NURSING SERVICE

POLICY TITLE: **CENTRICITY PERINATAL SYSTEM**

POLICY:
All patients arriving to the Labor & Delivery and Nursery Units will be admitted to the Centricity Perinatal System for purposes of surveillance and documentation.

QUALIFIED PERSONNEL:
REGISTERED NURSE (RN)
CERTIFIED NURSE MIDWIFE (CNM)
CERTIFIED NURSING ASSISTANT (CNA)
SURGICAL TECHNICIAN (ST)
UNIT SECRETARY (US)
PHYSICIAN
NEONATAL NURSE PRACTITIONERS (NNP)
SUPPORT STAFF

STANDARD
All Labor & Delivery and NICU/Nursery staff to include RNs, LPNs, CNAs, STs, US, Physicians, Certified Nurse Midwives, Neonatal Nurse Practitioners and any other staff that are required to document in the medical record will be trained and deemed competent in the usage of the Centricity Perinatal System (CPN). Training and check-off will be performed by a Master Trainer or Super User.

EQUIPMENT:
CENTRICITY PERINATAL SYSTEM
PAPER

Qualified personnel will function within the scope of their practice when utilizing the CPN system.

Passwords:

1. Every user will have a user ID that is recorded and stored in the CPN System. This ID will be the same as their Network/Meditech ID.

2. Every user will have a password known only to that user. This password must consist of at least 8 characters and include mixed case, at least one number and one punctuation symbol. It can not contain any part of the username.

3. Every user has the ability to change their Network/Meditech password. Password changes are required every 90 days. A warning will appear when you are fourteen (14) days away from expiration. If you do not have your password changed within that time, the system will lock you out, rendering you unable to chart. If this happens you may unlock/change/reset your password by using the Quest One Password Manager. The Quest One Password manager icon is on all hospital computer desktops. If after attempting to reset/unlock your password in Quest you are still unable to access the system please call the IT Help Desk at Ext. 2829.

4. User access will be defined by job responsibilities and assigned accordingly by the System Manager.

5. Passwords cannot be shared. Doing so is grounds for corrective action.

6. Every user will be given a competency list to be completed during CPN Training or new-hire orientation to the unit. The completed list will be kept in the employee's file on the unit.

7. Resources will be available to users. These resources include the CPN User's Resource Manual, staff designated as Super Users, System Managers, and On Line Help available at the top of the CPN application. GE technical support is available 24 hours a day, 7 days a week. GE Clinical support is available Monday through Friday from 0800-1700 and on call 24 hours a day, 7 days a week for issues which impact patient safety .– System managers and IT will be responsible for placing calls to GE

CPN Downtime:

1. If this is an unplanned downtime please notify the system manager immediately. FOR CPN ELECTRONIC CHARTS IN NICU/Nursery: During downtime, if electronic chart forms usually generated by the CPN system cannot be accessed, there will be paper back-up forms available at the NICU/Nursery Nurses Station.

2. **FOR CPN ELECTRONIC CHARTS: System Downtime for <u>less</u> than two (2) hours:**
The RN assigned to that patient will be responsible for entering all the information in the system once system functionality resumes.

   Once the system is functional, the RN assigned to each patient will make sure the right patient is in the correct room and has all of the correct information. Any problems should be communicated to the System Manager immediately.

4. **FOR CPN ELECTRONIC CHARTS: System Downtime for <u>more</u> than two hours:**
The assigned RN for the patient will need to proceed and chart in the paper records.

   Blank CPN forms will be used to record documentation while the system is down. If the system is down for two hours or less the documentation on the paper forms will be transcribed into CPN by the RN assigned to the patient. If the system is down for more than two hours the paper documentation should be labeled and put in the patient's chart and will become the official Medical Record. Each nurse providing care will need to have her initial & signature on the paper flowsheet documentation.

   Once the system is functional**,** the RN assigned to each patient will make sure the right patient is in the correct room and has all of the correct information. Any problems should be communicated to the System Manager immediately.

   All charting must resume on CPN and a note should be entered in the comment section of the appropriate chart that states that "CPN was down and all notes prior to that specified date and time were written in the paper record".

5. Any software issues or problems you can contact the System Managers
For all technical problems with the CPN system contact the Help desk x2829 and ask for the CPN Clinical Analyst or your System Managers. (Nurse Manager/Asst.Manager, IT Clinical Analyst).

LABOR AND DELIVERY

Admission of a patient:

Policy:
All obstetric patients should be admitted into CPN. All nurses caring for an antepartum / laboring patient will be able to demonstrate the ability to admit the patient to CPN. It is understood that emergent or precipitous situations arise that may adversely affect the timeliness of admitting a laboring patient to CPN.

Recommended guidelines:
Do not turn on the fetal monitor until the patient is admitted to CPN unless there is an emergent, precipitous situation present. In that event, obtain heart tones, tend to the patient and delegate a qualified person to admit the patient to CPN as soon as possible.

1. Log On (See Log on / Log off Procedure)

2. Patients are only admitted to the system **ONCE** during each pregnancy. Always check the "Undelivered Hold" and search by "Name" and Medical Record Number "Pt ID" before trying to "create a patient". You may enter a few letters of either first or last name. Inquire as to correct spelling of first and last names, or if any name changes have occurred.

3. From Undelivered Hold, you may select the "Transfer" choice and transfer the patient to the appropriate empty bed. Confirm that the correct patient name appears on the chalkboard in the correct room.

4. Admitting a patient that has never been entered in CPN
   a. Select "Patient Administration from the menu bar.
   b. Select "Create Patient Record"
   c. Type in patient MR#
   d. Type patient last and first name
   e. In an emergent situation (ex precipitous delivery, hemorrhage, etc.) where no MR# is available, use the unique patient identifier "lastnamefirstinitial6digitDOB" until MR# is available.
   f. If patient name changes or has been previously misspelled select "Change Patient Info" and correct the patient's name
   g. To change the unique patient identifier from "lastnamefirstintial6digitDOB" to MR#, select "Patient Administration" then select "Change Patient ID". Input proper MR# to change information.

5. Select an empty bed to place patient in. (Bed must correspond with room they are in.)

6. Turn Fetal Monitor on. Attach U/S and Toco to patient. Begin EFM.

Undelivered Hold:

Patients arriving to the Labor and Delivery (L&D) unit should be admitted to the undelivered hold file via the ADT link. Antepartum patients who are sent home undelivered are to be transferred to the "Undelivered Hold" file so that the record may be reactivated for subsequent instances of observation, admission, or perinatal testing during this pregnancy.

Recommended guidelines:
To Transfer
1. Patients who leave the hospital undelivered are NOT discharged from CPN. All obstetric patients are

admitted only once (the first time they present to the hospital with the current pregnancy). After that, the patient's CPN record is to be recalled from the Undelivered Hold file. Each time she is sent home undelivered during the current pregnancy, her record must be transferred to the Undelivered Hold file.

2. When ADT Interface is functioning as designed To transfer to undelivered hold:
   a. Check to make sure correct patient name is in patient banner
   b. Left click on Patient administration
   c. Left click on Transfer
   d. Click on Unit and search for Undelivered Hold file
   e. Select undelivered hold bed
   f. Confirm the transfer, and then click yes

To retrieve:

1. Left click on Patient Administration
2. Left click on Select Patient
3. Search by unit
   a. Select undelivered hold
   b. Type in first couple letters of patient's first or last name. List will auto alphabetize
   c. Left Click on patient's name
   d. Select empty bed
   e. Patient's name will display in patient banner
4. Search by patient's name
   a. Type in first couple letters of patient's first or last name. List will auto alphabetize
   b. Left Click on patient's name
   c. Select empty bed
   d. Patient's name will display in patient banner
5. Search by patient ID
   a. Type in patient ID (medical record number)
   b. Left click on patient name
   c. Select empty bed
   d. Patient's name will display in patient banner
5. Confirm the transfer
6. Turn on monitor and begin recording strip.

Special Instructions:

1. ALL UNDELIVERED patients are transferred to Undelivered hold- NO EXCEPTIONS.
2. Patient stays active in system for 308 days, after that time the patient record is archived
3. When patient is discharged information auto populates to birth log, if no birth present birth log errors.

Documentation:

Policy:

CPN will be used for documentation of patient information when the patient is on the obstetrical (OB) unit. CPN Documentation will include: antenatal procedures/triage, Non Stress Test, Pre-term labor, Labor, Inductions, Cesarean Sections, and Recovery. CPN documentation will take the place of PIE charting in Labor and Delivery.

Recommended Guidelines:

1. Documentation of interventions should be timely as patient situation allows.
2. Documentation regarding interventions that occurred on a particular shift should be entered prior to the RN leaving her/his shift.
3. During emergency situations RNs should utilize the "mark" button to indicate that they are in the room and that interventions are occurring. RNs may then review the strip once the situation has resolved and enter charting specific to that time. CPN allows the RN to place entry at the date and time of occurrence, but also stamps the actual date and time the occurrence is documented at the end of her/his electronic signature.

4. All admitted patients will have their intake and output documented each shift.

User name Standardizations:

1. Provider Name: Will use providers last name, first initial
2. Nurse Name: Will use Last Name, 1st Initial
4. Ancillary staff: Last Name, 1st Initial

The electronic signature will be first and last name, title

Confidential Patients:

1. In Meditech: Patient will show a "Y" in the OPT column on the status board.
2. If the patient chooses to opt out initially it will be documented in Meditech and the interface will treat it accordingly in CPN causing a mask to be placed over the patients name on the chalkboard. If patient chooses to opt out later during their stay they can follow the following procedure: Staff will double click on patient's name on the chalkboard and Select "No Information given". If patient chooses to opt out at a later date and time patient access must be notified so that Meditech can be updated.

Flow sheet Charting

1. Log on
2. Select patient to be documented on: Menu Bar-Patient administration-Select Patient
3. Search by patient name. Type 1st few letters of patient's first or last name
4. To go directly to flow sheet charting click on the "Flow sheet" quick key. This will take user directly to patient flow sheet.
5. Double Left Click on the pencil icon, a date/time/method screen will pop up
6. Select the appropriate date/time entry if different than the one appearing before you.
7. Carry Forward Function: draws arrow ⟶ to all items. Copy Forward Function: Copy Forward copies data from previous column to current column. **These functions should NOT be utilized. Exception – Copy Forward may be used with Care Plan review and update.**
10. Annotating from fetal strip
    a. Each annotation can accommodate 5000 characters.
    b. Can have multiple annotations tied to one time period.
    c. Can annotate from active or stored strip.
11. Pain scale will be documented using the OMH pain scale of 0-5.

Fall Risk Assessment

Fall Risk Assessment will be completed on all admitted patients in the CPN system. Information regarding medications, dizziness or seizures should be documented under "Fall Comment". Risk level will be determined based on the Morse Fall Scale. Patients determined to be at high risk for falling will then be treated with OMH fall safety interventions to include:

- Reorient patient
- Side rails up x 2
- Call bell within reach
- Privacy maintained
- Stretcher wheels locked
- Family member involvement
- Blue armband applied

FHR Notifications (Alarms):

- Fetal heart notification will be activated for all units using the CPN system for fetal surveillance.
- Alert tones will be tested at the beginning of every shift by the charge nurse.
- This notification will alert the care providers of High Notification (fetal tachycardia), Low Notification (fetal bradycardia), and poor signal quality (the absence of fetal heart signal/sketchy fetal heart tracing).
- Default Alarm/Alert limits will be configured by the CPN System Manager based on national standards, nurse and medical provider collaboration.
- Fetal heart rate notification will be on all viable fetal tracings or any tracing which the Medical Provider has ordered continuous fetal heart monitoring.

- The Registered Nurse may individualize alert settings based on clinical assessment. If a default alert setting has been altered, it is the responsibility of the nurse to include this information in the hand off communication when changing care providers.

DEFINITIONS:

- **Poor Signal Quality:** Any loss of the fetal heart signal for the specified duration. The symbol that denotes this condition is an arrow pointing to the right with a circle and line crossed through it.

- **High Notifications:** Any fetal heart rate above the specified limit of beats per minute for the specified duration. The symbol that denotes this condition is an arrow pointing up (↑)

- **Low Notifications:** Any fetal heart rate that falls below the specified limit for the specified period of time. The symbol that denotes this condition is an arrow pointing down (↓).

- **Limit:** The identified fetal heart rate value that triggers the alert/alarm

- **Duration:** The time frame specified for the fetal heart rate to maintain a certain condition before the care-giver will be alerted that the condition exists

- **Rest:** The number of seconds allowed to elapse after the user has acknowledged the alert before a re-alarm will occur

- **Recovery:** The minimum number of seconds that the fetal heart rate is allowed to lapse after the user has acknowledged the alert/alarm before the notification is considered within normal limits and returns to the no alarm state.

- **Normal State:** A green bell in the active patient fetal tracing banner denotes the Fetal Heart Rate is within limits as set by the specified parameter in the CPN system. The FHR Notification in the upper corner of the screen appears green.

- **FHR Alert/Alarm:** When a fetal heart rate condition exists (low, high or poor signal quality, for the specified duration, an alert/alarm is triggered in the QS. The patient banner on the tracing will turn blue and flash, a red arrow will appear in the upper right corner of the banner and an audible alarm will be activated at the charting stations. The FHR in the upper corner of the screen appears red and flash.

- **Beds in alert:** FHR tracing that fall with the set parameters to alert/alarm.

- **Fetal Monitor Strip Storage:** This setting in the Fetal Notification Settings will be turned off once the patient delivers. This will allow maternal vital signs to continue to flow into the patient record, but prevent alert/alarms for fetal heart tones.

PROCEDURE:

1. The default settings are set by the CPN System Manager as determined by national fetal monitoring standards.

2. Identify beds in alert by clicking on the red flashing FHR in the top right corner of the screen or by clicking on Surveillance then screen alert beds

3. The RN must acknowledge fetal alerts.

4. If the audible alarm is silenced on the surveillance computer at the main desk, the RN silencing the alarm is required notify the attending RN or to personally go to the bedside.

5. The fetal monitor alarms or strip storage will be turned off once the patient has delivered. This allows the vital signs to be recorded while the alarms are no longer activated.

6. Alarm settings will revert to the default settings once the patient has been discharged or transferred from the assigned bed in the CPN.

Mother-Baby Link:

- Mother-Baby Link will be initiated once a patient is admitted for delivery by Labor and Delivery staff.
- Mother-Baby Link will be updated again after delivery and at the completion of all maternal documentation.

Printing the Medical Record:

1. Hard copy Fetal Monitor Strips will be saved only during downtime procedures. The strips must be labeled appropriately and placed with the patient's paper chart.
2. A copy of the maternal prenatal record will be sent to the nursery with the transfer of the infant.
3. Upon transfer to the post partum unit or any other designated unit in the hospital, the electronic record will flow to Meditech by way of the Outbound interface and will not need to be printed. If the outbound interface is down then the chart will be printed in its entirety and each paper portion of the chart should be placed under the appropriate tab. This task should be carried out by a Unit Secretary if available. It is the ultimate responsibility of the patient's assigned nurse to make sure printing of the patient record is accomplished prior to transfer. Any printed prenatal history received will be scanned into the infants chart by Medical Records at Discharge.

NICU/NURSERY

Admission of a Patient:

Policy:
All NICU/Nursery patients should be admitted into CPN by patient access via the ADT Interface. Babies will be pre-admitted into a Pre-Admit Hold Unit bed for immediate charting after birth. The patient will be placed in the physician ordered Unit/Bed by the ADT Interface once fully admitted in Meditech. All nurses caring for infants in the NICU/Nursery will be able to demonstrate the ability to admit the patient to CPN if for some reason the ADT Interface fails to admit the patient in a timely manner. It is understood that emergent situations arise that may adversely affect the timeliness of admitting a patient to CPN.

Recommended guidelines:
Do not turn on the hemodynamic monitors until the patient is admitted to CPN unless there is an emergent situation present. In that event tend to the patient and delegate a qualified person to admit the patient to CPN as soon as possible.

1. Log On (See Log on / Log off Procedure)

2. Patients are admitted to the system after delivery or upon transfer into the NICU/Nursery from an outside hospital via the ADT Interface. Always check the "Pre-Admit Hold" and search by "Name" and Medical Record Number "Pt ID" before trying to "create a patient". You should never need to "create a patient" in

the NICU/Nursery if the system is working correctly. You may enter a few letters of either first or last name. Inquire as to correct spelling of first and last names, or if any name changes have occurred.

3. The ADT Interface will move the patient from Pre-Admit Hold to the correct bed once assigned in Meditech.

4. Admitting a patient that is not available in CPN (Should only occur in emergent situations or if the ADT Interface is down)
   a. Select "Patient Administration" from the menu bar.
   b. Select "Create Patient Record"
   c. Type in patient MR# if available using the "M" and all zeros
   d. Type patient last name and babygirl or babyboy as the first name based on baby's sex
   e. In an emergent situation where no MR# is available, use the unique patient identifier "lastnamefirstinitial of sex 6digitDOB" until MR# is available.(SmithG120514)
   f. If changes are needed to the baby's information notify Patient Access to make the changes in Meditech. The changes made in Meditech will flow through the ADT interface and update the baby's information.
   g. To change the unique patient identifier from "lastnamefirstintial6digitDOB" to MR#, select "Patient Administration" then select "Change Patient ID". Input proper MR# to change information.

5. Select an empty bed to place patient in NICU/Nursery. If patient is in NICU/NU2 and on a monitor, the bed in CPN must correspond with the room they are assigned in Meditech for the Carescape Interface to function properly.

6. Once admitted to a Unit/Bed hemodynamic monitoring can be initiated.

Pre-Admit Hold:

Babies will be Pre-Admitted into Meditech upon admission of the actively laboring mother to L&D. The ADT interface will place the baby into the Pre-Admit Hold Unit in CPN. Once the baby is delivered patient access will be notified of the birth by L&D staff and will admit the baby to the appropriate unit determined by the provider within 15 minutes of notification.

Transfer of a Patient:

Recommended guidelines:

To Transfer From One Unit To Another:

1. When an infant needs to be transferred from one unit/bed to another within the Nursery the ADT interface will complete the transfer. When unit/bed changes are needed Patient Access will need to be alerted by NICU/Nursery staff.

To Transfer To An Outside Facility:

1. Patients who leave the hospital as a transfer to another facility will be placed into the Unit hold bed when discharged from Meditech. The Nurse/US/CNA will then need to transfer them into the PreAdmit Hold Unit so that their record will be available upon transfer back to our facility. If infant returns within 4 months to NICU/Nursery their chart will be recalled from the Pre-Admit Hold Unit. If patient does not return back to the NICU/Nursery from the transfer facility the record will be archived after 4 months.

To Transfer To Pre-Admit Hold:

1. Check to make sure correct patient name is in the patient banner
2. Left click on Patient Administration
3. Left click on Transfer
4. Click on Unit and search for Pre-Admit Hold

5. Select Pre-Admit Hold bed
6. Confirm the transfer and then click-Yes

To Retrieve Patient:
1. Left click on patient administration
2. Left click on select patient
3. Search by unit
    a. Select PreAdmit Hold
    b. Click on PT Name Column and list will auto alphabetize
    c. Double click on patient's name and the patient will be placed in the patient banner
    d. Then follow instructions to transfer from one unit to another
4. Search by Patient's Name
    a. Type in the first couple of letters of the patient's last name. List will auto alphabetize
    b. Double click on patient's name and it will be pulled into the patient banner
    c. Follow instructions for transfer of patient from the PreAdmit Hold unit to the desired care unit (NUR, NU2, NICU).
5. Search by patient ID:
    a. Type in patient ID (Medical Record Number)
    b. Double click on patient's name and it will be pulled into the patient banner
    c. Follow instructions for transfer of patient into desired care unit.
6. Confirm the Transfer
7. Turn on the Hemodynamic Monitoring if ordered.by patient ID

Special Instructions:
1. The ADT interface will complete admissions, transfers, and discharges of infants within the CPN system.

Documentation:

Policy:
CPN will be used for documentation of patient information when the patient is on the NICU/Nursery Unit.
CPN Documentation will include: Assessment and care of the neonate.

Recommended Guidelines:
1. Documentation of interventions should be timely as patient situation allows.
2. Documentation regarding interventions that occurred on a particular shift should be entered prior to the RN leaving her/his shift.
3. During emergency situations RNs should follow hospital policy regarding documenting of Codes/Resuscitative efforts and utilize a nurse to record events in CPN.
4. All admitted patients will have their intake and output documented each shift.

User name Standardizations:
1. Standard fields will have drop downs available for choosing Providers and Nursing staff and will have full name – First Name Last Name, Title
2. The Electronic Signature will be first and last name, title

If a name needs to be placed in a free text field:
1. Provider Name: Will use providers last name, first initial
2. Nurse Name: Will use Last Name, 1st Initial
3. Ancillary staff: Last Name, 1st Initial

Confidential Patients:

1. In Meditech: Patient will show as "Opt Out"
2. Opt Out patients will be designated in the CPN system by the following: Staff will double click on patient's

name on the chalkboard and Select "No Information given"

Flow sheet Charting

1. Log on
2. Select patient to be documented on: Menu Bar-Patient administration-Select Patient
3. Search by patient name. Type 1st few letters of patient's first or last name
4. To go directly to flow sheet charting click on the "Flow sheet" quick key. This will take user directly to patient flow sheet.
5. Double Left Click on the pencil icon, a date/time/method screen will pop up
6. Select the appropriate date/time entry if different than the one appearing before you.
7. Copy Forward Function: Copy Forward copies data from previous column to current column. **These functions should NOT be utilized. Exception- Copy Forward may be used with review and update of the Care Plan.**
8. Pain scale will be documented using the OMH pain scale of 0-5. NICU/Nursery is the Neonatal Infant pain Scale.

Printing the Medical Record:

Prior to the transfer of the patient to the an outside facility the electronic record will be printed in its entirety. Upon transfer to the pediatric unit or any other designated unit in the hospital, the electronic record will flow to Meditech by way of the Outbound interface and will not need to be printed. If the outbound interface is down then the chart will be printed in its entirety and each paper portion of the chart should be placed under the appropriate tab. This task should be carried out by a Unit Secretary if available. It is the ultimate responsibility of the patient's assigned nurse to make sure printing of the patient record is accomplished prior to transfer. Any printed prenatal history received will be scanned into the infants chart by Medical Records at Discharge.

EFFECTIVE DATE: _____

APPROVED BY: _____