SELF-GUIDED PRACTICE WORKBOOK [N51-A]
CST Transformational Learning

WORKBOOK TITLE:

Allied Health: General

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	**4 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 different learning activities at your own pace
Key Learning Review	■ At the end of the session, you will be required to complete a Key Learning Review ■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios

Using the 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 necessarily the actual workflow
- An attempt has been made to ensure scenarios are as clinically accurate as possible. However, many disciplines are represented by Allied Health. Some scenarios and discipline-specific functionality may not align perfectly with your role
- Some clinical scenario details have been simplified for training purposes
- Some screenshots may not be identical to what is seen on your screen and are meant to demonstrate an approximate view
- Follow all steps to be able to complete activities
- If you have difficulty, get the attention of the instructor (e.g. raise your hand or make eye contact) and they can attend to you
- Ask for assistance whenever needed

PATIENT SCENARIO 1 – Patient List

Learning Objectives

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

- Review how to create a Departmental View list
- Create a Location Patient List
- Create a Custom Patient List
- Find patients on your Location Patient List and move them onto your Custom Patient List

SCENARIO

You arrive at the unit want to see which patients you will be caring for today. You begin by logging in and reviewing patients that are under your care for your shift.

As an Allied Health Clinician you will be completing the following activities:

- Set-up a Location Patient List
- Create a Custom Patient List

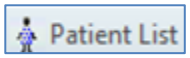
Activity 1.1 – Set Up a Location Patient List

1

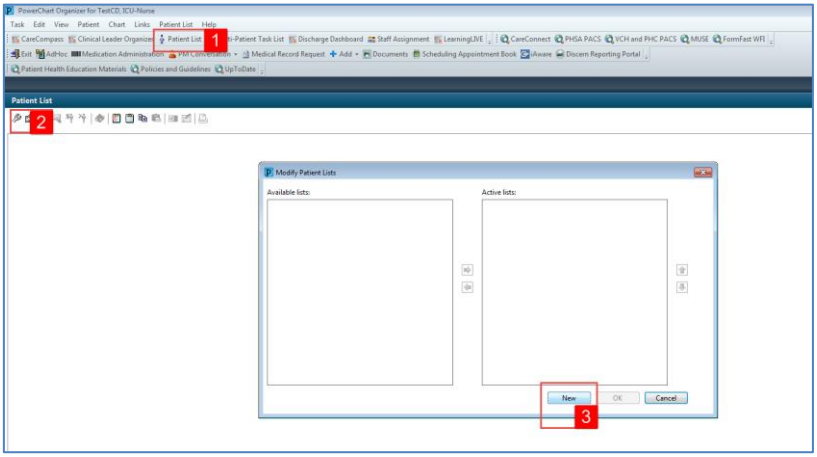
Once you have logged into the system you will see the **Multi-Patient Task List** (**MPTL**).

Before you can use the MPTL you will need to set-up a **Patient List**. A **Patient List** is a view of all the patients that meet a common chosen criterion. For example, some of the possible types of lists include a location list, an assignment list, or a custom list.

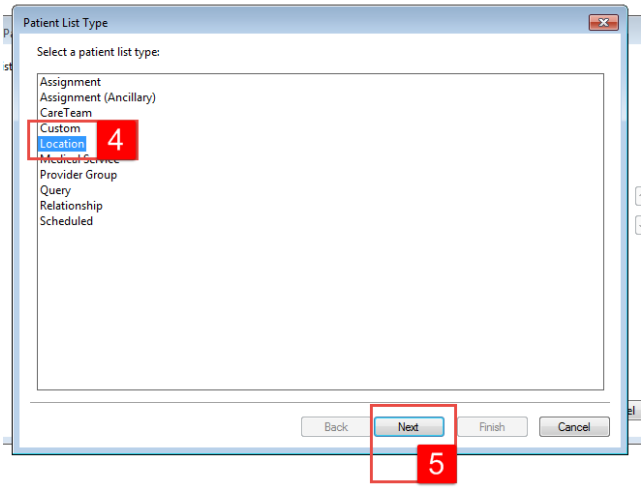
At the start of your first shift (or when working in a new location), you will create a **Location Patient List** that will consist of all patients assigned to your unit.

1. Select the **Patient List** 

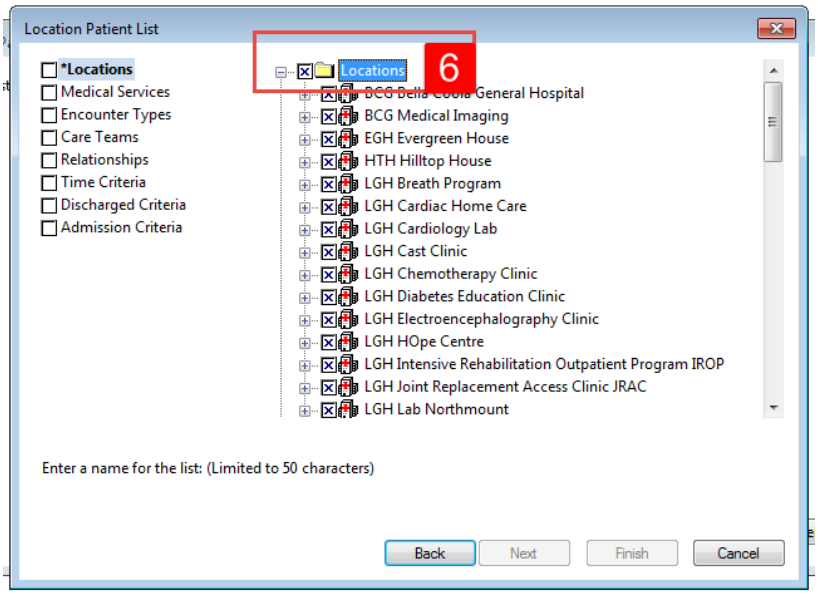
from the **Toolbar** at the top of the screen.
2. The screen will be blank. To create a location list, click the **List Maintenance** icon  .
3. Within the **Modify Patient Lists** window, select **New** in the bottom right corner.



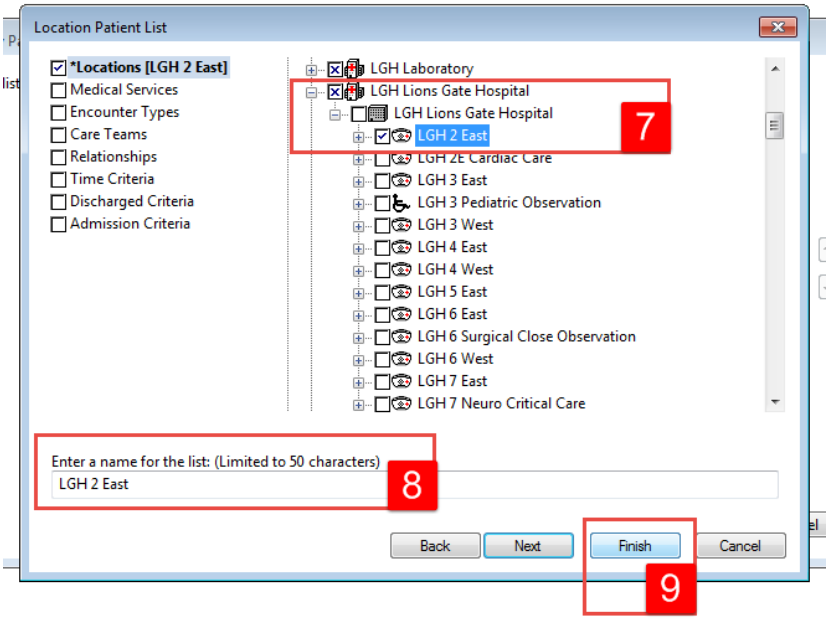
4. From the **Patient List Type** window select **Location**.
5. Click **Next**



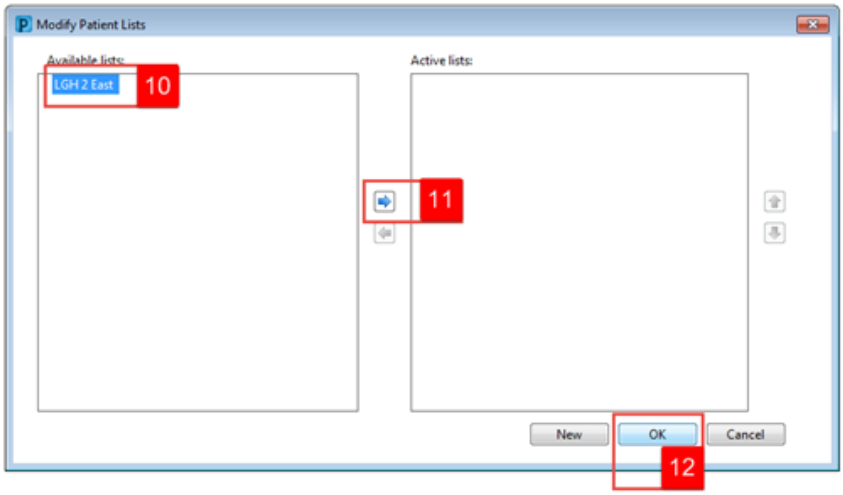
6. In the **Location Patient List** window, a location tree will be on the right hand side. Expand the list of locations by clicking on the **tiny plus** [+] sign next to **Locations**.



7. Scroll down until you find the location assigned to you. (You may need to further expand a facility to select your specific unit. To select check the box next to the unit name.
8. All patient lists need a name to help identify them. Location lists are automatically named for the location you select.
9. Click **Finish**



10. In the **Modify Patient Lists** window select the **Location** list you've created.
11. Click the **blue arrow** icon  to move the **Location** to the right, under **Active Lists**.
12. Click **OK** to return to **Patient Lists**. Your Location list should now appear.



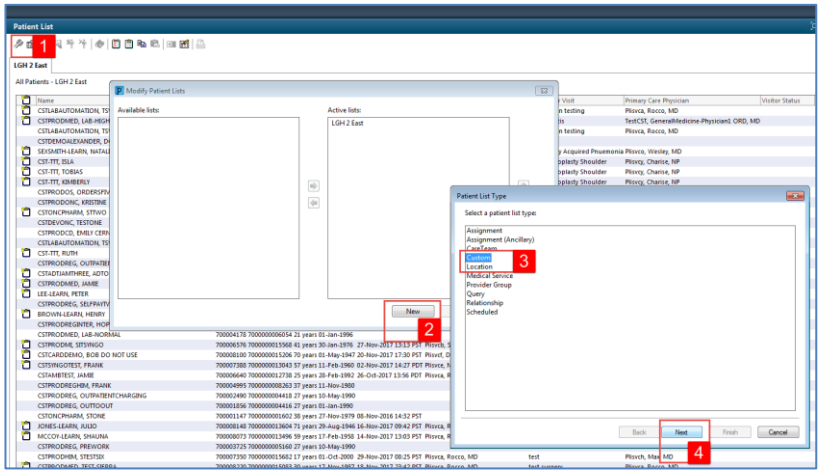
Key Learning Points

- Patient List can be accessed by clicking on the Patient List icon in the Toolbar.
- You can set up a Patient List based on location.

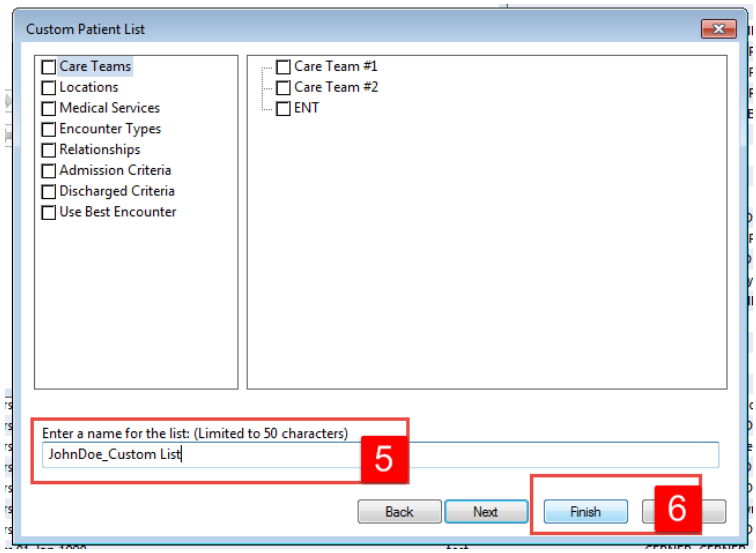
Activity 1.2 – Create a Custom Patient List

1 Next, you need to create a **Custom List** that will contain only the patients that you are covering. Patients in custom Lists are added and removed manually.

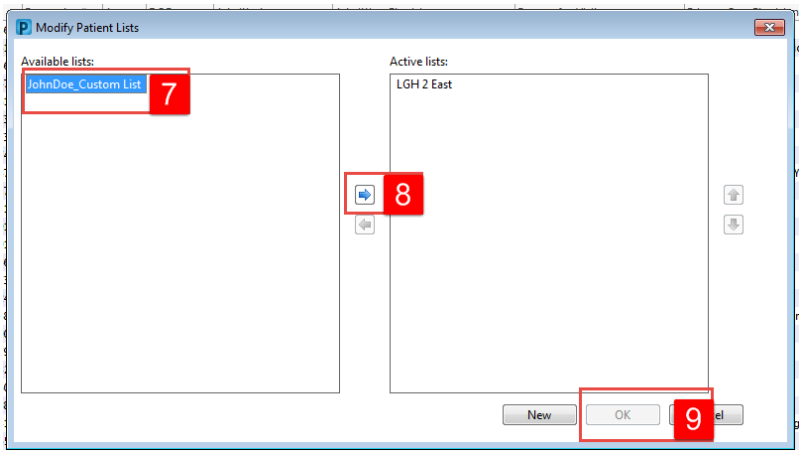
1. To create a **Custom List**, click the **List Maintenance** icon in the **Patient List**
2. Click **New** in the bottom right corner of the **Modify Patient Lists** window
3. From the **Patient List Type** window, select **Custom**
4. Select **Next**



5. **The Custom Patient List** window opens. **Custom Lists** need a unique name. Type in a name for the list = *YourName_Custom* (for example Sara_Custom).
6. Click **Finish**

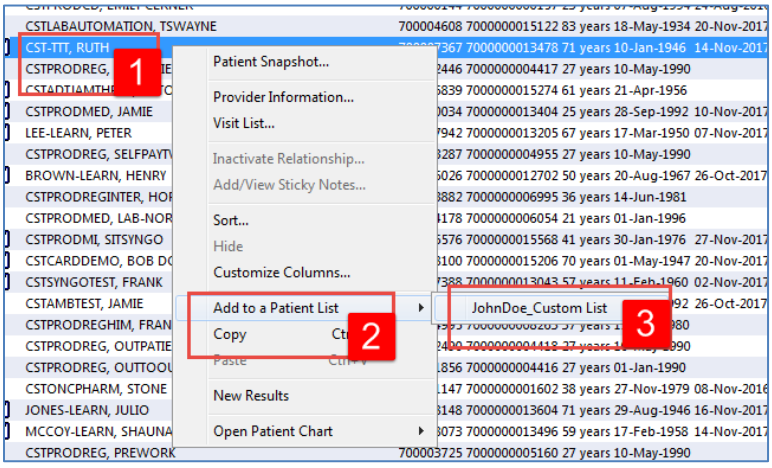


7. In the **Modify Patient Lists** window select your newly created **Custom List**
8. Click the **blue arrow** icon  to move your **Custom List** to the right, under **Active Lists**
9. Click **OK**

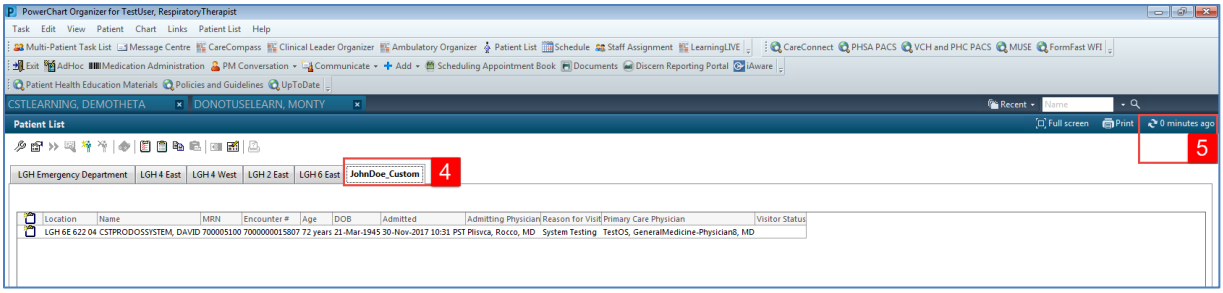


2 At the beginning of a shift and with any assignment changes, you will need to add patients from your location list to your custom list. To do this:

1. First, find your patient on your **Location List**. Right-click your **patient's name**.
2. Hover your cursor over **Add to a Patient List**
3. Select **YourName_Custom List**



4. Navigate to your custom list by clicking on **YourName_Custom** tab. The tab will be empty.
5. Click the **Refresh** icon  to refresh your screen. Now your patient will appear in your **Custom List**. Please ensure the patient you have just added to your custom list is the patient assigned to you today.



Note: You can remove a patient from your custom list by selecting the patient and clicking the Remove Patient icon .

Key Learning Points

- You can create a Custom List that will only consist of the patients that you are caring for
- Patients are added and removed from Custom Lists manually

PATIENT SCENARIO 2 – Multi-Patient Task List

Learning Objectives

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

- Set up Multi-Patient Task List (MPTL)
- Review and complete patient tasks in MPTL
- Establish a relationship with a patient

SCENARIO

You will use the **Patient List** and **Multi-Patient Task List** (**MPTL**) to identify your patients and help organize your day.

As an Allied Health Clinician, you will complete the following activities:

- Set up your view of the **Multi-Patient Task List**
- Review MPTL functionality
- Review patient tasks
- Document a patient task as complete

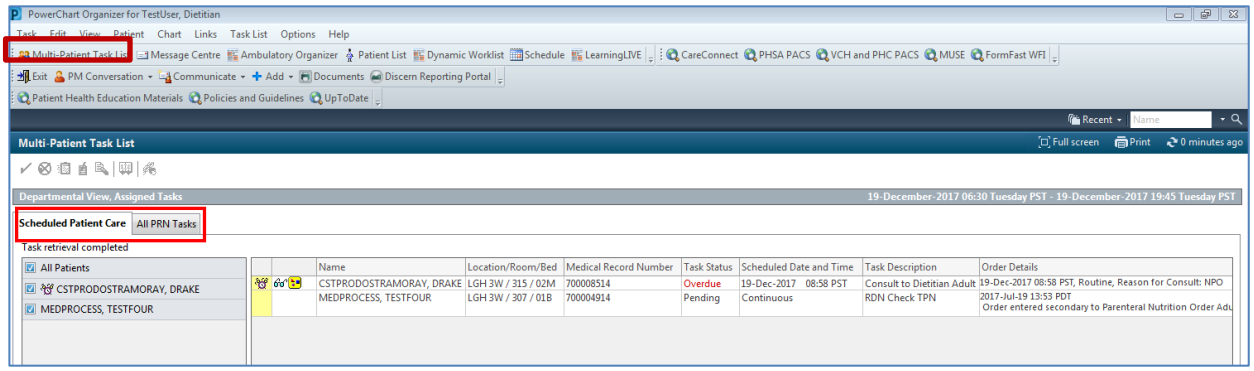
Activity 2.1 – Set up your view of the Multi-Patient Task List

1 As an Allied Health Clinician, the first page you saw upon logging into the Clinical Information System (CIS) was the **Multi-Patient Task List (MPTL).** Navigate there now by clicking on the Multi-Patient Task List button on the toolbar.

The **MPTL** displays specific tasks for multiple patients. Tasks are activities that need to be completed for the patient. Tasks are generated by certain orders or rules in the system and show up in a list format to notify you to complete specific patient care activities. They are meant to supplement your current paper to-do list and highlight activities that are outside of regular care.

Note: Not all orders create tasks. Examples of tasks include orders for consult, important communications and specific therapies or treatments.

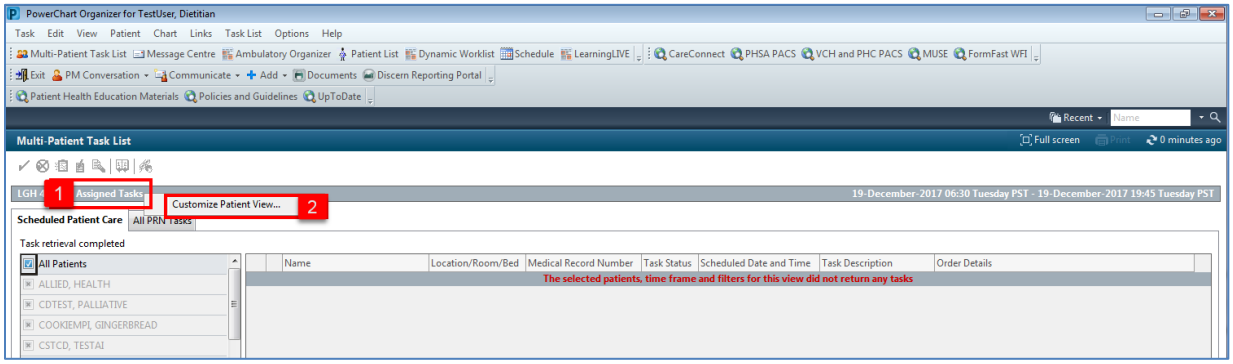
The **MPTL** for Allied Health may have more than one tab. Tasks will fall into one of the available task categories (tabs).



2 You will use a location based **Patient List** when working on your unit/location. It will be important to reference the steps listed below for when you need to set up a location based **Patient List.**

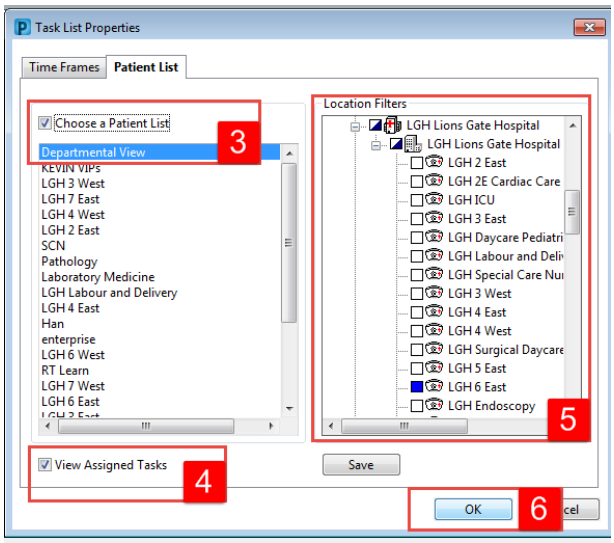
The first time you log in, you will need to set up the **MPTL**. To do this you need to select the appropriate **Patient List** and **Time Frame** to display. This will need to be done for each tab.

1. Right-click directly on the words **Assigned Tasks** in the grey information bar.
2. Select **Customize Patient View**.



Within the **Task List Properties** window:

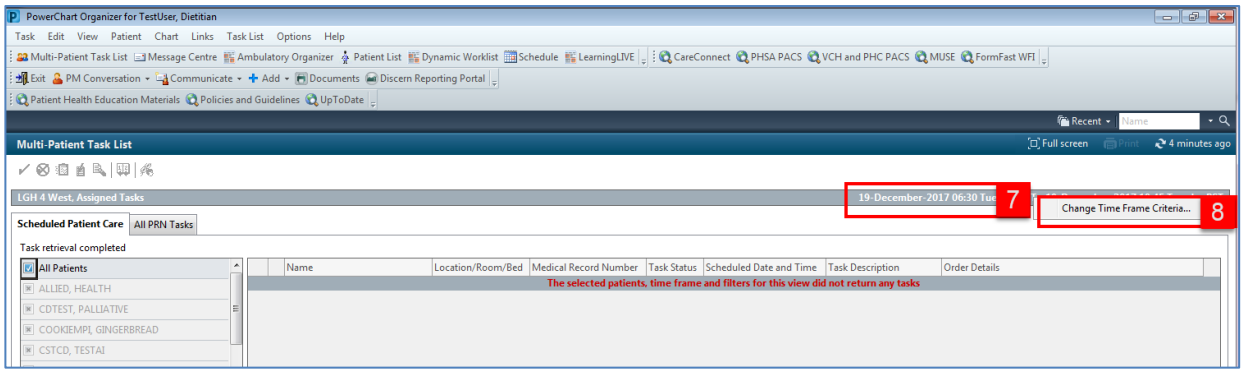
3. In the **Patient List** tab, select **Choose a Patient List** and select **Departmental View**
4. Ensure **View Assigned Tasks** is checked as this will ensure tasks display on your **MPTL**.
5. Select the **appropriate location** using the location filter (use the + symbol to expand the location tree until you find the desired unit).
6. Click **OK.**



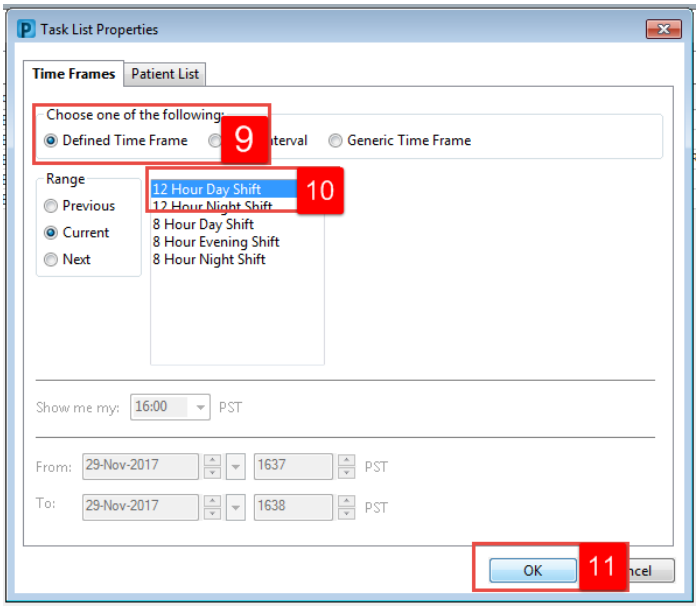
After selecting the appropriate Patient List you need to set up the **Defined Time Frame**.

To select appropriate **Time Frame** for your MPTL:

7. Right-click directly on the words describing the **date range** in the far right hand side of the grey information bar
8. Select **Change Time Frame Criteria**. This will open the **Task List Properties** window.



9. In the **Time Frames** tab select **Defined Time Frame** for your shift.
10. Select **12 Hour Day Shift**.
11. Click **OK**. The **Scheduled Patient Care** tab within the MPTL is now set to the correct patients and their tasks.



Note: You will need to repeat these steps for each patient list tab to set up the MPTL.

3 For the purposes of training, you will practice setting up your view of the Multi-Patient Task List (MPTL) with a different Patient List (**Custom List**) today than the one you will be using outside of this training.

Note: It is recommended for you to use **Departmental View** at Go-Live, however for training purposes, we will use the **Custom List**.

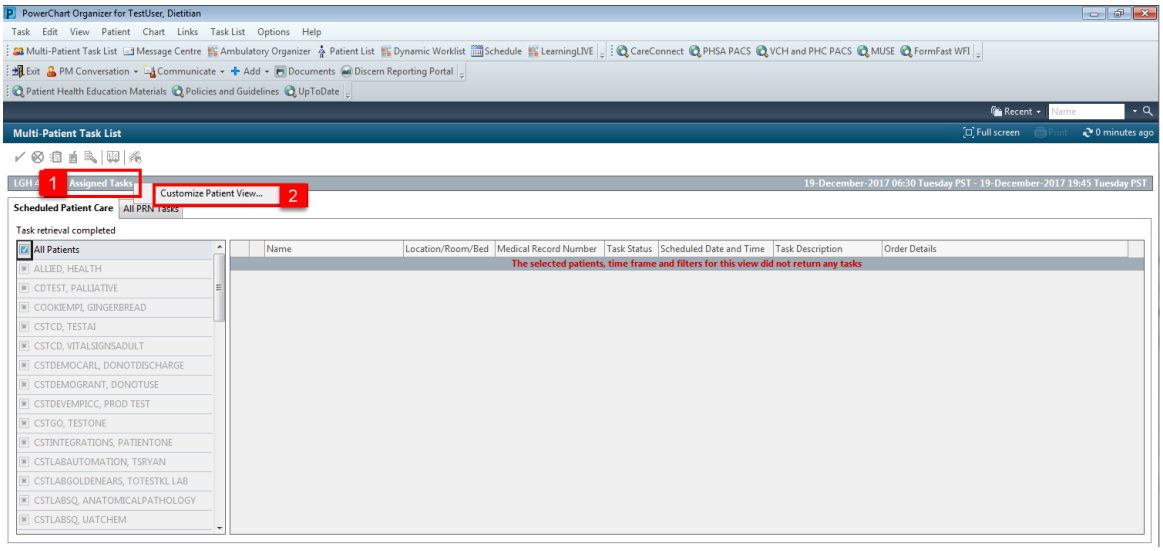
Departmental View: Used when you are looking at an entire department. Discharged patients will stay on this list for a short while allowing you to easily find them if you did not finish your documentation.

Custom List: Used when you have a few patients assigned to you. This is your own personal list and patients will stay on it until you remove them from the list.

Outside of training, the first time you log in, you will need to set up the **MPTL**. To do this you need to select the appropriate **Patient List** and **Time Frame** to display. This will need to be done for each tab.

Follow these steps to set up the appropriate patient list**:**

1. Right-click directly on the words **Assigned Tasks** in the grey information bar.
2. Select **Customize Patient View**



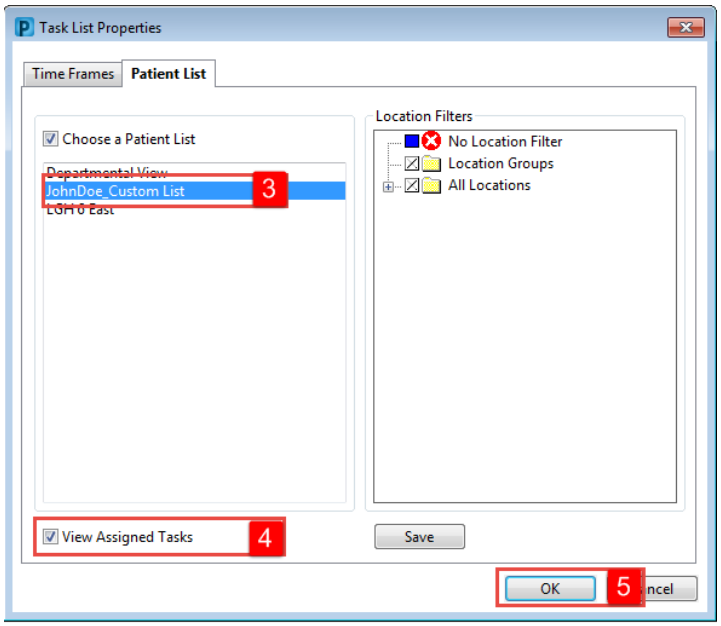
Within the **Task List Properties** window:

3. In the Patient List tab, select **Choose a Patient List** and select **YourName_Custom List**

   Note: Outside of training, if you want to create a custom list to help you track your current patients, it is recommended you first look at a location based list so that you don't miss any tasks. We are using Customized list in this training for simplicity.

4. Ensure **View Assigned Tasks** is checked as this will ensure tasks display on your **MPTL**.

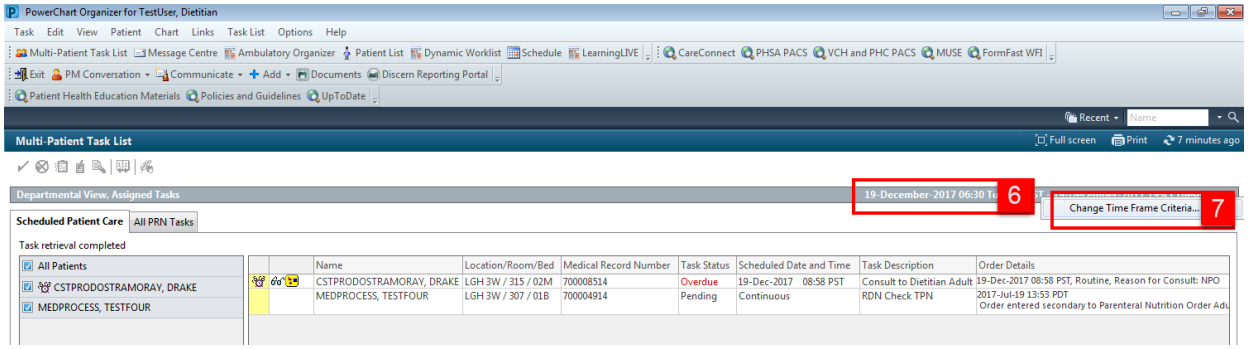
5. Click **OK**



After selecting the appropriate Patient List you need to set up the **Defined Time Frame**.

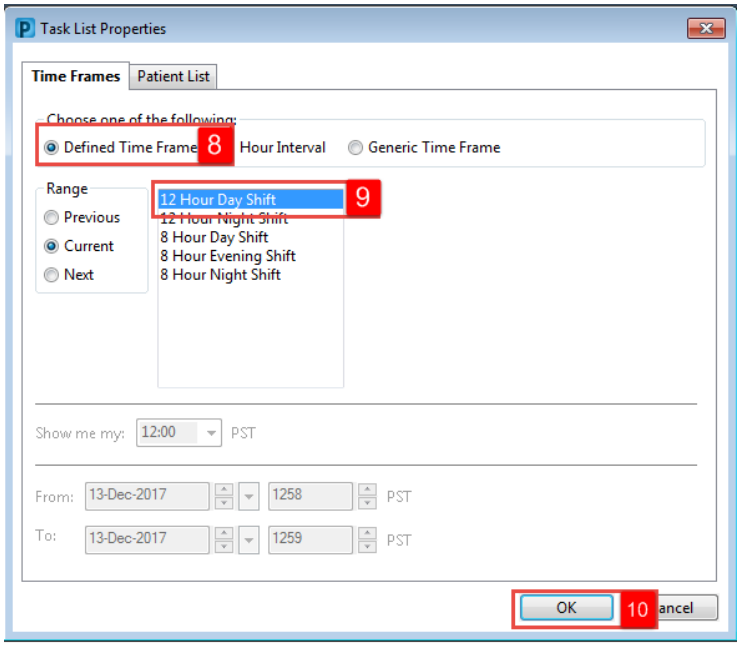
To select appropriate **Time Frame** for your MPTL:

6. Right-click directly on the **date range** words in the far right hand side of the grey information bar
7. Select **Change Time Frame Criteria**.



The **Task List Properties** window opens.

8. In the **Time Frames** tab select **Defined Time Frame** for your shift.
9. Select **12 Hour Day Shift**.
10. Click **OK**. The **Scheduled Patient Care** tab within the MPTL is now set to the correct patients and their tasks.



Note: You must now repeat these steps for each location tab when setting up the MPTL.

In this Activity, you practiced setting up a **Custom list** in your **MPTL**. Outside of this practice, you will need to set up your **MPTL** using a location based list to appropriately show all the patients on the unit who you are caring for.

You can now proceed to the Key Learning Points section at the end of this Activity. It will be important to reference the steps listed directly below for when you need to set up a location based **Patient List.** You will use a location based **Patient List** when working on your unit/location.

Key Learning Points

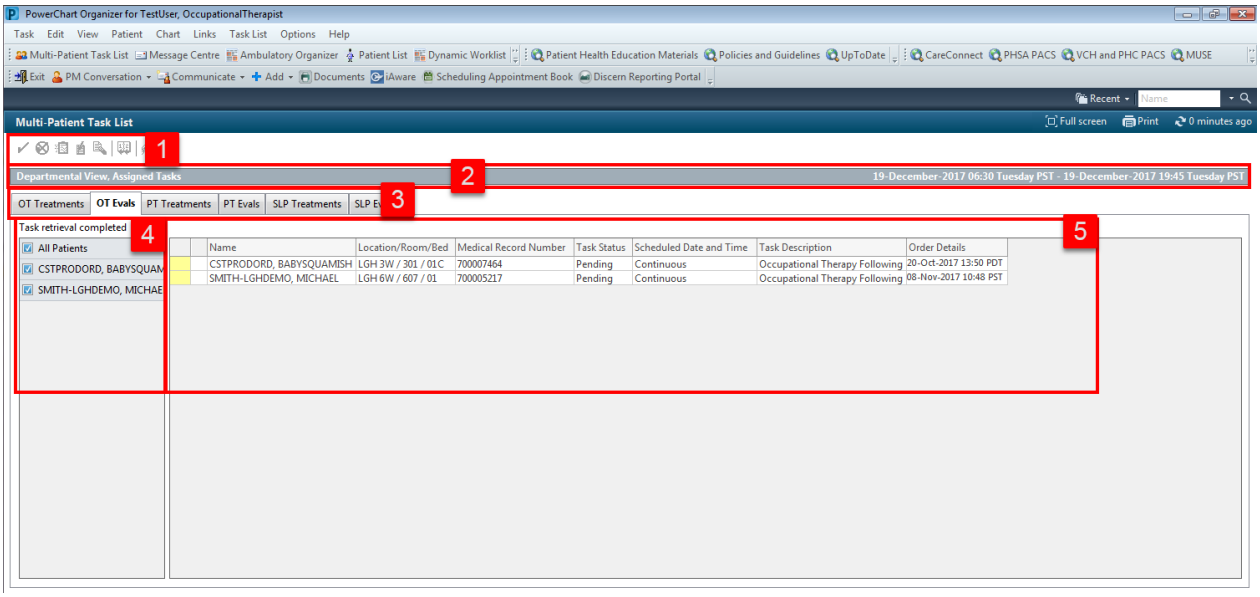
- The MPTL is a tool used to display tasks for multiple patients.
- You must select the correct patient list(s) and define the appropriate time frame in order to see assigned tasks for your patients.
- Ensure you set up the correct view for each tab in the MPTL so you can see all of your tasks.
- Click refresh to ensure you can see the most current tasks.

Activity 2.2 – Review MPTL functionality

1 On the **MPTL** you will see the following:

1. **Task list toolbar**

2. **Information bar** with name of the patient list (far left) and the set time frame (far right)
3. **Task categories** (tabs)
4. A window on the left with the patient names
5. List of patient tasks



Key Learning Points

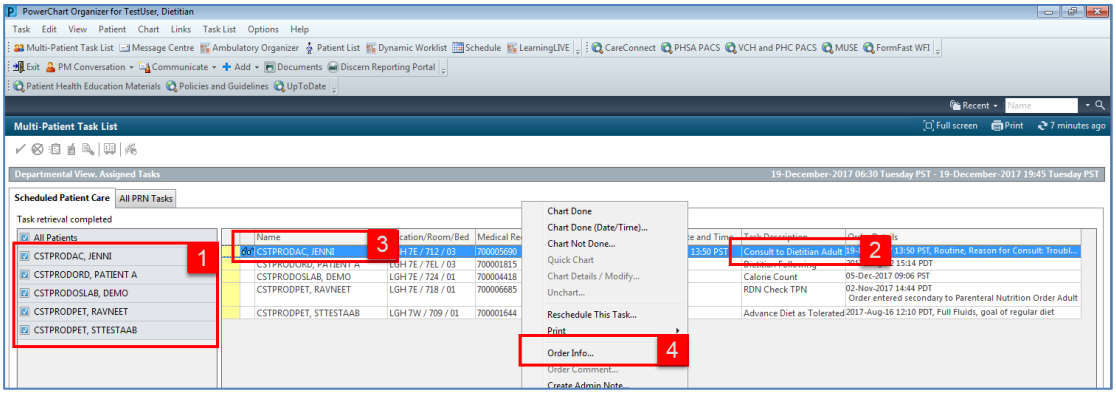
- Components of the MPTL include the Task list toolbar, Information bar, Task categories, patient name list, and List of patient tasks.

Activity 2.3 – Review Patient Tasks

1 After setting up the **MPTL** you can see the patients that are under your care. Let's locate a patient and review one of their tasks.

1. Under the window with the patient names, locate the correct patient and click on [**Patient Name**].
2. Review tasks associated with the patient and locate your profession's consult task (e.g. **Consult to Dietitian Adult** task.
3. Right-click on your profession's consult task (e.g. **Consult to Dietitian Adult)**.
4. Select **Order Info…** to learn more about the order.

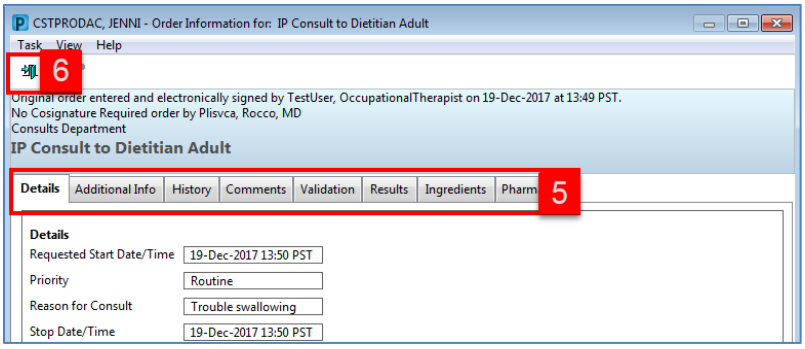
Note: If you do not see your profession's task, please navigate to the other available MPTL tabs.



The **Order Information** window opens.

5. Click the **different tabs** to review the order information. The order information will have the Reason for Consult which is mandatory for all consults.
6. Click the **Exit** icon when you finish reviewing the information.

   Note: When the blue exit door is available within a pop up window, use it instead of the Red X close window button. If you select this on the main screen you will exit right out of the application.



Key Learning Points

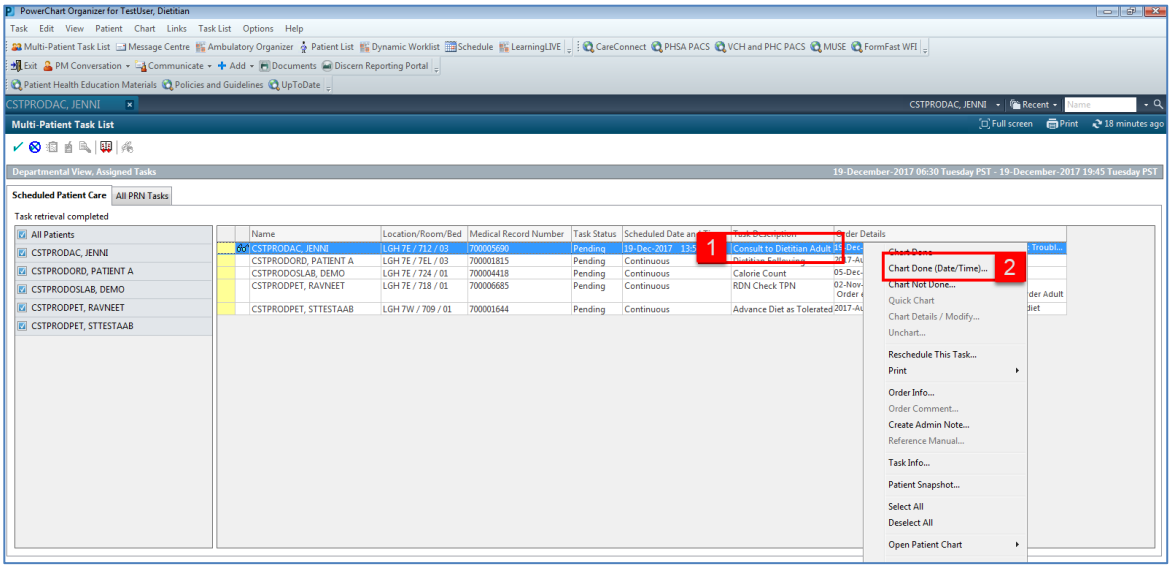
- You can select specific patients for whom you would like to review tasks in the MPTL
- Order Information will provide more details about the consult order

Activity 2.4 – Document a Patient Task as Complete

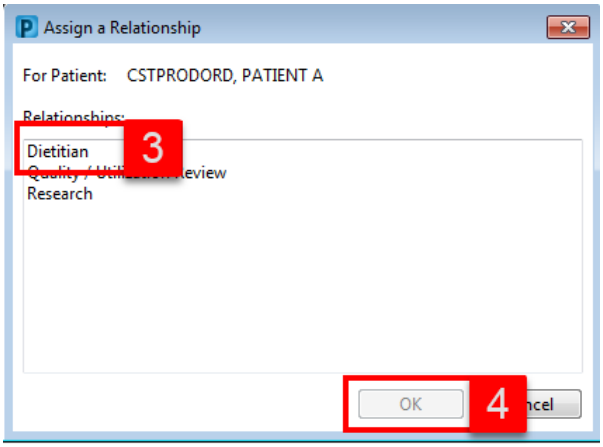
1 After you review your patient tasks and perform them, it is important to complete the appropriate documentation within the CIS. Documenting that a task has been done will allow the task to be cleared and will help prevent your **MPTL** from being cluttered with tasks that have already been completed.

Let's document your consult task for your patient as complete in the **MPTL**.

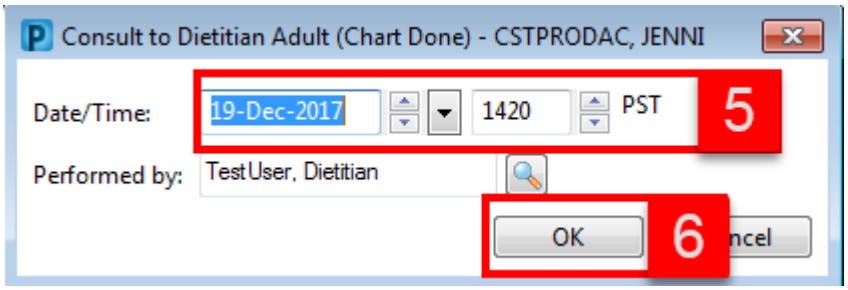
1. On the **list of patient tasks**, locate the correct patient (**[patient's name]**) and right click on **consult task**.
2. Select **Chart Done (Date/Time)**.



3. You will be asked to establish a relationship with the patient before you can open the patient's chart or proceed with completing a task. Select your profession's relationship (e.g. **Dietitian**) in the **Assign a Relationship** window.
4. Click **OK**

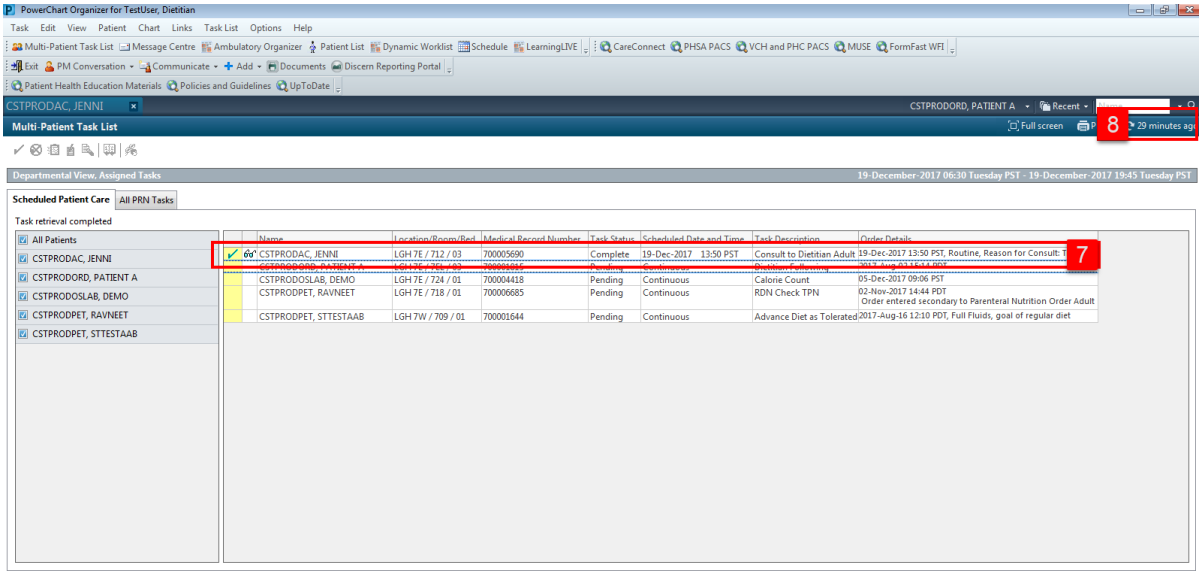


5. Review the **Date/Time** cells in the **Consult to** window (e.g. **Consult to Dietitian** (**Chart Done**) and adjust details as needed**.**
6. Click **OK**



7. The task now will now have a **Chart Done** icon  next to it. (Only complete one for this exercise)

8. Click the **Refresh** icon  and the task will fall off the task list.



Key Learning Points

- It is important to document completed tasks as done to clear them from your MPTL

PATIENT SCENARIO 3 – Patient Chart Overview

Learning Objectives

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

- Access patient chart and review information including Patient Summary, Orders, Results Review, Documentation, and more

SCENARIO

After setting up the MPTL you can access your patient's chart.

As you will be completing the following activities:

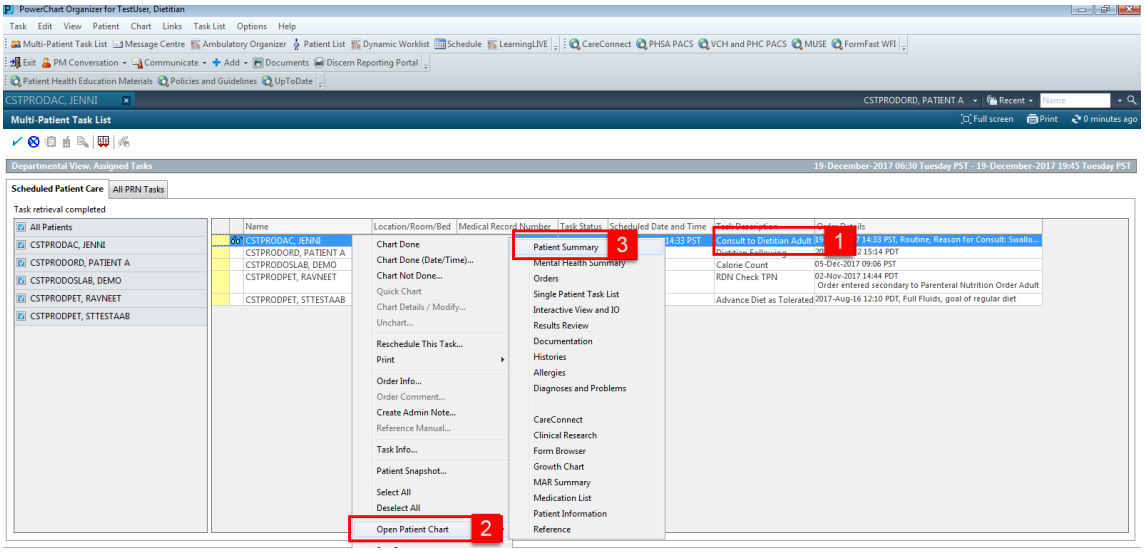
- Review patient information
- Review Documentation
- Review Results using Results Review
- Become familiar with the Single Patient Task List (SPTL)
- Review Allergies

Activity 3.1 – Review Patient Information

1

After reviewing your patient's tasks, you will access the patient's chart directly from the MPTL screen.

1. Right click [**Patient Name**]
2. Select **Open Patient Chart**
3. Select **Patient Summary**



2

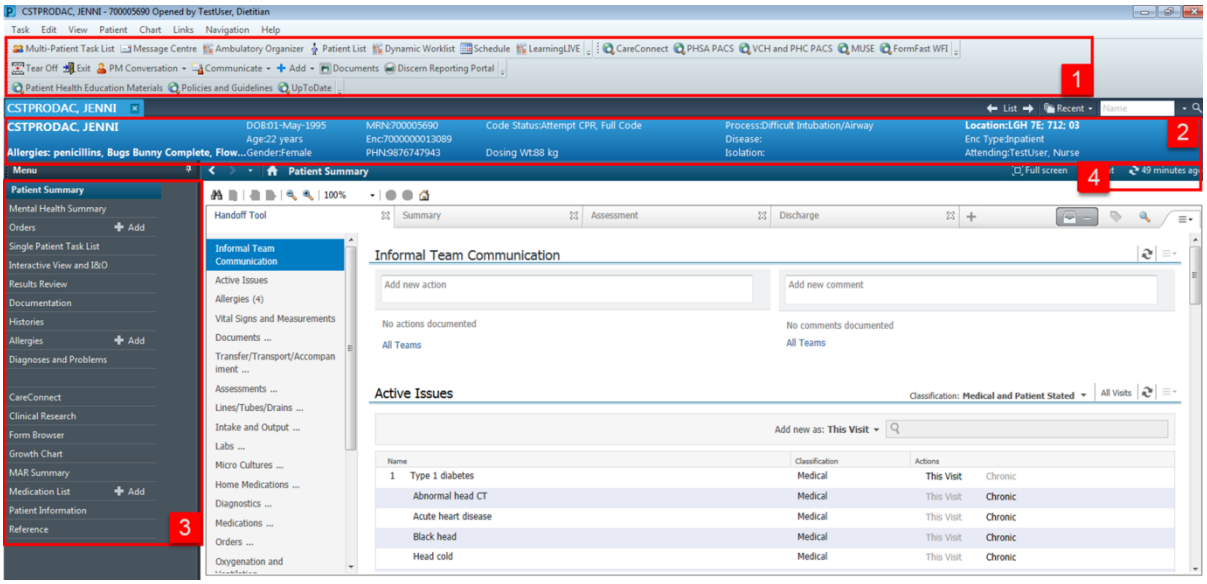
The patient's chart is now open to the **Patient Summary** or the **Mental Health Summary** page depending on your profession.

Before we proceed any further, let's go through an overview of the general 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 (CIS).
2. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information displayed includes:
   - Name
   - Allergies
   - Age, date of birth, etc.
   - Encounter type and number
   - Code status
   - Weight
   - Process, disease and isolation alerts
   - Location of patient
   - 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-based patient chart. Examples of sections included are **Orders**, **Medication Administration Record Summary** (**MAR Summary**) and more.

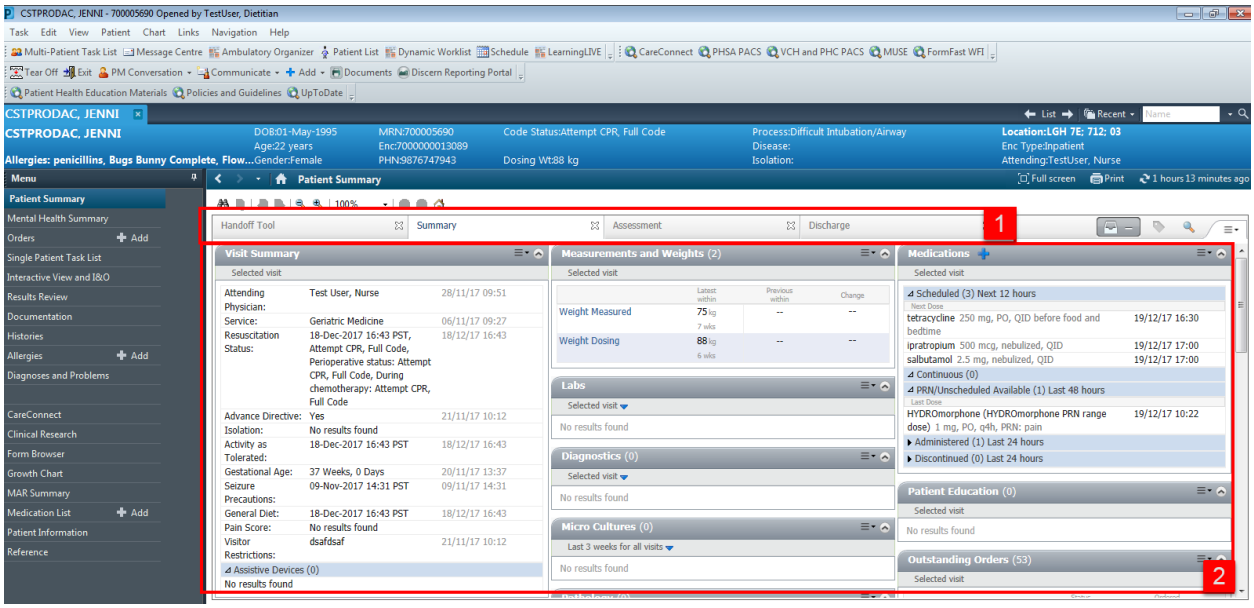
4. The **Refresh** icon updates the patient chart with the most current entries. The chart does not automatically update. As other clinicians may be accessing and documenting in the patient chart simultaneously, it is important to click **Refresh** frequently. Each page refreshes separately so you must refresh each page. When in doubt, click Refresh.



Note: If you Refresh while in the middle of an entry before completing (i.e. if you have not yet clicked on **Sign**, **Complete**, **OK**, or whatever is required for completion), your entry will not be updated and saved. You have to complete your entry before refreshing to save it.

3 Now that you have been introduced to some key parts of the general screen, let's look more closely at the **Patient Summary View** or the **Mental Health Summary View**.

1. There are different tabs available to access information: **Handoff Tool, Summary, Assessment,** and **Discharge.** Click on the different tabs to see a quick overview of the patient.
2. **Handoff Tool, Summary, Assessment,** and **Discharge** tabs display a summarized view of patient information organized into various components. Information that displays is populated from other parts of the patient chart and includes nursing documentation, RT documentation, lab results, and medication orders.



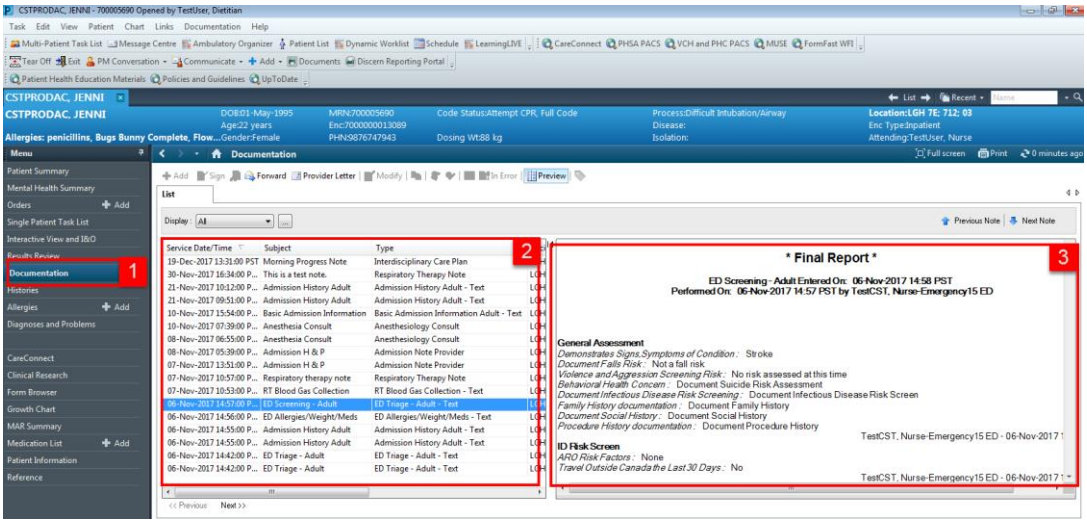
Key Learning Points

- 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 a paper-based chart
- The Summary tab in the Patient Summary view provides a summarized view of patient information pulled from other parts of the chart
- The Refresh icon should be used regularly to view the most current information

Activity 3.2 – Review Documentation

1 Documentation can include provider notes, nurse notes, clinician notes, completed forms, assessments, and more.

1. Click on **Documentation** in the **Menu List** to open the screen.
2. Select the document that you want to review under the **List** box and the document will open in the window to the right.
3. Select any document in the **List** box and review what was documented about the patient.



Key Learning Points

You can review all documents placed on a patient chart. Documents may include notes by nursing or another clinician, a physician consult note, a physician daily rounding note, or even a diagnostic imaging report. Each document has a title, an author, and a date.

Activity 3.3 – Review Results Using Results Review

1

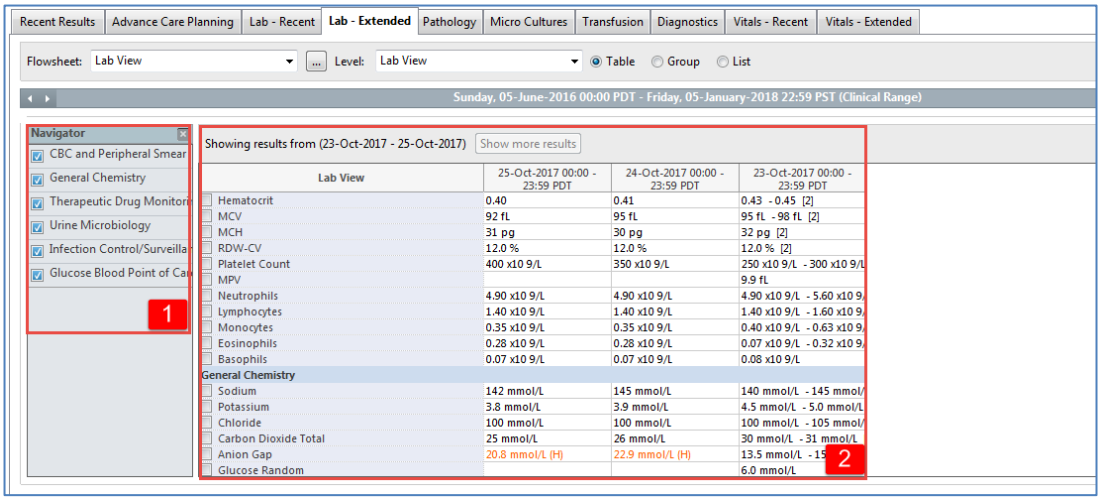
As explained previously, the **Menu** on the left side of your screen contains different sections of the patient's chart. We will explore some of the Menu sections in the following Activities. Let's begin with **Results Review**.

Throughout your shift, you will need to review your patient's results. One way to do this is to navigate to **Results Review**.

Results are presented using flowsheets. Flowsheets display clinical information recorded for a person such as labs, vital signs, cultures, transfusions and diagnostic imaging and more.

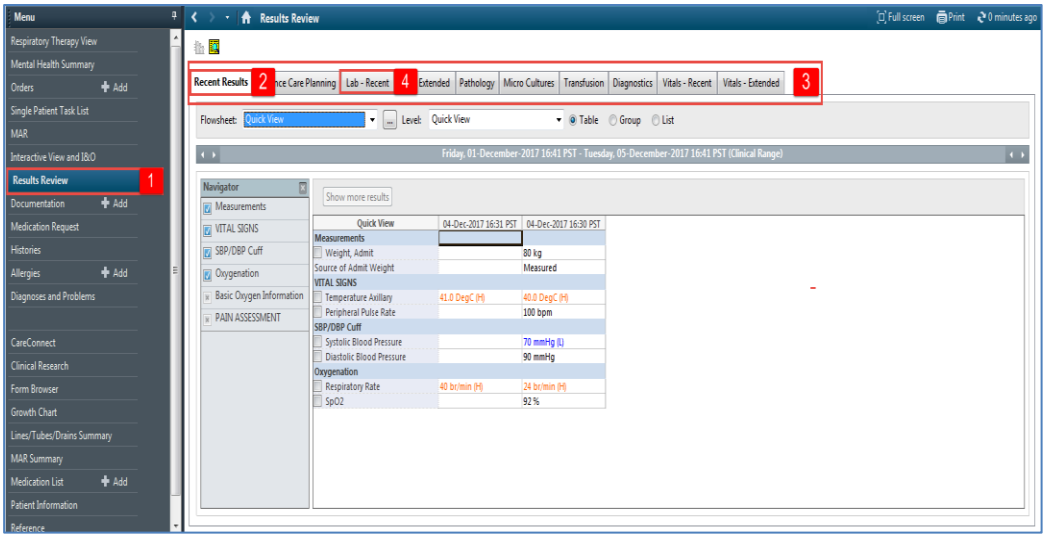
Flowsheets are divided into two major sections.

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**.



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

Blood Gases	
pH Capillary	7.29 (L)
pCO2 Capillary	37 mmHg
pO2 Capillary	70 mmHg (L)
HCO3 Capillary	15 mmol/L (L)
Base Excess Capillary	3 mmol/L *
Ventilation Capillary	Nasal Prongs
Oxygen Administered Capillary	0.50
General Chemistry	
Glucose Random	5.5 mmol/L
Lactate	3.7 mmol/L (H)
Bilirubin Direct	2 umol/L
Urine Microbiology	
Urine Culture	
Infection Control/Surveillance	
MRSA Culture	
VRE Culture	

Note: Specific lab results may populate in different colours. Indications of the colours are listed below:

- 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 in Results Review 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
- Lab work is coloured to represent low, normal, high and critical values
- View additional details of a result by double-clicking the value

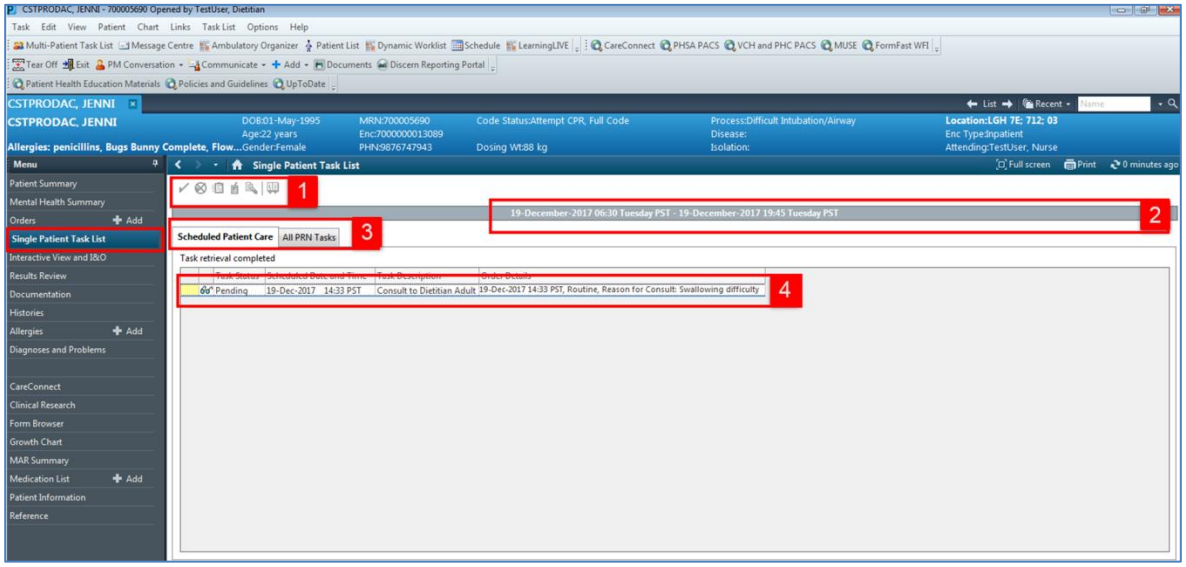
Activity 3.4 – Become familiar with the SPTL

1

The **Single Patient Task List** (**SPTL**) is accessible via the **Menu**. It displays all tasks available for the specific patient whose chart you are viewing. The tools and functionalities of the **SPTL** are similar to the **MPTL**.

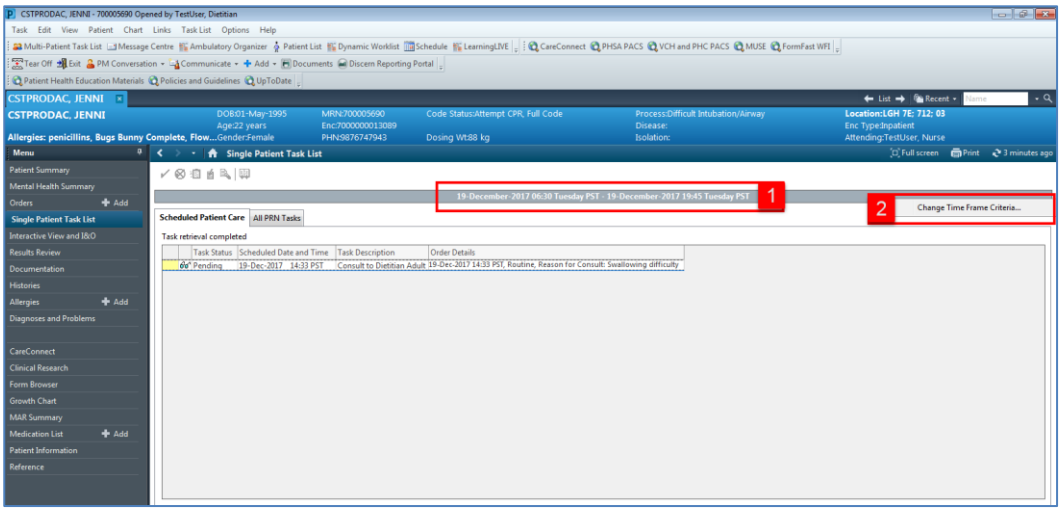
Click on the **Single Patient Task List** in the **Menu.** You will see:

1. Task List toolbar
2. Time Frame for the tasks to be displayed
3. Task Categories (Tabs)
4. List of Tasks



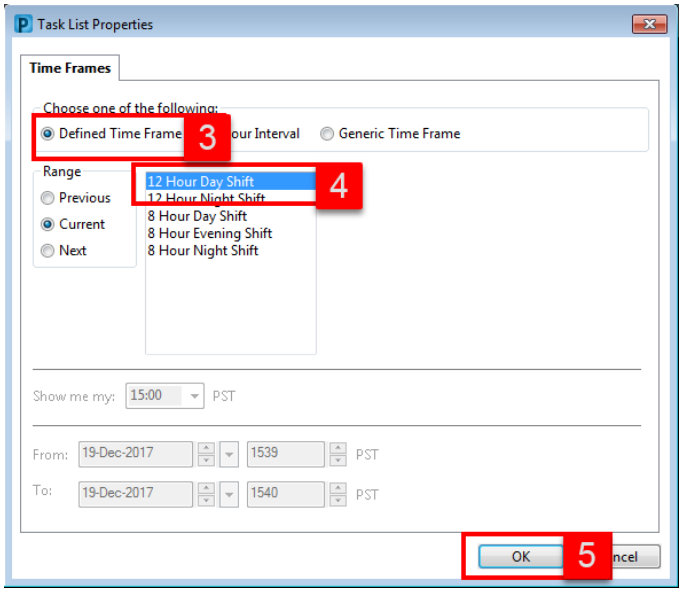
2 As with the MPTL, the **Time Frame** can be changed to the appropriate date.

1. Right-click directly on the time frame words on the grey information bar.
2. Select **Change Time Frame Criteria**.



The **Task List Properties** window opens.

3. Under the **Time Frames** tab, select **Defined Time Frame** for your shift.
4. Under **Range**, ensure **Current** is selected. Click **12 Hour Day Shift.**
5. Click **OK**. The Task Categories (Tabs) within the **SPTL** is now correctly set for your day shift.



Note: Similar to the steps outlined in the MPTL, patient tasks can be documented as complete through the SPTL. When using the SPTL however, you can only complete tasks for the patient whose chart you have open.

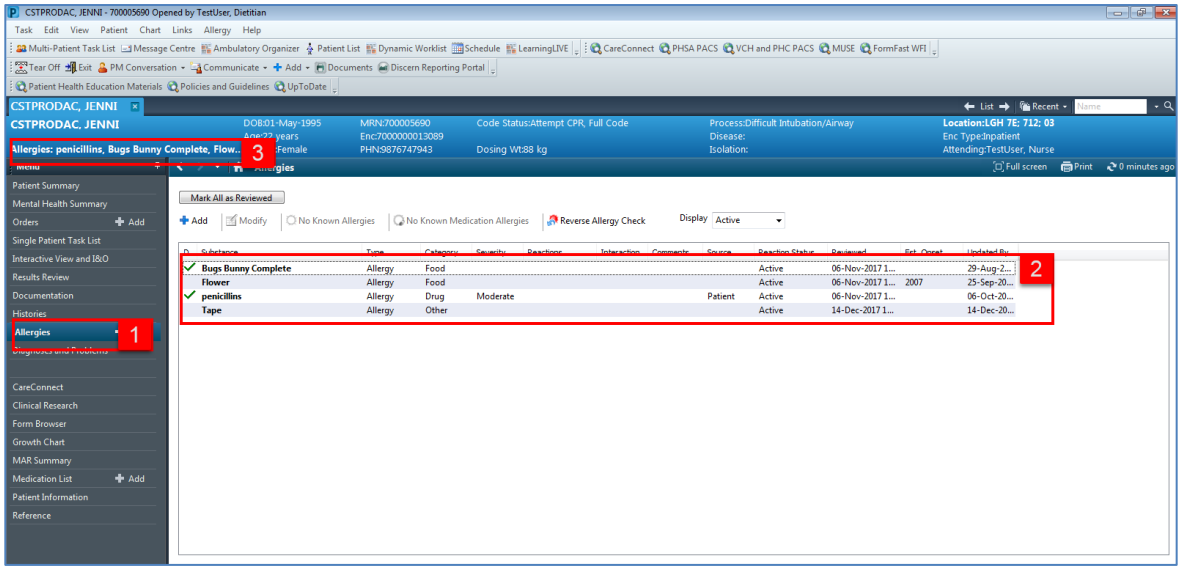
Key Learning Points

- The SPTL has similar tools and functionalities as the MPTL
- The SPTL displays tasks for the patient's chart that you have open

Activity 3.5 – Review Allergies

1 You can review allergies for a patient through the **Allergies** section under the **Menu**.

1. Click on **Allergies** in the **Menu**.
2. View the list of the patient's allergies. They will be listed from most severe to less severe. In this case, Penicillin causes a more severe reaction than Tape.
3. View the **Allergies** information in the banner bar.



Note: Allergies 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

- The Allergy section of the chart displays detailed information about a patient's allergies.
- The Banner Bar displays allergy information on the left side.

PATIENT SCENARIO 4 – Orders

Learning Objectives

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

- Review the Orders Profile and place Orders
- Complete an Order
- Review the components of a PowerPlan

SCENARIO

As an Allied Health Clinician, you will need to be able to review orders on your patient. You will also need to place orders on your patient in certain situations.

As an Allied Health Clinician, you will complete the following activities:

- Review the Orders Profile
- Place a No Co-signature Required order
- Review order statuses and details
- Place a verbal order
- Complete an order
- Review components of a PowerPlan

Activity 4.1 – Review Orders Profile

1

Throughout your shift, you will review your patient's orders. The **Orders Profile** is where you will access a full list of the patient's orders.

To navigate to the **Orders Profile** and review the orders:

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

Moving the mouse over order icons allows you to **hover to discover** additional information.

Some examples of icons are:

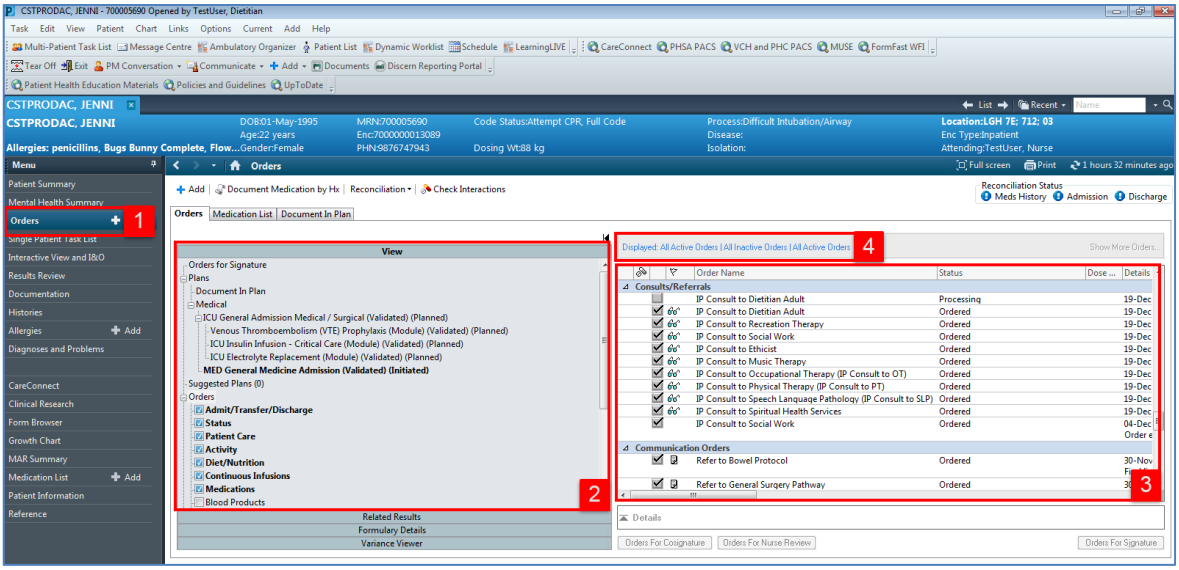
 Order for nurse to review

 Additional reference text available

 Order is part of a PowerPlan (preprinted order)

 Order requires Pharmacy verification

4. Notice the display filter default setting is set to display **All Active Orders**. This can be modified to display other order statuses by clicking on the blue hyperlink.



Key Learning Points

- The Orders Page consists of the orders view (Navigator) and the order profile
- The Orders View displays the lists of PowerPlans (preprinted orders) and clinical categories of orders
- The Orders Profile page displays All Active Orders for a patient

Activity 4.2 – Place an Order

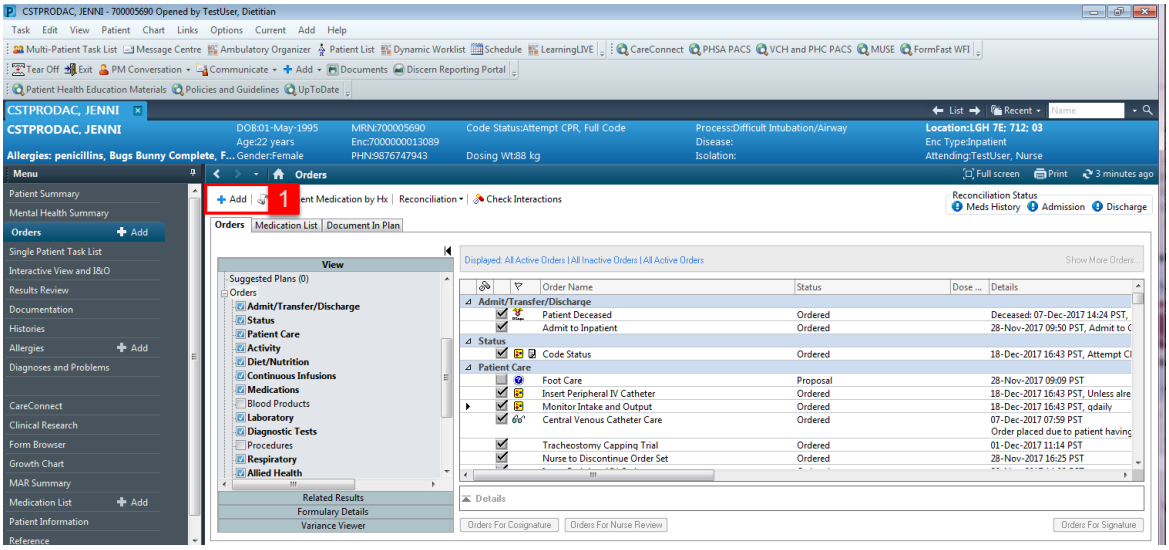
1

You can place orders according to your profession.

Once you have responded to a consult order and have seen the patient, you can place an order indicating you are following that patient. This is called a **Following Order**, e.g. Dietician Following.

Let's place a **Following** order for your patient.

1. Click **Add** + Add within the **Orders** page.

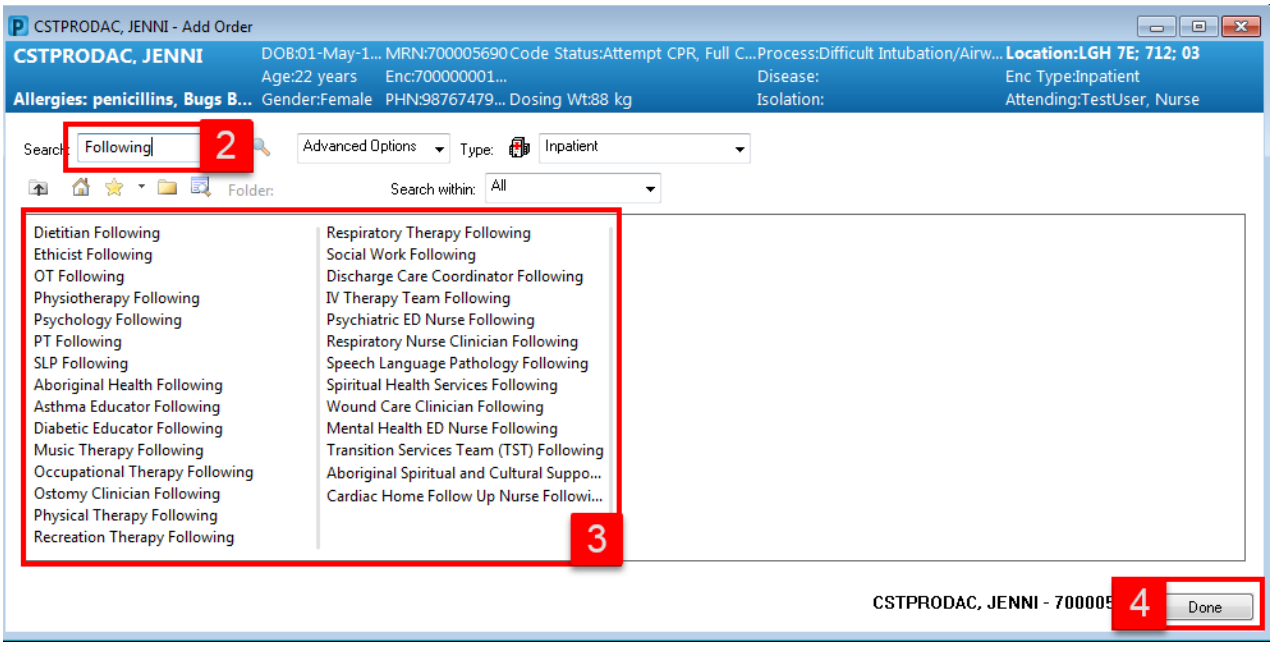


The **Add Order** window will open.

2. Type in **Search** *[Your Allied Profession] Following,* and then press Enter key.
3. Select your profession's following order (e.g. **Dietitian Following**) from the search results.

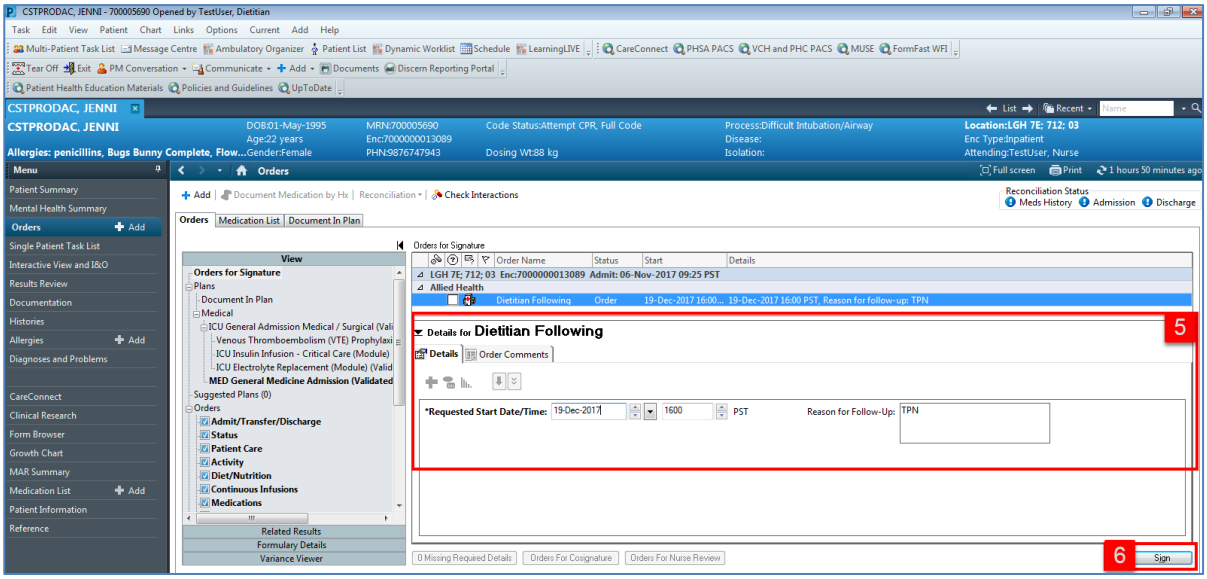
Note: You will see all following orders so be careful to select the correct one for your profession.

4. Click **Done** to close the Add Order window.

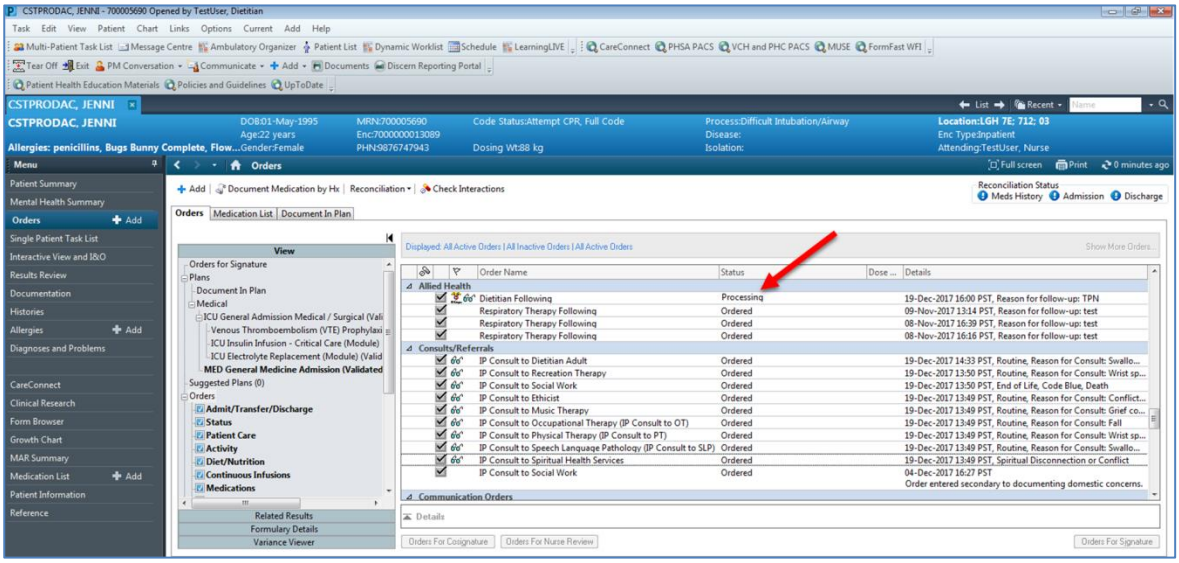


Note: This order will not prompt you to add in an ordering physician name, unlike other types of orders.

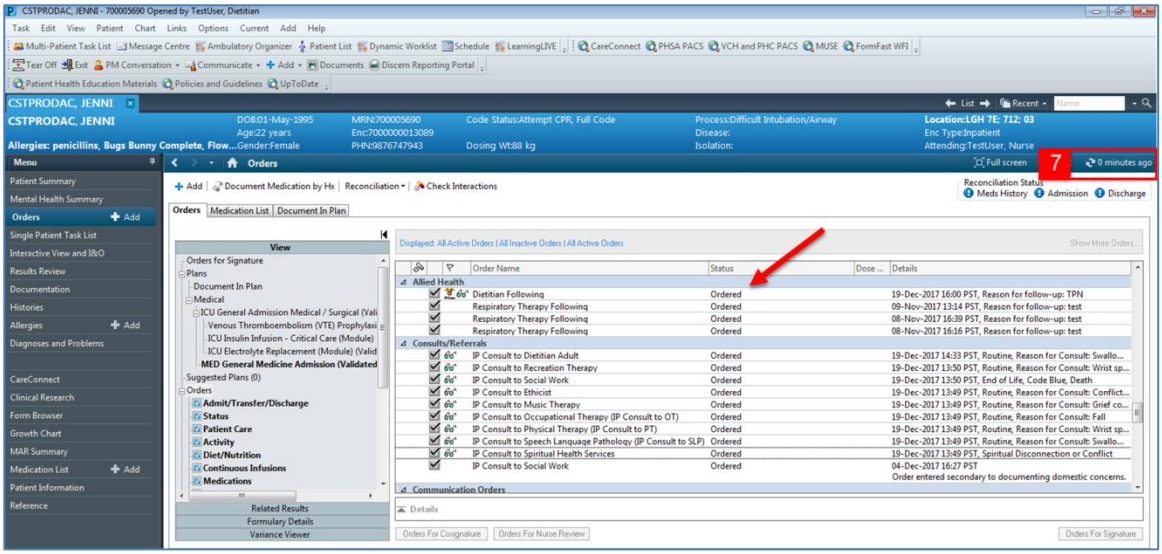
5. Review the order detail fields. Write your **Reason for Follow-Up** in the box. It is a free text box.
6. Click the **Sign** button.



The **Following** order will display in the status column of the order profile as **Processing**.



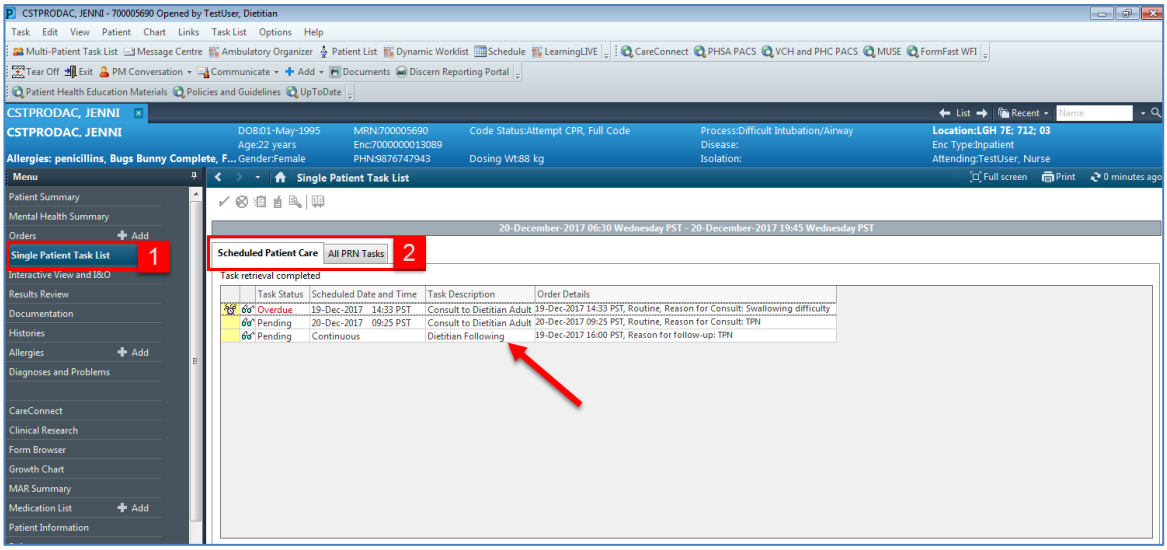
7. Click the **Refresh** icon  . and the status will change from Processing to Ordered.



2 A task associated with your newly placed patient Following order can now be found on the **Single Patient Task List** (**SPTL**) and **Multi Patient Task List** (**MPTL**).

1. Click on **Single Patient Task List** in the **Menu**
2. The **Following** task displays under one of the **SPTL** tabs (e.g. **Scheduled Patient Care** tab for Dietitians).

Note: Refresh and review all tabs in your **SPTL** to see all tasks



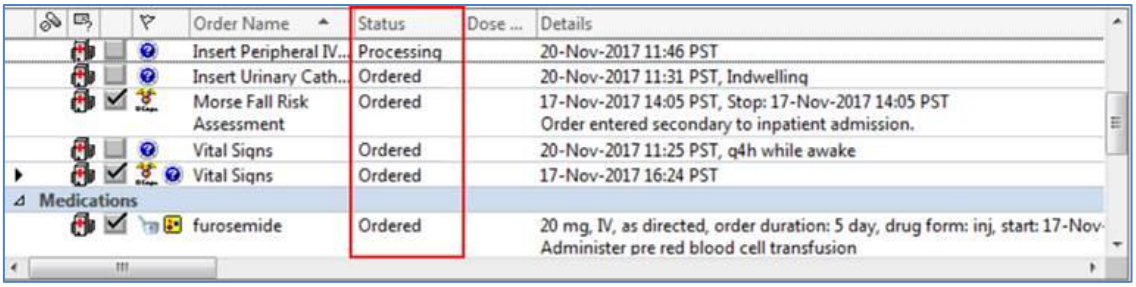
Key Learning Points

- You can place an order depending on your profession
- A Following order can be placed to show you are following patient
- Once a Following order is placed, a task will be placed on the SPTL and MPTL

Activity 4.3 – Review Order Statuses and Details

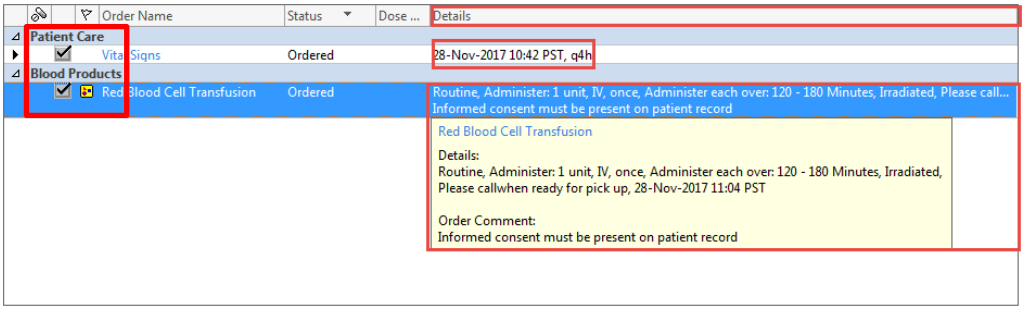
1 To see examples of different order statuses, review the image below:

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



To see examples of order details review the image below:

- Notice in the **Details** column of the **Orders Profile**
- Hover your cursor over certain order details to see the complete order information
- Note the start date and that orders are organized by clinical category



When new orders are placed in the chart, a nurse must acknowledge reviewing these new orders. If you see a **Nurse Review** icon  to the left of the order, this means the order still needs to be reviewed by a nurse. Review, in this case, means a nurse will be able to see that an order to your profession has been picked up and is being followed`. (this helps to avoid multiple referrals for the same patient). In most cases, once an order has been marked reviewed by a nurse, the icon will no longer display.

Key Learning Points

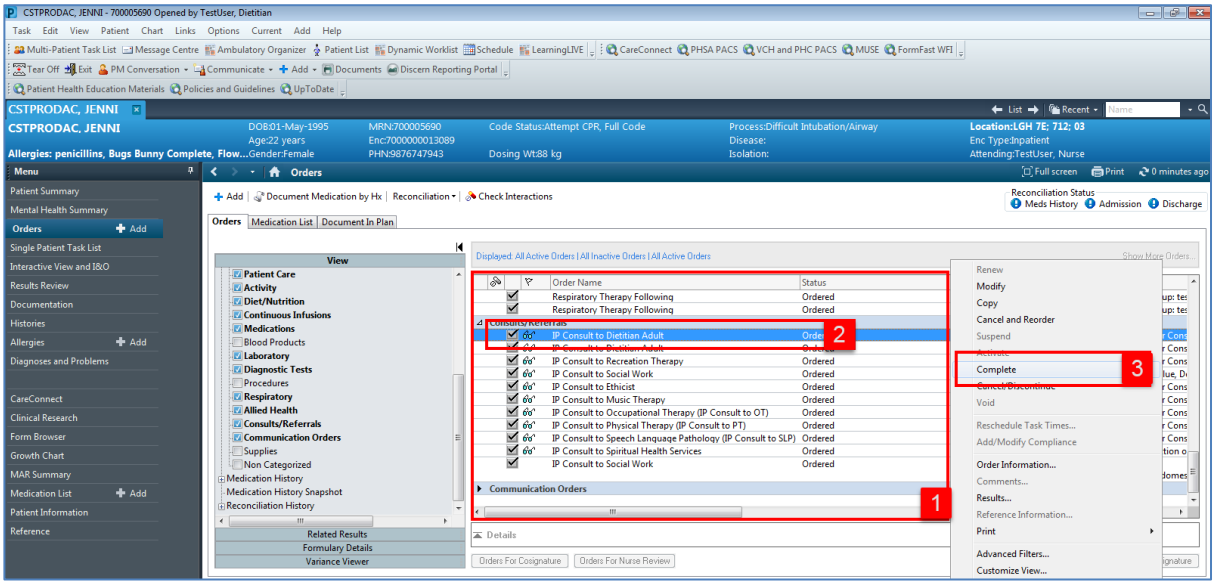
- Remember to review and verify the status of orders
- Hover over items in the chart to view additional order information.

Activity 4.4 – Complete or Cancel/Discontinue an Order

1 When a one-time order has been carried out, the order needs to be removed from the patient's Orders Profile. This is done by completing the order.

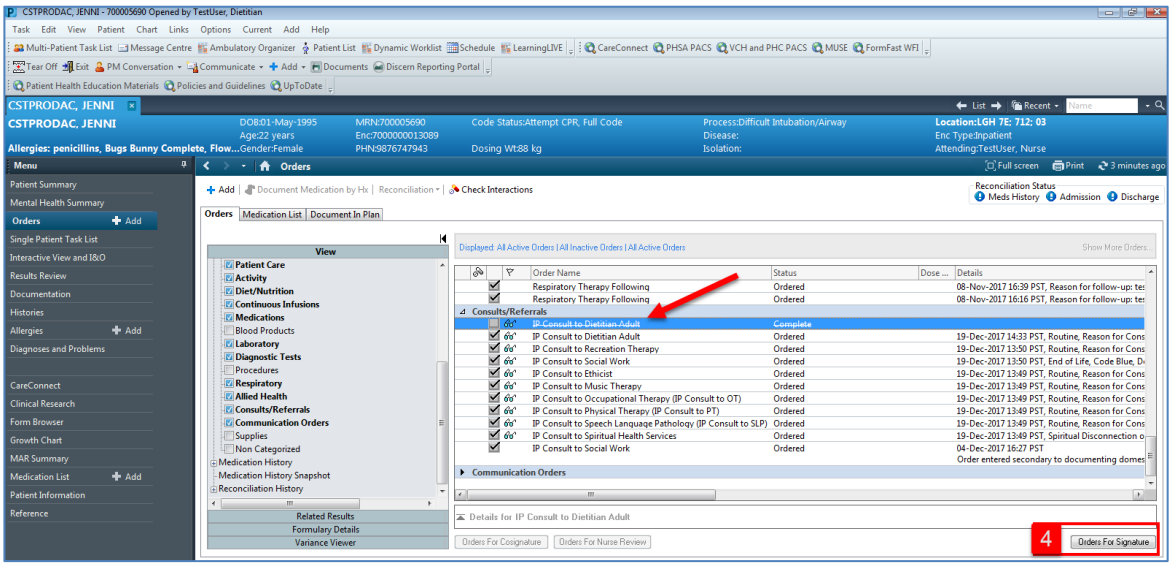
Let's complete an order.

1. Review the **Orders Profile**
2. Right-click the **Consult** order for your profession
3. Select **Complete**



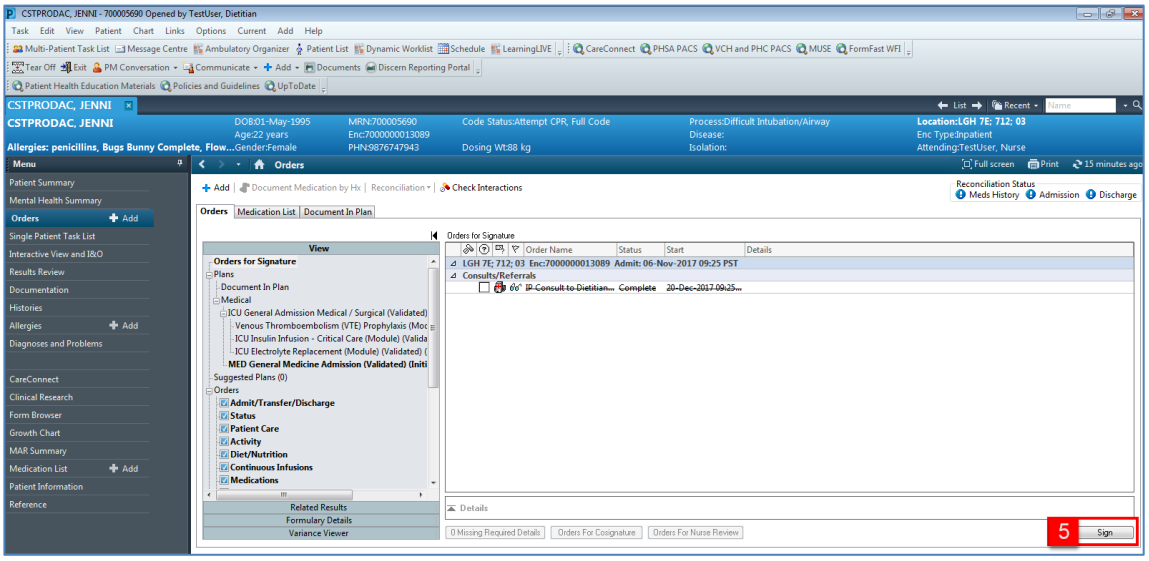
Notice that the order is now crossed out.

4. Click **Orders for Signature**



The **Orders for Signature** window displays.

5. Review the order for signature details and click **Sign**.



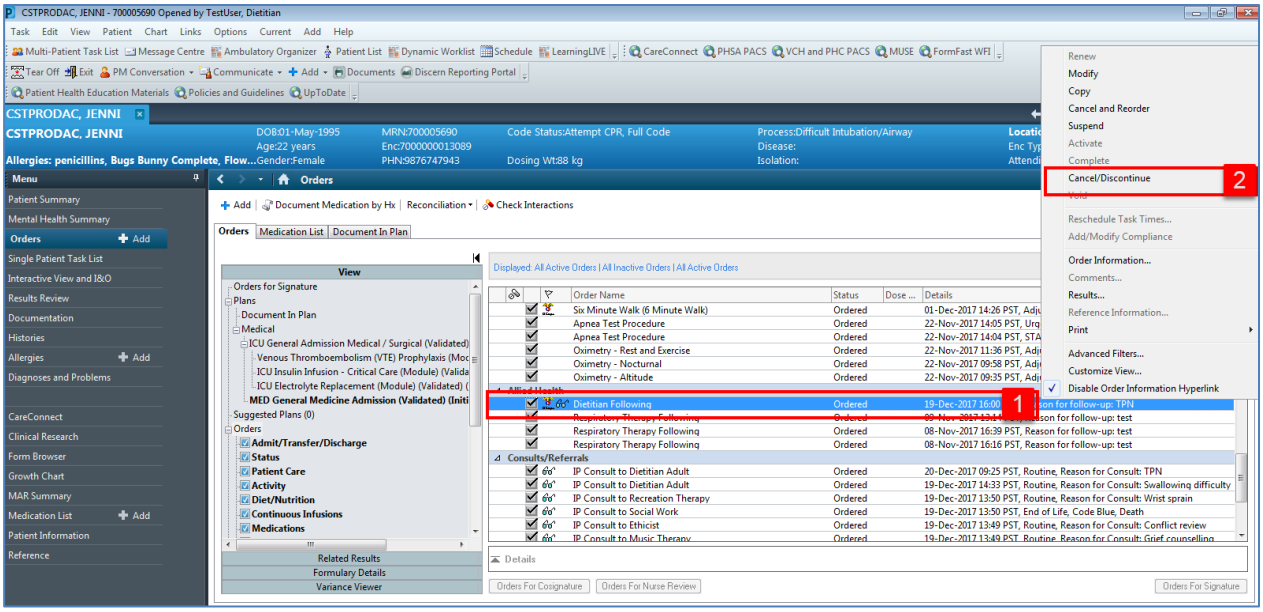
You will return to the **Orders Profile** where the order will show as processing.

6. Click the **Refresh** icon  and the order will no longer be visible in the **Orders Profile**.

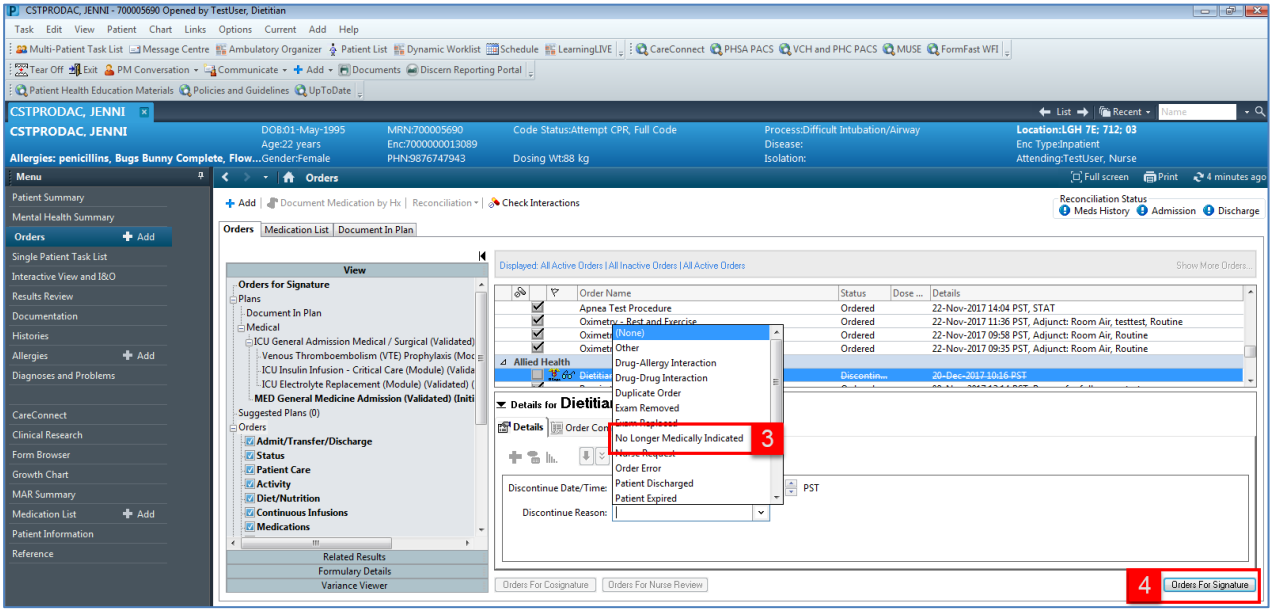
2 Now let's **Cancel/Discontinue** an order.

Certain orders such as **Following** orders are not a one-time order and cannot be completed. These tasks will remain on your SPTL or MPTL until the order is cancelled or discontinued.

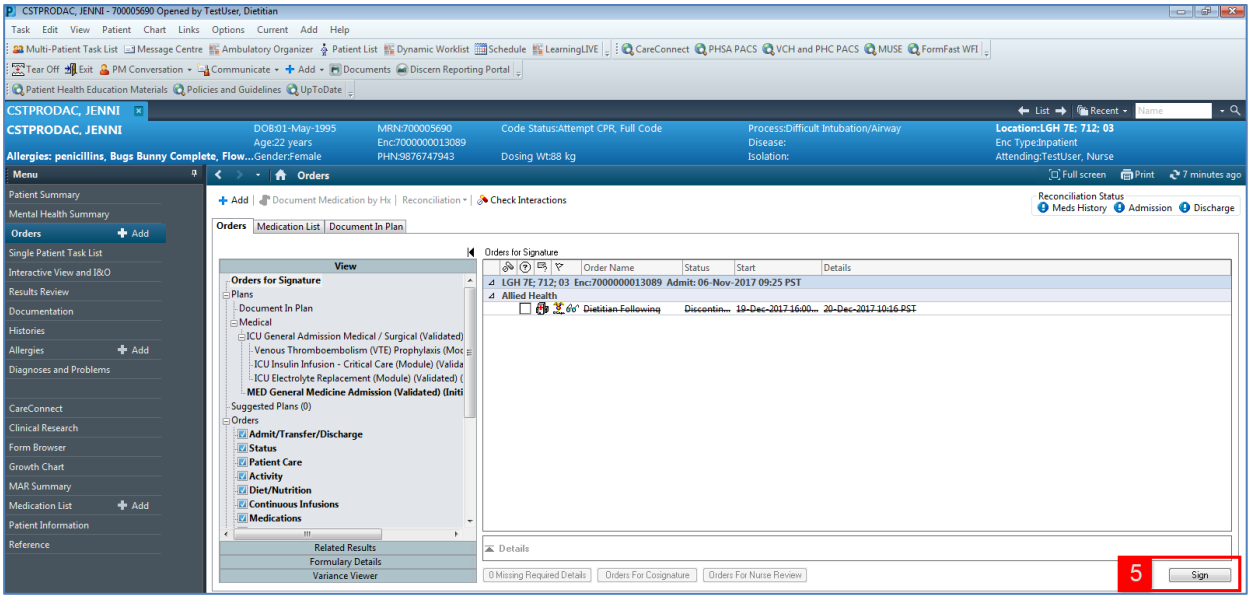
1. Within the **Orders Profile**, locate the **Following** order for your profession and right click on the order
2. Select **Cancel/ Discontinue**



3. Select **No Longer Medically Indicated** in the **Discontinue Reason** drop-down
4. Click **Orders for Signature**



5. Click **Sign**



You will return to the Orders Profile where the order will show as processing.

6. Click the **Refresh** icon and the order will no longer be visible in the Orders Profile.

Key Learning Points

- Right-click to mark an order as completed or cancel/discontinued.
- Once an order is cancelled or discontinued the order will be removed from the patient's Orders Profile

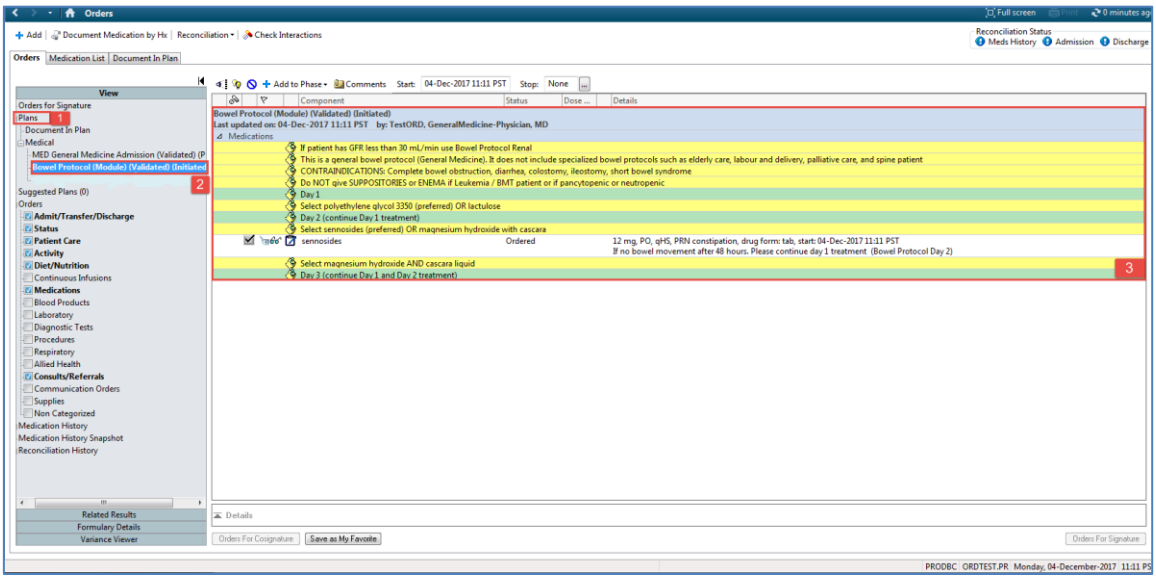
Activity 4.5 – Review Components of a PowerPlan

1

A **PowerPlan** in the CIS is the equivalent of preprinted paper orders. **PowerPlans** help to coordinate patient care by defining sets of orders that are often used together. At times it may be useful to review a **PowerPlan** to distinguish its associated orders from orders placed in an individual manner.

Let's review a **PowerPlan**. From the **Orders Profile**:

1. Locate the **Plans** category to the left side of the screen under the **View menu**
2. Select the **Bowel Protocol** PowerPlan
3. Review orders within the PowerPlan (*Sennosides 12mg, PO, qHS, PRN)*



Key Learning Points

- The View Menu displays the lists of PowerPlans and clinical categories of orders
- At times it may be useful to review a PowerPlan to distinguish its associated orders from orders placed in an individual manner

PATIENT SCENARIO 5 – Patient Management Conversation

Learning Objectives
At the end of this Scenario, you will be able to: ■ Review and update patient details in **Patient Management Conversation** (**PM Conversation**)

SCENARIO

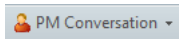
You just finished reviewing the patient's chart. You were given a phone number that needs to be compared to the current number on file and then updated.

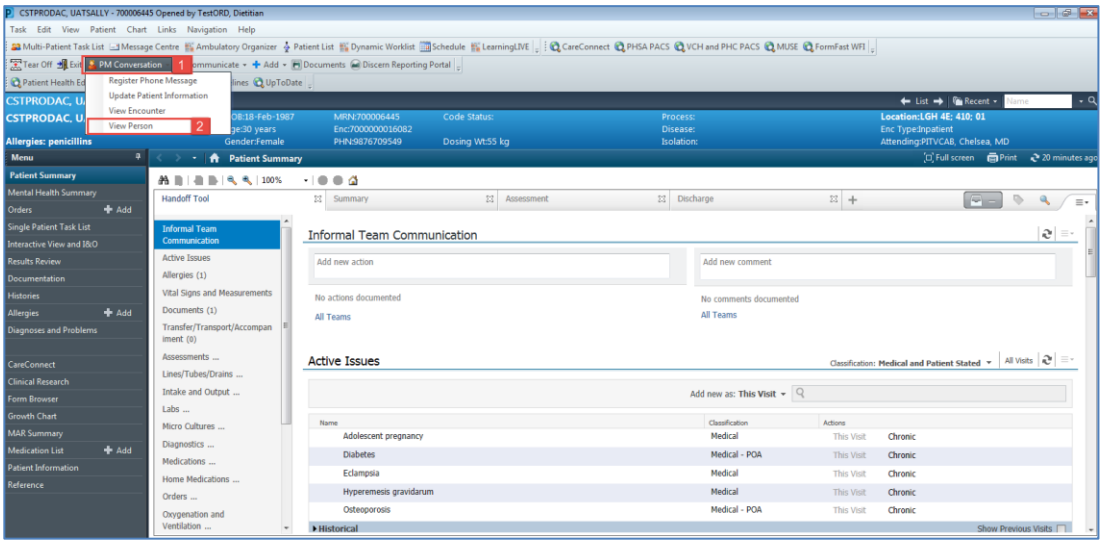
As an Allied Health Professional you will be completing the following activities:

- View Person
- View Encounter
- Update Patient Information

Activity 5.1 – View Person

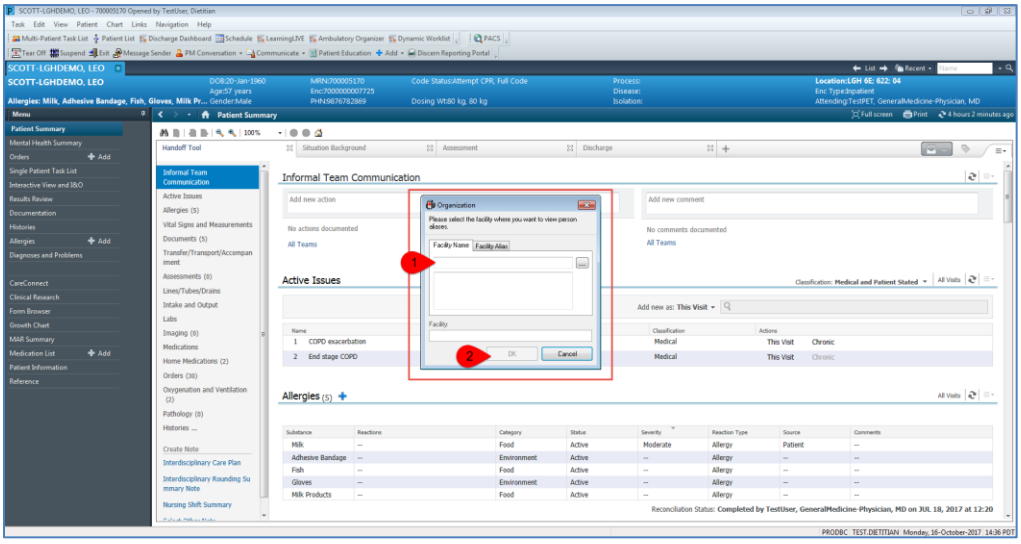
1 You can view patient information through **Patient Management Conversation** (**PM Conversation**). Let's review the patient's alerts.

1. Click the drop-down arrow within **PM Conversation**  in the **Toolbar**.
2. Select **View Person** from the drop-down.



The **Organization** window opens. To select the facility:

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



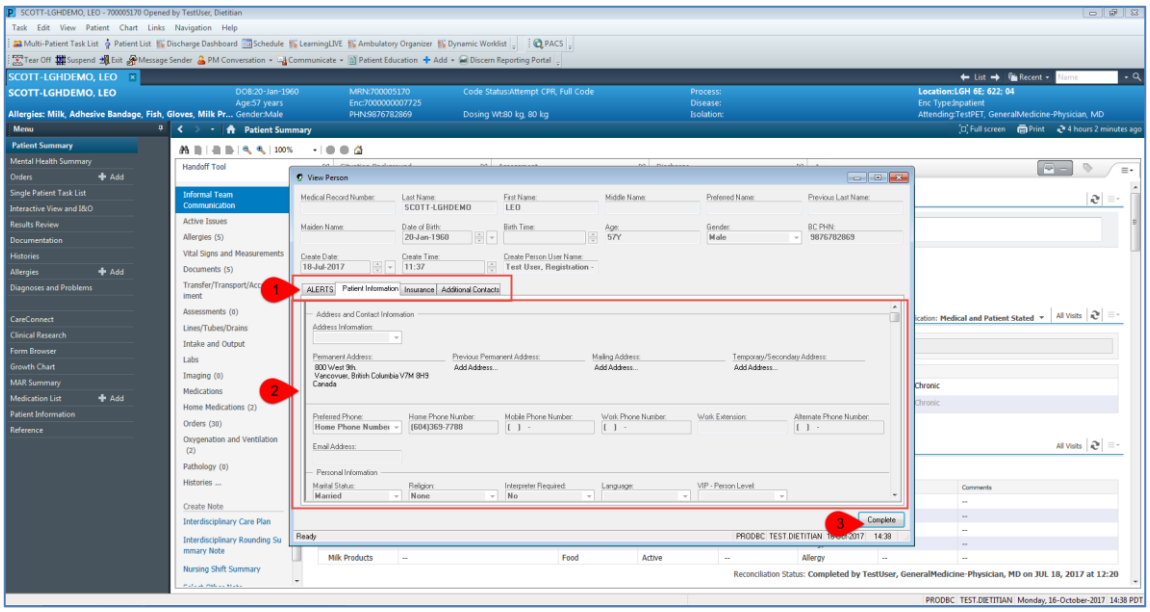
The **View Person** window displays and lands on the **Patient Information** tab.

1. Review the **Address Information**, **Preferred Phone** and **Home Phone Number** fields.

Note: There are other tabs including:

- **ALERTS**
- **Insurance**
- **Additional Contacts**

2. Click the **Complete** button.

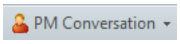


Key Learning Points

- View Person is located within the PM Conversation tool
- View Person displays patient information such as address and phone number

Activity 5.2 – View Encounter

1 You can view patient encounter information through **Patient Management Conversation** (**PM Conversation**). Let's review the patient's registration and admission date and time.

1. Click the drop-down arrow within **PM Conversation**  in the **Toolbar**.
2. Select **View Encounter** from the drop-down.

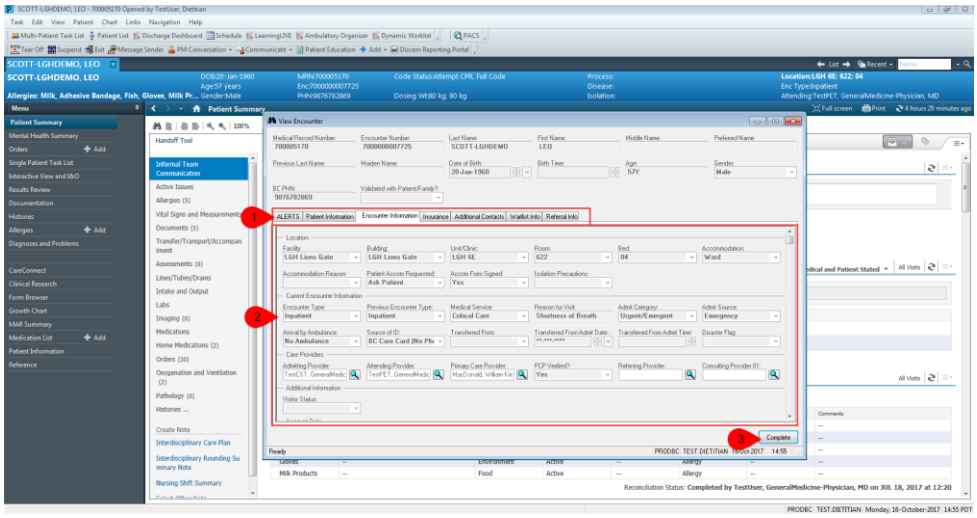
The **View Encounter** window displays and lands on the **Patient Information** tab.

3. Click the **Encounter Information** tab.
4. Review the **Registration Date, Registration Time, Patient Admit Date, Patient Admit time** fields.

Note: There are other tabs including:

- **ALERTS**
- **Patient Information**
- **Insurance**
- **Additional Contacts**
- **Waitlist Info**
- **Referral Info**

5. Click the **Complete** button.



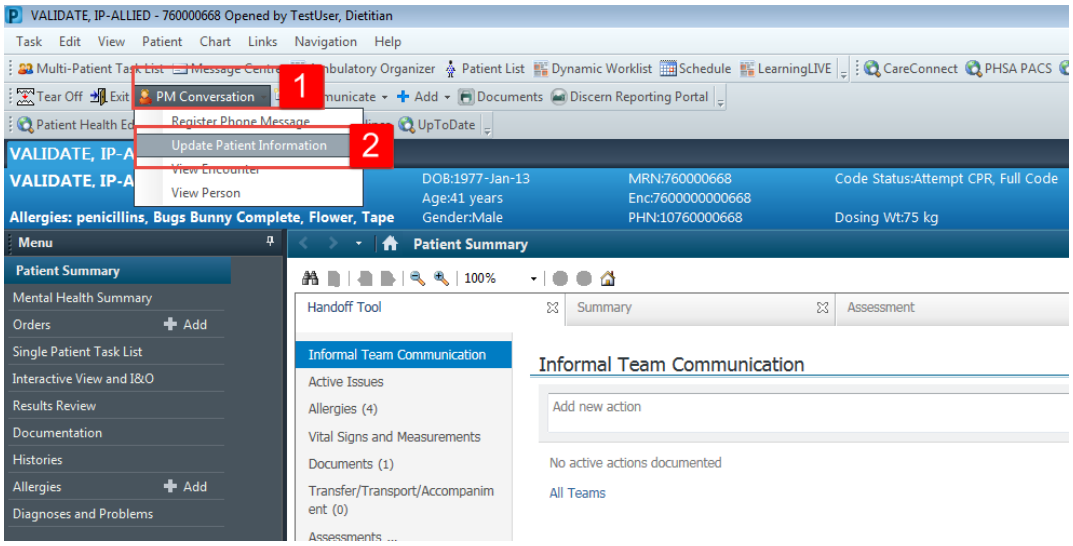
Key Learning Points

- View Encounter is located within the PM Conversation tool
- View Encounter allows you to access patient information more quickly than View Person by bypassing the Facility Search

Activity 5.3 – Update Patient Information

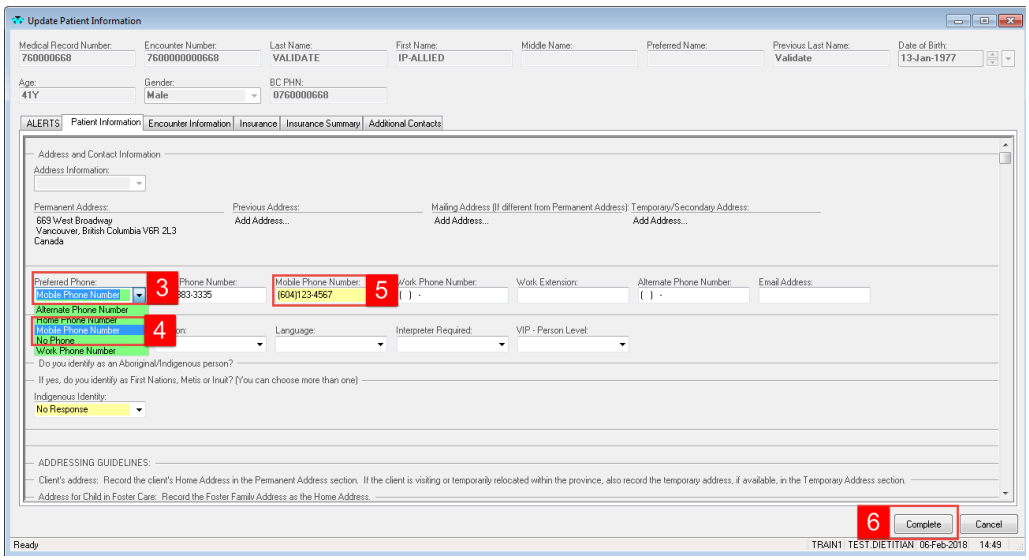
1 You can update patient information through **Patient Management Conversation** (**PM Conversation**). Let's update the patient's phone number.

1. Click the drop-down arrow within **PM Conversation** PM Conversation in the **Toolbar**.
2. Select **Update Patient Information**.



The **Update Patient Information** window opens and lands on the **Patient Information** tab.

3. Click the **Preferred Phone** drop-down.
4. Select **Mobile Phone Number**. The **Mobile Phone Number** field automatically highlights.
5. Enter the patient's Mobile **Phone Number** = *604-123-4567*
6. Click the **Complete** button when finished.



Key Learning Points

- PM Conversation allows you to update patient information
- When selecting a Preferred Phone Number the field you need to populate automatically highlights

PATIENT SCENARIO 6 – Handoff Tool

Learning Objectives

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

- Navigate and utilize the Handoff Tool

SCENARIO

In this scenario, you will practice using the Handoff Tool in the CIS to communicate patient information with other healthcare professionals.

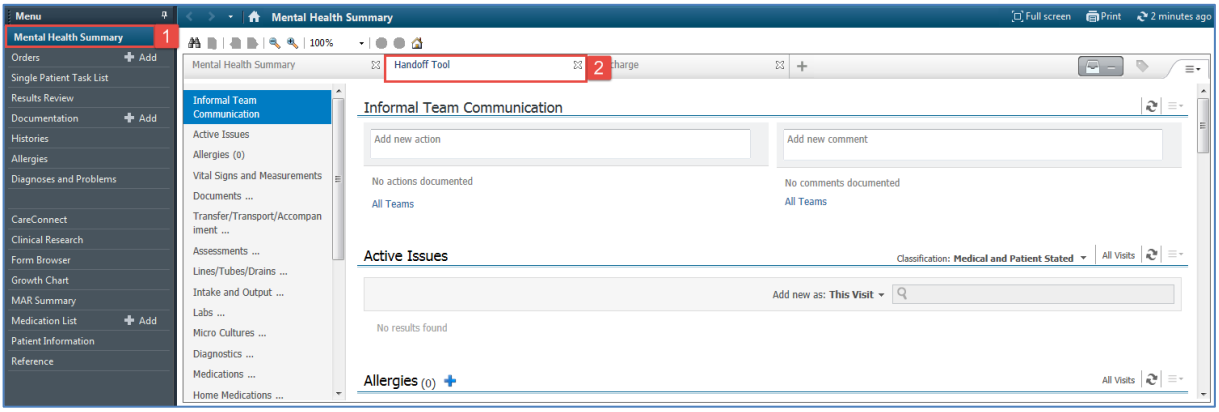
As an Allied Professional, you will be completing the following activities:

- Navigate Handoff Tool
- Document Informal Team Communication

Activity 6.1 – Navigating the Handoff Tool

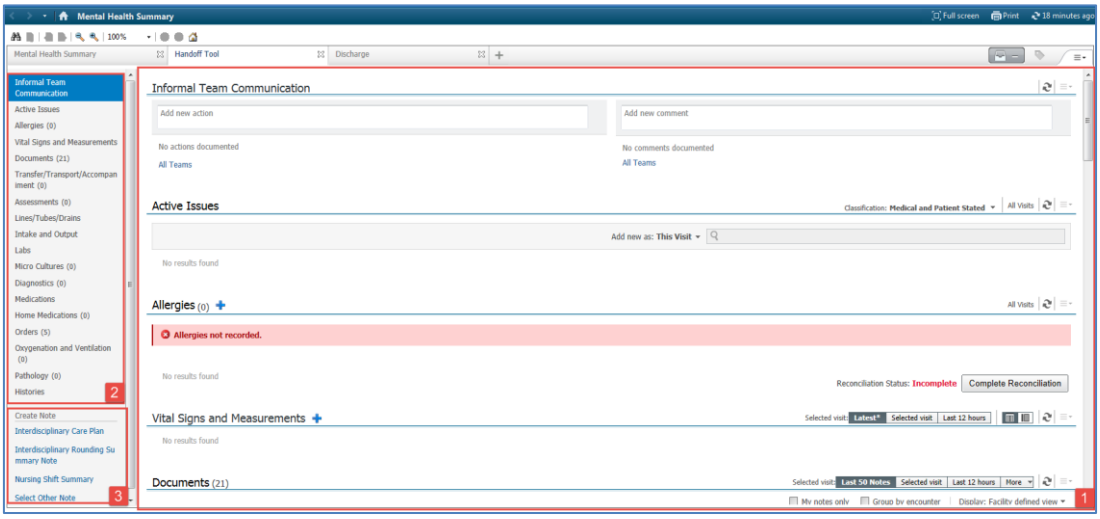
1 The **Handoff Tool** can be used to review a summary of specific patient information.

1. Navigate to the **Patient Summary/ Mental Health Summary** page in the patient's chart
2. Select the **Handoff Tool** tab



Let's review the information you can find on the **Handoff Tool** tab**:**

1. You can use the scroll bar on the right to view all of the components of the tool such as Active Issues, Intake and Output, Diagnostics, Medications, Orders etc.
2. Or you can click on each component on the left and it will bring you directly to that information.
3. You can also find quick links to commonly used documentation under the **Create Note** section on the left



Key Learnings Points

- Use the Handoff Tool to review patient information with the oncoming nurse
- You can add information or create common note types directly from the Handoff Tool

Activity 6.2 – Documenting Informal Team Communication

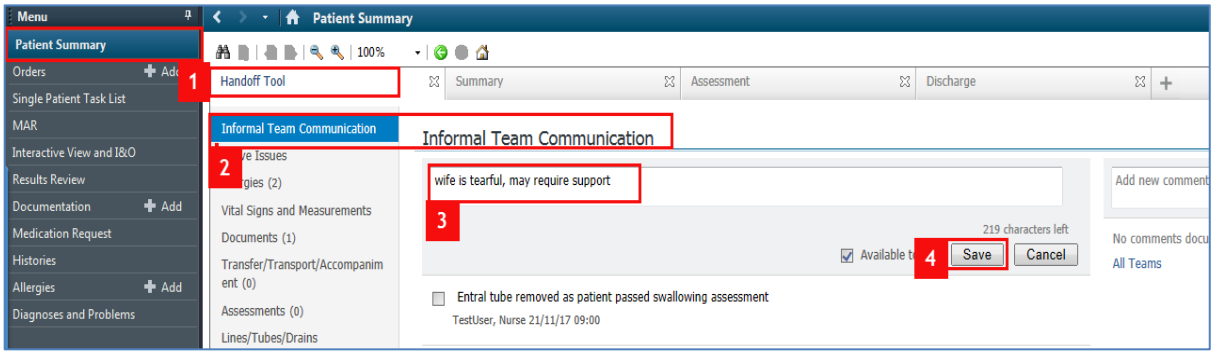
1 Within the **Handoff Tool** there is an **Informal Team Communication** component that can be used for documenting informal communication between all interdisciplinary care team members. The **Informal Team Communication** Tool can be used to add actions or comments to handover to your colleagues much like you would in a Kardex.

- Use the **Add new action** section to create a list of to-do action items
- Use the **Add new comment** section to leave a free text comment for the oncoming respiratory therapist or other team members

Note: The **Informal Team Communication** is NOT part of the patient's legal chart. This is not to be used for legal documentation purposes.

Within the **Patient Summary** page:

1. Select the **Handoff Tool** tab
2. Navigate to the **Informal Team Communication** component
3. Type the following = *Wife is tearful, may require support*
4. Click **Save**



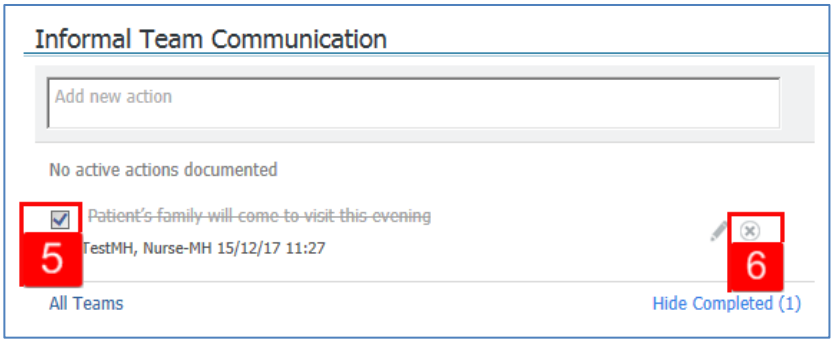
You may complete or delete these informal team communications when they no longer apply.

To complete a task in Informal Team Communication:

5. Click the **checkbox** to the left of the note. The task will appear as completed and is still viewable.

To delete a task in Informal Team Communication:

6. Click the **small circle** with the x to the right of the note



Note: It is important to remove/delete these informal team communications when they no longer apply.

Key Learning Points

- Informal Team Communication component provides a way to create a list of to-do action items or leave a message for another clinician.
- An Informal Team Communication message is NOT part of the patient's legal chart.

SELF-GUIDED PRACTICE WORKBOOK
CST Transformational Learning

CURRICULUM TRACK:

ALLIED HEALTH: ADD-ON for MH

Complete the following activities if you are one of the following, working in the field of **Mental Health**:

- Occupational Therapist
- Social Worker
- Counsellor

PATIENT SCENARIO 1 – Dynamic Documentation

Learning Objectives
At the end of this Scenario, you will be able to: ■ Create a Dynamic Document ■ Modify a Dynamic Document

SCENARIO

In this scenario, you will be creating a progress note for your patient.

As an Allied Health Professional, you will be completing the following activities:

- Dynamic Documentation
- Documenting a Therapeutic Note

Activity 1.1 – Dynamic Documentation

1

Dynamic Documentation is similar to written progress notes. In a dynamic document, you have the ability to enter free text to document narrative information such as one-to-one sessions or family meetings.

After reviewing the patient's information we want to complete and document the assessment in the patient's chart.

1. With the patient's chart open, click **Documentation** in the **Menu**.

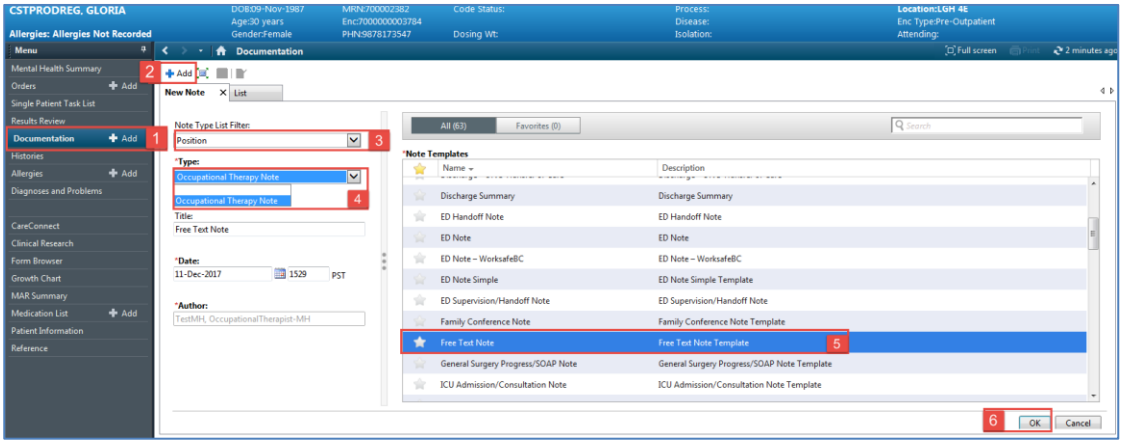
The **Documentation** screen opens.

2. Click the **Add** button.
3. Click the **Note Type List Filter** drop-down menu and select **Position**.
4. Click the **Type** drop-down and select the appropriate note for your position: **Occupational Therapy Note**.

Note: please choose Social Work Note or Counselor Note if that applies to you

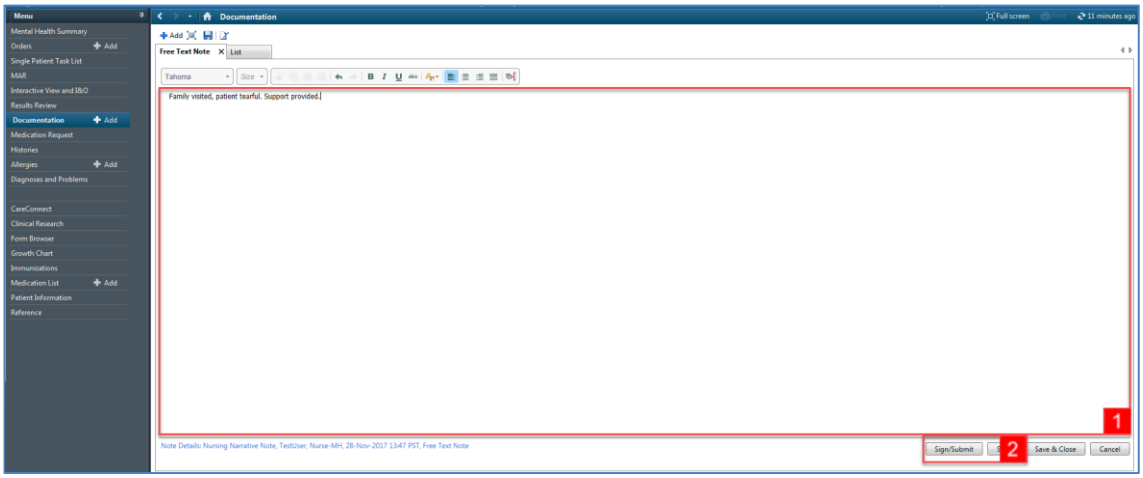
5. From the **Notes Template** box select **Name: Free Text Note**.
6. Click the **OK** button.

Note: There are other templates that are available for you to choose from in the Note Templates box



2

1. Type = *Family visited, patient tearful. Support provided.*
2. Click **Sign/Submit**



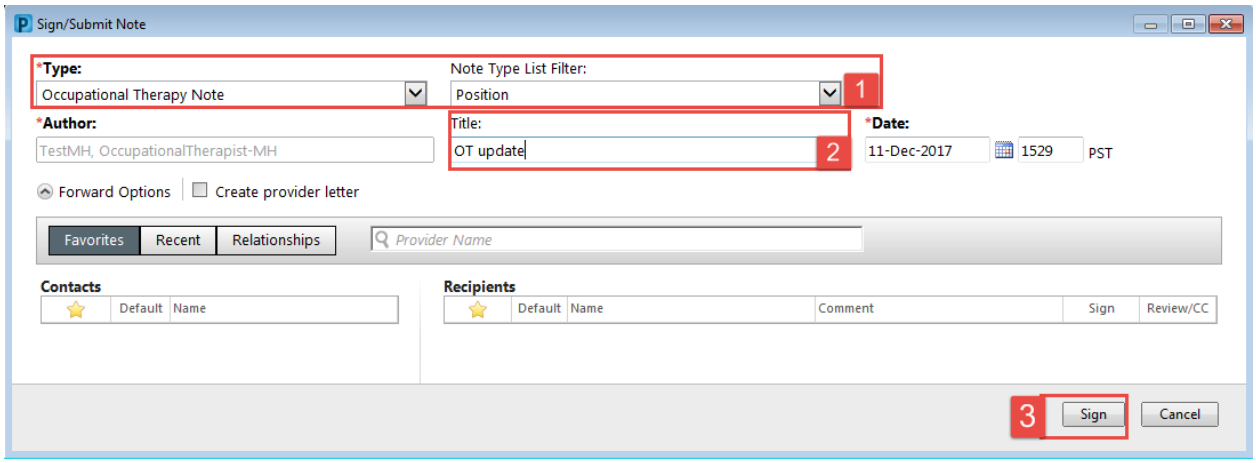
3

The **Sign/ Submit Note** window opens.

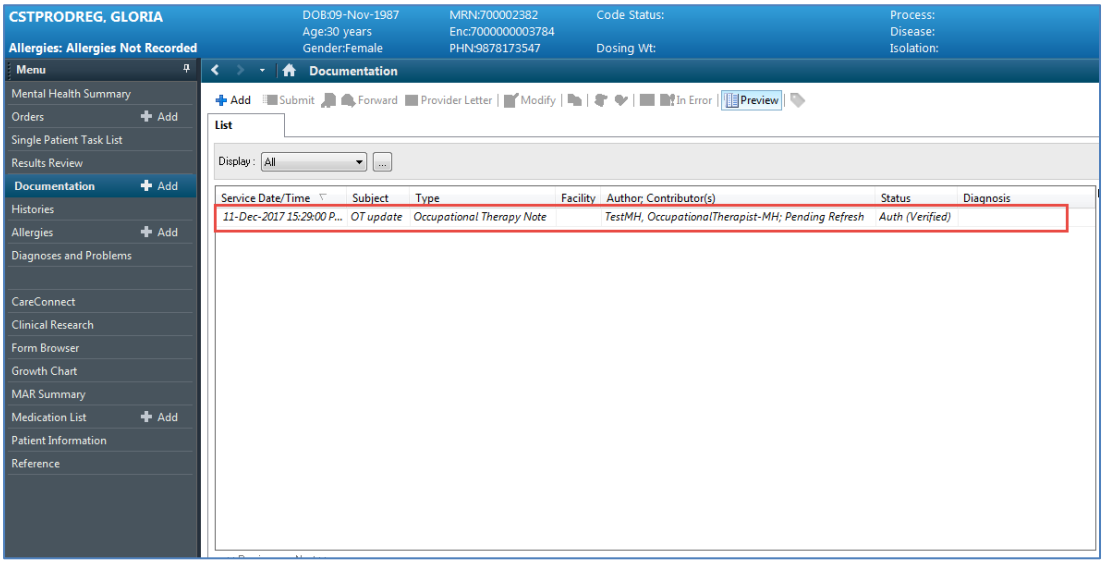
1. Review the **Type** and **Note Type List Filter**.
2. In the **Title** text box type = *OT update* and change the date and time as desired

Note: please type in *Social Work Update* or *Counselor Update* if that applies to you

3. Click the **Sign** button



4 The note that you just entered and signed can now be found in the **List** tab of **Documentation**.

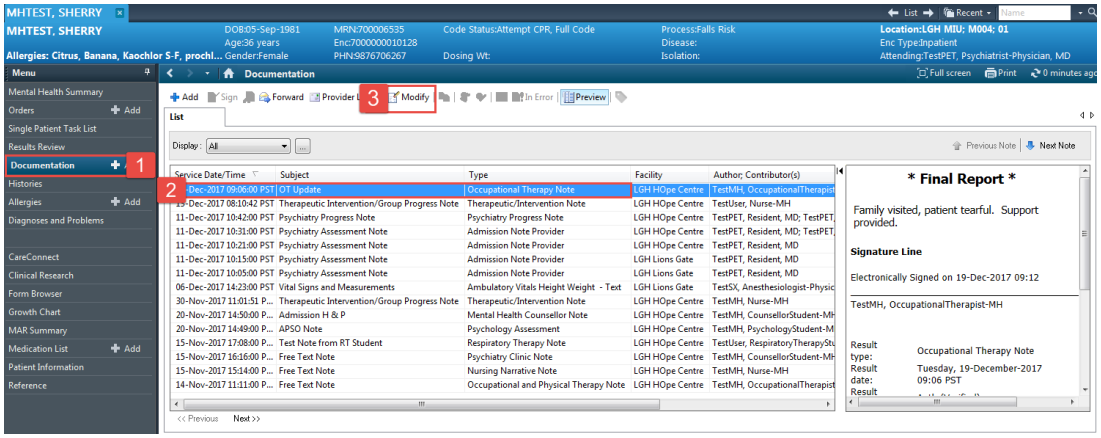


5 You want to modify the note that you just signed.

1. Select **Documentation** in the **Menu** if you are currently on the page.
2. Under the **List** tab, select the note you want to modify. In our example, we will select the Occupational Therapy Note.

Note: please select Social Work Note or Counselor Note if that applies to you.

3. Click the **Modify** button.



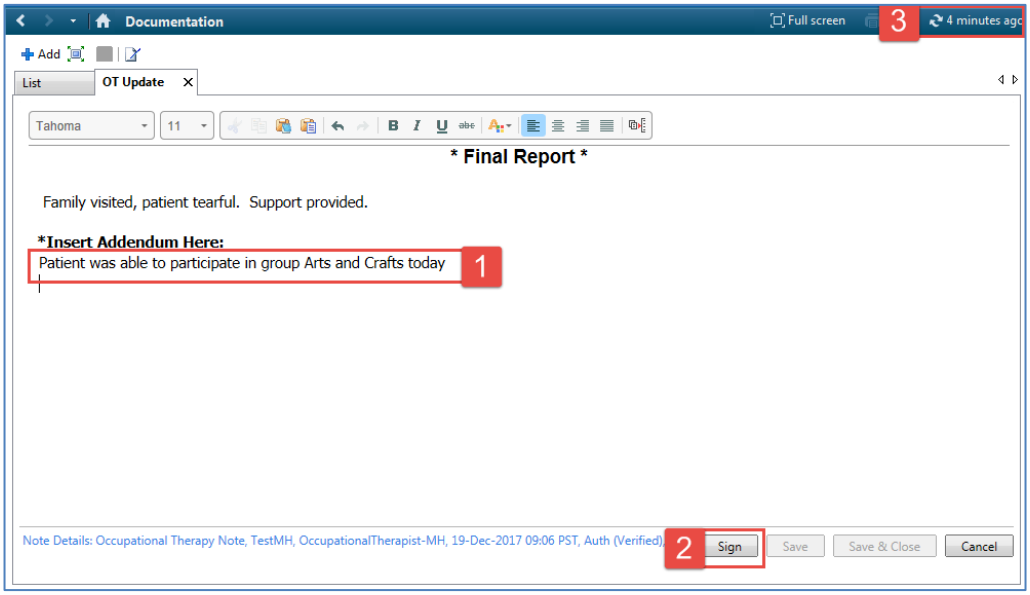
6 The **OT Update** note opens in a new tab.

Note: This will be Social Work Update or Counselor Update, depending on the title you chose.

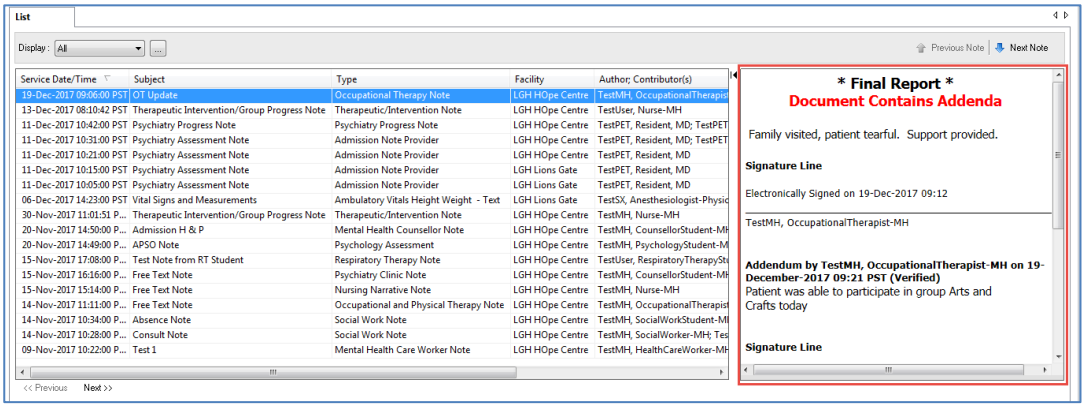
1. Edit/ update/ modify the note. Type = *Patient was able to participate in group Arts and Crafts today*
2. Click the **Sign** button.

You will return to the **List** tab.

3. Click the **Refresh** button near the top right corner of the window.



7 The note has now been updated and is reflected with the red **Document Contains Addenda**.



8

It may be necessary to unchart a document if information was entered on the wrong patient.

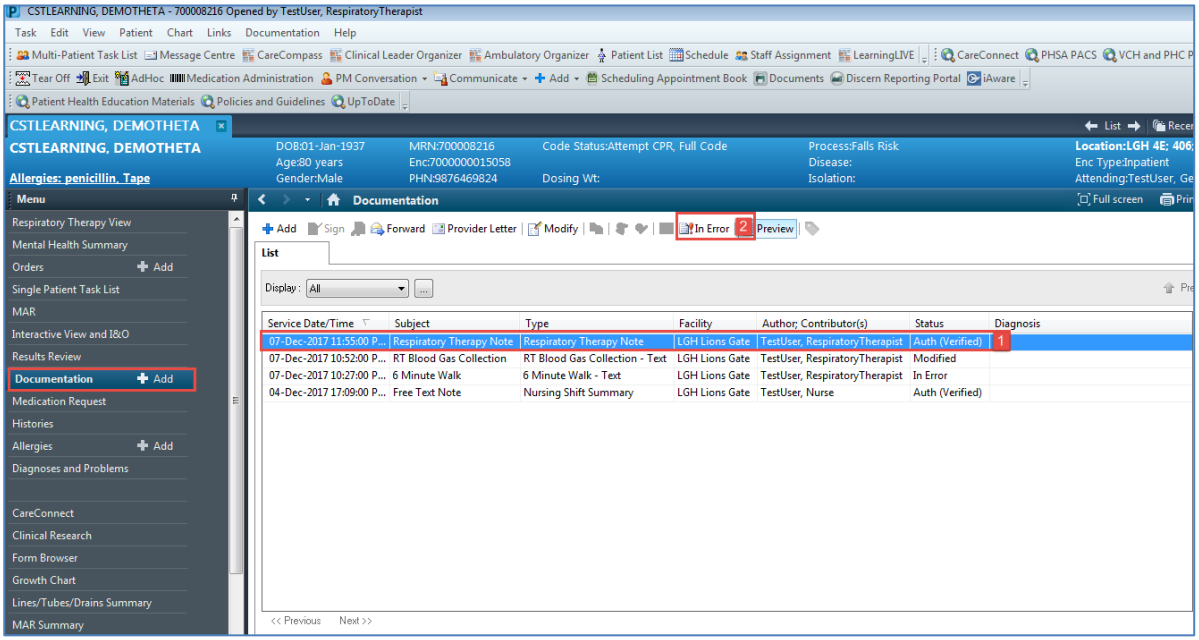
Let's unchart the note that you previously documented.

Under the **List** tab on the **Documentation** page:

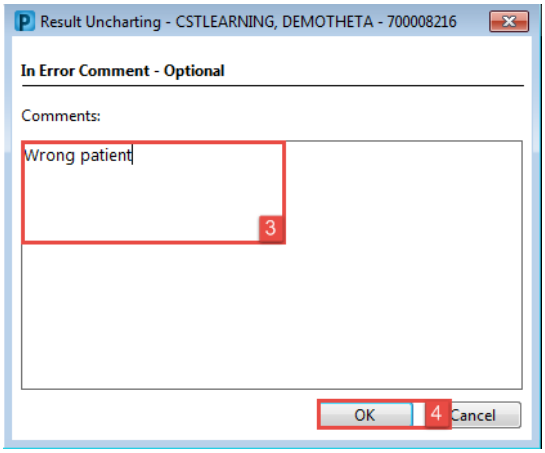
1. Click on **Occupational Therapy Note**

Note: please select Social Work Note or Counselor Note if that applies to you.

2. Click **In Error**



3. Enter a reason for uncharting in the comment box of the new window = *Wrong patient*
4. Click **OK**



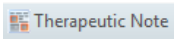
The document will still appear in the Document tab but will now be under the status of IN ERROR.

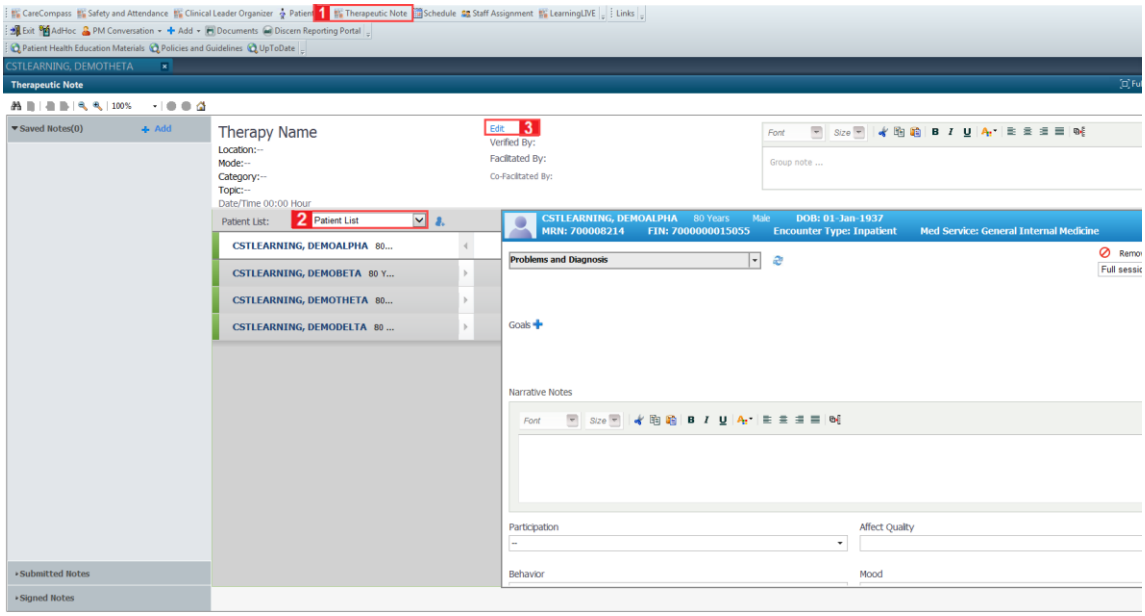
Key Learning Points

- Dynamic Documents notes can be found in the Documentation section of the Menu
- Remember to click the Sign button when you finish entering a new Free Text Note

Activity 2.2 - Documenting a Therapeutic Note

1 You can create a group note for multiple patients at once using the Therapeutic Note component in Powerchart. You can modify notes to reflect group content in addition to the progress of each patient.

1. Click Therapeutic Note  from the Organizer Toolbar
2. Select **YourName_Custom** from Patient List Drop-down
3. Click **Edit**  and a Therapeutic Notes pop-up window will appear

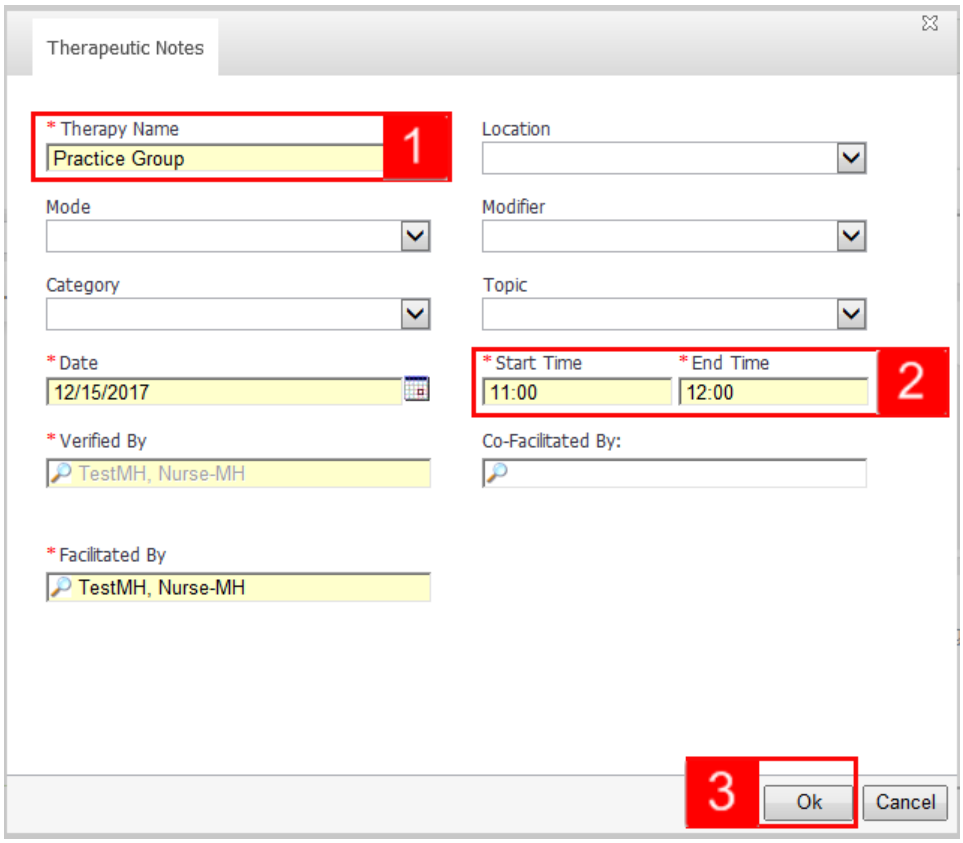


2

1. Enter into Therapy Name text box = *Practice Group*

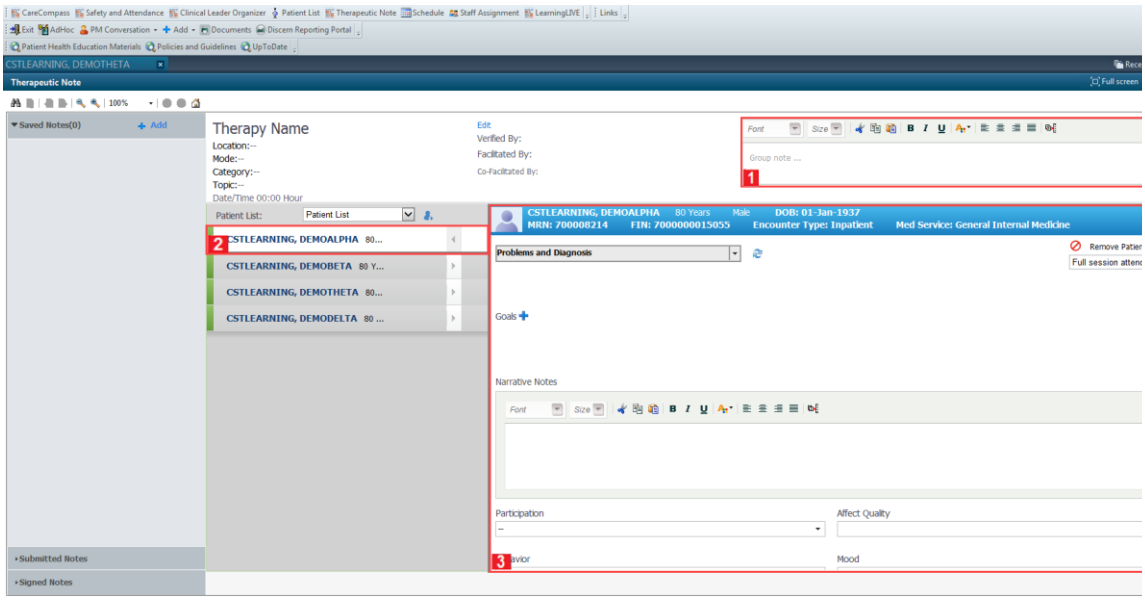
Note: Start and End Times are both pre-populated to the current time. You will need to modify the time to ensure it aligns with the time the group was run. Other fields will be pre-populated. You may modify these as necessary.

2. Modify the **Start Time** to **11:00**. Modify the **End Time** to **12:00**.
3. Click **Ok**



3

1. Enter group note description into free text box = *Today we covered …*
2. Select your patient from the list by clicking arrow next to the patient's name to document individual patient progress
3. Explore the various elements that you can modify to reflect your patient's participation in the group and enter some values as you wish
4. Click Sign



Note: Each patient will now have a Therapeutic Note in their documentation section.

Key Learning Points

- You can create a group note for multiple patients at once using the Therapeutic Note component
- You can modify notes to reflect group content in addition to the individual progress of each patient

End Book One

You are ready for your Key Learning Review. Please contact your instructor for your Key Learning Review.