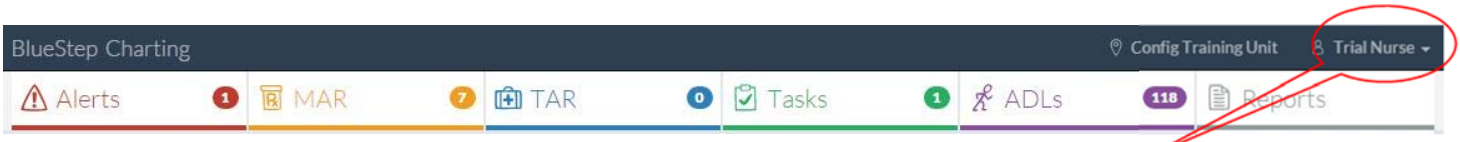
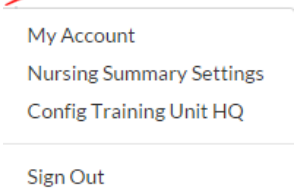
Bluestep Charting – MAR/TAR

Step 1. The BlueStep Charting home page will display the Charting Dashboard which could include Messages, New Resident list, Birthdays, Recent Records, etc. Depending on the user's permissions it may also display Alerts, MAR, TAR, Tasks, ADLs, and Reports.

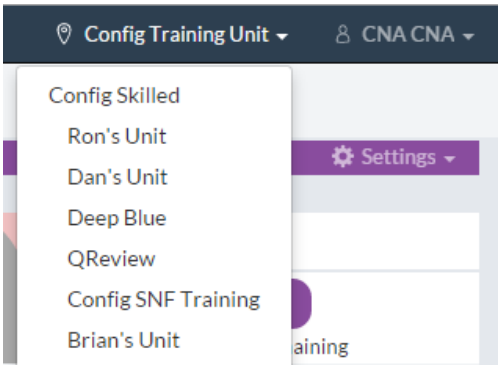


The name of the user appears in the upper right corner of the page. If you select your name, you can:

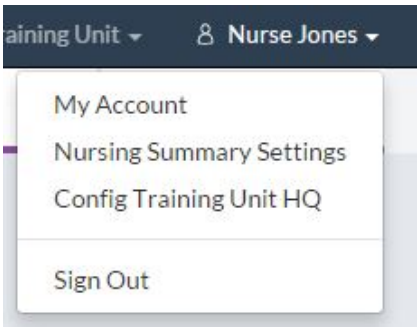


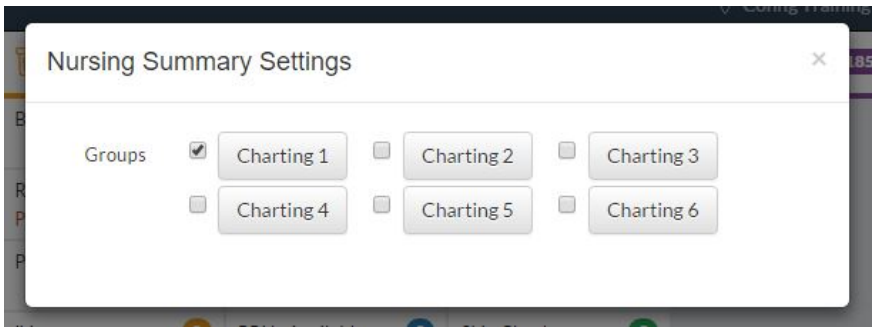
- View your profile account
- Nursing Summary Settings
- Navigate to the main HQ page
- Sign out

If you work in a facility where you need to have access to multiple units/buildings then the unit location label (next to your name) may be editable. Clicking the label will provide you with the other locations that are available to you. To view the charting tasks for other units, simply make the selection from the list.



Step 2. Select your name from the upper right hand corner and then select Nursing Summary Settings. This bring up the available Charting Groups for the unit. Select the Charting Groups you wish to be displayed in the Nursing Summary.



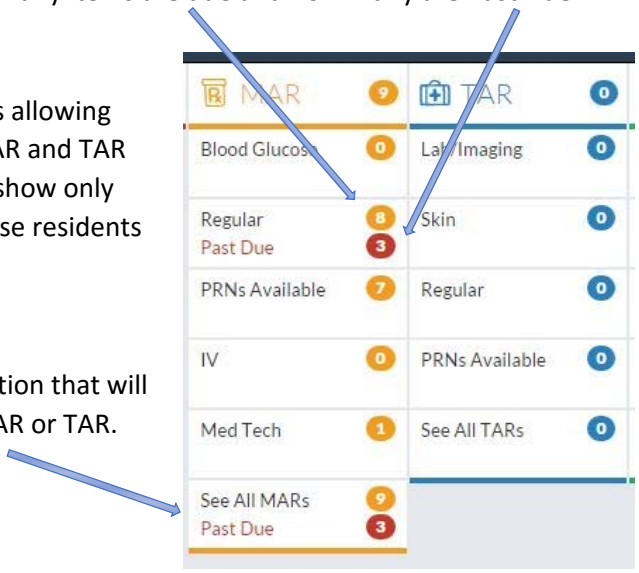


After you have made your selection you can click the 'x' in the upper right corner of the popin or on the page behind it to hide the popin. The numbers on the Nursing Summary will then immediately reflect your selection.

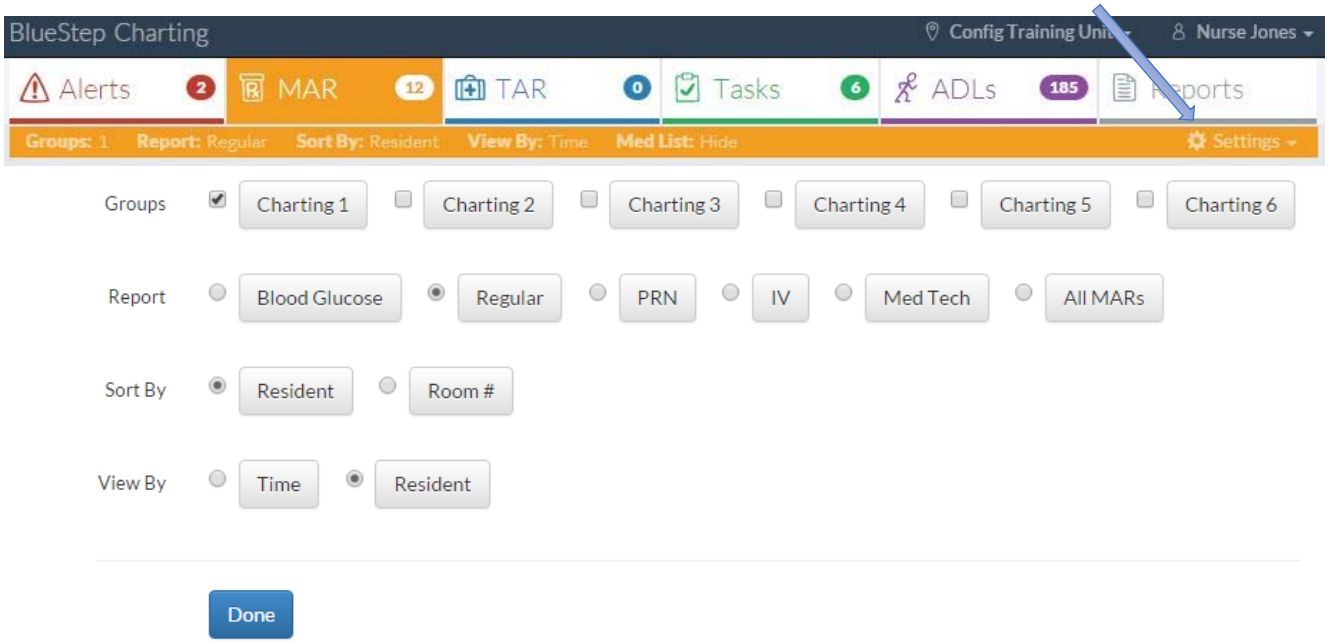
Step 3. To view the details of any MAR and/or TAR item that shows due, simply click on the desired item under the MAR or TAR modules. Each sub item shows how many items are due and how many are Past Due.

The MAR and TAR modules have additional filters allowing you to filter the items due to specific types of MAR and TAR items. For example selecting PRNs Available will show only the PRN's that are available to administer for those residents assigned to your charting group.

At the bottom of each section you will find an option that will show ALL items due or past due for either the MAR or TAR.



Step 4. After making a selection for any item under the Nursing Summary, you will be taken into that report. Each report has additional settings that allow you to change the view according to your personal preference.



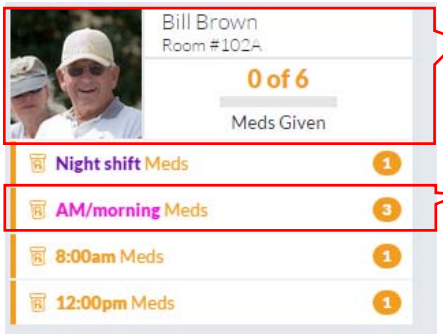
Groups – Select which charting group(s) to show.

Report – Switch reports within that module.

Sort By – Sort by Resident alphabetically or by room #.

View By – Groups items due by Time or by Resident.

View By Resident will show all Bill Brown's medications that are due now, under one tile. You can see in this example that he has six different medications to be administered across four different times.

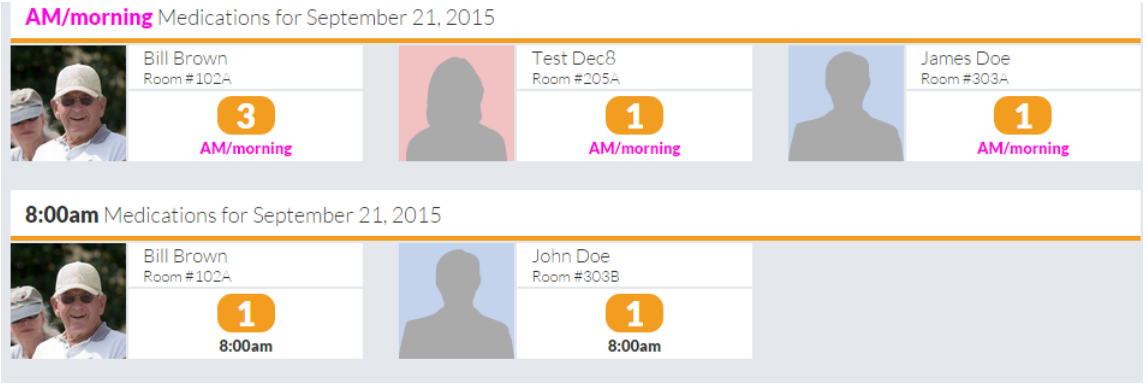


Selecting the top section of Bill Brown's tile will allow you to view ALL 6 of his medications for sign off.

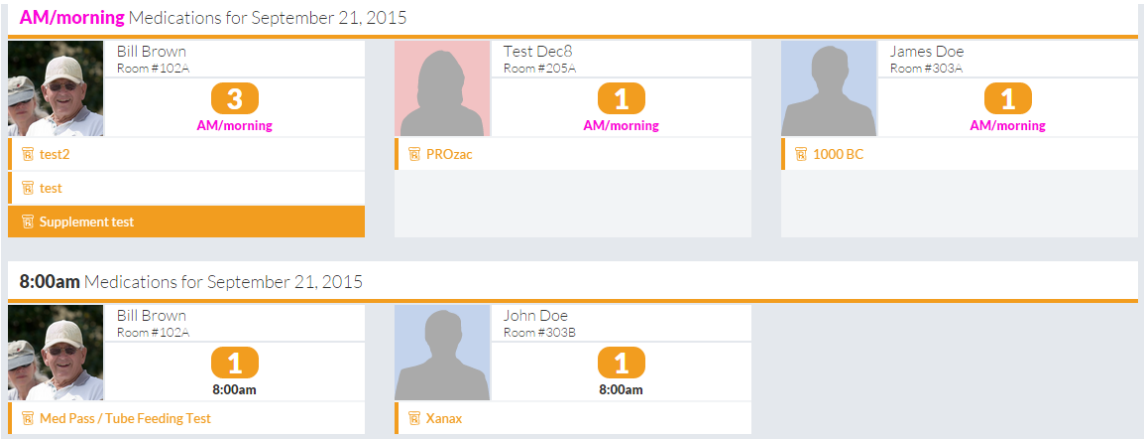
Selecting on the individual time will show you ONLY those medications to be administered at that time.

View By Time will show you the meds due by time. For example the AM/morning meds are grouped together and the 8:00am meds are grouped together. When Time is selected you will also see another option called Med List. You have the option to Hide or Show the medications due for each resident on the report.

Med List = Hide

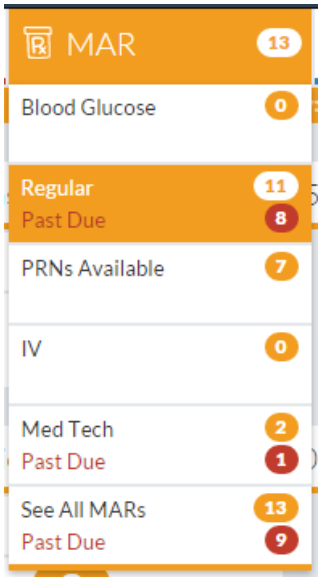


Med List = Show



Recording Medication Administration (MAR)

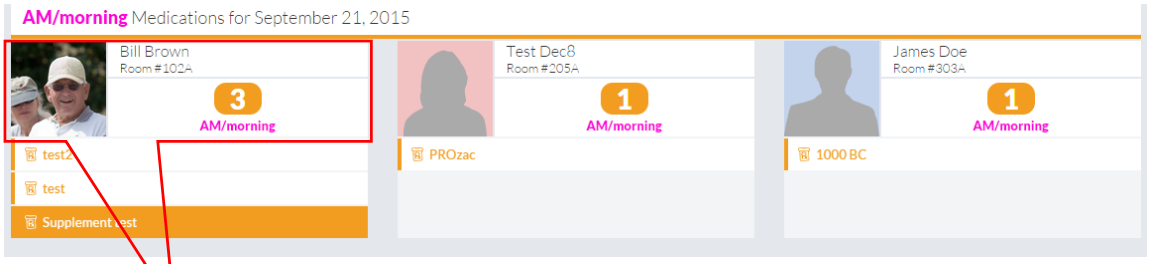
Step 1. Select the desired menu option under the MAR module.



In this example we will select the MAR->Regular report. The report will display all medications that do not fall under the Blood Glucose, IV, or Med Tech report. Also it will not show any PRN's. The report will show the medications due and those that are past due but it won't show any medications that are due in the future.

**These times are based on the Nursing Summary settings on the Facility Record.*

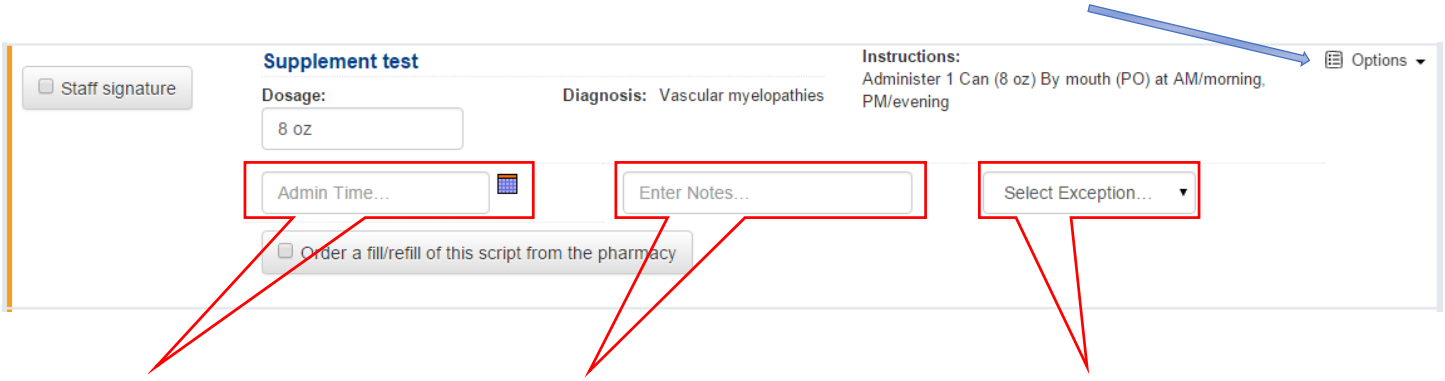
Step 2. Select the resident you wish to adminster medications for.



Selecting the top section of the resident's tile will dislay all medications available to administer in the group. Or if the report settings have been set to show each medication you can select and view them individually.

Each MAR entry has several things in common.

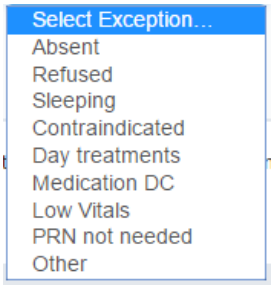
Options – Selecting the Options link will display the additional options below for each MAR entry.



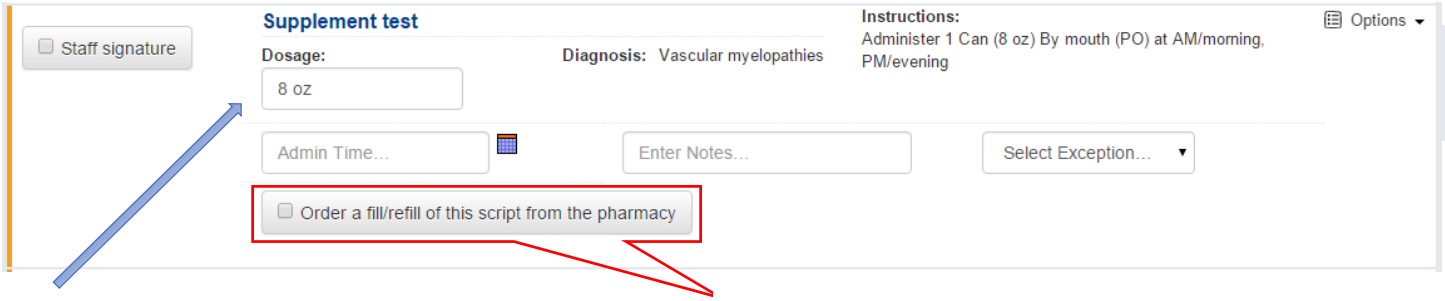
Administration date/time Override field – Used ONLY when the actual medication administration date/time is different than the current date/time.

Notes – This allows the nurse to enter a short note related to that particular medication administration. *Not intended to replace an actual "Nurses Note".

Exception – This field is to be used ONLY when the administration DID NOT occur. Options are:



If "Other" is selected you will be required to leave a note in the "Notes" field..

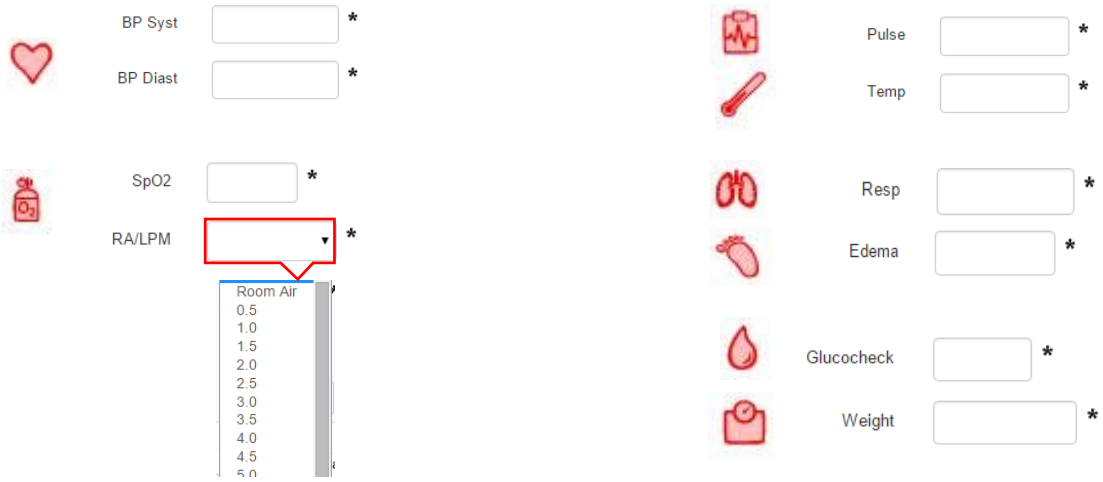


Dosage – This field is editable in the event you need to add or change this data to match the actual administration of the medication.

If your facility has a pharmacy interface, this field is used to request a refill of a medication. **Each individual interface is different and how the pharmacy receives this information may vary.*

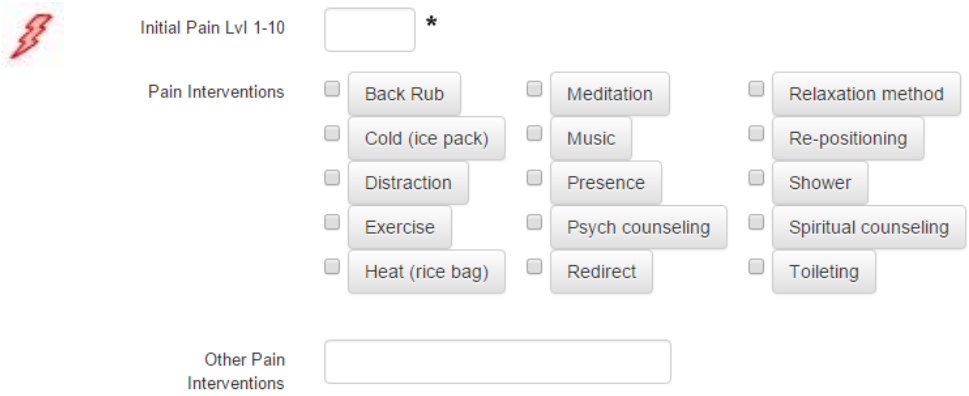
Staff signature – By selecting the Staff signature you are telling the system that you have administered this medication. In doing so the system may require some additional documentation, depending on how the medication was setup on order entry. Below are some examples of additional documentation requirements you might see when administering a medication.

Vitals – Vitals on occasion need to be documented before certain medications are to be administered. They include Blood Pressure, Pulse, Temperature, Respiratory rate, SpO2, RA/LPM (Room Air/ Liters per minute), Edema, Glucocheck, and Weight. Below is an example of how each of these fields look and the corresponding icon that will visually indicate what is required.

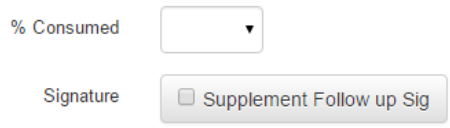


Other items that might require documentation before a medication can be administered might include:

Pain Scale – This allows you to document the initial pain level for a resident as well as interventions when administering a pain reliever.

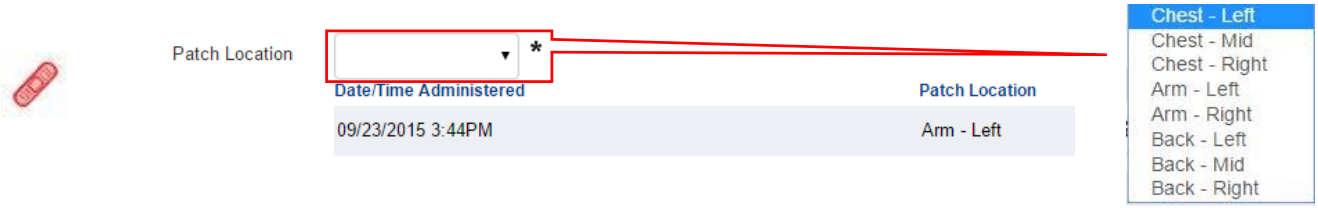


Supplement Percentage – This is to document the percentage consumed of a liquid nutrition supplement. You will notice that the fields are not required. The nurse has the option to leave them blank the first time and receive a follow-up alert later to document % Consumed. The follow-up alert will only trigger if activated on the Nursing Alerts setup under the Facility Record, which also allows you to edit the amount of time that passes before triggering the alert.

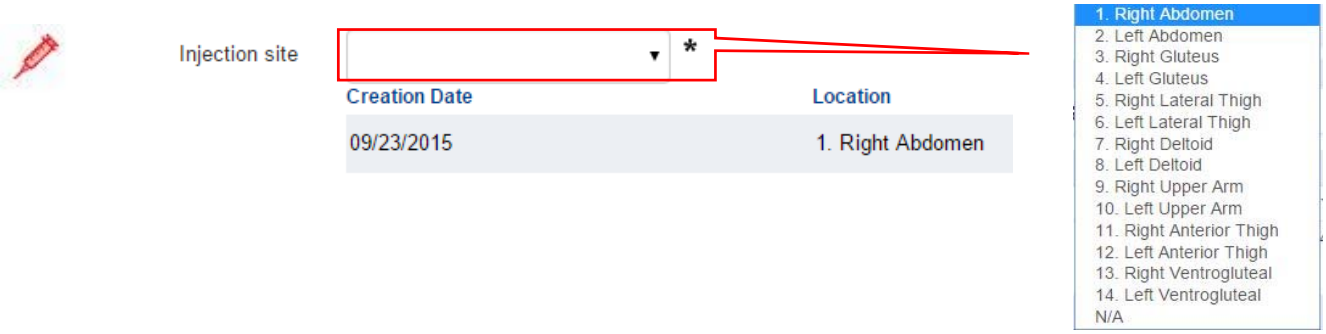


"IV/TF Intake" – This field is for the documentation of fluid intake, either via an IV or Tube Feeding. This field will show on the MAR if the resident has an active order for Intake and Output (via the Physician's Orders) and the medication order Route of admin field is Enteral Tube (ET) or Intravenous (IV). This field is directly tied to a Nursing Alert that shows on the Nursing Summary. If the information isn't completed at the time of administration then the nurse will receive an alert to enter the data after a preset time has passed.

Patch Location – The Patch location field allows you to document where on the body the patch has been placed. In subsequent administrations of a patch the MAR will display the previous location(s) which helps with any necessary rotation of the patch.



Injection site – The Injection site field allows you to document where the injection is administered. In subsequent administrations of an injection the MAR will display the previous injection(s) which helps with any necessary rotation of injections.



Step 3. Select the Staff signature for the specific medications you wish to administer.

Once you have selected the signature and completed any additional requirements for those medications you will click the Save button at the bottom of the page.

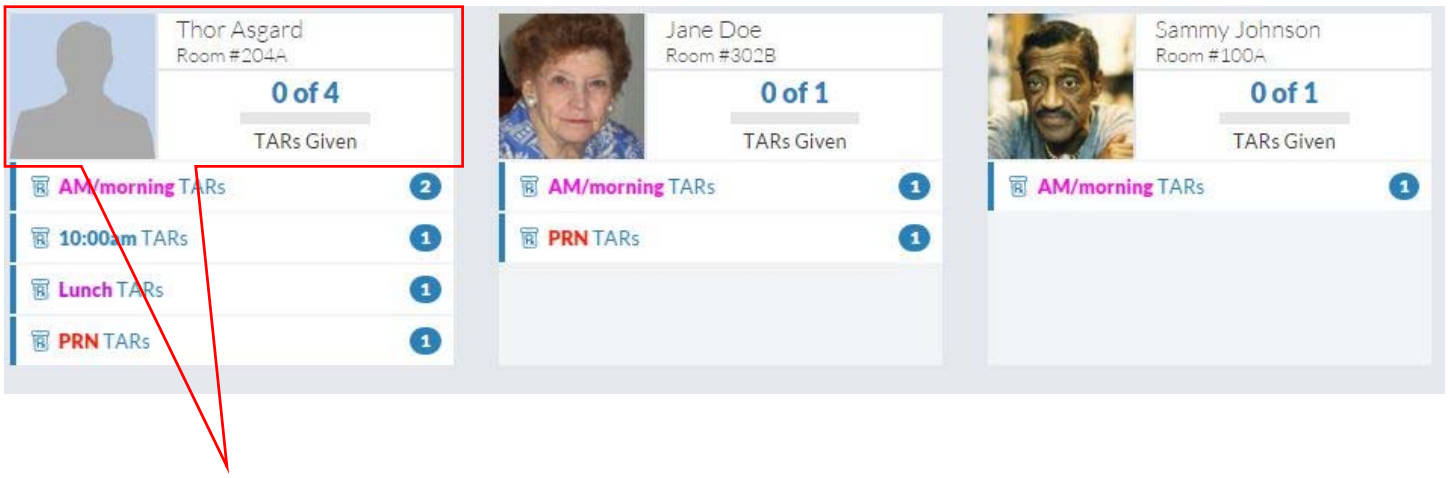
Recording Treatment Administration (TAR)

Step 1. Select the desired menu option under the TAR module.

In this example we will select the TAR->All TARs. The report will display all treatments, but will only show those due now and those that are past due. It won't show any that are due in the future.

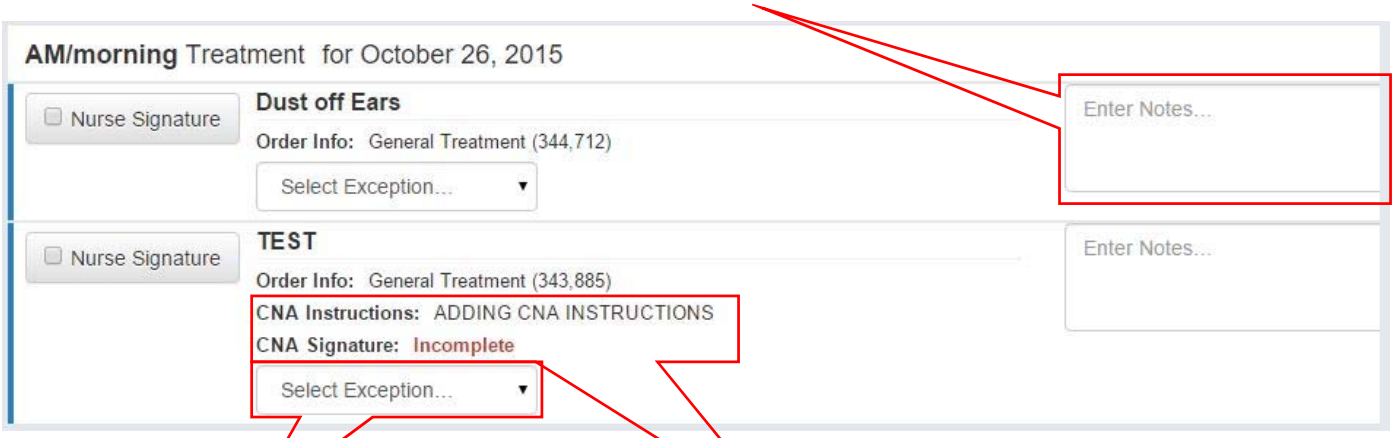
**These times are based on the Nursing Summary settings on the Facility Record.*

Step 2. Select the resident you wish to adminster treatments for.

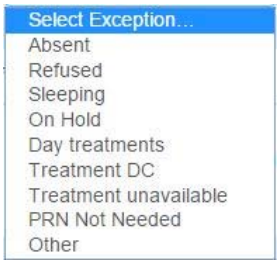


Selecting the top section of the resident's tile will dislay all treatments available to administer in the group. Or if the report settings have been set to show each treatment you can select and view them individually.

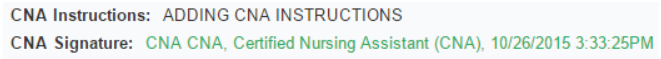
Each TAR entry has a notes field in which to enter specific details about that treatment.



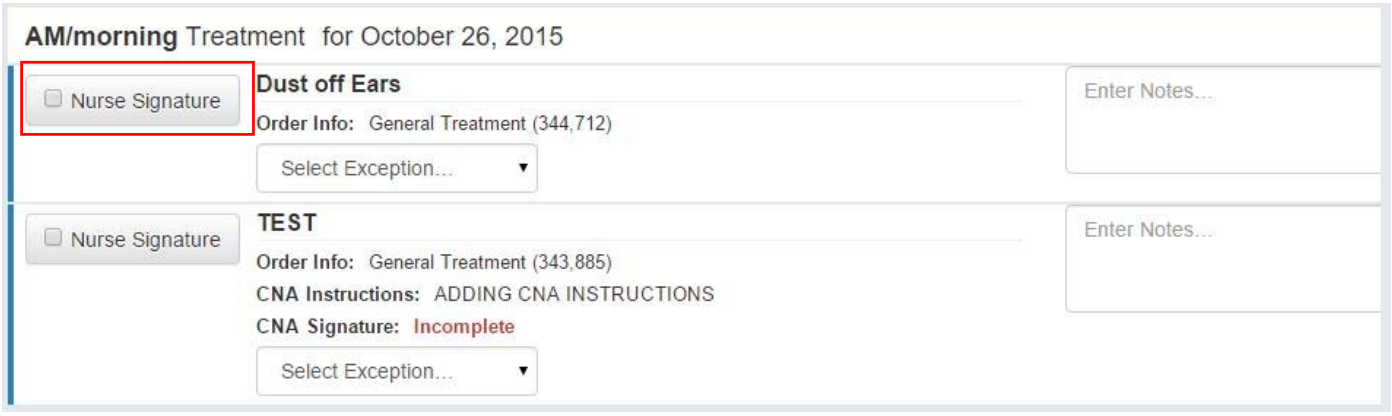
Exception – This field is to be used ONLY when the administration DID NOT occur. Options are:



CNA Assist – This field indicates that a CNA may also complete this task. Currently it shows Incomplete. If it was completed by the CNA then the signature along with the date/time it was completed would show in green.



Step 3. Select the Staff signature for the treatment(s) you wish to administer.



Once you have selected the signature(s) for the treatment(s) you have completed, you will click the Save button at the bottom of the page.

If you have any questions regarding these steps or any others, please contact your SNF implementer or Client Care.

Bluestep Client Care Department
(801) 336-3043