# NurseSquared: Student Tips for Nurse$^2$

The first time you use Nurse$^2$ on your computer, you will need to install a small piece of software on your computer. It is totally safe, and there is no limit on how many computers you can put it on. Nurse$^2$ is already installed on all the nursing computers in the MLK, MEC and LS207 for your convenience.

To install Nurse$^2$, go to http://216.121.98.36/

Follow the instructions on the screen to download and install. When it asks if you want to run or save, click "run" and say "yes" to any permission questions. A handout with screen-by-screen instructions, and troubleshooting guide can be found on the RCC Student Information page under the "Nurse Squared Information" link at
http://www.rcc.edu/academicPrograms/nursing/login.cfm

**Login Instructions**:
**Username:** *Your RCC student ID#*
**PW:** *Password1* (The 1st time you log in, this is your password. You will then be prompted to create your own password. Be sure to use one that will be easy for you to remember, or write it down in a safe place. If you forget your password, contact Dr. Kinser to obtain it):
Anita.Kinser@rcc.edu

**Quick Tip on Mouse Clicks:**

- Double click when using text lists or menus
- Single click when click checkboxes, radio buttons, etc.

**Student Tabs:**

**My Scenarios List**

Your instructor will assign you scenarios as needed, for class assignments, makeup work, etc. Double click on the scenario you want to work with.

**Scenario Introduction**

This will give you basic introductory information regarding what to expect with the scenario.

**Phase Information**

Each phase will be a separate page of information regarding your patient and instructions on what you need to document for that phase. This may include completing assessment forms, entering orders, developing care plans, etc.

**Buttons:**

**'Print Phase'** – if you desire, you can print out each screen for review. However, this is not necessary, as you can move back and forth between phases to review information as needed.

**'View Patient History' –** click this button to review basic patient history that has been provided for the scenario

**'Close me and perform tasks' –** after reading the information and instructions for the current phase, click this button to access the patient chart. Click on the appropriate chart tabs to complete the documentation tasks you need for the phase.

**When you are done charting, or if you need to refresh your memory on what to chart, click the link for "Scenario Info" in the upper right hand corner above the chart tabs. This

will bring you back to the current phase page. Then click 'close me and perform tasks' again to finish charting.

**'Complete this stage and Go Next' –** click this button when you have completed all documentation for the current phase/stage and are ready to move to the next one.

**'Further Understanding Questions' –** IF your instructor has provided study questions for this scenario, they will be accessed by clicking on this button. Follow the instructions on the screen to answer the questions.

**Patient List** – Not currently active. This tab will be used in the future as we develop a database of simulation patients.

**My Clinicals** – This is where you will enter, and access, the patients you chart on from your weekly clinical practice. Your instructor may also require you to use this section to create and chart on a 'patient' from the simulation lab.

**To create a new patient:**

Click on green "new clinical" button.
Double click on class you are currently in
Complete information on the screen.
Click green "save new clinical" button

**Quick tip #2: *Always* click "save" at the bottom of the page before moving to another screen, no matter where you are in the chart.**

**Chart tabs are listed from left to right:**

**Patient Charting Tab –** Choose the type of chart you want to open:

- **Admission/DC (Discharge)**
- **Assessment –** note-this list contains specialty assessments as well:
  - Peds admission history
  - OB Admission
  - Psych admission
- **Treatments**
- **Show all charts**
- **Wounds, IVs, Ostomies, Drains and Tubes (Purple button)**

**Vital Signs Tab**

- Vital Signs
- Intake / Output Area
- Height / Weight Area
- Glucose Monitoring
- Pain Assessment

**Order Entry Tab**

- Pharmacy Order Entry
- Lab Order Entry
- Radiology Order Entry
- PT / OT / ST Order Entry
- Nursing Order Entry
- Dietary Order Entry

**Click 'Enter Orders' to save your orders**

**Order Review Tab –** This is where you can review existing orders.

**Diagnostic Result Screen (Lab and Radiology)**

**Pending vs Resulted –** *In preprogrammed scenarios only,* lab results will be displayed here if the order has been completed in the scenario.

**Patient Teaching Tab**

**'Teaching Topics' –** Click on the general topic you taught, or will teach your patient.

**If the desired topic is not listed, click the red "Add Teaching Topic" button and enter your own topic.

**'Topics taught' –** Check the boxes for all the topics you included in your teaching plan.

**If the desired topic is not listed, click the green "Add Topics Taught" button and enter your own topic.

**'Review Previous Teaching' –** click this button to review teaching that has already been documented.

Complete remaining sections, including person(s) taught, teaching methods, learning barriers, and outcomes.

Click Green '**add to backpack'** button when you are done with this teaching topic. This allows you to start over and document the next teaching topic without leaving the page.

**SAVE**- Click green 'save' button before leaving this page to save all your work.

**Patient Card Tab –** This is the same as what is frequently called the "Kardex" – a summary of all existing orders and activities for the patient

**Patient Data Tab –** this is another location to display, or enter, pertinent admission data such as:

Allergies
Home Meds
Health History

**MAR Tab –** When medication orders have been entered into the system, they will be displayed here on the Medication Administration Record (MAR). You can review and chart medications here.

**Remember, this is for documentation practice only, to be submitted to your instructor. This MAR does NOT replace the official hospital MAR for your "live" patients. All hospital records and guidelines must be followed when caring for patients in the clinical setting.

All
Scheduled
PRN
Infusions

**Care Plans Tab –** this is where you develop, revise, and evaluate your plan of care for your patients. Options are similar to common care planning books.

**Choose by Nursing Diagnosis**

**Choose by Medical Diagnosis with Related Nursing Diagnoses**

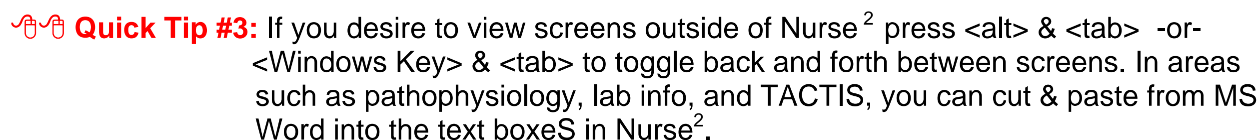
Double click on the desired diagnosis.

**If the desired nursing diagnosis is not listed, click on the RED 'add NEW Nursing Dx' button and type in your own.

**Choose 'actual or potential'.** This will then populate appropriate data in the remaining fields.
**'Related to' –** click all the 'related to' options that apply to your patient.
**If a desired option is not on the list, type your own into the blank box below the list and click on the GREEN '**add related to'** button
**'Evidenced by' -** click all the 'evidenced by' options that apply to your patient.
**If a desired option is not on the list, type your own into the blank box below the list and click on the GREEN '**add evidenced by'** button
**'Goals/Outcomes' -** click all the goals and outcomes options that apply to your patient.
**If a desired option is not on the list, type your own into the blank box below the list and click on the GREEN '**add Goal'** button**.**
**'Interventions' -** click all the interventions that apply to your patient.
**If a desired option is not on the list, type your own into the blank box below the list and click on the GREEN '**add intervention'** button.
**'Rationale for Interventions' –** In the blank text box, type the evidence-based rationale for *each intervention* you entered for your patient. Count the interventions you chose from the top down, starting with "1" and number the rationale to correspond to the intervention. *Be sure to cite your reference for each rationale, including author, year, & p#, per APA format.*
Click the GREEN '**add to backpack'** button to store your work for this nursing diagnosis. This allows you to return to the top of the page and start over with another diagnosis if you desire.
**SAVE** – click **GREEN SAVE** button to save all your work before leaving the page so you don't lose anything.
**'Review/Edit care plan' –** this button in the upper left hand corner allows you to review and edit any care plans you have previously created. This is also where you evaluate interventions, and evaluate goals**.**

**Reports Tab –** this tab allows you to view your documentation in a report format. Buttons at the bottom of the page allow you to zoom in and out for ease of viewing. You may also print these reports. The print function will allow you to print in small, medium, or large font.

Admission History
Care Plans
Discharge Plan
Discharge Summary and Instructions
MAR
Nurse's Notes
Patient Card
Patient Teaching
Vitals / I&O



**Quick Tip #3:** If you desire to view screens outside of Nurse$^2$ press <alt> & <tab> -or- <Windows Key> & <tab> to toggle back and forth between screens. In areas such as pathophysiology, lab info, and TACTIS, you can cut & paste from MS Word into the text boxeS in Nurse$^2$.

**Preclinical Manager (Mgr)Tab-** This section is for those of you who attend preclinical sessions, where you review your patient charts the day before and gather data to prepare for patient care. You will gather your data, enter it here, and print the report to take to clinical with you the next day.

**'Diagnosis'**– enter primary & secondary (if applicable) med diagnosis for your patient. Complete the pathophysiology for this diagnosis, using appropriate references.
Enter the current health problems/related fundamental changes.
**'Medications'** – Click "add medication" to enter medications that your patient is currently taking, or has ordered. Choose from the drop-down list. If the medication is not listed, type it in.
Choose the classification of medication, and enter the route, dose, unit of measurement, frequency, and date ordered, as indicated.
**TACTIS**-Complete each section of the TACTIS in the fields below.
Click SAVE at the bottom of the window to save your work, then click the green "add medication" button to enter another medication.
**'Diagnostic Tests' –** Click here to enter lab and radiology orders for your patient.
Choose the type of test and enter the date ordered.
Type in the description and definition of the test, using appropriate references.
Explain the significance of this particular test for THIS specific patient, again using appropriate references.
**Result**- in the box at the bottom, under the name of the test, enter the numerical result, then click "low" – "WNL" or "high" …whichever is correct for the value.
'**Result significance' –** Explain what this result means for THIS patient in THIS situation.
'**REVIEW**' – provides the data you have entered in a report format that you can print and take to clinical with you. If you have entered basic admission information, such as allergies, that will display as well.