

**SELF-GUIDED PRACTICE WORKBOOK [N55]**  
CST Transformational Learning

WORKBOOK TITLE:

**Health Care Assistant: General**

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## SELF-GUIDED PRACTICE WORKBOOK

<b>Duration</b>	4 hours
<b>Before getting started</b>	<ul style="list-style-type: none"><li>■ Sign the attendance roster (this will ensure you get paid to attend the session).</li><li>■ Put your cell phones on silent mode.</li></ul>
<b>Session Expectations</b>	<ul style="list-style-type: none"><li>■ This is a self-paced learning session.</li><li>■ A 15 min break time will be provided. You can take this break at any time during the session.</li><li>■ The workbook provides a compilation of different scenarios that are applicable to your work setting.</li><li>■ Work through the different learning activities at your own pace.</li></ul>
<b>Key Learning Review</b>	<ul style="list-style-type: none"><li>■ At the end of the session, you will be required to complete a <b>Key Learning Review</b>.</li><li>■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.</li><li>■ Your instructor will assist you.</li></ul>

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## 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 – Access and Set-up

### Learning Objectives

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

-  Create a Location Patient List
-  Create a Custom Patient List
-  Find patients on your Location Patient List and move them onto your Custom Patient List
-  Establish a relationship with patients and open patient charts

### SCENARIO

An 80 year old male presents to the ED with a fever and productive cough. He is admitted with a diagnosis of Pneumonia and prescribed IV antibiotics. You begin your shift and will be receiving the patient into your care. To start, ensure you are logged into the Clinical Information System (CIS) with your provided username and password.

As a Health Care Assistant, you will be completing the following activities:

-  Set up a Location Patient List
-  Create a Custom Patient List
-  Establish a relationship with your patient and then open your patient's chart

## Activity 1.1 – Set Up a Location Patient List

As a Health Care Assistant, upon logging into PowerChart, you will land on **Patient List**. The Patient List is a tool designed to assist you in locating the correct patient and accessing their chart.

1

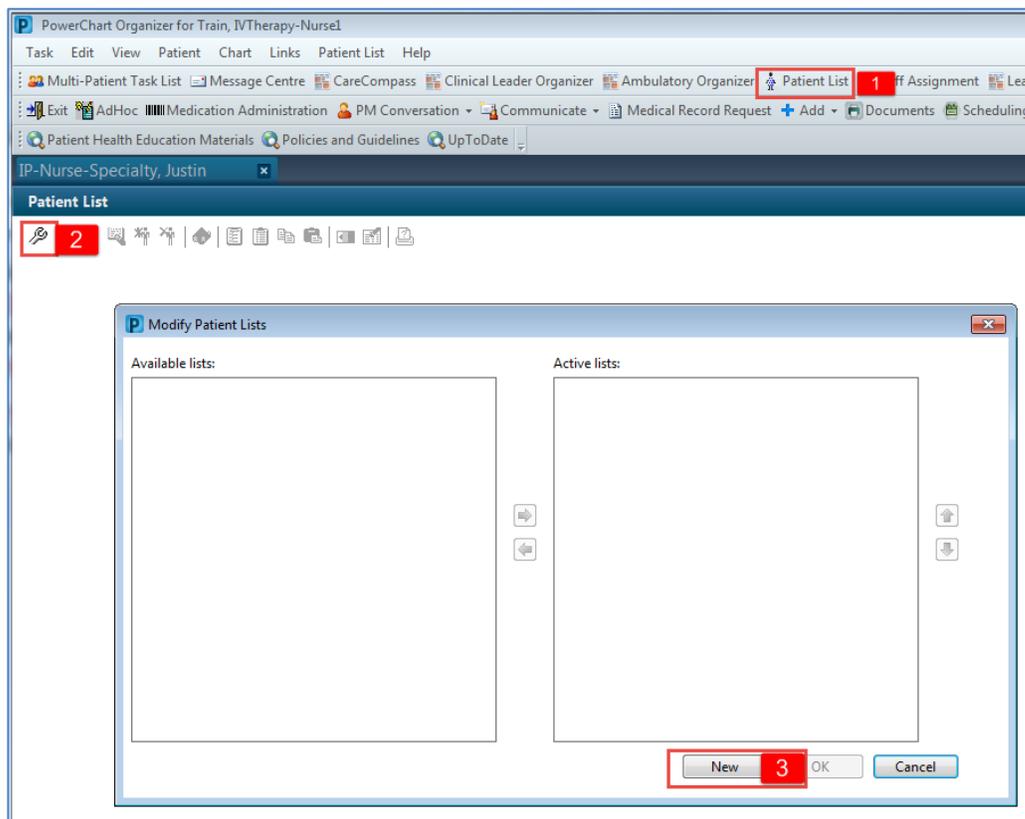
At the start of your first shift (or when working in a new location) using the Clinic Information System (CIS), you will only need to create a **Location List** once. This list will capture all of the patients on your unit. Then, whenever you log into the CIS each shift, the list will be available for you to use.

1. Ensure you are viewing the **Patient List**.

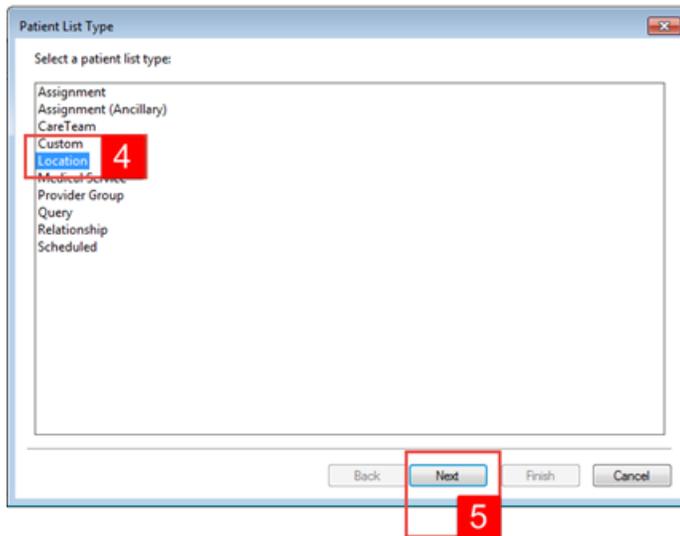
(Click on  **Patient List** from the **Toolbar** at the top of the screen to navigate to the Patient List from anywhere within the patient's chart).

2. The screen will be blank. To create a location list, click the **List Maintenance** icon . When you hover over the wrench with your cursor, it will say **List Maintenance**.

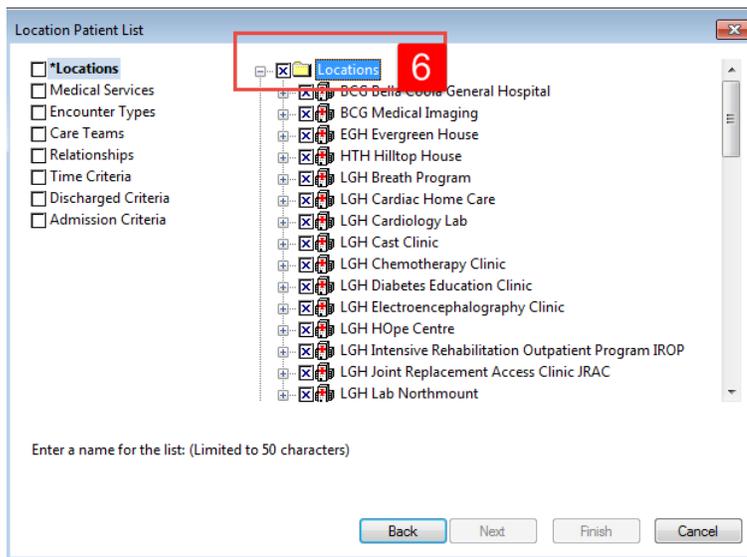
3. Select **New** at the bottom right corner of the Modify **Patient Lists** window.



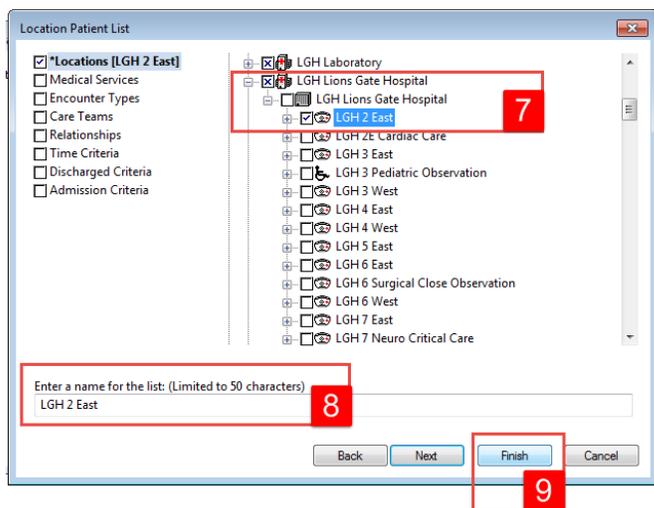
4. From the Patient List Type window select **Location**
5. Click **Next**



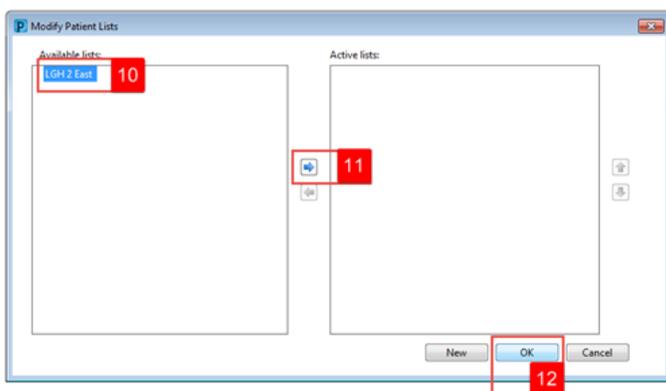
6. In the **Location Patient List** window, a location tree will be on the right hand side. Expand the list by clicking on the **tiny plus +** sign next to the locations folder.



7. Scroll down until you find the location assigned to you today from your handout sheet. Expand the location and select your unit by checking the box next to it.
8. Patient Lists need a name to differentiate them. Location lists are automatically named by the Location.
9. Click **Finish**



10. In the **Modify Patient Lists** window select your **Location** list.
11. Click the **Blue Arrow** icon  to move the **Location** to the right **Active List**.
12. Click the **OK** button at the bottom right corner to return to **Patient Lists**. Your Location list should now appear.



### Key Learning Points

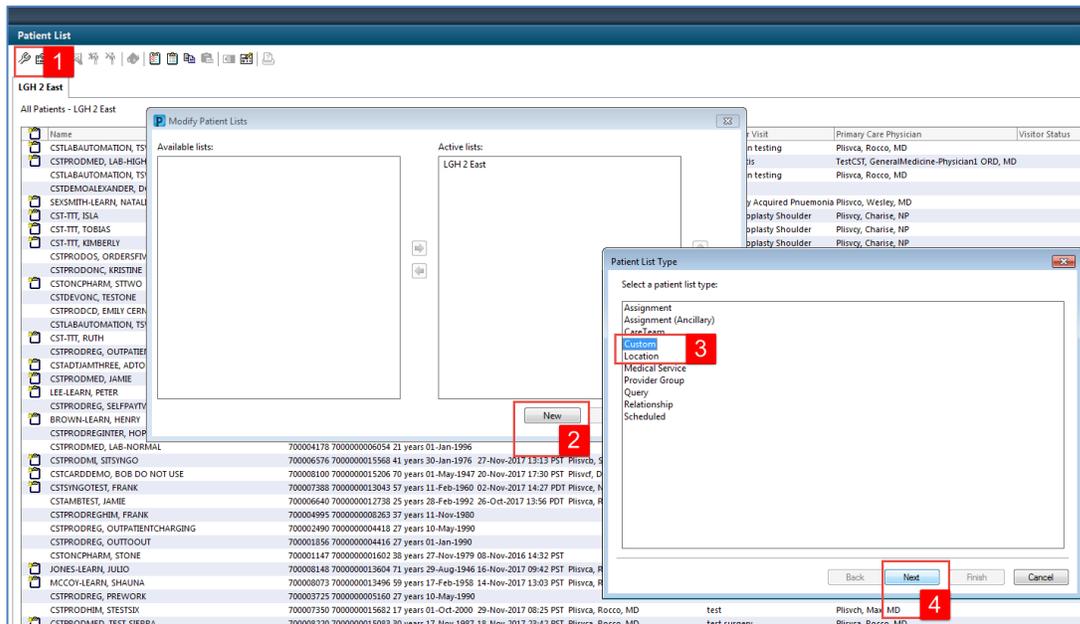
- Patient List can be accessed by clicking on the Patient List icon in the Toolbar.
- You can set up a patient list based on location.

## Activity 1.2 – Create a Custom Patient List

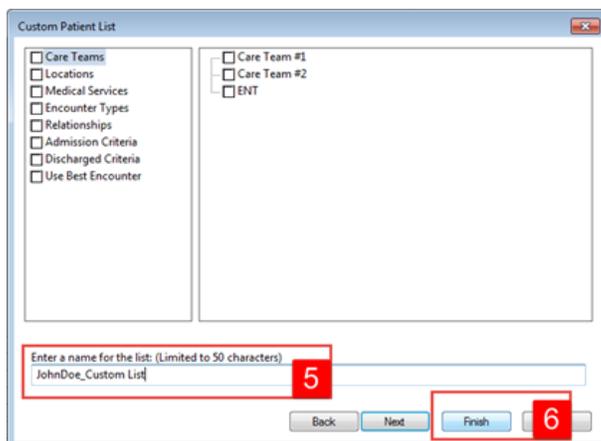
1

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 the **New** button at the bottom right corner of the **Modify Patient Lists** window.
3. From the **Patient List Type** window select Custom.
4. Click **Next**



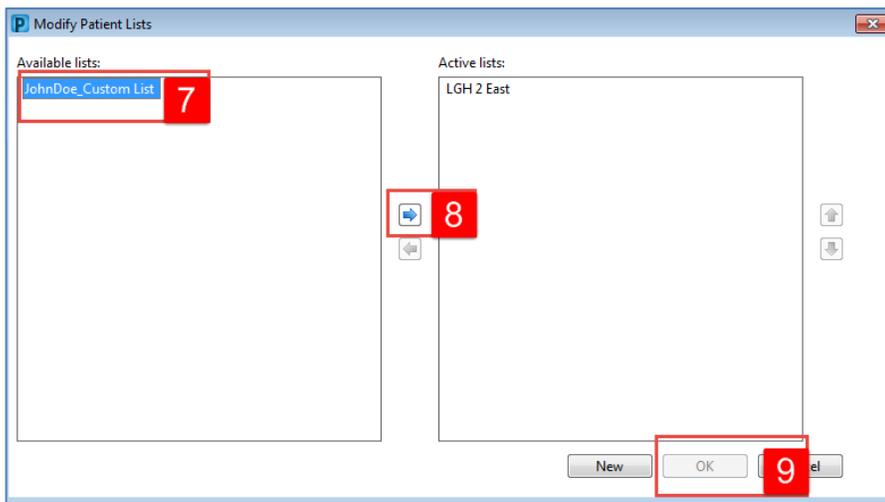
5. The **Custom Patient List** window opens. **Custom Lists** need a unique name. Type YourName\_Custom (for example JohnDoe\_Custom).
6. Click **Finish**



7. In the **Modify Patient Lists** window select your Custom List.

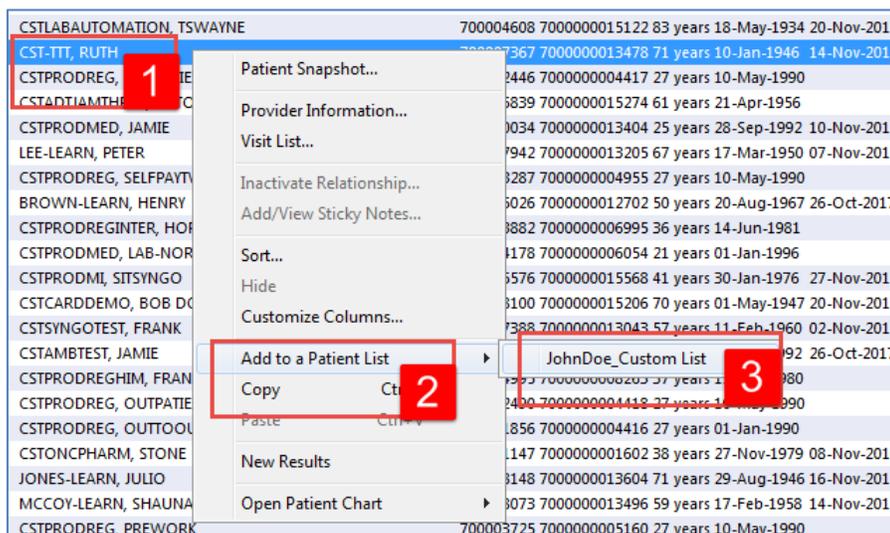
8. Click the **Blue Arrow** icon  to move your **Custom List** (e.g., JohnDoe\_Custom) to the right **Active List**.

9. Click **OK**



**2** At the beginning of each shift or assignment change, you will add your patients to your custom list from your location list.

1. First, find the patient that is assigned to you today from your handout sheet. Your patient is located on your **Location List**. Right- click on the **patient name**.
2. Select **Add to a Patient List**.
3. Select **YourName\_Custom List**.



4. Select YourName\_Custom tab.
5. Now your patient will appear on your Custom List. You may need to click **Refresh**

 1 minutes ago for them to appear.



\*Please check to ensure this is the patient assigned to you today from your handout sheet.

**Note:** you can remove a patient from your custom list by highlighting the patient and clicking the Remove Patient  icon.

### Key Learning Points

-  You can create a Custom List that will consist of only patients that you are caring for on your shift

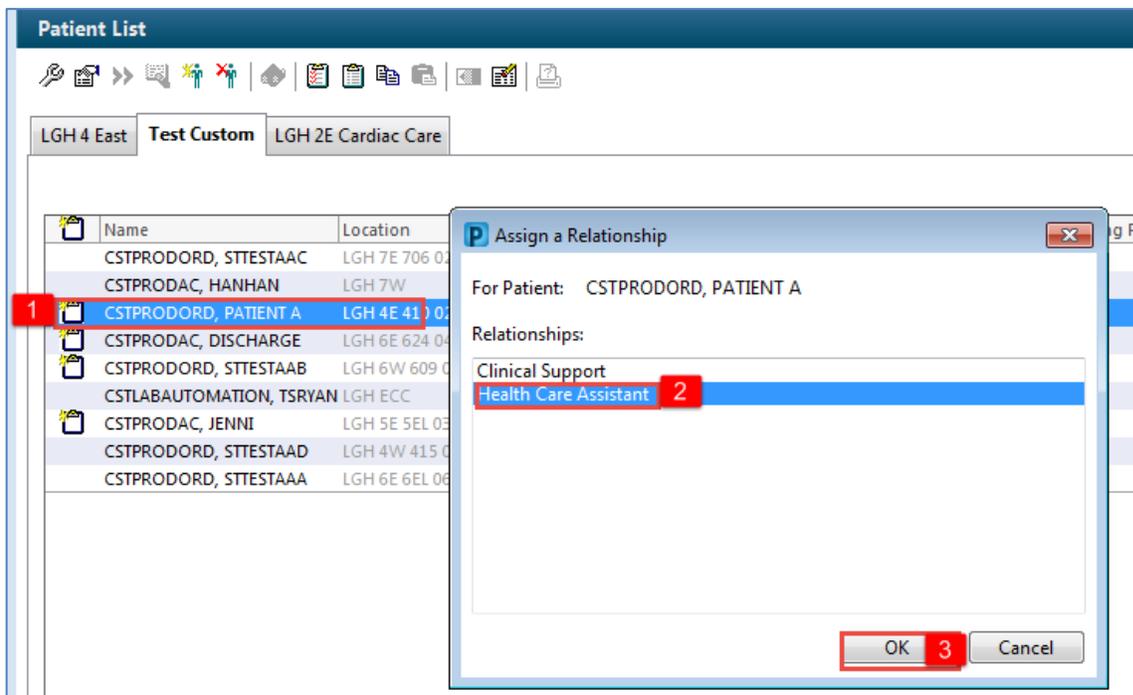
## Activity 1.3 – Open Patient Chart from Patient List

- 1 In the Patient List tool, you can establish a relationship with your patient and open the patient's chart.

To establish a relationship:

1. Double-click on your patient's name
2. Select the relationship of **Health Care Assistant**
3. Click **OK**

Your patient's chart will open to allow you to review patient information.



The screenshot shows the 'Patient List' window with a table of patients. The patient 'CSTPRODORD, PATIENT A' is selected. A dialog box titled 'Assign a Relationship' is open, showing the patient's name and a list of relationships. The 'Health Care Assistant' relationship is selected. The 'OK' button is highlighted.

Name	Location
CSTPRODORD, STTESTAAC	LGH 7E 706 02
CSTPRODAC, HANHAN	LGH 7W
CSTPRODORD, PATIENT A	LGH 4E 41 02
CSTPRODAC, DISCHARGE	LGH 6E 624 04
CSTPRODORD, STTESTAAB	LGH 6W 609 02
CSTLABAUTOMATION, TSTRYAN	LGH ECC
CSTPRODAC, JENNI	LGH 5E 5EL 03
CSTPRODORD, STTESTAAD	LGH 4W 415 02
CSTPRODORD, STTESTAAA	LGH 6E 6EL 06

### Key Learning Points

- Establishing a relationship with your patient allows you to access their electronic chart.

## 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 patient tasks in MPTL
-  Open patient chart from MPTL

### SCENARIO

In this scenario, you will use the Multi-Patient Task List (MPTL) to identify your patients and help organize your day.

As a health care assistant, you will complete the following activities:

-  Set up your Multi-Patient Task List (MPTL) View
-  Review the Multi-Patient Task List (MPTL) components
-  Establish a relationship with patient and open the patient's chart from MPTL

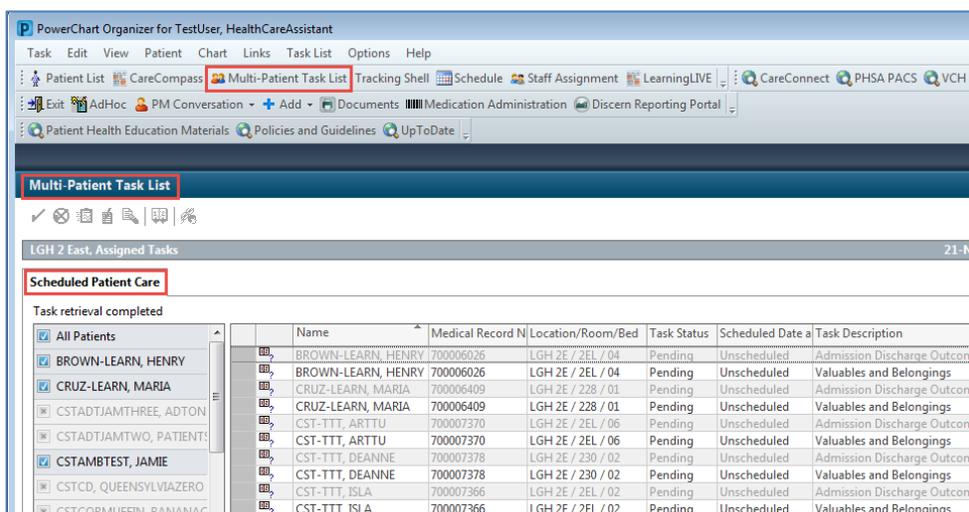
## Activity 2.1 – Set Up Your View of the Multi-Patient Task List

1 The **Multi-Patient Task List (MPTL)** displays your patient list and a list of tasks associated with the patients. Tasks are activities that need to be completed for the patients.

To navigate to the MPTL:

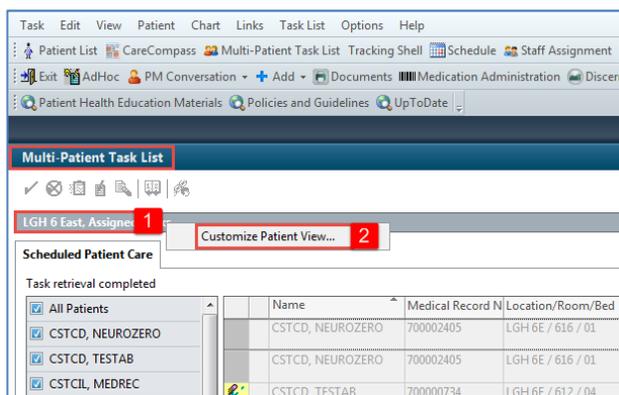
- Click on the **Multi-Patient Task List** on the toolbar

The **MPTL** for Health Care Assistant has a tab for **Scheduled Patient Care** tasks. This tab is a task category and is used to group tasks such as complete the Valuable and Belongings PowerForm (patient form).



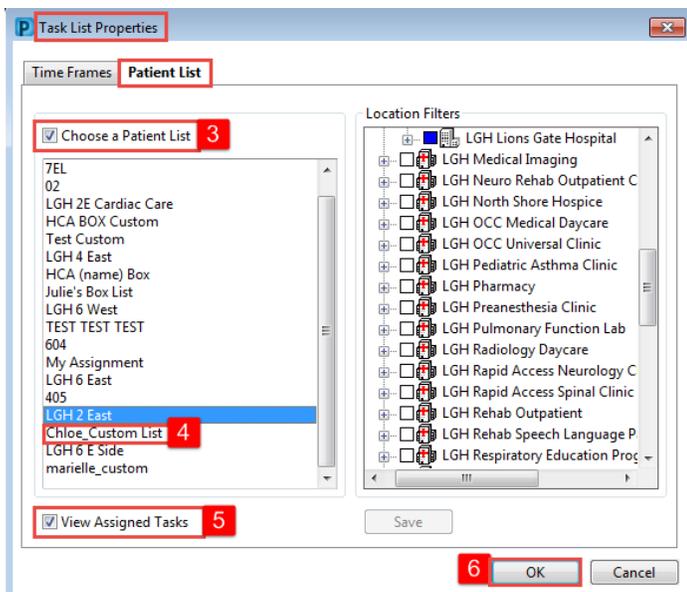
2 The first time you log in, you will need to set up the **Multi-Patient Task List (MPTL)**. To do this you need to select an appropriate **Patient List** and **Time Frame** to display.

- Right-click on **Assigned Tasks** in the grey information bar (above Scheduled Patient Care tab)
- Select **Customize Patient View**



Within the **Task List Properties** window:

3. In the Patient List tab, ensure **Choose a Patient List** is checked
4. For training purposes select your **Custom List**. (However, in the hospital, you would select Department View and select the location, e.g. LGH 2 East)
5. Ensure **View Assigned Tasks** is checked as this will ensure tasks display on your **MPTL**
6. Click **OK**

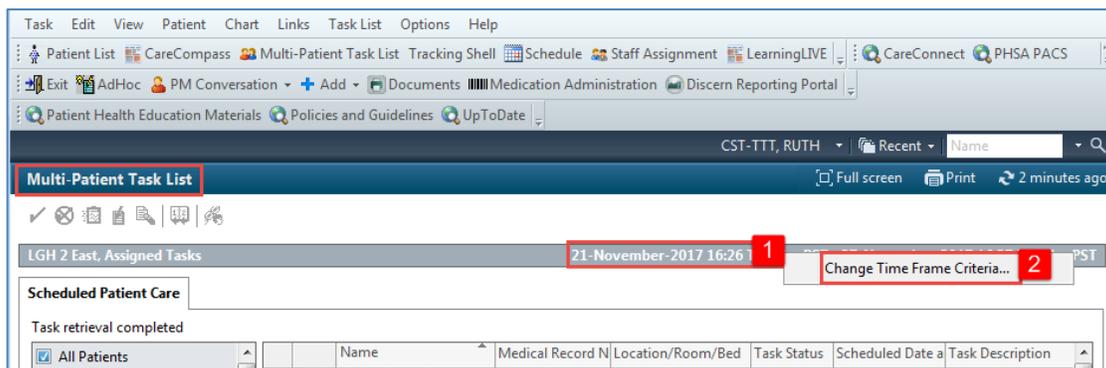


3

After selecting the appropriate Patient List, next you need to set up the **Defined Time Frame** for viewing tasks.

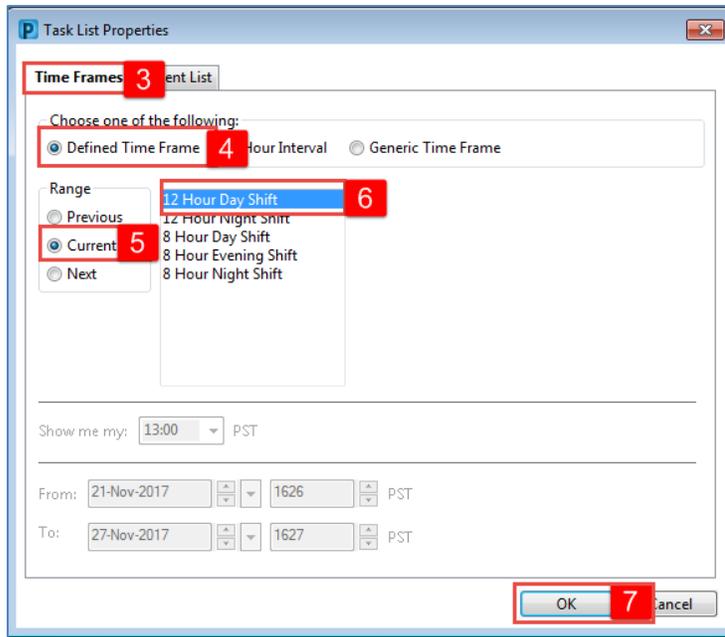
In this practice scenario, you work a 12-Hour shift. To select the appropriate Time Frame for your MPTL:

1. Right-click the **date range** on the far right hand side of the grey information bar
2. Select **Change Time Frame Criteria**. This will open the **Task List Properties** window



Within the **Task List Properties** window:

3. Click on **Time Frames** tab
4. Click on **Defined Time Frames**
5. Select **Current** for **Range**
6. Select time frame of **12 Hour Day Shift**
7. Click **OK**



After you have set up the appropriate Patient List and Time Frame for your MPTL, you are ready to review the tasks associated with your patient as shown in the next Activity.

### Key Learning Points

-  You can customize the patient list for MPTL.
-  You can change the time frame for MPTL to view tasks within a certain time range.

## Activity 2.2 – Review Tasks on the Multi-Patient Task List

1

On your **MPTL**, review the following components:

1. Task list toolbar - hover over the **icons** to discover their functions.
2. Information bar with the name of the patient list (far left) and the set time frame (far right).
3. Task categories (tabs) – to group tasks. HCA position has only one tab named **Scheduled Patient Care**.
4. Navigator window displays a list of your patients.
5. List of patient tasks. Task names are displayed in the **Task Description** column.

Name	Medical Record N	Location/Room/Bed	Task Status	Scheduled Date a	Task Description
BROWN-LEARN, HENRY	700006026	LGH 2E / 2EL / 04	Pending	Unscheduled	Admission Discharg
BROWN-LEARN, HENRY	700006026	LGH 2E / 2EL / 04	Pending	Unscheduled	Valuables and Belor
CRUZ-LEARN, MARIA	700006409	LGH 2E / 228 / 01	Pending	Unscheduled	Admission Discharg
CRUZ-LEARN, MARIA	700006409	LGH 2E / 228 / 01	Pending	Unscheduled	Valuables and Belor
CST-TTT, ARTTU	700007370	LGH 2E / 2EL / 06	Pending	Unscheduled	Admission Discharg
CST-TTT, ARTTU	700007370	LGH 2E / 2EL / 06	Pending	Unscheduled	Valuables and Belor
CST-TTT, DEANNE	700007378	LGH 2E / 230 / 02	Pending	Unscheduled	Admission Discharg
CST-TTT, DEANNE	700007378	LGH 2E / 230 / 02	Pending	Unscheduled	Valuables and Belor
CST-TTT, ISLA	700007366	LGH 2E / 2EL / 02	Pending	Unscheduled	Admission Discharg
CST-TTT, ISLA	700007366	LGH 2E / 2EL / 02	Pending	Unscheduled	Valuables and Belor
CST-TTT, RUTH	700007367	LGH 2E / 2EL / 03	Pending	Unscheduled	Admission Discharg
CST-TTT, RUTH	700007367	LGH 2E / 2EL / 03	Pending	Unscheduled	Valuables and Belor
CST-TTT, TOBIAS	700007371	LGH 2E / 2EL / 01	Pending	Unscheduled	Admission Discharg

### Key Learning Points

- Task list toolbar, Information bar, Task categories, Navigator, and List of the patient tasks are components of the MPTL.
- The location list is maintained by the system. The custom list is maintained by you. When a patient is discharged, they fall off the location list but remain on the MPTL until your shift is over.



### **Key Learning Points**

-  Establishing a relationship with your patient allows you to access their electronic chart.

## PATIENT SCENARIO 3 – Accessing and Navigating the Patient Chart

### Learning Objectives

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

- Navigate the patient's chart to learn more about the patient

### SCENARIO

In this scenario, we will review how to access the patient's chart and navigate the different pages of the chart to learn more about the patient.

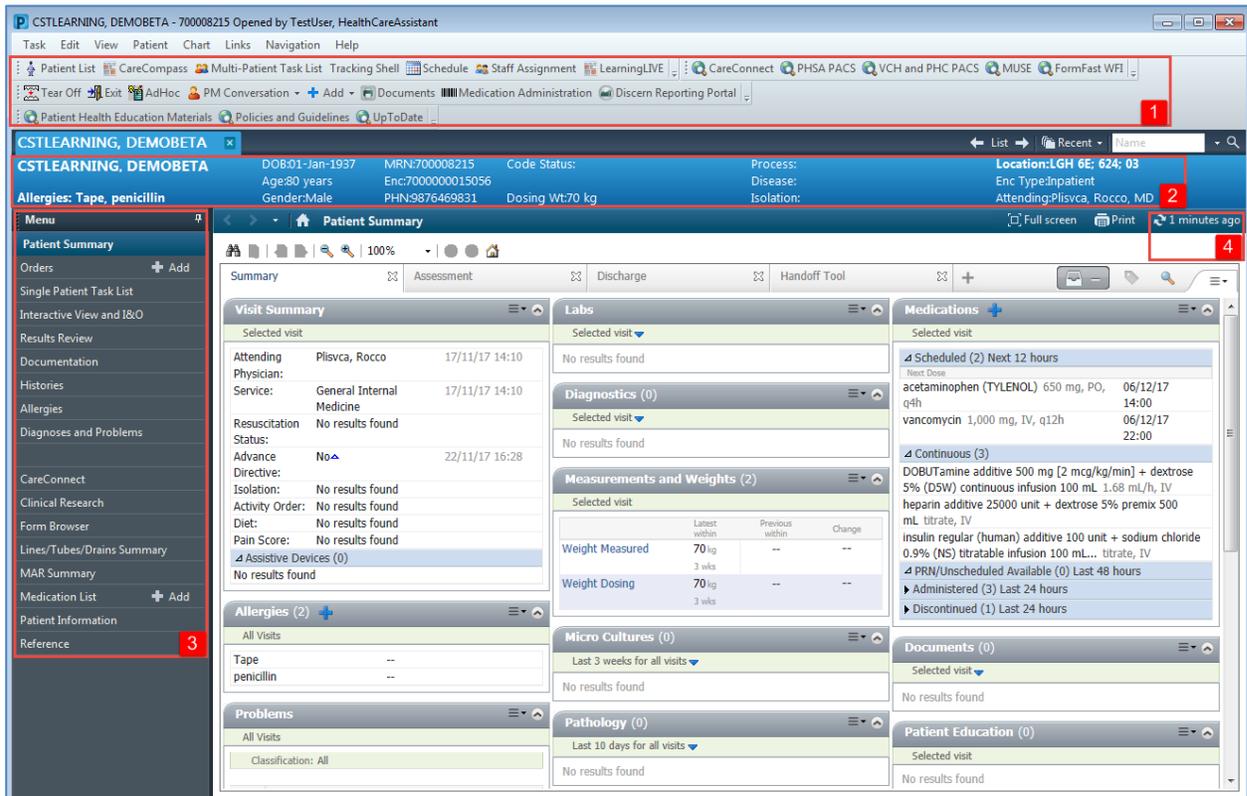
As a Health Care Assistant you will be completing the following activities:

- Introduction to Banner Bar, Toolbar, and Menu
- Introduction to Patient Summary

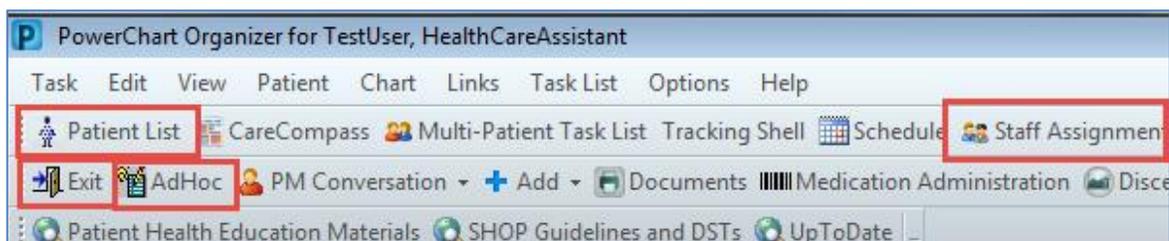
PATIENT SCENARIO 3 – Accessing and Navigating the Patient Chart

**Activity 3.1 – Introduction to Banner Bar, Toolbar, and Menu**

1 You have opened your patient’s chart in the previous step. Now let’s review some key parts of the patient chart.



1. The **Toolbar** is located above the patient’s chart and it contains buttons that allow you to access various tools within the Clinical Informatics System, such as Adhoc folders where you will find patient documentation forms or the exit button to safely close the patient’s chart.



## PATIENT SCENARIO 3 – Accessing and Navigating the Patient Chart

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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 Interactive View and I&O, Orders and more.
4. The **Refresh** icon  updates the patient chart with the most up to date entries when clicked. It is important to click the **Refresh** icon regularly especially as other clinicians may be accessing and documenting in the patient chart simultaneously.

**Note:** The chart does not automatically refresh. When in doubt, Refresh. Also, you may hover over icons to display more information.

### Key Learning Points

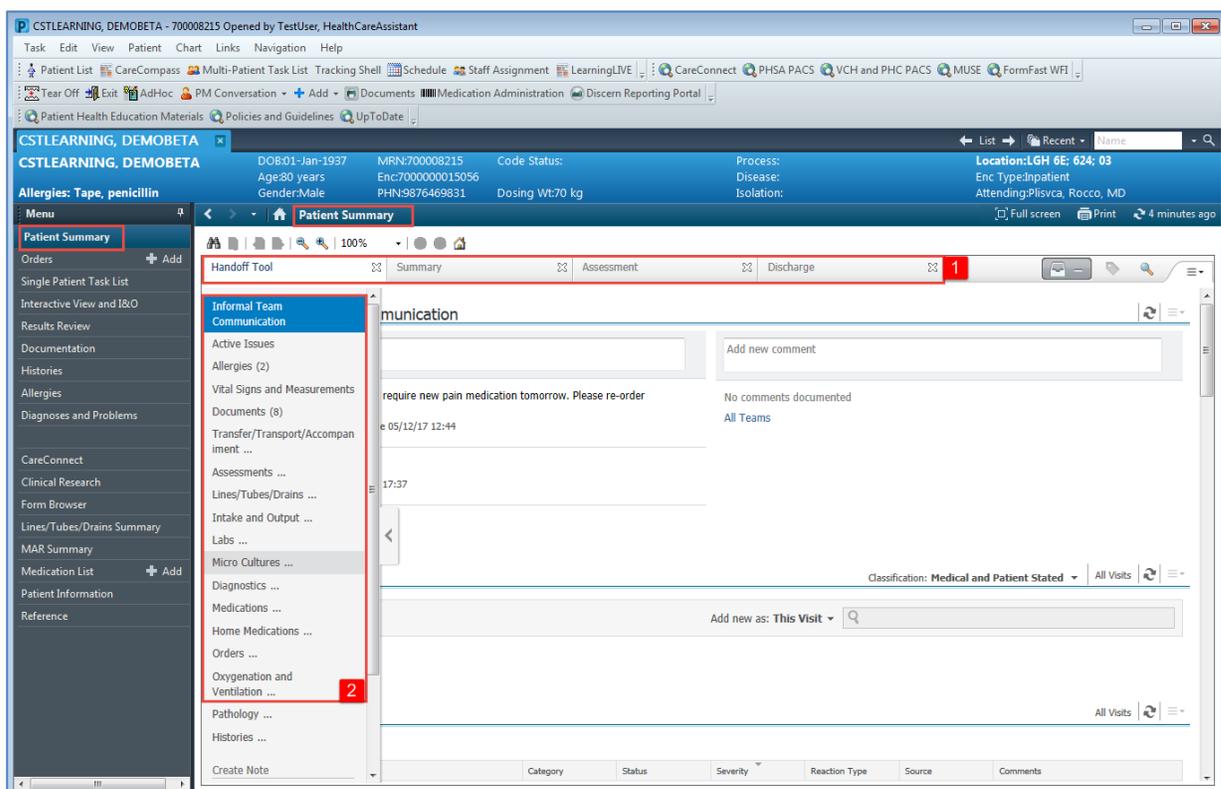
-  The Toolbar is used to access various tools within the Clinical Information System
-  The Banner Bar displays patient demographics and important information
-  The Menu contains sections of the chart similar to your current paper chart
-  The Refresh icon should be used regularly

## PATIENT SCENARIO 3 – Accessing and Navigating the Patient Chart

### Activity 3.2 – Introduction to Patient Summary

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

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



2 Click the **Refresh** icon . Notice the time since the last refresh is displayed and will reset to 0 minutes  0 minutes ago.

### Key Learning Points

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

## PATIENT SCENARIO 4 – Orders

### Learning Objectives

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

- Review the Orders Page

### SCENARIO

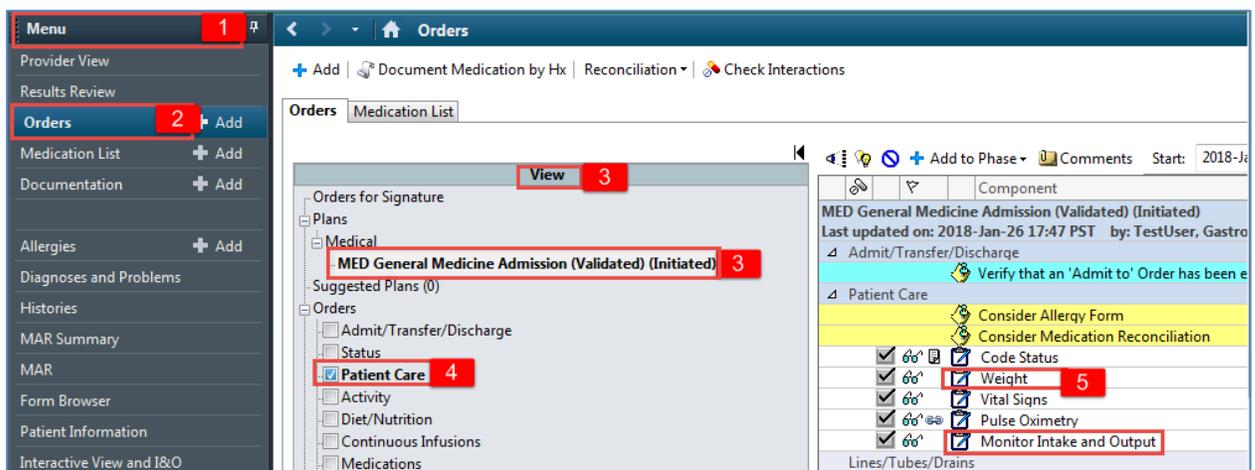
As a Health Care Assistant, you will need to be able to review orders on your patient. To do so, you will complete the following activity:

- Review Orders Page

## Activity 4.1 – Review Orders Page

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

- 1 To navigate to the **Order Page** and review the orders:
  1. Locate **Menu**
  2. Select **Orders**
  3. In the next pane, locate the **View** and click the **Med General Medicine Admission** Powerplan **MED General Medicine Admission (Validated) (Initiated)**. PowerPlans are like Order Sets.
  4. Select **Patient Care** clinical category
  5. Review the **Weight** Order



The screenshot displays the 'Orders' page in a clinical system. On the left, a 'Menu' sidebar has 'Orders' selected (2). The main area shows a tree view of orders under 'Patient Care' (4), with 'MED General Medicine Admission (Validated) (Initiated)' selected (3). The 'View' button is highlighted (3). The right pane shows details for the selected order, including 'Weight' (5) and 'Monitor Intake and Output'.

The Orders are listed under clinical categories, e.g.: Patient Care, Laboratory or Medications.

**Note:** there are icons displayed for some orders. Moving the mouse over order icons allows you to **hover to discover** additional information. For example, the  icon (nurse to review) indicates the order is yet to be reviewed by a nurse.

### Key Learning Points

-  The Order Profile page displays all the orders for a patient.

## PATIENT SCENARIO 5 – 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 and Modify your Documentation in iView

### SCENARIO

When you reviewed the orders, there were patient care orders for your patient:

- Monitor intake and output
- Document weight

In this scenario, your patient requires assistance with bathing. After providing the appropriate care for your patient, you will complete your documentation in **Interactive View and I&O (iView)**. iView is the electronic equivalent of current state paper flow sheets.

As a Health Care Assistant, you will be completing the following activities:

-  Document patient's location and activity in the Individual Observation Record band
-  Document weight
-  Document your patient's the oral intake and urinary output details
-  Document patient's activities of daily living including bathing details

## Activity 5.1 – Document Location and Activity in iView

1

Interactive View and I&O (iView) is like your paper flowsheets. The majority of documentation occurs in iView. You can document a variety of findings for your patient.

1. Go to the **Menu** and select **Interactive View and I&O**
2. Locate the  **Health Care Assistant Band**
3. Click once to select the **Individual Observation Record** section
4. Click on the cells and document for Patient Location and Patient Activity. Cells are fields where data is documented.
  - Patient Location = *Patient Room*
  - Patient Activity = *Lying down*

To sign your documentation, click the **Green Checkmark** icon .



**Note:** Documentation will appear in purple until signed. Once signed, the documentation will become black. Documentation must be signed to display for all healthcare team members accessing the patient chart. Once the documentation is signed the text becomes black.

### Key Learning Points

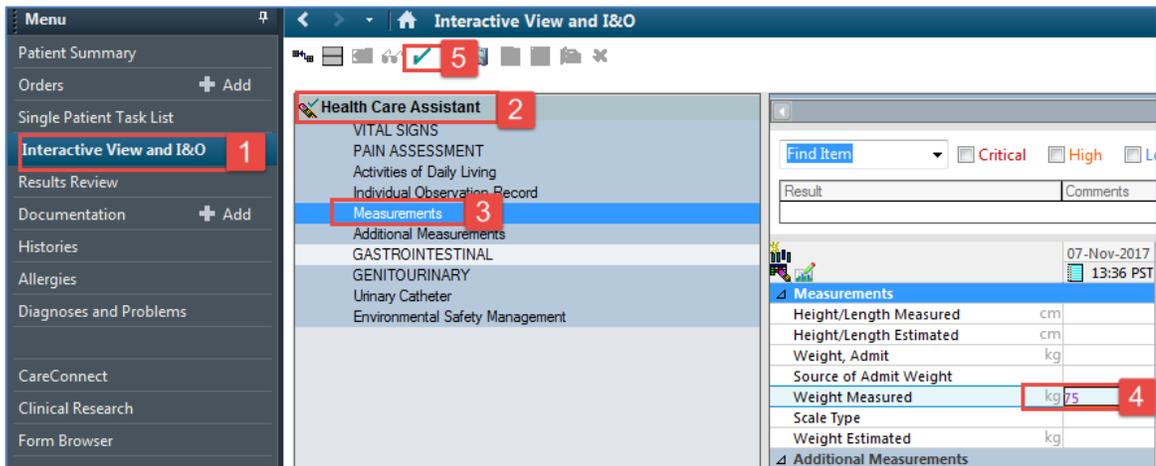
-  Documentation will appear in purple until signed. Once signed, the documentation will become black.
-  You do not have to document in every cell. Only document to what is appropriate for your assessment.

## Activity 5.2 – Document and Modify Weight in iView

1 After weighing your patient, you note the weight is 75 kg.

To document the weight in iView:

1. Go to the **Menu** and select **Interactive View and I&O**
2. Locate the  **Health Care Assistant** band
3. Select **Measurements** section
4. Document weight of 75 kg in the weight measured field:
  - Weight Measured = 75
5. Click  to sign and then refresh screen 



2 Occasionally errors occur, and they need to be corrected. In this scenario, you realize you transcribed the weight in error, to correct this:

- Right Click on the cell you just charted in
- select **Modify** from the dropdown list
- Change it to 80 kg (from 75 kg)
- Click  to sign and then refresh screen

		07-Nov-2017	
		14:03 PST	13:36 PST
<b>Measurements</b>			
Height/Length Measured	cm		
Height/Length Estimated	cm		
Weight, Admit	kg		
Source of Admit Weight			
Weight Measured	kg	75	
Scale Type			
Weight Estimated	kg		
<b>Additional Measurements</b>			
Mid-Upper Arm Circumference (M...	cm		
Upper Arm, Left Circumference	cm		
Upper Arm, Right Circumference	cm		
Lower Arm, Left Circumference	cm		
Lower Arm, Right Circumference	cm		
Upper Leg, Left Circumference	cm		
Upper Leg, Right Circumference	cm		
Lower Leg, Left Circumference	cm		
Lower Leg, Right Circumference	cm		
Ankle, Left Circumference	cm		

Add Result...  
 View Result Details...  
 View Comments...  
 View Flag Comments...  
 View Reference Material...  
 View Order Info...  
 View History...  
**Modify...**  
 Unchart...  
 Change Date/Time...  
 Add Comment...  
 Duplicate Results  
 Clear

Within the cell will now show your change 80 kg and a blue triangle displays  . When you double-click on the blue triangle, a **Result Detail** will pop-up with the modified details displayed

**Note:** With a right click on the result in the cell, you can see actions that can be applied to the result:

- **View Result Details** - To view detailed information about the result
- **Unchart** - if you charted on the wrong patient, you use this option to unchart the result. Uncharted results are marked as “In Error”
- **Add Comment** – add a free text comment to the result

### Key Learning Points

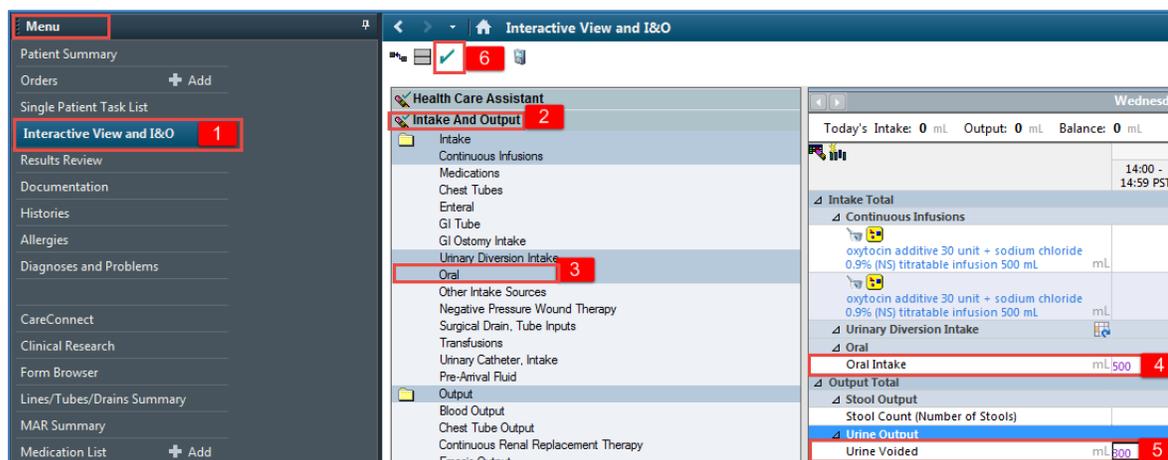
- Weight can be documented and/or modified in the iView.

## Activity 5.3 – Document Intake and Output in iView

1 During the day, your patient has intake and output data. In this scenario, your patient's earlier documentation of 600 mL of oral intake and 400 mL of urine output is displayed

To document intake and output:

1. Go to the **Menu** and select **Interactive View and I&O**
2. Locate the  **Intake And Output** band (you may need to scroll to the bottom of the page)
3. Select **Oral** section
4. Double click the cell for **Oral Intake** under the appropriate date and time, next document:
  - Oral Intake = **500**
5. Double click on the cell for **Urine Voided** under the appropriate date and time, next document:
  - Urinary Voided = **300**
6. Click  to sign and then refresh screen



### Key Learning Points

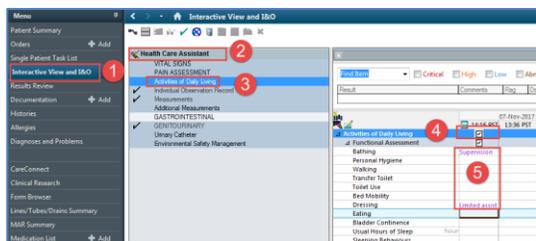
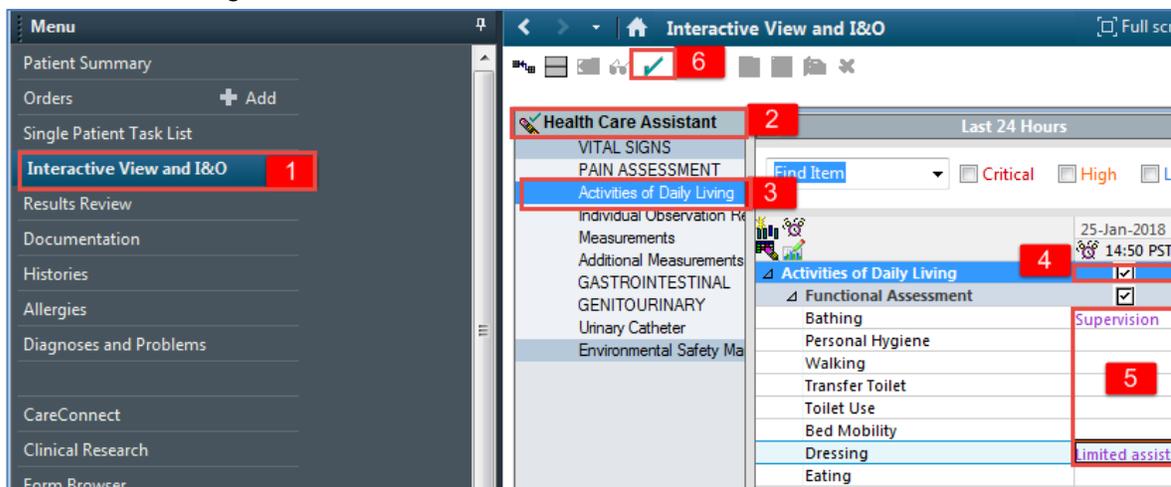
-  You can document Intake and output in the iView Intake and Output band.

## Activity 5.4 – Document Activities of Daily Living in iView

1 You have just supervised your patient taking a bath. You then need to update the documentation for your patient’s activities of daily living.

To document bathing details:

1. Go to the Menu and select **Interactive View and I&O**
2. Locate the **Health Care Assistant** band
3. Select **Activities of Daily Living** section
4. Double click on the blue line next to the **Activities of Daily Living** section to document on several cells. You can move through the cells by pressing the **Tab** key
5. Click on **Bathing** and document:
  - Bathing = *Supervision*
  - Dressing = *Limited Assist*
6. Click to sign and then refresh screen.



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

### Key Learning Points

-  You do not have to document in every cell. Only document what is appropriate for your assessment.

## PATIENT SCENARIO 6 – PowerForm

### Learning Objectives

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

- Document in PowerForms through AdHoc Charting
- View and Modify existing PowerForms

### SCENARIO

In this scenario, we will review another method of documentation. You will be capturing any valuables and belongings documentation in an electronic equivalent of the paper form.

As a Health Care Assistant, you will be completing the following activities:

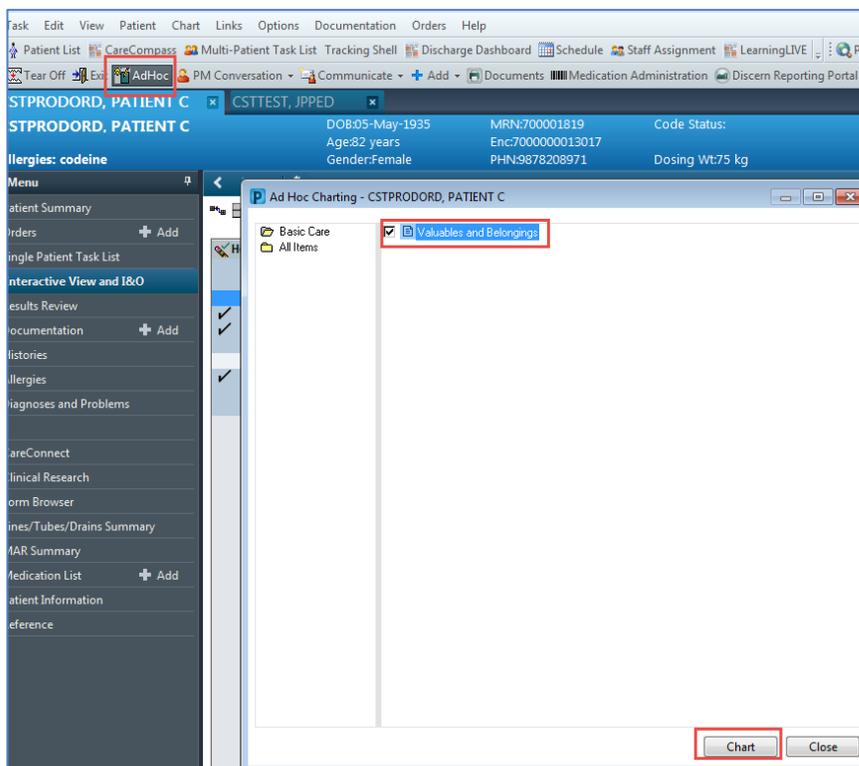
- Locate the Valuables and Belongings PowerForm
- Document on the Valuables and Belongings PowerForm
- View an existing PowerForm
- Modifying an existing PowerForm
- Unchart an existing PowerForm

## Activity 6.1 – Locate the Valuables and Belongings PowerForm

- 1 **PowerForms** are the electronic equivalent of the paper forms currently used to document patient care. In this scenario, you will document your patient's personal belongings on the **Valuables and Belongings** PowerForm.

To access the PowerForm:

1. Go to the Toolbar and click **Ad Hoc**  button
2. Click the **Valuables and Belongings** PowerForm
3. Click **Chart**. The PowerForm will open.

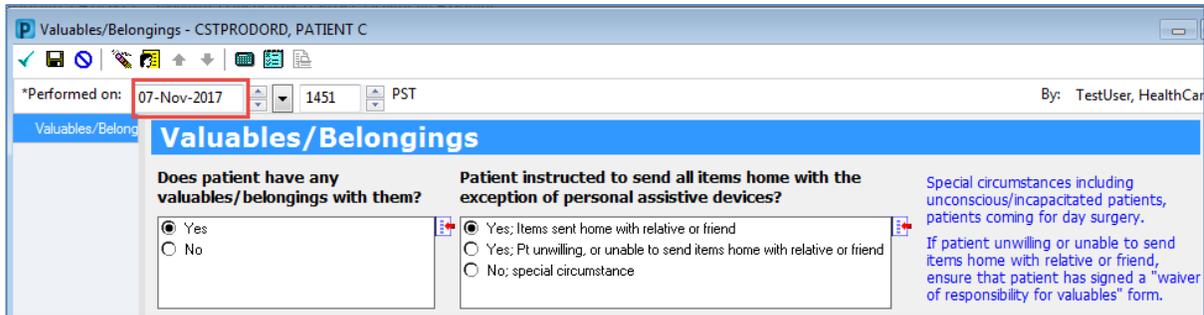


### Key Learning Points

- 1 The Valuables and Belongings PowerForm can be accessed by clicking Ad Hoc  button.

## Activity 6.2 – Document on the Valuables and Belongings PowerForm

- 1 You have opened the **Valuables and Belongings** PowerForm in the previous step. Note if there are previously documented values within the form, those values are denoted by an Icon . These values were documented during the patient’s admission.



**Valuables/Belongings**

Does patient have any valuables/belongings with them?  
 Yes  
 No

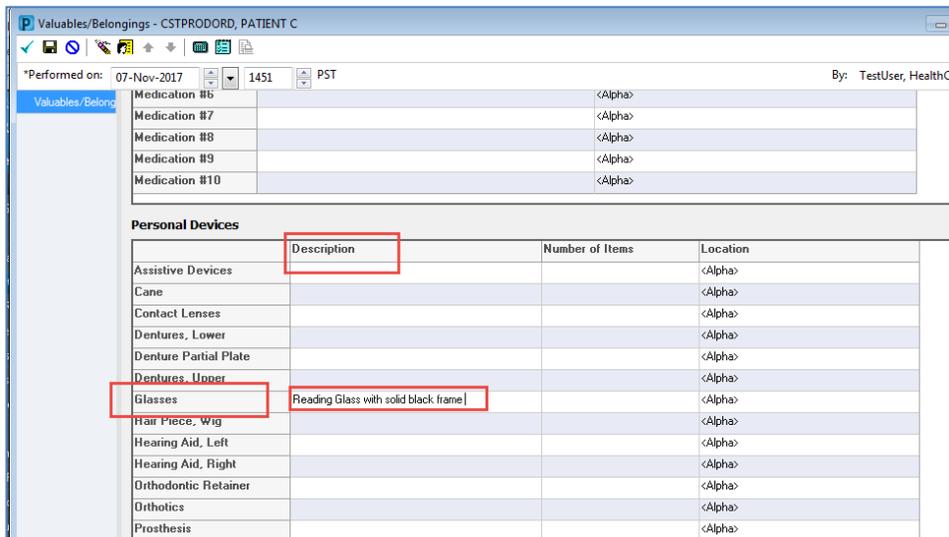
Patient instructed to send all items home with the exception of personal assistive devices?  
 Yes: Items sent home with relative or friend  
 Yes: Pt unwilling, or unable to send items home with relative or friend  
 No; special circumstance

Special circumstances including unconscious/incapacitated patients, patients coming for day surgery.  
 If patient unwilling or unable to send items home with relative or friend, ensure that patient has signed a "waiver of responsibility for valuables" form.

**Note:** You can add changes to this form and your changes will be added to the previous documentation. Changes may be added multiple times after the PowerForm is signed. Also, there are many fields to select on the form, choose only the ones that best reflect your patient’s situation.

In this scenario, you noticed your patient had glasses. You will document this finding on the **Valuables and Belongings** form by following the steps below:

1. Scroll down to **Personal Devices**
2. Click on the **Description** cell for **Glasses**, and document:
  - Glasses Description = Reading glasses with solid black frame
3. Click **Sign** 



Personal Devices			
	Description	Number of Items	Location
Assistive Devices			<Alpha>
Cane			<Alpha>
Contact Lenses			<Alpha>
Dentures, Lower			<Alpha>
Denture Partial Plate			<Alpha>
Dentures, Upper			<Alpha>
Glasses	Reading Glass with solid black frame		<Alpha>
Hair Piece, Wig			<Alpha>
Hearing Aid, Left			<Alpha>
Hearing Aid, Right			<Alpha>
Orthodontic Retainer			<Alpha>
Orthotics			<Alpha>
Prosthesis			<Alpha>

### Key Learning Points

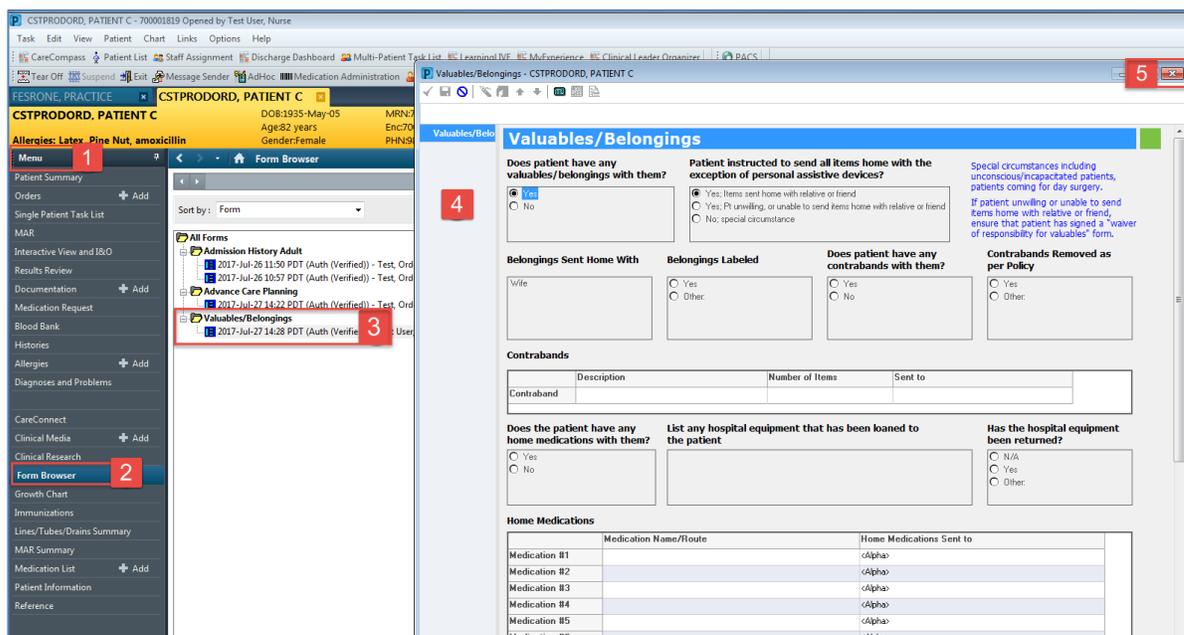
-  The Valuables and Belongings PowerForm can be accessed by clicking Ad Hoc  button on the toolbar.
-  There are many fields to select on the form. Document only in the ones that best reflect your patient's situation.

## Activity 6.3 – View an Existing PowerForm

- 1 There are several places from which you can review your Valuables and Belongings documentation to ensure you have captured everything correctly. You can review the form via the **Form Browser**.

To access **Form Browser** and view your previously documented PowerForm:

1. Go to **Menu**
2. Select **Form Browser**
3. Double-click the **Valuables and Belongings** Form
4. Review your Documentation
5. Close the form when done



The screenshot shows the PowerForm interface for a patient named CSTPRODORD, PATIENT C. The left sidebar contains a 'Menu' with 'Form Browser' highlighted. The main area displays the 'Valuables/Belongings' form, which includes sections for 'Does patient have any valuables/belongings with them?', 'Belongings Sent Home With', 'Belongings Labeled', 'Does patient have any contrabands with them?', 'Contrabands', 'Does the patient have any home medications with them?', 'List any hospital equipment that has been loaned to the patient', 'Has the hospital equipment been returned?', and 'Home Medications'. A table at the bottom lists medications and their home destinations.

Medication	Medication Name/Route	Home Medications Sent to
Medication #1		Alpha
Medication #2		Alpha
Medication #3		Alpha
Medication #4		Alpha
Medication #5		Alpha
Medication #6		Alpha

**Note:** A PowerForm can have different statuses and can be modified by different users.

- For a **saved** document, **(In Progress)** appears in the **status** next to the title. The form is not complete and cannot be viewed by another user
- For a **completed** document, **(Auth (Verified))** appears in the **status** next to the title. The form has been signed off by the author and is viewable to other users
- For a **modified** document, **(Modified)** appears in the **status** next to the title
- For an **unchanged** documented, **(In Error)** appears in the **status** next to the title

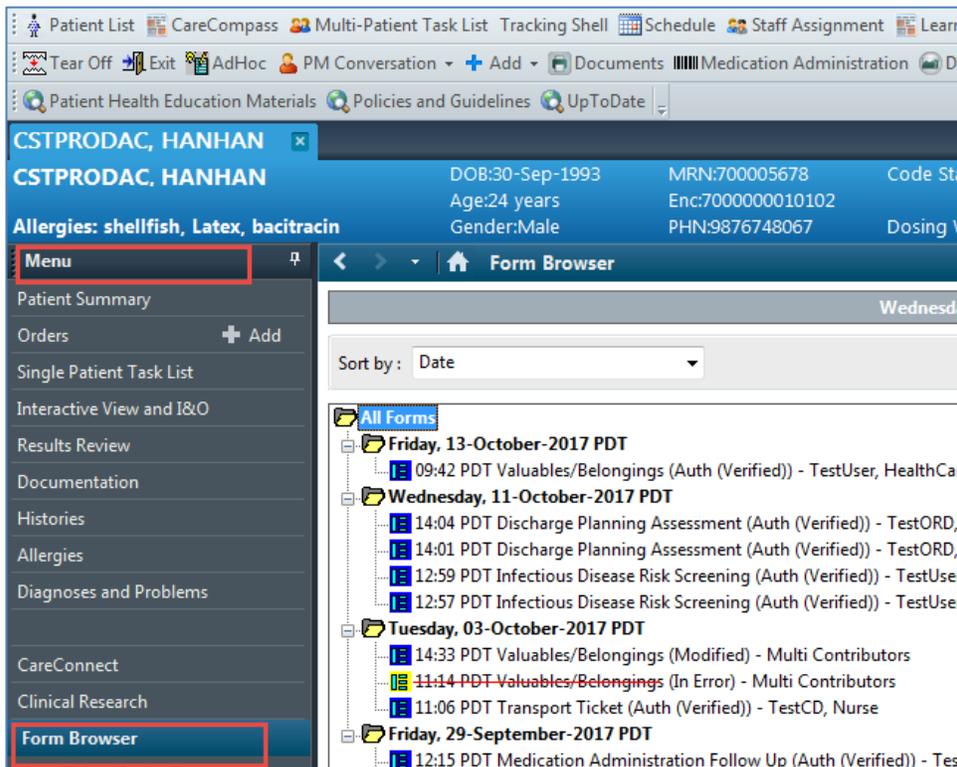
### Key Learning Points

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

## Activity 6.4 – Modify an Existing PowerForm

1

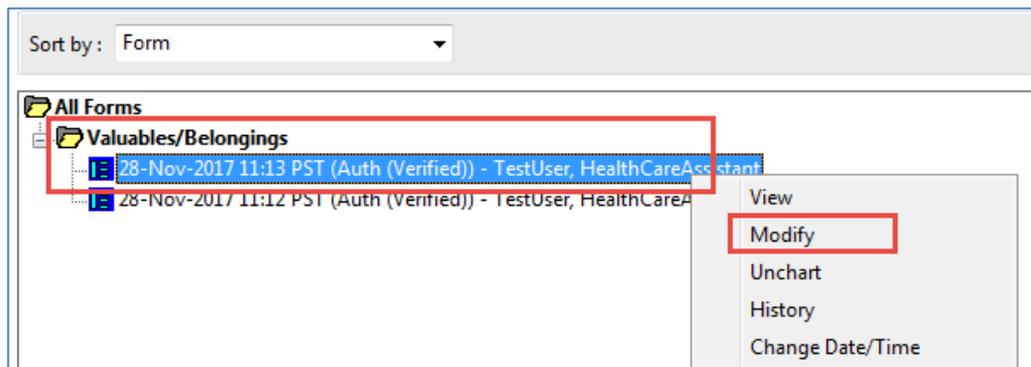
It may be necessary to modify PowerForms if information needs to be added or clarified. Let's modify the **Valuables and Belongings** form.



The screenshot shows the PowerForm interface for patient CSTPRODAC, HANHAN. The 'Form Browser' menu is highlighted in the left sidebar. The main area displays a list of forms, with the 'Valuables/Belongings' form from Tuesday, 03-October-2017 PDT, selected. The form is currently in an 'In Error' state.

To **modify** a PowerForm select it from within **Form Browser**:

1. Right-click on the most recently completed **Valuables and Belongings** form in **Form Browser**
2. Select **Modify**



This close-up screenshot shows the 'Form Browser' interface with the 'Sort by' dropdown set to 'Form'. A right-click context menu is open over the 'Valuables/Belongings' form, and the 'Modify' option is highlighted with a red box.

3. Scroll down to **Personal Devices**
4. Click on the **Description** cell for **Cane**, and document:
  - a. Cane Description = *Black Cane*

Personal Devices			
	Description	Number of Items	Location
Assistive Devices			<Alpha>
Cane	Black Cane		<Alpha>
Contact Lenses			<Alpha>
Dentures, Lower			<Alpha>
Denture Partial Plate			<Alpha>
Dentures, Upper			<Alpha>
Glasses	Reading glasses with solid black frame		<Alpha>
Hair Piece, Wig			<Alpha>
Hearing Aid, Left			<Alpha>
Hearing Aid, Right			<Alpha>
Orthodontic Retainer			<Alpha>
Orthotics			<Alpha>
Prosthesis			<Alpha>
Walker			<Alpha>
Wheelchair			<Alpha>
Other			<Alpha>

5. Click **Sign** to complete the documentation and then refresh the screen.

When you return to this document in the form browser, it will show the document has been modified.

All Forms
Thursday, 25-January-2018 PST
15:09 PST Valuables/Belongings (Modified) - TestUser, HealthCareAssistant
Monday, 22-January-2016 PST
15:50 PST Valuables/Belongings (In Error) - TestUser, HealthCareAssistant
Wednesday, 28-September-2016 PDT
15:27 PDT ED Triage - Adult (Auth (Verified)) - Test, ED Emergency - Nurse

### Key Learning Points

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

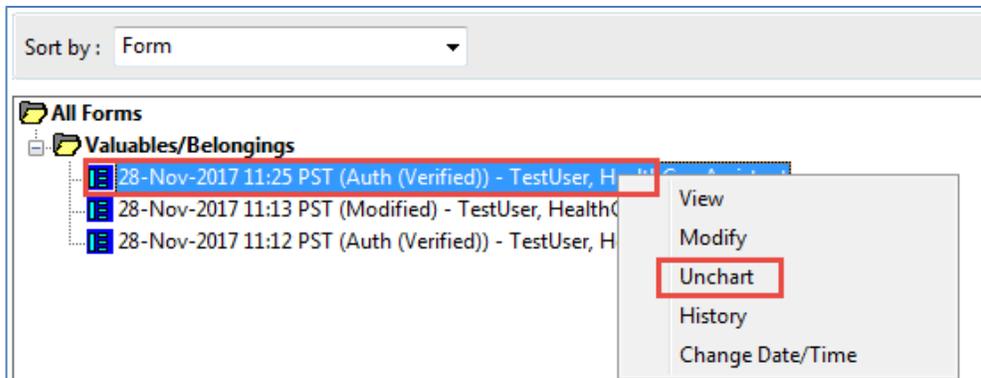
## Activity 6.5 – Unchart an existing PowerForm

1

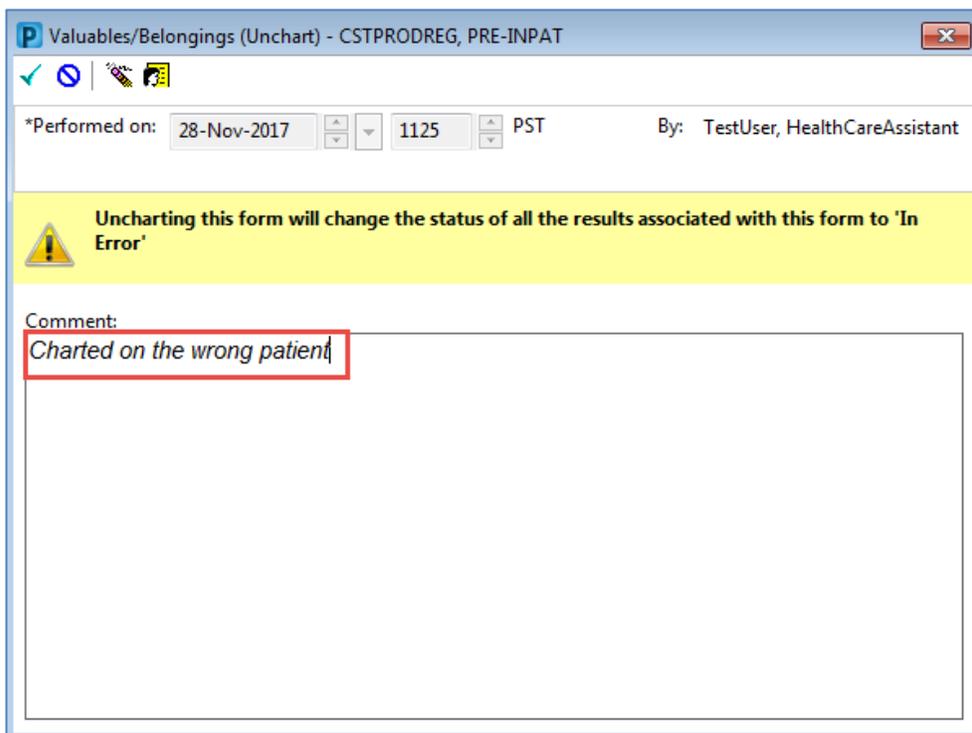
It may be necessary to unchart an existing PowerForm (e.g. an incorrect PowerForm was completed). Let's say the **Values and Belongings** form was documented in error.

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

1. Right-click on **Valuables/Belongings**
2. Select **Unchart**

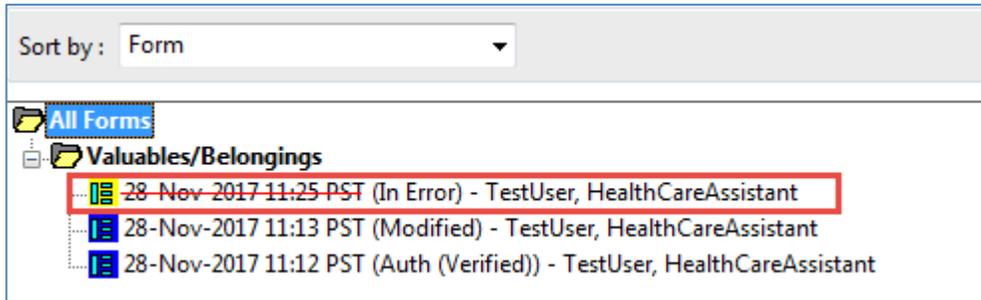


3. The **Unchart** window opens. Enter a reason for uncharting in the **Comment** box.  
Comments = *Charted on the wrong patient*



4. Sign the documentation and then refresh your screen.

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.

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## End of Workbook

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