SELF-GUIDED PRACTICE WORKBOOK [N60]

CST Transformational Learning

WORKBOOK TITLE:

Nursing: Residential Care

Last update: March 12, 2018 (v2)

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	**2 hours**
Before getting started	- Sign the attendance roster (this will ensure you get paid to attend the session). - Put your cell phones on silent mode.
Session Expectations	- This is a self-paced learning session. - A 15 min break time will be provided. You can take this break at any time during the session. - The workbook provides a compilation of different scenarios that are applicable to your work setting. - Work through learning activities at your own pace
Key Learning Review	- At the end of the session, you will complete Key Learning Review - This will involve completion of specific activities that you have had an opportunity to practice through the scenarios.

Using Train Domain

You will be using the train domain to complete activities in this workbook. It has been designed to match the actual Clinical Information System (CIS) as closely as possible.

Please note:

- Scenarios and their activities demonstrate the CIS functionality not the actual workflow
- An attempt has been made to ensure scenarios are as clinically accurate as possible
- Some clinical scenario details have been simplified for training purposes
- Some screenshots may not be identical to what is seen on your screen and should be used for reference purposes only
- Follow all steps to be able to complete activities
- If you have trouble following the steps, immediately raise your hand for assistance to use classroom time efficiently
- Ask for assistance whenever needed

PATIENT SCENARIO 1 – Residential Care Patient Admission

Learning Objectives

At the end of this Scenario, you will be able to:

- Build a Patient List
- Access the patient chart
- Navigate the patient's chart to learn more about the patient
- Add an allergy

SCENARIO

You are notified of a 65 year old male being admitted to Residential Care following an inpatient stay at the hospital for COPD exacerbation. Prior to the patient's arrival, you will need to do a handoff with the inpatient nurse to review pertinent patient information using the patient's chart. The patient arrives and you have notified central registration of the patient's arrival in order for registration to update/add encounter information into the Clinical Information System. You will also learn how to add an allergy.

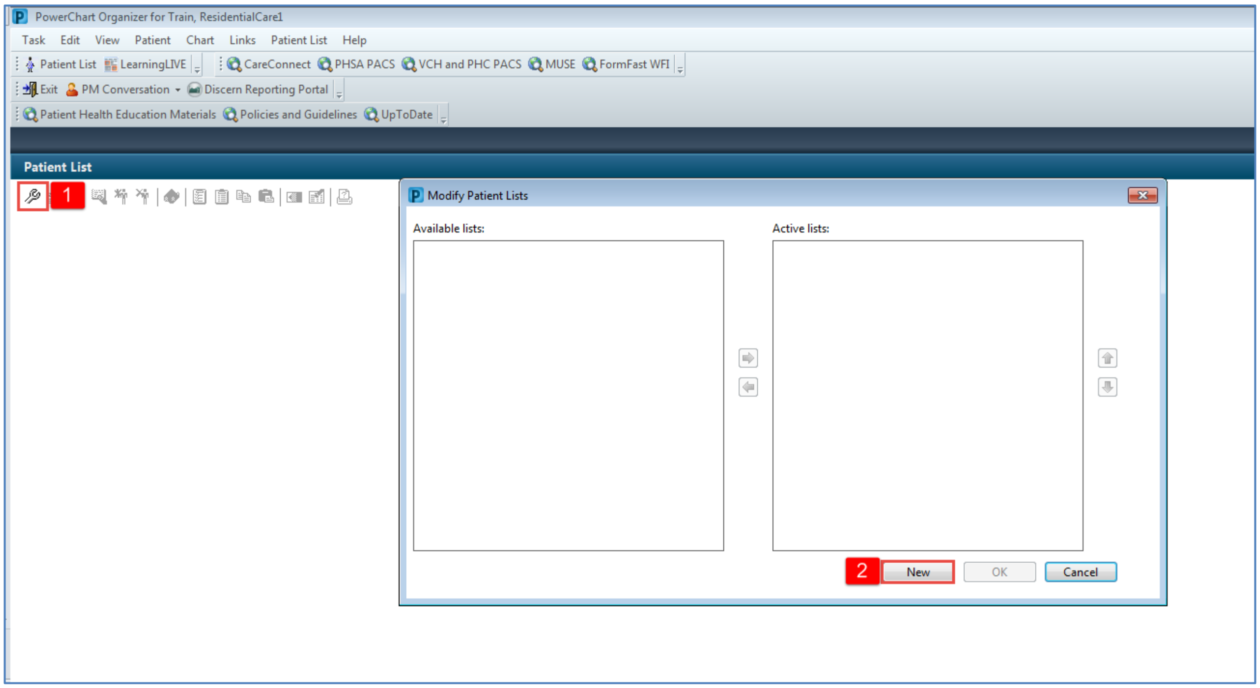
As a nurse working in Residential Care, you will complete the following activities in the Clinical Information System (CIS):

- Create a Patient List
- Search for Correct Patient, Correct Encounter
- Review Patient Information
- Add an allergy

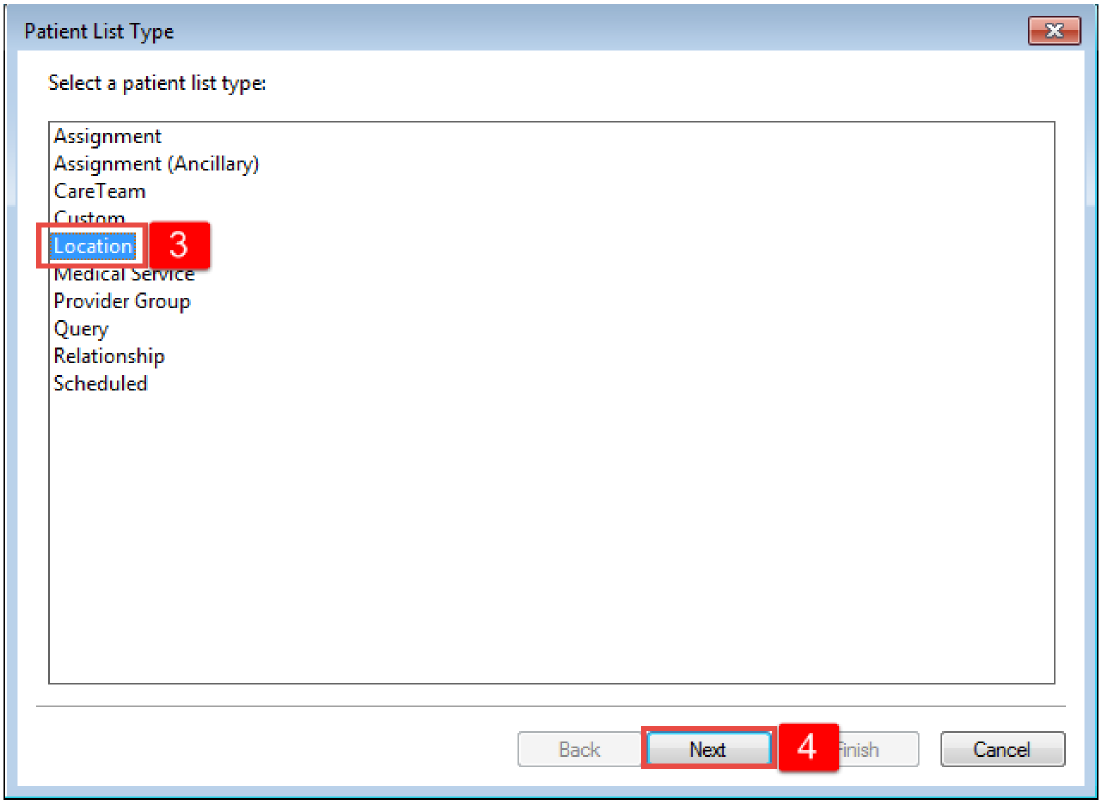
Activity 1.1 – Set Up a Location Patient List

1 At the start of your first shift (or when working in a new location), you will create a **Location List** that will consist of all patients assigned to your unit.

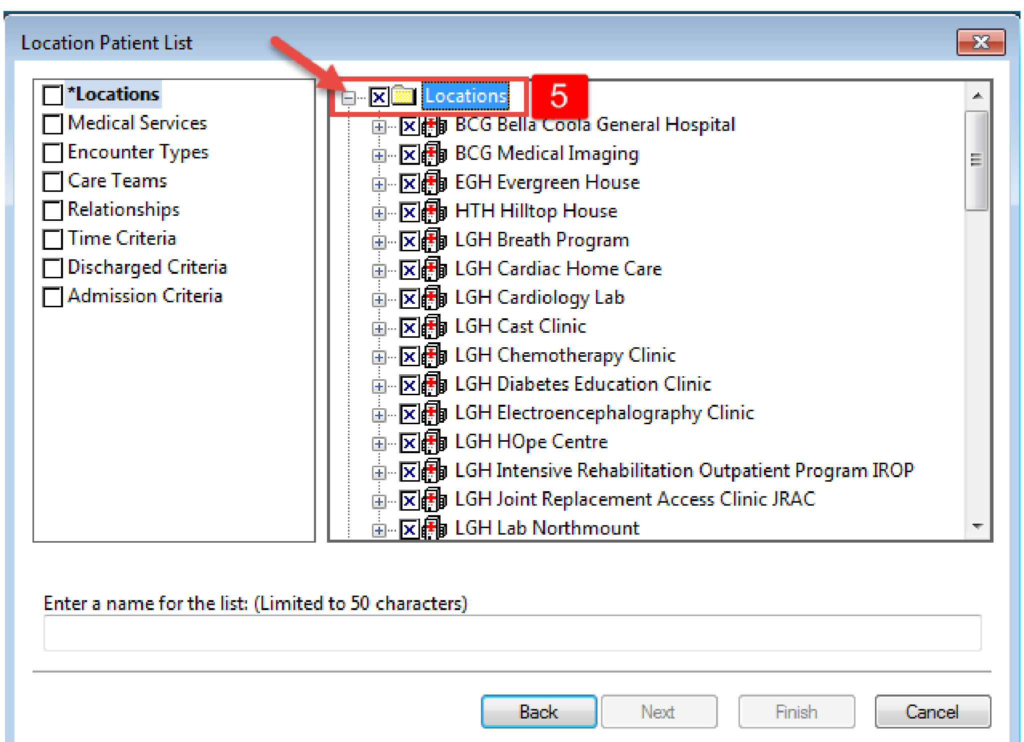
1. The screen will be blank. To create a location list, click the **List Maintenance** icon . When you hover over the wrench it will say **List Maintenance**.
2. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window.



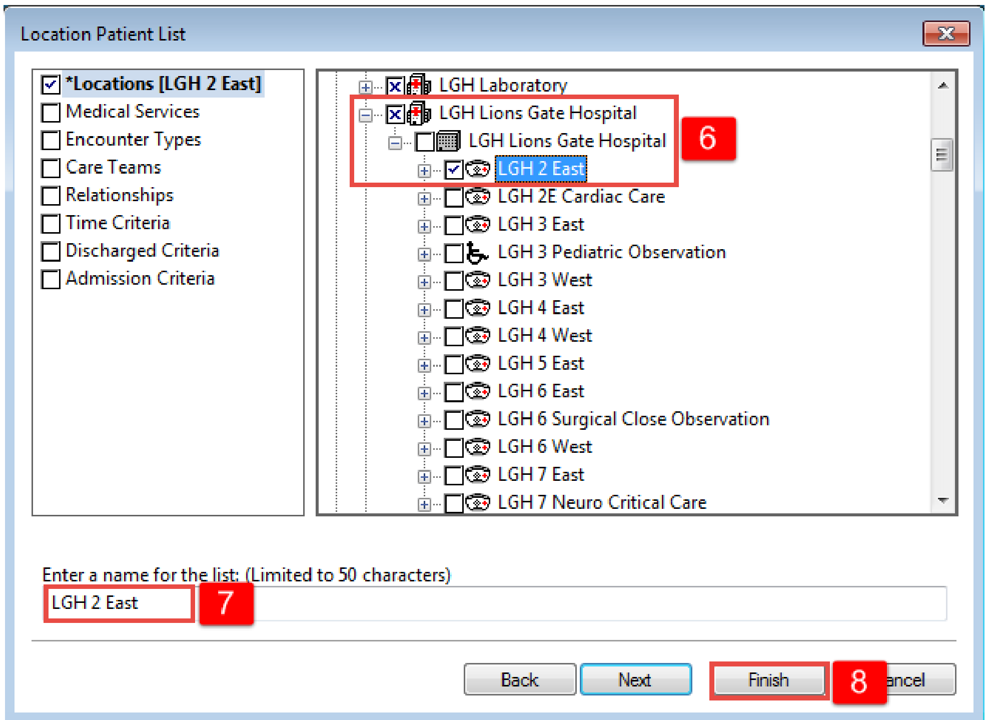
3. From the Patient List Type window select **Location**.
4. Click the **Next** button in the bottom right corner.



5. In the **Location Patient List** window a location tree will be on the right hand side. Expand the list by clicking on the tiny **plus** + sign next to the Locations.



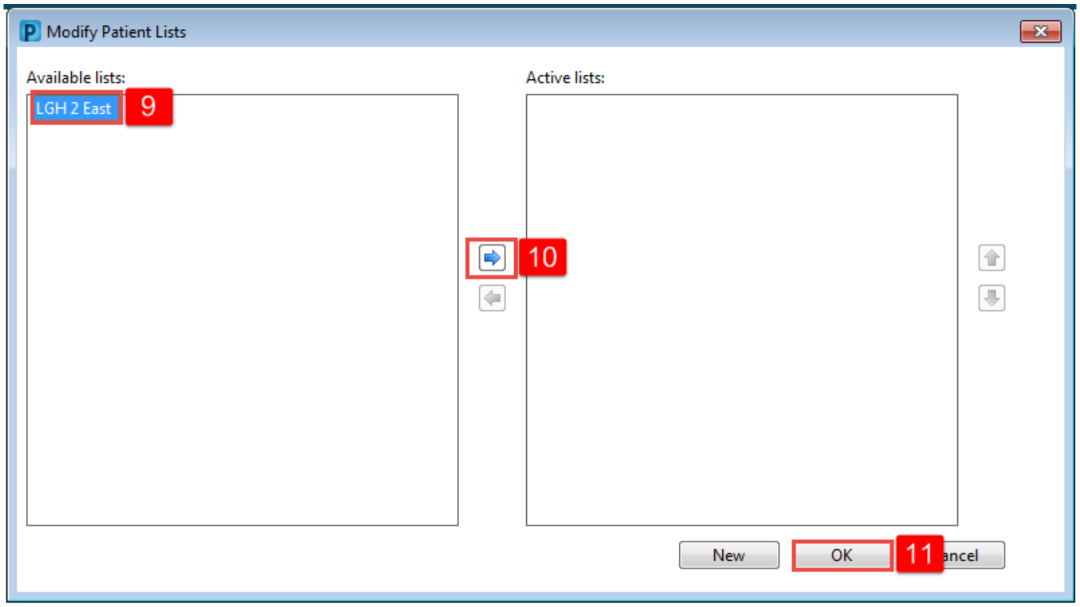
6. Scroll down until you find the location assigned to you. Expand the location by clicking on the tiny **plus + sign**
    - Click on **the box next to the unit assigned** to you to select it
7. Location lists are automatically named by the Location.
8. Click the **Finish** button in the bottom right corner.



9. In the **Modify Patient Lists** window click on the **Location** to select it.

10. Click the **Blue Arrow** icon  to move the **Location** to **Active List** on the right.

11. Click the **OK** button in the bottom right corner to return to **Patient Lists**. Your Location list should now appear in Patient List window.



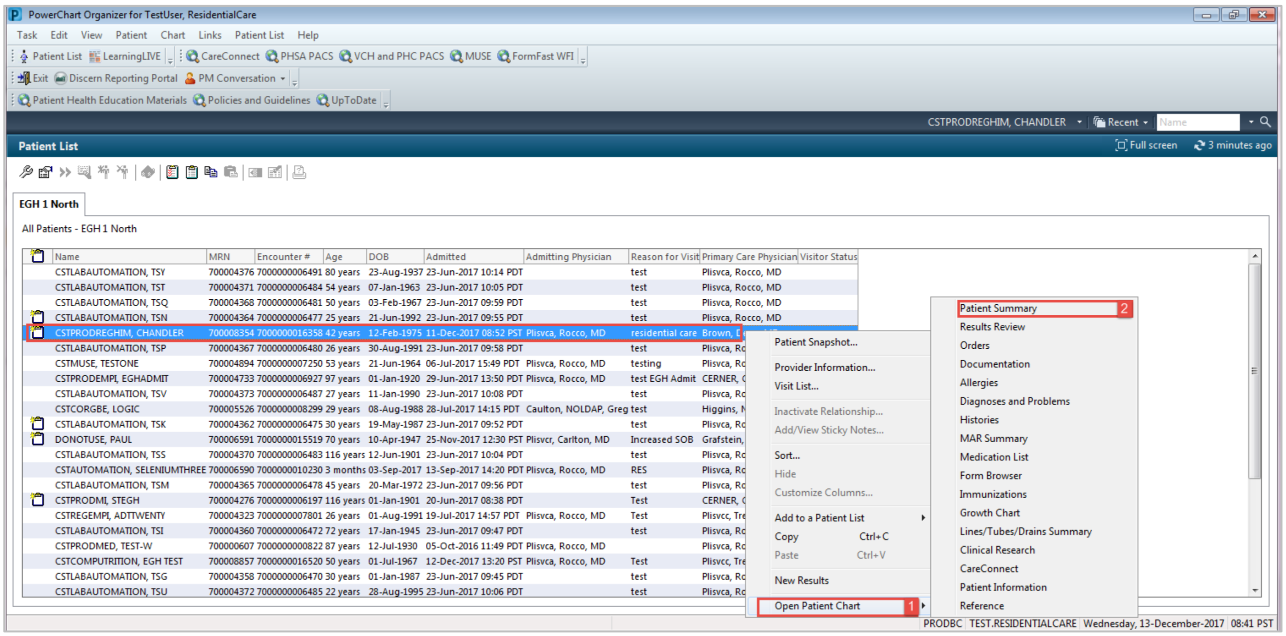
Key Learning Points

- Patient List can be accessed by clicking on the Patient List icon in the Toolbar.
- Patient lists, including Location list only need to be set up once.
- Once a Location list has been setup, you will have it available to you every time you log in.

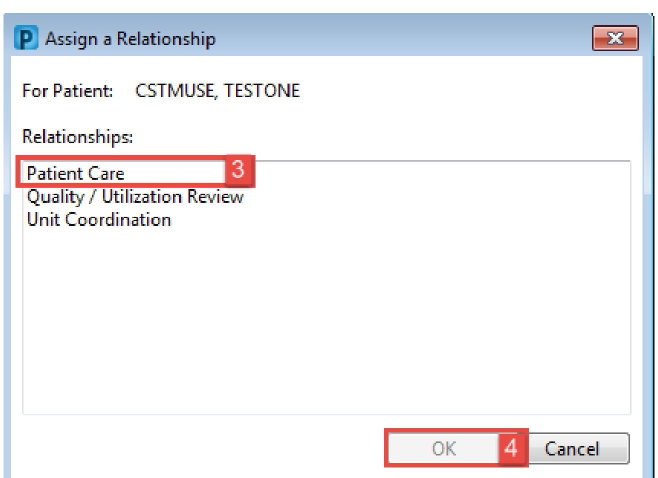
Activity 1.2 – Access and Review Patient Chart

1 From Patient List, locate patient assigned to you.

1. Locate your patient, right click on **patient's name** and select **Open Patient Chart**
2. Click on **Patient Summary**

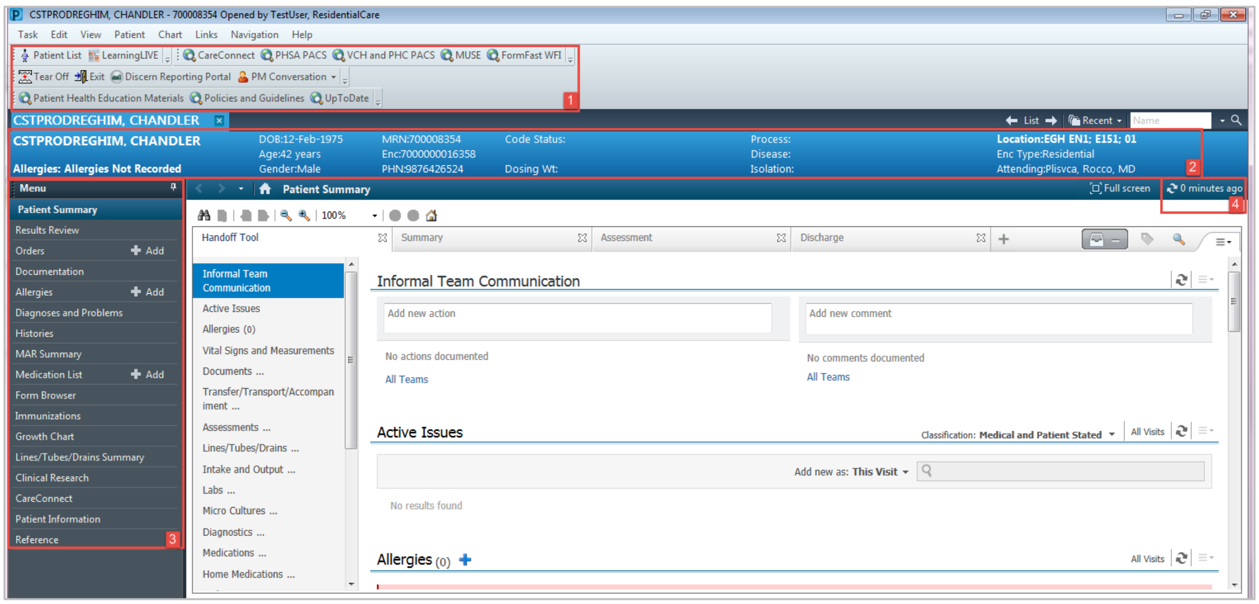


3. You will be asked to establish a relationship with the patient before you can open the patient's chart. Select **Patient Care** in the **Assign a Relationship** window
4. Click **OK** to open patient's chart



2 The patient's chart is now open. Review key parts of this screen.

1. The **Toolbar** is located above the patient's chart and it contains buttons that allow you to access various tools within the Clinical Information System.
2. The **Banner Bar** displays patient information such as:
    - Patient name and demographics
    - Allergies, Dosing weight, Code Status, and Alerts
    - MRN, Encounter, PHN
    - Location and Attending Physician
3. The **Menu** on the left allows access to different sections of the patient chart. This is similar to the coloured dividers within a paper chart.
4. The **Refresh** icon updates the patient chart with the most recent entries. Click Refresh frequently to view information entered into the patient chart by other clinicians.



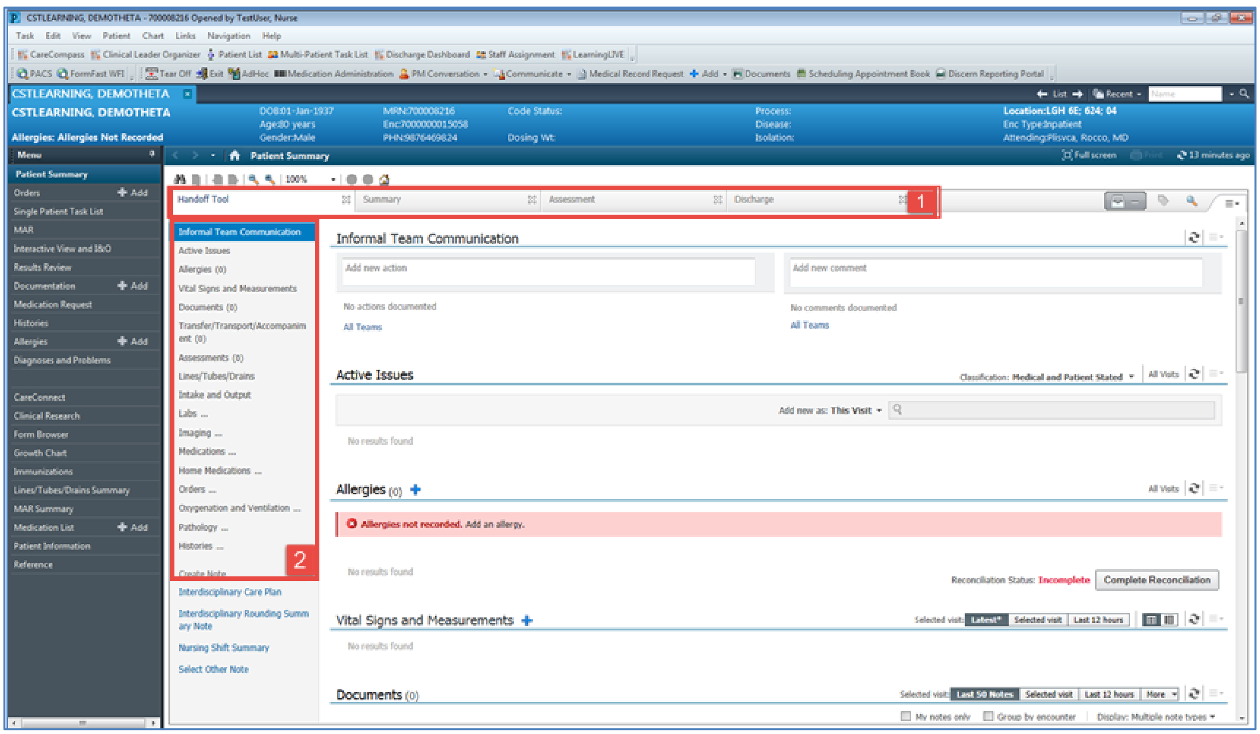
Key Learning Points

- A relationship must be established with patients in order to access their patient chart
- The Toolbar is used to access various tools within the Clinical Information System
- The Banner Bar displays patient demographics and important information
- The Menu contains sections of the chart similar to tabs in paper chart
- The Refresh icon should be used regularly to update patient information you can view

Activity 1.3 – Introduction to Patient Summary

1 Upon accessing the patient's chart you will see the **Patient Summary** section open. The **Patient Summary** will provide views of key clinical patient information.

1. There are different tabs across the page including **Handoff Tool**, **Summary**, **Assessment**, and **Discharge** that can be used to learn more about the patient.
    - Click on the **different tabs** to see a quick overview of the patient.
2. Each tab has different components. You can navigate through these using the component list on the left side of each tab.



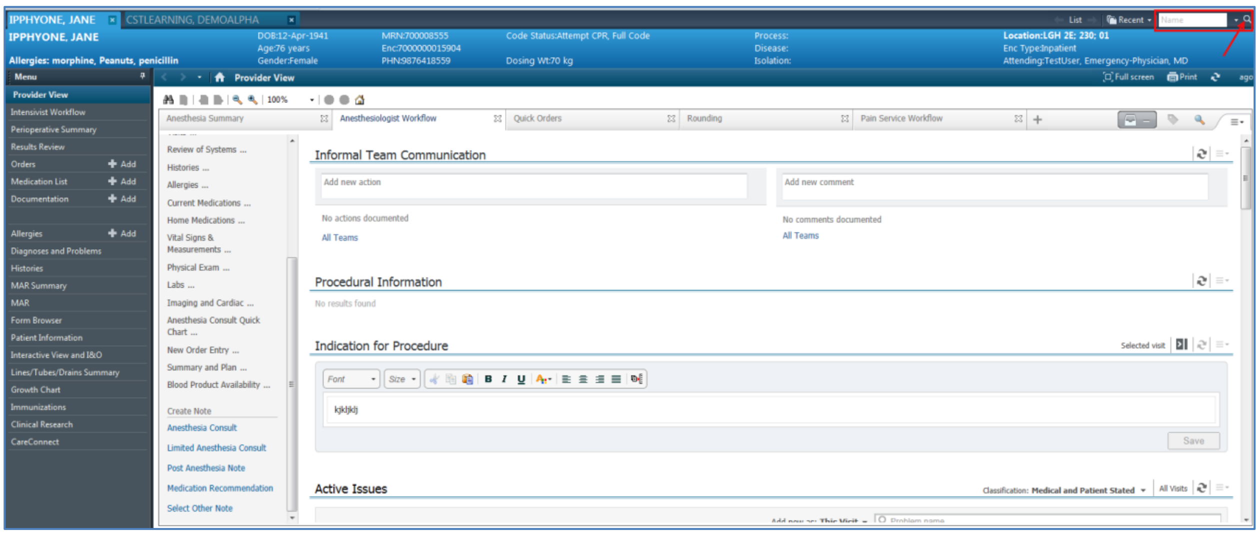
Key Learning Points

- Patient Summary provides access to key information about the patient.
- Click the Refresh icon to get the most updated information on the patient.

Activity 1.4 – Searching for an Inpatient Patient

1 Prior to the patient being discharged from the hospital, you will need to complete handoff with the inpatient nurse. The patient will not appear in your patient list as this patient is not in residential care yet. You will need to search for the appropriate patient and encounter.

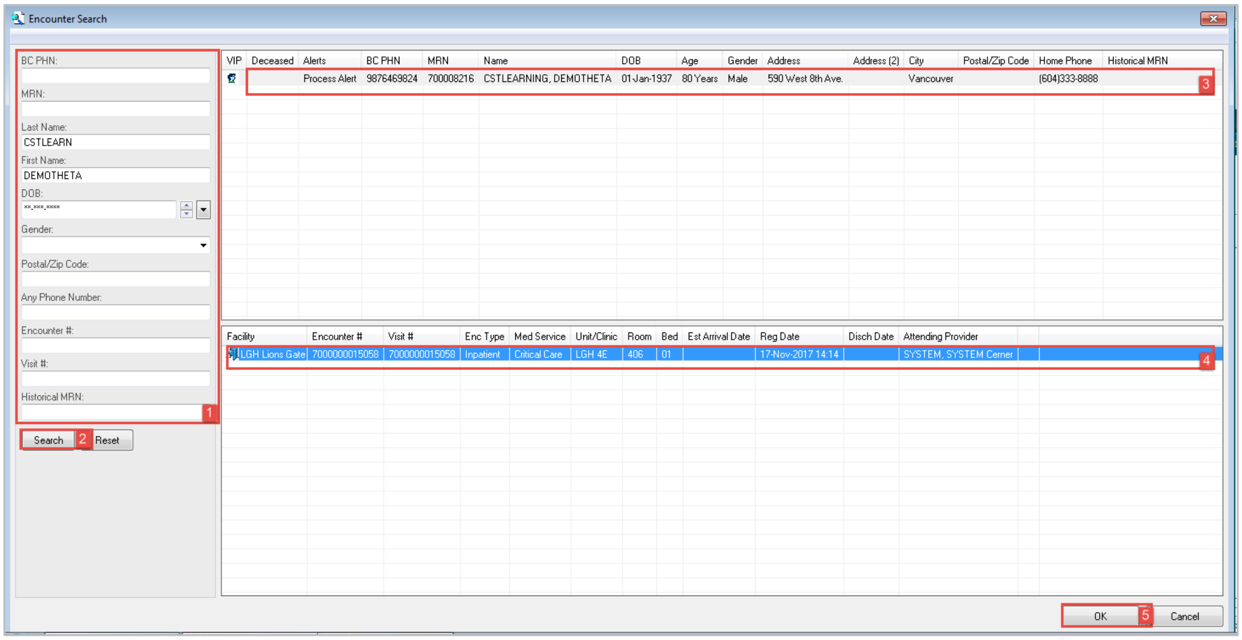
Navigate to the patient search tool and select the magnifying glass icon to open the encounter search window.



1. Use the Encounter Search fields to locate correct **Patient** and **Encounter**

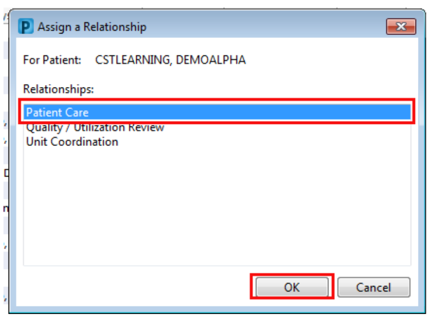
   Type in the following for Patient A:

   - Last name = *Last Name*
   - First name = *First Name*
2. Click on **Search**
3. Select the **Correct Patient (Patient A)** from the box on the top part of the screen.
   - Verify other identifiers (such as PHN, DOB, MRN) to ensure correct patient
4. Select the **Correct Encounter** from the box in the lower part of the screen for **Patient A**
5. Click **OK**



Assign a Relationship window pops up and you will need to establish a relationship with the patient's chart.

6. Select **Patient Care** and click **OK**



Patient's chart opens to **Patient Summary**. You can review pertinent patient information with the Inpatient Nurse using handoff/report page.

Key Learning Points

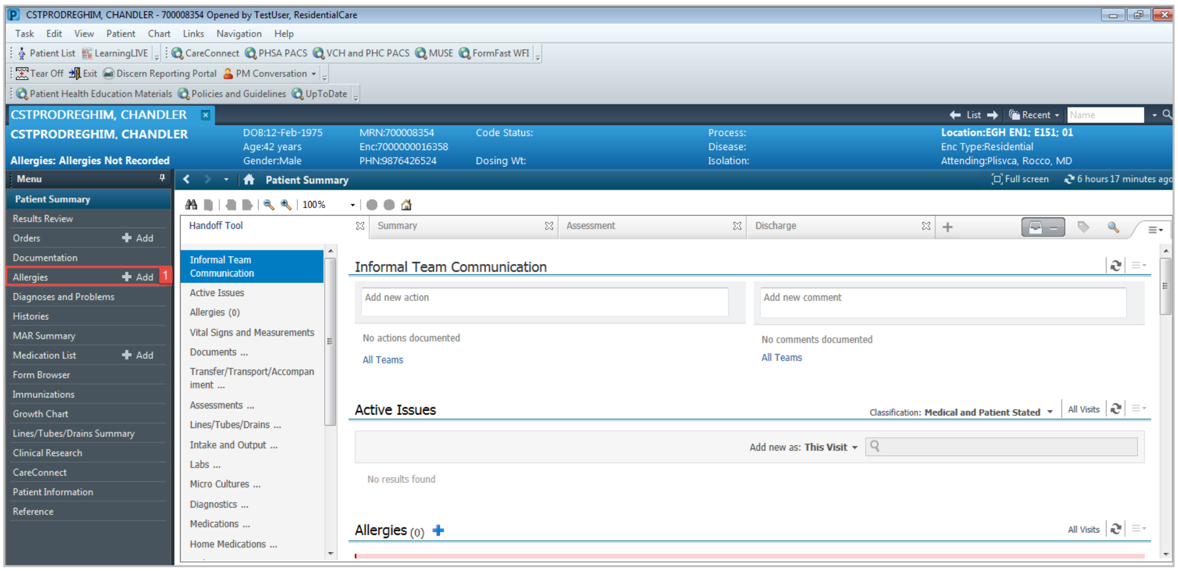
- Search for a patient by selecting the magnifying glass icon
- Use First and Last name to search for patient and verify that it is the correct patient by checking PHN, MRN and DOB
- Ensure that correct encounter is selected by verifying the encounter number on the patient's chart.

Activity 1.5 – Transcribe Allergies

1 Your patient arrives to residential care and as part of admission to residential care, you will need to verify and complete the paper allergy record.

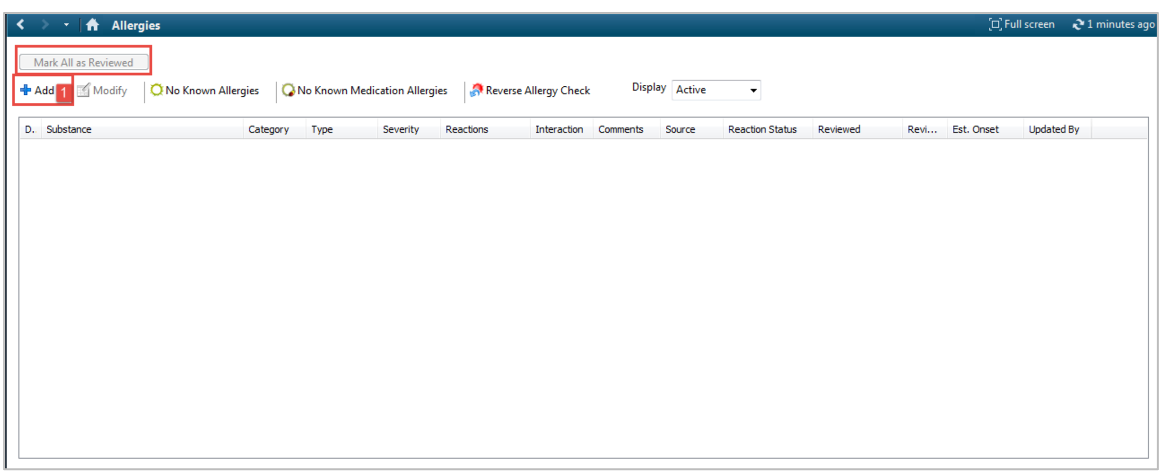
Note: You will also need to update the information in PARIS as there is no communication between the CIS and PARIS.

From the **Menu** within the Patient Chart, click on the **Allergies** tab



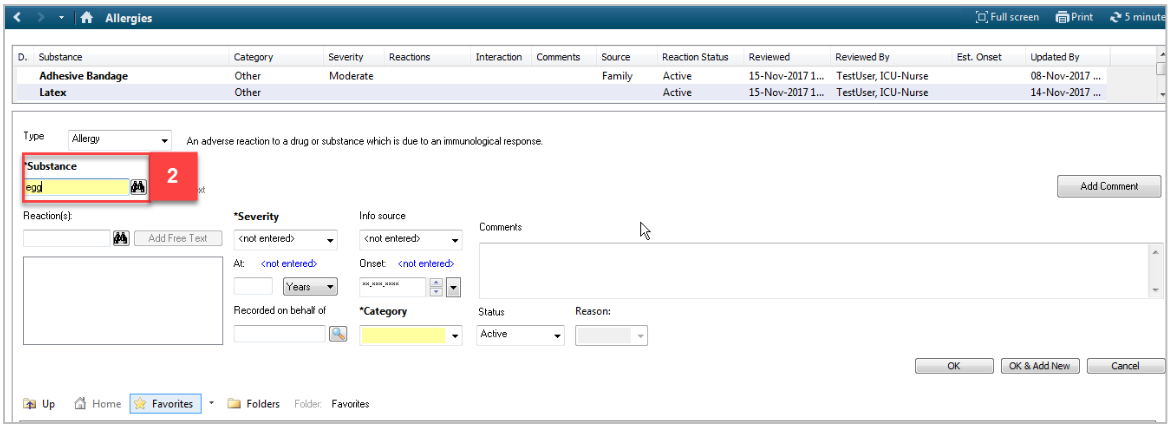
The Allergies window opens.

1. Click the Add button

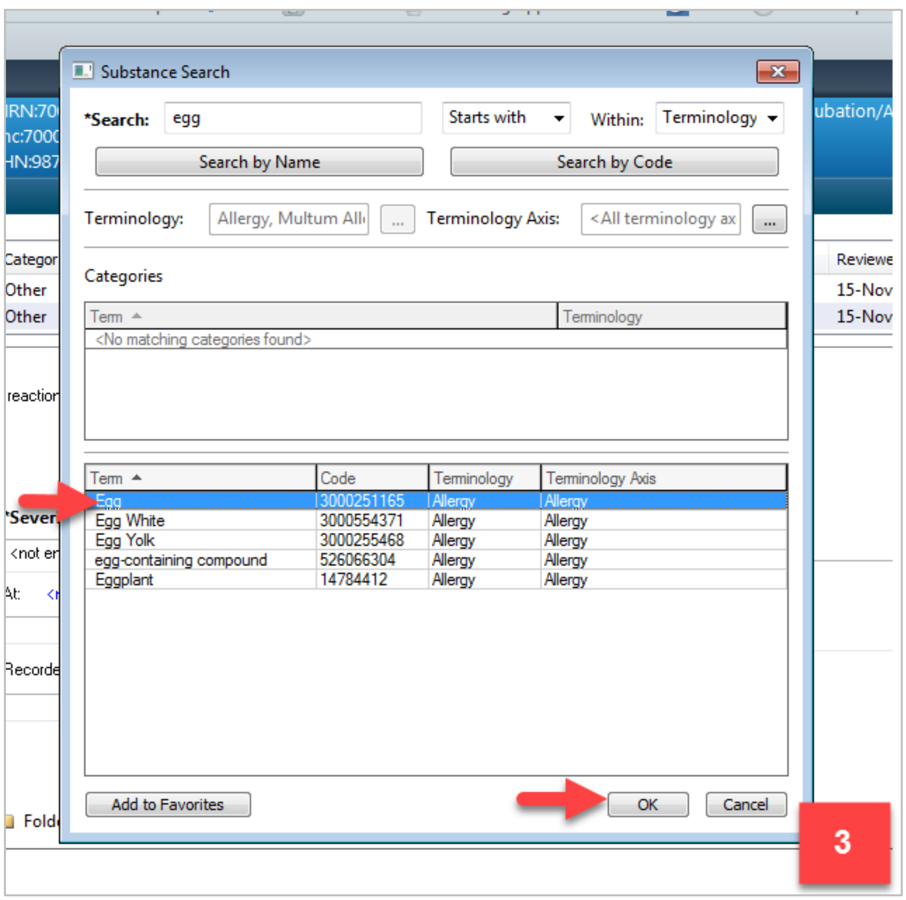


2. Enter in the **Substance** field type = *Egg* and click the **Search** icon .

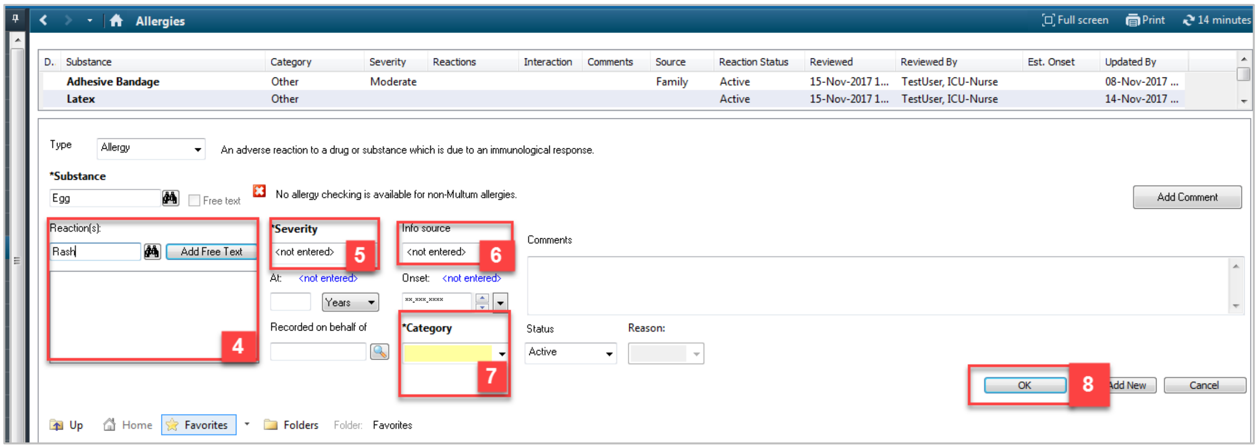
Note: Yellow fields including **Substance** and **Category** are mandatory fields that need to be completed.



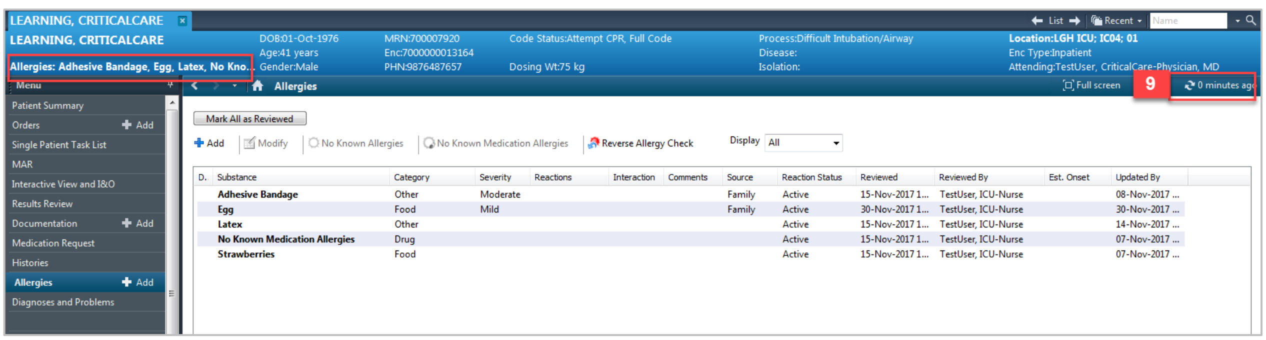
3. The Substance Search window opens. Select **Egg** and click the **OK** button.



4. In the **Reaction(s)**, Enter = ***Rash*** and click **search icon**
5. In the **Severity** dropdown = *Mild*
6. In the **Info source** dropdown = *Family*
7. In the **Category** dropdown = *Food*
8. Click **OK**



9. Refresh the screen and the Egg allergy will now appear in the Banner Bar



Note: Allergies in the banner bar are sorted by severity (most to least). If the allergies listed are longer than the space available, the text will be truncated. Hovering over the truncated text will display the complete allergies list.

Key Learning Points

- Documented allergies are displayed in the Banner Bar of the patient’s chart.
- You can add allergies by clicking on the add button in the Allergies tab
- Yellow fields are mandatory fields that need to be completed.
- Within the Banner Bar, allergies will display with the most severe allergy first.

PATIENT SCENARIO 2 – Orders and Results

Learning Objectives

At the end of this Scenario, you will be able to:

- Transcribe new orders
- Review orders
- Cancel/Discontinue an order
- Review results

SCENARIO

The physician has assessed the new patient and you need to enter orders into the Clinical Information System (CIS), as well as other Order Management associated activities. You will also review results within the CIS.

Note: Not all orders will need to be entered into the CIS. Only lab, diet and cardiology orders will be entered into CIS by unit clerks or nurses. Medication orders will be entered by the pharmacy department.

Nurses will review both the paper record and CIS to ensure that the orders are captured accurately.

As a nurse, you will be completing the following activities:

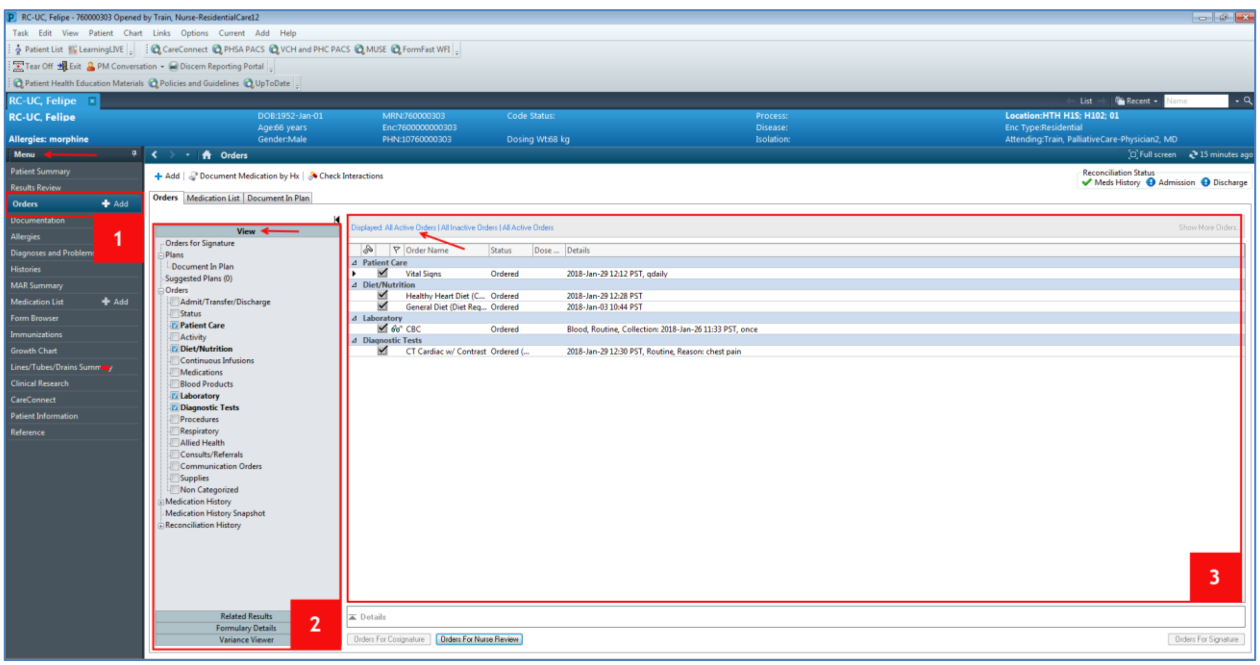
- Review orders
- Transcribe new orders
- Cancel/Discontinue an order
- Review results

Activity 2.1 – Review Orders in Orders Profile

1 The **Orders Profile** Page is where you will access a list of the patient's orders that have been entered into the Clinical Information System.

To navigate to the **Order Profile** page and review the orders:

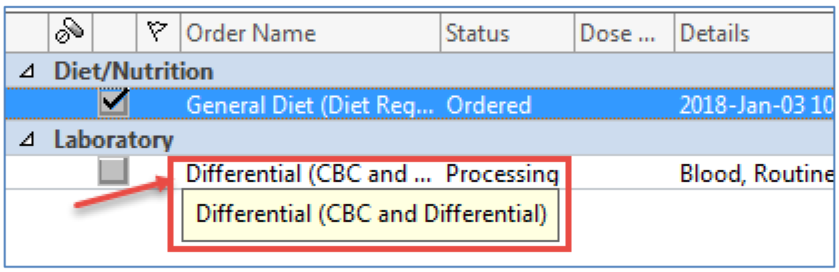
1. Select **Orders** from **Menu**
2. On the left side of the Orders Page is the Navigator (**View**) which includes several categories including:
    - Plans
    - Categories of Orders
    - Medication History
    - Reconciliation History
3. On the right side is the **Order Profile** where you can:
    - Review the list of **All Active Orders**



Some examples of icons you will see in Orders Profile are:

	Order for nurse to review
	Additional reference text available
	Order waiting for Pharmacy verification

Note: Hover your cursor over specific orders to discover additional information



Key Learning Points

- The Order Page consists of the orders view (Navigator) and the order profile.
- The Orders View displays the lists of PowerPlans and clinical categories of orders.
- The Order Profile page displays All Active Orders for a patient.
- Hover your cursor over the order name or icon to discover more detail (if available)

Activity 2.2 – Transcribe Orders

1 Residential care orders will remain on paper. Transcription into CIS is only needed for the following orders: Diet, Lab, Cardiology and Medication.

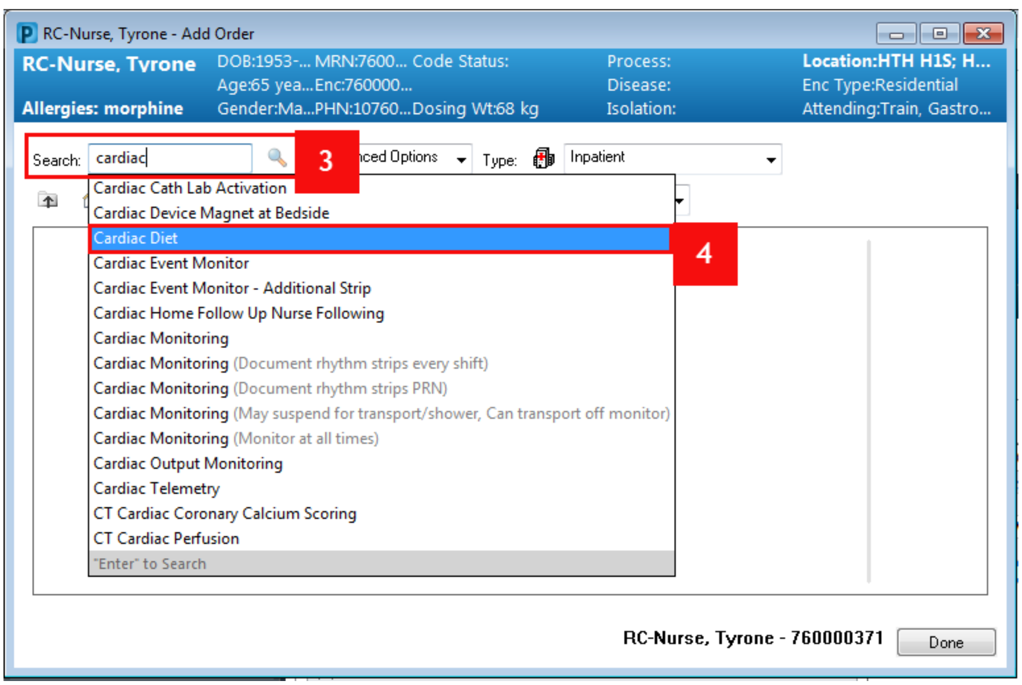
Note: Diet, lab and cardiology orders will need to be entered by unit clerks and nurses. You will continue to fax the medication orders to pharmacy. Pharmacy department will enter all medication orders into CIS.

In this activity you are going to transcribe a Diet order into the CIS.

To place an order:

1. Select **Orders** from the **Menu**
2. Click the 

button
3. The **Add Order** pop-up window will appear (Screen Shot below)
4. Type = *Cardiac Diet* in the **search** field and press **Enter** to search
5. Select **Cardiac Diet** from the list

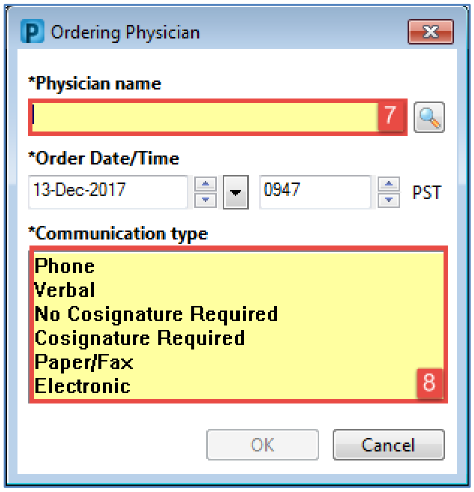


Note: You can add multiple orders from Add Order window and sign for all orders added at the same time

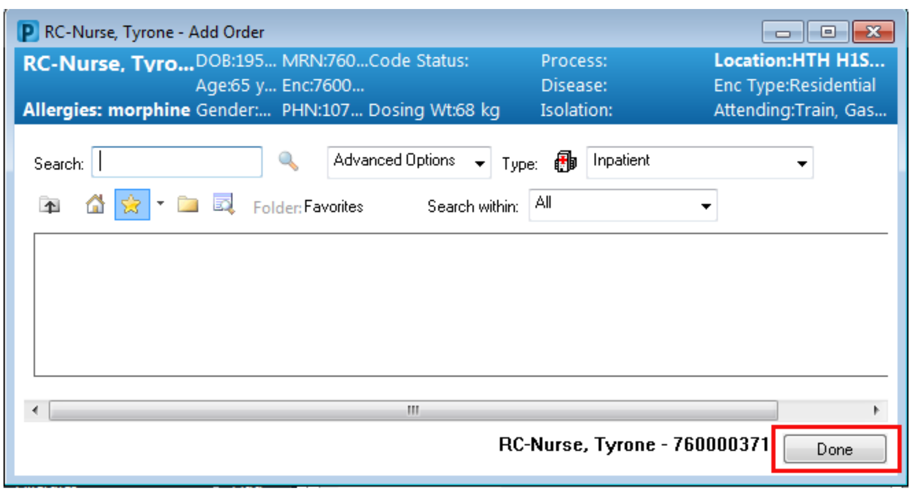
6. The ordering Physician pop-up window will appear
7. The **Ordering Physician** pop-up window appears. Fill out information below:

- **Physician name** = Last name, First name (Physician name on the right of the Banner Bar)
- **Communication type** = Paper/Fax

8. Click **OK**



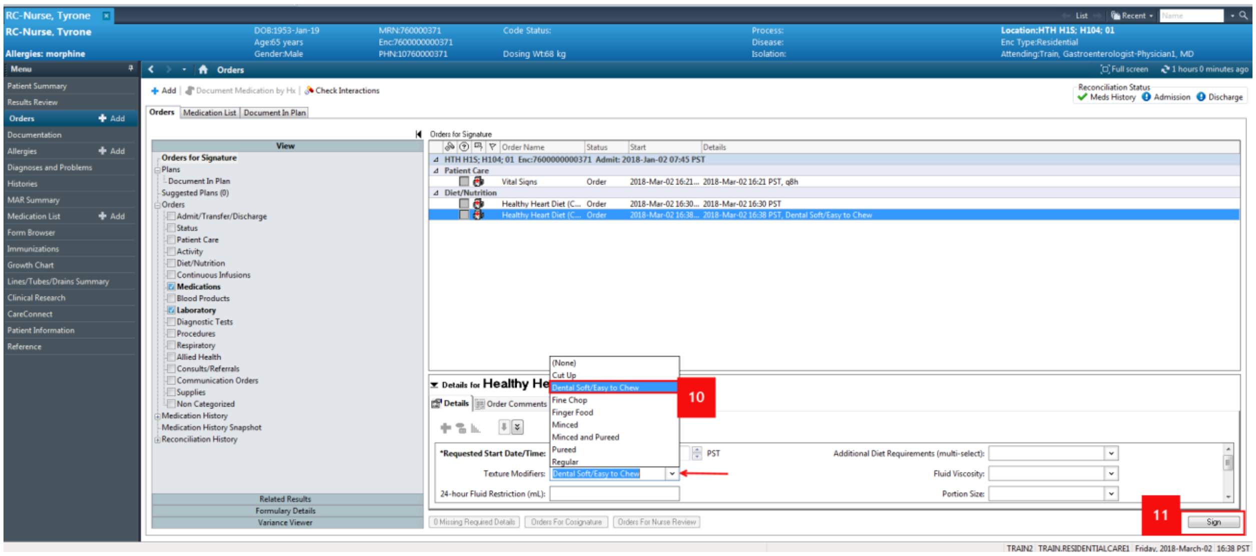
9. Click **Done** on the Add Order window to close that window



Order Details window opens in the lower part of the Order Profile.

10. Select **Dental Soft/Easy to Chew** under **Texture Modifier**

11. Click **Sign**.



The order status will display as **Processing.** Click **Refresh**  to update status to **Ordered.**

Key Learning Points

- Orders related to Diet, Lab, and Cardiology will need to be transcribed into CIS
- Required fields are always highlighted yellow or marked with *.
- Medication Orders will be entered by the Pharmacy department. Fax Doctor’s order to Pharmacy.

Activity 2.3 – Review Order Statuses and Details

1

In the following activity, you will only be reviewing order status. Status information will help you decide on further action they may be required on your part.

Orders are classified by status including:

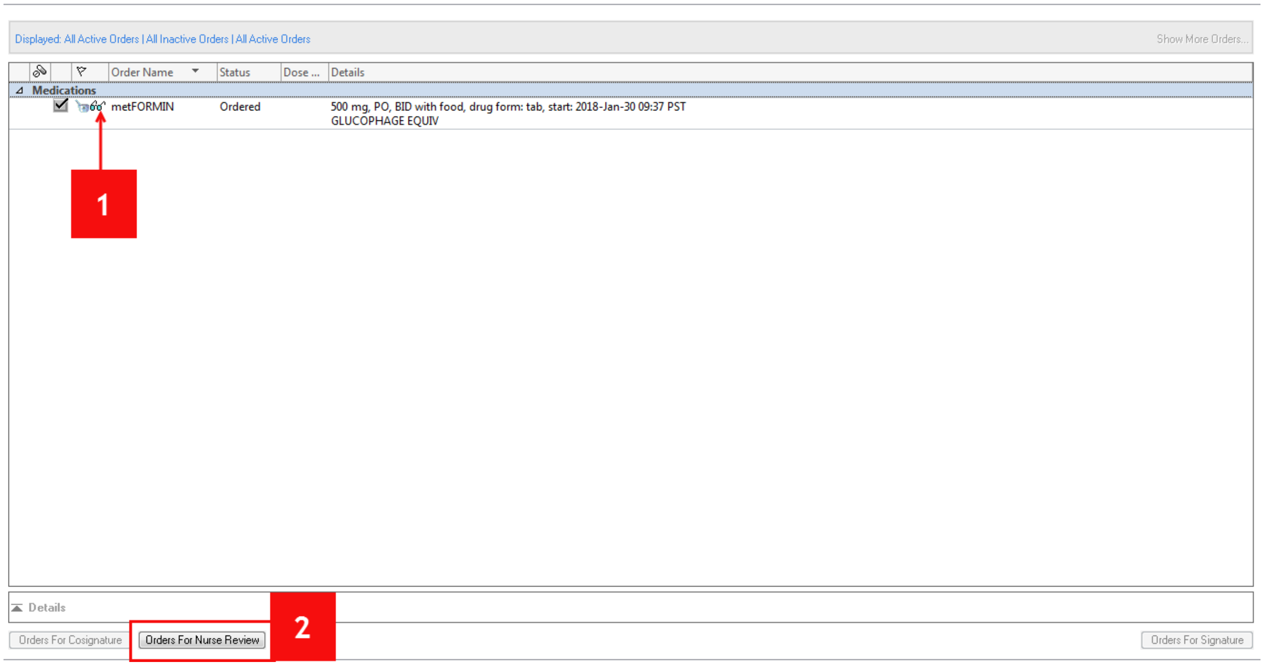
- **Processing**- order has been placed but the page needs to be refreshed to view updated status
- **Ordered**- active order that can be acted upon

	Order Name	Status	Dose ...	Details
Diet/Nutrition				
	General Diet (Diet Req...	Ordered		2018-Jan-03 10:44 PST
Laboratory				
	Differential (CBC and ...	Processing		Blood, Routine, Collection: 2018-Jan-26 11:33 PST, once

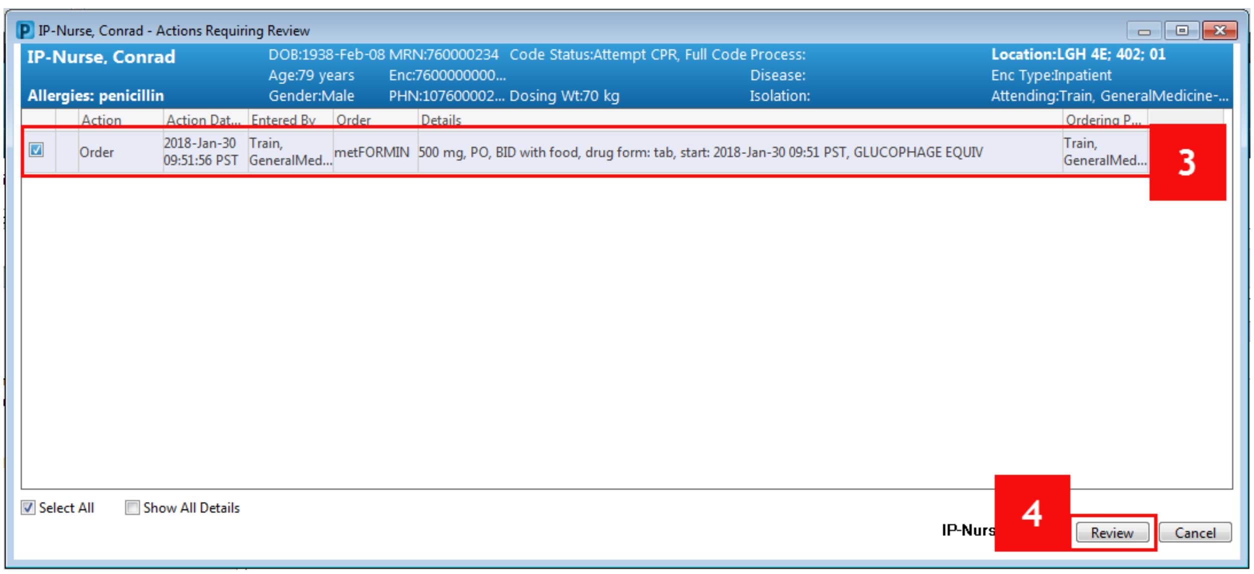
2

Nurses need to review medication orders transcribed into CIS and acknowledge that they have seen these. Nurse Review in CIS is the equivalent of nurses signing paper chart to say that they have seen the orders. Follow the steps below to Review Orders:

1. A Nurse Review icon appears to the left of the Order Profile. This serves as a visual for the nurse that orders need to be reviewed.
2. Click on **Orders For Nurse Review** button to open the Review window.



3. Review order details
4. Click **Review**



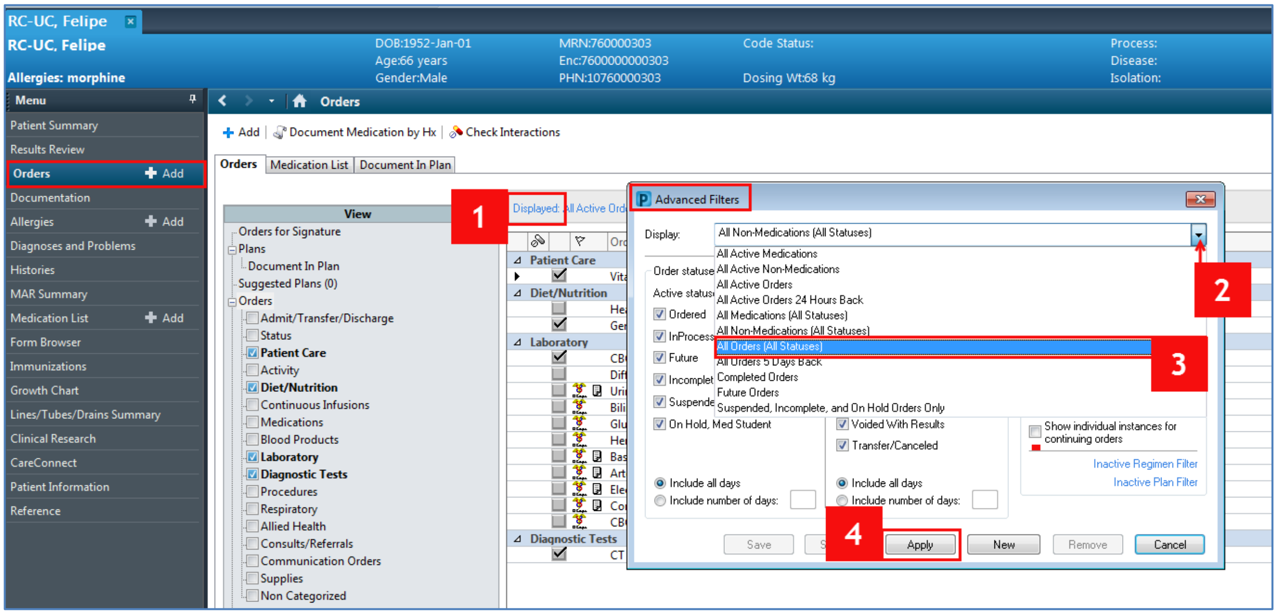
Note: You will return to the Orders page once you have reviewed your orders.

3

To be able to check your charts, you need to see all orders including those that are discontinued, cancelled, or completed. To make all orders visible in the Order Profile, follow the steps below:

1. Click on **Displayed** on the top right corner of the Order Profile
2. Advanced Filter window opens. Click on the **drop-down**

3. Select **All Orders (All Stautses)**
4. Click **Apply** to see all orders for this patient



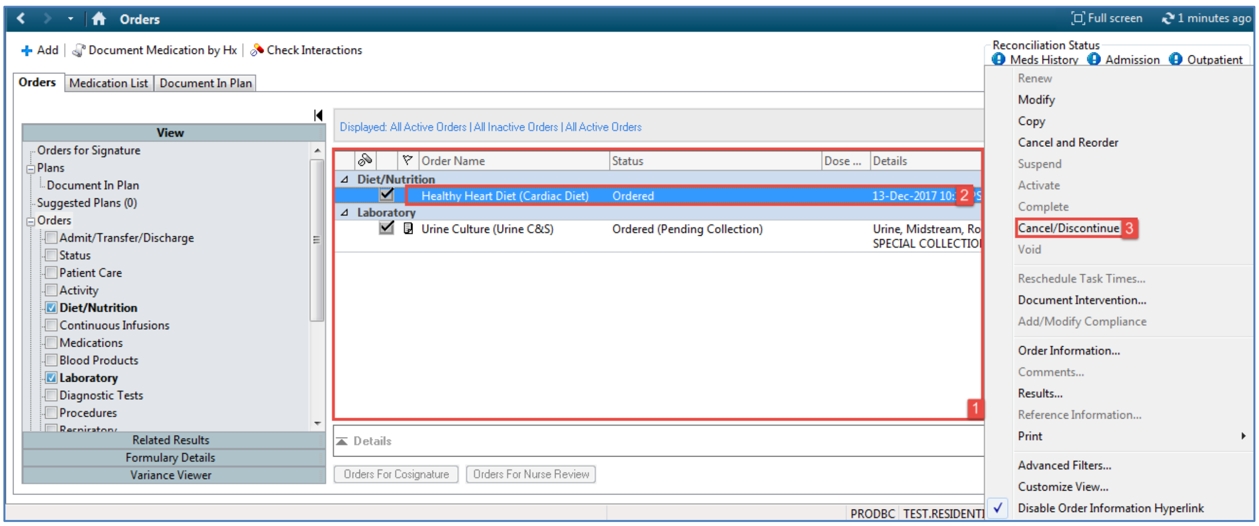
Key Learning Points

- Verify order status to know if you need to perform further action related to that order
- Nurses acknowledge that they are aware of the new orders by completing nurse review
- For checking charts, you can see all orders for a patient by changing Displayed filter to All Orders

Activity 2.4 – Cancel/Discontinue an Order

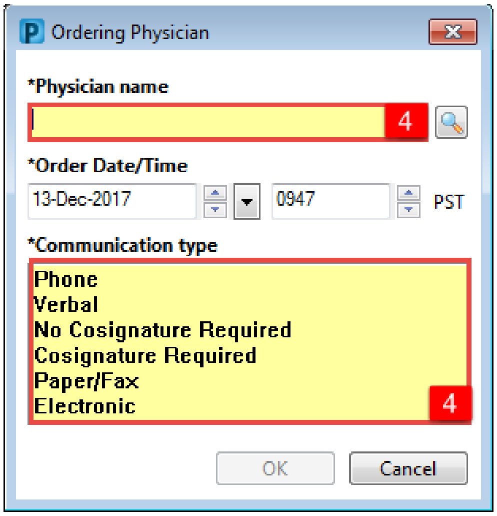
1 To **Cancel/Discontinue** an order:

1. Review order profile
2. Right-click order **Cardiac Diet**
3. Select Cancel/Discontinue

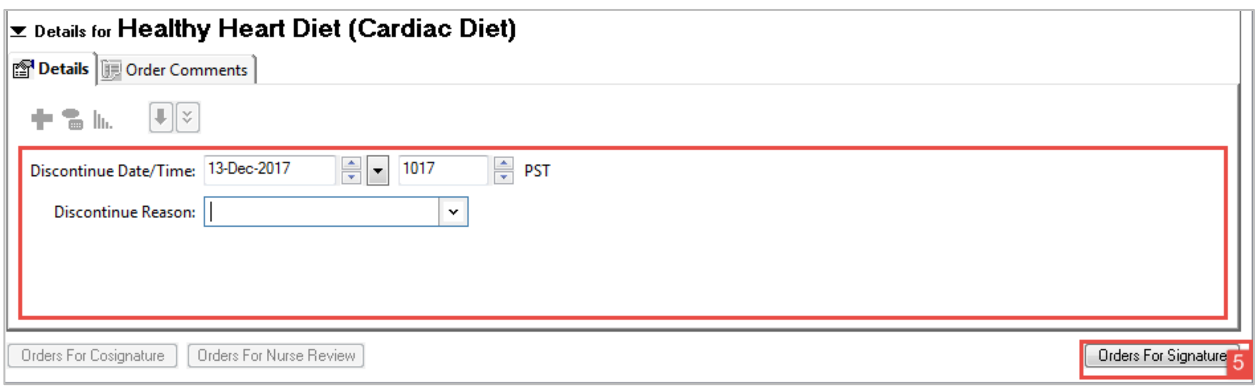


4. **Ordering Physician** pop-up window will appear. Fill out required fields highlighted yellow below and then click **OK**

   - Physician name = Last name, First name (Attending Physician name is on the right of the Banner Bar)
   - Communication type = Paper/Fax

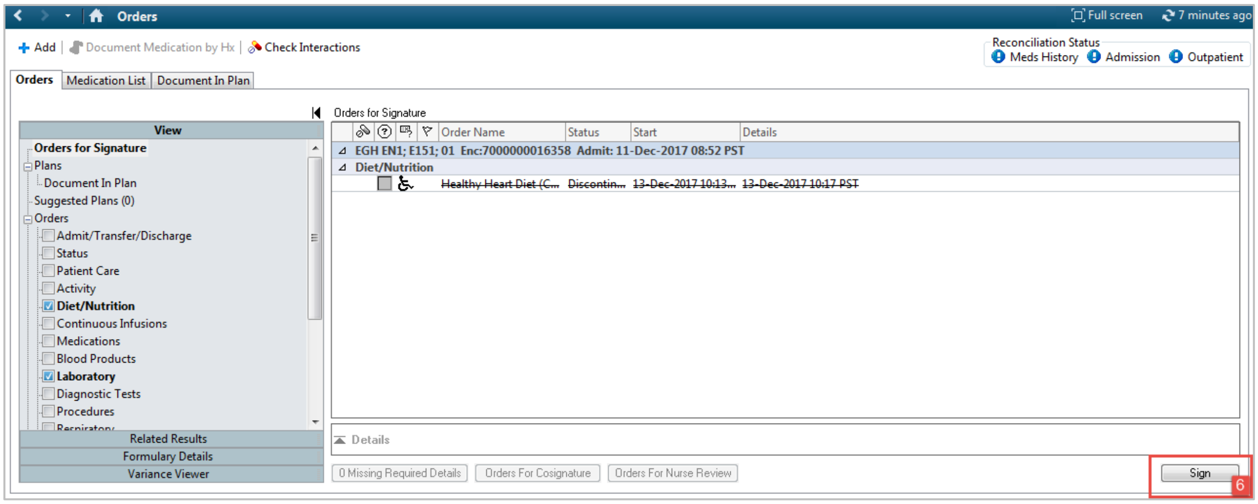


5. Review order details and add in additional information as needed. Click **Orders For Signature**



Order for Signature window opens; the Cardiac Diet order displays with a strike-through.

6. Click **Sign**.



The status of the order changes to **Discontinued.** Once you Refresh, the order will no longer be visible on the order profile.

Note: Lab and Cardiology orders that have been processed and resulted will have the status, **Completed**. This status is not visible on the Orders Profile when “All Active Orders” is chosen. Change the display filter to “All Orders [All Statuses]” to view completed orders.

Key Learning Points

- Right click to mark an order as cancel/discontinued.
- Once lab and cardiology orders have been processed and resulted, the status of Complete will appear.
- Cancelled, discontinued, and completed orders are not visible in patient’s Order Profile.
- Change the display filter to view all orders

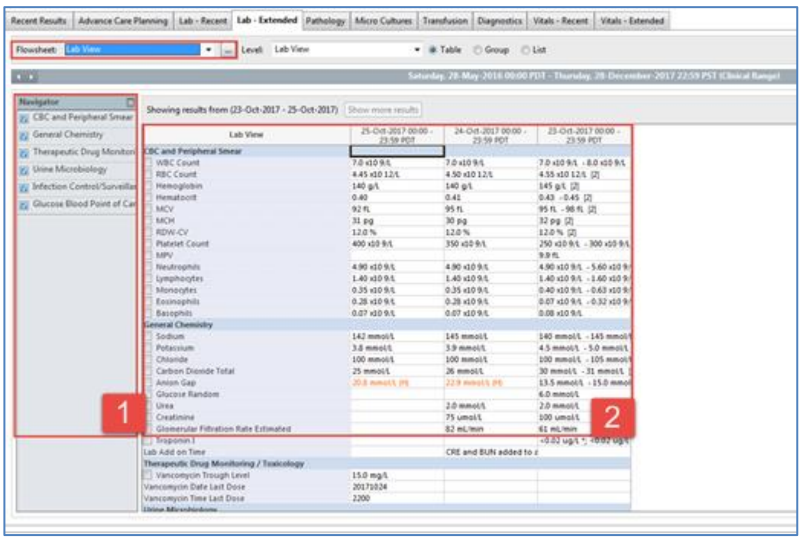
Activity 2.5 – Results Review

1 Throughout your shift, you will need to review your patient's results. You may review patient's result by navigating to **Results Review** on the **Menu**.

In **Results Review**, patient's results are presented using Flowsheets. **Flowsheets** display clinical information recorded for a person such as labs, cultures, transfusions, diagnostic imaging, and assessments.

Flowsheets are divided into two major sections.

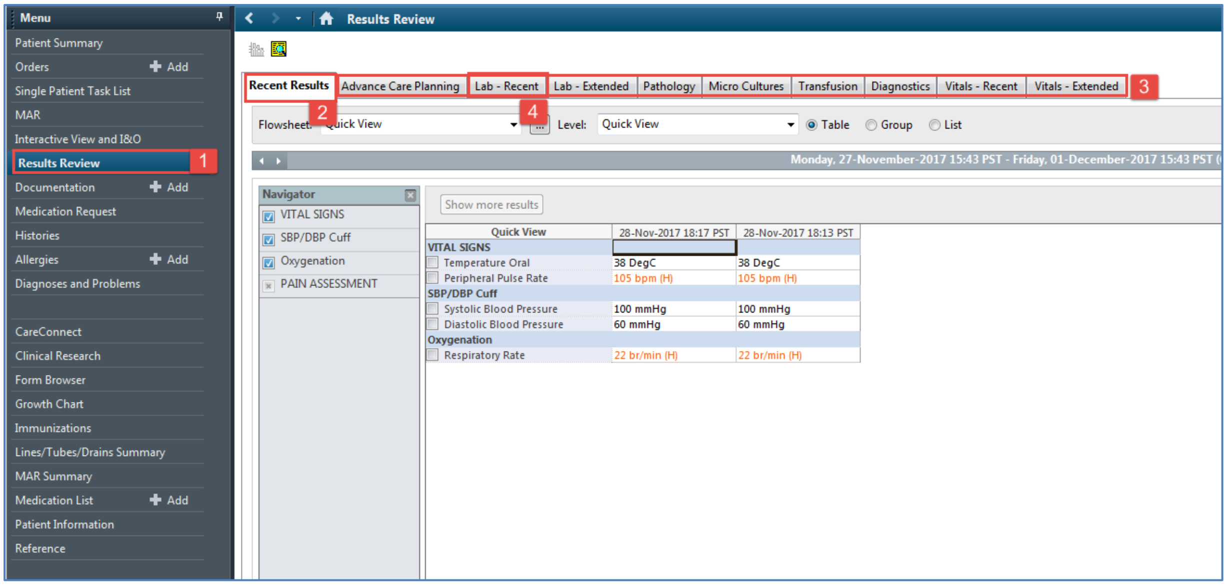
1. The left section is the Navigator. By selecting a category within the navigator, you can view related results, which are displayed within the grid to the right.
2. The grid to the right is known as **Results Display**.



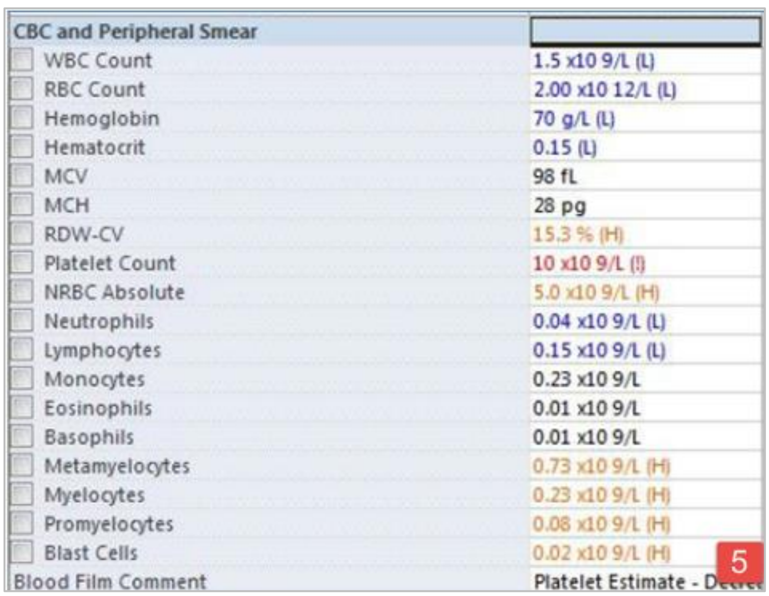
Note: Test Results will no longer print to your units.

Review the most recent results for your patient:

1. Navigate to **Results Review** from the **Menu**
2. Review the **Recent Results** tab
3. Review each individual tab to see related results
4. Select **Lab – Recent**



5. Review your patient's recent **lab results.**



CBC and Peripheral Smear	
WBC Count	1.5 x10 9/L (L)
RBC Count	2.00 x10 12/L (L)
Hemoglobin	70 g/L (L)
Hematocrit	0.15 (L)
MCV	98 fL
MCH	28 pg
RDW-CV	15.3 % (H)
Platelet Count	10 x10 9/L (!)
NRBC Absolute	5.0 x10 9/L (H)
Neutrophils	0.04 x10 9/L (L)
Lymphocytes	0.15 x10 9/L (L)
Monocytes	0.23 x10 9/L
Eosinophils	0.01 x10 9/L
Basophils	0.01 x10 9/L
Metamyelocytes	0.73 x10 9/L (H)
Myelocytes	0.23 x10 9/L (H)
Promyelocytes	0.08 x10 9/L (H)
Blast Cells	0.02 x10 9/L (H) 5
Blood Film Comment	Platelet Estimate - Decrea

Note: the colors of specific lab results and what they indicate:

- Blue values indicate results lower than normal range
- Black values indicate normal range
- Orange values indicate higher than normal range
- Red values indicate critical levels

To view **additional details** about any result, for example a *Normal Low* or *Normal High* value, **double click** the result.

Key Learning Points

- Flowsheets display clinical information recorded for a patient such as labs, cultures, transfusions, medical imaging, and vital signs
- The Navigator allows you to filter certain results in the Results Display
- Results are colored to represent low, normal, high and critical values
- View additional details of a result by double-clicking the value

PATIENT SCENARIO 3 – PM Conversation

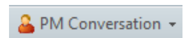
Learning Objectives
At the end of this Scenario, you will be able to: - Access PM Conversation

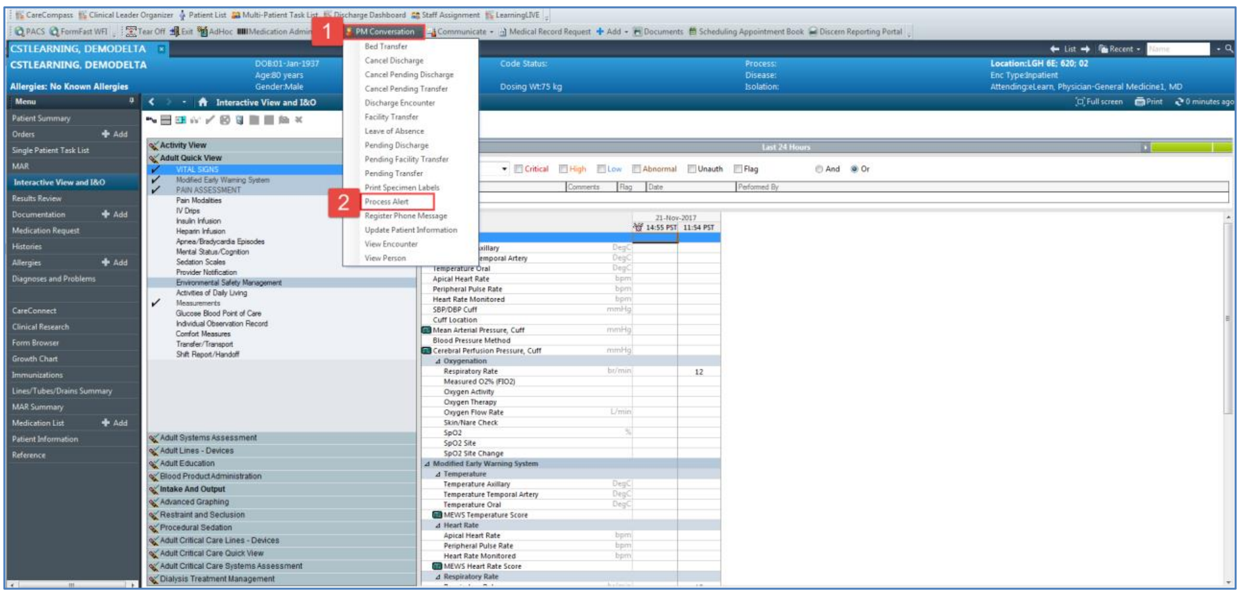
SCENARIO
In this scenario, you will access PM Conversation to add a Process Alert As a member of the Residential team, you will be completing the following activity: - Access PM Conversation - Add a Process Alert

Activity 3.1 – Add a Process Alert

1 Patient Management Conversation (PM Conversation) provides access to manage alerts such as violence risk, encounter information, and demographics. Process alerts are flags that highlight specific concerns about a patient. These alerts display on the banner bar and can be activated by any clinician including nurses.

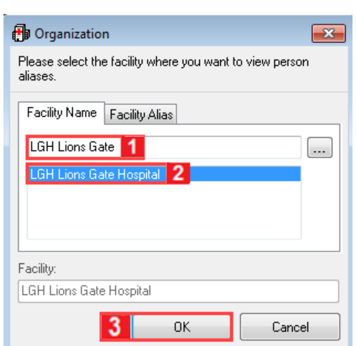
Let's look at how alerts are managed.

1. Click the drop-down arrow within **PM Conversation**  in the Toolbar
2. Select **Process Alert** from the drop-down menu



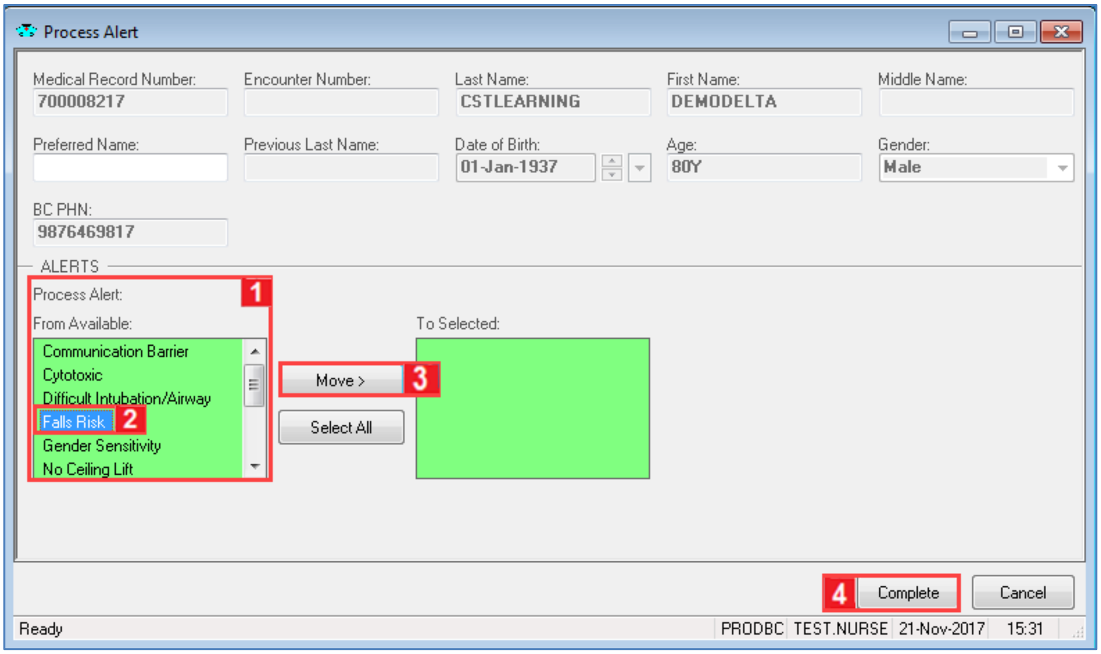
An organization window will display to select location.

1. In the **Facility Name** field, type = *LGH Lions Gate* and press **Enter** on your keyboard
2. Select **LGH Lions Gate Hospital**
3. Click **OK**



2 The **Process Alert** window displays. To activate the **Violence Risk** process alert on the patient's chart:

1. Click into the empty **Process Alert** box. A list of alerts that can be applied to the patient will display. **Note:** This box will be empty until you click into it.
2. Select **Violence Risk**
3. Click **Move**  The alert will now display within the **To Selected** box
4. Click **Complete**



Note: Multiple alerts can be activated at once. Alerts can be removed using the same process in PM Conversation. Site policies and practices should be followed with regards to adding and removing specific flags and alerts.

3

1. Click **Refresh**  to update the chart
2. Once complete, the process alert will appear within the banner bar of the chart where it is visible to all those who access the patient's chart.

Key Learning Points

- Using PM Conversation allows you to manage alerts, patient location, and demographics
- Updating Process Alerts in PM Conversation allow clinicians to see specific concerns related to the patient in the Banner Bar

PATIENT SCENARIO 4 – Discern Reporting Portal

Learning Objectives

At the end of this Scenario, you will be able to:

- Utilize Discern Reporting Portal for printing paper reports

SCENARIO

The physician came in to assess the patient and has ordered a new medication. You notice there is no more space on the monthly MAR report and need to print a blank MAR for this patient so this medication can be added onto the MAR report.

Medication administration documentation will remain on paper. The pharmacy department will enter the new medication order into the CIS and you will be able to view medication orders and related details under the Orders Profile page. However, you will still need to transcribe the medication to the paper MAR and you may need to print a blank MAR.

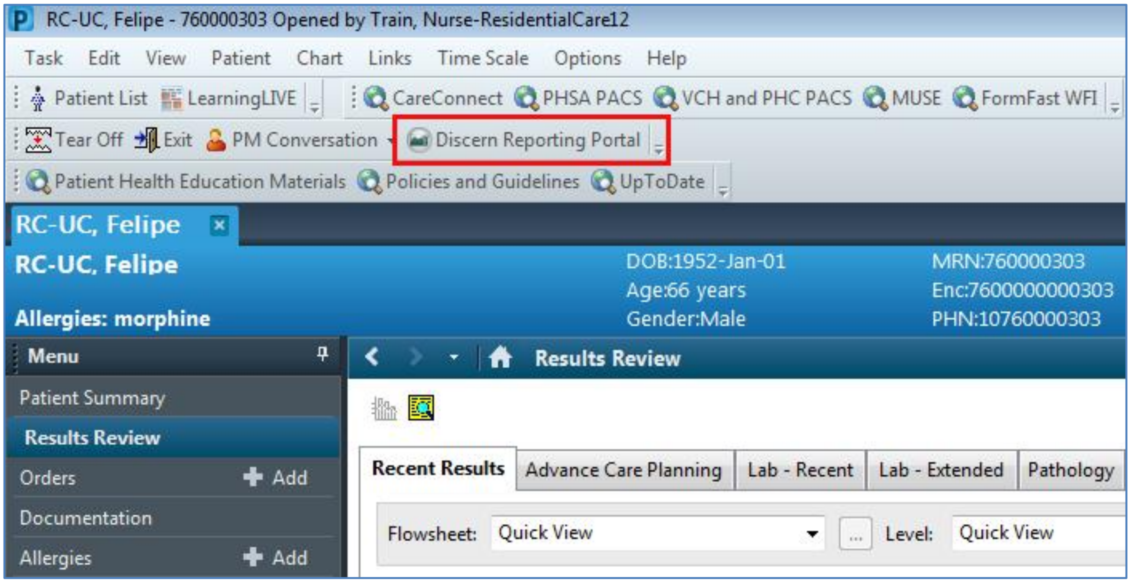
As a nurse, you will be completing the following activities:

- Access the Discern Reporting Portal
- Find and Print Reports

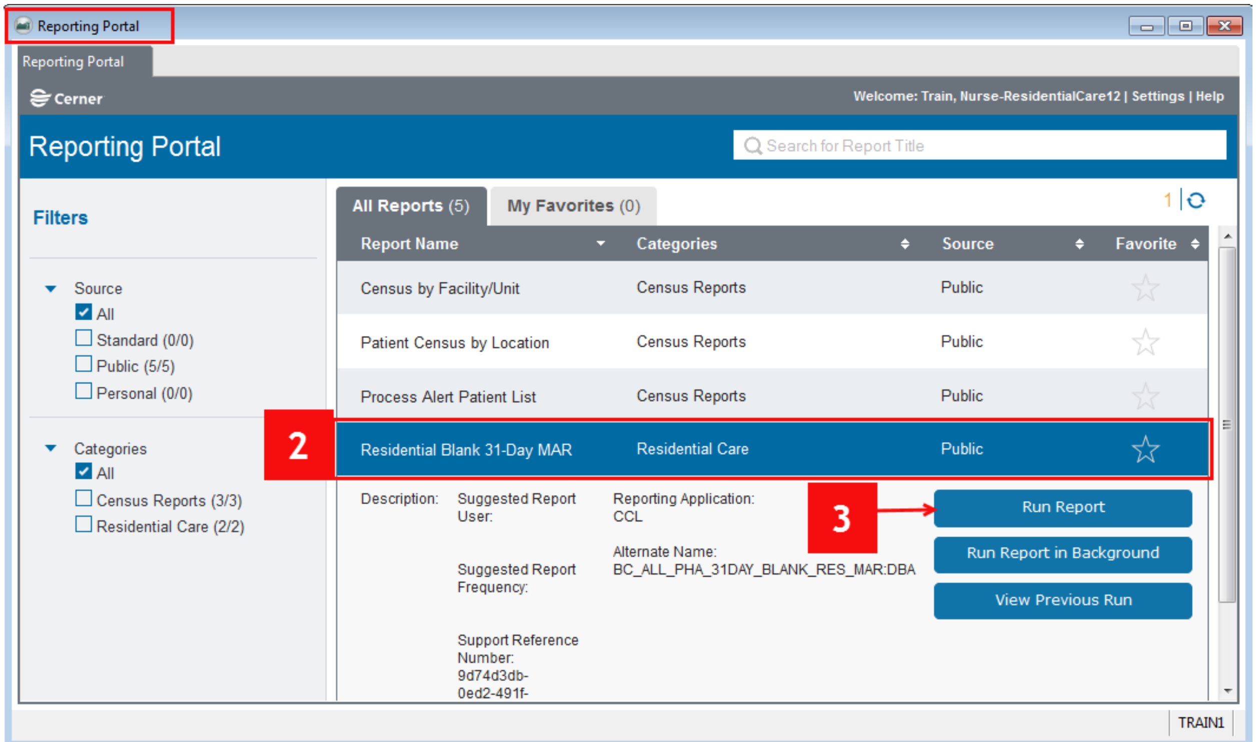
Activity 4.1 – Print Report from Discern Reporting Portal

1

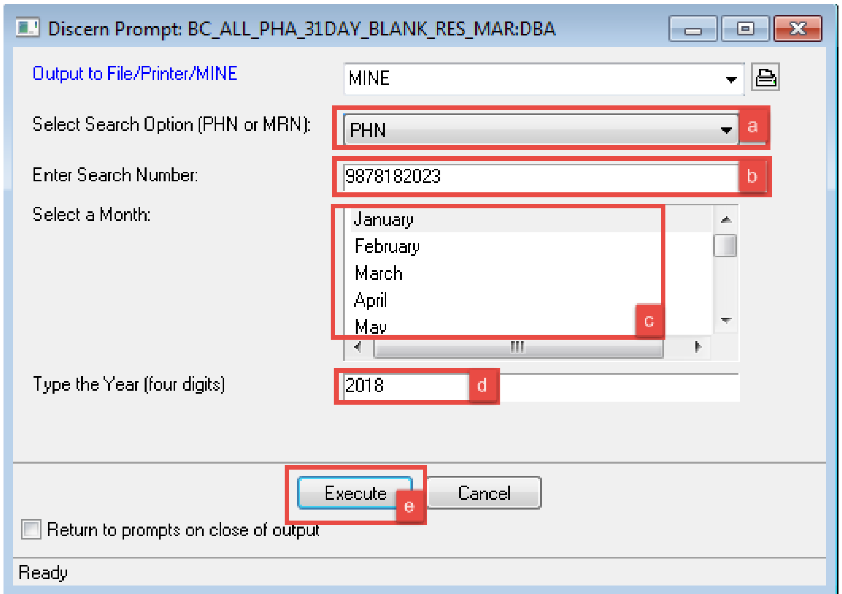
1. Select the **Discern Reporting Portal** in the toolbar



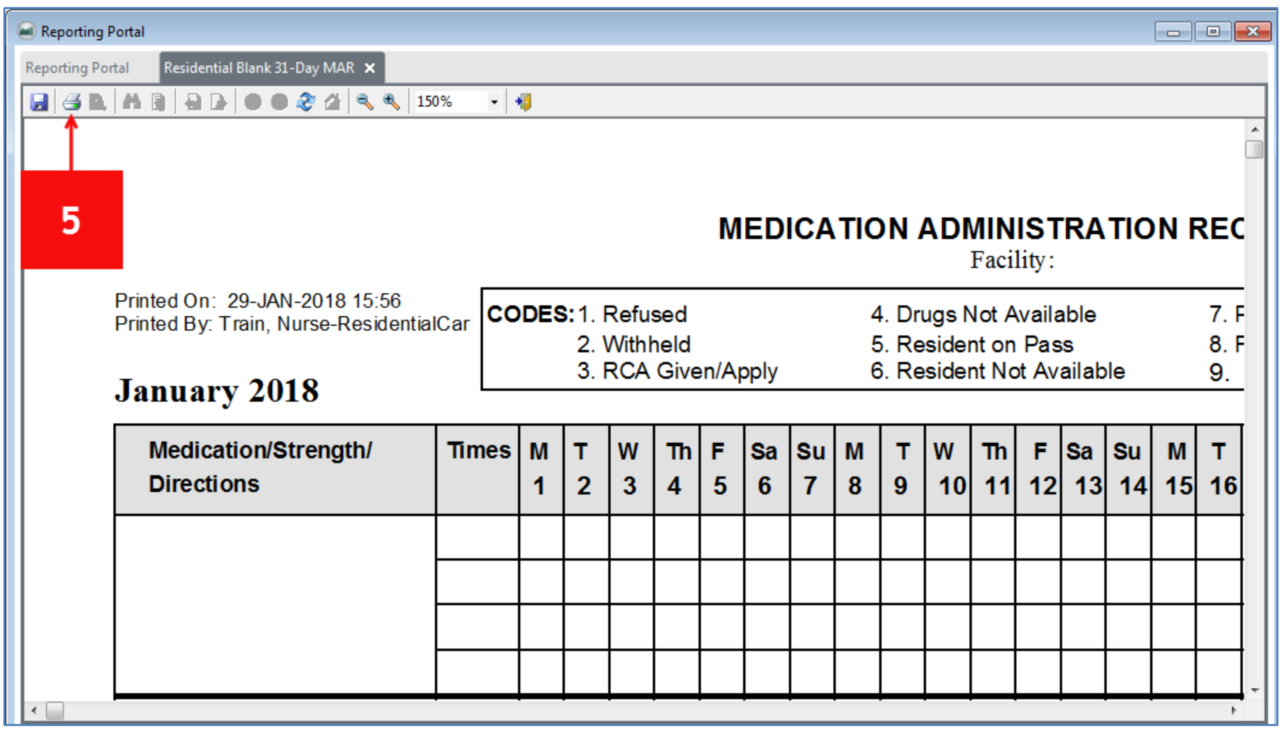
2. Reporting Portal window appears. Select **Residential Blank 31-Day MAR** report
3. Select **Run Report**



4. Discern Prompt Window appears
    a. **Select Search Option (PHN or MRN)** = *PHN*
    b. **Enter Search Number** = *[Patient PHN]*
    c. **Select a Month** = *Current Month*
    d. **Type the Year** = *Current Year*
    e. Click **Execute**



5. When the MAR displays, click on the **Print** icon. This will print the paper MAR. **Do not Print**



Key Learning Points

- The Discern Reporting Portal is accessible through the toolbar.
- The Residential Care printable reports are found within Discern Reporting Portal.
- Pharmacy will print monthly MARs. Pharmacy will not print new MARs for new medication orders.
- If there is no space available on the MAR sheets printed by the Pharmacy, you can print a blank 31-day MAR and manually enter the new medication.

End of Workbook

You will now complete Key Learning Review. Please contact your instructor for this exercise.