SELF-GUIDED PRACTICE WORKBOOK [N59] CST Transformational Learning

WORKBOOK TITLE: Nursing: Critical Care



Last update: February 4, 2018 (v2)

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F SELF-GUIDED PRACTICE WORKBOOK

Duration	12 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.
	The workbook provides a compilation of different scenarios that are applicable to your work setting.
	Each scenario will allow you to work through different learning activities at your own pace to ensure you are able topractice and consolidate the skills and competencies required throughout the session.
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.
	Upon completion of the Key Learning Review, both you and your instructor will provide feedback and sign the review.



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
- Find patients on your Location Patient List and move them onto your Custom Patient List

SCENARIO

Your patient, a 41-year-old gentleman, presented to the emergency department with fever and shortness of breath. His oxygen saturation continued to drop even though he was on oxygen. The patient was intubated successfully after three attempts. An NG tube was also placed. An ICU consult has been completed by the intensivist and ICU admission orders have been entered. The patient was admitted to the ICU. You begin your shift and receive the patient into your care.

As a Critical Care Nurse 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 Upon logging in, you will land on **CareCompass. CareCompass** provides a quick overview of select patient information.

Note: if you are a Patient Care Coordinator or Charge Nurse, your landing page may be the Clinical Leader Organizer (CLO).

- At the start of your first shift (or when working in a new location), you will create a **Location List** that will consist of all patients assigned to your unit.
 - 1. Select the **Patient List** icon I 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 \mathbb{P}^{I} .
 - 3. Click the New button in the bottom right corner of the Modify Patient Lists window.

PowerChart Organizer for TestCD, ICU-Nurse			
Task Edit View Patient Chart Links PatientList Help			
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🗄 🎢 Exit 🎬 AdHoc 🎟 Medication Administration 🔏 PM Conversation 👻 🗎 Me	dical Record Request 🕂 Add 👻 📻 Documents 箇 Schedul	ing Appointment Book 💽 iAware 📾 Discern Reporting Portal 🤤	
🗄 🔃 Patient Health Education Materials 🔍 Policies and Guidelines 🔍 UpToDate	Ŧ		
Patient List			
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	Available lists:	Active lists:	¬
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- 4. From the Patient List Type window select Location
- 5. Click the **Next** button in the bottom right corner.

Pa	Patient List Type	x	
ist	Select a patient list type: Assignment Assignment (Ancillary) CareTeam Custom Cocation Medical Schee Provider Group Query Relationship Scheduled		6
	Back Next Finish Cancel		
	5		-

In the Location Patient List window, open the Locations folder by clicking the Plus Sign
 Locations
 A location tree will be displayed.

1	Location Patient List		×
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	Enter a name for the list: (Limite	d to 50 characters)	
		Back Next Finish Can	cel



- 7. In this activity, use LGH Lions Gate Hospital as a selected location. Expand the location by clicking the **Plus Sign:** LGH Lions Gate Hospital
- 8. Then, click the next Plus Sign: LGH Lions Gate Hospital
- 9. For your practice, select LGH 7 East by checking the box next to the unit I Con LGH 7 East .

Patient Lists need a name to differentiate them. Location lists are automatically named by the Location.

10. Click the **Finish** button Finish in the bottom right corner.

Location Patient List	×
 *Locations [LGH 7 East] Medical Services Encounter Types Care Teams Relationships Time Criteria Discharged Criteria Admission Criteria 	7 Image: Construction of the constructio
Enter a name for the list: (Limited LGH 7 East 9	to 50 characters)
	Back Next 10 Finish Cancel

- 11. In the Modify Patient Lists window select a location or a unit.
- 12. Click the **Blue Arrow** icon icon to move the selected location or unit to the **Active List** on the right side.
- 13. Click the **OK** button in the bottom right corner to return to **Patient List** page. Your Location list should now appear.





P Modify Patient Lists			
Available lists:	1	Active lists:	
LGH 7 East 11			
LGH ICU			
		2	
		New	Cancel

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

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** window that you have created based on location (refer to Activity 1.1).
- 2. Click the New button in the bottom right corner of the Modify Patient Lists window.
- 3. Select Custom from the Patient List Type window.
- 4. Click the Next button.

Patie	nt List									je
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10	CSTPRODMED, LAB-HIGH				LGH 2 East			tis	TestCST, GeneralMedicine-Ph	ysician1 ORD, MD
	CSTLABAUTOMATION, TS							n testing	Plisvca, Rocco, MD	
	CSTDEMOALEXANDER, D									
Ü	SEXSMITH-LEARN, NATALI							y Acquired Pnuemo	onia Plisvco, Wesley, MD	
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	CSTREODEEG OLITEATER						Custom 3			
m	CSTADTIANTHREE ADTO						Location			
l H	CSTREODMED JAMIE						Medical Service			
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	CSTPRODREG, SELFPAYTY						Relationship			
10	BROWN-LEARN, HENRY				New	41	Scheduled			
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10	CSTCARDDEMO, BOB DO N	NOT USE	700008100 700000015206 70	years 01	-May-1947 20-Nov-2017 17:30 PST Plisvel,	D				
2	CSTSYNGOTEST, FRANK		700007388 7000000013043 5	years 1	-Feb-1960 02-Nov-2017 14:27 PDT Plisvce,	N				
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	CSTPRODREGHIM, FRANK		700004995 700000008263 3	years 11	-Nov-1980	4				
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	CSTPRODREG, OUTTOOUT		700001856 7000000004416 2	years 01	-Jan-1990					
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- 5. **The Custom Patient List** window opens. In the **Enter a name for the list:** Type *YourName_Custom* (i.e. John_Custom).
- 6. Click the **Finish** button.

	Custom Patient List	
rs rs rs rs rs rs	Enter a name for the list: (Limited to 50 characters) JohnDoe_Custom List Back Next Finish 6	



- 7. In the Modify Patient Lists window select your Custom List.
- 8. Click the **Blue Arrow** icon icon to move your **Custom List** to the **Active List** on the right side.
- 9. Click OK button.

P Modify Patient Lists	······ la •···· la	×
Available lists: JohnDoe_Custom List 7	Active lists:	() ()



- 2 At the beginning of each shift or assignment change, you will add your patients to your custom list from your location list.
 - 1. In the **Patient List** window, find the right location and your patient's name. Right click on patient's name.
 - 2. Select Add to a Patient List
 - 3. Select YourName_Custom List

	con nob co, emiler centren		7000001447000000015725 years 07-Aug-1554 24-Aug-201
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)	CST-TTT, RUTH	Dationt Spanshot	700007367 7000000013478 71 years 10-Jan-1946 14-Nov-2017
	CSTPRODREG,	Patient Shapshot	2446 700000004417 27 years 10-May-1990
)	CSTADTIAMTH	Provider Information	839 700000015274 61 years 21-Apr-1956
)	CSTPRODMED, JAMIE	Minia I ina	034 700000013404 25 years 28-Sep-1992 10-Nov-2017
)	LEE-LEARN, PETER	VISIT LIST	942 700000013205 67 years 17-Mar-1950 07-Nov-2017
	CSTPRODREG, SELFPAYT	Inactivate Relationship	\$287 700000004955 27 years 10-May-1990
)	BROWN-LEARN, HENRY	Add/View Sticky Notes	026 700000012702 50 years 20-Aug-1967 26-Oct-2017
	CSTPRODREGINTER, HOP	Add, New Sticky Notesti	882 700000006995 36 years 14-Jun-1981
	CSTPRODMED, LAB-NOR	Sort	178 700000006054 21 years 01-Jan-1996
)	CSTPRODMI, SITSYNGO	Hide	576 700000015568 41 years 30-Jan-1976 27-Nov-2017
]	CSTCARDDEMO, BOB DC	Customize Columns	\$100 700000015206 70 years 01-May-1947 20-Nov-2017
)	CSTSYNGOTEST, FRANK	Customize Columns	73 <mark>88 700000013043 57 years 11-Eeb-19</mark> 60 02-Nov-2017
	CSTAMBTEST, JAMIE	Add to a Patient List	JohnDoe_Custom List
	CSTPRODREGHIM, FRAN	Conv Ct 2	80 years 1 3 980
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	CSTONCPHARM, STONE	New Results	.147 700000001602 38 years 27-Nov-1979 08-Nov-2016
)	JONES-LEARN, JULIO		\$148 700000013604 71 years 29-Aug-1946 16-Nov-2017
)	MCCOY-LEARN, SHAUNA	Open Patient Chart	3073 700000013496 59 years 17-Feb-1958 14-Nov-2017
	CSTPRODREG PREWORK		700003725 700000005160 27 years 10-May-1990

4. Return to Patient List window. Select YourName_Custom tab.

Note: Your custom list will be empty as you have not yet added any patients.

- 5. Click the **Refresh** icon red to update the **Patient List** window.
- 6. Now your patient will appear in your Custom List.



Note: Ensure this is the patient assigned to you today. You can remove a patient from your custom list by highlighting the patient and clicking the **Remove Patient** icon $\stackrel{*}{\rightarrow}$.



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



PATIENT SCENARIO 2 – CareCompass

Learning Objectives

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

Introduction to CareCompass

Establish a relationship with your patient(s) and review the patient's information

SCENARIO

As a Critical Care Nurse, you will complete the following activities:

- Introduction to CareCompass
- Establish a relationship with your patient(s) and review patient information



Activity 2.1 – Introduction to CareCompass

CareCompass is an innovative, interdisciplinary, summary workflow solution that guides you, as a clinician, in the organization, planning and prioritizing the care of your patients. CareCompass displays important details such as allergies, planned physician order sets, Plan of Care, resuscitation status, reason for visit, and more.

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

PowerChart Organizer for TestCD, ICU-Nurse							7 X		
lask Edit View Patient Chart Links Navigation Help									
🙀 CareCompass 1 hical Leader Organizer 🖉 Patient List 🚔 Multi-Patient Task List 🎇 Discharge Dashboard 📾 Staff Assignment 🎇 LearningLIVE 🚏 🛱 CareConnect 🕲 PHSA PACS 🕲 VCH and PHC PACS 🕲 MUSE 🕲 FormFast WFI 🖕									
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2EL - 03 CST-TTT, RUTH	-	**		-			^		
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71yrs F No Relationship Exists									



Let's review CareCompass

- 1. The **Toolbar** is a quick way to navigate the Clinical Information System (CIS) using the various buttons.
- 2. The **Patient List** drop-down menu enables you to select the appropriate patient list you would like to view.
- 3. Until you establish a relationship with your patients in the system, the only information visible about them is their location, name and basic demographics.

Note: You will establish a relationship in the next activity.

PowerChart Organizer for TestCD, ICU-Nurse										
Task Edit View Patient Chart Links Navigation Help										
🎬 CareCompass 🚟 Clinical Leader Organizer 🎍 Patient List 😂 Multi-Patient Task List 🎬 Discharge Dashboard 🎕 Staff Assignment 🎆 LearningLIVE 💡 💐 🔃 CareConnect 🐧 PHSA PACS 🐧 VCH and PHC PACS 🐧 MUSE 🐧 FormFast WFI 💡										
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Patient List: JohnDoe_Custom List 🔽 2 t Maintenance 🕂 Add Patient 💰	Establish Relationships									
Location Patient	Visit	Care Team	Activities	Plan of Care						
2EL - 03 CST-TTT, RUTH	-	-	_	-						
71yrs F										
	No Keetonship Exists 3									



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 2.2 – Establish a Relationship and Review Patient Information

1

Now that you have created your custom patient list, you must establish a relationship with your patient in order to view more patient information or access their chart.

1. Click Establish Relationships

CareCompass	🎬 Clinical Leader Organizer 🛔 Patient List 🔐 Mi	ulti-Patient Task List 🎬 Discharge Dashboard 🏾 🎎 Staff Assignm	ent 🎬 LearningLIVE 🝦 🤅 😋 CareConnect	💐 PHSA PACS 💐 VCH and PH	ic pacs 🔍 Muse	10 7
Exit MadHoo	Medication Administration 🍰 PM Conversati	on 👻 🗎 Medical Record Request 🕂 Add 👻 🛅 Documents 👹	Scheduling Appointment Book 💽 iAware	\bigcirc Discern Reporting Portal $_{\mp}$		
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IC06 - 01	CSTDEMO, ZEUS 38yrs M - No Relationship Exists	-	-	-		= =
IC01 - 01	CSTEDPARK, SEAN 27yrs M No Relationship Exists	-	-			
IC02 - 01	CSTEICIA, BRIAN 32yrs M No Relationship Exists	-	-			
IC10 - 01	CSTLABAUTOMATION, TSAD 41yrs M No Relationship Exists	-	-			
IC09 - 01	CSTLABAUTOMATION, TSAD 50yrs F - No Relationship Exists	-	-	-		
Activity Timeline						 -
Opens the CareCom	pass		PROD	BC TEST.NURSEICU Sunday, 26	5-November-2017	16:56 PST

- 2. An Establish Relationships window opens. Select all or individual patients as appropriate.
- 3. Once patients are selected, you will see a check mark beside each patient's name.
- 4. From the Relationship drop-down menu, select Nurse.
- 5. Click the **Establish** button.

Note: A relationship will last for 16 hours and the nurse will need to re-establish the relationship at the next shift.

0%	6 🔹 🛑 🗰 🚮								
	Establish Relationships								
	* Relationship					vitie			
D	Name Nurse		Date of Birth	MRN	Encounter #	<u> </u>			
rs	CSTADTJANQuality / Utilizatio	on Review	02/28/1967	700005400	700000008221				
E	3 TDEMO Unit Coordination	4	02/01/1979	700004780	700000013571	_			
	CSTEDPARK, SEAN	М	05/26/1990	700003792	700000005313				
D rs	CSTEICIA, BRIAN	М	01/05/1985	700007877	700000013058				
TC	CSTLABAUTOMATION, TSADLEY	М	03/28/1976	700004427	700000015168				
rs	CSTLABAUTOMATION, TSADRIEN	F	06/23/1967	700004428	700000015165				
A.	CSTLABAUTOMATION, TSAIKEN	F	11/15/1947	700004430	700000015162				
rs	CSTPRODEMPI, TESTICIDATIENT	F	03/01/1988	700007747	700000012682	-			
A. rs	Select All Deselect All	2			5 Establish Cancel				

Once a relationship is established with your patients, additional information will appear on CareCompass.



- 2 **CareCompass** provides a quick overview of select patient information including patient care activities and orders that require review.
 - 1. You can hover your cursor over icons, buttons, and patient information to discover additional details.
 - Activity Timeline appears at the bottom of CareCompass. Click the green or red boxes on the timeline. They provide a visual representation of certain activities that are due for the patients on your list. Green colour means Scheduled Activities. Red colour means Overdue Activities.
 - 3. Note that there is also an exclamation mark on the top right corner of the **CareCompass** page. This shows the total numbers of patients with new orders.

AdHoc CareCompass	Medication Administration 🍰 PM Conversation - 🔩 Com	municate 👻 🖄 Medical Record Request 🔸 Add	- 🗃 Documents 👹 Scheduling Appointment Book 4	Discern Reporting Portal 🤤	_	% Recent + Name + Q. (0) Full screen
Patient List: Pat	 I 100% → ● ● 益 ient list	Patient 🥵 Establish Relationships				<mark>3</mark> 0 2 0
Location		Vat	Care Team	Isolatio	Activities	Plan of Care
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M No Allergies Recorded -	Pneumonia LOS: 3d	Plavca, Rocco, MD Business (322)366-4896		- 7	Add Plans
620 - 02	CSTLEARNING, DEMODELTA 80yrs M CSTLEARNING, DEMODE No Allergies Recorded - Age Age	Pneumonia S: 3d 80 years	Plavca, Rocco, MD Business (322)366-4896		-7 Scheduled/Unsch	Add Plans
624 - 03	CSTLEARNING, DEMOBETA 80yrs M MRN Allergies Diet Diet	eumonia 700008217 S: 3d 700000015060	Plavca, Rocco, MD Business (322)366-4896		PRN/Contine Assessment	ions: 0 arin Infusion Standard (Module) (Validated) Care: 2 (1) ment: 5 (4)
624 - 02	CSTLEARNING, DEMOALPHA 80yrs M No Known Allergies	eumonia LOS: 3d	Plavca, Rocco, MD Business (322)366-4896			Cher: 0 Red Blood Cell (RBC) Transfusion (Module) (Validated)
Activity Timeline	2					

3 Notice there may be a **red [@]or orange** [@] exclamation</sup> icon next to the patient's name.

Note: Indicates new non-critical results or orders for a patient requiring review.

Indicates new critical results or STAT/NOW orders requiring review.

1. Click the **Exclamation** icon.



CareCompass										
	👫 🗎 🚔 🖿 🔍 🔍 100% 🛛 🖌 🖨									
Patient List: Pa	Patient List; Patient list 🔽 🔀 List Maintenance 💠 Add Patient 🥵 Establish Relationships									
Location	▼ Patient	Visit	Care Team							
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M No Allergies Recorded	Pneumonia LOS: 3d	Plisvca, Rocco, MD Business (322)366-4							
620 - 02	CSTLEARNING, DEMODELTA 80yrs M No Allergies Recorded	Pneumonia LOS: 3d	Plisvca, Rocco, MD Business (322)366-4							
624 - 03	CSTLEARNING, DEMOBETA 80yrs M Allergies	Pneumonia LOS: 3d	Plisvca, Rocco, MD Business (322)366-4							
624 - 02	CSTLEARNING, DEMOALPHA New Rev Rev New	sults/Orders new results and orders.	Plisvca, Rocco, MD Business (322)366-4							

- 2. Review the list of new orders and results in the Items for Review window
- 3. Click Mark as Reviewed when done

💐 100% 🛛 + 🌑 🖷 🕍			
Items for Review			x
CSTDEMO, ZEUS M 38yrs			IC06 - 01
Results No new results	Orders ✓ & Respiratory NAT Panel BCCDC Nasopharyngeal Swab, Routine, Unit collec ✓ Select All	Ordered By Test User, Physician	2 Entered By Test User, Physici 18:00 Today

4. Once you have marked the orders as reviewed, you are taken back to **CareCompass** and the red or orange exclamation icon will disappear.



Key Learning Points
A relationship must be established with patients in order to view more detailed patient information and access their chart
Remember to select the correct role when establishing a relationship with patients
A relationship will last for 16 hours and the nurse will need to re-establish the relationship at the next shift
CareCompass provides a quick overview of patient information including patient care activities, scheduled and unscheduled tasks and new orders and results for the patient
Indicates new non-critical results or orders for a patient requiring review
Indicates new critical results or STAT/NOW orders requiring review



PATIENT SCENARIO 3 – Access and Navigate the Patient's Chart for Handover

Learning Objectives

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

- Introduction to patient's chart
- Introduction to CareAware Critical Care

SCENARIO

Your patient has just arrived at ICU with the emergency nurse, RT, and porter. During handover report, you and the ER nurse will review the patient's chart together.

You will be completing the following activities:

- Introduction to Banner Bar, Toolbar, and Menu in patient's chart
- Introduction to Patient Summary
- Introduction to CareAware Critical Care



Activity 3.1 – Introduction to Banner Bar, Toolbar, and Menu in Patient's Chart

- 1 To access a patient's chart from CareCompass:
 - 1. Click on patient's name to open the patient's chart.

👯 🕄 Patient Health	Education Materials 🕄 Policies and Guidelines 🕄 UpToDate 🖕				
					Recent 🗸 Name 🔹
CareCompass					🗇 Full screen 👘 Print 🍣 0 minutes a
	🔍 🔍 100% 🛛 + 🌑 🗠 🏠				
Patient List: as	signment 🔽 💥 List Maintenance 💠 Add Patient 🛭 💰 Esta	olish Relationships			y 4 🕥
Location	Patient	Visit	Care Team	Activities	Plan of Care
IC06 - 01	CSTDEMO, ZEUS 38yrs M Attempt CPR, Full Code Allergies	15 foot fall onto a concerte pylon LOS: 13d	Pisvca, Rocco, MD Business (322)366-4896	RN/Continuous	ICU Continuous Renal Replacement (CRRT) - Critical ICU General Admission Medical / Surgical (Validated) Restraints Adult (Module) (Validated) TM Red Blood Cell (RBC) Transfusion (Module) (Valid
IC04 - 01	LEARNING, CRITICALCARE 41yrs M Attempt CPR, Ful Code Allergies	15ft fall onto left side, hit concrete LOS: 21d	left side, hit concrete TestUser, CriticalCare-Physician, MD Business (604)001-0322		Restraints Adult: (Module) (Validated) ICU Continuous Renal Replacement (CRRT) - Critical ICU General Admission Medical / Surgical (Validated) ICU General Admission Medical / Surgical (Validated)
Activity Timeline					~
Overdue	00-00 10-00 11-00	12:00 12:00	14-00 15-00	15:00 17:00	19:00 10:00 20:00

2 The patient's chart is now open. Let's review the key parts of the screen.

- 1. The **Toolbar** is located above the patient's chart and it contains buttons that allow you to access various tools within the Clinical Information System (CIS).
- 2. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information displayed includes:
 - Name
 - Allergies
 - Age, date of birth, etc.
 - Encounter type and number
 - Code status
 - Weight
 - Process, disease and isolation alerts
 - Location of patient
 - Attending provider's name
- 3. The **Menu** on the left allows different sections of the patient chart. This is similar to the colored dividers within a paper-based patient chart. Examples of sections included are



Orders, Medication Administration Record (MAR), and more.

4. The **Refresh** icon values the patient chart when clicked. It is important to refresh the chart frequently especially as other clinicians may be accessing and documenting in the patient chart simultaneously.

Note: The chart does not automatically get updated until you click the Refresh icon 2.

CSTLEARNING, DEMOTHETA - 70000	8216 Opened by TestUser, Nurse				
Task Edit View Patient Chart	Links Navigation Help				
👫 CareCompass 👫 Clinical Leader Or	rganizer 🛔 Patient List 🔉 Multi-Patien	nt Task List ii Discharge Dashboard 🔐 Staff Assi	gnment 🌇 LearningLIVE 🝦		
🔃 PACS 🕄 FormFast WFI 🝦 🕄 Tei	ar Off 📲 Exit 🎬 AdHoc 💵 Medication	n Administration 🔒 PM Conversation 👻 🕞 Com	municate 👻 🗎 Medical Record Request 🕂	Add 👻 📻 Documents 🛗 Scheduling App	pointment Book 🝙 Discern Reporting Portal 🝦 🚺
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CSTLEARNING, DEMOTHETA	DO8:01-Jan-1937	MRN:700008216 Code Sta	tus:	Process:	Location:LGH 6E; 624; 04
Allergies: Allergies Not Recorded	Gender:Male	PHN:9876469824 Dosing W		Isolation:	Attending:Plisvca, Rocco, MD
Menu 🤻	🔹 🔹 者 🛛 Patient Summary				🗇 🗇 Full screen 👘 Print 🛛 🍣 0 minutes ago
Patient Summary	AA				1
Orders 🕂 Add	Handoff Tool	Summary	St Assessment	22 Discharge	
Single Patient Task List		5 Sammary	Da researce	Ed energy a	
MAR	Informal Team 📫	Informal Toam Communication			a =- Â
Interactive View and I&O	Communication				
Results Review	Active Issues	Add new action		Add new comment	
Documentation 🕂 Add	Allergies (0)				
Medication Request	Vital Signs and Measurements	No actions documented		No comments documented	
Histories	Documents (0)	All Teams		All Teams	
Allergies 🕂 Add	Transfer/Transport/Accompan				
Diagnoses and Problems	iment				
	Assessments	Active Issues			Classification: Medical and Patient Stated 👻 🛛 All Visits 🛛 🔁 👘
CareConnect	Lines/Tubes/Drains				
Clinical Research	Intake and Output			Add new as: This Visit 👻	<
Form Browser	Laos	No results found			
Growth Chart	imaging				
Immunizations	Medications				
Lines/Tubes/Drains Summary	Home Medications	Allergies (0) 🕇			All Visits 🤁 👘
MAR Summary	Orders	-			
Medication List 🛛 🛨 Add	Ventilation	Allergies not recorded. Add an allergy.			
Patient Information	Pathology				
Reference 3	Histories	No results found			
					Reconciliation Status: Incomplete Complete Reconciliation
< III +	Create Note +				*

Note: The Clinical Information System (CIS) will allow you to have up to two patient charts open at a time

Key Learning Points

- The Toolbar is used to access various tools within the CIS
- 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



Activity 3.2 – Introduction to Patient Summary

- When the patient's chart is first opened, you will see the **Patient Summary** page. The **Patient Summary** summarizes key clinical patient information, orders, medications, lab results, and so on. This will be the place in the chart that is accessed during handover for nurses to review critical patient information.
 - 1. There are different tabs including **Handoff Tool**, **Summary**, **Assessment**, **Discharge** and **Quick Orders** that can be used to learn more about the patient. Click on the different tabs to see an overview of the patient.

Note: The **Quick Orders** tab can be used to enter orders for the patient. Order entry will be covered later on in this book.

- 2. Each tab has different components of information. You can use the scroll bar on the right hand side to look at all the components on the page.
- 3. The **Handoff Tool** tab has a list of the components on the left hand side. You can click on any item in this list and it will bring you to that component rather than using the scroll bar on the far right of the screen.

CSTLEARNING, DEMOTHETA - 700008216 Open	ned by TestUser, ICU+Nurse						- 0 💌
Task Edit View Patient Chart Links N	lavigation Help						
🗄 🎬 CareCompass 📲 Clinical Leader Organizer 💰	Patient List 🔐 Multi-Patient Task List	🔹 🚛 Staff Assignment 🎬	LearningLIVE 🝦 🤅 😋 CareConnect 😋 PHSA	PACS 🔍 VCH and PHC PACS	🖏 MUSE 🔍 FormFast WFI 🝦		
🗄 🎇 Tear Off 📲 Exit 🎬 AdHoc 🎟 Medication A	dministration 🔒 PM Conversation 👻	Medical Record Request	🕂 Add 👻 📻 Documents 🖀 Scheduling A	ppointment Book 💽 iAware 🌘	Discern Reporting Portal		
👯 🕄 Patient Health Education Materials 🕄 Policies	s and Guidelines 🕄 UpToDate 🝦						
CSTLEARNING, DEMOTHETA 🛛 🗷						🔶 List 🔿 🖀 Recent 🗸	Name 🗸 🔍
CSTLEARNING, DEMOTHETA	DOB:01-Jan-1937 I Age:80 years I	MRN:700008216 Enc:7000000015058	Code Status:Attempt CPR, Full Code	Process:Falls Disease:	Risk	Location:LGH 4E; 406; 01 Enc Type:Inpatient	
Allergies: penicillin, Tape	Gender:Male	PHN:9876469824	Dosing Wt:	Isolation:		Attending:SYSTEM, SYSTEM Cer	ner
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Orders 🕂 Add	Handoff Tool	Summary	😂 Assessment	😂 Discharge	🔀 Quick Orders	× 1 🖓 –	
Single Patient Task List		1					
MAR	Informal Team	Informal Tean	Communication				∂ ≡- 🗍
MAR Summary	Communication						=
Interactive View and I&O	Active Issues	Add new action			Add new comment		
Results Review	Allergies (2)	-					
Documentation 🕂 Add	Vital Signs and Measurements	Dressing chan	ged. Will require new pain medication order t	omorrow. Please	jklj;lkj		2
Medication Request	Documents	re-order Morp TestUser, Nurse	nine. 04/12/17 16:53		TestUser, Nurse 09/12/17 18:59		
Histories	Transfer/Transport/Accompan iment	· · · · ·			All Teams		
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Diagnoses and Problems	Lines/Tubes/Drains						
	Intake and Output	Active Issues			Charal Banklar	. Madinal and Delivery Changed at 1	
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Clinical Research	Micro Cultures				Add new as: This Visit 👻 🤉		
Form Browser	Home Medications						
Growth Chart	Diagnostics	No results found					
Immunizations	Medications						
Lines/Tubes/Drains Summary	Orders						Wirite 2 =-
Medication List 🕂 Add	Overgenation and	Aller gies (2)	,			,	
Patient Information							*
	-				PROD	DBC TEST.NURSEICU Thursday, 14-D	ecember-2017 09:10 PST

Note: Click the **Refresh** icon to get the most updated information on the patient. Notice the time since the last refresh is displayed and when clicked, the time since the last refresh will reset to 0 minutes .



Key Learning Points

- Patient Summary provides a summary of critical patient information that can be utilized during handover.
- Clicking on the tabs within the Patient Summary (such as Handoff Tool, Summary, Assessment, Discharge, and Quick Orders) will provide an extensive overview of the patient's status
- Using the scroll bar will allow you to view all of the components of each tab
- Click the Refresh icon to get the most updated information on the patient

1



Activity 3.3 – Introduction to CareAware Critical Care

CareAware Critical Care 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.

You can compare **CareAware Critical Care** to your current state critical care flowsheets. It is another useful tool to utilize during handover.

1. To access CareAware Critical Care, click the **iAware** button **iAware** in the toolbar

CSTDEMO, ZEUS - 700004780 Opened by TestUser, ICU-Nurse														
Task Edit View Patient Ch	nt L	inks Navigatio	n Help											
👫 CareCompass 👫 Clinical Lead	er Orga	inizer 🛔 Patient	List 🔐 Multi-Patien	t Task List	🌃 Discharge Dashboard	😂 Staff Assignment 📲	LearningLIVE 🝦 🗄 🜊	CareConnect 🔍 P	PHSA PACS 🕄 VCE	H and PHC PACS 🕄 MI	JSE 🜊 FormFas	it WFI 🝦		
🏋 Tear Off 🚽 Exit 🍟 AdHoc 💵	IMedi	cation Administra	ation 🔒 PM Convers	ation 👻 🗎	Medical Record Request	🕂 Add 👻 📻 Document	s 🛗 Scheduling Appe	intment Book 🕑	iAware 1 scerr	Reporting Portal				
🕄 Patient Health Education Mater	als 😭	Policies and Gui	delines 😭 UpToDate	:				_						
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CSTDEMO, ZEUS			DOB:01-Feb-1979 Age:38 years	M Er	IRN:700004780 hc:700000013571	Code Status:Attempt	CPR, Full Code	Pro Dis	ocess:Falls Risk sease:		Lo Er	cation:LGH ICU; IC06	; 01	
Allergies: cloNIDine, Adhesive	Banda	ige, Banana	Gender:Male	PH	HN:9876810595	Dosing Wt:75 kg		Iso	olation:		At	tending:Plisvca, Rocco	MD	
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Documentation 🔹 Add		Allergies (3)												
Medication Request		Vital Signs and	I Measurements	No a	ctions documented				No comme	nts documented				
Histories		Documents		All Te	eams				All Teams					
Allenia		Transfer/Trans	sport/Accompan =											

2. The **CareAware Critical Care** dashboard opens and displays a summary of various clinical data that has been documented in your patient's chart. This information includes vital signs, hemodynamics, IV drips, lab results, intake and output and more.

Note: The dashboard has several tabs such as ICU Summary, Meds Review, Vitals/Infusions, I/O etc. There is an ability to collapse sections for better viewing of data, unselect data elements in the graphs for a less cluttered view, as well as zoom into specific time frames.

📴 Young, Jim - CareAware Critical Care					EN English ((Canada) 😢 Help 🏮 💷 💷 📕
iAware Help						
MyList Patient Search ICU Summary Meds Review Vitals/Infusions (24hr) I/O Blood Glucose					Rese	et Perspective 🛛 🚱 📚 0 minutes a
Young, Jim 62 years M DOB: 3/25/1955 MRN: 01022014 FIN: 00	00007	75 Admit	: 11/26/2017	Unit LOS	: 2 days Lo	ocation: ICU/01
Dose Weight: 86kg (11/27/2017 09.35) Actual Weight: 85.8kg (11/27/2017 09.35)	Allergi	ies: Latex				
Vitals, CV, Neuro, Infusions (12 hr)		I/O (3 day)				2
Reset Graphs Display: C Zoom Tool			11/26	11/27	11/28*	Range tota
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Image: Solution (See (Sec)) Provide (Sec) Provide (Sec)		4,000 3,000 2,000 1,000 - - 2,000 - 2,000 - 4,000 * Indicates a day w	07:00-06:59	07:00-06:59 easurement period	07:00-06:59	Continuous Infusion Medication J Tube Feeding NR Tube Output Drain Stool Chest Tube
▼- CVP [2.13] 50	•	Labs			Respiratory	
PAS [20.30]		Blood Gases (Last 2 in	24 hours)	â ^	Respiratory	8
♥ → PAD [5-14] •		Lab	11/28 08:35	11/27 20:05		08:53
Blood Pressures (11/28/2017 00:55> Current)	~	рH	7.4	7.38	BB	13 bpm
A-line O2:00 04:00 06:00 08:00 10:00 12:00		P02	79↓	79↓	SpO2	90
	V	PCO2	39	37	FiO2	35%
• MAP [71-88] = 100		HCO3	23	22	Ventilator	*
~ DBP [48-69] 75		DE		-		08:53
		Chemistry		~	Mode	SIMV
- SU 1		Lab	Latest	Previous	TV Set	700



 You can hover over certain dots on the graph to discover more detailed clinical information. Hovering to discover will allow you to see how certain interventions may have affected the patient's vital signs or hemodynamics.



Note: CareAware Critical Care is a useful tool to use during shift report and handoff. It can also be utilized in rounds for clinical decision-making and care planning.

After receiving or giving handover report, you need to document shift report/handoff in the patient's chart. This activity will be addressed later in the workbook.

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 4 – Bedside Medical Device Interfaces (BMDI)

Learning Objectives

At the end of this Scenario, you will understand how to:

Associate a patient with the BMDI monitor

SCENARIO

After the patient arrives in the ICU, you will need to connect the patient to the BMDI. However, hands on practice with BMDI will be covered in another training session.

These activities include:

- Introduction to BMDI
- Documenting vital signs through BMDI
 - Disassociating BMDI monitor from the patient



Activity 4.1 – Introduction to BMDI

Bedside Medical Device Interfaces (BMDI) is a device that automatically records information from bedside monitors in select units. Results gathered by BMDI can be automatically transferred into the electronic health record (EHR).

BMDI pulls data from monitors to the IView/I&O. Information is not saved until the RN views and verifies the data is correct. This prevents incorrect data from being documented. The RN must associate the patient to the appropriate monitor for data to pull into the flowsheet.

Associate a patient with the BMDI monitor.

- ect 🔃 PHSA PACS 🔃 VCH and PHC PACS 🕄 MUSE 🕄 Ca Ca 4 - | 🔿 🖨 🏠 ۹. / э Informal Team Communication Add new Add new a Allergies (3) ital Signs and Documents (1) All Teams All Teams Active Issues Intake and Output Add new as: This Visit + 9 Labs Imaging Acute chest nai Diabetes type 2, contr Medical Chronic Home Medicat Headarhe Medical Oxyger Medical Hyperlipi Chron Datholom Medical Leg pain, left Medical PRODBC ELEARN.NURSES Tuesday, 28-November-2017 09:55 PST
- 1. Select Interactive View and I&O (iView) within the Menu

2. A window called **Device Association** may automatically display. Otherwise, click on the **Associate Device** icon

Interactive View and I&O							1]. Full screen	C Print	€ 0 minutes ago
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Ventilator Subset	Find Item - Critical	E High	Low 🗖 🗛	Abnormal	🔲 Unauth	Flag	And	Or		
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IV Drips			· (g 08.54 P31	11.10 P31						
Glucose Blood Point of Care	Temperature Axillary	DeaC								
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a Intervente Output	SBP/DBP Supine	mmHg								
Advanced Graphing	Pulse Supine	bpm			_					
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av Adult Procedures	Cerebral Perfusion Pressure Cuff	mmHg			-					
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							PRODBC TEST.NU	RSEICU Frida	y, 15-Decem	ber-2017 08:54 PST



Note: The next steps are to be viewed only. Do not complete these steps in this activity.

3. The **Device Association** window opens. At this point, you would scan or enter a device name (for example, LGH_ICU_BED01) to search for the monitor that should be associated with your patient.

C Device Association Help	×
Validate, IP-CriticalCareNurse MRN: 760000659 DOB: 1/13/1977 Gender: Male	ę
Associated Devices	
Select All	🕻 Disassociate 🛪 🛛
There are currently no associated devices.	
Device Search	
Device.	
Scan or Enter a device name.	3
System Time: 1/19/2018 10:41 PST User: test.nurseicu@train1.healthbc.org Domain: train	

4. If you manually enter a device name, press **Search** to locate the name of the bedside monitor.

Note: If you scan the device, it will display the device name.

- 5. The **Device** drop-down menu shows a list of device names. Click the box I next to the BMDI monitor that needs to be associated with your patient in the CIS.
- 6. Click the **Associate** icon ³ Associate

D			
,			
STDEMO, ZEUS MF	RN: 700004780 E	DOB: 2/1/1979	Gender: Male
ssociated Devices			
SelectAll			🗱 Disassociate
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uire Saarch			A.Y.
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- 7. The selected bedside monitor that is associated with the patient's chart through BMDI is shown in the **Associated Devices** field
- 8. Click the **Close** icon **B**after verifying the correct bedside monitor



The correct monitor is now associated with the correct patient.

Vital signs and some hemodynamic measures can now be documented in the patient's chart with a simple double-click.

Hands on practice with BMDI association, disassociation and documentation will be covered in another education session.

Key Learning Points

BMDI stands for Bedside Medical Device Interface

It is important to always associate the correct monitor with the correct patient



PATIENT SCENARIO 5 – Interactive View and I&O (iView)

Learning Objectives

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

- Review the Layout of Interactive and I&O (iView)
 - Document and Modify your Documentation in iView

SCENARIO

In this scenario, you will be charting on your patient.

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 5.1 – Navigate to Interactive View and I&O

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

1. Select Interactive View and I&O (iView) within the Menu.

CSTDEMO, ZEUS - 700004780 Opene	d by Elearn, Karin Demo-Olson					
Wask Edit View Patient Chart	Links Navigation Help					
🗄 🎬 CareCompass 🎬 Clinical Leader O	rganizer 🖕 Patient List 🚨 Multi-Pat	tient Task List 🎬 Discharge Dashboard	I 🤐 Staff Assignment 🎬 LearningLIVE 🝦 👯 Care	Connect 😋 PHSA PACS 😋 VCH and PHC PACS 😋	MUSE 🜊 FormFast WFI 💡	
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CSTDEMO, ZEUS 🔳					🗲 List 🔿 🌇 Recent - Name	- Q
CSTDEMO, ZEUS	DOB:01-Feb-197 Age:38 years	79 MRN:700004780 Enc:7000000013571	Code Status:Attempt CPR, Full Code	Process:Falls Risk Disease:	Location:LGH ICU; IC06; 01 Enc Type:Inpatient	
Allergies: cloNIDine, Adhesive Ban	ndage, Banana Gender:Male	PHN:9876810595	Dosing Wt:75 kg	Isolation:	Attending:Plisvca, Rocco, MD	
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	Lines/Tubes/Drains					

2 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 **Adult Critical Care Quick View** band is expanded displaying the sections in it.
- 2. The bands below **Adult Critical Care Quick View** are collapsed. Bands can be expanded or collapsed by clicking on their names.
- 3. A **section** is an individual flowsheet that contains related assessment and intervention documentation. When you click a section from the list on the left, the documentation flowsheet for that section opens on the right.
- 4. A cell is the individual field where data is documented.

CSTDEMO, ZEUS		DOB:01-Feb-1979	MRN:700004780				Proo
Allergies: cloNIDine, Adhesiv	e Bandage, Banana	Gender:Male	PHN:9876810595	Dosing Wt:75 kg			Isolat
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CareConnect		Prod Correct Contract Income	SBP/	DBP Arterial Line	mmHg		116/66
Clinical Research	Adult Ch	tical Care Systems Assess	ment Mean	n Arterial Pressure, Invasive	mmHg		83
	Adult Cri	tical Care Lines - Devices	Cent	rai venous Pressure	mmHg		-
Form Browser	🔨 Intake Ar	id Output		cranial Pressure	mmHa		
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	Procedu	ral Sedation	S	PU2	70		100





Nurses will complete most of their documentation in iView

IView contains flowsheet type charting



Activity 5.2 – Document Vital Signs and Physical Assessment in IView

In this activity, you are going to practice manually documenting vital signs. With the **Adult Critical Care Quick View** band expanded you will see the **Vital Signs** section.

- 1. Select the Vital Signs component under Adult Quick View
- 2. Double-click the **blue box** to the right of the **Vital Signs** section name on the flowsheet to document in several cells. You can move through the cells by pressing the **Enter** key on the keyboard.

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.

- 3. Document the following data:
 - **Temperature Oral** = 38.0°C
 - Heart Rate Monitored = 108
 - SBP/DBP Arterial Line = 92/45

Note: When entering blood pressure, type systolic blood pressure (SBP) value then press ENTER and this will take you to the next cell for diastolic blood pressure (DBP).

- **Mean Arterial Pressure, Invasive** = double-click empty cell for the automated result.
- Central Venous Pressure = 12
- **Respiratory Rate** = 22
- Measured O2 % (FiO2) = 45
- **Oxygen Therapy** = Artificial Airway
- SpO2= 77
- SpO2 Site= Other; in the freetext box, type Finger

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

4. To sign your documentation, click the Sign icon 🖌

Note: The **Calculation** icon icon context that the cell will populate a result based on a calculation associated with it. Hover over the calculation icon to view the cells required for the calculation to function. For example, SBP and DBP are required cells for the Mean Arterial Pressure calculation to function.



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CareConnect		Individual Observation Record		Cuff Location		12.2		
Clinical Research		Confot Measures		Mean Arterial Pressure, Cuff	mmH-107			
Farm Descent		Inanster/ Inansport		Blood Pressure Method				
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Medication List	Add	Adult Lines - Devices		SpO2	77	-		
Patient Information		Adult Education		SpO2 Site	Ham	4 3		
Belavarra		Second Product Administration		SpO2 Site Change		9		
THEI EVENUE				Modified Fash Warning System				

Note: Once the documentation is signed the text becomes black. In addition, notice that a new blank column appears after you sign 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.

5. Abnormal values will show in different colors. Critical results are in red. High results are in orange. Low results are in blue.

X Adult Critical Care Quick View	4	
VITAL SIGNS		
Hemodynamic Measures Ventilator Subset	Find Item - Critical High Low	Abnormal
PAIN ASSESSMENT		
Insulin Infusion Hepatin Infusion	29-Nov-20 1 10 06:12 F	17 ST 16:47 PST
IV Drips	⊿ VITAL SIGNS	
Glucose Blood Point of Care	Temperature Axillary DegC	-
Glasgow Coma Assessment	Temperature Oral Degu	38
Sedation Scales	Apical Heart Rate bpm	-
Provider Notification	Peripheral Pulse Rate bpm	
Measurements	Heart Rate Monitored bpm	108
Transfer/Transport	SBP/DBP Cuff mmHg	1.1
Shift Report/Handoff	Cuff Location	
	Mean Arterial Pressure, Cuff mmHg	
	SBP/DBP Arterial Line mmHg	92/45
X Adult Critical Care Systems Assessment	Mean Arterial Pressure, Invasive mmHg	61
X Adult Critical Care Lines - Devices	Central Venous Pressure mmHg	12
VIntake And Output	Intracranial Pressure mmHg	
Advanced Craphing	Cerebral Perfusion Pressure, Cuff mmHg	
Advanced Graphing	Cerebral Perfusion Pressure, Invasive mmHg	
Slood Product Administration	△ Oxygenation	
Continuous Renal Replacement Therapy	Respiratory Rate br/min	22 1
Adult Education	Measured O2% (FIO2)	45
Pastraist and Castusian	Oxygen Activity	
& Restraint and Secusion	Oxygen Therapy	Artificial ai
V Pediatric Quick View	Oxygen Flow Rate L/min	
Adult Quick View	End Tidal CO2 mmHg	
Procedural Sedation	SpO2 %	P 77 J 9


- 2 Let's expand the **Adult Critical Care Systems Assessment** band and practice documenting your assessment on the patient's cardiovascular system.
 - 1. Click on the Adult Critical Care Systems Assessment band
 - 2. Click on the **Cardiovascular** section. Double-click the **blue box** to the right of the **Cardiovascular** section name on the flowsheet to document in several cells. You can move through the cells by pressing the **Enter** key:
 - Heart Rhythm = Regular
 - Heart Sounds = S1S2
 - Heart Sounds Location = Mitral
 - Nail Bed Color = Pink
 - Capillary Refill Peripheral = less than or equal to 3 seconds
 - Skin Temperature, Upper Extremities = Warm
 - Skin Temperature, Lower Extremities = Warm
 - 3. Click on the **Cardiac Rhythm Analysis** section. Double-click the **blue box** to the right of the Cardiac Rhythm Analysis section name on the flowsheet to document in several cells. You can move through the cells by pressing the **Enter** key:
 - Strip Placed in Chart = Yes
 - Cardiac Rhythm = Sinus tachycardia
 - **Ectopic Description** = *Premature atrial contraction(s)*
 - Ectopic Pattern = Infrequent
 - 4. Click the Sign [✓] icon to complete your document

Note: ECG strips will be printed and placed in patient's chartlet as per unit specific standard policy.

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Adult Critical Care Quick View		Last 24
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Airway Management	Find Item Critical High	ow 🔲 Abnormal 📃 Ur
Mobilization of Secretions		
Ventilation	¥ 9/8	
 Ventilation Assessment 		29-Nov-2017
VAR Bundle		2 10:50 PST
CARDIOVASCULAR	Cardiovascular Symptoms Reported	
Cardiac Rhythm Analysis	Heart Rhythm	Regular
	Heart Sounds	5152
Fielders Accessment	Heart Sounds Location	Mitral
Pacemaker	Nail Bed Colour	Pink
Neumyascular Check	Capillary Refill Central	
Insulin Infusion	Capillary Refill Peripheral	Less than or
Heparin Infusion	Capillary Refill Left Hand	
IV Drips	Capillary Refill Right Hand	
Glucose Blood Point of Care	Capillary Refill Left Foot	
Adult Critical Care Lines - Devices	Capillary Refill Right Foot	
🗙 Intake And Output	Capillary Refill Other Site	
X Advanced Graphing	Clubbing Present	
S Blood Product Administration	Skin Temperature, Opper Extremities	vvarm
Continuous Renal Replacement Therapy	Varirosities	
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X Adult Quick View	Ectopy Description	Premature a
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Note: Once the documentation is signed, the text turns black.

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Glasgow Coma Assessment		
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RESPIRATORY	Cardiovascular Symptoms Reported	
Breath Sounds Assessment	Heart Rhythm	Regular
Apnea/Bradycardia Episodes	Heart Sounds	5152
Airway Management	Heart Sounds Location	Mitral
Mobilization of Secretions	Nail Bed Colour	Pink
Ventilation	Capillary Refill Central	
 Ventilation Assessment 	Capillary Refill Peripheral	Less than
VAP Bundle	Capillary Refill Left Hand	
CARDIOVASCULAR	Capillary Refill Right Hand	
Cardiac Rhythm Analysis	Capillary Refill Left Foot	
Adult Critical Care Lines - Devices	Capillary Refill Other Site	
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3 Let's pretend that you just did a bladder scan on your patient and now you want to document.

- 1. Click the Adult Critical Care Systems Assessment Band in iView
- 2. Click the Genitourinary section in the Adult Critical Care Systems Assessment Band
- 3. Notice that there is nothing in this section that you can see about bladder scanning
- 4. Click the **Customize View** icon to search for a section regarding bladder scanning

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Adult Critical Care Quick View		4
🗙 Adult Critical Care Systems Assessment 🛛 🚺		
Glasgow Coma Assessment	-	Find Item - Critical High Low Abnorn
Pupils Assessment		
Mental Status/Cognition		06-Dec-2017
Sedation Scales		💌 4 🛯 🛞 11:11 PST
RESPIRATORY		
Breath Sounds Assessment		Urinary Symptoms Reported
Apnea/Bradycardia Episodes		Urinary Elimination
Airway Management		Urine Voided mL
Mobilization of Secretions		Urine Amount Unmeasured
Ventilation		Patient Voided, Unknown Amount
Ventilation Assessment		Episodes of Bladder Accident
		Diaper/Brief Check
CARDIOVASCULAR Cardiae Distance Academia		Last Wet Diaper/Brief
Cardiac Knythm Analysis Bulace		Urine Colour/Characteristics
Fuises	=	Urine Odour
Edema Assessment		Bladder Distention
Pacemaker		Last Menstrual Period
Neurovascular Check		Menses Present
Insulin Infusion		d Genitalia Assessment
Heparin Infusion		
IV Drips		
Glucose Blood Point of Care		
GASTROINTESTINAL		
Gastrointestinal Tubes		
GENITOURINARY 2		
Urinary Catheter		
INTEGUMENTARY		
Incision/Wound/Skin/Pin Site	Ŧ	T
Adult Critical Care Lines - Devices		
VIntake And Output		



5. A **Customize** window opens displaying all the content within the Genitourinary section. Click the **Collapse All** button to see all of the section names at a glance.



- 6. Now that all the sections are collapsed, scroll down to find the **Bladder Scan/Postvoid Residual** section and click on the checkbox ☑ under the **Default Open** column.
- 7. Click OK

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Customize	Preferences	Dynamic Groups			
Display GENITO Urinary Bladde Urinary INTEG Incision Braden MUSCU Muscu PSYCH CIWA-J Ongoir Point o	Name DURINARY Catheter Diversion JMENTARY N/Wound/Skin/I Assessment JLOSKELETAL loskeletal Interv OSOCIAL Ar ng Columbia Su f Care Testing	Residual Pin Site ention icide Severity Rating	On Viev	v Default O	pen 1
Search for In Section	Item:	Collapse All	Expand All	ок 7	₹



- 8. You will now see that the **Bladder Scan/Postvoid Residual** section is available to document on in iView.
- 9. Document your assessment findings by double clicking in the following cell under the current time column:
 - Random Scan Bladder Volume = 300
- 10. Press Enter and click Sign icon [✓] to complete your document

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IV Dring		Urine Voided mL
Glucose Blood Point of Care		Urine Amount Unmeasured
		Patient Voided, Unknown Amount
Gastmintestinal Tubes	11	Episodes of Bladder Accident
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		Last Wet Diaper/Brief
Bladder Scan/Postvoid Residual		Urine Colour/Characteristics
		Urine Odour
Incision/Wound/Skin/Pin Site	-	Bladder Distention
✓ Braden Assessment	-	Last Menstrual Period
Adult Critical Care Lines Devices		Menses Present
Addit Childar Care Lines - Devices		⊿ Genitalia Assessment
W Intake And Output		⊿ Bladder Scan/Postvoid Residual
X Advanced Graphing		Voided Within 15 Minutes Prior to Scan
Slood Product Administration		Post Void Bladder Volume mL
Continuous Renal Replacement Therapy		Random Scan Bladder Volume mL 300
Adult Education		Was Patient Catheterized 9
Additeducation		Post Void Residual Catheterization Amt mL
Restraint and Seclusion		
X Adult Procedures		Skin Colour General

- 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.

Use the **Customize View** icon to find additional documentation that isn't automatically visible



Activity 5.3 – Change the Time Column

1 You can create a new time column and document under a specific time. For example, you have been busy with patient care and forgotten to chart the previous hour temperature.

- 1. Click the Insert Date/Time icon im.
- 2. A new column and the **Change Column Date/Time** window appear. Choose the appropriate date and time you wish to document under. In this example, use *today's date* and enter *one hour early from now*.
- 3. Click the **Enter** key.

Menu P	< 🔹 🔸 🚹 Interactive View and I&O		
Patient Summary	. 🛰 🖃 💷 🎶 🖌 🚫 🖏 📑 📑 🍋 🛪		
Orders 🕂 Add		R	
Single Patient Task List	X Adult Critical Care Quick View		Last 24 Hours
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MAR	Ventilator Subset	Find Item	📃 Low 🔄 Abnormal 📄 Unauth 📄 Flag
Interactive View and I&O	PAIN ASSESSMENT		
Results Review	Heparin Infusion	M 1	28-Nov-2017
-	IV Drips		💥 17 👝 Change Column Date/Time 🛛 🗙 13:49 F
Documentation 🛛 🕈 Add	Glucose Blood Point of Care	Cuff Location	∠ 28-Nov-2017 🚔 👻 1600 🚔 PST
Medication Request	Glasgow Coma Assessment	Mean Arterial Pressure, Cuff mm	Hg
	Sedation Scales	SBP/DBP Arterial Line mm	Hg 92/45 116/66 130/6
Histories	Provider Notification	Mean Arterial Pressure, Invasive mm	Hg 61 ↓ 83
Allergies 🕂 Add	Measurements	Central Venous Pressure mm	Hg
	Transfer/Transport	Intracranial Pressure mm	Ig
Diagnoses and Problems	Shift Report/Handoff	Cerebral Perfusion Pressure, Cuff mm	Hg
		Cerebral Perfusion Pressure, Invasive Mm A Oxygenation	
CareConnect		Bespiratory Bate br/r	nin 22 ↑ 19 20
	Adult Critical Care Systems Assessment	Measured O2% (FIO2)	45
Clinical Research	Adult Critical Care Lines - Devices	Oxygen Activity	
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Immunizations	Blood Product Administration	SpO2	70 77 ↓ 100 95
Lines/Tubes/Drains Summan/	Continuous Renai Replacement Therapy	SpO2 Site Change	Uther: finger
cines, rubes, brains summary	Adult Education	A DATH ACCECCMENT	
MAR Summary	Restraint and Seclusion	Pain Present	

4. In the new hour column, enter **Temperature Oral** = 37.8° C and click the **Sign** icon \checkmark to complete the documentation.

CSTDEMO, ZEUS	8	N										
CSTDEMO, ZEUS	-	.a.	DO8:01-Feb-1979 Age:38 years	MRN:700004780 Enc:70000000135	Code 71	Status:Attempt	CPR, Full Code		Pro Dis	icess:F ease:	alls Risk	
Allergies: cloNIDine, A	dhesive Bandag	e, Banana	Gender:Male	PHN:9876810595	Dosir	ng Wt:75 kg			Iso	lation:		_
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Histories		Provide	er Notification		Apical Heart Ra	ste	pbu					
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Diagnoses and Problems		Shift Re	eport/Handoff		SBP/DBP Cuff		mmHg			_		
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CareConnect		Adult Critic	al Cara Syclame Accesem	ant	SBP/DBP Arten	al Line	mining		92/45	4		116/
Clinical Research		Adult Online	al Care Lines Devices	CTR C	Cantral Vancus	Pressure, invasive	monte		01	*		83
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Form Browser	9	Intake And	Output		Cerebral Perfus	tion Pressure Cut	mmHc			-		
Growth Chart	9	Advanced	Graphing	6	Cerebral Perfut	sion Pressure, Inv	asive mmHe					
Immunitations	9	Blood Prod	duct Administration		⊿ Oxygenatio	on .	Sector Contractor		1			-
annonzacions		Continuou	s Renal Replacement Ther	ару	Respiratory	Rate	br/mir		22	1		19
Lines/Tubes/Drains Summ	hary	Adult Educ	ation	2517.	Measured C	02% (F102)			45			147



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



Activity 5.4 – 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, and more.

Let's pretend that the attending ICU provider just inserted a central line and an x-ray was done to confirm tip placement. Now you need to document the following:

- 1. Click on the Adult Lines Devices band
- 2. Now that the band is expanded. Select the Central Line section
- 3. Click on the **Dynamic Group** icon **R** to the right of the central line heading in the flowsheet





- 4. The Dynamic Group window appears. A dynamic group allows you to label a line, wound, or drain with unique identifying details. Let's document the following to create a label for the central line:
 - Central Line Access Type= Central venous catheter
 - Central Line Number of Lumens = triple

Scroll down to document the following:

- Central Line Insertion Site = Internal jugular vein
- **Central Line Laterality** = *Right*
- Central Line Catheter Size = 7 French
- 5. Click OK

Note: Yellow highlighted fields are mandatory fields that need to be completed. You can add as many dynamic groups as you need for your patient in order to identify each unique line/tube/drain/wound etc.

Dashboard 🔉 Staff Assignment 🎬 LearningLIVE 🖕 🗄 🕄 CareC	onnect 💐 PHSA PACS 💐 VCH and PHC PACS 💐 MUSE 💐 FormFast WFI 🝦
rd Request 🔸 Add 👻 🖲 Documents 🚆 Scheduling Appointm	P Dynamic Group - CSTDEMO, ZEUS - 700004780
0 Code Status:Attempt CPR, Full Code 3571	Label: Central Line Access Type:> <central line="" lumens:="" number="" of=""><central access="" line="" type:=""><central laterality:="" line=""><central catheter="" line="" size:=""></central></central></central></central>
35/1 25 Dosing Wt:75 kg Ind Item Critical High Low (Critical High Low (Critical High Key (Critical Key	Central Line Access Type: Central Line Access Type: Central venous catheter Cuffed Implanted venous access device (IVAD) Introducer sheath Non-tunneled Peripherally inserted central catheter (PICC) Tunneled Power injectable Hemodulysis/Phresis catheter Non-valved Other Central Line Number of Lumens: Single Double Triple Quad Central Line Insertion Site: Antecubital Basilis roain



- 6. The label created ∠ <Central venous catheter Triple Internal jugular... will display underneath the **Central** Line section heading.
- 7. Double-click the **light grey box** next to the central line label to document in several cells. You can move through the cells by pressing the **Enter** key.

Note: A trigger icon \bigotimes 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 \bigotimes indicates the additional documentation cells that appear as a result of these responses being selected. These cells are not mandatory.

Now document the activities related to the central line:

- Activity= Inserted central line
- **Insertion Technique =** *ultrasound guidance*
- **Performing Procedure =** *type in attending provider's name* **Note:** The provider's name can be found in the top right corner of the Banner bar.
- **Department Placing line =** *ICU*
- Did you assist with/observe line insert = yes
- **Before the procedure did the inserter? =** Wash their hands, Scrub insertion site with Chlorhexidine, Drape patient in sterile fashion w/ large fenestrated drape
- Total Insertion Attempts = 1
- **Tip Confirmation and Location =** *Radiographic*
- Indication= Medications, Monitoring
- External Catheter Length cm = 2
- **Site Condition**= *No complications*
- **Dressing** = Applied, Transparent dressing
- 8. Click the **Sign** icon [✓] to complete your document. Notice that the text will turn from purple to black font.

Note: Once signed the label will be accessible for other clinicians to complete their assessment documentation within the same dynamic group.





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

Let's say your central line has been discontinued. To **inactivate** your Central Line dynamic group complete the following steps:

Note: you would first document that the line was discontinued under Activity and chart the removal reason, but for the purpose of this exercise we will skip this step.

- 1. Right-click the dynamic group label ⊿ <Central venous catheter Triple Internal jugular...
- 2. Select Inactivate.





3. The section is now greved out and inactive for documentation.



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 reactivate a dynamic group!

4. Right-click the dynamic group label for the Central venous catheter, select Activate



Note: You and other users can now access this dynamic group for documentation.



- Examples of Dynamic Groups include wound assessments, IV sites, chest tubes, etc.
- Once documentation of Dynamic Groups 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, it should be inactivated



Activity 5.5 – Modify, Unchart or Add a Comment in Interactive View

1 Sometimes mistakes will be made in documentation and you will need to modify, unchart or add a comment to provide clarity for your documentation.

First, let's discuss how to Modify iView documentation.

You realize that the SpO2 value that was documented is not accurate. After ensuring proper placement of the O2 sat probe, you would like to correct the SpO2 value. Let's modify the SpO2 reading that was originally documented in Activity 4.2.

- 1. Click on the Vital Signs section heading in the Adult Critical Care Quick View band.
- 2. Right click on the documented SpO2 value (77).
- 3. Select Modify





4. Enter in new **SpO2** value = 89 and click the **Sign** icon \checkmark to complete the document.

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•	Ventilator Subset	Find Item 🔹 🔲 Critical	🔲 High 📃	Low 🔳 🗛	bnormal
•	PAIN ASSESSMENT				
	Insulin Infusion	Result	Comments	Flag	Date
	Heparin Infusion				
1	IV Drips				
	Glucose Blood Point of Care	w			
	Glasgow Coma Assessment	<u>m</u>		C2	
	Sedation Scales		9	👷 12:51 PST	12:50 PST
	Provider Notification	Intracranial Pressure	mmHg		45
•	Measurements	Cerebral Perfusion Pressure, Cuff	mmHg		
	Transfer/Transport	Cerebral Perfusion Pressure, Invasive	mmHg		
	Shift Report/Handoff	⊿ Oxygenation			
		Respiratory Rate	br/min		
		Measured O2% (FIO2)			
		Oxygen Activity			
		Oxygen Therapy	17.5		
		Oxygen Flow Rate	L/min		
0	Adult Critical Care Systems Assessment	End Tidal CO2	mmHg		
	Adult Critical Care Lines - Devices	SpO2	%	4	89
	N	SpO2 Site		_	

5. **89** now appears in the cell and the corrected icon **a** will automatically appear on the bottom right corner to denote a modification has been made.

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	Respiratory Rate	br/min			
	Measured O2% (FIO2)				
	Oxygen Activity				
	Oxygen Therapy				
	Oxygen Flow Rate	L/min			
X Adult Critical Care Systems Assessment	End Tidal CO2	mmHg			_
X Adult Critical Care Lines - Devices	Sp02	70	5	89	↓ ▲
Vintake And Output	SpO2 Site		_		
Advanced Oceahing	2 PAIN ASSESSMENT				
Advanced Graphing	Pain Present				

2 Unchart

The unchart function will be used when information has been charted in error and needs to be removed. For example, a set of vital signs is charted in the wrong patient's chart. Let's pretend the temperature documented earlier was meant to be documented on one of your other patients. It needs to be uncharted.



- 1. Right click on the documented Temperature Oral 38.
- 2. Select Unchart

					Add Result
✓ Critical ■	Hiah		L	.ast 24	View Result Details View Comments View Flag Comments View Reference Material
					View Order Info
in W		29-Nov-2017			View History
🦉 🚮 🗗		📆 10:48 PST	16:47 PST	16:0	Modify
	Deed				
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Anisel Heart Date	bog	-	38	31	Change Date/Time
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SBP/DBP Cuff	mmHe		100		Duplicate Results
Cuff Location		5			Clear
Mean Arterial Pressure, Cuff	mmHe	1			View Defaulted Info
SBP/DBP Arterial Line	mmHe	9	92/45		view Defaulted Info
🛄 Mean Arterial Pressure, Invasive	mmHg	9	<mark>61</mark> ↓		View Calculation
Central Venous Pressure	mmHg	9	12		Recalculate
Intracranial Pressure	mmHg	9			View Interpretation
Cerebral Perfusion Pressure, Cuff	mmHg	9			
Cerebral Perfusion Pressure, Invasive	mmHg	9			Reinterpret
⊿ Oxygenation				_	Create Admin Note
Respiratory Rate	br/mir	n	22 1		Chart Details
Measured O2% (FIO2)			45		NUE
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Oxygen Flow Kate					i log
Secol		2	W 00 I	↓	Flag with Comment
SpO2 Site			7 09 44		Unflag
					Unflag with Comment

- 3. The Unchart window opens. Select **Charted on Incorrect Patient** from the Reason dropdown.
- 4. Click Sign

-19	979	MRN:700004780	Code Status:A	ttempt CPR, Fu	Ill Code	Process:Falls Risk	
s e	P Unch	art - CSTDEMO, ZEUS - 70	00004780				
iv	Unchart	Date/Time	Item	Result	Reason	Comment	
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L			Cerebral Perfusion Press	ure, invasive	mmig		



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

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Sedation Scales	Apical Heart Rate	bpm	
Provider Notification	Peripheral Pulse Rate	bpm	
Measurements	Heart Rate Monitored	bpm	108 个
Transfer/Transport	SBP/DBP Cuff	mmHg	
Shift Report/Handoff	Cuff Location		
	Mean Arterial Pressure, Cuff	mmHg	
	SBP/DBP Arterial Line	mmHg	92/45

3 Add a Comment

A comment can be added to any cell to provide additional information. For example, you notice patient's SpO2 is low and you have notified the RT.

- 1. Right click on the documented value for SpO2 Site (89).
- 2. Select Add Comment.

🗙 Adult Critical Care Qu	ck View				Last 24 Hou
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Sedation Scales	ssmern	Intracranial Pressure	mmHg		
Provider Notification		Cerebral Perfusion Pressure, Cuff	mmHg		Add Result
Measurements		Cerebral Perfusion Pressure, Invasive	mmHg		View Result Details
Transfer/Transport		⊿ Oxygenation			
Shift Report/Handoff		Respiratory Rate	br/min		View Comments
		Measured O2% (FIO2)			View Flag Comments
		Oxygen Activity			View Reference Material
		Oxygen Flow Bate	L/min		View Order Info
		End Tidal CO2	mmHg		view order mildin
		SpO2	%	$\square 1$	View History
		SpO2 Site			Modify
		SpO2 Site Change			in dan yan
		⊿ PAIN ASSESSMENT			Unchart
		Pain Present			Change Date/Time
		Respiratory Rate	br/min		Add Comment 2
		Onset			Duplicate Results
		Provoking			
		Quality			Clear
		Location			View Defaulted Info
		Laterality			16- Coloriation
X Adult Critical Care Sys	stems Assessment	Radiation Characteristics			view Calculation
🗙 Adult Critical Care Lin	es - Devices	Pain Comment			Recalculate
🔨 Intake And Output		😔 Secondary Pain Site			View Interpretation
Advanced Graphing		Additional Pain Sites			Reinterpret
Blood Product Adminis	tration	Pain Tool Used		_	
Continuous Ronal Roy	lacoment Thereny	⊿ Glasgow Coma Assessment			Create Admin Note
Adult Education	accinent merapy	Verbal Perpopse			Chart Details
Adult Education		Motor Response			Not Done
Kestraint and Seclusio	n	Glasgow Coma Score			
Vediatric Quick View		Response to Stimuli Affected by			Flag
X Adult Quick View		⊿ Sedation Scales			Flag with Comment
Vertice Procedural Sedation		Sedation Scale Used			Unflag



3. The comment window opens, type comment **Notified RT regarding low SpO2**, and click **OK**.

Comment - CSTLEARNING, DEMOTHETA - 700008216	
SpO2: 89 %	
Comment	
Notified RT regarding low SpO2	د ع

Note: The Corrected icon \triangleq and Result Comment or Annotation icon \square will display in the cell.

Key Learning Points

- Always sign your documentation once completed
- Dynamic groups are created within specific sections of iView
- Dynamic groups allow for the documentation and display of grouped data elements such as multiple IV or wound sites
- Results can be modified or uncharted within iView
- A comment can be added to any cell



PATIENT SCENARIO 6 - Document Intake and Output

Learning Objectives

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

Review and Document Intake and Output

SCENARIO

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

- Navigate to Intake and Output
- Review and Document in the I&O Record



Activity 6.1 – Navigate and Review Intake and Output

1 Intake and Output (I&O) is found as a band within Interactive View and I&O (IView) and is where a patient's intake and output will be recorded. From here, you are able to review specific fluid balance data including 1 hour totals, 12 hour shift totals, daily (24 hour) totals, and cumulative balances.

The I&O window is structured like other flowsheets in iView. Values representing a patient's I&O are displayed in a spreadsheet layout with subtotals and totals for time ranges. The left portion of the display lists the categories of input and output sections. Notice that the time columns in I&O are set to hourly ranges (e.g. 0600-06:59). You will need to document under the correct hourly range column.

1. Click Interactive View and I&O from the Menu

2. Select the Intake and Output band.



The **Intake and Output** band expands displaying the sections within it and the I&O window on the right. Let's review the layout of the page.



- 2 The Intake and output screen can be described as per below:
 - 1. The **I&O navigator** lists the sections of measurable I&O items. The dark grey highlighted sections (for example, Oral) are active and are automatically visible in the flowsheet.
 - 2. To add other Intake or Output sources, you will need to click on the Customize View icon
 to select the appropriate section to be added in.
 - 3. The grey information bar indicates the date/time range that is currently set to be displayed.
 - 4. To change the date/time range being displayed:
 - Right-click on the **grey bar** and select **a new date/time range** (Admission to Current, Today's Results or Other)
 - 5. The I&O summary at the top of the flowsheet displays a quick overview of today's intake, output, balance, and more.



3

Some values in the Intake and Output record automatically populate from volumes documented in other parts of the chart such as in iView. A few examples of values that pull from iView documentation include the following:

Note: This is NOT a step for you to do in the system. Please only view the steps and the screenshots below in this activity.

- 1. Continuous Infusions: (e.g. Sodium Chloride 0.9% infusion)
 - Double clicking in each hourly time column will populate hourly volumes. These volumes are based on the order for the continuous infusion rate.
 - A partial volume will display if the infusion is not initiated on the hour
- 2. Oral liquid medications and IV fluid bolus/medications: (e.g. Piperacillin-tazobactam IV minibags)
 - Volumes are displayed as a single dose amount and are pulled from the Medication Administration Wizard (MAW) documentation.



- The **Diluent Volume** of an IV medication like antibiotics must be documented in the MAW in order for a volume to flow to I&O
- 3. Dynamic Groups: (e.g. Nasogastric (NG) Tube intake and output)
 - Volumes will be pulled from Dynamic Group documentation in iView.
- 4. Blood transfusion
 - Blood transfusion volumes will be pulled from Blood Production Administration documentation in iView
- 5. Actual hourly fluid removal from Continuous Renal Replacement Therapy (CRRT)
 - Volumes will be pulled from CRRT documentation in iView

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Medications		⊿ Continuous Infusions			75	75	75	
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Enteral	112	⊿ Medications			50	_		_
GI Tube	ш	piperacillin-tazobactam + dextrose 5% mL			50	2		
GI Ostomy Intake	11	⊿ Enteral				_		
Urinary Diversion Intake	ш	⊿ GI Tube						
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- Time columns are organized into hourly intervals with a column for a 12 hour (Day/Night Shift) Total and 24 Hour Total
- Volumes documented in dynamic groups and other sections in iView will automatically pull values into the Intake and Output record
- After administering continuous infusions through the MAR/MAW, volumes will flow into I&O by double clicking on each hourly cell



Activity 6.2 –Document in the I&O Record

1 Other intake and output values require direct charting in I&O flowsheet.

Let's practice documenting these values directly in the I&O record.

- 1. Select Interactive View and I&O from the Menu
- 2. Select the Intake and Output band
- 3. Click GI Tube from the Intake section and enter the data below:
 - Nasogastric (NG) tube, Nare, Right, 18 French, Intake= 150
- 4. Click Urinary Catheter Output from Output section and enter the data below:
 - Urethral Indwelling/Continuous 14 French Silicone, Output= 135
- 5. Click the **Sign** </ icon to complete your documentation

Menu 4	< 👻 🛉 Interactive View and I&O					
Patient Summary	🖦 🚍 📈 5 K 🧃					
Orders 🕂 Add		_				
Single Patient Task List	X Adult Critical Care Quick View		Mo		08-January	-2018 06:00
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	GI Ostomy Intake		⊿ Intake Total			
Results Review	Urinary Diversion Intake		⊿ Medications		_	
Documentation 🛛 🕂 Add	Oral Oral		⊿ GI Tube	¢	\checkmark	
	Other Intake Sources		 Orogastric (OG) tube Oral 14 French 			
Medication Request	Negative Pressure Wound Therapy		⊿ <nasogastric (ng)="" 18="" french="" nare,="" right="" tube=""></nasogastric>			
Histories	Surgical Drain, Tube Inputs		Intake	mL	.50	
	Transfusions		Flush	mL	3	
Allergies 🕂 Add	Urinary Catheter, Intake		Irrigant In	mL		
Diagnoses and Problems	Pre-Arrival Fluid		⊿ Oral			
blaghoses and Problems	Output		Oral Intake	mL		
	Blood Output		⊿ Other Intake Sources			
	Chest Tube Output	Ξ	⊿ Output Total			
CareConnect	Continuous Renal Replacement Therapy		∠ Emesis Output			
Clinical Research	Emesis Output		⊿ GI Tube			
	GI Tube		∠ Orogastric (OG) tube Oral 14 French			
Form Browser	GI Ostomy Output		Output	mL		
Growth Chart	Other Output Sources		Irrigant Out	ml		
	Paracentesis Output		Residual Discarded	mL		
Immunizations	Pericardiocentesis Output		A <nasogastric (ng)="" 18="" french="" nare,="" right="" tube=""></nasogastric>			1
Lines/Tubes/Drains Summary	Negative Pressure Wound Therapy		Output	mL		
	Surgianal Desin. Turka Outra ta		Irrigant Out	mL		
Medication List 🕈 Add	Themeenteen Outputs		Residual Discarded	mL		
Patient Information	Lipary Catheter, Output		⊿ Other Output Sources			
2.4	and Advanded Compliant	الث ا	⊿ Stool Output			
Reference	Advanced Graphing		Stool Count (Number of Stools)			
	Second Product Administration		⊿ Urinary Catheter, Output			
	Continuous Renal Replacement Therapy		⊿ Urethral Indwelling/Continuous 14 French Silicone			
	Adult Education		Output	mL	135	4
	Pestraint and Seclusion		Irrigant Out	mL		
	Nestiant and Secusion		l			

Note: You may get **Urinary Catheter Alert - Discern Notification** pop-up screen. Click the **Close** icon **to** acknowledge and close the Discern Notification window.



6. The fluid balance for the hour is automatically calculated and displayed.

•••	Interactive View and 1&0							
XA	dult Critical Care Quick View		Tuesday, 28-November	-2017 06:0				
A	dult Critical Care Systems Assessment			1242 222				
A	dult Critical Care Lines - Devices		Today's Intake: 1753.3333 mL Output: 511 mL Balance:	1242.333				
	take And Output		PS 111					
2	Continuous Infusions			14:00 -				
1	Medications		Intake	150				
	Chest Tubes		Flush	150				
1	Enteral		Irrigant In ml					
~	GI Tube	E	4 Oral					
	GI Ostomy Intake		Oral Intake ml					
	Urinary Diversion Intake		△ Other Intake Sources					
	Oral		⊿ Transfusions					
	Other Intake Sources		Red Blood Cells Volume Transfused mL					
	Negative Pressure Wound Therapy		Urinary Catheter, Intake					
	Surgical Drain, Tube Inputs		△ Output Total	135				
~	Transfusions		△ Continuous Renal Replacement Therapy					
	Urinary Catheter, Intake		Actual Hourly Fluid Removed mL					
	Pre-Amval Huid	_	⊿ Other Output Sources					
	District Output	-	⊿ Stool Output					
SX A	dvanced Graphing	1.0.0	Stool Count (Number of Stools)					
R	lood Product Administration		⊿ Urinary Catheter, Output	135				
	and a second dealer and the second second		△ Urethral Indwelling/Continuous 14 French Silicone					
8 C	ontinuous Renai Replacement Therapy		Output mL	135				
X A	dult Education		Irrigant Out mL					
X R	estraint and Seclusion		CBI Output mL					
ST P	ediatric Quick View		⊿ Urine Output					
A	dult Quick View		Urine Voided ml					
			6 Balance	15 mL				

7. 12-hour shift balances (0600-1759 hours & 1800-0559 hours) and 24-hour balances are calculated by the system.

< - A Interactive View and I&O				
•• ⊟ ✓ ⊠ × 3				
& Adult Critical Care Quick View	↔ Wednesday, 29-November-2017 06:00 PST - Sa	turday, 02-Decemb	er-2017 05	:59 PST
Adult Critical Care Systems Assessment	Tadavis Jataka 0 al. Outaut 0 al. Palance 0 al. Vesterdavis Jataka 20	55 2222 - Out		Dalaase 1
Adult Critical Care Lines - Devices	Today's intake: O'mu Output: O'mu balance: O'mu Testerday's intake: 20	555.5555 mL Outp	oc IIII	at balance: 1
Intake And Output	30-Nov-2017			
Continuous Infusions	07:00 - 06:00 - 07:59 PST 06:59 PS	24 Hour Total	Night Shif	05:00 - 0
Medications	A Orogastric (OG) tube Oral 14 French		Total	03.33 F31 0
Chest Tubes	Intake	250		
 Enteral 	Flush mL	300	250	250
GI Tube	E Irrigant In mL			2.00
GI Ostomy Intake	4 Oral			
Urinary Diversion Intake	Oral Intake mL			
Oral	△ Other Intake Sources			
Other Intake Sources	⊿ Transfusions	300		
Negative Pressure Wound Therapy	Red Blood Cells Volume Transfused mL	300		
Surgical Drain, Tube Inputs	⊿ Output Total	1111	600	600
Iranstusions	⊿ Continuous Renal Replacement Therapy	200		
Unnary Catheter, Intake	Actual Hourly Fluid Removed mL	200		
	△ Other Output Sources			
Blood Output				
& Advanced Graphing	Stool Count (Number of Stools)			
S Blood Product Administration	△ Urinary Catheter, Output	911	600	600
Continuous Renal Replacement Therany	⊿ Urethral Indwelling/Continuous 14 French Silicone			
A de la Causakas	Output mL	911	600	600
& Adult Education	Irrigant Out ml.			
Restraint and Seclusion	CBI Output mL			
Pediatric Quick View	⊿ Urine Output			
Adult Quick View	Urine Voided mL		600 ml	
Procedural Sedation	Balance	1744.3333 mL	502 mL	502 7
		the second se		



8. Additional functions can be viewed by right clicking the cell. You can unchart, modify or add a comment to any result.



Note: It is important that you verify all volumes are entered correctly. The system automatically calculates fluid balances based on the volumes entered.

- Now let's say your patient just vomited and you need to document the emesis amount. You need to add in this section because it is not yet active in the I&O band.
 - 1. Click on the **customize view** icon
 - 2. A Customize window will open, listing all available sections that can be manually added
 - 3. Scroll down to the **Emesis Output** and click the box 🗹 under the **Default Open** column
 - 4. Click the **Right arrow** icon next to the **Emesis Output** to expand this section.
 - 5. Click the box 🗹 next to **Emesis Amount** under the **On View** column. This section will now be displayed in iView.
 - 6. Click OK



CSTDEMO, ZEUS - 700004780 Customize 2 eferences Dynamic Groups	3
Display Name 5 On View Default Open 3 Chest Tube Output Continuous Renal Replacement Therapy 2 2 Emesis Output Emesis Count Emesis Description Emesis Amount 5 Emesis Amount 5 Emesis Classic Residie Volume Est	
GI Tube Image: Stress of the	
Search for Item:	

Once you refresh your page, you will see the **Emesis Output** section is now available in I&O and you can document against **Emesis Amount**.

- 1. In the appropriate time column, document **Emesis Amount =** *Moderate* in the cell
- 3. Click the **Sign** [✓] icon. You will now see this volume displayed in the patient's fluid balance.





- Some values will require direct charting in the Intake and Output band.
- Values can be modified and uncharted within the I&O band
- A comment can be added to any cell by right clicking
- It is important to verify all volumes in I&O are accurate. The system automatically calculates fluid balance totals based on these volumes
- To add other Intake or Output sources, you will need to click on the Customize View icon to select the appropriate section to be added in.



PATIENT SCENARIO 7 – Introduction to PowerForm

Learning Objectives

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

- Document in PowerForm through AdHoc Charting
 - View, Modify and Unchart an existing PowerForm

SCENARIO

In this scenario, we will review another method of documentation.

As a critical care nurse you will be completing the following activities:

- Navigate and document on a new PowerForm using AdHoc
- View an existing PowerForm
- Modify an existing PowerForm
- Unchart an existing PowerForm



Activity 7.1 – Opening and Documenting on PowerForms

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. The **AdHoc** folder is an electronic filing cabinet that allows you to find any PowerForm on an as needed basis.

Now a sample of Powerform is displayed. Let's review the layout:

- 1. The title of the current PowerForm you are documenting on
- 2. On the left hand side of the PowerForm is a list of form sections that can be documented
- 3. Form sections that have a red asterisk contain required field(s) that must be filled out
- 4. The **required field(s)** within the form section will be highlighted in yellow. You will be unable to sign the PowerForm unless all required fields are completed.

P Admission History Adult CSTLE	ARNING, DEMODELTA			- • •
🗸 🖬 🛇 🕱 🗖 🛧 🗣 📾				
*Performed on: 27-Nov-2017	↓ 1422 ▲ PST			By: TestUser, Nurse
General Information	Violence and Aggressi	on Screening		<u> </u>
Barriers to Communication	violence and Aggressi	Shreening		-
Violence and Aggression Screening	Violence and Aggression Screening	Additional Information		
Review Violence Risk Alert	No risk assessed at this time			
* Advance Care Planning	Previous history of violent behaviour			E
3 rium Screen	Current verbal threats of physical violence			
RS Quick Screen	C Other:			
CAGE-AID Assessment	4			
Nicotine Dependence Assessment	If patient has a previous history of or curr	ent indication of violence or ago	gression, complete the remainder of the form as applicable.	
Psychosocial				
Nutrition	Current Patient Presentation	Curr	rent Presentation Additional Information	
Social History	Attack on object			
Procedure History	Instrument of harm/weapon			
Family History	Physical threat			
	Unwanted sexual touch			
	Verbal aggression with another behaviour or history Verbal or written threat of physical violence	of violence		
2	Dther:			
	Perceived Staff Approach Stressors	Perc	ceived Staff Stressors Additional Information	
	Enforcing or authoritative Denial or delay of request, action or item Rushed or fast pace			
	Sudden or unanticipated approach			
	Unwelcome touch			-

Let's document on the **Advanced Care Planning** PowerForm. To open and document on a new PowerForm:





The **Ad Hoc Charting** window opens. It contains two panes. The left side displays folders that group similar forms together. The right side displays a list of Powerforms.

2. The Admission/Transfer/Discharge folder is now opened and a list of Powerforms is displayed on the right side of Ad Hoc Charting window. Select Advance Care Planning PowerForm.

3. Click the Ch	art button Chart].	
Ad Hoc Charting - Validate, IP-Critical	CareNurse		
All Items	Advision Histor Adv. Advision Histor Adv. Back Advision Information Discharge Checklist Discharge Planning Assessment Expandion Record Histor Advisor Disease Screening Pre-Transfer/Transpot Checklist Transpot Checklist Advables and Belongings	₽	
			Chart 3 ose

- 4. Fill in the following fields:
 - Advanced Care Plan= Yes
 - Type of Advance Care Plan= Advance Care Plan
 - Location Of Advance Care Plan= Family to bring in copy from home
- 5. To complete the PowerForm, click the **Sign** icon \checkmark and then refresh the screen.

Note: Using **Save Form** icon is discouraged because no other user will be able to view your documentation until it is signed.

27-Nov-2017 📮 💌 1442	PST		By: 1
Advance Ca	re Planning		
Advance Care Plan	Yes No Unable to answer at this time	Patient Wishes to Receive Further Information on Advance Care Planning	No No Documenting "Yes" automatically fires consult for follow up
Type of Advance Care Plan	Advance Care Plan Section 7 Standard Representative Agreement Section 9 Enhanced Representative Agreement Advance Care Plan Form No Castloculturoary Resultation - Medical Order Retual of Blood Product Trause, Body, or Organ Donation Other:	Advance Care Plan Details	
Location of Advance Care Plan	Copy to be obtained from previous records Copy placed on paper chast Family to bring in copy from home Available as scanned document in EHB	Reason Copy Cannot Be Obtained	
Documenting "Unable to obtain copy" automatically fires consult for follow up.	C Unable to obtain copy O Other:		



PowerForms are electronic forms used to chart patient information.

- The AdHoc button MAdHoc in the toolbar allows you to locate a new Powerform on an as needed basis.
- PowerForms may be broken up into several sections. Section headings are displayed to the left side of the PowerForm.



Activity 7.2 – 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 form can have different statuses (e.g. Modified, In Error, Auth Verified and In Progress)



Activity 7.3 – Modify an existing PowerForm

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 Advanced Care Planning form.

To modify a PowerForm select it from within Form Browser:

- 1. Right-click on the most recently completed **Advance Care Planning** form within **Form Browser**
- 2. Select Modify

1



- 3. Change the selection for Advance Care Planning from Yes to No
- 4. Click the **Sign** icon \checkmark to complete the documentation and then refresh the screen.

✓ 4 [™] Image: Second sec	ICU-Nurse
*Performed on: 19-Jan-2018 T 1306 PST By: TestUser,	ICU-Nurse
Advance Care Pic Advance Care Planning	Î Î
Advance Care Plan Advance Care Plan Patient Wishes to Receive Further No Documenting "Yes" automatically fres Consult for follow up. Patient Wishes to	
Type of Advance Care Plan Advance Care Plan Section 7 Standard Representative Agreement Advance Care Plan Details Advance Care Plan Form No Cardiopulmonay Resuccitation - Medical Order Refuta do Blood Product Tissue, Body, or Organ Donation Other: Other:	
Location of Advance Care Plan Care Plan Copy laced on paper chat Care plan Copy alcoed on paper chat Care plan Copy alcoed on paper chat Care plane Care p	
۲ In Pre	gress

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



A document can be modified if needed

A modified document will show up as (Modified) in the Form Browser



Activity 7.4 – Uncharting an Existing PowerForm

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 **Advanced Care Planning** form was documented in error.

To unchart the PowerForm, within Form Browser:

- 1. Right-click on Advance Care Planning
- 2. Select Unchart



- 3. The **Unchart** window opens. Enter reason for uncharting in the **Comment** box = *Wrong PowerForm*
- 4. Click the **Sign** icon \checkmark to complete the documentation and then refresh your screen

P Advance Care	Planning (Unc	hart) - Validate, IP	-CriticalCareNu	rse	×
🗹 4 🌂 🗖					
*Performed on:	19-Jan-2018	× v 1306	PST	By:	TestUser, ICU-Nurse
Unchart to 'In Er	ting this form v ror'	will change the sta	atus of all the re	esults associa	ated with this form
Comment:					
Wrong Powerf	orm)				
					3

Uncharting the form will change the status of all the results associated with the form **In Error**. A redstrike through will also show up across the title of the **PowerForm**.

All Forms						
🖶 🗁 Wednesday, 22-November-2017 PST						
	estORD, Nurse					



A document can be uncharted if needed.

An uncharted document will show up as In Error in the Form Browser



PATIENT SCENARIO 8 – Review and Complete Tasks in CareCompass

Learning Objectives

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

- Understand what tasks are
- Navigate to the task list in CareCompass
- Review and complete tasks through documentation

SCENARIO

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

- Navigate and review tasks in CareCompass
 - Document completed tasks by using PowerForms and iView



Activity 8.1 – Review and Complete Tasks in CareCompass

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 the clinician to complete specific patient care activities. They are meant to supplement your current paper to-do list and represent activities that are outside of regular care.

Note: Not all orders will trigger a task. For example, collecting a sputum sample is tasked as it is not a regular occurrence, whereas vital signs are part of basic daily care and therefore are not tasked.

Let's locate tasks on your patient:

- 1. Clicking **CareCompass** button **CareCompass** in the Toolbar navigates you back to **CareCompass**.
- 2. Scheduled tasks for multiple patients are summarized in the Activity Timeline.
- 3. Hover over the patient's name and the **grey forward arrow** icon appears. Click the same icon to open the single patient task list.
- 4. Review the tasks for your patient in the task box.

Task Edit View	Patient Chart Links Navigation Help									
🗱 CareCompanser 🧃 ulteader Organizer 🛓 Patient list 🖴 Multi-Patient Task list 🔣 Discharge Dathboard 📾 Staff Assignment 🎬 Learning LIVE										
🔯 Care-Connect 💭 matrixes 🖄 VCH and PHC PACS 🕲 NUSE 🕲 Formizes Wit 🔄 🗐 Adriece 📾 Medication Administration 🖕 PM Conversation + 🗋 Medical Record Request + Add + 📆 Documents 🎆 Scheduling Appointment Book 🔐 Discom Reporting Portal										
C Petient Health Education Materials & Policies and Guidelines & UpToDate										
CSTLEARNING, D	DEMOALPHA 💌 CSTLEARNING, DEMOTHETA 💌					CSTPRODOST, JL	STINE • Mi Recent • Name			
CareCompass						(C)	Full screen 🛛 🗇 Print 🛛 🗞 4 hours 58 minut			
的目前目	🔍 🔍 100% 🔹 🌑 🌑 🏠									
Patient List: Lori	S 💌 💥 List Maintenance 🛛 💠 Add Patient 🛛 💰 Establish Relationships						(i) 0			
Location	Patient	CSTPRODOST, JUSTINE	Age: 26yrs	Sex: F	DOB: 01/19/1991	MRN: 700002377	Encounter #:			
-	CSTPROD, CHECK EMPI						700000003771			
	17yrs F No Allergies Recorded	Scheduled/Unscheduled PRN/Cont	tinuous Plans of Care Patient Informatio	n						
DAGU 1 . 27	COTRADOCT NUTTING	🖌 🖸 🗊 📝 🛛 2 Hours	4 Hours 12 Hours							
PAC0 1 - 27	26yrs F	Current								
	No Known Allergies	Vrinalysis Macroscopic (dipstic)	Winalysis Macroscopic (dipstick) with Microscopic Nurse Collect Urine, Routine, Unit collect, Collection: 2017-May-10 10:56 PDT, once							
619 - 01	LINESTUBESDRAINS, KATHY	Unscheduled								
	9m 2w F No Known Allergies	Medication History								
201 0114		18:00 (No Activities)								
301-01M	32yrs M	Interdisciplinary (No Activities)								
	Allergies									
Activity Timeline										
		1								
							Done Not Done Doc			
Overdue	17:00 18:00 19:00 2						4			

² The task box contains different tabs which help to categorize patient tasks.

To see different information you can navigate to:

1. Scheduled/Unscheduled tasks tab


- 2. PRN/Continuous tab
- 3. Plans of Care tab
- 4. Patient Information tab

When a patient is admitted, the Clinical Information System (CIS) generates multiple admission tasks. These tasks are tailored to patient's age and location. **Basic Admission Information Adult** is one of these tasks. Let's complete this task by documenting:

5. Select Basic Admission Information Adult

6. Click **Document** button

CareCompass	👫 Clinical Leader Organizer 🎍 Patient Li	st 🚨 Multi-Patient Task List 👫 Discharge	Dashboard 🚉 Staff Assignment 🌇 LearningLWE 💡		
; C PACS C Form	Fast WFI 🛫 🕄 🎝 Exit 🦉 AdHoc 🎟 Med	ication Administration 🔒 PM Conversation	🔹 🛁 Communicate 👻 🔄 Medical Record Request. 🌩 Add 👻 🕞 Documents. 😂 Scheduling Appointment Book. 🕍 Discern Reporting Portal 🖕		
CSTLEARINING, I	JEMUALPHA		CSTLEANNING, DEM	The content of the co	ame
CareCompass				U, Full screen C	to minutes a
		7.40			
Patient List: Pra	tice List **	🖞 📉 List Maintenance 🛛 🛉 Add Patier	t 🦨 Establish Relationships		😝 3 😡
Location	Patient		CSTLEARMING 1 DOE:01/01/1937 H81:700008217	Encounter #: 7000000015060	0
620 - 02	CSTLEARNING, DEMODELTA 80yrs M - No Allergies Recorded -	·	Scheduled/Unscheduled PRIV/Continuous Plans of Care Patient Information		
624 - 02	CETLEADNING DEMOALDUA		2 Hours 4 Hours 12 Hours		
064 - 06	80yrs M		Current		*
624 - 03	No Known Allergies		Basic Admission Information Aduit Basic Admission Information 17-Nov-2017 14/28 PST, Stop: 17-Nov-2017 14/28 PST Comment: Order entered secondary to inpatient admission.		
	80yrs M Allergies	٩	Amission History Adult 17-Hov-2017 14-28 PST. Stop: 17-Nov-2017 14-28 PST Comment: Order entered secondary to inpatient admission.		
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M		Braden Assessment 17-Nov-2017 14:28 PST, Sisop 17-Nov-2017 14:28 PST Comment: Order entered secondary to inpatient admission.		
	Allergies -		Infectious Disease Screening 17-80w-2017 14.28 PBT Comment: Order entered secondary to inpatient admission.		
			Morse Fall Risk Assessment Norse Fall Risk Scale 17-Nov-2017 14.28 PST, Stop: 17-Nov-2017 14.28 PST Comment: Order entered secondary to inpatient admission.		
			Unscheduled		
			Valuables and Belongings		
			Admission Discharge Outcomes Assessment		
			15:00 (No Activities)		
			Interdisciplinary (No Activities)		_
Activity Timeline					
				Done Not (6 Document
Overdue	14:00	15:00 16:00			

Note: If a task is associated with documentation, clicking **Document** button takes you directly to the appropriate documentation within the patient's chart, either in iView or to a PowerForm. Basic Admission Information Adult is a PowerForm.

3 Once you click **Document**, the **Basic Admission Information** PowerForm will pop up. This form is used to document a patient's allergies, weight, and home medications.

Note: Patient information that stays relatively static may be pre-populated throughout the chart if it was previously entered by another clinician and will be populated within the PowerForm. In this case, allergies and weight are populated as they may have been entered in ED.



To complete this PowerForm:

- 1. Review the allergies and select Mark All as Reviewed
- 2. Select Weight and review the previously documented weight of 75kg.

P Basic Admission In	Information - CSTLEARNING, DEMODELTA		
🗸 🖬 🚫 🔌 🕅	🛿 🛧 🗢 🖾 🔛		
*Performed on: 20-	0-Nov-2017 💌 💌 1537 💽 PST		By: TestUser, Nurse
Alergies 2	Allergies		^
Weight Medication Histor			
1	Mark All as Reviewed		
_	Add Modify O No Known Allergi	es 🖓 No Known Medication Allergies 🔗 Reverse Allergy Check Display All	_
	D/A Substance	Category Severity Reactions Interaction Comments Source Reaction	tion Statu:
	Ho klown Alergies	Didy Acit	
		**	
	•	III.	4
4	<		•
			In Progress

1. Select Medication History

4

- 2. Review current medications that are ordered for your patient.
- 3. Click the **Sign** ✓ icon. After signing the **PowerForm**, you will be brought back to CareCompass.





4. Click **Refresh** icon to update the CareCompass. You will find the **Basic Admission Information** task has been removed from the patient's task list after completing the documentation.

Validate, IP-CriticalCareNurse	Validate, IP-CriticalCareNurse 👻 🌆 Recent 🗙 Name 💌
CareCompass	□ Full screen 4 😵 O minutes a
A	kô
Patient List: test 💌 💥 List Maintenance 💠 Add Patient	🔹 Establish Relationships 🕴 6 💿
Location Patient	Validate, IP-CriticalCareNurse Age: 41yrs Sex: M DOB: 01/13/1977 MRII: 760000659 Encounter #: O
7EL - 06 A Validate, IP-CriticalCareNurse 41yrs M Attempt CPR, Full Code Attempt (PA)	Scheduled/Unscheduled PRII/Continuous Plans of Care Patient Information
Aleigies NPO	
	Intensive Care Delinium Screening Checklist 2018-Jan-14 06:00 PST, to be done at 06:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00 and as needed Instruction; to be done at 06:00 and 10:00
	Arternal Blood Gas Nurse Collect Whole Blood, Urgent, Unit collect, Collection: 2017-Dec/27 12:14 PST, once Commont: SPECIAL COLLECTION PEOLIDENELITS: Please refer to essentia calculational Tool Monute
	Done Not Done Document

Note: An accurate and comprehensive medication history is needed before medication reconciliation can be completed by the provider. This is known as the Best Possible Medication History (BPMH). For patients admitted from the ED, a pharmacy technician will complete the BPMH where possible. Where a pharmacy tech is unable to do so, the BPMH may need to be completed by the admitting nurse. Please refer to the BPMH Quick Reference Guide for detailed instructions on how to complete this when necessary.

5 Let's complete another admission task

Complete Braden Assessment task:

- 1. Select Braden Assessment task
- 2. Click **Document** button Document

Note: If a task is associated with documentation, clicking **Document** takes you directly to the appropriate documentation within the patient's chart. Braden Assessment is documented in Interactive View and I&O (iView).



	d Patient 🗳 Establish Ratifornitipe					•	3
	LEARNING, CRITICALCARE	Aper-41ym	Sec.10	008:10/05/1976	HBN: 700007928	Crickenter #: 2000000013164	
	C Scheduled/Unecheduled PR00/Continue	NE Plane of Care Patient	t Information				
	P 🗅 🗇 🗭 🔹 2 Hours	4 Hours 12 Hours	n				
	Carrent						
	Basic Admission Information Adult	Tasic Admission Information (2)	7-Nov-2017 98:35 PST, 0	og: 07-Nov-2017 08:35 PST			
•	Administra History Adult 07-Nov-201 Comment: Order entered seconds	7 09:35 P0T, Blog: 07-Nov-201 vy to inpatient admission.	7 09:35 P97				
	1 Breden Assessment 07-90v-2017 0 Comment Order entered second	9.35 PST. Stop. 07-Nov-2017 O ry to impatient admission	0.35 PST				
	Intectious Disease Screening 07-M Commant: Order entered seconds	w2017 0935 PST ry to inputient admission.					
	Blood Culture (Blood Culture x2) fau Comment: SPECIAL COLLECTION	se Collect Blood, Urgent, Unit VREQUIREMENTS: Playou ref	Collect, Collection: 07-Ho er to specific site Laborat	v2017 13:03 PST, once sty Test Manual			
	Blood Culture Nurse Collect Blood, C Comment: BPECIAL COLLECTION	irgent, Unit Collect, Collection (REQUIREMENTS: Please ref	07.44ov-2017 13.04 PST. er to specific site Laborat	ince iry Test Manual.			
	Unscheduled						

3. Double click the blue box to the right of the section name **Braden Assessment**. A check mark inside the blue box will appear , and the section is now active for documentation. You can move through the cells by pressing **Enter**.

Document using the following data:

- Sensory Perception Braden = Slightly Limited
- Moisture Braden = Occasionally moist
- Activity Braden = Bedfast
- Mobility Braden = Very limited
- Nutrition Braden = Very poor
- Friction and Shear Braden = Potential problem
- Braden Score = 12 (automatically calculates)
- Braden Interventions Initiated = Yes
- 4. Click the **Sign** ✓ icon. You will notice that your documentation changes from purple text to black text once signed.





Note: When text appears in blue it means there is a hyperlink attached. Clicking on the hyperlink opens a window that provides additional information to clarify or support documentation decisions.

6 Let's complete one final task. You have collected a urine sample from your patient.

- 1. Navigate back to CareCompass by clicking **CareCompass** button **Section** in the Toolbar
- 2. Hover over the patient's name and the **grey forward arrow** icon appears. Click the same icon to open the single patient task list.
- 3. Select Urine Culture (Urine C&S)
- 4. Click **Done** button Done.
- 5. A **Nurse Collect (Chart Done)** box appears. Fill in date and time that urine culture is collected and then click **OK**. After clicking OK, the Urine Culture task is removed from the patient's task list.

Task Edit View Patient Chart Links Navigation Help
👫 CareCompass 1 nical Leader Organizer 🖕 Patient List 🎎 Multi-Patient Task List 🎎 Staff Assignment 🎼 LearningLUX 🗒 🛱 CareConnect 🛱 PHSA PACS 🛱 VCH and PHC PACS 🛱 MUSE 🚳 FormFast WFI 💡
🔄 Exit 🔮 AdHoc 📲 Hedication Administration 🔮 PM Conversation 🔹 🗿 Medical Record Request 💠 Add 🔹 📻 Documents 🏙 Scheduling Appointment Book 📾 Discent Reporting Portal 💽 HAware 🖕
🖸 🔯 Patient Health Education Materials 🖏 Policies and Guidelines 🖏 UpToDate 💡
Validate, IP-CriticalCareNurse - Minecent - Name - Validate, IP-CriticalCareNurse - Minecent - Name -
🖸 Full screen 🗍 Print 🕹 0 minutes
Patient Latz test 🔍 📉 Kat Maintenance 🕂 Add Patient 💰 Establish Relationships 🕹 6 🥥
Location Patient Validate, IP-CriticalCareNurse Age:413ys Sec:M D08:01/13/1977 H81:76000059 ZB000000059 ZB000000089 ZB0000000059
78L-06 ▲ Valkate, IP-CriticalCareNurse Alysis IN Attempt CPR, Eli Code
Alergies NPO
V III Collect (Chart Done) - Validate (JP-Critical CareNuise
2 Date/Time: 15-Jan-2010 1 1 1 1 1 2 1 2 1 PS1
Comme Performed by: TetUser. ICUNurse
5 OK Cancel
septic short
Arterial Blood Gas Nurse Collect Whole Blood, Urgent, Unit collect, Collection: 2017-Dec-27 12:14 PST, once
Comment: SPECIAL COLLECTION REQUIREMENTS: Please refer to specific site Laboratory Test Manual.
Respiratory (lower) Culture (Sputum Culture) Nurse Collect Tracheal Aspirate, Urgent, Unit Collect, Collection: 2917-Dec 27 12:14 PBT, once
If Unine Culture Nurse Colled Unine Indivelling catheter, Routine, Unit Collect, Collection 2018-Jan-15 15:00 PST, once Comment: SPECIAL COLLECTION REQUIREMENTS: Please refer to specific site Laboratory Test Manual. 3
Unscheduled
C Valuables and Belongings
Admission Discharge Outcomes Assessment
Done 4 one Document
Activity Timeline

Note: For the purpose of this workbook, the additional Admission tasks will not be addressed in this workbook but will need to be completed in your clinical setting. It is important to review CareCompass and patient task lists throughout your shift to view new orders and results, tasks and more.

Key Learning Points
Tasks are electronic notifications that alert nurses to patient-related activities that require completion.
Tasks can be viewed and completed within CareCompass by clicking "Document" or "Done".
Completion of a task will remove the task from the patient task list.
CareCompass should be reviewed throughout the shift.



PATIENT SCENARIO 9 - Document an Allergy

Learning Objectives

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

Document an Allergy

SCENARIO

Your patient is sedated, so you verify his allergy status with his wife. She mentions that her husband is allergic to eggs as he usually develops a mild rash.

As a critical care nurse you will be completing the following activity:

Add an allergy to the patient's chart



🔹 Activity 9.1 – Add an Allergy

To document an allergy:

1

1. Navigate to the Allergies section of the Menu and click + Add

E CareCompass M Clinical Lead	r Organizer 🤵 Patient List 🚘 Multi-Patient Tas	k List 🚉 Stall Assignme	nnt 15 Learnin	gLIVE 📮	CareConnect Q PHSA	ACS Q VCH	ind PHIC PACS	NJSE 📿 FormFast V	NFI			
Tear Off n Exit MAdHos II	IMedication Administration 🔒 PM Conversation	• 🔄 Medical Record R	Request 🕂 Ad	d . Doci	uments 🗂 Scheduling App	intment Book	🔄 iAmpre 🔒 Discer	n Reporting Portal				
Patient Health Education Mater	als Q Policies and Guidelines Q UpTeDate											
LEARNING, CRITICALCARE	0	-								← Liz → 降	Recent - Name	- 0
LEARNING, CRITICALCARI	MRN/700007920 Code Status:Attempt CPR, Full Code Enc/200000013164				1	Process:Difficult Intubation/Airway Disease:			Location:LGH ICU: IC04; 01 Enc Type:Inpatient			
Allergies: Adhesive Bandage, L	itex, No Known M Gender Male	PHN:9876487657	Dos	ng Wti75 k			solation:		Atten	ding:TestUser,	CriticalCare-Physi	ian, MD
Menu	Allergies									O Full s	reen 💮Print	0 minutes ap
Patient Summary	*											
Orders + Add	Mark All as Reviewed											
Orders 🔶 Add Single Patient Task List	Add 1 dify O No Known	Allergies QNo Kno	wn Medication	Allergies	Reverse Allergy Check	Display	All •					
Orders + Add Single Patient Task List MAR	Add 1 dily O No Known	Allergies 🖓 No Kno	own Medication	Allergies	Reverse Allergy Check	Display	- IIA					
Orders + Add Single Patient Task List MAR Interactive View and 1840	Mark All as Reviewed Add Add One Known One Substance	Allengies QNo Kno	wn Medication	Allergies Reactors	Reverse Allergy Check	Display ts Source	All • Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By	1
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Orders + Add Single Patient Task List MAR Interactive View and I&O Results Review Documentation + Add	Mark All as Reviewed Add 1 dey O No Known 0. Substance Adhesive Bandage Latex No Known Molication Allergies	Allergies No Kno Category Other Other Drug	own Medication Severity Moderate	Allergies Reactors	Reverse Allergy Check	Display ts Source Family	All • Reaction Status Active Active	Reviewed 15-Nov-2017 1 15-Nov-2017 1 15-Nov-2017 1	Reviewed By TestUser, ICU-Nurse TestUser, ICU-Nurse TestUser, ICU-Nurse	Est. Onset	Updated By 08-Nov-2017 - 14-Nov-2017 - 07-Nov-2017 -	
Orders + Add Single Patient Task List MAR Interactive View and 38:0 Results Review Documentation Medication Request	Mark All as Reviewed Add 1 dify O No Known 0. Substance Adhesive Bandage Later No Known Medication Allergies Strawberries	Allergies Q No Kno Category Other Other Drug Food	own Medication Sevenity Moderate	Allergies Reactors	Reverse Allergy Check	Display ts Source Family	All • Reaction Status Active Active Active Active	Reviewed 15-Nov-2017 1 15-Nov-2017 1 15-Nov-2017 1 15-Nov-2017 1	Reviewed By TestUser, ICU-Nurse TestUser, ICU-Nurse TestUser, ICU-Nurse TestUser, ICU-Nurse	Est. Onset	Updated By 08-Nov-2017 14-Nov-2017 07-Nov-2017 07-Nov-2017	
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Onders ♦ Add Single Patient Task Lut MAR Interactive View and MoO Results Review Documentation ♦ Add Medications Reverst Hataopies ♦ Add	Mark & a Roberton Ads 1 dry No Known C. Substance Attricive Bandage Lite: No Known Medication Altergies Strawberries	Allergies Ro Knr Category Other Other Drug Food	swn Medication Severity Moderate	Allergies Reactions	Reverse Allergy Check	Display ts Source Family	All Reaction Status Active Active Active	Reviewed 15-Nov-2017 1 15-Nov-2017 1 15-Nov-2017 1	Reviewed By TestUser, ICU-Nurse TestUser, ICU-Nurse TestUser, ICU-Nurse TestUser, ICU-Nurse	Est. Onset	Updated By 08-Nov-2017 - 14-Nov-2017 - 07-Nov-2017 - 07-Nov-2017 -	

2. Enter in the **Substance** field type = *Egg* and click the **Search** icon ^(M). Please note yellow fields including **Substance** and **Category** are mandatory fields that need to be completed.

Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By	
Adhesive Bandage	Other	Moderate				Family	Active	15-Nov-2017 1	TestUser, ICU-Nurse		08-Nov-2017	
Latex	Other						Active	15-Nov-2017 1	TestUser, ICU-Nurse		14-Nov-2017	
e Allergy - Ana bstance 2 xt	dverse reaction to a drug or :	substance wł	iich is due to an immu	nological respor	nse.						Add	Com
action(s)	*Severity	Info	source	Comments		•						
Add Free Text	<not entered=""></not>	✓ <nd< p=""></nd<>	ot entered>			h						
	At: <not entered=""></not>	Ons	et: <not entered=""></not>									
	Years	v	13,0000 🔺 💌									
	Recorded on behalf o	f *Cat	tegory	Status	Re	ason:						
			•	Active	•	~						

3. The Substance Search window opens. Select Egg (Code 3000251165) and click OK.





- 4. In the Reaction(s), repeat step 2 and 3. Type Rash and Search Rash(Code 82559)
- 5. In the **Severity** drop-down = *Mild*
- 6. In the **Info source** drop-down = *Family*
- 7. In the **Category** drop-down = *Food*
- 8. Click OK

4	<	> 🝷 🔒 Allergies										[0] Full scree	n 💼 Print	€ 14 minutes
4	_					_								
		0. Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By	^
11		Adhesive Bandage	Other	Moderate				Family	Active	15-Nov-2017 1	TestUser, ICU-Nurse		08-Nov-2017	
		Latex	Other						Active	15-Nov-2017 1	TestUser, ICU-Nurse		14-Nov-2017	· ·
E		Type Alergy An advers *Substance Egg Substance Egg Free text Reaction(s): Reaction(s): Add Free Text 4 Up Add Home Reaction	Recorded on behalf of Folders Folders	substance while is available for info to info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info info	ich is due to an immu r nor-Multum allergies source t entered: 6 it entered: 6 it on tentered: egory 7	Comments Comments Status Active	nse. Re	vason:				ок 8	Add	Commert

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

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

LEARNING, CRITIC	ALCARE 🛛 🕨	3						+	🔹 List 🔿 🌾 Recent 👻 Nar	me - Q
LEARNING, CRITIC	ALCARE	DOB:01-Oct-1976	MRN:700007920	Code Status:Attempt C	CPR, Full Code	Process:Diff	icult Intubation/Airway	Locati	on:LGH ICU; IC04; 01	
Allersies Adhesive Re	udana Ena I	Age:41 years	Enc:700000013164	Desing MB/75 kg		Disease:		Enc Type:Inpatient Attending:TestLicer, CriticalCare-Physician, MD		
Allergies. Autresive ba	nuaye, cyy, c	atex, No Kno., Gender.Male	PHIN.9670467037	Dosing ways kg		ISUIAUUII.		Atteriu	ing, restoser, critical care-en	
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MAR										
Interactive View and I&O		D. Substance	Category S	everity Reactions	Interaction Comments	Source Reaction	Status Reviewed	Reviewed By	Est. Onset Updated By	
		Adhesive Bandage	Other !	/loderate		Family Active	15-Nov-2017 1	TestUser, ICU-Nurse	08-Nov-2017	7
Results Review		Egg	Food 1	vlild		Family Active	30-Nov-2017 1	TestUser, ICU-Nurse	30-Nov-2017	7
Documentation	🕂 Add	Latex	Other			Active	15-Nov-2017 1	TestUser, ICU-Nurse	14-Nov-2013	7
Medication Request		No Known Medication Allergies	Drug			Active	15-Nov-2017 1	TestUser, ICU-Nurse	07-Nov-2017	7
Histories		Strawberries	Food			Active	15-Nov-2017 1	TestUser, ICU-Nurse	07-Nov-2017	7
Tilstones										
Allergies	Add									
Diagnoses and Problems										

Key Learning Points

- Documented allergies are displayed in the Banner Bar for all who access the patient's chart
- Allergies will display with the most severe allergy first
- Yellow fields are mandatory fields that need to be completed



PATIENT SCENARIO 10 – Placing a Process Alert

Learning Objectives

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

Utilize PM Conversation to place a process alert

SCENARIO

From the handover report from the ED nurse, you are told it took three attempts to intubate the patient. You also notice an order in the patient's order profile for Difficult Airway/Intubation. A task also appears on the patient's activity/task list in CareCompass to place a process alert for Difficult Airway/Intubation. You need to enter a Difficult Airway/Intubation Alert so that everyone on the ICU team is aware.

In this scenario, you will be completing the following activity:

Place a Difficult Airway/Intubation process alert through PM Conversation



Activity 10.1 – Place a Process Alert

Patient Management Conversation (PM Conversation) provides access to manage alerts, patient location, encounter information and demographics. Let's look at how alerts are managed.

Within the system, process alerts are flags that highlight specific concerns about a patient. These alerts display on the banner bar and can be activated by any clinician including nurses.

Since the patient has a difficult airway, a **Difficult Airway/Intubation** process alert should be added to the patient's chart. To do this:

- 1. Click **CareCompass** button Figure CareCompass in the Toolbar to navigate back to **CareCompass**.
- 2. Click the **grey forward arrow** to the right of your patient's name to open the single patient task list.
- 3. Scroll down and you will find the Add Difficult Airway/Intubation Alert task.

Note: This task acts as a reminder for you to complete an activity. You need to add the Difficult Airway/Intubation Alert before you can complete the task.

CareCompass			(2) Full screen 🛛 Trimit 🔹 9 minutes ag								
ABIBB	🔍 🔍 100% 🔷 - 🌰 🌰 🙆										
Patient List: C	ustom Test JIRA 8365 💌 🔀 List Maintenance	💠 Add Pa	atient 🖸 Establish Relationships 🛛 🥹 2 🔮								
Location	Patient		CSTLEARNING, DEMOTHETA Age: 80yrs Sex: M D08: 01/01/1937 MRI: 700008216 Encounter #: 0								
1009 - 01	CSTLABAUTOMATION, TSADRIEN 50yrs F Allergies		Scheduled/Unscheduled PRU/Continuous Plans of Care Patient Information								
406 - 01	CSTLEARNING, DEMOTHETA 80yrs M Attempt CPR, Full Code Allergies General Diet	•	Comment MEWS citteria: 04 December; 2017 14:100 PST Respiratory Rate = 22 (2 point								
🐨 ACWR	SEPSIS, GUY Soyrs Undifferentiated No Known Allergies	2	Unscheduled Valuaties and Belongings								
			Admission Discharge Outcomes Assessment								
			16:00								
Artists Tonale a		_	Intensive Care Detirium Screening Checklist (CDSC) Intensive Care Detirium Screening Checklist 08-Dec-2017 16:00 PST, To be done at 0600 and 1600 and as need Instruction: To be done at 0600 and 1600 and as needed.								
ACONCY TIMEINE			Interdisciptinary								
			RT to Insert Arterial Line 08-Dec-2017 12:18 PST								
Overdue	15:00 16:00	17:00									



4. To add a Process Alert, you need to return to the patient's chart. Click the patient's name in the banner bar. Notice the patient's chart is still open.



- 5. Click the drop-down arrow to the right of **PM Conversation** button ^{A PM Conversation} in the toolbar
- 6. Select **Process Alert** from the drop-down menu

Task Edit View Patient Chart	Links Navigation Help								
👫 CareCompass 👫 Clinical Leader Org	anizer 🎍 Patient List 🔛	Multi-Patient Task List	ssignment 🌇 Le	arningLIVE	A PACS 🔕 VCH and	PHC PACS 🖏 MUSE 🔍 FormFast WFI			
Tear Off 📲 Exit 🎦 AdHoc 💵 Med	ication Administration	PM Conversation 5	Record Request	🕈 Add 🔹 🛅 Documents 🗂 Scheduling Ap	opointment Book 🔄	iAware 🔒 Discern Reporting Portal			
Q Patient Health Education Materials	Policies and Guidelin	Bed Transfer							
CSTDEMO, ZEUS	CSTDEMO, ZEUS						+	ist 🔶 隆 Recent - Name	- Q
CSTDEMO, ZEUS DOB Age: Cancel Pending Discha			80 13571	Code Status:Attempt CPR, Full Code	Pro Dise	cessFalls Risk ease:	Location Enc Type	LGH ICU; IC06; 01	
Allergies: Egg, cloNIDine, Adhesive Bandage, BanGen Discharge Encounter			i95 Dosing Wt:75 kg Isola			ilation: Attending:Plisvca, Rocco, MD			
Menu 9	K 🤉 - 🏦 P	Facility Transfer						(0) Full screen 👘 Print	20 minutes ago
Patient Summary	ABIBBIS	Leave of Absence							
Orders 🕂 Add	Handoff Tool	Pending Discharge		52 Autestment 52	Discharge	57 Ouerk Orders	22 1		9 (-
Single Patient Task List		Pending Transfer			Provide Br.	Contraction of the second second	~ T		
MAR	Informal Team	Print Specimen Labels		inication					
Interactive View and I&O	Communication	Process Alast	6	111080011					1×1
Results Review	Active Issues	Update Patient Information				Add new comment			
Documentation 🕂 Add	Allergies (4)	View Encounter							
Medication Request	Vital Signs and Mea	View Person	ented			No comments documented			



The **Organization** window will display to select a location.

1. In the Facility Name field, type = *LGH Lions Gate* and press Enter on your keyboard

Note: Alternatively, you may type *LGH* and use **Search** icon — to look for the full name of the facility.

2. Select LGH Lions Gate Hospital

3. Click OK

🚯 Organization
Please select the facility where you want to view person aliases.
Facility Name Facility Alias
LGH Lions Gate 1
LGH Lions Gate Hospital 2
Facility:
LGH Lions Gate Hospital
3 OK Cancel

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

- 1. Click on the empty **Process Alert** box. A list of alerts that can be applied to the patient will display. (This box will be empty until you click on it).
- 2. Select Difficult Intubation/Airway
- 3. Click Move. The alert will now display within the To Selected box
- 4. Click **Complete**

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

Process Alert				- • •
Medical Record Number: 700004780	Encounter Number:	Last Name: CSTDEMO	First Name: ZEUS	Middle Name:
Preferred Name:	Previous Last Name:	Date of Birth: 01-Feb-1979	Age: 38Y	Gender: Male
BC PHN: 9876810595				
ALERTS Process Alert:				
From Available:	ToS	Selected:		
Cytotoxic Tytockic Gender Seatitvity No Celling Lift Rn Research Study	Telect All			
				4 Complete Cancel



- 3
- 1. Click **Refresh** icon **to** update the chart
- 2. Once complete, the process alert will appear within the banner bar of the chart where it is visible to all those who access the patient's chart.

		🔶 List 🔿 📠 Recent 🗸 Name 🛛 🗸 🔍
)de	Process:Difficult Intubation/Airway 2	Location:LGH 4E; 406; 01
	Disease:	Enc Type:Inpatient
	Isolation:	Attending:SYSTEM, SYSTEM Cerner
		(그) Full screen 🛛 📄 P 🚺 🎅 0 minutes ago



Now you need to go back to CareCompass to complete the task:

- 1. Click **CareCompass** button **CareCompass** in the Toolbar to navigate back to **CareCompass**.
- 2. Click the **grey forward arrow** to the right of your patient's name to open the single patient task list.
- 3. Scroll down and click to highlight the Add Difficult Airway/Intubation Alert task.
- 4. Click Done

CareCompass			🗐 Full screen 👘 Print	€ 0 minutes ago
	🔍 🔍 100% 🔷 🌑 🖷 🕍			
Patient List: C	ustom Test JIRA 8365 🔽 💥 List Maintenance	💠 Add Pa	atient 🤹 Establish Relationships	2 🥹
Location	A Patient		CSTLEARNING, DEMOTHETA Age: 80yrs Sex: M DOB: 01/01/1937 MRN: 700008216 Encounter #: 700000015058	8
IC09 - 01	CSTLABAUTOMATION, TSADRIEN 50yrs F Allergies		Scheduled/Unscheduled PRIV(Continuous Plans of Care Patient Information	
406 - 01	CSTLEARNING, DEMOTHETA 80yrs M Attempt CPR, Full Code Allergies General Diet	• <	Comment MEWS Criteria: 04 December; 2017 14:14:00 PST Temperature Axillary = 38 (1 point(s)) 04 December; 2017 14:14:00 PST Respiratory Rate = 22 (2 point)	t
🛞 ACWR	SEPSIS, GUY 50yrs Undifferentiated	2	Unscheduled	
	No Known Allergies		Admission Discharge Outcomes Assessment	
			16:00	
Activity Timoloo			Intensive Care Delirium Screening Checklist (ICDSC) Intensive Care Delirium Screening Checklist 08-Dec-2017 16:00 PST, To be done at 0600 and 1600 and as ne Instruction: To be done at 0600 and 1600 and as needed.	ed
Accivicy filleline			Interdisciplinary	
			RT to Insert Arterial Line 08-Dec-2017 12:18 PST	*
			Done 4 Done	Document
Overdue	15:00 16:00	17:00		

5. An **Add Difficult/Intubation Alert** window will pop up to ask you to enter the correct date/time when the task was completed. Confirm the fields are correct and click **OK**.





Congratulations! You have added a Difficult Airway/Intubation process alert and completed the task through CareCompass! The task no longer appears on the task list.

Key Learning Points

- Process Alerts are important in alerting staff members to specific concerns related to the patient
- Use refresh after adding an alert to confirm it has been added to the patient's banner bar



PATIENT SCENARIO 11 - Orders

Learning Objectives

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

- Review Orders Page and Place Orders
- Complete an Order
- Review the General Layout of a PowerPlan

SCENARIO

As a critical care nurse, 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. To do so you will complete the following activities:

- Review the Orders Profile
- Place a no-cosignature order
- Review order statuses and details
- Place a verbal order
- Complete an order
- Review components of a PowerPlan



Activity 11.1 – Review Orders Profile

1 Orders Profile is where you access a full list of patient's orders for review. To navigate to Order Profile:

- 1. Select Orders from the Menu
- 2. The Navigator (**View**) band is located on the left side of the Orders profile page. It includes several categories including:
 - Plans
 - Categories of Orders
 - Medication History
 - Reconciliation History
- 3. On the right side is the Order Profile where you can:
 - Review the list of orders

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

Some examples of icons are:

- Grder for nurse to review
 - Additional reference text available
 - Order part of a PowerPlan
- Order waiting for 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.

Menu	4	< 🖂 🕂 Orders						🗇 Full screen 🛛 👼 Print	₽ 0 minutes ago
Provider View		+ Add Record	liation 🛪 👌 Check Interac	rtions				Reconciliation Status	
Results Review			autori - 0 - crieck interio					Meds History 1 Admissio	n 😗 Discharge
Orders	+ Add	Orders Medication List Document In Plan							
Medication List	+ A 4								
Documentation	1	View	Displayed: All Active Order	s All Inactive Orders All Active Orders*					w More Orders
Cocumentation		Orders for Signature		Order Name	Status	Doce Details X	Stop	Ordering Physician	1.0
		Plans	4 Admit/Transfor/Dis	sebaras	50003	DOSE DECONS	Joop	ordening Physician	
Allergies	🕂 Add	- Document In Plan		Admit to Innatient	Ordered	04-Dec-2017 10-15 PST. Admit to General Internal Medicine. Admitting provider: TestORD	04-Dec-2017 10:15 PST	TestORD GeneralMedicine-	Physici Te
Diagnoses and Problem		Medical	⊿ Status	Harne to apparent		of becault 2012 1 212 1 21, Harme to denote theme meaning portion reaction,			ingarcian re
		MED General Medicine Admission (Validated) (P	🥀 🗹 🖬 🛛	Code Status	Ordered	24-Oct-2017 13:24 PDT, 5-No CPR, Critical Care, May Intubate, Perioperative status: Attem	p	eLearn, Physician-General M	Aedicin eL
Histories		Gi General Admission (prototype) (Initiated)	⊿ Patient Care						
MAR Summary		Suggested Plans (0)	💮 💆 👘	Insert Peripheral IV Catheter	Ordered	24-Oct-2017 13:24 PDT, Unless already in place	24-Oct-2017 13:24 PDT	eLearn, Physician-General M	Aedicin eL
MAR		Admit/Tennefor/Direbaran		Weight	Ordered	24-Oct-2017 13:24 PDT, Stop: 24-Oct-2017 13:24 PDT, On admission	24-Oct-2017 13:24 PDT	eLearn, Physician-General M	fedicin eL
<u> </u>		Statur		Vital Signs	Ordered	24-Oct-2017 13:24 PDT, q8h		eLearn, Physician-General M	fedicin eL
Form Browser		Patient Care		Admission History Adult	Ordered	24-Oct-201/13:1/PDT, Stop: 24-Oct-201/13:1/PDT	24-Oct-201/13:17 PD1	SYSTEM, SYSTEM Cerner	SY.
Patient Information		Activity	A v	Braden Assessment	Ordered	24-Oct-2017 13:17 PDT Store 24-Oct-2017 13:17 PDT	24-Oct-2017 13:17 PDT	SVSTEM SVSTEM Cerner	SV
Interactive View and 180		Diet/Nutrition		broch Assessment	oracica	Order entered secondary to inpatient admission.	24 000 2027 2027 10	or or one of or other the center	
Lines/Tubes/Drains Sum		Continuous Infusions	e 🖉	Basic Admission Information Adult	Ordered	24-Oct-2017 13:17 PDT, Stop: 24-Oct-2017 13:17 PDT	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	SY =
Growth Chart		- Medications	A M	Morse Fall Risk Assessment	Ordered	24-Oct-2017 13:17 PDT Stop: 24-Oct-2017 13:17 PDT	24-Oct-2017 13:17 PDT	SYSTEM SYSTEM Cerner	SY
		Blood Products				Order entered secondary to inpatient admission.			
Immunizations		Caporatory Discussion Tests	🕀 🗹	ED Readmission Risk	Ordered	24-Oct-2017 13:17 PDT, Stop: 24-Oct-2017 13:17 PDT	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	SY.
Clinical Research		Procedurer				Order placed due to patient being admitted as an inpatient in the last 30 days.			
CareConnect		Respiratory	⊕ ⊻	Infectious Disease Screening	Ordered	24-Oct-2017 13:17 PDT Order entered secondary to inpatient admission.	24-Oct-2017 13:17 PDT	SYSTEM, SYSTEM Cerner	SY
		- Allied Health	💮 🗹	Smoking Cessation Assessments	Ordered	03-Nov-2017 13:41 PDT	03-Nov-2017 13:41 PDT	TestCST, CardiothoracicSure	geon-P Te
		Consults/Referrals	💮 🗹	Insert Urinary Catheter (Insert Foley)	Ordered	03-Nov-2017 13:40 PDT, Indwelling	03-Nov-2017 13:40 PDT	TestCST, CardiothoracicSure	geon-P Te
		Communication Orders	⊿ Activity						
		Supplies		Activity as Tolerated	Ordered	24-Oct-2017 13:24 PDT		eLearn, Physician-General M	1edicin eL
		Non Categorized	△ Diet/Nutrition						
		Medication History	2 H	General Diet	Ordered	24-Oct-201/13:24 PD1		eLearn, Physician-General M	fedicin eL
		Medication History Snapshot	t Madiatian	Advance Diet as Tolerated	Urdered	US-NOV-2017 13:41 PDT, Advance diet to Regular, Provider must order starting diet. RN or I	L	TestCST, CardiothoracicSurd	Jeon-P le
		Reconciliation History	A Medications	acetaminophen (acetaminophen BPN	Ordered	dore more 225 to 650 ms PO, oth PPN psin mild or fever, downform tab, start 24, Oct-	,	el esto Physician-General	2
		Ζ.		range dose)	ordered	Maximum acetaminophen 4 g/24 h from all sources		Medicine1, MD	3



Key Learning Points

- The Orders page consists of the orders view (Navigator) and the order profile
- The Orders View displays the lists of PowerPlans (order sets) and clinical categories of orders
 - The Order Profile displays All Active Orders for a patient and can be filtered



Activity 11.2 – Place an Order

- 1 Throughout your shift, you will review your patient's orders. Nurses can place the following types of orders:
 - Orders that require a cosignature from the provider (e.g. telephone and verbal orders)
 - Orders that do not require a cosignature (e.g. order within nursing scope, Nurse Initiated Activities (NIA))

To place an order that does not require a cosignature (Nurse Initiated Orders):

1. Click Add button + Add in the Orders Profile.



- 2. The **Add Order** window opens. Type *ECG* into the search box and a list of choices will display
- 3. Select ECG 12 Lead STAT.





Note: An alternate way to look up orders is to click **Quick Orders** Tab in **Patient Summary**. Quick Orders Tab consists of orders organized in different categories. Further information about Quick Orders can be found in Quick Reference Guides.

The Ordering Physician window opens.

- 4. Type in the name of the patient's Attending Physician (Last name, First name)
- 5. Select No Cosignature Required and click OK





6. Click the **Done** button **Done**. You will return to the Orders Profile and see the order details.

ESTDEMO, ZEUS - Add Order			- 0 🛋
CSTDEMO, ZEUS DOB:01-Feb-1979 MRN:700004 Age:38 years Enc:7000000	780 Code Status:Attempt CPR, Full Citie	Process:Falls Risk Disease:	Location:LGH ICU; IC06; 01
Allergies: Egg, cloNIDine, Adhesive Ba, Gender:Male PHN:9876810	595 Dosing Wt:75 kg	Isolation:	Attending:Plisvca, Rocco, MD
Sewetz Advanced Options - Turer 👰 Inpatient			
tas 🖬 🛒 Y 🖾 🖏 🛶 Folder: Nursing Oldens Search within: 🗠			
Cardiology Orders	Rheumatology Orders		
Critical Care Orders	General Surgery Orders		
Dermatology Orders	Urology Orders		
Calendocrinology orders	Intraoperative		
General Medicine Orders			
Geriatric Orders			
Infectious Disease Orders			
Mental Health Orders			
Nephrology Orders			
Neurology Orders			
Neurosurgery Orders			
OB Orders			
Craft and Maxilotacial Surgery Orders			
Control pedic Orders			
Palliative Care Orders			
Pediatric and Newborn Orders			
Physical Medicine Rehab Orders			
Plastic Surgery Orders			
Respirology Orders			
			CSTDEMO, ZEUS - 70000 6 Done

- Some orders require you to fill out the details for ordering. Notice the Reason for Procedure field is yellow, meaning that it is a required field. Let's select Arrhythmia(s) from the Reason drop-down menu. Then click Sign button sign.
- 8. Click **Refresh** icon **to** update the Order Profile

Note: Do not tick the checkbox beside the order. This will change to proposed order. Proposed orders are inactive until reviewed and signed by physicians.

 < ↑ Orders ↑ Add ↓ Document Medication by Hx Reconciliation • ↓ 	Check Interactions	0 Full scree 8 t 25 minutes ag
		Meds History Admission Discharge Discharge
Orders Medication List Document In Plan		
K	Orders for Signature	
View	- A Order Name Status Start Details	
Orders for Signature *	⊿ LGH ICU; IC06; 01 Enc:7000000013571 Admit: 15-Nov-2017 15:09 PST	
Plans	⊿ Diagnostic Tests	
-Document In Plan	📕 🤁 Electrocardiogram 12 Order 30-Nov-2017 14:40 30-Nov-2017 14:40 PST, STAT, Reason: Anhythmia(s	
Medical		
TM Pad Blood Call (PBC) Transfurion (Module) (Val		
CICU General Admission Medical / Surpical (Validates		
ICU Insulin Infusion - Critical Care (Module) (Valid		
ICU Continuous Renal Replacement (CRRT) - Critica		
ICU Continuous Renal Replacement (CRRT) - Daily	▼ Details for Electrocardiogram 12 Lead STAT (ECG 12 Lead STAT)	
- Suggested Plans (0)	z otani a Electroardigi an l'E Ecua o l'Al (Ecua o l'Al)	-
Orders	Details III Order Comments	
Admit/Transfer/Discharge		
Patient Care	TTEL IN	
Activity	18 annual of Start Data (Terr 20 Mar 2017 A v 1440 A DOT Data by CTAT	
Diet/Nutrition	requested start bare hime:	-
Continuous Infusions	*Reason for Procedure (multi-sel Anhythmia(s) * 7 Special instructions:	
Medications *	Chest Pain	
Palated Parcitic	Ambythmia(s)	
Formulary Details	Dyspnea or Shortness of Breath	
Variance Viewer	0 Missing Required Details Orders For Palpitations	Sign
	Pre-operative evaluation	
	Other (please specify) PRODBC	TEST.NURSEICU Thursday, 30-November-2017 14:51 PST

Congratulations! You just placed an order for a STAT 12 Lead ECG!



Key Learning Points

- Nurses can place Nurse Initiated orders as **No Cosignature Required** Orders
- Some orders have required fields that need to be completed before the order can be signed.
- When **No Cosignature Required** is selected the order will not route to a provider for cosignature.



Activity 11.3 – Review Order Statuses and Details

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

S	7	Order Name 🔻	Status	Dose	Details
Status					
		MEWS Alert	Processing		
	>	Code Status	Ordered		30-Nov-2017 09:41 PST, Attempt CPR, Full Code, Perioperative status: Attempt CPR, Full Code, Du.
Patient	Care				
\checkmark	-	Weight	Ordered		30-Nov-2017 09:41 PST, Stop: 30-Nov-2017 09:41 PST, On admission, standing weight is preferred
		Vital Signs	Ordered		06-Dec-2017 12:51 PST, q4h
\checkmark	-	Pulse Oximetry	Ordered		30-Nov-2017 09:41 PST, q8h, with vital signs
\checkmark	*	Negative Pressure Wound Therapy	Ordered		30-Nov-2017 09:26 PST, 125 mmHg, Pressure interval: Continuous, Filler: Black Foam, Dressing ch
\checkmark	2	Morse Fall Risk Assessment	Ordered		17-Nov-2017 14:17 PST, Stop: 17-Nov-2017 14:17 PST
					Order entered secondary to inpatient admission.
		Intensive Care Delirium Screening Checklist (ICDSC)	Ordered		05-Dec-2017 12:00 PST, BID, To be done at 0600 and 1600 and as needed.

To see examples of order details review the image below:

- Focus on the Details column of the Orders Profile
- Hover your cursor over specific orders to discover additional information
- Note the start date and that orders are organized by clinical category

	S	7	Order Name	Status	*	Dose	Details	
2	Patie	ent Car	e					
►		\checkmark	Vital Signs	Ordered			28-Nov-2017 10:42 PST, q4h	
2	Bloo	d Prod	ucts					
		2 🗈	Red Blood Cell Transfusion	Ordered			Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Pl Informed consent must be present on patient record	ease call
							Red Blood Cell Transfusion	
							Details: Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please callwhen ready for pick up, 28-Nov-2017 11:04 PST Order Comment: Informed consent must be present on patient record	

When new orders are entered for the patient by a clinician or a provider, the nurse caring for the patient must review these new orders. You may recall that you already reviewed new orders in **CareCompass**. You can also review new orders from the **Orders Profile** as shown in the following steps.

Note: Do NOT follow these steps in the system but instead refer to the screenshots to understand the process.



- 1. A **Nurse Review** icon *may* appear to the left of an order. This identifies the order as one that needs to be reviewed by a nurse.
- 2. The nurse should click the Orders for Nurse Review button to open the review window

	S	\$	Order Name	Status 🔻	Dose	Details	
⊿	Patie	nt Car	e				
►		∕ ‰	Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h	
		1					
		_					
4							4
	Detai	ls					
_							
0	ders F	or Cosig	nature Orders For Nurse Review 2				Orders For Signature

An **Actions Requiring Review** window opens. This window displays any new orders that have been placed by other clinicians that need to be acknowledged as reviewed by the nurse.

- 3. Read through the list of new orders
- 4. Click Review to acknowledge that you are aware of the new orders

P CSTLEARNING, DEMOALPHA - Actions Requiring Review										
CSTL	EARNI	NG, DEMOALPHA	DOB:01-Jan-19	37 MRN:700008214	Code Status:				Location:LG	H 6E; 624; 02
Allerg	ies: Bees	/Stinging Insects, ci	Gender:Male	PHN:9876469856	o Dosing Wt:		Isolation:		Attending:Pli	aueni svca, Rocco, MD
	Action	Action Da Entered	By Order	Details	2			Orderi	ıg	
	Order	28-Nov-201 Plisvcf, 7 10:42:56 Dillon, N	D Vital Signs 2	28-Nov-2017 10:42 PST, q4	h			Plisvcf, Dillon,	MD 3	
V Select	t All [Show All Details								
								COLLEARNI	IG, DEMUALP	Review 4 Cancel

All new orders have now been reviewed and the **Orders for Nurse Review** button is no longer available.

Note: Reviewing new orders using the **Orders for Nurse Review** button makes the **Nurse Review** icon disappear.





- Always review and verify the status of orders
- Hover over order details to view additional order information
- The Orders For Nurse Review button is available when there has been new orders placed and the nurse needs to review them

1



Activity 11.4 – Place a Verbal Order

Similar to current practice, nurses 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.

Note: Verbal and phone orders that nurses 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 Add button + Add in Order Profile





- 3. The Add Order window opens
- 4. Type *ns continuous* in the search field and press **Enter** on the keyboard to view search results
- 5. Select sodium chloride 0.9% (NS) continuous infusion with order sentence order rate: 75mL/hr, IV drug form: bag [Greater than or equal to 17 year]
- 6. The **Ordering Physician** window opens. Fill out required fields highlighted yellow with the 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, Phone, would be selected.

7. Click **Done** button **Done** to close the **Add Order** window

Validate, IP-CriticalCareNurse Add Order 3 Validate, IP-CriticalCareNurse Obis:1977-Jan-13 MRN:760000659 Age:41 years Age:41 years Enc:7600000000 Allergies: Egg Gender:Male PHN:10760000059	Code Status:Attempt CPR, Full Code Pr 559 Di 59 Dosing Wt:70 kg Iso	rocess: L isease: E olation: A	Coation:LGH 7E: 7EL; 06 nc Type:Inpatient ttending:Train, GeneralMedicine-Physicia
Search Type:	Proposal Order Proposal Proposal Proposal Proposal Order Order Proposal Proposal Order Date/Time Toder Date/Time	ard lard	Ŗ
		Validate, IP-Critical	CareNurse - 7600 7 Done

- 8. Orders for Signature window opens and order details are displayed. Fill out Detail fields as needed
- 9. Click **Sign** button sign and then click **Refresh** icon **to** update Orders Profile.

Note: Do not tick the checkbox beside the order. This will change to proposed order. Proposed orders are inactive until reviewed and signed by physicians.

Menu	9 < → A Orders (Cfull	koreen 🛱 Paint	20 minutes a
atient Summary Orders 🕈 Add	Add @ Document Medication by Hz Reconciliation - A Check Interactions	tion Status History 🚺 Admis	ision 🕐 Discharge
ngle Patient Task List	Orders Medication List Document In Plan		
u.e	Orders for Sprature		
	View (A (O (P) (V Order Name Status Start Datals		
eractive view and toro	Orders for Signature		
uits Review	🛛 🖗 Lodium chévide 0.0%. Order 28-Nev-2017 15:34. order refe: 75 mil./h, 1/, order duration: 24 hour, drug form: kao	s start 28-Nev 20	17 15:34 PST,
umentation 🕂 Add	Document In Plan		
stication Request	Medical Megarin Infusion Standard (Modul Medical Megarin Infusion Standard (Modul Medical		
tories	Suggested Plans (I) Egroceate and an original streams		
ngies 🕂 Add	Orders Base Solution Bag Volume Rate Infuse Over		
anotes and Problems	Adm/U Transfer/Dircharge Joint Common State		
	Seture Care Minimum and Seture Care Care Care Care Care Care Care Ca		
	Activity Total Bag Volume 1000 mL	2	
eConnect	Dist/Nutrison		
ical Research	Continuous Infusions Weight		
ns Browser	Medications		
wth Chart	Blood Preducts		0
nunitations	Related Results		8
	Formulary Details		
ed Tubed Draint Summary	Variance Viewer DHamp Fieuwed DHale Orders For Dogostum Didets For Nurse Review		Sign
R Summary			
	PRODEC TEST MURSE	Tuesday, 28-Nove	mber-2017 15:35



10. The Orders Profile now displays the NS continuous infusion with a status of Ordered.

sodium chloride 0.9% (NS) continuous i <mark>Ordered 10</mark>	order rate: 75 mL/h, IV, drug form: bag, start: 22-Nov-2017 11:09 PST, bag volume (mL): 1,000	22-Nov-2017 11:09 PST
Key Learning Points		
Verbal orders are only encouraged to directly into the CIS themselves, for e sterile in mid procedure	be entered when a physician cannot enter the example in an emergency situation or when the	e order e physician is
Required fields are always highlighted	d yellow	
Verbal and phone orders that are enterprovider for co-signature	ered into the CIS automatically get routed to the	he ordering

1



Activity 11.5 – Complete or Cancel/Discontinue an Order

Orders can be documented as completed or discontinued depending on the type of order.

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

Let's say the patient has a peripheral IV that has gone interstitial. An order has been placed to remove it.

You remove the IV and now you have to complete the order so that it no longer appears on the patient's order profile:

- 1. Scroll down the Orders Profile to find the order for Remove Peripheral IV Catheter
- 2. Right-click the order Remove Peripheral IV Catheter
- 3. Select Complete





4. Once **Complete** is selected, the check mark beside **Remove Peripheral IV Catheter** order is removed and the order is crossed out. Click the **Orders For Signature** button

😽 > 🔹 🚔 Orders						(미) Full screen 👼 Print 🛷 5 minutes ag
+ Add Tocument Medication by Hx Reconciliation	- 👌	Check Int	eractio	15		Reconciliation Status Meds History ④ Admission ④ Discharge
Orders Medication List Document In Plan						
	M I					
View		Displayed:	All Activ	e Orders (All Inactive Orders (All Orders (All Statuses)		Show More Orders
Suggested Plans (0)	^	<i>B</i>	2	Order Name	Statur Doco	Detaile
		04	1		Status Dose	Details
Admit/Transfer/Discharge				Braden Assessment	Completed	07-Nov-2017 09:35 PS1, Stop: 07-Nov-2017 09:35 PS1 Order entered secondary to inpatient admission.
V Status		~	1 🖪	Cardiorespiratory Monitoring	Ordered	08-Nov-2017 11:23 PST. Remains on at all times
- Patient Care		~	1 🖪	Critical Care Goals	Ordered	08-Nov-2017 11:23 PST, MAP goal: 65 mmHg or greater, pH goal: great
C Activity		~	1 🖪	Height/Length	Ordered	08-Nov-2017 11:23 PST, once. Stop: 08-Nov-2017 11:23 PST, on admissi
- Diet/Nutrition		~	1 📭	ICU Early Mobilization Goal	Ordered	08-Nov-2017 11:23 PST. Stages 3 to 6
Continuous Infusions		~	1	Infectious Disease Screening	Ordered	07-Nov-2017 09:35 PST
Medications				,		Order entered secondary to inpatient admission.
- Blood Products		► <u></u>	1 🗈	Intensive Care Delirium Screening Checklist	Ordered	08-Nov-2017 11:23 PST, BID, to be done at 0600 and 1600 and as needed
- Laboratory	=	► <u></u>	1 🗈	Monitor Intake and Output	Ordered	08-Nov-2017 11:23 PST, q1h
Diagnostic Tests		~	1 🗈	Oximetry - Continuous (Pulse Oximetry Continuous)	Ordered	08-Nov-2017 11:23 PST
Procedures		~	1 🗈	Pain Assessment	Ordered	08-Nov-2017 11:23 PST, q4h, if patient expresses pain, use Numeric Rati
Respiratory				Remove Peripheral IV Catheter	Complete	
Allied Health		~	1 🗈	Richmond Agitation Sedation Scale Goal (RASS Goal)	Ordered	08-Nov-2017 11:23 PST, RASS goal of 0, Alert and Calm
Consults/Referrals		V	1 🗈	Sedation Assessment (Richmond Agitation Sedation Scale)	Ordered	08-Nov-2017 11:23 PST, q4h and PRN
Communication Orders		▶ ⊻	1 🗈	Vital Signs	Ordered	08-Nov-2017 11:23 PST, q1h
Supplies		×	1 🗈	Weight	Ordered	08-Nov-2017 11:23 PST, Stop: 08-Nov-2017 11:23 PST, On admission
Non Categorized	-	A Activi	tv			•
4 III +		•		III		•
Related Results		▲ Details	for R	emove Peripheral IV Catheter		
Formulary Details	1			•		
Variance Viewer		Orders Fo	r Cosign	ature Orders For Nurse Review		4 Orders For Signature

5. Review the completed order and click **Sign** button <u>sign</u>. You will return to Orders Profile where the order will show as processing.

⊿ LGH 4E; 406; 0	1 Enc:7000000015058 Admit: 17-Ne	vv-2017 14:14 PST	
⊿ Patient Care			
□ 🗛	Remove Peripheral IV Complete	09-Dec-2017 20:23	
🛣 Details			
0 Missing Required I	Details Orders For Cosignature Ord	ers For Nurse Review	Sign



6. Click Refresh icon <a>T and the order will no longer be visible in the Orders Profile.

🗟 🔿 - 🔒 Orders						[□] Full screen @ P 6 3	* 0 minutes aç
🕂 Add 🍣 Document Medication by Hx I	Reco	onciliation 🕶 🛛 🔊	Check Interactions			Reconciliation Status	Discharge
Orders Medication List Document In Plan	1						
K							
View	D	splayed: All Active	Urders (All Inactive Urders (All U	Irders (All Statuses)*			
Orders for Signature		A 17	Order Name - X	Shahur Da		Detaile	Last Lineb 🔿
🗆 Plans		Admit (Terrefe	-(Disabases	otatus	.se	Details	Last Option
- Document In Plan		Admit/Transfe	r/Discharge	Ordered		2017 Dec 271245 DST Admitte Critical Core Admittice consider Text loss Critical Core Displaye	Testilize
Medical	4	Statur	Admit to inpatient	Ordered		2017-Dec-27 12:13 PS1, Admit to Chical Care, Admitting provider: Testoser, ChicalCare-Physicia	restoser, =
ICU General Admission Medical /	2	Status	Sentic Shock Alert	Ordered		2018-Jan-15 10-20 DST_Ston: 2018-Jan-15 10-20 DST	SVSTEM
Venous Thromboembolism (VT			Septic Shock Merc	ordered		SIRS Criteria: 15/01/18 10:36:00 Heart Rate Monitored = 108 bpm (H) [greater than or equal to 9	STSTEIN,
ICU Insulin Infusion - Critical Ca		M 🖪 🛛	Code Status	Ordered		2017-Dec-27 12:14 PST_Attempt CPR_Full Code_Perioperative status: Attempt CPR_Full Code_Du	TestUser
ICU Electrolyte Replacement (I	⊿	Patient Care					
- Suggested Plans (0)	•	M 🗈	Weight	Ordered		2017-Dec-27 12:14 PST, gdaily	TestUser.
Orders	•	1	Vital Signs	Ordered		2017-Dec-27 12:14 PST, q1h	TestUser,
- Admit/Transfer/Discharge		1	Sedation Assessment (Rich	Ordered		2017-Dec-27 12:14 PST, q4h and PRN	TestUser,
- Status		🗹 🗈	Richmond Agitation Sedat	Ordered		2017-Dec-27 12:14 PST, RASS goal of 0, Alert and Calm	TestUser,
- Patient Care		🗹 📭	Pain Assessment	Ordered		2017-Dec-27 12:14 PST, q4h, if patient expresses pain, use Numeric Rating Scale (goal less than 4)	TestUser,
- Activity		🗹 🔛	Oximetry - Continuous (P	Ordered		2017-Dec-27 12:14 PST	TestUser,
Diet/Nutrition		\checkmark	Morse Fall Risk Assessment	Ordered		2017-Dec-26 14:28 PST, Stop: 2017-Dec-26 14:28 PST	SYSTEM,
Continuous Infusions		_				Order entered secondary to inpatient admission.	
Medications	•	₽	Monitor Intake and Output	Ordered		2017-Dec-27 12:14 PST, q1h	TestUser,
Blood Products	•	<u> </u>	Intensive Care Delirium Scr	Ordered		2017-Dec-27 12:14 PST, BID, to be done at 0600 and 1600 and as needed	TestUser,
Laboratory T	4	M	Infectious Disease Screening	Ordered		2017-Dec-26 14-28 PST	SVSTEM

Congratulations! You just completed a one-time order and removed the order from the Orders Profile.

- 2 Now let's **Cancel/Discontinue** an Order:
 - 1. Review the Orders Profile
 - 2. Right-click order Clear Fluid Diet
 - 3. Select Cancel/Discontinue





- 4. **Ordering Physician** window will appear. Fill out required fields highlighted yellow below and then click **OK**
 - **Physician name** = type name of Attending Physician (last name, first name)
 - **Communication type** = No Cosignature Required

P Ordering Physician
Order
Proposal
*Physician name
Plisvca, Rocco, MD
*Order Date/Time
28-Nov-2017
*Communication type
Phone
Proposed
No Cosignature Required
Cosignature Required
Fapenrax
4 OK Cancel

5. Review order to discontinue and click Orders For Signature

🔀 🔿 👻 者 Orders		🗇 Full screen 🚔 Print 🕹 7 minutes a
🕂 Add 🦨 Document Medication by Hx Reconciliation • 💡	> Check Interactions	Reconciliation Status ✓ Meds History ④ Admission ④ Discharg
Orders Medication List Document In Plan		
View View Orders for Signature Plans Document In Plan Medical Restraints Adult (Module) (Validated) (Planned) CU General Admission Medical / Surgical (Validatere CU General Admission Medical / Surgical (Validatere CU Continuous Renal Replacement (CRRT) - Critice CU Continuous Renal Replacement (CRRT) - Daile CU Continuous Infusions C Activity C Diec/Nutrition C Continuous Infusions C Medications C M	Displayed Al Active Orders (Al Inactive Orders (Al Orders (Al Statuses) Image: Constraint of the state of the st	Show More Orders Status Dose Details Ordered 08-Nov-2017 11:23 P5T, g1h Ordered 08-Nov-2017 11:23 P5T, 30 degrees or greater, if no thoracic / lumbars of Ordered 08-Nov-2017 11:23 P5T, 30 degrees or greater, if no thoracic / lumbars of Discontinue Reason:
Formulary Details Variance Viewer	Orders For Cosignature Orders For Nurse Review	Dirders For Signature



6. Review Order for signature and click **Sign** button <u>sign</u>. You will return to the Order Profile.

	06: 01 Enci70000000150	59 Admits 17 N	Jour 2017 14:14 PCT		
4 Diet/Nutr	ition	50 Aumit. 17-N	00-2017 14.14131		
	Clear Eluid Diet	Discontin	09-Dec-2017 20:24	09-Dec-2017-20-24 PST	
		Ciscontanin	US DEC LOLI EULIM	n os dec Extrementar	
🔺 Details					_
0 Missing Requ	ired Details Orders For C	osignature Or	ders For Nurse Review	0	Sign

7. Click the **Refresh** icon **to** refresh the screen and the Clear Fluid Diet order will no longer be visible in the Orders Profile.

< > - A Orders						(D) Full screen 🖷 🕇 🤇	• 0 minutes ag
+ Add Pocument Medication by Hx 1	Reconciliation - 👌	Check Interactions			k	Reconciliation Status Heds History Admission	Discharge
Orders Medication List Document In Plan							
H III							
View	Displayed: All Active	Orders All Inactive Orders All 0	Irders (All Statuses)*			Show	More Orders
· Orders for Signature				-	I-		
Plans	0° 7	Order Name	Status	Dose	Details		Last Updi
- Document In Plan	△ Diet/Nutrition		0.1.1				7.00
🖻 Medical	A Cantinuan In	NPO	Ordered		2017-Dec-27 12:14 PST, Except for Medications, Constant Order		TestUser,
ICU General Admission Medical /		vasopressin additive 20 uni	Ordered		titrate IV. 0 unit/min minimum rate 0.04 unit/min maximum ra	ate titrate instructions: For MAP >	Testliser
Venous Thromboembolism (VT	V 8	sodium chloride 0.9% (NS)	Ordered		order rate: 75 ml /h IV drug form: bag start: 2018-Jan-15 12:01	PST_bag volume (ml.): 1 000	Train ICI
ICU Insulin Infusion - Critical Ca	🗹 🚡 🖬	norepinephrine additive 8	Ordered		titrate, IV, 0 mcg/min minimum rate, 20 mcg/min maximum rate	te, titrate instructions: titrate to m	TestUser,
ICU Electrolyte Replacement (I	🗹 🍗 🖻	insulin regular (human)	Ordered		titrate, IV, 1 unit/h starting rate, 0 unit/h minimum rate, 20 unit/	h maximum rate, titrate instructio	TestUser,
- Suggested Plans (0)		additive 100 unit + sodium			Protocol for Patient NOT currently receiving insulin infusion	slood glucose: 4 mmol/L or LESS	
Orders	⊿ Medications						E
Admit/Transfer/Discharge		vancomycin	Ordered		1,000 mg, IV, q12h, administer over: 60 minute, drug form: bag,	start: 12-Jan-2018 10:00 PST, bag	TestUser,
V Status	M 10 2	thiamine	Ordered		200 mg, IV, qdaily, order duration: 3 day, drug form: inj, start: 20 VITAMIN B1 EQUIV	J17-Dec-27 12:14 PST, stop: 2017	TestUser,
Activity	🗹 🐚 🖻	SODIUM phosphate	Ordered		15 mmol, IV, q4h interval, PRN hypophosphatemia, administer of Dose as per ICU Electrolyte Replacement Protocol if creatinine le	over: 120 minute, order duration: 3 ess than 150 umol/L and urine out	. TestUser,
	\checkmark	sodium chloride 0.9% (sod	Ordered		500 mL, IV, once, drug form: bag, first dose: Routine, start: 2017	-Dec-27 05:00 PST, stop: 2017-Dec	TestUser,
Medications	🗹 🍗 🖻	ranitidine	Ordered		50 mg, IV, q8h interval, start: 2017-Dec-27 13:00 PST For ventilated patients		TestUser,
Blood Products	🗹 🍗 🍋	potassium chloride	Ordered		40 mmol. NG-tube. TID. PRN hypokalemia. drug form: oral lig. s	start: 2017-Dec-27 12:14 PST	TestUser. *
Laboratory	•	III					P.
Related Results	A Details						
Formulary Details	- Dotalls						
Variance Viewer	Orders For Cosigna	ture] [Orders For Nurse Review	N			Orders	For Signature

Key Learning Points

- Right-click to mark an order as completed or cancel/discontinued
- Both complete and cancel/discontinued will remove orders from patient's Order Profile

1



Activity 11.6 – Review Components of a PowerPlan

A **PowerPlan** in the CIS is the equivalent of preprinted orders in current state and is often referred to as an order set.

At times it may be useful to review a **PowerPlan** to distinguish its orders from stand-alone orders. Doing this allows a user to group orders by PowerPlan.

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

- 1. Locate the Plans category to the left side of the screen under View
- 2. Click on the ICU General Admission Medical/Surgical (Validated) (Initiated) PowerPlan
- 3. Review the individual orders within the PowerPlan by using the scroll bar on the right hand side. Any order that has a check mark *I* next to it is an individual order that has been entered through the **PowerPlan**.



Key Learning Points

- PowerPlan in the Clinical Information System (CIS) is the equivalent of preprinted orders in current state and is often referred to as an order set.
- Any order that has a check mark I next to it is an individual order that has been entered through the PowerPlan.



PATIENT SCENARIO 12 - Review Medication Administration Record (MAR)

Learning Objectives

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

- Review and Learn the Layout of the MAR
- Request a Medication from Pharmacy

SCENARIO

In this scenario, you will be reviewing the scheduled and PRN medications for your patient today.

As a critical care nurse, you will complete the following activities:

Review and learn the layout of the MAR

Request a medication from pharmacy



Activity 12.1 – Review the MAR

1 The MAR is a record of medications administered to the patient by the clinician. 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, PRN medications and continuous infusions.

- 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.

Menu	4	< > 🖌 者 MAR				
Patient Summary		*酒 66* 🗎				
Orders 🕂 Add						_
Single Patient Task List		All Medications (System)	▼		Wednesday, 13-	Decemb
MAR	1	Show All Rate Change Docu	Medications	14-Dec-2017 15:09 PST	14-Dec-2017 15:08 PST	14-Dec 14:00
MAR Summary		Time View	Scheduled	19.09191	15.00151	14.00
Interactive View and I&O		Scheduled	acetaminophen	650 mg Last given:		
Results Review		Unscheduled	650 mg, NG-tube, q4h, drug form: tab, start: 14-Dec-2017 15:09 PST Maximum acetaminophen 4 q/24 b from all sources	11-Dec-2017 11:18 PST		
Documentation 🛛 🖶 Add		PRN	acetaminophen			
Medication Request		Continuous Infusions	Temperature Axillary Temperature Oral			
Histories		👿 Future	Numeric Pain Score (0-10)	50		
Allergies 🕂 Add		Discontinued Scheduled	ranitidine	Not previously		
Diagnoses and Problems		Discontinued Unscheduled	50 mg, IV, q12h, start: 14-Dec-2017 15:09 PS1 ranitidine	given		
		Discontinued PRN	ه ر		1,000 mg	
CareConnect		Discontinued Continuous Infus	Vancomycin 1,000 mg, IV, q12h, start: 14-Dec-2017 15:08 PST		11-Dec-2017 11:18 PST	
Clinical Research			vancomycin			
Form Browser			PRN PRN	1 mg		
Growth Chart			HYDROmorphone (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, start:	Last given: 11-Dec-2017		
Immunizations			11-Dec-2017 10:43 PST HYDROmorphone	11:18 PS1		
Lines/Tubes/Drains Summary			Respiratory Rate			
Medication List 🛛 🕂 Add			PRN salbutamol	5 mg Last given:		
Patient Information			5 mg, nebulized, q4h, PRN shortness of breath or wheezing, drug form: neb start: 12-Dec-2017 10:32 PST	12-Dec-2017 10:42 PST		
Reference			salbutamol			

- 3. Next, select in order, **Unscheduled**, **PRN** and **Continuous Infusions**, bringing each section to the top of the list for your review.
- 4. Review the medications on the MAR e.g. acetaminophen 650 mg PO Q4H. Be sure to review all medication information.
- 5. If you wish to review the Reference Manual right-click on the medication name and select the **Reference Manual**.

°ක් සිං 📄 201 All Active Medications (System	n) 💌 📖 🔹 🕨			Tue		
Show All Rate Change Docu	Medications	23-Nov-2017 14:00 PST	23-Nov-2017 10:00 PST	23-Nov-2017 06:00 PST		
Time View	Scheduled	and the second s	A construction of the	A cost courses and a cut		
Scheduled	acetaminophen 650 mg, PO, g4h, drug form: tab, stada	650 mg ast given: 10-Nov-2017	650 mg Last given: 20-Nov-2017	650 mg Last given: 20-Nov-2017		
PRN	20-Nov-2017 14:04 PST Maximum acetaminophen 4 g/24 t	rder Info	LANR PCT	_14-08 PST		
👿 Continuous Infusions 🛛 🔒	acetaminophen Temperature Axillary	Event/Task Summary Link Info				
Future	Temperature Oral					
Discontinued Scheduled	Numeric Pain Score (0-10)	Reference Manua	5			
Discontinued Unscheduled	cefTRIAXone	Med Request	-			
Discontinued PRN	1,000 mg, IV, q12h, start: 20-Nov-2 14:18 PST	Reschedule Adm				
	cefTRIAXone	Additional Dose.	-			
Urscontinued Continuous Infus	HYDROmorphone 3 mg, NG-tube, q4h, start: 20-Nov- 15:54 PST	View MAR Note. Create Admin No	3 mg given: Nov-2017 7 PST			
	HYDROmorphone Respiratory Rate	Infusion Billing				



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 a PowerPlan

< > ᠇ 者 MAR						
**** 60^						
MI Medications (System)	▼ Monday, 20	18-January-15 (09:13 PST - Wee	Inesday, 2018-J	anuary-17 09:13	3 PST (Clinical Ra
Show All Rate Change Docu	Medications	2018-Jan-16 09:13 PST	2018-Jan-16 08:00 PST	2018-Jan-16 07:00 PST	2018-Jan-16 06:00 PST	2018-Jan-16 02:00 PST
Time View Scheduled	ेक है। ranitidine 50 mg, IV, q8h interval, start: 2017-Dec-27 13:00 PST					50 mg Not previously given
Unscheduled	For ventilated patients ranifidine					
PRN	sodium chloride 0.9% (sodium chloride 0.9% (NS) bolus)			500 mL		
Continuous Infusions	500 mL, IV, once, drug form: bag, first dose: Routine, start: 2017-Dec-27 05:00 PST, stop: 2017-Dec-27 05:00 PST			Not previously given		
🔽 Future	sodium chloride 0.9%					
Discontinued Scheduled	tniamine 6		200 mg Not previously			200 mg Not previously
Discontinued Unscheduled	200 mg, IV, qdaily, order duration: 3 day, drug form: inj, start: 2017-Dec-27 12:14 PST, stop: 2017-Dec-30 07:59 PST		given			given
Discontinued PRN	VITAMIN B1 EQUIV					
Discontinued Continuous Infus	a 分が 夏 6 ancomp cin 1,000 mg, IV, q12h, administer over: 60 minute, drug form: bag, start: 12-Jan-2018 10:00 PST, bag volume (mL): 250					1,000 mg Not previously given
	vancomycin					
	PRN	125 a				

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 in future. This totals a period of **48 hours**. (If you prefer to see only your 12 hour shift, you can right click on the Clinical Range bar to adjust the time frame that is displayed).
- 8. The dates/times are displayed in **reverse chronological order**. (this differs from current state paper MARs)
- 9. The current time and date column will always be highlighted in yellow.

📆 All Orders with Active Tasks in Tir 🗸 🛄 < 🔸 Tuesday, 28-November-2017 12:21 PST - Thursday, 30-November-2017 12:21 PST (Clinical Range)											
Show All Rate Change Docu	Medications	30-Nov-2017 10:00 PST	30-Nov-2017 06:00 PST	30-Nov-2017 02:00 PST	29-Nov-2017 22:00 PST	29-Nov-2017 18:00 PST	29-Nov-2017 14:00 PST	29-Nov-2017 12:26 PST	29-Nov-2017 12:22 PST	29-Nov-2017 10:00 PST	28-Nov-2017 22:00 PST
Time View	Scheduled										
👿 Scheduled	acetaminophen (TYLENOL)	640 mg Last given:									
Unscheduled	640 mg, PO, q4h, drug form: oral liq, start: 29-Nov-2017 14:00 PST	22-Nov-2017 12:41 PST									
💟 PRN	Maximum acetaminophen 4 g/24 h from all sources										
Continuous Infusions	acetaminophen Temperature Axillary										
V Future	Temperature Oral										
Discontinued Scheduled	Numeric Pain Score (U-10)	1.000 mg			1.000 mg				1.000 mg		
Discontinued Unscheduled	vancomycin	Last given:			Last given:				Last given:		
Discontinued PRN	1,000 mg, IV, q12h, start: 29-Nov-2017 12:22 PSI	10:00 PST			10:00 PST				10:00 PST		
	vancomycin										
Uiscontinued Continuous Infu	PRN										
	HYDROmorphone (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, PO, q1h, PRN pain, drug form: oral lic start: 29-Nov-2017 12:24 PST	r L						1 mg Not previously given			
	HYDROmorphone										
	Respiratory Rate										
	Continuous Infusions										
	sodium chloride 0.9% (NS) continuous infusion 1,000 mL order rate: 75 mL/h, IV, drug form: bag, start: 29-Nov-2017 12:23 PST, bag volume (mL): 1,000							Pending Not previously given			
	Administration Information							9			
	sodium chloride 0.9%							v			


Note: different sections of the MAR and statuses of medication administration are identified using color 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 a clinician
- 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 12.2 – Request a Medication

1 You can't find the Vancomycin IV medication vial. You need to submit a **Med Request** to Pharmacy.

- 1. Right click on the medication order name vancomycin 1,000mg, IV, q12h
- 2. Select Med Request...

Menu	+ <	> - 🔒 MAR			
Patient Summary	^ *	á & 📄			
Orders 🕂 Add					
Single Patient Task List	党	All Medications (System)	✓ Vednesday	y, 13-December-2	017 10:58 PST -
MAR	V	Show All Rate Change Docu	Medications	14-Dec-2017	14-Dec-2017 10:00 PST
MAR Summary		Time View	Scheduled	10.56 + 51	10.00 P31
Interactive View and I&O		Scheduled	acetaminophen		650 mg Last given:
Results Review		Unscheduled	650 mg, NG-tube, q4h, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources		11-Dec-2017 11:18 PST
Documentation 🕂 Add		PRN	acetaminophen		
Medication Request		Continuous Infusions	Temperature Axillary Temperature Oral		
Histories		Future	Numeric Pain Score (0-10)		
Allergies 📥 Add	=	Discontinued Scheduled	vancomycin		1,000 mg
		Discontinued Unscheduled	1,000 mg, IV, q12h, start: 11-Dec-2017 10:43 PST	Order Info	
Diagnoses and Problems		Discontinued PRN	vancomycin	Event/Task Summ	nary
		Discontinued Continuous Infus	PRN	Link Info	
CareConnect		Discontinued Continuous Infus		Reference Manua	i
Clinical Research			dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, sta	Med Request	2
Form Browser			HYDROmorphone	Reschedule Admi	in Times
Grouth Chart			Respiratory Rate	Additional Dose	
			-m	View MAR Note	
Immunizations		Theraneutic Class View	5 mg, nebulized, q4h, PRN shortness of breath or wheezing, drug fo	Create Admin No	te
Lines/Tubes/Drains Summary		Route View	start: 12-Dec-2017 10:32 PST	Alert History	
Medication List 🕂 Add		Plan View	Continuous Infusions	Infusion Billing	

- 3. In the Reason drop-down menu, select Cannot locate.
- 4. Select a priority option. Select High.
- 5. Click **Submit**

P Medication Request
CSTLEARNING, DE 80 years M DOB: 01-Jan-1937
vancomycin 1,000 mg, IV, q12h, start: 11-Dec-2017 10:43 PST
Last request: View History
*Reason: Cannot locate
Priority Low Medium High 4
* Comment
Submit 5 Cancel



- 6. To view the status of Medication Request, select **Medication Request** from the **Menu**.
- 7. You will find a pending note beside the medication that you have sent for Medication Request. Click **View History** button View History to review details of the pending request.

Validate, IP-CriticalCareNurse	×							
Validate, IP-CriticalCareNurse		DO	B:1977-Jan-13	MRN:760000659	Code Status:Attempt CPR, Full Code	Process:		
Allergies: No Known Allergies		Gen	ider:Male	PHN:10760000659	Dosing Wt:70 kg	Isolation:		
Menu	ņ	< > ·	- 🚹 Medicatio	n Request				
Patient Summary	-	8 D		0% • • • 🚮				
Orders 🕂 Add			aniudine, so m	g, IV, qon interval, start: 2017-	Dec-27 13:00 PS1, For ventilated patients			
Single Patient Task List								Priority
MAR								Low 🗸
MAR Summary			sodium chloride 0.99	% (NS) bolus, 500 mL, IV, once,	drug form: bag, first dose: Routine, start: 201	7-Dec-27 05:00	View History	Reason
Interactive View and I&O			PST, stop: 2017-Dec	-27 05:00 PST				~
Results Review								Priority
Documentation 🕂 Add								LOW
Medication Request 6			thiamine, 200 m	ng, IV, qdaily, order duration: 3	day, drug form: inj, start: 2017-Dec-27 12:14 P	PST, stop: 2017-	View History	Reason
Histories			Dec-30 07:59 PST, V	/ITAMIN B1 EQUIV				Priority
Allergies 🕂 Add	Ε							Low
Diagnoses and Problems			<u></u>				View History	Reason
			Vancomycin, 1,0	000 mg, IV, q12h, administer ov	er: 60 minute, drug form: bag, start: 12-Jan-20	018 10:00 PST, bag		
CareConnect			Last requi	est: Pending (1) - 0 min ag	10		7	Priority
Clinical Research								Low

Key Learning Points

Right clicking on the medication order name provides options such as Med Request

Med Request sends a message to pharmacy to send the medication



FATIENT SCENARIO 13 - Medication Administration

Learning Objectives

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

- Administer medications using Medication Administration Wizard
- Document administration of different types of medications
- Document patient's response to a medication
- Document continuous infusions (non-barcoded)
- Document titratable medication infusions

SCENARIO

Your patient is on several medications including PO medications, PRN medications, intermittent IV medications, and continuous infusions. You will be using a Barcode Scanner to administer these medications. The barcode scanner is meant to scan both your patient's wristband and medication barcodes to correctly populate the MAR.

As a critical care nurse, you will complete the following activities:

- Administer medication using the Medication Administration Wizard (MAW) and barcode scanner
- Document administration of different types of medications
- Document patient's response to a medication on MAR
- Document continuous infusion (non-barcoded)
 - Document titratable medication infusion



Activity 13.1 – Administering Medication Using Medication Administration Wizard (MAW) and the Barcode Scanner

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 also ensures the correct medication is being administered. Once a medication is scanned, applicable allergy and drug interaction alerts may be triggered, further enhancing 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 medications to your patient. You will scan all three medications sequentially.

Occasionally a dose requires scanning two pills to make up the full dose. At other times, the dose requires only part of a pill.

- PO medication: **acetaminophen 650 mg NG**, the drug form is tablet (acetaminophen 325 mg x 2 tabs)
- Range dose medication: **hydromorphone 0.5 mg NG**, PRN for pain, using hydromorphone 1 mg tab product barcode
- IV medication: vancomycin 1 g, IV, premixed bag

Note: IV normal saline does not have a barcode to be scanned as it is a Stores Item. Stores items are documented on the MAR differently and we will practice this later on.

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) button in the Toolbar.



Menu	÷9.5	<			*	MAR	
Allergies: penicillin						Gender:Male	PHN:9876
CSTLEARNING, DEM	ИОВЕТА					DOB:01-Jan-1937 Age:80 years	MRN:7000 Enc:70000
CSTLEARNING, DEM	OBETA	×					
Q PACS Q FormFast W	R . I 🍸 I	ear O	et 🗐	Exit	1	AdHoc Medication Ad	Iministration 1
CareCompass 👫 Clin	ical Leader	Organ	nizer	2 P	atien	t List 🔉 Multi-Patient Ta	isk List ## Disch

2. The Medication Administration window opens.

P Medication Administration			
LINESTUBESDRAINS, MAX Male	MRN: 700002077 FIN#: 700000003266	DOB: 23-Feb-1985 Age: 32 years	Loc: 301; 01M ** Allergies **
	Please scan Alternatively, select the patient	the patient's wristband. profile manually by clicking the (Next) button.	
Ready to Scan		1 of 2	Next 2

3. Scan the patient's wristband and the **Medication Administration** window will display the medications that you can administer.

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



P N	ledication Ad	ministration				
					Nurse Review Last Refresh at 11:	:02 PST
CS Ma	STLEARN	IING, DEMOTHE	TA MRN: 700008216 FIN#: 700000015058	DOB: 01-Jan-1937 Age: 80 years	Loc:	406; 01 Allergies **
			11-D	ec-2017 09:47 PST - 11-Dec-3	2017 12:17 PST	
		Scheduled	Mnemonic		Details	Result ^
	ोस	11-Dec-2017 10:42 PST	acetaminophen		650 mg, NG-tube, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources	
	e	11-Dec-2017 10:43 PST	vancomycin		1,000 mg, IV, start: 11-Dec-2017 10:43 PST	
	هر	PRN	hydromorphone HYDROmorphone (DILAUDID PRN ra	nge dose)	dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, start: 11-	·
	` @ (\$ <mark>}</mark>	Continuous	insulin regular insulin regular (human) additive 100	unit + sodium chloride 0.9	titrate, IV, 1 unit/h starting rate, 0 unit/h minimum rate, 20 unit/h maximum r Protocol for Patient NOT currently receiving insulin infusion Blood glucos.	·
	••	Continuous	norepinephrine norepinephrine additive 8 mg + dext	rose 5% (D5W) titratable i	titrate, IV, 0 mcg/min minimum rate, 20 mcg/min maximum rate, titrate instr	
	5	Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (NS) continuou	is infusion 1,000 mL	order rate: 125 mL/h, IV, drug form: bag, start: 10-Dec-2017 15:52 PST, bag	
		Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (NS) continuou	is infusion 1,000 mL	order rate: 75 mL/h, IV, drug form: bag, start: 11-Dec-2017 10:43 PST, bag .	
•			III			+
Rea	dy to Scan]		2 of 2	Back	Sign 3

4. Scan the medication barcode for **acetaminophen 325 mg** tab. **Filtered Tasks** window opens.

Note: Underdose appears in the qualifications column for the medication. This is because you have only scanned 325 mg of the total 650 mg of acetaminophen required.

CareNu	rse, Terry	MRN: 760000277 FIN#: 7600000000277	DOB: 1977-Jan-1 Age: 41 years	3	Loc: 710; 04 ** No Known Medication Allergies
Strength	Volume				
325 mg	1 tab				
	Mnemonic	Details		Qualifications	
02:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab Maximum acetaminophen 4 g/24	, start: 2018-Jan-1. h from all sources	.Underdose	
06:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab Maximum acetaminophen 4 g/24	, start: 2018-Jan-1. h from all sources	.Underdose	
10:00 PST	acetaminophen	650 mg, NG-tube, drug form: tab Maximum acetaminophen 4 g/24	, start: 2018-Jan-1. h from all sources	.Underdose	
	Strength 325 mg 02:00 PST 06:00 PST 10:00 PST	Strength Volume 325 mg 1 tab Mnemonic 02:00 PST acetaminophen 06:00 PST acetaminophen 10:00 PST acetaminophen	MRN: 760000277 FIN#: 760000000277 Strenqth Volume 325 mg 1 tab Mnemonic Details 02:00 PST acetaminophen acetaminophen 650 mg, NG-tube, drug form: tab, Maximum acetaminophen 4 g/24 10:00 PST acetaminophen 650 mg, NG-tube, drug form: tab, Maximum acetaminophen 4 g/24	CareNurse, Terry MKN: 760000277 Dds: 1977-Jan-1 FIN#: 7600000000277 Age: 41 years Strenqth Volume 325 mg 1 tab Mnemonic Details 02:00 PST acetaminophen 650 mg, NG-tube, drug form: tab, start: 2018-Jan-1. Maximum acetaminophen 4 g/24 h from all sources 7 06:00 PST acetaminophen 650 mg, NG-tube, drug form: tab, start: 2018-Jan-1. Maximum acetaminophen 4 g/24 h from all sources 7 10:00 PST acetaminophen 650 mg, NG-tube, drug form: tab, start: 2018-Jan-1. Maximum acetaminophen 4 g/24 h from all sources 7 10:00 PST acetaminophen 650 mg, NG-tube, drug form: tab, start: 2018-Jan-1. Maximum acetaminophen 4 g/24 h from all sources	CareNurse, Terry MRX: /600002/7 DOB: 19/7-Jan-13 FIN#: 760000000277 Age: 41 years Strenqth Volume 325 mg 1 tab Mnemonic Details Volume Qualifications Volume Maximum acetaminophen 4 g/24 h from all sources V 06:00 PST acetaminophen 650 mg, NG-tube, drug form: tab, start: 2018-Jan-1. V 06:00 PST acetaminophen 650 mg, NG-tube, drug form: tab, start: 2018-Jan-1. V 06:00 PST acetaminophen 4 g/24 h from all sources V 10:00 PST acetaminophen 650 mg, NG-tube, drug form: tab, start: 2018-Jan-1. V 10:00 PST acetaminophen 4 g/24 h from all sources Maximum acetaminophen 4 g/24 h from all sources 4

- 5. Now scan the second **acetaminophen 325 mg** tab barcode to complete the 2 tablet drug administration. After the second scan, the system may find more than one exact matches. In this activity, the system displays three exact matches for the prescribed dose of acetaminophen at 02:00, 06:00, and 10:00.
- 6. Select the one that is close to the current time you administering acetaminophen. In this activity, let's select 06:00.
- 7. Click OK



-CriticalCareN	urse, Terry	MRN: 760000277 FIN#: 7600000000277	DOB: 1977-Jan-13 Age: 41 years	Loc: 710; 0 ** No Known Medication Allergies
nned:				
dication Strengt taminophen 650 mg	h Volume 2 tab			
lified Tasks:		1		
Scheduled 2018-Jan-17 02:00 PS	Mnemonic T acetaminophen	Details 650 mg, NG-tube, drug form: ta Maximum acetaminophen 4 g/2	b, start: 2018-Jan-1 Exact match hb, start: 2018-Jan-1 Exact match h from all sources	h
2018-Jan-17 06:00 PS	T acetaminophen	650 mg, NG-tube, drug form: ta Maximum acetaminophen 4 g/2	ib, start: 2018-Jan- <mark>1</mark> Exact matc 4 h from all sources	h
2018-Jan-17 10:00 PS	T acetaminophen	650 mg, NG-tube, drug form: ta Maximum acetaminophen 4 g/2	ib, start: 2018-Jan-1 Exact matc 4 h from all sources	5

8. The **Early/Late Reason** window opens and asks why the medication is being documented early or late. This is a mandatory field to be filled out. Pretend you administering acetaminophen later than 06:00. From the drop-down menu, select a reason. For this activity, select the **First dose given**. Then click **OK**.





9. You will return to **Medication Administration** window. The blue check mark **r** indicates the task of scanning the prescribed dose of acetaminophen is completed.

P Med	dication Ad	dministration				
					Nurse Review	Last Refresh at 11:21 PST
IP-0 Male	Critical	lCareNurse, Juan	MRN: 760000270 FIN#: 7600000000270	DOB: 1977-Jan-13 Age: 41 years		Loc: 706; 01 ** No Known Allergies **
			2018-Jan-17 1	0:06 PST - 2018-Jan-17 12:	36 PST	
		Scheduled	Mnemonic	Details	Recult	A
	1 🕅 🔁	2018-Jan-17 06:00 PST	acetaminophen	650 mg, NG-tube, drug Maximum acetaminoph	form: tab, star acetaminophe en 4 g/24 h fr	en 650 mg, NG-tube <mark>9</mark>
21	2 <u>-</u>	2018-Jan-17 10:00 PST	acetaminophen	650 mg, NG-tube, drug f Maximum acetaminophe	orm: tab, start: n 4 g/24 h from	
	3 60°	2018-Jan-17 10:00 PST	vancomycin	1,000 mg, IV, administer	over: 60 minute,	
	66° 📜	PRN	Dextrose 50% in Water dextrose 50% (dextrose.	12.5 g, IV, q15min, PRN h For blood glucose 4 mm	iypoglycemia, a ol/L or LESS: ad	
	66	PRN	hydromorphone HYDROmorphone (HYD.	dose range: 0.5 to 1 mg, DILAUDID EQUIV	NG-tube, q4h,	
	••	PRN	magnesium sulfate	5 g, IV, once, PRN hypom Dose as per ICU Electroly	nagnesemia, ad /te Replacement	
	60 🐣 🗄	PRN	potassium chloride	20 mmol, IV, q30min, PR Dose as per ICU Electroly	v hypokalemia, rte Replacement	E
	60 () :	PRN	potassium chloride	40 mmol, NG-tube, TID, F Dose as per ICU Electroly	RN hypokalemi /te Replacement	
	5	PRN	sodium phosphate SODIUM phosphate	15 mmol, IV, q4h interval, Dose as per ICU Electroly	, PRN hypophos /te Replacement	
	60 () :	Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting Protocol for Patient NOT	g rate, 0 unit/h currently receivi	
	60° 📁	Continuous	norepinephrine norepinephrine additive.	titrate, IV, 0 mcg/min min 	imum rate, 20	
	60	Continuous	vasopressin	titrate, IV, 0 unit/min mini	mum rate, 0.04	-
Ready	to Scan			2 of 2		Back Sign

Now let's scan the next medication.

- 1. Scan your medication barcode for hydromorphone 1 mg tab
- 2. You are using the hydromorphone 1 mg tab product barcode. Note that this medication is a range dose order. A **Range Dose Warning** screen will display to remind you of this dose range. Click **OK** to acknowledge the alert.

Cerner	Range Dose Warning
You are a HYDROn mg.	dministering a Range Dose order for norphone. The range is from 0.5 mg to 1
Please ver	ify you are administering the correct



3. You want to give hydromorphone 0.5 mg NG. Click the **Missing Details** icon to fill in pertinent information about hydromorphone.

Medication Ac	Iministration				
				Nurse Review	Last Refresh at 11:02 PST
STLEARI	NING, DEMOTHETA	MRN: 700008216 FIN#: 7000000015058	DOB: 01-Jan-1937 Age: 80 years		Loc: 406; 0 " Allergies
		11	-Dec-2017 09:47 PST - 11-Dec-2017 12:17 PS	5T	
	Scheduled	Mnemonic	Details	Result	
1 🖉 词	11-Dec-2017 10:42 PST	acetaminophen	650 mg, NG-tube, drug form: tab, star Maximum acetaminophen 4 g/24 h fr	. acetaminophen 650 mg, NG-tube	
ল	11-Dec-2017 10:43 PST	vancomycin	1,000 mg, IV, start: 11-Dec-2017 10:43 PST		
8 🛛 🕤	PRN	hydromorphone HYDROmorphone (DI	dose range: 0.5 to 1 mg, NG-tube, q4h	.HYDROmorphone 1 mg, NG-tube, pain_	
` ভ িঁ	Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting rate, 0 unit/h . Protocol for Patient NOT currently receivi		
ेन 🎫	Continuous	norepinephrine norepinephrine additive.	titrate, IV, 0 mcg/min minimum rate, 20		
-	Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 125 mL/h, IV, drug form: bag,		
	Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 75 mL/h, IV, drug form: bag,		
ady to Scan			2 of 2		Back Sign

- 4. A charting window will appear. Enter the following details:
 - **Respiratory Rate** = 12 breaths/min
 - **Hydromorphone** = 0.5 mg (changed from 1 mg)
- 5. Click **OK.** You will return to **Medication Administration** window.

*Performed date / time: 11-Dec-2017 ↓ 1109 PST *Performed by: TestUser, ICU-Nurse Witnessed by:	YDROmorpho ose range: 0.5 to	one (DIL/ 1 mg, NG	UDID PRN rang tube, q4h, PRN pair	e dose) n, drug form: ta	ab, start: 11-De	c-2017 10:43 PST	
*Performed by: TestUser, ICU-Nurse Witnessed by: Medication not given within the last 5 days. Respiratory Rate: 12 bt/min Acknowledge Respiratory Rate: 12 bt/min Acknowledge Respiratory Rate: 12 bt/min Acknowledge Respiratory Rate: 12 bt/min Acknowledge Respiratory Rate: 12 bt/min Acknowledge Respiratory Rate: 12 bt/min Respiratory Rate: 10 ml ml * ml *HYDROmorphone: 0.5 mg Volume: 0 ml *Route: NG-tube • Total Volume: 0 Infused Over: 0 minute • 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017	Performed date	e / time :	11-Dec-2017	÷ • 1	109	PST	(
Witnessed by: Image: State of the st	*Perfor	med by :	TestUser, ICU-Nur	se			
Medication not given within the last 5 days. Respiratory Rate: 12 br/min Acknowledge Respiratory Rate No Result found in previous 5 minutes. Irend *HYDROmorphone: 0.5 mg Volume: 0 ml Diluent: <none> ml "Route: NG-tube Site: Reason: pain Total Volume: 0 Infused Over: 0 minute 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 1000 PST 1100 PST 1200 PST 1300 PST 1400 PST 1500 PST</none>	Witnes	ssed by :					
Diluent: <none> ml *Route: NG-tube Site:</none>	Respiratory Rat	te: 12	br/min				
Reason: pain ▼ Total Volume: 0 Infused Over: 0 minute ▼ 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 1100 PST 1100 PST 1200 PST 1300 PST 1400 PST 1500 PST	HYDROmorpho	Respira	tory Rate No Resul	t found in prev	rious 5 minutes	s. <u>Trend</u> ml 4	
Reason: pain Total Volume: 0 Infused Over: 0 minute I1-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 1000 PST 1100 PST 1200 PST 1300 PST 1400 PST 1500 PST	HYDROmorphoe iluent : <a> *Route :	Respira ne: 0.5 NG-tube	tory Rate No Resul	▼ Volun Site :	ne : 0	ml 4	
Total Volume: 0 Infused Over: 0 minute ▼ 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 1000 PST 1100 PST 1200 PST 1300 PST 1400 PST 1500 PST	HYDROmorpho iluent : <pre> <none *route="" :="" [<="" pre=""></none></pre>	Respira ne: 0.5 > NG-tube	tory Rate No Resul	✓ Volun ✓ Molun Site :	rious 5 minutes	ml 4	
◆ 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 11-Dec-2017 100 PST 1000 PST 1	HYDROmorphoe iluent : <none *Route : Reason :</none 	Respira ne: 0.5 > NG-tube pain	vory Rate No Resul	volun ml Site : v	rious 5 minute:	s. <u>Trend</u> ml 4	
	HYDROmorpho iluent : <none *Route : [Reason : [otal Volume :]</none 	Respira ne: 0.5 NG-tube pain 0	Infused Over :	volun volun ml Site: v	ne: 0	s. <u>Trend</u>	
4 III +	HYDROmorpho iluent: <none "Route: [Reason: [otal Volume: [11-Dec-2017 1000 PST</none 	Respira ne: 0.5 NG-tube pain 0 11-Dec-2 1100 PS	Infused Over : 017 11-Dec-2017 1200 PST	✓ Volun ✓ Volun ✓ Ili-Dec-2017 1300 PST	minute ▼ 11-Dec-2017 1400 PST	5. <u>Trend</u> ml 4	
Not Given	Acknowledge HYDROmorpho iluent : <none *Route : [Reason : [otal Volume : [11-Dec-2017 1000 PST</none 	Respirat ne: 0.5 NG-tube pain 0 11-Dec-2 1100 PS	Infused Over : 017 11-Dec-2017 1200 PST	✓ Volun ✓ Volun ✓ II-Dec-2017 1300 PST	minute	s. <u>Trend</u> ml 4	
Reason ·	Acknowledge HYDROmorpho iluent : <none *Route : [Reason : [otal Volume : [11-Dec-2017 1000 PST</none 	Respirat ne: 0.5 NG-tube pain 0 11-Dec-2 1100 PS	Infused Over : 017 11-Dec-2017 1200 PST	✓ Volun ✓ Volun ✓ II-Dec-2017 1300 PST	minute	s. <u>Trend</u> ml 4	



Let's scan your last medication.

- 1. Scan the barcode for vancomycin 1 g IV bag.
- 2. The system finds an exact match for IV vancomycin showing in **Filtered Tasks** window. After selecting the appropriate administering time for IV vancomycin, click **OK**. You will return to **Medication Administration** window.

Note: If the system finds more than one exact matches of the prescribed dose for IV vancomycin, select the one that is close to the current administering time. Enter reason in **Early/Late Reason** window when appropriate (see steps in above activity that demonstrate scanning acetaminophen).

P Filtered Tasks				×
IP-CriticalCareNurse, Juan Male	MRN: 760000270 FIN#: 760000000270	DOB: 1977-Jan Age: 41 years	-13	Loc: 706; 01 ** No Known Allergies **
Scanned:				
Medication Strength Volume vancomycin 1,000 mg 250 mL				
Qualified Tasks:				
Scheduled Mnemonic	Details		Qualifications	
2018-Jan-17 02:00 PST vancomycir	1,000 mg, IV, administer over: 60 mir	nute, drug for E	xact match	
2018-Jan-17 10:00 PST vancomycir	1,000 mg, IV, administer over: 60 min	nute, drug for E	xact match	
Scan additional ingredients or choose	a task to continue.			OK Canc 2

3. Click vancomycin 1,000 mg IV bag in the Results column.

P Medicat	tion Adr	ministration				- C ×
					Nurse Review	Last Refresh at 11:02 PST
CSTLE Male	EARN	IING, DEMOTHETA	MRN: 700008216 FIN#: 700000015058	DOB: 01-Jan-1937 Age: 80 years		Loc: 406; 01 " Allergies "
			11	Dec-2017 09:47 PST - 11-Dec-2017 12:17 P	ST.	
0 🗸 ସ	9' e	Scheduled 11-Dec-2017 10:42 PST	Mnemonic acetaminophen	Details 650 mg, NG-tube, drug form: tab, star Maximum acetaminophen 4 g/24 h fr	Result . acetaminophen 650 mg, NG-tube	•
	10 10	11-Dec-2017 10:43 PST PRN	vancomycin hydromorphone HYDROmorphone (DI	1,000 mg, IV, start: 11-Dec-2017 10:43 dose range: 0.5 to 1 mg, NG-tube, q4h.	vancomycin 1,000 mg, IV HYDROmorphone 0.5 mg, NG, be, pair Respiratory Rate : 12 br/min	3
	- 3 :	Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting rate, 0 unit/h Protocol for Patient NOT currently receivi.		
	n 🙂	Continuous	norepinephrine norepinephrine additive	titrate, IV, 0 mcg/min minimum rate, 20		
		Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 125 mL/h, IV, drug form: bag,	ai.	
		Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 75 mL/h, IV, drug form: bag,	1	
Ready to S	Scan			2 of 2		Back Sign



4. The **Charting** window opens. The **Premixed Volume** (250 mL) of Vancomycin prepared by pharmacy is auto-populated.

Note: If the premixed volume is entered manually by the nurse, the value will not flow to Intake and Output (I&O) in iView.

- 5. The premixed volume of Vancomycin is also reflected in **Total Volume** showing in the **Charting** window. The total IV medication volume will flow to I&O.
- 6. Click the **OK** button **OK** after verification.

olume (mL): 250			anagre				
*Performed da	te / time :	16-Jan-201	8	•	1039	🕆 PST 📝	ď
*Perfo	rmed by :	TestUser, IC	U-Nurs	•	1	2	
Witn	essed by :	i i					
	Children				POST		
vancomycin:	1,000	mg	•	Volume :	250	ml 4	
Diluent : <nor< td=""><td>ne></td><td>2</td><td>•</td><td>,</td><td>nl</td><td></td><td></td></nor<>	ne>	2	•	,	nl		
*Route :	IV		•	Site :		٠	
Total Volume :	250	5	Over :	60	minute	•	
← 2018-Jan-16 0900 PST	2018-Jan- 1000 PS	16 2018-Ja T 1100 P	n-16 2 IST	018-Jan-16 1200 PST	2018-Jan-16 1300 PST	2018-Jan-1/	⁶ →
	87.5	162.	5				Π.,
4			11	_			
Not Given							
Reason :						~	
Comment							

Note: Nurses often mix their own IV medications. If so, the barcode on the vial of the medication will be scanned. Then the type of diluent solution and the diluent volume will be manually entered in the **Charting** window (see screenshot below). The diluent volume is reflected in the **Total Volume** showing in the **Charting** window. After verifying the correct total volume, click **OK**. The total IV medication volume will then flow to I&O. If the diluent volume is left blank, no medication volume will be populated in I&O.

Note: The reconstitution volume to mix the medication in the vial is added to the diluent volume.



,000 mg, IV, dru	ig form: inj,	start: 2018-Ja	n-16 10	24 PST			
Performed da	te / time :	16-Jan-2018	8	•	1025	🕴 PST 📑	đ
*Perfo	ormed by :	TestUser, IC	U-Nurs	e		96	
Witn	essed by :	1				3	
						1	
vancomycin:	1,000	mg	•	Volume :	0	ml	
liluent : dext	rose 5%		- 1	n	at .		
*Route :	IV			Site :	-	•	
otal Volume :	0	nfused	Over:	0	minute	•	
2018-Jan-16 0900 PST	2018-Jan 1000 PS	-16 2018-Jan T 1100 P	n-16 2 ST	018-Jan-16 1200 PST	2018-Jan-16 1300 PST	2018-Jan-16 1400 PST	•
e	10			ur l			11
Not Given							
Reason						-	
Comment							

7. Now that you have scanned the patient and all three medications, you can complete your medication checks and administer the medications. Then, click **Sign** button **Sign** to sign off the medications administered.

PN	Medication Ad	ministration				
					Nurse Review	Last Refresh at 11:02 PST
C: Ma		IING, DEMOTHETA	MRN: 700008216 FIN#: 7000000015058	DO8: 01-Jan-1937 Age: 80 years		Loc: 406; 01 " Allergies "
			11	-Dec-2017 09:47 PST - 11-Dec-2017	12:17 PST	
4	e 🖸 🖌	Scheduled 11-Dec-2017 10:42 PST	Mnemonic acetaminophen	Details 650 mg, NG-tube, drug form: tab Maximum acetaminophen 4 g/24	Result b, star acetaminophen 650 mg, NG-tube	
य य	100	11-Dec-2017 10:43 PST PRN	vancomycin hydromorphone HYDROmorphone (DL	1,000 mg, IV, start: 11-Dec-2017 dose range: 0.5 to 1 mg, NG-tube	10:43 vancomycin 1,000 mg, IV e, q4h HYDROmorphone 0.5 mg, NG-tube, pai Respiratory Rate : 12 br/min	n.
	10 (D 2	Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting rate, 0 u Protocol for Patient NOT currently	init/h receivi	
Γ	-9 1	Continuous	norepinephrine norepinephrine additive.	titrate, IV, 0 mcg/min minimum rate	e, 20	
	1	Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 125 mL/h, IV, drug form	n: bag	
		Continuous	Sodium Chloride 0.9% sodium chloride 0.9% (order rate: 75 mL/h, IV, drug form:	.bag	8
Rea	dy to Scan			2 of 2		Back 7 Sign



8. A warning window opens stating that a partial dose of hydromorphone was given, do you want to continue? Click **Yes**.



9. Congratulations, you have successfully administered three medications! The medications will now appear as **Complete** on the MAR.

Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:54 PST	21-Nov-2017 11:57 PST	21-Nov-2017 11:54 PST	21-Nov-2017 11:11 PST	21-Nov-2017 11:09 PST
Scheduled						
18 acetaminophen 650 mg, PO, q4h, drug form tab, start: 21-Nov-2017 11:11 PST Maximum acetaminophen 4 g/24 h from.	650 mg Not previously given				Complete	
acetaminophen						
Temperature Axillary						
Temperature Oral						
Numeric Pain Score (0-10)						
Vancomycin 1,000 mg, N, q12h, start: 21-Nov-2017 11.09 PST						Complete
vancomycin						
PEN				1		
PRJ HYDROmorphone OYDROmorphone P- dose range: 0.5 to 1 mg, PO, q4h, PRN gain, drug form: tab, start: 21-Nov-2017 11:09 PST 00 41/007 FOC		Med Response	1 mg Not previously given	Complete	4.	
HIDROmorphone Respiratory Rate						9

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

All Active Medications (System)	• 📖 🔹				Monday, 2
Show All Rate Change Docu	Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:54 PST	21-Nov-2017 12:02 PST	21-Nov-2017 11:54 PST
Time View	Scheduled	COLORADO DE COLORADO	11. And a second		
Scheduled	10	650 mg			
Unscheduled	650 mg, PO, q4h, drug form: tab, start:	21-Nov-2017			
PRN PRN	Maximum acetaminophen 4 g/24 h from				
Continuous Infusions	acetaminophen Temperature Axillary				650 mg Auth (V
Future	Temperature Oral				
Discontinued Scheduled	Numeric Pain Score (0-10)				
Discontinued Unscheduled	vancomycin 1 000 mo. N. ol 2h. starth 21, New 2017				
Discontinued PRN	11:09 PST				
Discontinued Continuous Infus	vancomycin PEN			-	1,000 mg Auth (
	HYDROmorphone (HYDROmorphone PL) dose range: 0.5 to 1 mg. PO, oth, PB, pain, drug form: tab, start: 21-Nov-2017 11:09 PST DILAUDID EQUIV		Med Response	1 mg Last given: 21-Nov-2017 11:54 PST	
10	HIDROmorphone Respiratory Rate				* 0.5 mg Auth () 12 Auth (Verifie



Note: there is a new Med Response box that displays for the PRN medication hydromorphone. For some PRN medications, the system will ask you to complete a medication response assessment. We will address this in the next activity.

Key Learning Points

- Use barcode scanner to administer medications
- Medication volumes will flow from the MAR into the Intake and Output section of iView
- Often times, additional information will be required upon administration

1



Activity 13.2 – Documenting Patient Response to Medication (Medication Response)

When you administer some PRN medications, it is necessary to document how the patient responds to the medication. You can do this directly in the MAR.

1. You have given PRN hydromorphone to your patient. In the MAR that shows PRN hydromorphone, click on the blue **Med Response** cell.

Medications	11-Dec-2017	11-Dec-2017	11-Dec-2017	11-Dec-2017	11-Dec-2017	11-Dec-2017
	18:00 PST	14:00 PST	12:18 PST	11:19 PST	11:18 PST	08:00 PST
Scheduled						
T	650 mg	650 mg				
acetaminophen	Last given:	Last given:				
650 mg, NG-tube, g4h, drug form: tab, start: 11-Dec-2017 10:42 PST	11-Dec-2017	11-Dec-2017				
Maximum acetaminophen 4 g/24 h from all sources	11:18 PST	11:18 PST				
acetaminophen					650 mg Auth (Ve	
Temperature Axillary						
Temperature Oral						
Numeric Pain Score (0-10)						
74						
vancomycin						
1 000 mg IV g12h start: 11-Dec-2017 10:43 PST						
vancomycin					1.000 mg Auth ()	
PRN						
PR	N		Med Response	1 mg		
HYDROmorphone (DII AUDID PRN range dose)				Last given:		
dose range: 0.5 to 1 mg. NG-tube, g4h, PRN pain, drug form; tab, start;				11-Dec-2017		
11-Dec-2017 10:43 PST		1		11:18 PST		
HYDROmorphone		_			* 0.5 mg Auth (V	
Respiratory Rate					12 Auth Merifier	

- 2. The Medication Administration Follow Up window opens. In the Medication Effectiveness Evaluation field, click Yes.
- 3. Click **Sign** icon **✓** to complete the document. You will return to the MAR.



4. Click the **Refresh** icon **C** to update the screen. Now that you have documented the medication response and it has disappeared from the MAR.

PATIENT SCENARIO 13 - Medication Administration



Medications	11-Dec-2017 22:00 PST	11-Dec-2017 18:00 PST	11-Dec-2017 14:00 PST	11-Dec-2017 11:26 PST	11-Dec-2017 11 11:18 PST 0
Scheduled					
acetaminophen 650 mg, NG-tube, q4h, drug form: tab, start: 11-Dec-2017 10:42 PST Maximum acetaminophen 4 g/24 h from all sources	650 mg Last given: 11-Dec-2017 11:18 PST	650 mg Last given: 11-Dec-2017 11:18 PST	650 mg Last given: 11-Dec-2017 11:18 PST		
acetaminophen					650 mg Auth (Ve
Temperature Axillary					
Temperature Oral					
Numeric Pain Score (0-10)					
vancomycin 1,000 mg, IV, q12h, start: 11-Dec-2017 10:43 PST	1,000 mg Last given: 11-Dec-2017 11:18 PST				
vancomycin					1,000 mg Auth (\
PRN					-
PRN HYDROMorphone (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, start: 11-Dec-2017 10:43 PST	4			1 mg Last given: 11-Dec-2017 11:18 PST	
HYDROmorphone					* 0.5 mg Auth (V
Respiratory Rate					12 Auth (Verified

Key Learnings Points

Some PRN medications require further documentation on how the patient responds to the drugs. This can be done under Med Response from the MAR. 1



Activity 13.3 – Administering Continuous IV Fluids (Non-barcoded)

To administer normal saline continuous IV infusion, complete the following steps:

1. From the **MAR**, review the order details for the **sodium chloride 0.9% continuous infusion**.

Note: the status is Pending meaning it has not been administered yet.

Menu		ą	≺ > - 🛧 MAR							[I] Full screen	Print	₽1 minutes ago
Patient Summary		^	*16 60' 📄									
Orders	🕇 Add											
Single Patient Task List			All Orders with Active Tasks in	n Tir ▼	7-November-20)17 13:45 PST -	Wednesday, 29	-November-20	17 13:45 PST (C	inical Range)		
MAR			Show All Rate Change Docu	Medications	28-Nov-2017 13:45 PST	28-Nov-2017 12:09 PST	28-Nov-2017 12:00 PST	28-Nov-2017 10:00 PST	28-Nov-2017 08:59 PST	28-Nov-2017 08:48 PST	28-Nov-2017 08:00 PST	28-Nov-201 *
Interactive View and I&C			Time View	sodium chloride 0.9%	251151151	12107101	22100101	20100101	00000101	0010101	0000101	
Results Review			👿 Scheduled	sodium chloride 0.9% (NS) continuous infusion 1,000 mL order rate: 75 mL/h, IV, drug form: bag, start: 28-Nov-2017	Pending Not previously							
Documentation	+ Add		👿 Unscheduled	13:43 PST, bag volume (mL): 1,000	given							
Medication Request			🗹 PRN	Administration Information sodium chloride 0.9%	1							
Histories		-	Continuous Infusions	Discontinued Scheduled								
Allergies	🖶 Add		🗹 Future	250 mL, IV, once, administer over: 60 minute, drug form: bag, start: 20-Nov-2017 14:00 PST stop: 20-Nov-2017 14:00 PST								
Diagnoses and Problem	s		Discontinued Scheduled	sodium chloride 0.9%								
			🗾 Discontinued Unscheduled	Discontinued Continuous Infusions								
CareConnect			Discontinued PRN	BUpivacaine-fentanyl 0.08%-2 mcg/mL epidural (maternity)								
Clinical Research			Discontinued Continuous Infus	bolus, 0 min bolus frequency, 5 mL PCEA dose, 5 min PCEA lockout interval max PCEA doses/b: 5 epidural drug form:								_
Form Browser				bag, start: 24-Nov-2017 15:55 PST, pump type: CADD Solis, therapy: epi								
Growth Chart			Therapeutic Class View	Administration Information								E
Immunizations			Route View	sodium chloride 0.9% (NS) continuous infusion 1,000 mL		1		1				<u></u> _
Lines/Tubes/Drains Sun	nmary		Plan View	50, IV, drug form: bag, start: 21-Nov-2017 12:10 PST, bag volume (ml): 1 000								
			Taper View	1	III							Þ

To administer the infusion, click on Medication Administration Wizard (MAW) button
 Immedication Administration from the toolbar.

P CSTLEARNING, DEMOALPHA - 700008214 Opened by TestUser, Nurse						
Task Edit View Patient Chart Links Options Help						
🗄 🎬 CareCompass 🌃 Clinical Leader Organizer 🍦 Patient List 😫 Multi-Patient Task List 🐒 Discharge Dashboard 😂 Staff Assignment	The LearningLIVE					
🛛 😋 CareConnect 🔍 PHSA PACS 🔍 VCH and PHC PACS 🔍 MUSE 🔍 FormFast WFI 🚏 🖉 Tear Off 🖧 Exit 🎬 AdHoc 🎟 Meditatio	n Administration 2 Conversation •					
Q Patient Health Education Materials Q Policies and Guidelines Q UpToDate _ [Launch Medication Administration Woard]						
CSTLEARNING, DEMOALPHA						



3. The **Medication Administration** window opens prompting you to scan the patient's wristband. Scan the barcode on the patient's wristband.

P Medication Administration			
LINESTUBESDRAINS, MAX Male	MRN: 700002077 FIN#: 700000003266	DOB: 23-Feb-1985 Age: 32 years	Loc: 301; 01M ** Allergies **
	Please scan Alternatively, select the patient	the patient's wristband. profile manually by clicking the (Next) button.	
Ready to Scan		1 of 2	Next 3

- 4. A list of ordered medications that can be administered appears in the Medication Administration window. The next step would be to scan the barcode on the medication, but with items that do not have a barcode, such as Normal Saline, we cannot do this. Instead, scroll down to manually select the small box on the left beside the order for the Sodium Chloride 0.9% (NS) continuous infusion 1,000mL, order rate: 75ml/hr, IV.
- 5. Click on the **Task Incomplete** icon and the **Charting** window will open for the sodium chloride 0.9% (NS) continuous infusion 1,000mL

P Med	cation Administration						- • •
					Nurse Rev	riew	Last Refresh at 13:53 PST
CST Male	LEARNING, DEMOALPH	HA MRN: 700008214 FIN#: 70000001	4 DOB: 01-Jan-1937 L5055 Age: 80 years				Loc: 624; 02 ** Allergies **
			28-Nov-2017 12:38 PST - 28-Nov-2017	15:08 PST			
	Scheduled	Mnemonic	Details	Result			*
🗖 🗹	328-Nov-2017 10:00 PST	ciprofloxacin	200 mg, IV, administer over: 60 minute, o	I			
0 18	28-Nov-2017 10:00 PST	hydromorphone HYDROmorphone	3 mg, NG-tube, start: 28-Nov-2017 10:00				
🗖 🗹	328-Nov-2017 10:00 PST	vancomycin	1,000 mg, IV, start: 28-Nov-2017 10:00 P	ST			
🗖 🗹	28-Nov-2017 12:00 PST	piperacillin-tazobactam	3.375 g, IV, start: 28-Nov-2017 12:00 PST				
	328-Nov-2017 14:00 PST	acetaminophen	650 mg, PO, drug form: tab, start: 28-No Maximum acetaminophen 4 g/24 h from				
	28-Nov-2017 14:00 PST	hydromorphone HYDROmorphone	3 mg, NG-tube, start: 28-Nov-2017 14:00				
	328-Nov-2017 15:00 PST	moxifloxacin MOXIfloxacin	400 mg, IV, administer over: 60 minute, o	l			
	PRN	fentanyl fentanyl (fentanyl PRN r	dose range: 25 to 50 mcg, IV, q5min, PR 				
	🗃 Continuous	norepinephrine norepinephrine additive.	titrate, IV, 0 mcg/min minimum rate, 20 .				
4 5	Continuous	Sodium Chloride 0.9%	order rate: 50 mL/h, IV, drug form: bag,				
2	Continuous	Sodium Chloride 0.9% sodium chloride 0.9% .	order rate: 75 mL/h, IV, drug form: ba	1,000 mL, I\	/, 75 mL/h, <site>_</site>		



- 6. Fill in the following information, in this case:
 - **Performed time** = 0600
 - **Site** = Jugular, Internal Right
- 7. Click OK

Charting for: CSTLEARNI		•	Ť		
order rate: 75 ml/h_IV_drug	NS) continuous infusion 1,0 form: bag_start: 11-Dec-2017 10	300 mL :43 PST_bag volume (ml)	: 1 000		
		···· · · · · , ··· · · · · · · · · · ·	,		
Ves No sodi	um chloride 0.9% (NS) continuc	ous infusion 1,000 mL			Change
*Performed date / time :	11-Dec-2017 🚽 🗸 06	00 6 PST			Comment
*Performed by :	TestUser, ICU-Nurse				
Witnessed by :					
*Bag # :	1				
*Site :	-				
	<show all=""></show>				
*Volume (mL) :	Antecubital Fossa - Left				
*Rate (mL/h) :	Antecubital Fossa - Right				
	Arm, Lower - Left				
	Arm, Lower - Right				
	Arm, Upper - Left				
	Arm, Upper - Right				Paula Paul
	Chest, Anterior - Left				ведіп вад
	Chest, Anterior - Right			OK	7 Cancel
	Foot - Left			OK	Cancer
η	Foot - Right				
	Groin - Left				
	Groin - Right				
1 1 1 1 1	Hand - Left				
	Hand - Right				
	Jugular, External - Left				
	Jugular, External - Right				
	Jugular, Internal - Left	² f ²			
	Jugular, Internal - Right	6			

8. Click the Sign button

P Medi	cation A	dministration				
					Nurse Review	Last Refresh at 11:24 PST
CST Male	DEMO	D, ZEUS	MRN: 700004780 FIN#: 7000000013571	DOB: 01-Feb-1979 Age: 38 years		Loc: ICO6; 01 ** Allergies **
			02-Dec-2017 1	0:09 PST - 02-Dec-2017 12:3	39 PST	
		Scheduled	Mnemonic	Details	Result	*
- W	स	02-Dec-2017 08:00 PST	thiamine	200 mg, PO, drug form: ta Vitamin B1	ab, start: 02-De	
	1	02-Dec-2017 12:00 PST	piperacillin-tazobactam	3.375 g, IV, start: 02-Dec-2	2017 12:00 PST	
	1	PRN	Dextrose 50% in Water dextrose 50% (dextrose.	12.5 g, IV, q15min, PRN hy For blood glucose 4 mmo	/poglycemia, dr il/L or LESS: ad	
	ক	PRN	fentanyl	25 mcg, IV, q5min, PRN pa	ain-breakthrou	
	ेला	PRN	fentanyl fentanyl (fentanyl PRN r	dose range: 25 to 50 mcg	, IV, q5min, PR	
	ক	PRN	hydromorphone HYDROmorphone (HYD	dose range: 0.5 to 1 mg, I . DILAUDID EQUIV	V, q1h, PRN pa	
	स्त	PRN	salbutamol salbutamol (salbutamol .	100 mcg = 1 puff, inhalati	on, q1h, PRN s	
	-	PRN	sodium citrate sodium citrate (sodium .	3 mL, instillation, q4h inter PRN Reason: For capping.	val, PRN other of dialysis cath	
	` @ (9 0	Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting . Protocol for Patient NOT (rate, 0 unit/h currently receivi	
	**	Continuous	norepinephrine norepinephrine additive.	titrate, IV, 0 mcg/min mini	mum rate, 20	-
~ ~	•	Continuous	Sodium Chloride 0.9% sodium chloride 0.9% .	order rate: 25 mL/h, IV, o	drug form: ba 1,000 mL, IV, 2	5 mL/h, Jugular, Internal - Rig
٠ -						
Ready t	o Scan			2 of 2		B 8 Sign



9. You will return to the **MAR** where the initiation of sodium chloride 0.9% continuous infusion at 75mL/h is now shown as complete.

ochachanaic n	i 45070010555 Dobing With 5 kg toolation.		Accordingent	oven, 100000, 10	
🗙 > - 者 MAR			[□] Full screer	n 🛑 Print	∂ 1 n
*11 60' 📄	Evideur 01 December 2017 00:26 BET	Fundau 02 December 2017 0)-26 PCT (Clinical	Pango)	
All Medications (System)	•	Sunday, 05-December-2017 0	5.30 F31 (Clinical	Kaliye)	
Show All Rate Change Docu	Medications	02-Dec-2017 12:00 PST 11:24 PST	02-Dec-2017 11:16 PST	02-Dec-2017 11:15 PST	02-E 10
Time View Scheduled Unscheduled	norepinet additive 8 mg dextrose 5% (DSW) titratable infusion 250 mL titrate, IV, 0 mcg/min minimum rate, 20 mcg/min maximum rate, titrate instructions: titrate to maintain MAP goal, start: 15:Nov-2017 15:18 PST, bag volume (mL): 250		Pending Last bag started: 15-Nov-2017 16:04 PST		
 ✓ PRN ☑ Continuous Infusions 	Administration Information NORepinephrine dextrose 5%				
Future Discontinued Scheduled	sodium chloride 0.9% (NS) continuous infusion 1.000 mL order rate: 25 mL/h, IV, drug form: bag, start: 15-Nov-2017 15:18 PST, bag volume (mL): 1.000	1,000 mL Last bag starte 02-Dec-2017 11:15 PST	9	Complete	
Therapeutic Class View Route View	Administration Information sodium chloride 0.9%			Begin Bag 1,000)
Disc. Marca	Discontinued Scheduled		-		_

- 10. Navigate to Interactive View and I&O from the Menu
- 11. Select the Intake and Output band.
- 12. Click the Refresh icon 🜊.
- 13. After you refresh the page you should see the **sodium chloride 0.9% (NS) continuous infusion**

Menu		4	< 🔹 🔹 👫 Interactive View and I&O									(D) Full	screen 👼	Print 🕹	1 minutes ago
Patient Summary		4	h =												10
Orders	🕂 Add														12
Single Patient Task List			Adult Critical Care Quick View		Sunday, 10-December	-2017 06:00	PST - Wedr	esday, 13-D	ecember-20)17 05:59 PS	5T				
MAR			Adult Critical Care Systems Assessment		Today's Intake: 0 mL Output: 0 mL Balance: 0 m	L Yester	day's Intake	0 mL Ou	utput: 0 mL	Balance: (D mL				
MAR Summary				S 101			11-De	c-2017						11-Dec-2017	
Interactive View and I&O 10 Intake And Output 11					11:00 - 11:59 PST	10:00 - 10:59 PST	09:00 - 09:59 PST	08:00 - 08:59 PST	07:00 - 07:59 PST	06:00 - 06:59 PST	24 Hour Total	Night Shift Total	05:00 - 05:59 PST	04:00 - 04:59 PST	
Interactive View and 18:0 10 Continuous Infusions				4	⊿ Intake Total										
Results Review			Medications		Continuous Infusions										
Documentation	🕂 Add		Chest Tubes	-	sodium chloride 0.9% (NS) continuous infusion	13			75	75	75				
Medication Request			GLTube	비는	⊿ Oral					17					
medication nequest			GI Octomy Intaka		Oral Intake mi										
Histories			Urinary Diversion Intake		△ Other Intake Sources										
Allergies	🛨 Add		Oral	4	⊿ Output Total										
- 0'			Other Intake Sources		⊿ Emesis Output										
Diagnoses and Problem	ns		Negative Pressure Wound Therapy		⊿ Other Output Sources										
			Surgical Drain, Tube Inputs		⊿ Stool Output										
			Transfusions	_ _	Stool Count (Number of Stools)										
CareConnect			Hinan/Cathatar Intaba	÷	⊿ Urinary Catheter, Output										
Clinical Research			Advanced Graphing		⊿ Urine Output										
Curci			Solution Report Administration		Urine Voided ml										
Form Browser Continuous Renal Replacement There		Continuous Renal Replacement Therapy		Balance											

- 14. Since the NS continuous infusion was started at 0600, you can double click in the blank cells under each hourly column since 0600 to populate the hourly continuous infusion volumes.
- 15. Click the **Sign** icon \checkmark to complete your documentation

Note: A partial volume will populate if the infusion was started or stopped part way through the hour.



< 🔹 🔸 🔒 Interactive View and I&O									(C) Fel	screen 🖨	Print .
~= 215											
Adult Critical Care Quick View		Sunday, 10 Decemb	er-2017 06:00	175T - Wede	sesday, 13 D	Neurober-2	017 05:59 P	ST.		16.16	
Adult Critical Care Systems Assessment		Today's Intake 0 mi Output 0 mi Balance 0 mi. Yesterday's Intake 0 mi. Output 0 mi Balance 0 mi									
Adult Critical Care Lines - Devices Intake And Output		R in	11:00 -	10:00 -	11-04 09:00 -	08:00 -	07:00 -	06:00 -	24 Hour	Night Shift	05:00 -
Contruct Multim		d Intake Total	11:39 PSF	10:39 PST	09.39 P31	00.39 PSI	07.39 PST	00.39 Pat	TOTAL	101ai	100.00 POI
Medications		// Continuous Infusions			_				_		
Chest Tubes Enteral		sodium chioride 0.9% (Kil) continuous infusion 3,000 mi.	int.	14	-	1	25	75			
GI Tube	1.00	⊿ Oral		. Atlat	-	1	1.5				
GI Ostomy Intake		Oral Intake	nd.]		-						
Ultrary Diversion Intake		d Other Intake Sources									
Onal		⊿ Output Total				-	_			C	
Other Intake Sources		⊿ Emesis Output				Do	uble clici	king the I	blank		
Negative Pressure Wound Therapy		∠ Other Output Sources				0	ells will r	onulate	the		
Surgical Drain, Tube Inputs		a Stool Output					and trin p	lumo of	ha		
Transfusione		Stool Count (Number of Stools)	10	-			iourly vo	iume or t	ne	-	
Advanced Graphing		d Usine Output	0				continuo	us infusio	on		
Contract Administration		Unine Voided				-	_	_	_		
Continuous Renal Replacement Therapy		Ealar	ce								

Key Learning Points

- Continuous infusions are administered using MAR and MAW
- Non-barcoded IV fluids cannot be scanned, but the patient's wristband should still be scanned through MAW to help identify the correct patient
- All fluids administered through MAR and MAW should flow to the Intake and Output record within iView. Always double check the volumes flow correctly. (Sometimes manual entry is necessary)



Activity 13.4 – Documenting Titratable Infusions

Titrating medication infusions is a common practice in critical care areas. This scenario will use norepinephrine infusion as an example.

First, let's document the patient's blood pressure in the vital signs section of iView.

Note: In critical care areas, the bedside monitors will be interfaced with the CIS, automatically pulling in patient vital signs and reducing the need for manual documentation. This will be taught in another education session.

In order to complete the following activity in this workbook you will have to manually enter vital signs:

- 1. Navigate to Interactive View and I&O from the Menu
- 2. In the Adult Critical Care Quick View band, select the Vital Signs section
- 3. For the purposes of documenting titratable vasopressors, let's say we need to document q15min vital signs. Right click on the most current time column on your screen.
- 4. An **Insert Date/Time** drop-down menu appears. Select **Q15min.** Once selected, note the time columns now display in 15-minute intervals.

Menu	\$ - A Interactive View and I&O 							[D] Full screen	💼 Print	💸 2 minutes ago
Patient Summary	■ ■ ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ● ●									
Ordere Add										
Thus Thus	Adult Critical Care Quick View			Last 24 Hours						
Single Patient Task List	VITAL SIGNS			Last 24 mours						_
MAR	Ventilator Subset	Find Item	Abnormal Unauth	E Flag	And Or					
MAR Summary	PAIN ASSESSMENT	Danuk Commente	Date Date	Parlomed Br						
Interactive View and I&O	Heado Infusion	Conneres	ring Dave	Terretified by						
	V IV Drips	× 1//								
Results Review	 Glucose Blood Point of Care 		tar 🗖 11-20 🗖 11-11		12	-Dec-2017		00.30		-
Documentation 🕂 Add	Glasgow Coma Assessment		1:45 - 11:50 - 11:15	11:14 PST 10:5	9 PST 10:44 PST	10:29 PST 10:14	PST 09:59 PST (09:44 PST 09:29 PST	09:14 PS	08:59 PS1
Medication Request	Sedation Scales Provider Notification	d VITAL SIGNS	Insert Date/Time							
1 Estavior	Measurements	Temperature Axillary DegC	Actual							
HISTORIE	Transfer/Transport	Temperature Oral Degu	030 (85							
Allergies 🕂 Add	Shift Report/Handoff	Perinheral Pulse Pate hnm	quo sec							
Diagnoses and Problems		Heart Rate Monitored bpm	Q1 min							
		SBP/DBP Cuff mmHg	Q3 min							
		Cuff Location	Q5 min							=
CareConnect		Mean Arterial Pressure, Cuff mmHg	010 min	-						
Clinical Research		SBP/DBP Arterial Line mmHg	✓ Q15 min							
Form Prowner		Central Venous Pressure mmHg	030 min							
		Intracranial Pressure mmHg	01.64							
Growth Chart		Cerebral Perfusion Pressure, Cuff mmHg	Q1 III							
Immunizations		Cerebral Perfusion Pressure, Invasive mmHg	Q2 hr							
Lines (Tabas (Desire Summers)		⊿ Oxygenation	Q4 hr							
Lines/Tubes/Drains Summary		Meanured 02% (EIO2)	Q8 hr							
Medication List 🔹 🕈 Add		Owgen Activity	012 hr							
Patient Information		Oxygen Therapy	024 br							
Defense		Oxygen Flow Rate L/min	944							
		End Tidal CO2 mmHg	Q40 hr							
		SpO2 %	Q72 hr							
	Adult Critical Care Systems Assessment	SpO2 Site	Q120 hr							
	& Adult Critical Care Lines - Devices	∠ PAIN ASSESSMENT								
	🔨 Intake And Output	Pain Present								
	& Advanced Graphing	Respiratory Rate br/min								
	Contract Administration	Onset								
	Continuous Renal Replacement Therapy	Provoking								
	Adult Education	Quality								
	CRestraint and Seclusion	Location								
	Adult Procedures	I skewlike								

Let's document vital signs for 08:00

- 5. Under the 08:00 time column double click in the blank cell to document SBP/DBP Cuff as follows:
 - SBP/DBP Cuff = 90/37
 - **Press Enter** on the keyboard



- 6. Under the same time column, double click in the blank cell to document **Mean Arterial Pressure, Cuff**.
 - This cell will populate based on a calculation
- 7. A **Warning** window will display to say the value of 55mmHg for MAP is outside the defined critical limits, do you want to accept it? Select **Yes**

🔨 Adul	It Critical Care Quick View		Last 24 Hours										
~	VITAL SIGNS												
	Ventilator Subset PAIN ASSESSMENT	Find Item Critical	High	Low	Abnormal	Unauth	Flag	0	And 💿 Or				
~	Insulin Infusion	Denik	Commente	Dee	Data		Defensed De						
	Heparin Infusion	X. 36						12 De	c 2017				
1	IV Drips	R Ža		08:30 -	08:15 -	08:00 -	07:45 -	07:30 -	07:15	07:00 -	06:45 -	06:30 -	06
~	Glucose Blood Point of Care			08:44 PST	08:29 PS	08:14 PST	07:59 PS1	45 - 07:50 - 07:29 PST 07:14 PST 06:59 PST 06:44 PST					
	Glasgow Coma Assessment	⊿ VITAL SIGNS											
	Sedation Scales	Temperature Axillary	DegC										
	Provider Notification	Temperature Oral	DegC										
	Measurements	Apical Heart Rate	bpm										8
	Transfer/Transport	Peripheral Pulse Rate	bpm				-						
	Shift Report/Handoff	Heart Rate Monitored	bpm				5						
		SBP/DBP Cuff	mmHg			90/37	Warning						
		Cuff Location					Training						
		💷 Mean Arterial Pressure, Cuff	mmHg				e						
		SBP/DBP Arterial Line	mmHg				0	The value of	55 mmHg fo	r Mean Arteria	I Pressure, Cu	iff is outside th	ne 🛛
		Mean Arterial Pressure, Invasive	mmHg					defined criti	cal limits, wh	ich are set fror	n 60 to 200. D	o you want to	
		Central Venous Pressure	mmHg					accept it?				·	
o√ Adul	It Critical Caro Systems Assessment	Intracranial Pressure	mmHg										
Auu	a chucaí care systems Assessment	Cerebral Perfusion Pressure, Cuff	mmHg										
💊 Adu	It Critical Care Lines - Devices	Cerebral Perfusion Pressure, Invasive	mmHg										
💊 Intal	ke And Output	⊿ Oxygenation									Yes		0
X Adva	anced Graphing	Respiratory Rate	br/min									_	7
S Blog	d Product Administration	Measured O2% (FIO2)					-						
	finnens Danal Danlagement Thereny	Oxygen Activity											
Con	unuous kenai kepiacement Therapy	Oxygen Therapy											
🗙 Adul	It Education	Oxygen Flow Rate	L/min										
K Res	traint and Seclusion	End Tidal CO2	mmHg										
a√ ∆dul	t Procedures	SpO2	%										Ψ.

8. Click the **Sign** icon \checkmark to complete your documentation. Notice the MAP value of 55 displays in red, indicating it is a critically low value.

Adult Critical Care Quick View	4			Liste	4 Hours	
VITAL SIGNS						
Ventilator Subset	Find Item	High	Low E	Abnormal	Unauth	Flag
PAIN ASSESSMENT						
 Insulin Infusion 	LG b	-IC	10ma	LOuis		Dudamed D.
Heparin Infusion	Sale Hol					
V Drips	n 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		08:30	08:15 -	08:00 -	07:45 -
 Glucose Blood Point of Care 			08:44 P	ST 08:29 PS	T 08:14 PST	07:59 PST
Glasgow Coma Assessment	J VITAL SIGNS			Mit collected	C	1
Sedation Scales	Temperature Axillary	DegC				
Provider Notification	Temperature Oral	DegC				
Measurements	Apical Heart Rate	bpm				
Transfer/Transport	Peripheral Pulse Rate	bpm				
Shift Report/Handoff	Heart Rate Monitored	bpm				
	SBP/DBP Cuff	mmHg			90/37 4	
	Cuff Location			_		
	Mean Arterial Pressure, Cuff	mmHg			55	
	SBP/DBP Arterial Line	mmHg		_	1 - CARR - R. 1	
	Mean Arterial Pressure, Invasive	mmHg				
	Central Venous Pressure	mmHg				
Adult Critical Care Systems Assessment	Intracranial Pressure	mmHg				
Autor Critical Care Systems Assessment	Cerebral Perfusion Pressure, Cuff	mmHg				
Adult Critical Care Lines - Devices	Cerebral Perfusion Pressure, Invasive	immH9				
Vintake And Output	⊿ Oxygenation					
& Advanced Graphing	Respiratory Rate	br/min				
S Blood Product Administration	Measured O2% (FIO2)			_		
Continues Dend Designment Thereau	Oxygen Activity					
Continuous Renal Replacement Therapy	Oxygen Therapy			-		
& Adult Education	Oxygen Flow Rate	L/min				
Restraint and Seclusion	End Tidal CO2	mmHg				-
Adult Procedures	SpO2					8



- 2 Your patient has an order for a titratable **norepinephrine infusion 0-20mcg/min** to maintain the patient's MAP goal of 65mmHg or greater. Since your patient's MAP is now 55mmHg, we need to initiate the norepinephrine infusion.
 - 1. Navigate to MAR from the Menu and select Continuous Infusion.
 - 2. Hover over the medication **norepinephrine additive 8mg dextrose 5% (D5W) titratable infusion 250 mL** to see additional details about the order.

Menu		< > - 🔒 MAR										
Patient Summary		** 60 🗎										
Orders	🕈 Add											
Single Patient Task List		All Medications (System)	▼		Wednesday, 13-	-December-201	7 10:58 PST - Fr	iday, 15-Decem	ber-2017 10:58	8 PST (Clinical Ra	inge)	
MAR 1		Show All Rate Change Docu	Medications	14-Dec-2017 15:09 PST	14-Dec-2017 15:08 PST	14-Dec-2017 14:00 PST	14-Dec-2017 10:00 PST	14-Dec-2017 06:00 PST	14-Dec-2017 02:00 PST	13-Dec-2017 22:00 PST	13-Dec-2017 18:00 PST	13-Dec-2017 14:00 PST
MAR Summary		Time View	Scheduled									
Interactive View and I&O		Scheduled	acetaminophen	650 mg Last given:								
Results Review		Unscheduled	650 mg, NG-tube, q4h, drug form: tab, start: 14-Dec-2017 15:09 PST Maximum acetaminophen 4 g/24 h from all sources	11-Dec-2017 11:18 PST								
Documentation	🕂 Add	PRN PRN	acetaminophen									
Medication Request		Continuous Infusions	mperature Axillary mperature Oral									
Histories		V Future	umeric Pain Score (0-10)									
Allergies	🕂 Add	Discontinued Scheduled	ranitidine	50 mg Not previously								
Diagnoses and Problems		Discontinued Unscheduled	50 mg, IV, q12h, start: 14-Dec-2017 15:09 PST ranitidine	given								
		Discontinued PRN	13		1,000 mg Last given:							
CareConnect		Discontinued Continuous Infus	1,000 mg, IV, q12h, start: 14-Dec-2017 15:08 PST		11-Dec-2017 11:18 PST							
Clinical Research			vancomycin									
Form Browser			PRN	PPN 1mg								
Growth Chart			HYDROmorphone (DILAUDID PRN range dose)	Last given:								
Immunizations			dose range: 0.5 to 1 mg, NG-tube, q4h, PRN pain, drug form: tab, start: 11-Dec-2017 10:43 PST	11-Dec-2017 11:18 PST								
Lines/Tubes/Drains Summ			HYDROmorphone Respiratory Bate									
Lines/Tubes/Drains Summ	nary		Respiratory Rate	PRN 5 mg								
Medication List	🖶 Add		salbutamol	Last given:								
Patient Information			start: 12-Dec-2017 10:32 PST	10:42 PST								
Reference			salbutamol									
				Pending								
			norepinephrine additive 8 mg	Last bag started								
			dextrose 5% (DSW) titratable infusion 250 mL titrate, IV, 0 mcg/min minimum rate, 20 mcg/min maximum rate, titrate,	06:30 PST								
			instructions: titrate to maintain MAP goal, start: 10-Dec-2017 15:52 PS volume (mL): 250	orepinephrine additiv	e 8 mg + dextros	ie 5% (D5W) titra	able infusion 25	0 mL				
			Administration Information t	itrate, IV, 0 mcg/min r	ninimum rate, 20) mcg/min maxir	num rate, titrate					
			NORepinephrine	nstructions: titrate to i	maintain MAP go	oal, start: 10-Dec-	2017 15:52 PST, E	bag				
		Therapeutic Class View	Oextrose 5%	oiume (mL): 200				2				
Route View			sodium chloride 0.9% (NS) continuous infusion 1,000 mL	Not previously			_	2				
		Plan View	order rate: 125 mL/h, IV, drug form: bag, start: 10-Dec-2017 15:52 PST, b	ag given								

3. Click the **Medication Administration Wizard (MAW)** button In the Toolbar. The **Medication Administration** window opens prompting you to scan your patient's wristband. Scan the barcode on your patient's wristband now.

Medication Administration			
CSTLEARNING, DEMOTHETA Male	MRN: 700008216 FIN#: 7000000015058	DOB: 01-Jan-1937 Age: 80 years	Loc: 406; 01 ** Allergies **
Alte	Please scar rnatively, select the patient	n the patient's wristband. profile manually by clicking the (Next) button.	
Ready to Scan		1 of 2	Nex 3



4. Now scan the barcode for the **norepinephrine vial (4mg/4mL).** The **Filtered Tasks** window appears suggesting that not all ingredients were scanned. This is because the order calls for 8mg of norepinephrine in 250mL of dextrose 5%. You are being asked to scan both of these additional ingredients.

P Filtered Tasks			X
CSTLEARNING, DEMOTHETA Male	MRN: 700008216 FIN#: 7000000015058	DOB: 01-Jan-1937 Age: 80 years	Loc: 406; 01 ** Allergies **
Scanned:			
Medication Strength Volume VORepinephrine 4 mg 4 mL			
Qualified Tasks:			
Scheduled Mnemonic	Details		Qualifications
Continuous norepinephrine norepinephrine additive 8 mg +	titrate, IV, 0 mc dextrose	g/min minimum rate, 20 mcg/min m	Not all ingredients scanned
Scan additional ingredients or choose a task to	continue.		



- 5. Scan the barcode for the **norepinephrine vial (4mg/4mL)** again. Notice the strength changed to **8mg** and the volume changed to **8mL**. This matches the order.
- 6. The **Filtered Tasks** window is still suggesting that not all ingredients were scanned. This is because the 250mL of dextrose 5% has not been scanned. You cannot scan the dextrose because it is a Stores item and does not have a barcode.

7.	Click to	highlight the	qualified t	task and	select OK.

STLEARNING, DEMOTHETA	FIN#: 700008216	Age: 80 years	Loc: 406; ** Allergie
anned:			
edication Strength Volume Repinephrine 8 mg 8 mL 5			
alified Tasks:			
Scheduled Mnemonic	Details		Qualifications
			The second
norepinephrine additive 8 mg	+ dextro		/

8. A **Warning** window displays to tell you that not all ingredients in the task have been scanned. Click **Yes** to continue documentation (as you cannot scan the dextrose).





- 9. The Charting window for norepinephrine displays. Fill in the following fields:
 - *Performed date/time = Today at 0800
 - **Site** = Jugular, Internal Right
 - ***NORepinephrine Dose** = 5 mcg/min

Note: The **Rate (mL/h)** field automatically populates based on the dose. Always double check the dosage and infusion rates in the **Charting** window with the infusion pump. If there is a discrepancy between two values, follow the readings from the infusion pump and change the values in the **Charting** window.

10. Click OK

∥Yes ⊡No ∥Yes ⊡No	o nore dextr	pinephrine ad rose 5% (D5W	lditive 8 mg/8 mL) titratable infusio	n 250 mL	 Change
Performed date	e/time:	12-Dec-2017		800 9 PST	Comment
*Perfor	med by :	TestUser, ICU	I-Nurse		
Witne	essed by :				
	*Bag # :	1		_	
	*Site :	Jugular, Inte	rnal - Right 👻	9	
*Volu	me (mL) :	250			
"Rate	e (mL/h) :	9.38			
*NORepinephri	ne Dose :	5	mcg/min	•	



11. You are brought back to the **Medication Administration** window. Click **Sign** button

					Nurse Review	Last Refresh at	13:11 PST
CST	PROD	AC, JENNI	MRN: 700005690 FIN#: 7000000016323	DOB: 01-May-1995 Age: 22 years			Loc: ; "Allergies "
			12-Dec-2017 1	1.56 PST - 12-Dec-2017 14:	26 PST		
T	1.772.5	Scheduled	Mnemonic	Details	Result		
1	78.23	12-Dec-2017 13:09 PST	thiamine	200 mg, IV, drug form: in VITAMIN B1 EQUIV	, start: 12-Dec		
1		PRN	Dextrose 50% in Water dextrose 50% (dextrose.	12.5 g. IV, q15min, PRN h For blood glucose 4 mm	ypoglycemia, dr xl/L or LESS: ad		
1	18	PRN	magnesium sulfate	5 g. IV. once, PRN hypom Dose as per ICU Electroly	agnesemia, ad te Replacement		10
		PRN	potassium chloride	20 mmol, IV, q30min, PRM Dose as per ICU Electroly	I hypokalemia, te Replacement		
3	1033	PRN	potassium chloride	40 mmol, NG-tube, TID, P Dose as per ICU Electroly	RN hypokalemi te Replacement		
		PRN	sodium phosphate SODIUM phosphate	15 mmol, IV, q4h interval, Dose as per ICU Electroly	PRN hypophos te Replacement		E
1	10030	Continuous	insulin regular insulin regular (human)	titrate, IV, 1 unit/h starting Protocol for Patient NOT	g rate, 0 unit/h currently receivi		
		Continuous	norepinephrine norepinephrine additi	titrate, IV, 0 mcg/min m	inimum rate, 250 mL, I	V, 9.38 mL/h, Jugular, In	ternal - Rig
1					0		

12. The norepinephrine task now appears as complete on the MAR. Click **Refresh** icon and you will see Begin Bag details under the 0800 time column.

< > - 🏦 MAR							(D) Full s	reen 🝙 🖡	2 2 0 minutes ago
*** 6* 🗎	L.								
MII Medications (System)	▼ Tuesday.	2018-January-16	14:50 PST - Thi	ursday, 2018-Ja	nuary-18 14:50	PST (Clinical Rar	nge)		4 F
Show All Rate Change Docu	Medications	2018-Jan-17 15:21 PST	2018-Jan-17 14:00 PST	2018-Jan-17 10:00 PST	2018-Jan-17 08-00 PST	2018-Jan-17 07:00 PST	2018-Jan-17 06:00 PST	2018-Jan-17 02:00 PST	*
Time View Scheduled Unscheduled PRN	PI SODUM phosphate 15 mmol, IV, geh intenal, PRN hypophosphatemia, administer over: 120 minute, order duration: 3 dosextimes, drug form: bag, start: 2017-Dec-27 12:14 PST, stop: Limited # of times, bag volume (mL): 100 Dose as per L'O Bectoryte Replacement Protocol if creatinine less than 15	IS mmol Not previously given	1.001.01	20100101				02100101	
Continuous Infusions	SODIUM phosphate								
Future Future Discontinued Scheduled Discontinued Unscheduled Discontinued PRN	insulin regular (human) additive 100 unit sodium chloride 0.9% (NS) titratable infusion 100 mL ttrate, N, 1 unit/n starting rate, 0 unit/n minimum rate, 20 unit/n maximum rate, ttrate instructions: Titrate as per insulin infusion protocol, start: 2017-Dec:27 1214 PST, bag volume (mL) 100 Protocol for Patient NOT currently receiving insulin infusion Biood quico	Pending Not previously given							
Discontinued Continuous Infus	Administration Information insulin regular codium choiride 0.9%								
Theorem of the Marine	compensation and the set of	Pending Last bag started: 2018-Jan-17 15:21 PST Begin Bag 250 n	12						E
Therapeutic Class View Route View	NORepinephrine dextrose 5%	5 mcq/min Auth	12						



3 You initiated the norepinephrine infusion at 0800 at 5mcg/min. At 0815, your patient's MAP is 70 so you decrease the norepinephrine to 3mcg/min.

Let's practice how to document this in iView:

- 1. Navigate to Interactive View and I&O from the Menu
- 2. Under the Adult Critical Care Quick View band, select the Vital Signs section.
- 3. Scroll to the right to find the **08:15** time column. Document the patient's SBP/DBP Cuff as follows:
 - **SBP/DBP Cuff** = 100/55
 - Mean Arterial Pressure, Cuff = (double click in blank cell to auto-fill) 70





- 4. Now, under the **Adult Critical Care Quick View** band select the **IV Drips** section. Here you will see titratable infusions that have pulled in from documenting on the MAR.
- 5. Notice the documentation for the **norepinephrine infusion** pulls in under the **0800** column showing that the infusion is running at **5 mcg/min** (9.38mL/h).
- 6. Double click the blank cell under the **0815** time column for the **NORepinephrine mcg/min** dose. Change the dose from 5 to **3**. Press **Enter** on the keyboard. Notice the Rate in mL/h automatically updates.

Note: Always double check the dosage and infusion rates in **IV Drips** section with the infusion pump. If there is a discrepancy between two values, follow the readings from the infusion pump and change the values in **IV Drips** section.

Menu		🕫 🔇 🔹 🛉 Interactive View and I&O	<u> </u>	
Patient Summary				
Orders	+ Add			_
Single Patient Task Li		Adult Critical Care Quick View		1
MAR		VirtAL SIGNS	The second states when the second states it	ie.
MAR Commune		PAIN ASSESSMENT	· Douge - Douge Bude Eren Brennen - Douge -	10
much summary		Insuln Infusion	Result Connents Rag Date	Per
Interactive View an	aiwo	V Des		
Results Review		Glucose Blood Point of Care		-
Documentation	+ Add	Glasgow Coma Assessment	08:29 PST 08:14 PST 07:59 PST	-
Medication Request		Provider Notification	SpO2 Site	
Histories		Measurements	Sp02 Site Change	
		Transfer/Transport	Pain Present	
winder	T 400	Shift Nepot/Handoff	Respiratory Rate br/min	
Diagnoses and Proble	1715		Onset	
			Provoking	
A			Paliating	
CareConnect			Location .	
Clinical Research			Laterality	
Form Browser			Radiation Characteristics	
			Pain Comment	
Growth Chart			Secondary Pain Site	
Immunizations			Additional Pain Sites	
Lines/Tubes/Drains S	ummary		W Pain Tool Used	
Medication List	+ 444		V 3 3	
Patient Information			insulin regular (human) additive 100 unit + todium chloride 0.9% (NS) titratable infusi Rate	
And and a second se			ingulin regular	
Reference			100	
			norepinephrine additive 8 mg +	
		X Adult Critical Care Systems Assessment	NOReside that have been a state of the state	
		Adult Critical Care Lines - Devices	A Claiman Come Assessment	
		Vintake And Output	Eve Coening Response	
		Advanced Graphing	Verbal Response	
		Blood Product Administration	Motor Response	
		Continuous Renal Replacement Therapy	Glasgow Coma Score	
		Adult Education	Response to Stimuli Affected by	
		Pastraint and Sarbisian	A Section Scales	
		A data Datas datas	A senarrow state rosea	
		Noul Procedures	(C	

7. Click the **Sign** icon \checkmark to complete your documentation.



- At 0830, your patient's MAP is still 70 mmHg so you decrease the norepinephrine to 2mcg/min. Again, let's document this in iView:
 - 1. Click on the **Vital Signs** section in iView
 - 2. Under the **08:30** time column, document the patient's SBP/DBP Cuff as follows:
 - **SBP/DBP Cuff** = 102/54
 - Mean Arterial Pressure, Cuff = (double click in blank cell to auto-fill) 70

🗧 🕈 🕺 Interactive View and I&O												[0]	Full screen	🛱 Print	~2°0 n
💷 🎶 🖌 🚫 🦉 📰 📰 🍋 🛪															
ult Critical Care Quick View						Lact 24 M	0.1155								
VITAL SIGNS						Last 24 In	burs								
Ventilator Subset	Find Item - Critical	🔲 High	Low	Abnormal	🔲 Unauth	Elag	C	And	Or						
PAIN ASSESSMENT															
Insulin Infusion	Result	Comments	Flag	Date		Performed By									
Heparin Infusion															
IV Drips	X . 34								12 Dec 3	17					
Glucose Blood Point of Care			00.15	00:00	08-45	08-30	09-15	08-00	15-Dec-2	07:30	07:15	07:00	06:45	06-20	
Glasgow Coma Assessment			09:29 PS	T 09:14 PS	T 08:59 PS	08:44 PST	08:29 PS	T 08:14	PST 07:59	PST 07:44 P	T 07:29 PS	T 07:14 PS	T 06:59 PS	T 06:44 F	PST 🛄
Sedation Scales	4 VITAL SIGNS														
Provider Notification	Temperature Axillary	DeqC													
Measurements	Temperature Oral	DegC													
Transfer/Transport	Apical Heart Rate	bpm													
Shift Report/Handoff	Peripheral Pulse Rate	bpm													
	SBP/DBP Cuff	mmHq				102/54	100/55	90/37	4						
	Cuff Location														
	Mean Arterial Pressure, Cuff	mmHg			10	70	70	55	!						
	Mean Arterial Pressure, Manual	mmHg							-						_
	Blood Pressure Method					2									
	Central Venous Pressure	mmHg													
	SBP/DBP Supine	mmHg													
	Pulse Supine	bpm													
	SBP/DBP Sitting	mmHq													
	Pulse Sitting	bpm													
	SBP/DBP Standing	mmHq													
	Pulse Standing	bpm													
	Intracranial Pressure	mmHq													
	Cerebral Perfusion Pressure, Cuff	mmHg													
	Cerebral Perfusion Pressure, Invasive	mmHg													
	⊿ Oxygenation														
	Respiratory Rate	br/min													
	Measured O2% (FIO2)														
Critical Care Systems Assessment	Oxygen Activity														
Orthog Orea Lines Devices	Oxygen Therapy														
Childal Care Lines - Devices	Oxygen Flow Rate	L/min													
e And Output	End Tidal CO2	mmHg													
nced Graphing	Skin/Nare Check														
1 Product Administration	SpO2	%													
inverse Denel Denlagement Thereny	SpO2 Site														
inuous renai replacement Therapy	SpO2 Site Change														
Education	⊿ PAIN ASSESSMENT														
traint and Seclusion	Pain Present														
Procedures	Derniraton: Data	hr/min			_										



- 3. Scroll down, or click on the IV Drips section
- Double click the blank cell under the 0830 time column for the NORepinephrine mcg/min dose. Change the dose from 3 to 2. Press Enter on the keyboard. Notice the Rate in mL/h automatically updates.

Note: Always double check the dosage rate and infusion rates in **IV Drips** section with the infusion pump. If there is a discrepancy between two values, follow the readings from the infusion pump and change the values in **IV Drips** section.

Interactive View and I&O											0	Full screen	🖨 Print 🗟
™⊟≝₩ <mark>⊻ 5</mark> ∎∎⊨×													
Adult Critical Care Quick View					Lact 24 Hz								
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Ventilator Subset	Find Item - Critical El High		hnormal I	Upoutb	Elan	0	And @ Or						
PAIN ASSESSMENT	Chical Fright			Onauth	ray	0							
Insulin Infusion	Result Commer	ts Flag	Date		Performed By								
Heparin Infusion													
V IV Drips	8. 34							12 0 2017					
Glucose Blood Point of Care		09:15	09:00 -	08:45 .	08:30 -	08:15 .	08.00 -	07:45	07:30 -	07:15 -	07:00 -	06:45	06:30 -
Glasgow Coma Assessment	NNNN	09:29 PST	09:14 PST	08:59 PS1	08:44 PST	08:29 PST	08:14 PS	07:59 PS1	07:44 PST	07:29 PST	07:14 PS	T 06:59 PS	T 06:44 PST
Secation Scales	⊿ IV Drips												
Magairmante	🔰 🖄 😍 📴												
Transfer/Transport	insulin regular (human) additive 100 unit +												
Shift Report/Handoff	sodium chioride 0.9% (NS) titratable infusi Rate												
		-											
	noraninanhrina additiva 8 mg +												
	dextrose 5% (DSW) titratable inf Rate ml /				0.75	5.62	0.22						
	NORepinephrine mcg/mi	0			2	3	5						
	⊿ Glasgow Coma Assessment												
	Eye Opening Response				4								
	Verbal Response												
	Motor Response												
	Glasgow Coma Score												
	Response to Stimuli Affected by												
	△ Sedation Scales												
	Sedation Scale Used												
Adult Critical Care Systems Assessment													
Adult Critical Care Lines - Devices													
ov Intoke And Output													
a material coupling													
Advanced Graphing													
Second Product Administration													
Continuous Renal Replacement Therapy													
X Adult Education													
Kestraint and Seclusion													
Adult Procedures													
· · · · ·													

5. Click the **Sign icon** \checkmark to complete your documentation.

Your patient's blood pressure remains stable on norepinephrine at 2 mcg/min. You can continue to document vital signs and the norepinephrine rate as per policy.

Congratulations! You have now documented the patient's low MAP, the initiation of the norepinephrine infusion in the MAR, as well as the patient's improved MAP and corresponding titration of the norepinephrine.

Key Learning Points

- When initiating an infusion, document in the MAR using the Medication Administration Wizard (MAW) and the barcode scanner
- Subsequent titration rates are recorded in the IV drips section in iView
- When documenting the titration of a vasopressor such as norepinephrine, document a corresponding blood pressure in the same time column in iView



PATIENT SCENARIO 14 - Results Review

Learning Objectives

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

- Review Patient Results
- Identify any Abnormal Results

SCENARIO

In this scenario, you will review your patient's results. One way to do this is using Result Review.

You will complete the following activity:

Review results using Results Review

1



Activity 14.1 – Review Results Using 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** on the **Menu**.

Results are presented using **flowsheets**. Flowsheets display clinical information recorded for a patient including labs results, iView entries (e.g. vital signs), cultures, transfusions and diagnostic imaging.

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.
- Recent Results Advance Care Planning Lab Recent Lab Extended Pathology Micro Cultures Transfusion Diagnettics Vitals Recent Vitals Extended • _ Level Lab Vi • * Table © Group © List om (23-Oct-2017 - 25-Oct-2017) 25-041-2017 23:59 8 . 8.0 x00 9/ 7.0 x10 9.4 #.45 x10 12.1 140 g/t 0.40 92 ft 31 pg 12.0 % 400 x20 9.1 ine Mice 4.50 x10 12,5 140 g-1 4.55 x10 12/1 [2] on Electric Design of C 12.0 % 350 x00 9.1 4.90 x10 9.5 1.40 x10 9.5 4.90 +10 9.1 0.35 x10 9.1 0.25 x10 9.1 0.07 x10 9.1 143 mmol/1 3.8 mmol/1 100 mmol/1 25 mmol/1 145 m CRE and BUlli added to a 15.0 mg/L 20171024 2200
- 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 section within to see related results
- 4. Select Lab Recent



Menu 🕈	< 🔉 👻 🚔 Results Review
Patient Summary	
Orders 🕂 Add	
Single Patient Task List	Recent Results Advance Care Planning Lab - Recent Lab - Extended Pathology Micro Cultures Transfusion Diagnostics Vitals - Recent Vitals - Extended 3
MAR	
Interactive View and I&O	
Results Review	 Monday, 27-November-2017 15:43 PST - Friday, 01-December-2017 15:43 PST -
Documentation 🕂 Add	Navigator Fi
Medication Request	VITAL SIGNS Show more results
Histories	Quick View 28-Nov-2017 18:17 PST 28-Nov-2017 18:13 PST
Allergies 🛨 Add	VITAL SIGNA VITAL SIGNA
Diagnoses and Problems	PAIN ASSESSMENT Pripheral Pulse Rate 105 bpm (H) 105 bpm (H)
	SBY/DBP Cutt SBY/DBP Cutt SBY/D
CareConnect	Diastolic Blood Pressure 60 mmHg 60 mmHg
Clinical Research	Oxygenation Respiratory Rate 22 br/min (H) 22 br/min (H)
Growth Chart	
Immunizations	
Lines/Tubes/Drains Summary	
MAR Summary	
Medication List 🛛 🛨 Add	
Patient Information	
Reference	

5. Review your patient's recent lab results.

CBC and Peripheral Smear	
WBC Count	1.5 x10 9/L (L)
RBC Count	2.00 x10 12/L (L)
Hemoglobin	70 g/L (L)
Hematocrit	0.15 (L)
MCV	98 fL
🗐 мсн	28 pg
RDW-CV	15,3 % (H)
Platelet Count	10 ×10 9/L (!)
NRBC Absolute	5.0 x10 9/L (H)
Neutrophils	0.04 x10 9/L (L)
Lymphocytes	0.15 x10 9/L (L)
Monocytes	0.23 x10 9/L
Eosinophils	0.01 x10 9/L
Basophils	0.01 x10 9/L
Metamyelocytes	0.73 x10 9/L (H)
Myelocytes	0.23 x10 9/L (H)
Promyelocytes	0.08 x10 9/L (H)
Blast Cells	0.02 x10 9/L (H)
Blood Film Comment	Platelet Estimate - Dece

Note the colours of specific lab results and their indications:

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

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


Key Learning Points

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



PATIENT SCENARIO 15 – Rounding Activities

Learning Objectives

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

- Utilize various tools in the Clinical Information System (CIS) to review your patient's status during rounds
- Document an Interdisciplinary Rounding Summary Note

SCENARIO

Interdisciplinary rounding occurs on every patient in critical care, so it is important to know how the CIS can help you in the rounding process.

As a critical care nurse, you will complete the following activity:

- Utilize various tools and resources in the CIS to review patient's status during rounds
- Document Interdisciplinary Rounding Summary Notes



Activity 15.1 – Tools to Utilize During Rounds

The interdisciplinary team participates in rounds every day. During rounds, the team reviews the patient status in order to make decisions about the goal of care and plans for interventions.

The CIS provides various tools that help the team to obtain clinical information and results about the patient. As you may recall, these tools were also utilized during handoff report.

As a critical care nurse, you will most likely refer to the following tools during rounds:

1) Handoff Tool tab in the Patient Summary page

• Summarizes vital signs, recent assessment documentation, lines/tubes/drains, intake and output, recent lab, micro and diagnostic results, oxygenation and ventilation, as well as orders and medications.

Menu 7	< 🖂 🔸 者 Patient Summar											🗐 Print 👌 2	iours 40 minut	es ago
Patient Summary	A 1 10%	- • • 4												
Orders 🕂 Add	Handoff Tool	Summary	X Assessme	nt	🛛 Discha	rge	X	Quick Orders		× +				=.
Single Patient Task List								-						-
MAR	Informal Team Communication	Assessments (2)										Selected v	isit ∂ =+	- ^
MAR Summary	Active Issues			Result			Author			Date/Time				
Interactive View and I&O	Allergies (2)	⊿ Results (2)												
Results Review	Vital Signs and Measurements	All Lobes Breath Sounds		Clear			TestUser, Respir	ratoryTherapist		06/12/17	11:39			
Documentation 🕂 Add	Documents (1)	Actual Hourly Fluid Removed		300 mL			TestUser, ICU-N	lurse		07/12/17	12:00			
Medication Request	Transfer/Transport/Accompanim													
Histories	ent (0)	Lines/Tubes/Drains (3)_										Selected '	/sit ⊉ ≡ -	
Allergies 🕂 Add	Assessments (2)													п
Diagnoses and Problems	Lines/Tubes/Drains	Туре		Location						Inserted				
	Intake and Output	4 Lines (1)		a.:	0.00									Ξ
CareConnect	Labs	Peripheral IV		Peripheral Forearm Li	rt 20 gauge					-				
Clinical Research	Micro Cultures (0)	Gastrointestinal Tubes		Nasonastric (NG) tub	Nare left 18 French	1								Ц
Form Browser	Home Medications (0)	Urinary Catheter		Urethral Indwelling/C	ontinuous 14 French									
Growth Chart	Diagnostics (0)	Discontinued (4)												
Immunizations	Medications													
Lines/Tubes/Drains Summary	Orders (48)													
Medication List 🕂 🕂 Add	Oxygenation and Ventilation (2)	Intake and Output								s	elected visit (24 hour	periods starting at 06.	00) ⋧ ≡ -	
Patient Information	Pathology (0)			13/12/17#	12/12/17	11/12/17	10/12/17	09/12/17	08/12/17	07/12/17	06/12/17	05/12/17	04/12/17	-
Reference	Histories	Total Summary												
	Contraction (Contraction)	Intake m.			14.075	80	200		60	1420			1000	
	Create Note	Output ml.								570				
	Interdisciplinary Care Plan		Fluid Balance		14.075	80	200		60	850			1000	
	Interdisciplinary Rounding Summ	Intake (11)												
	ary note	• Output (2)												
	Nursing Shift Summary	Counts (0)												
	Select Other Note	" Indicates a day without a full 24 hour measurement perior	1											
									_				- 1 - 1	1
													a	_

• Use the scroll bar to see all of the information in the Handoff Tool.

2) CareAware Critical Care

- Accessed through the iAware button EiAware in the toolbar
- Provides an at-a-glance graphical display to trend key patient information
- Similar content to the Handoff Tool including: vital signs; hemodynamic; intake and output; lab results; infusions; oxygenation and ventilation etc.



Voung. Jim - CareAware Critical Care					EN English (Canada) 🕐 Help 🥊 🗖 🖻
MyList Patient Search I ICU Summary Meds Review Vitals/Infusions (24hr) 1/O Blood Glucose					Rese	et Perspective 👔 🎯 ninutes ag
Young, Jim 62 years M DOB: 3/25/1955 MRN: 01022014 FIN: 0000	000775	Admit:	: 11/26/2017	Unit LOS	: 2 days Lo	ocation: ICU/01
Dose Weight: 86kg (11/27/2017 09:35) Actual Weight: 85.8kg (11/27/2017 09:35) Al	lergies: La	atex				
Vitals, CV, Neuro, Infusions (12 hr)	I/O (3	day)				2
Reset Graphs Display: 🔲 Zoom Tool			11/26	11/27	11/28*	Range tote
Vital Signs (11/28/2017 00:55> Current) 2	Net (m	L)	-120	695	885	1,460
V	t e	4,000		07-00.05-50	07-00.06-50	Continuous Infusion Medication J Tube Feeding Not Urine NG Tube Output Drain Stool Chest Tube
V:-*- Chest Tube Output (mL) [20.25] V:-*- UOP (mL/hr) [30.40]	* Indicat	əs a day wi	thout a full 24 hou	neasurement period	07.00-06.59	
☑ — CVP [2.13]	Labs				Respiratory	
PAS [20:30]	Blood Ga	ses (Last 2 in	24 hours)	* _	Respiratory	*
	Lab		11/28 08:35	11/27 20:05		08:53
02:00 04:00 06:00 00:00 10:00 12:00	pH		7.4	7.38	RR	13 bpm
A-line A-line	PO2 PCO2		79↓ 30	79↓ 37	5pU2	90 35%
SBP[110-120]	HCO3		23	22	Ventilator	0070
MAP [/1-88]	BE		1	1		08-53
	Chemistr	y		*	Mode	SIMV
	Lab		Latest	Previous	TV Set	700
	Na		138	149 1	TV Inhaled	690 mL

Key Learning Points

Critical care nurses will utilize the Handoff Tool and CareAware Critical Care during rounds as both of these tools summarize key patient information



Activity 15.2 – Document an Interdisciplinary Rounding Summary Note

During or after rounds, nurses or physicians can document what the team discussed in an **Interdisciplinary Rounding Summary Note.**

- 1. Select the **Patient Summary** from the **Menu** and navigate to the **Handoff Tool** tab if you're not already there.
- 2. On the left hand side of the Handoff Tool, use the scroll bar to scroll down the list of components
- 3. Under the **Create Note** section, click on the **Interdisciplinary Rounding Summary Note** which appears in blue text





- 4. You will be brought to a Free Text Note document
- Type two single apostrophes " and a drop-down list will appear. Double click on "icu_rounds_checklist*. This shortcut creates an auto-text template for your Interdisciplinary Rounding Summary Note.



Note: Completing the ICU Rounds Checklist ensures that all of the general house-keeping concerns for the patient have been addressed during rounds.



- Go through the checklist and select Yes next to all of the questions that should be addressed during rounds. To do this, click on the blue Downward Arrow icon _.
 - **Prophylaxis Treatments for** = *DVT*
- 7. At the bottom of the note there is a free text area where you can type any pertinent information related to the discussion during rounds.
 - Try writing the following = *Plan is to wean patient off vasopressors as tolerated. The family meeting will occur tomorrow afternoon.*
- 8. Click **Sign/Submit** button sign/Submit when completed.

Menu	4	< > + ∫♠ Documentation
Patient Summary		+ Add 🔟 🔛 I'
Orders	🕂 Add	Free Text Note X Free Text Note X New Note X Free Text Note X New Note X List
ängle Patient Task List		
MAR		Tahoma * 11 * 1 * 1 * 1 * 1 * 1 * 1 * 1 * 1 *
MAR Summary		ICII Bounde Chacklist
nteractive View and I&O		CO ROUND CREAKING
tesults Review		PAD
Documentation	+ Add	PAIN: The Pain Score & management plan reviewed Yes* AGITATION: RASS Goal ordered Yes*
Medication Request		DELIRIUM: Delirium Score & management plan reviewed Yes-
fistories		MORILI TATION State Stated Ver
Allergies	🕂 Add	PROTIDATION stage states res-
Diagnoses and Problems		Weaning Readiness Reviewed Yes-
		Medication, fluids, nutrition, lines & blood work
CareConnect		Initiation of previous medications Yes-
Dinical Research		Whether Abx can be narrowed or stopped Yes- Dependence for DUP
form Browser		Nutrition and Electrolyte Repletion Yes*
Srowth Chart		Fluid Balance Goals Yes
mmunizations		Need for invasive catheters (including Hexiseal) Yes* Need for routine blood work Ves*
ines/Tubes/Drains Sumr	mary	
Medication List	🕂 Add	Code Status & Goals of Care Reviewed Yes-
atient Information		Family Needs & Communication Reviewed Yes-
Ceference		. <u> </u>
		Ner is to you a stirt of conserver a table bad. See it was to see to see a table a stirt of the second se
		Plan is to wear patient on vasopressors as tolerated, Planny meeting will occur tomorrow alternoon 7
		Note Details: Interdisciplinary Rounding Summary Note, TestUser, ICU-Nurse, 13-Dec-2017 18:19 PS1, Free Test Note Sign/Submit.
		8
		×



 A Sign/Submit Note window will display to confirm the Note Type, Author, Date etc. Click the Sign button sign. The note is now part of the patient's chart and can be read by other clinicians.

Туре:	Note Type List Filter:			
nterdisciplinary Rounding Summary Note	✓ Position	\checkmark		
Author:	Title:	*Date:		
estUser, ICU-Nurse	Free Text Note	13-Dec-2017 🔢 181	9 PST	
Forward Options				
Favorites Recent Relationships	rovider Name			
ontacts	Recipients			
🚖 Default Name	Cefault Name	Comment	Sign	Re

- 10. Navigate back to Patient Summary from the Menu and click the Refresh icon
- 11. In the Handoff Tool tab on the left hand side, click on Documents
- 12. This is where you will be able to read any **Interdisciplinary Rounding Summary Notes** that have been documented on your patient.

Menu		K 🗧 🛉 🛉 Patient Summ	ary		20			🖸 Full screen 🛛 👼 Pa	nt 21min
Patient Summary	10	A							10
Orders	Lana de la compañía de la	Handoff Tool	11 mary	51 Assessment	22 Discharge	12 Duick Orden	s 12	+	
Single Patient Task List			1.1	and the second					× • • = •
MAR		Informal Team	Deguments (3)			S.d.a.	advert Last 50 Mater	Calendaria (1988 17 hours) He	
MAR Summary		Communication	Documents (3)			200	Last 30 Mores	SOCUCE YINK LEASE ALL INVES	
Interactive View and 18		Active Issues				1	ly notes only 🔲 Group	by encounter Display: Multipl	e note types *
Results Review		Allergies (2)	Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By	
Documentation	+ Add	Vital Signs and Measurements	13/12/17 18:19	Free Text Note	Interdisciplinary Rounding	TestUser, ICU-Nurse	13/12/17 18:35	TestUser, ICU-Nurse	12
Medication Request		Documents (3)	1		Summary Note				12
Histories		Transfer/Transport/Accompany	13/12/17 18:13	Free Text Note	Interdisciplinary Rounding Summary Note	TestUser, ICU-Nurse	13/12/17 18:36	TestUser, ICU-Nurse	
Alegies	+ Add	Accessments (%)	04/12/17 17:09	Free Text Note	Nursing Shift Summary	TestUser, Nurse	04/12/17 17:10	TestUser, Nurse	
Diagnoses and Problem		Lines/Tubes/Drains	* Displaying up to the I	ast 50 recent notes for the selector	ivist				
CareConnect		Intake and Output							E
Clinical Research		Labs	Transfer/Transpo	ort/Accompaniment (0)	+.		Selected visit: Select	ed visit Last 2 hours Last 12 h	ours 2 -
Form Browser		Micro Cultures	the second stand						L
Growth Chart		Home Medications	NO RESULT FOUND						
Immunications		Diagnostics							
Lines/Tubes/Drains Sur	mmary	Medications	Assessments (2)					Selecte	dvist 2
Medication List	+ Add	Orders		Ind		le there		uta/Tona	
Patient Information		Oxygenation and	⊿ Results (2)						
Reference		Pathology	All Lobes Breath Soun	ds Clear	N	TestUser, RespiratoryTherap	pist 0	6/12/17 11:39	



Key Learning Points

ICU Interdisciplinary Rounding Summary allows nurses or providers to document a summary of the discussion during rounds.

- This includes an ICU Rounds Checklist as well as plans of care for the patient
- Typing two single apostrophes " is a shortcut to auto-text note templates
- After signing and submitting the note, the document becomes a permanent record in the patient's chart and can be viewed from the Documents component in the Handoff Tool.



PATIENT SCENARIO 16 – 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 nurse, you will be completing the following activities:

- Documenting Informal Team Communication
- Documenting a Nursing Shift Summary Note
- Handoff Tool
- Documenting Handoff in iView

1



Activity 16.1 – Document Informal Team Communication

The **Informal Team Communication** tool can be used to add actions or comments to handover to your colleagues much like you would in a Kardex.

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

It is encouraged to 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 nurse or other team members.

From the Menu select Patient Summary

- 1. Within the Handoff Tool tab
- 2. Select the Informal Team Communication component
- 3. Under Add new action type Re-order Dilaudid. Click the Save button Save.



4. Under **Add new comment** type *Dressing changed. Will require new pain medication order tomorrow. Please re-order Dilaudid.* Click the **Save** button **Save**.

X	Handoff Tool	≍ +			▶	<u></u>
					æ	=-
Dressing cha	nged. Will require new pa	in medication tomorrov	v. Please re-ord	er Dilaudid		^
						I
				932 char	acters left	
		🗸 Avail	able to All	Save	4 ancel	

To complete a task in Informal Team Communication:

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



To delete a task in Informal Team Communication:

6. Click the **Cancel** icon ^(S) to the right of the action item. The note will now have disappeared from under the Informal Team Communication component.

Note: It is important to complete or delete these **Informal Team Communications** when they no longer apply.

Informal Team Communication	
Add new action	
Re-order Dilaudid 5 TestUser, Nurse 04/12/17 16:53	1 🗵 6

Key Learning Points

The Informal Team Communication component is a way to leave an informal message for another clinician

You can leave an action item or a comment

Informal Team Communication message is NOT considered as part of the patient's legal record

1



Activity 16.2 – Document Nursing Shift Summary Note

Nurses should document within PowerForms and iView as much as possible and should avoid duplicate documentation via narrative notes. However, a narrative note can be used to document information that may require more details that can be documented otherwise. If a **Nursing Shift Summary** note is required, follow these steps.

- 1. Review patient information in the Handoff Tool
- 2. Click on the Nursing Shift Summary blue link

Handoff Tool	Summary	23	Assessment	🛛 Disch	harge	#				
Informal Team Communication Active Issues Allergies (3) Vital Signs and Measurements	Add new action	ommunication				Add new comment				∂ =-
Documents (1) Transfer/Transport/Accompanim ent (0)	No actions documented All Teams					No comments docume All Teams	nted			
Assessments Lines/Tubes/Drains Intake and Output Labs	Active Issues					Add new as: This Visit a	nd Chronic 👻 🔍		Classification: All	- All Visits ⋧ ≡-
Imaging Medications Home Medications Orders	Name Pneumonia Diabetes Peripheral vascul	ar disease				Classification Medical Medical Medical	Actions This This This	Visit Visit Visit	Chronic Chronic Chronic	
Oxygenation and Ventilation Pathology Histories Create Note	Allergies (3) 🕂									All Visits $ oldsymbol{artheta} =$ -
Interdisciplinary Care Plan Interdisciplinary Rounding Summ ary Note Nursing Shift Summary Select Other Note	Substance Bees/Stinging Insects ciprofloxacin diebenhydrAMINE	Reactions 	Cates Envi Drug Drug	iory ronment I	Status Active Active Active	Sevenby ¥	Reaction Type Allergy Allergy Allergy	Source 	Comments Reconciliation Status: Incomplet	te Complete Reconciliation
	Vital Signs and Me	easurements 🕂						Selecte	d visit: Latest* Selected visit La	st 12 hours 🛛 📰 🔟 💐 ≡-

- 3. Enter required data. For this activity, type *Wife visited, very teary. Provided support and will follow up tomorrow.*
- 4. Click Sign/Submit button Sign/Submit

Menu		A Documentation A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A A	(D) Full screen 💮 Print 🔹
Patient Summary		+ Add (X) [2] [2]	
Orders	+ Add	Free Text Note X List	
Single Patient Task Lis			
MAR		Tahona * 11 * 4 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
MAR Summary		Wife visited very teary. Provided support and will follow up tomorrow	
Interactive View and IR	80	The funce, it's tear in Frontieur apport and the following contactoring	
Results Review			
Documentation	🕈 Add		
Medication Request			
Histories			
Allergies	+ Add		
Diagnoses and Proble			
CareConnect			
Clinical Research			
Form Browser			
Growth Chart			
Immunizations			
Lines/Tubes/Drains Su			
Medication List	+ Add		
Patient Information			
Reference			
			3
		Note Details: Nursing Shift Summary, TestUser, KU-Nurse, 14-Dec-2017 1610 PST, Free Test Note	4 Save & Close



5. Click **Sign** button in the **Sign/Submit Note** window.

P Sign/Submit Note			- • •
*Type: Nursing Shift Summary *Author: TestUser, ICU-Nurse	Note Type List Filter: Position Title: Free Text Note	*Date: 04-Dec-2017 📖 0741	PST
Forward Options Create provider letter Favorites Recent Relationships Q Provide	r Name		
Default Name	Comm	ent	Sign Review/CC
		5	Sign Cancel

6. Click **Refresh** icon . Once the page is refreshed, you and others will be able to see your **Nursing Shift Summary** note saved under **Documents** in the **Handoff Tool.**

Handoff Tool	🛙 Summary	23 Assessment	23 Discharge	23 Quick Orders	*		🔄 – 🔖 🔍 (=-
Informal Team Communication					My notes only	y 🔲 Group by encounter	Display: Multiple note types 🔻
Active Issues	Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By	
Allergies (4)	01/12/17 11:49	Free Text Note	Nursing Shift Summary	TestUser, ICU-Nurse	01/12/17 11:52	TestUser, ICU-Nurse	
Vital Signs and Measurements	27/11/17 15:52	Nursing Discharge Checklist	Nursing Discharge Checklist - TextA	TestUser, Nurse	27/11/17 16:15	TestUser, Nurse	
Documents (2)	* Displaying up to the last	50 recent notes for the selected visit					
Transfer/Transport/Accompanim ent (0)							Γ
Assessments (0)	Transfer/Transport/	Accompaniment (0) 🕂 🚽			Selecte	ed visit: Selected visit Last 2	hours Last 12 hours 🛛 🤁 😑 -
Lines/Tubes/Drains	No results found						E
Intake and Output	No results round						
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Micro Cultures (0)	Assessments						Selected visit 🛛 🖉 📃 = -
Home Medications (7)	No results found						
Diagnostics (0)							
Medications							
Orders (3)	Lines/Tubes/Drains	(0) 🗸					Selected Visit 🤁 💷
Oxygenation and Ventilation (0)	Туре	Location			Inse	rted	
Pathology (0)	⊿ Lines (0)						
Histories	No results found						
Create Note	⊿ Tubes/Drains (0)						
	No results found						



As well as in the Handoff Tool, other care team members can also view your note by completing the following steps:

- 1. Click on the **Documentation tab** from the **Menu**
- 2. Find and click on the Nursing Shift Summary Note
- 3. Note the **Final Report** can be read on the right side of the screen



Key Learning Points

- A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses
- The note must be signed in order for it to be recorded to the patient chart and viewable by other team members
- Nurses and other team members can view signed notes from the Documentation tab in the Menu



Activity 16.3 – Document Handoff in iView

1 Document that you have given Report or 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 Adult Critical Care Quick View
- 3. Document using the following data:
 - Clinician Receiving Report = Nurse 1
 - Clinician Giving Report = Nurse 2
 - Lines Traced Site to Source = Yes
 - Orders Reviewed = Yes
 - Isolation Activity = leave blank if not on isolation
- 4. Click the **Sign** icon **V** to complete your documentation

Note: Prior to leaving at the end of your shift, the offgoing nurse should ensure all tasks and orders have been reviewed and completed



Key Learning Points

Document that you have given or received report in the Shift Report/Handoff section in iView

Ensure all orders and tasks being reviewed, completed, and documented before the end of the shift.

SELF-GUIDED PRACTICE WORKBOOK [N54] CST Transformational Learning

WORKBOOK TITLE: Nursing: Supervisor

Complete the following activities if you are one of the following:

- Patient Care Coordinator
- Charge Nurse
- Inpatient Nurse who takes on charge duties





PATIENT SCENARIO 17 – Navigating Clinical Leader Organizer (CLO)

Learning Objectives

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

Review the Clinical Leader Organizer

SCENARIO

As an inpatient charge nurse, you will be completing the following activities in order to review your patients for the day:

Review the Clinical Leader Organizer (CLO)



Activity 17.1 – Review Clinical Leader Organizer (CLO)

Clinical Leader Organizer (CLO) is an interactive organizer that supports communication and coordination across the continuum of care. It provides a high-level overview of patient data such as location, visit summary, risks and more. It is a very useful tool for understanding patient care goals and assists charge nurses in assigning appropriate patients to nurses.

With **CLO**, charge nurses, nursing managers and other users can view the following data for each patient: patient name; location; active discharge orders; high risks; isolation precautions; restraint information; elopement risk; pending transfer; diet order; falls risk; suicide precaution; skin integrity; ventilator; airway information; telemetry order; central line insitu; catheter insitu; visitor information; care team; non-invasive ventilation; and oxygen therapy.

Note: Patient Care Coordinators and nurses who are always in charge will land on the CLO page when logging into the system. Inpatient nurses who are only occasionally in charge will land on CareCompass but can navigate to CLO when necessary.

Let's review Clinical Leader Organizer:

1

- 1. Select Clinical Leader Organizer from the toolbar
- 2. Confirm that the displayed Patient List is your unit. In this activity, use LGH 7 East
- 3. Click Establish Relationship

PowerChart Organizer for TestUser, Nurse							
Task Edit View Patient Chart Links Navigation Help							
🗄 🎬 CareCor 1 📲 Clinical Leader Organizer 🖕 Patient List 🚨 Multi-Patient	🎬 CareCor 🚹 🎆 Clinical Leader Organizer 🎍 Patient List 🕮 Multi-Patient Task List 🎆 Discharge Dashboard 📾 Staff Assignment 🎬 LearningLIVE 🖕						
🕴 😋 PACS 🜊 FormFast WFI 🝦 🗄 🏦 Exit 🎬 AdHoc 🎟 Medication Administrat	😋 PACS 🙀 FormFast WFI 🚽 🛃 Buit 🍯 AdHoc 🎟 Medication Administration 🔮 PM Conversation 🔹 🗎 Medical Record Request 💠 Add 🗸 👼 Documents 🍏 Scheduling Appointment Book 📾 Discern Reporting Portal 💡						
👯 🕄 Patient Health Education Materials 🔇 Policies and Guidelines 🔇 UpToDate							
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Clinical Leader Organizer							
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Clinical Leader Organizer 🛛 🕄 🕂							
Patient List: LGH 3 West V 2 Maintenance Establish Relationships	3						
Patient Location	Dis Hi Care Team Air Fall Sui Iso Tel Central Ox						
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CSTPRODREGAAA, B 11 m F LGH 3W	No Relationship Exists						
*MEDPROCESS, TES 44 yrs F LGH 3W 305 - 01A	No Relationship Exists						



2 Establish relationships with all of the unit's patients as a **Nurse.**

- 1. Select Nurse from the Relationship drop-down
- 2. Click top checkbox to select all patients
- 3. Click Establish

telationship	s						
	Dis	Establis	sh Relationships				23
	No Re	Relatio	nship Nurse	⊻ 1			
	No Re		2	Sex	DOB	MRN	*
05 - 01A	No Re		CSTMATTEST, BABY	м	Nov 9, 2017	700008024	
)7 - 01M	No Re	V	CSTLABVIRTUAL, VI	F	Mar 20, 1962	700001989	
07 - 01A	No Re		FORD-LEARN, HARRY	м	Oct 13, 2010	700008093	
)7 - 01B	No Re	√	CSTPRODMAT, MAR	F	Jul 16, 1986	700008120	
1 - 01A	No Re		CSTPRODREGHIM, B	м	Nov 16, 2017	700008170	
1 - 01M	No Re		CSTSMITH, CSTDAN	м	Nov 14, 1945	700008053	
.7 - 01M	No Re		CSTPRODMAT, BAB	F	Nov 19, 2017	700008260	
.5 - 01M	No Re						Ŧ
5 - 01B	No Re			Se	lect All Deselect 3	Establish Can	icel

3 CLO contains several different columns displaying patient data. The first time you access CLO, all columns in the configuration are displayed in the dashboard. You can customize your columns to view relevant patient data. Hovering over the column titles enables you to see the full name of the column.

- 1. Hover over a column heading to see the full title of the column
- 2. Click the Menu icon =-
- 3. Click the green check mark beside a viewable topic(s) of your choice to de-select it from the viewable columns
- 4. Click Apply

Note: Columns can also be reordered by dragging the column name into the order you prefer.

Clinical Leader Organizer																	0	Full screen 🛛 👼 Print	\$3	minute	is ago
A)% •																				
Clinical Leader Organizer		- 23																		1	•
Patient List: LGH 7 East	List Ma	intenan	ce Establ	lish Relationshin	s														2	=	
				1	- T	1										v		Viewable	-	۰.	
Patient			Location		Dis	Hi	Care Team	Air	Fall	Sui	Iso	Tel	Central	0x	Ski	Ve	Visit	Patient	48	0	
*CSTPRODPET, RAV	34 yrs	F	LGH 7E	718 - 01	F	A	-		75				V			<u> </u>	Length of Stay: 2 months	Location		0	Â
*CSTPRODREG, HLS	27 yrs	F					-		60								Length of Stay:	Discharge	1	0	
																		High Risk	1	0	
CSTPRODCOW, SNT	104 yrs	м	LGH 7E	-			-										Length of Stay:	Care Team		0	
CSTSCHHARVEY, ST	26 yrs	м	LGH 7E	-			-										Length of Stay:	Airway	0	0	
consenting the second	20 115		CONTRE														Longer of Diayr	Fall		0	
*TESTSQBBVPP, SA	37 yrs	М	LGH 7E	-					70								Length of Stay: 6 months 2 weeks	Suicide	0	0	3
*TECTCORRVDD CA	80	м	LGH 7E	-													Langth of Stay: 6 months 7 weeks	Isolation	1	0	
ILJIJQUUTE, JA	00 yis		CONTRE						22		۲						Earger of Stay, o monora 2 measure	Telemetry	0	0	=
*TESTSQBBVPP, SA	66 yrs	М	LGH 7E	-													Length of Stay: 6 months 2 weeks	Central Line	1	0	
STECTCORRUPD CA	45		101175														Length of Chara 6 months 2 months	Oxygen Therapy	0	0	
*TESTSQDDVPP, SA	HD Yrs	m	LOH /E	-													Lengui of Stay, o months 2 weeks	Skin Integrity		-	
TESTCSTSQ, SIX LAU.	17 yrs	F	LGH 7E														Length of Stay: 6 months 2 weeks	Ventilator	1	-	
			1.011.00															Visit	0	-	
CSTLABADDON, DEM	33 yrs	F	LGH /E	/22 - 03			-		25								Length of Stay: 5 months 1 week	Rectrointe	0	0	
CSTPRODOSLAB, DE	53 yrs	М	LGH 7E	724 - 01			-										Length of Stay: 5 months	Flopement	0		
		-																Not in View		Ť.	
*WINRECS, INPATIE	67 yrs	F	LGH 7E	708 - 01			-										Length of Stay: 5 months			- 1	-
*CSTLABAUTOMATL.	41 yrs	м	LGH 7E														Length of Stay: 5 months	4 Apply	Carlcel		



- 4 Clicking on icons within CLO provides additional information. The system displays a pop-up box when an icon is clicked.
 - 1. The topic(s) that you de-selected previously are no longer viewable columns in your CLO view
 - 2. Click on an icon within the CLO to see additional information

Clinical Leader Organizer																	[D] F	ull screen	🗐 Pri	nt 🧈 8	minutes	ago
🗚 🗎 🖶 🖿 🔍 🔍 100%	-		₫																			
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Patient			Location	1	Dis	Ні	Care Team	Air	Fall	Iso	Tel	Central	Ox	Ski	Ve	Visit	Са	Re	Elo	Pe	Diet	
*CSTPRODPET, RAV	34 yrs	F	LGH 7E	718 - 01	F	A	-		75			V			<u></u>	Length of Stay: 2 months					۲L	Â
*CSTPRODREG, HLS 7	27 yrs	F					-	Г	Isolation							Length of Stay:						
CSTPRODCOW, SNT	104 yrs	м	LGH 7E	-			-		Patient Isola	ition		_				Length of Stay:						
CSTSCHHARVEY, ST 2	26 yrs	м	LGH 7E						31-Oct-2013 Ordered at:	08:52 PE	T, Contac 17 8:52 A	t Plus M				Length of Stay:						
*TESTSQBBVPP, SA	37 yrs	м	LGH 7E													Length of Stay: 6 months 2 weeks				-		
*TESTSQBBVPP, SA 8	89 yrs	м	LGH 7E						55	-	2					Length of Stay: 6 months 2 weeks						Ξ
*TESTSQBBVPP, SA	66 yrs	м	LGH 7E													Length of Stay: 6 months 2 weeks						
*TESTSQBBVPP, SA	45 yrs	м	LGH 7E													Length of Stay: 6 months 2 weeks						
TESTCSTSQ, SIX LAU	17 yrs	F	LGH 7E													Length of Stay: 6 months 2 weeks				-		
CSTLABADDON, DEM	33 yrs	F	LGH 7E	722 - 03					25							Length of Stay: 5 months 1 week						
CSTPRODOSLAB, DE	53 yrs	м	LGH 7E	724 - 01												Length of Stay: 5 months					۲ł	
*WINRECS, INPATIE	67 yrs	F	LGH 7E	708 - 01			-									Length of Stay: 5 months						

Note: Customization of the CLO is only visible to the user customizing their views.

Key Learning Points

- Clinical Leader Organizer (CLO) is an interactive organizer that supports communication and coordination across the continuum of care
 - CLO provides a high-level overview of patient data
 - CLO can be customized to display patient information pertinent to your workflow



PATIENT SCENARIO 18 – Reports

Learning Objectives

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

Run a report in the CIS

SCENARIO

As an inpatient charge nurse or nurse manager, you will be completing the following activities:

Run a report for your unit/organization in the CIS



Activity 18.1 – Running Reports for your Unit/Organization

The reporting functionality in the Clinical Information System (CIS) allows users to run reports at a unit and/or organizational level. Reports are important for performing audits and in informing safe patient care. Some of the reports that can be generated include the following: number of falls; catheterized patients; and isolated patients.

Note: Only Patient Care Coordinators, managers, or nurses who are always in charge will have the ability to run reports in the system.

Assuming you are a charge nurse, generate a report for **Patient Census by Location**.

1. Navigate to **Discern Reporting** by selecting the **Discern Reporting Portal** button

Solution of the Reporting Portal in the Toolbar to open the Reporting Portal window

Task I	Edit Vie	w Patient	Chart	Links	Options	Documentation	Orders	s Help
: 🌃 Care	Compass	📲 Clinical	Leader O	rganizer	🛉 Patient	t List 🔐 Multi-Pat	ent Task	k List 😂 Staff Assignment 🎬 LearningLIVE 🖕 🕴 🕄 CareConnect 🔍 PHSA PACS 🔃 VCH and PHC PACS 🔃 MUSE 🔃 FormFast WFI 💡
: 🔀 Tear	Off 📶 I	xit 🎦 AdHo	oc IIIIIMe	edication	Administr	ation 🔒 PM Conv	ersation ·	🔹 🖹 Medical Record Request 💠 Add 👻 📻 Documents 🛎 Scheduling Appointment Book 🗃 Discern Reporting Portal 🖕 🕇
Patie	ent Health	Education M	/laterials	Q Polic	ies and Gu	idelines UpToD	ate 🚊	

2. Locate **Patient Census by Location** by typing it into the search box

Note: This report can also be located by navigating through the pages

Reporting Portal				- 8
Reporting Portal				
⊖ Cerner				Welcome: TestORD, Nurse Settings Help
Reporting Portal			2 Q Search for Report Title	
Filters	All Reports (37) My Favorites (0)			1 2 > Last >> O
	Report Name	▼ Categories	♦ Source	🗢 Favorite 🔶 🄶
Source	Arterial Line	Nursing Supervisor	Public	Å
 Categories 	Bed Status	Nursing Supervisor	Public	$\stackrel{\wedge}{\sim}$
Perent Penorts	Braden Assessment - Current Inpatients	Nursing Supervisor	Public	$\sum_{i=1}^{n}$
Moderate Sedation	Braden Q Assessment - Current Inpatients	Nursing Supervisor	Public	÷.
Braden Assessment - Current Inpatients Diet Orders - Current Patients	Central Line Days - Current Inpatients	Nursing Supervisor	Public	$\stackrel{\wedge}{\sim}$
Braden Q Assessment - Current Inpatients	Central Line Days - Discharged Inpatients	Nursing Supervisor	Public	$\overline{\lambda}$
Patient Census by Location	Charting After Discharge	Nursing Supervisor	Public	5/2

- 3. Click the name of the report to expand the field
- 4. Click Run Report



Reporting Portal			Q patient censu	s by location X
Filters	All Reports (1) My Favorites (0)			1 0
	Report Name	- Categories		♦ Favorite ♦
Source 3	Patient Census by Location	Nursing Supervisor	Public	☆
Categories	Description: Passed Testing: NO (replace with YES after completed)	Suggested Report User:	Reporting Application: CCL	4 Run Report
Recent Reports	Tested By: Tested Date:	Suggested Report Frequency:	Alternate Name: BC_ALL_PM_CENSUS_LOCN_LYT:DBA	Run Report in Background
Moderate Sedation		Support Reference Number:		View Previous Kuri
Braden Assessment - Current Inpatients		00/5c058-e494-478t-9467-3622315tta02		
Diet Orders - Current Patients				
Braden Q Assessment - Current Inpatients				
Patient Census by Location				

The **Discern Prompt** window opens. This window is where you indicate the information you would like in the report.

Select the following information:

2

- 1. **Encounter Type** = *Inpatient*
- 2. Site = Lions Gate Hospital
- 3. Facility = LGH Lions Gate Hospital
- 4. **Unit/Clinic(s)** = All Nurse Units
- 5. Click Execute

Discern Prompt: BC_ALL_PM_CE	INSUS_LOCN_LYT:DBA
*Output to File/Printer/MINE	MINE 👻 🖻
*Output Type	Exportable(CSV)
*Encounter Type(s)	Deceased Emergency Inpatient
Health Organization	Vancouver Coastal Health Authority
*Site	Lions Gate Hospital
*Facility	All Facilities EGH Evergreen House LGH HOpe Centre UGH Lons Gate Hospital LGH North Shore Hospice 3
Unit/Clinic(s)	All Nurse Units LGH 2 East LGH 2 E Cardiac Care LGH 3 West LGH 4 East 4
Include VIP Patients?	Yes 🔹
Page break on Unit?	No
Return to prompts on close of output	Execute Cancel
Ready	

The Patient Census by Location report will now display.



3 Review the Report.

- 1. Navigate the Report by clicking the **Next Page** icon
- 2. To print the report, click on the **Print** icon. **Note:** For this activity, we will only view and not print the actual report.

🔊 Rej	porting Port	al											
Report	ting Portal	Diet Or	ders - Current Patients	Braden Q Asse	ssment - Cu	urrent Inpa	tients Pat	ient Census by L	ocation	×			
	3 B. H		ء 🖄 🌑 🜑 🕘 🕒	4 100%	- 🥡								
	2 1												
	Patient Census By Location												
					Facility:		LGH Lions Ga	ate					
					Encoun	ter Type:	Inpatient						
	Submitted E	By: TestOR), Nurse		Unit/Cli	nic(s):	All						
	Submitted (Dn: 30-NOV	-2017 15:13		Privacy	Patients:	INCLUDED						
	Room/ Bed	MRN	Patient	Age	Gender	Service		Admit Date/Time	LOS	Attending Provider	LOA	Encounter Type	Visitor Status
	Unit/Cil nic:	LGH 2E											
	204-01	70000034	CSTPRODMED, JAMIE	25 Years	Female	General Inte	ernal Medicine	10-NOV-2017 10:52	20 days	Pliev of, Dillon, MD		Inpatient	
	204-02	700006576	CSTPRODMI SITSYNGO	41 Years	Female	General Inte	mai Medicine	27-NOV-2017 13:13	3 days	Plisy op Trevor, MD		Innationt	

Key Learning Points

- The reporting functionality in the CIS allows users to run reports
 - Specific information can be selected to be included in the report



b End of Workbook

When you are ready for your Key Learning Review, please contact your instructor.