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Advanced Manual

Overview

This manual has been created to ensure consistent training for providers and staff who need to document clinical and other information in the Nightingale on Demand (NOD) system. This manual can also be used as a reference manual for providers and Super Users at the Centres. This guide and practice exercises will enable providers to:

- Create and use Letter Templates
- Create a Consultation from CPP or Encounter
- Create a General Letter from Print Manager
- Create and use Clinical Templates
- Create Health Maintenance (HM) profiles
- Run and manage HM Reports
- Apply Data Masking
- Review the Activity Log

A high-speed internet connection and specific Internet Explorer settings are required to use NOD. Before logging into the training site, use the Getting Starting Guide to make sure your computer is set up properly.

Throughout this manual, there are several conventions that are used to make the information easier to use and understand.

- Navigation is presented as bold text separated with a vertical line (|) e.g. Patients | Registration | New.
  This means the Module (found to the left of the screen) is clicked. The rest of the menu items are selected by pointing the mouse over the selection (hovering, not clicking) until the final menu item which is clicked.
- Modules and other specific buttons, windows, etc. of NOD are Bold; e.g. Click Save to save changes to a client demographics.

Boxes like this are included in the manual to provide hints or tips about a particular section. Many items are related to differences between NOD and Purkinje. Differences between NOD and Healthscreen will be added when known.
Letter Templates

The table below describes three types of letter templates that can be created in the Nightingale application:

<table>
<thead>
<tr>
<th>Type</th>
<th>Used For</th>
<th>Printed From</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral</td>
<td>Creating Referral Letters (Consultations)</td>
<td>CPP</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encounter</td>
</tr>
<tr>
<td>General</td>
<td>Creating 3(^{rd}) Party Letters (Sick Notes...etc)</td>
<td>System Setup</td>
</tr>
<tr>
<td>Health Maintenance</td>
<td>Generate Letters for patients on HM lists</td>
<td>Office Actions</td>
</tr>
</tbody>
</table>

Creating a Referral Letter Template

New Letter Templates are created from System Setup | Templates | Documents | Manage Letters and then by clicking New. Then the Create a Letter Template page displays.
1. Click Modify Template Content to format the letter template. The Modify Template Content page displays.

2. Select the checkbox next to the Letter Options to be included in the letter.
3. Edit the format and/or modify the letter options as appropriate.
4. Select the position of attached chart elements.
5. Click << Back to return to the Edit Letter Template page.
6. Click Preview to view the Letter.
7. Click Save to save the template.

8. Click Yes to update any saved letters with this template.
9. Click Cancel to return to the Manage Letter templates page.

New letter templates can also be made by copying an existing template.
Patient’s HCN can be added by adding the ‘Identifier Type’ field to the Subject line.
Create a General Letter Template

New General Letters are created from **System Setup** | **Templates** | **Documents** | **Manage Letters** and then by clicking **New**.

1. Type in a name for the letter.
2. Select General as the letter Category.
3. Type a description in the text box to identify the template (optional)
4. Click **Next >>**. The Edit a Letter Template page displays.

### Clinical Templates

Clinical templates are pre-defined forms that facilitate the capture of clinical information during a client visit. Nightingale provides a number of evidence-based clinical templates by default.

**To view all the available System templates**

Go to **System Setup** | **Templates** | **Template Designer** | **Manage Templates** and from the drop down menu select Master Templates:

A sample of the available master templates is shown below

<table>
<thead>
<tr>
<th>Template Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABDOMEN/GI (HPI)</td>
<td>Record Hx and physical findings related to the GI system</td>
</tr>
<tr>
<td>Ankle Injury</td>
<td></td>
</tr>
<tr>
<td>AOHC - Adult Nutrition</td>
<td>Adult Nutrition</td>
</tr>
<tr>
<td>AOHC - Child and Youth Preventative Care</td>
<td></td>
</tr>
<tr>
<td>AOHC - Chiropody</td>
<td>Chiropody</td>
</tr>
<tr>
<td>AOHC - Counselling</td>
<td>Counselling</td>
</tr>
<tr>
<td>AOHC - Diabetes Education</td>
<td>Diabetes Education</td>
</tr>
<tr>
<td>AOHC - Female Preventative Care</td>
<td>Female Preventative Care</td>
</tr>
</tbody>
</table>
Creating Clinical Templates

If the data collected will need to be reported on, reportable fields will need to be created in templates. Reportable fields are also needed if you want template information to flow into a flowsheet. If the data will not need to be reported on, you can skip to step 6.

How to create reportable fields

Step 1)

Step 2)
Step 3)

To create more reportable fields, follow steps 1 through 4 again.

Step 4)

Step 5)

To create more reportable fields, follow steps 1 through 4 again.
How to Create Template Dialogues

Step 6)

Step 7)

Enterprise Dialogues List:

Step 8)

Enter a Dialogue name, and then select new control. The Dialogue name will populate like a heading.
Step 9)

If you want this control to be reportable, pull in the previously created corresponding reportable field by selecting reportable control.

Step 10)

Add a caption name
Select caption position
Select the desired reportable field that corresponds to this control.
Step 11)
Once you have created all the controls for that Dialogue, click the Edit/Preview Button

<table>
<thead>
<tr>
<th>Control name</th>
<th>Index</th>
<th>Control Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>test</td>
<td>1</td>
<td>Checkbox</td>
</tr>
</tbody>
</table>

Step 12)
Move the controls from the right hand side of the screen to the left hand side and place them is the desired layout.
Step 13)

Step 14)

** Please note that any one of the controls can be adjusted by clicking on the blue and underlined control name **

You can have multiple Dialogues in one template. To make another Dialogue follow steps 7 – 14 again.
Copying Dialogues

If you want to reuse a dialogue with a slight modification, you can copy it instead of creating a new one.

Select the dialogue that you wish to copy by clicking the radial button, then select copy at the top of the page.

A new window will appear and prompt you to name the new dialogue.

Once the dialogue has been copied, you can go in and alter it. This might be useful if you were creating similar templates ie for males and females, and certain dialogues differ slightly.
How to Create the Final Template

Build the template using the Dialogues that have been previously created.

Step 15)

Step 16)
Step 17)

Add a template name. Only if you want to give more information regarding the template, add a template description.

Select Enterprise Dialogues from the Category Dropdown (location where we created the dialogues).

Step 18)

Select the desired dialogue and then click the add button to push it to the list on the right. Do this for every dialogue you want to add.

Step 19)

If you want to rearrange the order of the dialogues, select the dialogue you wish to move and then use the arrows to move it up or down.
Step 20)

Your template has been created.

**Health Maintenance (HM)**

A Health Maintenance report is a list of clients that fit a user defined set of criteria so that a health maintenance activity can be performed and tracked for these clients.

Once a HM report is generated, the clinic can produce letters, record phone calls, or messages and track the clinic’s activity on the clients. When an HM report is run, a HM alert can be created in the client chart for all who meet the criteria. The client’s response to the HM activity can be tracked.

**Creating a HM Profile (per provider)**

In order to create a HM report, a health maintenance profile must be created. This details the search criteria and clinical parameters and is used repeatedly.

To create a HM Profile, go to Office Actions | Setup | Health Maintenance.

Click on New

<table>
<thead>
<tr>
<th>Profile Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coumadin (any dosage)</strong></td>
<td>Patients prescribed Coumadin</td>
</tr>
<tr>
<td><strong>Diabetes List (dm2)</strong></td>
<td>Patients with DM2</td>
</tr>
<tr>
<td><strong>Hypertension List</strong></td>
<td>Patients Diagnosed with Hypertension</td>
</tr>
<tr>
<td><strong>Patients with IBS and prescribed PredniSONE</strong></td>
<td>Patients with IBS and prescribed PredniSONE</td>
</tr>
</tbody>
</table>
Provide a name for your profile

1. Select the “Add to Patient Alerts” checkbox to create an alert for each client that meets the profile criteria.
2. Choose the sex of the clients you are running a report for (Male or Female; Male; Female)
3. Select whether this profile is set for clients of any age or a specific age and if the later specify the age range.
4. You can narrow your profile search by entering in various other demographic information; shown in previous image.
5. Check the “Rostered” check box if you only want a report of just your clients flagged as primary care clients within their demographics.
6. You can add additional “Patient Statuses” you are searching for by selecting the status on the left and clicking Add.

**Adding Parameters**

Health Maintenance profiles offer any combination of the following parameters that the client “has” or “does not have” as part of their chart.

- Activities (appointments)
- Allergies
• Diagnosis (in the CPP the problem list)
• Family History
• Immunizations
• Injections
• Lab Results
• Medications
• Procedures
• Social History
• Vitals

If you select multiple items of the same parameter, you have the ability to define relationships by not selecting the “required” check box. Items selected from different parameter types are always treated as an “and” statement. You can add a parameter to your profile by clicking on New Parameter.

1. Select from the drop down of available parameters; shown in previous image. Each parameter chosen from the list will change the options available.
2. Select whether you are searching for the “Patient Has” or “Patient Has Not” drop down.
3. Once you have completed your first parameter Click Save.

You can add additional parameters by clicking on “New Parameter” and completing the above 3 steps.

Once you have completed adding all parameters you can click Save on your profile.
**Important Note:** you cannot go back and alter your profile, you need to change the name of the profile and create a copy to alter or update current profiles. NB If you create a copy and also ‘add alert’ a second alert will be added to the patient chart and duplicate alerts cannot easily be removed. Alerts that have been added to patient charts from an initial HM profile, will not be removed if you delete the original profile after creating a copy of that original profile.

**Creating an HM Report**

HM reports are created from the **Office Actions | Administration | Work Queue | Health Maintenance** and must be created for each individual provider. Select a profile for the HM report from the New HM Report page.

And the results are displayed and managed from the Report Results page.
Tracking Client Response to an HM alert

Tracking a client response to an HM alert is done through Patients | Details | Summary.

An Alert on the Patient Summary page and on the Orange bar is created when running a HM report. The client response can be tracked from the Patient Summary Page (picture #1) from the HM button on the orange bar (picture #2). When a client response is recorded, the HM alert is saved to the Archive page.

Picture #1
Creating CDM Templates (Flowsheets)

CMD templates can be used to easily monitor information about clients over time.

If you want to monitor information tracked in reportable fields of a template the fields must be created before the template. For more information, see Creating Reportable Fields.

1. In the Enterprise module, click the Templates menu.
2. Click Manage Templates and CDM Templates.
   The Manage CDM Templates screen displays.
Click the **New** button.

The New CDM Template screen displays.

3. In the **Template Title** field, type the name of the template.

4. In the **Description** field, type a description for the template.

5. In the **Guideline URL** field, you can type a website address with care guidelines for this condition. This will be linked to the flowsheet so that it is easy to access. It will be accessed using the **Guide** button in the top right hand corner of the flowsheet. This is optional only and not required when building a flowsheet.
The flowsheet Options section (see below) is where you specify the type of information you want to display in the header, body and footer sections of the flowsheet.

- **Header:**
  - Provider
  - Patient
  - Diagnosis
  - Vitals

- **Body:**
  - Medical History
  - User Defined
  - Visits

- **Footer:**
  - Signature
  - Footer

The flowsheet Options section will not display in the flowsheet if there is no checkmark in the box in front of the row name. In order for the information to display on the screen and not only in a printout, remove the checkmark in the box for that row in the Printout Only column.

The Header section is where you specify the information that displays in a flowsheet header.

In the **Provider** row, click the **Edit** button.

The Provider section expands to show all elements that can be added to the flowsheet about the provider.

Select an element in the list and click **Add to Selection**. Do this for all elements to add.

For each selected element, you can change the options for displaying the element such as font size, text
alignment, bold, underline or italics.

When all provider elements have been added, click the Apply button and then click the Hide button to collapse the section.

In the Patient row, click the Edit button. The Patient section expands.

Select an element in the list and click Add to Selection. Do this for all elements to add.

For each selected element, select the options for displaying the element such as font size, text alignment, bold, underline or italics.

When all client information has been added, click the Apply button and then click the Hide button to collapse the section. Keep in mind that if the purpose of this flowsheet is to be used in the client’s chart and it will not be printed you might not need information about the client on it.

If a Diagnosis is required click the Edit button in the Diagnosis section.

For each diagnosis, an Assessment Date or Onset Date can be added using the Date column. This will appear as the diagnosis date in the flowsheet.
When all diagnosis information has been added, click the **Apply** button and then click the **Hide** button to collapse the section.

In the **Vitals** row, click the **Edit** button. The vitals section expands. This section will show you a snapshot of the last set of vitals that were collected. This section will update nightly to show the latest vitals recorded.

Select an element in the list and click **Add To Selection**. Do this for all elements to add.

For each element, you can add a target, specify a measurement unit, or type a description.

When all vitals information has been added, click the **Apply** button and then click the **Hide** button to collapse the section.

The **Body** section is where you specify the body of the flowsheet.

In the **Medical History** row, click the **Edit** button.

The Medical History section expands with all items selected by default.

Clear the checkboxes for the items that you do not want to display in flowsheet.
In each section, click the **Edit** button to configure what data will display in that section. For example in the Problem list section, you can specify to display which diagnoses have been added in the Problem List section of that patient’s CPP.

When all Medical History items have been added, click the **Apply** button and then click the **Hide** button to collapse the section.

In the **User Defined** row, click the **Edit** button. This is where you access Reportable Fields that you have created in a template.

In the displaying field, select the reportable field from the list and click **Add**. Do this for all reportable fields you want to display on the flowsheet.
When all User Defined items have been added, click the **Apply** button and then click the **Hide** button to collapse the section.

In the **Visits** row, click the **Edit** button. This section displays information from each visit ie vitals, electronic lab results, template data etc.

In the **Select the Elements** field, select the items (lab tests, medication, vitals, user defined) from the list to add to the template.

For each item, select an associated test, medication, vitals measurement or user defined (reportable) field and click **Add**.

Select the **Show Baseline** checkbox to display the first measurement at the start of the maintenance plan in the flowsheet in addition to the current measurement.

Select the **Include patient target input** checkbox to include a column in the flowsheet where the patient’s defined targets can be entered.

When all items in the Visits section have been added, click the **Apply** button and then click the **Hide** button to collapse the section.

In the **Signature** row, select the relevant checkboxes to include the provider’s signature in the template.

In the **Footer** row, click the **Edit** button.

In the text field, type the text you want to display in the footer.

Click the **Add Line** button to add additional text line.
When all Footer items have been added, click the **Apply** button and then click the **Hide** button to collapse the section.

To edit where the information displays in the template, click the **Layout** in each section.

How the items are arranged in the dialog box will indicate how they will display in the flowsheet.

Click **Save**. The Layout dialog box will close.

On the New CDM Template screen, click **Save**.

The flowsheet is saved and can be loaded in the Patients module either from the client information bar or the client’s CPP.

**Creating Clinical Profiles**

The Nightingale application supports the creation of clinical profiles to speed up the documentation of assessments, lab requisitions, medications, consultations (referrals) and plan notes. These elements are created as individual profiles and combined together to create a master profile for a specific condition.
When the master profile is loaded in the encounter, the sections included in the profile are loaded with a pending status, ready to be selected.

Profiles are created in System Setup | Templates | Manage Profiles.

Clinical profiles are created by provider, although they can be accessed by other providers. Ensure that the correct provider is displaying at the top of the screen before starting to create a profile.

1. In the System Setup module, click the Templates menu and select Manage.
2. If the profiles are not for the correct provider, select the provider’s name from the list.
3. Click New.

The New Master Profile screen displays.

4. In the Profile Name field, type the name of the profile.
5. In the Description field, type a description or purpose of the profile.
6. Click New.

The Active Assessment Profiles screen displays.

7. Select the checkbox for profiles you wish to add to the master profile once they are all created (see below for instructions on creating).
8. Click **Add to Profile**.

9. Continue the above steps until you have added all the required profiles from the available screens.

10. Click **Save**.

**Creating Assessment Profiles**

Used to automatically load assessments (Issues Addressed) into an encounter.

To create an assessment profile:

1. Click the **Options** menu and select **View Assessment**. The Manage Assessment Profiles screen displays.

2. Click New. The New Assessment Profile screen displays.

3. In the **Profile Name** field, type the profile name.

4. Click New to add the specific assessment to the profile.

The Add Diagnosis window displays.

```
Add Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis:</th>
<th>Find ICD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status:</td>
<td>Acute</td>
</tr>
<tr>
<td>Description:</td>
<td>Acute</td>
</tr>
<tr>
<td>Comments:</td>
<td></td>
</tr>
</tbody>
</table>

☐ Add to CPP
☐ Automatically add assessment to Encounter when Profile loaded
```

5. Click the **Find ICD** button and search for the appropriate EncodeFM code. Click **Add**.

6. In the Comments field, type any additional information that you would like to auto-populate into the encounter.

7. Select the ‘**Automatically add assessment to Encounter when Profile is Loaded**’ checkbox to add the assessment when the profile is loaded in the encounter.

8. Click **Save**.

Your assessment profile is ready to be added to the master profile.
**Creating Consultation Profiles**

If you want a consult or referral letter to be loaded into the encounter when loading the profile create a consultation profile to add to your master profile.

1. Click the **Options** menu and select the **Consultation profiles**. The Manage Consultations Profile screen displays.

2. Click **New**.

3. In the Profile Name field, type the name of the profile and in the Description field type a description or purpose consultation profile.

4. Click New for the New Referral window displays.

5. Who you send the consult/referral letter to may not be known while setting up your profile, so you can leave the consultant and copy to area blank, to be filled out once the profile is loaded into an encounter.

6. In the **Template** field, select the template from the list of available letter templates created by your centre.

7. In the **Referral Letter** field, type the body of the letter (if needed).

8. If required, click the **Select** button in the **Supporting Documents** field and add any documentation that should be included in the consultation profile.
9. In the **Check for report in** field, enter a time frame when to look for the referring provider’s report in the Outstanding Correspondence list.

10. In order for your referral letter to load into an encounter you must check the box beside **Automatically add consultation to encounter when profile is loaded.**

![Image of new consultation profile screen]

**Creating Prescription Profiles**

1. In the System Setup module, click the **Templates** menu and select **Manage Profiles.** The Manage Master Profiles screen displays.

2. If the profiles are not for the correct provider, select the provider’s name from the list.

3. Click the **Options** menu and select **View Prescription Profiles.** The Manage Prescription Profile screen displays.

![Image of manage prescription profile screen]

4. Click **New.** The New Prescription Profile screen displays.

5. In the **Profile Name** field, type the name of the prescription profile.

6. In the **Description** field, type a brief description or purpose of the profile. The New Prescription Profile screen displays.

7. Click **New.**
Your list of favorite medications displays.

8. Select the checkbox for the drugs that you wish to add and click Add to Profile.

   ![Image of a medication list with a checkbox selected]

   If the drug is not in your favorite list, use the Options menu to search for a drug from the drug database.

9. Select the ‘Automatically Add Medication to Encounter when Profile is Loaded’ checkbox.

10. Click Add to Profile.

Continue the above steps until you have added all the required medications.

Creating Lab Requisition Profiles

You can create a requisition profile for lab tests for specific medical conditions or for particular visit types that require the same lab tests. Example: a physical.

1. In the System Setup module, click the Templates menu and select Manage Profiles. The Manage Master Profiles screen displays.

2. If the profiles are not for the correct provider, select the provider’s name from the list.

3. Click the Options menu and select View Laboratory Requisition Profiles.
The Manage Laboratory Profiles screen displays.

4. Click **New**.
The New Laboratory Profile screen displays.

5. Enter a Profile Name and description for the profile.

6. Click **New**. The Lab requisition window displays.

7. Follow the same steps you would to fill out the Ontario General Lab Requisition and click **Save**.

Reception/Super Users to Set Up

The Address Book
The Address Book should be populated with specialists that your providers refer to and a list of internal providers and provider types to allow for quick creation of referral letters. Nightingale will populate this with generic provider types as part of the setup of the software.

The Address book can be included in the icons available at the bottom left corner of the software.

Creating Contacts in the Address Book

When the Global option is selected, the contact is shared with all users at a location. When the Personal option is selected, that contact is only available for the provider that creates the entry.

1. Click on the Address Book Icon in the lower left hand corner. The same screen can also be accessed from System Setup I Practice I Directories I Address Book.

2. Click New.
The New Contact screen displays.
Only fields with an asterisk (*) are mandatory fields.

1. In the Contact List field, select either the Global or Personal checkbox.

2. In the Contact Type field, select a contact type from the list or click Add to create a new contact type.

3. In the Contact Company field, select the contact company from the list or click Add to enter a new company.

4. Enter the family name, first name or use these fields to enter organizations or institutions.

5. Enter the name in the appropriate fields or document the organization name as appropriate.

6. The Department field is searchable and can be used for organization/agency names.

7. Additional fields can be used as appropriate.

8. Click Save.

Creating Pharmacies (per location)
A preferred pharmacy can be added to a client’s demographic information and can be used when prescribing and refilling medications.

Pharmacies are created in System Setup | Pharmacies
   1. Click New to create a new pharmacy; enter the pharmacy name and address
   2. Enter the pharmacy phone number and fax in their designated fields.
   3. Click Save.
Edit Label Templates (per location)

The Nightingale application has two standard label types, an address label and a lab label. You can edit these two labels but you cannot delete them. You can create additional labels to be used by a label printer or printer on label sheets.

Labels are customized in System Setup | Templates | Documents | Manage Labels

The Manage Labels screen displays a list of all active and inactive label templates. The two default system labels cannot be removed from the system but their content may be edited.

1. To edit an existing label, click on the title of the label.

2. If you require additional fields to be added to your label template select the elements from the list located to the right of the label and click Add to Label. Only fields included in the list can be added to a label.

3. Once the required fields have been added the font size can be increased or decreased, the alignment of each field can be changed and the fields can be bolded, underlined and italicized as desired.

4. Use 'Layout' to organize which side of the label fields will appear on.
Creating Laboratory Sites (per location)

In addition to the system-defined labs that are standard with NOD, you can create new labs in System Setup | Lab | Lab Sites. It is not possible to delete the system defined lab sites. It might be appropriate to add your own location as a Lab Site in order to document tests that are done on site (i.e., urine dip stick tests).

1. Click New, and enter the laboratory name and contact details.
2. Click Save.

Creating DI (Diagnostic Imaging) Categories (per location)

To make Diagnostic Imaging tests more manageable, you can create DI categories and associate tests to that category. When the category is loaded in the DI requisition, only those particular tests will display.

DI categories are created in System Setup | Lab | DI Categories
1. Type the new test name in the **New Category Title** field on the right side of the 

   **Create a D.I. Category**

   ![Create a D.I. Category](image)

   screen.

2. Associate lab tests to the new category by selecting Master List from the **Current Categories** field. All DIs associated to the master list load in the list box below the **Current Categories** field.

3. In the list box on the left, select the test(s) that you want to add to the new category and click **Add**.

   ![Create a Laboratory Test Category](image)

   You can select more than one test by holding the **Ctrl** key down and selecting each test from the list.

4. Once completed adding all necessary test, click **Save**.

**Creating DI (Diagnostic Imaging) Tests (per location)**

If a Diagnostic Imaging test cannot be located in Nightingale, you can create it and link it to a category.

1. In the System Setup module, click the **Lab** menu.

2. Select **DI Tests**.

The DI Tests screen displays.
3. In the **Select Category** field, select the category for the test.

4. In the **Test Name** field, type the name of the test and click **Search**.

  💡 When creating new records, always search for the item first to ensure that it has not already been created by other users.

5. If no matching results are found, click the **New** button. The Add New DI Test field displays.

6. In the **Select Category** field, select the category that you want to associate the DI test to.

7. In the **Test name** field, type the name of the test.

**Add New D.I. Test**

8. Click **Save**.

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**Creating Correspondence Types (per provider)**

Correspondence types are used when filing scanned documents or uploading correspondence reports to a client’s chart. Correspondence types must be created for each provider.

To create correspondence types go to **Office Actions | Setup | Correspondence Types**.
1. In Manage Correspondence Types select the appropriate provider.

2. Click New and enter the new correspondence type. Click Save or Save and Continue.

Setting up Appointment Types

Nightingale allows you to create Appointment types with specific time intervals, colors, and/or any time constraints. You can also control what days and times that a created Appointment type can be booked.

To create appointment types

1. Go to Schedule | Setup | Appointment | Type.

2. Click New. The Create New Appointment Type page displays.

3. Type in or select the Appointment type details (Name, length of time, etc.).
4. Click the Recall Visit After drop-down arrow to select a number in the first field that you will with the second drop-down field of days, week(s), month(s) or year(s) so that you can set a patient’s recall date based on scheduled appointment type. For example, a yearly physical could be set for 1 year then that following year a recall will automatically prompt you of the system suggested recall date for the patient’s current appointment type.

5. Click Next>>. The Edit Appointment Type-Step Two page displays:

6. Select the day and the time periods that are available for that appointment type.

7. Click Save.

Checking the Allow Double Book: option, enables you to book two appointments at the same time slot, as shown for the 2:30 time period below.

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**Setting up Schedules and Schedule Groups**

With Nightingale you can create individual schedules for every Provider in the clinic. You have the ability to specify the start and end time of the schedule, the time scale on the schedule, the daily work hours, and also restrict the appointment types that can be booked on the schedule.
To setup a Schedule

1. Go to Schedule | Setup | Schedule.

2. Click New. The Create New Schedule (Step 1) page displays.

3. Select default clinical templates or patient handouts to be automatically presented when a patient is scheduled for a specific appointment type.

4. Click Next.

   The Responsible Provider is the default billing Provider for that schedule. To associate one or more appointment types to a schedule, simply check them.

   Once a schedule is created, it may be edited from Schedule | Setup | Schedule.

   Once a time scale or responsible provider is selected and saved, they can not be changed.
Copying Schedules

You can copy a schedule in the Schedule module’s schedule list view in order to create a new schedule quickly. The new copied schedule must have a name different from the original schedule.

1. In the Schedule module, select the Setup menu and select Schedule. The Manage Schedules screen displays showing a list of existing schedules.

2. Click the check box next to the schedule you are going to copy, and then click Copy. A new schedule displays with every item copied from the original schedule included into the new schedule except for the name.

3. Enter the name for the new schedule in the Schedule Name field.

4. If you need to make some changes to this copied schedule, use the screen as you would when starting a new schedule.

5. Click Next when finished. The available times display on the next page from the original copied schedule.

6. Add and remove times needed for this new schedule using the check boxes.

7. Click Save Schedule when you are finished. The Manage Schedules page displays with your new schedule.