SELF-GUIDED PRACTICE WORKBOOK [N52-A]
CST Transformational Learning

WORKBOOK TITLE:

Allied Health: Respiratory Therapy

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

Last update: February 8, 2018 (v2)

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	**8 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 30 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 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 to follow the steps, immediately raise your hand for assistance to use classroom time efficiently
- Ask for assistance whenever needed

PATIENT SCENARIO 1 – Patient List

Learning Objectives

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

- Create a Location Patient List
- Create a Custom Patient List
- Add a Patient from a Location Patient List to a Custom Patient List

SCENARIO

You arrive on the unit and are eager 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 a Respiratory Therapist (RT) 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

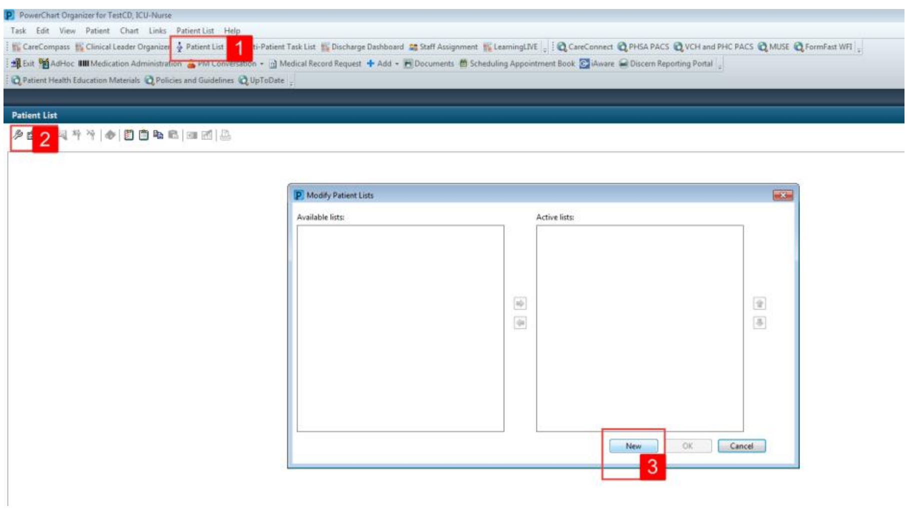
1 Once you have logged into the system you will see the **Multi-Patient Task List** (**MPTL**).

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 criterion chosen. For example, some of the possible types of lists include a location list, an assignment list, or a custom list.

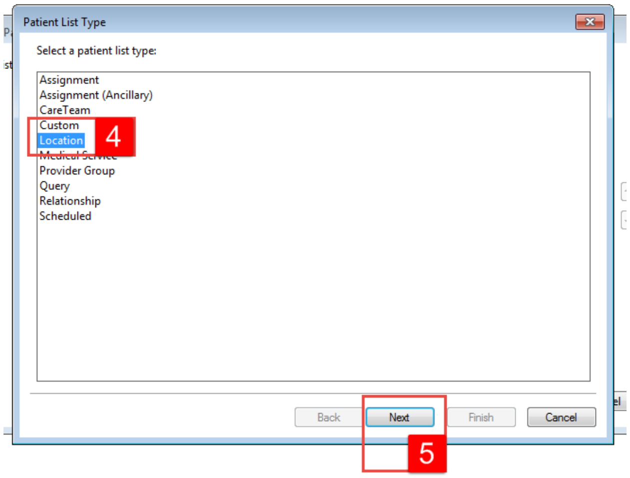
At the start of your first shift (or when working in a new location), you will create a **Location Patient List** that will consist of all patients assigned to your unit.

1. Select the **Patient List** 

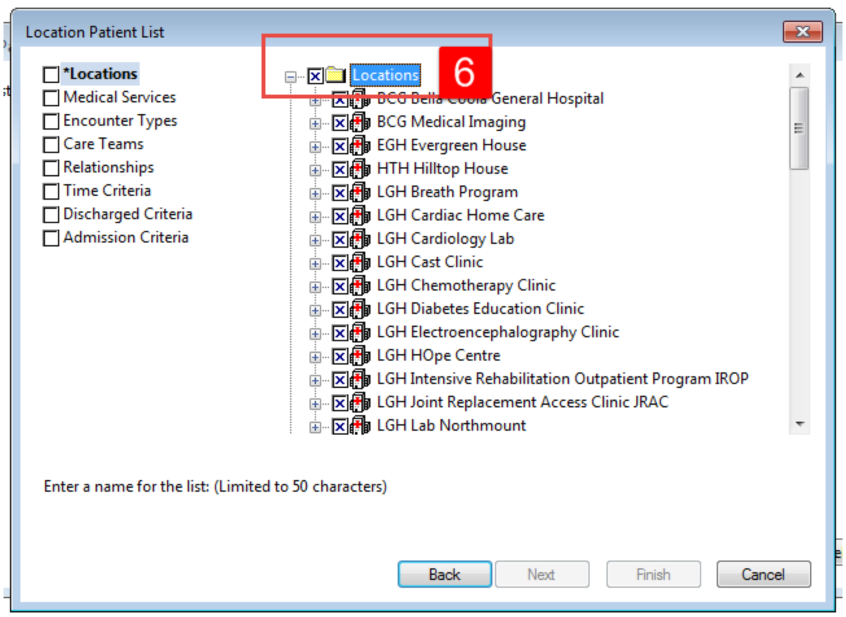
from the **Toolbar** at the top of the screen.
2. The screen will be blank. To create a location list, click the **List Maintenance** icon  .
3. Within the **Modify Patient Lists** window, select **New** in the bottom right corner.



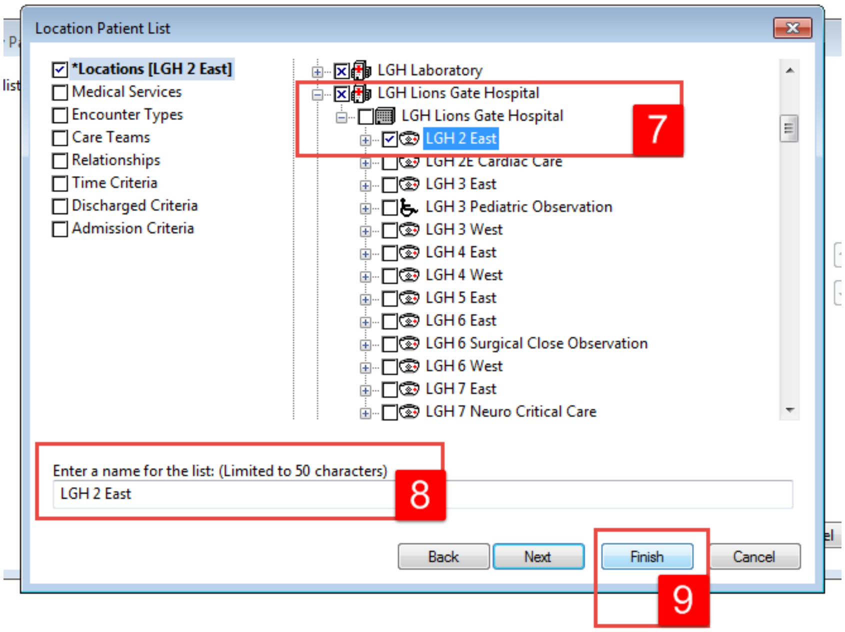
4. From the **Patient List Type** window select **Location**.
5. Click **Next**



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**.



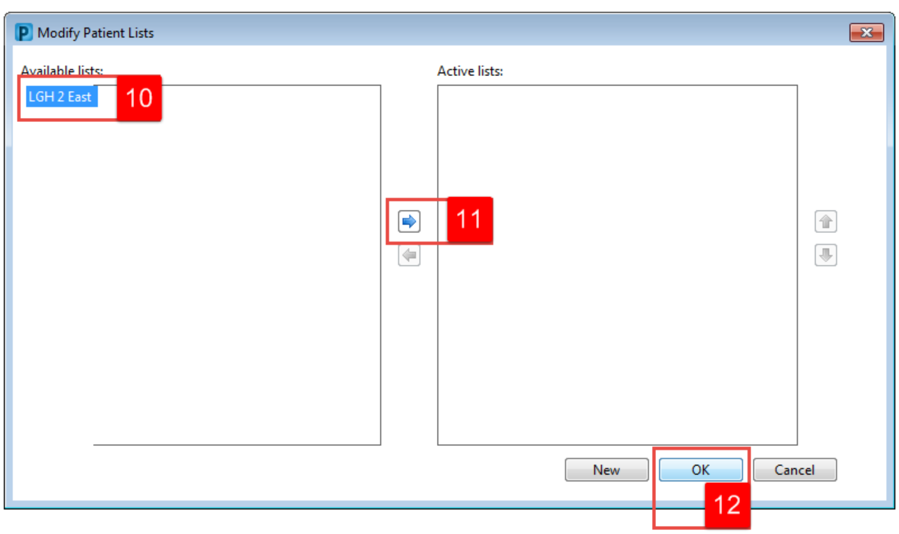
7. Scroll down until you find the location assigned to you. (You may need to further expand a facility to select your specific unit. To select check the box next to the unit name.
8. All patient lists need a name to help identify them. Location lists are automatically named for the location you select.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



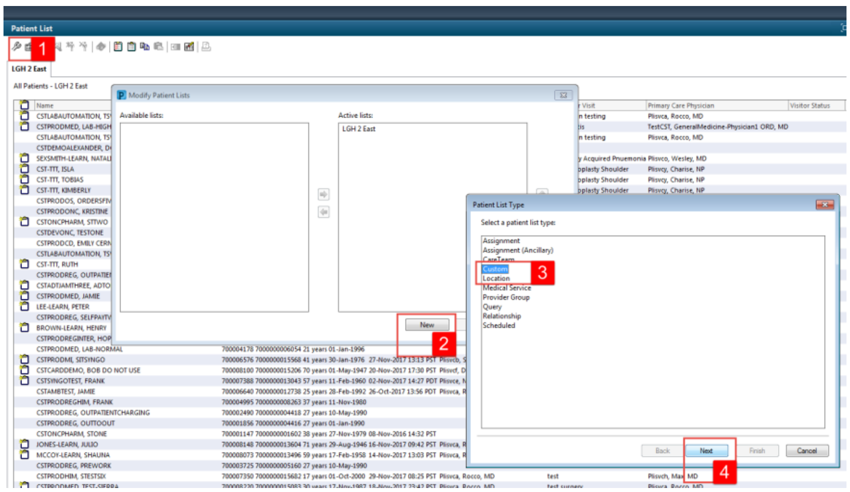
Key Learning Points

- 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

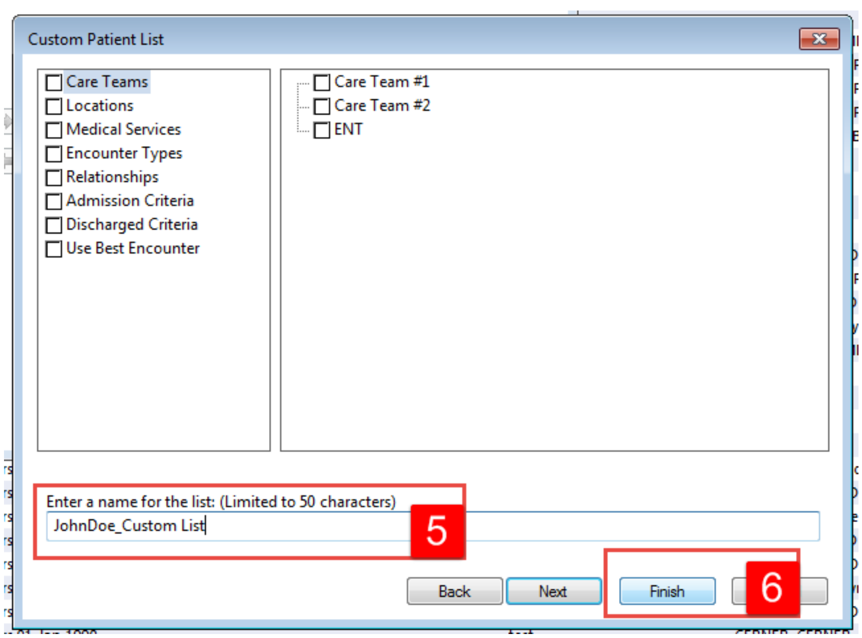
Activity 1.2 – Create a Custom Patient List

1 Next, you need to create a **Custom List** that will contain only the patients that you are covering.

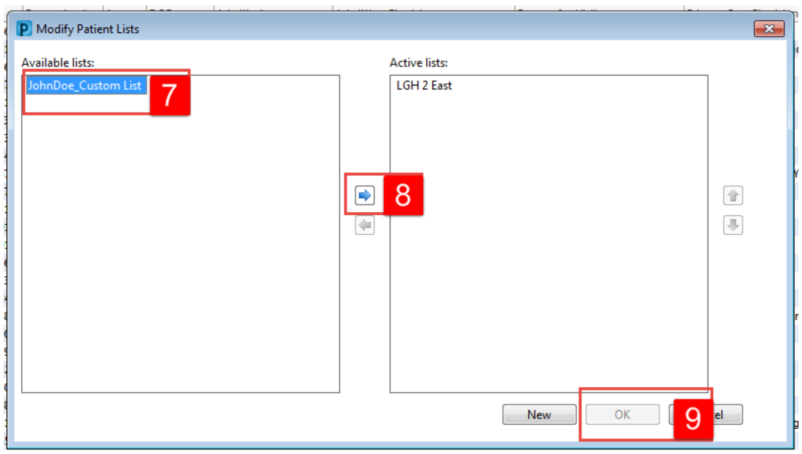
1. To create a **Custom List**, click the **List Maintenance** icon in the **Patient List**
2. Click **New** in the bottom right corner of the **Modify Patient Lists** window
3. From the **Patient List Type** window, select **Custom**
4. Select **Next**



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**



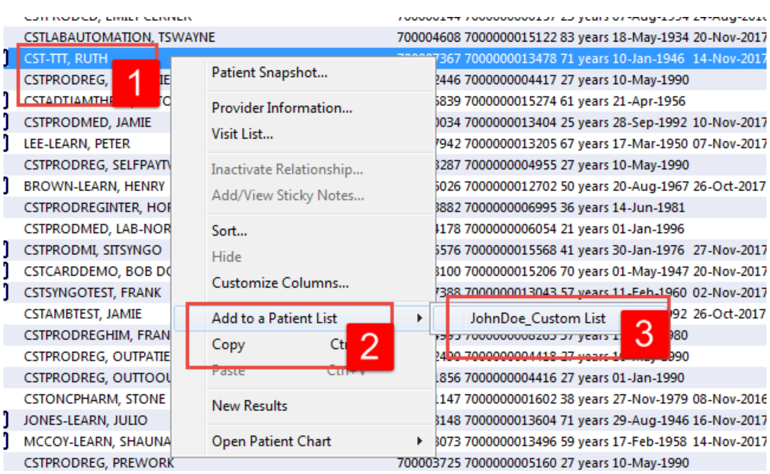
7. In the **Modify Patient Lists** window select your newly created **Custom List**
8. Click the **blue arrow** icon  to move your **Custom List** to the right, under **Active Lists**
9. Click **OK**

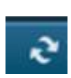


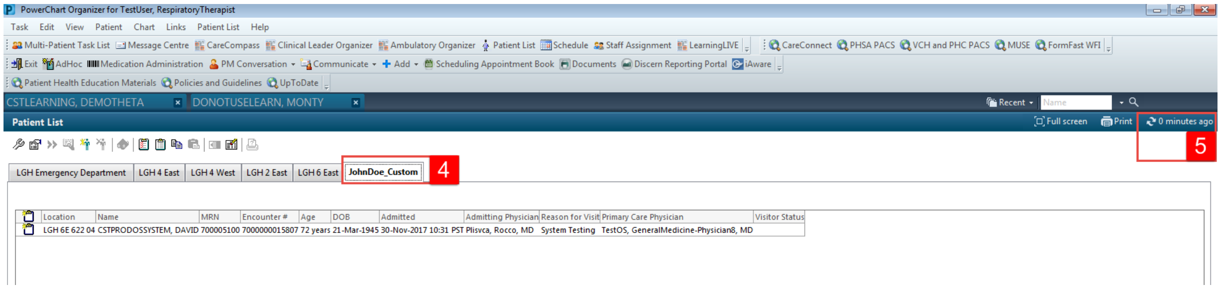
2

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

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 a Respiratory Therapist, 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

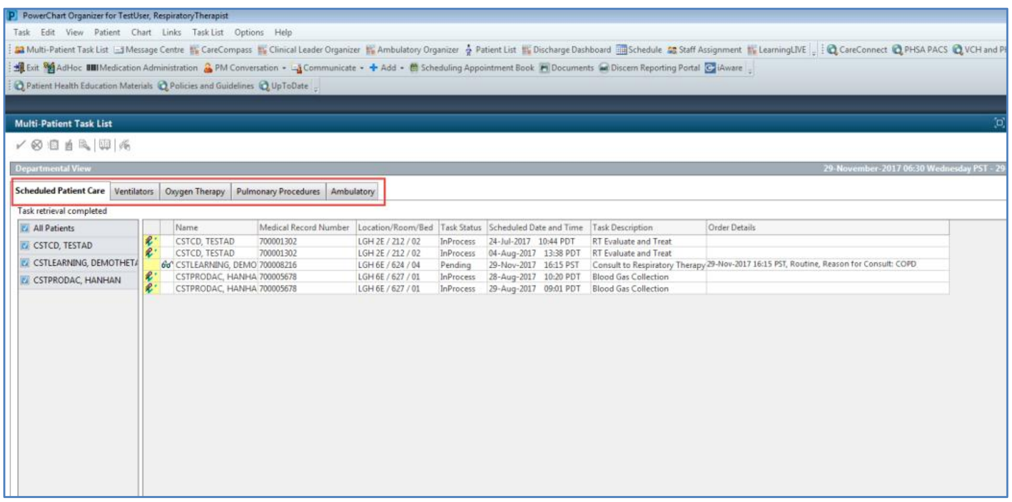
1

As a Respiratory Therapist the first page you will see upon logging into the Clinical Information System (CIS) is the **Multi-Patient Task List (MPTL).**

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, ventilator settings, important communications and specific therapies or treatments.

The **MPTL** for RTs has several tabs. Tasks will fall into one of these task categories (tabs).

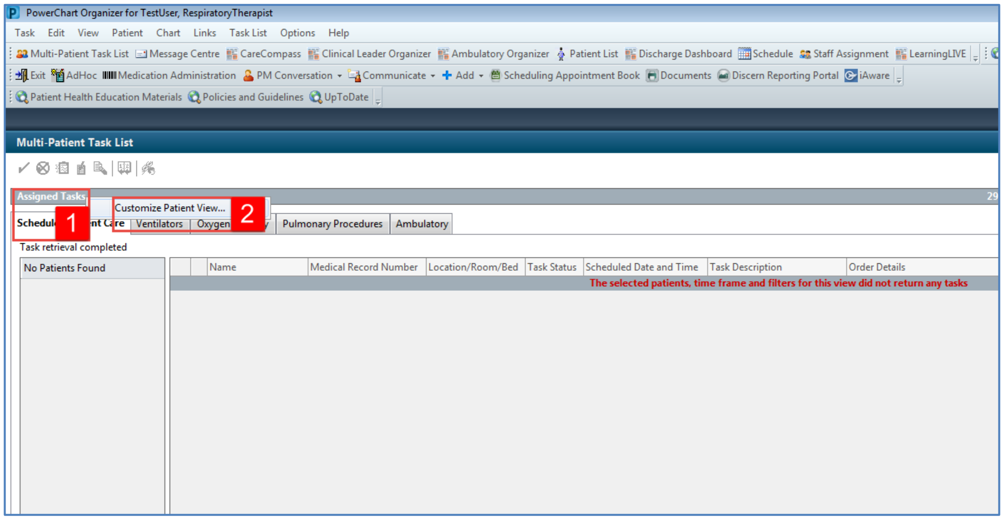


2

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. You will only have to set up the MPTL once. The next time you sign into the system the **MPTL** will populate with the **Patient List** and **Time Frame** that you have selected.

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

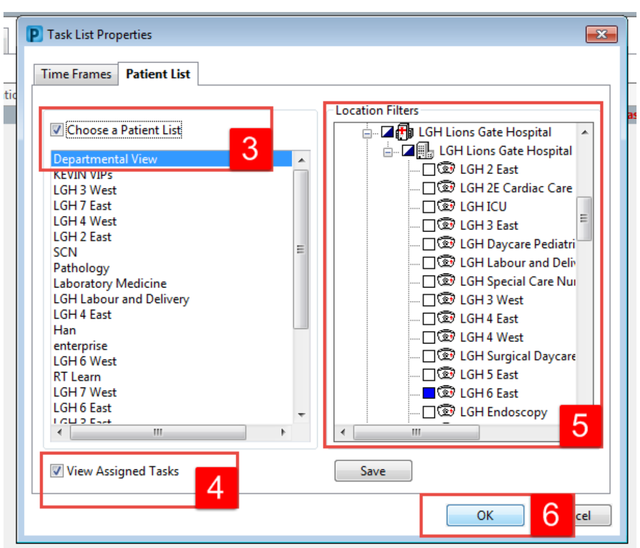


Within the **Task List Properties** window:

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).

Note: Only choose locations for units you are working on. If you choose an entire hospital or too many locations, the system might not be able process all the tasks in the MPTL. Alternatively, you can set up several separate location based lists.

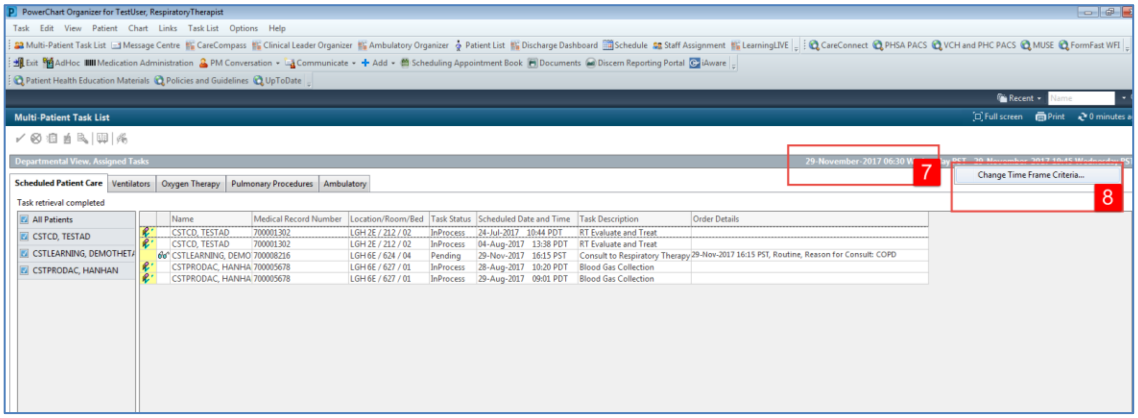
6. Click **OK**



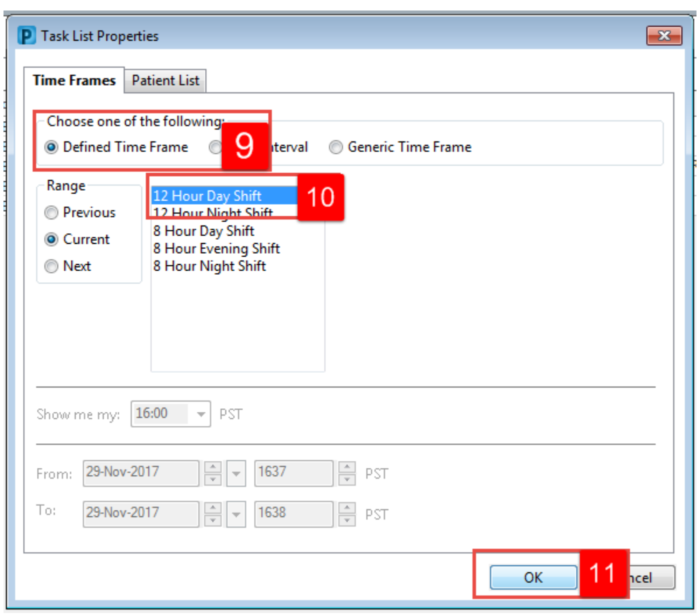
After selecting the appropriate Patient List you need to set up the **Defined Time Frame**.

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

7. Right-click 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 must now repeat the previous steps for the remaining tabs to complete setting up the MPTL.

3 For the purposes of training, you will practice setting up your view of the Multi-Patient Task List 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**.

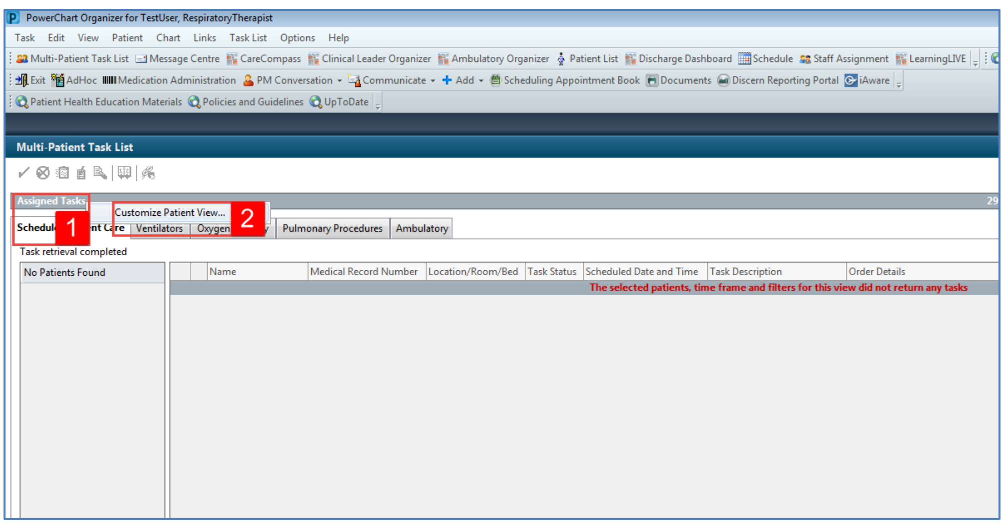
Departmental View: Used when you are looking at an entire department. Discharged patients will stay on this list for a short while allowing you to easily find them if you did not finish your documentation.

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.

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.

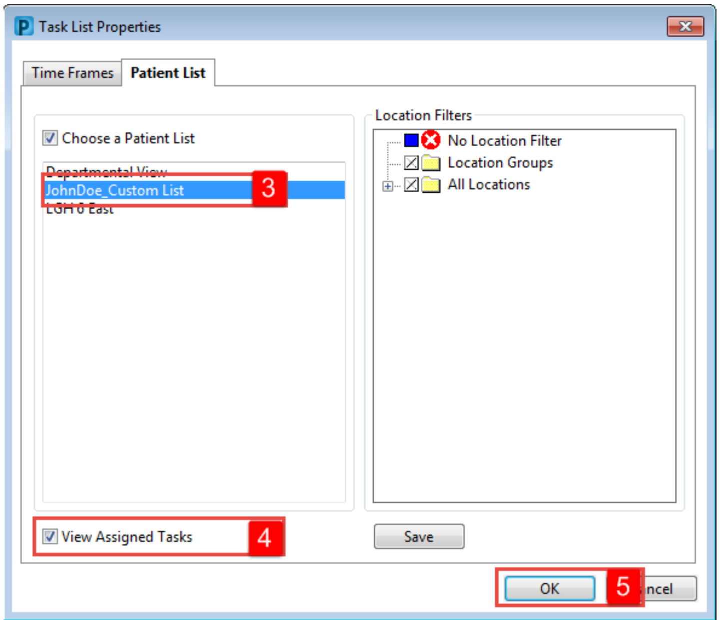
Follow these steps to set up the appropriate **Patient List:**

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



Within the **Task List Properties** window:

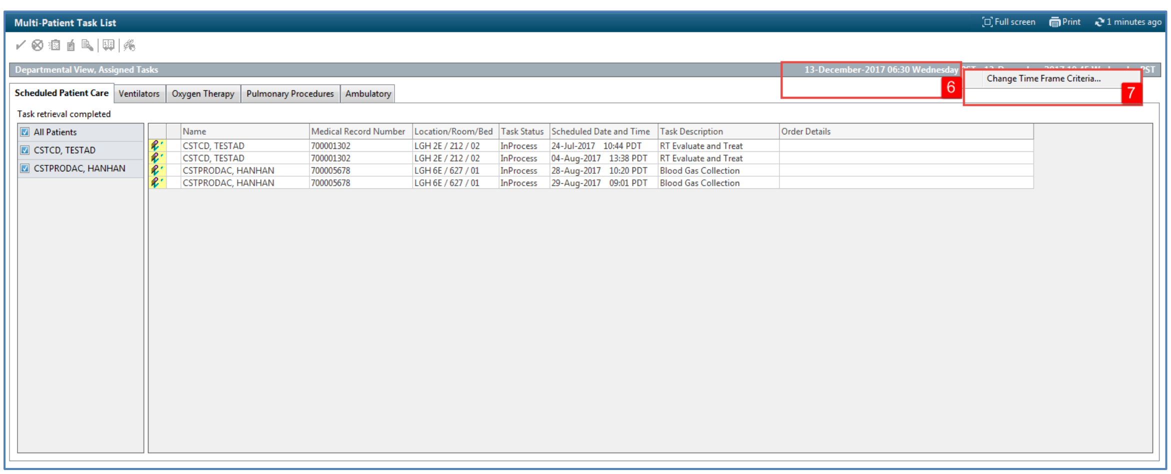
3. In the Patient List tab, select **Choose a Patient List** and select **YourName_Custom List**
4. Ensure **View Assigned Tasks** is checked as this will ensure tasks display on your **MPTL**.
5. Click **OK**



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

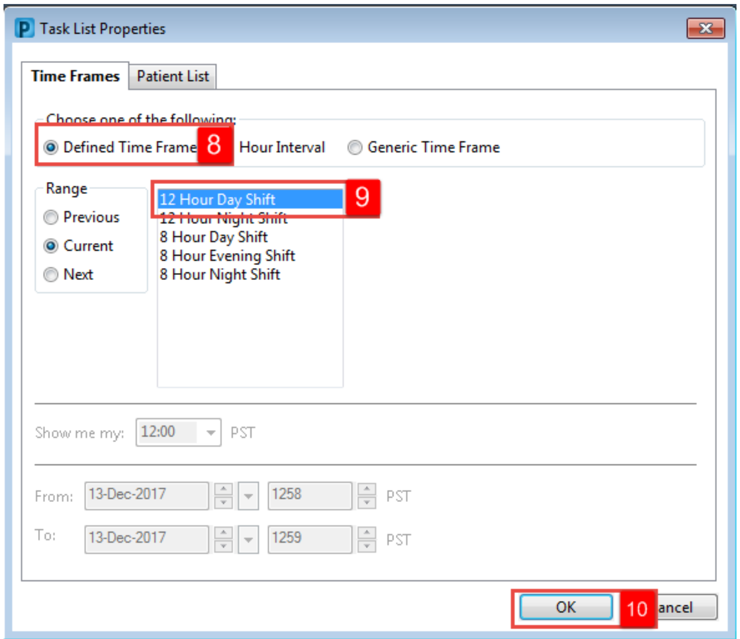
To select appropriate **Time Frame** for your MPTL:

6. Right-click the **date range** on 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 with the correct patients and their tasks.



Note: You must now repeat the previous steps for the remaining tabs to complete 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.

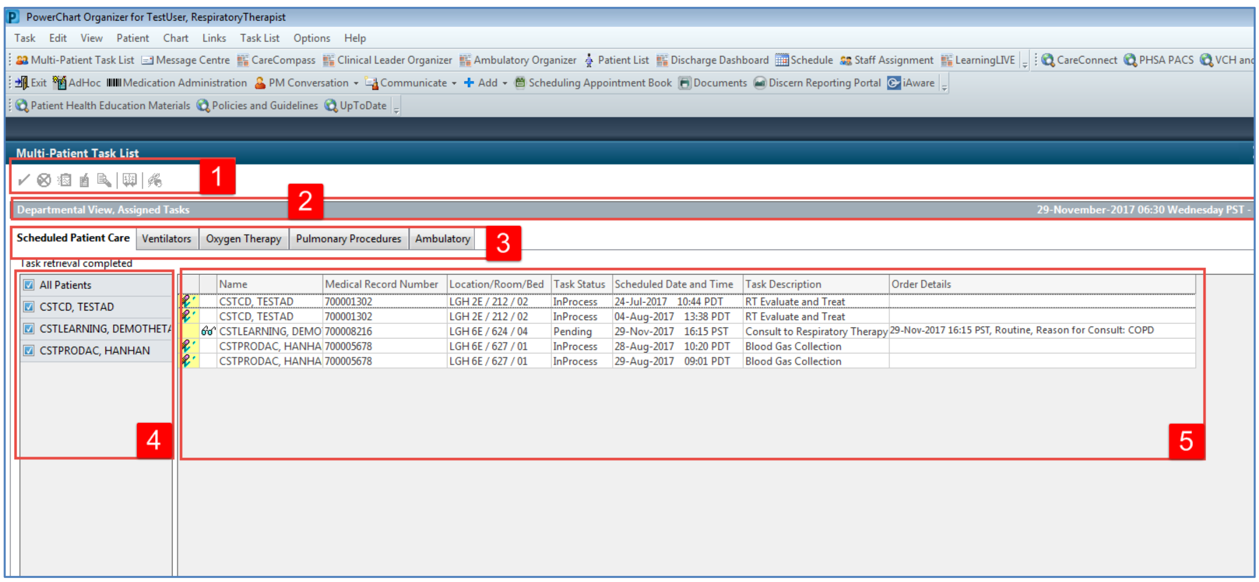
Key Learning Points

- The MPTL is the first page you will see upon logging in
- 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. **Navigator** window with the patient names with associated tasks
5. List of patient tasks



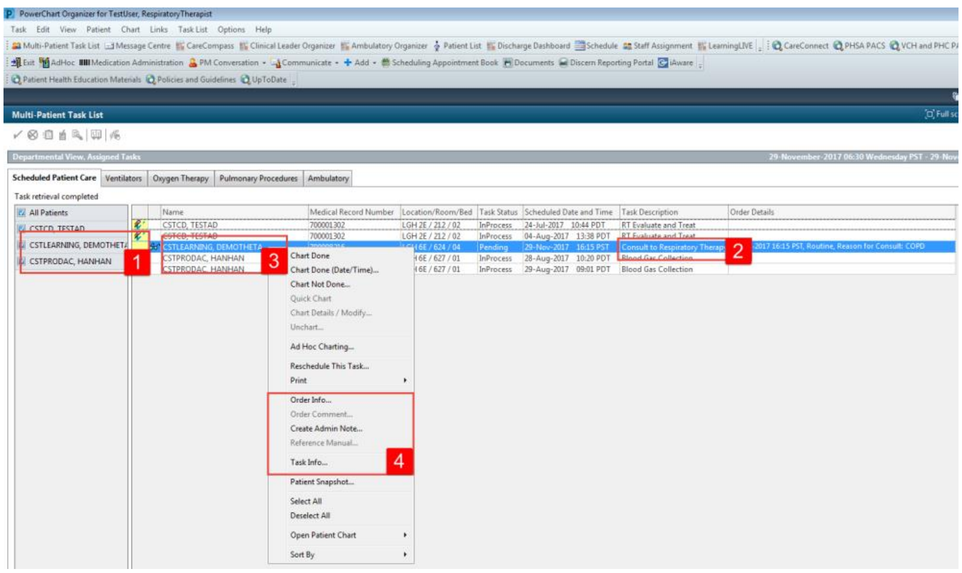
Key Learning Points

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

Activity 2.3 – Review Patient Tasks

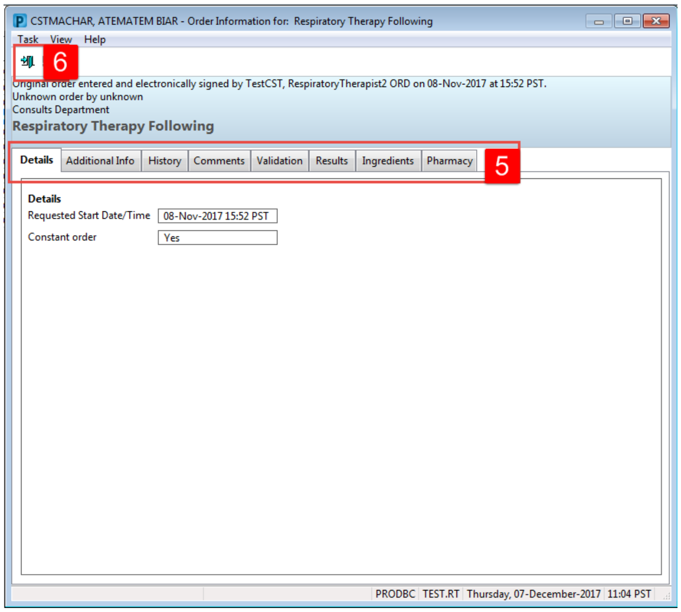
1 After setting up the **MPTL** you can see the patients that are under your care. Let's locate a patient and review one of their tasks.

1. Under the **Navigator** window with patient names, locate the correct patient and click on [**Patient Name**].
2. Review tasks associated with patient and locate the **Consult to Respiratory Therapy** task.
3. Right-click **Consult to Respiratory Therapy**.
4. Select **Order Info…** to learn more about the order.



The **Order Information** window opens.

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



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 to Respiratory Therapy order

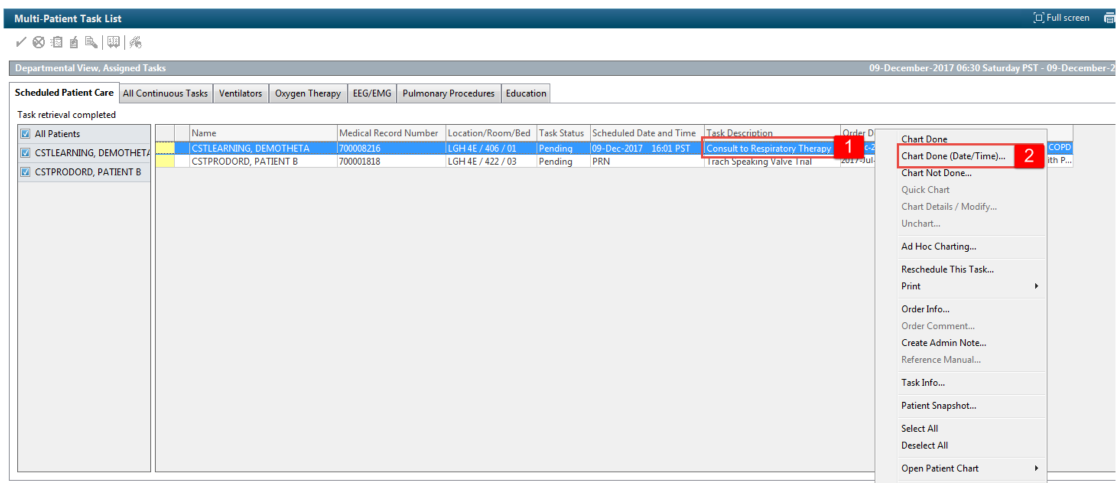
Activity 2.4 – Document a Patient Task as Complete

1

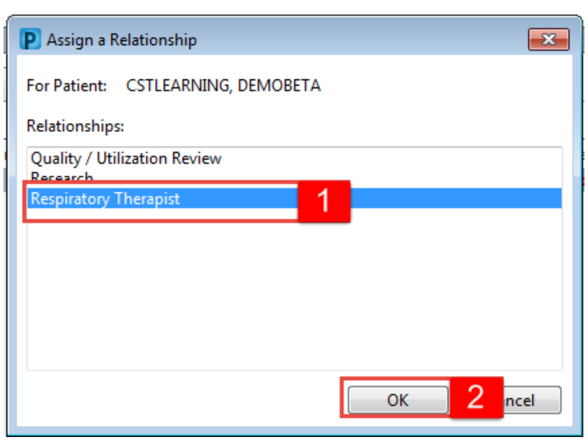
After you review your patient tasks and perform them, it is important to complete the appropriate documentation within the CIS. Documenting that a task has been done will allow the task to be cleared and will help prevent your **MPTL** from being cluttered with tasks that have already been completed.

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 to Respiratory Therapy**.
2. Select **Chart Done (Date/Time)**



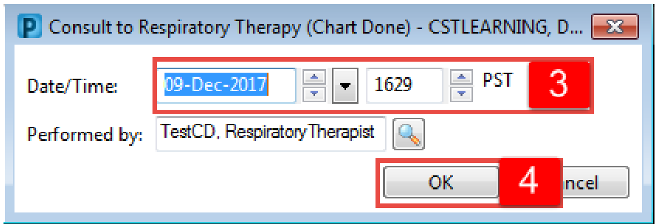
3. You will be asked to establish a relationship with the patient before you can open the patient's chart or proceed with completing a task. Select **Respiratory Therapist** in the **Assign a Relationship** window.
4. Click **OK**



5. Review the **Date/Time** cells in the **Consult to Respiratory Therapy (Chart Done)** window

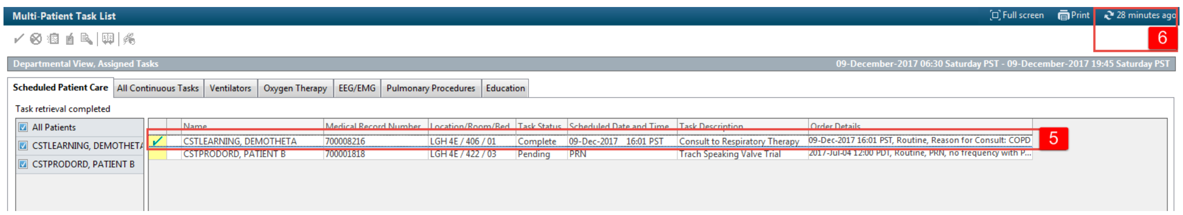
and adjust details as needed**.**

6. Click **OK**



7. The task now will now have a **Chart Done** icon next to it.

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.

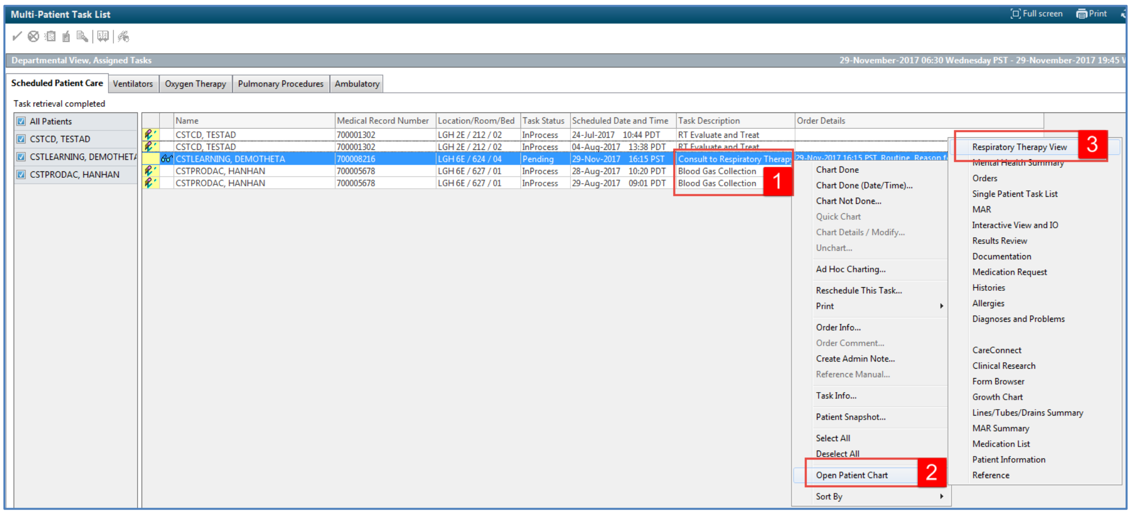
As a Respiratory Therapist you will be completing the following activities:

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

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 **Respiratory Therapy View**



2 The patient's chart is now open to the **Respiratory Therapy View** page. Before we proceed any further, let's go through an overview of the general screen.

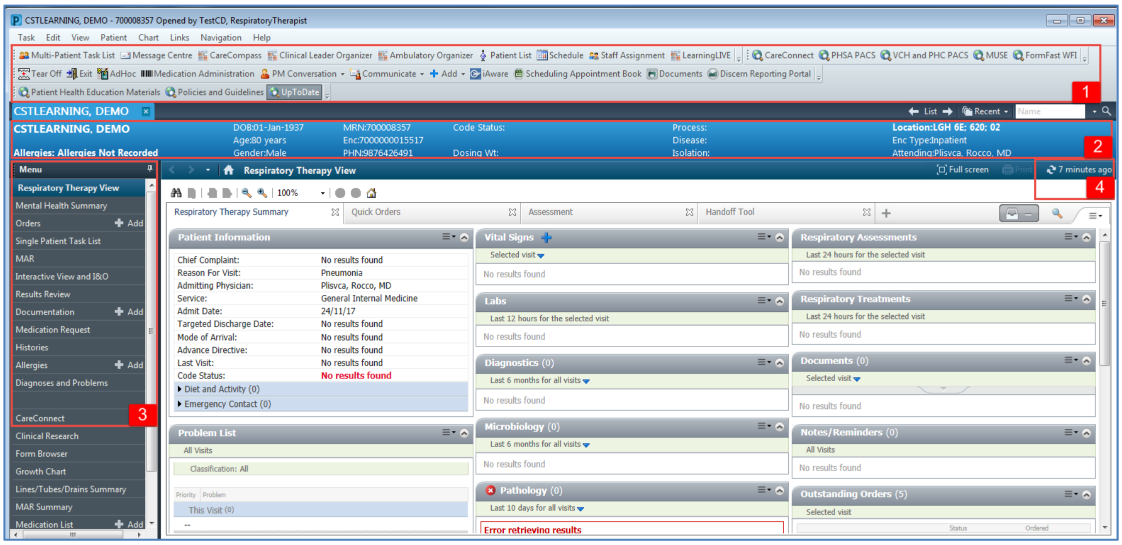
1. The **Toolbar** is located above the patient's chart and it contains buttons that allow you to access various tools within the Clinical Information System.
2. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information 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** (**MAR**) and more.

4. The **Refresh** icon updates the patient chart with the most up to date entries when clicked. It is important to click **Refresh** frequently as other clinicians may be accessing and documenting in the patient chart simultaneously.

Note: The chart does not automatically update. When in doubt, click Refresh

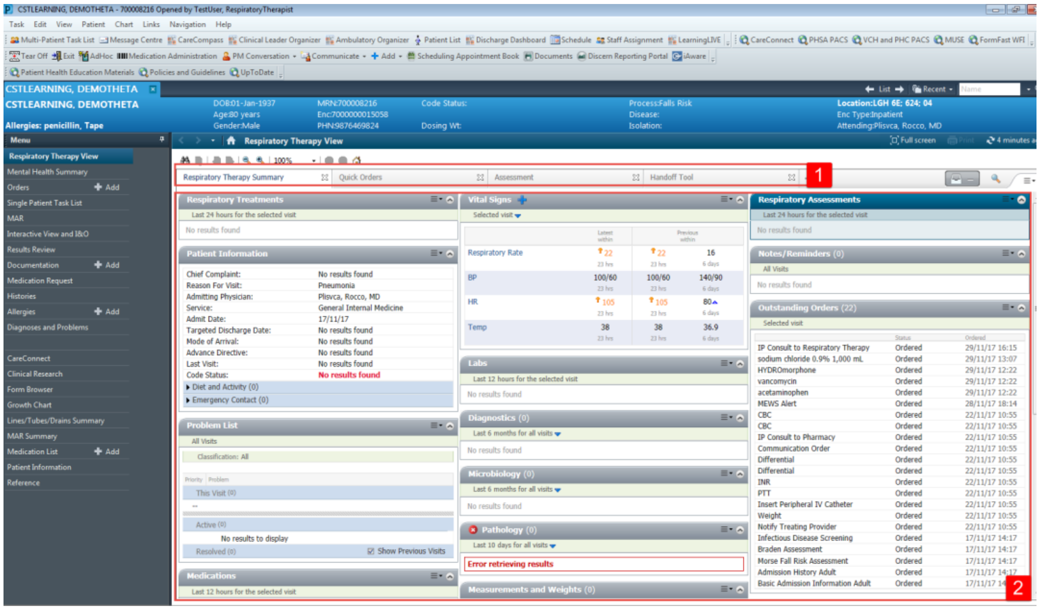


3

Now that you have been introduced to some key parts of the general screen, let's look more closely at the **Respiratory Therapy View**.

1. There are different tabs available to access information: **Respiratory Therapy Summary, Quick Orders, Assessment,** and **Handoff Tool**. Click on the different tabs to see a quick overview of the patient.

2. The **Respiratory Therapy Summary, Assessment, and Handoff Tool** 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. The **Quick Orders** tab displays several colour-coded components that represent an aspect of patient care (for example, Noninvasive Ventilation) and is tailored to the user. Within each component is a collection of orders relevant to that particular aspect of patient care.



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

Activity 3.2 – Review Results Using Results Review

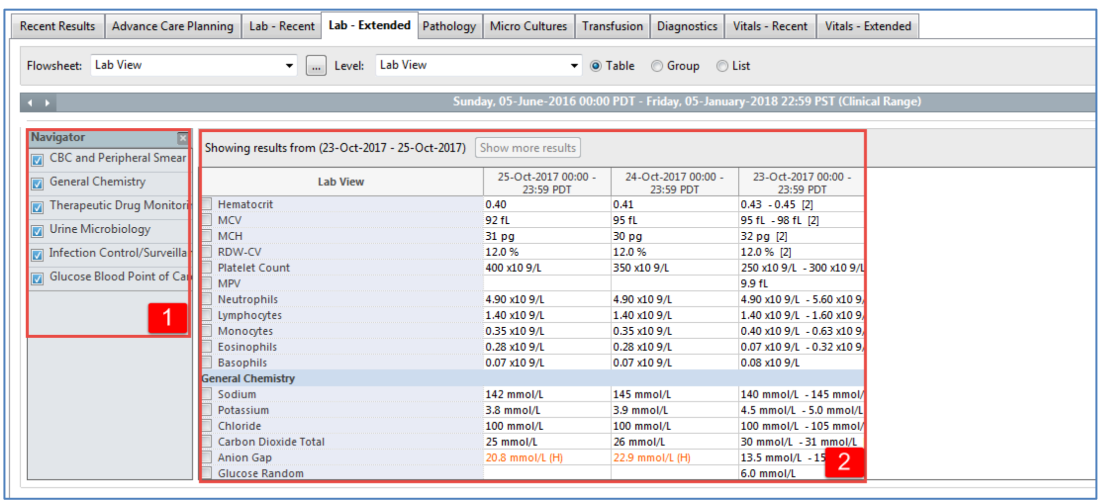
1 As explained previously, the **Menu** on the left side of your screen contains different sections of the patient's chart. We will explore some of the Menu sections in the following Activities. Let's begin with **Results Review**.

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.

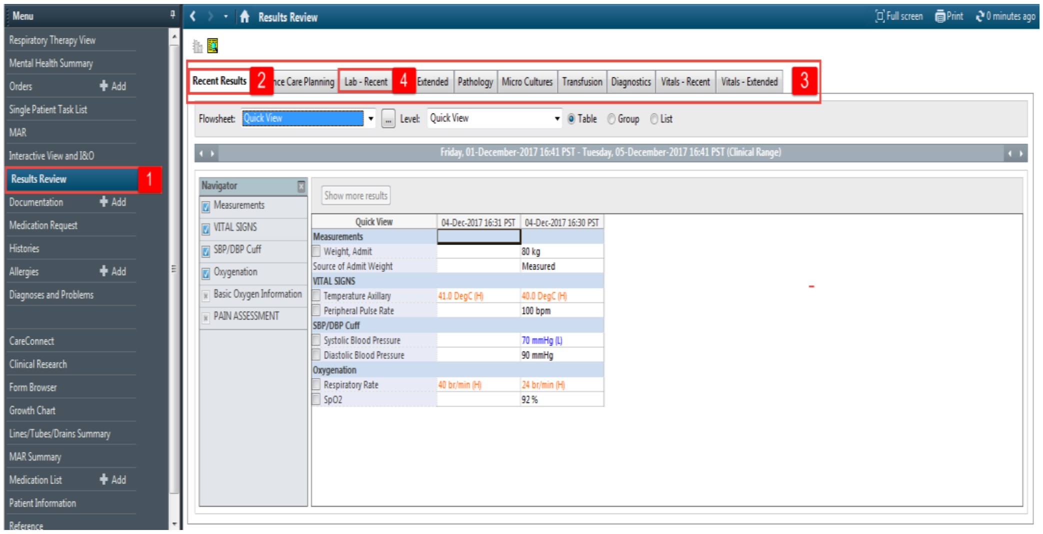
Flowsheets are divided into two major sections.

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

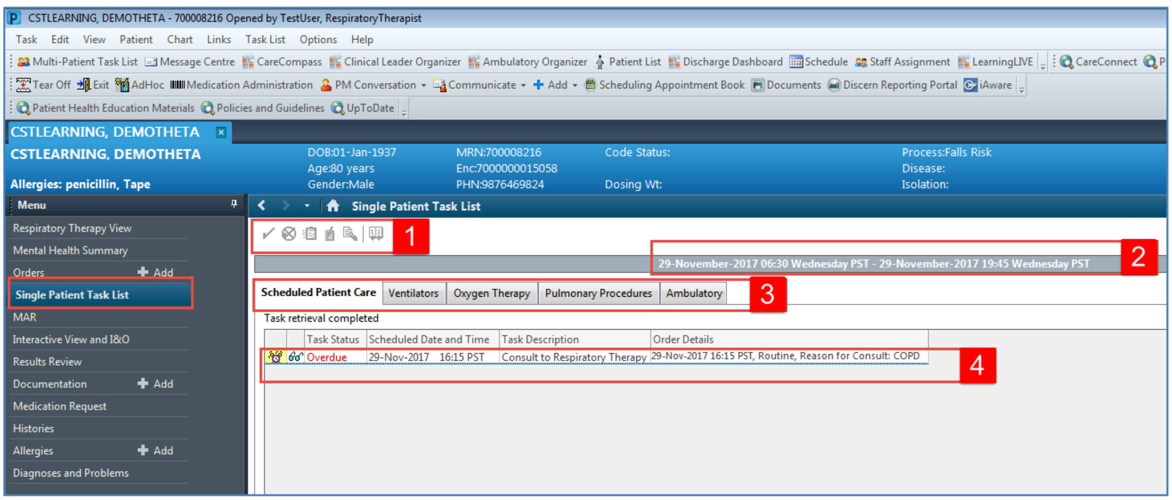
- Flowsheets in Results Review display clinical information recorded for a patient such as labs, cultures, transfusions, medical imaging, and vital signs
- The Navigator allows you to filter certain results in the Results Display
- Bloodwork is coloured to represent low, normal, high and critical values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

Activity 3.3 – 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

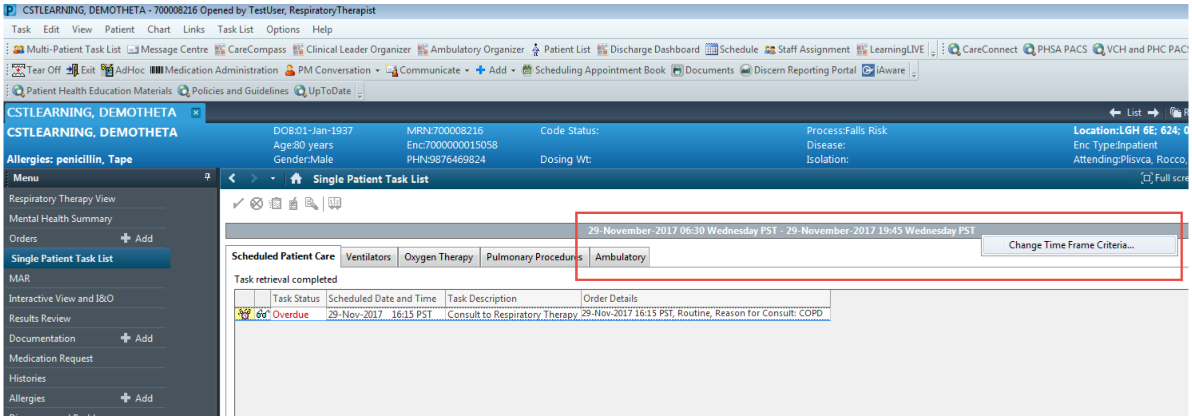


2 As with the MPTL, the **Time Frame** can be changed to the appropriate date.

1. Right-click the grey information bar with the time frame.
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** are 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

PATIENT SCENARIO 4 – Interactive View and I&O

Learning Objectives

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

- Review the Layout of Interactive View and I&O (iView)
- Document within Interactive View and I&O
- Modify, unchart or add a comment to your documentation

SCENARIO

As your shift continues, you will need to document various assessments and patient care. The following activities will introduce you Interactive View and I&O charting.

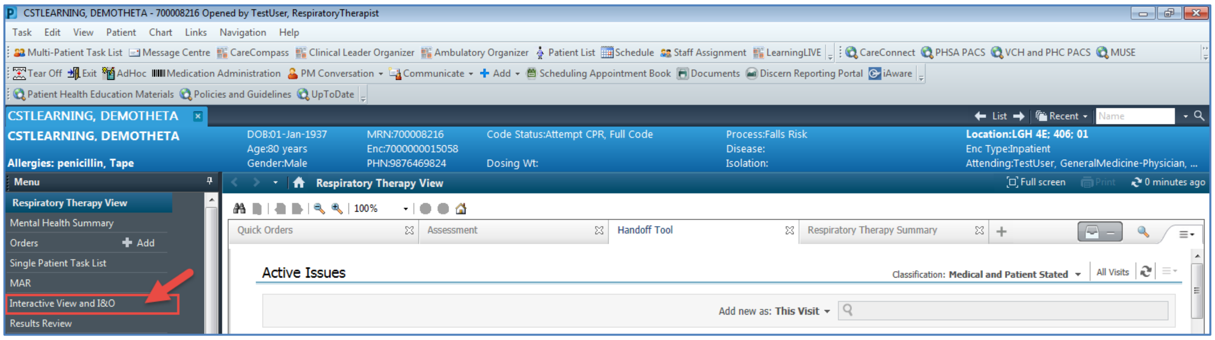
As a Respiratory Therapist you will be completing the following activities:

- Navigate to Interactive View and I&O (iView)
- Document in iView
- Change the time column
- Document a dynamic group in iView
- Modify, unchart or add a comment in iView

Activity 4.1 – Navigate to Interactive View and I&O

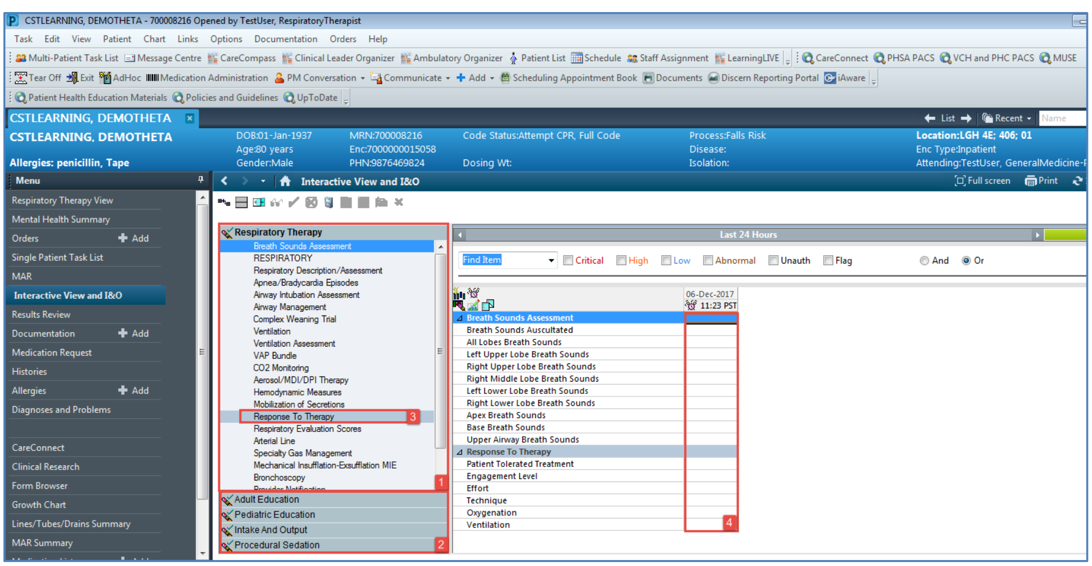
1 Respiratory therapists will complete most of their documentation in **Interactive View and I&O (iView)**. **iView** is the electronic equivalent of paper flowsheets. For example, vital signs and pain assessment will be charted in iView.

From the Menu, select the **Interactive View and I&O** section.



Now that the iView page is displayed, let's view the layout.

1. A **band** is a heading that has a collection of flowsheets (**sections**) organized beneath it. In the image below, the **Respiratory Therapy** band is expanded displaying the sections within it.
2. The set of bands below **Respiratory Therapy** are collapsed. Bands can be expanded or collapsed by clicking on their name.
3. A **section** is an individual flowsheet that contains related assessment and intervention documentation.
4. **Cells** are fields where data is documented.



Key Learning Points

- Interactive View and I & O allows you to access a variety of flowsheets for documentation
- Respiratory Therapists will complete most of their documentation in iView

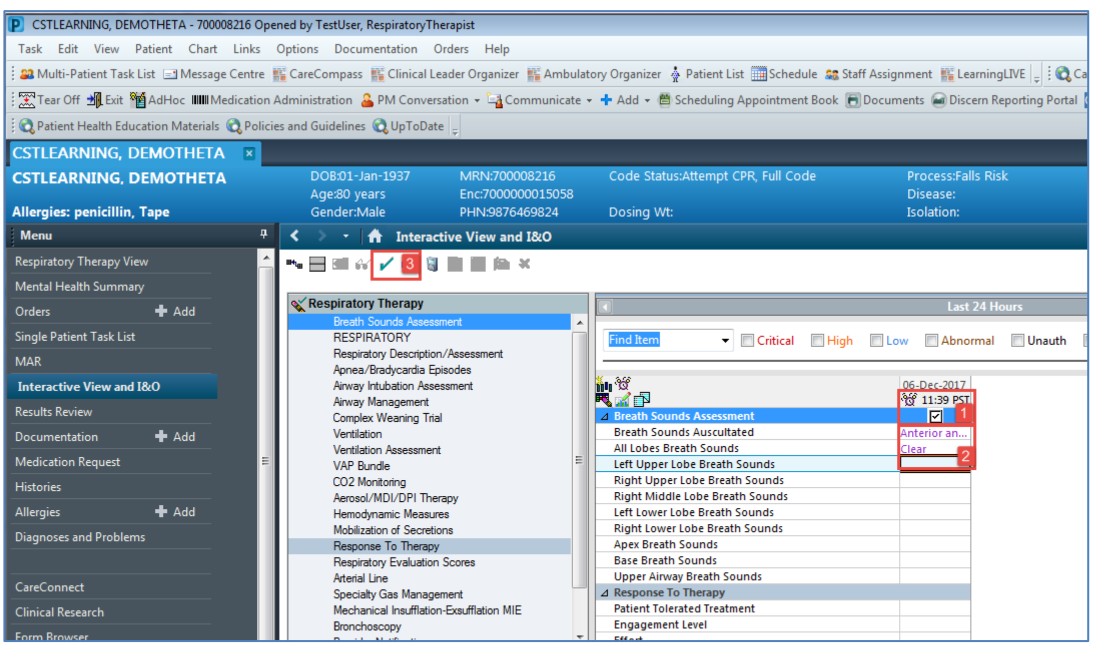
Activity 4.2 – Documenting in Interactive View and I&O

1 With the Respiratory Therapy band expanded you will see the Breath Sounds Assessment section. Let's practice documenting in iView. Remember to review the contents of the section before documenting.

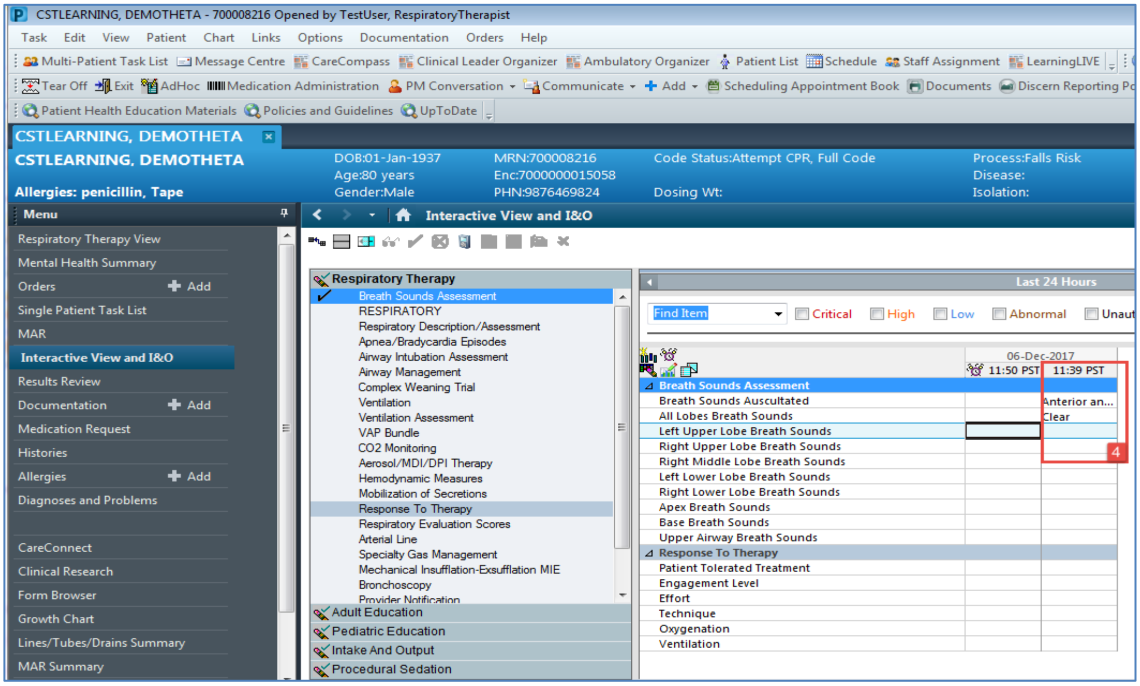
1. Double-click the **blue box** next to the name of the section to document in several cells. You will see this check mark icon appear after double clicking. You can move through the cells by pressing the **Enter** key.
2. Document the following data:
   - Breath Sounds Auscultated**: Anterior and Posterior**
   - All Lobes Breath Sounds: **Clear**

Notice that the text is purple upon entering. This means that the documentation has not been signed and is not part of the chart yet.

3. To sign your documentation, click the **green check mark** icon



4. Once the documentation is signed the text becomes black. Notice that a new blank column also appears after you sign your documentation, in preparation for the next set of charting. The columns are displayed in actual time. You can now document a new result for the patient in this column. The newest documentation is to the left.



Note: You do not have to document in every cell. Only document to what is appropriate for your assessment and follow appropriate documentation policies and guidelines at your site.

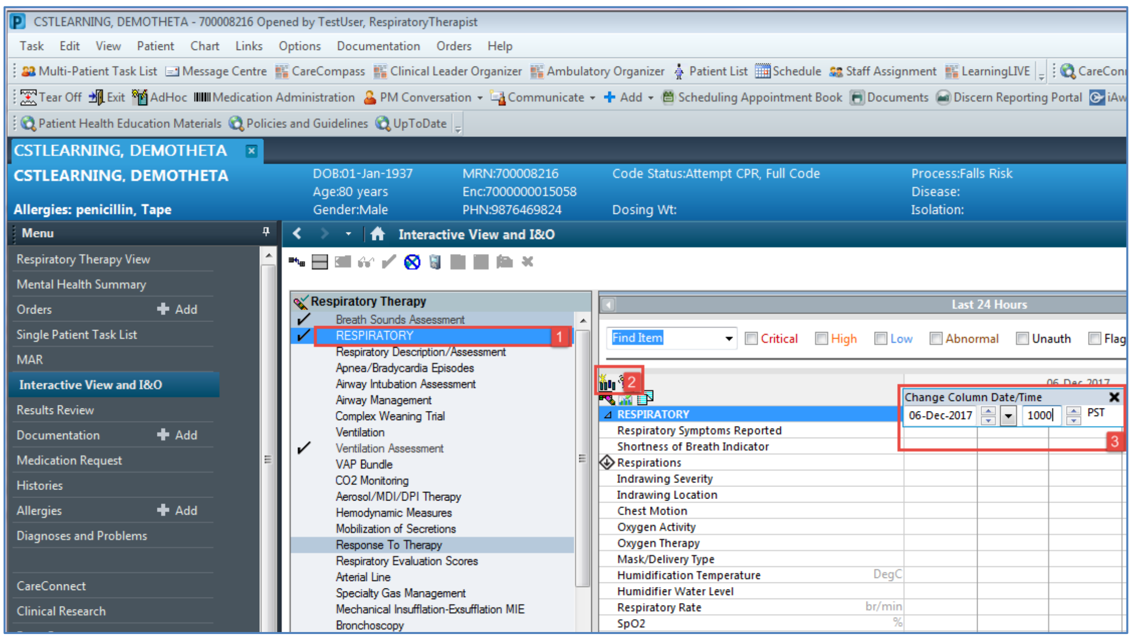
Key Learning Points

- Remember to review the contents of the section before documenting.
- Documentation will appear in purple until signed. Once signed, the documentation will become black.
- The newest documentation displays in the left most column
- Double-click the blue box  next to the name of the section to document in several cells; the section will then be activated for charting
- You do not have to document in every cell. Only document to what is appropriate to your assessment.

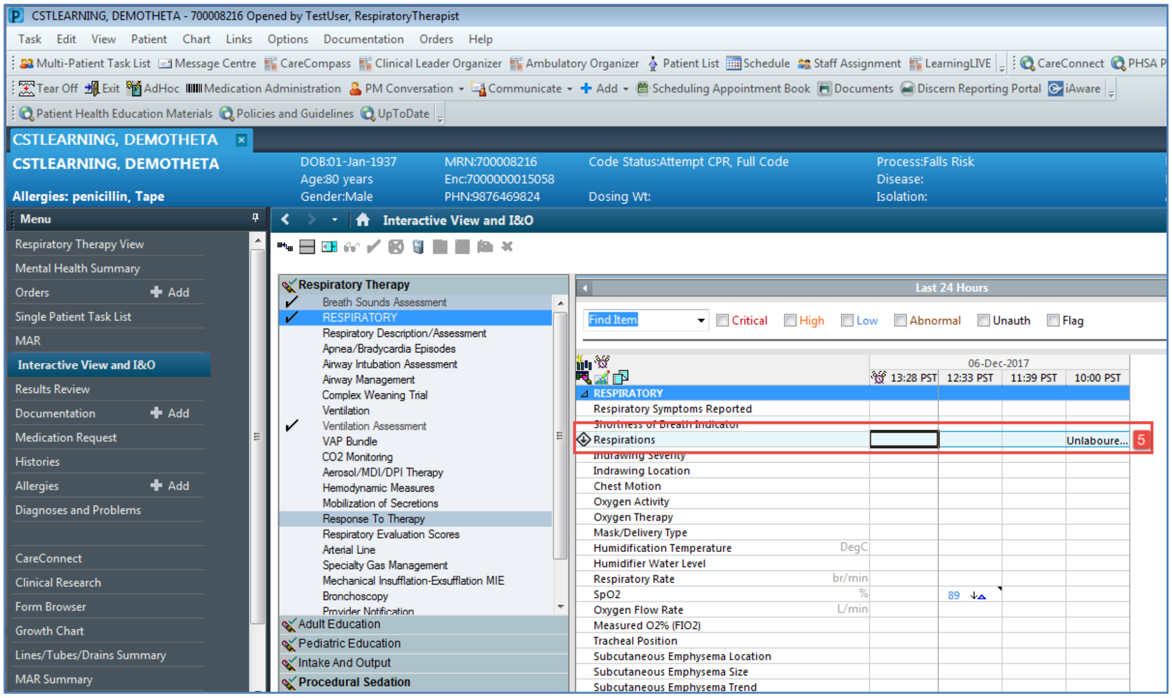
Activity 4.3 – Change the Time Column

1 You can create a new time column and document under a specific time. For example, let's pretend it is now 12:00 pm and you still need to document your patient's 10:00 am respirations.

1. Click on the **RESPIRATORY** section to display documentation under this section
2. Click the **Insert Date/Time** icon .
3. A new column and Change Column Date/Time window appear. Choose the appropriate date and time you wish to document under. In this example,
   - Date: **today's date**
   - **Time** = *09:00*
4. Click the **Enter** key



5. In the new column, enter Respirations: **Unlaboured**, **Regular** and click **green check mark** icon to sign your documentation.



The documentation is now black and saved into the chart.

Key Learning Points

- If required, you can create a new time column and document under a specific time

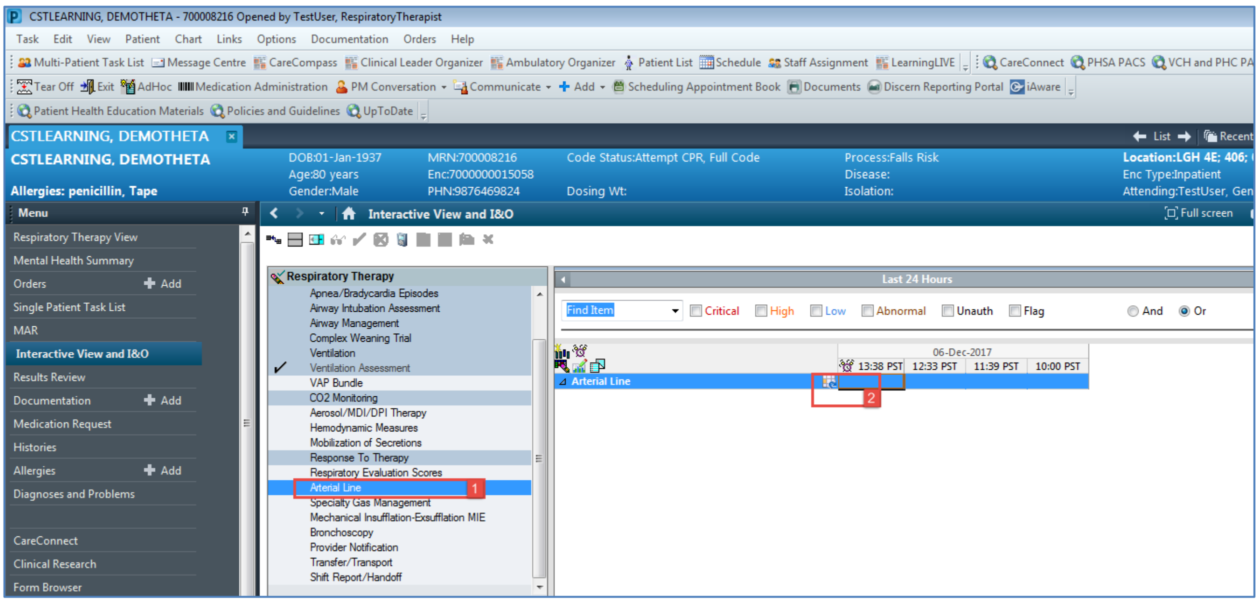
Activity 4.4 – Document a Dynamic Group in iView

1

Dynamic Groups allow the documentation and display of multiple instances of the same grouping of data elements. Examples of Dynamic Groups include Wound Assessments, IV Sites, chest tubes and more.

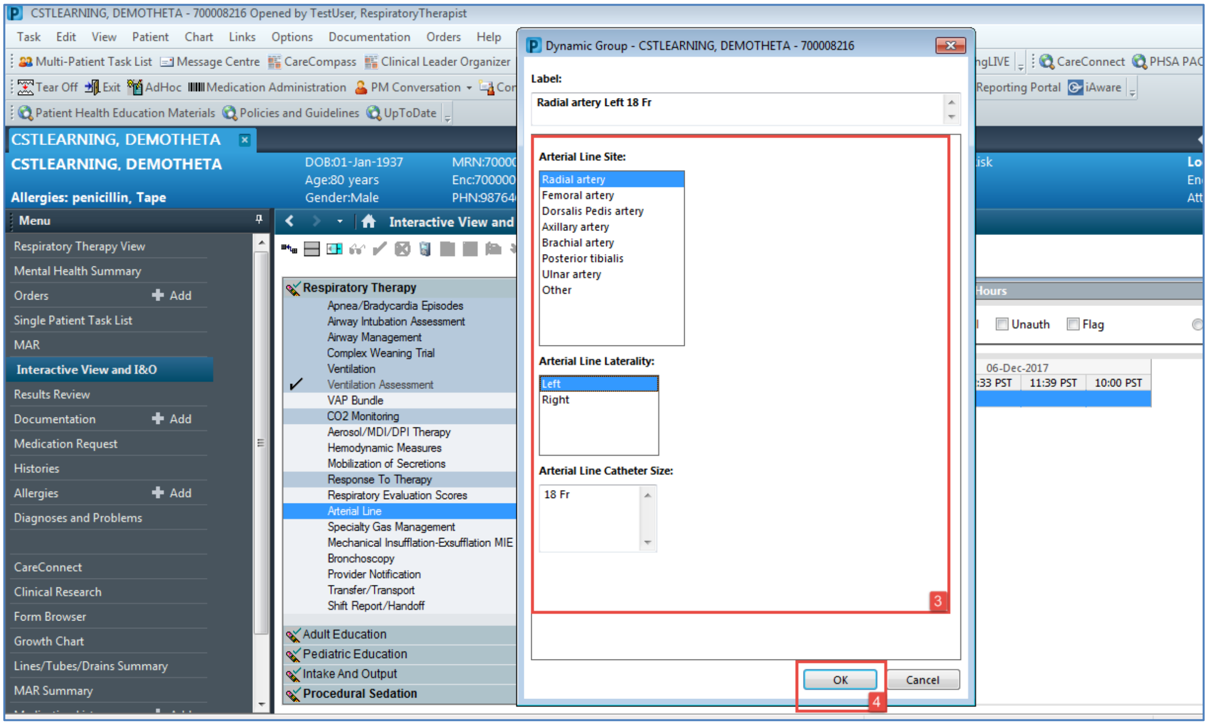
You are aware that your patient requires an arterial line to be inserted. After inserting the arterial line successfully, you are now ready to document the details of the arterial line insertion.

1. Click on the **Arterial Line** section to display documentation under this section
2. Now that the band is expanded, click on the **Dynamic Group** icon to the right of the Arterial Line heading in the flowsheet.



The **Dynamic Group** window appears. A dynamic group allows you to label a line, wound, or drain with unique identifying details. You can add as many dynamic groups as you need for your patient. For example, if a patient has two arterial lines, you can add a dynamic group for each arterial line.

3. Select the following to create a label:
   - Arterial Line Site: **Radial artery**
   - Arterial Line Laterality: **Left**
   - **Arterial Line Catheter Size** = *18 French*
4. Click **OK**

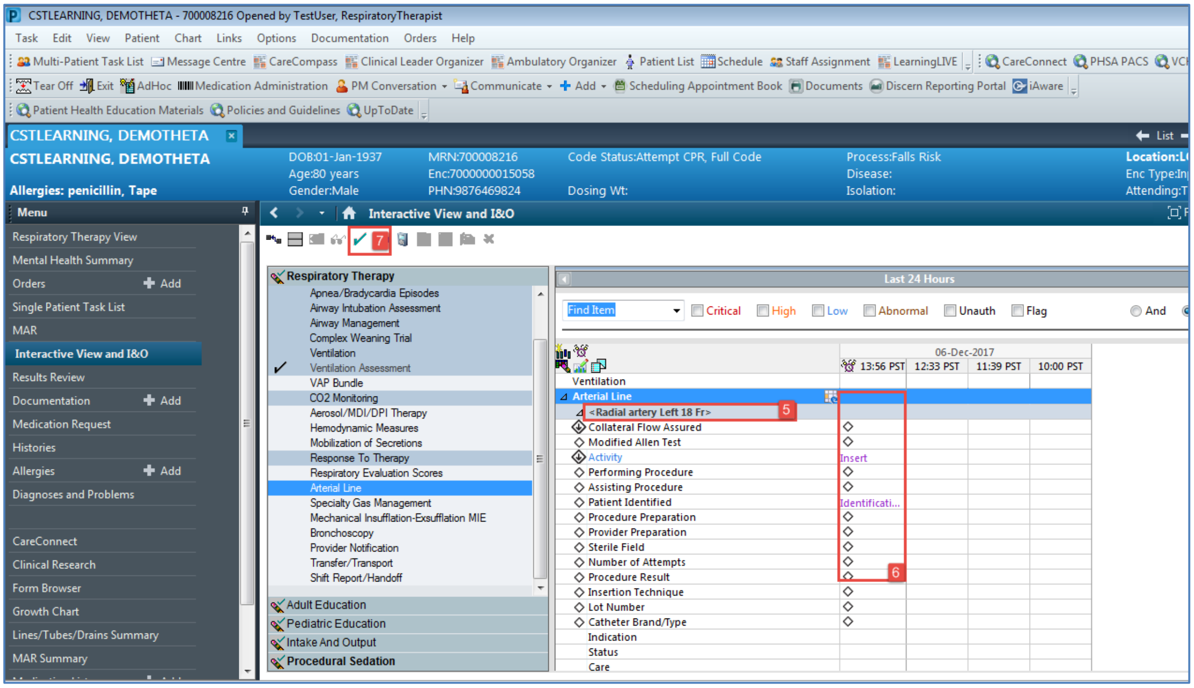


5. The label created will display at the top, under the Arterial Line section heading.
6. Double-click the **blue box** next to the name of the section to document in several cells. You will see this check mark icon  appear after double clicking. You can move through the cells by pressing the **Enter** key.

Now document the activities related to this arterial line:

- **Activity:** Insert
- **Patient Identified:** Identification band
- **Sterile Field:** Maintained
- **Number of Attempts:** *1*
- **Indication:** Frequent arterial blood gas sampling
- **Status:** Flushes easily, Good blood return, Satisfactory
- **Dressing:** Transparent securement dressing

7. Click **green check mark** icon  to sign your documentation. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.

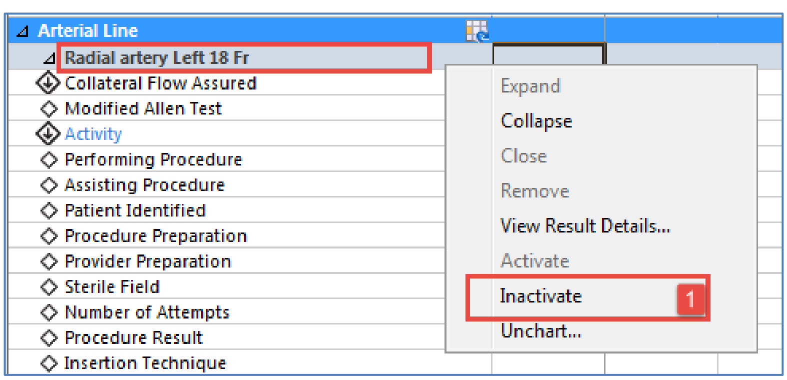


Note: A trigger icon can be seen in some cells, such as Activity, indicating that there is additional documentation to be completed if certain responses are selected. The diamond icon indicates the additional documentation cells that appear as a result of these responses being selected. These cells are not mandatory.

2 You can inactivate a **Dynamic Group** when it is no longer in use, such as when a drain or tube is removed.

To inactivate your arterial line dynamic group section:

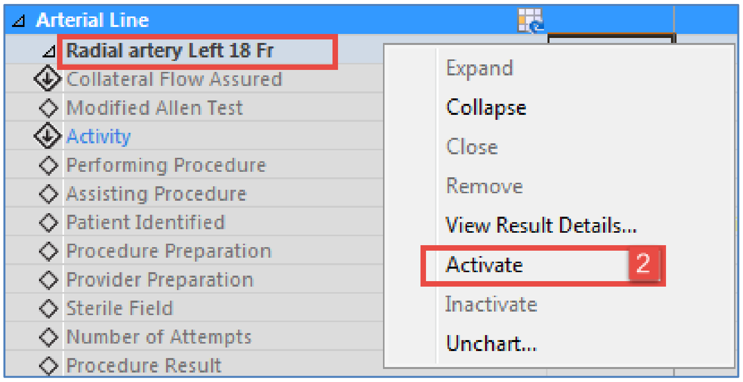
1. Right-click the dynamic group label **Radial arterial Left 18 Fr,** select **Inactivate**.



Note: The inactivated dynamic group remains in the view, but is unavailable, meaning clinicians cannot document on it. If there are no results for the time frame displayed, the inactive dynamic group is automatically removed from the display.

Now let's say you accidentally inactivated the wrong dynamic group. Don't worry! You can re-activate a dynamic group!

2. Right-click the dynamic group label for the **Radial arterial Left 18 Fr,** select **Activate**.



You and other users can now access this **Dynamic Group** for documentation.

Key Learning Points

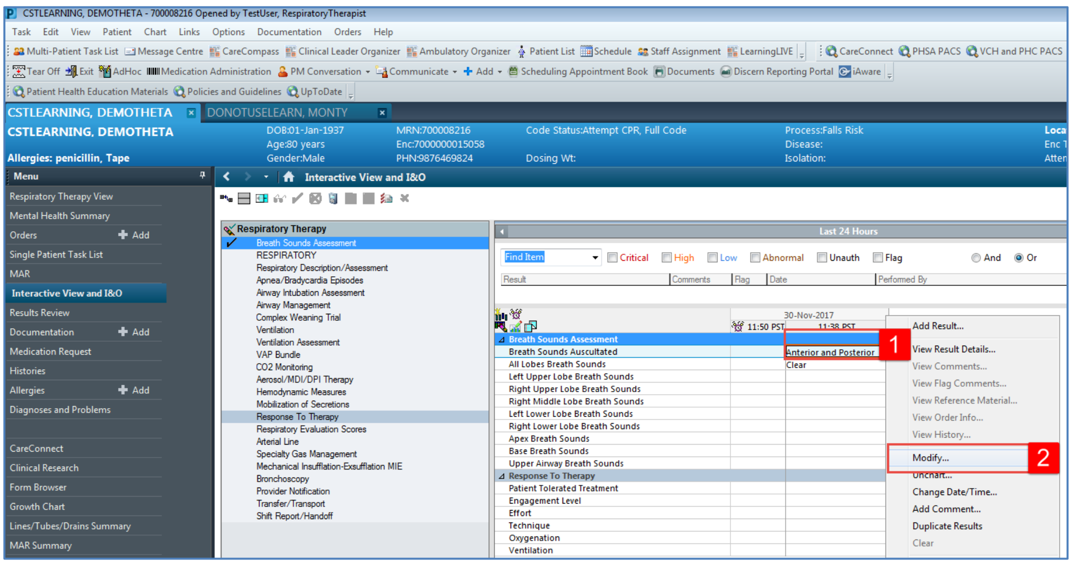
- Examples of Dynamic Groups include wound assessments, IV sites, chest tubes, and other lines or drains
- Once documentation within a dynamic group is signed, the label will be accessible for other clinicians to complete further documentation within the same dynamic group
- When a dynamic group is no longer in use, such as when a drain or tube is removed, you can inactivate it

Activity 4.5 – Modify, Unchart or Add a Comment in Interactive View

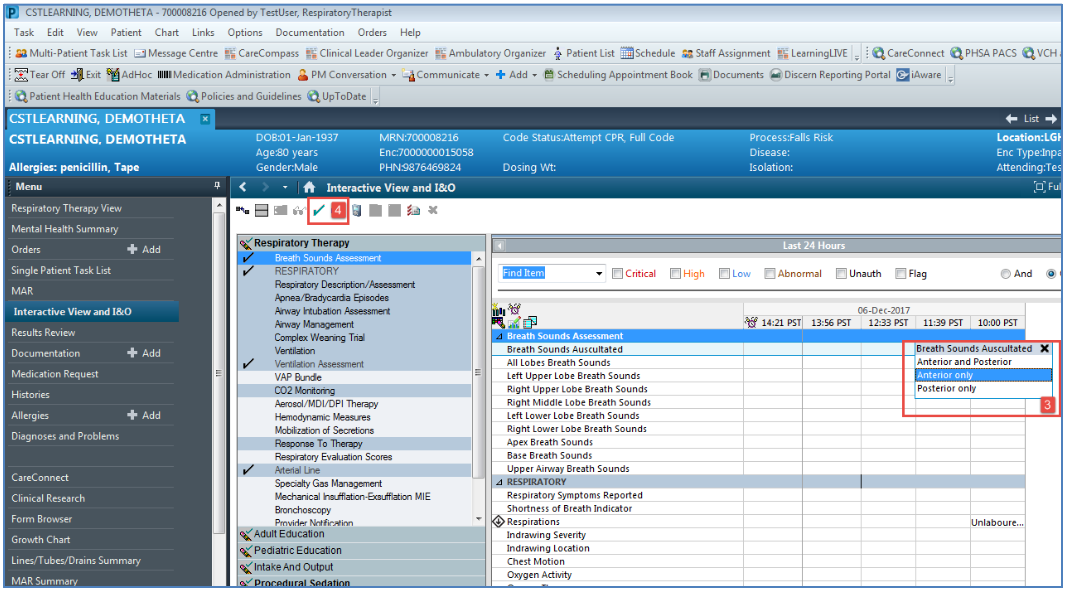
1 You just realized that you made an error when documenting Breath Sounds Auscultated and you want to modify the entry.

Modify a Comment:

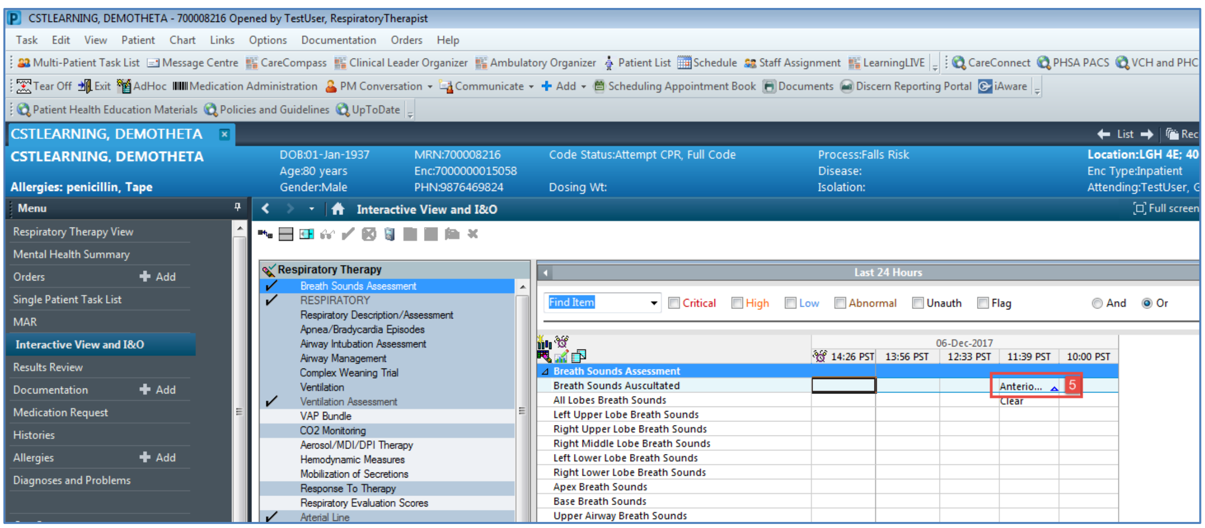
1. In the **Breath Sounds Assessment** section in the **Respiratory Therapy** band, right-click on **Anterior and Posterior** (your documented finding for **Breath Sounds Auscultated**).
2. Select **Modify…**



3. Select Breath Sounds Auscultated: **Anterior only**
4. Click the **green check mark** icon ✓ to sign your documentation.



5. Anterior only now appears in the cell and the corrected icon will automatically appear in the bottom right corner to denote a modification has been made.

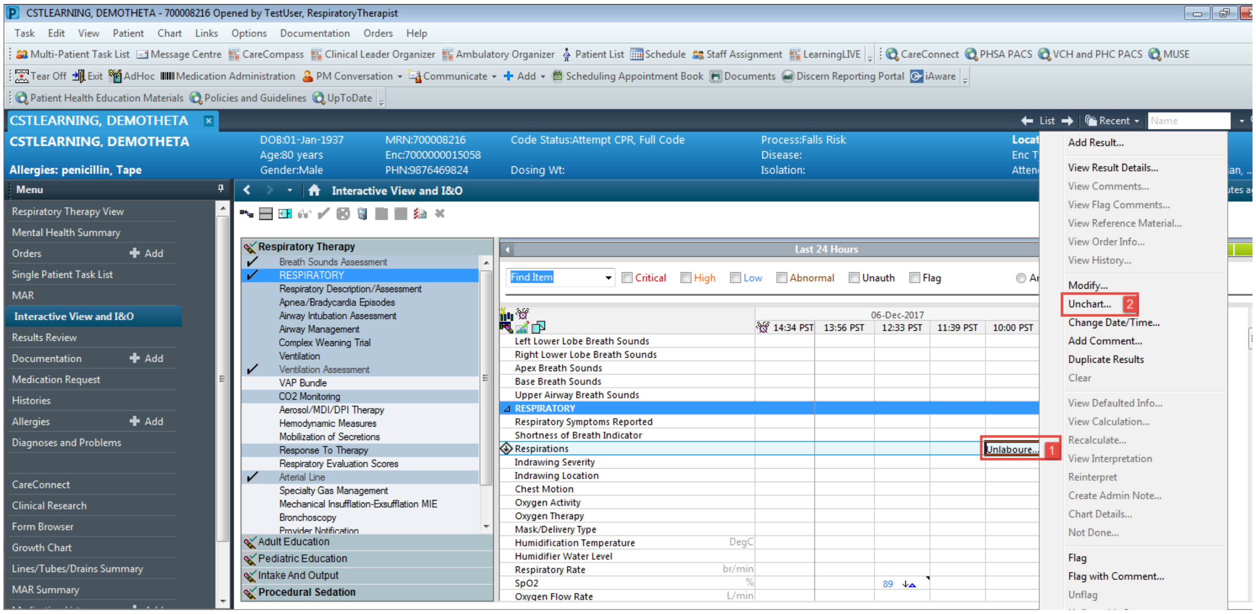


2 The unchart function will be used when information has been charted in error and needs to be removed. For example, respirations were charted in the wrong patient's chart.

Let's pretend that the respirations documented earlier were meant to be documented on one of your other patient's charts. It needs to be uncharted.

Unchart a Comment:

1. Right-click on the documented cell of **Unlaboured** for Respirations
2. Select **Unchart**

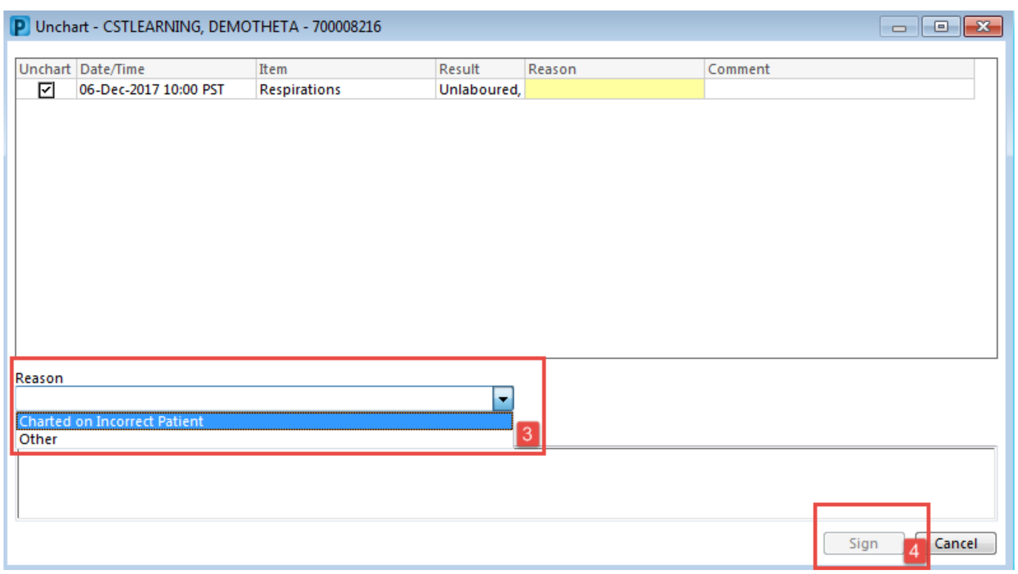


The **Unchart** window opens.

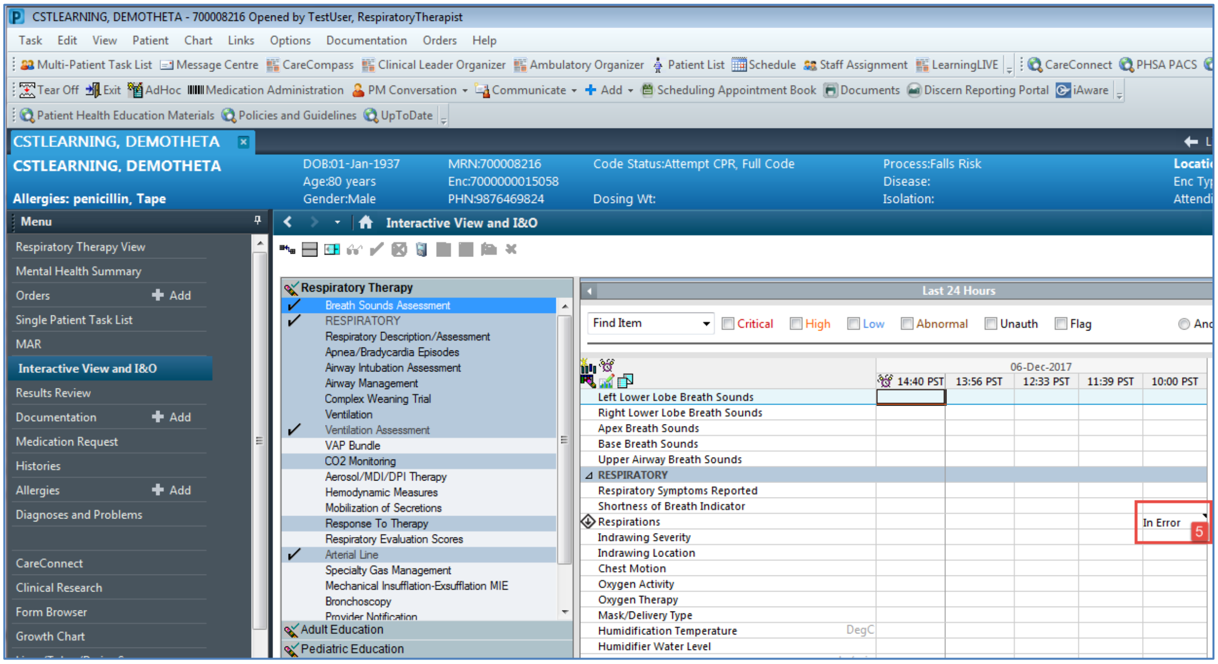
3. Select **Charted on Incorrect Patient** from the reason drop-down.

Note: The yellow field under Reason denotes a required field. You will not be able to click the Sign button until the reason is selected.

4. Click **Sign**



5. You will see **In Error** displayed in the uncharted cell. The result comment or annotation icon  will also appear in the cell.

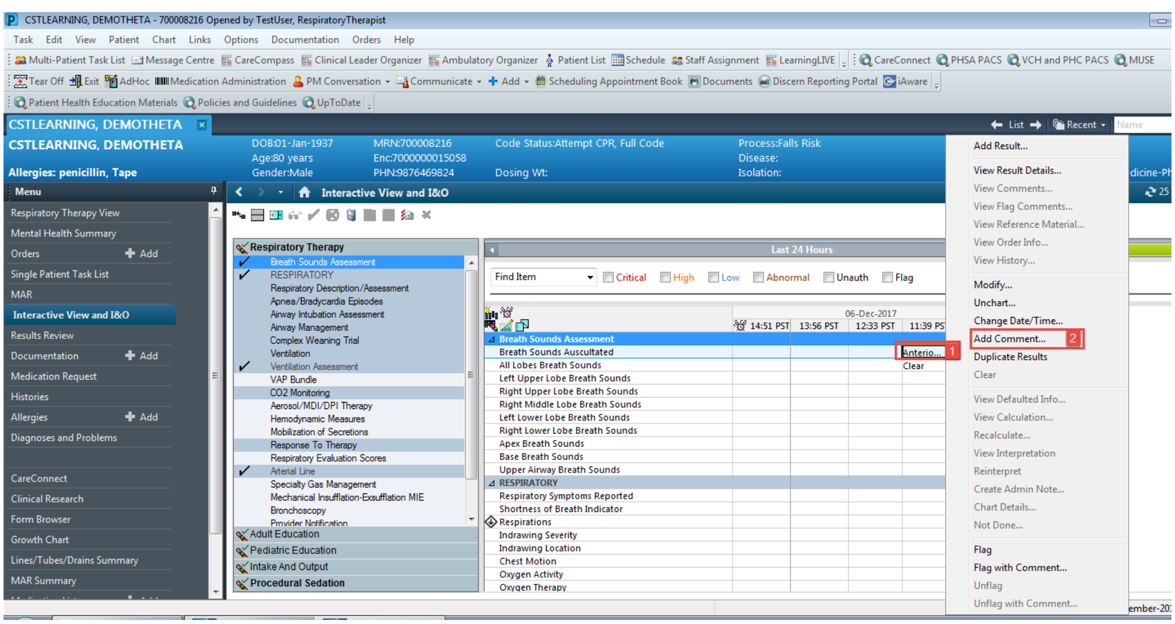


3

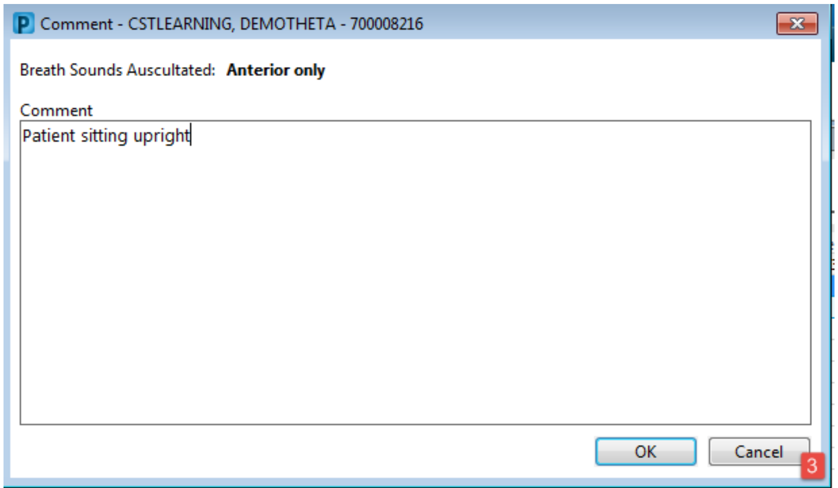
A comment can be added to any cell to provide additional information. For example, you want to clarify that the Breath Sounds Auscultated that you documented with the patient sitting upright. Let's add this comment.

Add a Comment:

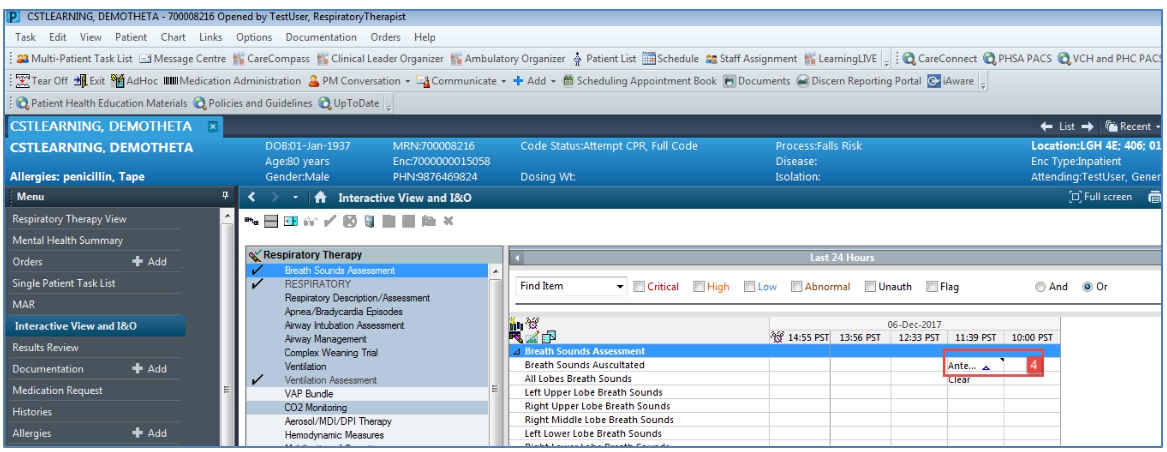
1. Right click on the documented value for Breath Sounds Asuculted, **Anterior only**
2. Select **Add Comment**



3. The comment window opens, type = *Patient sitting upright* and click **OK**.



4. An icon indicating the documentation has been modified will display and another icon indicating comments can be found will display in the cell. Right-click on the cell and select **View Comments…** to view a comment.



Key Learning Points

- Results can be modified and uncharted within iView
- A comment can be added to any cell in iView

PATIENT SCENARIO 5 – PowerForms

Learning Objectives

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

- Document in PowerForms through tasks or on an as needed (AdHoc) basis
- View, modify and unchart existing PowerForms

SCENARIO

In this scenario, another method of charting called PowerForms will be covered.

As a Respiratory Therapist you will be completing the following activities:

- Documenting on a new PowerForm through a task
- Opening and documenting on a new PowerForm on an as needed or AdHoc basis
- Viewing an existing PowerForm
- Modifying an existing PowerForm
- Uncharting an existing PowerForm

Activity 5.1 – Document in PowerForms through Tasks

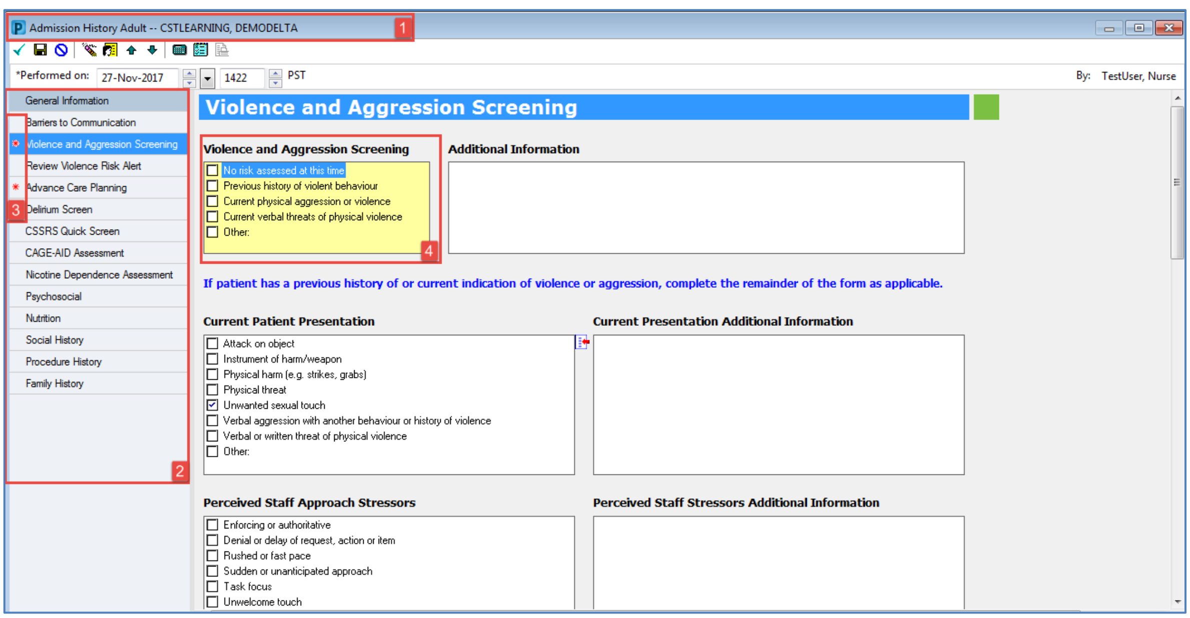
1 **PowerForms** are the electronic equivalent of paper forms currently used to chart patient information.

Data entered in **PowerForms** can flow between iView flowsheets, Clinical Notes, the Problem List, Allergy Profile, and Medication Profile.

Note: Do not attempt the next 4 steps in the system and instead review the screenshot below.

Review the screenshot below for a general overview of **PowerForm** features:

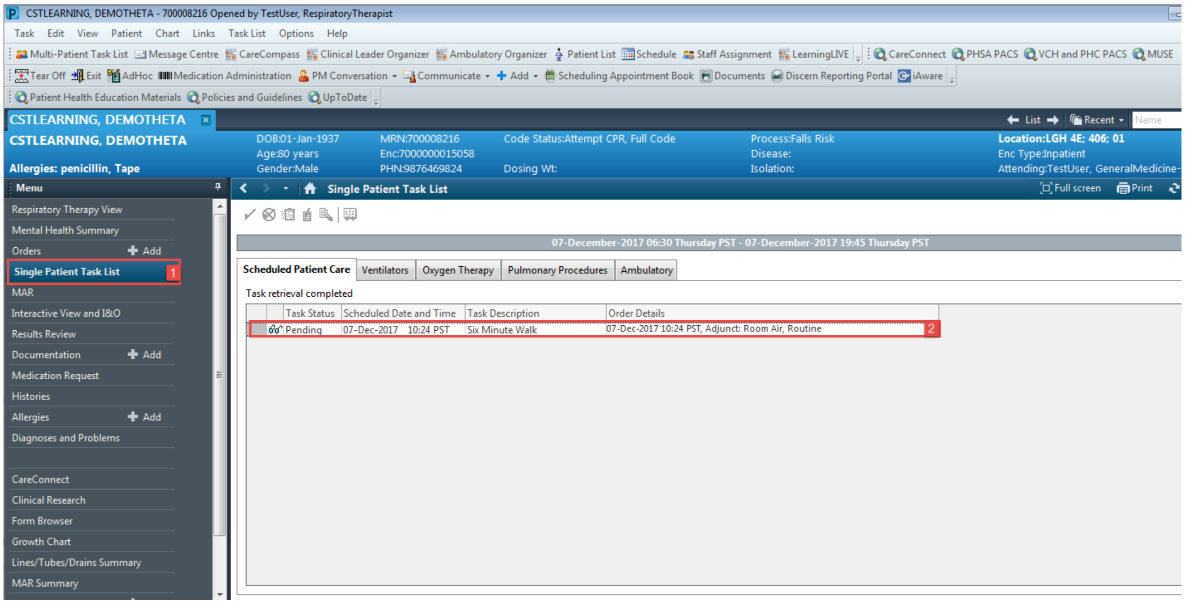
1. Title of the current **PowerForm** you are documenting on
2. List of sections within the **PowerForm** for documentation
3. A red asterisk denotes sections that have required field(s)
4. Required field(s) within the **PowerForm** will be highlighted in yellow. You will be unable to sign a **PowerForm** unless all required fields are completed.



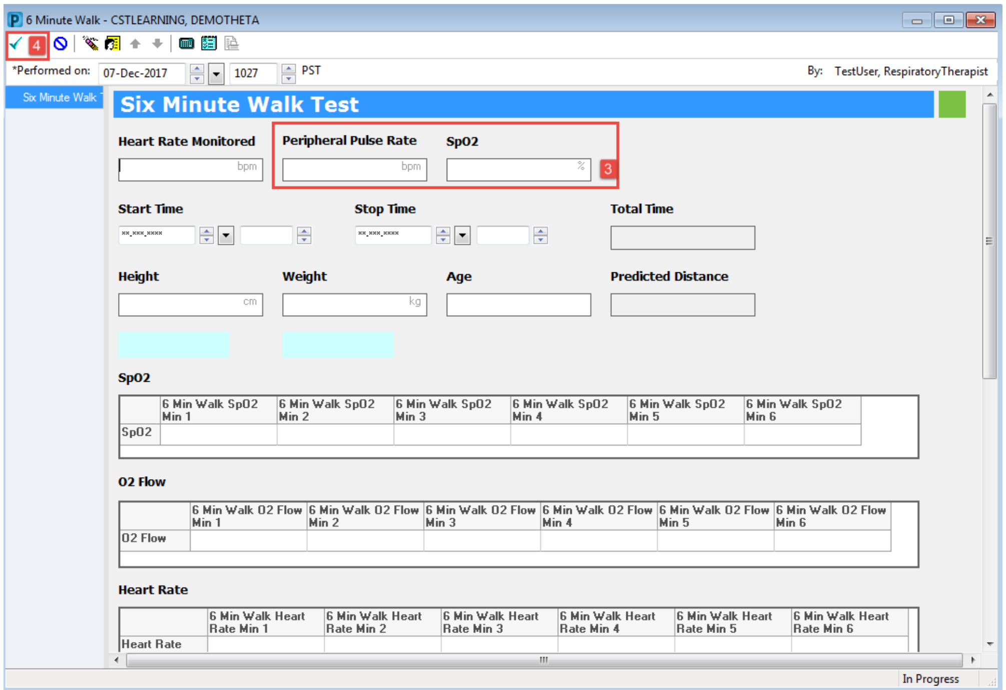
2 One way to access certain **PowerForms** will be through a task that appears on the **SPTL/MPTL**.

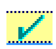
Now let's practice how to chart in a **PowerForm** that shows up as a task in the **SPTL** and **MPTL**. A 6 Minute Walk test has been ordered by the Physician.

1. Click on **SPTL** from the **Menu**. Once the **SPTL** displays, you should see the **Six Minute Walk** task.
2. Double click on the **Six Minute Walk** Task to open the associated **PowerForm**.

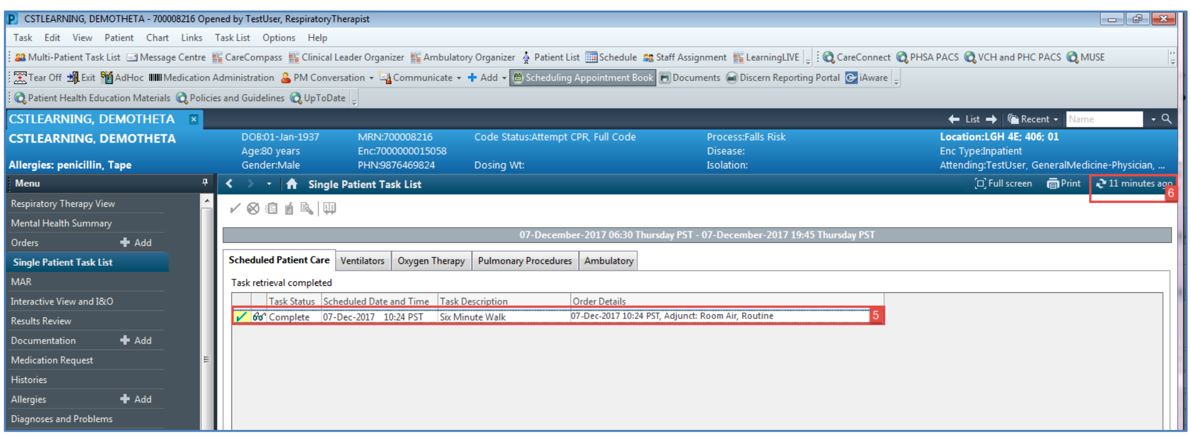


3. After you review the contents of the form, fill in the following fields:
   - **Peripheral Pulse Rate** = *70 bpm*
   - **SpO2** = *94%*
4. To complete the **PowerForm**, click the **green check mark** icon to sign the documentation.



5. After signing it, the **PowerForm** will close and your screen will display the **SPTL** again. The **Chart Done**  icon is now next to the task.

6. Click the **Refresh** icon  and the task will fall off both the **SPTL** (and **MPTL**).



Key Learning Points

- PowerForms are electronic forms used to chart patient information
- PowerForms may be broken up into several sections. Section headings are displayed to the left side of PowerForm
- Certain PowerForms can be accessed through a task on SPTL and MPTL

Activity 5.2 – Opening and Documenting on PowerForms on an As Needed Basis

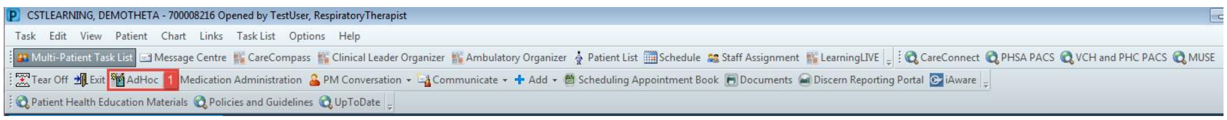
1

Throughout your shift, you may also need to document in **PowerForms** that are not tasked from your **SPTL** or **MPTL**. The **AdHoc** folder  is an electronic filing cabinet that allows you to find any **PowerForm** on an as needed basis.

In this example, we are going to document on the **Blood Gas Collection** PowerForm.

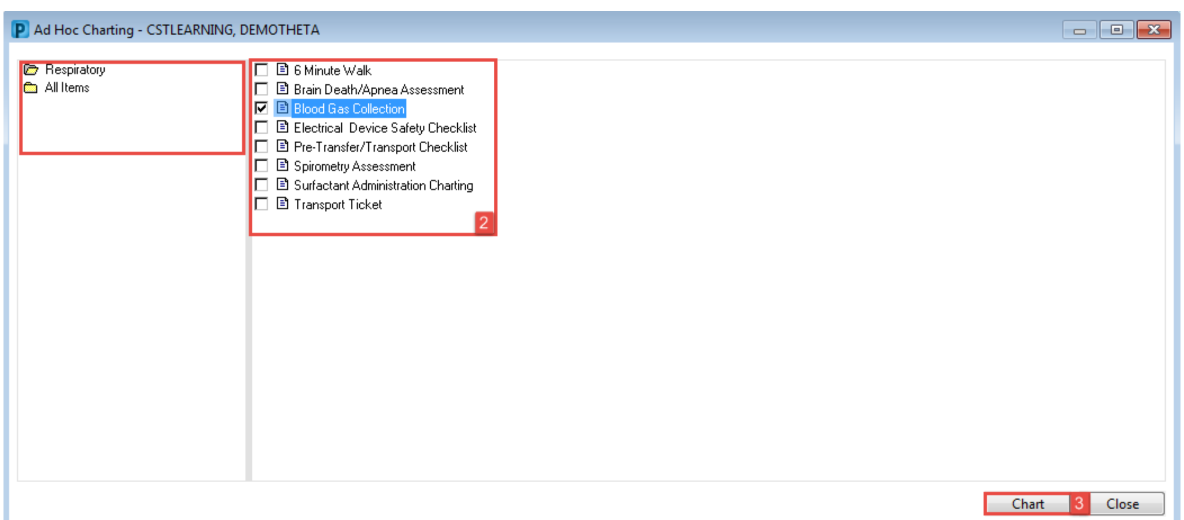
To **open** and **document** on a new **PowerForm**:

1. Click the **AdHoc** button  from the **Toolbar.**



2. Select the **Blood Gas Collection** PowerForm by clicking on the **box** beside the form name.
3. Click **Chart**.

Note: The **Ad Hoc Charting** window contains two panes. The left side displays folders that group similar forms together. The right side displays a list of **PowerForms** within the selected folder.

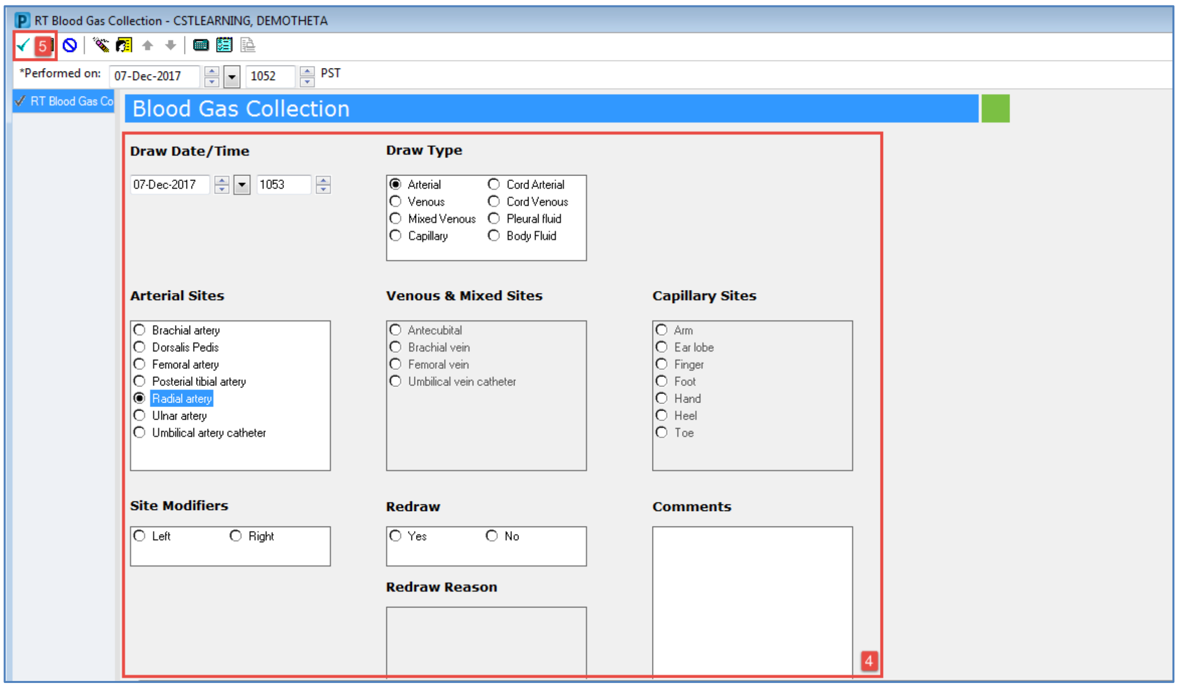


4. Fill in the following fields:
   - **Draw Date/Time** = *T* for Today's Date *and N* for Now/current time
   - **Draw Type** = *Arterial*

Note: Additional documentation that was previously greyed out turns white for additional charting.

- **Arterial Sites** = *Radial artery*
- **Site Modifiers** = *Left*

5. To complete **PowerForm**, click the **green check mark** icon to sign the documentation.



Note: using the Save Form icon is discouraged because no other user will be able to view your documentation until it is signed using the green check mark icon.

Key Learning Points

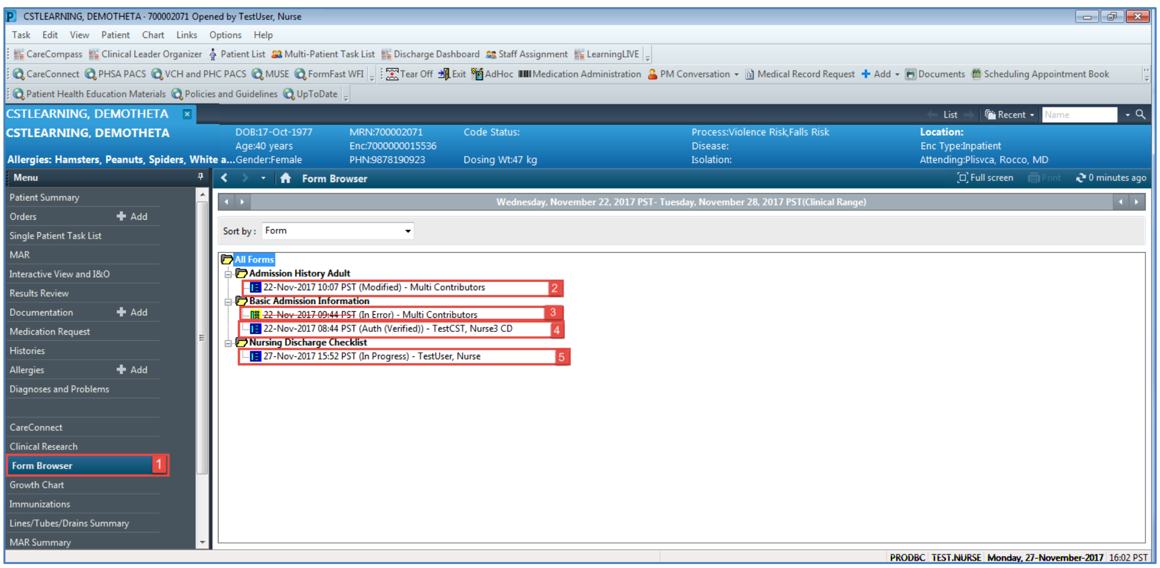
- The AdHoc button AdHoc in the Toolbar allows you to locate a new Powerform on an as needed basis.
- Always Sign the PowerForm using green check mark so that other users can see it on the chart.

Activity 5.3 – Viewing an Existing PowerForm

1 Throughout your shift, you may need to view previously documented **PowerForms**.

To view a **PowerForm**:

1. Select **Form Browser** in the **Menu**
2. For a **PowerForm** that has been modified, (**Modified**) appears next to the title of the document
3. For a **PowerForm** that has been entered incorrectly and has been uncharted, (**In Error**) appears next to the title of the document
4. For a **PowerForm** that has been completed and signed, (**Auth (Verified)**) appears next to the title of the document
5. When a **PowerForm** is saved, it is not complete and cannot be viewed by another user. (**In Progress**) appears next to the title of the document.



Key Learning Points

- Existing PowerForms can be accessed through the Form Browser.
- A PowerForm can have different statuses (e.g. Modified, In Error, Auth Verified and In Progress).

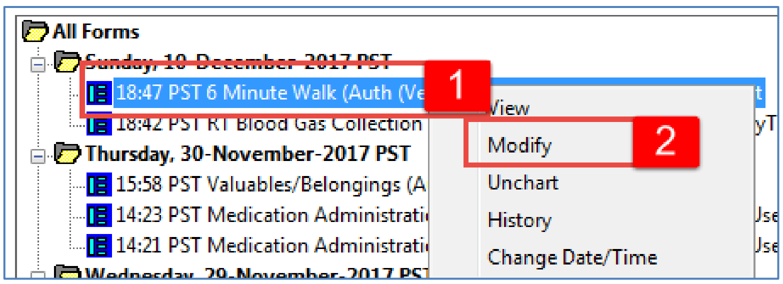
Activity 5.4 – Modify an Existing PowerForm

1 It may be necessary to modify **PowerForms** if the information was entered incorrectly.

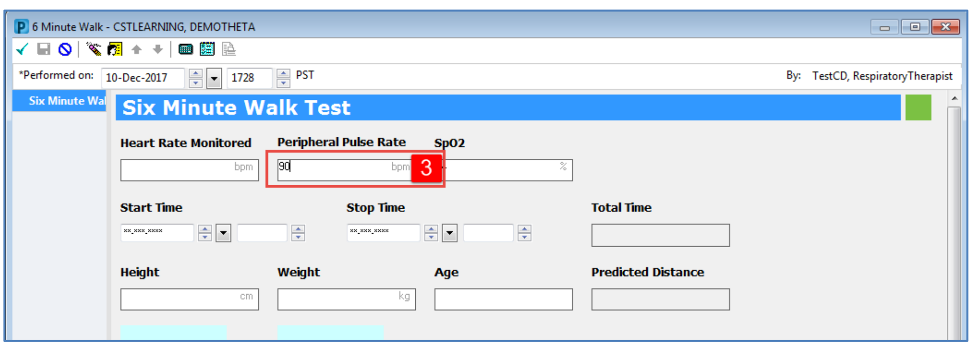
Note: If new or updated information needs to be documented, it is recommended to start a new **PowerForm** and not to modify an already existing **PowerForm**.

Let's modify the **6 Minute Walk Test** form.

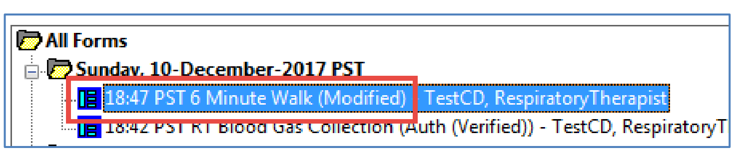
1. Right-click on the most recently completed **6 Minute Walk Test** form within **Form Browser**
2. Select **Modify**



3. Change the **Peripheral Pulse Rate** from 70 to **90**.



4. Click **green check mark** to sign the documentation.
5. When you return to this document in the form browser, it will show the document has been modified.



Key Learning Points

- A document can be modified if needed.
- A modified document will show up as (Modified) in the Form Browser.

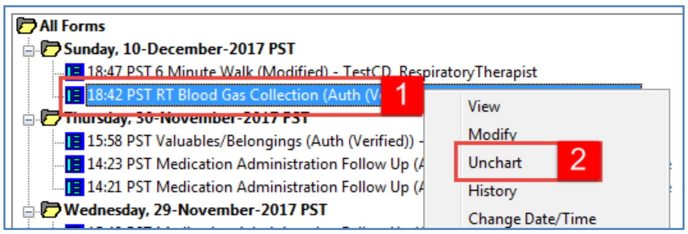
Activity 5.5 – Uncharting an Existing PowerForm

2

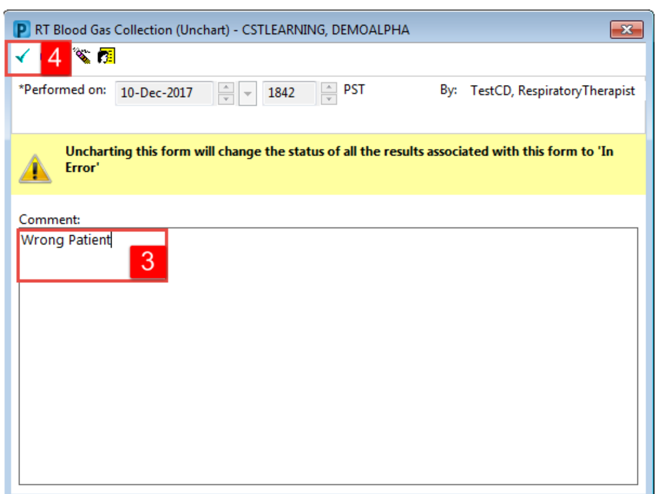
It may be necessary to unchart an existing **PowerForm** if, for example, the **PowerForm** was completed on the wrong patient or it was the wrong **PowerForm**. Let's say the **RT Blood Gas Collection** form was documented in error.

To unchart the **PowerForm**, within **Form Browser**:

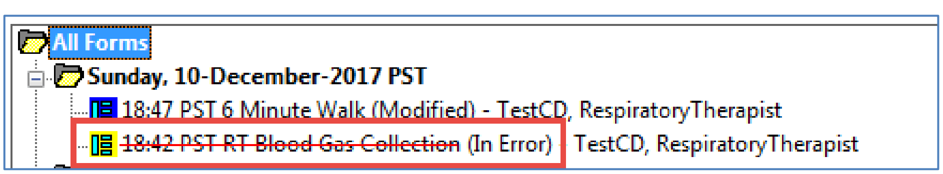
1. Right-click **RT Blood Gas Collection**
2. Select **Unchart**



3. Enter a reason for uncharting in the comment box of the new window = *Wrong PowerForm*
4. Click **green check mark** ✓ to sign the documentation.



5. Uncharting the form will change the status of all the results associated with the form to **In Error**. A **red-strike** through will also show up across the title of the **PowerForm**.



Key Learning Points

- A document can be uncharted if needed
- An uncharted document will show up as In Error in the Form Browser

PATIENT SCENARIO 6 – Additional Charting

Learning Objectives

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

- Document and unchart a narrative note
- Review documentation done in a note or text format of a Powerform

SCENARIO

In the previous scenarios, you completed charting in iView and PowerForms. Now you will learn about documenting in narrative notes, as well as reviewing notes completed by other disciplines.

As a Respiratory Therapist you will be completing the following activities:

- Document a narrative note
- Unchart a narrative note
- Review documentation done in a note or text format of a Powerform

Activity 6.1 – Document a Narrative Note

1 There may be instances where **iView** and **Powerforms** do not capture all the information during a patient event and you may want to supplement with a narrative note.

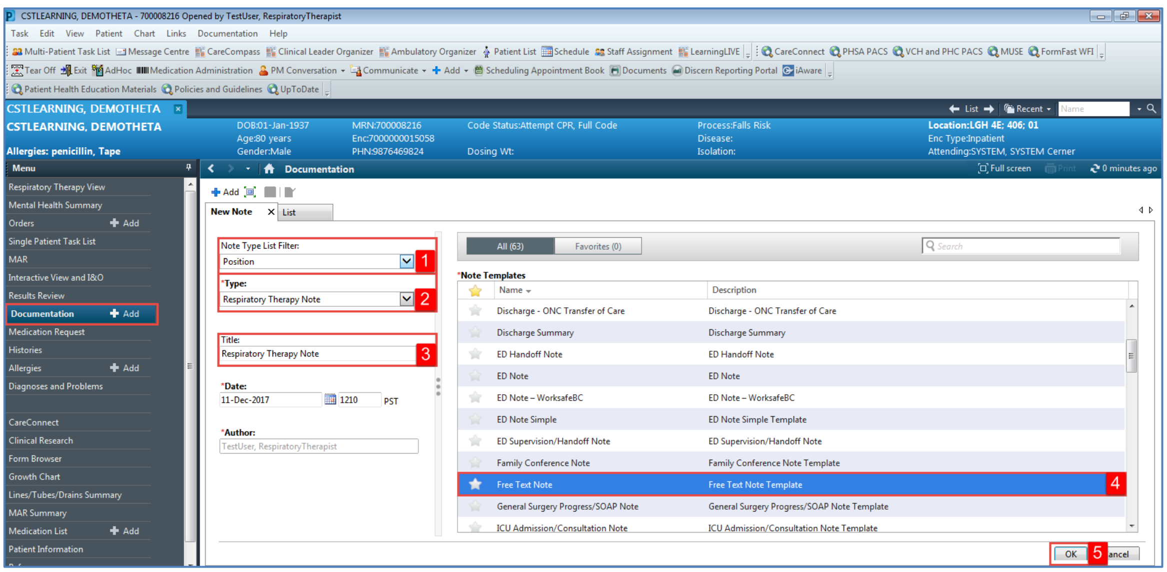
To start this documentation, click + **Add** 

next to **Documentation** on the **Menu**

1. Under **Note Type List Filter,** select **Position**
2. Under **Type**, select **Respiratory Therapy Note**
3. Under **Title**, type = *Respiratory Therapy Note*
4. Under **Note Templates,** select **Free Text Note**

Note: It is recommended that Free Text Notes are given specific titles (step #3) to help identify them rather than using the generic title of Free Text Note.

5. Click **OK**

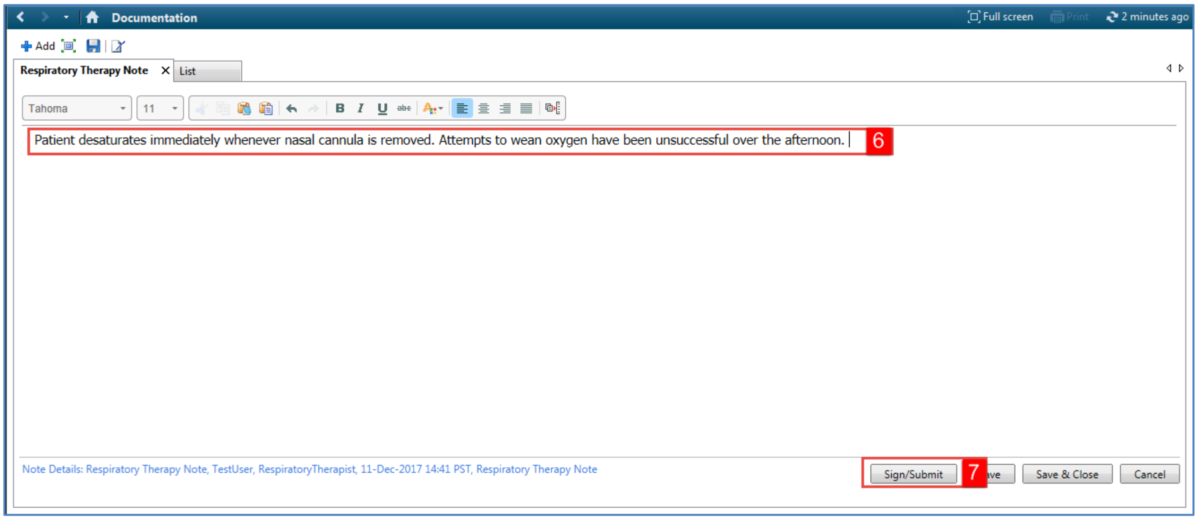


6. A blank Free Text Note will open. Within this note, document patient assessments or care which are not readily captured within **iView** or **PowerForms**.

   Type = *Patient desaturates immediately whenever nasal cannula is removed. Attempts to wean oxygen have been unsuccessful over the afternoon.*

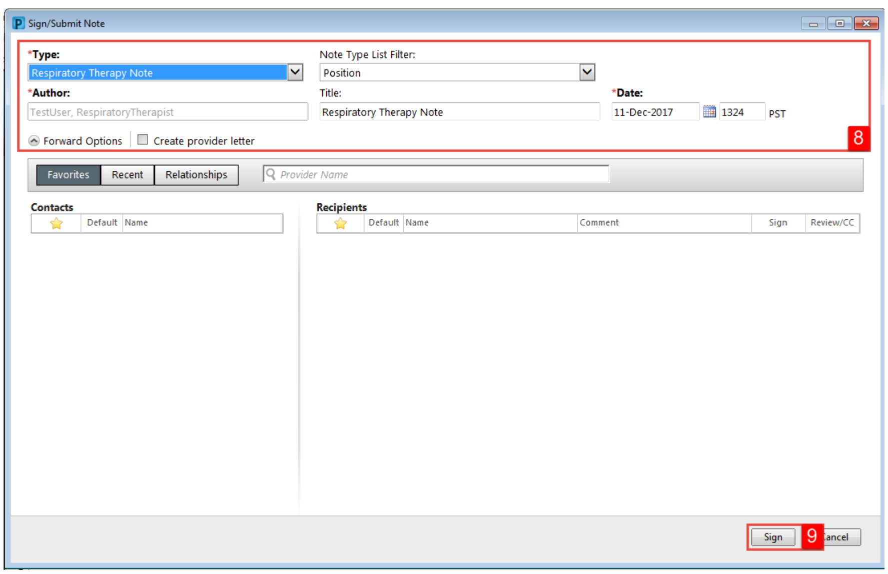
Note: Ensure documentation is accurate as there is no ability to edit this information once you have clicked the sign/submit button. You are only able to modify this charting by inserting an addendum.

7. Click **Sign/Submit**

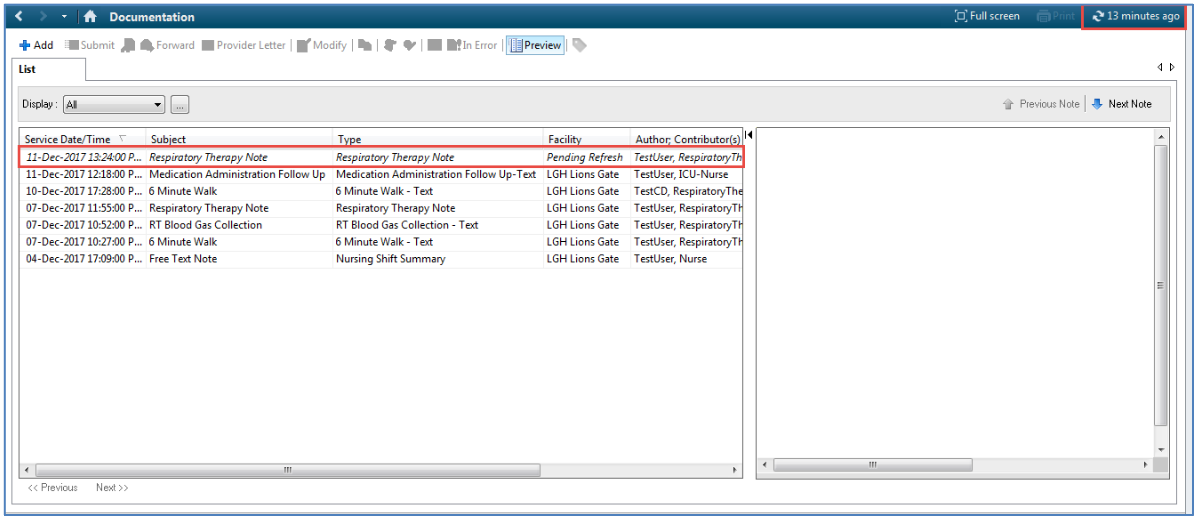


8. Verify the information in the Sign/Submit Note window is correct.

9. Click **Sign**



10. Click **Refresh** . The **Respiratory Therapy Note** that you just charted can now be viewed within the Documentation section.



Key Learning Points

- In circumstances where iView and Powerforms do not capture all the information that needs to be documented, you may want to supplement with a narrative note.
- To initiate a narrative note, click +Add  next to Documentation
- It is recommended that Free Text Notes be given specific titles to help identify the note
- Click Sign to complete a new narrative note

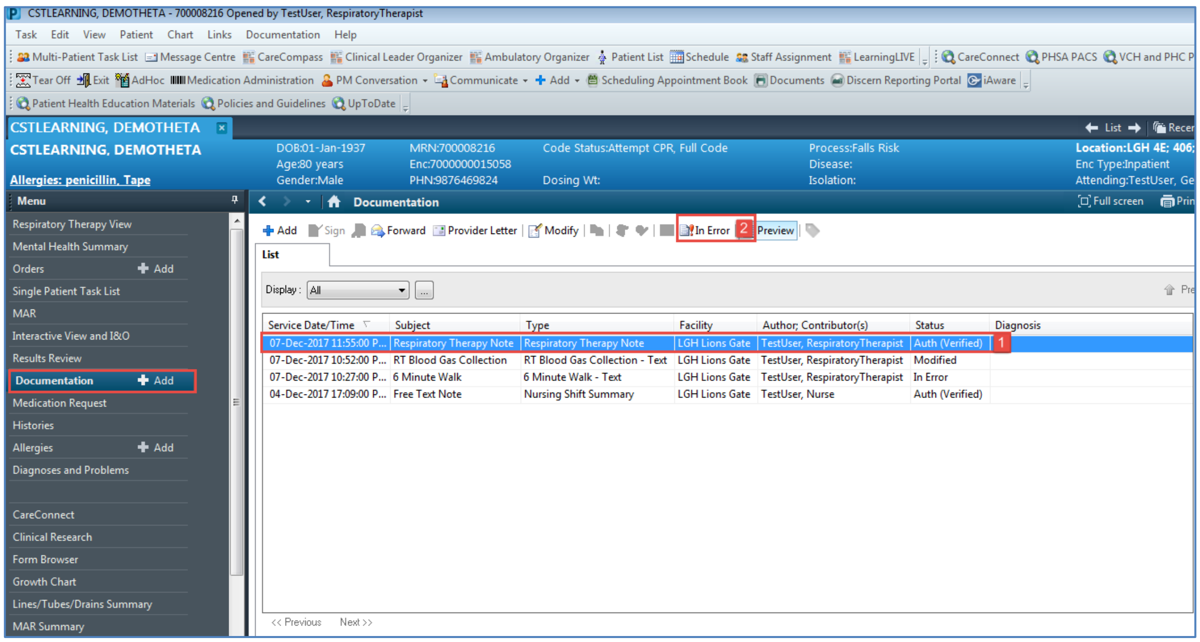
Activity 6.2 – Unchart a Narrative Note

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

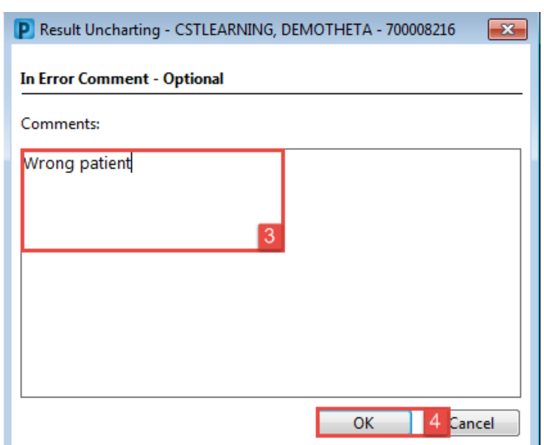
Let's unchart the **Respiratory Therapy Note** that you previously documented.

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

1. Click on **Respiratory Therapy Note**
2. Click **In Error**

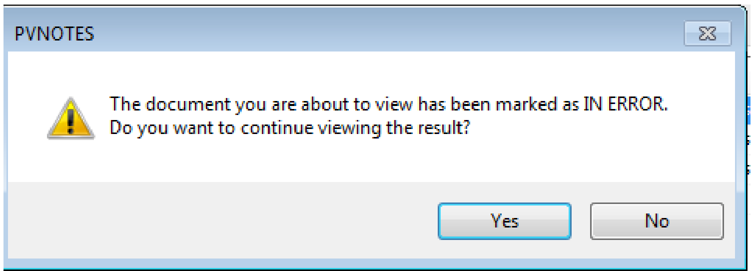


3. Enter a reason for uncharting in the comment box of the new window = *Wrong patient*
4. Click **OK**

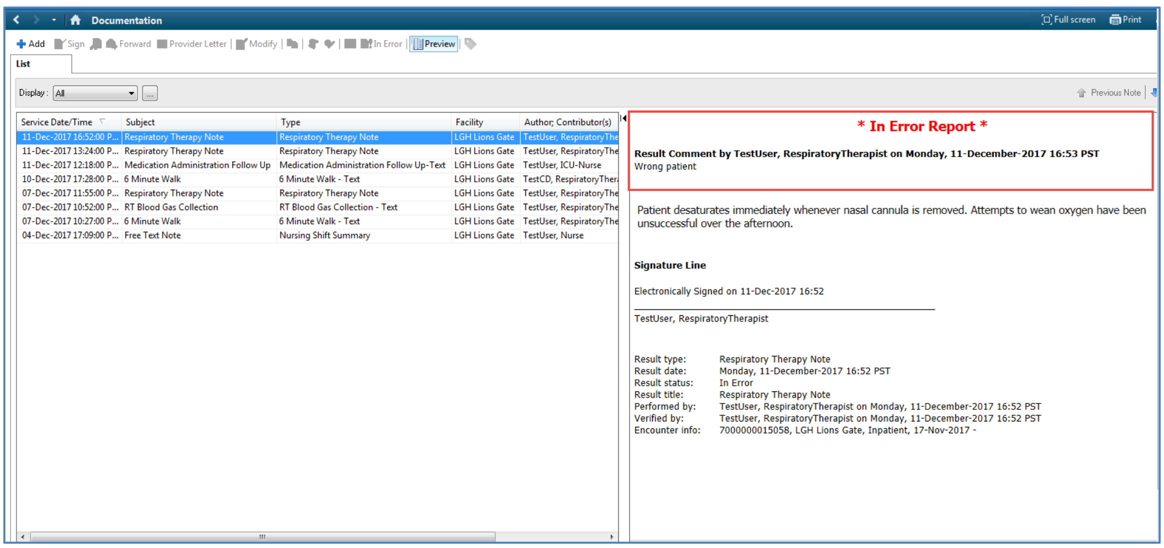


5. The document will still appear in the Document tab but will now be under the status of IN

ERROR.



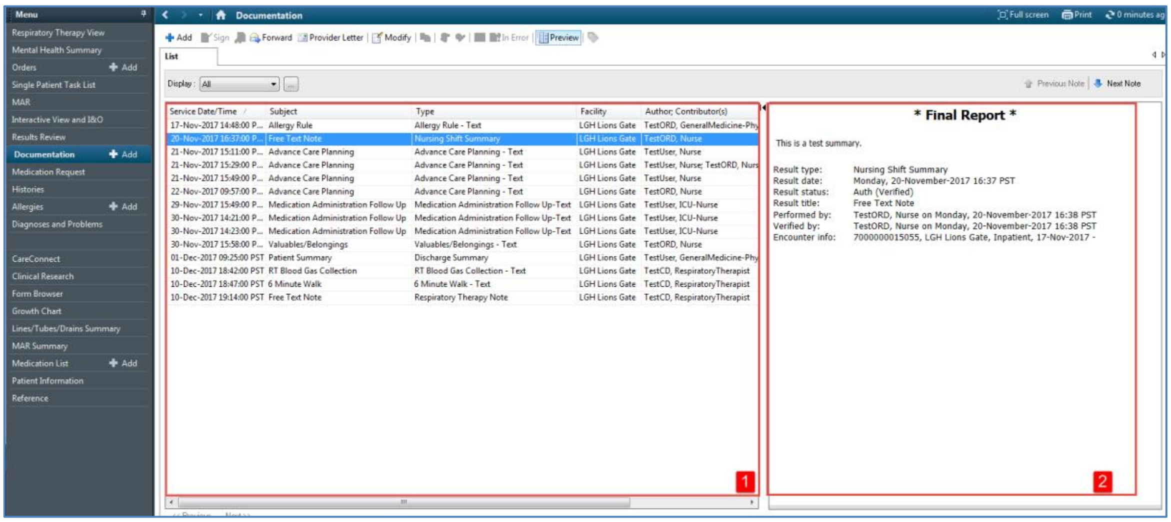
If you click yes, you can view the original document but it will have a header with *In Error Report* as well as the reason on the top of the document.



Activity 6.3 – Review Document

1 Documents completed by other disciplines can also be found under the Documentation section on the Menu. Additionally, documentation such as dictated diagnostic imaging reports, and **PowerForms** displayed in text format can be found here.

1. Select the document that you want to review under the **List** tab.
2. The document will open in the window to the right and you are able to review what was documented about the patient. In the example below, it is an ED Screening PowerForm that was documented on by a nurse.



Key Learning Points

- Documents that have been completed by other disciplines can be found in Documentation
- Dictated diagnostic imaging reports and PowerForms displayed in text format are found in Documentation

PATIENT SCENARIO 7 – Medication Administration

Learning Objectives
At the end of this Scenario, you will be able to: - Navigate through the layout of the Medication Administration Record (MAR) - Administer Medication Using the Medication Administration Wizard (MAW)

SCENARIO

In this scenario, you will be reviewing the scheduled and PRN medications for your patient today prior to administering a nebulizer medication. You will be using a Barcode Scanner to administer the medication. The scanner will scan both the patient's wristband and medication barcode to correctly populate into the MAR.

As a Respiratory Therapist you will be completing the following activities:

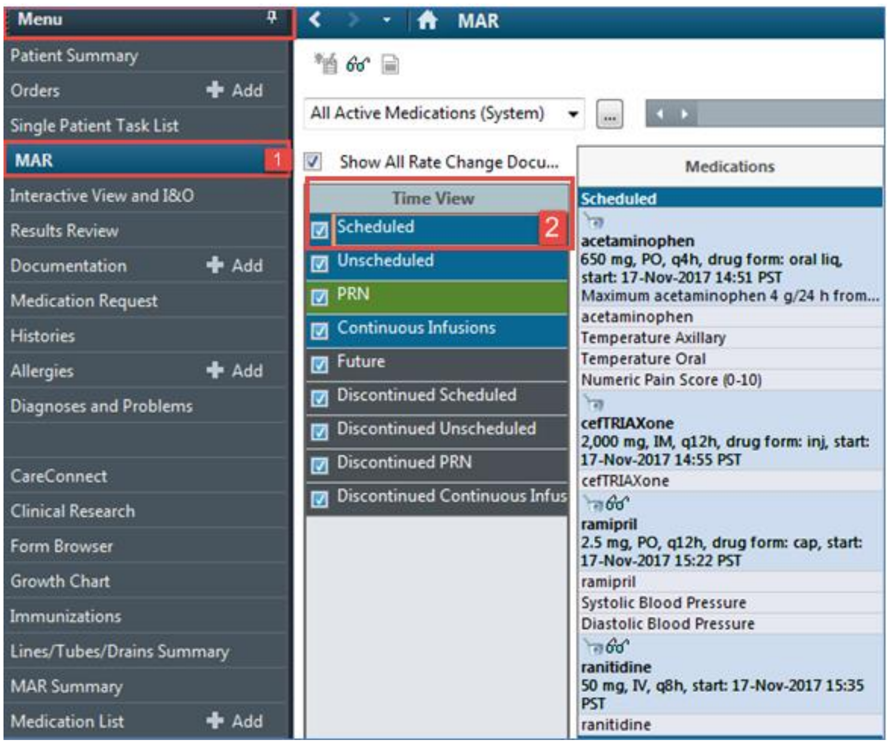
- Review and learn the layout of the MAR
- Administer medication using the Medication Administration Wizard (MAW) and the barcode scanner

Activity 7.1 – Review the Medication Administration Record (MAR)

1 The **MAR** is a record of medications administered to the patient by clinicians. The **MAR** displays medication orders, tasks, and documented administrations for the selected time frame.

You will be locating and reviewing your patient's scheduled, unscheduled and PRN medications.

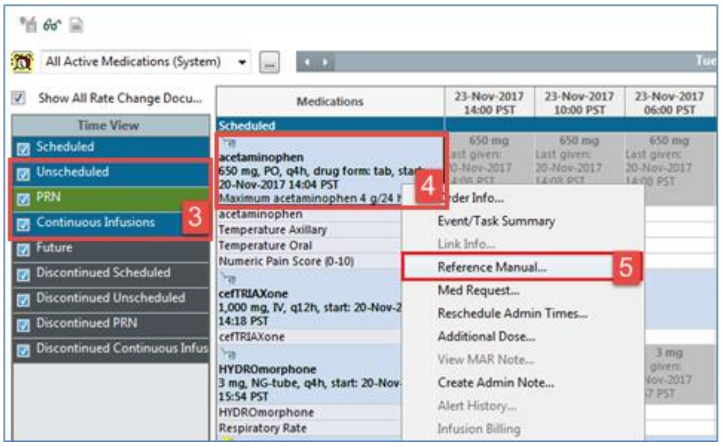
1. Go to the **Menu** and click **MAR**
2. Under **Time View** locate and ensure the **Scheduled** category is selected and is displaying at the top of the MAR list.



3. Next, select in order, **Unscheduled**, **PRN** and **Continuous Infusions**, bringing each section to the top of the list for your review.

Review the medications on the **MAR** e.g. acetaminophen 650 mg PO Q4H. Be sure to review all medication information.

4. A Reference Manual is accessible if you right-click on a medication's name **Acetaminophen 650 mg PO Q4H.**
5. Select the **Reference Manual**. Reference material specific to the medication chosen will display.



6. Note the icons that may appear on the **MAR**. Examples include:

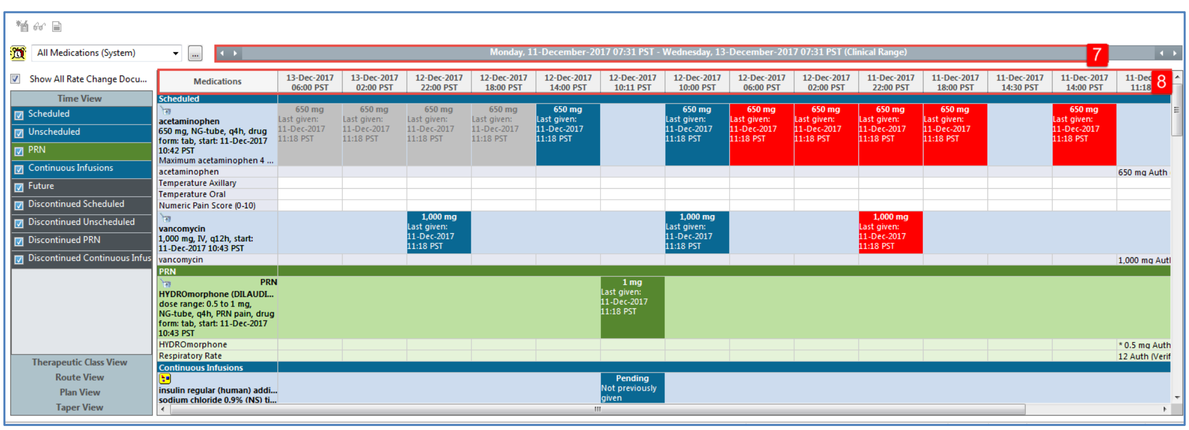
   – Indicates the medication order has not been verified by pharmacy

   – Indicates the order needs to be reviewed by the nurse

   – Indicates the medication is part of an electronic equivalent of a preprinted order, known as a PowerPlan in the CIS

Upon further review of the MAR you will note the following:

7. The Clinical Range is defaulted to display 24 hours in the past and 24 hours into the future. The total range is a period of **48 hours**. If you prefer to only see your 12 hour shift, you can right click on the **Clinical Range** bar to adjust the time frame that is displayed.
8. The dates and times are displayed in **reverse chronological order**, which is contrary to the order found on most paper based MARs.



Note: Different sections of the MAR and statuses of medication administration are identified using colour coding**:**

- **Scheduled medications-** blue

- **PRN medications**– green
- **Future medications -** grey
- **Discontinued medications**- grey
- **Overdue**- red

Key Learning Points

- The MAR is a record of the medication administered to the patient by clinicians
- The MAR lists medication in reverse chronological order
- The MAR displays all medications, medication orders, tasks, and documented administrations for the selected time frame

Activity 7.2 – Administering Medication using the Medication Administration Wizard (MAW) and the Barcode Scanner

1 Medications will be administered and recorded electronically by scanning the patient's wristband and the medication barcode. Scanning of the patient's wristband helps to ensure the correct patient is identified. Scanning the medication helps to ensure the correct medication is being administered. Once a medication is scanned, applicable allergy and drug interaction alerts may be triggered which will further enhance your patient's safety. This process is known as **closed loop medication administration**.

Tips for using the barcode scanner:

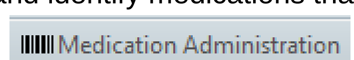
- Point the barcode scanner toward the barcode on the patient's wristband and/or the medication (Automated Unit Dose- AUD) package and pull the trigger button located on the barcode scanner handle
- To determine if the scan is successful, there will be a vibration in the handle of the barcode scanner and/or, simultaneously, a beep sound
- When the barcode scanner is not in use, wipe down the device and place it back in the charging station

2 It is time to administer the following medication to your patient.

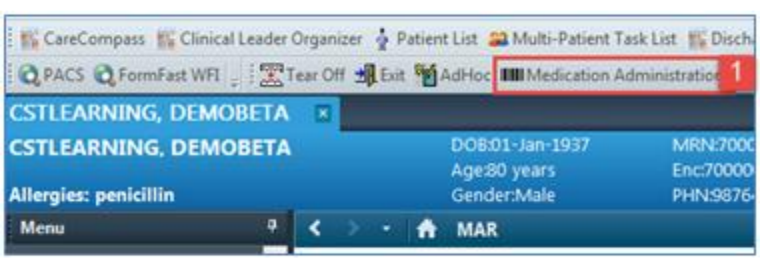
Occasionally a dose requires scanning the medications twice to make up the full dose. At other times, the dose requires only part of a medication.

For your practice, you will be administering the following medication: **salbutamol 5mg nebulized,** PRN for shortness of breath or wheezing, the drug form is nebulizer (salbutamol 2.5mg x 2)

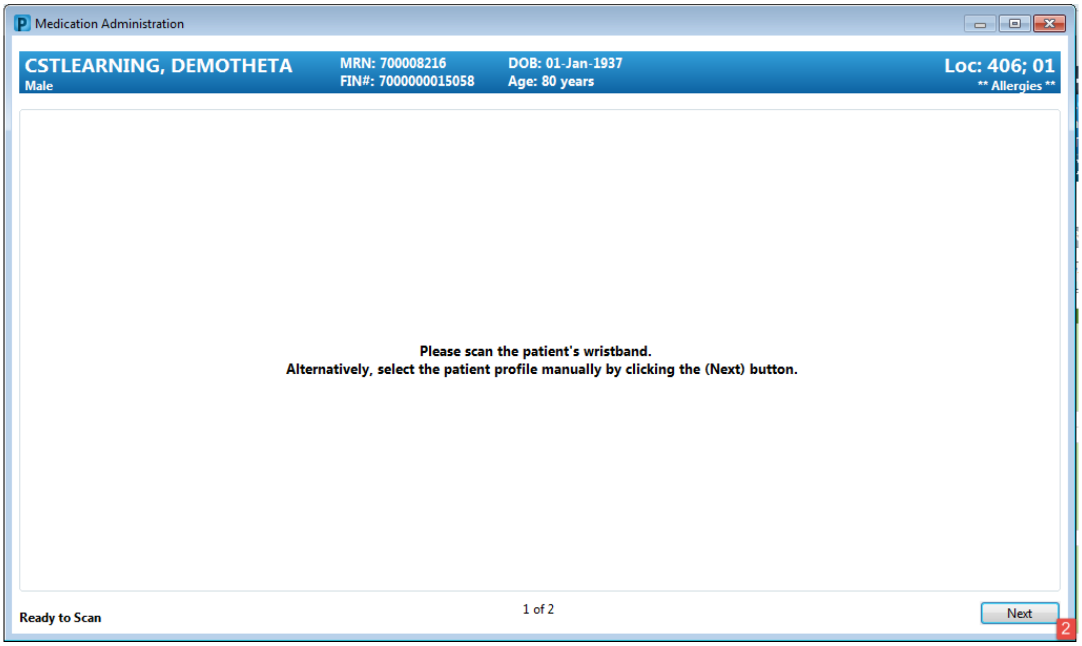
Let's begin the medication administration following the steps below:

1. Review medication information in the **MAR** and identify medications that are due. Click **Medication Administration Wizard** (**MAW**) 

in the Toolbar.

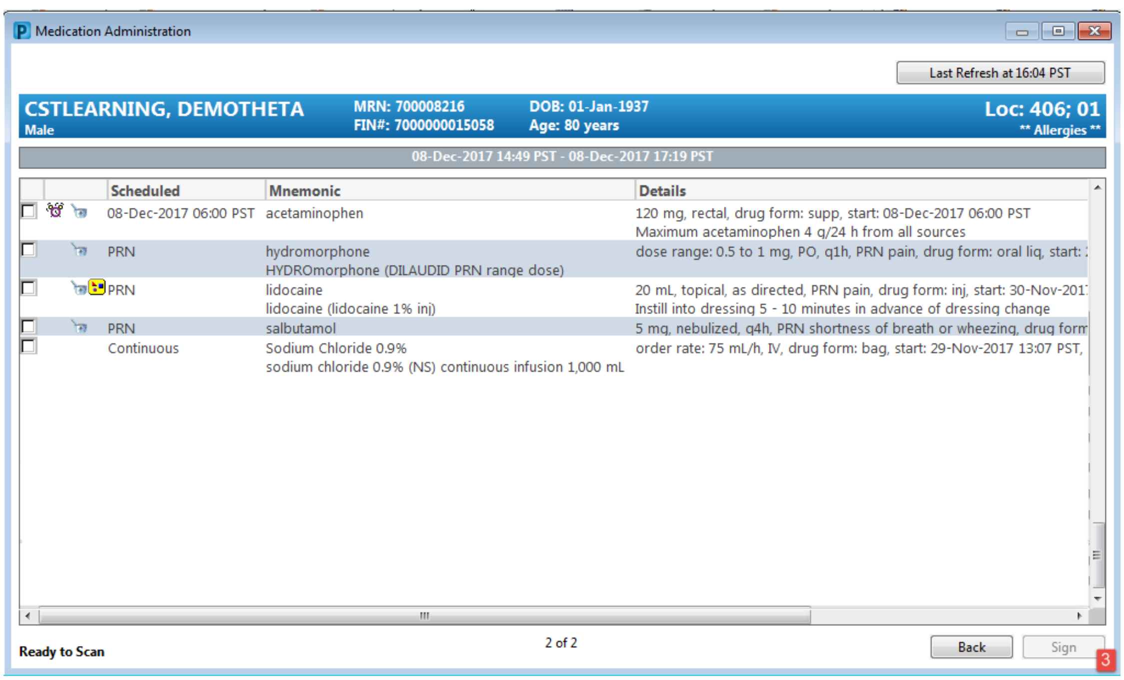


2. The **Medication Administration** pop-up window will appear.



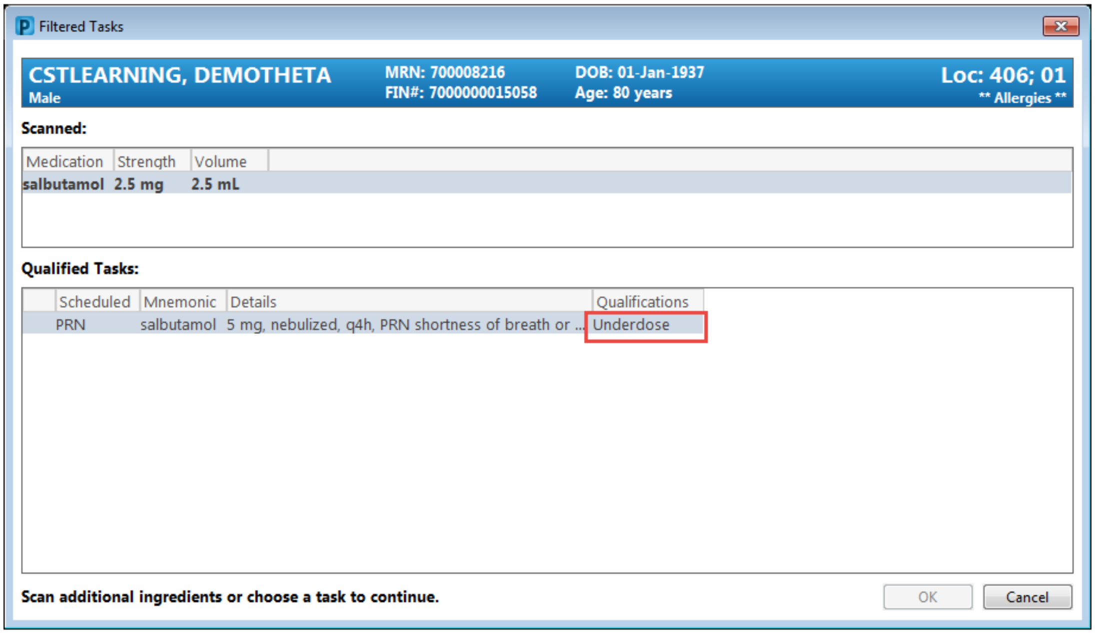
3. Scan the patient's wristband, a window will pop-up display the medications that you can administer.

Note: this list populates with medications that are scheduled for 1 hour ahead and any overdue medications from up to 7 days in the past.

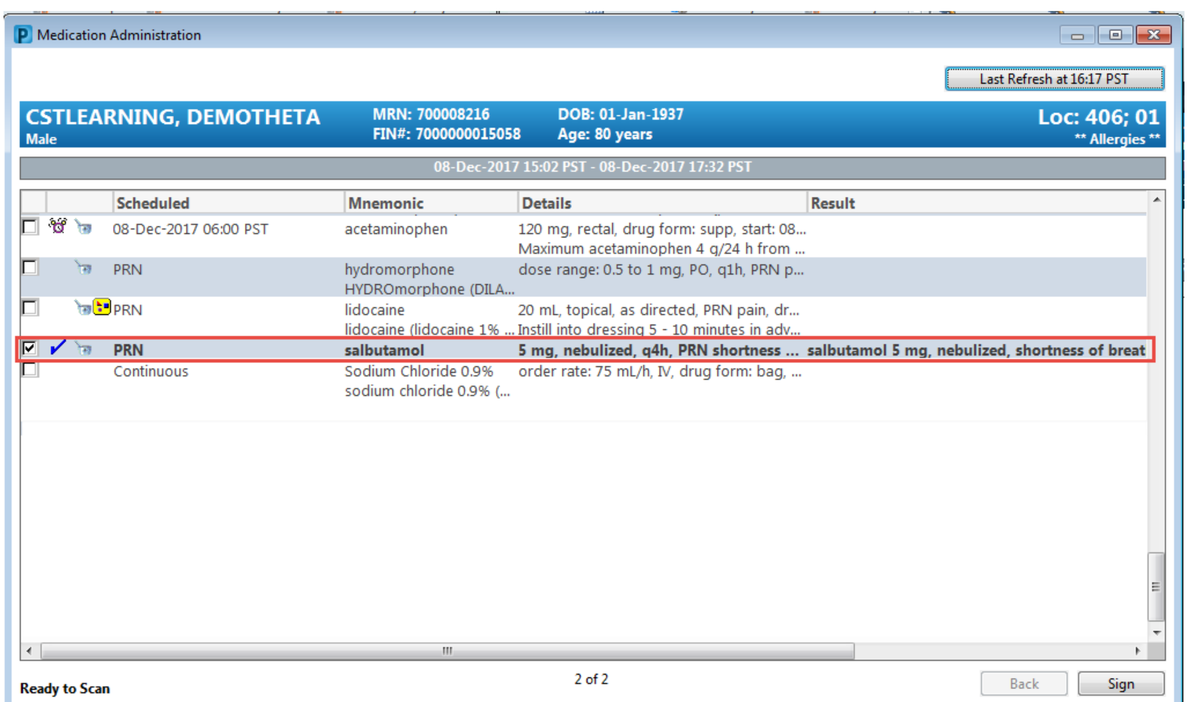


4. Scan the medication barcode for **salbutamol 2.5 mg nebulizer**.

Note: Underdose appears in the qualifications column for the medication. This is because you have only scanned 2.5mg of the total 5mg of salbutamol required

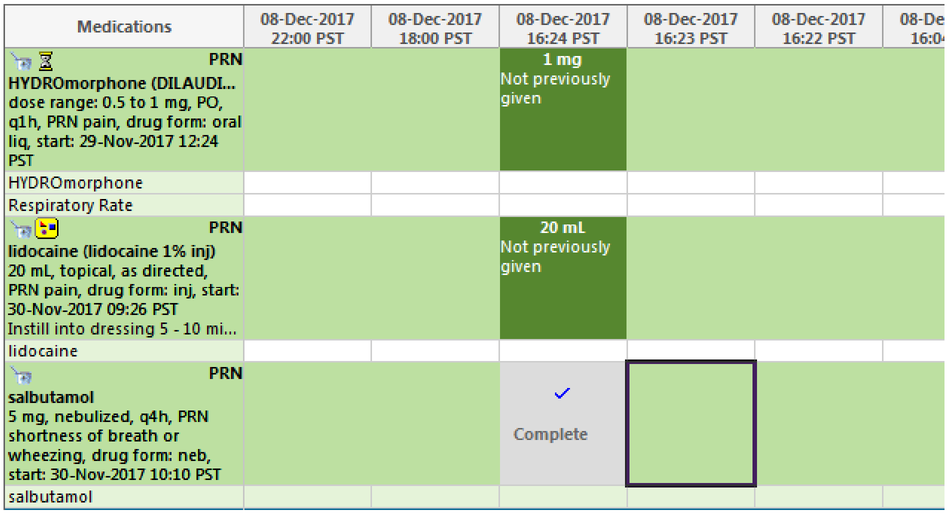


5. Now scan the **salbutamol 2.5 mg** nebulizer barcode again to administer the full 5 mg dose of the medication. After the second scan, the system finds an exact match for the prescribed dose.

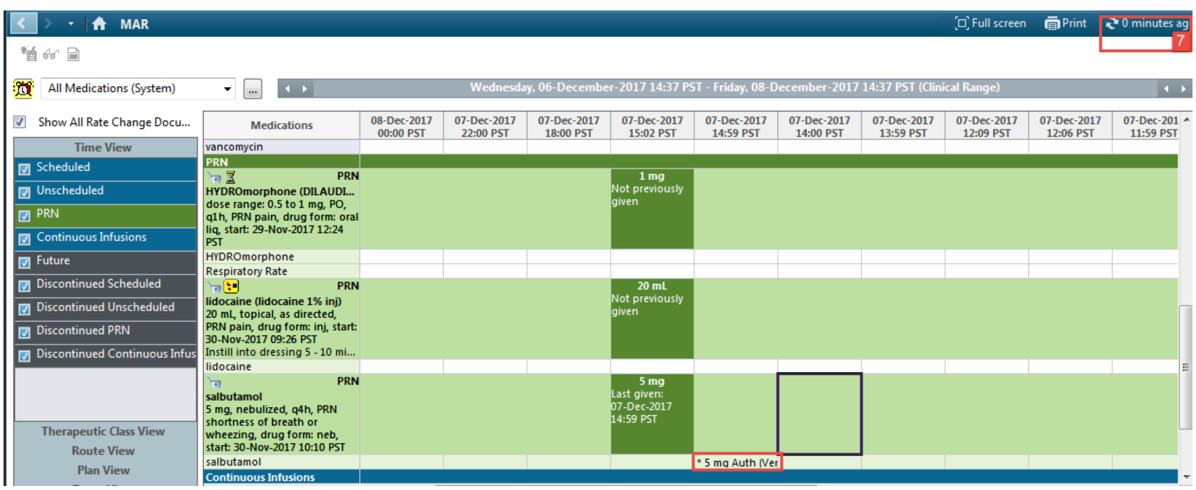


6. Click **Sign** after you have administered the medication to the patient.

   Once you click Sign, the **Medication Administration** window will close and the MAR will display. The medication will now appear as **Complete** on the MAR.



7. Click the **Refresh** icon and you will be able to see more details including the time the last dose was given.



Key Learning Points

- Scanning of the patient's wristband helps to ensure the correct patient is identified
- Scanning the medication helps to ensure the correct medication is being administered
- Review the MAR first to identify medications that are due
- Use the Medication Administration Wizard (MAW) and barcode scanner to document medications administered

PATIENT SCENARIO 8 – 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 a respiratory therapist, you will need to be able to review orders for your patient. You will also need to place orders for your patient in certain situations.

As a Respiratory Therapist you will complete the following activities:

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

Activity 8.1 – 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:

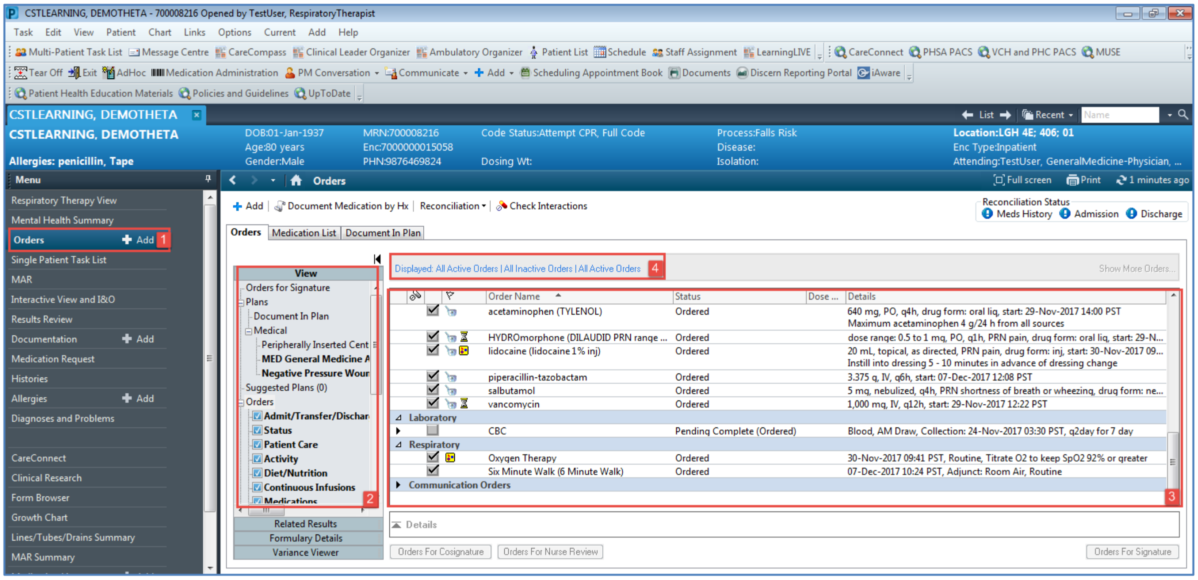
1. Select **Orders** from the **Menu**
2. On the left side of the screen is the navigator (**View**) which includes several categories including:
   - **Plans**
   - **Categories of Orders**
   - **Medication History**
   - **Reconciliation History**
3. On the right side is the **Orders Profile** where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

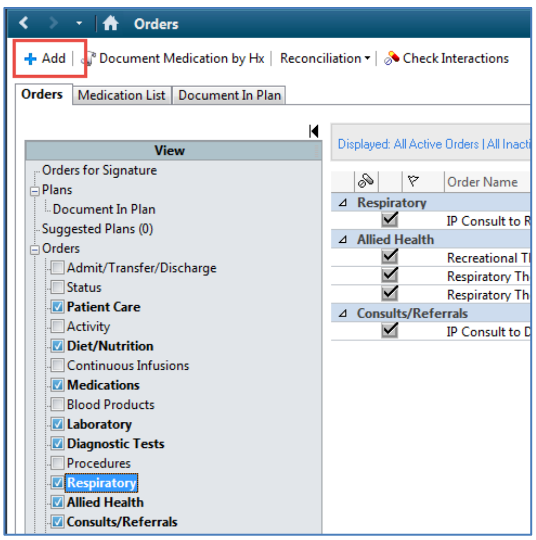
Activity 8.2 – Place an Order

1 Throughout your shift, you will review your patient's orders. Respiratory therapists can place the following types of orders:

- Orders that do not require a cosignature e.g. order within respiratory therapy scope
- Orders that require a cosignature from the provider e.g. telephone and verbal orders

To place an order that does **not** require a cosignature (within your scope of practice):

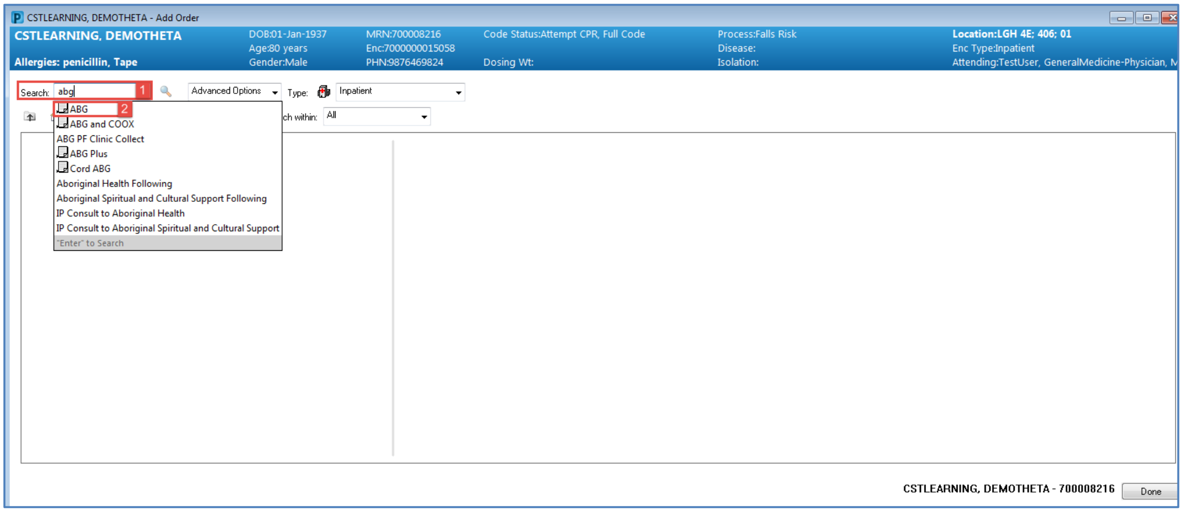
Within the **Orders** page click **Add** + Add



The **Add Order** window will open.

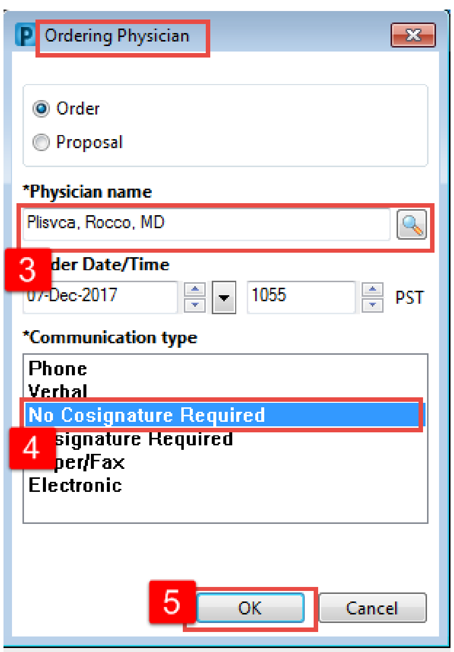
1. Type in **Search** = *abg* into the search window and a list of choices will display.
2. Select **ABG.**

Note: You will see similar orders, select the most appropriate order.

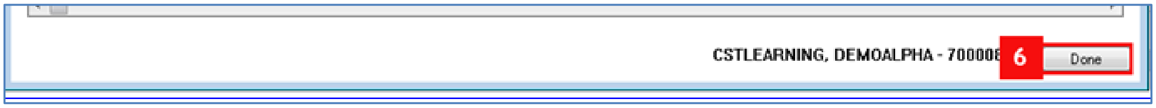


The **Ordering Physician** window opens.

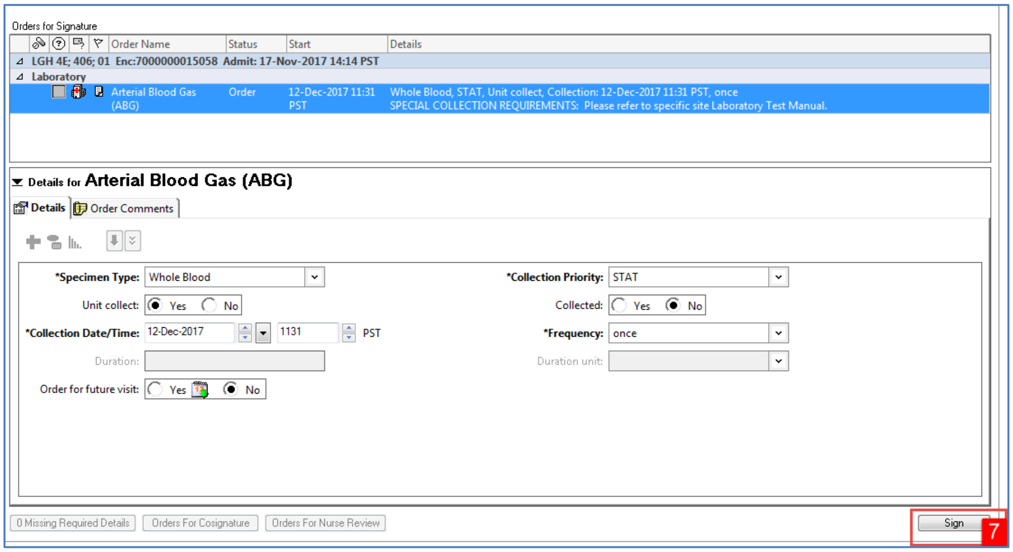
3. Type in the name of the patient's Attending Physician [**Lastname, Firstname**]
4. Select **No Cosignature Required**
5. Click **OK**



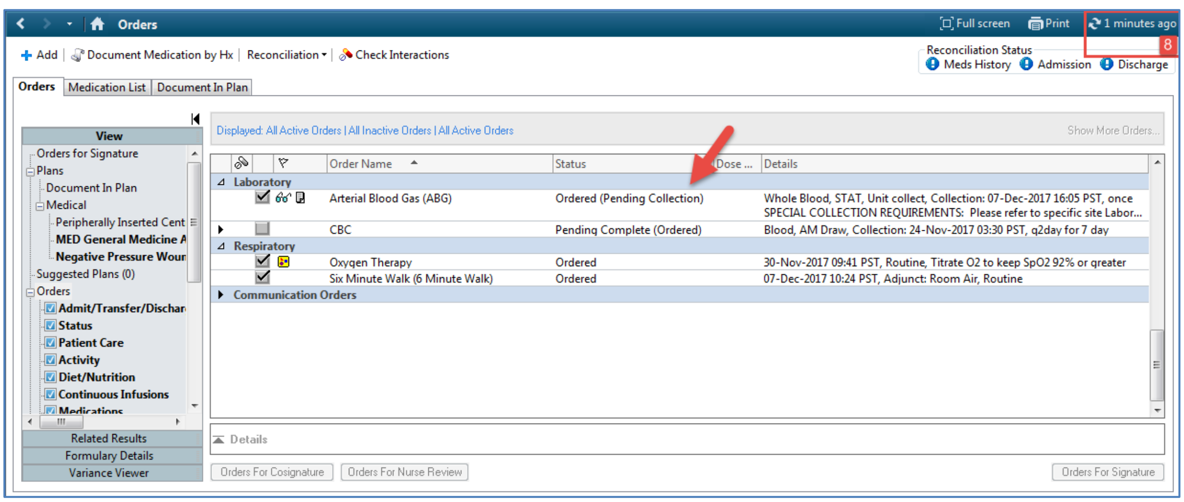
6. Click **Done** and you will be returned to the **Orders Profile** to see the order details.



7. Review the order details and modify as needed. Click **Sign.**



8. Click the **Refresh** icon .



Note: The status of the ABG order will change from Processing to Ordered (Pending Collection)

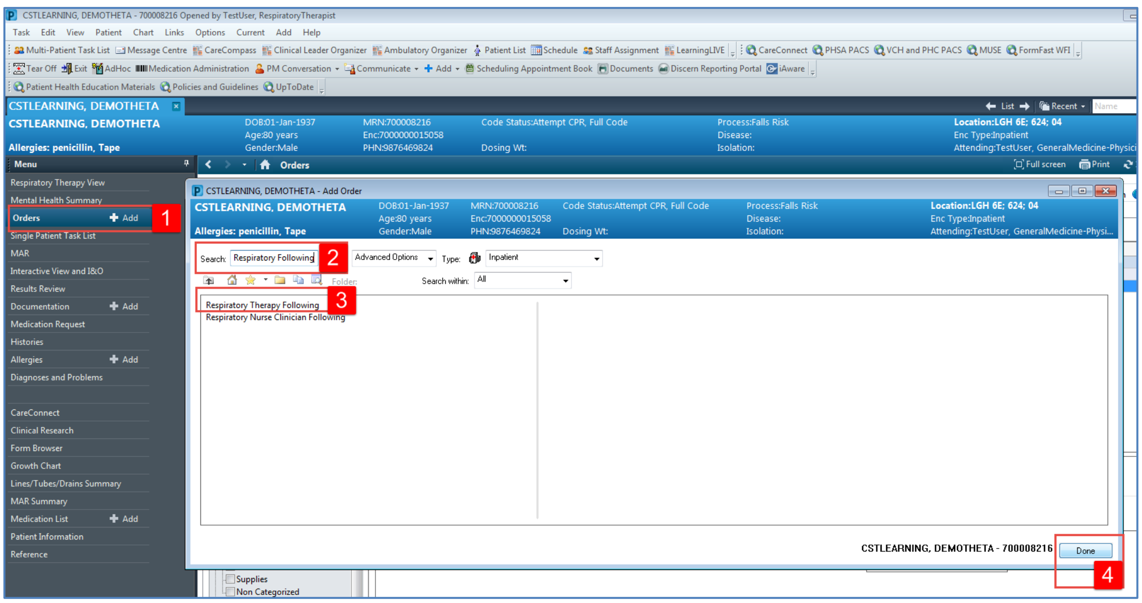
2

There may be certain circumstances where you may find yourself needing to follow up on specific patients or follow up on specific results. In these cases, you can place an order called Respiratory Therapy Following as a reminder to continue to check up on that patient.

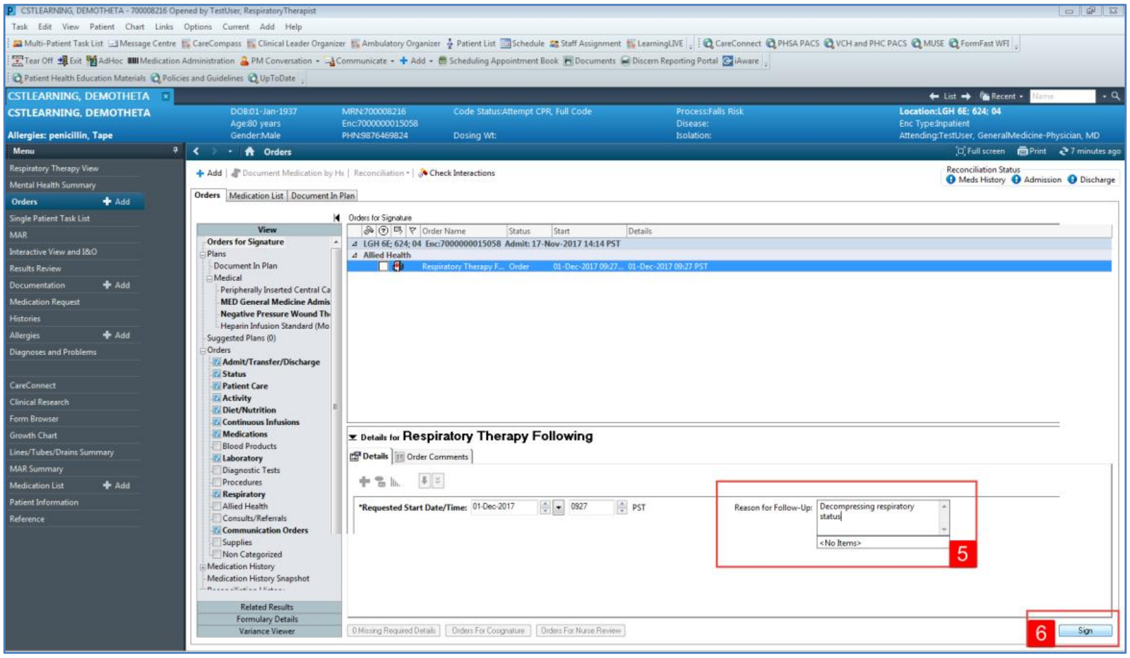
Let's place a **Following** order for your patient.

1. Click **Add** within the **Orders** page
2. Type **Respiratory Following** into the search window and then hit the **Enter** key
3. Select **Respiratory Therapy Following** from the search results
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.

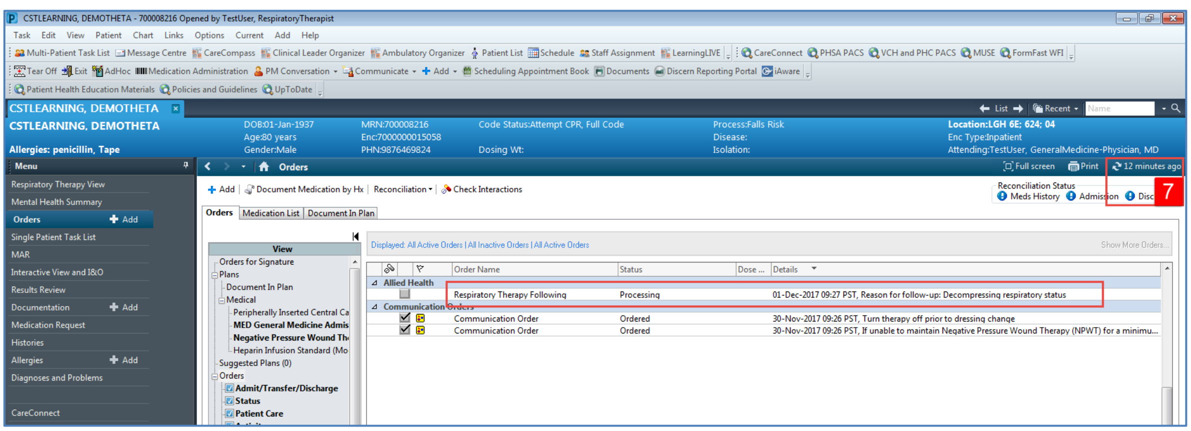


5. Review the order detail fields and modify as needed. In this example, document **Reason for Follow- Up** = *Decompensating respiratory status*
6. Click the **Sign** button.



The **Respiratory Therapy Following** order will display in the status of **Processing**.

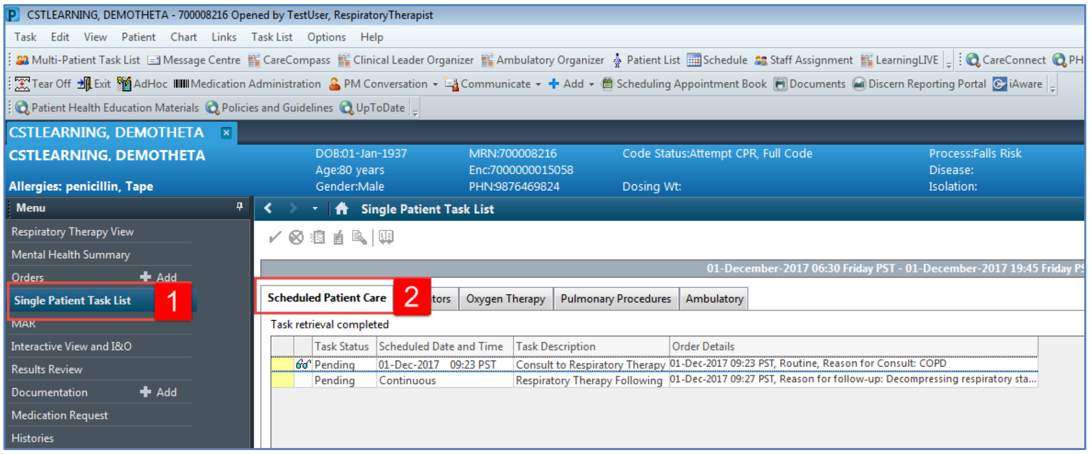
7. Click **Refresh** near the top right corner of the screen. Once the page refreshes, the order status will display as **Ordered**.



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**). For now, navigate to the **SPTL** to view this task.

8. Click on **Single Patient Task List** in the **Menu**
9. Within the **SPTL,** under the **Scheduled Patient Care** tab you should see the **Respiratory**

Therapy Following task.



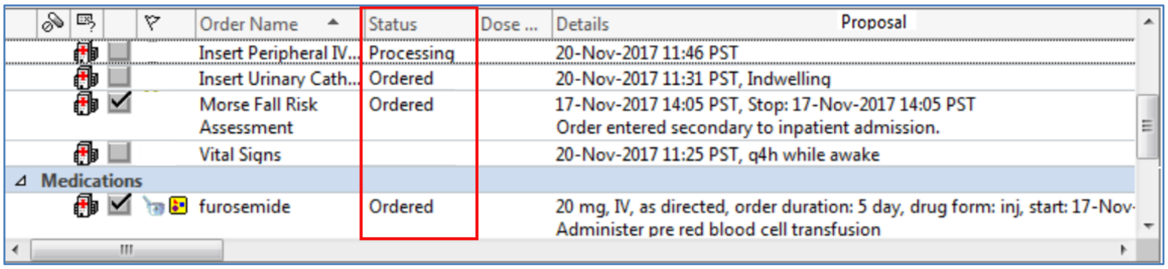
Key Learning Points

- Respiratory therapists can place orders that do not require a cosignature (e.g. order within respiratory therapy scope) and orders that require a cosignature from the provider (e.g. verbal orders)
- A Respiratory Therapy Following order can be placed for further follow up on the patient
- Once a Respiratory Therapy Following order is placed, a task will be placed on the SPTL and MPTL

Activity 8.3 – Review Order Statuses and Details

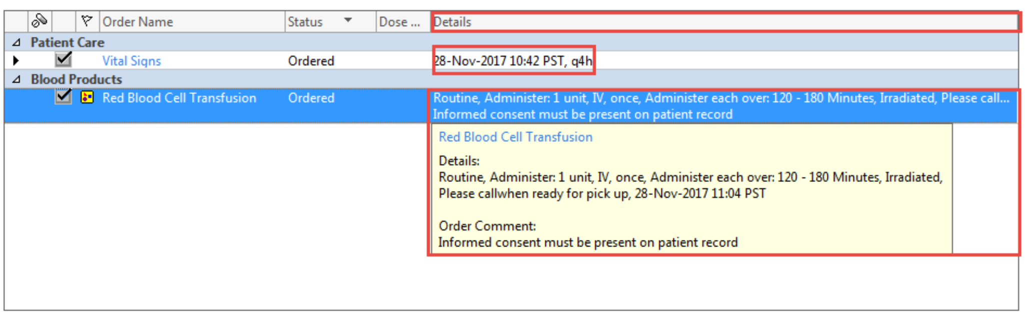
1 To see examples of different order statuses, review the image below:

- **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:

- Focus on 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  appear to the left of the order, this means the order still needs to be reviewed by a nurse. Once the order has been 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.

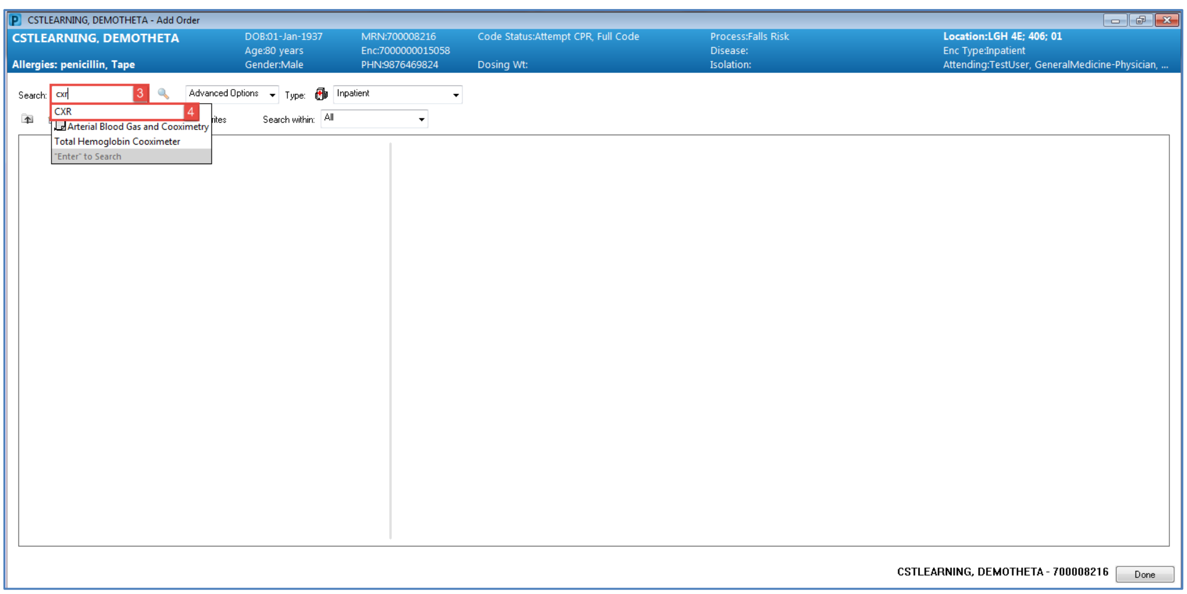
Activity 8.4 – Place a Verbal Order

1 Similar to current practice, respiratory therapists can place verbal and telephone orders. In this activity, we are going to practice placing a verbal order. **Verbal Orders** are only encouraged when there is no reasonable alternative for the provider to place the order in the CIS themselves. For example, in emergency situations, a verbal order may need to be placed by a respiratory therapist.

Note: Verbal and phone orders that respiratory therapists enter in the CIS will be automatically routed to the ordering provider for co-signature.

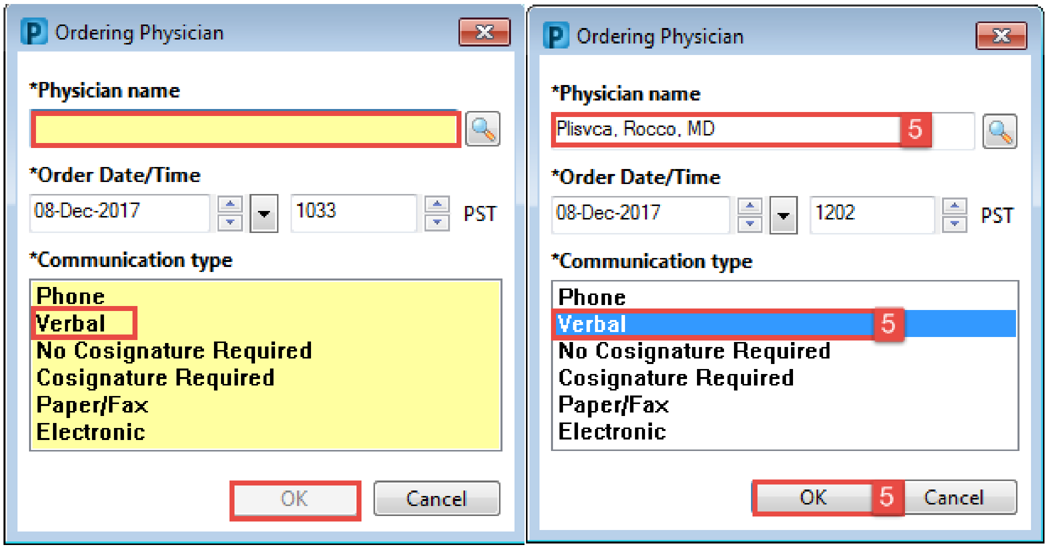
To place a verbal order:

1. Select **Orders** from the **Menu**
2. Click the **Add** button  on the **Orders Profile**
3. Type = *CXR* in the search field of the pop-up window and press **Enter** on the keyboard to view search results.
4. Select **CXR**



The Ordering Physician window opens.

5. Fill out **required fields** highlighted in yellow with details below and click **OK**
   - **Physician name** = *type name of Attending Physician (last name, first name)*
   - **Communication type** = *Verbal*

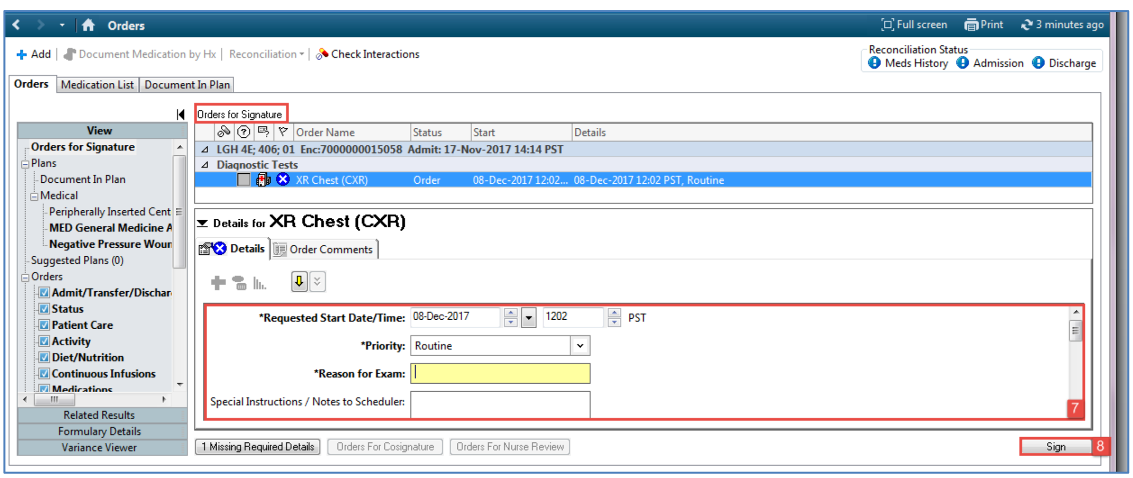


Note: If this were a telephone order, the communication type of Phone would be selected.

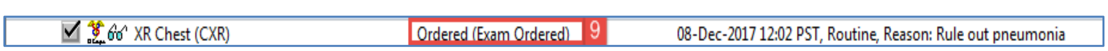
6. Click **Done** to close the **Add Order** window

Orders for Signature window opens and order details are displayed.

7. Fill out required fields highlighted in yellow (and other fields as needed).
   - **Reason for Exam** =*Rule out pneumonia*



8. Click **Sign** and then click **Refresh**  .
9. The Order Profile now displays the CXR with a status of **Ordered.**



Key Learning Points

- Verbal orders are only encouraged to be entered when a physician cannot enter the order directly into the CIS themselves. For example, a verbal order might be needed in an emergency situation.
- Required fields are always highlighted yellow
- Verbal and phone orders that are entered into the CIS automatically get routed to the ordering provider for co-signature

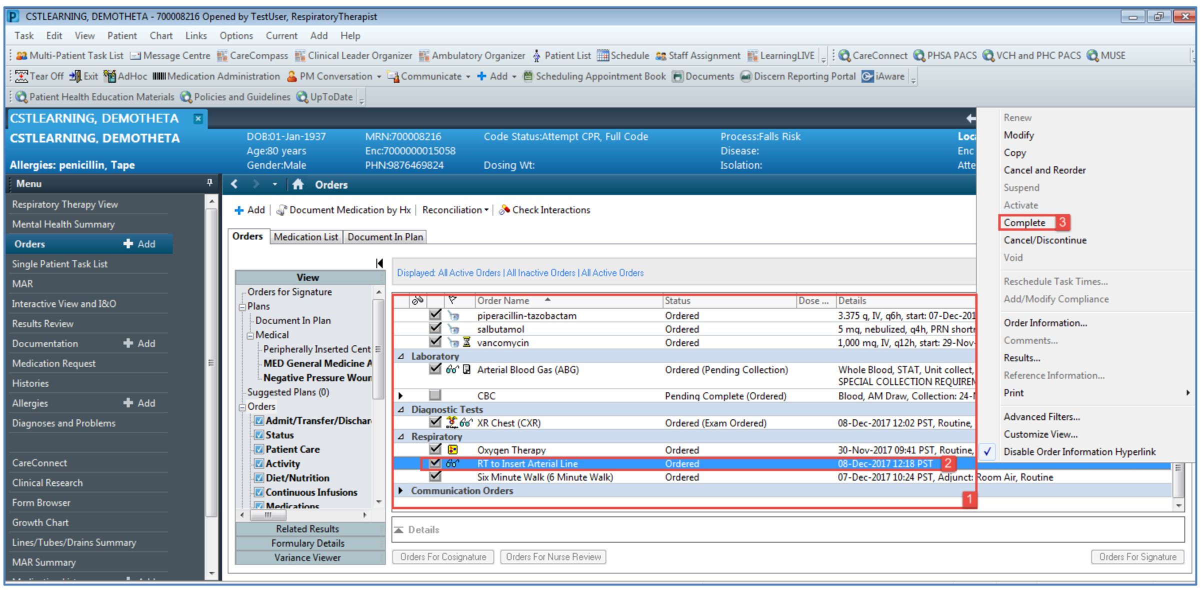
Activity 8.5 – Complete or Cancel/Discontinue an Order

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.

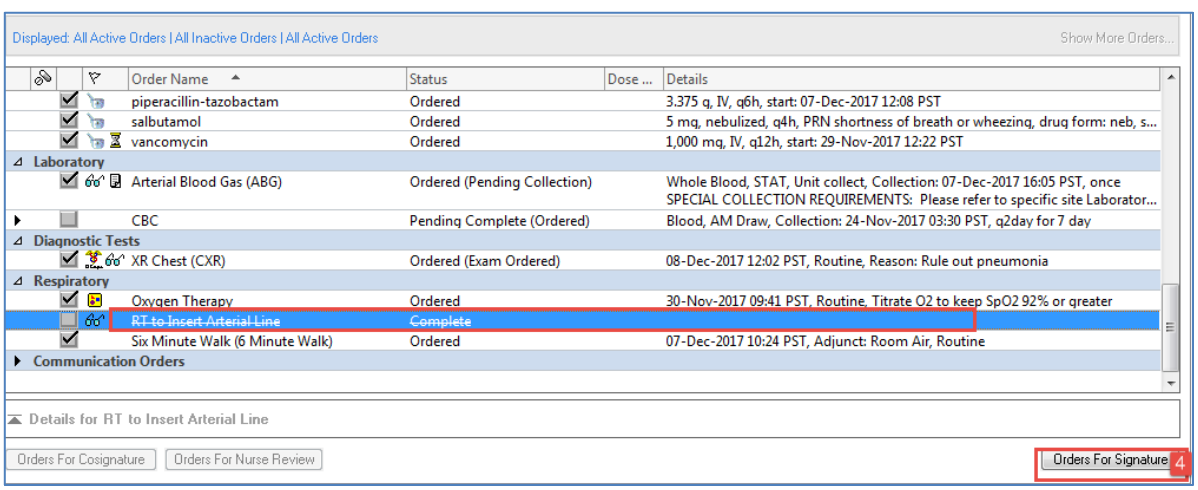
Let's complete an order.

1. Review the **Orders Profile**
2. Right-click the order **RT to Insert an Arterial Line**
3. Select **Complete**



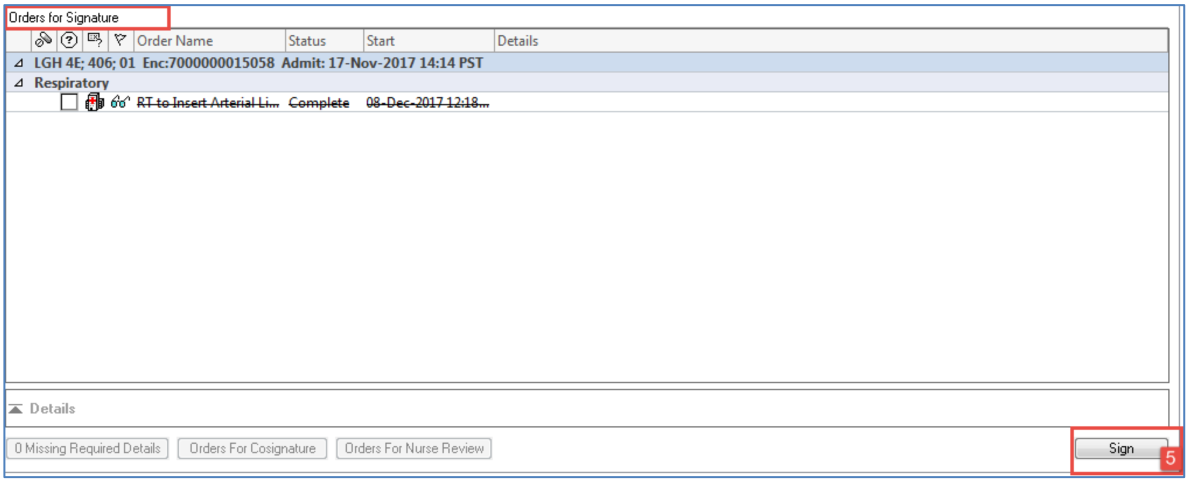
Notice that the order is now crossed out.

4. Click **Orders for Signature**



5. Review the order for signature details and click **Sign**. You will return to the Orders Profile

where the order will show as processing.

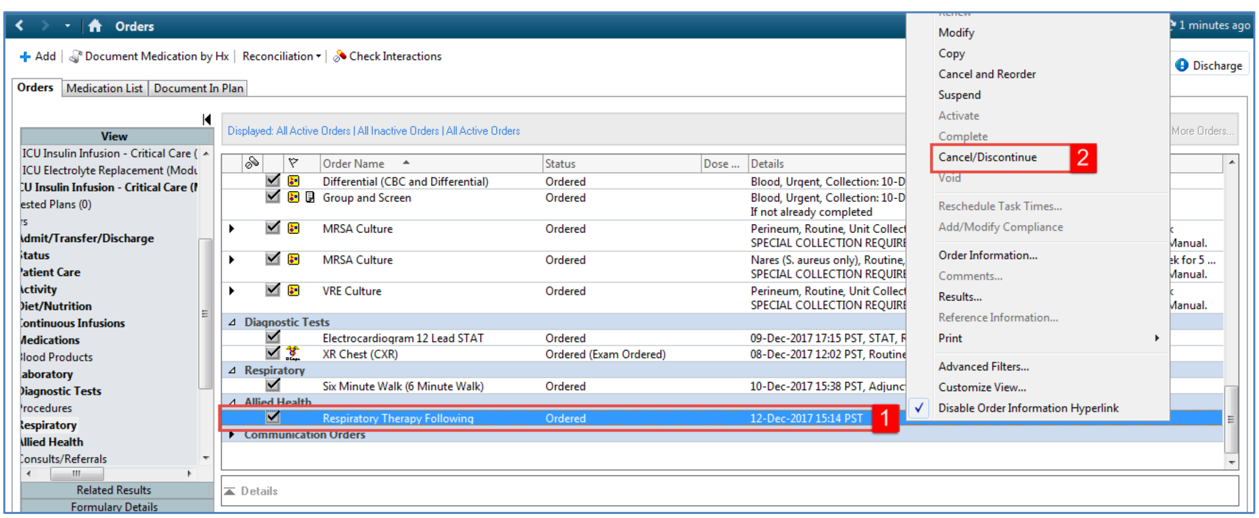


6. Click the **Refresh** icon  and the order will no longer be visible in the **Orders Profile**.

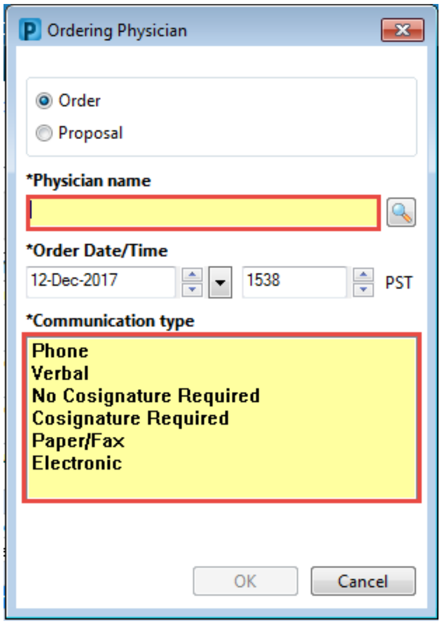
2 Now let's **Cancel/Discontinue** an order.

Certain orders such as **Respiratory 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.

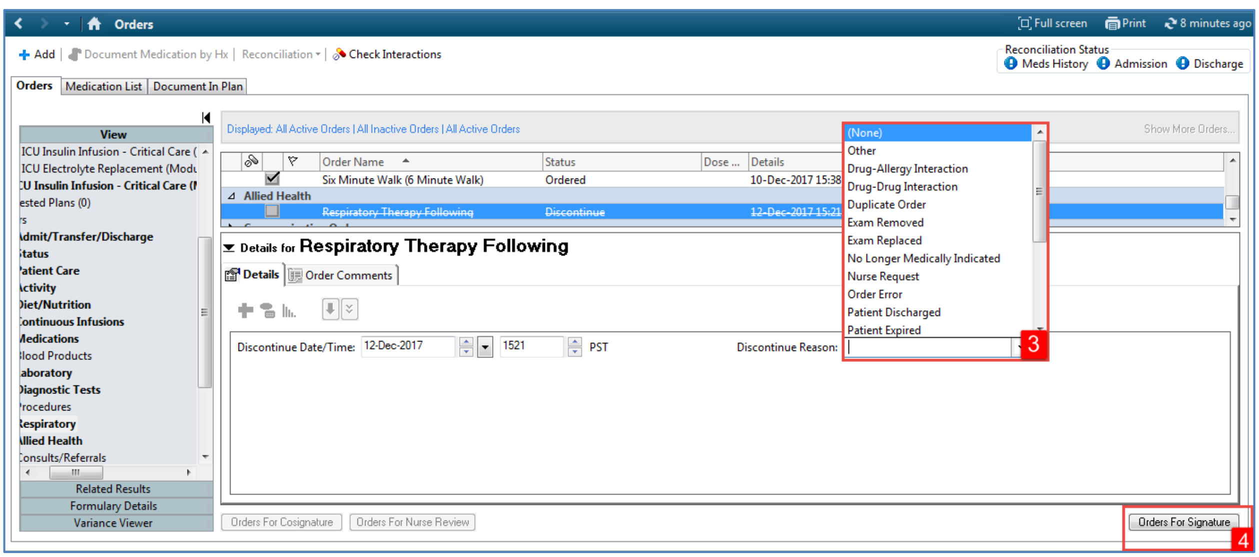
1. Within the **Orders Profile**, locate the **Respiratory Therapy Following** order and right click on the order
2. Select **Cancel/ Discontinue**



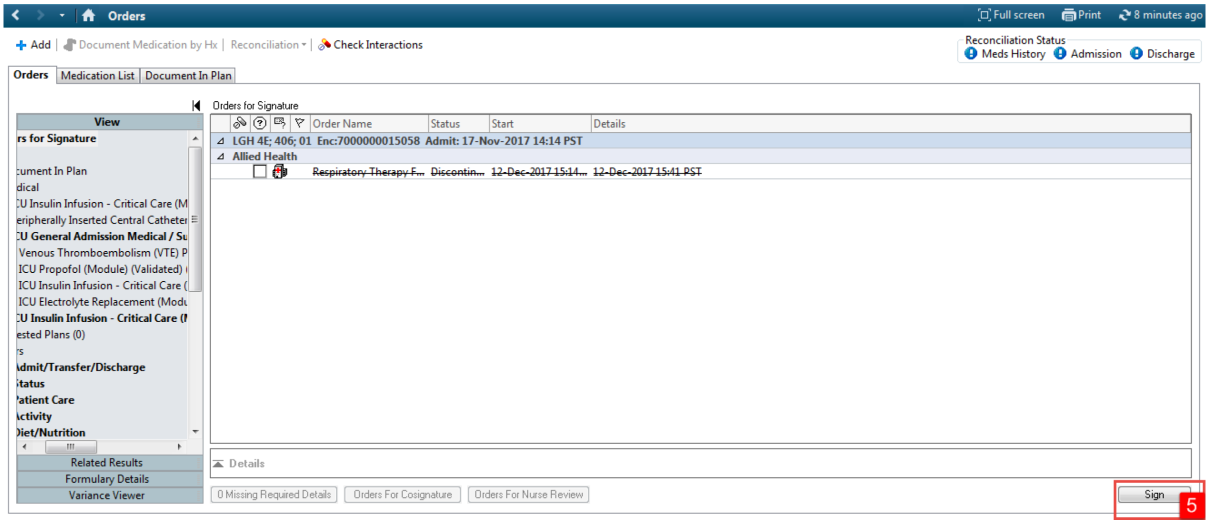
Note: There are orders that may require you to input the ordering physician after you click on Cancel/Discontinue. You will need to complete the required fields and then click OK for such orders. See image below to review the required fields.



3. Select the appropriate **Discontinue Reason** from the drop-down
4. Click **Orders for Signature**

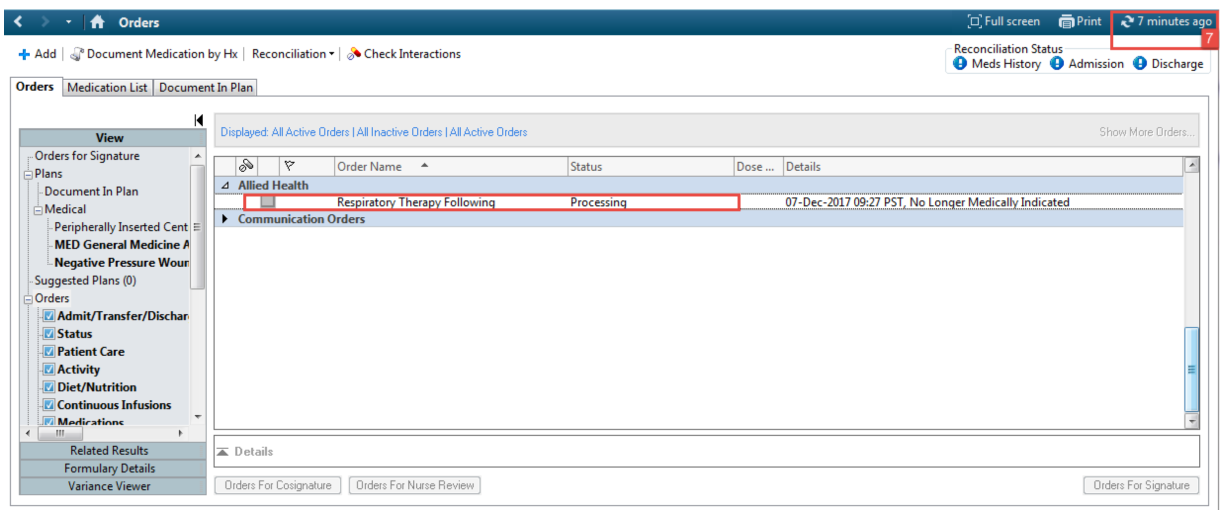


5. Click **Sign**



6. You will see that the order status is now processing.

7. Click the **Refresh** icon  and the order will no longer be visible on the Orders Profile.



Key Learning Points

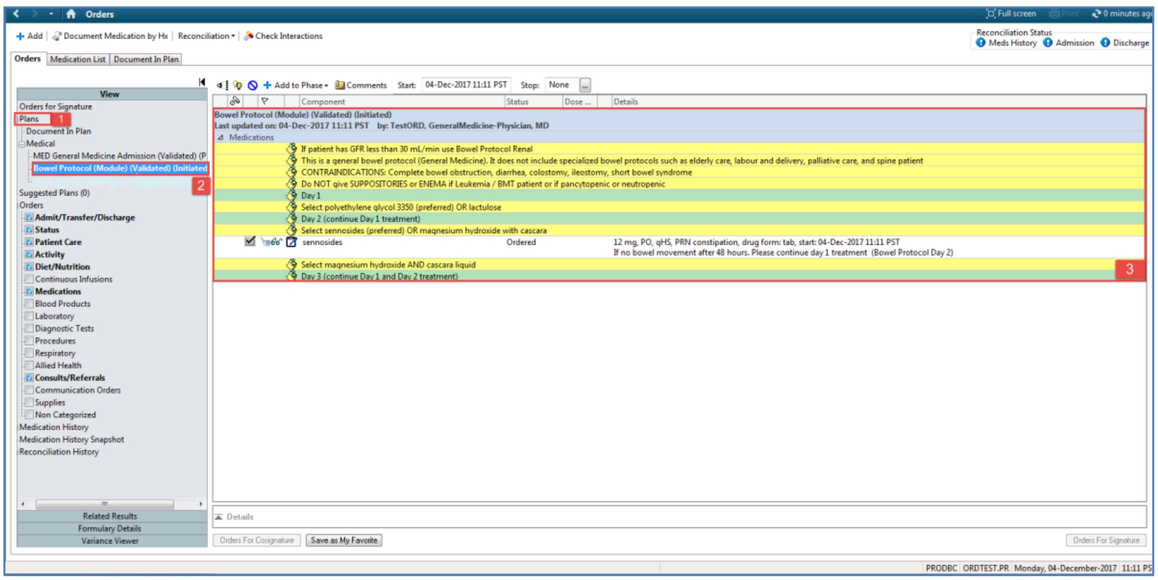
- Right-click to mark an order as completed or cancel/discontinued.
- Once an order is cancelled or discontinued the order will be removed from the patient's Orders Profile

Activity 8.6 – 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 **Navigator** (**View)**
2. Select the **Bowel Protocol** PowerPlan
3. Review orders within the PowerPlan (*Sennosides 12mg, PO, qHS, PRN)*



Key Learning Points

- The Navigator (View) 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 9 – CareCompass and CareAware Critical Care

Learning Objectives

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

- Access and utilize CareCompass
- Access and utilize CareAware Critical Care

SCENARIO

For respiratory therapists that work in the intensive care unit or high acuity unit where there is a designated assignment, you can use additional functionality such as CareCompass and CareAware Critical Care to see an overview of your patient(s).

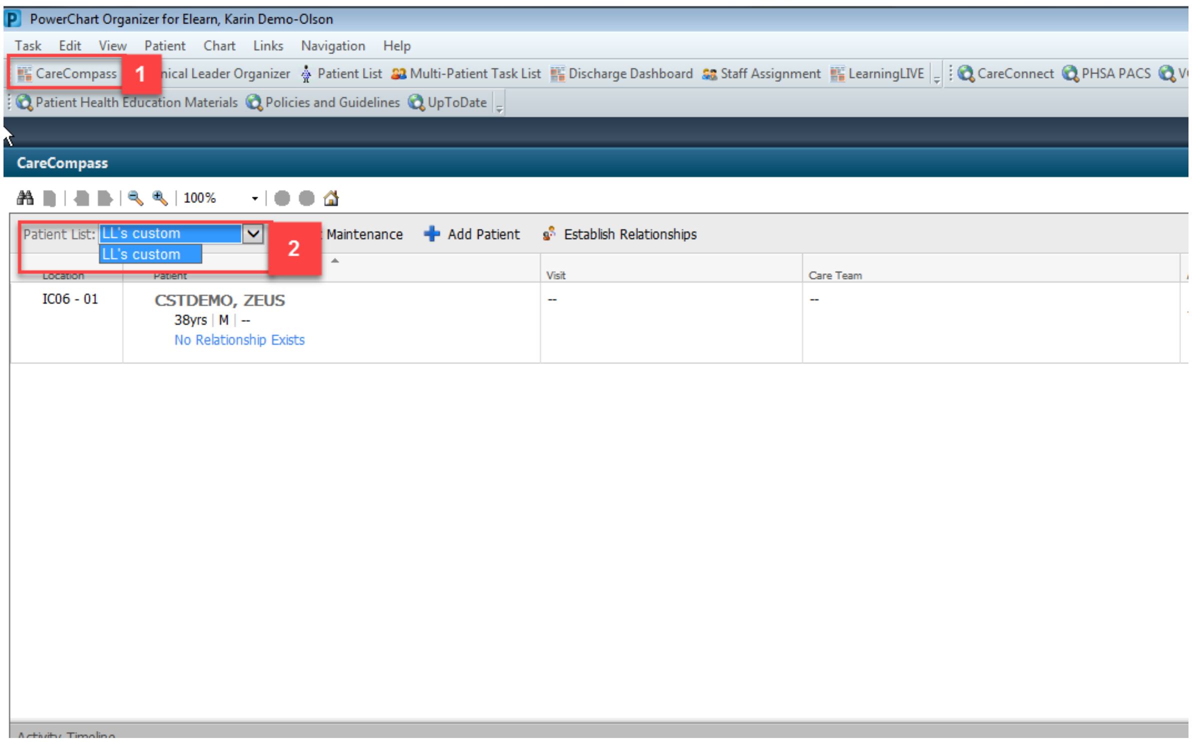
As a Respiratory Therapist you will be completing the following activities:

- Introduction to CareCompass
- Introduction to CareAware Critical Care (iAware)

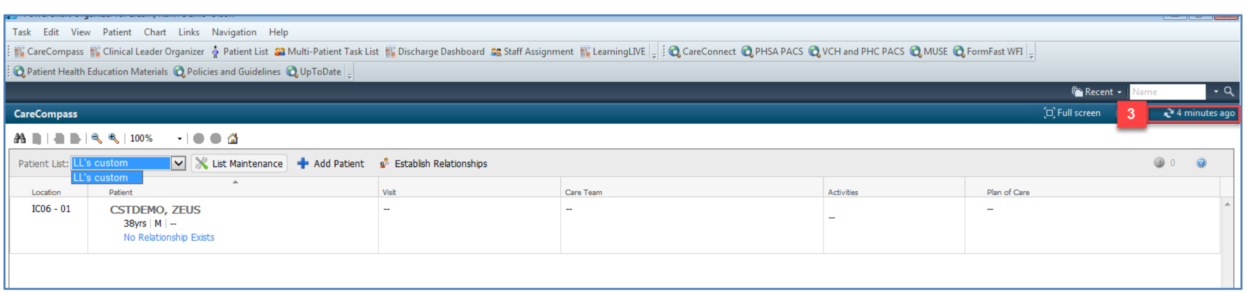
Activity 9.1 – Introduction to CareCompass

1 **CareCompass** displays information you need about your patients directly, including important details such as allergies, resuscitation status, reason for visit, activities (tasks), ABG results, ventilator modes and type of oxygen therapy.

1. Navigate to **CareCompass** by clicking on the **CareCompass** icon CareCompass in the **Toolbar**.
2. Select **YourName_Custom** from the **Patient List** drop-down.

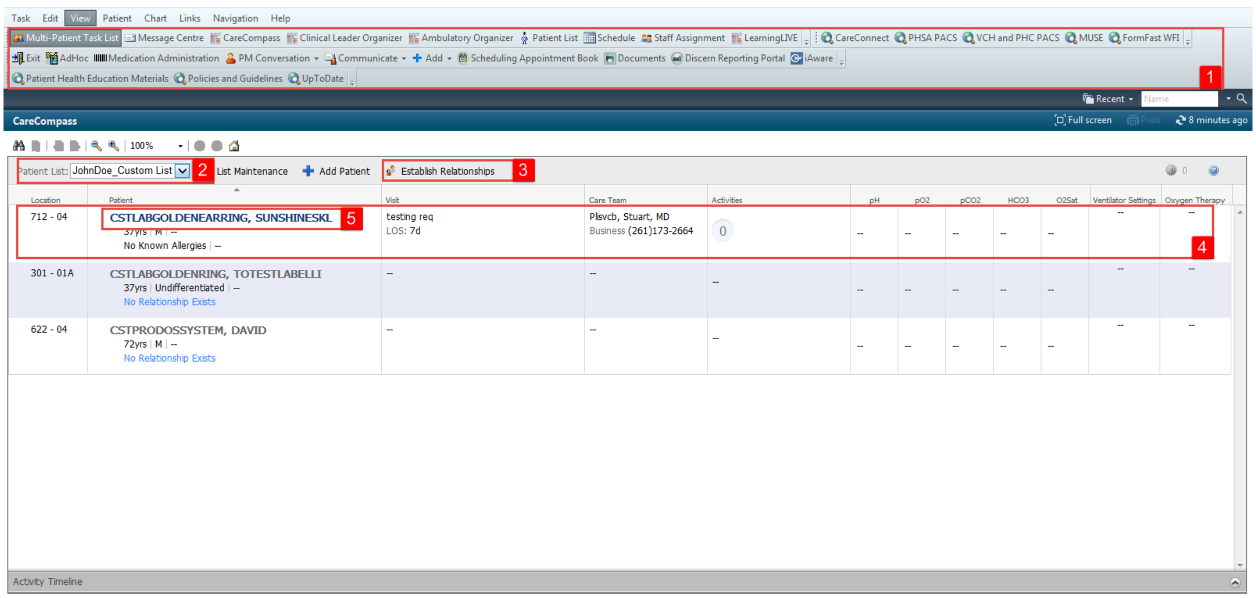


3. Click **Refresh** . Your selected patients are now visible on your custom list.



2 Let's review the **CareCompass** page.

1. The **Toolbar** is located above the patient's chart. It contains buttons to navigate other parts or functions of the Clinical Information System (CIS)
2. The **Patient List** drop-down menu enables you to select the appropriate patient list you would like to view
3. The only information visible about a patient is their location, name, and basic demographics until you establish a relationship. You can establish the relationship with the patient's chart using the **Establish Relationships** button
4. After the relationship is selected, it will open up additional information pertaining to your patient.
5. After reviewing additional information, click on **[patient's name]** and the patient's chart will open. CareCompass allows you to access a patient's chart directly as well as providing an overview of patient information.



Key Learning Points

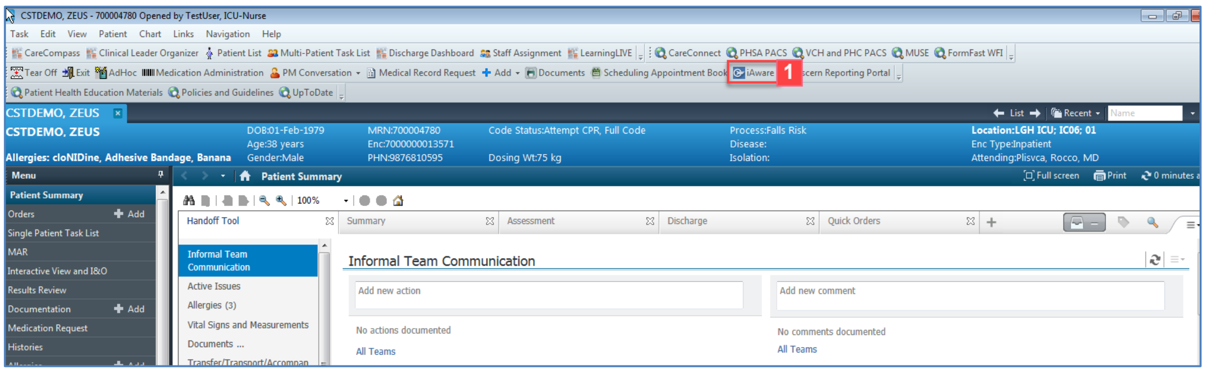
- CareCompass provides a quick overview of patient information
- Prior to establishing a relationship with the patient, the only information visible about a patient is location, name and basic demographics

Activity 9.2 – Introduction to CareAware Critical Care (iAware)

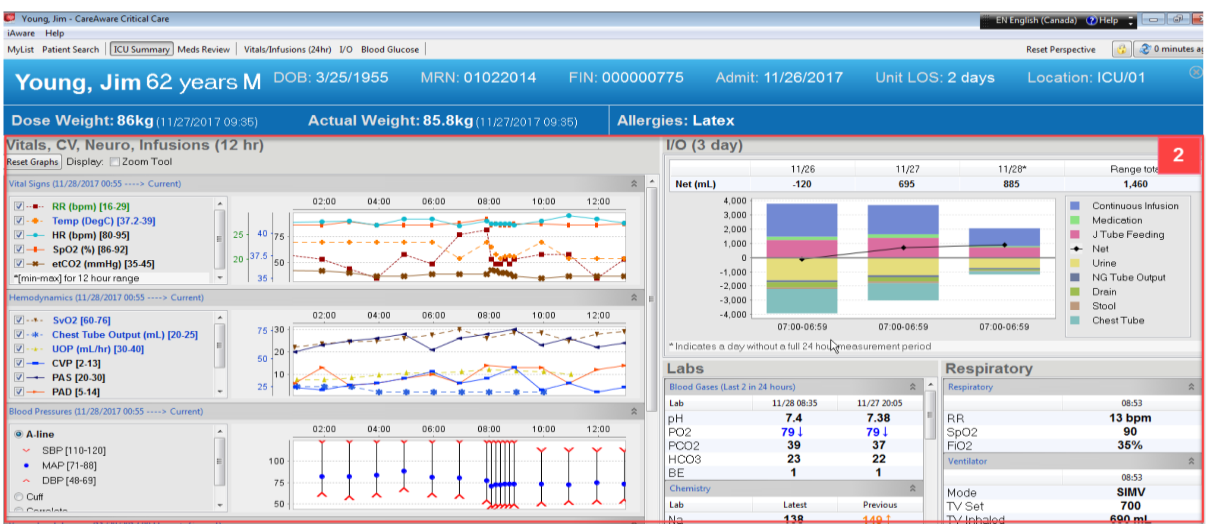
1 CareAware Critical Care (iAware) provides an interactive dashboard that aggregates critical patient information from multiple sources (such as vital signs, IV drips, intake and output), allowing providers and clinicians to gain an understanding of the complete picture of the patient at a glance.

1. With your patient's chart open, you can access **CareAware Critical Care** by clicking the **iAware** button 

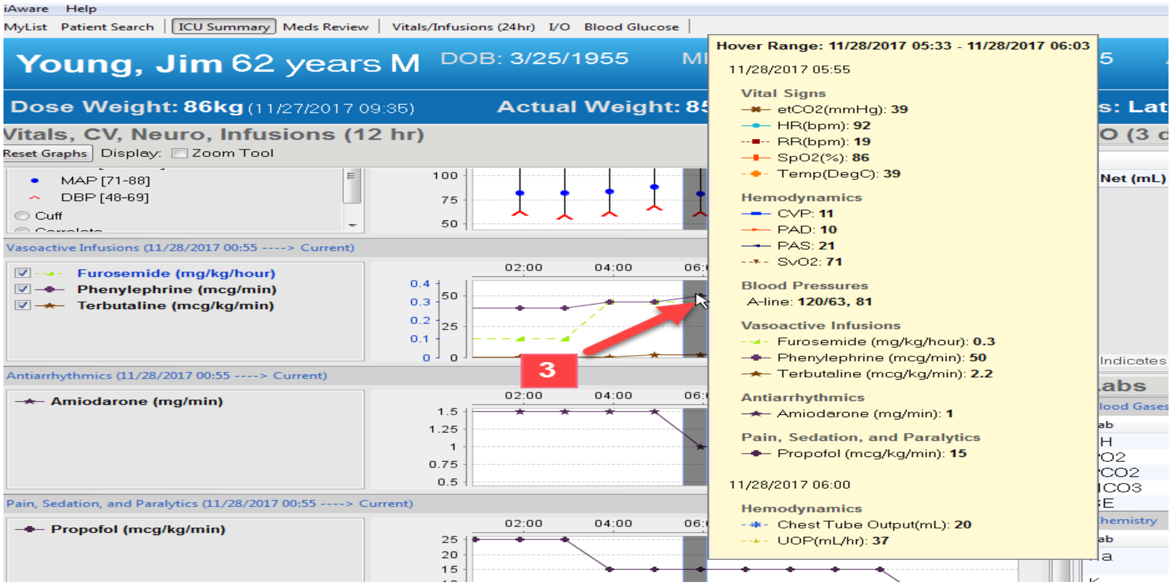
on the **Toolbar**.



2. The **CareAware Critical Care** dashboard consisting of various sources of clinical information opens.



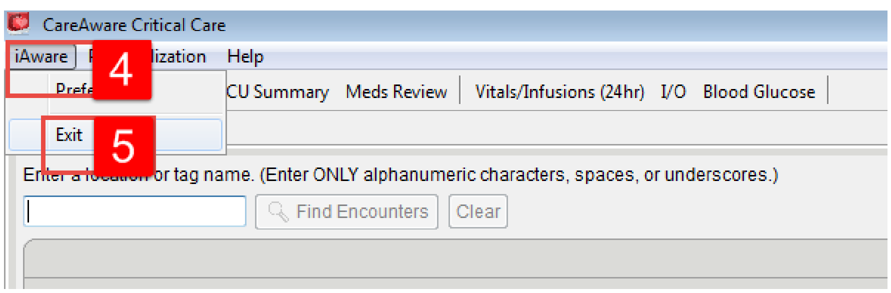
3. Hover over the **actual time dot** and detailed clinical information will display.



Note: Besides being able to view patient's clinical data during shift report and handoff, CareAware Critical Care can also be utilized in rounds for clinical decision-making and care planning.

To exit out of CareAware Critical Care,

4. Click on the **iAware** button in the top left corner of the screen.
5. In the **iAware** drop-down, select **Exit** and the window will close and you will see the patient's chart display again.



Key Learning Points

- CareAware Critical Care provides critical patient information from multiple sources in the chart that allows providers and clinicians to understand the complete picture of the patient. This helps to make clinical decisions for patient care and treatment plans.

PATIENT SCENARIO 10 – End of Shift Activities

Learning Objectives

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

- Perform End of Shift Activities

SCENARIO

In this scenario, you will practice activities associated with giving report and documenting handover.

As a respiratory therapist, you will be completing the following activities:

- Documenting Informal Team Communication
- Handoff Tool
- Documenting Handoff in iView

Activity 10.1 – Documenting Informal Team Communication

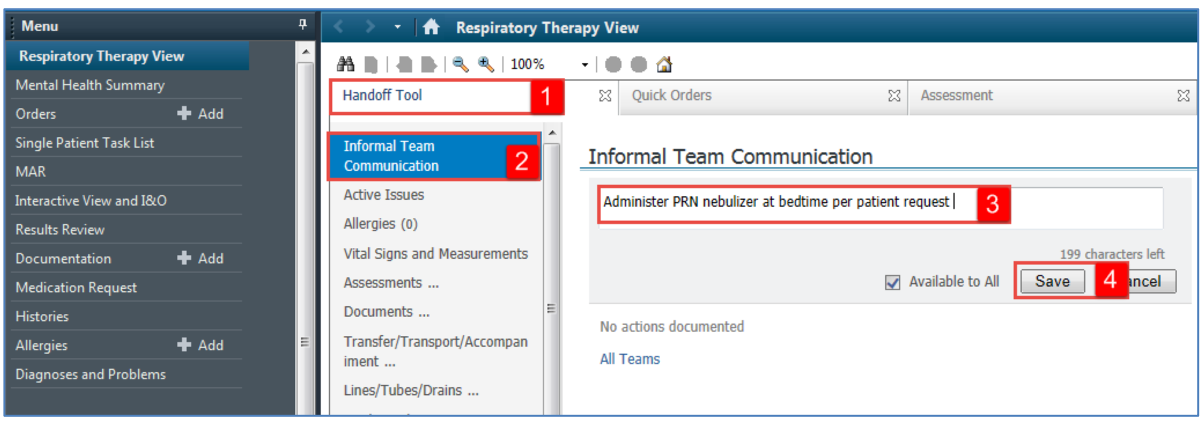
1 Within the **Handoff Tool,** there is an **Informal Team Communication** component that can be used for documentation of informal communication between all interdisciplinary care team members.

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

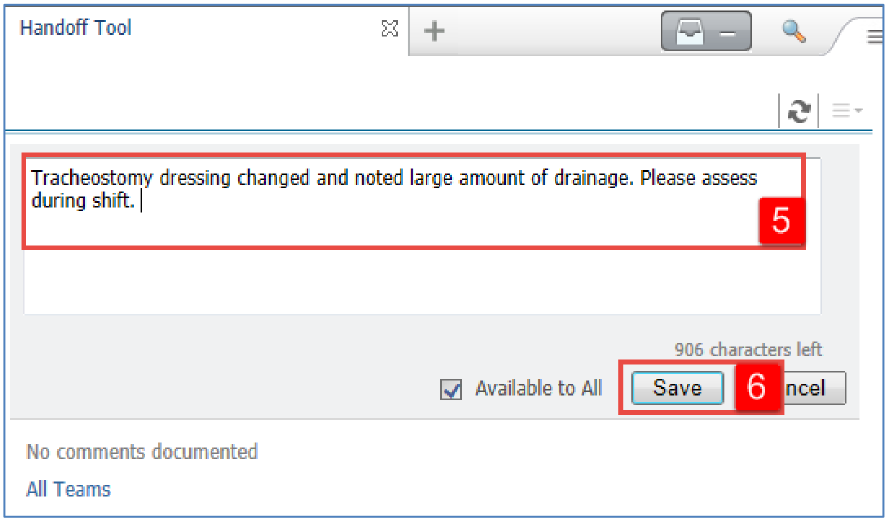
Note: Items documented within the Informal Team Communication component are **NOT** part of the patient's legal chart

Select **Respiratory Therapy View** from the Menu:

1. Click on **Handoff Tool**
2. Select the **Informal Team Communication** component
3. Under **Add new action** type = *Administer PRN nebulizer at bedtime per patient request*
4. Click **Save**.



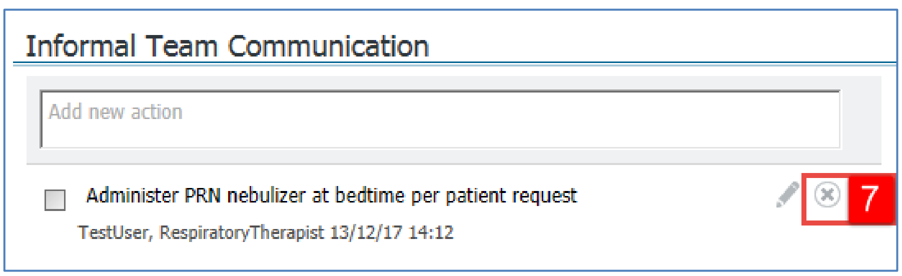
5. To **Add new comment,** type = *Tracheostomy dressing changed and noted a large amount of drainage. Please assess during the shift.*
6. Click **Save**



It is important to remove/delete **Informal Team Communication** when they no longer apply.

To remove/delete **Informal Team Communication**:

7. Hover over action or comment text and then click the **small circle with the X** icon to the right of the action/comment.



The note will now have disappeared from under the Informal Team Communication component.

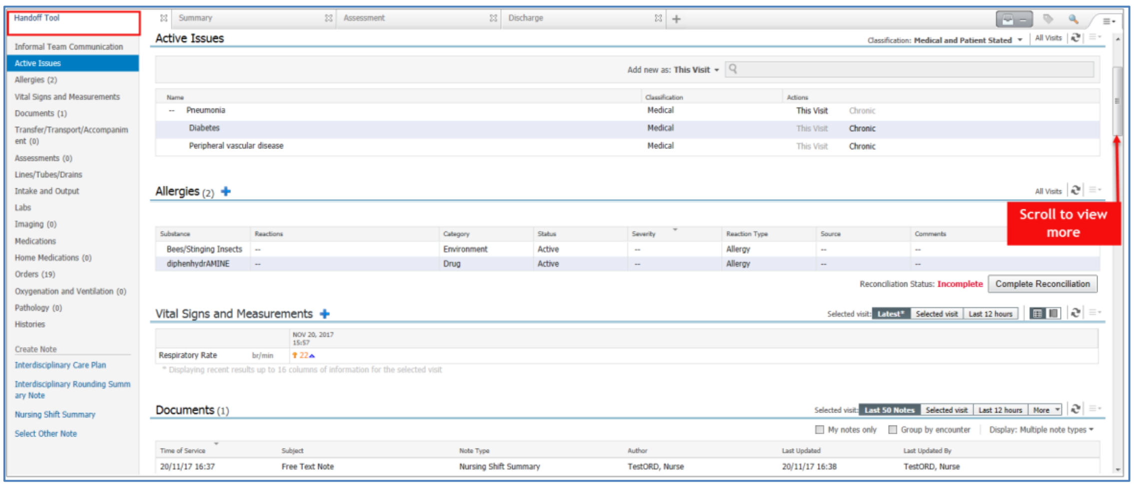
Key Learning Points

- 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

Activity 10.2 – Handoff Tool

1 When performing shift handover, respiratory therapists will use the Handoff Tool to review patient information between the oncoming and off going clinicians.

From the **Menu** select **Respiratory Therapy View**. From the **Handoff Tool Tab,** scroll down the page or access each component by clicking within the Handoff components on the left.



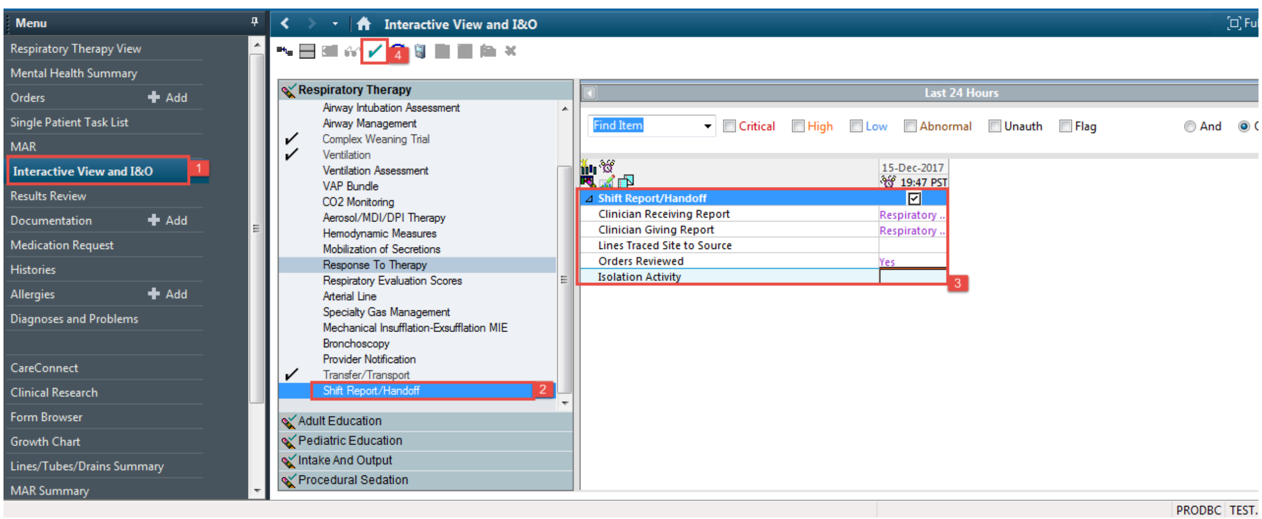
Key Learning Points

- Use the Handoff Tool to review patient information between respiratory therapists

Activity 10.3 – Documenting Handoff in iView

1 As the off going respiratory therapist, you will document that you have given handoff in iView by completing the following steps:

1. Select **Interactive View and I&O** from the **Menu**
2. Select **Shift Report/Handoff** section from **Respiratory Therapy** band
3. Document using the following data:
   - **Clinician Receiving Report** = *Respiratory Therapist 1*
   - **Clinician Giving Report** = *Respiratory Therapist 2*
   - **Orders Reviewed** = *Yes*
4. Sign your documentation by clicking the **green check mark** icon



Key Learning Points

- Document that you have given report in the **Shift Report/Handoff** section in iView

End Book One

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