens allow you to record subjective, objective, assessment, patient history and plan information at a physician's office (if installed there), a patient's bedside and/or the nurses' station.

Figure 13-1 on page 13-2 illustrates how the Prenatal Record and all of the screens are accessed. Notice that each of the screens is available directly from a corresponding button on the Prenatal Record screen. Also notice that there is a second page to the Prenatal Record screen.

Figure 13-1 *Accessing the Prenatal Record Screens*



Usage Notes:

- From several first-level screens you can move to the next or previous screen using arrow buttons, shown at right.

- When you select any button (except **Cancel**) that takes you to another screen, your changes to the current screen are automatically saved.
- The **OK** and **Cancel** buttons on all but the first screen will return you to the Prenatal Record screen.
- All of the procedures in this chapter assume that you know how to access the Chart screen.

Using the Prenatal Record Screen-1

1. Display the Prenatal Record screen, shown in Figure 13-2 on page 13-3. Some of the patient information you enter on this screen is identical to that gathered on the Obstetric Admitting Record screen. Common information is shared by the two screens, so that any common information entered on either screen will appear on both screens.

   Because many of the screens are already described elsewhere in this book, this chapter describes only those screens not previously described. Table 13-1 shows you where to find the information about each screen.

Figure 13-2 *Prenatal Record Screen-1*

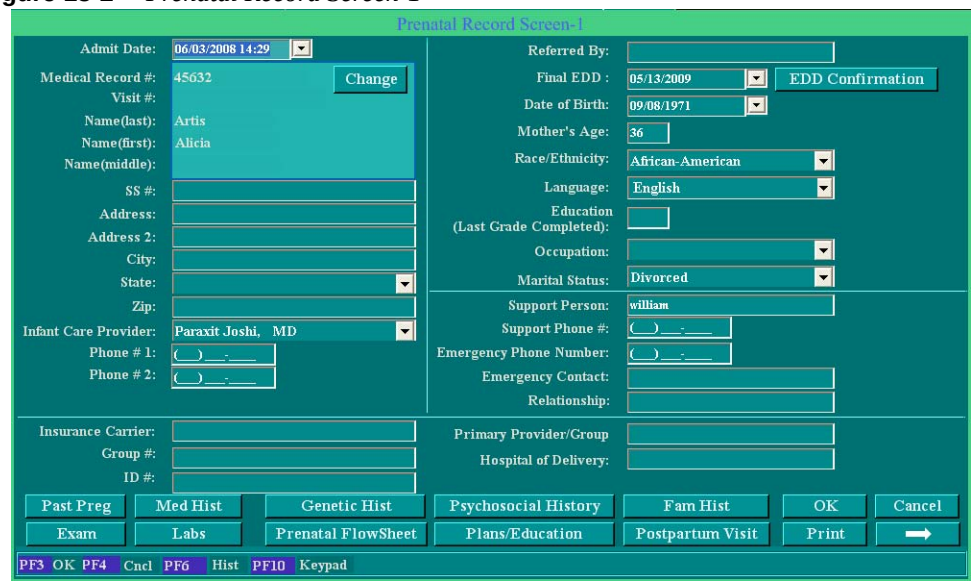


Table 13-1 *Screen Buttons and Where to Find Usage Information*

Button	Go to...
Past Preg	“Past Pregnancies Screen” on page 4-8
Exam	“Initial Physical Examination Screen” on page 13-4
Med Hist	“Medical History Screens” on page 4-10
Labs	“Laboratory Results” on page 13-12
Genetic Hist	“Genetic/Infection History Screen” on page 4-12
Prenatal Flowsheet	“Prenatal Flowsheet” on page 13-5
Psychosocial History	“Psychosocial History Screen” on page 13-6
Plans/Education	“Recording Plans and Education” on page 13-7
Fam Hist	“Family History Screen” on page 4-13
Postpartum Visit	“Postpartum Visit” on page 13-8

Usage Notes:

- When **Other** is a drop-down menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list.
- The **Print** button generates multiple separate print jobs, one for each screen that can be accessed by selecting the ⇨ button to go from one Prenatal screen to the next.

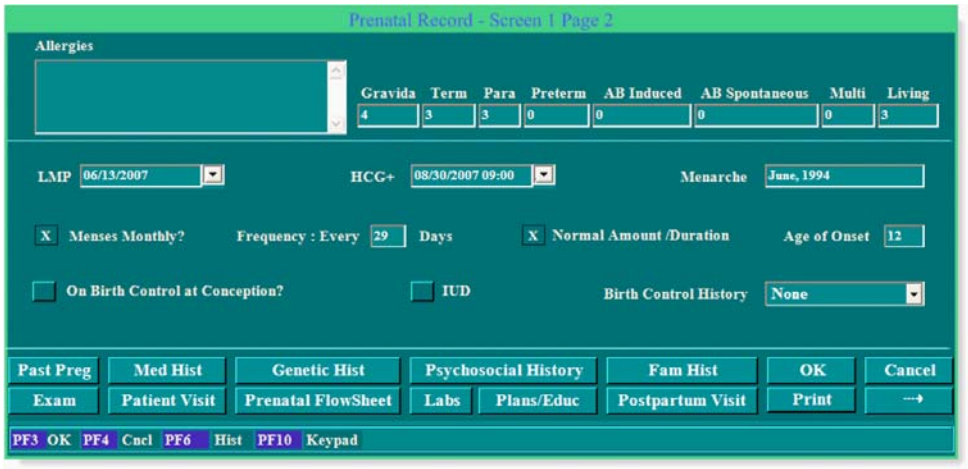
2. Do you need to change the patient’s MRN (medical record number), visit number or name?

   If Yes, go to “Changing a Patient’s MRN, Visit Number or Name” on page 3-9 and follow the procedure.

If No, proceed to step 3, below.

3. To add or update information on the initial Prenatal Record screen.
4. Select the ⇨ (arrow) button on the Prenatal Record - Screen 1 and Page 2 opens, as shown in Figure 13-3.

Figure 13-3 *Prenatal Record - Screen 1 Page 2*



5. Complete the following information as needed:

   Usage Notes:

   - If the answer for any of the following fields is *none*, enter 0 (zero).
   - The **Print** button generates multiple separate print jobs, one for each screen that can be accessed by selecting the ⇨ button to go from one Prenatal screen to the next.

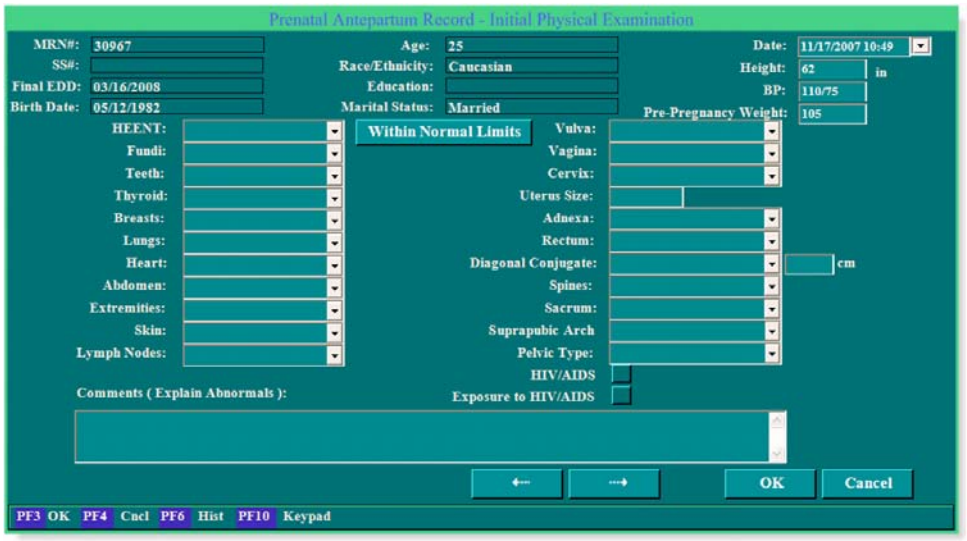
6. Select **OK** to save any changes and close the screen.

Initial Physical Examination Screen

Use this procedure to record the patient prenatal physical examinations.

1. Display the Prenatal Record Screen-1 screen for your patient.
2. Select **Exam**. The Initial Physical Examination screen appears, as shown in Figure 13-4 on page 13-5.

Figure 13-4 *Initial Physical Examination Screen*

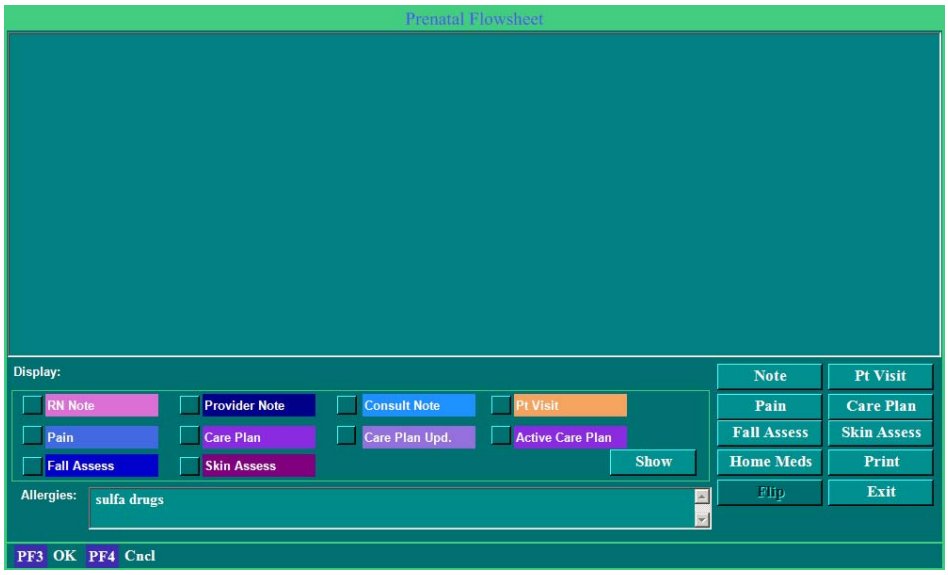


3. If all or most of the examination results are normal, select **Within Normal Limits** to automatically fill in most fields with that result.
4. Complete all fields as appropriate to the examination performed.
5. Select **OK** to save your changes and close the screen.

Prenatal Flowsheet

The Prenatal Flowsheet, shown in Figure 13-5, is accessed by selecting **Prenatal Flowsheet** on the Prenatal Record screen. Use of this screen is identical to using any other flowsheet (see Chapter 12, "Flowsheets Overview" for more information).

Figure 13-5 *Prenatal Flowsheet*



The screens you can access directly from buttons on the Prenatal Flowsheet are described elsewhere in this manual. Table 13-2 shows which screens are accessed by which button and where descriptive information can be found.

Table 13-2 *Prenatal Flowsheet Buttons to Other Screens Reference*

Button	Screen Accessed	Described In...
Note	Notes	"Notes Screen" on page 4-20
Pt Visit	Patient Visit	"Patient Visit Screens" on page 13-10
Pain	Pain	"Pain Screen" on page 4-15
Care Plan	Care Plan	"Care Plan" on page 4-33
Fall Assess	Fall Assessment	"Fall Assessment Screen" on page 4-37
Skin Assess	Skin Assessment	"Skin Assessment Screen" on page 4-38
Home Meds	Home Medications	"Home Medications Screen" on page 4-18

Psychosocial History Screen

The Psychosocial History - Screen 5 screen, shown in Figure 13-6, is accessed as shown in Figure 13-7. The screen enables you to interview your patient and record answers about behavioral or environmental factors that might adversely affect her or her baby's health and safety.

Figure 13-6 *Psychosocial History - Screen 5 Screen*

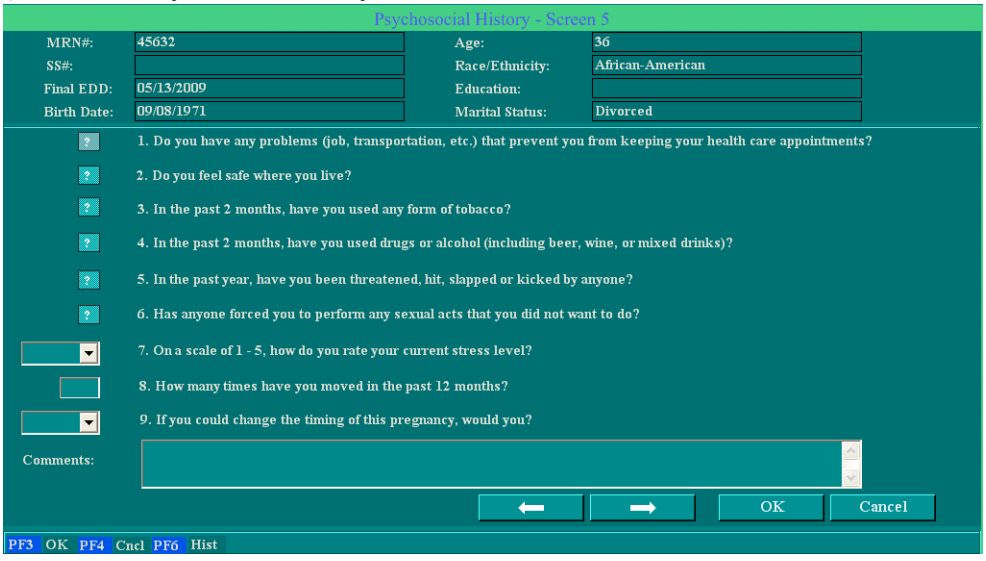


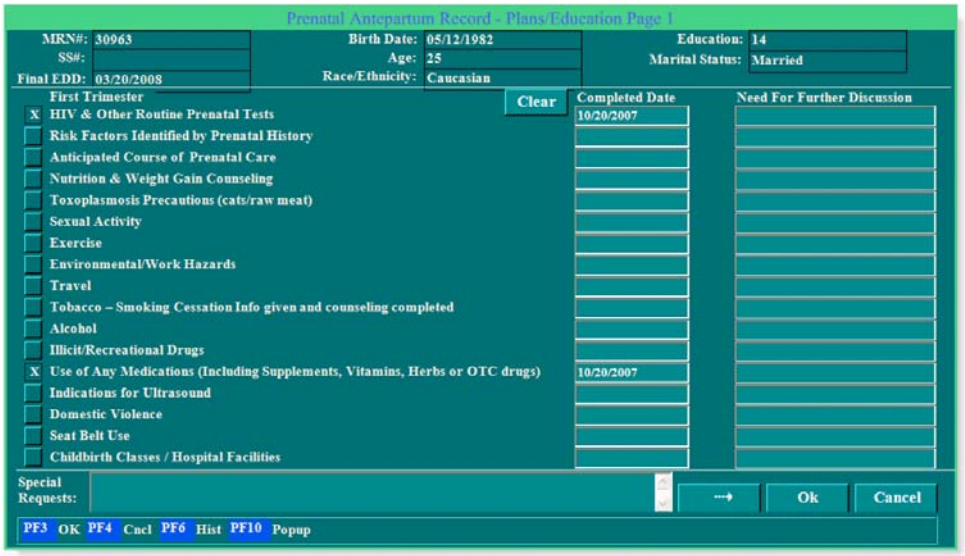
Figure 13-7 *Accessing the Psychosocial History - Screen 5 Screen*

Recording Plans and Education

Use the following procedure to record any plans and education for the patient.

1. Display the Prenatal Record screen for your selected patient.
2. Select **Plans/Educ**. The Plans/Education Page 1 screen appears, as shown in Figure 13-8.

Figure 13-8 *Plans/Education Screen*

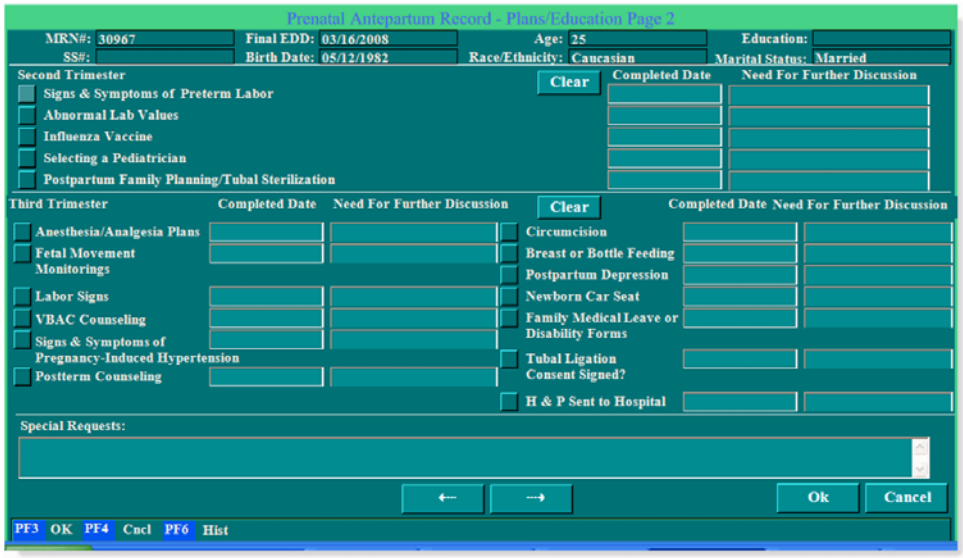


3. Check or blank the appropriate boxes and complete their corresponding fields as needed.

   Usage Note: If most of the check boxes will be marked blank (indicating No), select **Clear** to blank all of the check boxes, then select to X only those needing a Yes indication.

4. When all applicable fields on this screen have been selected, select the ⇨ button to proceed to the Plans/Education Page 2 screen, shown in Figure 13-9 on page 13-8.
5. Select or deselect check boxes and fill in fields in the same manner as on the previous screen.

Figure 13-9 *Plans/Education Page 2 Screen*

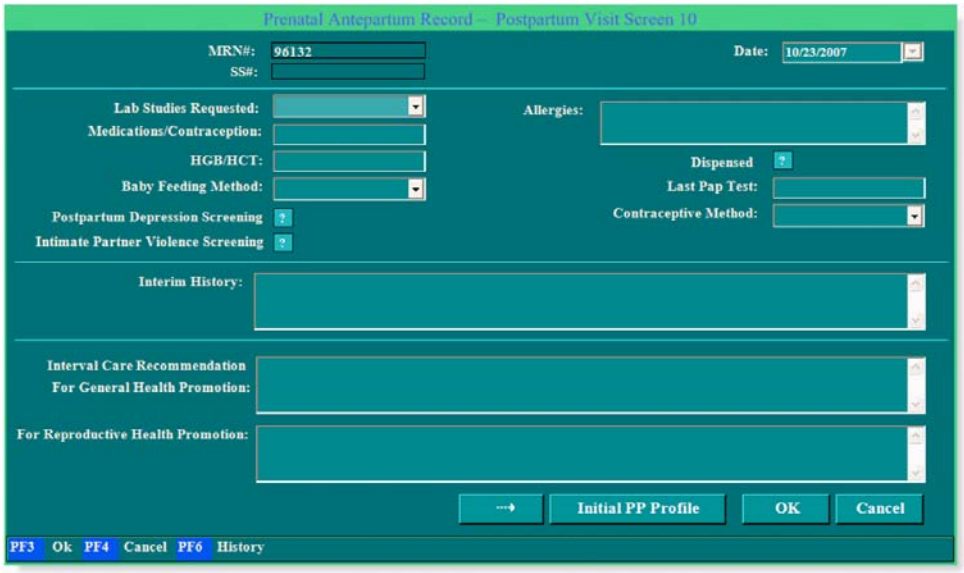


6. When you have completed selection and data entry, select **OK** to save your changes and close the screen.

Postpartum Visit

The Postpartum Visit screen, shown in Figure 13-10, is accessed by selecting **Postpartum Visit** on the Prenatal Record screen. This screen and the second page of this screen enable you to record postpartum assessment and patient recommendations information.

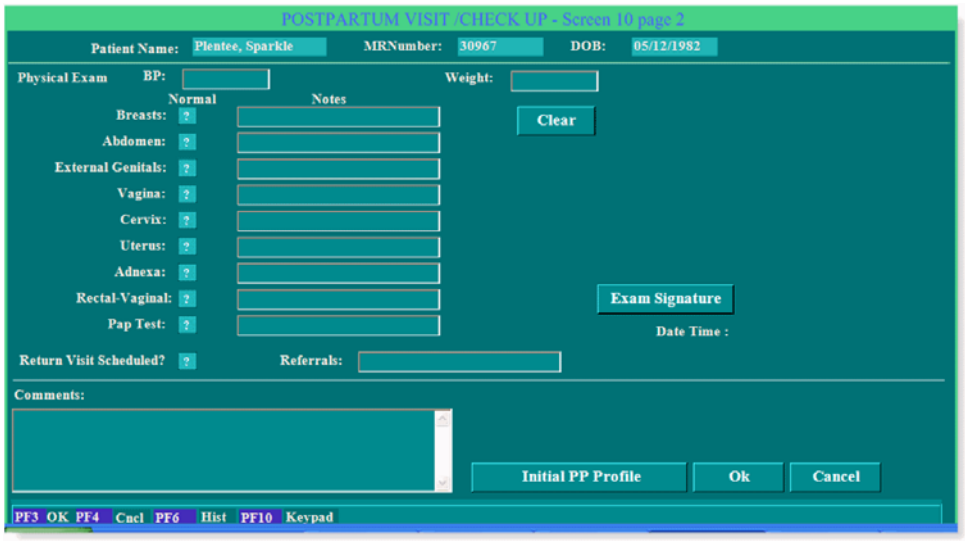
Figure 13-10 *Postpartum Visit Screen*



Usage Note: You can view and — to some degree — modify the Initial Postpartum Profile screen from either page of the Postpartum Visit screen by selecting **Initial PP Profile**. See "Recording the Initial Postpartum Profile" on page 17-3 for more information.

1. Use the data entry fields, drop-down selection menus and check boxes to record assessment and recommendations information.
2. Select the ⇨ button to access the Postpartum Visit/Check Up Page 2 screen, shown in Figure 13-11 on page 13-9.

Figure 13-11 *Postpartum Visit/Check Up Page 2 Screen*

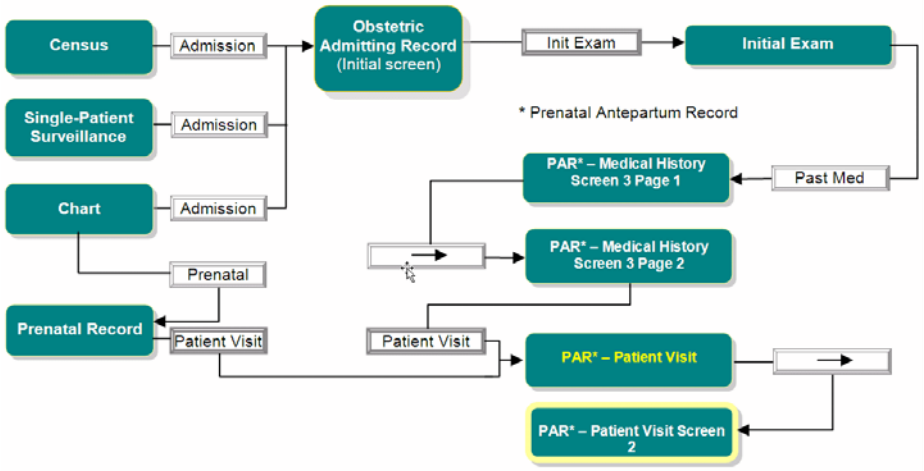


3. Enter the patient's blood pressure and current weight in the **BP** and **Weight** fields, respectively.
4. Select the **Clear** button to blank all check boxes, then use the check boxes and adjoining text entry fields to record your physical assessment of the patient.
5. Optionally, select **Exam Signature** to record your user ID and associated name as the examiner. If you use this feature, the date and time that you signed the exam appear automatically next to the **Date Time** label.
6. When you are finished with this screen, select **OK** to save your entries and close the screen.

Patient Visit Screens

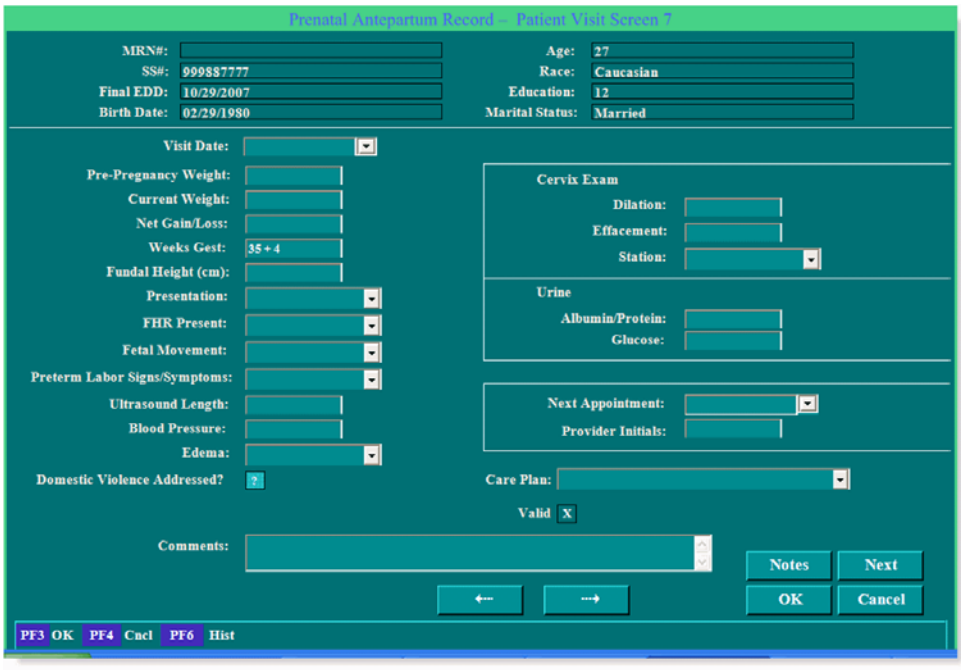
The Patient Visit screens enable you to record basic examination results for each visit a patient makes to either the hospital or her physician's office. Each patient visit recorded here becomes a Prenatal Flowsheet record. Access to the screens is illustrated in Figure 13-12.

Figure 13-12 *Accessing the Patient Visit Screens*



1. Access the first Patient Visit screen, shown in Figure 13-13, via any of the paths illustrated above.

Figure 13-13 *Patient Visit Screen*



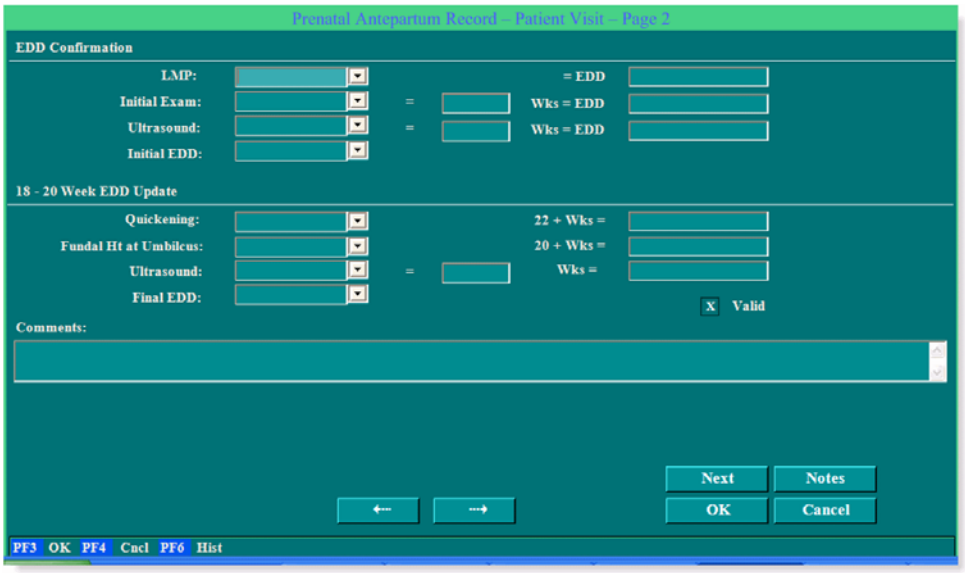
Usage Notes:

- Any drop-down menu with **OK** and **Cancel** buttons at the bottom of the menu enables you to select multiple items from the menu.

- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item.

2. Fill in all fields directly or by drop-down menu selection, as appropriate.
3. Enter any clarifying comments into the **Comments** field. To enter additional information, select the **Notes** button to open the Note screen (see "Notes Screen" on page 4-20 for usage instructions). You will return to the Patient Visit screen when you close the Note screen.
4. When finished entering data on this screen, select the ⇨ button to go to Patient Visit Screen 2, shown in Figure 13-14.

Figure 13-14 *Patient Visit Screen 2*



Usage Notes:

- All fields on the left side of the screen are date fields.
- All fields on the right side of the screen are automatically filled with values calculated from your corresponding date entries or selections.

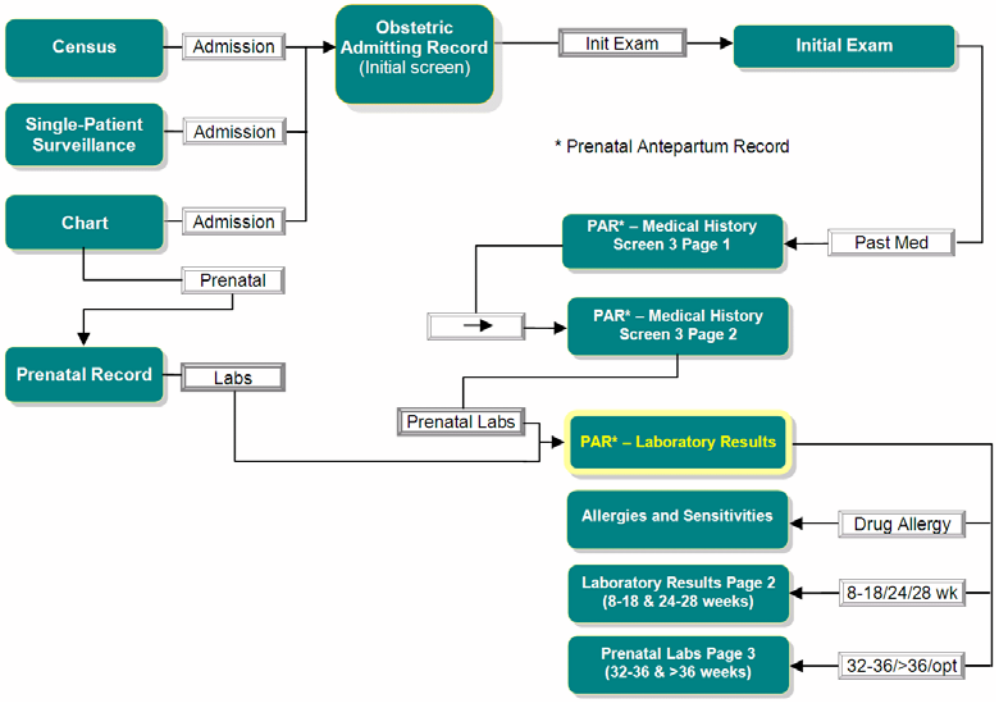
5. On the left side of the screen, enter or select appropriate dates for each of the fields.
6. Enter any clarifying comments into the **Comments** field. To enter additional information, select the **Notes** button to open the Notes screen (see "Notes Screen" on page 4-20 for usage instructions). You will return to the Patient Visit screen when you close the Notes screen.
7. When you have finished updating patient visit information, select one of the following:
   - ⇨ to save your entries and go to the Prenatal Flowsheet screen.
   - **OK** to save your entries and return to the screen from which you accessed Patient Visit screens.

Laboratory Results

The Laboratory Results screen enables you to record the results of lab tests performed throughout the patient's pregnancy. The screen is accessed via any of the paths illustrated in Figure 13-15.

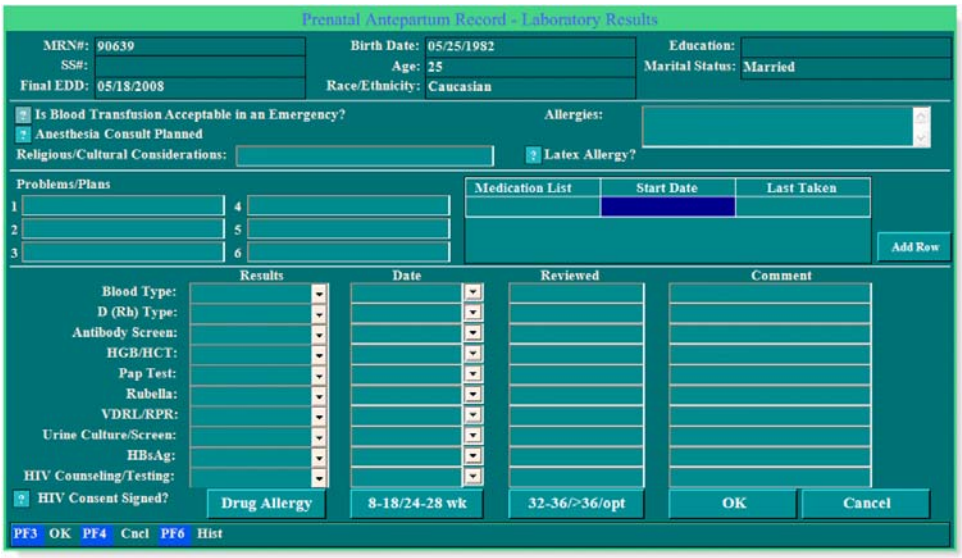
Notice that Laboratory Results consists of four screens. Whether or not you utilize all of the screens will depend on when or whether your patient began prenatal care.

Figure 13-15 *Accessing the Laboratory Results Screen*



1. Access the Laboratory Results screen, shown in Figure 13-16 on page 13-13, via any of the paths illustrated above.

Figure 13-16 *Laboratory Results Screen*

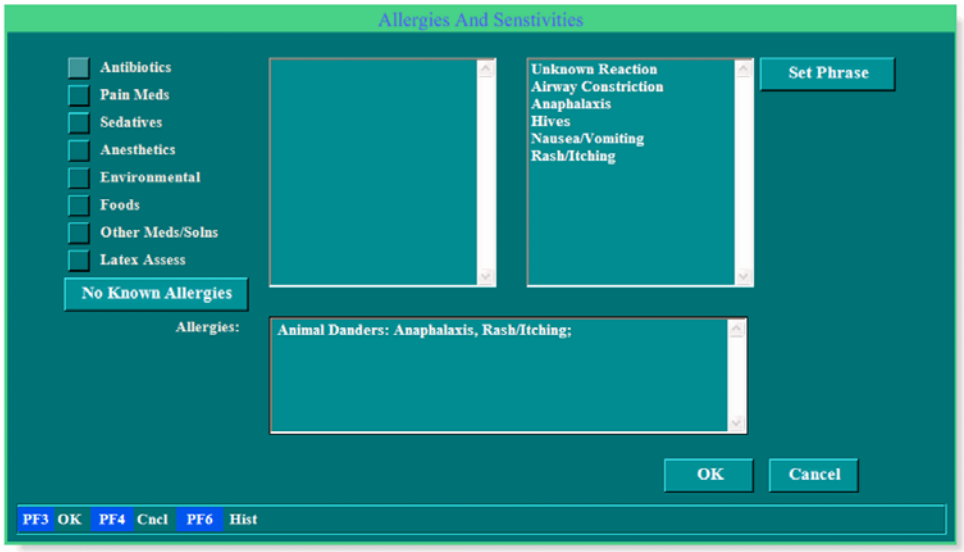


2. Fill in the fields as appropriate.
3. Does the patient have any drug or other allergies that are not already listed in the **Allergies** field (upper-right area of the screen)?

   If Yes, proceed to step 4.

   If No, skip to step 5 on page 13-14.
4. Select the **Drug Allergy** button. The Allergies and Sensitivities screen appears, as shown in Figure 13-17. Notice that in the example below, an allergy and reaction are already listed. That is because the Allergies and Sensitivities screen can also be accessed directly from the Initial Exam screen (described in "Initial Exam Screen" on page 4-6), where, in this case, an allergy to animal dander was already recorded.

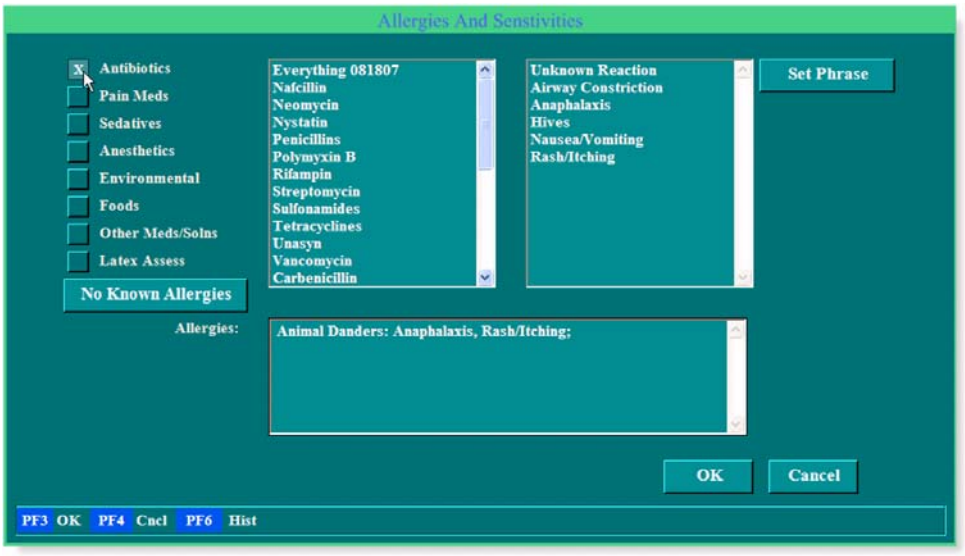
Figure 13-17 *Allergies and Sensitivities Screen*



To use this screen:

a. On the left of the screen is a list of allergy categories, each with a blank check box. Selecting a check box puts an X in it and, in the box to the right of the categories, generates a list of category-specific allergy triggers. To the right of that is a list of reactions. Figure 13-18 shows an example with **Antibiotics** selected.

Figure 13-18 *Antibiotic Allergies*



b. Select a trigger, then select a reaction caused by the trigger, then select **Set Phrase**. The trigger and reaction appear in the **Allergies** field. You can select as many trigger-reaction combinations from as many categories as necessary. You can also manually type additional information into the **Allergies** box if there is no appropriate trigger-reaction combination. For example, the patient's only allergy may be to cats, which cause uncontrollable sneezing. As none of the category triggers or reactions is that specific, simply type `Cats: Uncontrollable sneezing` into the **Allergies** field.

When you are done specifying allergies and sensitivities, select **OK** to save your changes and return to the Laboratory Results screen. Notice that your entries now appear in the **Allergies** field.

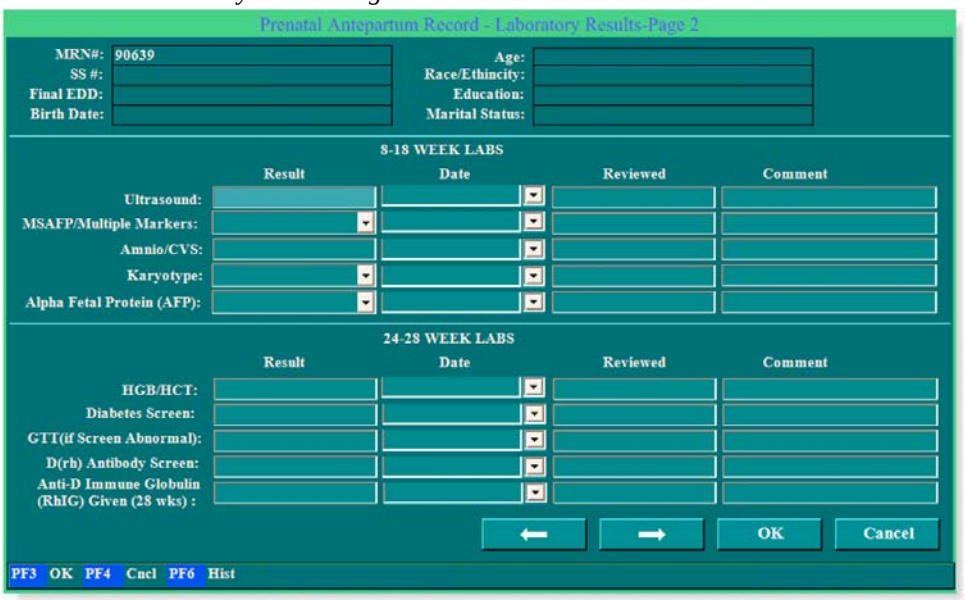
5. Are there any 8-to-18 or 24-to-28 week laboratory results for patients that have not yet been charted? (If you are not sure, answer *No*.)

If Yes, proceed to step 6.

If No, skip to step 8 on page 13-15.

6. Select the **8-18/24-28 wk** button. The Laboratory Results Page 2 screen appears, as shown in Figure 13-19 on page 13-15.

Figure 13-19 *Laboratory Results Page 2 Screen*



7. As with the first Laboratory Results screen, enter or select the results of the listed tests, as appropriate, enter or select the corresponding dates of the results, enter your name as the reviewer and any applicable comments.

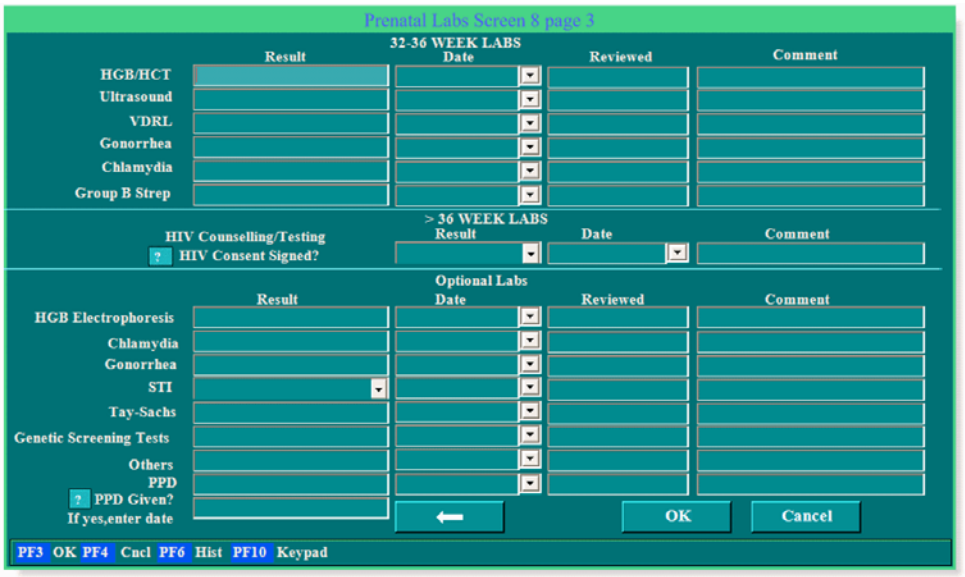
8. Are there any 32-to-36 week laboratory results or results for tests performed after 36 weeks for the patient that have not yet been charted? (If you are not sure, answer *No*.)

   If Yes, proceed to step 9.

   If No, skip to step 11 on page 13-16.

9. If you are currently on the Laboratory Results screen, select the **32-36/>36/opt** button. If you are currently on the Laboratory Results Page 2 screen, select the ⇨ button. The Prenatal Labs Page 3 screen appears, as shown in Figure 13-20.

Figure 13-20 *Prenatal Labs Page 3 Screen*



10. As with the previous two Laboratory Results screens, enter or select the results of the listed tests, as appropriate, enter or select the corresponding dates of the results, enter your name as the reviewer and any applicable comments.

11. When you have finished entering laboratory test results, select **OK** to save your entries and close the screen. If you are on Laboratory Results Page 2 or Prenatal Labs Page 3 when you select **OK**, you will return to the first Laboratory Results screen. If that is the case, select **OK** on that screen top save all results and close the screen.

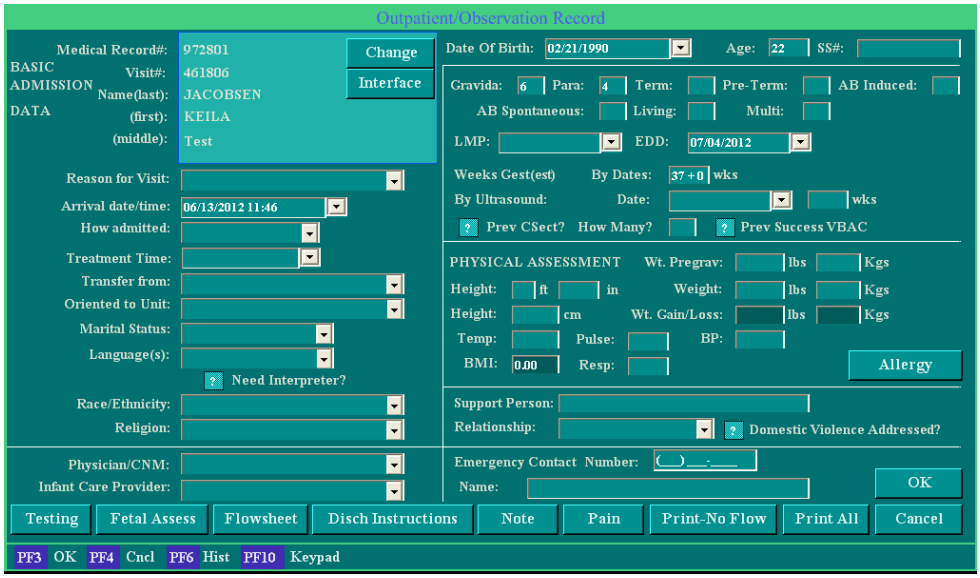
Chapter
14

Using the Outpatient/Observation Record

When admitting a patient as an outpatient or for observation, use the Outpatient/Observation Record to document assessment and procedure data gathered during the outpatient visit. The screen is accessed as illustrated in Figure 14-1 and is shown in Figure 14-2.

Figure 14-1 *Accessing the Outpatient/Observation Record Screen*

Figure 14-2 *Outpatient/Observation Record Screen*



The Outpatient/Observation Record screen is nearly identical to the Obstetric Admitting Record screen and contains all of the same data entry fields and selection menus as the Obstetric Admitting Record, plus an **Allergy** button and a **Domestic Violence Addressed?** check box. With the exception of the **Oriented to Unit** and **Wt. Pregrav (lbs)** fields, any data entered on either screen populates to the other screen.

Several of the buttons on this screen also take you to screens that are accessed via equivalent buttons on the Obstetric Admitting Record.

Use the data entry fields, drop-down selection menus and check boxes to enter patient information.

Select screen buttons as necessary to record additional patient information. Table 14-1 on page 14-2 shows you where each button takes you and where to find the instructions for that function.

Table 14-1 *Screen Buttons to Other Screens Reference*

Button	Screen or Function	Described in...
Allergy	Allergies And Sensitivities	"Initial Exam Screen", under step 5 on page 4-7
Testing	Obstetric Outpatient Record - Antepartum Testing	"Recording Outpatient/Observation Testing Data" on page 14-3
Fetal Assess	Uterine/Fetal Assessment	Chapter 7, "Uterine/Fetal Assessment Screen" on page 7-1
Flowsheet	Outpatient/Triage Flowsheet	Chapter 15, "Using the Ante/Intrapartum and Outpatient/Triage Flowsheets" on page 15-1
Disch Instructions	Antepartum Discharge Instructions	"Recording Discharge Instructions" on page 14-5
Note	Notes	"Notes Screen" on page 4-20
Pain	Pain	"Pain Screen" on page 4-15
Print-No Flow	Prints all Outpatient/Observation Record data, but not flowsheet information	N/A
Print All	Prints all Outpatient/Observation Record data including the applicable flowsheet information	N/A

Recording Outpatient/Observation Testing Data

The Obstetric Outpatient Record - Antepartum Testing screen, shown in Figure 14-4, is used to record outpatient and observation test information. Access to the screen is illustrated in Figure 14-3.

Figure 14-3 *Accessing the Obstetric Outpatient Record - Antepartum Testing Screen*

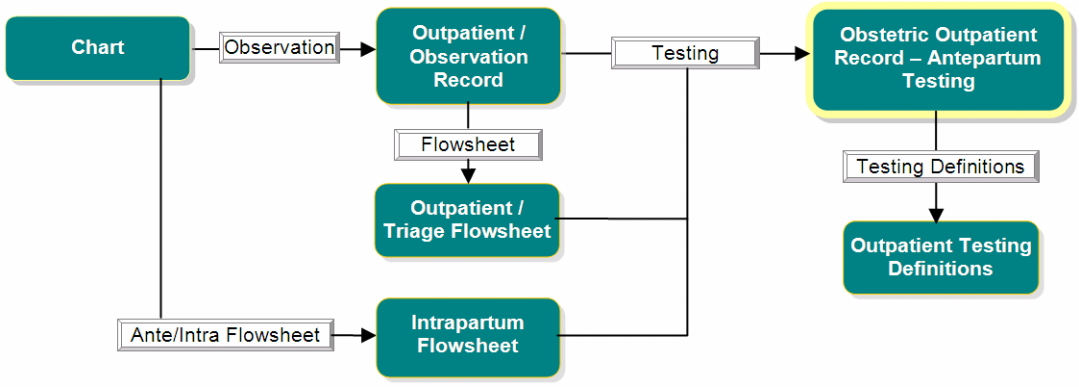
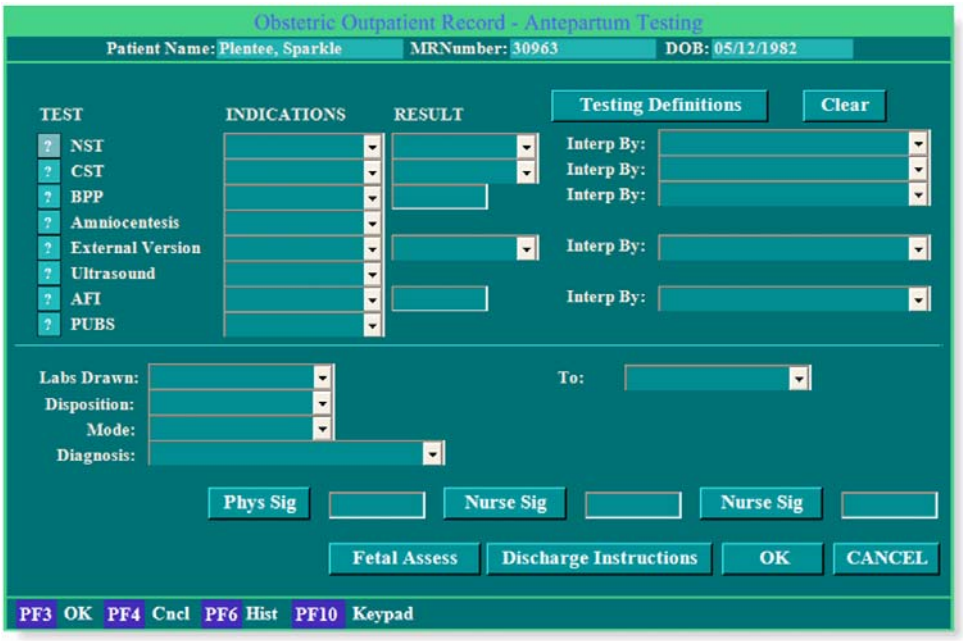


Figure 14-4 *Obstetric Outpatient Record - Antepartum Testing Screen*

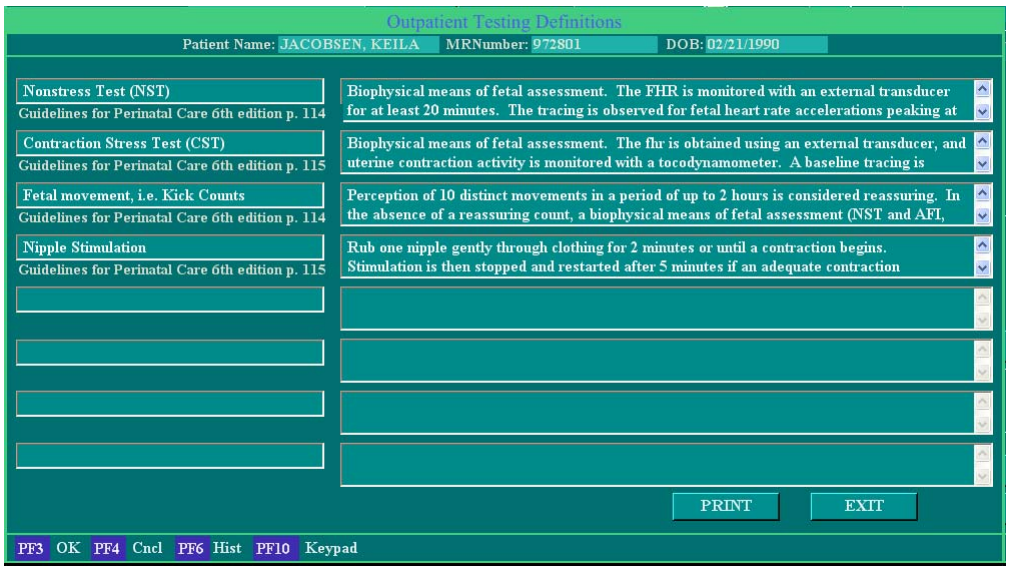


Usage Notes:

- The **Testing Definitions** button opens the Outpatient Testing Definitions screen, shown in Figure 14-5 on page 14-4. The screen lists your facility's formal definitions of the tests listed on the left side of the Obstetric Outpatient Record - Antepartum Testing screen.
- The **Clear** button sets all of the Test check boxes to *blank*.
- The **Fetal Assess** and **Discharge Instructions** buttons take you to the same screens as the **Fetal Assess** and **Disch Instructions** buttons on the Outpatient/Observation Record screen. See Table 14-1 on page 14-2 for details.
- Use the data entry fields, check boxes and drop-down selection menus to record patient information as appropriate.

- If your facility requires sign-off on this testing record, use the **Phys Sig** and **Nurse Sig** buttons to gather any required physician and nurse electronic signatures.

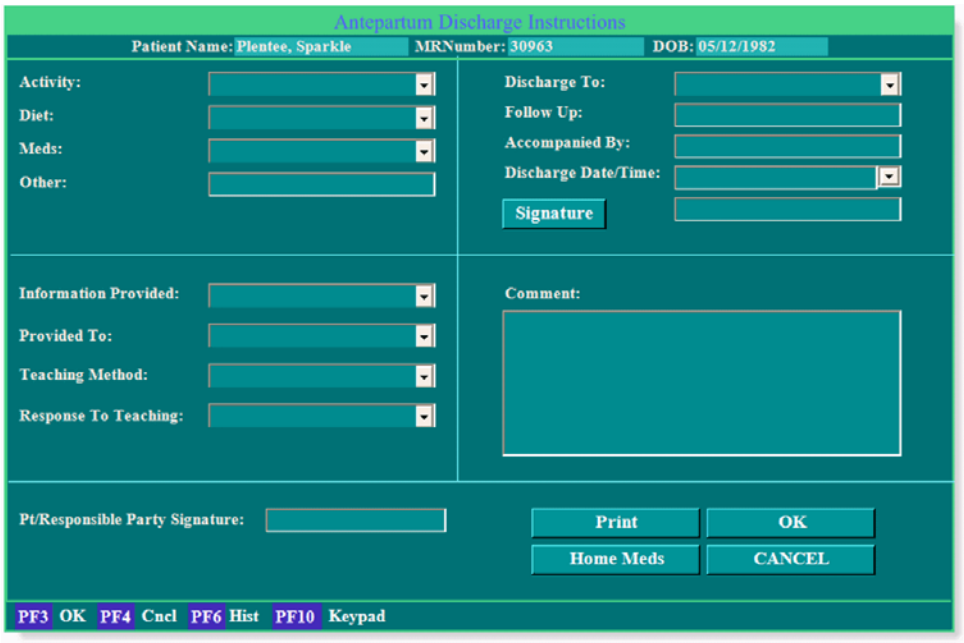
Figure 14-5 *Outpatient Testing Definitions Screen*



Recording Discharge Instructions

Discharge instructions (for example, any activity, diet or medications recommendations or limitations) are recorded on the Antepartum Discharge Instructions screen, shown in Figure 14-6. The screen is accessed by selecting either **Disch Instructions** on the Outpatient/Observation Record screen or **Discharge Instructions** button on the Obstetric Intrapartum Record - after opening the Testing screen.

Figure 14-6 *Antepartum Discharge Instructions Screen*



Usage Notes:

- Use the data entry fields and drop-down selection menus to record the applicable discharge instructions.
- Select the **Home Meds** button to display the Home Medications screen for recording any medications to be taken by the patient at home (see "Home Medications Screen" on page 4-18 for usage instructions).
- Select **OK** to save your changes and close the screen.

Chapter 15

Using the Ante/Intrapartum and Outpatient/Triage Flowsheets

The Intrapartum Flowsheet and the Outpatient/Triage Flowsheet are identical in every respect except the name. Both display the same information and access other NaviCare® WatchChild® screens via the same set of buttons. Both flowsheets are therefore presented together in this chapter.

This chapter assumes that you are familiar with navigation, data display and printing of flowsheet information. If you have not already done so, see "Flowsheet Types and Navigation" on page 12-1 for flowsheet usage information.

Accessing the Intrapartum and Outpatient/Triage Flowsheets

1. *From the Census or Multi-Patient Surveillance* screen, select the patient and then select **Chart.**

   From a Single-Patient Surveillance screen, select **Chart.**

   The Chart screen appears.

2. Do one of the following, depending on which flowsheet you want to access:

   - Intrapartum Flowsheet: select **Ante/Intra Flowsheet**
   - Outpatient/Triage Flowsheet: select **Observation** to display the Outpatient/Observation Record screen, and then select **Flowsheet**

   Depending on which flowsheet you opened, either the Intrapartum Flowsheet screen opens, as shown in Figure 15-1 on page 15-2, or the Outpatient/Triage Flowsheet screen opens, as shown in Figure 15-2 on page 15-2 or the "Recovery & Postpartum Records" on page 17-1.

3. Records will default to the flowsheets as determined by the parameter configuration. Records may show in more than one flowsheet if that selection is made in the Parameter Configuration.

Figure 15-1 *Intrapartum Flowsheet*

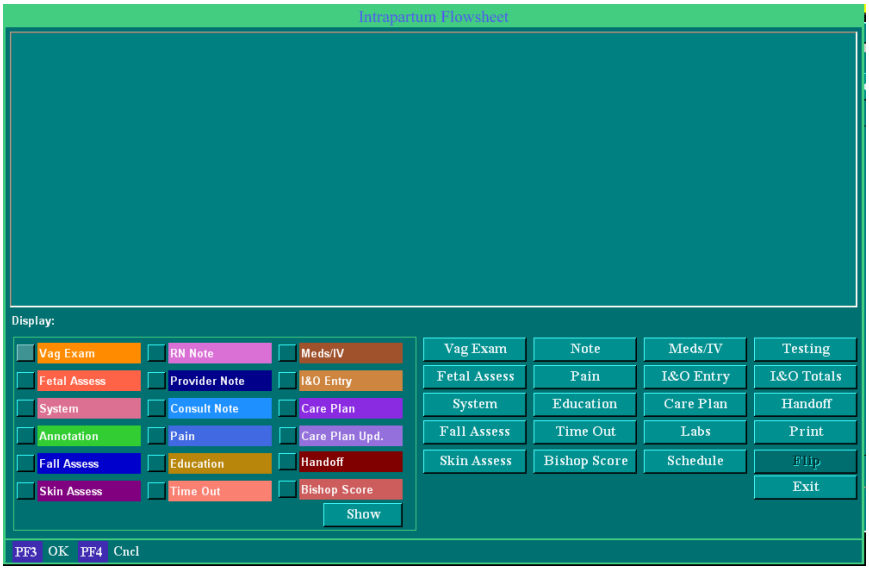


Figure 15-2 *Outpatient/Triage Flowsheet*

Several of the screens accessed by the flowsheet buttons are also accessed by other screens and are described elsewhere in this manual. Only those screens not already described elsewhere are described within this chapter. Table 15-1 shows you which screen each button takes you to and where to find that screen's usage information.

Table 15-1 *Screen Buttons-to-Other Screens Cross-Reference (Sheet 1 of 2)*

Button	Screen Accessed	Described in...
Vag Exam	Vaginal Exam	Chapter 5, "Vaginal Examination Screen" on page 5-1
Bishop Score	Bishop Score	Chapter 5, "Vaginal Examination Screen" on page 5-1

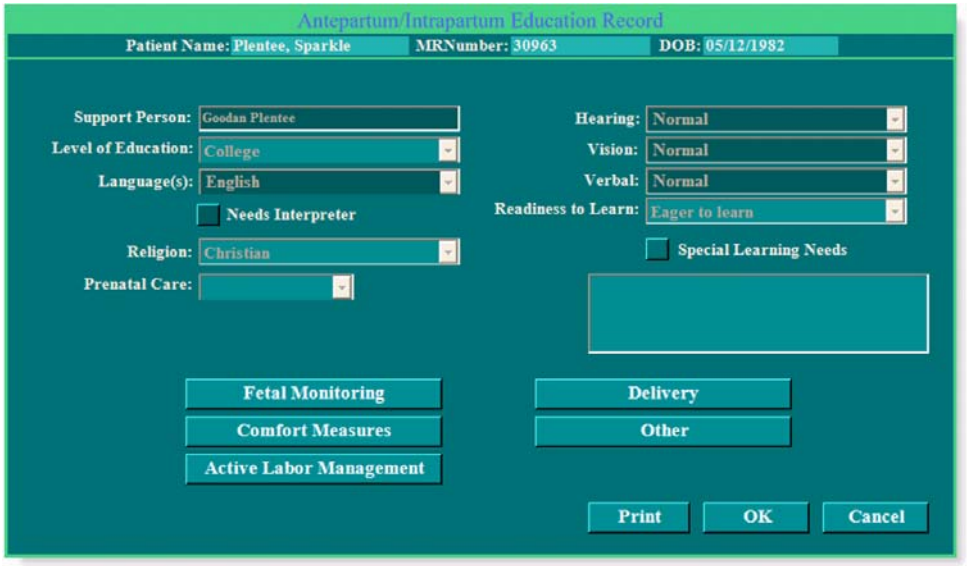
Table 15-1 *Screen Buttons-to-Other Screens Cross-Reference (Sheet 2 of 2)*

Button	Screen Accessed	Described in...
Handoff	Labor & Delivery Hand Off Communication	"Labor & Delivery Hand Off Communications" on page 6-7
Fetal Assess	Uterine/Fetal Assessment	Chapter 7, "Uterine/Fetal Assessment Screen" on page 7-1
System	Systems Assessment	"Systems Assessment Screen" on page 4-19
Fall Assess	Fall Assessment	"Fall Assessment Screen" on page 4-37
Skin Assess	Skin Assessment	"Skin Assessment Screen" on page 4-38
Note	Notes	"Notes Screen" on page 4-20
Pain	Pain	"Pain Screen" on page 4-15
Education	Antepartum/Intrapartum Education Record	"Recording Patient Education Data" on page 15-3
Time Out	Procedure Time Out	"Procedure Time Out" on page 15-5
Meds/IV	Medications/IVs	"Recording Medications and IV Information" on page 15-8
I&O Entry and **I&O Totals**	Intake/Output Entry Record and Intake and Output Totals	"Intake/Output Entry Record" on page 15-6
Care Plan	Care Plan	"Care Plan" on page 4-33
Labs	Laboratory Results	"Laboratory Results" on page 13-12
Testing	Antepartum Testing	"Recording Outpatient/Observation Testing Data" on page 14-3

Recording Patient Education Data

The Antepartum/Intrapartum Education Record screen, shown in Figure 15-3, is the first of six screens used to document the education that is provided to the patient and her family during her hospitalization. This documentation includes educating the family, the level of interaction with the family members and the method used to provide the instructions.

Figure 15-3 *Antepartum/Intrapartum Education Record*

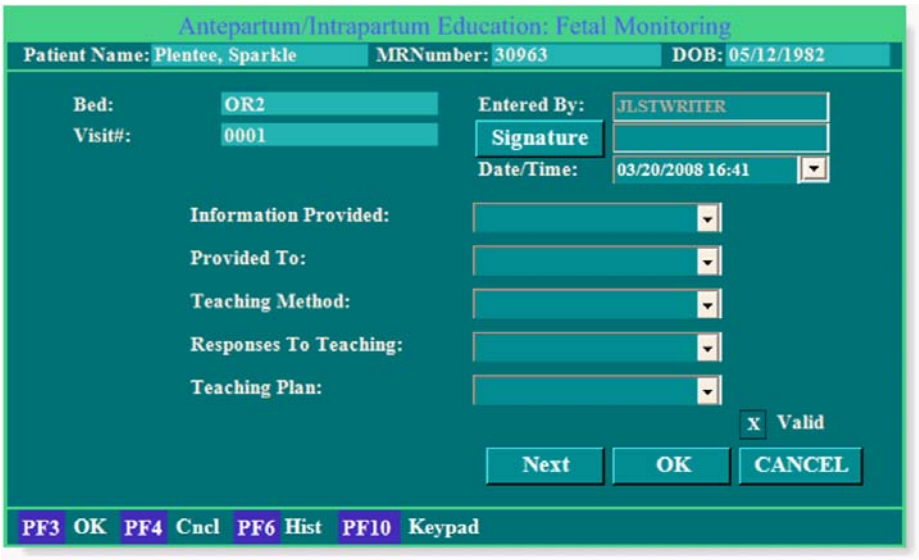


Most of the fields on this screen are pre-filled with data previously entered on other NaviCare® WatchChild® screens and cannot be modified here. The exceptions are the **Special Learning Needs** check box and its associated text entry field. If the patient has any special educational needs beyond those covered by the other Antepartum/Intrapartum Education Record screens, X the **Special Learning Needs** check box and type a description of the needed and/or provided education into the text entry field.

All of the screens accessed via the buttons on the Antepartum/Intrapartum Education Record screen have the same format and fields, as illustrated by the Antepartum/Intrapartum Education: Fetal Monitoring screen shown in Figure 15-4 on page 15-5. To use the screens:

1. On the Antepartum/Intrapartum Education Record screen, select an education topic button to open that topic's screen.
2. If the education was provided to the patient at a previous date and/or time, change the displayed date and time as appropriate.
3. For each of the remaining fields, select the most appropriate item(s) from the drop-down selection menus. You can select multiple items from each drop-down. You can also select **Other** from each menu and create your own entry if none of the existing the selections is a good match.
4. When you are finished entering data on a screen, select **OK** to save your entries and close the screen.

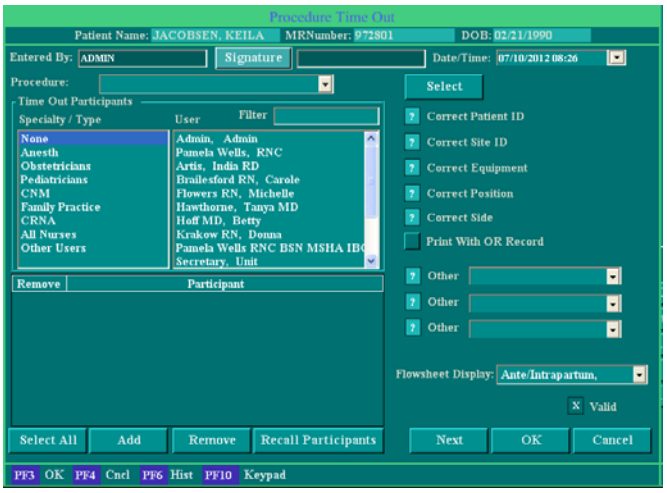
Figure 15-4 *Antepartum/Intrapartum Education: Fetal Monitoring Screen*



Procedure Time Out

The Procedure Time Out screen, shown in Figure 15-5, enables you to document, prior to its occurrence, any upcoming procedure. The screen is accessed by selecting the **Time Out** button on any flowsheet except the Prenatal flowsheet.

Figure 15-5 *Procedure Time Out Screen*



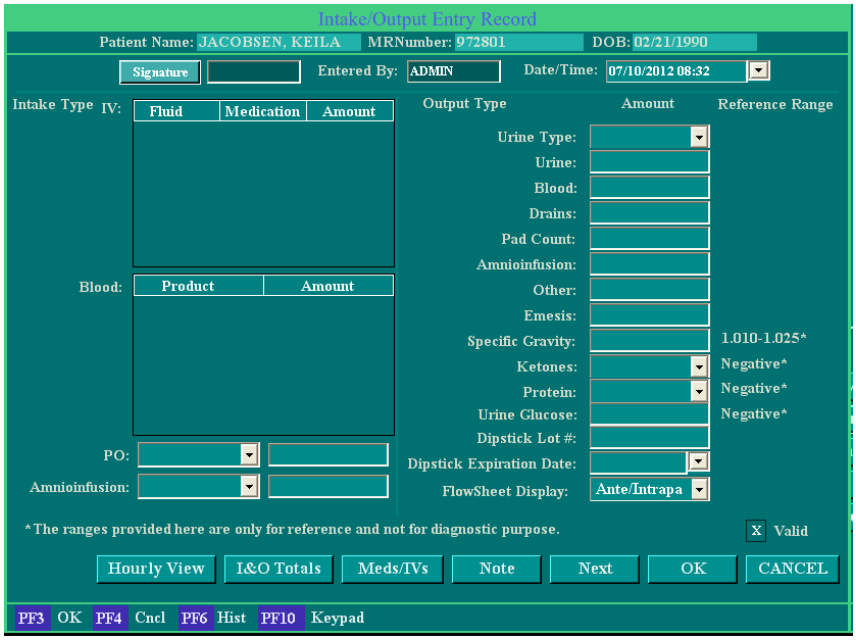
1. Select a procedure from the **Procedure** drop-down menu.
2. Select the participant **Specialty** from the **Time Out Participants** menu; select the Participant from the **User** menu then select the **Add** button.
3. If most or all of the reasons apply, select **Select** to check all of the check boxes except the **Other** items. If something other than the predefined reasons apply, select an **Other** check box and type a reason into the corresponding field. The Other items are multiselect so that more than one answer for each field can be selected if applicable.

4. To sign the time out and prevent other users from modifying your entry, select **Signature**, then enter your password into the pop-up prompt. Passwords are case sensitive. The User ID will display for the person that is currently logged in.
5. When finished entering time out information, select **OK** to save your entries and close the screen.

Intake/Output Entry Record

The Intake/Output Entry Record screen, shown in Figure 15-6 on page 15-6, enables you to record the patient's intake amounts of liquids and solids and record her output of various substances. The screen also shows input data for any IV inputs and blood transfusions that were entered on other screens; the information appears in the **IV** and **Blood** blocks on the left side of the screen. Notice that several reference ranges are provided on the right side of the screen.

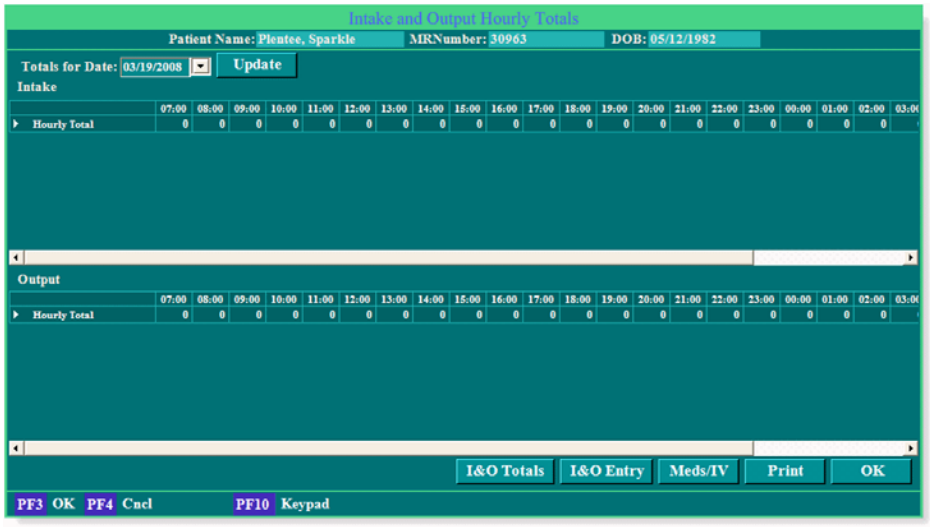
Figure 15-6 *Intake/Output Entry Record*



Usage Notes:

- Use the drop-down menus and data entry fields to enter patient intake and output as necessary.
- To see an hour-by-hour listing of all intakes and outputs, select **Hourly View** to display the Intake and Output Hourly Totals screen, shown in Figure 15-7. This is a view-only screen and the only I&O screen where the entry data is itemized.
- From any of the screens described in this section you can also go directly to the Medications/IVs screen for entering detailed medical and IV dispensing data that will be reflected on the screens described here. See "Recording Medications and IV Information" on page 15-8 for more information.

Figure 15-7 *Intake and Output Hourly Totals*



- To see intake and output totals, select **I&O Totals** from either the Intake/Output Entry Record or Intake and Output Hourly Totals screens. The Intake and Output Totals screen appears, as shown in Figure 15-8. This is a view-only screen except for the **Update** button at the top which shows I&O Totals for another date when selected. Click the correct calendar date and then click the **Update** button.

Figure 15-8 *Intake and Output Totals*

From this screen you can access the hourly view screen by selecting **Hourly View**, and can access the Intake/Output Entry Record by selecting **I&O Entry**.

When you are finished entering or viewing data, select **OK** to save any entries and close the screen.

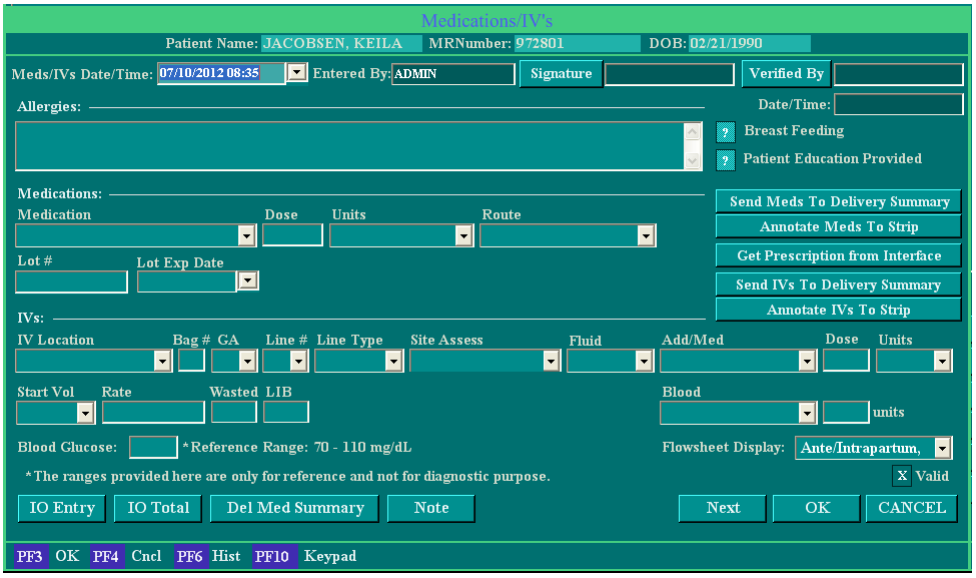
Recording Medications and IV Information

The Medication/IVs screen, shown in Figure 15-9, enables you to document medications given, IV starts, and additives. You may permanently mark the information on the monitoring strip by selecting **Annotate Meds to Strip** or **Annotate IV's to Strip**. This allows you to review medication and IV data on the strip.

Display the Medications/IVs screen for the selected patient by selecting **Meds/IVs** on any screen on which the button appears. The patient name, bed name, and patient medication record number are automatically displayed at the top of the screen.

Allergy information previously entered in other screens is displayed in the **Allergies** text box and cannot be modified here.

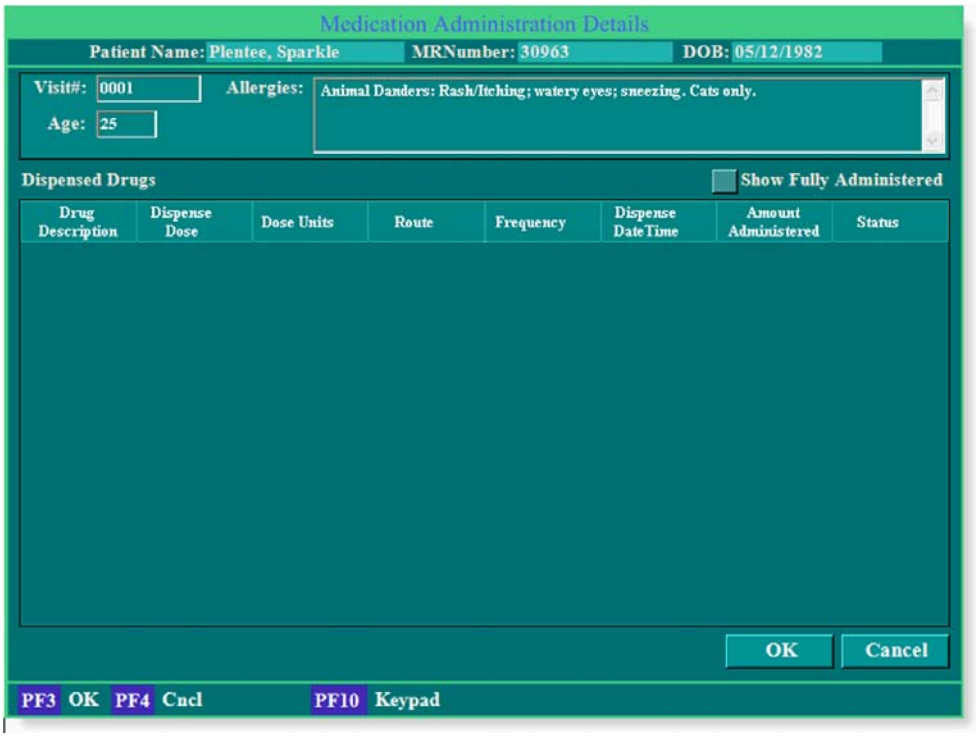
Figure 15-9 *Medications/IV's Screen*



Usage Notes:

- Use the data entry fields, drop-down menus and check boxes as necessary to document patient medications and IVs administered or started.
- Notice that a blood glucose reference range is provided on the screen.
- Select from **Annotate Meds To Delivery Summary**, **Annotate Meds To Strip**, **Annotate IVs to Strip**, and **Annotate IVs to Delivery Summary** as appropriate. You can display a list of all prescribed medications and IVs by selecting **Get Prescriptions from Interface**, which displays the Medication Administration Details screen, shown in Figure 15-10 on page 15-9.

Figure 15-10*Medication Administration Details*



If your facility has an HL7 medical data interface to the pharmacy, the Medication Administration Details screen will be automatically populated with data from the pharmacy.

To show only those medications and IVs that have been fully administered, select the **Show Fully Administered** check box.

- In the lower-right corner of the Medications/IVs screen, select from the **Flowsheet Display** drop-down menu the flowsheets on which you want your current meds and IV entries to appear.

When you have completed all data entry, select **OK** to save the entries and close the screen.

Chapter 16

Labor, Delivery, and Infant Summary

This chapter presents the **Labor, Delivery and Infant Summaries** subject to whether your system is configured with the Newborn application:

Configured with the Newborn Application (NICU=True)

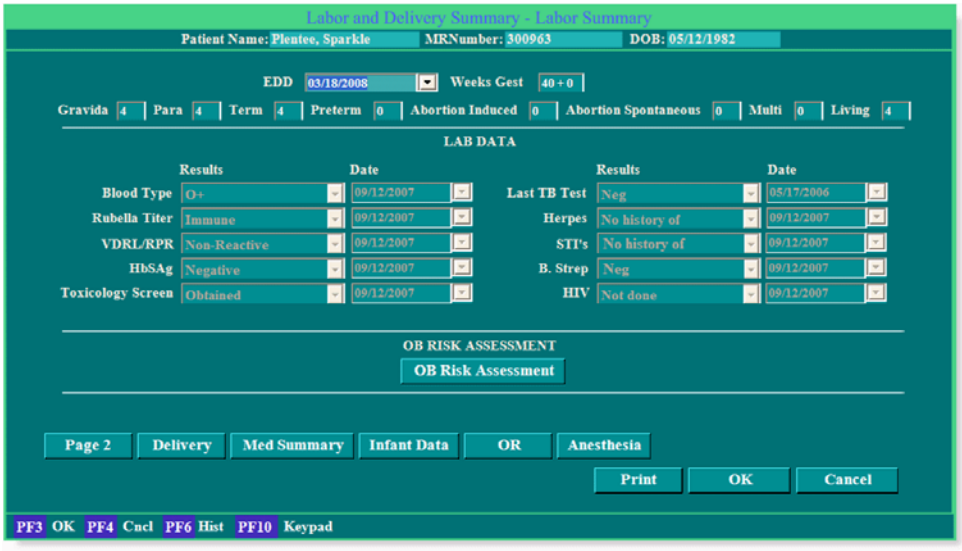
The Labor and Delivery Summary screens for Newborn Application configured systems are used to display and, to a limited degree, record labor and delivery information. From the Labor and Delivery Summary screens you can access the labor summary, the delivery summary, delivery anesthesia delivery medications, and infant data information screens.

Labor Summary Screens

The first of the labor, delivery and infant summary screens is the Labor and Delivery Summary - Labor Summary screen, shown in Figure 16-1, which displays previously recorded information, but enables you to modify entries if appropriate.

The Labor and Delivery Summary - Labor Summary screen is accessed from any screen that has a **Summary** button, including the Census and Chart screens. This screen is primarily view-only, displaying information that has been previously entered on other screens. The only fields that you can modify are those located above the LAB DATA section of the screen.

Figure 16-1 *Labor and Delivery Summary - Labor Summary Screen*



Refer to Table 16-1 for information on where each button on the screen takes you.

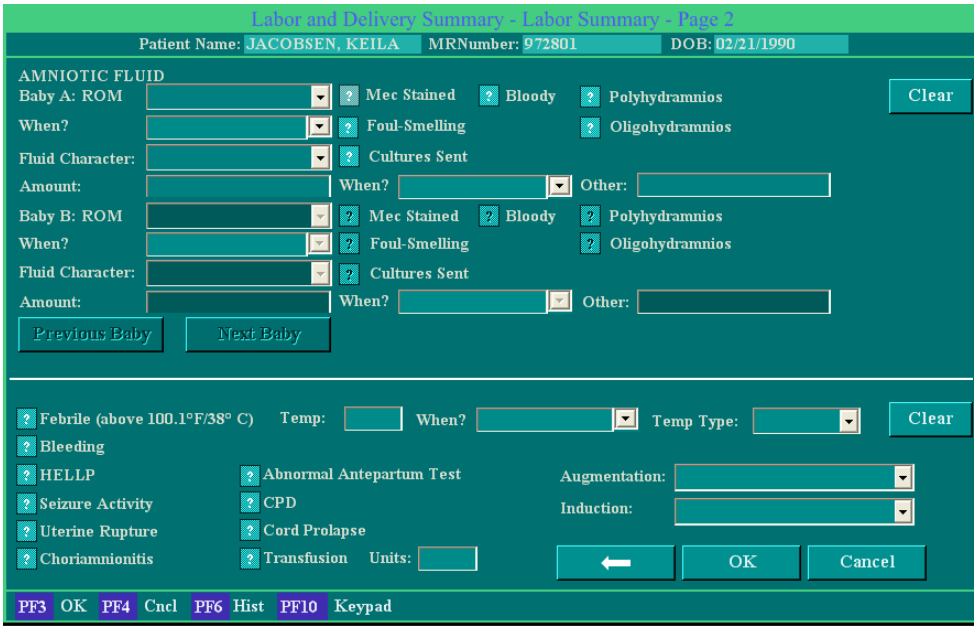
Table 16-1 *Labor Summary Buttons to Other Screens Reference*

Button	Screen Accessed	Described in...
Page 2	Labor and Delivery Summary - Labor Summary - Page 2	“Labor Summary Page 2” on page 16-2
Delivery	Labor and Delivery Summary - Delivery Data	“Recording Delivery Data” on page 16-3
Med Summary	Labor and Delivery Summary - Medication Summary	“Viewing the Medications/IVs/Blood Entry Summary” on page 16-4
Infant Data	Labor and Delivery - Infant Data	“Recording the Infant Data Summary” on page 16-5
OR	Pre-Operative Assessment	“Pre-Operative Assessment” on page 6-8
Anesthesia	Patient Assessment and Pre-Anesthetic Evaluation	“Pre-Anesthetic/Sedation Evaluation” on page 6-12

Labor Summary Page 2

The Labor and Delivery Summary - Labor Summary Page 2 screen, shown in Figure 16-2, enables you to record amniotic fluid and placental data. This screen is accessed using the **Page 2** button on the Labor and Delivery Summary - Labor Summary screen.

Figure 16-2 *Labor and Delivery Summary - Labor Summary Page 2 Screen*



Usage Notes:

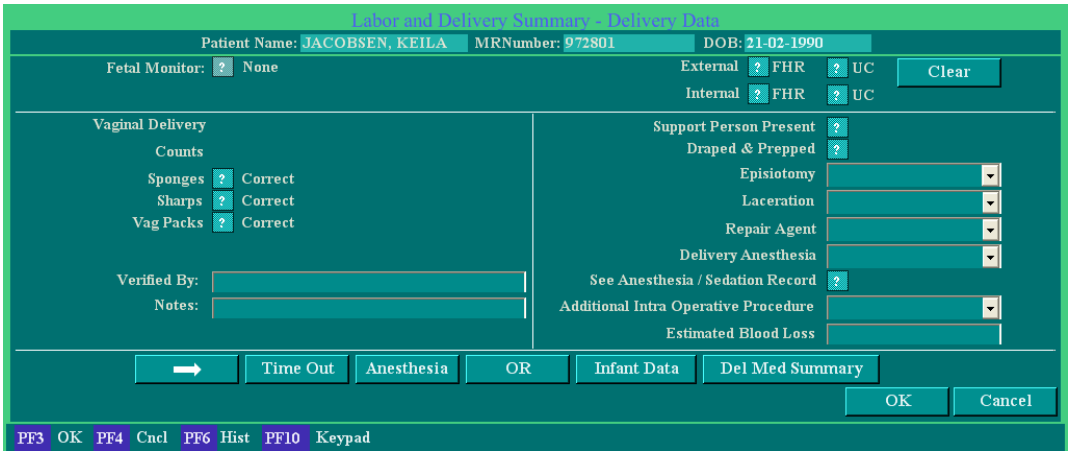
- You can clear the check boxes to *blank* (indicating No) by selecting the **Clear** button in each section of the screen.

- If multiple fetuses had been previously defined for the patient, the **Baby B** fields will be available for data entry. If more than two fetuses were previously defined, the **Next Baby** button will be active, enabling you to enter information about additional babies.
- Selecting the ⇦ button or **OK** will save your entries and return you to the Labor and Delivery Summary - Labor Summary screen.

Recording Delivery Data

The Labor and Delivery Summary - Delivery Data screen, shown in Figure 16-3, enables you to record data regarding the delivery. This screen is accessed only via the **Delivery** button on the Labor and Delivery Summary - Labor Summary screen.

Figure 16-3 *Labor and Delivery Summary - Delivery Data Screen*



Usage Notes:

- Use the data entry fields, drop-down selection menus and check boxes to record delivery information.
- The **Clear** button clears all check boxes to *blank* (indicating No).
- Refer to Table 16-2 for information on each of the screen buttons.

Table 16-2 *Delivery Data Buttons to Other Screens Reference*

Button	Screen Accessed	Described in...
⇨ and **Med Summary**	Labor and Delivery Summary - Medications Summary	"Viewing the Medications/IVs/Blood Entry Summary" on page 16-4
Time Out	Procedure Time Out	"Procedure Time Out" on page 15-5
Anesthesia	Patient Assessment and Pre-Anesthesia Evaluation	"Pre-Anesthetic/Sedation Evaluation" on page 6-12
OR	Pre-Operative Assessment	"Pre-Operative Assessment" on page 6-8

Table 16-2 *Delivery Data Buttons to Other Screens Reference*

Button	Screen Accessed	Described in...
Infant Data	Labor and Delivery - Infant Data	“Recording the Infant Data Summary” on page 16-5

Viewing the Medications/IVs/Blood Entry Summary

The Labor and Delivery Summary - Medication Summary screen, shown in Figure 16-4, is a view-only screen showing the medications administered to the patient and recorded on other screens. There are no data entry fields on this screen but direct access to other screens is provided via screen buttons. Refer to Table 16-3 for information on where each of the screen buttons take you.

Figure 16-4 *Labor and Delivery Summary - Medication Summary Screen*

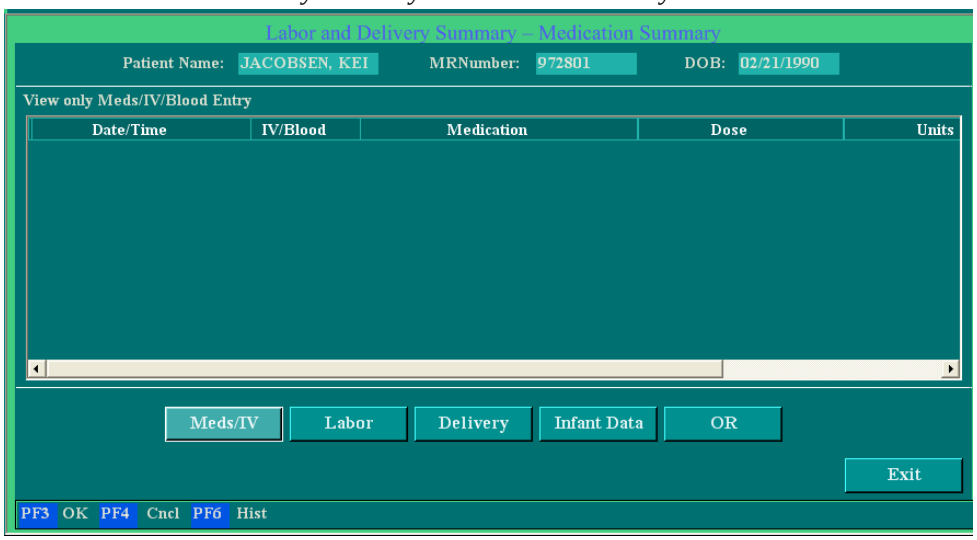


Table 16-3 *Medications Summary Buttons to Other Screens Reference*

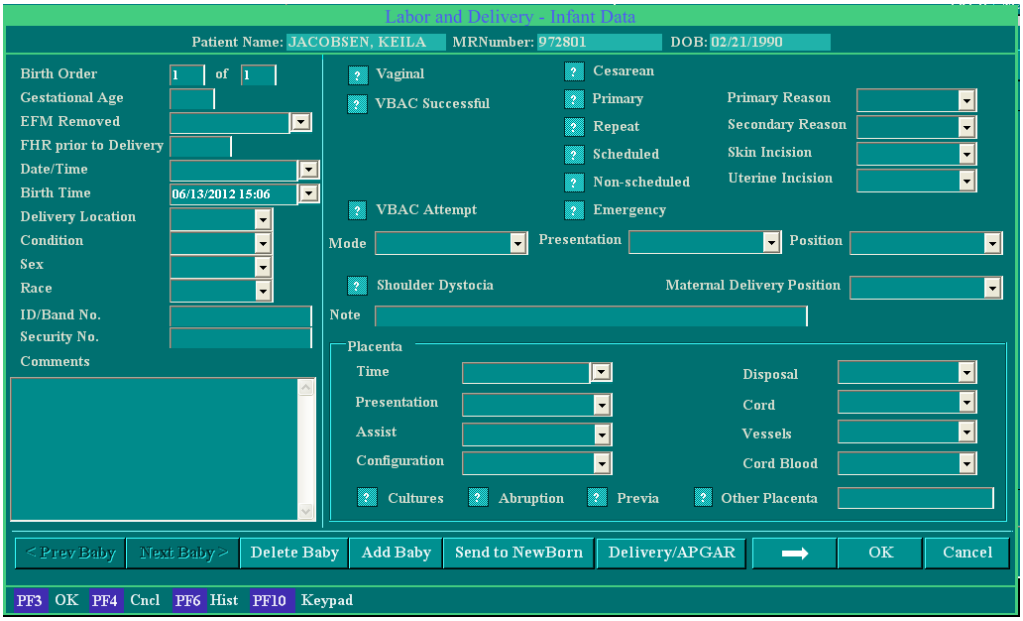
Button	Screen Accessed	Described In...
Meds/IV	Medications/IVs	“Recording Medications and IV Information” on page 15-8
Labor	Labor and Delivery Summary - Labor Summary	“Labor Summary Screens” on page 16-1
Delivery	Labor and Delivery Summary - Delivery Data	“Recording Delivery Data” on page 16-3
Infant Data	Labor and Delivery - Infant Data	“Recording the Infant Data Summary” on page 16-5
OR	Pre-Operative Assessment	“Pre-Operative Assessment” on page 6-8

Recording the Infant Data Summary

The Labor and Delivery - Infant Data screen, shown in Figure 16-5, is the first of two screens used to delivery details such as the method of delivery, summary of the placenta delivery, and other infant delivery information including multiple gestation delivery data. It also provides a link to newborn charts where you can enter data such as APGAR scores. Access the Labor and Delivery - Infant Data screen from any screen that contains an **Infant Data** button.

NOTE: Entering a time of birth creates a baby chart in the Newborn Record.

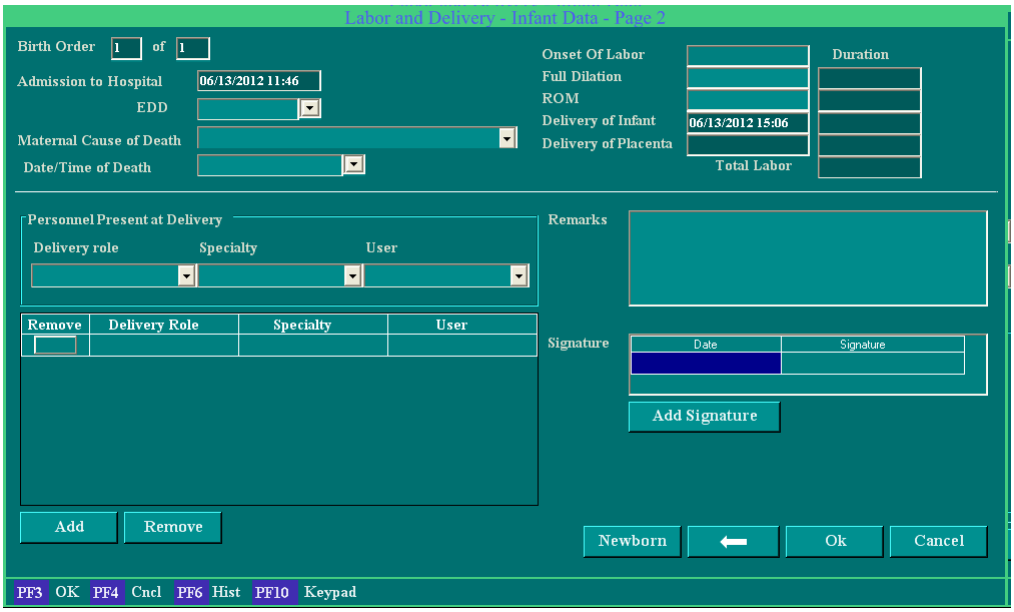
Figure 16-5 *Labor and Delivery - Infant Data Screen*



Usage Notes:

- Use data entry fields, drop-down menus, and check boxes to record information.
- To add subsequent baby records (i.e., for twins) select the **Next Baby** button for the *last created* Infant Data record. This creates an additional baby record. The birth order numbers will be imported from previous screens denoting Multiple Gestation. The **Add Baby** button allows you to add an unexpected delivery. The **Prev Baby** and **Next Baby** buttons allow you to quickly navigate between existing baby records. The **Delete Baby** button allows the user to correct a baby added in error.
- Use  to move back and forth betweek the pages (page 2 is shown in Figure 16-6 on page 16-6 with additional **Usage Notes)**.
- Entering a birth date activates the **Delivery/APGAR** button for charting APGAR scores. Clicking the button produces a pop-up stating *This infant's data has been successfully sent to newborn module*. Click **OK** to create a Newborn chart and refer to *NaviCare*® WatchChild® *Newborn User Manual, (LAB00691), Chapter 4* for related information.
- Click the **Newborn** button to access the Newborn charts.

Figure 16-6 *Labor and Delivery- Infant Data - Page 2 Screen*



Usage Notes:

- Use the data entry fields, drop-down selection menus, and check boxes to record the Maternal Data and Delivery attendees.
- Click **OK** on both open Labor and Delivery - Infant Data screen until the screens are closed.

NOTE: If you enter data on the summary screens after the message pop-up that data was sent to the Newborn chart, you must select **send to Newborn** in order for additional data to flow to the Newborn chart

Not Configured with the Newborn Application (NICU=False)

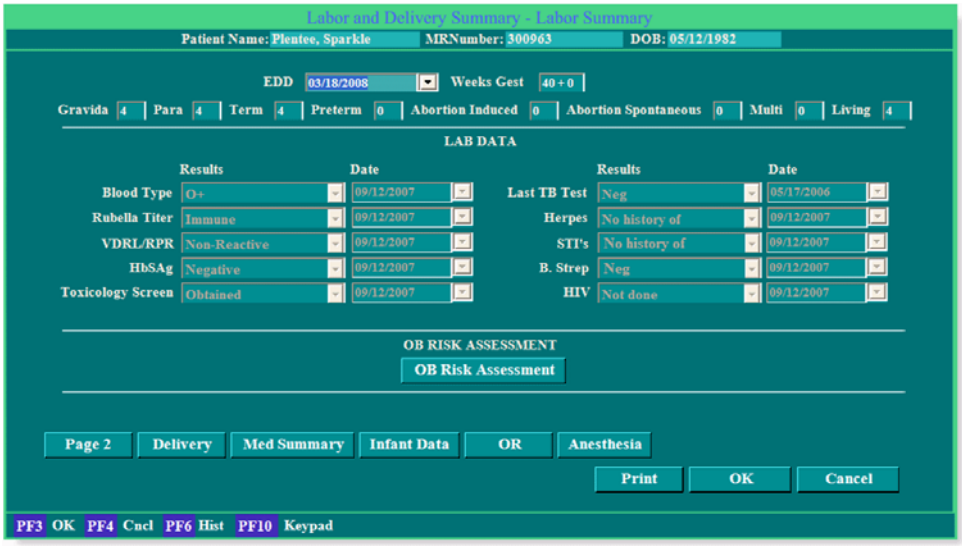
The Labor and Delivery Summary screens are used to display and, to a limited degree, record labor and delivery information. From the Labor and Delivery Summary screens you can access the delivery summary, delivery anesthesia delivery medications and infant data information screens.

Labor Summary Screens

The first of the labor, delivery and infant summary screens is the Labor and Delivery Summary - Labor Summary screen, shown in Figure 16-7, which displays previously recorded information, but enables you to modify entries if appropriate.

The Labor and Delivery Summary - Labor Summary screen is accessed from any screen that has a **Summary** button, including the Census and Chart screens. This screen is primarily view-only, displaying information that has been previously entered on other screens. The only fields that you can modify are those located above the LAB DATA section of the screen.

Figure 16-7 *Labor and Delivery Summary - Labor Summary Screen*



Refer to Table 16-4 for information on where each button on the screen takes you.

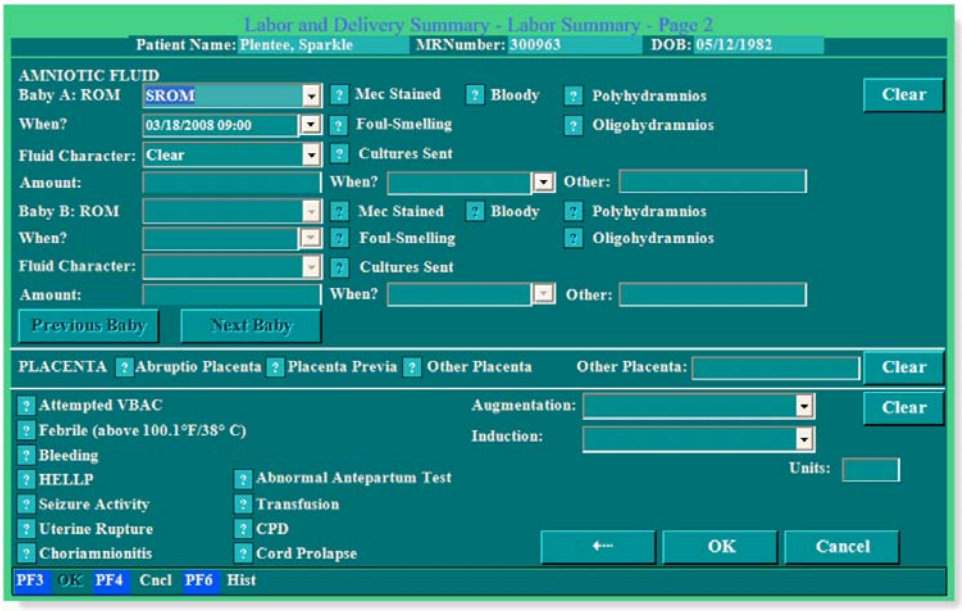
Table 16-4 *Labor Summary Buttons to Other Screens Reference*

Button	Screen Accessed	Described in...
Page 2	Labor and Delivery Summary - Labor Summary - Page 2	"Labor Summary Page 2" on page 16-7
Delivery	Labor and Delivery Summary - Delivery Data	"Recording Delivery Data" on page 16-8
Med Summary	Labor and Delivery Summary - Medication Summary	"Viewing the Medications Summary" on page 16-9
Infant Data	Labor and Delivery - Infant Data	"Recording the Infant Data Summary" on page 16-10
OR	Pre-Operative Assessment	"Pre-Operative Assessment" on page 6-8
Anesthesia	Patient Assessment and Pre-Anesthetic Evaluation	"Pre-Anesthetic/Sedation Evaluation" on page 6-12

Labor Summary Page 2

The Labor and Delivery Summary - Labor Summary Page 2 screen, shown in Figure 16-8, enables you to record amniotic fluid and placental data. This screen is accessed only via the ⇨ button on the Labor and Delivery Summary - Labor Summary screen.

Figure 16-8 *Labor and Delivery Summary - Labor Summary Page 2 Screen*



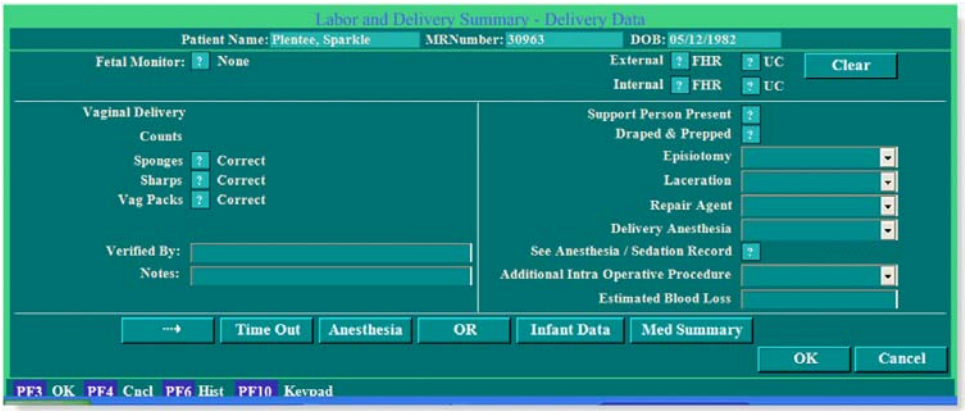
Usage Notes:

- You can clear the check boxes to *blank* (indicating No) by selecting the **Clear** button in each section of the screen.
- If multiple fetuses had been previously defined for the patient, the **Baby B** fields will be available for data entry. If more than two fetuses were previously defined, the **Next Baby** button will be active, enabling you to enter information about additional babies.
- Selecting the ⇦ button or **OK** will save your entries and return you to the Labor and Delivery Summary - Labor Summary screen.

Recording Delivery Data

The Labor and Delivery Summary - Delivery Data screen, shown in Figure 16-9, enables you to record data regarding the delivery. This screen is accessed only via the **Delivery** button on the Labor and Delivery Summary - Labor Summary screen.

Figure 16-9 *Labor and Delivery Summary - Delivery Data Screen*



Usage Notes:

- Use the data entry fields, drop-down selection menus and check boxes to record delivery information.
- The **Clear** button clears all check boxes to *blank* (indicating No).
- Refer Table 16-5 to for information on where each of the screen buttons take you.

Table 16-5 *Delivery Data Buttons to Other Screens Reference*

Button	Screen Accessed	Described in...
---→ and **Med Summary**	Labor and Delivery Summary - Medications Summary	"Viewing the Medications Summary" on page 16-9
Time Out	Procedure Time Out	"Procedure Time Out" on page 15-5
Anesthesia	Patient Assessment and Pre-Anesthesia Evaluation	"Pre-Anesthetic/Sedation Evaluation" on page 6-12
OR	Pre-Operative Assessment	"Pre-Operative Assessment" on page 6-8
Infant Data	Labor and Delivery - Infant Data	"Recording the Infant Data Summary" on page 16-5

Viewing the Medications Summary

The Labor and Delivery Summary - Medication Summary screen, shown in Figure 16-10, is a view-only screen showing the medications administered to the patient and recorded on other screens. There are no data entry fields on this screen but direct access to other screens is provided via screen buttons. Refer to Table 16-6 for information on where each of the screen buttons take you.

Figure 16-10*Labor and Delivery Summary - Medication Summary Screen*

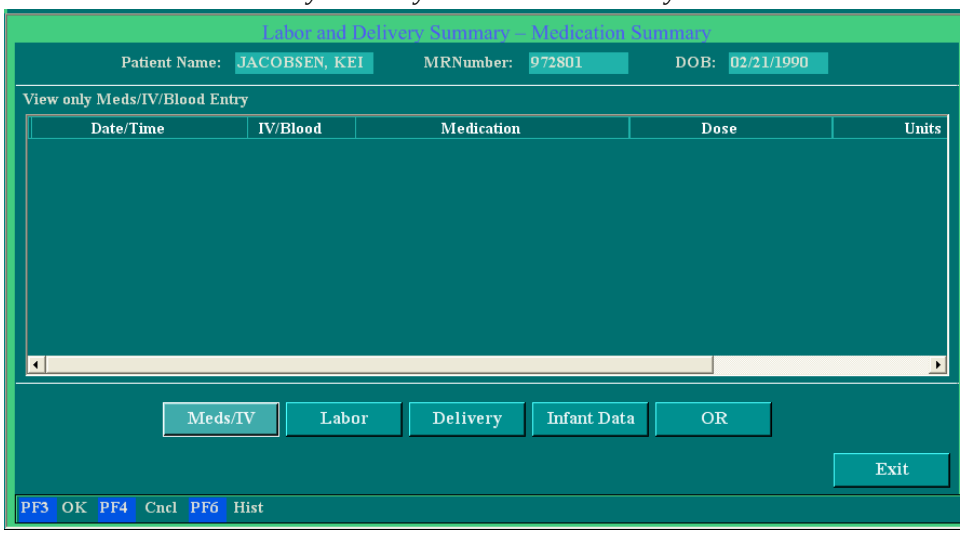


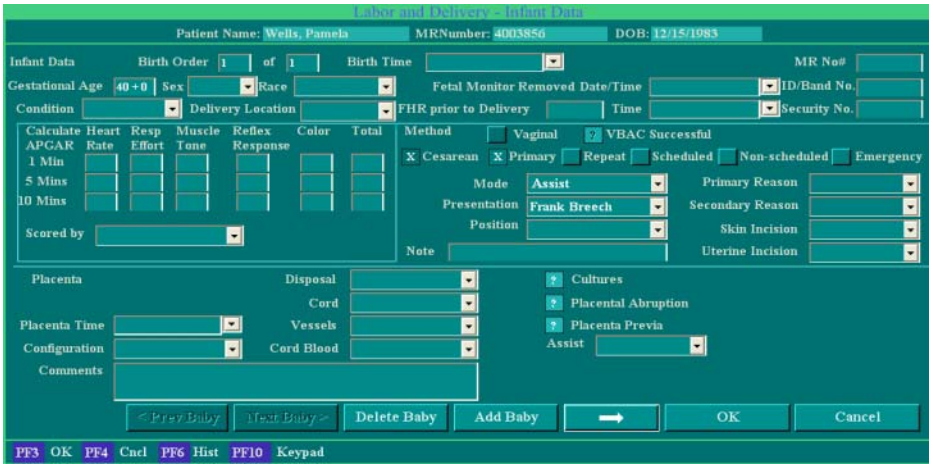
Table 16-6 *Medications Summary Buttons to Other Screens Reference*

Button	Screen Accessed	Described In...
Meds/IV	Medications/IVs	"Recording Medications and IV Information" on page 15-8
Labor	Labor and Delivery Summary - Labor Summary	"Labor Summary Screens" on page 16-6
Delivery	Labor and Delivery Summary - Delivery Data	"Recording Delivery Data" on page 16-8
Infant Data	Labor and Delivery - Infant Data	"Recording the Infant Data Summary" on page 16-10
OR	Pre-Operative Assessment	"Pre-Operative Assessment" on page 6-8

Recording the Infant Data Summary

The Labor and Delivery - Infant Data screen, shown in Figure 16-11, is the first of three screens used to record data such as the APGAR scores, method of delivery, summary of the placenta delivery and other infant delivery information. This screen is accessed via any screen that contains an **Infant Data** button.

Figure 16-11*Labor and Delivery - Infant Data Screen*

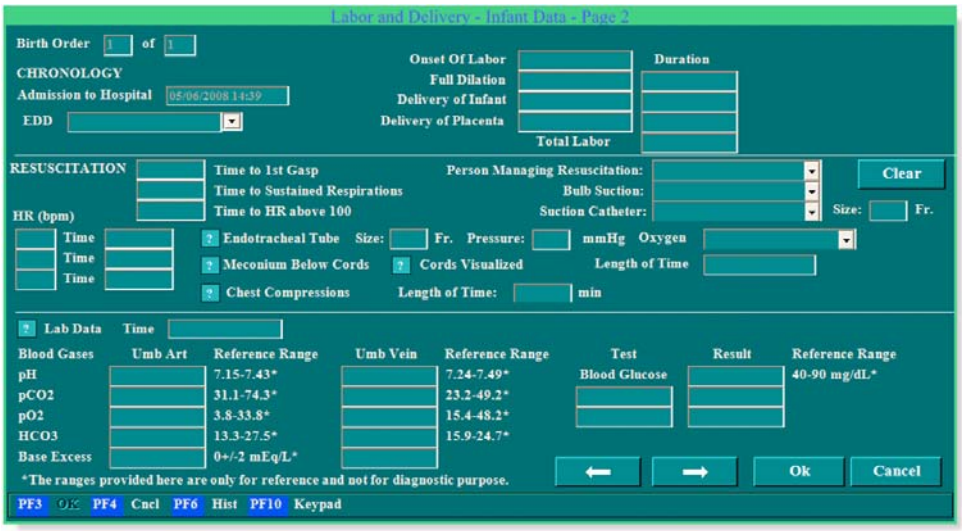


Usage Notes:

- Use the data entry fields, drop-down selection menus and check boxes to record the infant and placental information.
- To add subsequent baby records (i.e., for twins) select the **Add Baby** button for the *last created* Infant Data record. This creates an additional baby record. Enter the birth order number for Baby 2, Baby 3, etc. for multiple babies. The **Prev Baby** and **Next Baby** buttons allow you to quickly navigate between existing baby records. The **Delete Baby** button allows the user to correct a baby added in error.

- When you have finished entering data on this screen, select the ⇨ button to proceed to the L&D Summary - Infant Page 2 screen, shown in Figure 16-12.

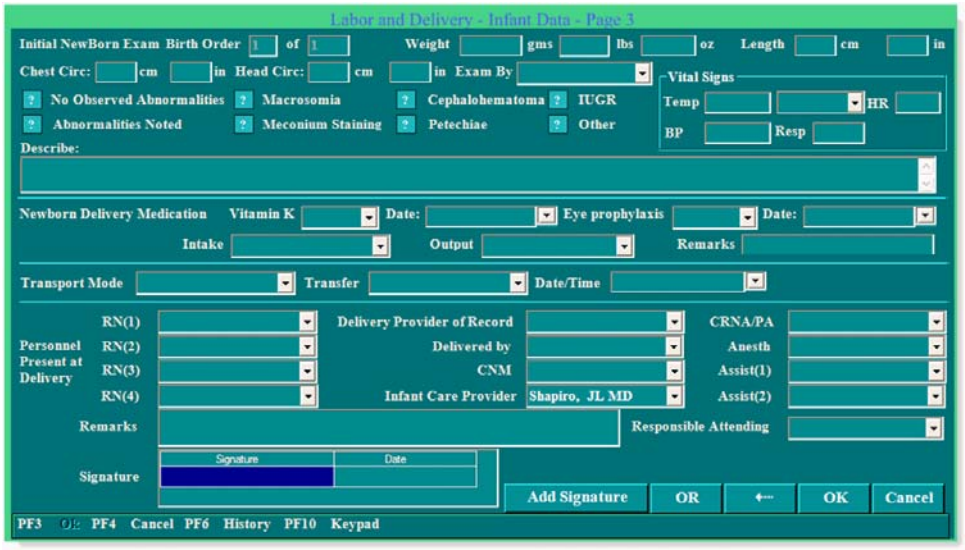
Figure 16-12*Labor and Delivery- Infant Data - Page 2 Screen*



Usage Notes:

- Use the data entry fields, drop-down selection menus and check boxes to record the infant Chronology, Resuscitation and Labs information. Some facilities may choose to hide the Lab Data section on this page via parameter configuration.
- When you have finished entering data on this screen, select the ⇨ button to proceed to the Labor and Delivery Summary - Infant Data - Page 3 screen, shown in Figure 16-13.

Figure 16-13*Labor and Delivery - Infant Data - Page 3 Screen*



Usage Notes:

- Use the data entry fields, drop-down selection menus and check boxes to complete recording of the infant data record.

- When you have finished entering data on this screen, select **Signature**, then enter your password in the pop-up Security Lock screen and select **OK** to complete your signing of the Infant Data record. If you are not the currently logged in user, then your user ID will need to be entered. Passwords are case sensitive.

Chapter 17

Recovery & Postpartum Records

Recovery/Postpartum Flowsheet

The Recovery/Postpartum Flowsheet and its associated screens enable you to record your patient's progress following delivery. Access the Recovery/Postpartum Flowsheet as follows:

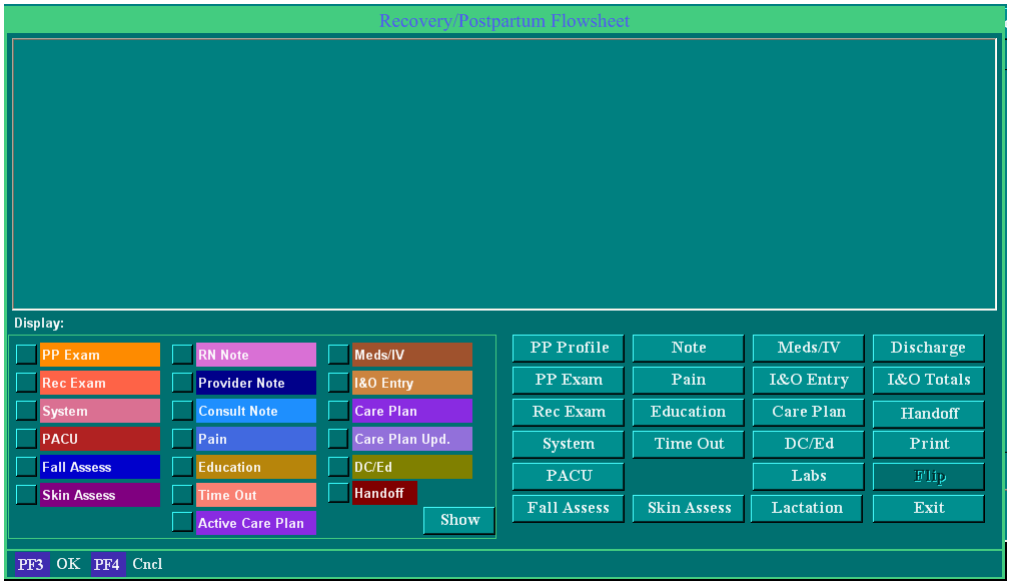
1. *From the Census or Multi-Patient Surveillance screen*, select the patient and then select **Chart.**

   From a Single-Patient Surveillance screen, select **Chart.**

   The Chart screen appears.

2. On the Chart screen, select **Rec/PP**. The Recovery/Postpartum Flowsheet appears, as shown in Figure 17-1.

Figure 17-1 *Recovery/Postpartum Flowsheet Screen*



Several of the screens accessed by the flowsheet buttons are also accessed by other screens and are described elsewhere in this manual. Only those screens not already described elsewhere are described within this chapter. Table 17-1 on page 17-2 shows you which screen each button takes you to and where to find that screen's usage information.

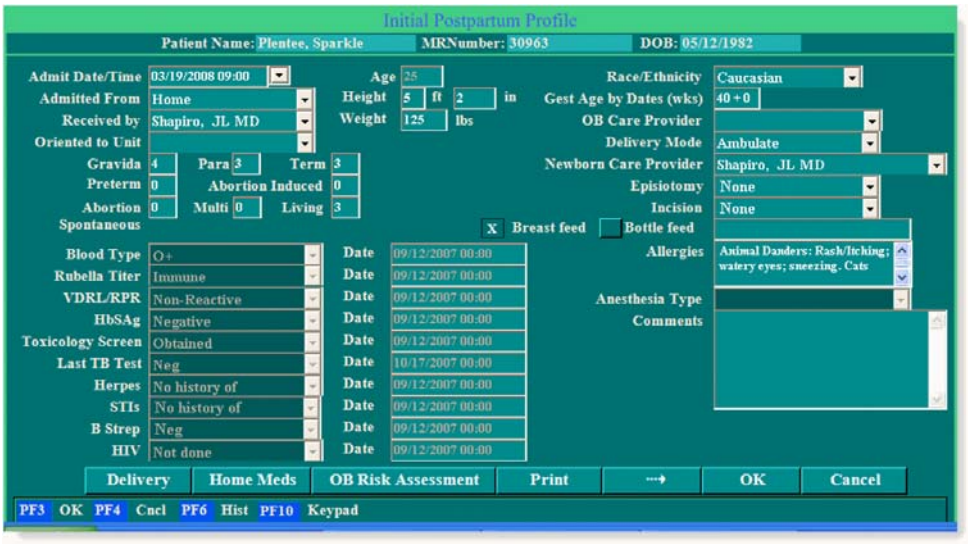
Table 17-1 *Screen Buttons-to-Other Screens Cross-Reference*

Button	Screen Accessed	Described in...
PP Profile	Initial Postpartum Profile	"Recording the Initial Postpartum Profile" on page 17-3
PP Exam	Postpartum Exam	"Recording Postpartum Examination Data" on page 17-4
Rec Exam	Recovery Exam	"Recovery Exam" on page 17-5
System	Systems Assessment	"Systems Assessment Screen" on page 4-19
PACU	PACU Care Record	"Recording PACU Care Record" on page 17-6
Fall Assess	Fall Assessment	"Fall Assessment Screen" on page 4-37
Note	Notes	"Notes Screen" on page 4-20
Pain	Pain	"Pain Screen" on page 4-15
Education	Postpartum Education Record	"Recording Postpartum Patient Education" on page 17-7
Time Out	Procedure Time Out	"Procedure Time Out" on page 15-5
Skin Assess	Skin Assessment	"Skin Assessment Screen" on page 4-38
Meds/IV	Medications/IVs	"Recording Medications and IV Information" on page 15-8
I&O Entry and **I&O Totals**	Intake/Output Entry Record and Intake and Output Totals	"Intake/Output Entry Record" on page 15-6
Care Plan	Care Plan	"Care Plan" on page 4-33
DC/Ed	Postpartum/Newborn Discharge	"Postpartum Discharge" on page 17-8
Labs	Laboratory Results	"Laboratory Results" on page 13-12
Lactation	Lactation Baby Search	"Lactation" on page 17-10
Discharge	Obstetric Discharge Summary	"Creating an Obstetric Discharge Summary" on page 17-10
Handoff	Labor & Delivery Hand Off Communication	"Labor & Delivery Hand Off Communications" on page 6-7

Recording the Initial Postpartum Profile

1. Select **PP Profile** on the Recovery/Postpartum Flowsheet for the selected patient or select **Initial PP Profile** on the Prenatal Antepartum Record — Postpartum Visit screen. The Initial Postpartum Profile screen displays, as shown in Figure 17-2.

Figure 17-2 *Initial Postpartum Profile Screen*



A number of the fields on this screen have been pre-populated by data entered on other screens.

2. Use the available data entry fields, drop-down selection menus and check boxes as appropriate to record your patients initial postpartum profile information.

3. If you have not previously recorded the labor and delivery summary data, select **Delivery** to display the Labor and Delivery Summary - Labor Summary screen, then see Chapter 16, “Labor, Delivery, and Infant Summary” on page 16-1 for screen usage information.

4. To view the patient’s home medications list, select **Home Meds** to display the Home Medications screen. The screen is view-only from the Initial Postpartum Profile screen. To add to or modify the displayed data, see “Home Medications Screen” on page 4-18.

5. To view the patient’s obstetric risk assessment information, select **OB Risk Assessment** to display the Obstetric Admitting Record - OB Risk Assessment screen. The screen is view-only from the Initial Postpartum Profile screen. To add to or modify the displayed data, see “OB Risk Assessment Screen” on page 4-35.

6. To record postpartum and newborn education information, select the ⇨ button to display the Postpartum/Newborn Discharge screen, then see “Postpartum Discharge” on page 17-8

7. Select **OK** to save your changes and to close the screen.

Recording Postpartum Examination Data

1. Select **PP Exam** on the Recovery/Postpartum Flowsheet for the selected patient. The Postpartum Exam screen displays.

Figure 17-3 *Postpartum Exam Screen*

2. Use the data entry fields and drop-down selection menus as appropriate to record your patient's postpartum examination. Table 17-2 shows you where screen buttons take you if you wish to perform other functions.

Table 17-2 *Postpartum Exam Screen Buttons to Other Screens Cross-Reference*

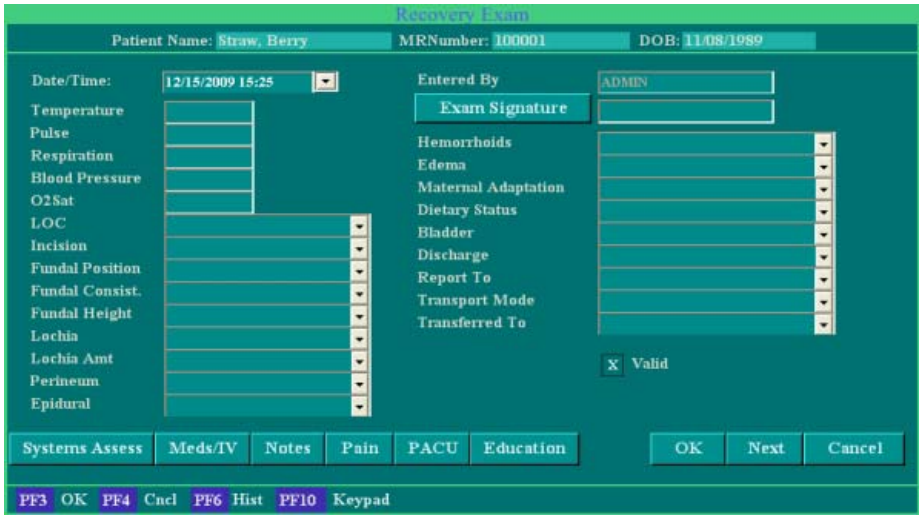
Button	Screen Accessed	Described in...
Systems Assess	Systems Assessment	"Systems Assessment Screen" on page 4-19
Pain	Pain	"Pain Screen" on page 4-15
Notes	Notes	"Notes Screen" on page 4-20

3. When you have finished entering data on this screen, either select **OK** to save your changes and close the screen or select one of the above buttons to save your entries and go to the specified screen.

Recovery Exam

The Recovery Exam screen, shown in Figure 17-4, is accessed by selecting **Rec Exam** on the Recovery/Postpartum Flowsheet screen. Use the data entry fields and drop-down selection menus as appropriate to report your patient's initial recovery status following delivery.

Figure 17-4 *Recovery Exam Screen*

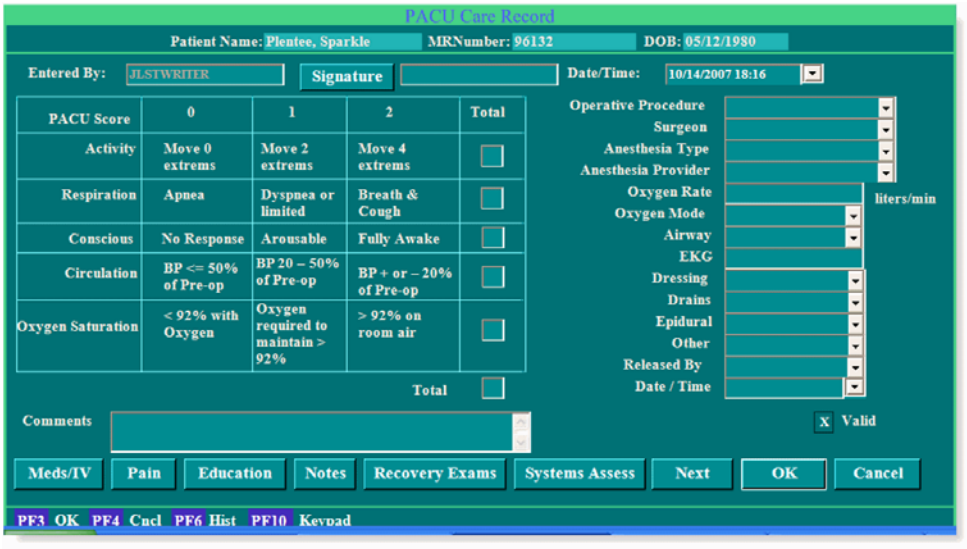


Recording PACU Care Record

The PACU Care Record screen enables you to assess your patient's status in the post anesthesia care unit following any procedure that required anesthesia.

1. Select **PACU** on the Recovery/Postpartum Flowsheet for the selected patient. The PACU Care Record screen displays, as shown in Figure 17-5. The Surgeon and Anesthesia fields are populated from the OR screen.

Figure 17-5 *PACU Care Record Screen*

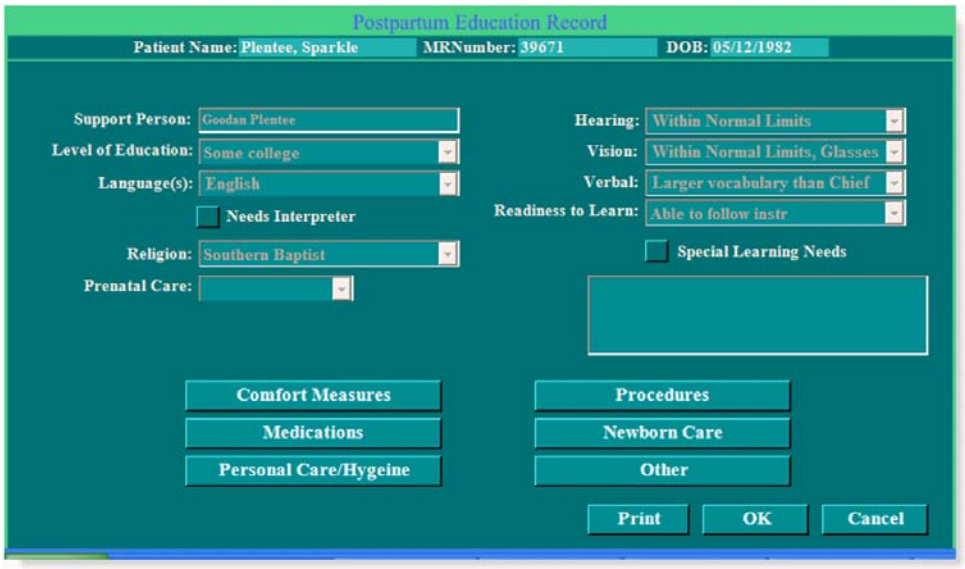


2. Use the data entry fields and drop-down selection menus as appropriate for your patient's post anesthesia status.
3. Select any screen buttons necessary to provide additional patient information.
4. Select **OK** to save your changes and close the screen.

Recording Postpartum Patient Education

Selecting **Education** on the Recovery/Postpartum Flowsheet opens the Postpartum Education Record screen, shown in Figure 17-6, which is the first of seven postpartum patient education screens. The information recorded on these screens documents the postpartum education that is provided to the patient and her family prior to her discharge. This documentation includes educating the family, the level of interaction with the family members and the method used to provide the instructions.

Figure 17-6 *Postpartum Education Record Screen*

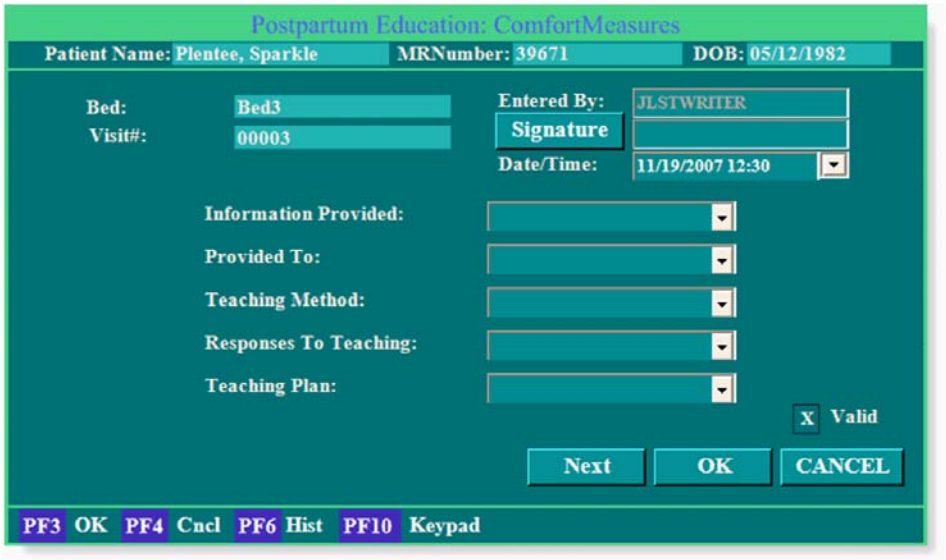


Most of the fields on this screen are pre-filled with data previously entered on other NaviCare® WatchChild® screens and cannot be modified here. The exceptions are the **Special Learning Needs** check box and its associated text entry field. If the patient has any special educational needs beyond those covered by the other Postpartum Education Record screens, X the **Special Learning Needs** check box and type a description of the needed and/or provided education into the text entry field. The **Date/Time** field on each of the educational topic screens is automatically filled in with the time that you opened the screen. If education was provided at an earlier time, change the date and time to reflect when education was actually performed.

All of the screens accessed via the buttons on the Postpartum Education Record screen have the same format and fields, as illustrated by the Postpartum Education: Comfort Measures screen shown in Figure 17-7 on page 17-8. To use the screens:

1. On the Postpartum Education Record screen, select an education topic button to open that topic's screen.
2. If the education was provided to the patient at a previous date and/or time, change the displayed date and time as appropriate.
3. For each of the remaining fields, select the most appropriate item(s) from the drop-down selection menus. You can select multiple items from each drop-down. You can also select **Other** from each menu and create your own entry if none of the existing selections are a good match.
4. When you are finished entering data on a screen, select **OK** to save your entries and close the screen.

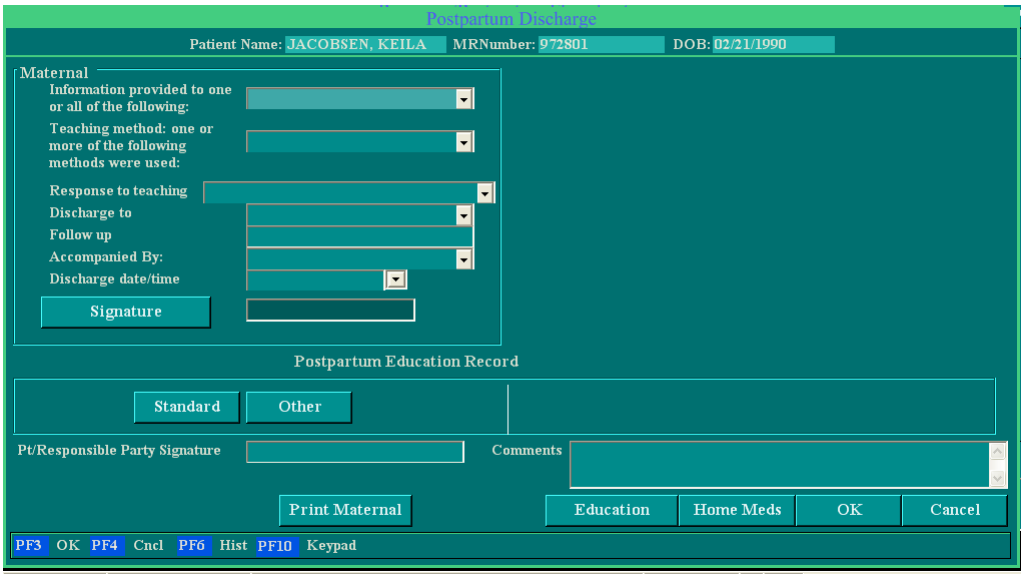
Figure 17-7 *Postpartum Education Record: Comfort Measures Screen*



Postpartum Discharge

The Postpartum Discharge screen, accessed by selecting **DC/Ed** on the Recovery/Postpartum Flowsheet or the Newborn Flowsheet and shown in Figure 17-8, enables you to establish a record of maternal and newborn discharge education given to your patient before she leaves the hospital.

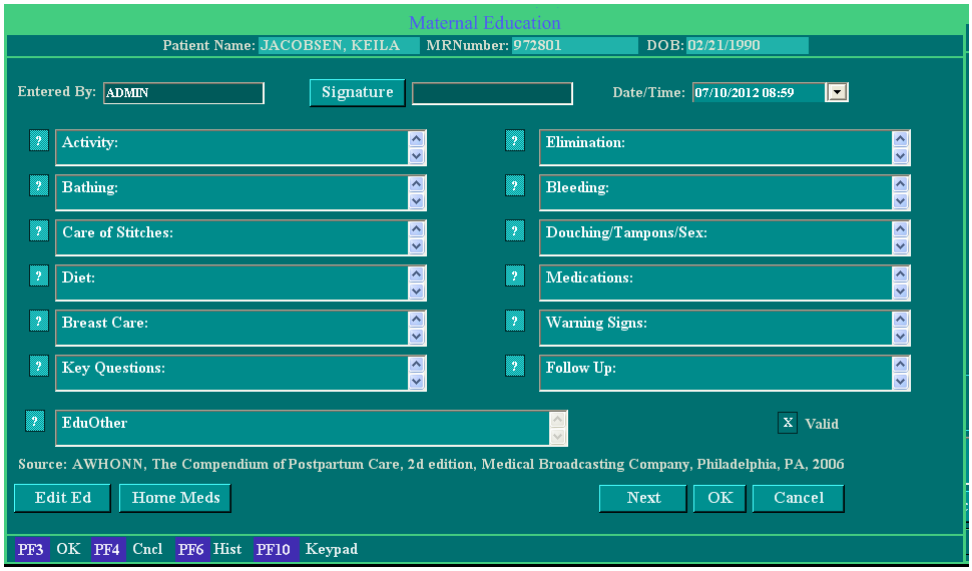
Figure 17-8 *Postpartum Discharge Screen*



1. On the Recovery/Postpartum Flowsheet screen, select **DC/Ed** to display the Postpartum Discharge screen.
2. In the top half of the screen, use the drop-down selection menus and data entry fields to fill in the appropriate **Maternal** information.
3. In the **Postpartum Education Record** area, under **Maternal**:

a. Select **Standard**. The Maternal Education screen displays, as shown in Figure 17-9.

Figure 17-9 *Maternal Education Screen*



b. Check off (select to X) each topic that you have covered with the patient. (Select to *blank* those that you did not cover.) To modify the education text, select **Edit Ed** (lower-left corner of screen), then change any education text in the textbox that is configurable by hospital as needed. The other topics are quoted from a reference source and should only be updated as the reference source itself is updated.

c. Select the **Signature** button at the top of the screen to certify that you have covered the information.

d. Select **OK** to close the screen and return to the Postpartum Discharge screen.

e. Your hospital may have additional education topics to be discussed with the patient that are not covered on the Maternal Education screen. If so, select **Other** to display the Other Education screen (not shown here) and see the hospital-specific education topics.

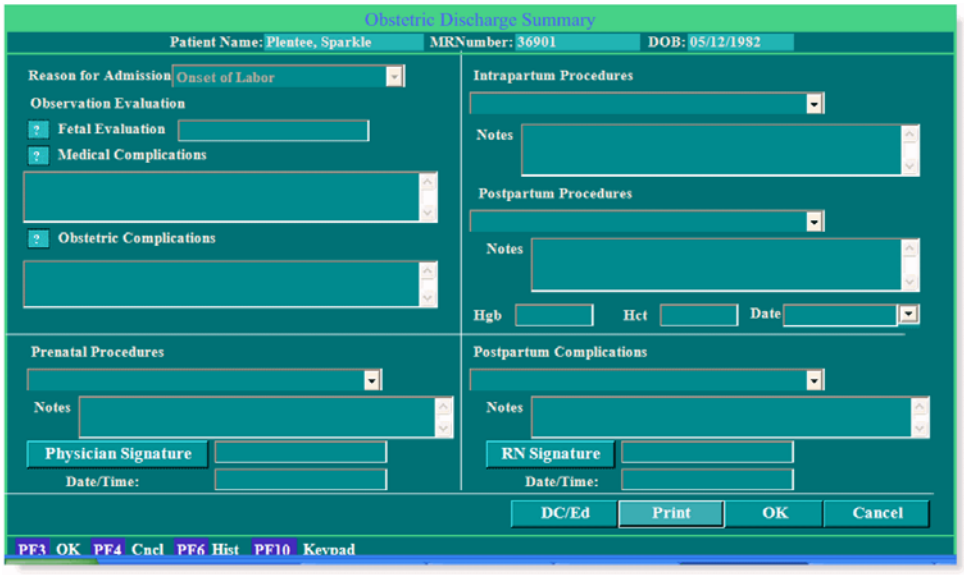
4. To print the education topics to give to your patient, select **Print Maternal**.

5. Select **OK** to save your entries and close the screen.

Creating an Obstetric Discharge Summary

1. Select **Discharge** on the Recovery/Postpartum Flowsheet for the selected patient. The Obstetric Discharge Summary screen displays, as shown in Figure 17-10.

Figure 17-10 *Obstetric Discharge Summary Screen*



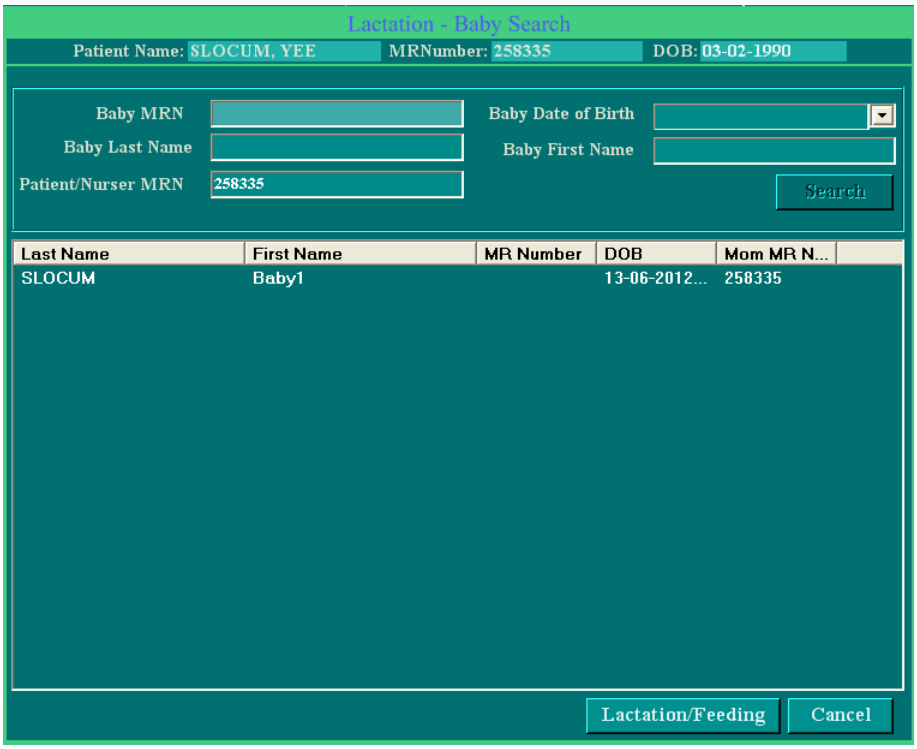
2. Use the check boxes, data entry fields and drop-down selection menus to enter the summary data appropriate to your patient.
3. When done entering discharge summary information, select **OK** to save your entries and close the screen.

Lactation

The Recovery/Postpartum Flowsheet **Lactation** button is available on NaviCare® WatchChild® systems configured with the Newborn Application (NICU=True). The Lactation option allows you to immediately access the Newborn Application Lactation Flowsheet.

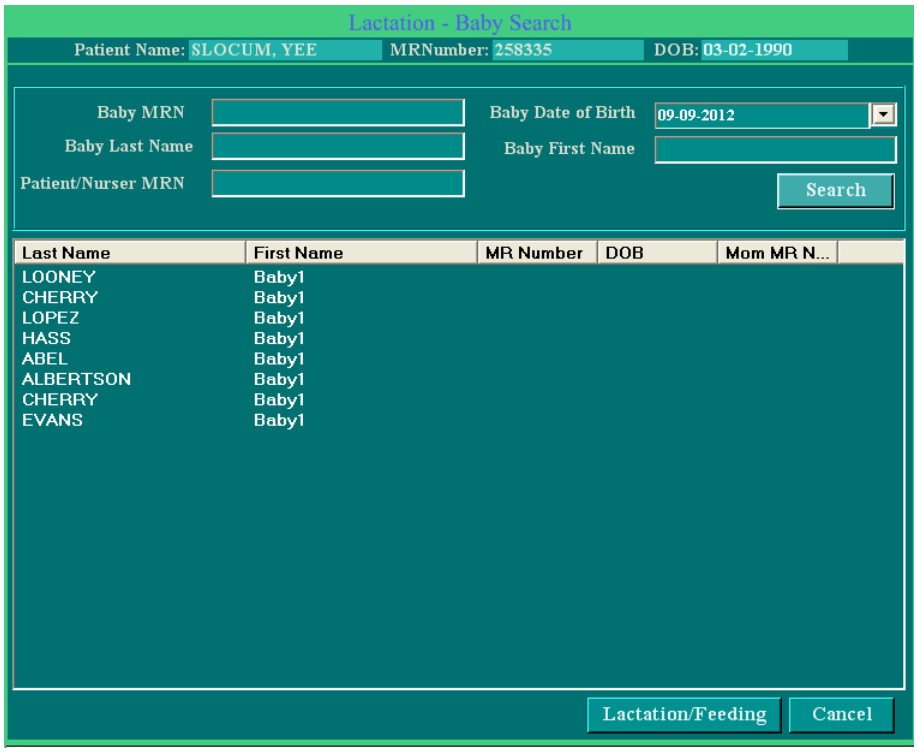
1. On the Recovery/Postpartum Flowsheet screen, select **Lactation** to display the Lactation Baby Search screen as shown in Figure 17-11 on page 17-11. The baby, or babies, associated with the patient (mother) automatically appear in the search result box.

Figure 17-11 *Lactation Baby Search Screen*



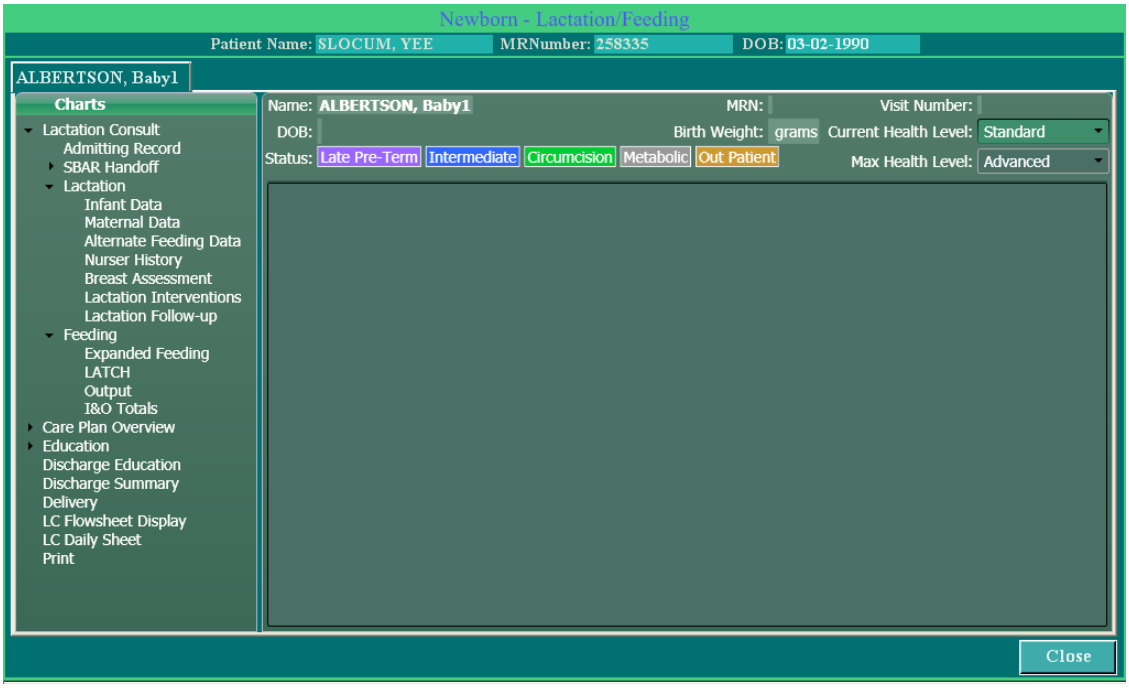
2. To search for a baby, enter a **Last Name** or select a **Date of Birth** and click **Search**.

Figure 17-12 *Lactation Baby Search Screen Results*



3. If the search results display more than one baby, select a baby and click **Lactation/Feeding** to access the Newborn Application in Lactation Navigation mode as shown in Figure 17-13.

Figure 17-13 *Newborn Lactation/Feeding Screen*



4. Refer to *NaviCare*® WatchChild® *Newborn User Manual, (LAB00691), Chapter 8* for information on using the Lactation Flowsheet.

5. Click **Close** to return to the Lactation Baby Search screen.

Chapter
18

Newborn Flowsheet

NOTE: This portion of the NaviCare® WatchChild® Record will only appear if the Newborn Application is configured to **OFF** (NICU=False).

The Newborn Flowsheet, shown in Figure 18-3, and the information in this section provides a variety of charting information about the newborn when using the traditional newborn charting package (NICU=False). When the Newborn module is turned on (NICU=True), all newborn charting is documented in the Newborn module.

When NICU=False, as shown in Figure 18-1, the Chart screen displays a **Newborn** button that links to the traditional newborn charting package described in this section. When NICU=True, that button does not appear on the Chart screen.

Figure 18-1 *Chart Screen when NICU=False*

Also when NICU=False, as shown in Figure 18-3, the **Newborn** System Function button at the bottom of the screen is disabled.

Figure 18-2 *Disabled Newborn System Function Button when NICU=FALSE*

The Newborn Flowsheet, shown in Figure 18-3, can be accessed when NICU=False. If multiple births are recorded for the selected patient, a separate flowsheet will exist for each newborn and the

<Prev Baby and **Next Baby>** buttons on the upper right of the screen will be active, taking you to the another baby's flowsheet.

Access the Newborn Flowsheet as follows:

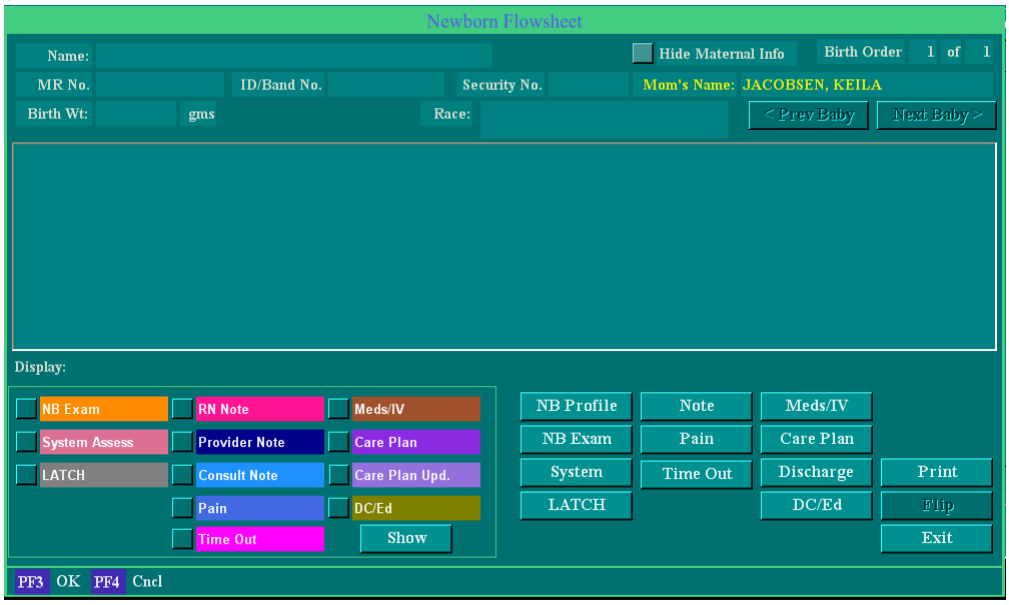
1. *From the* Census *or* Multi-Patient Surveillance screen, select the patient and then select **Chart.**

   From a Single-Patient Surveillance *screen*, select **Chart.**

   The Chart screen appears.

2. On the Chart screen, select **Newborn**. The Newborn Flowsheet appears, as shown in Figure 18-3.

Figure 18-3 *Newborn Flowsheet Screen*



NOTE: See the birth order in the upper right to ensure proper information entry for the correct baby.

Several of the screens accessed by the flowsheet buttons are also accessed by other screens and are described elsewhere in this manual. Only those screens not already described elsewhere are described within this chapter. Table 18-1 on page 18-3 shows you which screen each button takes you to and where to find that screen's usage information.

Table 18-1 *Screen Buttons-to-Other Screens Cross-Reference*

Button	Screen Accessed	Described in...
NB Profile	Initial Newborn Profile	Chapter 18, “Newborn Profile and Initial Physical Examination” on page 18-4
NB Exam	Newborn Examination	“Adding and Recording Newborn Examination Data” on page 18-6
System	Newborn System Assessment	“Recording Newborn System Assessment” on page 18-7
Education	Antepartum/Intrapartum Education Record	“Recording Postpartum Patient Education” on page 17-7
Note	Notes	“Notes Screen” on page 4-20
Pain	Newborn Pain	“Recording Newborn Pain Assessment” on page 18-8
Time Out	Procedure Time Out	“Procedure Time Out” on page 15-5
Meds/IV	Newborn Medications/IVs	“Newborn Medications” on page 18-9
Care Plan	Care Plan	“Newborn Care Plan” on page 18-10
Discharge	Newborn Discharge Summary	“Discharging the Newborn’s Chart” on page 18-13
DC/Ed	Postpartum/Newborn Discharge	“Postpartum Discharge” on page 17-8

Newborn Profile and Initial Physical Examination

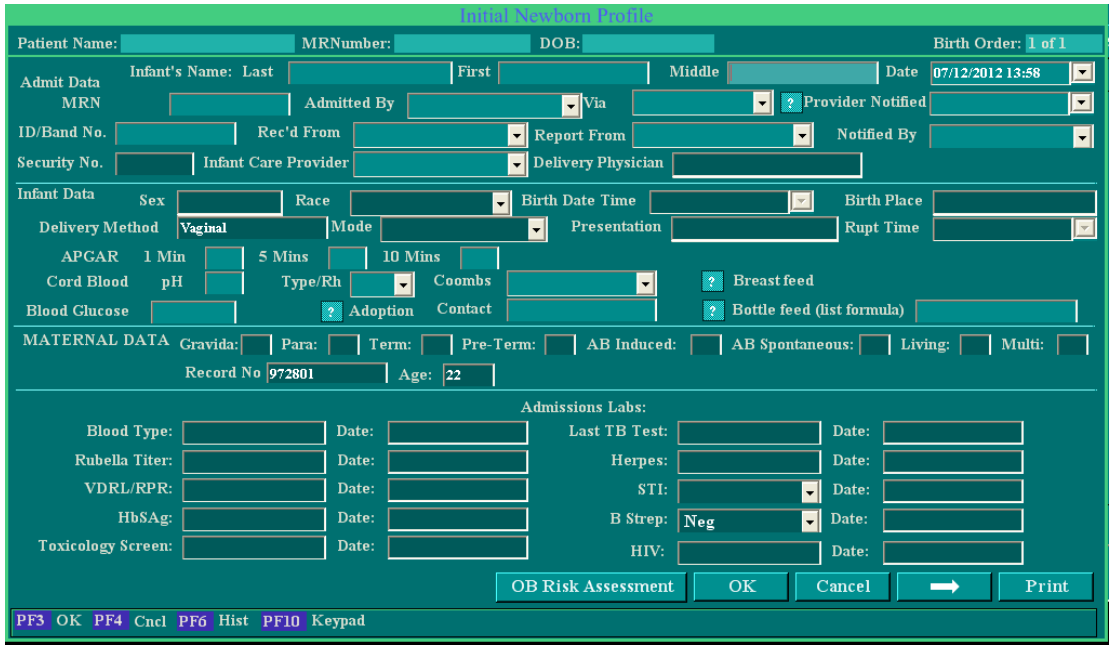
The Newborn Profile contains admission data, infant data, and maternal data. The Physical Examination screen in the Newborn Profile includes the initial systems assessment of the newborn.

Use this procedure to record and review the Newborn Profile and the initial physical examination. This series of screens admits the newborn to NaviCare® WatchChild® and records the newborn's initial physical examination.

NOTE: The Labor and Delivery Summary - Labor Summary and Labor and Delivery Summary - Infant Data screens must be completed before NaviCare® WatchChild® will store all of the data entered on the Initial Newborn Profile screen. If you have not already done so, ensure that the required Labor and Delivery Summary screens have been completed before proceeding with the Newborn Profile. This allows the user to benefit from the autopopulation of data into these fields. See Chapter 16, "Labor, Delivery, and Infant Summary" on page 16-1 for details.

1. Select **NB Profile** on the Newborn Flowsheet screen. The Initial Newborn Profile screen opens, as shown in Figure 18-4.

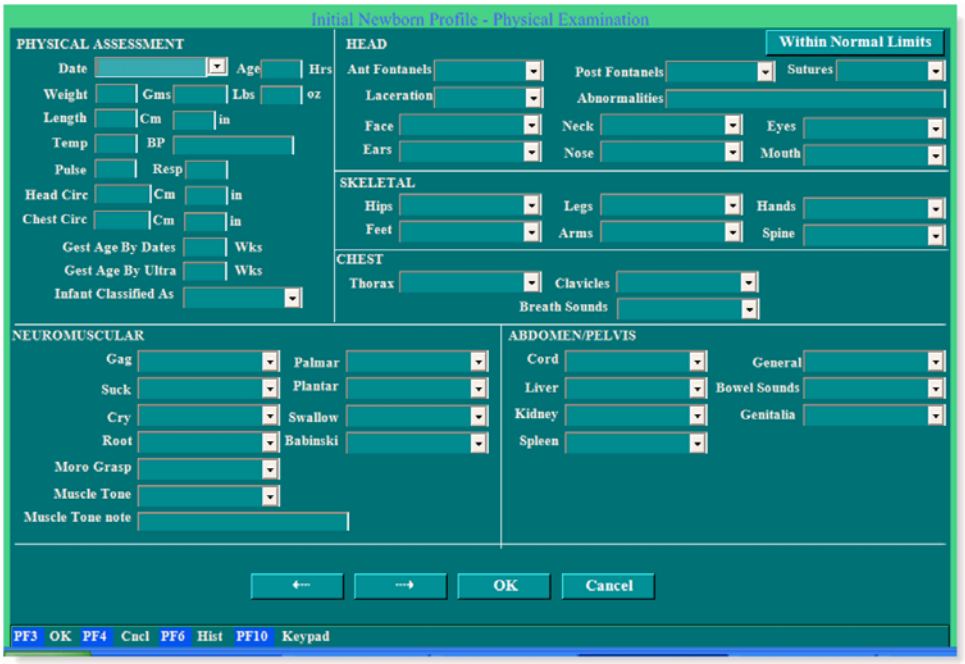
Figure 18-4 *Initial Newborn Profile Screen*



2. Some of the data for the newborn may be populated from previously entered information on the mother's chart. For fields that are not already populated, enter data or select from drop-down selections menus as appropriate for the newborn.
3. When you have completed entry of all applicable information, either select **OK** to save your entries and return to the Newborn Flowsheet screen, or select the ⇨ (arrow) button to proceed to the Initial Newborn Profile - Physical Examination screen, shown in Figure 18-5 on page 18-5.

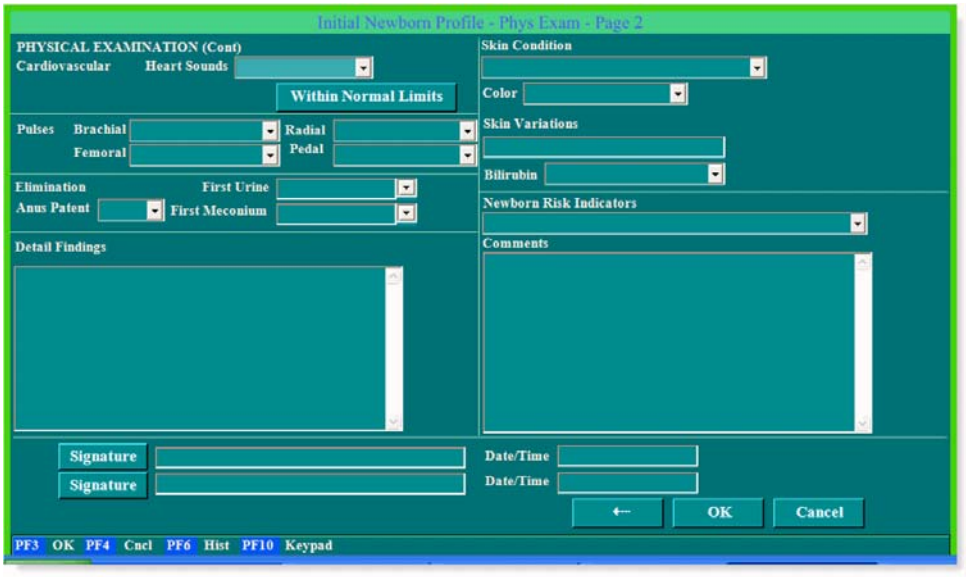
4. If you have proceeded to the Initial Newborn Profile - Physical Examination screen, use the data entry fields and drop-down selection menus to record your examination findings. If all body systems are within normal limits, the **Within Normal Limits** button may be used in the top right hand corner.

Figure 18-5 *Initial Newborn Profile - Physical Examination Screen*



5. Select the ⇨ button to display the Initial Newborn Profile - Phys Exam - Page 2 screen, shown in Figure 18-6.

Figure 18-6 *Initial Newborn Profile - Phys Exam - Page 2 Screen*



6. Use the data entry fields and drop-down selection menus to record your examination findings. If Heart Sounds, Brachial, Femoral, Radial and Pedal findings are all normal, you can fill these fields all at once by selecting the **Within Normal Limits** button.

7. When you have completed entering all examination data, select **OK** to save your changes and close the screen.

Adding and Recording Newborn Examination Data

Throughout the mother and newborn's hospital stay, you can record information from additional newborn examinations, for example, additional vital signs, cord care or circumcision care. Follow this procedure to add and record newborn examination data.

1. Select **NB Exam** on the Newborn Flowsheet screen. The Newborn Examination screen displays, as shown in Figure 18-7.

Figure 18-7 *Newborn Examination Screen*

It is not necessary to fill in everything on this screen. Any portion or all of the fields on this screen may be filled in as needed.

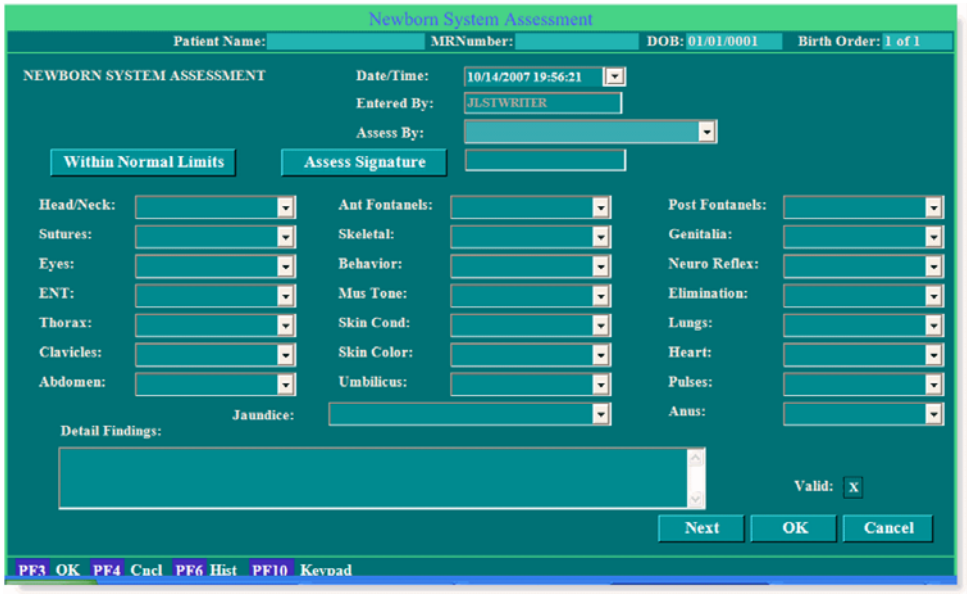
2. Use the data entry fields and drop-down selection menus to record your examination findings.
3. When you have completed recording examination data, select **OK** to save your changes and close the screen.

NOTE: Selecting **OK** on an Exam, Assessment or Medications/IVs screen without filling in any information will chart a blank entry on the flowsheet.

Recording Newborn System Assessment

1. Select **Assess** from the Newborn Examination screen or the Newborn Flowsheet to document the newborn's head-to-toe assessment. The Newborn System Assessment screen displays, as shown in Figure 18-8.

Figure 18-8 *Newborn System Assessment Screen*



2. Use the data entry fields and drop-down selection menus to record your examination findings. If all findings are within normal limits, you can fill all fields with that assessment by selecting the **Within Normal Limits** button.
3. When you have completed entering assessment information, select **OK** to save the assessment and close the screen.

Recording Newborn Pain Assessment

Recording the newborn pain allows pain management of the infant. The Neonatal Infant Pain Scale is a scoring system that consists of six categories. Each category is assigned a value and the six values are totalled for an overall score.

1. Select **Pain** on the Newborn Examination screen or on the Newborn Flowsheet. The Newborn Pain screen displays, as shown in Figure 18-9.

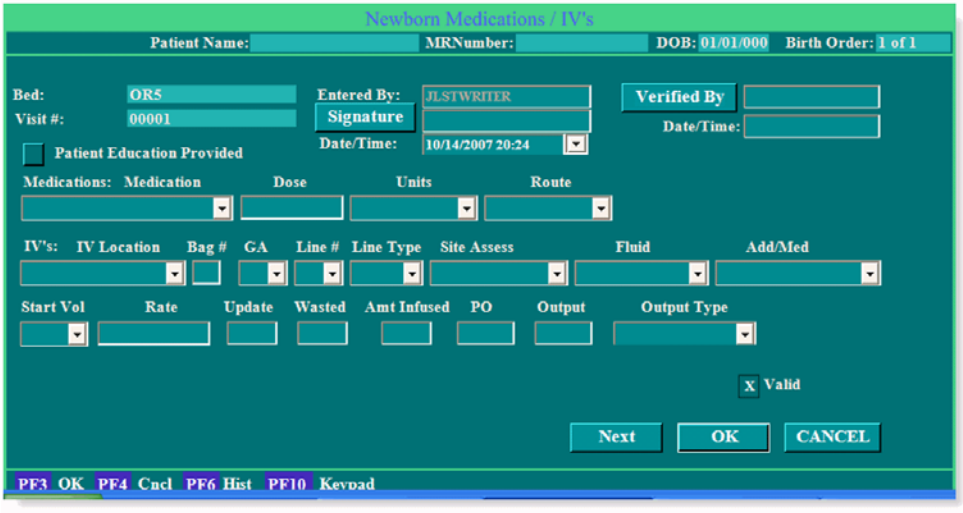
Figure 18-9 *Newborn Pain Screen*

2. Score each assessment with either 0, 1, or 2 according to the chart on the Newborn Pain Screen. The total is automatically calculated and appears at the bottom of the Score column.
3. Select **Signature** and enter your password in the Security Screen to record your electronic signature. Passwords are case sensitive. The user ID will show for the person currently logged in. Your signature should be entered to make sure that no one else is modifying your record. The date and time of your signature are automatically recorded.
4. Select **OK** to save your entries and close the screen.

Newborn Medications

The Newborn Medications/IVs screen, shown in Figure 18-10, enables you to record any medications and IV fluids administered to the newborn and also record any output produced by the newborn.

Figure 18-10 *Newborn Medications/IVs Screen*

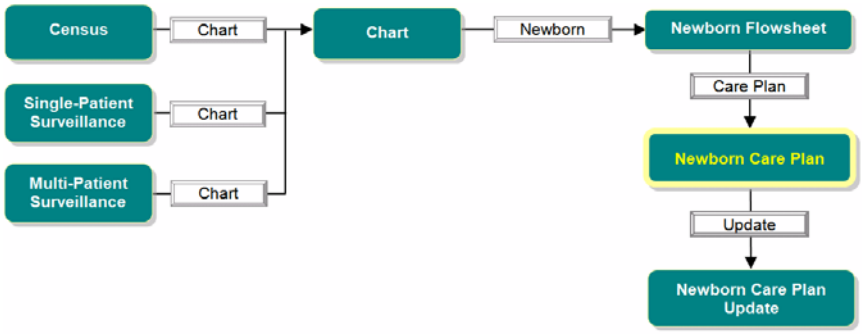


1. On the Newborn Flowsheet, select **Meds/IV** to display the Newborn Medications/IVs screen.
2. Use the check boxes, data entry fields and drop-down selection menus to enter medications and/or IV information about the newborn, including output.
3. When you are done entering and selecting data, select **OK** to save your entries and close the screen.

Newborn Care Plan

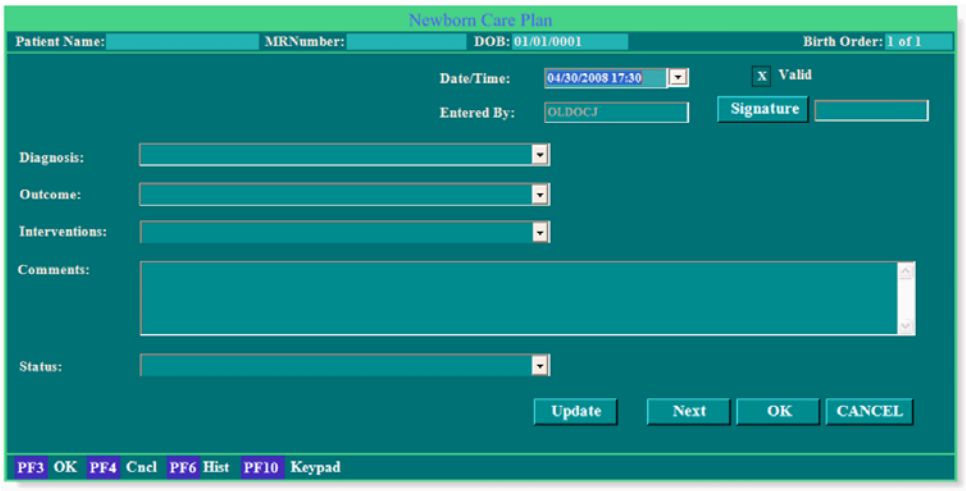
The Care Plan screen enables you to record problems that the newborn may be experiencing or is in danger of experiencing and document the plan for resolving or preventing the problem. The screen is accessed via the paths illustrated in Figure 18-11.

Figure 18-11 *Accessing the Newborn Care Plan Screen*



1. Access the Newborn Care Plan screen, shown in Figure 18-12, via any of the paths illustrated above.

Figure 18-12 *Newborn Care Plan Screen*



Usage Notes:

- Select the **Signature** button only *after* you have made entries on the screen and are sure the entries are accurate. **Signature** opens a pop-up screen for you to enter your user ID and password. Passwords are case sensitive. Once you have done that, your assessment on the screen cannot be modified by any other user.
- If you open an existing entry by selecting **Edit** on the Newborn Flowsheet screen and that entry was signed by another user, the signature field will be red and you can only view the entry.
- The **Valid** check box indicates that the Newborn Care Plan entries are currently accurate; it is the default setting. If, on the Newborn Flowsheet screen, you determine that a care plan is

no longer accurate, select **Edit** for that entry to open the entry's Newborn Care Plan screen, then deselect (*blank*) the check box.

- The **Next** button opens a new Newborn Care Plan screen for recording additional problems and their resolutions.
- Any drop-down menu with **OK** and **Cancel** buttons at the bottom of the menu enables you to select multiple items from the menu.
- When **Other** is a menu item, selecting it opens a text-entry pop-up that enables you to specify an option that the menu does not list. After typing in the option name, selecting **OK** adds the new option as a selected menu item.

2. Refer to Table 18-2 for guidance on what goes into each field.

Table 18-2 *Newborn Care Plan Screen Fields Usage Guide*

Field	Usage
Date/Time	Type in or select the date and time that this care plan is created.
Entered By	Shows the user ID of the person who initiated the care plan.
Diagnosis	Select from the drop-down menu the diagnosis for which this care plan applies.
Outcome	Select from the drop-down menu the desired outcome of the care plan.
Interventions	Select from the drop-down menu as many care options as apply to the problem.
Comments	Type any clarifying comments about the diagnosis, outcome or intervention.
Status	Select from the drop-down menu the current status of the problem.
Update button	If you have opened an existing care plan record by selecting **Edit** on a flowsheet and want to update the care plan, select Update to open the Newborn Care Plan Update screen, described in "Newborn Care Plan Update Screen" on page 18-11.

3. Select **Next** to save your entries and proceed to another Newborn Care Plan screen for entry of another care plan, or select **OK** to save your changes and return to the screen from which you accessed this screen.

Newborn Care Plan Update Screen

The Newborn Care Plan Update screen enables you to provide additional information or status on a previously defined care plan. The screen, shown in Figure 18-13 on page 18-12, is accessed only by selecting the **Update** button on the Newborn Care Plan screen. Refer to Table 18-3 on page 18-12 for descriptions of the screen fields.

Figure 18-13 *Newborn Care Plan Update Screen*

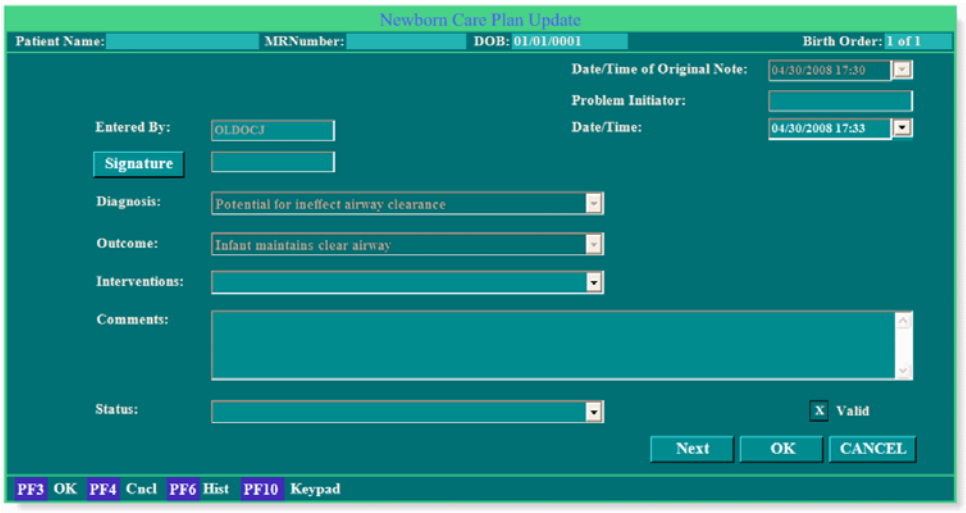


Table 18-3 *Newborn Care Plan Update Screen Fields Usage Guide*

Field	Usage
Problem Initiator	This display-only field shows the user ID of the person who signed the original care plan.
Date/Time	Type in or select the date and time that this care plan update is created.
Diagnosis	Display only, this field shows the original diagnosis for which this care plan applies.
Outcome	Display only, this field shows the original desired outcome of the care plan.
Interventions	Select from the drop-down menu as many care options as apply to the problem. You would normally use this field when one or more additional interventions were needed to achieve the desired outcome.
Comments	Type any clarifying comments about the diagnosis, outcome or intervention.
Status	Select from the drop-down menu the current status of the problem.
Next button	Use this button to display another Care Plan Update screen for this same care plan when you need to enter more information than can be accommodated on one screen.

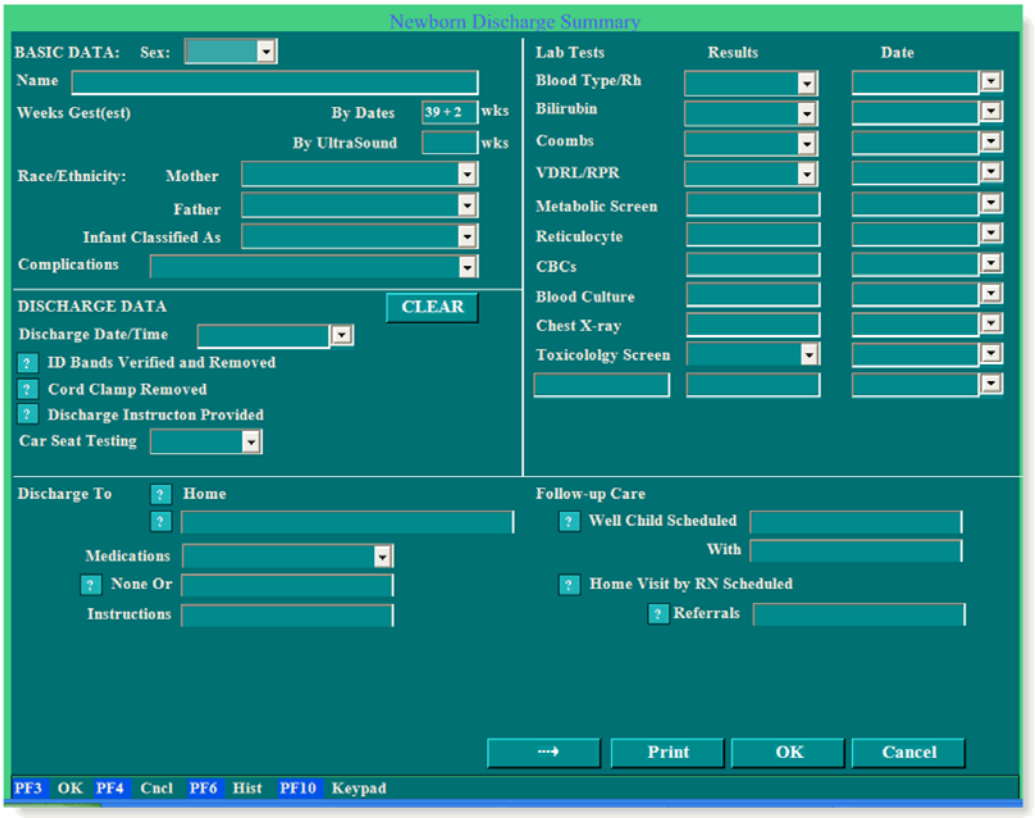
Discharging the Newborn's Chart

After the baby's birth, the newborn's chart is in NaviCare® WatchChild® under the mother's medical record number and name. To access newborn information, you must access the mother's chart.

Use the following procedure to complete the discharge summary prior to discharging the mother's chart.

1. Select **Discharge** on the Newborn Flowsheet screen. The Newborn Discharge Summary screen displays, as shown in Figure 18-14.

Figure 18-14 *Newborn Discharge Summary Screen*

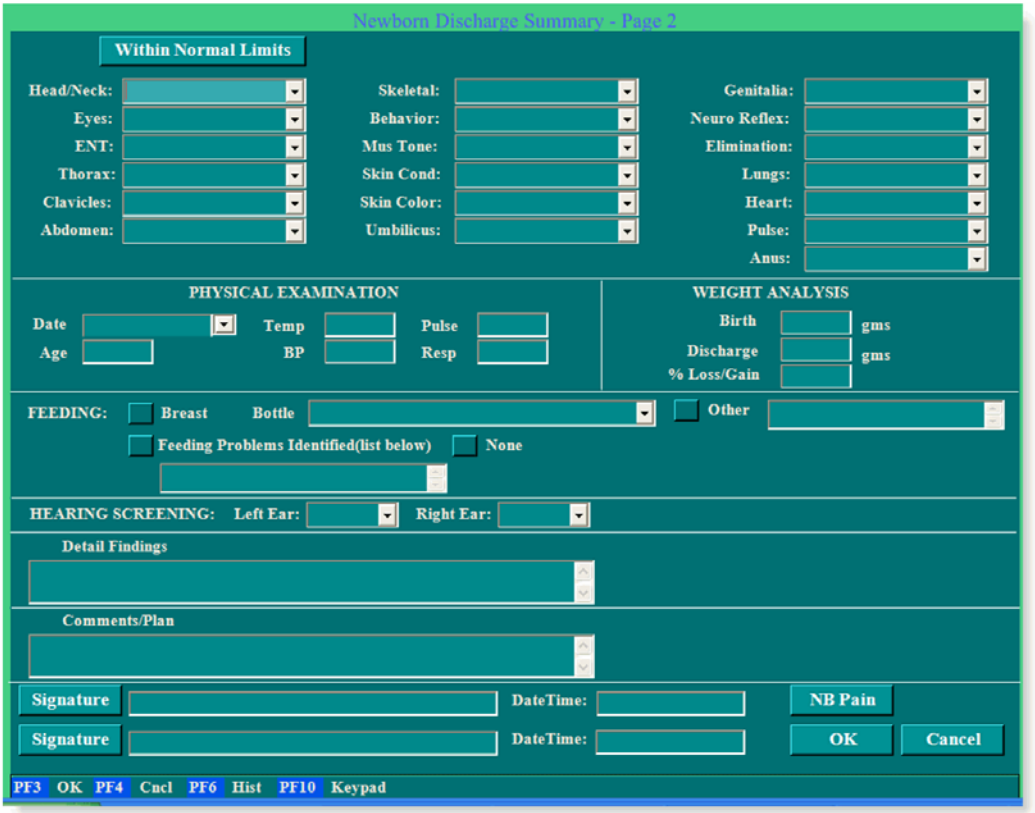


Much of the data requested on the Newborn Discharge Summary screen will automatically be populated from previously completed information.

2. Use the check boxes, data entry fields and drop-down selection menus to fill in the discharge summary information on this screen.

3. When you have completed entering discharge summary information on this screen, select the ⇨ button to display the Newborn Discharge Summary - Page 2 screen, shown in Figure 18-15 on page 18-14.

Figure 18-15 *Newborn Discharge Summary - Page 2*



4. Use the data entry fields and drop-down selection menus to record your summary information.
5. Select **OK** to save your entries and close the screen.

Chapter
19

ADT Interface

This chapter outlines and describes the NaviCare® WatchChild® expectations for receiving HL7 messages from other systems for admitting, transferring and discharging patients within the application. An *Admission* event message is sent for a patient needing a bed assignment. This operation indicates the beginning of a patient visit to the facility. A *Transfer* event message is sent when the patient's physical location is changed on the census. A *Discharge* event message is sent when the patient's visit has ended and the patient is no longer in the facility.

NaviCare® WatchChild® ADT is intended to assist users with the processing of admitting, transferring (intradepartmental and/or hospital wide), and discharging patients. Using ADT helps ensure the other hospital system's census boards are in sync with the unit census. ADT can be useful for the following areas:

- Prenatal Clinics
- Observation/Antenatal Units
- Labor and Delivery Units
- Postpartum Units

For Admission, Registration, Pre-Admission, and Update HL7 messages, the following fields may be mapped to the NWC Patient record:

- Medical Record Number (MRN)
- Patient First Name
- Patient Last name
- Date of Birth, Sex
- Race, Patient Address
- Home Phone Number, Language
- Marital status
- Religion
- Patient location
- Social Security Number
- Consulting doctor
- Admitting Doctor
- Visit Number (VN)
- Admission Date/Time

- Other Healthcare Provider (i.e. Advance Practice Nurse)
- Admit Reason
- Emergency Contact Name
- Emergency Contact Phone Number
- Emergency Contact Relationship
- Allergy code
- Allergy Description
- Diagnoses code
- Diagnoses description

ADT interface can be either a manual or automatic process, depending on the configuration set by the integration team. For more detailed information regarding admission, see Chapter 3, “Admitting a Patient” on page 3-1

Basic ADT

Basic ADT informs users when an ADT operation is present by displaying indicators on the census pertaining to admission. Discharge and Transfer messages are not sent to NaviCare® WatchChild® with basic ADT. HL7 messages are sent according to the bed names (bed-focused), not patient names (patient-focused). Due to the message focus, an (*) may appear on a bed with a different patient name. Both functions are manually done within the NaviCare® WatchChild® application independent of the hospital EMR; therefore, communication is imperative to maintain in sync census boards between registration and the patient unit(s).

When patients follow the admission path from registration to the unit, the patient interface information appears when the unit staff admits the patient. The reception of HL7 messages are:

- Open NaviCare® WatchChild®
- Login
- Navigate to the census screen
- Select a bed to admit the patient, and choose **Admission**

NOTE: A patient cannot be transferred or admitted to an empty bed with an active alert.

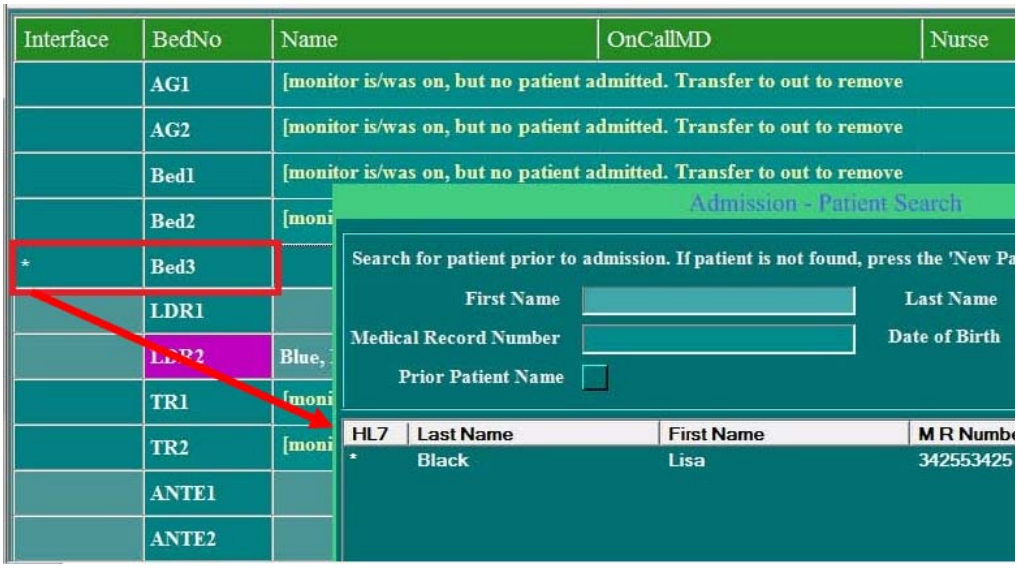
Interface Column

An (*) appears in the **Interface** column of the census when an HL7 registration message has been received, as shown in Figure 19-1.

Figure 19-1 *Census Screen with (*) in the Interface Column*

If the bed has an (*) without a patient name, click directly on the (*). The Admission Patient Search screen will appear with all patient names who have received messages for that specific bed.

Figure 19-2 *Admission Patient Search Screen for an Unoccupied Room*

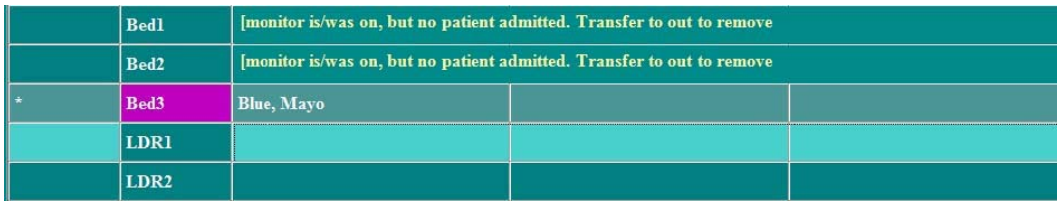


If the bed has an (*) with a different patient name than the patient name intended for admission, the (*) cannot be clicked directly. When this instance occurs, there are two options to resolve the issue:

- Transfer the patient (with the different name than the name intended from registration) to another bed, then click the (*) and the patient names with messages sent to that bed will appear (Figure 19-2), or

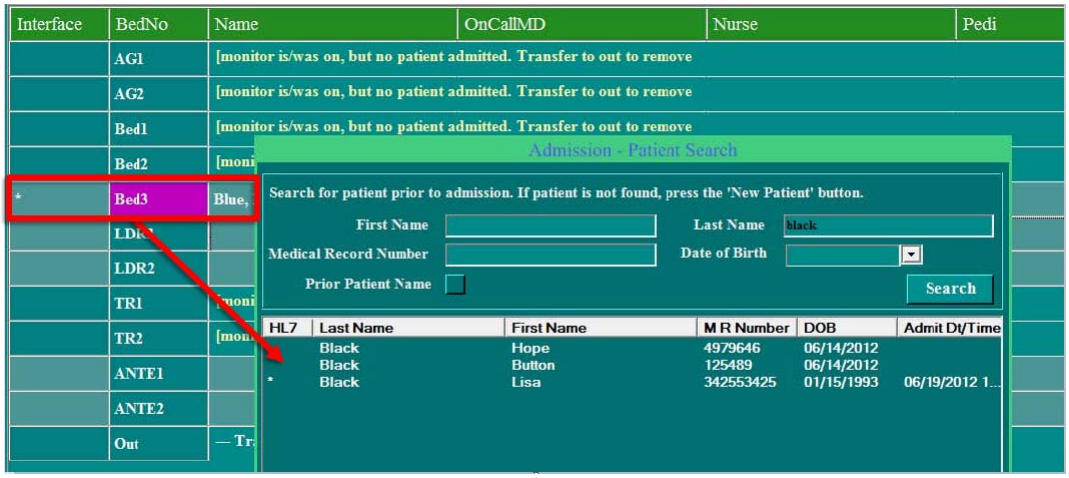
- Highlight another empty room, (Figure 19-3) click **Admission**; search by patient last name, first name, date of birth, and/or MRN.

Figure 19-3 *Admitting a Patient in Another Room other than the (*) Bed*



The search results will display all the patient names that match the search criteria, with and without an (*) in the HL7 column (Figure 19-4).

Figure 19-4 *Admission Patient Search Screen for an Occupied Room with Different Patient Name*



If the information for the patient visit is correct, select the patient, click **OK** and proceed from the census to the Obstetric Admitting Record (from **Admission**, see Chapter 4, "Obstetric Admitting Record — Comprehensive Charting" on page 4-1) or the Outpatient/Observation Record (from **Chart** to **Observation**, see Chapter 14, "Using the Outpatient/Observation Record" on page 14-1) and then use the "Interface Button" button.

Interface Button

When users admit the patient before informing patient registration, the patient can be immediately, manually admitted with only minimal detail. Once patient registration is notified and the patient is entered in the hospital Electronic Medical Record (EMR), the HL7 admission message is sent to NaviCare® WatchChild®.

The (*) appears on the Census in the Interface column beside a bed name to indicate a message is available for that specific bed; since the (*) cannot be clicked directly once a patient name exists for the bed where the message was sent, use the **Interface** button on the Obstetric Admitting Record or the Outpatient/Observation Record to review and accept the HL7 message(s) (Figure 19-5 and Figure 19-6).

Figure 19-5 *Interface Button: Obstetric Admitting Record*

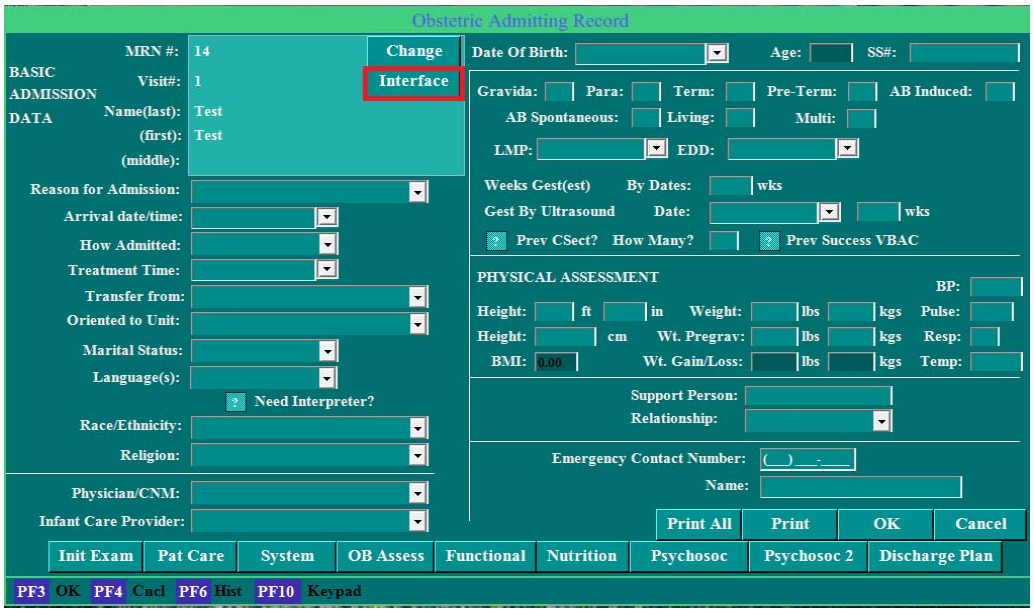
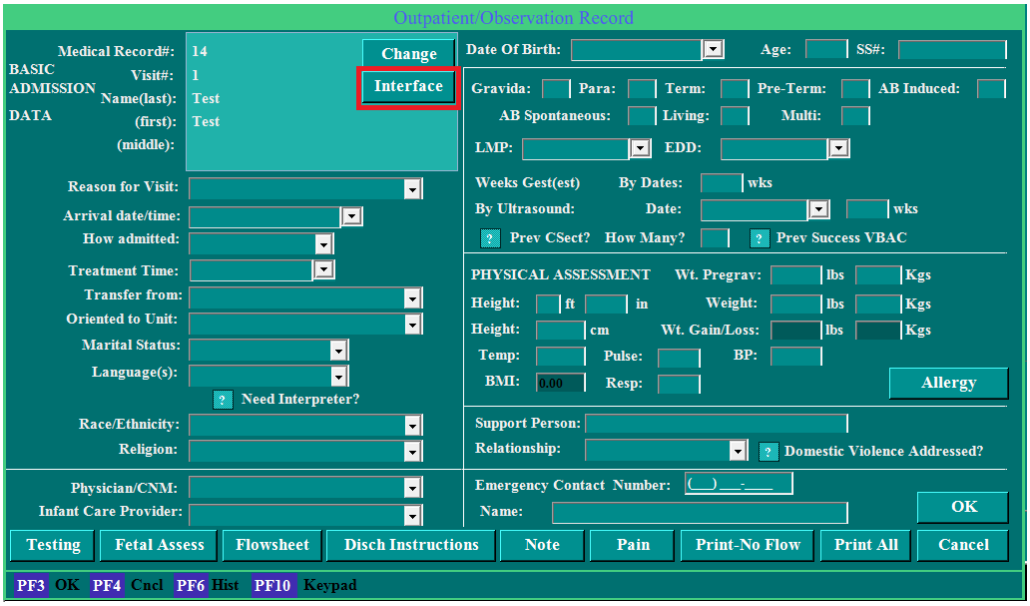


Figure 19-6 *Interface Button Outpatient/Observation Record*



The Interface button opens the “Interface Data Lookup Screen”.

Interface Data Lookup Screen

The Interface Data Lookup screen enables a search and applies the interface data to the current patient visit if the search results are accepted.

Figure 19-7 *Interface Data Lookup Screen*

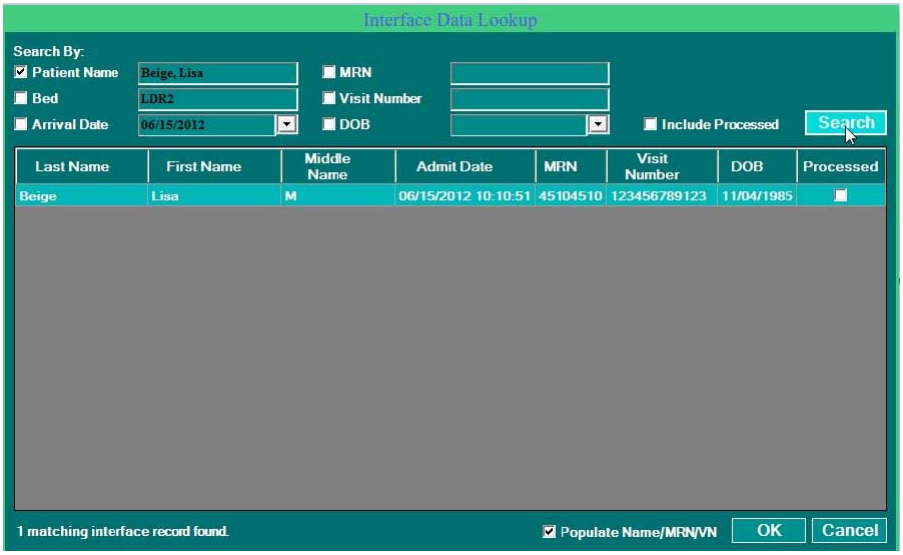
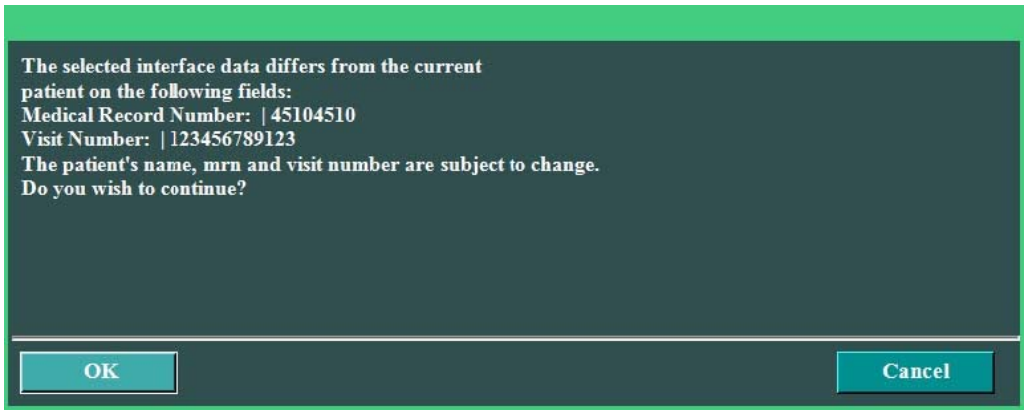


Table 19-1 *Interface Data Lookup Screen Fields*

Field	Usage
Search by	Defaults to search by the available details of the current patient visit. The search criteria can be changed, as needed.
Include Processed	Checkbox that, when checked, the search results include data that was applied to another patient visit. This checkbox is unchecked by default.
Populate Name/MRN/VN	Checkbox that alters the behavior of the interface import. By default, the checkbox is not checked if the MRN and VN have been entered prior to entering this screen. If the MRN and VN have not been entered prior to entering this screen, the checkbox will be checked, by default. ■ If the checkbox is unchecked, only charting data populates into the current patient record, without changing/updating the name, MRN or VN. ■ If the checkbox is checked, the **OK** button opens a message box informing the user of the differing information with the name, MRN, and VN of the selected interface patient (Figure 19-8 on page 19-7).

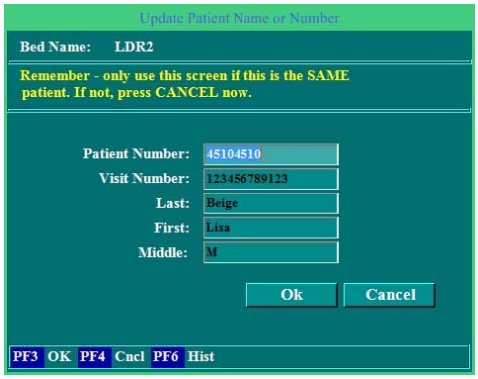
Figure 19-8 *Differing information from the interface*



When the data correction is performed and accepted, the charting data is imported into the appropriate fields of the patient chart (note: field mapping is configured by the hospital and NaviCare® WatchChild® interface teams).

After choosing **OK**, the changes are accepted and displayed on the Update Patient Name or Number (Figure 19-9).

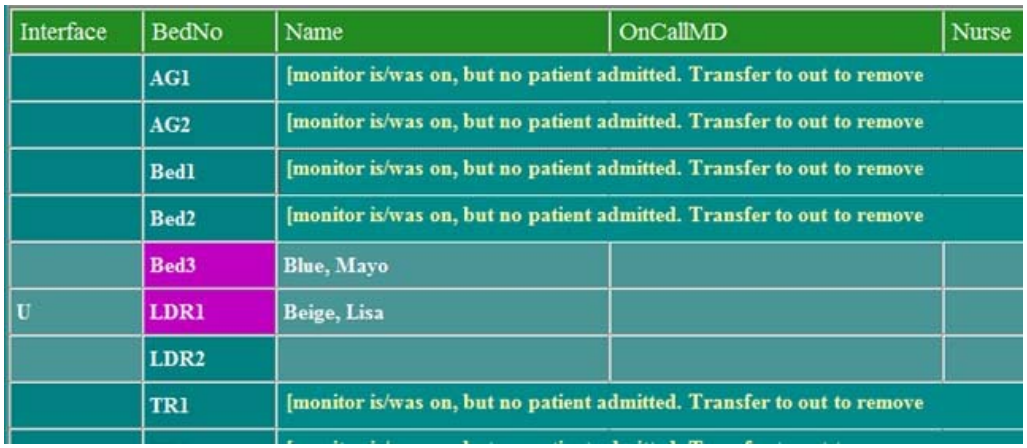
Figure 19-9 *Accepted demographic changes displayed*



The interface message(s) can be processed any time during the patient visit, but should be prior to patient discharge to ensure all the patient demographic data has been entered correctly and/or updated. Once the patient name, MRN, and VN are entered, all HL7 messages (i.e. updates) are automatically processed. If the patient name, MRN and VN are not entered, all HL7 messages must be manually accepted as outlined in the steps above, using the **Interface** button on the *Obstetric Admitting Record* or the *Outpatient/Observation Record*. When patient information is incorrect or missing, the unit should communicate with registration and request the data be corrected and/or updated.

Once the patient information is updated, an *Update* message is sent to NaviCare® WatchChild®, which is indicated with a *U* in the Interface column on the census (Figure 19-10). Clicking directly on the *U*, opens the Interface Data Lookup screen; choose the patient's name and click **OK**. The next screen displays the interface data that differs from the current patient for specific fields (Figure 19-8).

Figure 19-10 *Update indicator on census*



Interface	BedNo	Name	OnCallMD	Nurse
	AG1	[monitor is/was on, but no patient admitted. Transfer to out to remove		
	AG2	[monitor is/was on, but no patient admitted. Transfer to out to remove		
	Bed1	[monitor is/was on, but no patient admitted. Transfer to out to remove		
	Bed2	[monitor is/was on, but no patient admitted. Transfer to out to remove		
	Bed3	Blue, Mayo		
U	LDR1	Beige, Lisa		
	LDR2			
	TR1	[monitor is/was on, but no patient admitted. Transfer to out to remove		

Best practice for patient admission is to allow the patient admission to transmit via registration. Following this procedure will allow the patient demographic information to be in sync with other hospital systems. When the best practice process cannot be followed, it is the unit responsibility to communicate with whoever is responsible for patient registration.

Auto ADT

The auto ADT system augments the existing NaviCare® WatchChild® integration capabilities with the hospital's registration systems. The auto ADT integration introduces the capability for NaviCare® WatchChild® to:

- Perform admissions of patients with minimal to no user interaction based on requests from a hospital registration system.
- Perform transfers of patients with minimal to no user interaction based on requests from a hospital registration system.
- Perform discharges of patients with minimal to no user interaction based on requests from a hospital registration system.

This integration allows NaviCare® WatchChild® and other hospital systems that interact with the registration system to keep the censuses in sync. If the ADT interface has been purchased, the process functionality can be configured to be: auto or manual (see "Basic ADT" on page 19-2). The processing functionality (auto or manual) is controlled through the coordination of the hospital and NaviCare® WatchChild® integration teams. Transfer and admission messages accept charting information along with the transfer or admission request. The automation for processing the messages occurs when the patient demographics (first/last name and date of birth), Medical Record Number (MRN) and Visit Number (VN) match the HL7 message for the patient; if all the demographics do not match, the message will be received, but a conflict will occur and must be resolved by the user before the ADT operation can be completed, either manually or automatically (when the message is re-sent).

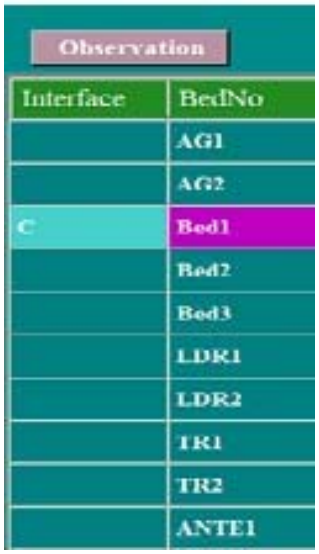
The functions included in auto ADT: Admission, Discharge and Transfer. Each of these functions exists in NaviCare® WatchChild® as a manual process when Auto ADT is configured: OFF

Table 19-2 *Interface Data Lookup Screen Fields*

Field	Usage
Admission	Displays the Admission Name Lookup screen if no patient is in the selected bed, or displays the Obstetric Admitting Record screen for the selected patient. See see Chapter 3, “Admitting a Patient” on page 3-1 for detailed information about the admission process.
Discharge	Displays the Discharge Patient screen to discharge the patient from NaviCare® WatchChild® See see “Discharging a Patient” on page 3-13 for detailed information about the discharge process.
Transfer	Select to transfer a patient to another bed, to an OUT bed, from an OUT bed to an active bed, or to merge patient monitoring strips. See Chapter 9, “Transfer Patients and Merge, Move or Delete Monitoring Strips” on page 9-1 for detailed information about the transfer process.

The ADT messages received from the registration system, via HL7, will impact the NWC census. With Auto ADT, the HL7 messages will change the census automatically. The Auto ADT integration informs users when an ADT operation (admission, transfer or discharge) does not perform the operation as intended. When the operation is not performed, the interface integrates with the census and generates a conflict message, which informs users why the operation did not succeed. Conflict messages provide enough information to the user so the issue can be resolved. Messages are indicated on the census board with a ‘**C**’ in the interface column for the patient the message was intended for (Figure 19-11).

Figure 19-11 *Conflict message indicator on the census board*



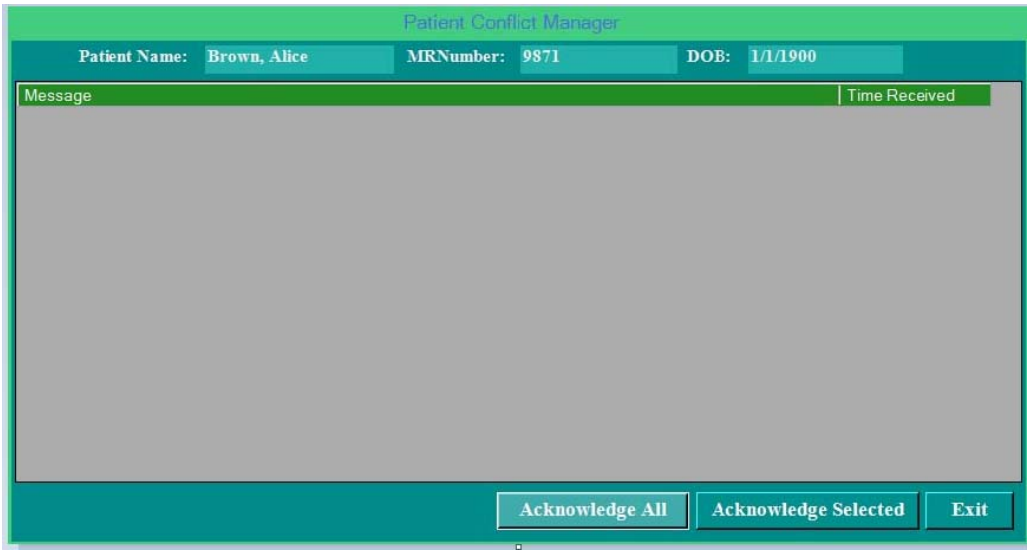
(For more detailed information regarding the census board, see Chapter 2, “Using the Census Screen” on page 2-7).

The Census screen always contains at least one unoccupied OUT bed; if patient data is placed in that OUT bed, another vacant OUT bed is automatically added to the Census screen. These “virtual”

beds are used for such things as admitting a patient when not placed into an actual bed, discharging a patient, clearing fetal data from an actual bed prior to admitting a patient to that bed, and other situations where a placeholder is needed for patient's data without being in an active bed. (See for Chapter 2, "OUT Beds" on page 2-7 more details on OUT Beds.)

Auto ADT introduced a new need for OUT beds. For any HL7 message transmitted that cannot perform the operation to the intended bed, the patient will be placed in an OUT bed with a conflict message. If the patient is transferred, the '**C**' follows the patient to the new bed. The Patient Conflict Manager screen (Figure 19-12), which is displayed when the '**C**' is clicked, contains patient identifying information such as patient name, medical record number and date of birth, a list of messages about the patient and the time the message(s) were received, a button to **Acknowledge All** of the messages, a button to **Acknowledge Selected** messages and an **Exit** button. A patient can receive multiple conflicts within the Patient Conflict Manager (Figure 19-21 on page 19-14). If more than one conflict exists, the census board only displays a single '**C**' in the Interface column for the patient.

Figure 19-12 *Patient Conflict Manager screen; Acknowledge All and Acknowledge Selected buttons*



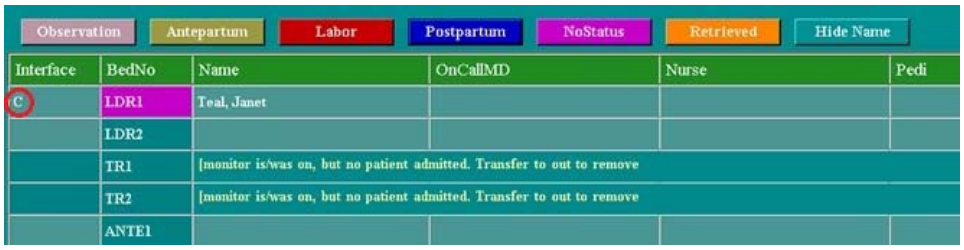
CAUTION: To avoid attaching strips to the incorrect patient, the fetal monitor should be turned off when the patient is discharged. Leaving the monitors running once the patient is discharged could result in an incorrect merging of the fetal monitor strip.

CAUTION: When beds alert without a patient name in the bed, verify the strip belongs to correct patient.

Conflict Messages

- Attempted to update [PATIENT NAME]'s visit number to [MESSAGE VISIT NUMBER], but that visit number was previously used.

Figure 19-13 *Patient admitted with conflict*



The Interface column indicates a conflict has occurred (Figure 19-13). This message informs the user of the need to enter a valid VN (Figure 19-14. NWC cannot reuse VNs for the same patient. When the registration system sends a VN that was previously used for a patient, NaviCare® Watch-Child® accepts the message and performs the message operation (admission, discharge or transfer) to the message location (if available), but does not update the VN (Figure 19-15).

Figure 19-14 *Conflict for VN previously used*

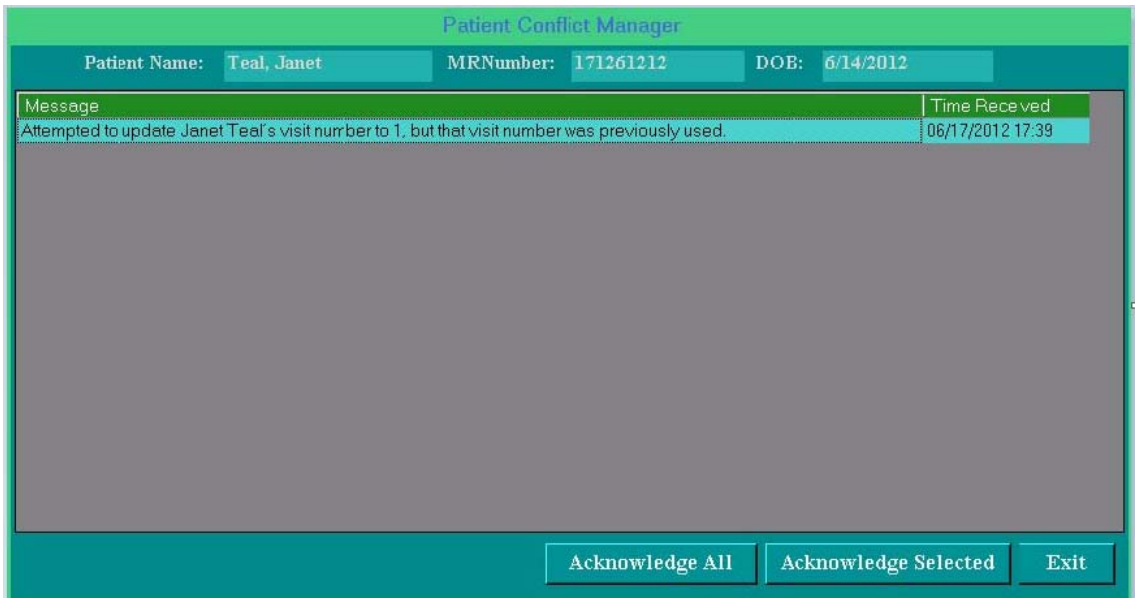


Figure 19-15 *Patient admitted via ADT without a VN*

- [PATIENT NAME] was not [TRANSFERRED/ADMITTED] into bed "[BED NUMBER]" because [OTHER PATIENT NAME] was in "[BED NUMBER]" when the message was received ([TIME OF MESSAGE]). (Figure 19-16 and Figure 19-17 on page 19-12)

NOTE: NaviCare® WatchChild® will not merge patients automatically. Merging patients is a manual operation.

Figure 19-16 *HL7 message sent to transfer a patient to another bed with another patient name*

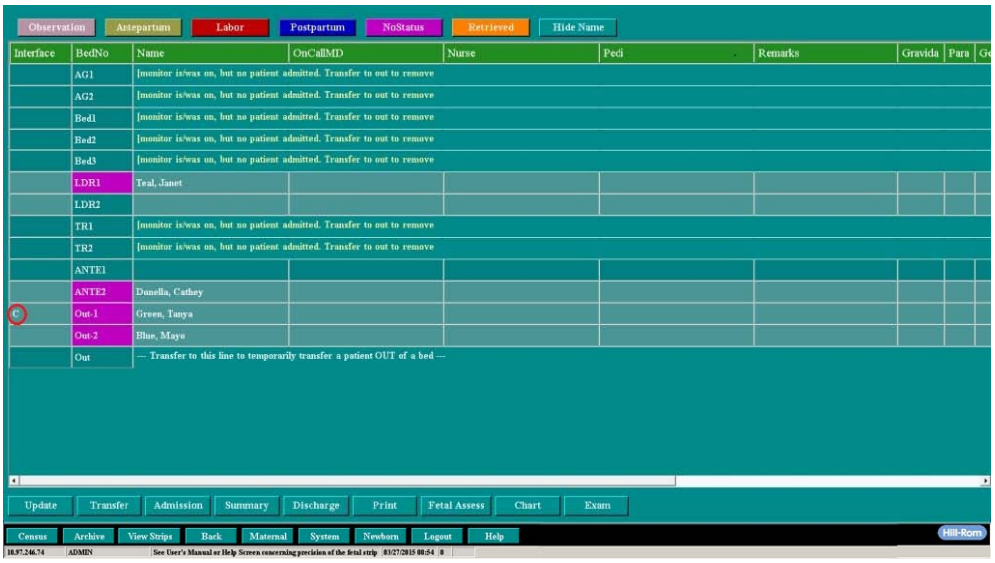
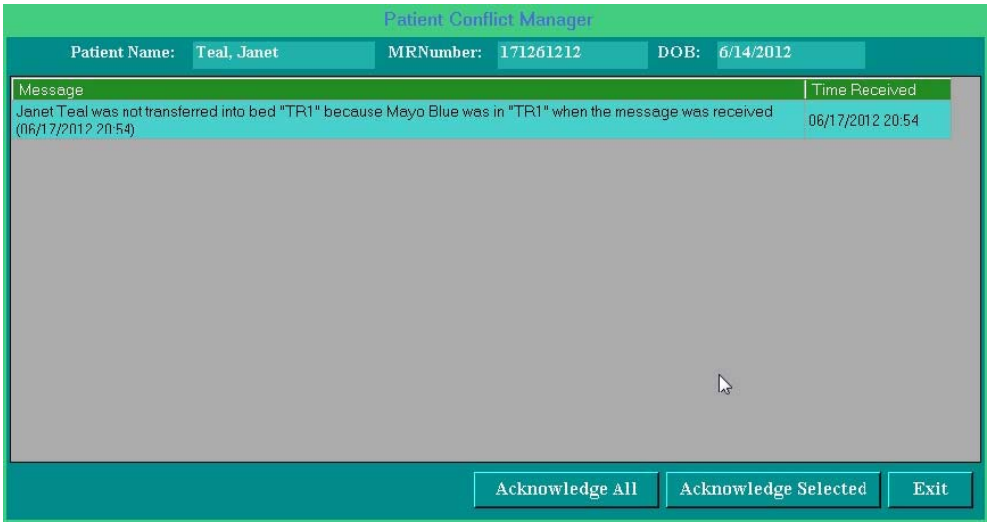
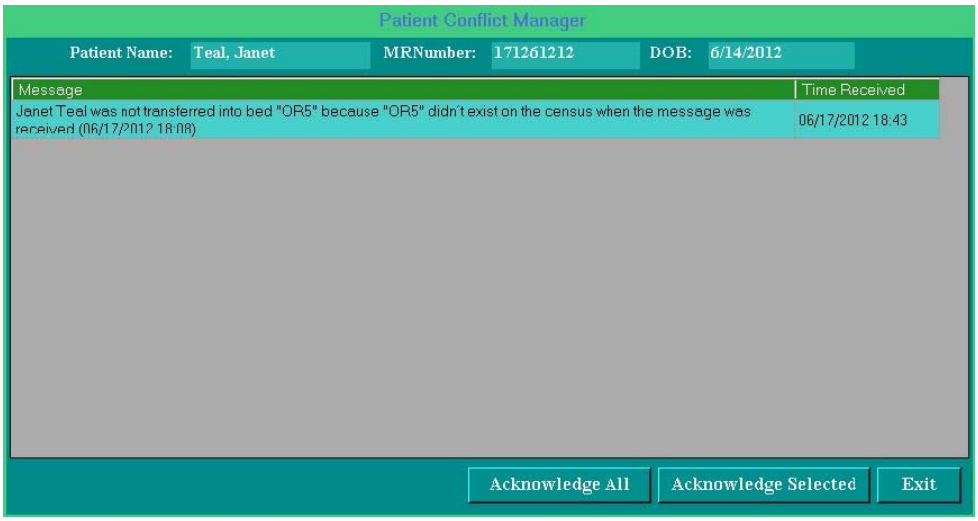


Figure 19-17 *Conflict message for inability to transfer to a bed because another patient exist*



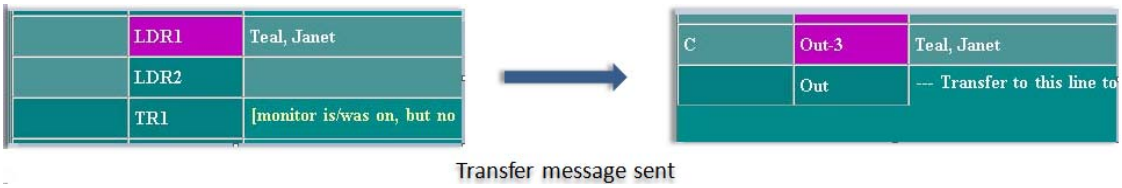
- [PATIENT NAME] was not [TRANSFERRED/ADMITTED] into bed "[BED NUMBER]" because "[BED NUMBER]" didn't exist on the census when the message was received ([TIME OF MESSAGE]) (Figure 19-18).

Figure 19-18 *HL7 message sent to a bed that does not exist*



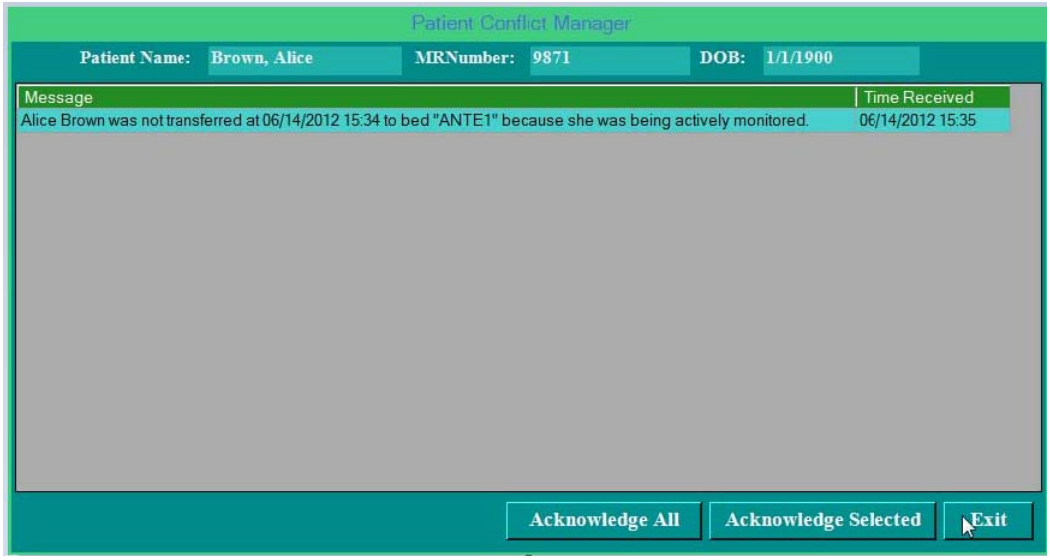
When the bed (to be transferred to) does not exist, the transfer message is accepted. (Ex. Transfer to OR5) The patient will be transferred from the present room to an OUT bed on the census with a conflict (Figure 19-19 and Figure 19-19 on page 19-13). If the message is an admit message, the patient will be admitted to an OUT bed with a conflict.

Figure 19-19 *Patient transferred from current room to an OUT bed*



- [PATIENT NAME] was not [TRANSFERRED/DISCHARGED/ADMITTED] at [MESSAGE TIME] for bed "[BED NUMBER] because she was being actively monitored (Figure 19-18 on page 19-13).

Figure 19-20 *Unable to perform [ADT operation] because the patient is actively being monitored*

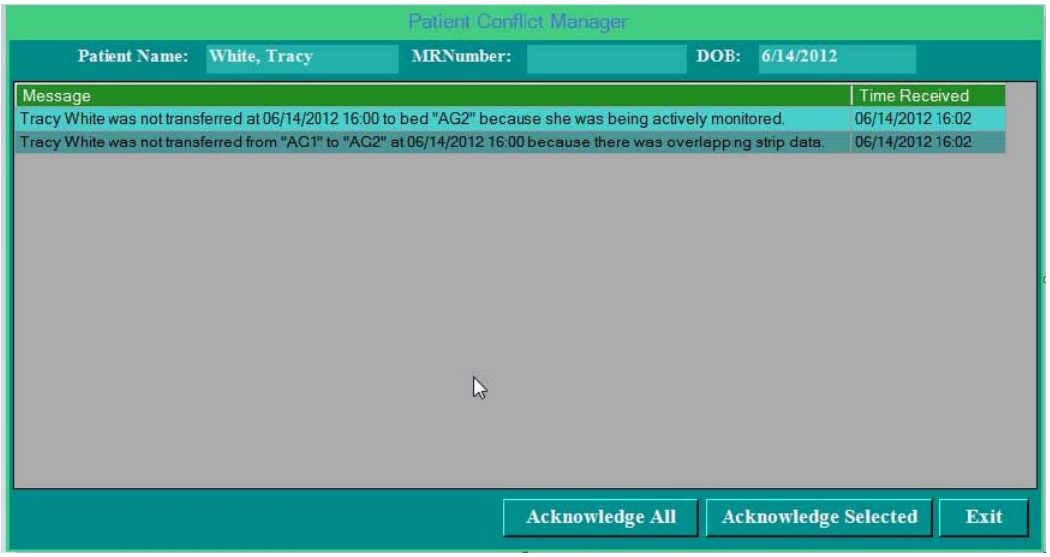


[PATIENT NAME] was not [TRANSFERRED] at [MESSAGE TIME] to bed “[BED NUMBER]” because she was being actively monitored.

- [PATIENT NAME] was not [TRANSFERRED] from“[BED NUMBER]” to “[BED NUMBER]” at [MESSAGE TIME] because she there was overlapping strip data.

If a patient is in a bed and the monitor is ON and an HL7 message is received to transfer the patient to another room that contains monitor data for the same time, conflicts are created (Figure 19-21).

Figure 19-21 *Unable to transfer operation because the patient is actively being monitored & overlapping strip exists*



CAUTION: To reduce the risk of strip issues, NWC prohibits ADT messages to remove patients from a bed when the monitor is on or if alerts are currently active on the bed.

- [PATIENT NAME] was not discharged at [MESSAGE TIME] from bed “[BED NUMBER]” because she did not have all of the information required to be discharged (Figure 2-22).

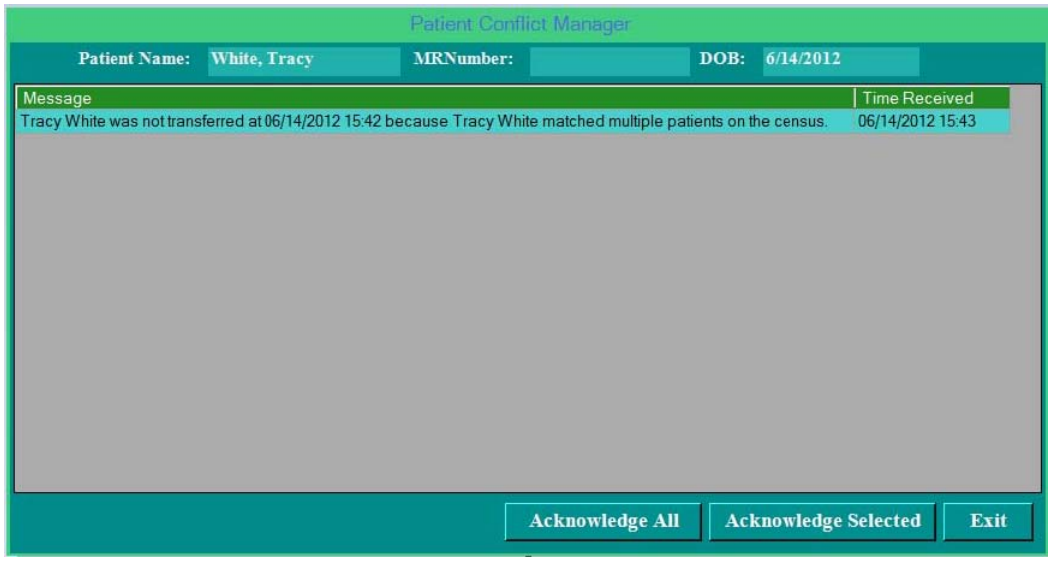
To allow a patient discharge operation, NWC requires:

- Medical Record Number (MRN)
- Visit Number (VN)
- Admission date/time
- Discharge date/time
- Discharge occurrence

Figure 19-22 *Patient cannot be discharged because information is missing*

- [PATIENT NAME] was not [TRANSFERRED/ADMITED/DISCHARGED] at [MESSAGE TIME] because [PATIENT NAME] matched multiple patients on the census (Figure 19-23).

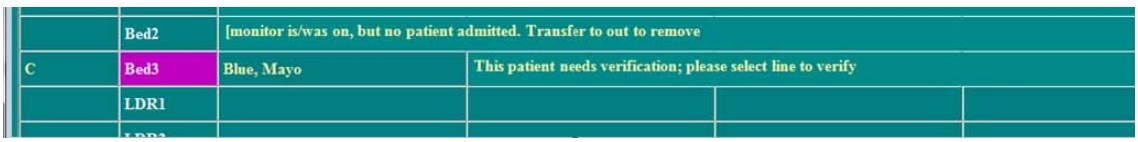
Figure 19-23 *HL7 transfer message is sent and the patient exists multiple times on the census board*



When results for a patient existing multiple times on the census occurs, NWC requires the user to manually resolve the conflict by either merging the patients together or discharging each patient individually from the census.

- [PATIENT NAME] was not [TRANSFERRED] at [MESSAGE TIME] to bed "[BED NUMBER]" because she was in a verify state (Figure 19-24).

Figure 19-24 *HL7 transfer message is sent and the patient is in a Verify state*



Auto-Admission

The designed functionality of Auto ADT is not intended to impede a patient admission due to a tracing without an associated patient name on the census board; the tracing may or may not have an active alert. Once a message is received from the Electronic Medical Record (EMR), NWC will admit the patient to the bed. A patient can be transferred or admitted to an empty bed with an active alert.

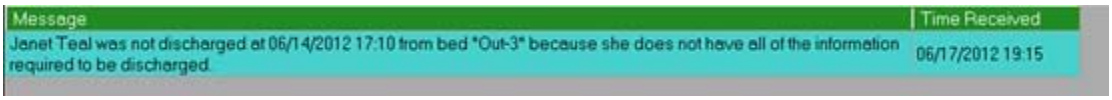
Auto-Transfer

Auto ADT allows patient transfers to an empty bed with an active alert. Patients in an active alert state cannot be Auto-Transferred to another bed until the alert has been acknowledged. For Retrieved patients, auto ADT attempts to admit the patient to a bed without a VN with a conflict.

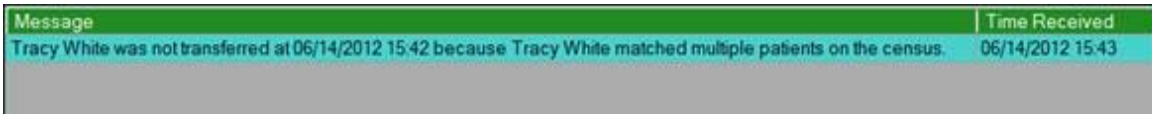
Auto-Discharging patients

Patients with conflicts that have not been acknowledged can be discharged as long as the reason for the conflict does not have any NWC discharge requirements.

Conflict Resolution Tips



The patient is moved to an OUT bed. The required information must be documented before a discharge can be performed. Once all the information has been entered, the patient can be manually discharged. Registration should be notified regarding the patient discharge. This helps ensure the other hospital systems census boards are in sync. Note: Registration can be notified of the conflict resolution and the message can be sent again for the message to be processed and the Auto Discharge will be performed.

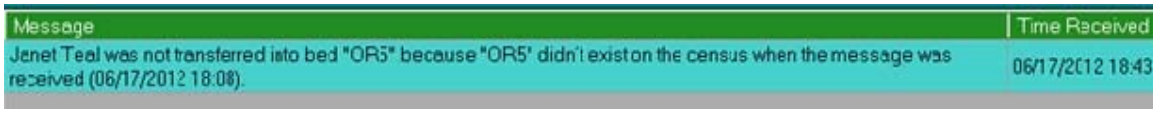


The patient must be manually merged or discharged individually. Registration should be notified regarding the patient discharge. This helps ensure the other hospital systems census boards are in sync.

NOTE: Registration can be notified of the conflict resolution and the message can be sent again for the message to be processed and the Auto Discharge will be performed.

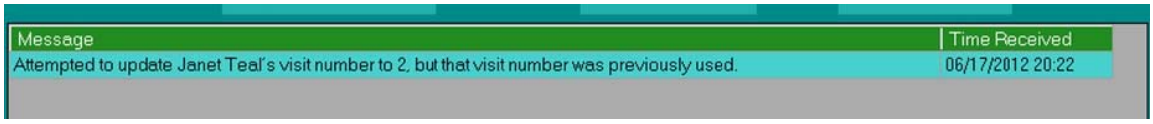
The overlapping strip must be manually resolved before the patient can be merged. Once the merge strip conflict is resolved, the patient can be manually transferred or Registration can be notified of the conflict resolution and the message can be sent again for the message to be processed and the Auto Transfer will be performed. If the transfer is manually performed, Registration should be no-

tified regarding the patient transfer. This helps ensure the other hospital systems census boards are in sync.



The patient is moved to an OUT bed. The bed must be configured, Registration must be given a bed that exists, or the patient can be manually transferred.

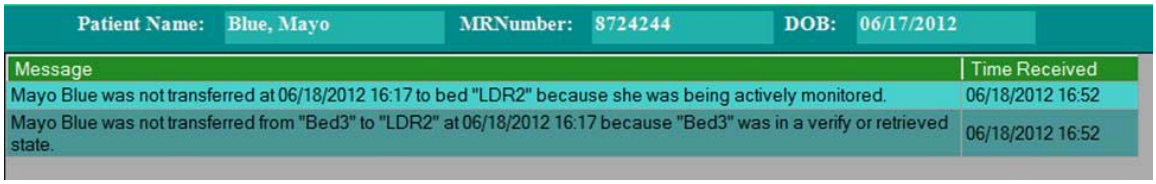
The patient is moved to an OUT bed. The patient must be transferred or discharged from the bed so the transfer can be manually performed or Registration can be notified when the bed becomes available and the message can be resent. If the transfer is manually performed, Registration should be notified regarding the patient transfer. This helps ensure the other hospital systems census boards are in sync. Registration can be notified of the conflict resolution and the message can be sent again for the message to be processed and the Auto Transfer will be performed.



The VN must be a number that has not been used before with the MRN. Each VN is unique to the MRN. For recurring VNs, the process outlined by the facility must be followed to accept the VN for recurring visits.

For Retrieved patients, Auto ADT attempts to admit the patient to another bed without a VN. If the patient does not need to be admitted, the patient needs a VN and should be discharged. The patient (with the correct VN) can also be *Reverse Discharged* from **Archive**, then the newly created patient can be merged with the patient name that was *Reverse Discharged*; after the merge, **Discharge** the patient.

NOTE: Failure to communicate with registration appropriately could result in an HL7 message being sent to the wrong patient.



Select the **Verify Bed** button from either single surveillance or multi-surveillance screen and then select either the **Same** or **New** button, as appropriate to your patient (See Chapter 2, “Verifying Patient Information” on page 2-18). The patient can be manually transferred or Registration can be notified of the conflict resolution and the message can be sent again for the message to be processed and the Auto Transfer will be performed. If the transfer is manually performed, Registration should be notified regarding the patient transfer. This helps ensure the other hospital systems census boards are in sync.

Chapter 20

Strip Analysis

This chapter covers the following information:

Strip Analysis Overview

The NaviCare® WatchChild® Solution Strip Analysis feature is a charting tool which analyzes specific user determined portion of fetal strip. The screen displays both the fetal heart rate and the uterine activity, along with an initial recommendation for the strip analysis. The Strip Analysis feature is intended to help caregivers analyze fetal heart rate data and uterine activity.The information obtained from the strip analysis can be recorded for the clinical assessments on the Uterine/Fetal Assessment record.

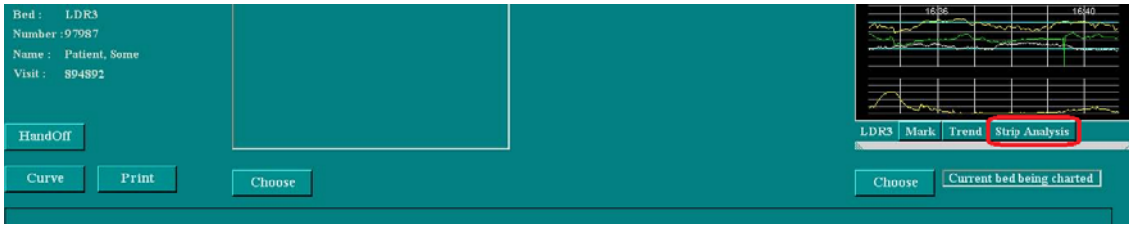
WARNING: Strip analytics tools are provided for charting assistance only and are intended as recommendations only. Use of Strip analytics tools are not intended to replace clinical assessment and evaluation of the patient, nor be used as the sole source for decisions regarding patient care. Users must follow clinical practices, hospital guidelines and policies for patient care, and other recognized acceptable standards such as the Association of Women's Health Obstetrics and Neonatal Nurses (AWHONN) and American College of Obstetrics and Gynecology (ACOG).

The Strip Analysis screen can be accessed via single surveillance, multi-surveillance, or charting screen-floating window regardless of which screen size is displayed: 6, 9, or 19, 7 or 14 minute view as shown in Figure 20-1, Figure 20-2, and Figure 20-3.

Figure 20-1 *Single Surveillance Screen (6 minute view) with the Strip Analysis Tool Enabled*

Figure 20-2 *Multi Patient Surveillance Screen with the Strip Analysis Tool Enabled*

Figure 20-3 *Chart Screen with the Strip Analysis Tool Enabled*



Strip analysis functionality is offered as a separate module from the NaviCare® WatchChild® Solution charting package (Basic or Comprehensive); therefore, this functionality can only be utilized after Hill-Rom Technical Support enables the parameter configuration as shown in Figure 20-4. There are several parameter configurations to be determined by the NaviCare® WatchChild® System Administrator.

Depending on the configuration set up, the strip will:

- Manually allow a strip analysis by a user or
  - Perform an auto-analysis of the strip, which can also be edited by a user
- Display a red vertical line on the strip which defines the 10 minute section of the strip that is being analyzed, or
  - Not display a marker on the strip to define which 10 minute section of the strip is being analyzed
- Use the last 10 minutes of the strip for the strip analysis when greater than 10 minutes of strip is displayed or
  - Allow the user to determine which 10 minute section to use for the strip analysis

System and Workstation Parameter Configurations

NOTE: This section only applies to those users designated as a NaviCare® WatchChild® System Administrator.

The options available for the strip analysis system parameter configurations include:

- **Strip Analysis Enabled** allows for a manual strip analysis to be performed by a user.
- **Strip Auto Analysis Enabled** allows for an automated strip analysis to be performed by the system.

Figure 20-4 *Strip Analysis System Parameter Configuration*

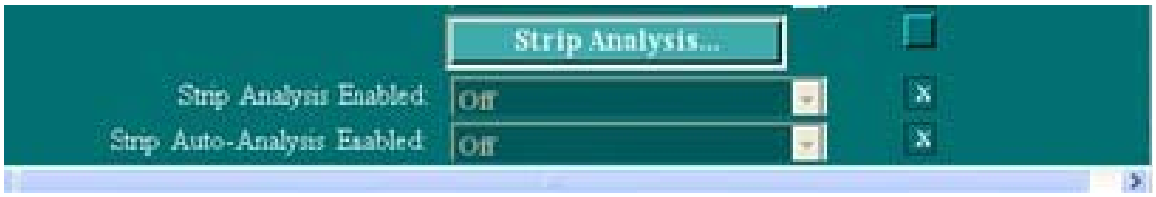


Figure 20-5 *Strip Analysis System Parameter Configuration.*

Assign Baseline Region Markers enables the system to mark the section of the strip that is analyzed with a red vertical line.

- 'True' is the system default and will display a red vertical marker on the strip that is being analyzed when greater than 10 minutes of strip is displayed with Auto-Analyze on.
- 'False' will not display a defining marker on the strip for the section being analyzed.

Baseline Determined From Final Segment enables the system to define which 10 minute section of the strip will be used for the strip analysis.

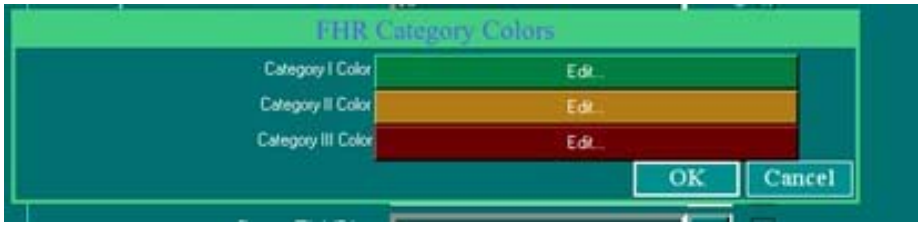
- 'True' is the system default. When set to 'True' the system will always use the last 10 minutes of the strip when the defined period display is greater than 20 minutes.
- 'False' will allow the user to select the section of the strip being used for the strip analysis when the defined period display is greater than 20 minutes

Clinical system administrators must determine these option; otherwise the system defaults will remain as the configuration. These system parameter configurations can only be enabled by Hill-Rom Technical Support at the Facility or Facility Group level (Figure 20-4 and Figure 20-5).

The options available for the strip analysis workstation parameter configurations include:

- **FHR Category Colors** can be configured for each category based on the strip analysis documentation. Based on the documentation on the strip analysis screen, the screen background color will reflect the appropriate category. (Figure 20-6)
  - Category I
  - Category II
  - Category III

Figure 20-6 *Strip Analysis Workstation Parameter Configuration*



Strip Analysis Periods in Minutes defines the display period of strip in minutes. The minimum is 5 minutes and the maximum is 60 minutes. Any number can be configured for a user to choose from using the drop-down list. The minutes can be sorted in any order by using the 'move up' or 'move down' buttons. The configuration saved for the workstation parameter will be displayed for a user on the strip analysis screen and the fetal assessment schedule screen as shown in Figure 20-7.

Figure 20-7 *Strip Analysis Workstation Parameter Configurations*

The workstation parameters shown in Figure 20-6 and Figure 20-7can be configured either by Hill-Rom Technical Support or a NaviCare® WatchChild® System Administrator.

Configuring the Strip Analysis

This section describes how to configure the Strip Analysis screen in:

- "Real Time Mode"
- "Trend Mode"

Real Time Mode

To configure the Strip Analysis screen in Real Time mode:

Click the **Strip Analysis** button from the single surveillance (Figure 20-8), multi patient surveillance (Figure 20-9) or the chart screen (Figure 20-10).

Figure 20-8 *Single Surveillance Screen Real Time*

Figure 20-9 *Multi-Patient Screen Real Time*

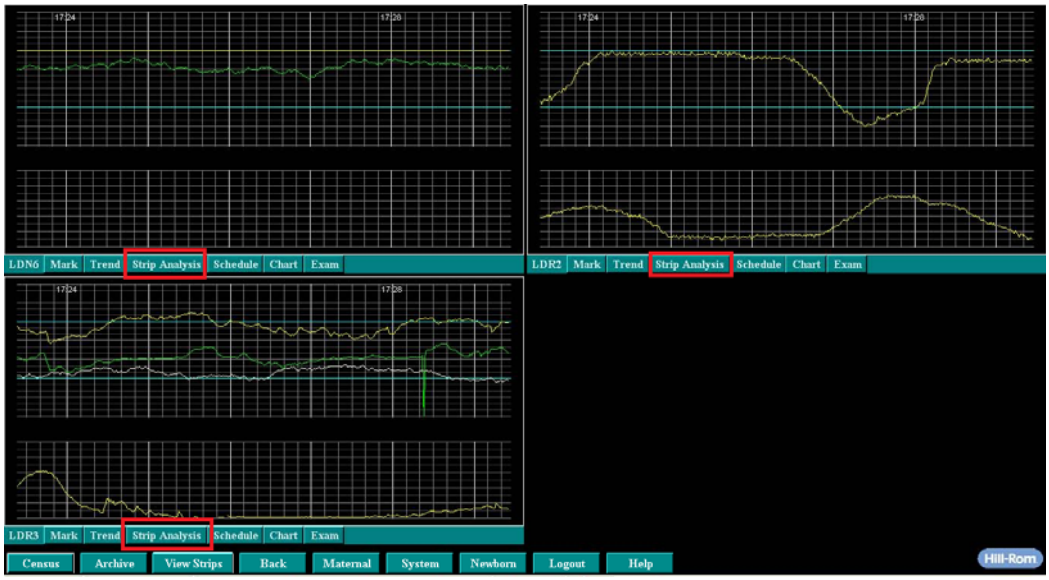
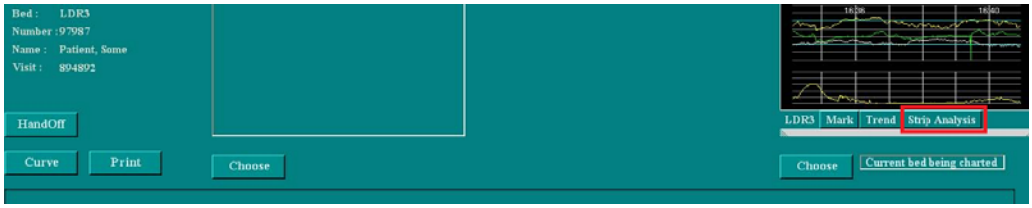


Figure 20-10 *Chart Screen Real Time*



When in real time mode, the right side of the screen displays current time, and strip displayed to the left will be the preceding minutes.

Trend Mode

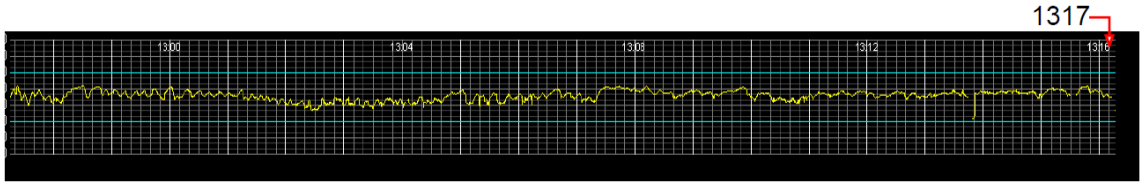
When the chart screen is displayed with the strip in trend mode, the surveillance window must be enlarged to reveal the **Strip Analysis** button.

When in trend mode, the left side of the strip along with the subsequent minutes to the right will be displayed for the strip analysis as long as the minutes remaining to the right do not extend beyond the present time. If the time would extend beyond the present time, the system will right justify the time by backing the time from the right most time displayed to allow for the desired length of time.

In the following examples, the ‘Display Period’ is set for 30 minutes:

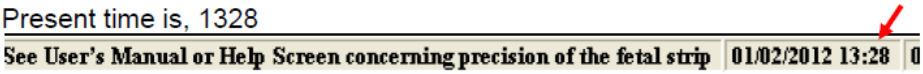
The actual time is 1317 as seen from the computer’s bottom menu.

In trend mode, this strip displays 1257 to 1317

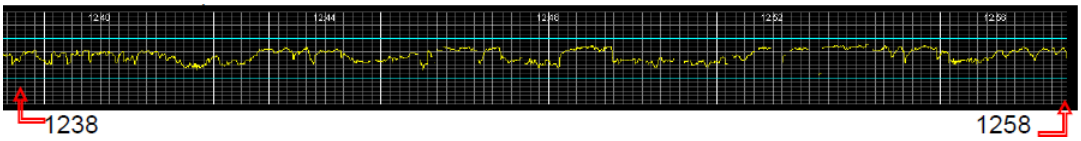


When the **Strip Analysis** button is clicked, the system backs the time 30 minutes from 1317. This screen is displayed.

In trend mode, when trending back far enough to the left to allow enough time for the 'Display Period', the system will begin the analysis from the left most margin time.



Strip displayed (in trend mode) is 1238 to 1258 (which is only 20 minutes, the 'Display Period' is set for 30 minutes).



The strip analysis begins from the left most margin, which is 1238.

The Strip Analysis screen will appear

Figure 20-11 *Strip Analysis Screen*

Understanding the Strip Analysis Screen

The date and time range of the strip is indicated in the upper left corner of the strip analysis window.

Bed number, full patient name, date of birth (DOB), and Medical Record Number (MRN) are displayed in the upper left corner beneath the date and time of the strip. The full patient name will display on the Strip Analysis screen, regardless of how the name is configured to display on the Census and/or the Surveillance screens as shown in Figure 20-12.

Figure 20-12 *Strip Analysis Screen with Full Patient Name Displayed*

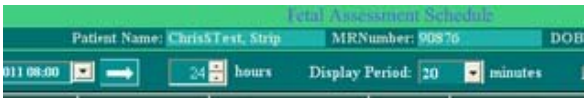
The  icon allows a user to save the settings desired for their display period. Once the display period has been saved by a user, that saved configuration will be the default setting for that user when logging on to any workstation.

To change the 'Display Period' setting:

1. The 'display period' can be configured from either the Strip Analysis screen

   or the Fetal Assessment Schedule screen.

2. On the **Display Period** field, click the drop-down arrow  .
3. Choose the desired number, click the **Change Period** button  .
4. The new display time will reconfigure to the appropriate setting.
5. Use the arrows to move the strip backward or forward  .

   - The extreme ends of the arrows move the strip display in increments according to the display period.

   - The middle gray area of the arrows moves the strip display in 1 minute increments.

   Users can only choose from the drop-down list; manual entries for the display period are not allowed. The numbers in the drop-down are configurable by a system administrator. If there is another desired option for the display period, contact a NaviCare® WatchChild® System Administrator to request the change.

6. The Rupture Time/Date is auto-populated from the Uterine/Fetal Assessment screen.

Figure 20-13 *Strip Analysis Screen with Membrane Rupture Information*

- The system calculates the time since rupture, from the time displayed on the strip analysis screen and the documented time of rupture.
- If the current time displayed is at least one day since rupture, the display will show the number of days and the time since rupture (HHMM format)

7. The gestational age will populate the strip analysis screen from the "Labor and Delivery Summary - Labor Summary Screen" on page 16-1.

   If the information is not documented on Labor and Deliver Summary screen, the information will be populated from the "Obstetric Admitting Record Screen for Comprehensive Charting" on page 3-8.

   NOTE: The Obstetric Admitting Record screen is a static form, which means the gestational age will not update daily on the strip analysis shown in Figure 20-13.

8. For multiple gestations:
   - Select the baby identification (Baby A, B, C).
   - Ensure the fetal heart rate (FHR Yellow, Green, Orange) is for the appropriate baby by clicking the single select drop-down as shown in Figure 20-14.

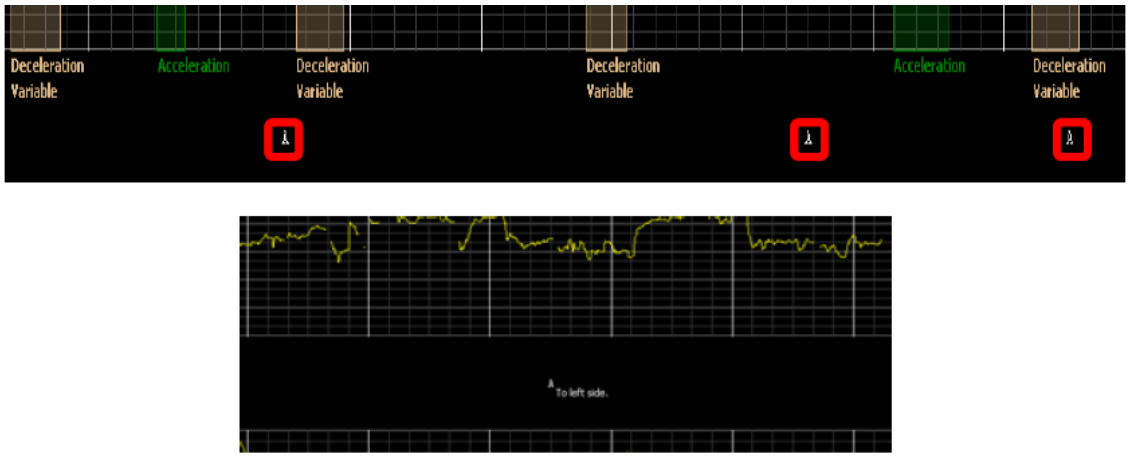
Figure 20-14 *Strip Analysis Screen with Multiple Baby Selection*

The rupture date and time documentation is unique for each infant. Each strip analysis generates a unique uterine fetal assessment

Strip Analysis Functionality

If annotations exist on the strip, the strip analysis screen will display an "A" to represent the presence of an annotation. If fetal heart markings exist, the "A" will appear under the strip markings. The user can hover over the "A" to read the annotation as shown in Figure 20-15.

Figure 20-15 *Strip Analysis Screen with Annotations.*



To begin analysis of a strip:

1. Do one of the following:
   - Manually mark up the screen, or
   - Allow the system to analyze and provide mark ups on the strip. A minimum strip display of 10 minutes is required for the ‘Analyze’ feature to work.

   A uterine fetal assessment screen is generated and the marked up strip analysis screen (manual or system generated) is not saved as a flowsheet record. The strip analysis screen will provide a cumulative total of uterine fetal assessment records that have been created and saved. The phrase ‘x assessments, x from current analysis’ provides an alert to inform the user that a uterine fetal assessment has been created and saved for the current segment of strip displayed as shown in Figure 20-16.

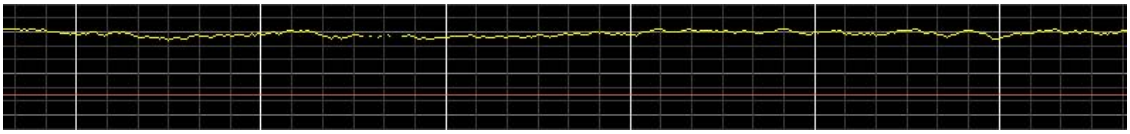
Figure 20-16 *Strip Analysis Screen Cumulative Total of Assessments Created.*

WARNING: Strip analysis is not saved as a flowsheet record or in an audit trail It is not intended to be the sole source of analysis of fetal strip data. It is a tool to assist the user in documenting a fetal assessment.

2. When the desired time range is displayed, do one of the following:
   - Select Analyze
   - Manually click the desired strip marking(s) as shown in the following figure.

3. The **Add Baseline** button appears if a baseline has not been documented.Click this button if the marking for baseline needs to be added manually.

4. A red line appears on the strip as shown in the following figure.You can adjust the red line by moving the mouse up and down. The line moves in increments of 5.

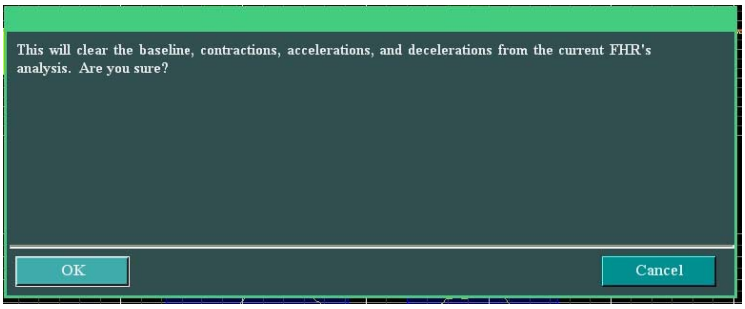


5. The **Remove Baseline** button appears once a baseline has been documented as shown in the following figure.

6. Click this button if the marking for the baseline needs to be removed (system generated or manually done).

7. Select **Analyze** to mark the strip for accelerations, decelerations, contractions, and baseline FHR as they appear in the 10 minute display window. See “Choosing What Portion of the Strip to Analyze” on page 20-19.

8. Select **Reset** to remove current markings on the strip, either system generated or manually. A message appears requesting confirmation to erase the markings as shown in the following figure.



9. Select Zoom In/Zoom Out to magnify or decrease the screen size. The screen size can be decreased smaller than original actual screen size.

10. Use the color coordinated “mark buttons” listed in Table 20-1to mark the screen with the corresponding color:

Table 20-1 *Screen Marking Options*

Button	Marking Option
Mark Accel	Mark accels which appear on the FHR tracing. Accels are labeled and marked green.
Mark Decel	Mark decels which appear on the FHR tracing. Decels are labeled and marked grayish brown.
Mark Contractions	Mark uterine contractions. Contractions are labeled and marked blue.
Add Baseline	Mark the baseline of the FHR. Baseline is marked with a red line.
Remove Baseline	Removes the baseline, either added by the system or manually.

The following figures provide default color coding examples:

NOTE: The following marked up screens are used for examples of color coding ONLY and are not intended to demonstrate accurate strip interpretation.

Figure 20-17 ***Category I***

Figure 20-18 ***Category II***

NOTE: The tool tip displays the actual value measured (Contraction Duration 84-118 sec). The field displays the rounded value to the nearest zero or five (Contraction Duration 80-120 sec).

Figure 20-19 *Category III*

11. The **Baseline FHR 'Characteristics'** are marked on the strip analysis screen according to the marked baseline of the strip as follows:

- Normal
- Tachycardia
- Bradycardia
- Sinusoidal
- Indeterminate

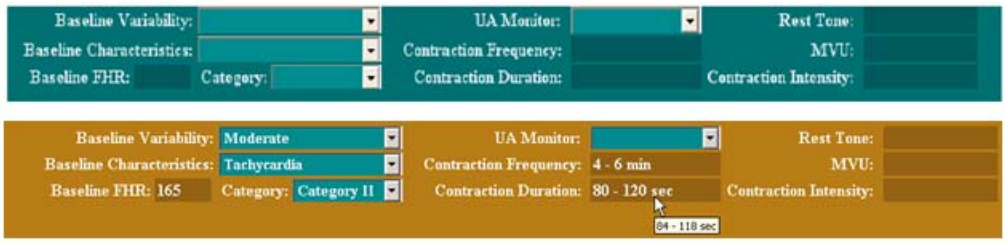
In order to create a uterine fetal assessment, documentation must exist for the following:

- Baseline Characteristics (autopopulates the Baseline FHR field)
- Category
- Variability'

If the baseline FHR is 'indeterminate', the 'Variability' field can be left blank and a Uterine/Fetal Assessment can be created.

After the markings are applied, the results are displayed in the respective fields beneath the strip as shown in Figure 20-20.

Figure 20-20 *Strip Analysis Documentation*

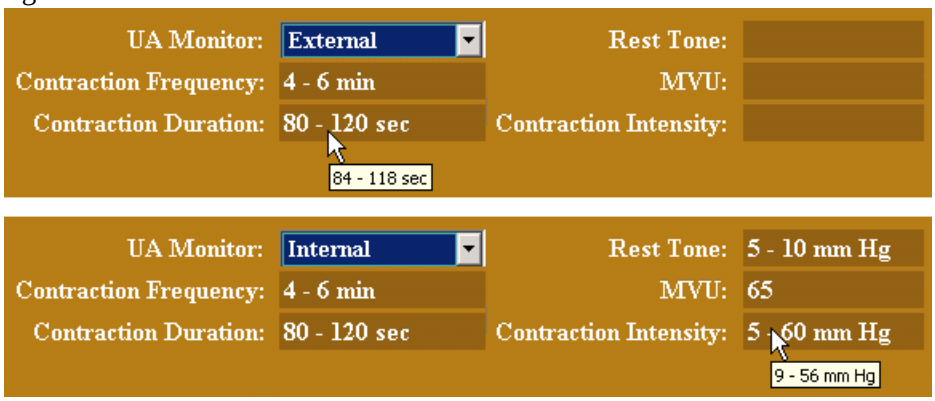


NOTE: The tool tip displays the actual value measured (Contraction Duration 84-118 sec). The field displays the rounded value to the nearest zero or five (Contraction Duration 80-120 sec).

12. Once a UA Monitor is designated, the system will calculate the following values for **Internal** UA monitoring:

    - Resting Tone
    - MVU
    - Contraction Intensity

    For External UA monitoring those fields are blank and disabled as shown in the following figure.



13. **Contraction Frequency** is populated when multiple contractions are marked on the fetal strip.

    When more than two contractions are marked, the documentation value shall be the minimum and maximum number in seconds. If you do not agree with the system generated results, then modify the markings. See “Modifying Markings” on page 20-17.

14. After completing updates of the documentation in the respective fields, do one of the following:

    - “Create a Uterine Fetal Assessment Record” on page 20-14 to save the information.
    - **Cancel** to close the screen without saving any information or markings.

Create a Uterine Fetal Assessment Record

1. Click the **Create Fetal Assessment** button to access the Uterine/Fetal Assessment window.

   The values from Strip Analysis fields are auto-populated to the respective fields on the Uterine/Fetal Assessment window.

2. Modify any of the auto-populated data.

   The record is created for the time indicated at the right side of the Strip Analysis screen.

3. To display a different time frame, edit the values in the **Date/Time** field to display the time desired for the documentation.

4. The **Entered by** field is auto-populated with the logged in user’s name.

5. In order to prevent other users from making edits, sign the record to lock it.

Refer to Table 20-2 for the field values that are auto-populated from the Strip Analysis screen to the Uterine/Fetal Assessment screen and also Figure 20-21 and Figure 20-22 on page 20-16 for differences between external and internal monitoring.

Table 20-2 *Strip Analysis Screen to Uterine/Fetal Assessment Screen*

Strip Analysis Screen	Uterine/Fetal Assessment Screen
UA Monitor	**Monitor** field in the Uterine Activity section.
Contraction Frequency	**Frequency** field
Contraction Duration	**Duration** field
Contraction Intensity	**Intensity** field (Internal only).
Rest Tone	**Rest Tone** field (only filled-in when internal monitors are selected on the Strip Analysis screen).
MVU	**MVU** field (only filled-in when internal monitors are selected on the Strip Analysis screen).
Baseline Variability	**Baseline Variability** field
Baseline FHR	**FHR** field
Acceleration	**Acceleration** field. The value shall be “Present” if any accelerations were marked on the Strip Analysis screen.
Deceleration	**Deceleration** field. The **Deceleration** field of the fetal assessment can store multiple characterizations about any decelerations indicated on the Strip Analysis screen. For example, if both late and variable decelerations are marked, the **Deceleration** field of the fetal assessment would store both the values “Late” and “Variable.”
Category	Categories
Baseline Characteristic	Characteristics (under Fetal Assessment)
Rupture Time	**Rupture Date/Time** field. (This field is not auto-populated. It is pre-populated if there is a prior fetal assessment with the entered Rupture Date/Time.)

Figure 20-21 *Strip Analysis Documentation for Uterine/Fetal Assessment with External Monitoring*

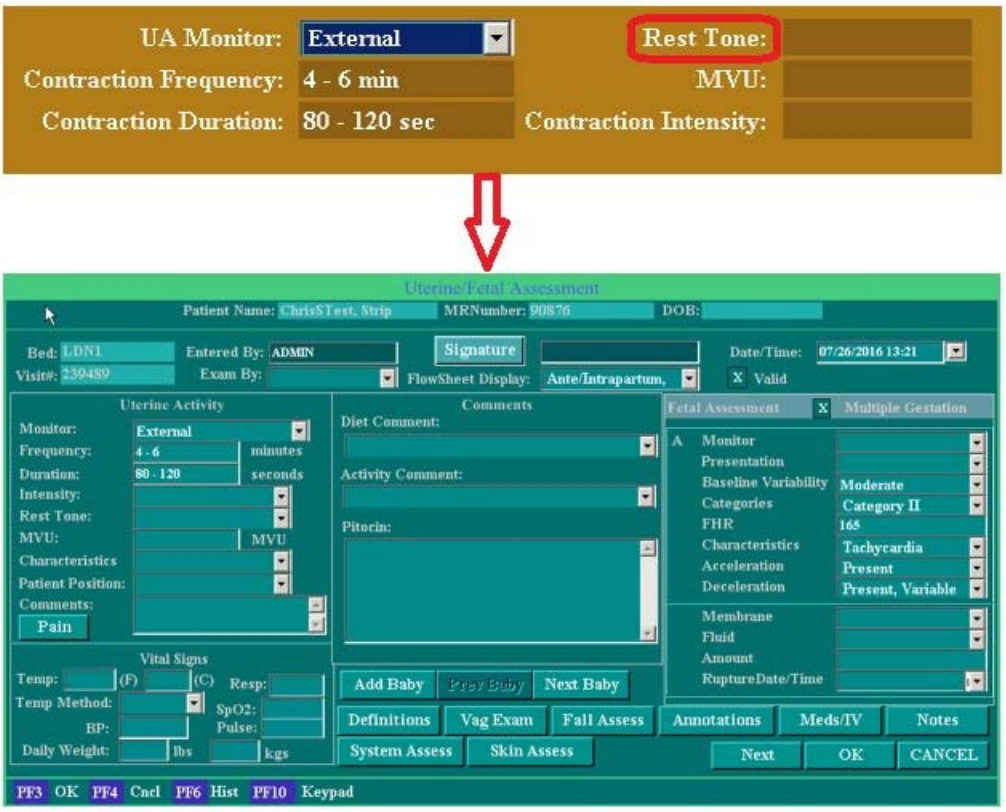
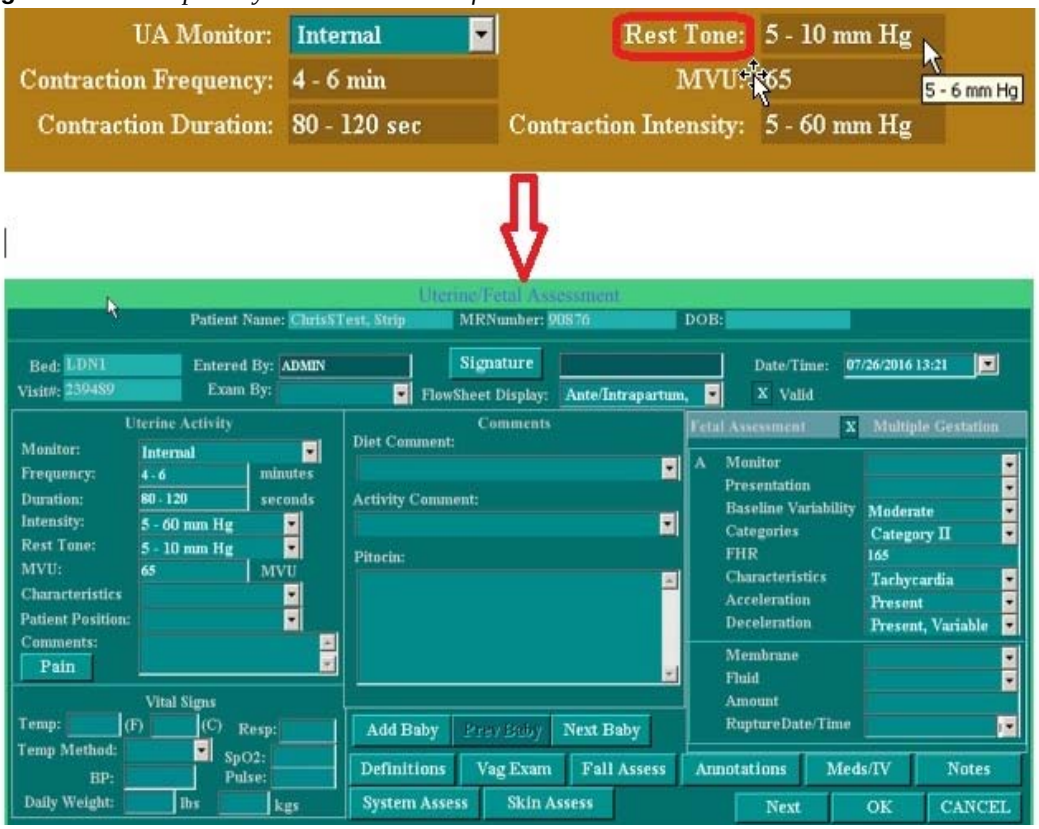


Figure 20-22 *Strip Analysis Documentation for Uterine/Fetal Assessment with Internal Monitoring*



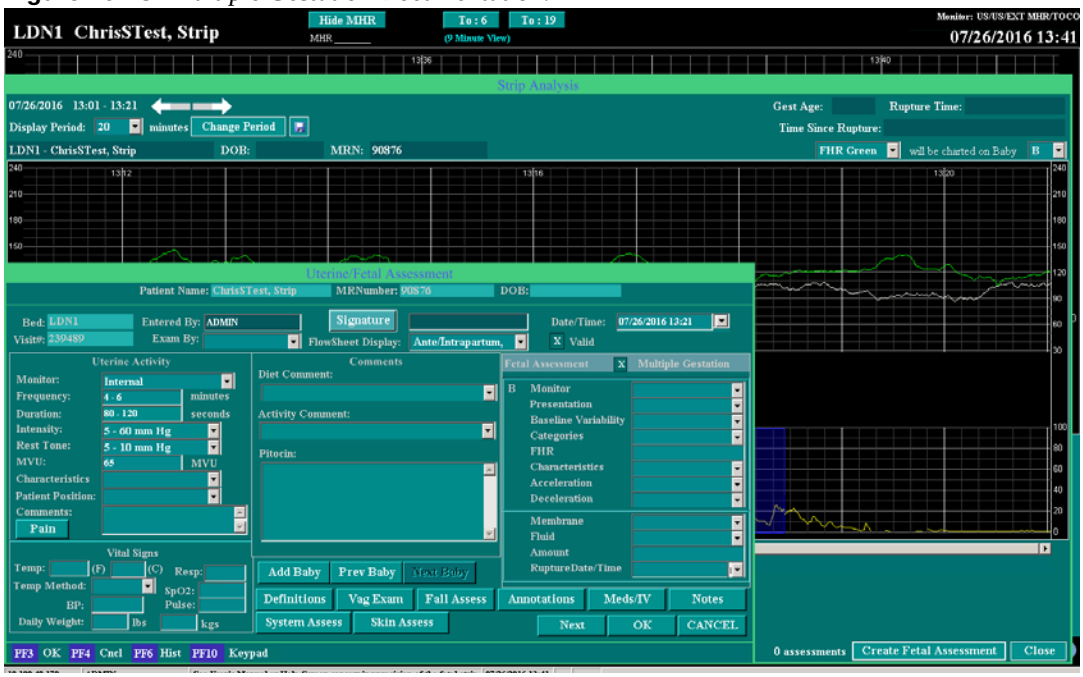
Multiple Gestation Documentation

Strip Analysis provides analysis for each unique infant fetal strip. To create a Uterine/Fetal Assessment record for each baby:

1. Click the **Create Fetal Assessment** button to open the record. The record displays *Baby A*.
2. Click **Next Baby** to access the other babies that exist.

Each record displays data generated from the Strip Analysis screen specific for each unique baby record as shown in Figure 20-23.

Figure 20-23 *Multiple Gestation Documentation.*



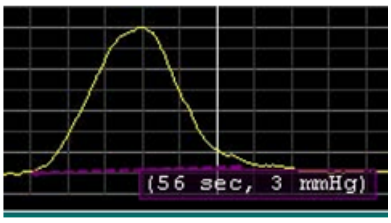
Modifying Markings

System generated markings on the strip can be modified by using the measuring tool with the mouse as follows:

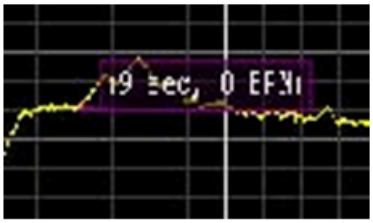
1. Remove the check marks from the desired box.
2. Once check mark(s) have been removed, move the mouse over the specific marking to be modified.
    - The accel/decel and contraction durations can be marked by clicking on the accel/decel or contraction, and stretching the cursor across the duration (which can only occur when no check marks are in the boxes).

- Durations are marked with a dotted purple line as shown in the following figure

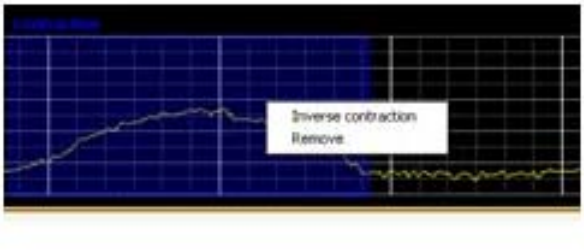
Contraction Duration

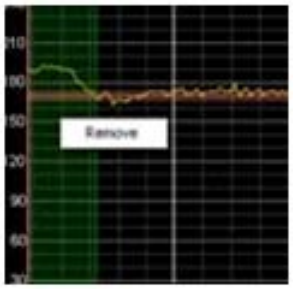


Acceleration Duration



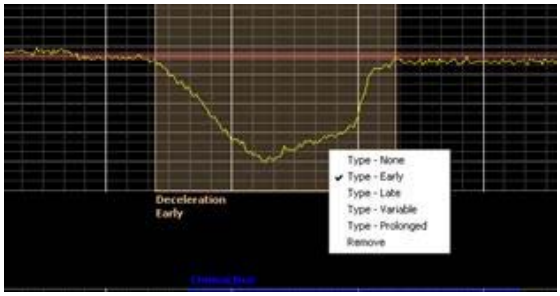
3. To remove a marking (accels, decels, or contractions), right-click on the marking.
4. Click **Remove** to remove the marking.





5. To mark decels, right-click to mark the type of decel:
   - None
   - Early
   - Late
   - Variable
   - Prolonged

   The descriptive wording displays under the decel as shown in the following figure:



6. To raise or lower the baseline (without using the measuring tool), hover over the red line.

   The cursor changes to an up and down arrow, allowing the red line to be raised or lowered by dragging the line.

7. As the red line is raised or lowered, the Baseline FHR field will display the number, set the FHR to the desired number; changes are in increments of 5.

   The variability is shaded around the baseline red line to denote the following:

   - Absent
   - Minimal
   - Moderate
   - Marked
   - Indeterminate

8. To remove the baseline, right click the red line and click **Remove**.

Choosing What Portion of the Strip to Analyze

The Strip Analysis screen requires a minimum strip display of 10 minutes for the 'Analyze' feature to automatically perform.

To manually choose the portion of strip:

1. The Strip Analysis displays the strip according to the defined 'Display Period'.
2. Decide where the analysis should begin by right clicking on the strip
   - If the defined period is greater than 20 minutes, Strip Analysis automatically uses the last 10 minutes of the strip and marks a vertical bold red line to indicate the strip portion (beginning and end) used for the auto analysis. See Figure 20-24 and Figure 20-25 on page 20-20.

Figure 20-24 *Start Marker*

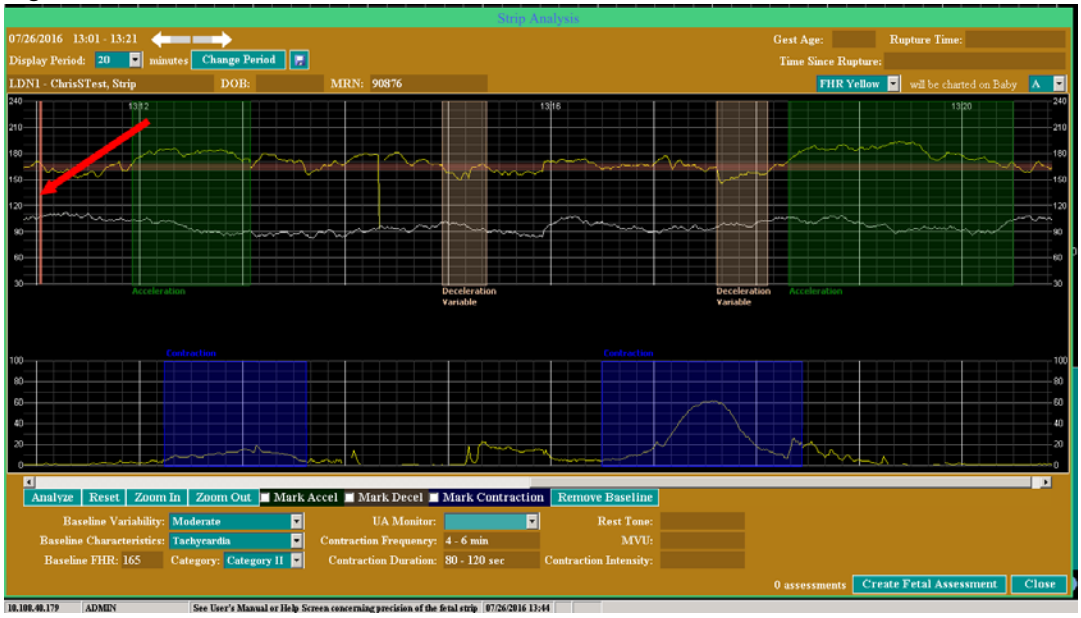
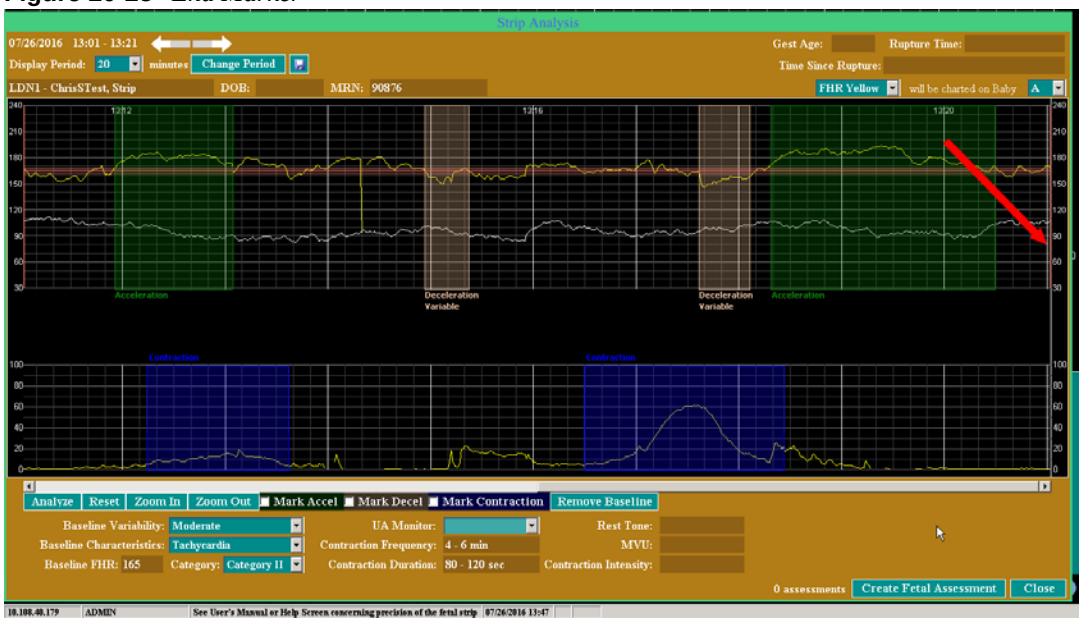


Figure 20-25 *End Marker*



3. When the display period is greater than 20 minutes and if more than 20 minutes of strip can be displayed to the right of the start analysis period when right clicking on the strip, the following 3 options are available as shown in Figure 20-26 on page 20-20:

   - Start the analysis at 'x' time ('x' minutes remaining),
   - Analyze only the next 10 minutes, or
   - Analyze only the next 20 minutes.

Figure 20-26 *Strip Options 20 Minute Display Period More Than 20 Minutes Displayed*

4. When the display period is greater than 20 minutes and if less than 20 minutes but greater than 10 minutes of strip can be displayed to the right of the start analysis period when right clicking on the strip, the following 3 options are available as shown in Figure 20-27:

- Start the analysis at 'x' time ('x' minutes remaining),
- Analyze only the next 10 minutes, or
- End analysis at 'x' time ('x' minutes remaining).

Figure 20-27 *Strip Options 20 Minute Display Period Less Than 20 Minutes Displayed*

5. When the display period is less than or equal to 20 minutes and if less than 20 minutes but greater than 10 minutes of strip can be displayed to the right of the start analysis period when right clicking on the strip, the following 2 options are available as shown in Figure 20-28:

- Start the analysis at 'x' time ('x' minutes remaining), or
- Analyze only the next 10 minutes.

Figure 20-28 *Strip Options Less Than 20 Minute Display Period Less Than 20 Minutes Displayed*

6. When the display period is less than or equal to 20 minutes and if less than 10 minutes of strip can be displayed to the right of the start analysis period when right clicking on the strip, the only option available is *End the analysis at 'x' time ('x' minutes remaining)* as shown in Figure 20-29.

Figure 20-29 *Strip Option Less Than 20 Minute Display Period Less Than 10 Minutes Displayed*

Fetal Assessment Schedule

This section provides the following Fetal Assessment Schedule (available with Strip Analysis enabled or disabled) instructions:

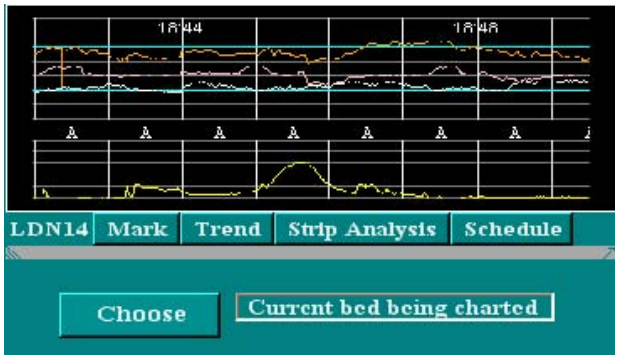
- "How to Access and Use the Fetal Assessment Schedule"
- "Using the Fetal Assessment Schedule"
- "Document/Edit a Fetal Assessment from the Schedule Screen"

How to Access and Use the Fetal Assessment Schedule

1. Click the **Schedule** button from the following screens:
    - Single Surveillance
    - Multi-Patient Surveillance
    - Chart screen (floating surveillance screen must be resized to access the button, see Figure 2-22)
    - Outpatient/Observation flowsheet
    - Ante/Intrapartum flowsheet

    NOTE: The first three screens listed are the same screens used to access Strip Analysis (in real time or trend mode).

Figure 20-30 *Chart Screen with Screen Resized to Reveal 'Schedule'*



2. It can be displayed horizontally or vertically, by clicking the **Flip** button, once the schedule screen appears. See Figure 20-31 and Figure 20-32 on page 20-23 for examples.

Figure 20-31 *Fetal Assessment Schedule-Vertical View*

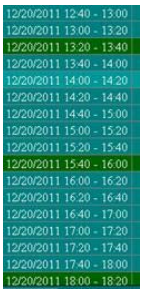
Figure 20-32 *Fetal Assessment Schedule-Horizontal View*

Using the Fetal Assessment Schedule

- The Fetal Assessment Schedule displays each baby when multiple gestations have been indicated from the documentation on the Uterine Fetal Assessment.
- Rows containing documentation are displayed in green.

- The screen can be displayed with or without documentation. Place a check mark in the box for the desired display of information.

- The Schedule displays in descending order with the following information:
  - assessment count and
  - all the documentation for:
    - Contraction frequency
    - FHR
    - Category for each baby (if multiples exist)



Document/Edit a Fetal Assessment from the Schedule Screen

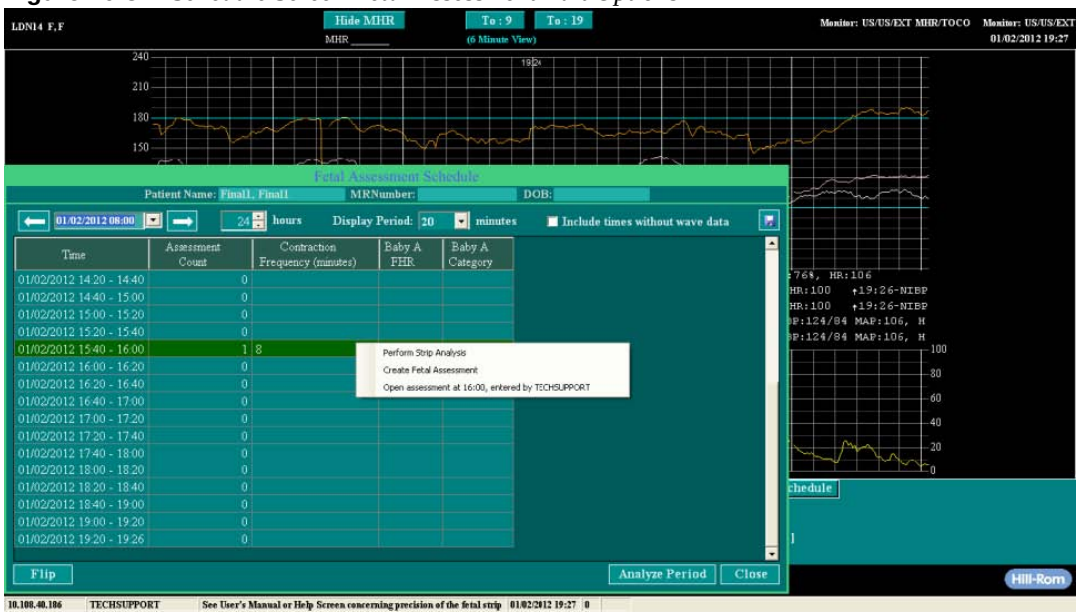
1. To create a fetal assessment or perform a strip analysis for a specific time period, right click any row which has ‘0’ in the assessment count column as shown in Figure 20-33.

Figure 20-33 *Schedule Screen Fetal Assessment Time Period Selections*

2. The strip analysis period or the Uterine Fetal Assessment screen opens for the time period selected.
3. Click **OK** from the screen selected and the system returns to the Fetal Assessment Schedule screen.
4. To edit a row with documentation, right click the row.

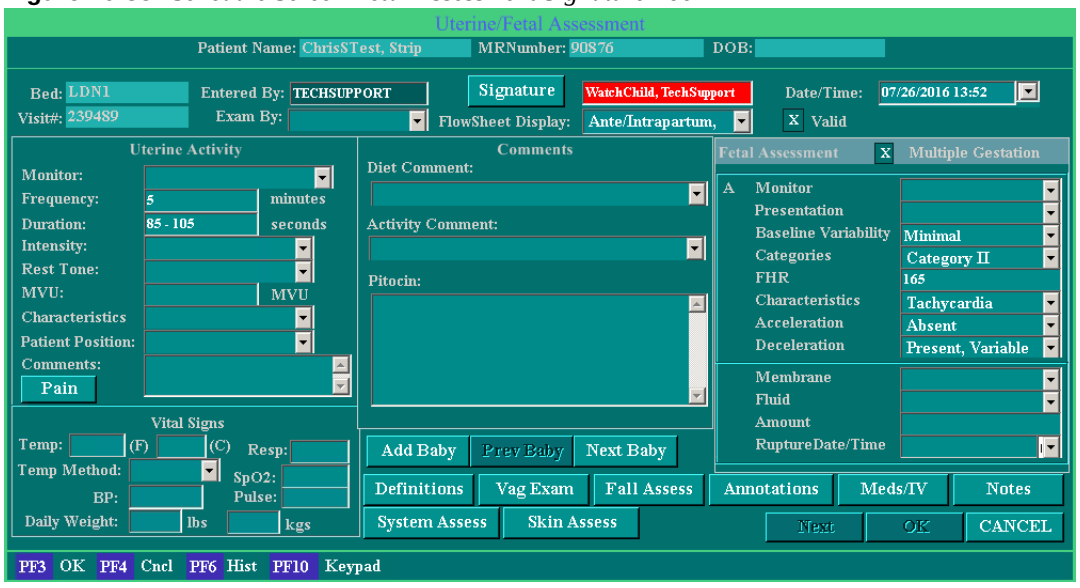
5. Choose one of the following options as shown in Figure 20-34 on page 20-25.
   - Perform a strip analysis
   - Create a fetal assessment
   - Open the documented assessment(s) for the date/time and user

Figure 20-34 *Schedule Screen Fetal Assessment Edit Options*



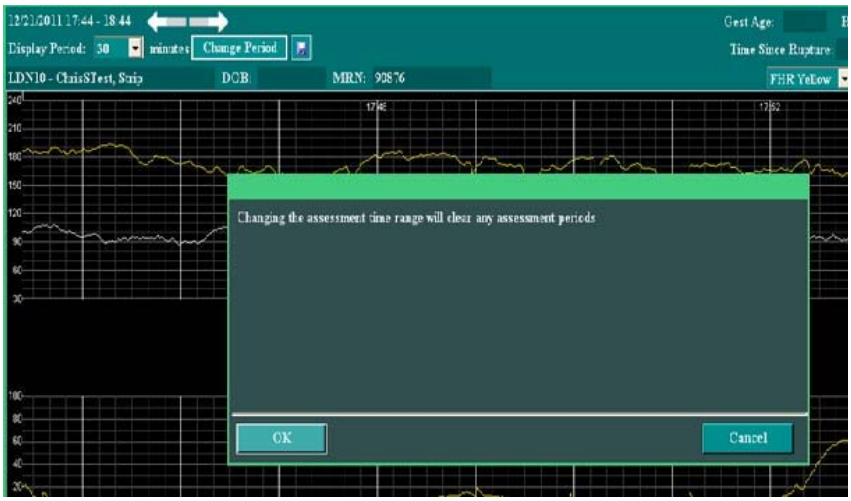
6. If opening an assessment signed by another user, viewing is all that will be allowed. Only the signed user can make changes to their documentation as shown in Figure 20-35.

Figure 20-35 *Schedule Screen Fetal Assessment Signature Lock*



Potential Message Pop-Up Boxes

Figure 20-36 *Pop-Up Message 1*



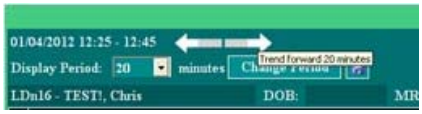
The message shown in Figure 20-36 appears if an assessment has been done, but not saved (by creating a Uterine Fetal Assessment) and the following are both changed:

■Time segment

■'Display Period'

The time segment can be changed by clicking one of the following:

- The extreme ends of the arrow (advances according to the display period time



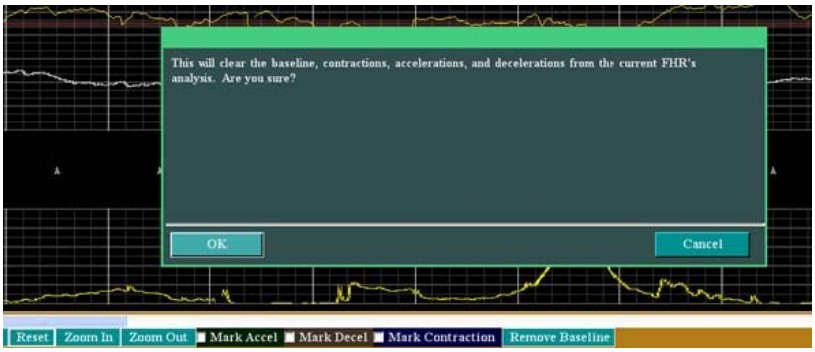
- The middle gray area (advances in 1 minute increments).

Either choice is an attempt to change the strip display with documentation to another time range with documentation not shown on the screen for the new time frame display.

Resolution options:

- Click **OK**, if the previous markings can be cleared, the new 'Display Period' is displayed and the previous strip analysis markings are deleted.
- Click **Cancel** if the previous marking(s) need to be saved.
  - The 'Display Period' is displayed with the original value
  - If the assessment needs to be saved, click the end of the arrow back or forward to the marked assessment, then click **Create Fetal Assessment** to save the information.

Figure 20-37 *Pop-Up Message 2*

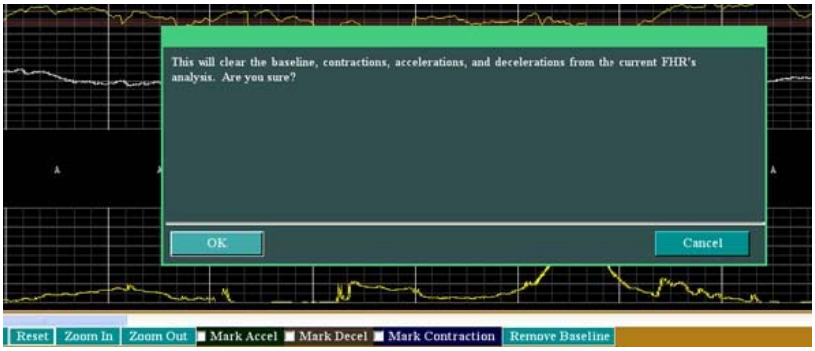


The message shown in Figure 20-37 appears when an assessment has been done, but not saved and then the **Reset**  button is clicked.

Resolution options:

- Click **OK**, if the marking(s) can be cleared, the strip analysis markings will be deleted.
- Click **Cancel** if the marking(s) need to be retained.
  - If the assessment needs to be saved, then click **Create Fetal Assessment** to save the information.

Figure 20-38 *Pop-Up Message 3*



The message shown in Figure 20-38 appears if the **Create Fetal Assessment** button is clicked, but 'Baseline Characteristics' is manually documented, but 'Baseline Variability' is left blank. The assessment can be created once variability is documented.

Resolution options:

1. Click **OK**, to return to the strip analysis.
2. Document 'FHR Variability'.
3. Click 'Create Fetal Assessment' to open the Uterine Fetal Assessment record.

Chapter
21

Troubleshooting Tips

How do I reset my workstation? What if my screen is frozen?

The answers to these and other questions are found in this chapter.

If there is an issue with the DAS endpoints or when a procedure refers you to Technical Support, call NaviCare® WatchChild® Technical Support.

NaviCare® WatchChild® Technical Support phone number: 1-800-445-3720, Option 3, Option 2

Resetting the Workstation

1. Press the keyboard **Ctrl+T** keys to change the NaviCare® WatchChild® display from full-screen to a window.
2. Select the **X** in the top-right corner of the window to close the window and exit NaviCare® WatchChild®.
3. Select the Windows **Start** button and then select **Shutdown,** then **Restart**. You can also use predefined Windows functionality Alt-F4 and then select Restart.

Workstation Seems to Have No Power

1. Ensure the workstation power cord is securely plugged into the electrical outlet.
2. Ensure that the workstation monitor is turned on.
3. Ensure that the monitor Contrast and Brightness settings are appropriately set.
4. Ensure that the main power cord is plugged into the line conditioner, which must be turned to **ON**.
5. If none of the above work, call your hospital support staff.

NaviCare® WatchChild® Displays the Login Screen but You Cannot Log In

1. Make sure the keyboard **Caps Lock** is off. The **Caps Lock** light is normally located on the upper- right corner of the keyboard and should be off.
2. Type your user ID and password and then press Enter on the keyboard or select the **OK** button. Passwords are case sensitive.
3. If the screen displays a *Login Failed* message, call your NaviCare® WatchChild® System Administrator.

4. Check the network.

Screen is Frozen

1. Check to make sure all cables are plugged into the wall outlets.
2. Press **Alt+Tab**.
3. Press **Ctrl+Alt+Del** to bring up the Windows task manager screen, then select the **Applications** tab.
4. Select the NaviCare® WatchChild® application from the list of programs working in your system and select the **End Task** button to end the program.
5. Select the Windows **Start** button and then select **Shutdown,** then **Restart**.
6. If none of the above work, call your hospital IS staff or NaviCare® WatchChild® System Administrator.
7. Check your facility network.

Blank Entry on a Flowsheet

A user selected **OK** on an examination, Pain, Care Plan, Meds/IVs, System Assessment or Time Out screen without filling in any information. This will chart a blank entry on the flowsheet. Add an annotation explaining the error to the strip, or use the appropriate flowsheet to display and edit the blank entry and fill in the needed information or uncheck the **Valid** check box.

Audible Alert Does Not Sound

If the visual alert is flashing, but you hear no alerting sound, check the following:

1. Verify the audible alert configuration for that workstation.
2. Check the volume control to verify that it has not been decreased.
3. If your system has external speakers, confirm that they are properly connected and turned on.
4. Contact your hospital IS or Biomed Department to determine if a sound card is present and properly configured in the workstation.
5. If the problem persists, contact NaviCare® WatchChild® Technical Support:

   1-800-445-3720, Option 3, Option 2

NIBP and SpO2 Sensor Data is Not Being Received

When a Corometrics® 120 Series monitor is used for NIBP (non-invasive blood pressure) and SpO2 (oxygen saturation) sensing, the sensor data may not be sent to NaviCare® WatchChild® even though the data is displaying on the Corometrics 120 Series monitor.

This problem occurs only when the Corometrics 120 Series monitor is run in communications mode *115*. To enable NIBP and SpO2 data to be sent to NaviCare® WatchChild®, set the Corometrics 120 Series monitor to run in communications mode *1371/NOTES*.

Fetal ECG Label Displays, Maternal Does Not

When using a Corometrics® 120 Series monitor with only fetal ECG (FECG) and maternal ECG (MECG) probes, the MECG label does not appear on the monitoring strip even though the maternal data displays as it should.

This problem occurs only when the Corometrics 120 Series monitor is running in communications mode *115*. To show both the FECG and MECG labels correctly, run the Corometrics 120 Series monitor in communications mode *1371/NOTES.*

Only First Mark Button Press Puts Mark on Strip

When a Corometrics® 120 Series monitor runs out of paper, pressing the **Mark** button puts a mark on the NaviCare® WatchChild® patient strip only the first time that the button is pressed. Subsequent pressings of the button do not mark the patient strip. This problem also occurs with *137/NOTES*. To solve this problem, load paper. Press the mark with more than one minute interval.

Server Not Recognizing Newly Attached Fetal/Maternal Monitor

When you disconnect one brand or model of fetal/maternal monitor and immediately connect another brand or model, the NaviCare® WatchChild® server is unable to determine which type of monitor is attached. This is caused by too short a time interval between disconnecting one monitor and connecting the other one. The server needs 5 to 8 seconds to fully process a monitor disconnection and be ready to accept a new connection.

To avoid the problem in the future, wait 10 seconds between disconnecting a fetal/maternal monitor and connecting another monitor. To clear a current “not recognized” problem, disconnect the unrecognized monitor, wait 10 seconds, then reconnect it.

Maternal Monitor Data is Not Getting to NaviCare® WatchChild®

After plugging in a new fetal/maternal monitor to a NaviCare® WatchChild® wall plate, maternal monitor data is not being received from the monitor by NaviCare® WatchChild® even though fetal data is getting through just fine and both fetal and maternal data is being displayed and recorded on the monitor.

This problem can be caused by plugging the fetal/maternal monitor into the secondary wall jack instead of the primary wall jack when a dual gang wall plate is used. Only the primary wall jack (left side) can transmit both fetal and maternal data. The secondary wall jack (right side) transmits only fetal data and is used for multiple gestation patients where a second EFM for triplets or quadruplets is in use. There can also be an arrangement for semi-private rooms where the dual gang wall plate can be used for two patients if NWC is configured for semi-private rooms.

Monitor Strip Display is Unevenly Distributed on Surveillance Screens

The maximum number of beds that can be simultaneously monitored by NaviCare® WatchChild® with optimal performance and accurate display of surveillance strips is 66. While NaviCare® WatchChild® can monitor more than 66 beds simultaneously, strip data may appear choppy and contain gaps. No data is actually lost when more than 66 beds are monitored simultaneously, but it may *appear* that data is missing on the displayed strips.

Monitor Strip Changes Colors

If moving a fetal monitor cable from the primary to the secondary monitor port, the FHR tracing on the strip is green. With a dual gang wall plate, a cable plugged into the primary port will trace the baby in orange and the secondary will trace the baby in pink.

NOTE: If using a triplet monitor with all three cables plugged in, ports 1, 2, and 3 will produce yellow, green, and orange tracings respectively. However, if only 2 cables are plugged in to any combination of ports, the order of colors will be yellow first followed by green. If only one cable is plugged in to any port, the tracing will be yellow.

Downtime and Data Recovery

CAUTION: Data retention and recovery may not be possible during an interruption in service to NaviCare® WatchChild®. To ensure that important medical record information is retained, always run fetal monitor paper when experiencing service delays or outages. Always revert to hospital standard practices for the completion and retention of patient medical data.

NaviCare® WatchChild® should run continuously without interruption of service. However, should service be interrupted and downtime occurs, refer to your hospital's procedure for the specific steps to take.

Loss of Data Collection and Display

If your monitor does not display any data, this may be due to a DAS or workstation problem.

1. Ensure that the fetal monitor is plugged in and selected in the NaviCare® WatchChild® wall plate.
2. Ensure that the maternal monitor cable is properly plugged into the wall plate.
3. If the monitoring strip still does not receive data, call your hospital IS staff or NaviCare® WatchChild® System Administrator.
4. Contact NaviCare® WatchChild® Technical Support: **1-800-445-3720, Option 3, Option 2**

Hospital Network Goes Down

If the hospital network (which is between NaviCare® WatchChild®–DAS) goes down, NaviCare® WatchChild® loses the monitor tracing and responds as if the fetal monitor was turned off.

When the system is restored, the Census screen bed line for the patient's name will display a *Verify Patient* message. For further information on verifying a patient, refer to "Verifying Patient Information" in the *NaviCare®* WatchChild® *User Manual.*

If it is the same patient, the name will remain on the monitoring strip. If it is a new patient, then leave the name of the previous patient in the OUT bed or discharge that patient if documentation was completed prior to the network going down, then admit the current patient's name on the Census screen.

NaviCare® WatchChild® Server Goes Down

When the system comes up, leave the patient's name on the Census screen if that patient is still in the room. If the patient has been transferred to another area or has been physically discharged, move the patient to an OUT bed or discharge that patient in NaviCare® WatchChild® if documentation was completed prior to the network going down. Then admit the patient who is currently in the actual bed.

Contact NaviCare® WatchChild® Technical Support and inform them of the downtime for further troubleshooting and to discuss the possibility of data recovery. NaviCare® WatchChild® Technical Support may recall the information saved in the Data Acquisition Server and apply it to the proper data storage conditions.

Data Restoration Delay After DAS-to-Server Connection Downtime

The DAS continues to collect monitor data when the NaviCare® WatchChild® server or connection to the server goes down. In the event of an extended downtime (roughly defined as more than 20 minutes) the amount of data collected can be quite large, especially so if the patient load is high during the downtime. When the server or server connection is back up, the DAS sends the stored data in incremental bursts rather than in one continuous feed in order to maintain system performance and prevent overloading the server or network. This burst mode restoration can result in data gaps in the monitoring strips until all restoration data has been transferred.

Hill-Rom Downtime and Data Recovery Recommendations

Hill-Rom recommends the following steps if NaviCare® WatchChild® downtime occurs:

- Notify appropriate hospital personnel to determine the cause of downtime.
- The System Administrator or designated personnel should contact NaviCare® WatchChild® Technical Support to report the system is down.
- Start running fetal monitor paper immediately for record keeping. (Hill-Rom recommends keeping fetal monitoring paper in the fetal monitors at all times to decrease risk of lost data should a system crash occur.)
- Save the fetal monitor strip generated during downtime until the data is recovered, restored and verified with the electronic record.

- Paper charting forms should be kept for documentation purposes during downtime. These records may be kept or the information may be keyed into NaviCare® WatchChild® after the system is back up and running. This will be defined by the hospital policy.
- The System Administrator or designated personnel should provide NaviCare® WatchChild® Technical Support with a list of current patients with room numbers, time of admission to room, and time of discharge to assist with restoring of records when the system is back up.

  A specific form is required to report the information: *NaviCare® WatchChild® System Data Recovery/Correction Form, FICAR-217*, an example[2] of which is shown in Figure 21-1 on page 21-7. The current version of the form must be used and it can be obtained from NaviCare® WatchChild® Technical Support.

[2]The example shown is Revision level 4 and was current as of the publication date of this manual.

Figure 21-1 *Example NaviCare® WatchChild® System Data Recovery Form*

Hill-Rom

NaviCare® WatchChild® Data Recovery/Correction Form

TO RECOVER DATA THIS FORM MUST BE COMPLETED AND BE RECEIVED BY TECHNICAL SUPPORT WITHIN 48 HOURS OF THE START OF DOWNTIME.

HOSPITAL NAME: _____

☐ DATA RECOVERY	☐ REMOVE EXTRA PREGNANCY	DATE & TIME SYSTEM WENT DOWN	DATE & TIME SYSTEM BACK UP
☐ MOVE STRIP DATA	☐ REMOVE EXTRA VISIT		
☐ MERGE TWO PATIENTS	☐ REMOVE EXTRA DELIVERY		

PROBLEM DESCRIPTION (other than data recovery)

For **Date & Time Admitted to Bed** column: Use **IN** if the patient was admitted prior to the outage.
For **Date & Time Discharged from Bed** column: Use **STILL** if the patient was still in the bed when the system came back up.

Patient Name	Medical Record Number	Bed Name on Census screen	Date & Time Admitted To Bed	Date & Time Discharged From Bed	Tech Support Use Only	
					Episode ID	Patient ID
Example: Smith, Jane	00123456789	LDR304	03/12/2008 13:23	STILL		
Example: Doe, Jane	00987654321	BS312E	IN	03/12/2008 14:19		

SIGNATURE: _____ **DATE:** _____

PRINTED NAME: _____ **CONTACT PHONE:** ( ) _____

Note: By signing this form you are authorizing NaviCare® WatchChild® Technical Support to make the changes to patient data requested above. Please fax the signed and completed form to: 1-888-840-4085. Then call Technical Support at 1-800-445-3720, option 3, option 2, and confirm that the fax was received.

Please record the name of the Support Specialist with whom you spoke: _____

Page _____ **of** _____

Form: QS12550

Appendix
A

List of Abbreviations

Table A 1 *NaviCare® WatchChild® On-Screen Abbreviations (Sheet 1 of 5)*

Abbreviation	Meaning
AB	Abortion
Acct#	Account number
ADL	Activities of Daily Living
AFDC	Aid to Families with Dependent Children
B Strep	Beta Strep
BedNo	Bed number
BM	Bowel movement
BP or B/P	Blood pressure
BPP	Biophysical profile
cc	centimeters
cncl	cancel
CNM	Certified Nurse Midwife
CON'T	Continue
CS	Cesarean Section
CST	Contraction stress test
CXR	Chest X-ray
DC	Discharge
DES	Diethylstilbestrol
Dia	Diastolic

Table A 1 *NaviCare® WatchChild® On-Screen Abbreviations (Sheet 2 of 5)*

Abbreviation	Meaning
Dil	Dilation
Dil/Sta/Eff	Dilation/Station/Effacement
DOB	Date of birth
dt	date
DTR	Deep tendon reflexes
EAB	Elective abortion (induced)
Ed or **ED**	Education
EDD	Estimated Date of Delivery
Eff	Effacement
EKG	Electrocardiogram
Est	Estimated
Fam	Family
FHR or **Fhr**	Fetal heart rate
FM	Fetal Monitor
FOB	Father of baby
ft	feet
G/P	Gravida/Para
ga or **GA**	gauge (this meaning is contextual; see below)
GA	Gestational Age (this meaning is contextual; see above)
GBS	Group Beta Strep
Gest	Gestation
gms	Grams
HbSAg	Hepatitis B Surface Antigen
HCG	Human chorionic gonadotropin, a pregnancy indicator
Hct	Hematocrit
HEENT	Head, ears, eyes, nose and throat

Table A 1 *NaviCare® WatchChild® On-Screen Abbreviations (Sheet 3 of 5)*

Abbreviation	Meaning
HELLP	Hemolysis, elevated liver enzymes, low platelet count
HIV	Human immunodeficiency virus
Hgb	hemoglobin
HR	Heart rate
Hx	history
in	inches
info	information
Init	Initial or initials, depending on context
Interp	Interpreted by
kgs	kilograms
lbs	pounds
LMP	Last menstrual period
MD	Medical Doctor
Med	Medication(s)
Med#	Medical record number (a.k.a. patient ID)
Meds/IV	Medications/Intravenous
Mem.Stat	Membrane Status
MGF	Maternal grandfather
MGM	Maternal grandmother
MHR or **Mhr**	Maternal heart rate
MI	Medicaid Insurance
MRN	Medical record number (a.k.a. patient ID)
Multi	Multiple
MVP	Mitral valve prolapse
MVU	Montevideo units
NBP or **NiBP**	Non-invasive Blood Pressure

Table A 1 *NaviCare® WatchChild® On-Screen Abbreviations (Sheet 4 of 5)*

Abbreviation	Meaning
NPO	Nothing by mouth
NST	Non-stress test
NSVD	Normal spontaneous vaginal delivery
OB	Obstetric
Pt	Patient
Pedi	Pediatrician
PGF	Paternal grandfather
PGM	Paternal grandmother
Phys	Physician
PIH	Pregnancy-induced hypertension
PO	By mouth
Pregrav	Pregravid
Prev	Previous
Psych	Pyschological
Pt	Patient
PUBS	Percutaneous umbilical blood sampling
Qty	Quantity
R or **Resp**	Respirations
RPR/VDRL	Syphillis
SAB	Spontaneous abortion
Sat	Saturation
SOB	Shortness of breath
SpO2	Oxygen saturation
SS or **SSNo**	Social Security Number
Sta	Station
STI or STD	Sexually transmitted infections

Table A 1 *NaviCare® WatchChild® On-Screen Abbreviations (Sheet 5 of 5)*

Abbreviation	Meaning
Sys	System or systolic (contextual)
TB	Tuberculosis
toco	tocotransducer
UA	Uterine Activity
UC	Uterine contraction
US	Ultrasound
UTI	Urinary tract infection
Vag	Vaginal
VBAC	Vaginal Birth After Cesarean Section
WIC	Women, Infants & Children
wks	weeks
Wt	Weight

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