SELF-GUIDED PRACTICE WORKBOOK [N59]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: Critical Care

CLINICAL + SYSTEMS TRANSFORMATION
Our path to smarter, seamless care

TRANSFORMATIONAL LEARNING

TABLE OF CONTENTS

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 to practice 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:

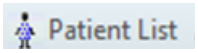
- Set-up a Location Patient List
- Create a Custom Patient List

Activity 1.1 – Set Up a Location Patient List

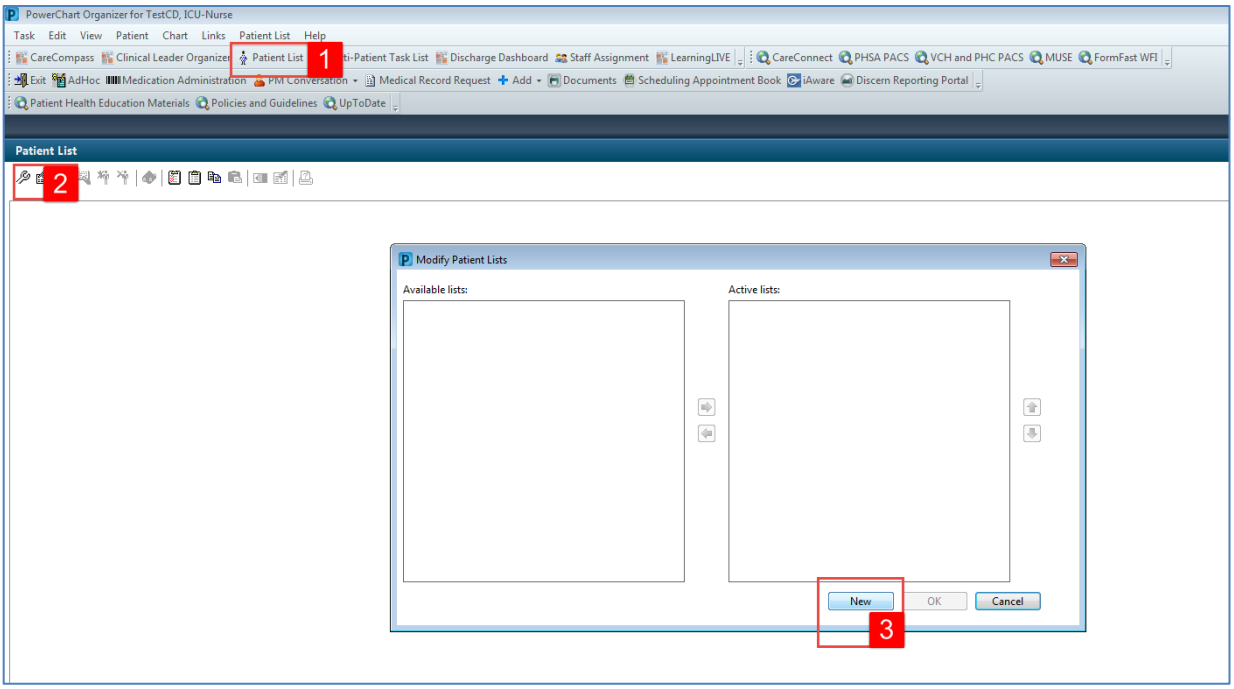
1 Upon logging in, you will land on **CareCompass. CareCompass** provides a quick overview of select patient information.

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

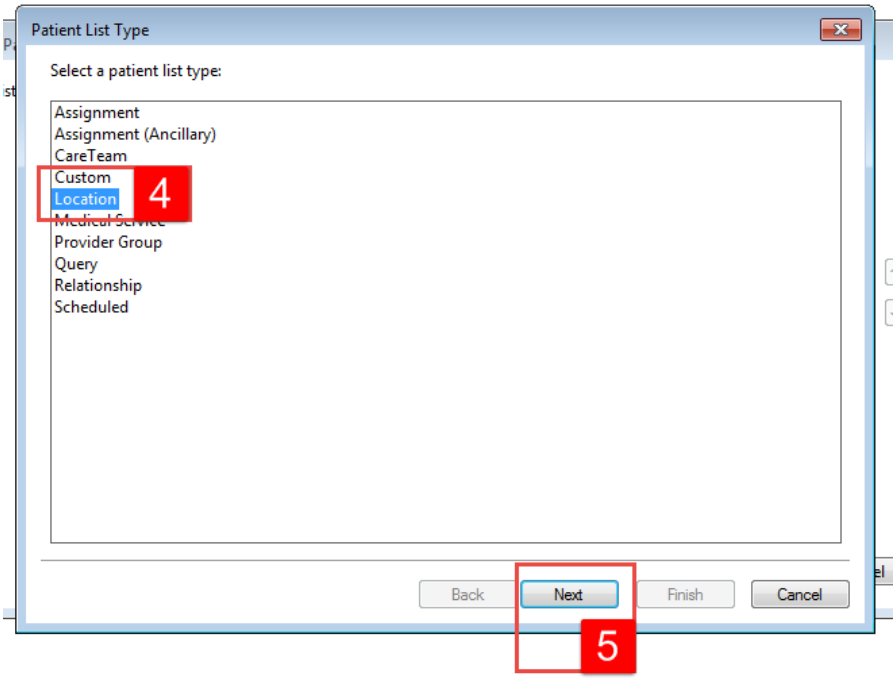
2 At the start of your first shift (or when working in a new location), you will create a **Location List** that will consist of all patients assigned to your unit.

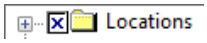
1. Select the **Patient List** icon 

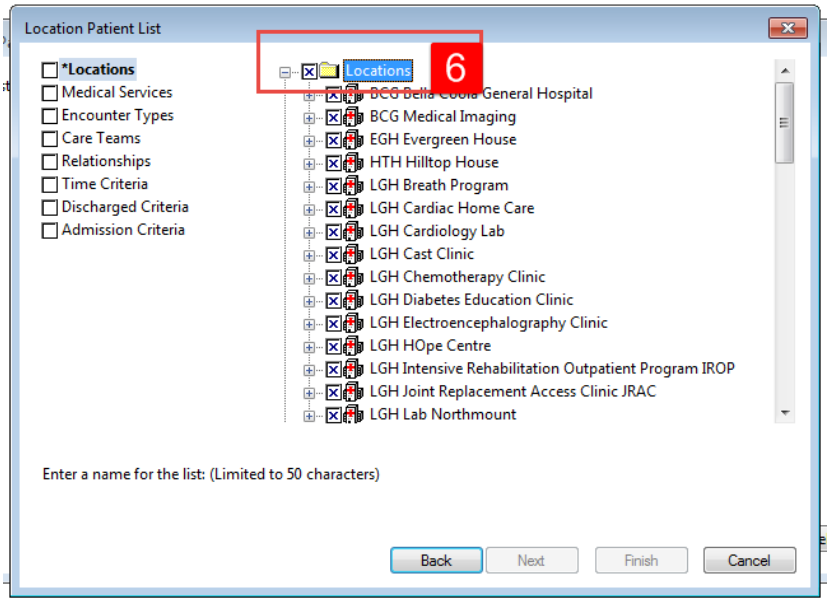
from the **Toolbar** at the top of the screen.
2. The screen will be blank. To create a location list, click the **List Maintenance** icon  .
3. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window.

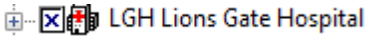


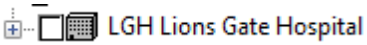
4. From the **Patient List Type** window select **Location**
5. Click the **Next** button in the bottom right corner.

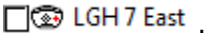


6. In the **Location Patient List** window, open the **Locations** folder by clicking the **Plus Sign**  . A location tree will be displayed.



7. In this activity, use LGH Lions Gate Hospital as a selected location. Expand the location by clicking the **Plus Sign:** 

8. Then, click the next **Plus Sign:** 

9. For your practice, select **LGH 7 East** by checking the box next to the unit 

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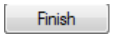
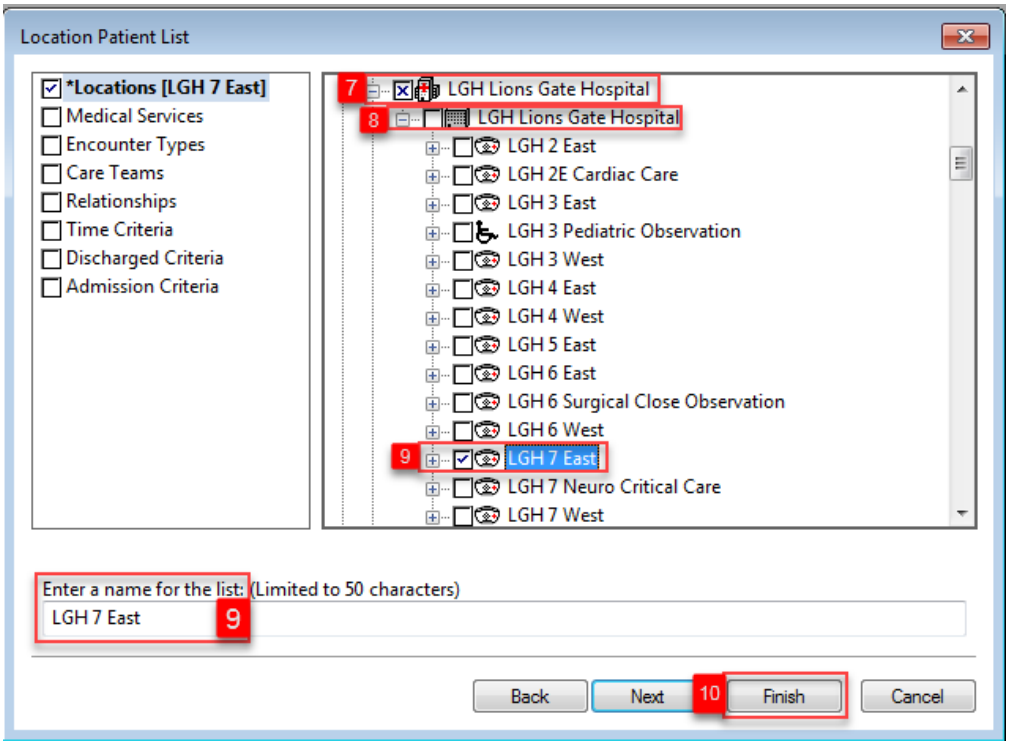
   Patient Lists need a name to differentiate them. Location lists are automatically named by the Location.

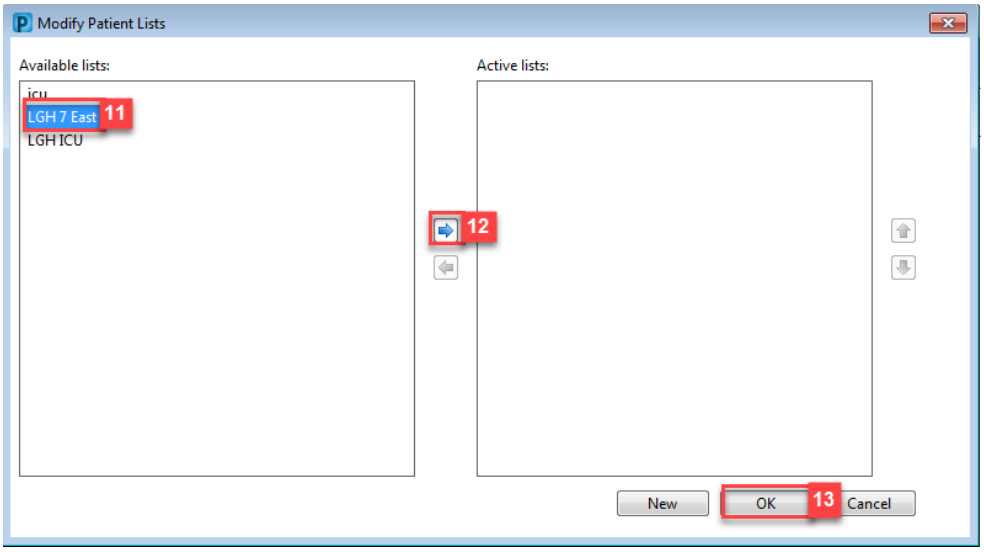
10. Click the **Finish** button 

in the bottom right corner.



11. In the **Modify Patient Lists** window select a location or a unit.
12. Click the **Blue Arrow** 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.



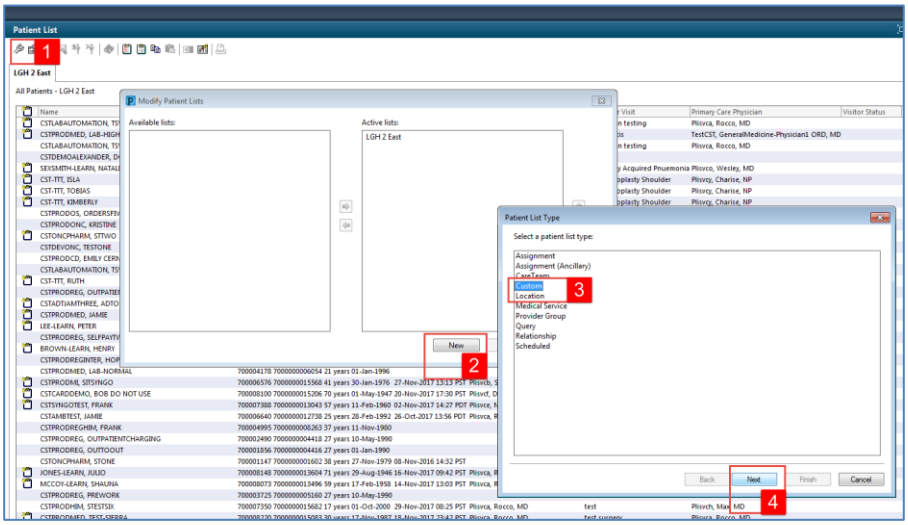
Key Learning Points

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

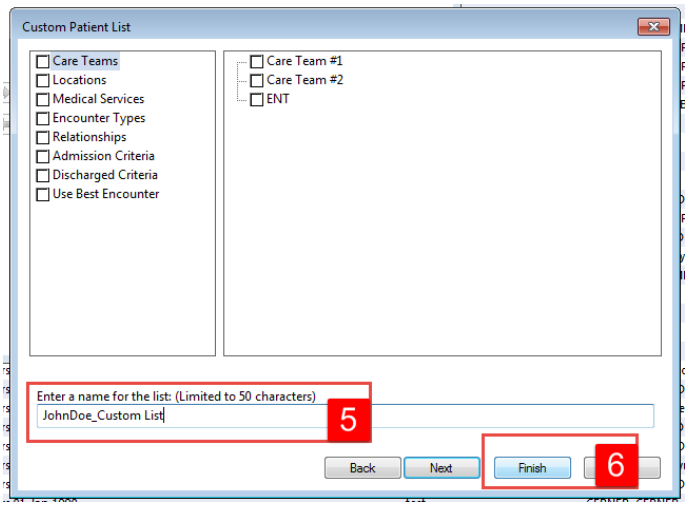
Activity 1.2 – Create a Custom Patient List

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

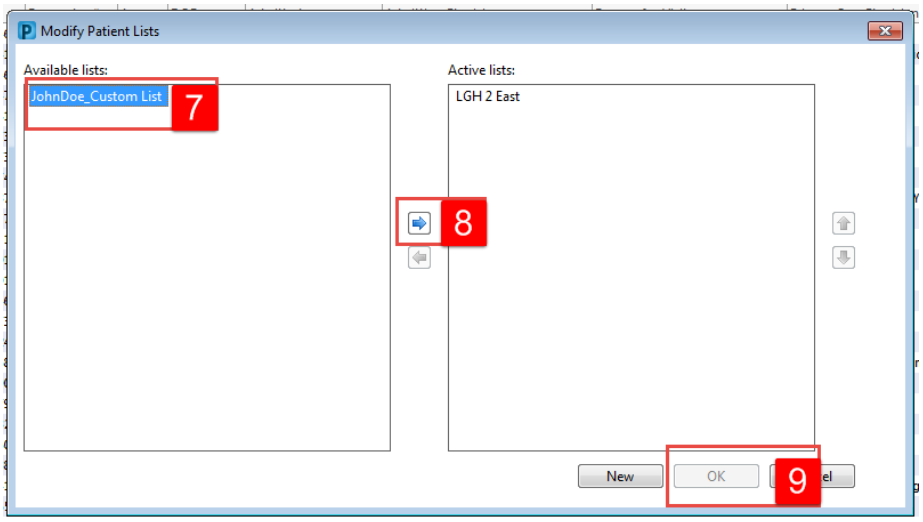
1. To create a **Custom List**, click the **List Maintenance** icon in the **Patient List** window that you have created based on location (refer to Activity 1.1).
2. Click the **New** button in the bottom right corner of the **Modify Patient Lists** window.
3. Select **Custom** from the **Patient List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



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.

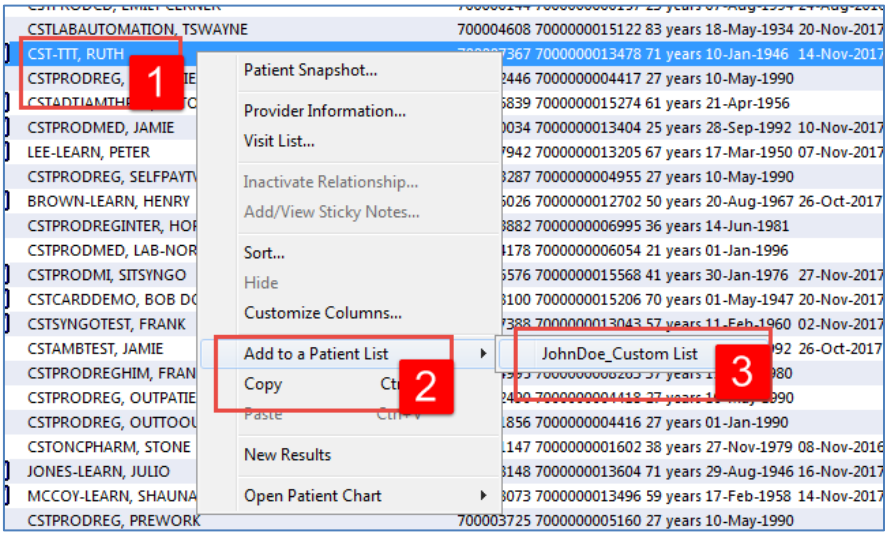


7. In the **Modify Patient Lists** window select your Custom List.
8. Click the **Blue Arrow** icon to move your **Custom List** to the **Active List** on the right side.
9. Click **OK** button.



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**



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 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 .

Key Learning Points

- 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

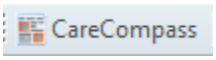
SCENARIO

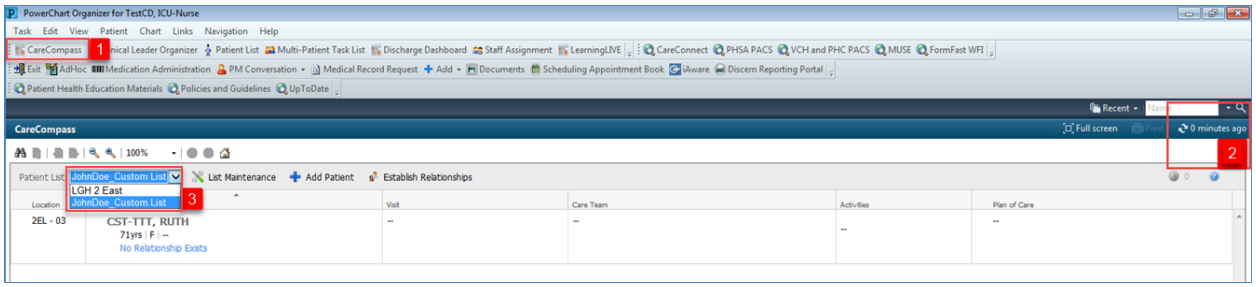
As a Critical Care Nurse, you will complete the following activities:

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

Activity 2.1 – Introduction to CareCompass

1 **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.

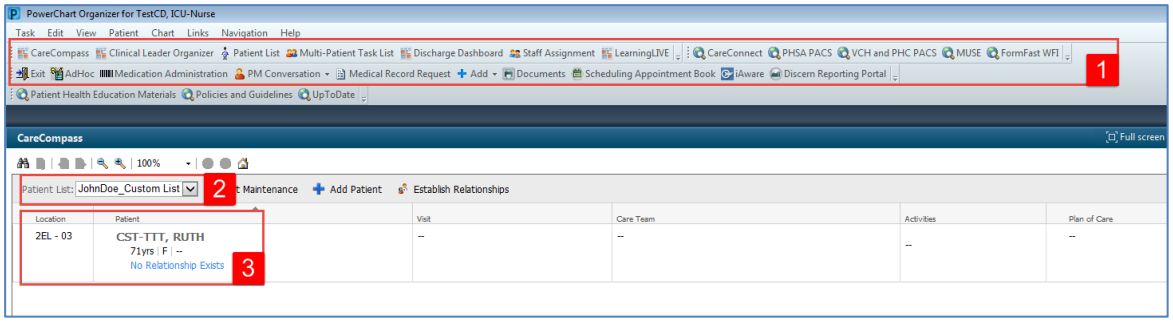
1. Navigate back to **CareCompass** by clicking on the **CareCompass** icon  in the **Toolbar**.
2. Click the **Refresh** icon.
3. Select **YourName_Custom** from the **Patient List** drop-down



2 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.



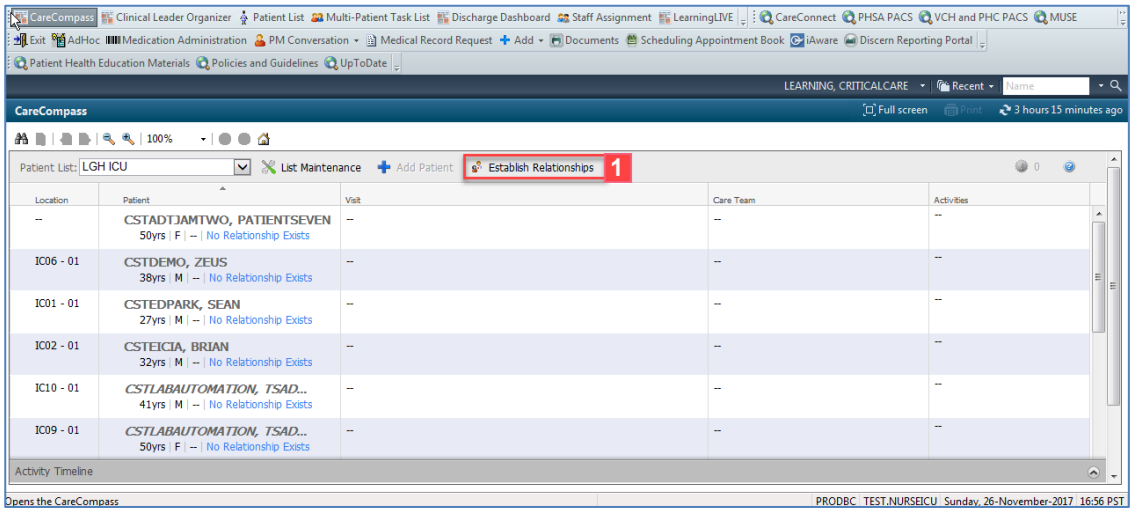
Key Learning Points

- 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

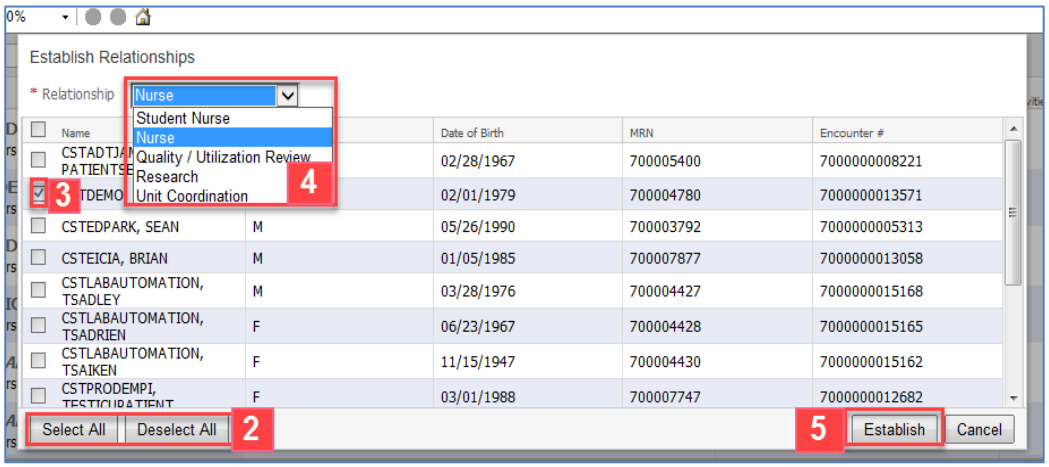
1 Now that you have created your custom patient list, you must establish a relationship with your patient in order to view more patient information or access their chart.

1. Click **Establish Relationships**



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.

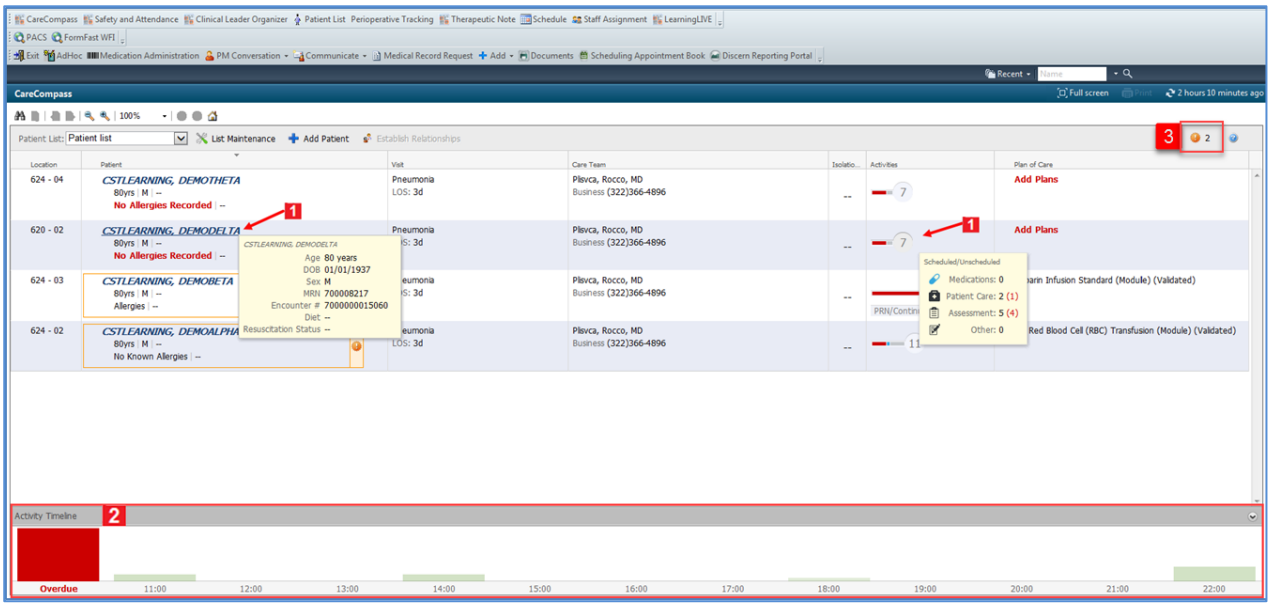
Note: A relationship will last for 16 hours and the nurse will need to re-establish the relationship at the next shift.



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.
2. **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.

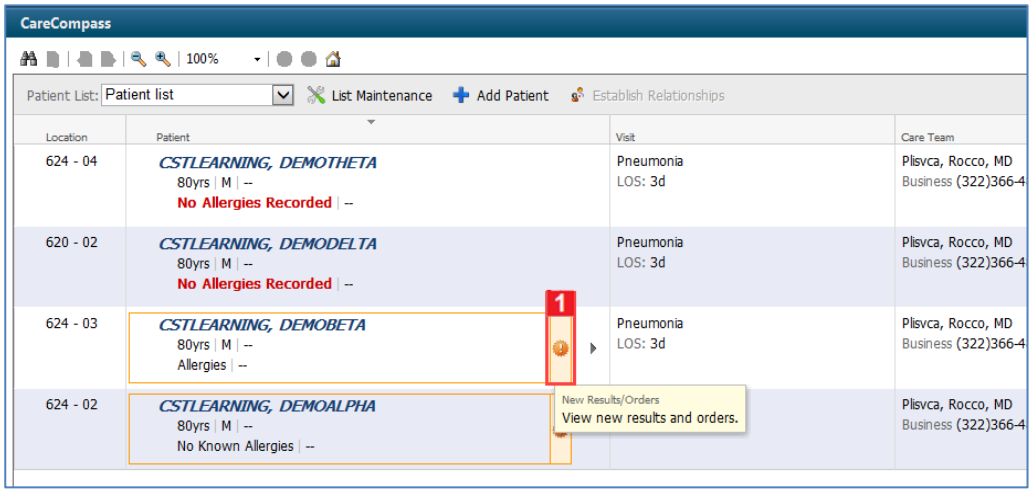


3 Notice there may be a **red** **or orange** **exclamation** icon next to the patient's name.

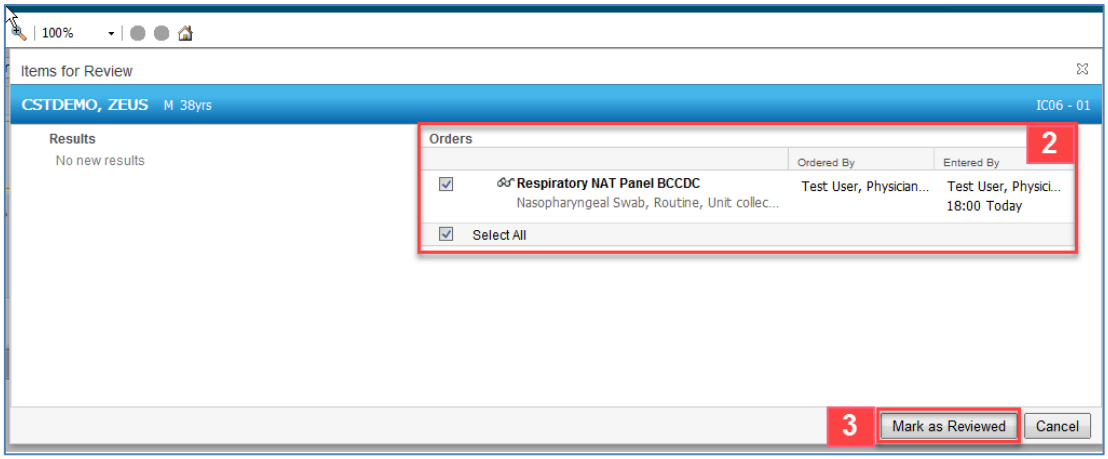
Note: Indicates new non-critical results or orders for a patient requiring review.

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

1. Click the **Exclamation** icon.



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



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.

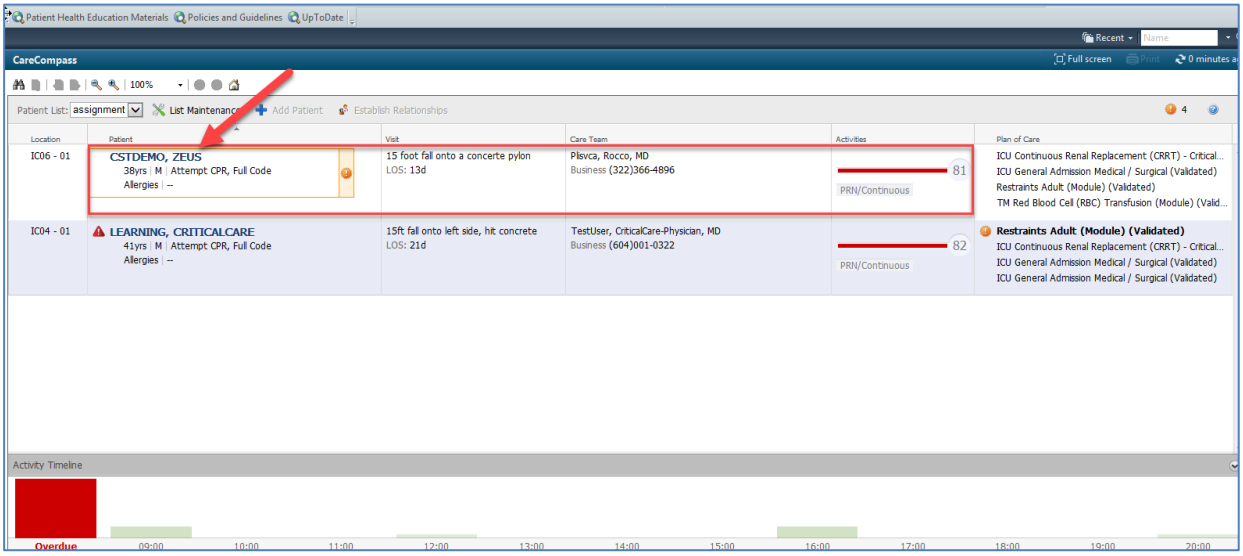
You will be completing the following activities:

- 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.



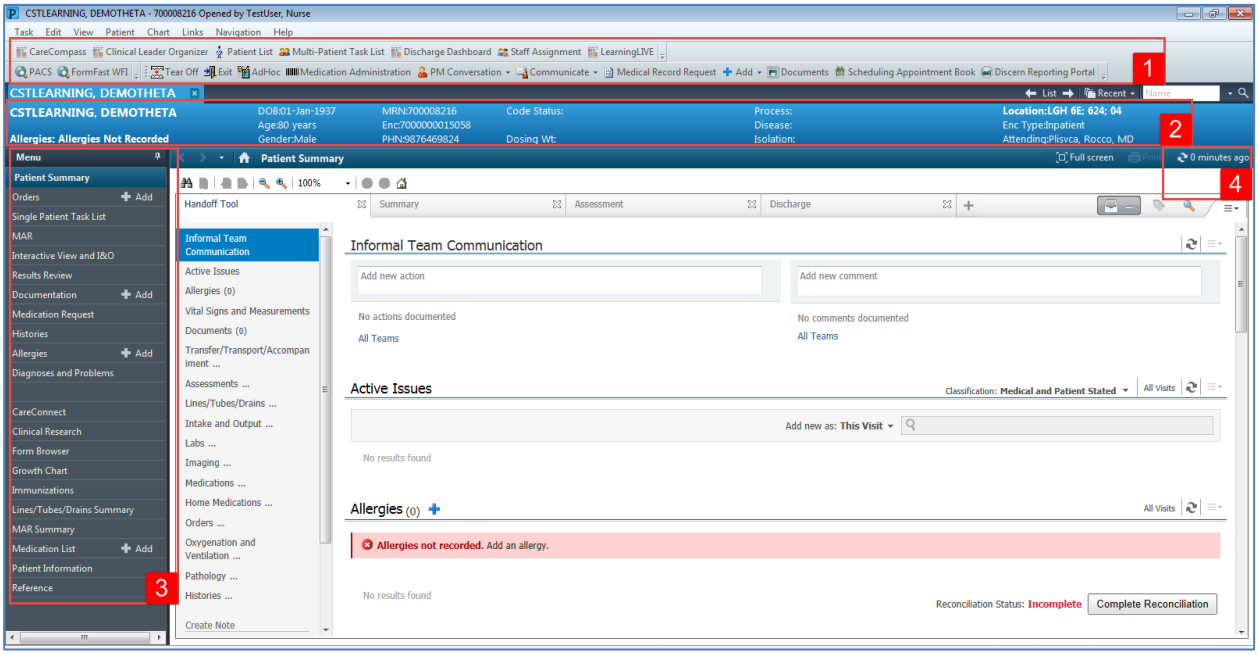
2 The patient's chart is now open. Let's review the key parts of the screen.

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 updates 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.



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

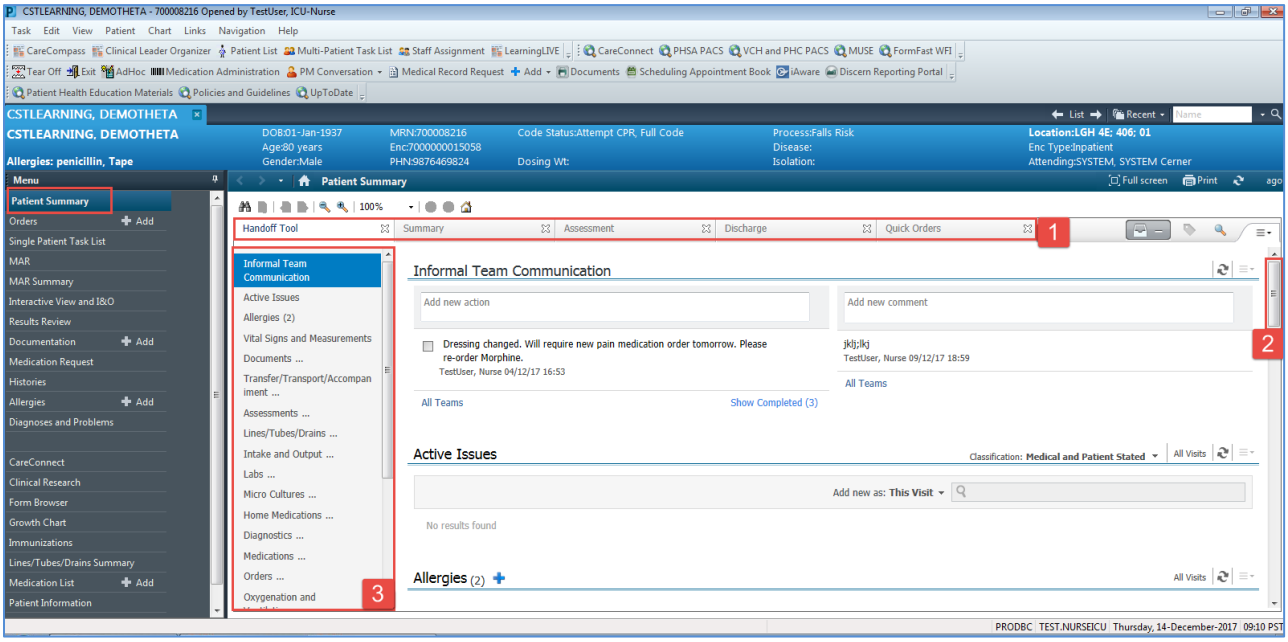
1 When the patient's chart is first opened, you will see the **Patient Summary** page. The **Patient Summary** summarizes key clinical patient information, orders, medications, lab results, and so on. This will be the place in the chart that is accessed during handover for nurses to review critical patient 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.



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 .

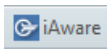
Key Learning Points

- 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

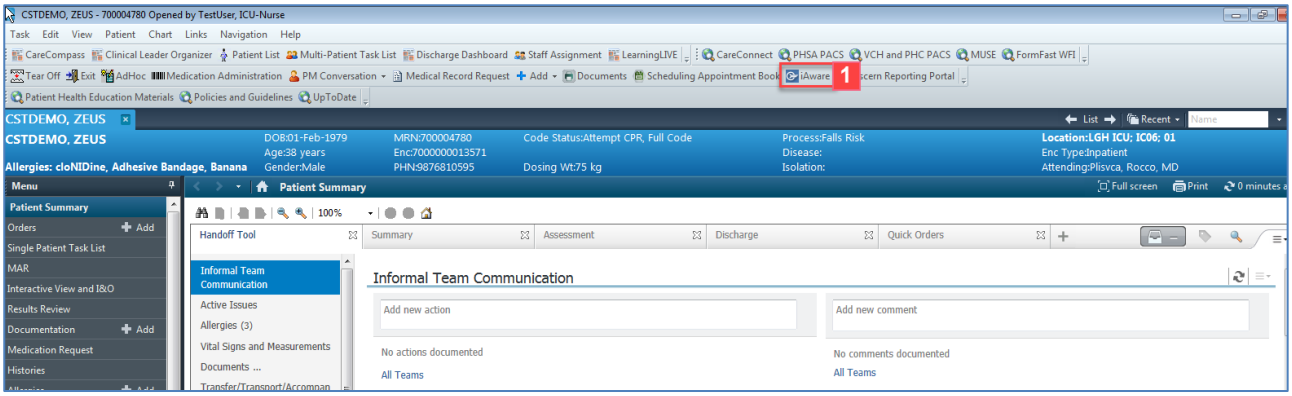
Activity 3.3 – Introduction to CareAware Critical Care

1 **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.

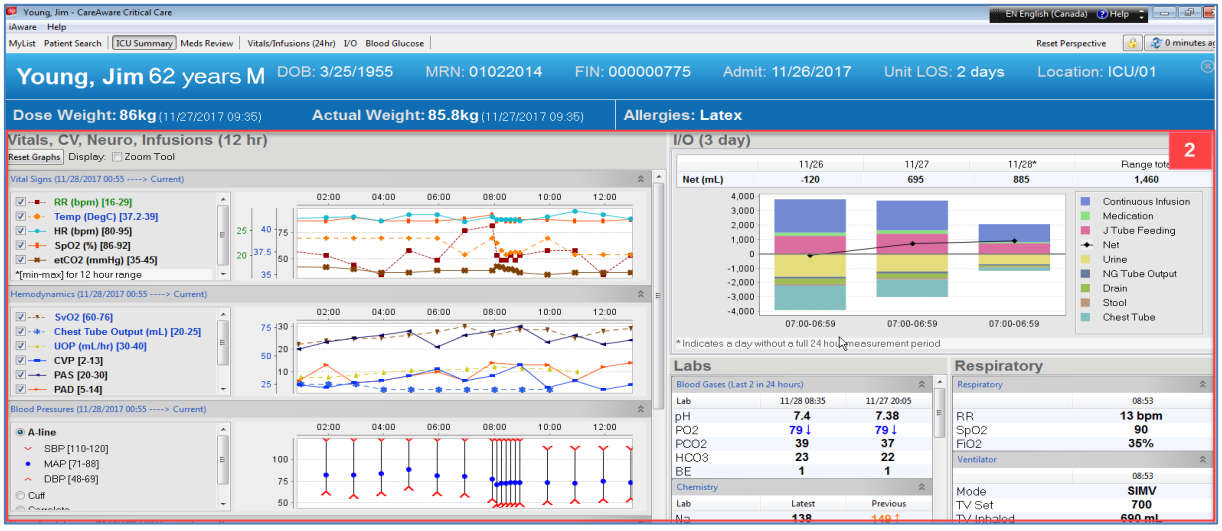
1. To access CareAware Critical Care, click the **iAware** button 

in the toolbar

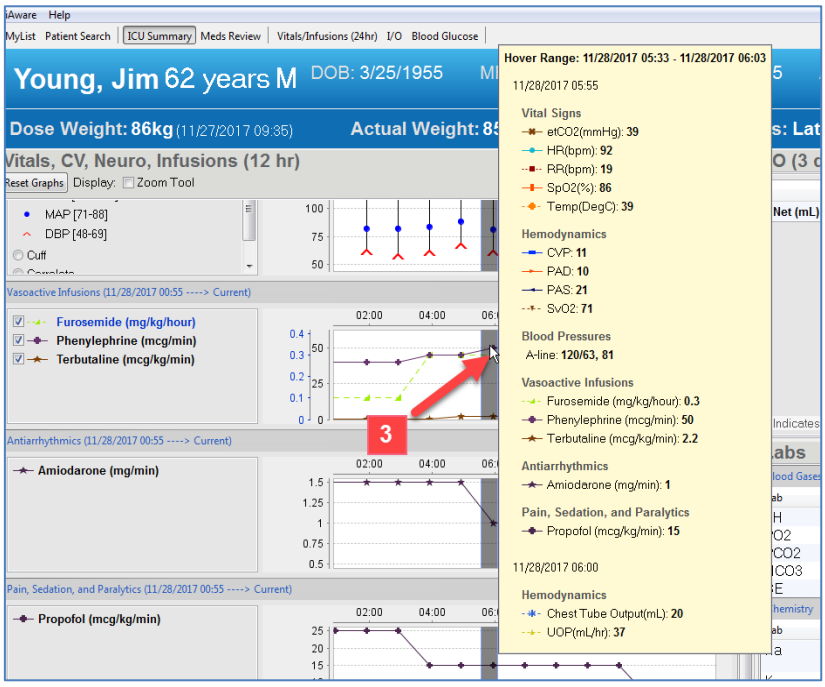


2. The **CareAware Critical Care** dashboard opens and displays a summary of various clinical data that has been documented in your patient's chart. This information includes vital signs, hemodynamics, IV drips, lab results, intake and output and more.

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.



3. 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

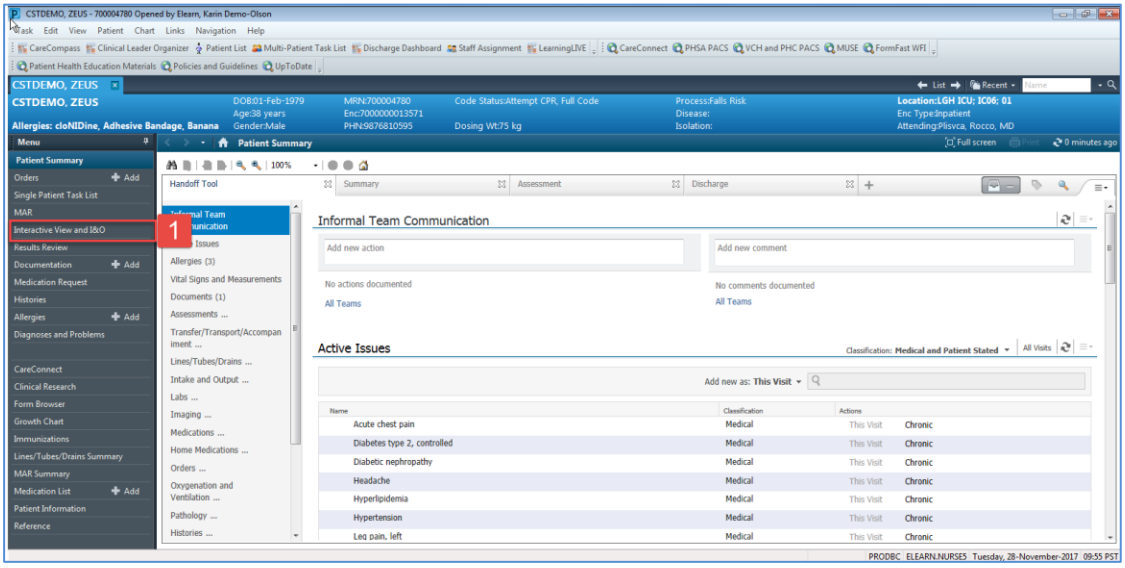
Activity 4.1 – Introduction to BMDI

1 **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).

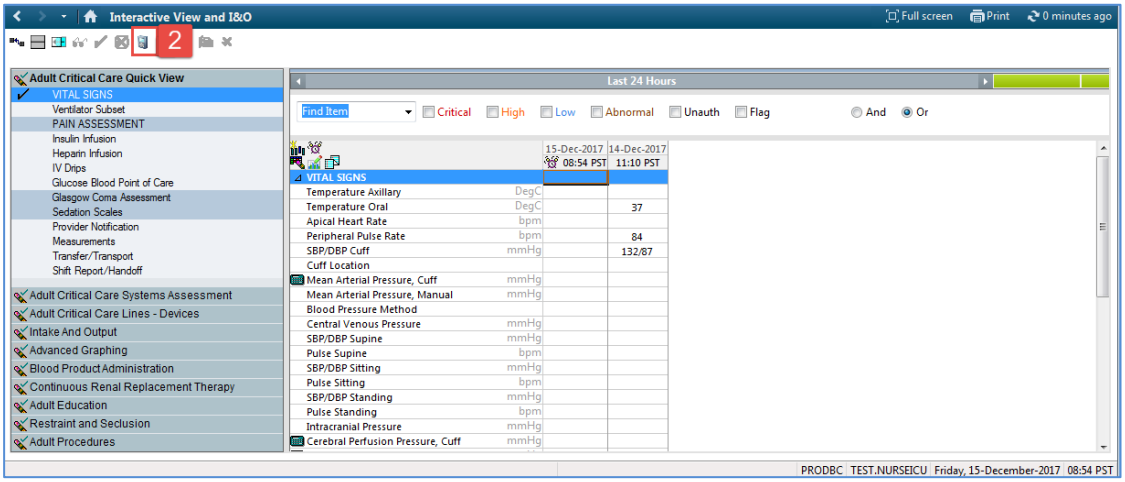
BMDI pulls data from monitors to the IView/I&O. Information is not saved until the RN views and verifies the data is correct. This prevents incorrect data from being documented. The RN must associate the patient to the appropriate monitor for data to pull into the flowsheet.

Associate a patient with the BMDI monitor.

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

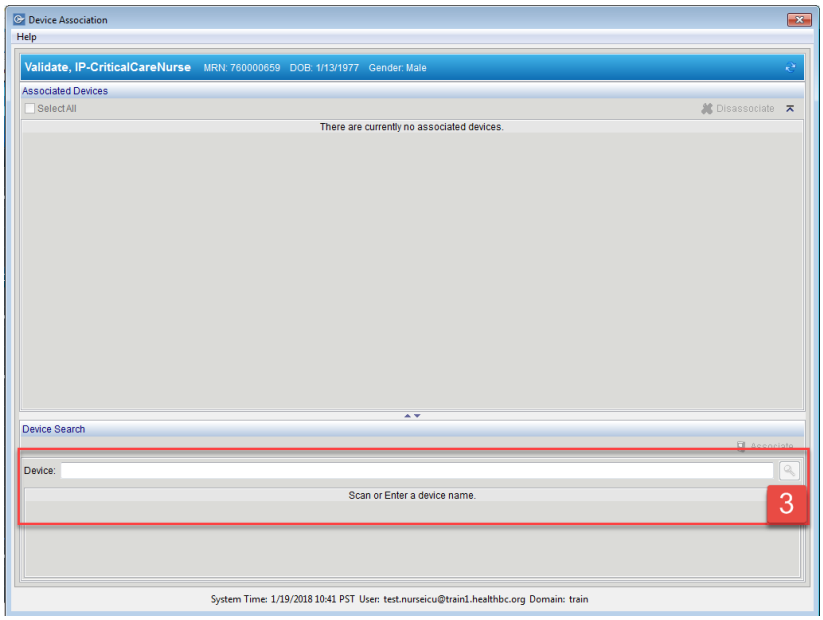


2. A window called **Device Association** may automatically display. Otherwise, click on the **Associate Device** icon .



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.

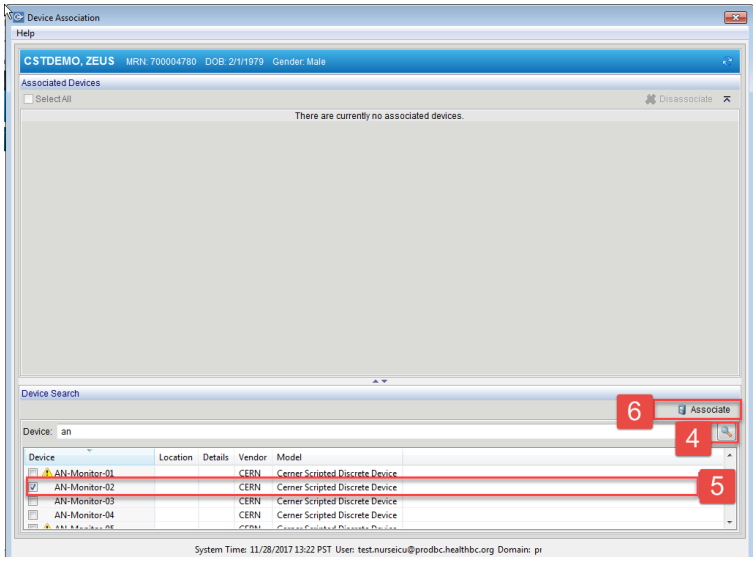


4. If you manually enter a device name, press **Search** to locate the name of the bedside monitor.

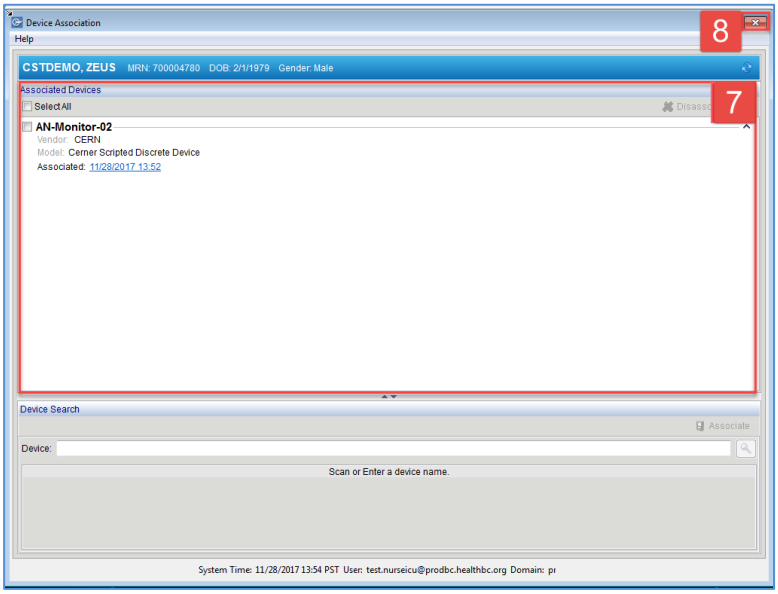
Note: If you scan the device, it will display the device name.

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

6. Click the **Associate** icon Associate



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 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.

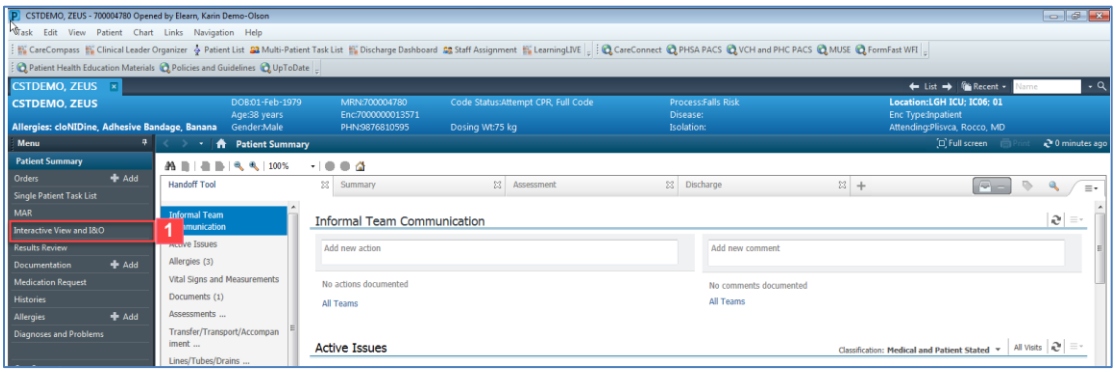
You will be completing the following activities:

- 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

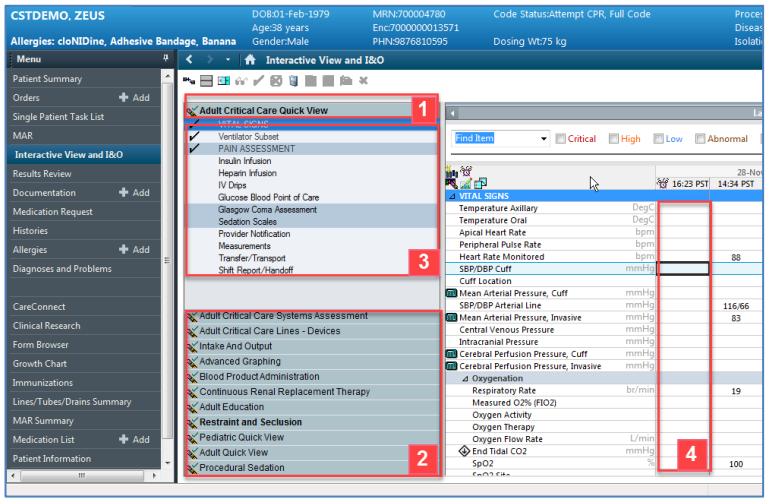
1 Nurses will complete most of their documentation in **Interactive View and I&O (iView)**. iView is the electronic equivalent of current state paper flow sheets. For example, vital signs and pain assessment will be charted in iView.

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



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.

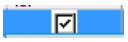


Key Learning Points

- 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

1 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*

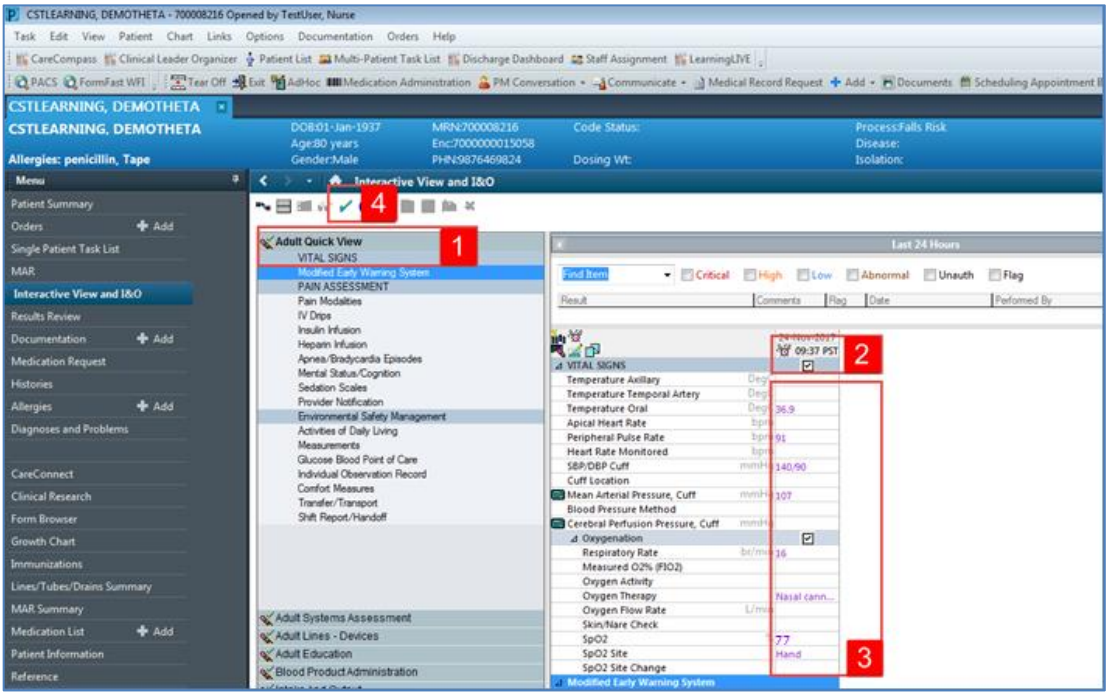
Note: When entering blood pressure, type systolic blood pressure (SBP) value then press ENTER and this will take you to the next cell for diastolic blood pressure (DBP).

- **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.

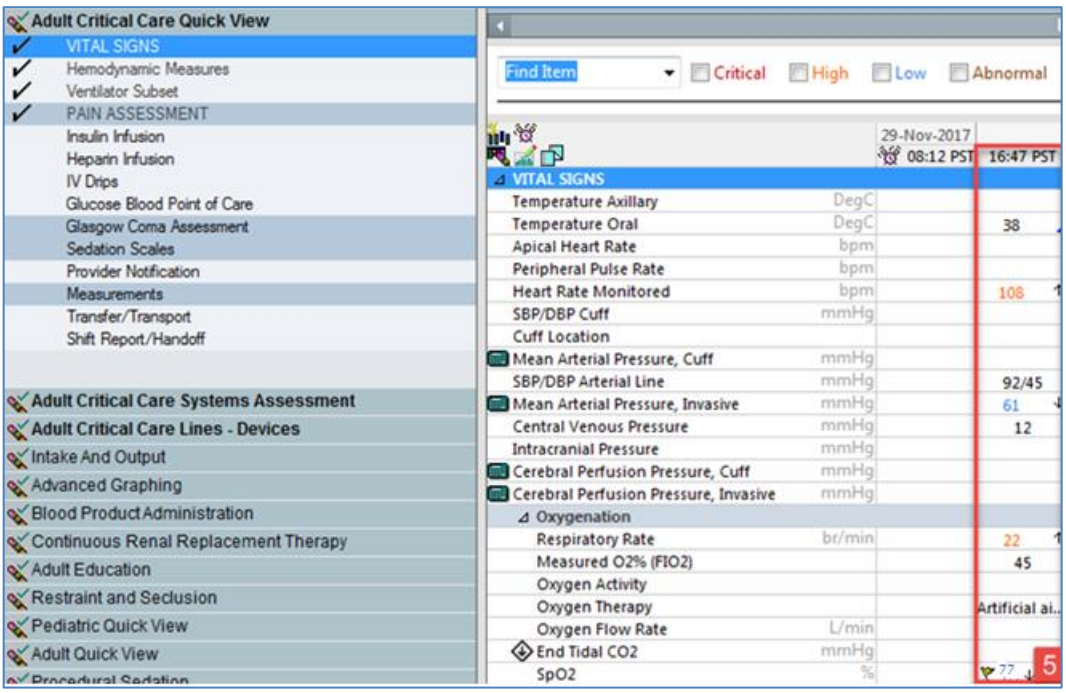
4. To sign your documentation, click the **Sign** icon 

Note: The **Calculation** icon  denotes 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.



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.

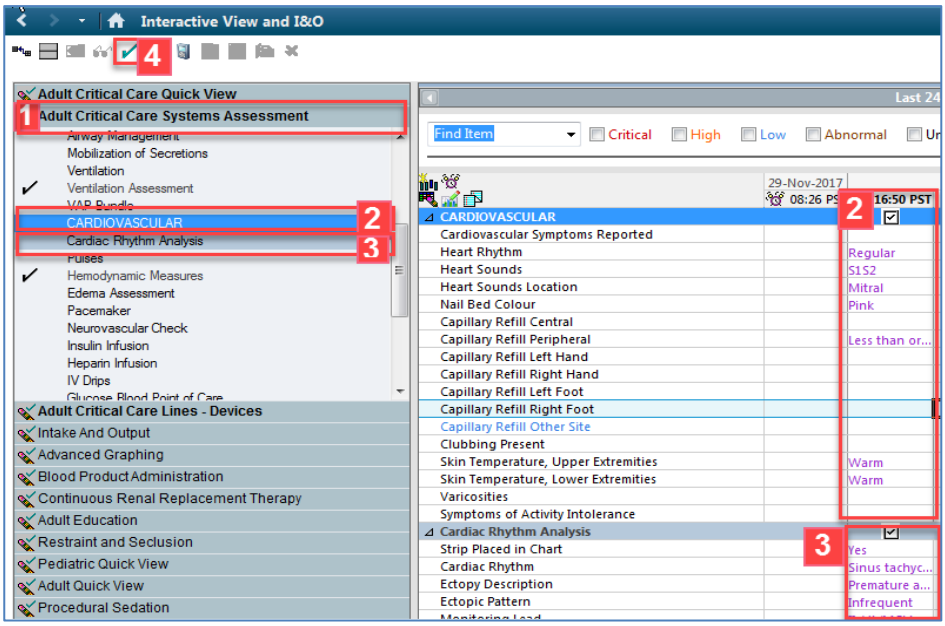
5. Abnormal values will show in different colors. Critical results are in red. High results are in orange. Low results are in blue.



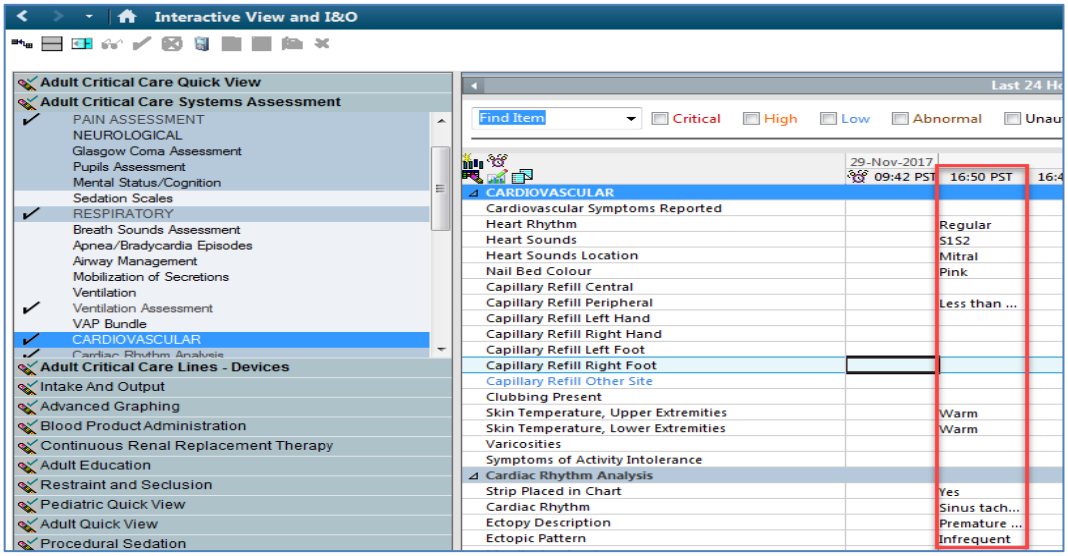
2 Let's expand the **Adult Critical Care Systems Assessment** band and practice documenting your assessment on the patient's cardiovascular system.

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.

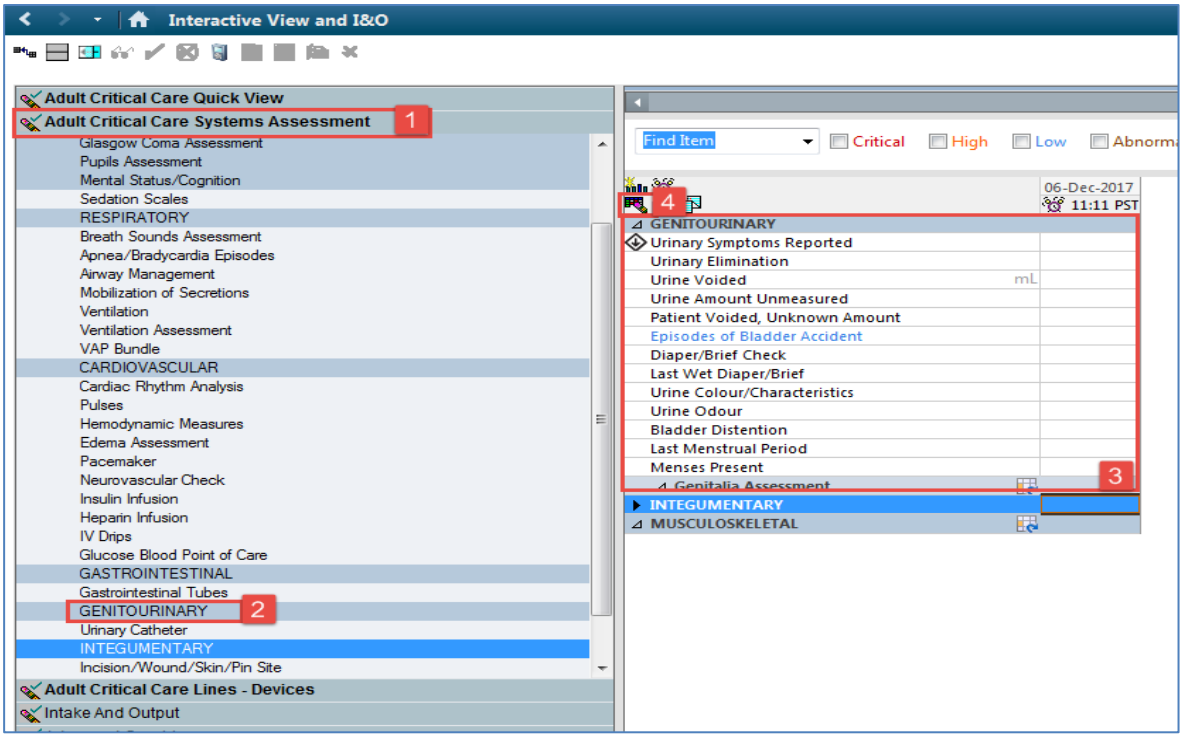


Note: Once the documentation is signed, the text turns black.

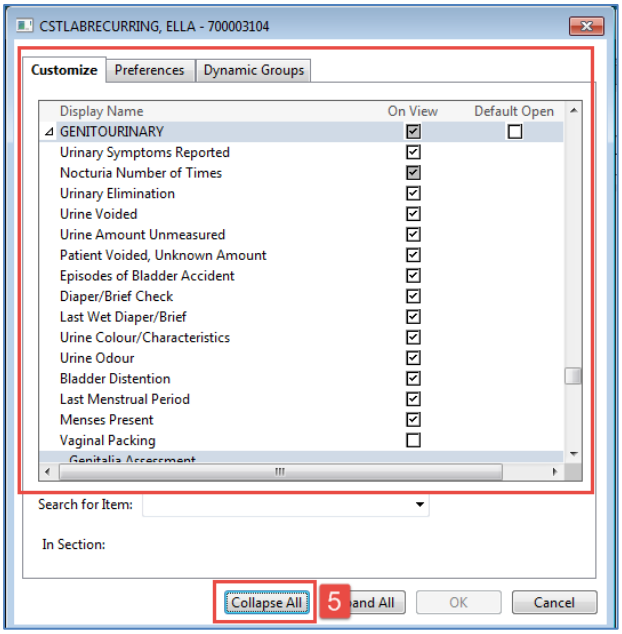


3 Let's pretend that you just did a bladder scan on your patient and now you want to document.

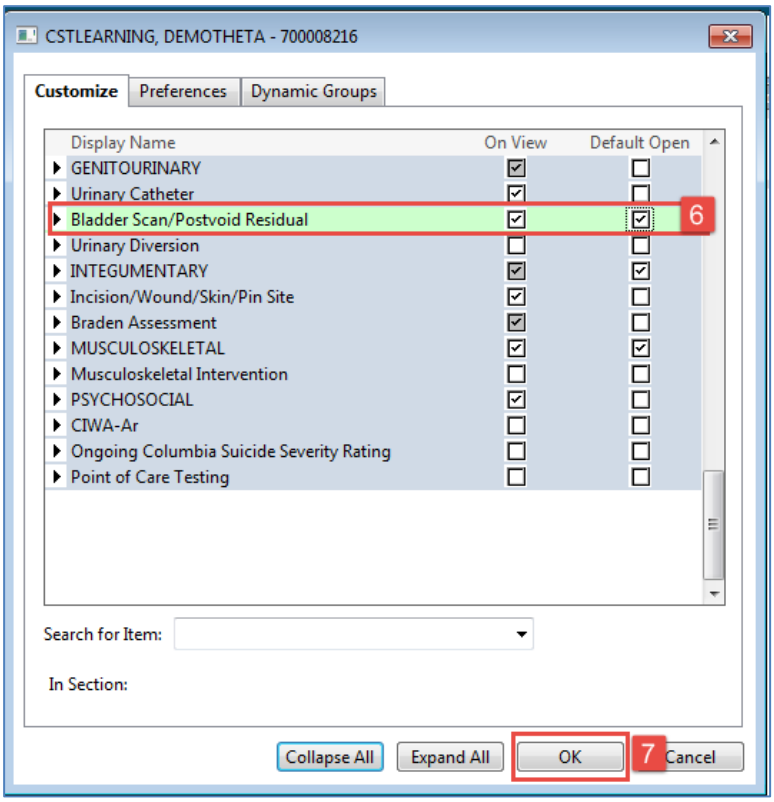
1. Click the **Adult Critical Care Systems Assessment** Band in **iView**
2. Click the **Genitourinary** section in the **Adult Critical Care Systems Assessment** Band
3. Notice that there is nothing in this section that you can see about bladder scanning
4. Click the **Customize View** icon  to search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



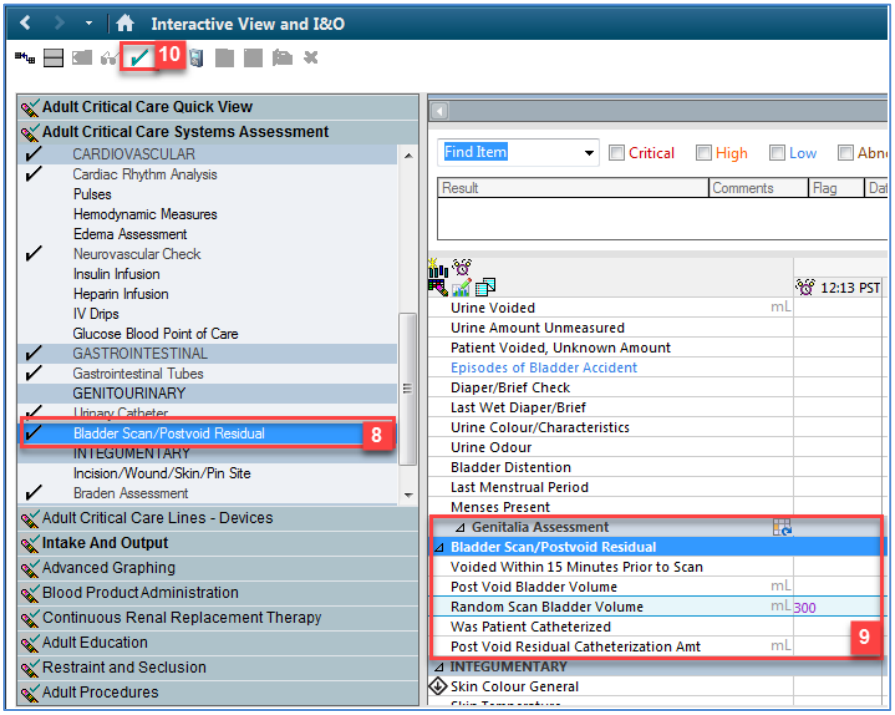
5. A **Customize** window opens displaying all the content within the Genitourinary section. Click the **Collapse All** button to see all of the section names at a glance.



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**



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



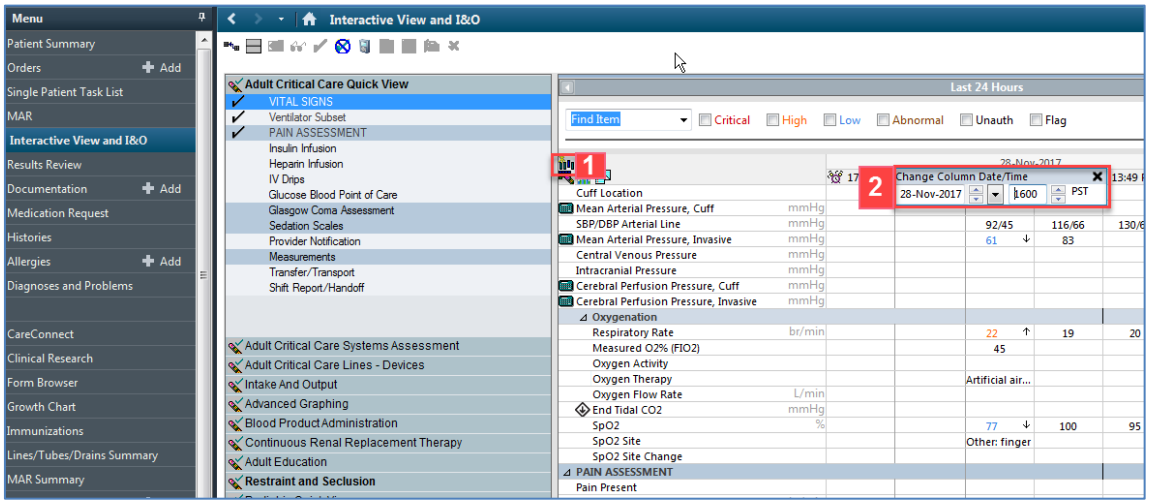
Key Learning Points

- 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

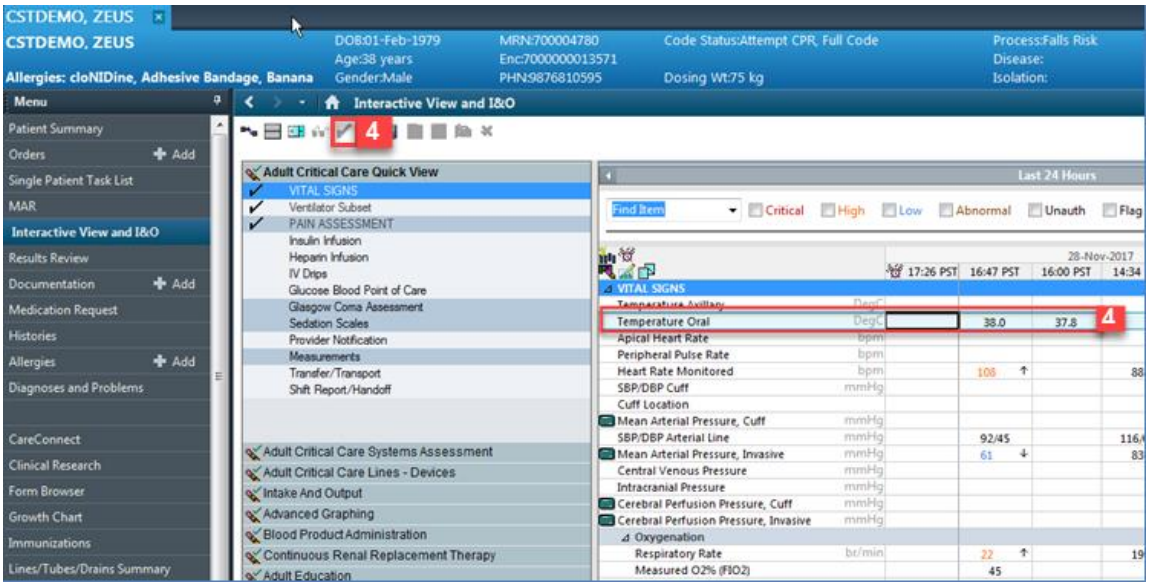
Activity 5.3 – Change the Time Column

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 .
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.



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



Key Learning Points

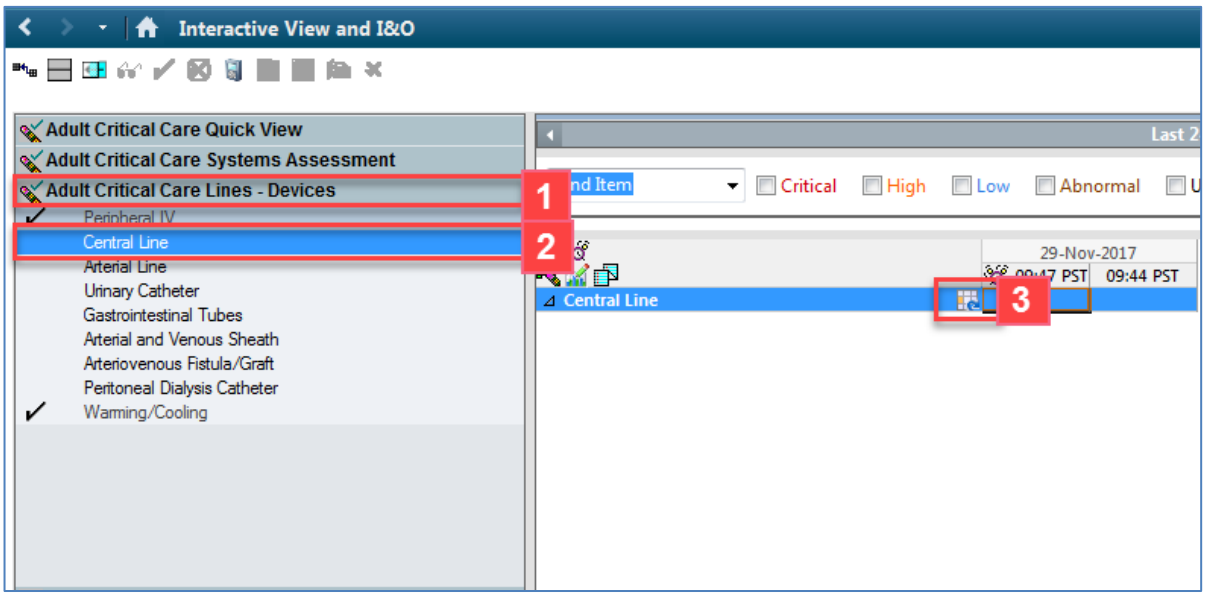
- If required, you can create a new time column and document under a specific time

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 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:

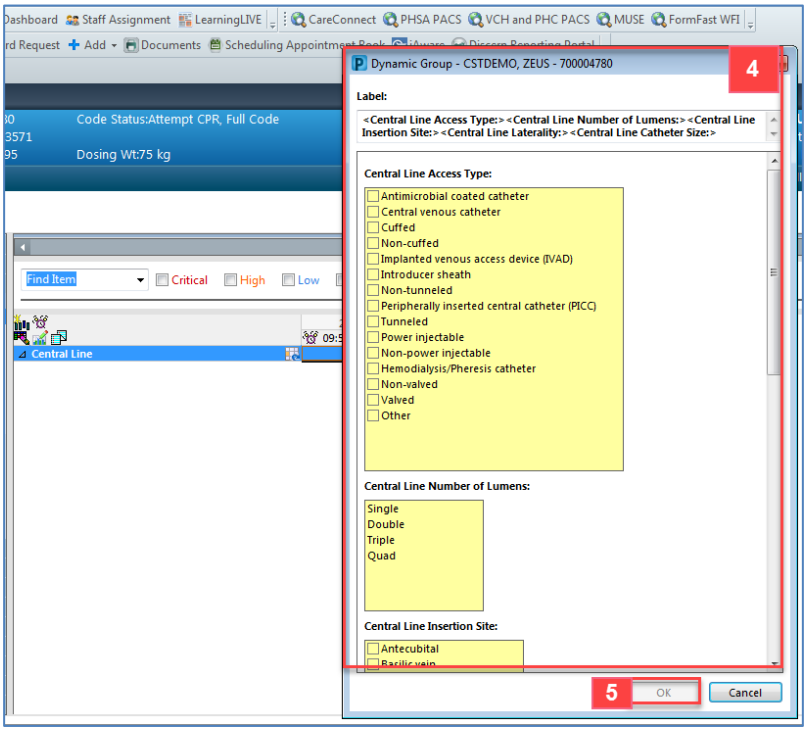
    - **Central Line Access Type**= *Central venous catheter*
    - **Central Line Number of Lumens** = *triple*

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.



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.

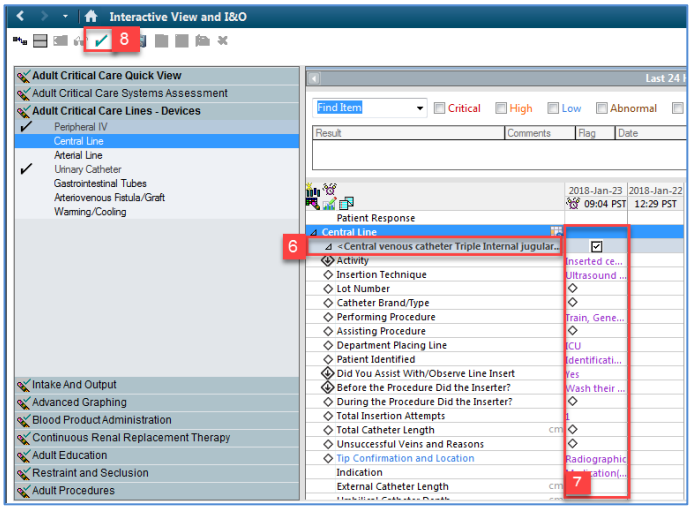
Note: A trigger icon can be seen in some cells, such as **Activity**, indicating that there is additional documentation to be completed if certain responses are selected. The diamond icon indicates the additional documentation cells that appear as a result of these responses being selected. These cells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

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.

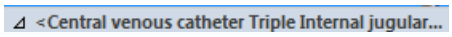
Note: Once signed the label will be accessible for other clinicians to complete their assessment documentation within the same dynamic group.



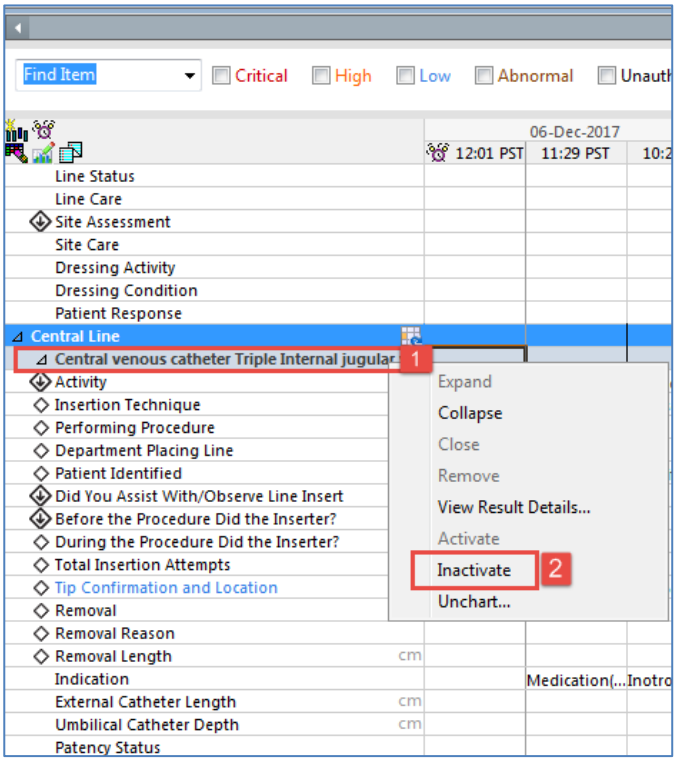
2 You can **inactivate** a dynamic group when it is no longer in use, such as when a drain or tube is removed.

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

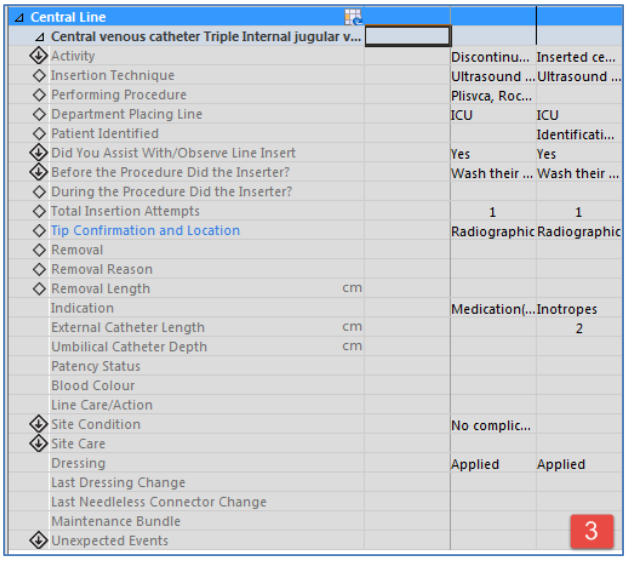
Note: you would first document that the line was discontinued under Activity and chart the removal reason, but for the purpose of this exercise we will skip this step.

1. Right-click the dynamic group label 

2. Select **Inactivate**.



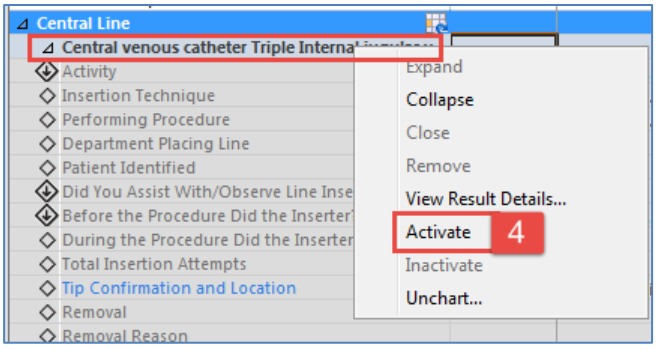
3. The section is now greyed out and inactive for documentation.



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 re-activate 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.

Key Learning Points

- 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

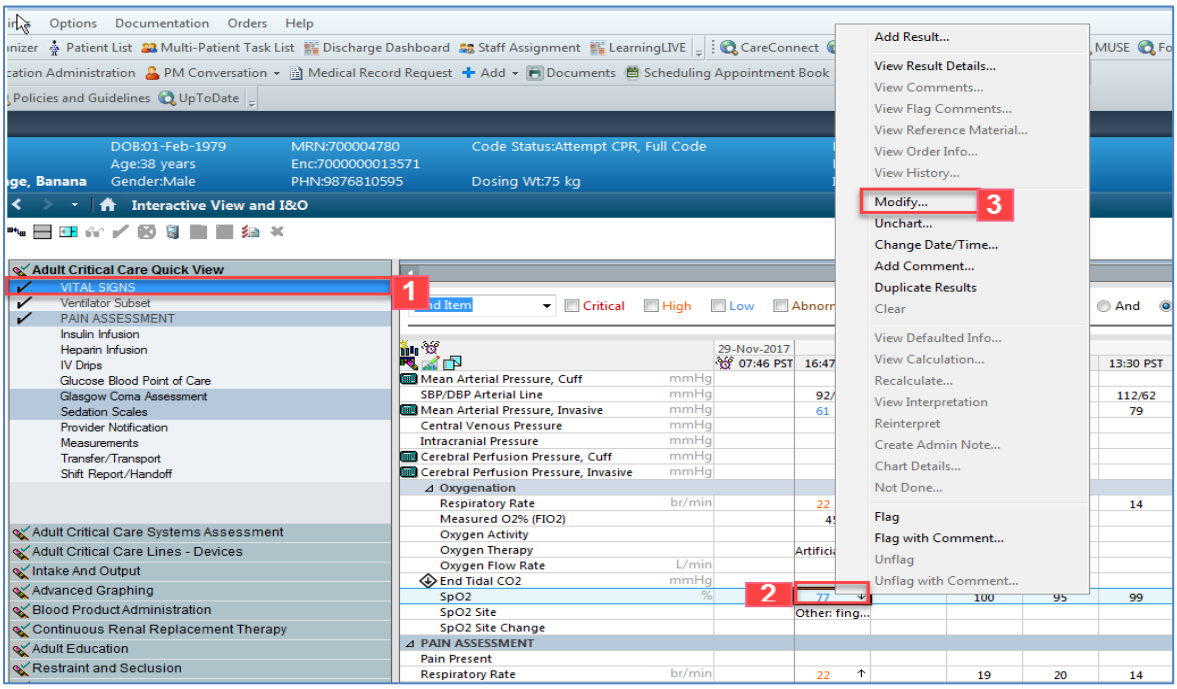
Activity 5.5 – Modify, Unchart or Add a Comment in Interactive View

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.

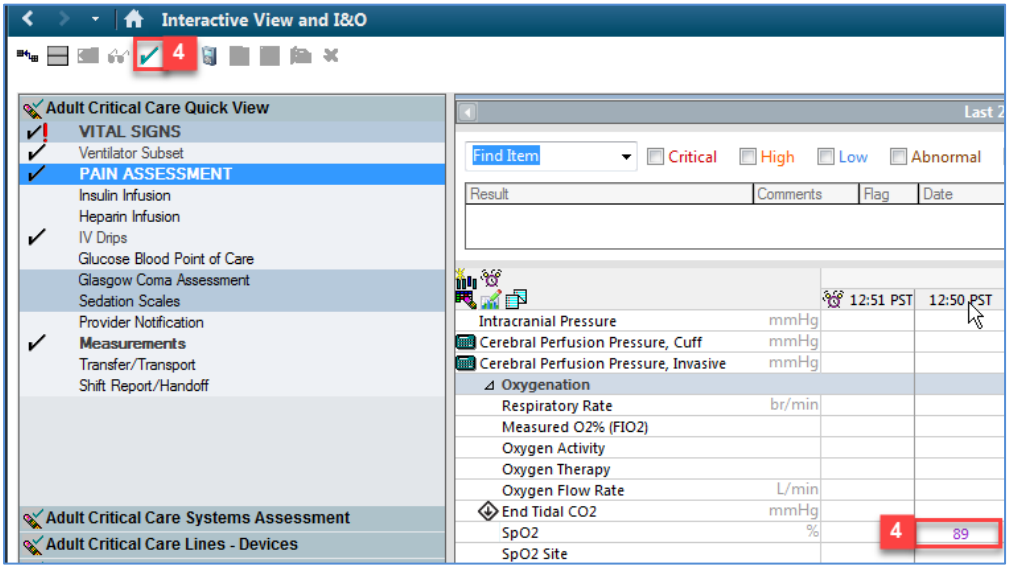
First, let's discuss how to **Modify** iView documentation.

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.

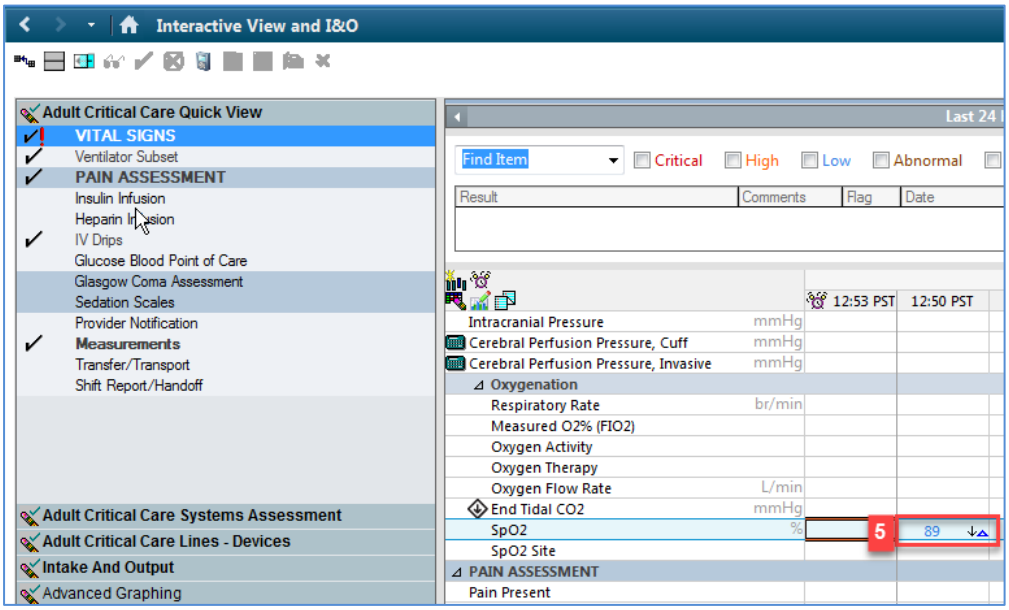
1. Click on the **Vital Signs** section heading in the **Adult Critical Care Quick View** band.
2. Right click on the documented SpO2 value (77).
3. Select **Modify**



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



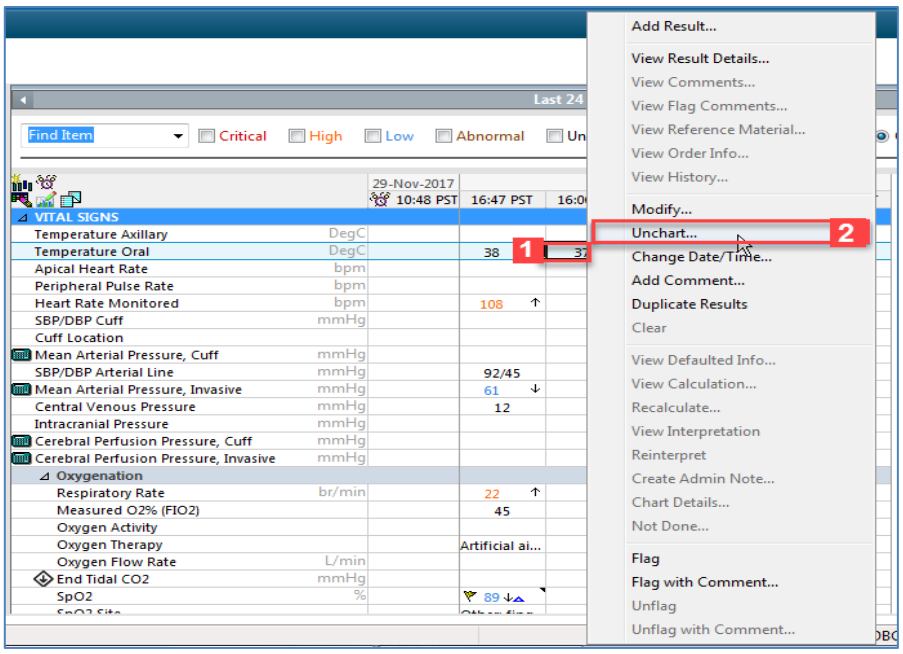
5. **89** now appears in the cell and the corrected icon will automatically appear on the bottom right corner to denote a modification has been made.



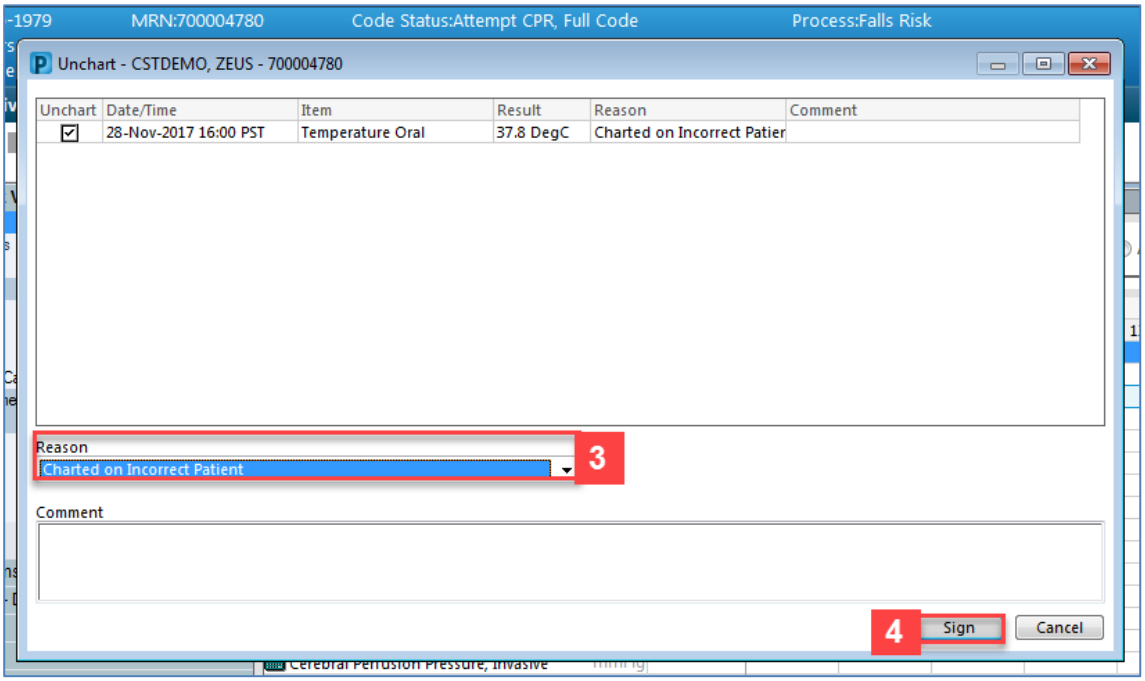
2 Unchart

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.

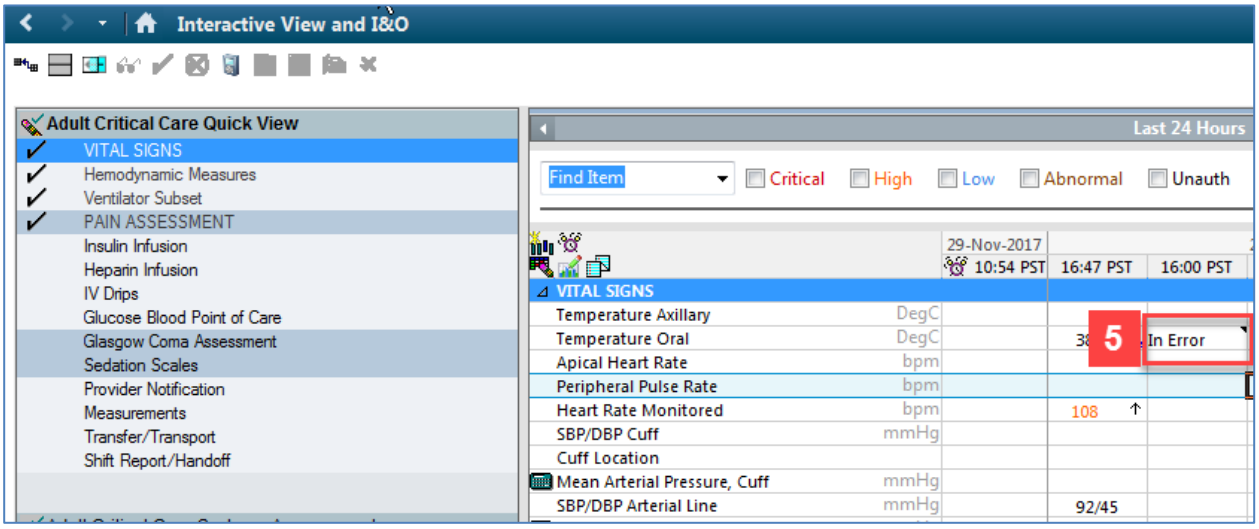
1. Right click on the documented Temperature Oral 38.
2. Select **Unchart**



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



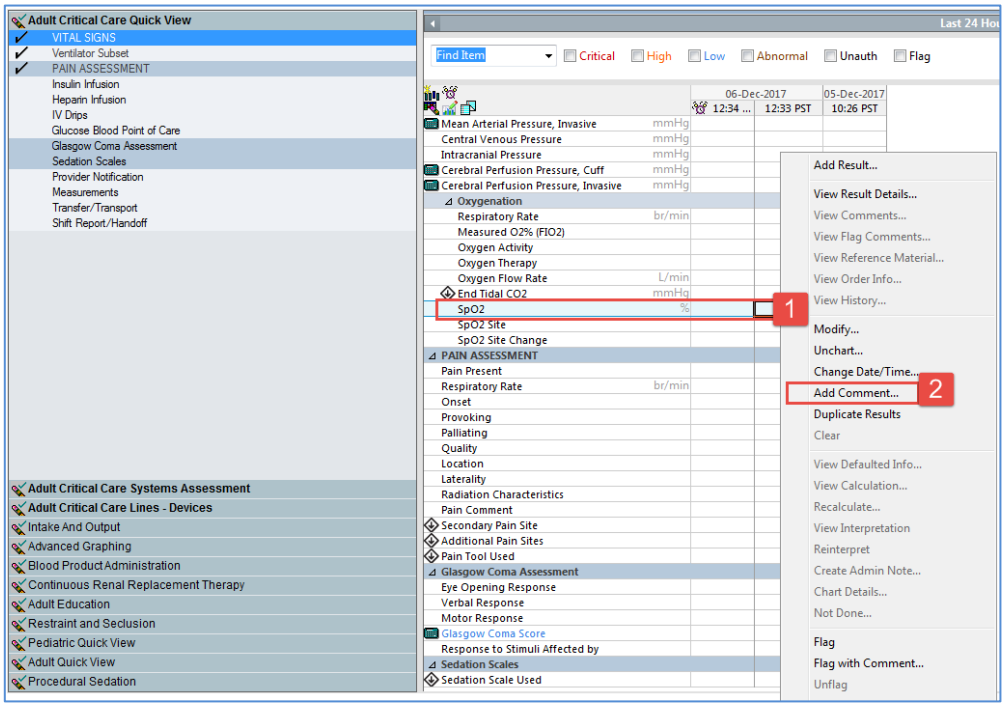
5. You will see **In Error** displayed in the uncharted cell. The result comment or annotation icon will also appear in the cell.



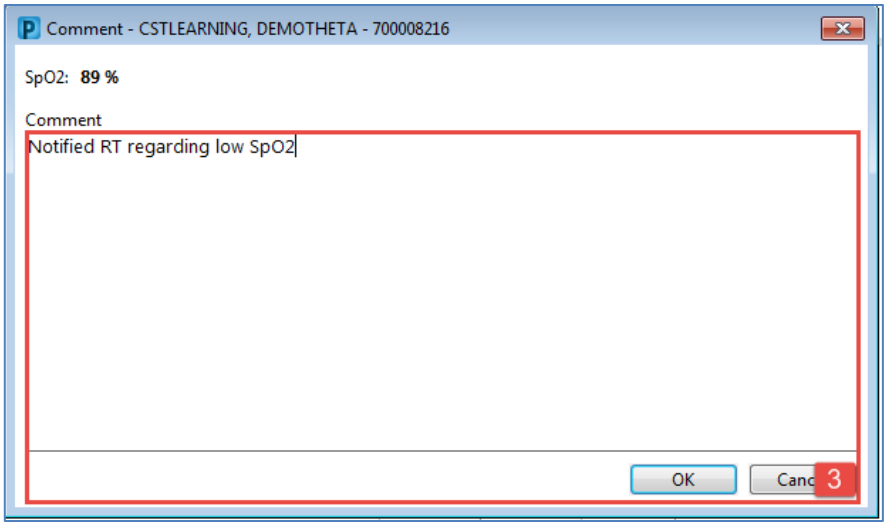
3 Add a Comment

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.**



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



Note: The Corrected icon and Result Comment or Annotation icon 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:

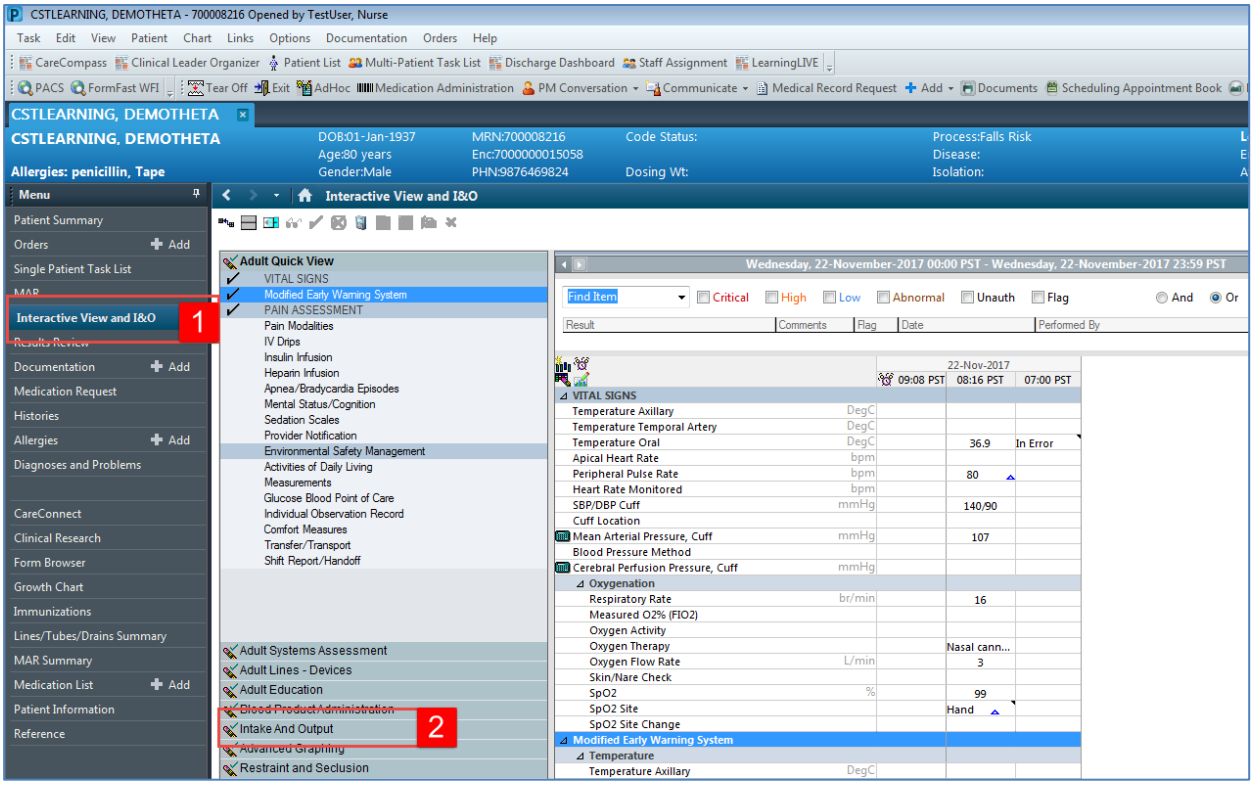
- Navigate to Intake and Output
- Review and Document in the I&O Record

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.

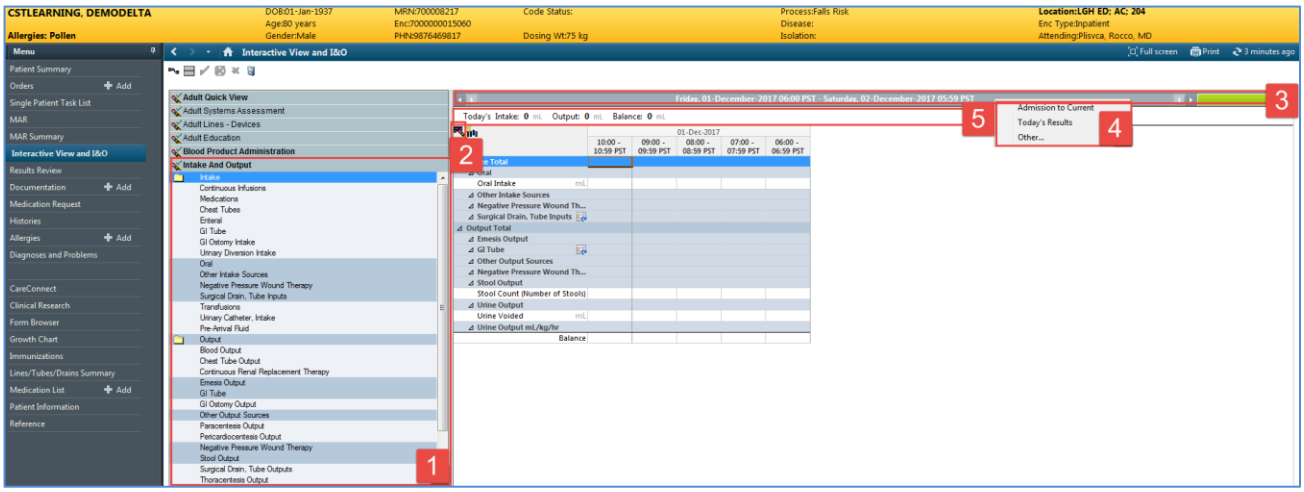
1. Click **Interactive View and I&O** from the Menu
2. Select the **Intake and Output** band.



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.



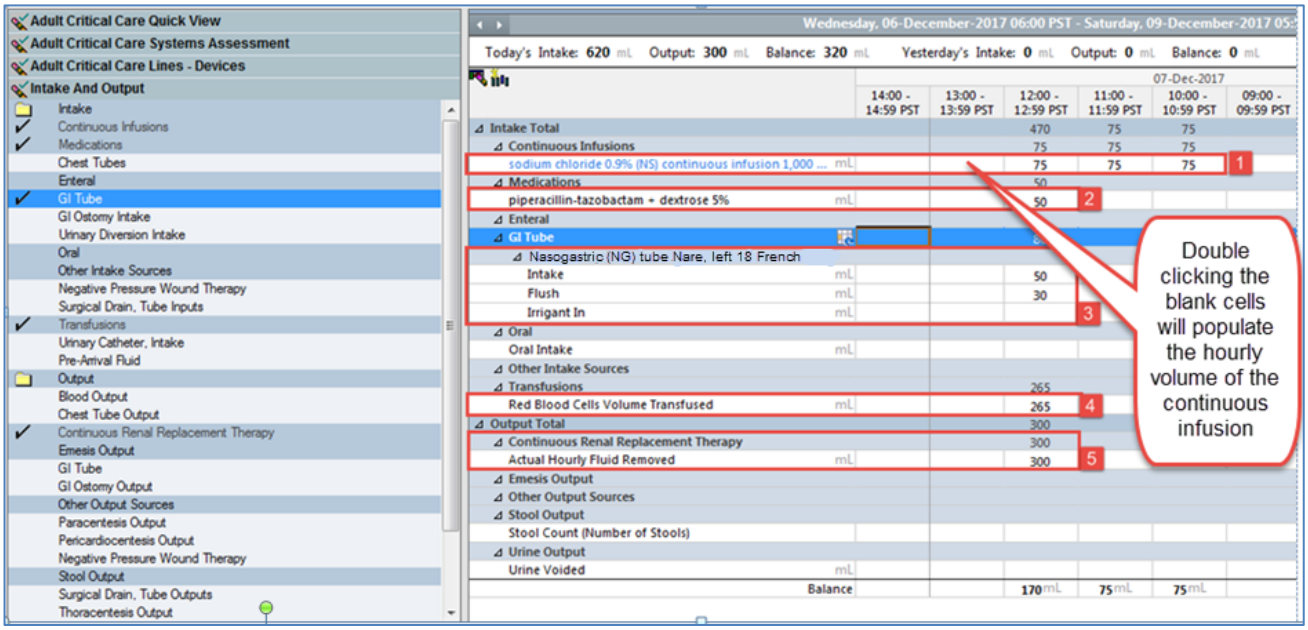
3 Some values in the Intake and Output record automatically populate from volumes documented in other parts of the chart such as in iView. A few examples of values that pull from iView documentation include the following:

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 mini-bags)
    - 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



Key Learning Points

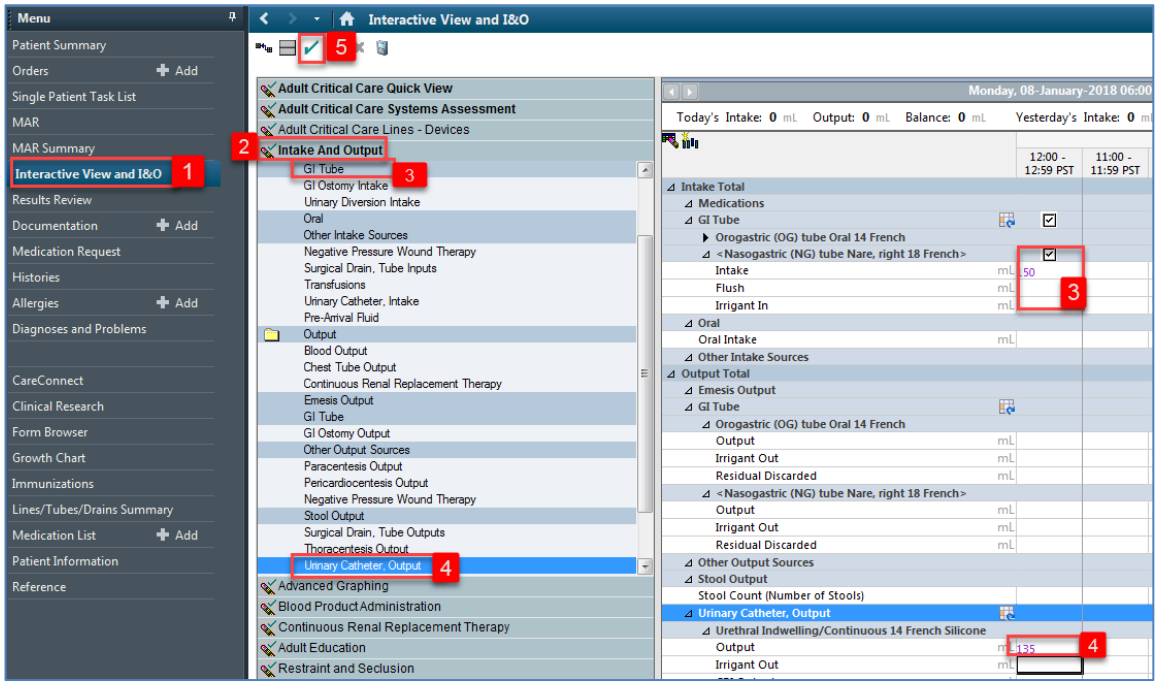
- Time columns are organized into hourly intervals with a column for a 12 hour (Day/Night Shift) Total and 24 Hour Total
- Volumes documented in dynamic groups and other sections in iView will automatically pull values into the Intake and Output record
- After administering continuous infusions through 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.

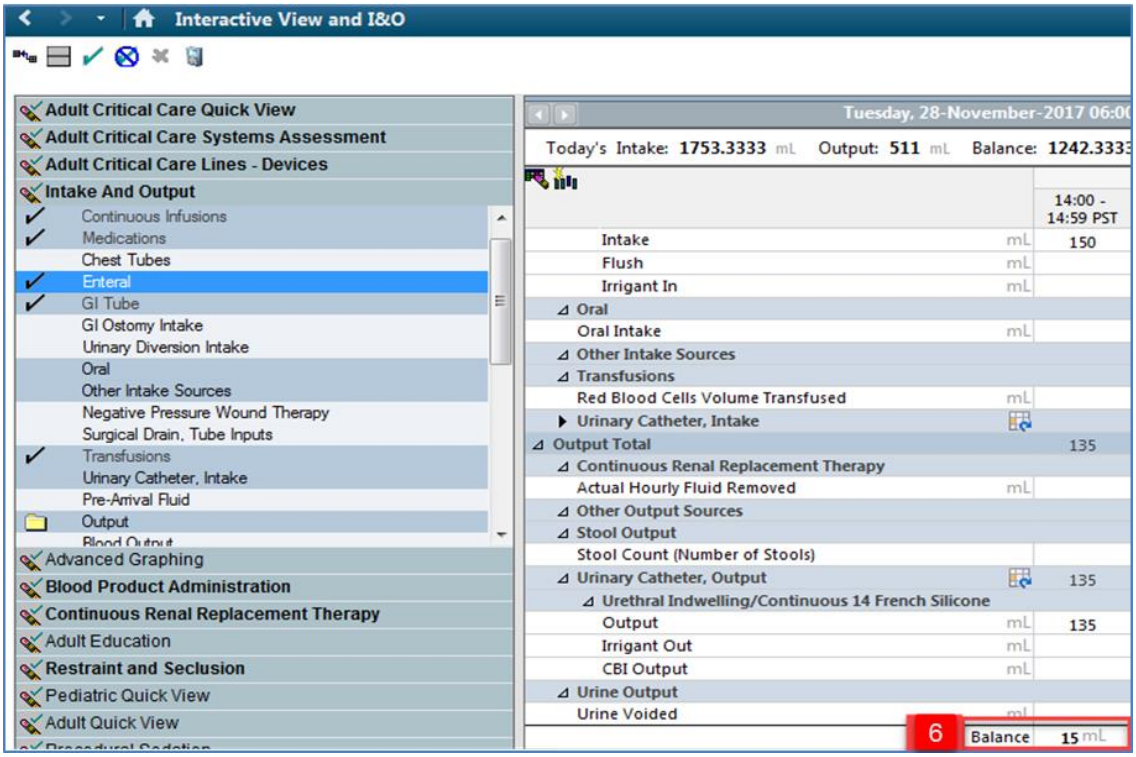
Let's practice documenting these values directly in the I&O record.

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

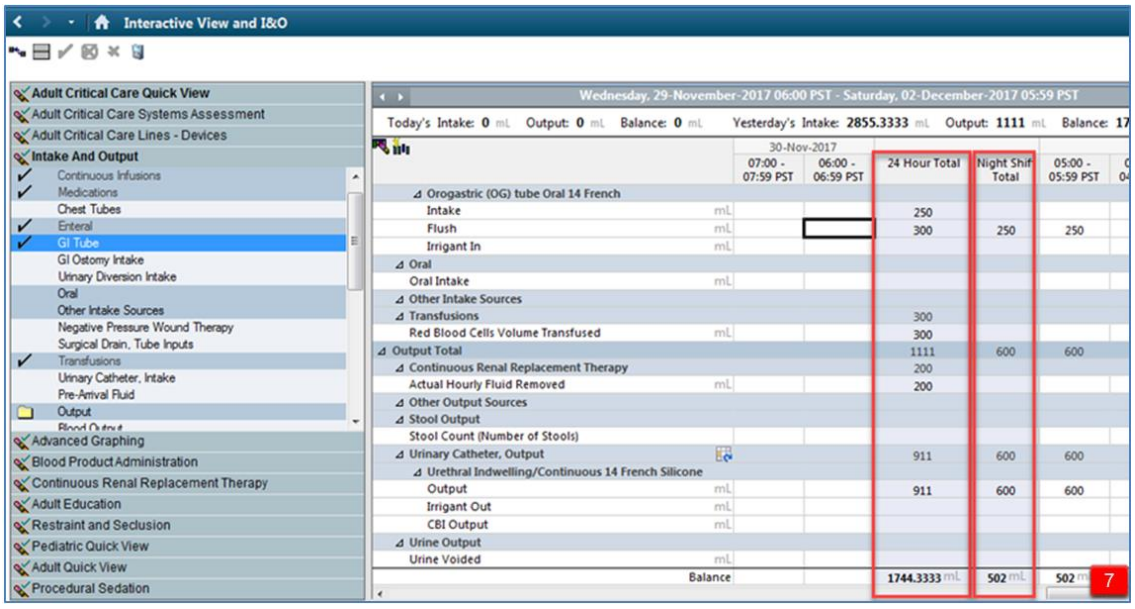


Note: You may get **Urinary Catheter Alert - Discern Notification** pop-up screen. Click the **Close** icon to acknowledge and close the Discern Notification window.

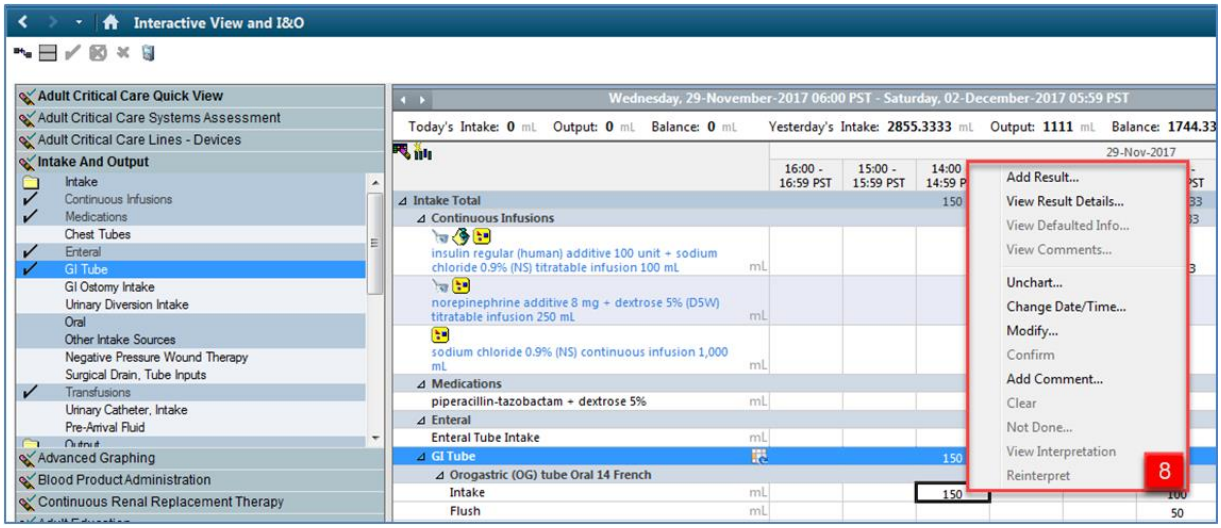
6. The fluid balance for the hour is automatically calculated and displayed.



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



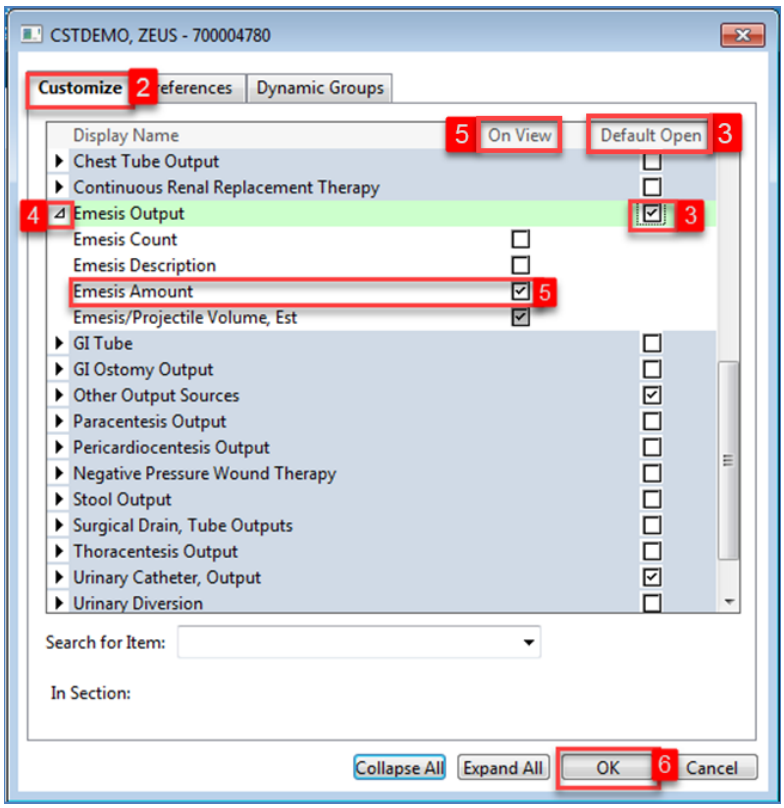
8. Additional functions can be viewed by right clicking the cell. You can unchart, modify or add a comment to any result.



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

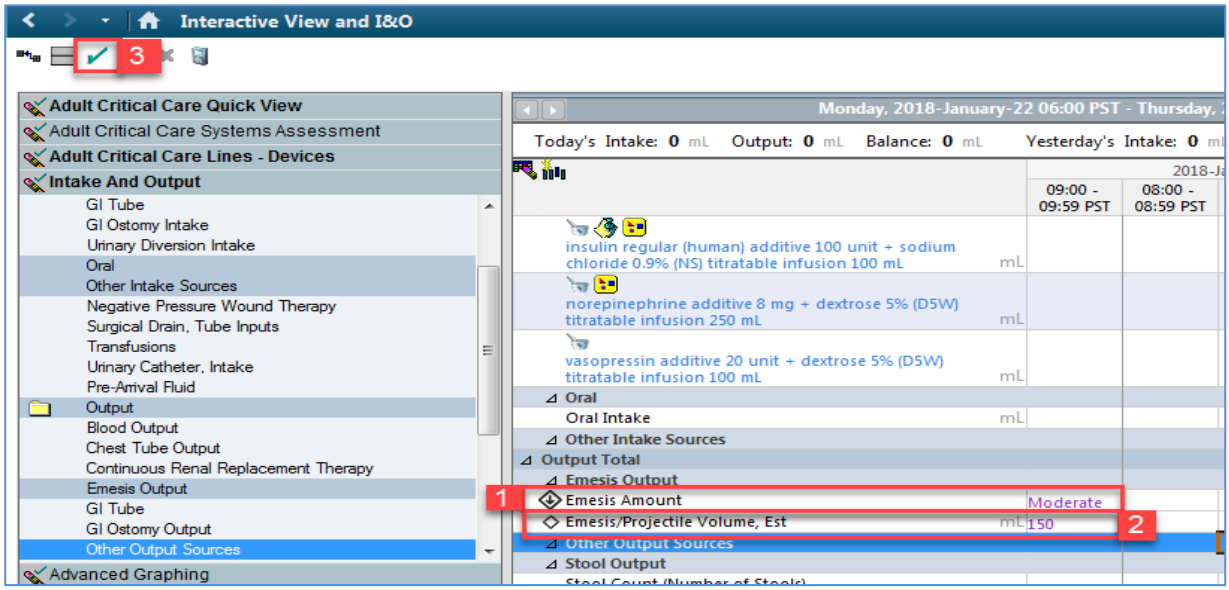
2 Now let's say your patient just vomited and you need to document the emesis amount. You need to add in this section because it is not yet active in the I&O band.

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**



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
2. Notice the downward arrow icon next to **Emesis Amount**, this means there are conditional cells that display if **Emesis Amount** is documented on. In this case, **Emesis/Projectile Volume, Estimated** is the conditional field that is now available to document on. Enter the following volume **Emesis/Projectile Volume, Est =** 150. Then press **Enter** on your keyboard.
3. Click the **Sign** icon. You will now see this volume displayed in the patient's fluid balance.



Key Learning Points

- 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

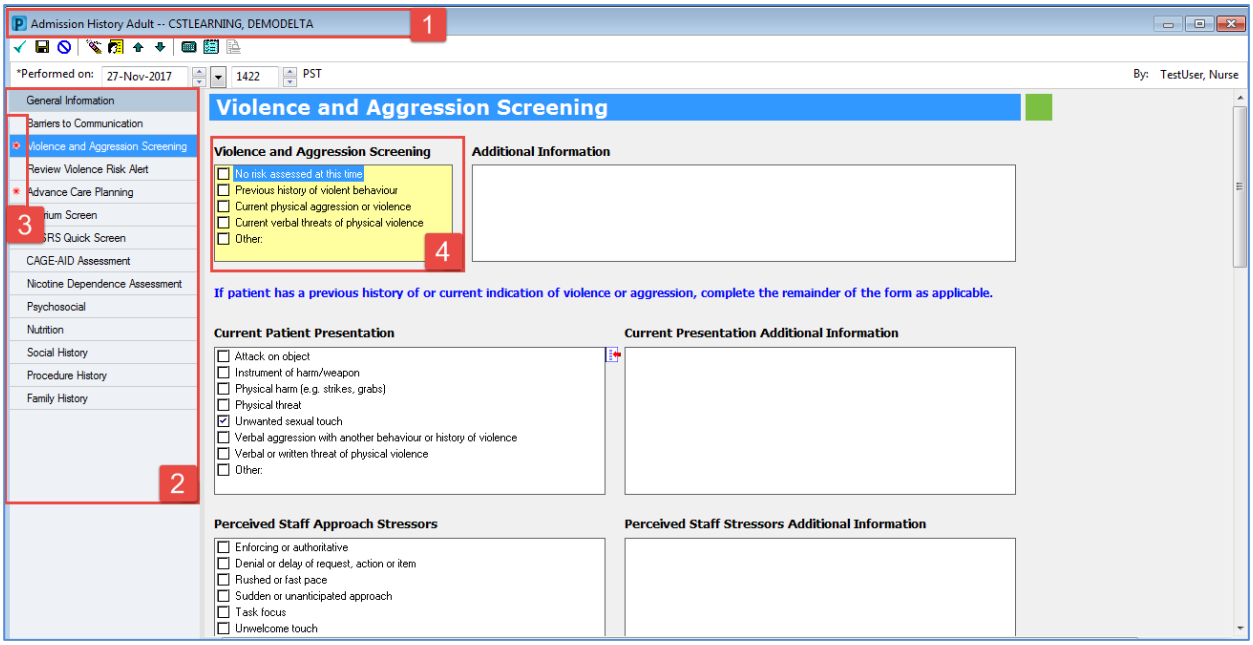
Activity 7.1 – Opening and Documenting on PowerForms

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

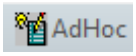
Data entered in **PowerForms** can flow between iView flowsheets, Clinical Notes, the Problem List, Allergy Profile, and Medication Profile. The **AdHoc** folder is an electronic filing cabinet that allows you to find any PowerForm on an as needed basis.

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

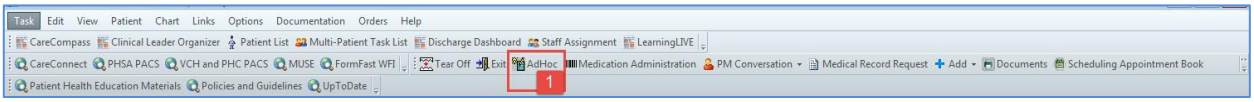
1. The **title** of the current PowerForm you are documenting on
2. On the left hand side of the PowerForm is a list of **form sections** that can be documented
3. Form sections that have a **red asterisk** contain **required field(s)** that must be filled out
4. The **required field(s)** within the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



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

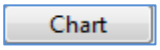
1. Click the **AdHoc** button 

from the **toolbar.**



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 **Chart** button 

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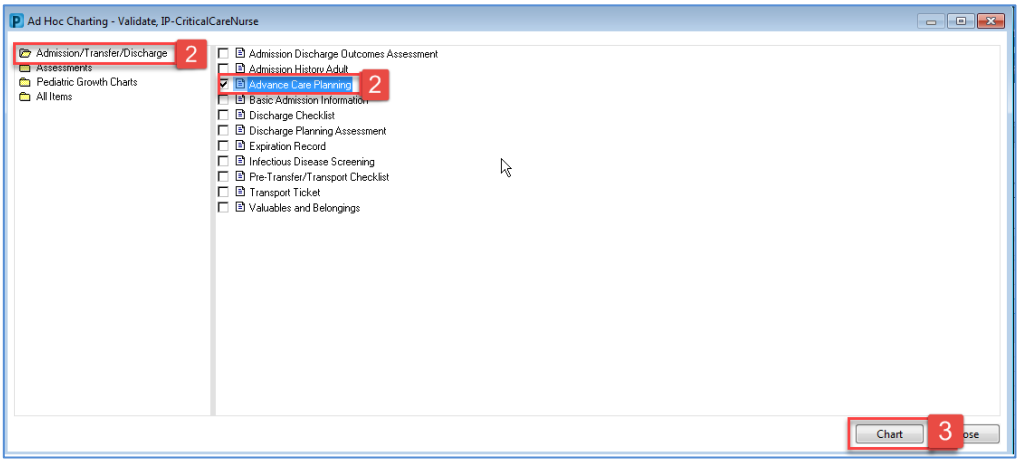
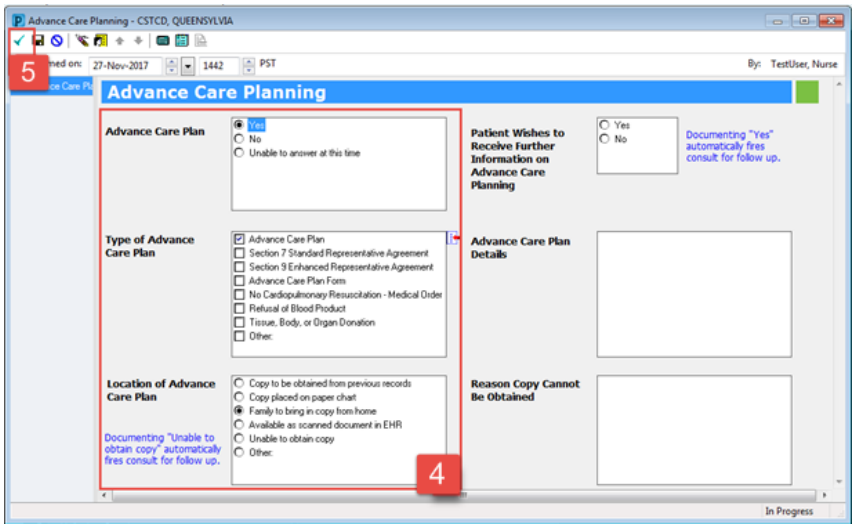


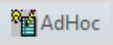
4. Fill in the following fields:
    - **Advanced Care Plan**= *Yes*
    - **Type of Advance Care Plan**= *Advance Care Plan*
    - **Location Of Advance Care Plan**= *Family to bring in copy from home*

5. To complete the PowerForm, click the **Sign** icon  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.



Key Learning Points

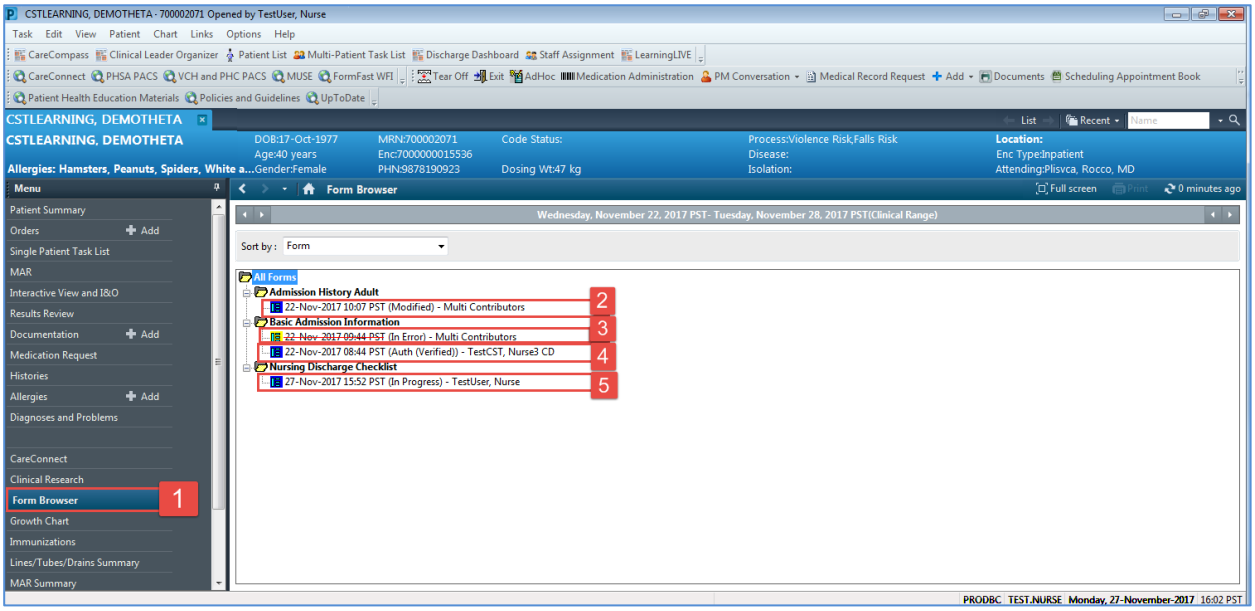
- PowerForms are electronic forms used to chart patient information.
- The AdHoc button  in the toolbar allows you to locate a new Powerform on an as needed basis.
- PowerForms may be broken up into several sections. Section headings are displayed to the left side of the PowerForm.

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

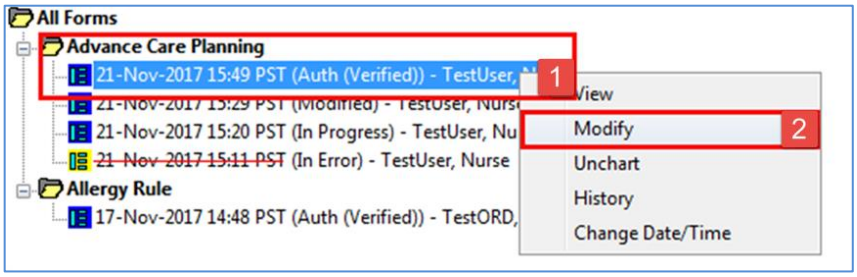
1 It may be necessary to modify PowerForms if the information was entered incorrectly.

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

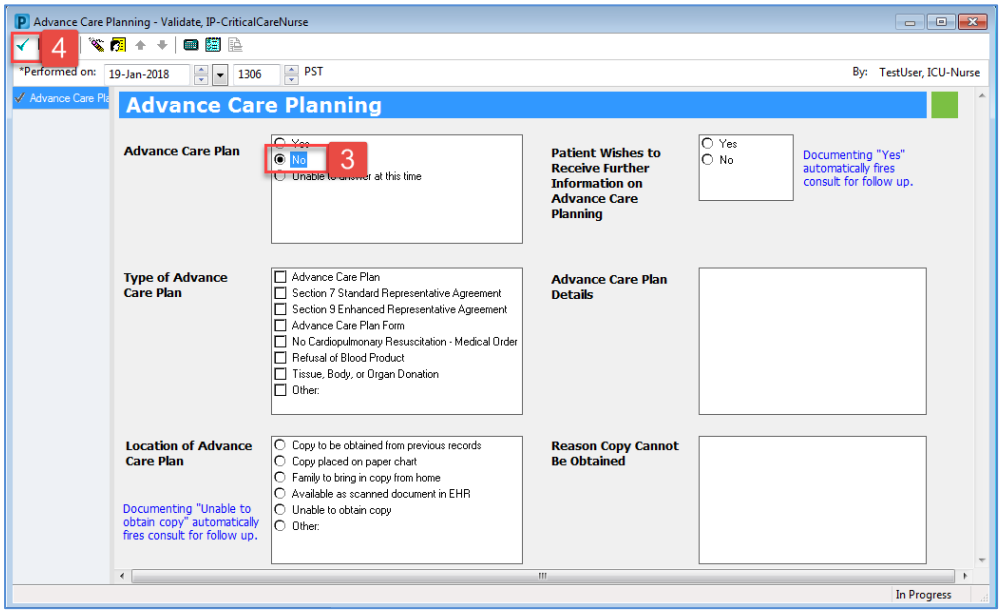
Let's modify the Advanced Care Planning form.

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**



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



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

Key Learning Points

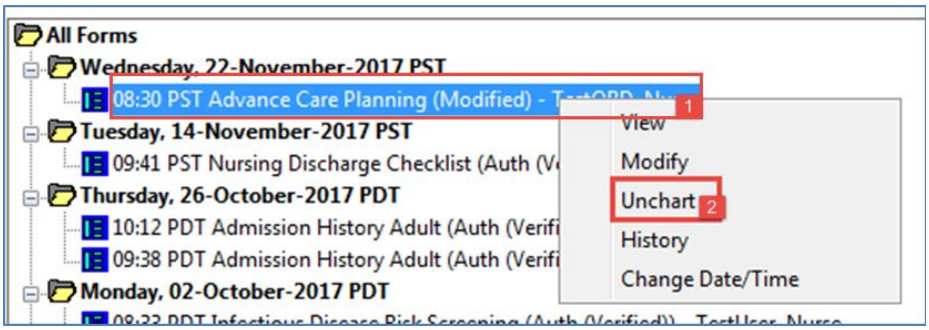
- A document can be modified if needed
- A modified document will show up as (Modified) in the Form Browser

Activity 7.4 – Uncharting an Existing PowerForm

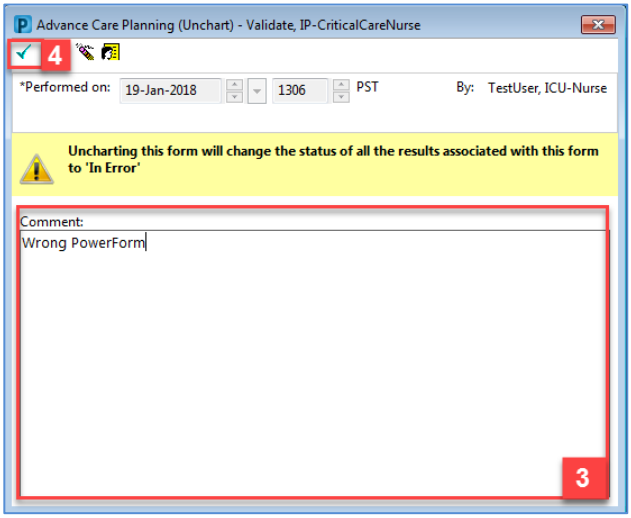
1 It may be necessary to **Unchart** an existing PowerForm if, for example, the PowerForm was completed on the wrong patient or it was the wrong PowerForm. Let's say the **Advanced Care Planning** form was documented in error.

To unchart the PowerForm, within Form Browser:

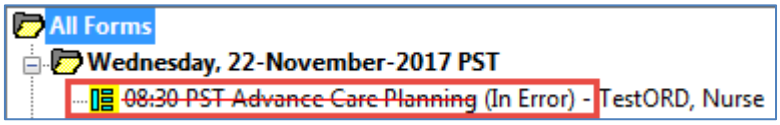
1. Right-click on **Advance Care Planning**
2. Select **Unchart**



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



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



Key Learning Points

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

PATIENT SCENARIO 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

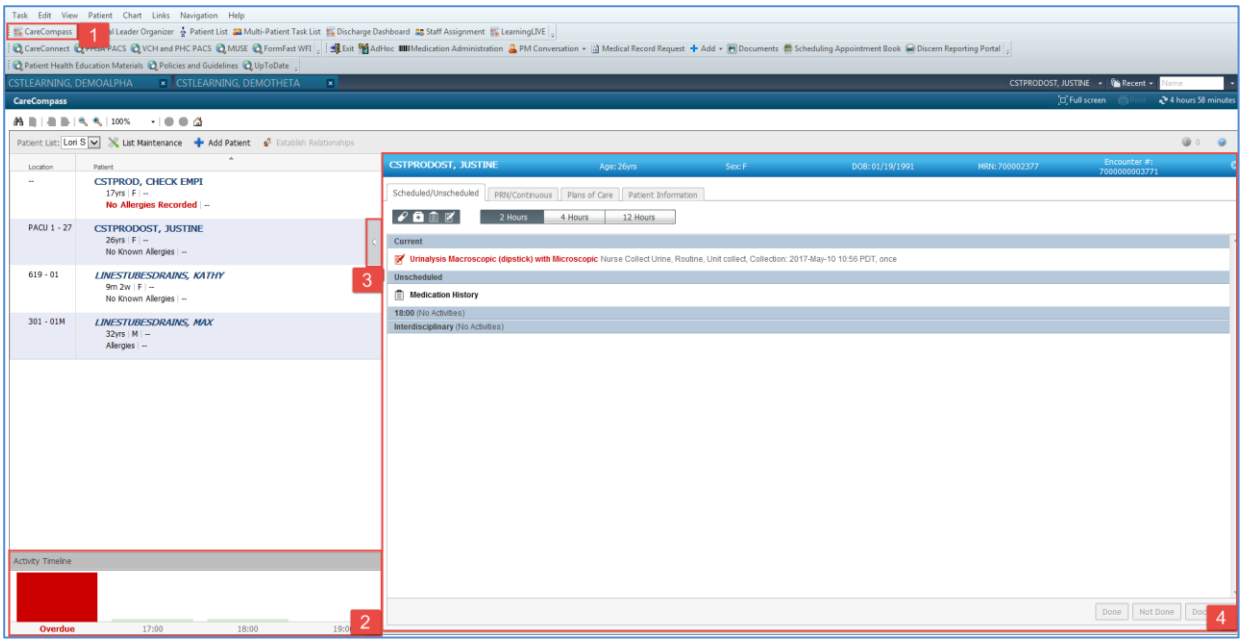
Activity 8.1 – Review and Complete Tasks in CareCompass

1 **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.



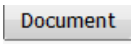
2 The task box contains different tabs which help to categorize patient tasks.

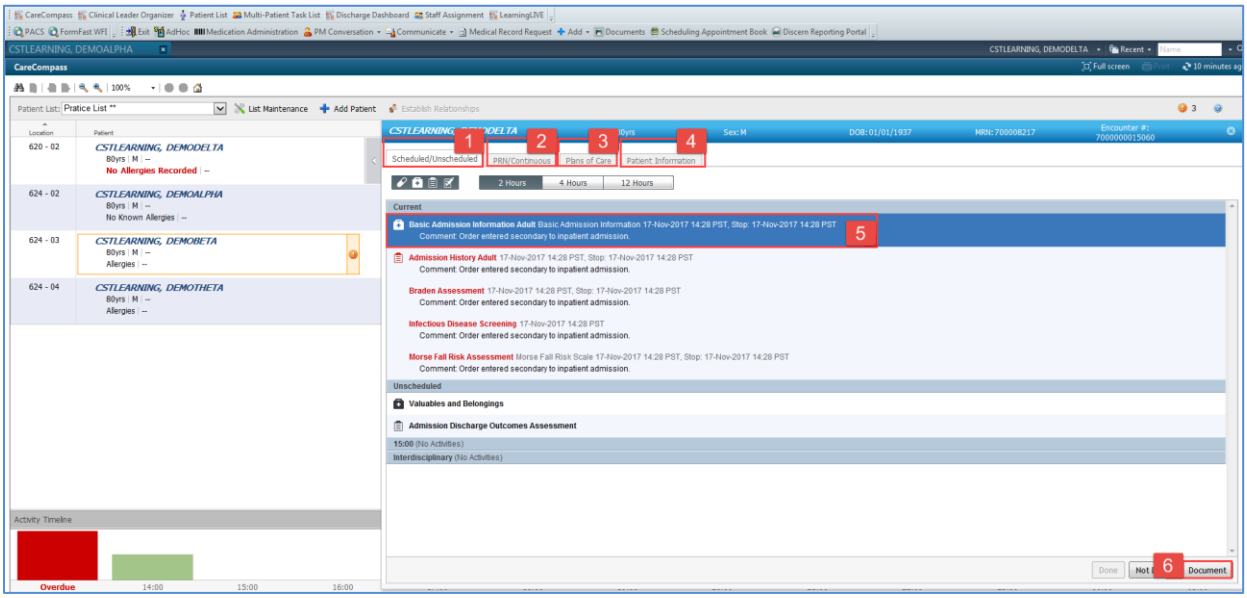
To see different information you can navigate to:

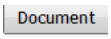
1. **Scheduled/Unscheduled** tasks tab

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 



Note: If a task is associated with documentation, clicking **Document** button 

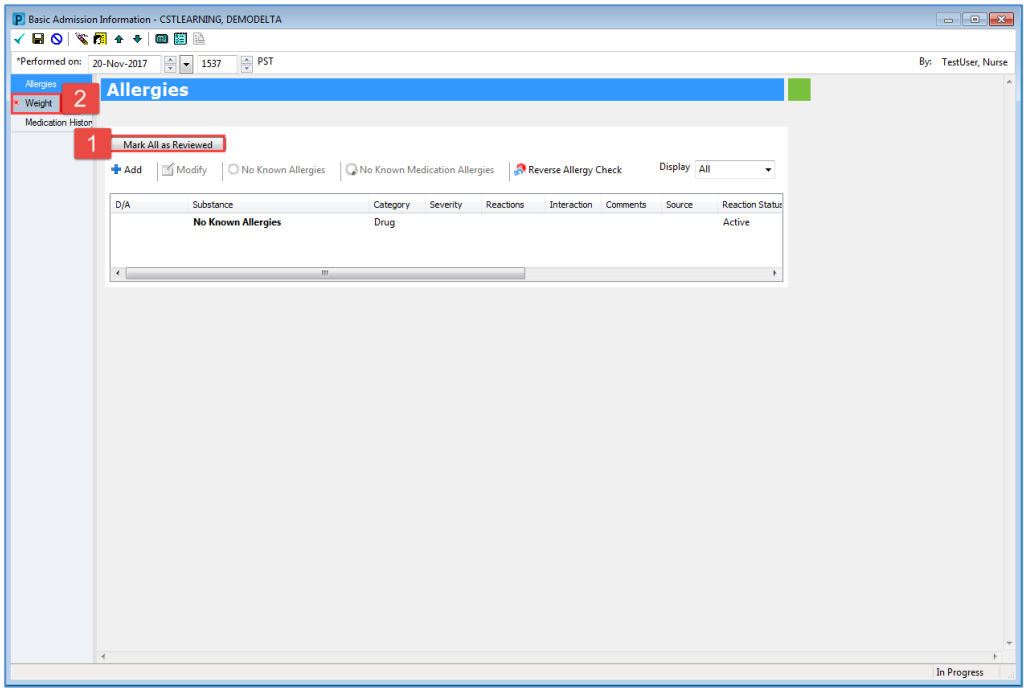
takes you directly to the appropriate documentation within the patient's chart, either in iView or to a PowerForm. Basic Admission Information Adult is a PowerForm.

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.

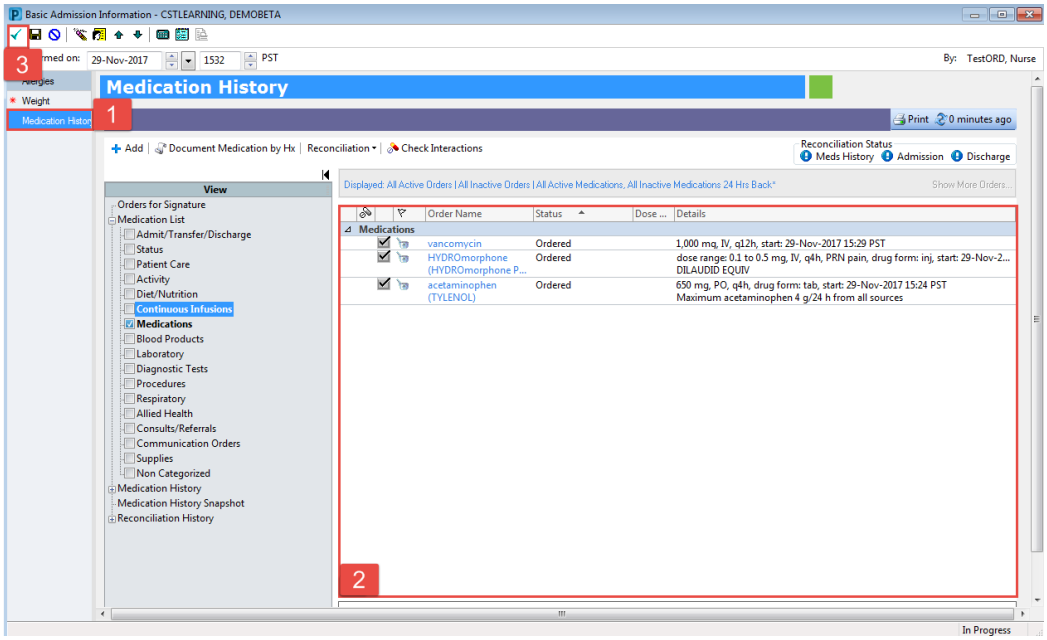
To complete this PowerForm:

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

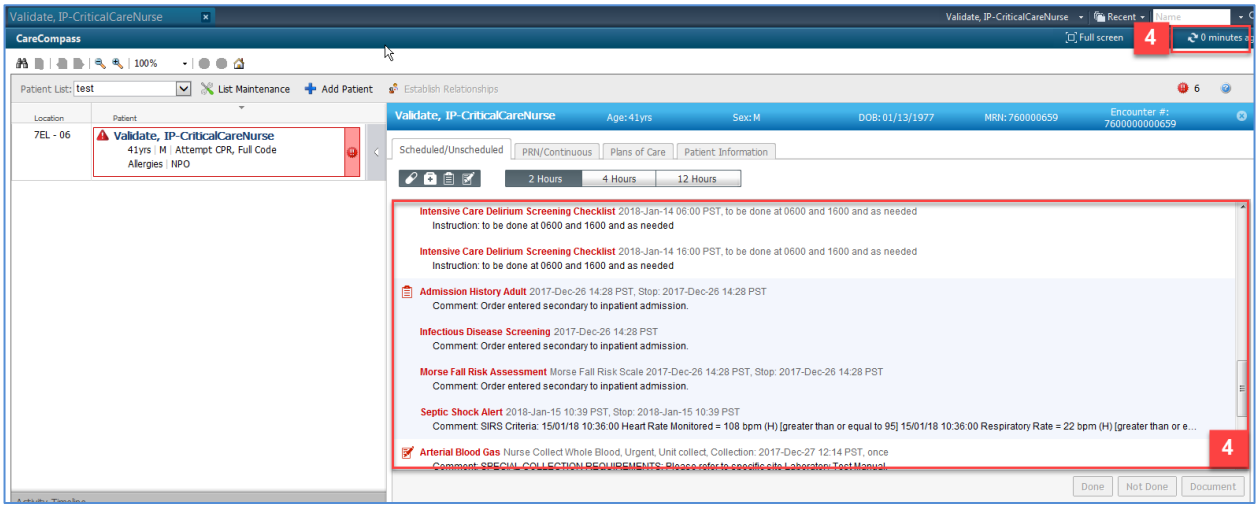


4

1. Select **Medication History**
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.



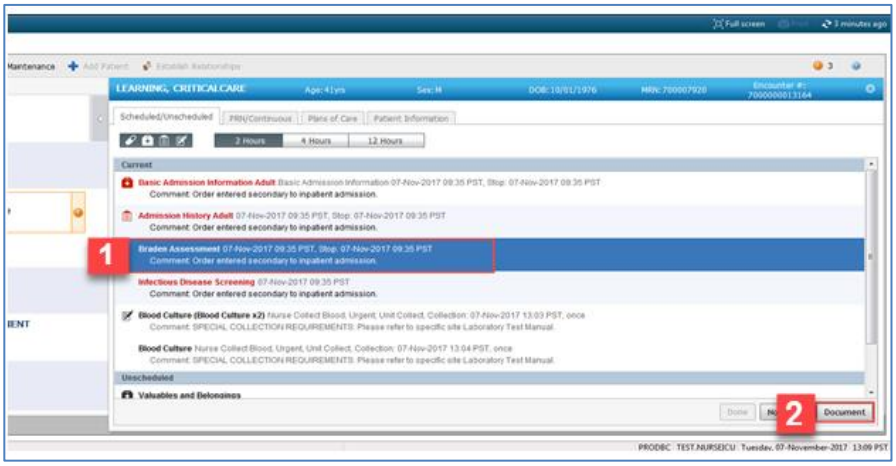
Note: An accurate and comprehensive medication history is needed before medication reconciliation can be completed by the provider. This is known as the Best Possible Medication History (BPMH). For patients admitted from the ED, a pharmacy technician will complete the BPMH where possible. Where a pharmacy 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.

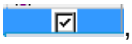
5 Let's complete another admission task

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).

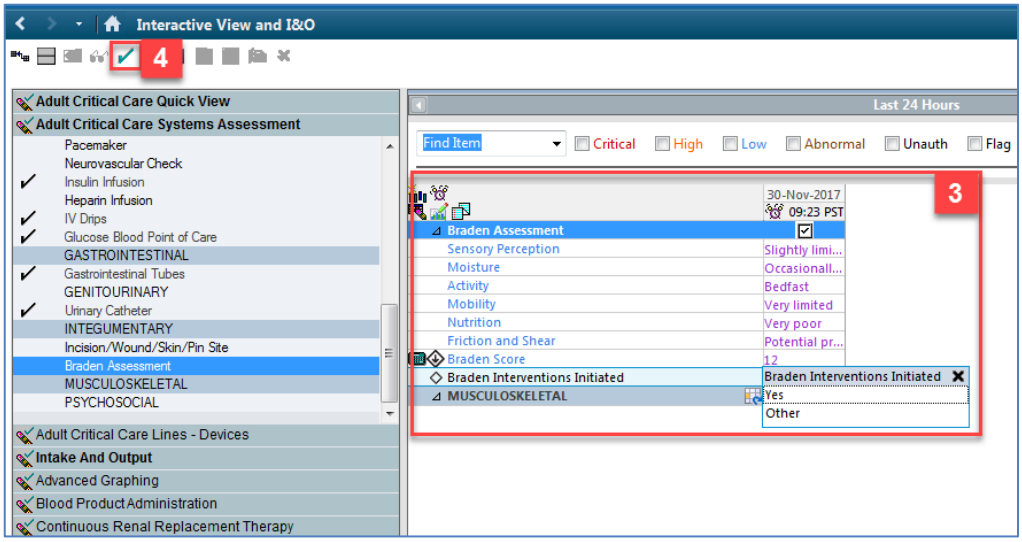


3. Double click the blue box to the right of the section name **Braden Assessment**. A check mark inside the blue box will appear  , and the section is now active for documentation. You can move through the cells by pressing **Enter**.

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*

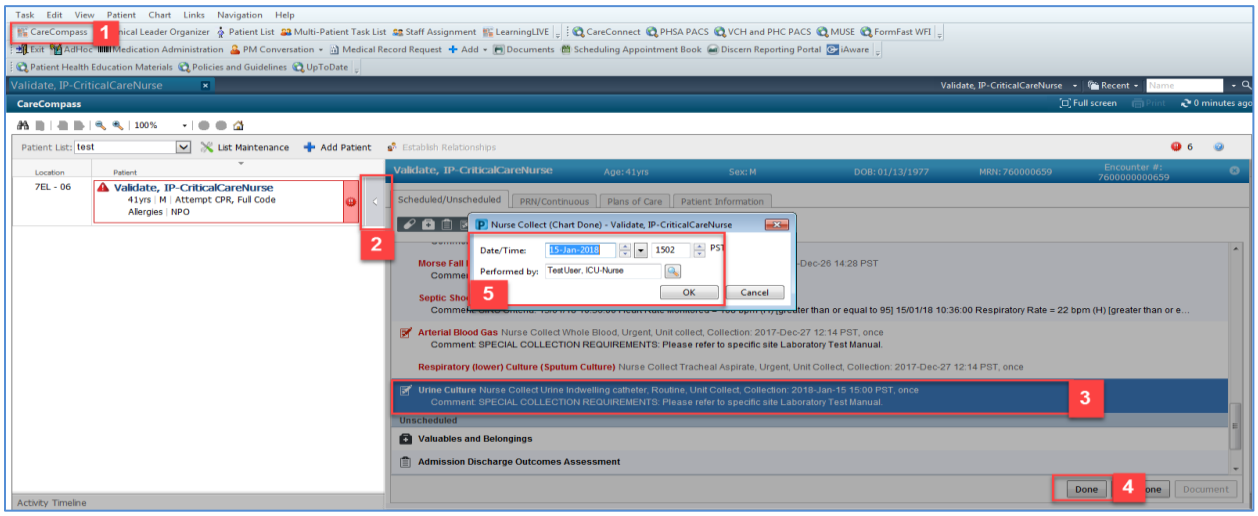
4. Click the **Sign** ✓ icon. You will notice that your documentation changes from purple text to black text once signed.



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 CareCompass 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.



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.

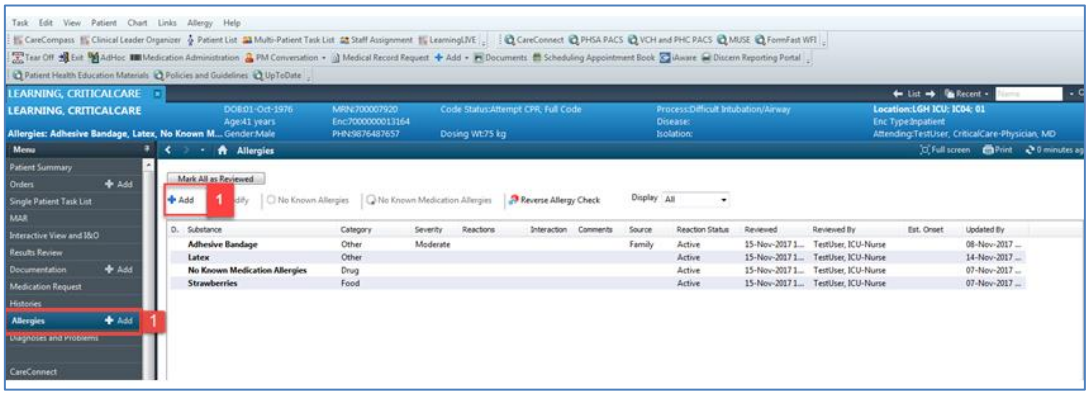
As a critical care nurse you will be completing the following activity:

- Add an allergy to the patient's chart

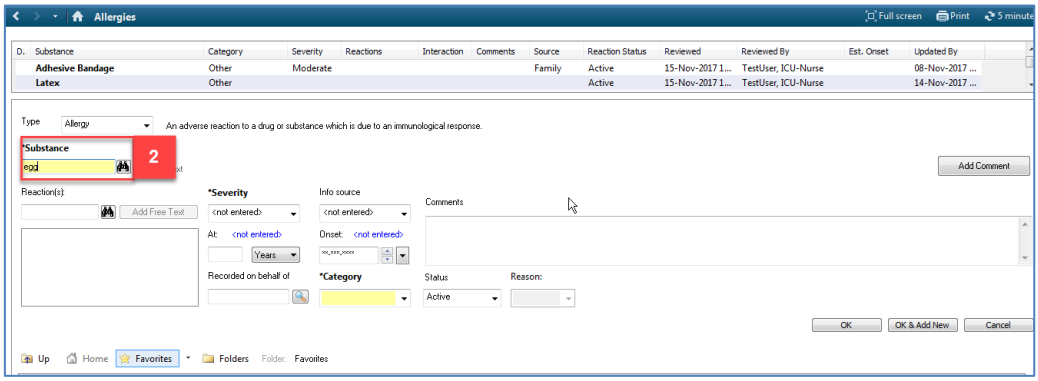
Activity 9.1 – Add an Allergy

1 To document an allergy:

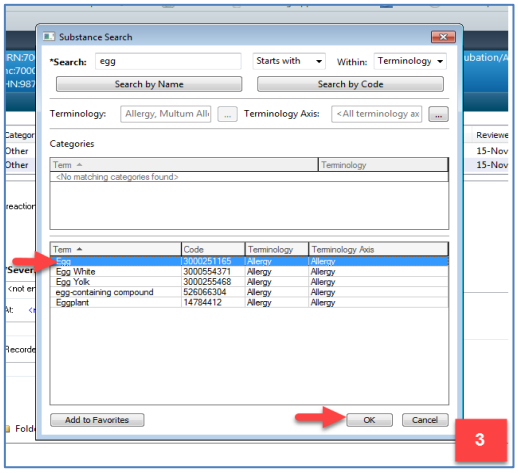
1. Navigate to the Allergies section of the Menu and click **+ Add**



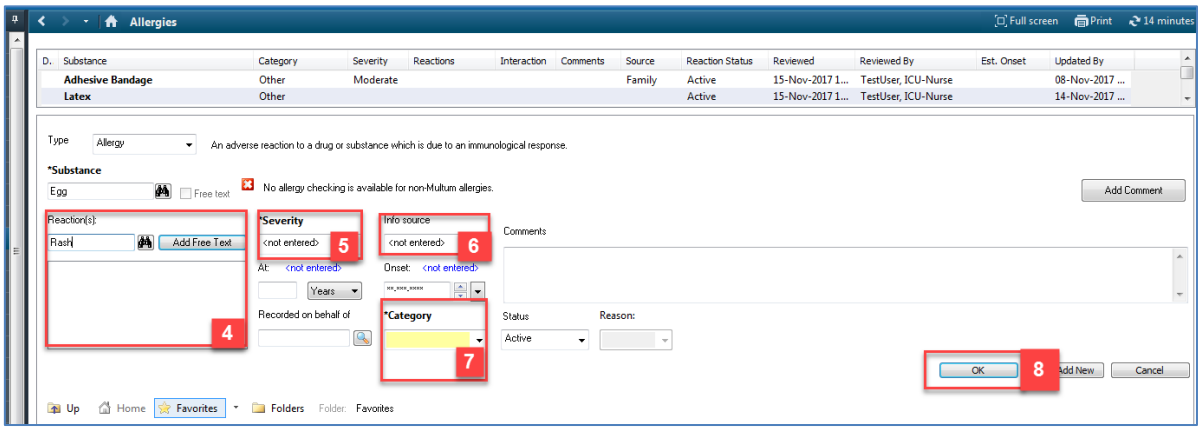
2. Enter in the **Substance** field type = *Egg* and click the **Search** icon . Please note yellow fields including **Substance** and **Category** are mandatory fields that need to be completed.



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

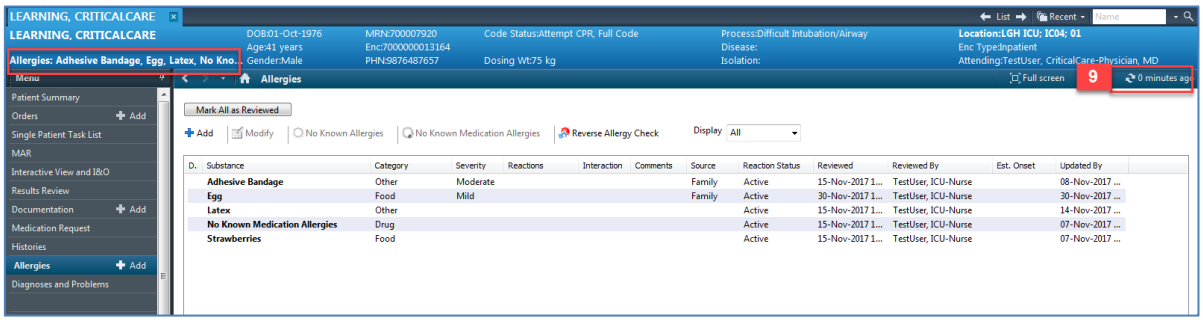


4. In the **Reaction(s)**, repeat step 2 and 3. Type *Rash* and Search **Rash(Code 82559)**
5. In the **Severity** drop-down = *Mild*
6. In the **Info source** drop-down = *Family*
7. In the **Category** drop-down = *Food*
8. Click **OK**



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

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



Key Learning Points

- Documented allergies are displayed in the Banner Bar 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:

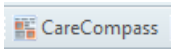
- Place a Difficult Airway/Intubation process alert through PM Conversation

Activity 10.1 – Place a Process Alert

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

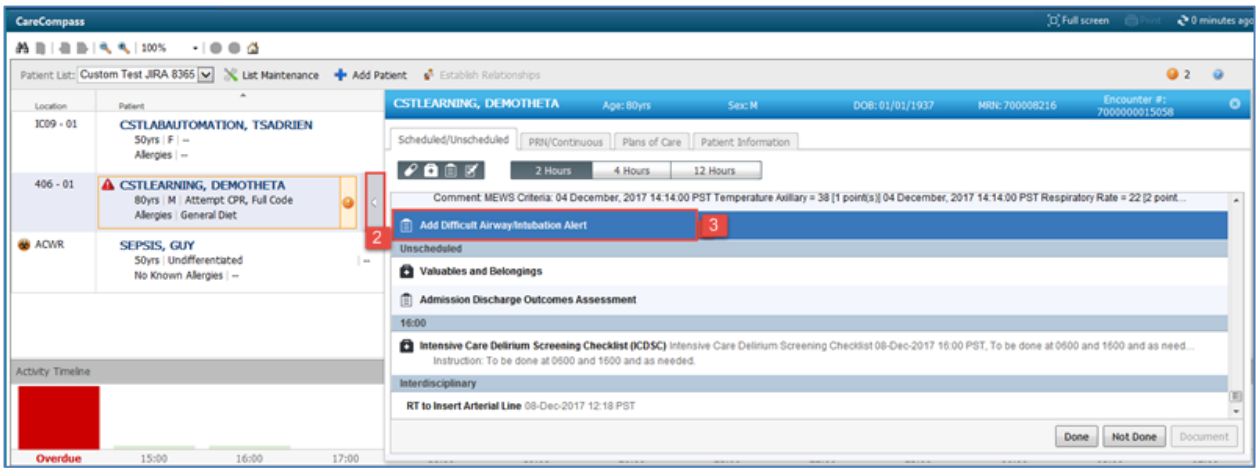
Within the system, process alerts are flags that highlight specific concerns about a patient. These alerts display on the banner bar and can be activated by any clinician including nurses.

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

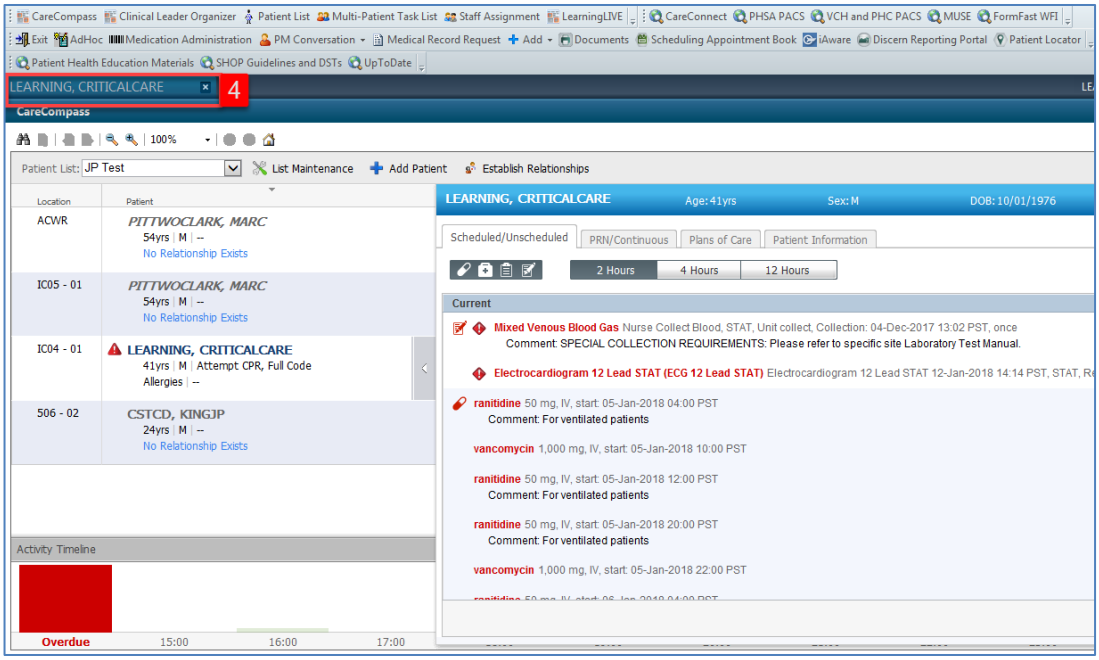
1. Click **CareCompass** button 

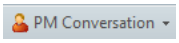
in the Toolbar to navigate back to **CareCompass**.
2. Click the **grey forward arrow**  to the right of your patient's name to open the single patient task list.
3. Scroll down and you will find the **Add Difficult Airway/Intubation Alert** task.

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.

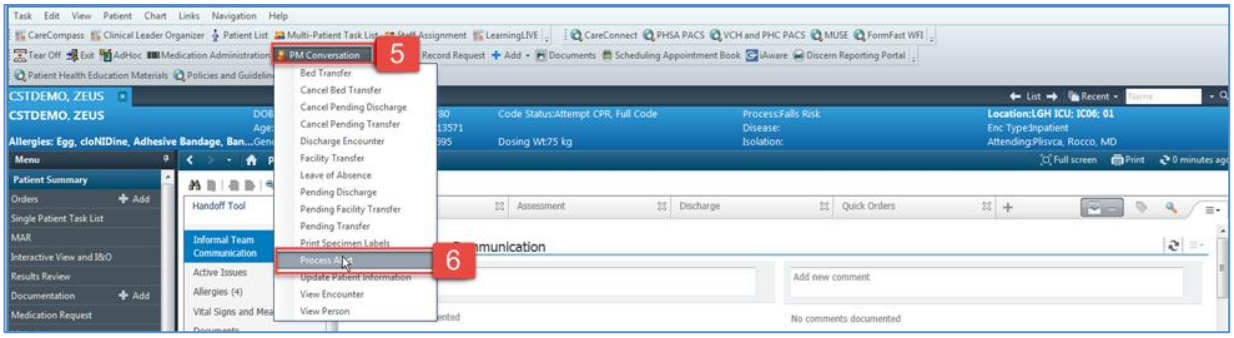


4. To add a Process Alert, you need to return to the patient's chart. Click the patient's name in the banner bar. Notice the patient's chart is still open.



5. Click the drop-down arrow to the right of **PM Conversation** button  in the toolbar

6. Select **Process Alert** from the drop-down menu

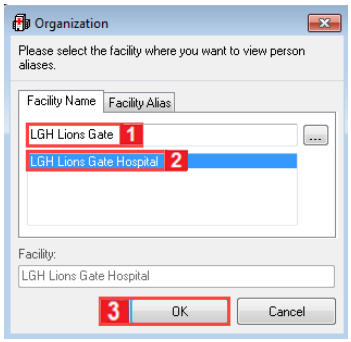


The **Organization** window will display to select a location.

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.

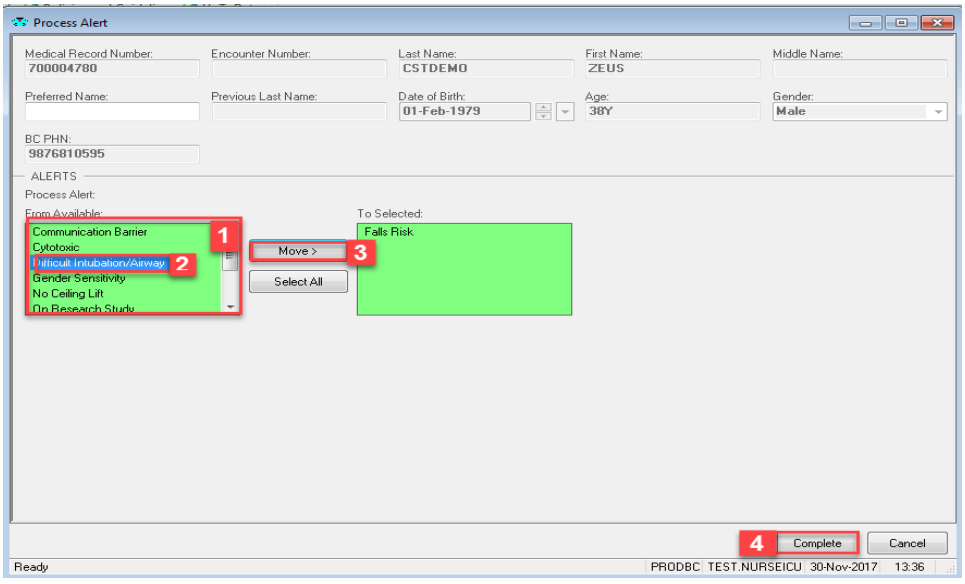
2. Select **LGH Lions Gate Hospital**
3. Click **OK**



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.

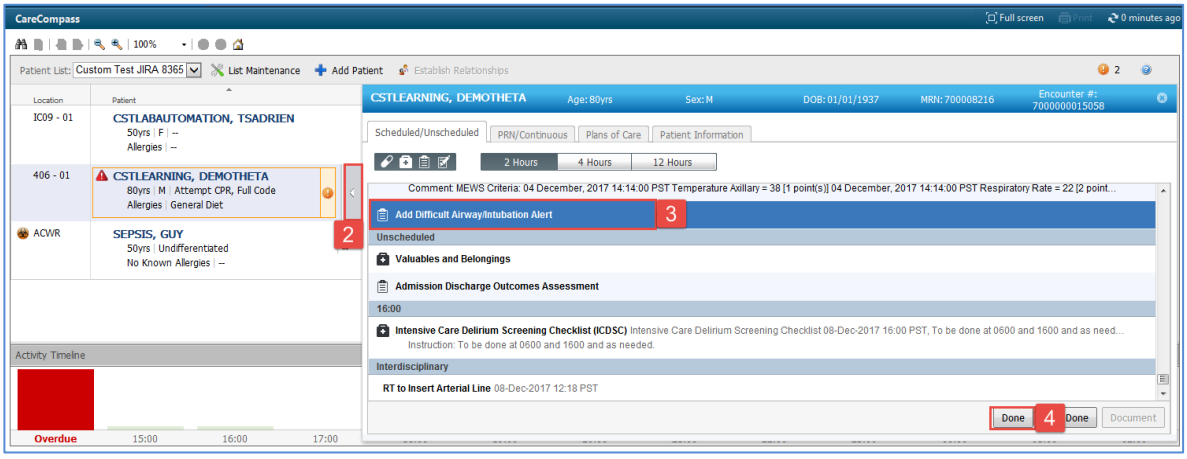


3

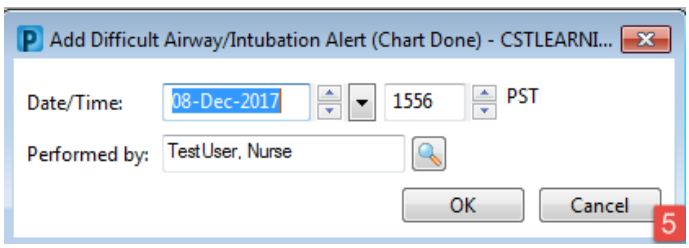
1. Click **Refresh** icon to update the chart
2. Once complete, the process alert will appear within the banner bar of the chart where it is visible to all those who access the patient's chart.

4 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**



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:**

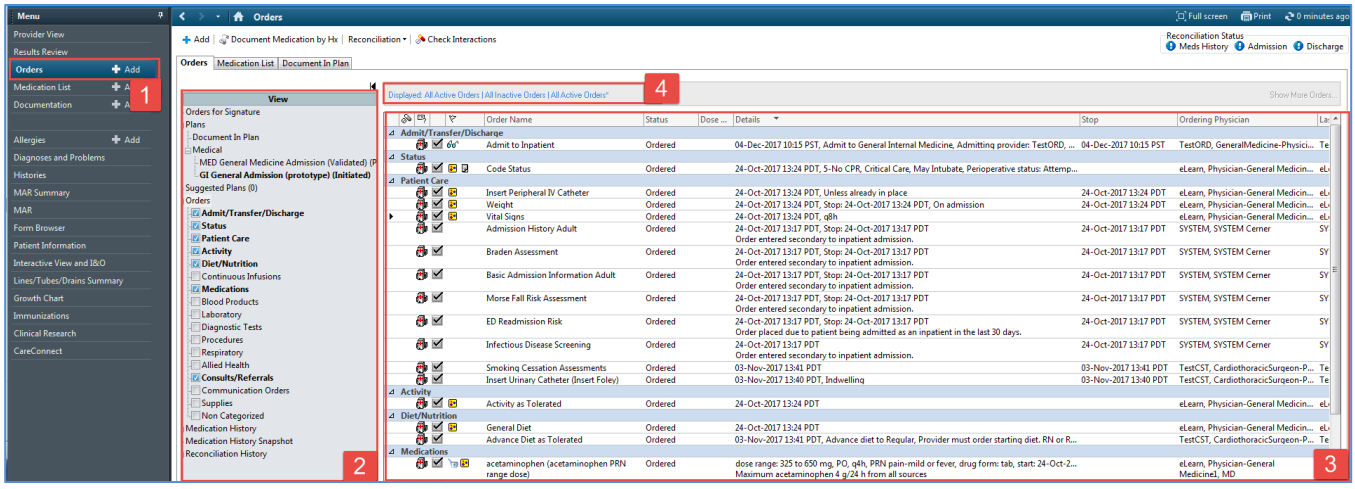
1. Select **Orders** from the **Menu**
2. The Navigator (**View**) band is located on the left side of the Orders profile page. It includes several categories including:
   - **Plans**
   - **Categories of Orders**
   - **Medication History**
   - **Reconciliation History**
3. On the right side is the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

- Order 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.



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

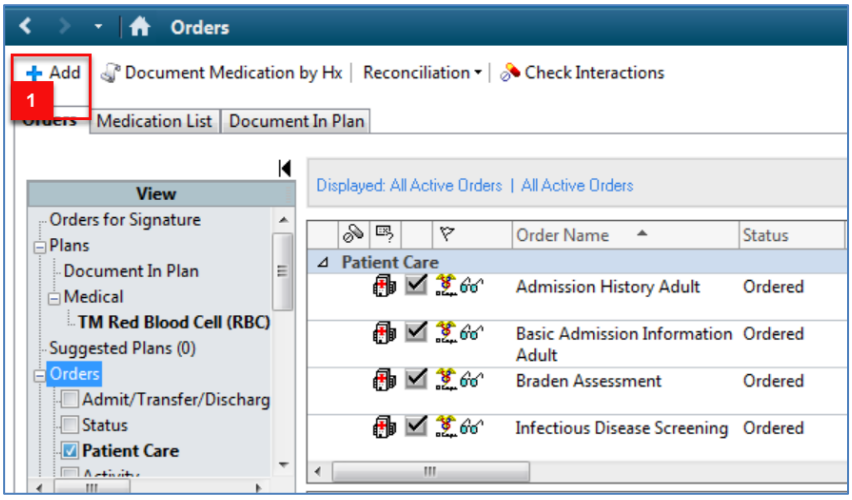
Activity 11.2 – Place an Order

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

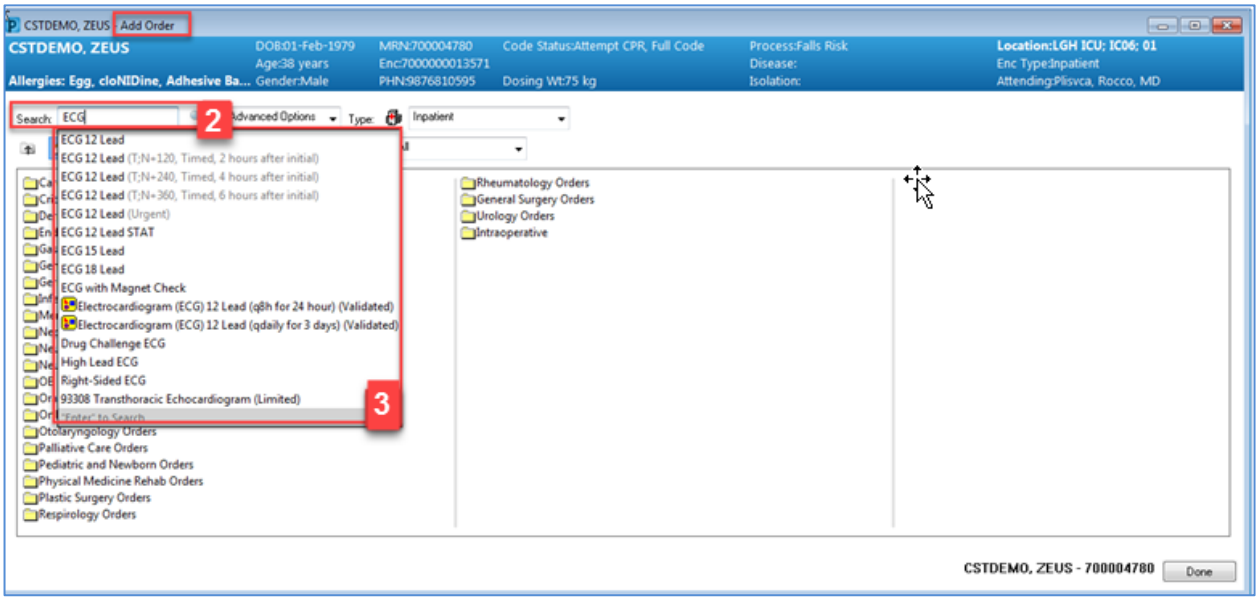
- Orders that require a cosignature from the provider (e.g. telephone and verbal orders)
- Orders that do not require a cosignature (e.g. order within nursing scope, Nurse Initiated Activities (NIA))

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

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



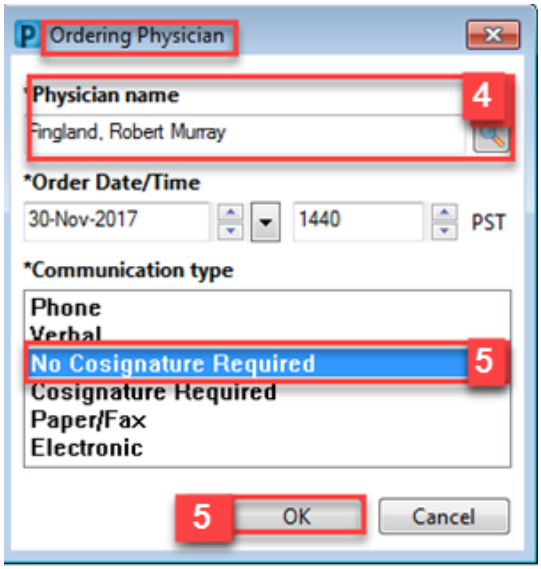
2. The **Add Order** window opens. Type *ECG* into the search box and a list of choices will display
3. Select **ECG 12 Lead STAT**.



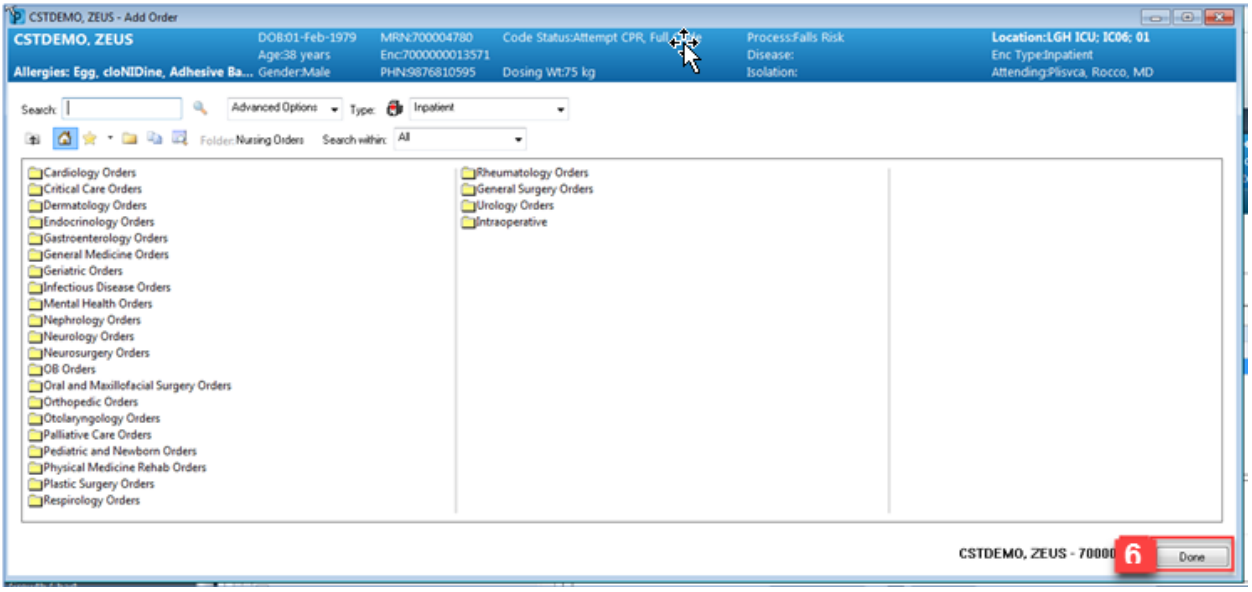
Note: An alternate way to look up orders is to click **Quick Orders** Tab in **Patient Summary**. Quick Orders Tab consists of orders organized in different categories. Further information about Quick Orders can be found in Quick Reference Guides.

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**



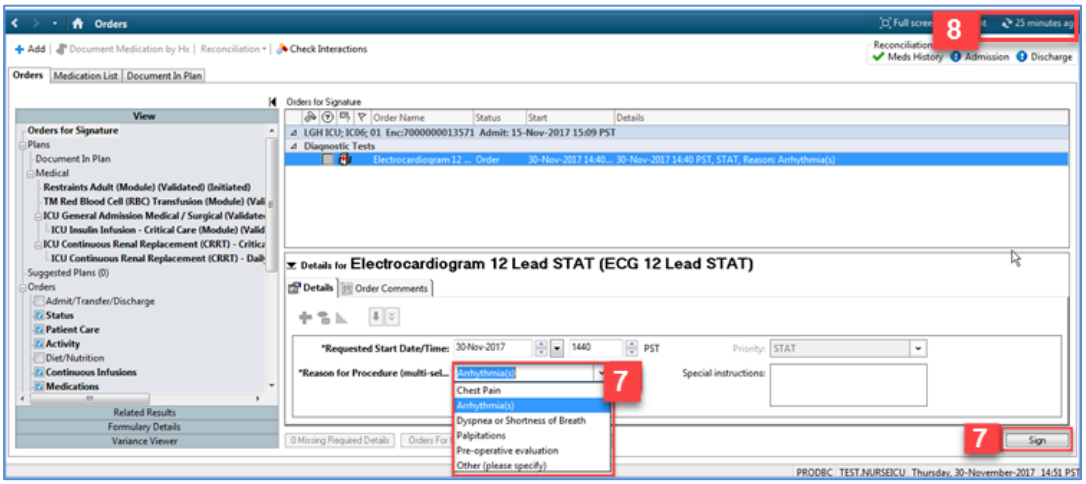
6. Click the **Done** button Done. You will return to the Orders Profile and see the order details.



7. 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.



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

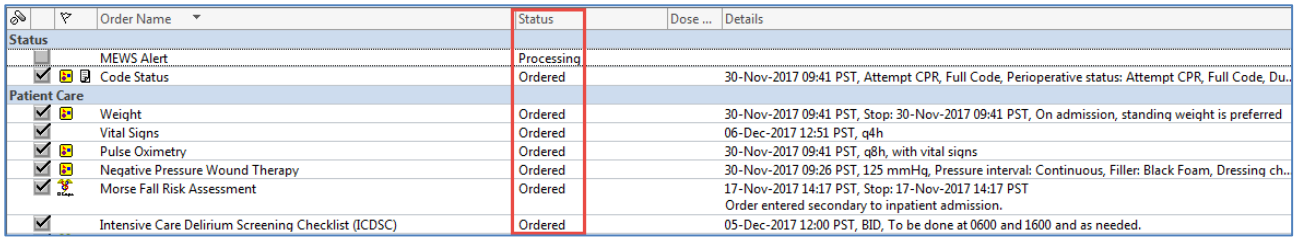
Key Learning Points

- 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

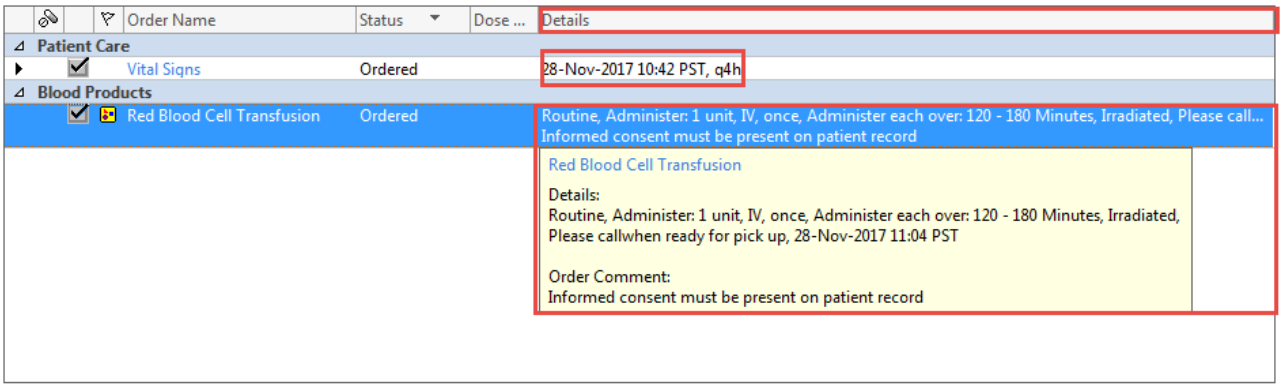
1 To see examples of different order statuses, review the image below:

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



To see examples of order details review the image below:

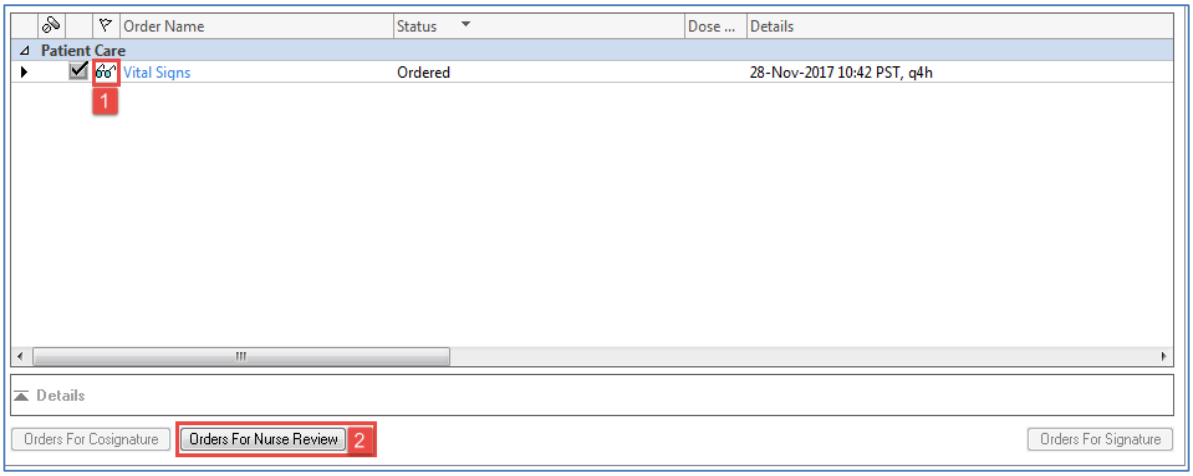
- Focus on the **Details** column of the Orders Profile
- Hover your cursor over specific orders to discover additional information
- Note the start date and that orders are organized by clinical category



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.

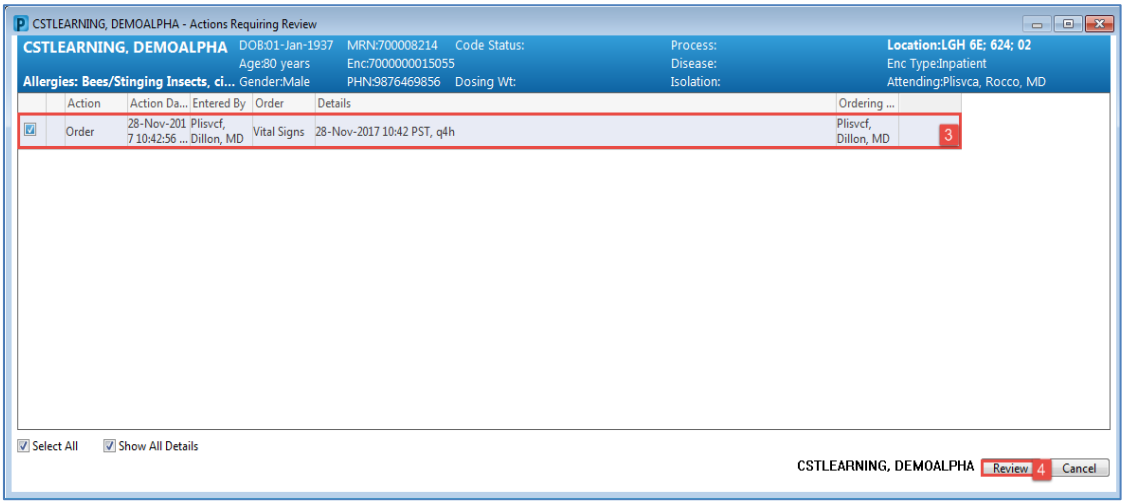
Note: Do NOT follow these steps in the system but instead refer to the screenshots to understand the process.

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



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



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.

Key Learning Points

- 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

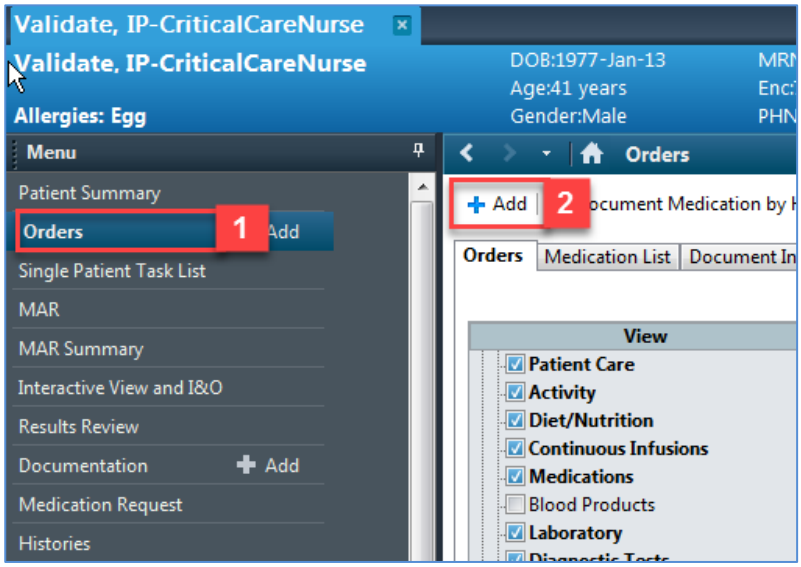
Activity 11.4 – Place a Verbal Order

1 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:

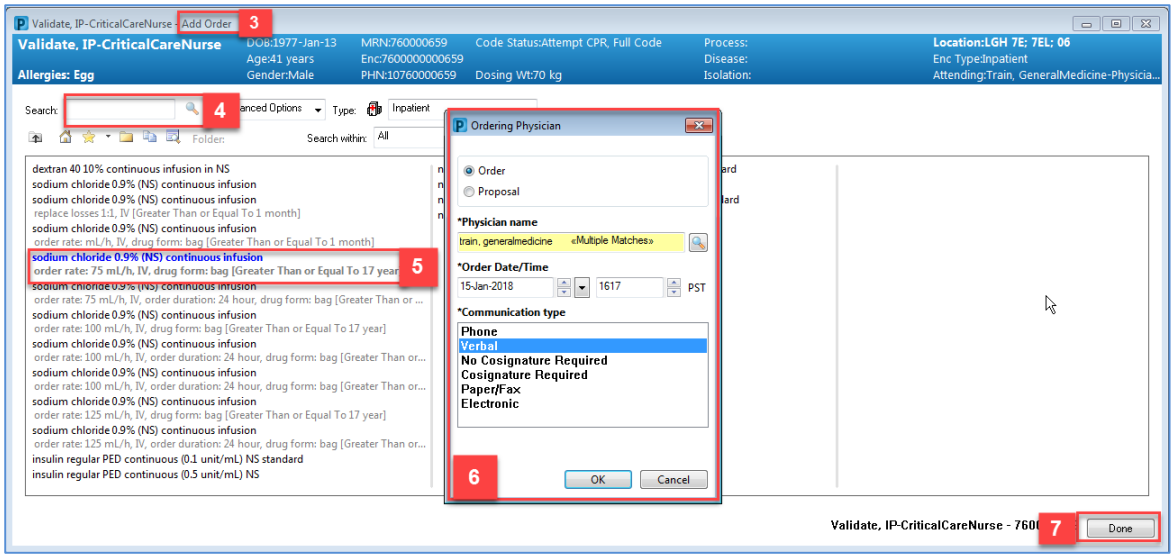
1. Select **Orders** from the **Menu**
2. Click **Add** button + Add in Order Profile



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*

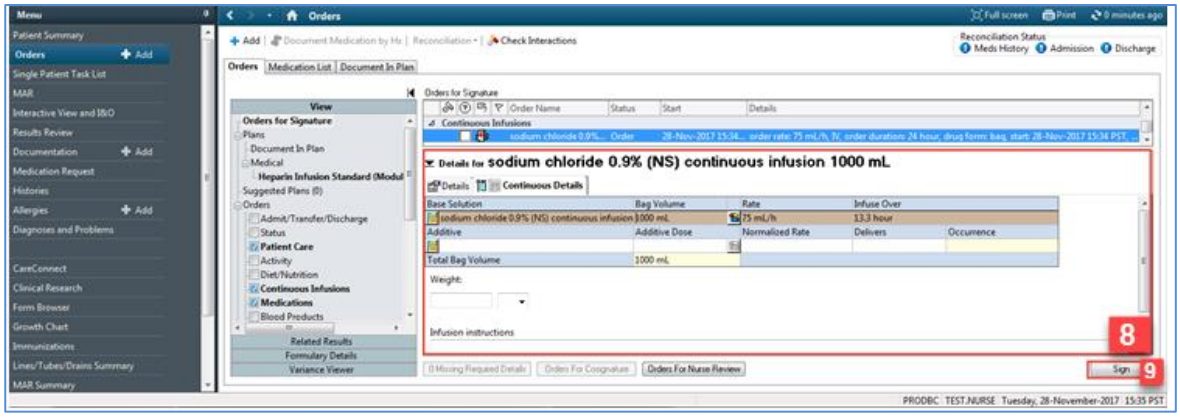
Note: If this were a telephone order, the communication type, Phone, would be selected.

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

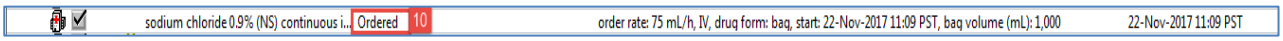


8. **Orders for Signature** window opens and order details are displayed. Fill out Detail fields as needed
9. Click **Sign** button Sign and then click **Refresh** icon to update Orders Profile.

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.



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



Key Learning Points

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

Activity 11.5 – Complete or Cancel/Discontinue an Order

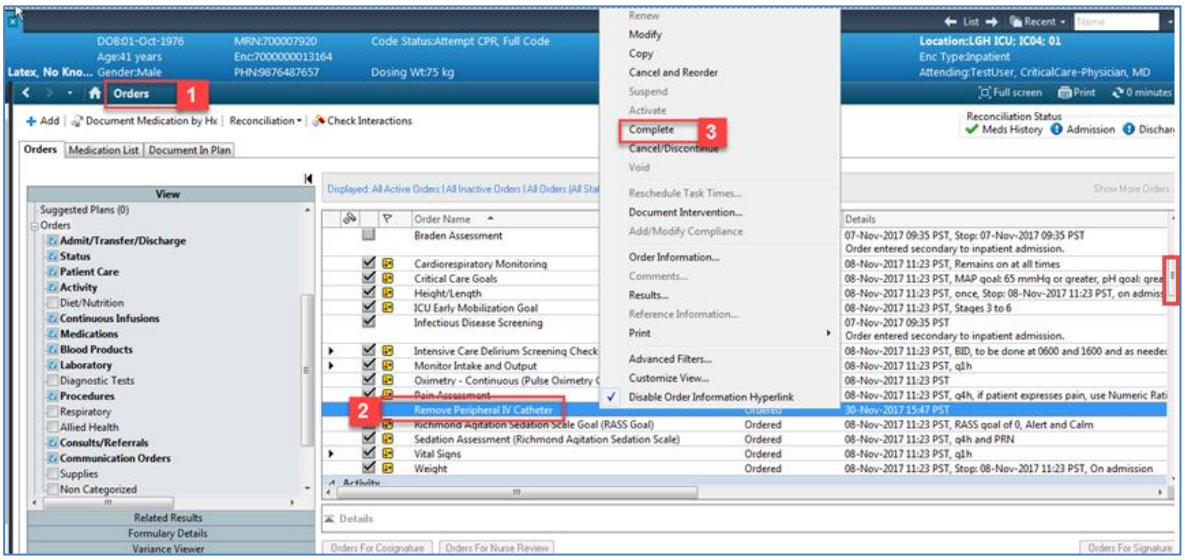
1 Orders can be documented as completed or discontinued depending on the type of order.

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.

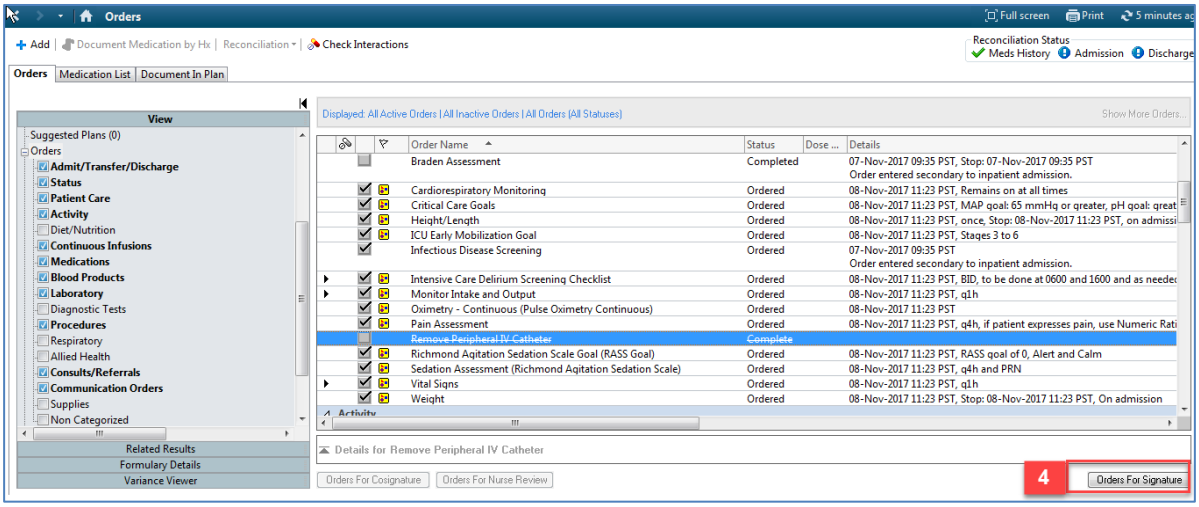
Let's say the patient has a peripheral IV that has gone interstitial. An order has been placed to remove it.

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

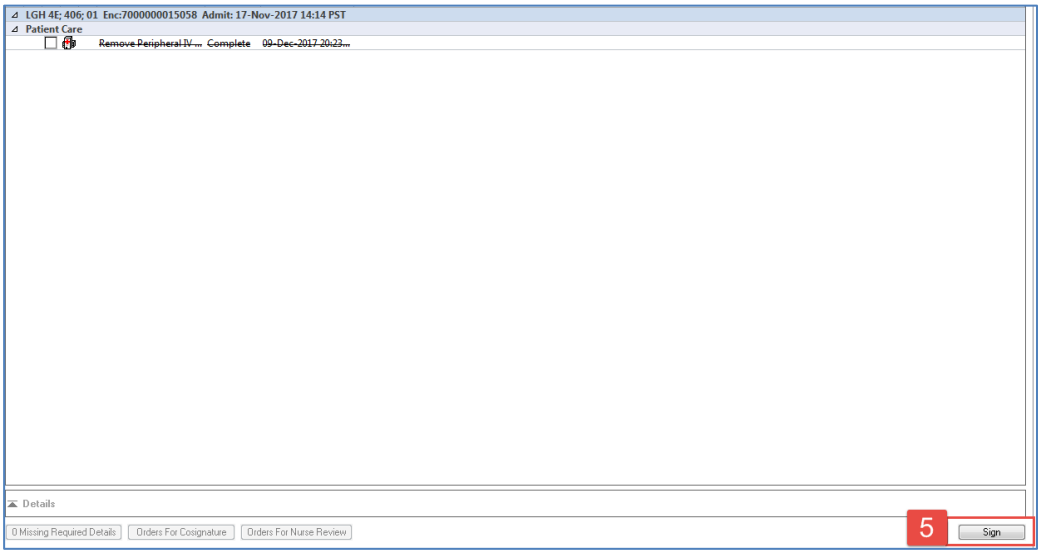
1. Scroll down the **Orders Profile** to find the order for **Remove Peripheral IV Catheter**
2. Right-click the order **Remove Peripheral IV Catheter**
3. Select **Complete**



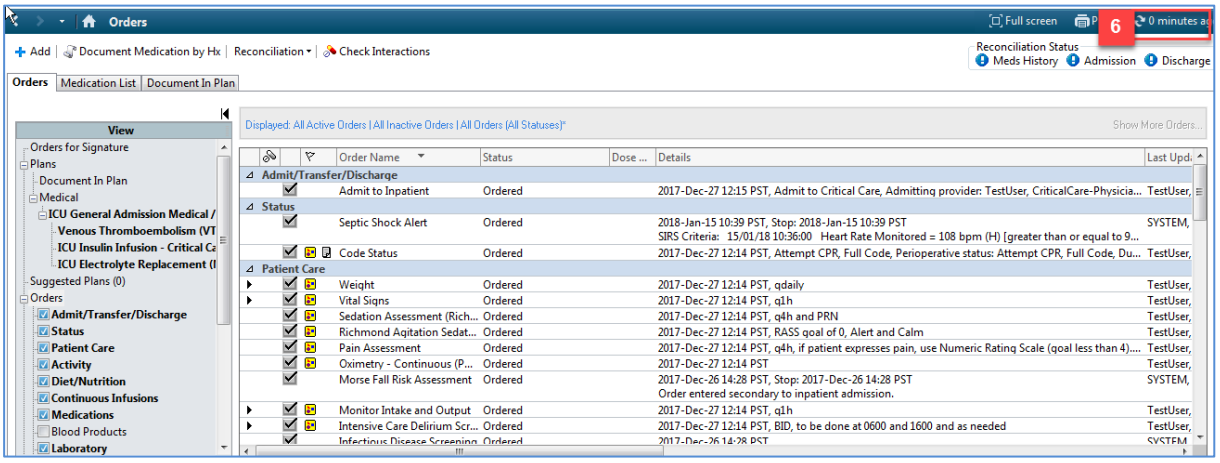
4. Once **Complete** is selected, the check mark beside **Remove Peripheral IV Catheter** order is removed and the order is crossed out. Click the **Orders For Signature** button



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



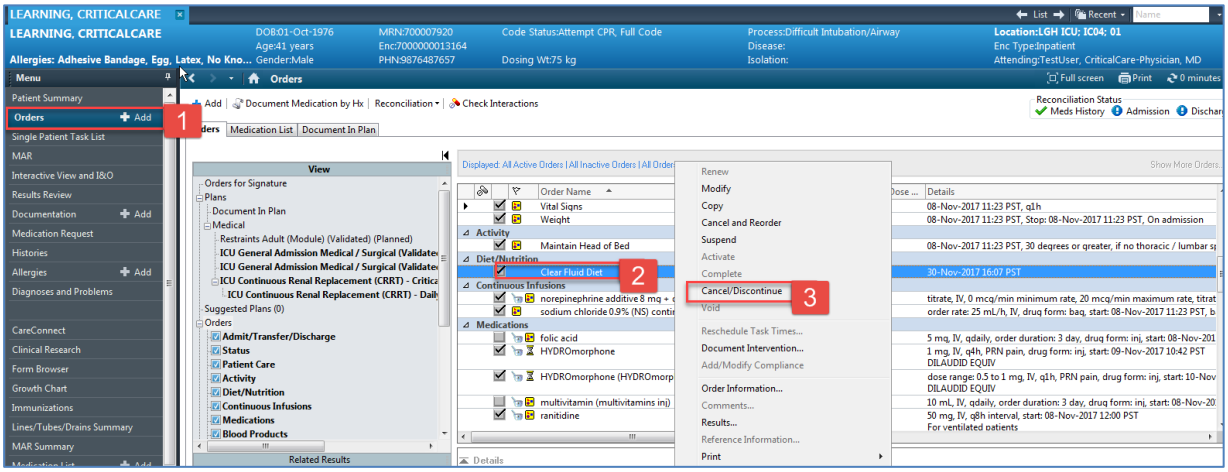
6. Click Refresh icon and the order will no longer be visible in the Orders Profile.



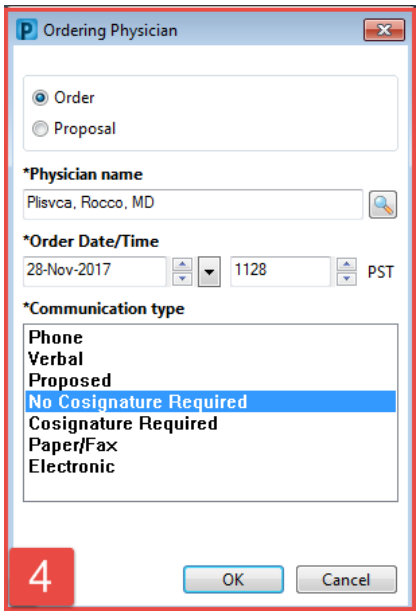
Congratulations! You just completed a one-time order and removed the order from the Orders Profile.

2 Now let's **Cancel/Discontinue** an Order:

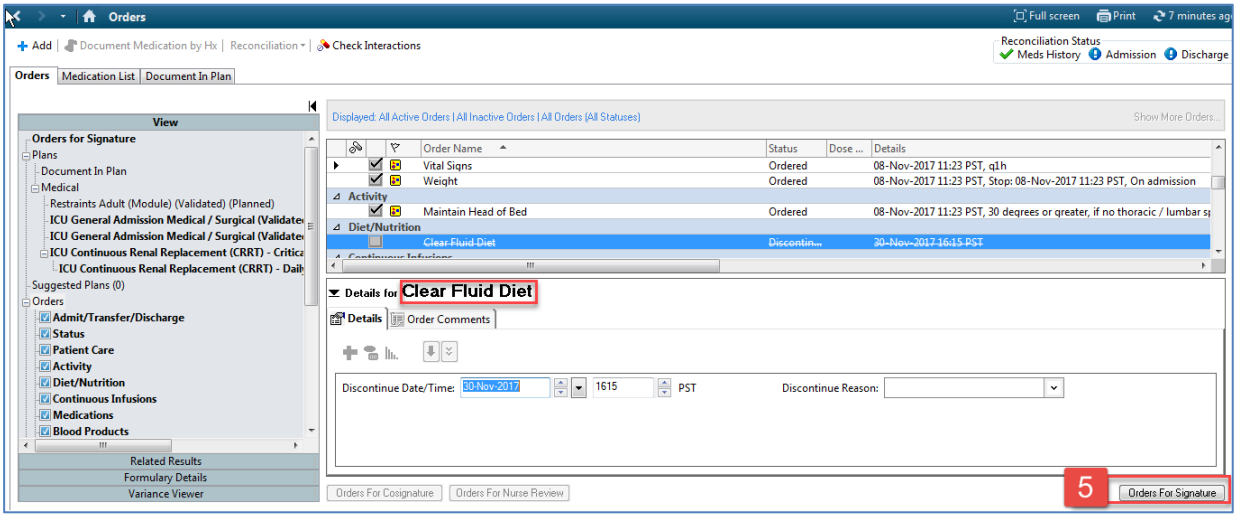
1. Review the **Orders Profile**
2. Right-click order **Clear Fluid Diet**
3. Select **Cancel/Discontinue**



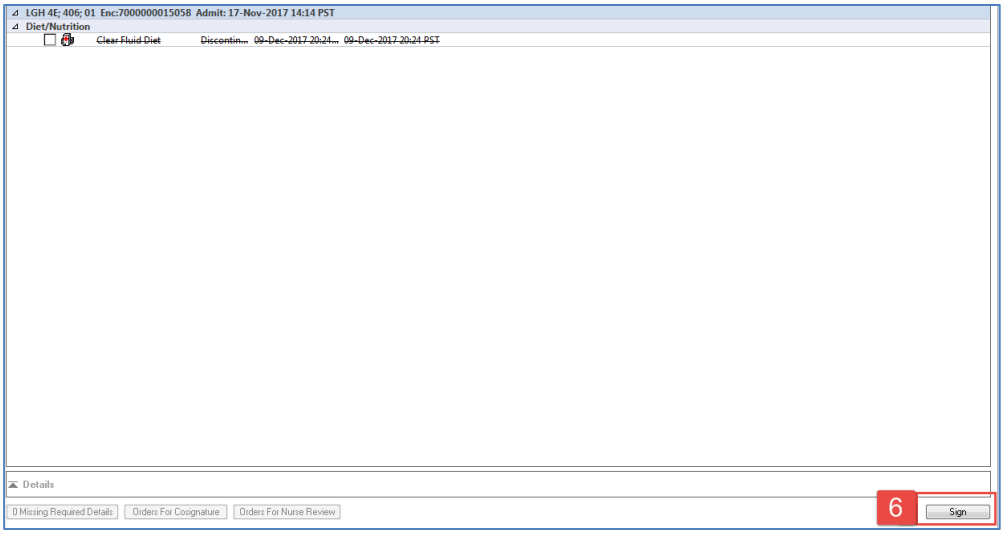
4. **Ordering Physician** window will appear. Fill out required fields highlighted yellow below and then click **OK**
   - **Physician name** = *type name of Attending Physician (last name, first name)*
   - **Communication type** = *No Cosignature Required*



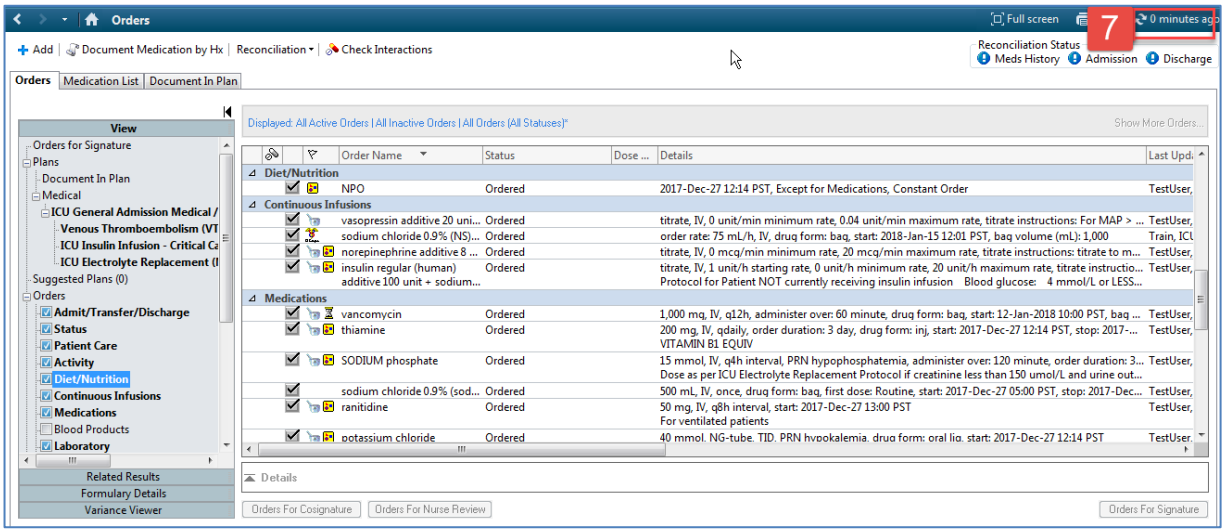
5. Review order to discontinue and click **Orders For Signature**



6. Review Order for signature and click **Sign** button Sign. You will return to the Order Profile.



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



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

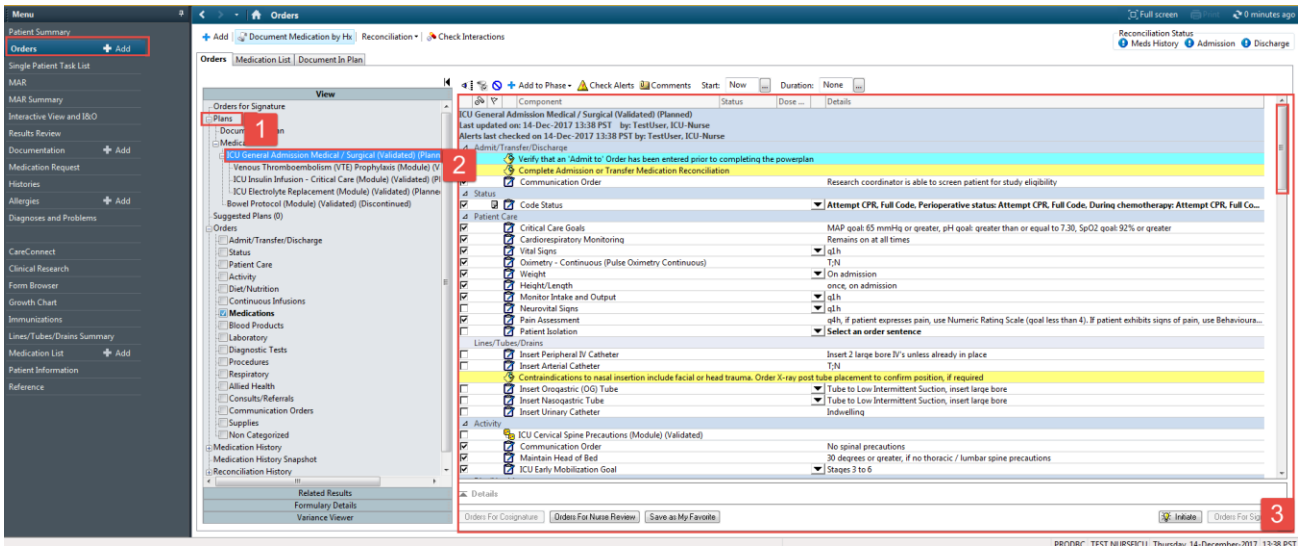
Activity 11.6 – Review Components of a PowerPlan

1 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 ☑ 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 ☑ 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:

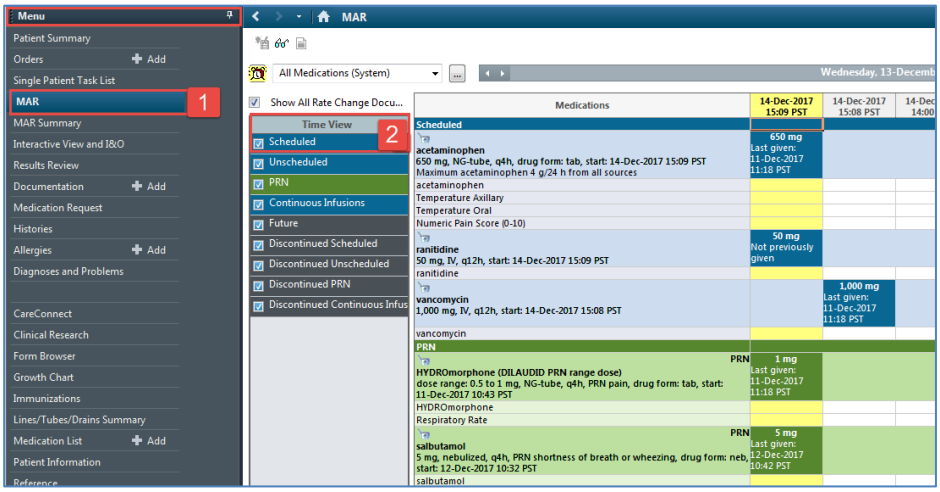
- Review and learn the layout of the MAR
- Request a medication from pharmacy

Activity 12.1 – Review the MAR

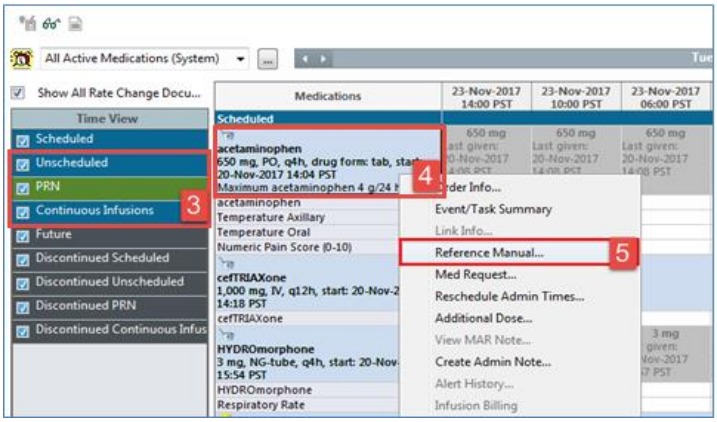
1 The MAR is a record of medications administered to the patient by the clinician. The MAR displays medication orders, tasks, and documented administrations for the selected time frame.

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.



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**.

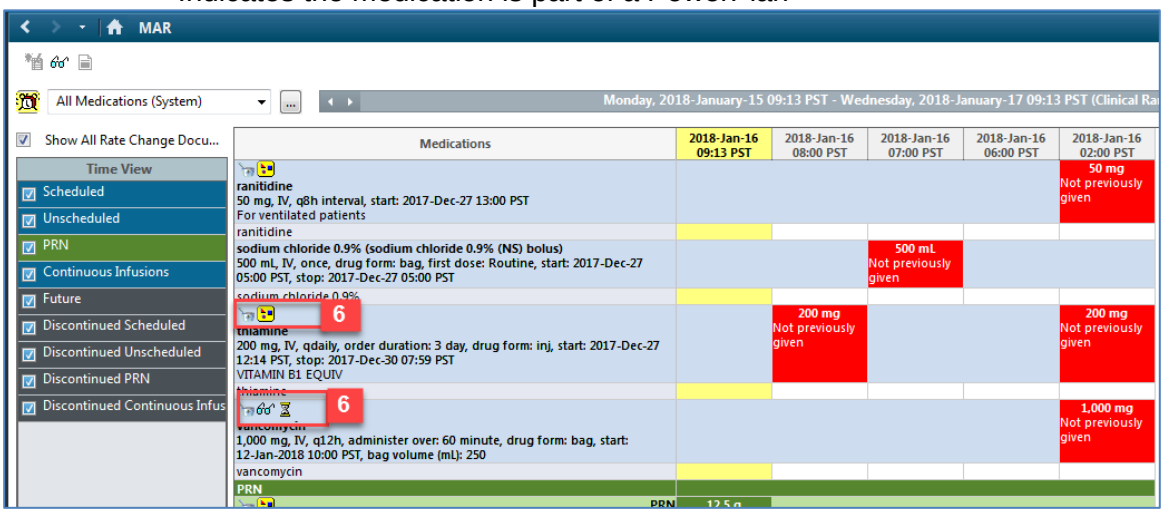


6. Note the icons that may appear on the MAR. Examples include:

– Indicates the medication order has not been verified by pharmacy

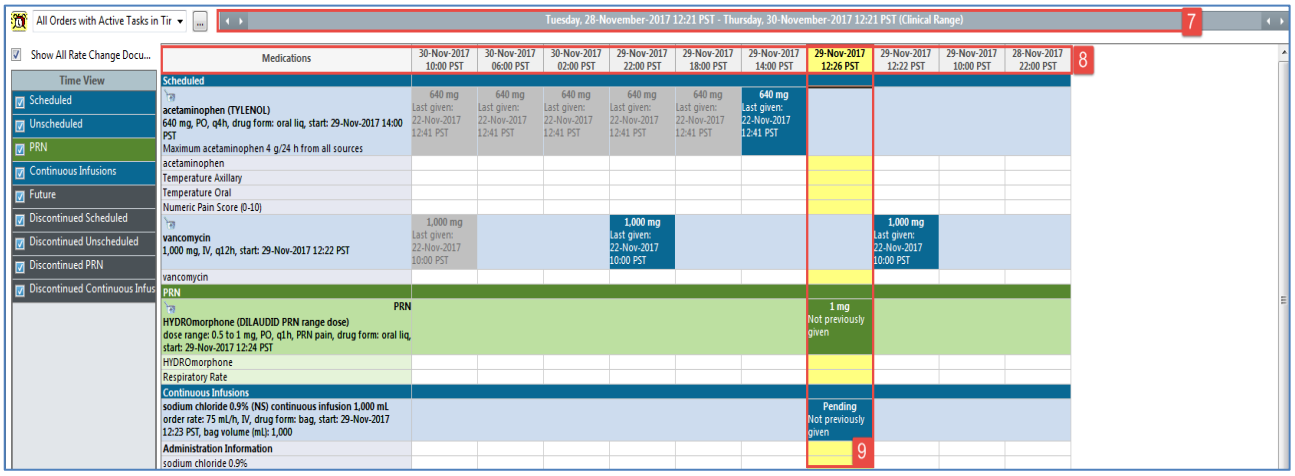
– Indicates the order needs to be reviewed by the nurse

– Indicates the medication is part of a PowerPlan



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.



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

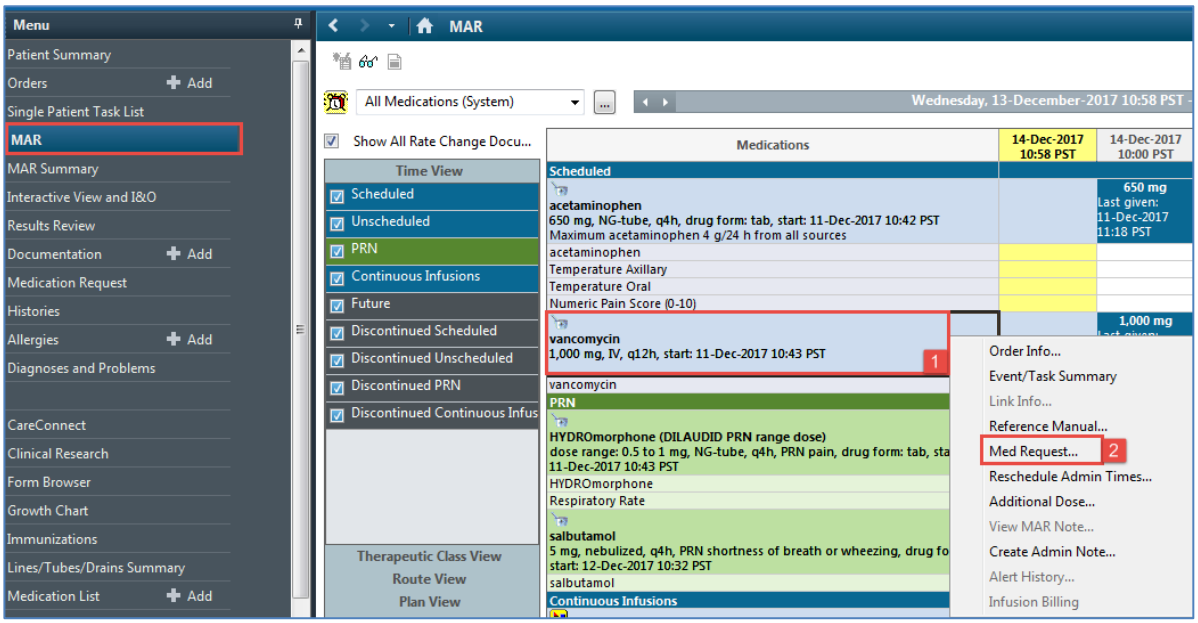
Key Learning Points

- 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

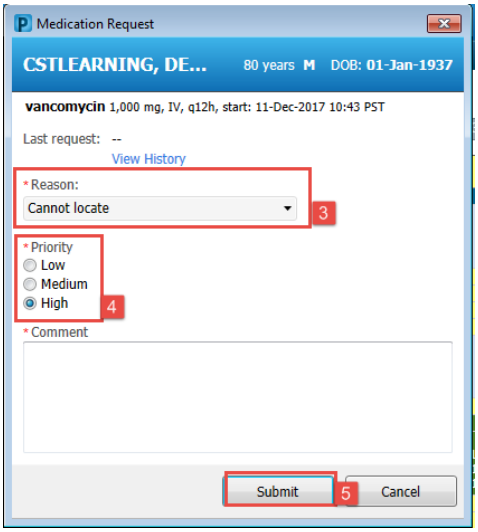
Activity 12.2 – Request a Medication

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

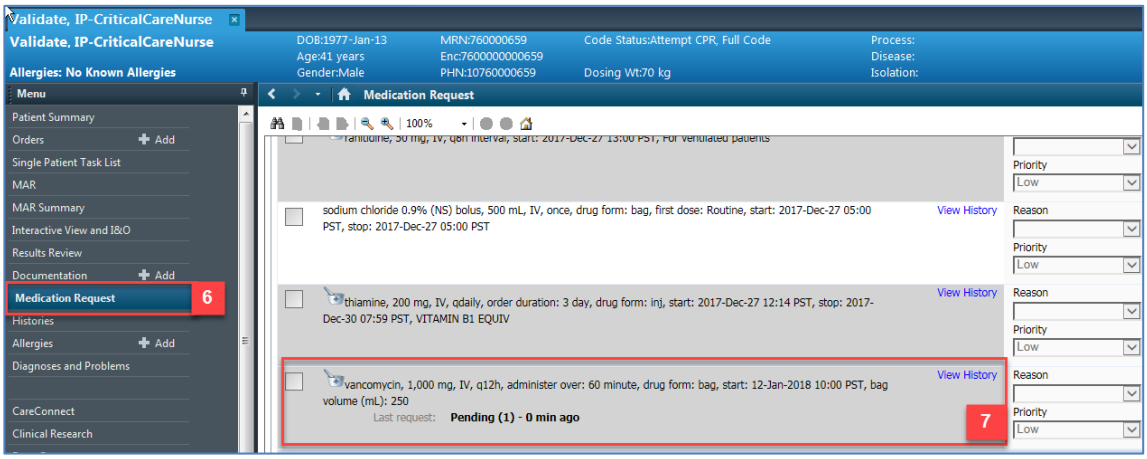
1. Right click on the medication order name **vancomycin 1,000mg, IV, q12h**
2. Select **Med Request…**



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



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.



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

PATIENT 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

1 Medications will be administered and recorded electronically by scanning the patient's wristband and the medication barcode. Scanning of the patient's wristband helps to ensure the correct patient is identified. Scanning the medication 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

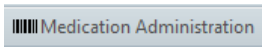
2 It is time to administer the following medications to your patient. You will scan all three medications sequentially.

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

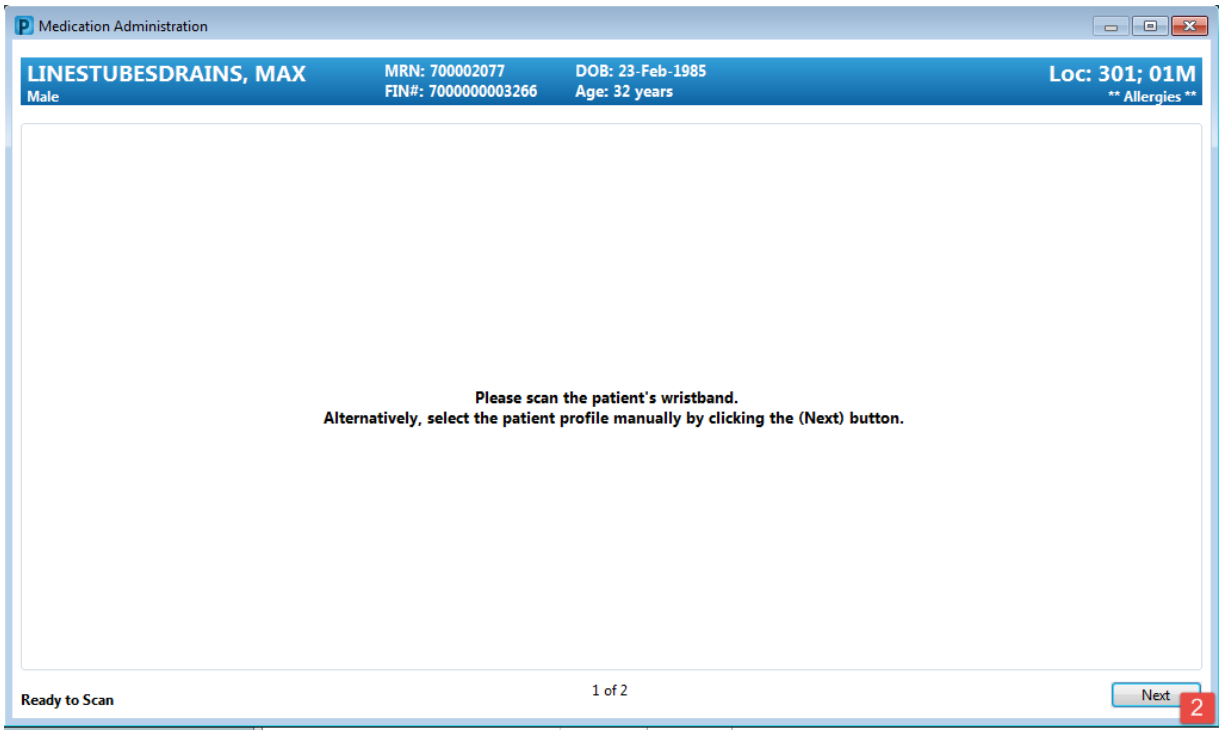
Note: IV normal saline does not have a barcode to be scanned as it is a Stores Item. Stores items are documented on the MAR differently and we will practice this later on.

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 

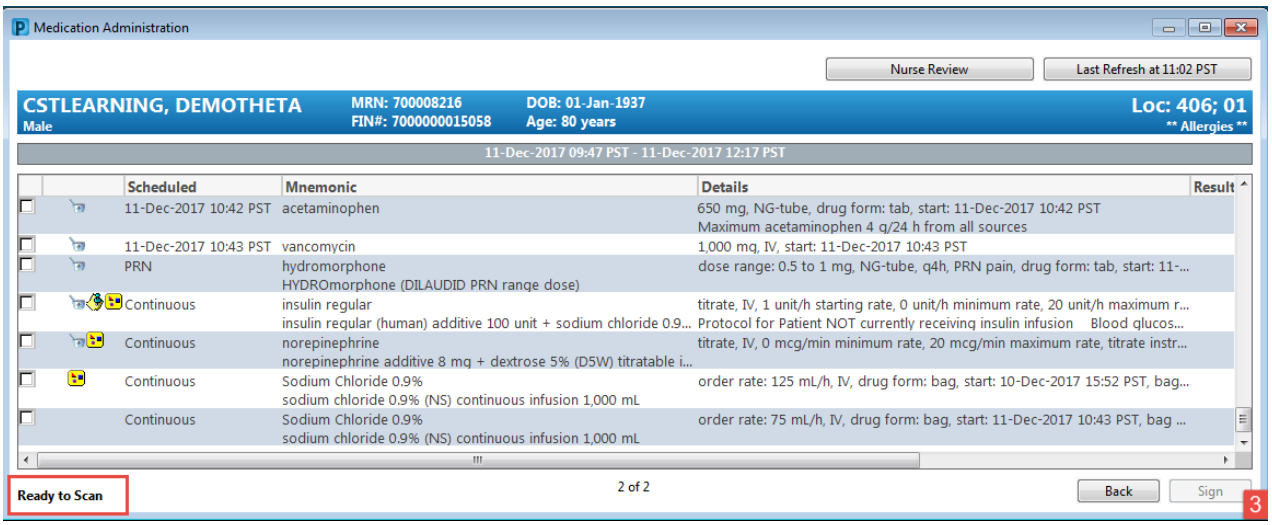
in the Toolbar.

2. The **Medication Administration** window opens.



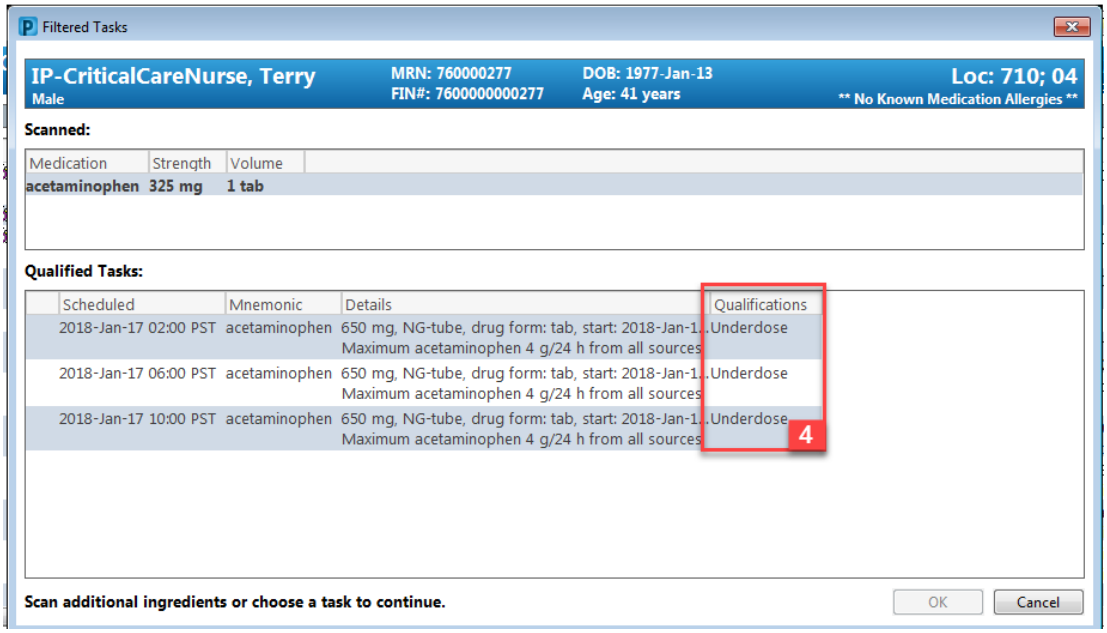
3. Scan the patient's wristband and the **Medication Administration** window will display the medications that you can administer.

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.

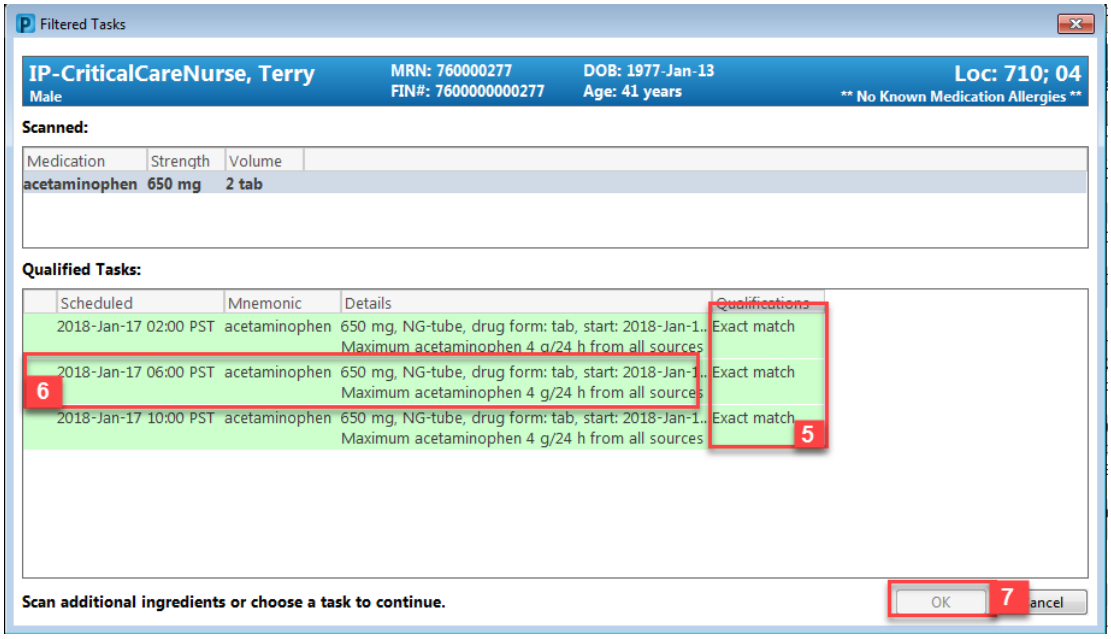


4. Scan the medication barcode for **acetaminophen 325 mg** tab. **Filtered Tasks** window opens.

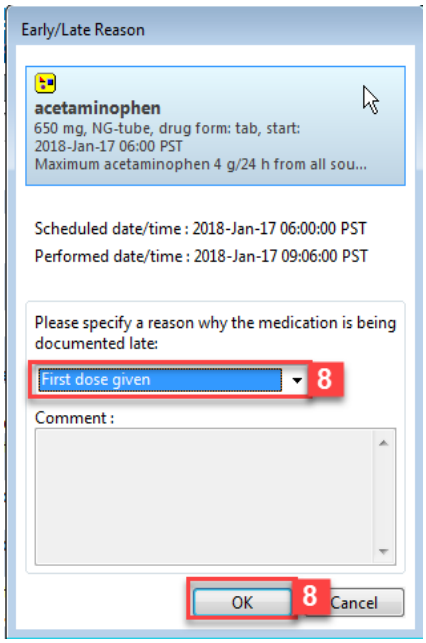
Note: Underdose appears in the qualifications column for the medication. This is because you have only scanned 325 mg of the total 650 mg of acetaminophen required.



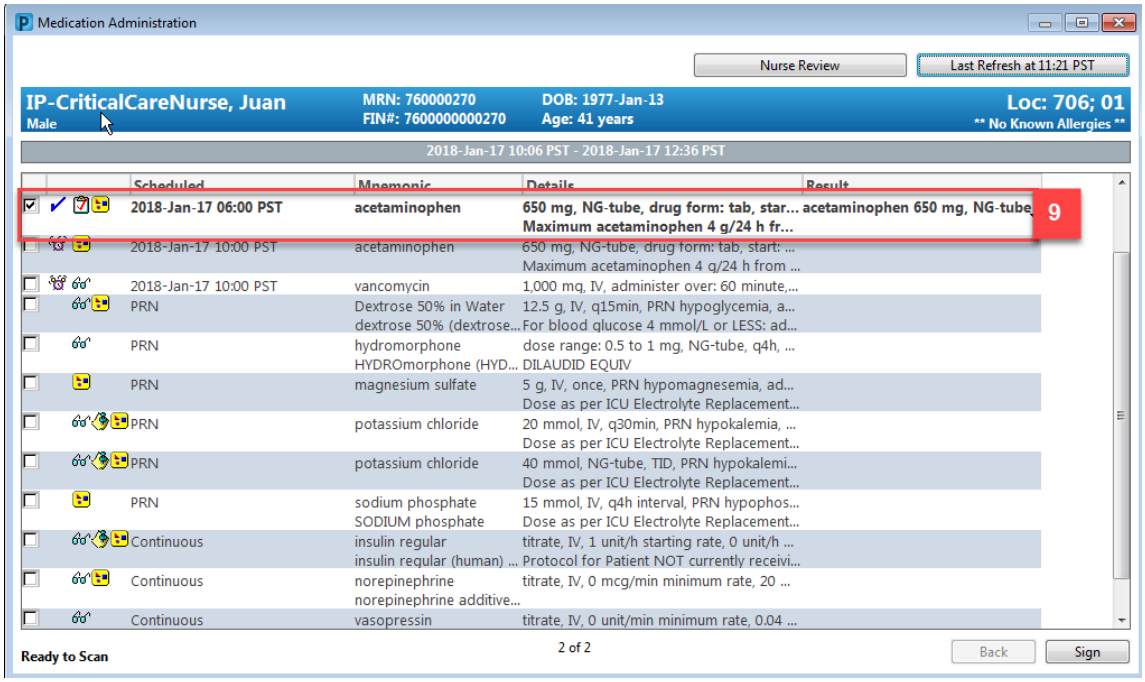
5. Now scan the second **acetaminophen 325 mg** tab barcode to complete the 2 tablet drug administration. After the second scan, the system may find more than one exact matches. In this activity, the system displays three exact matches for the prescribed dose of acetaminophen at 02:00, 06:00, and 10:00.
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**



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**.

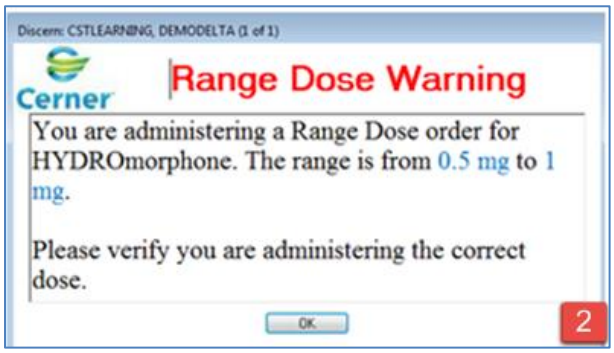


9. You will return to **Medication Administration** window. The blue check mark ✔ indicates the task of scanning the prescribed dose of acetaminophen is completed.

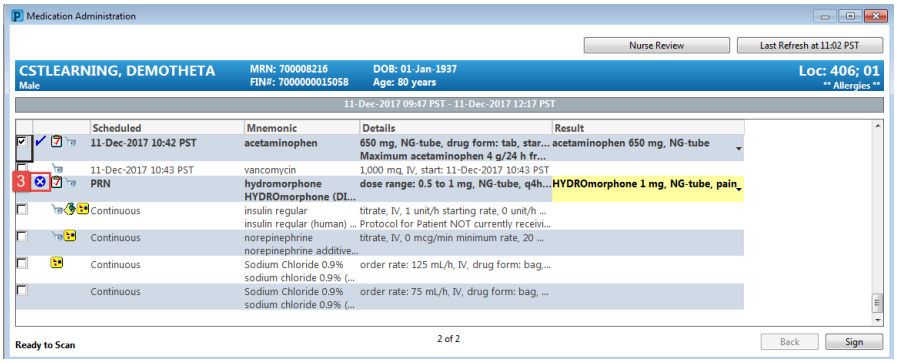


Now let's scan the next medication.

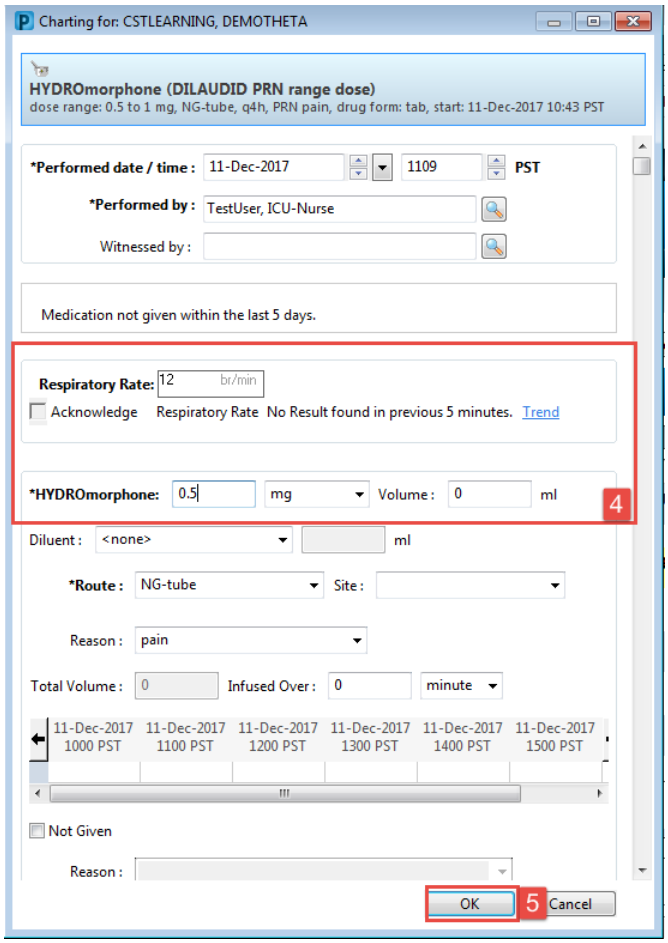
1. Scan your medication barcode for **hydromorphone 1 mg tab**
2. You are using the hydromorphone 1 mg tab product barcode. Note that this medication is a range dose order. A **Range Dose Warning** screen will display to remind you of this dose range. Click **OK** to acknowledge the alert.



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



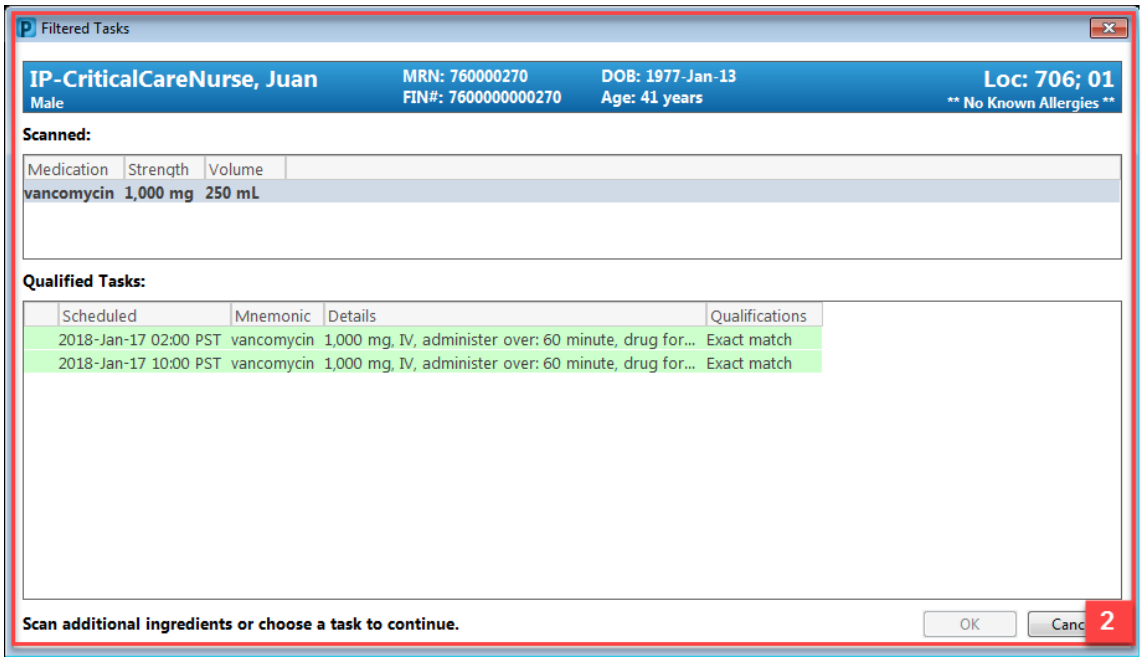
4. A charting window will appear. Enter the following details:
   - **Respiratory Rate** = *12 breaths/min*
   - **Hydromorphone** = *0.5 mg (changed from 1 mg)*
5. Click **OK.** You will return to **Medication Administration** window.



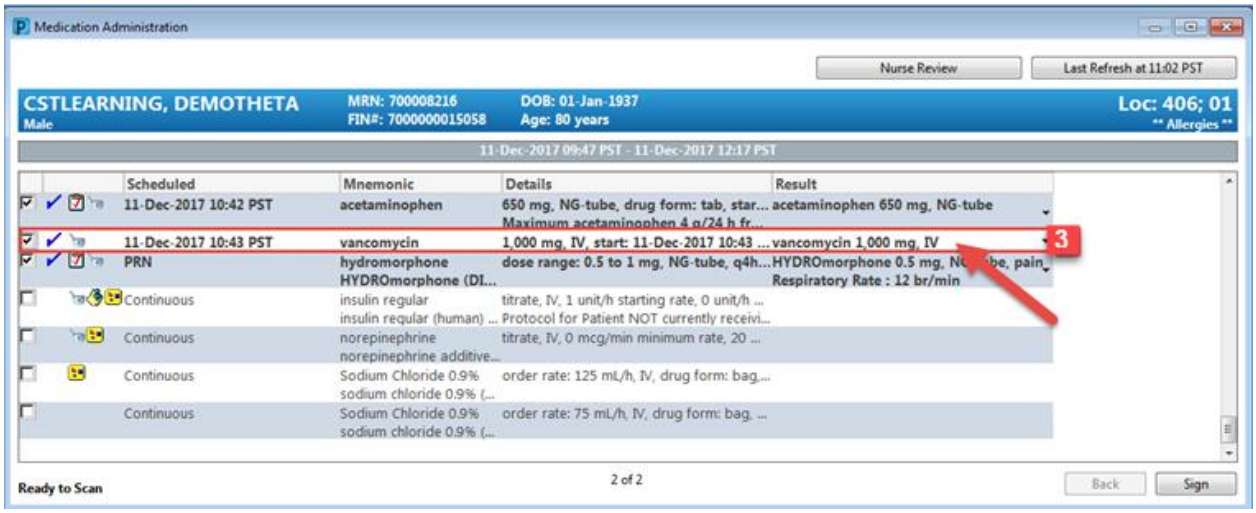
Let's scan your last medication.

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).



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

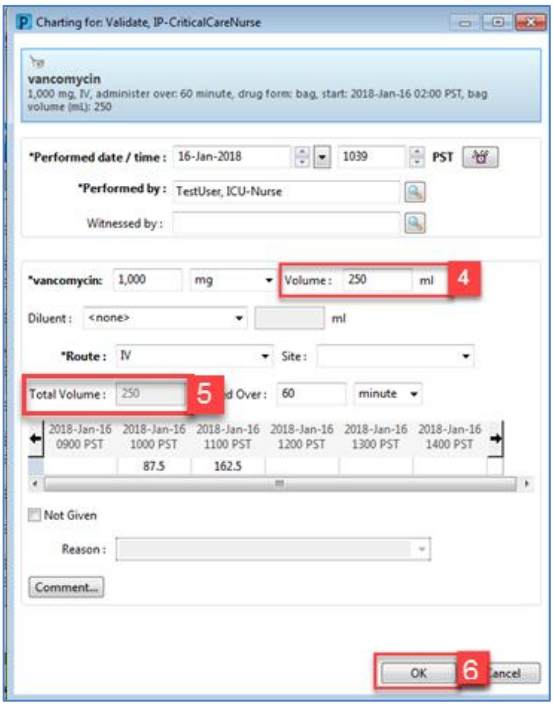


4. The **Charting** window opens. The **Premixed Volume** (250 mL) of Vancomycin prepared by pharmacy is auto-populated.

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

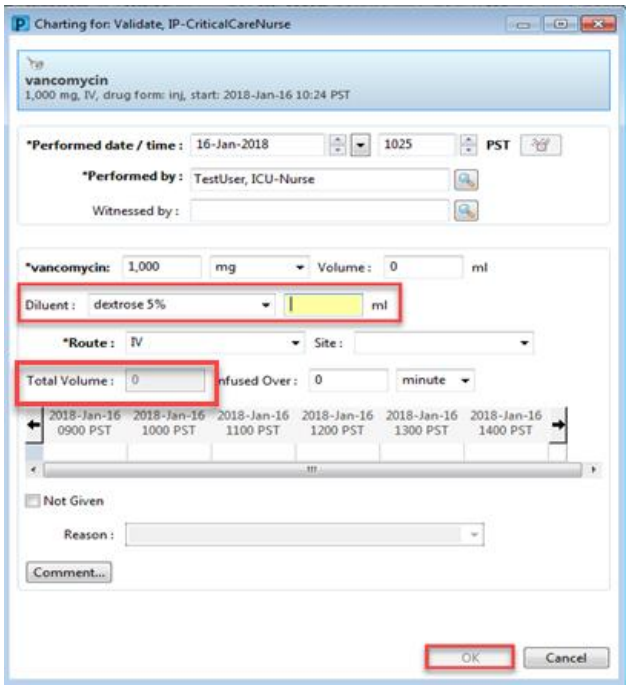
5. The premixed volume of Vancomycin is also reflected in **Total Volume** showing in the **Charting** window. The total IV medication volume will flow to I&O.

6. Click the **OK** button OK after verification.

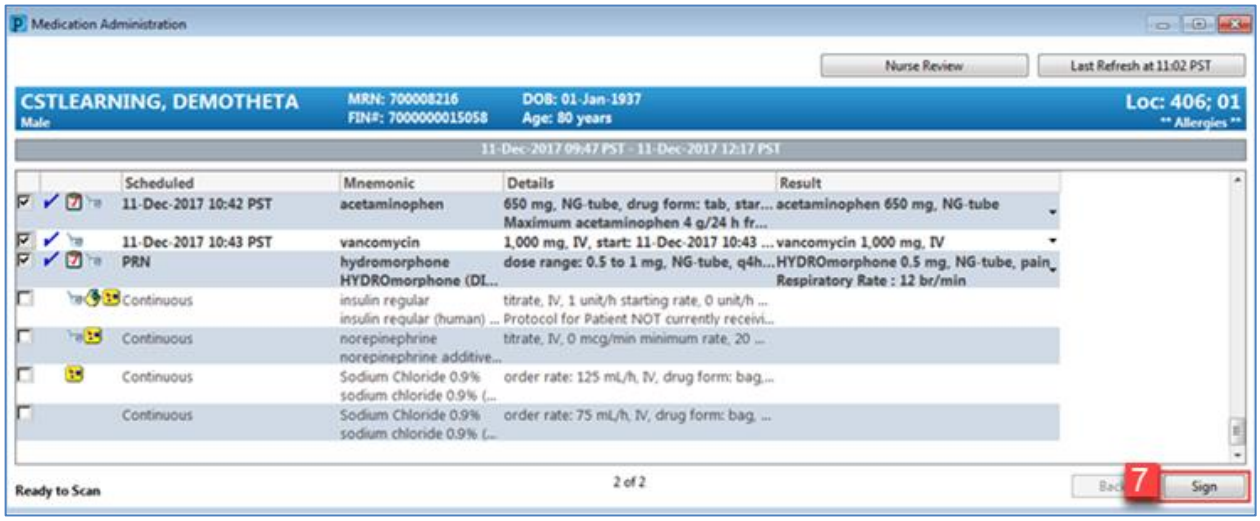


Note: Nurses often mix their own IV medications. If so, the barcode on the vial of the medication will be scanned. Then the type of diluent solution and the diluent volume will be manually entered in the **Charting** window (see screenshot below). The diluent volume is reflected in the **Total Volume** 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.

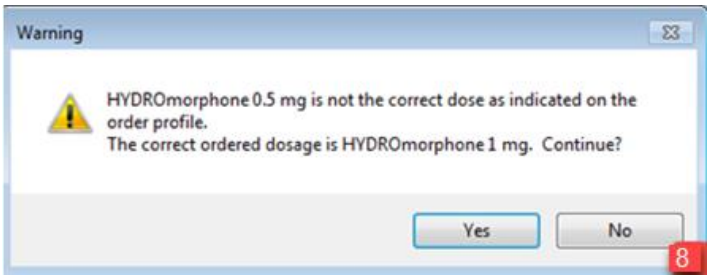
Note: The reconstitution volume to mix the medication in the vial is added to the diluent volume.



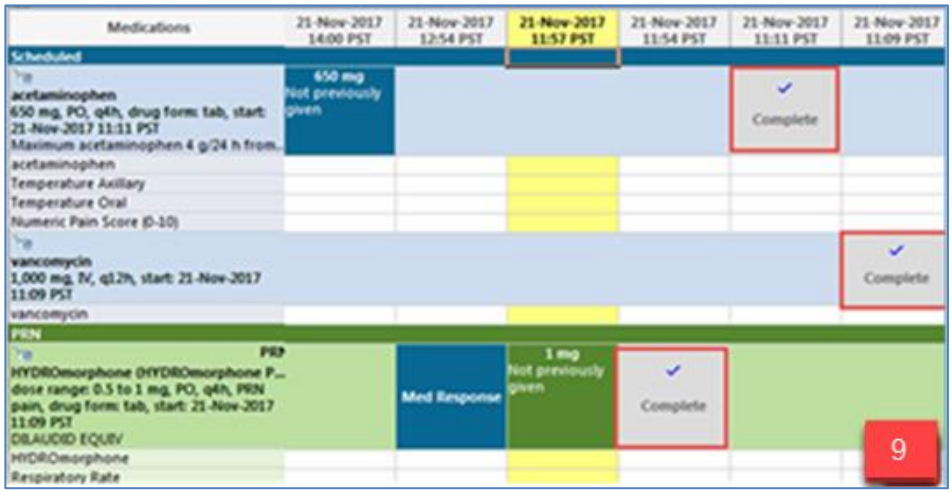
7. Now that you have scanned the patient and all three medications, you can complete your medication checks and administer the medications. Then, click **Sign** button Sign to sign off the medications administered.



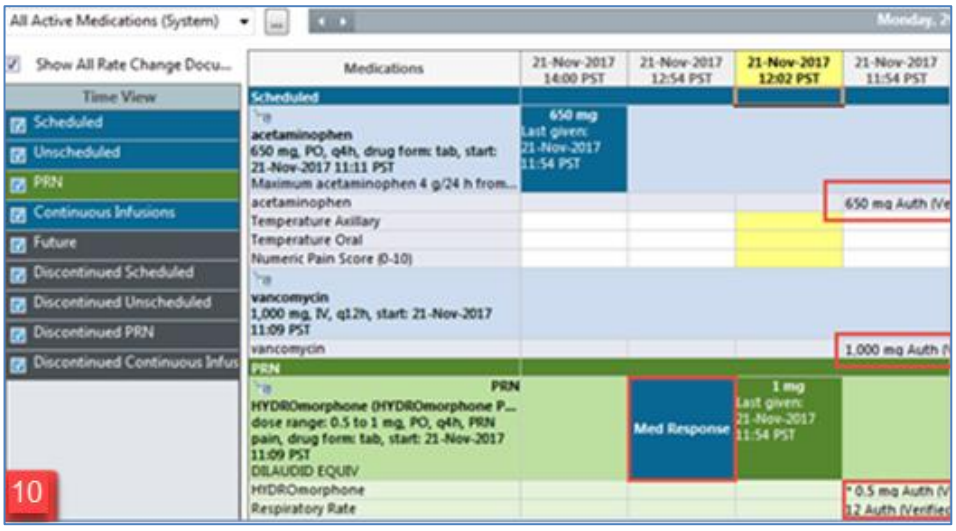
8. A warning window opens stating that a partial dose of hydromorphone was given, do you want to continue? Click **Yes**.



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



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



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.

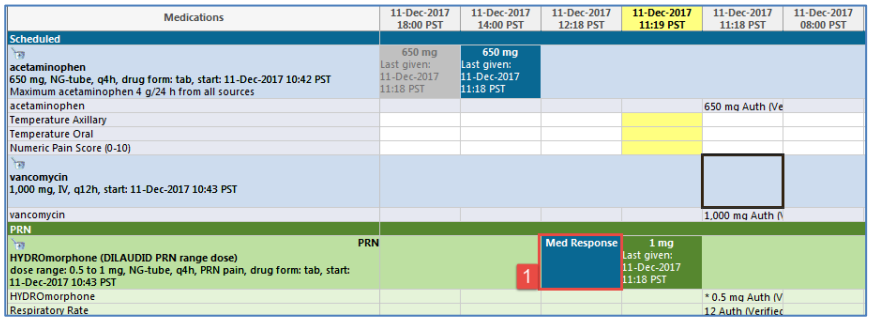
Key Learning Points

- 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

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

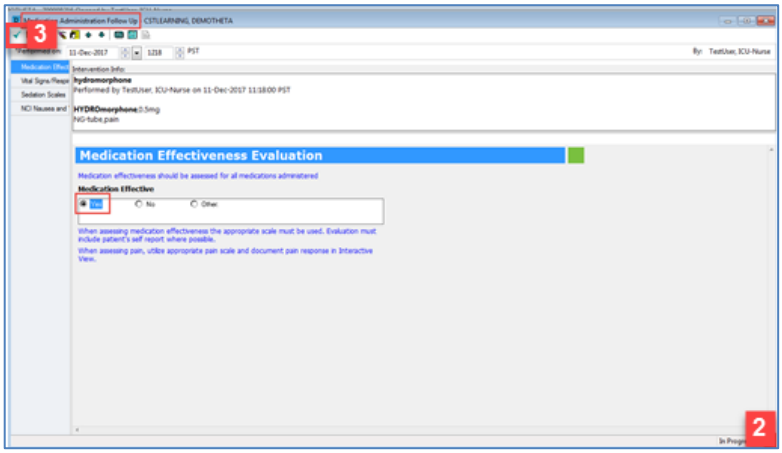
1 When you administer some PRN medications, it is necessary to document how the patient responds to the medication. You can do this directly in the MAR.

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



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 to update the screen. Now that you have documented the medication response and it has disappeared from the MAR.

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 11:18 PST	11
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 (V	
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**				**1 mg** **Last given:** **11-Dec-2017** **11:18 PST**		
HYDROmorphone					* 0.5 mg Auth (V	
Respiratory Rate					12 Auth (Verifiec	

Key Learnings Points

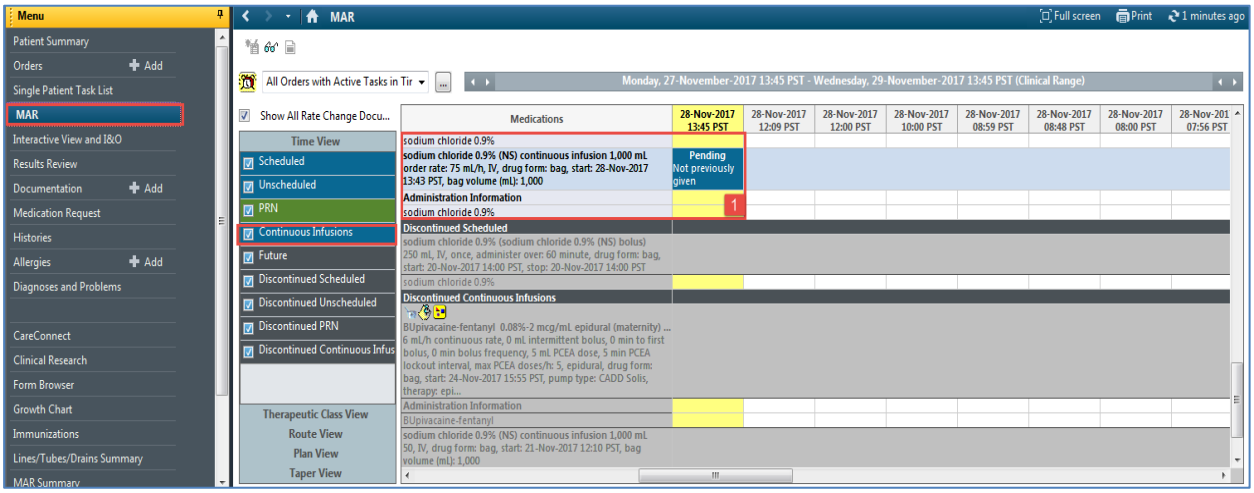
- Some PRN medications require further documentation on how the patient responds to the drugs. This can be done under Med Response from the MAR.

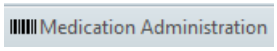
Activity 13.3 – Administering Continuous IV Fluids (Non-barcoded)

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

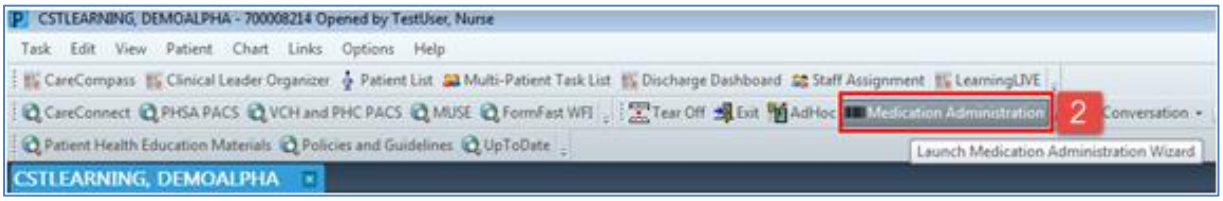
1. From the **MAR**, review the order details for the **sodium chloride 0.9% continuous infusion**.

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

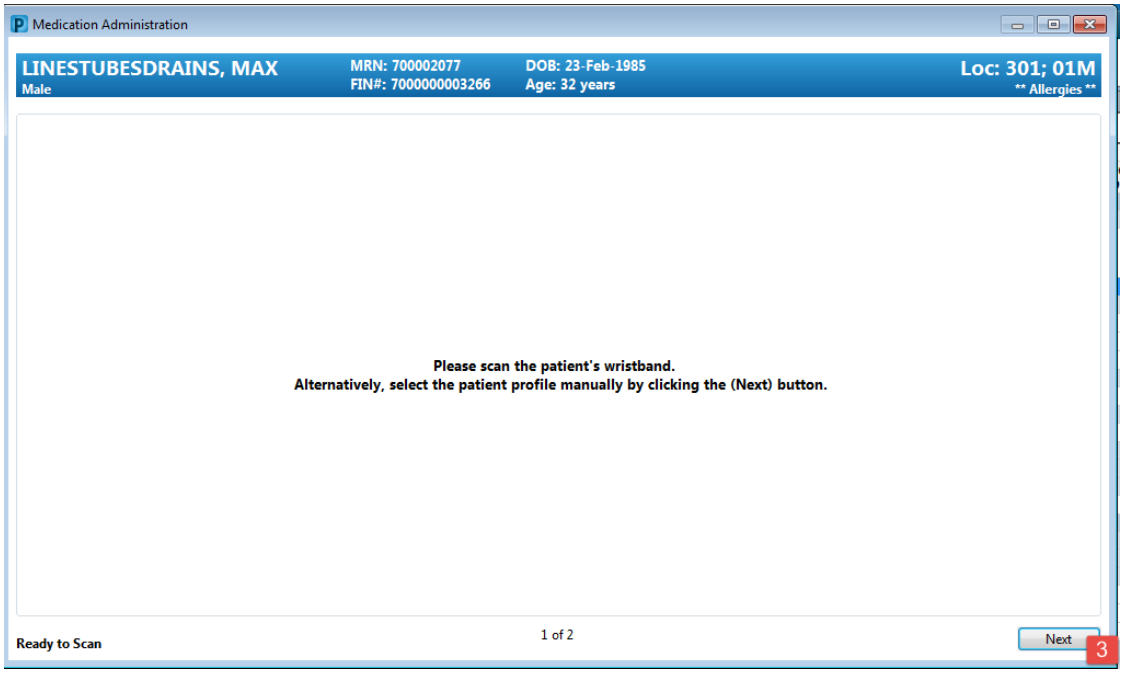


2. To administer the infusion, click on **Medication Administration Wizard (MAW)** button 

from the toolbar.

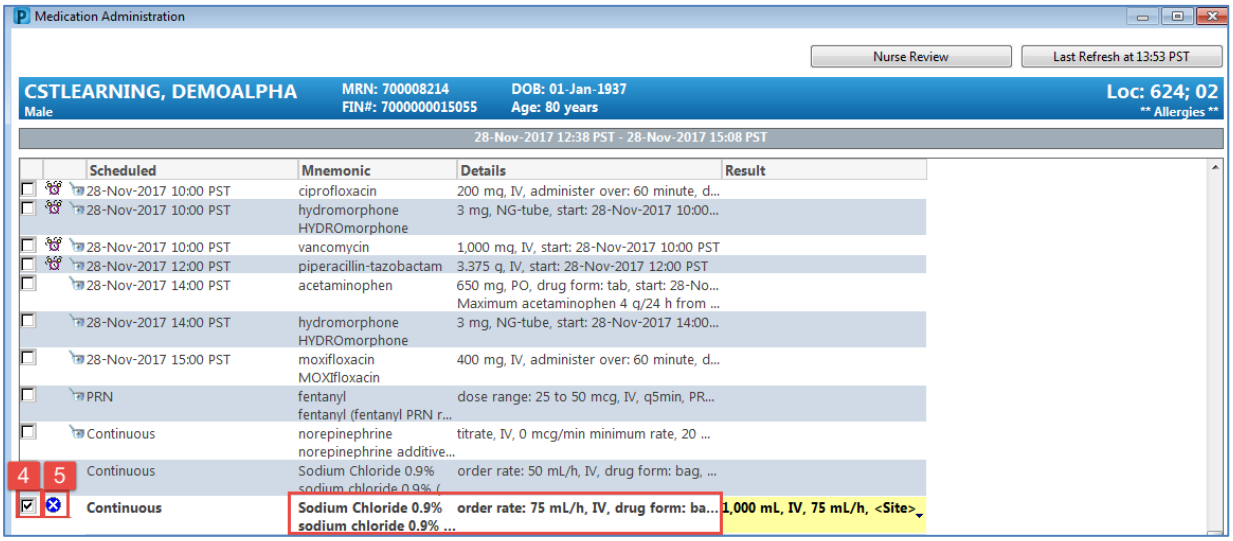


3. The **Medication Administration** window opens prompting you to scan the patient's wristband. Scan the barcode on the patient's wristband.

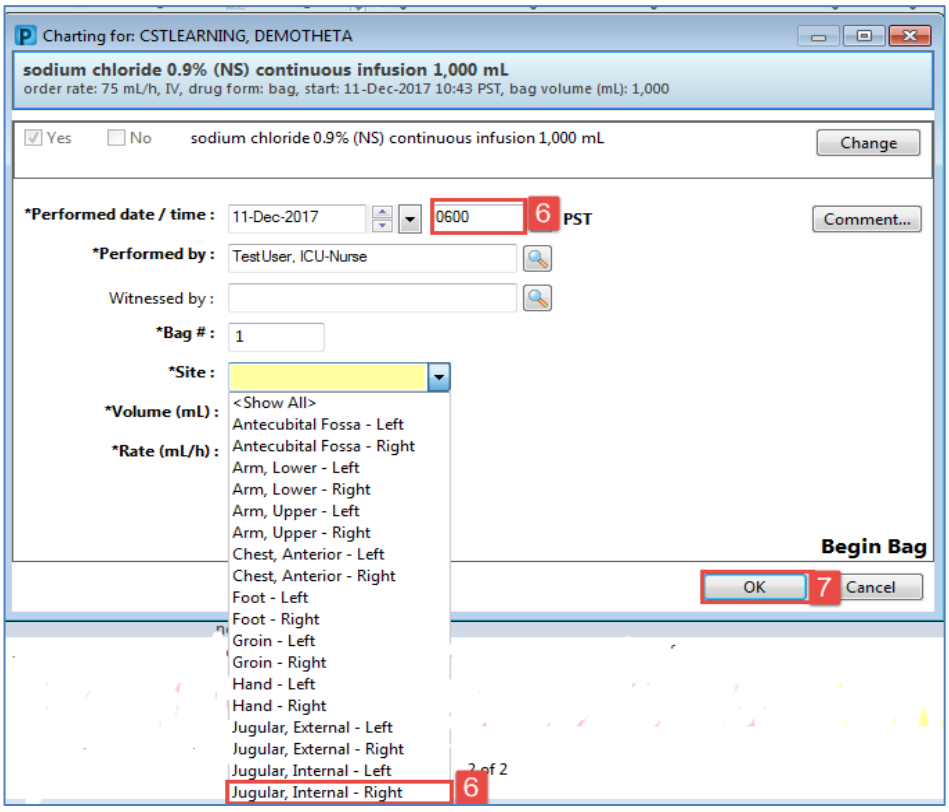


4. A list of ordered medications that can be administered appears in the **Medication Administration** window. The next step would be to scan the barcode on the medication, but with items that do not have a barcode, such as Normal Saline, we cannot do this. Instead, scroll down to manually select the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

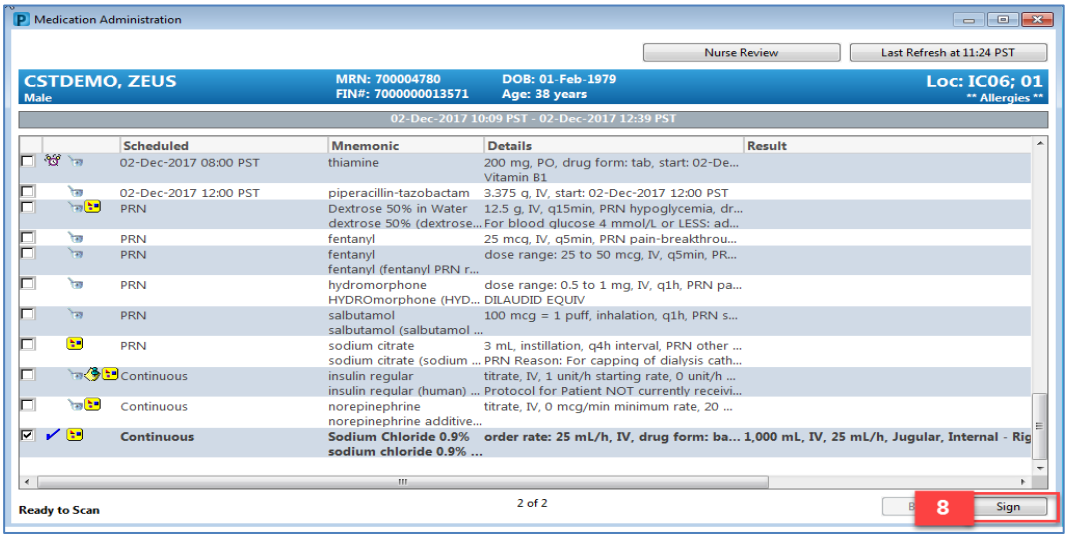
5. Click on the **Task Incomplete** icon and the **Charting** window will open for the sodium chloride 0.9% (NS) continuous infusion 1,000mL



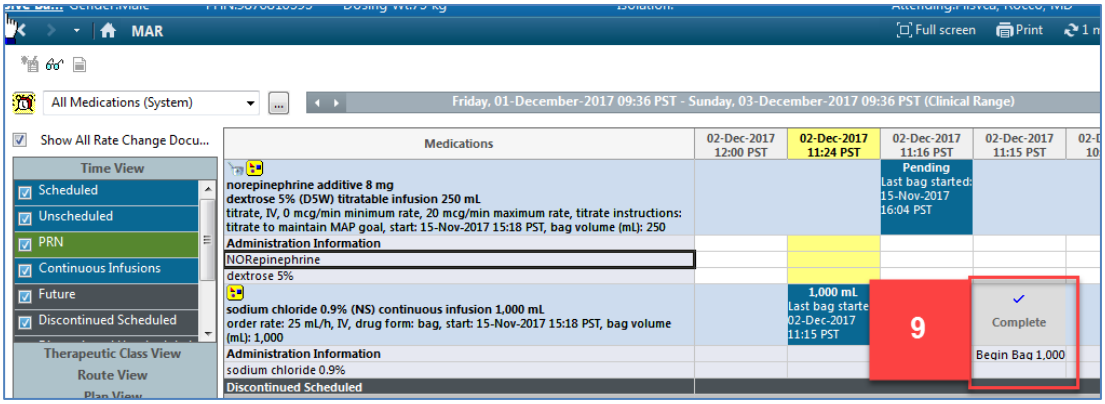
6. Fill in the following information, in this case:
    - **Performed time** = *0600*
    - **Site** = *Jugular, Internal – Right*
7. Click **OK**



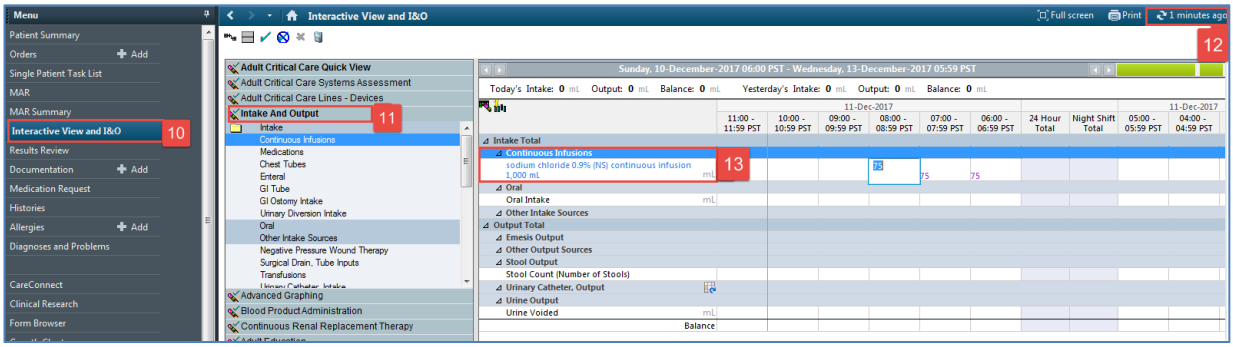
8. Click the **Sign** button 



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.

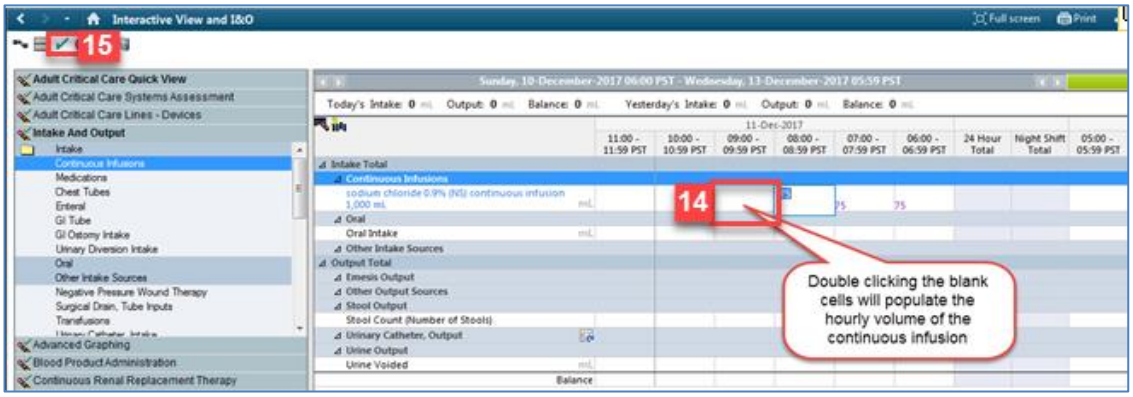


10. Navigate to **Interactive View and I&O** from the **Menu**
11. Select the **Intake and Output** band.
12. Click the **Refresh** icon .
13. After you refresh the page you should see the **sodium chloride 0.9% (NS) continuous infusion**



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 to complete your documentation

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



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

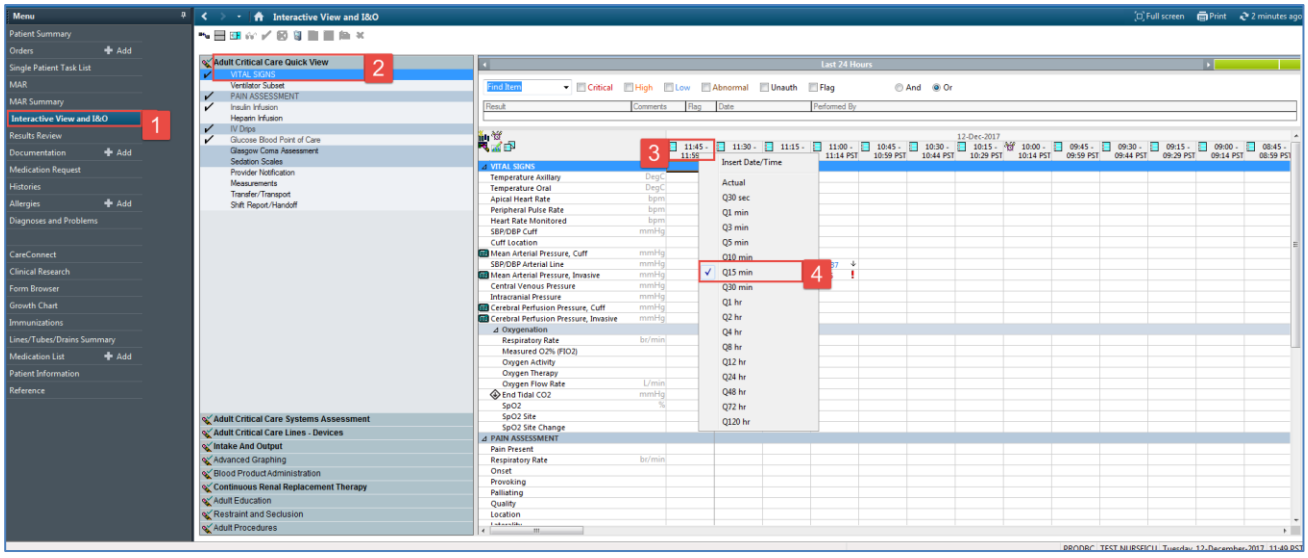
1 Titrating medication infusions is a common practice in critical care areas. This scenario will use norepinephrine infusion as an example.

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:

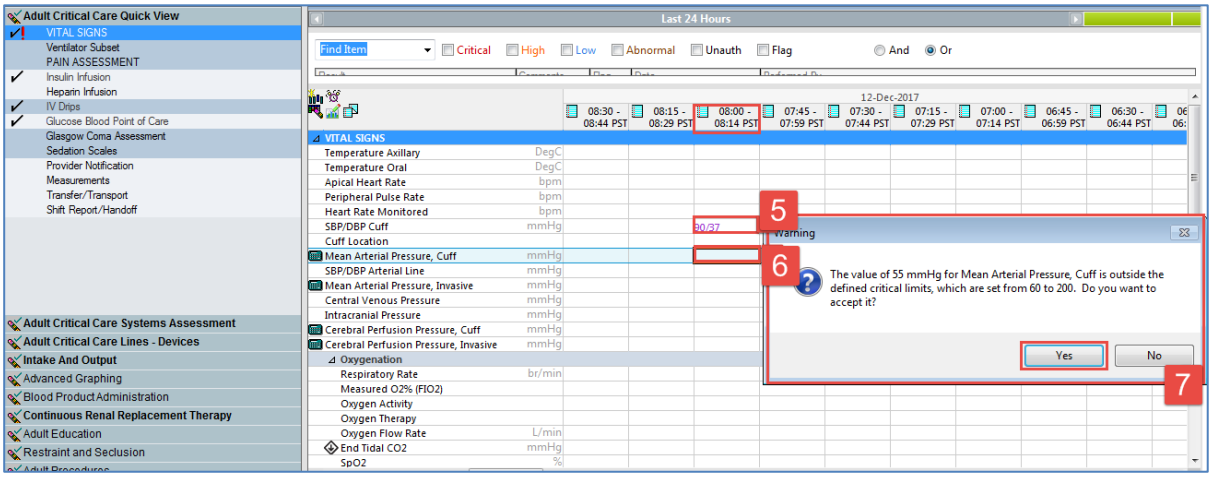
1. Navigate to **Interactive View and I&O** from the **Menu**
2. In the **Adult Critical Care Quick View** band, select the **Vital Signs** section
3. For the purposes of documenting titratable vasopressors, let's say we need to document q15min vital signs. Right click on the most current time column 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.



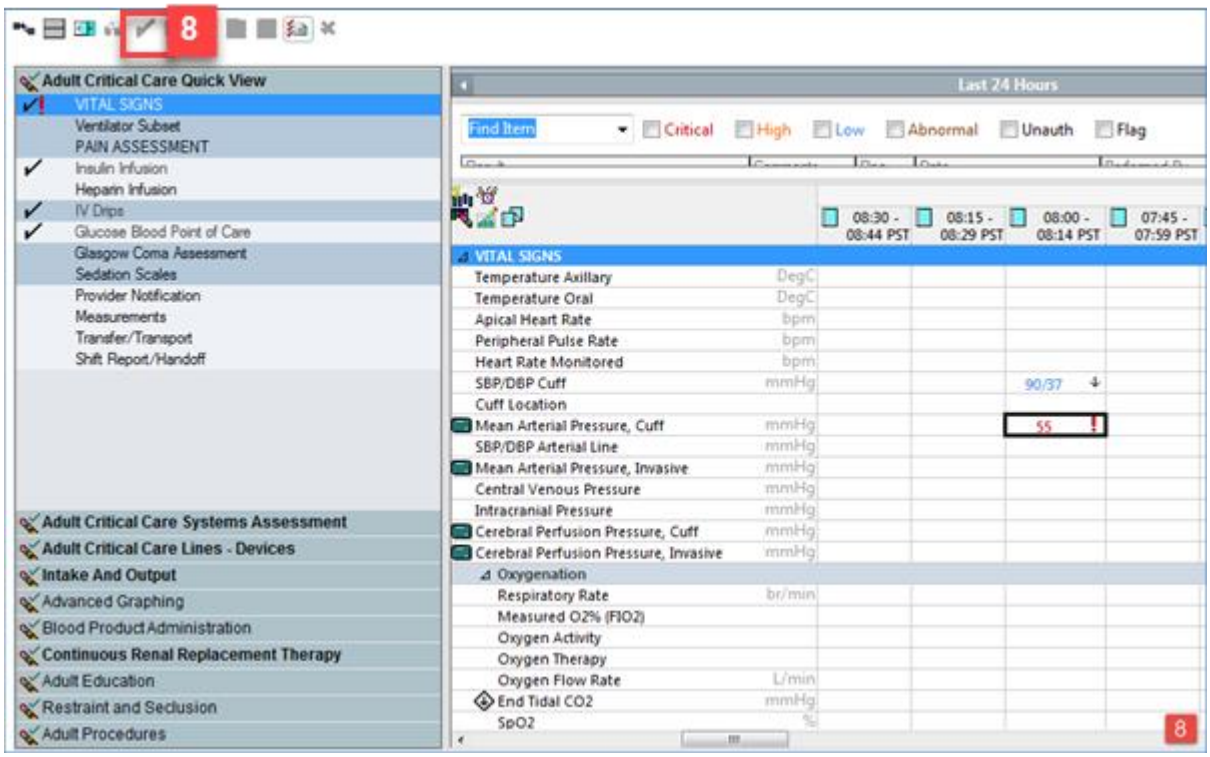
Let's document vital signs for 08:00

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**

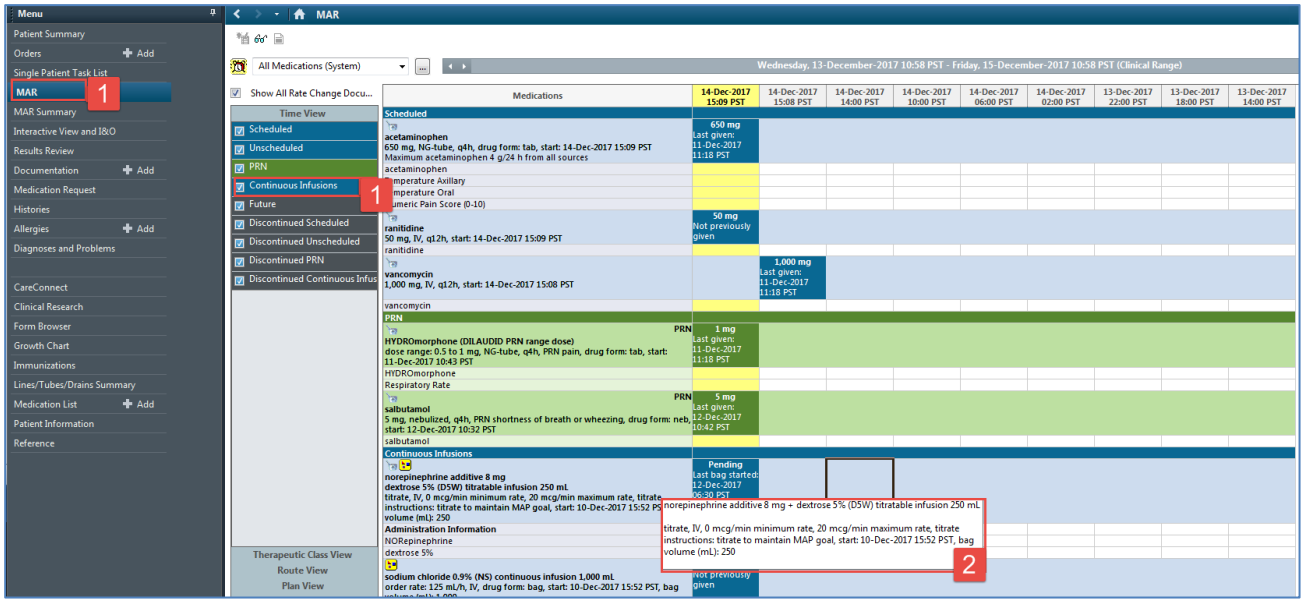


8. Click the **Sign** icon  to complete your documentation. Notice the MAP value of 55 displays in red, indicating it is a critically low value.

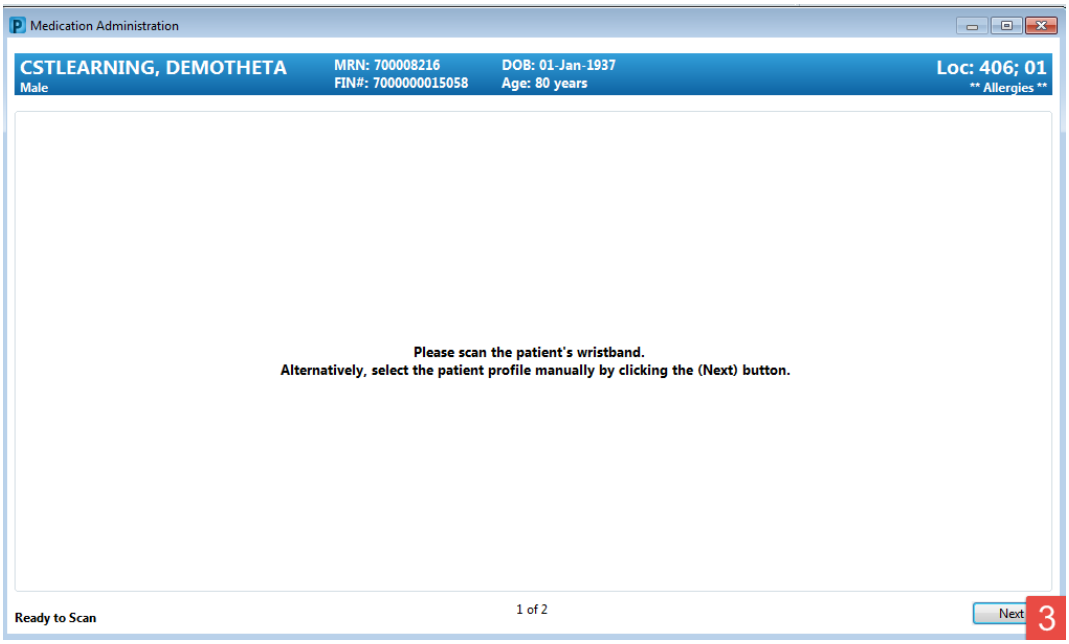


2 Your patient has an order for a titratable **norepinephrine infusion 0-20mcg/min** to maintain the patient's MAP goal of 65mmHg or greater. Since your patient's MAP is now 55mmHg, we need to initiate the norepinephrine infusion.

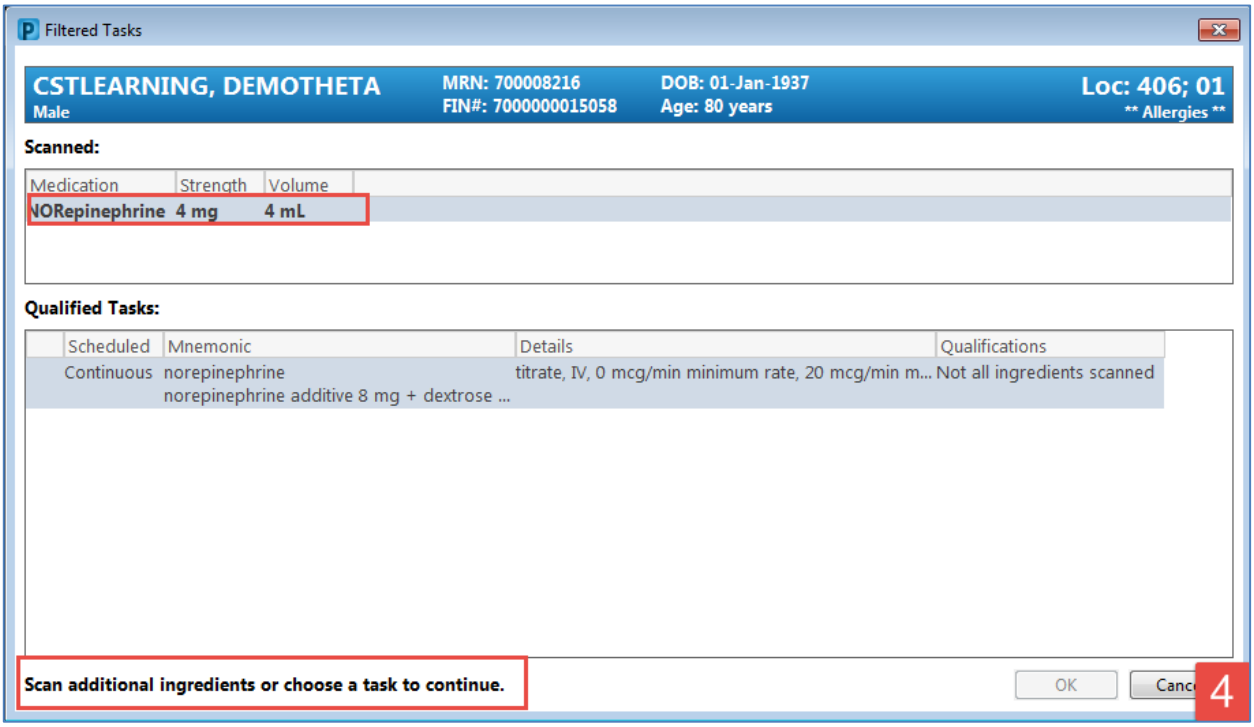
1. Navigate to **MAR** from the **Menu** and select **Continuous Infusion**.
2. Hover over the medication **norepinephrine additive 8mg dextrose 5% (D5W) titratable infusion 250 mL** to see additional details about the order.



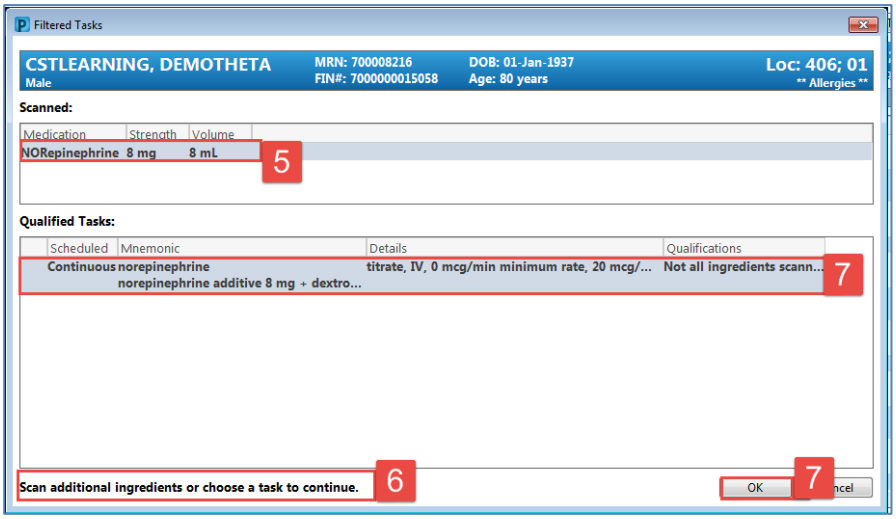
3. Click the **Medication Administration Wizard (MAW)** button Medication Administration in the Toolbar. The **Medication Administration** window opens prompting you to scan your patient's wristband. Scan the barcode on your patient's wristband now.



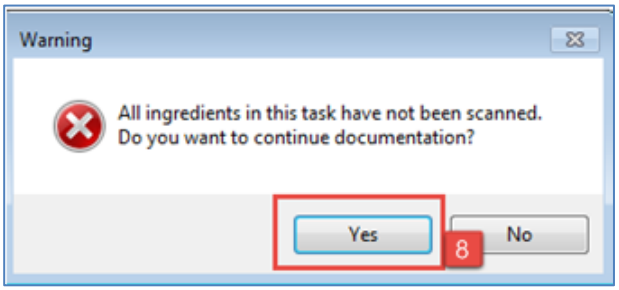
4. Now scan the barcode for the **norepinephrine vial (4mg/4mL).** The **Filtered Tasks** window appears suggesting that not all ingredients were scanned. This is because the order calls for 8mg of norepinephrine in 250mL of dextrose 5%. You are being asked to scan both of these additional ingredients.



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 task and select **OK**.



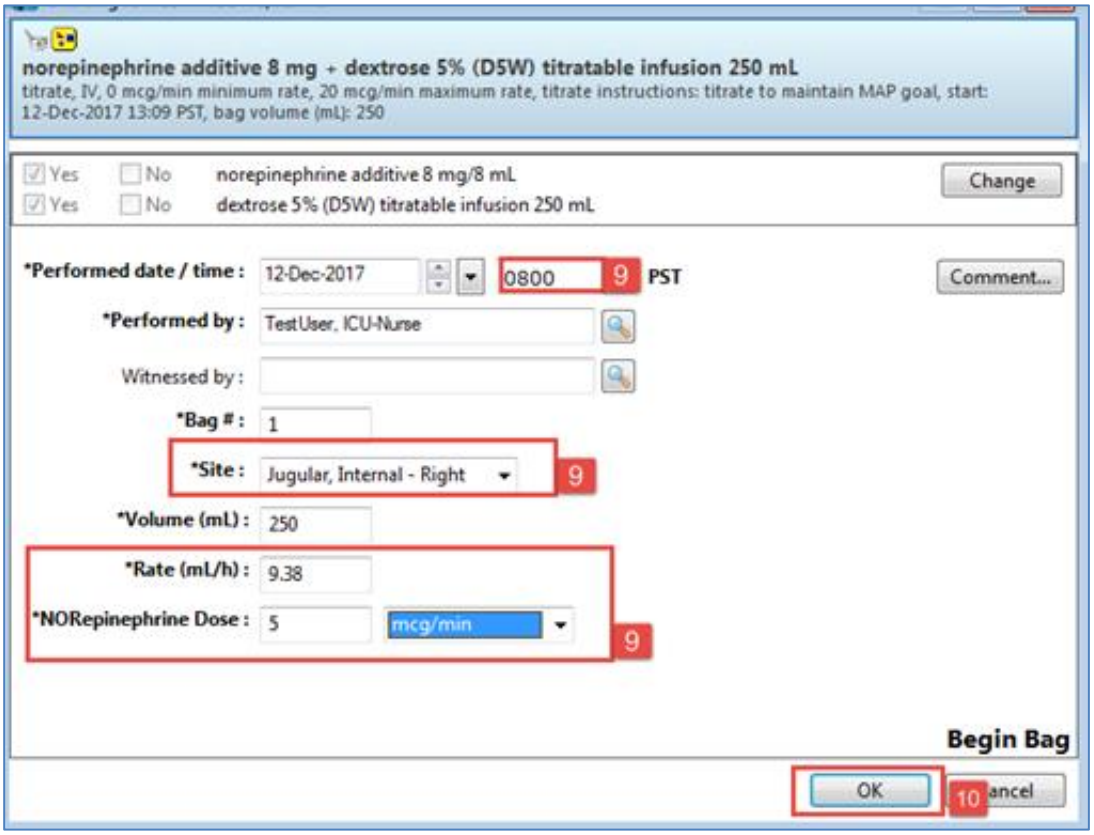
8. A **Warning** window displays to tell you that not all ingredients in the task have been scanned. Click **Yes** to continue documentation (as you cannot scan the dextrose).



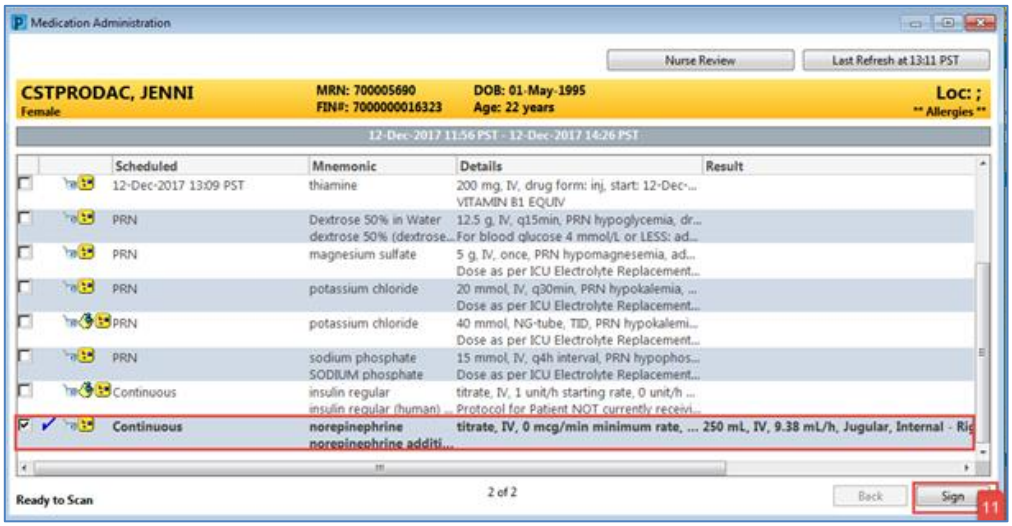
9. The **Charting** window for norepinephrine displays. Fill in the following fields:
   - ***Performed date/time** = *Today at 0800*
   - **Site** = *Jugular, Internal – Right*
   - ***NORepinephrine Dose** = *5 mcg/min*

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.

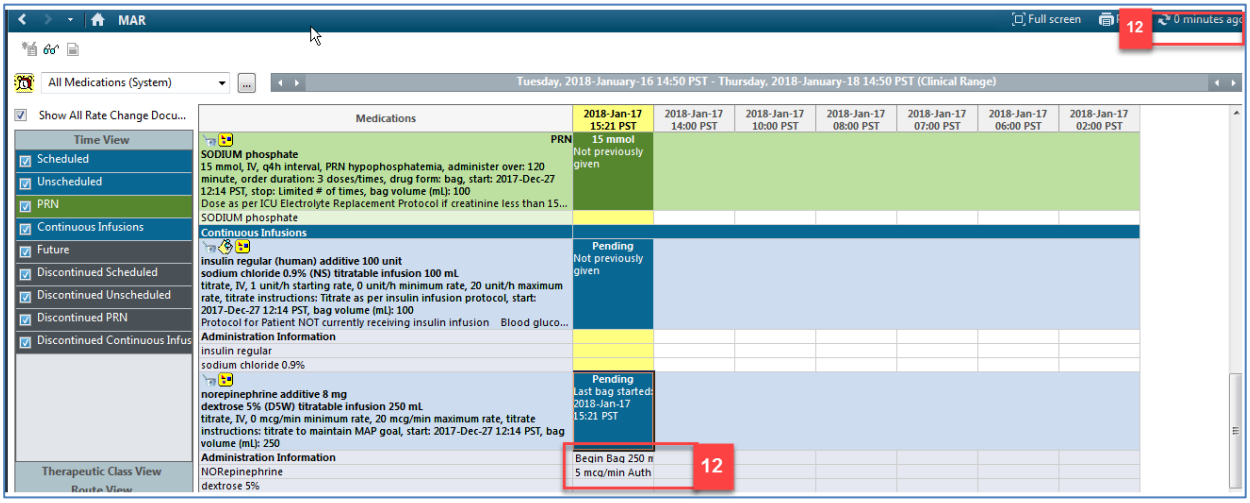
10. Click **OK**



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



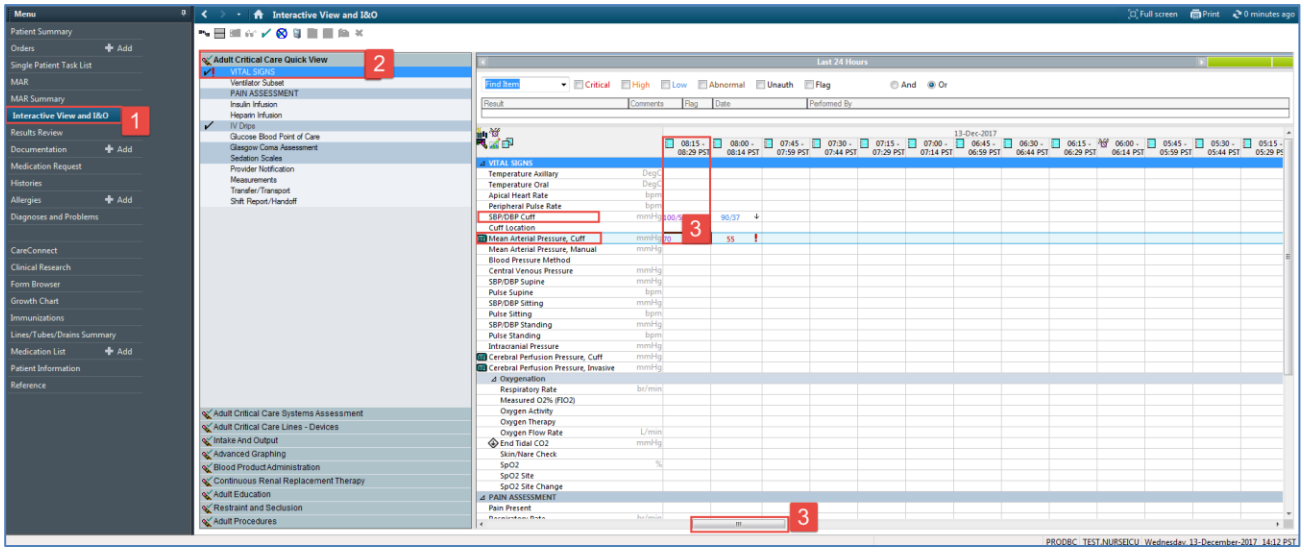
12. The norepinephrine task now appears as complete on the MAR. Click **Refresh** icon and you will see Begin Bag details under the 0800 time column.



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:

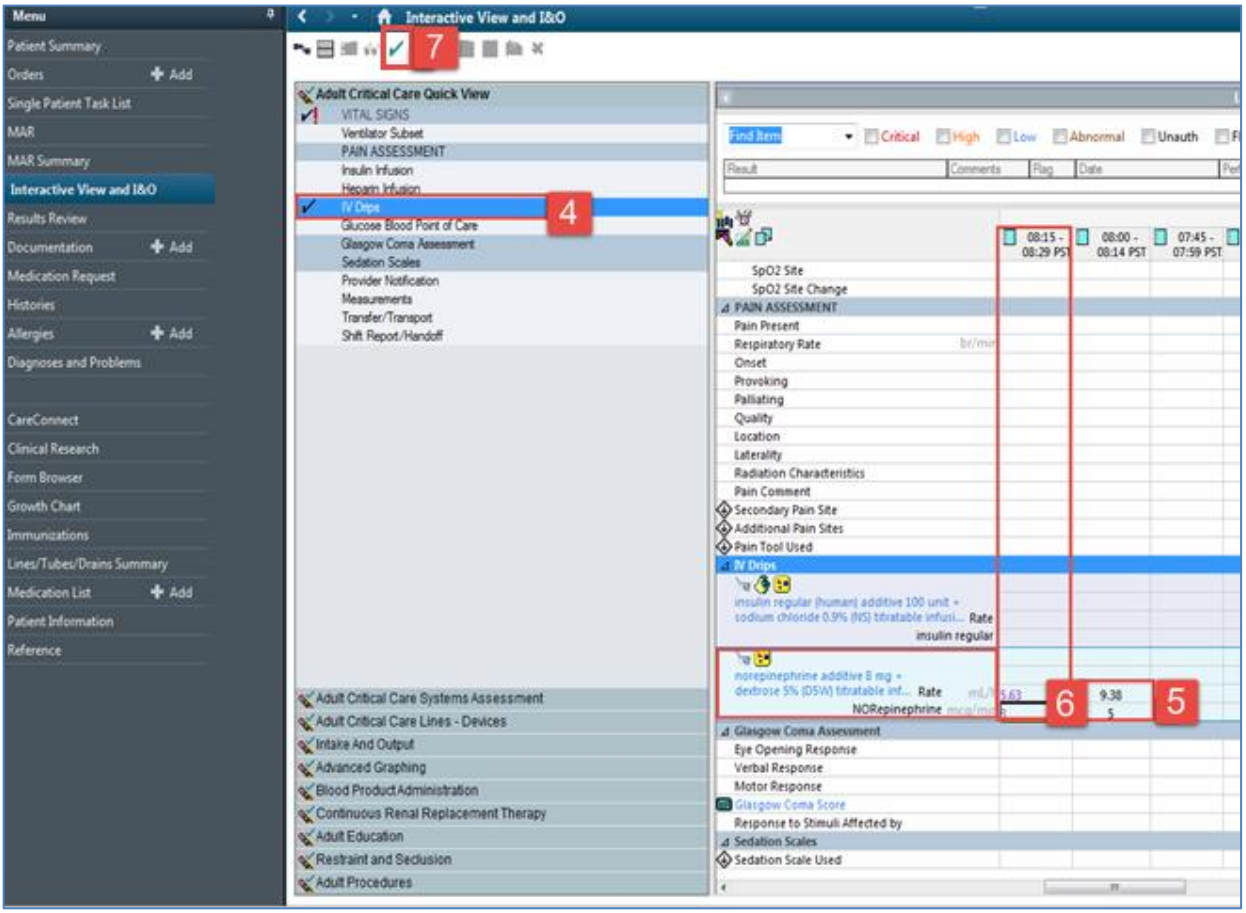
1. Navigate to **Interactive View and I&O** from the **Menu**
2. Under the **Adult Critical Care Quick View** band, select the **Vital Signs** section.
3. Scroll to the right to find the **08:15** time column. Document the patient's SBP/DBP Cuff as follows:
    - **SBP/DBP Cuff** = *100/55*
    - **Mean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

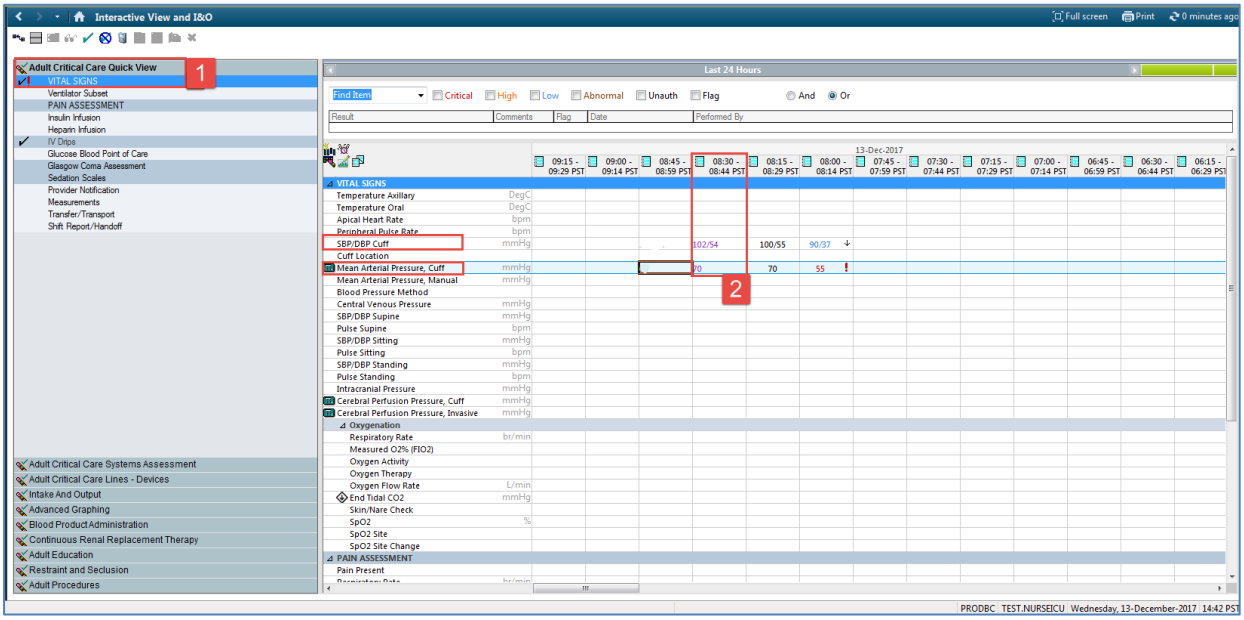
7. Click the **Sign** icon ✔ to complete your documentation.



4 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:

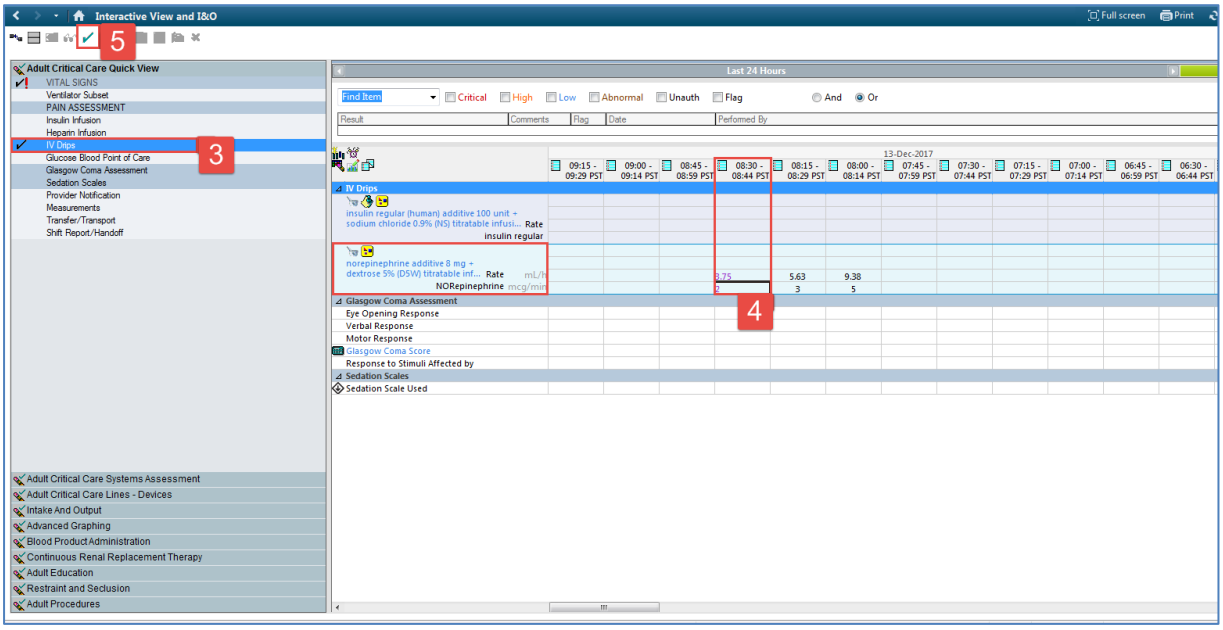
1. Click on the **Vital Signs** section in iView
2. Under the **08:30** time column, document the patient's SBP/DBP Cuff as follows:
   - **SBP/DBP Cuff** = 102/54
   - **Mean Arterial Pressure, Cuff** = (double click in blank cell to auto-fill) 70



3. Scroll down, or click on the **IV Drips** section
4. 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.

5. Click the **Sign icon** ✓ 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

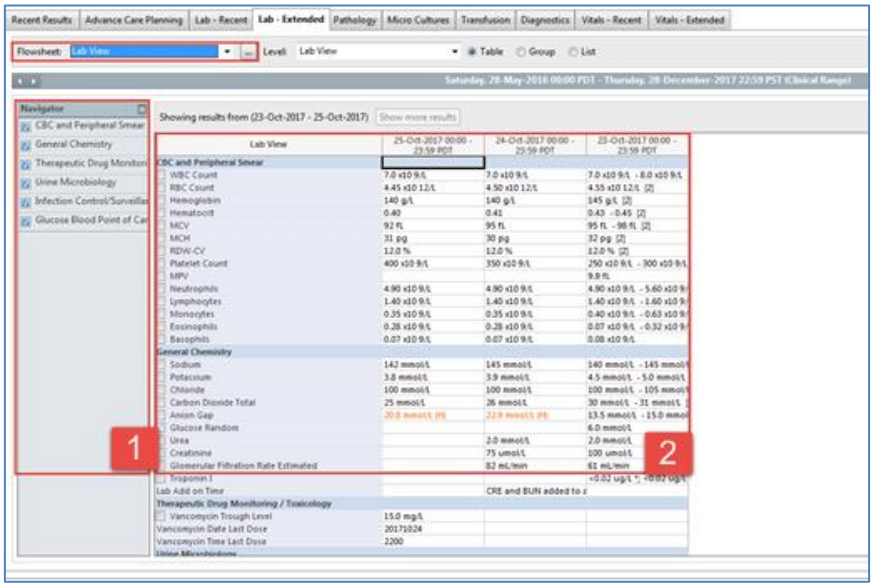
Activity 14.1 – Review Results Using Results Review

1 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.

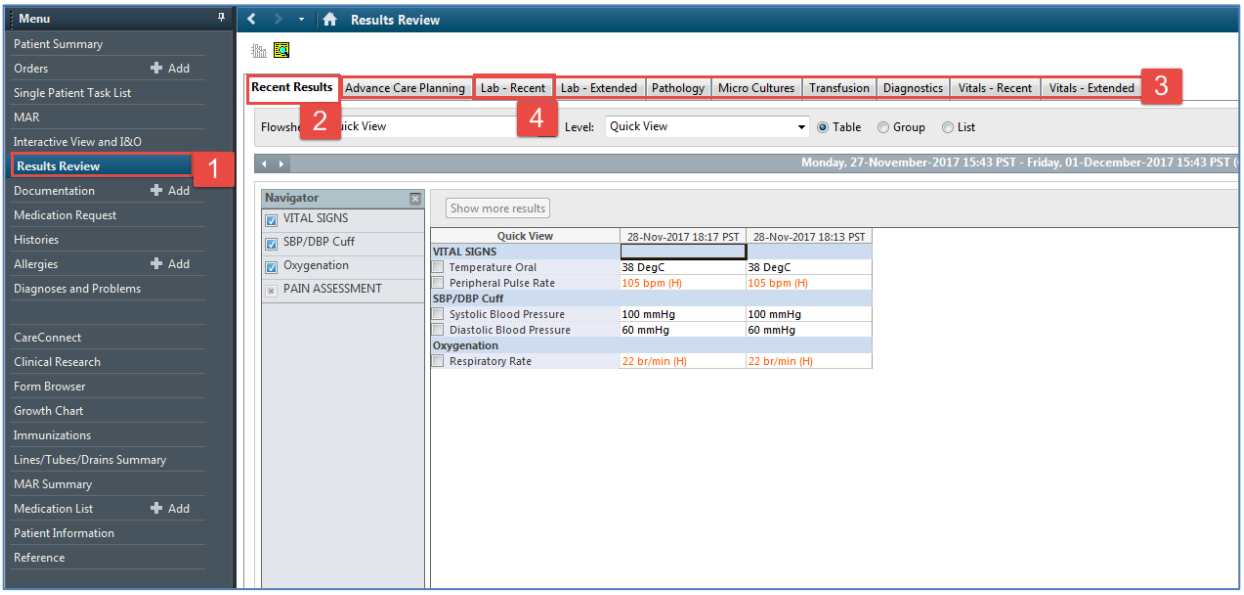
Flowsheets are divided into **two major sections**.

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.
2. The grid to the right is known as Results Display.

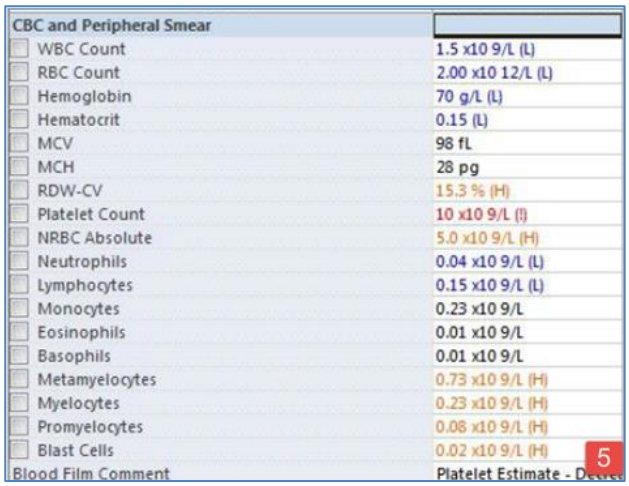


Review the most recent results for your patient:

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**



5. Review your patient's recent lab results.



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

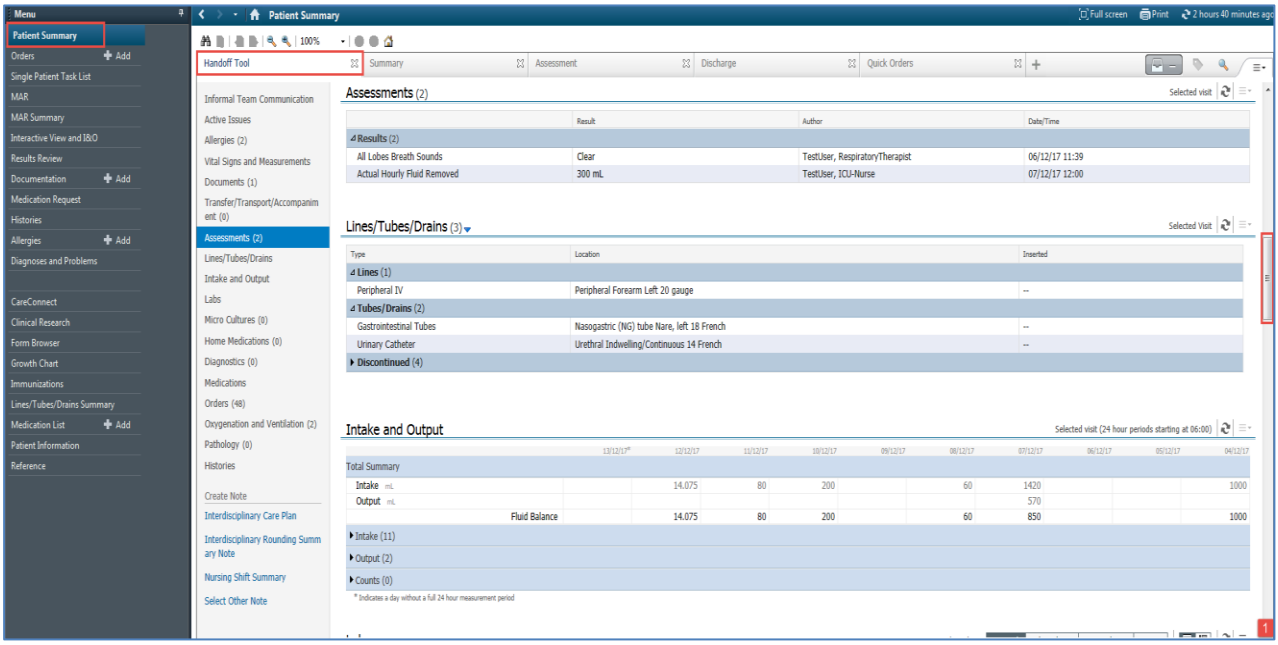
1 The interdisciplinary team participates in rounds every day. During rounds, the team reviews the patient status in order to make decisions about the goal of care and plans for interventions.

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.

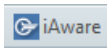
As a critical care nurse, you will most likely refer to the following tools during rounds:

1) **Handoff Tool** tab in the **Patient Summary** page

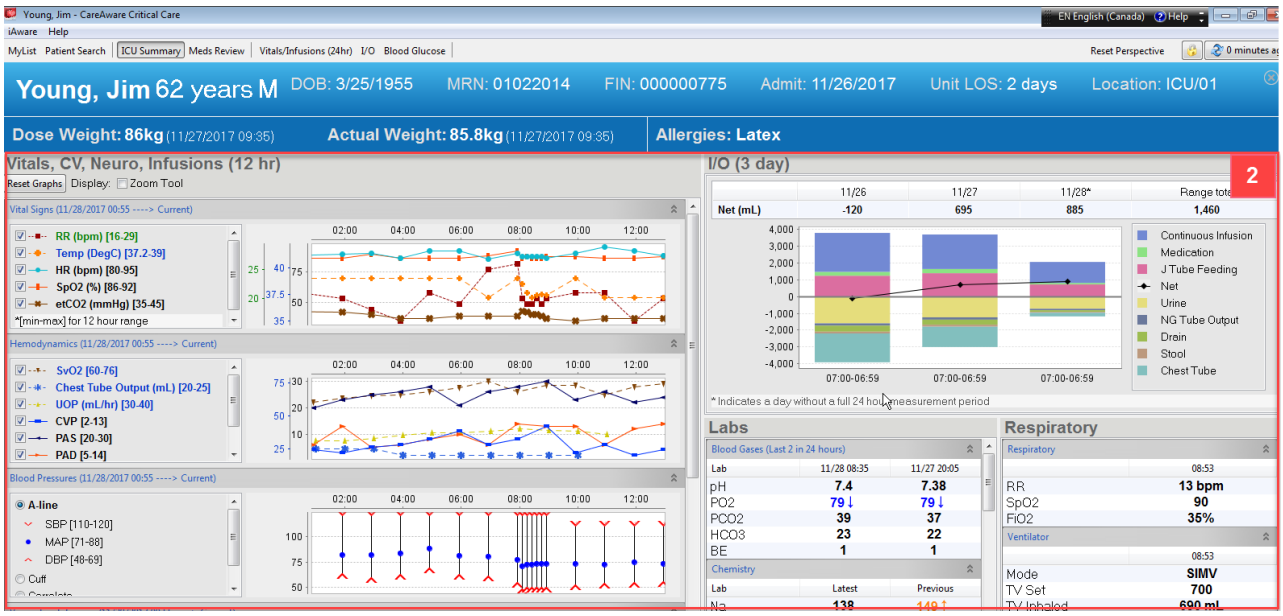
- Summarizes vital signs, recent assessment documentation, lines/tubes/drains, intake and output, recent lab, micro and diagnostic results, oxygenation and ventilation, as well as orders and medications.
- Use the scroll bar to see all of the information in the Handoff Tool.



2) **CareAware Critical Care**

- Accessed through the **iAware** button 

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.



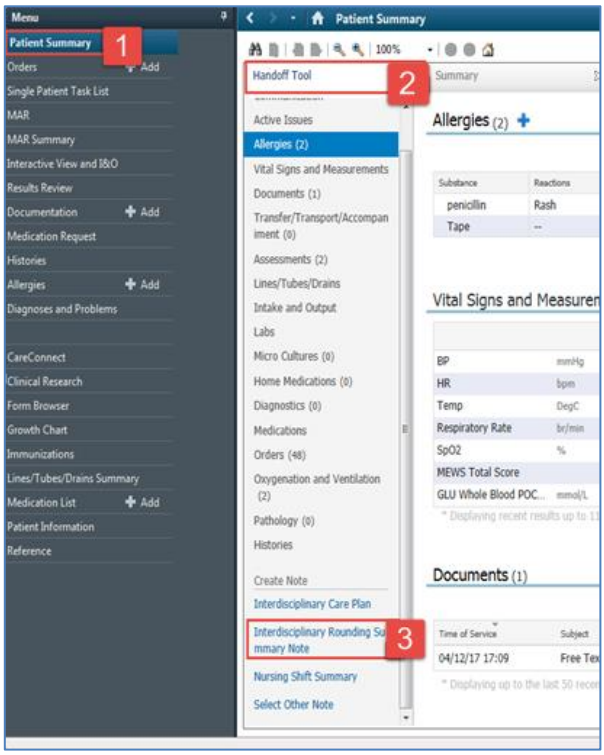
Key Learning Points

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

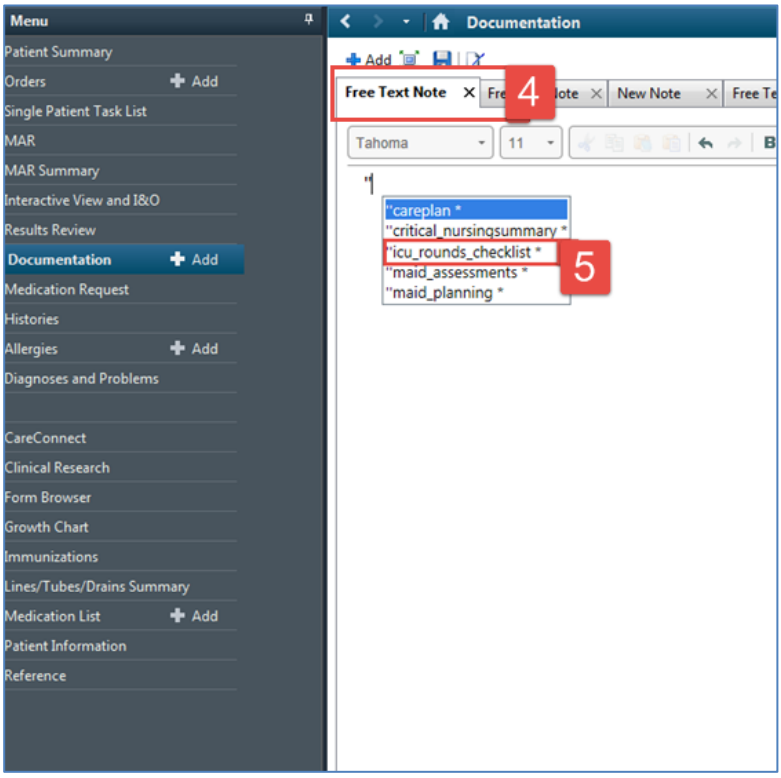
Activity 15.2 – Document an Interdisciplinary Rounding Summary Note

1 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
5. 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.

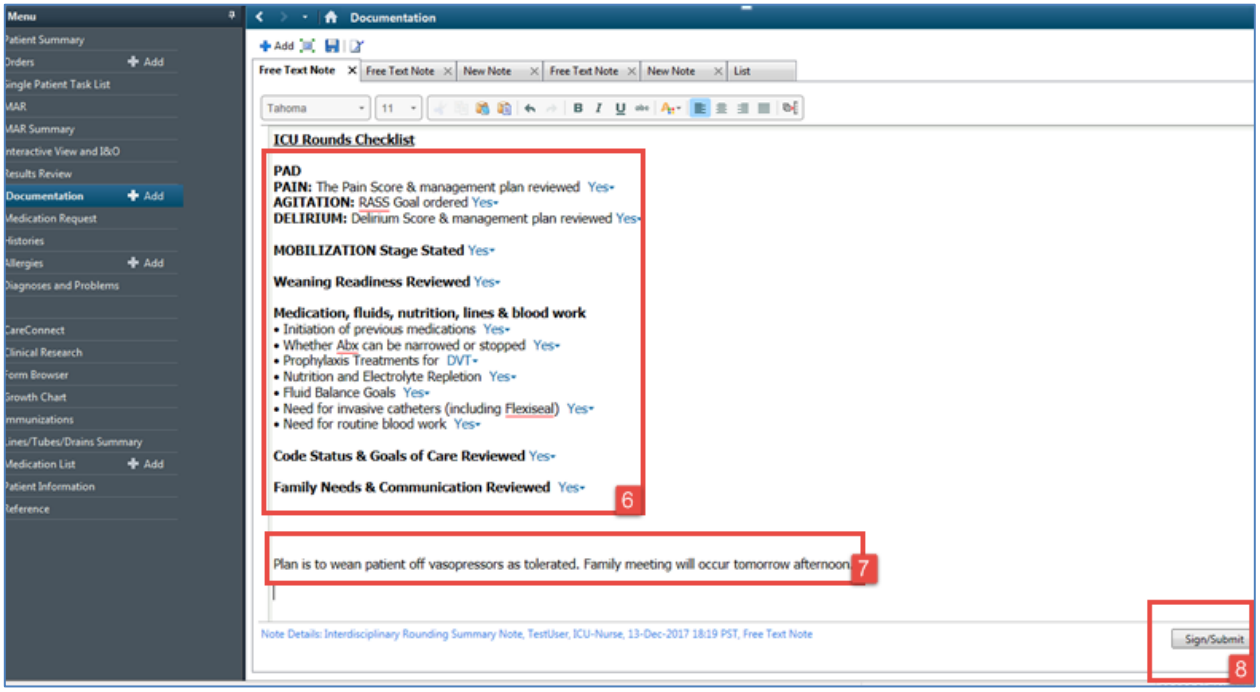
6. Go through the checklist and select **Yes** next to all of the questions that should be addressed during rounds. To do this, click on the blue **Downward Arrow** icon .

    - **Prophylaxis Treatments for** = *DVT*

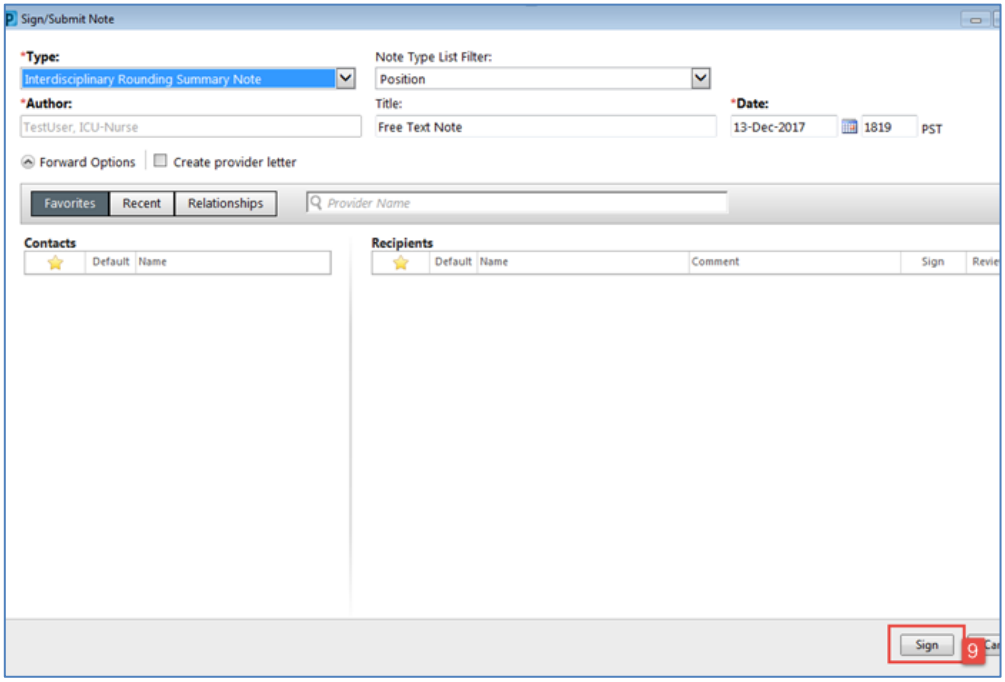
7. At the bottom of the note there is a free text area where you can type any pertinent information related to the discussion during rounds.

    - 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.



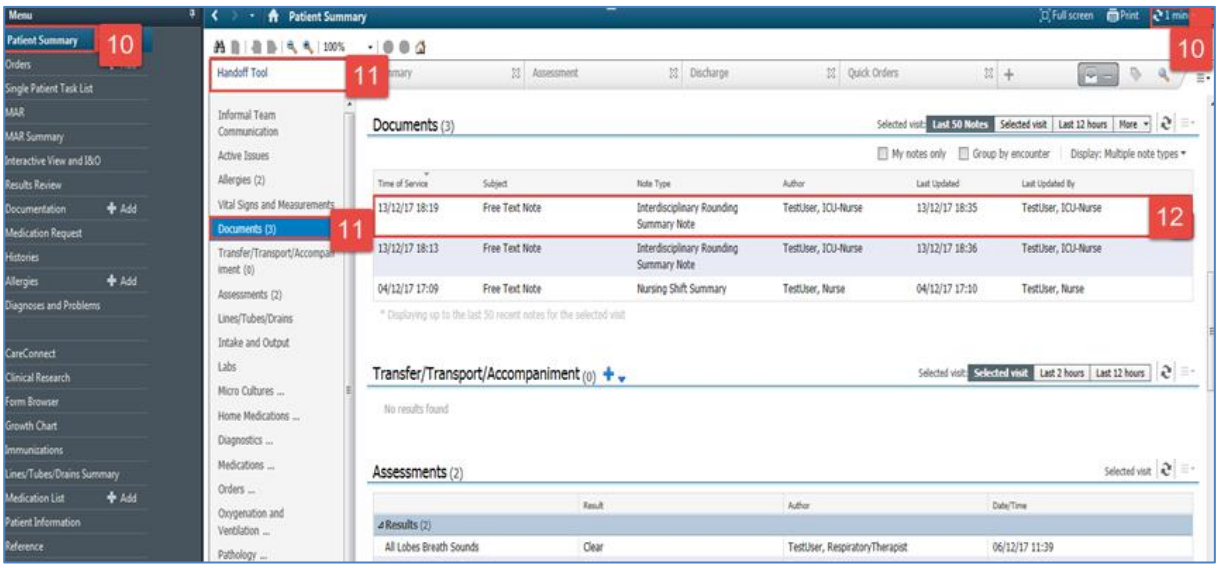
9. A **Sign/Submit Note** window will display to confirm the Note Type, Author, Date etc. Click the **Sign** button [Sign]. The note is now part of the patient's chart and can be read by other clinicians.



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.



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

Activity 16.1 – Document Informal Team Communication

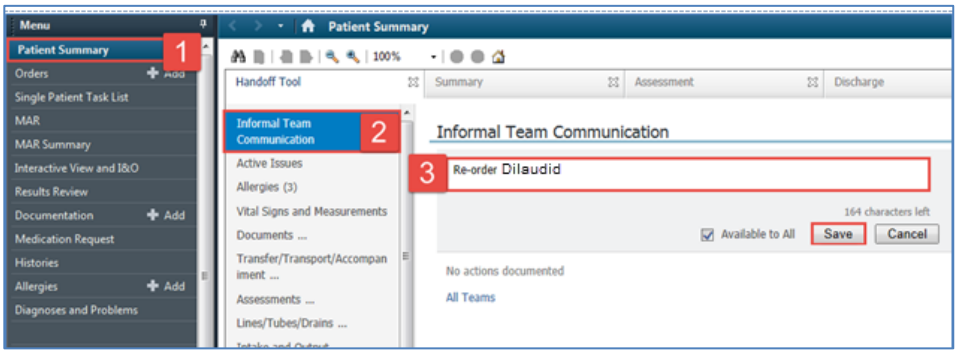
1 The **Informal Team Communication** tool can be used to add actions or comments to handover to your colleagues much like you would in a Kardex.

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

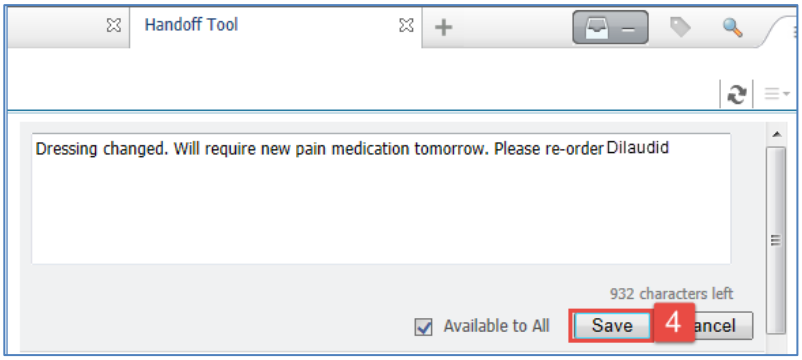
It is encouraged to use the **Add new action** section to create a list of to-do action items. Use the **Add new comment** section to leave a comment for the oncoming nurse or other team members.

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 **.**



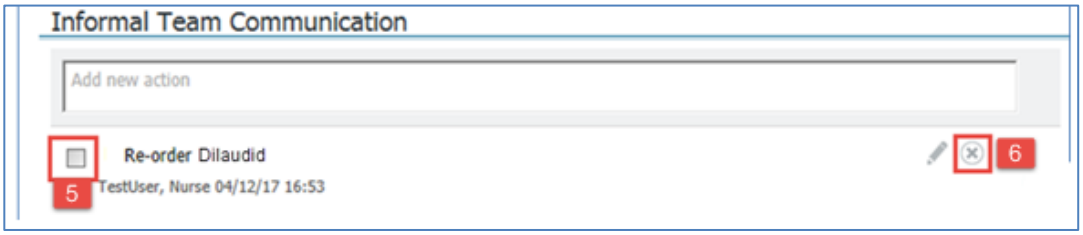
To complete a task in Informal Team Communication:

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 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.



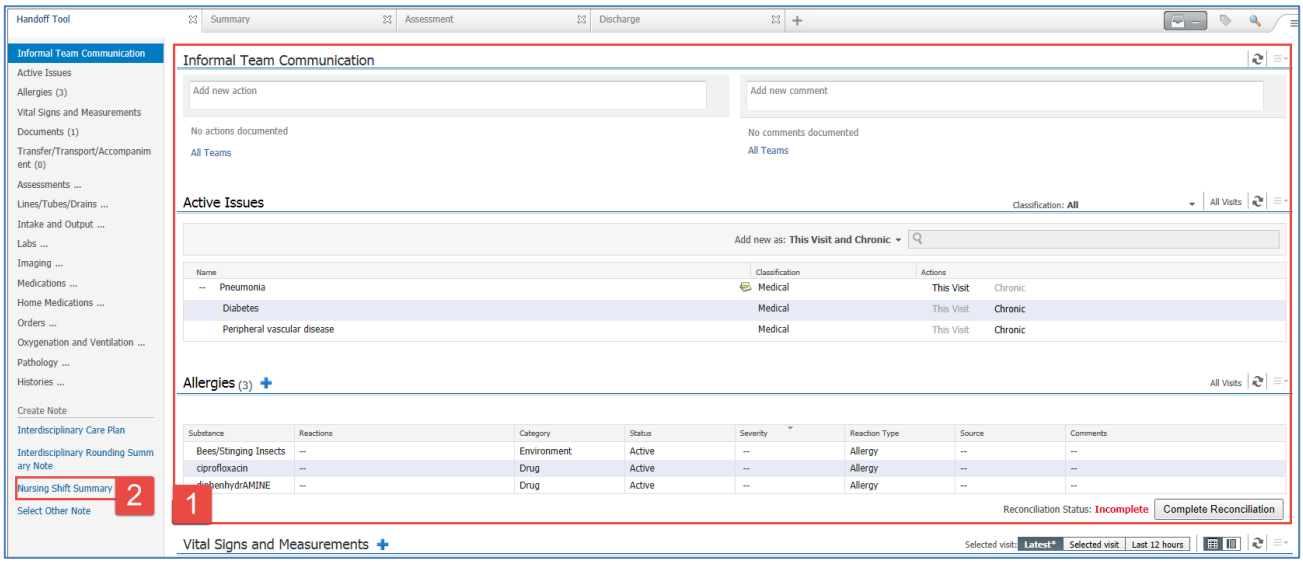
Key Learning Points

- 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

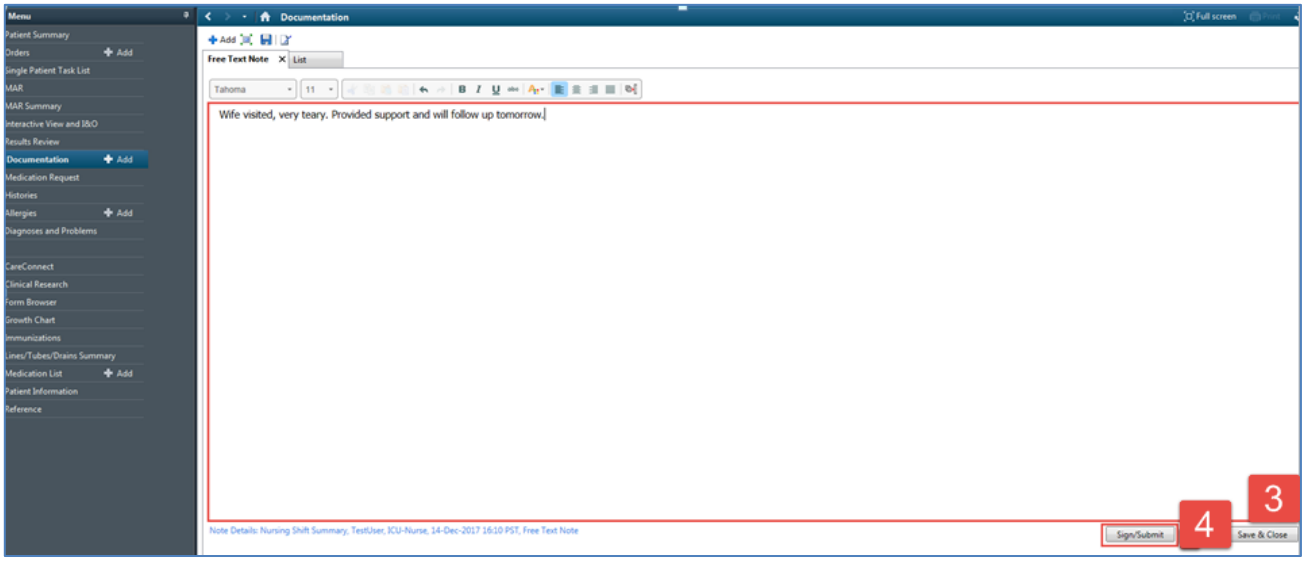
Activity 16.2 – Document Nursing Shift Summary Note

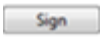
1 Nurses should document within PowerForms and iView as much as possible and should avoid duplicate documentation via narrative notes. However, a narrative note can be used to document information that may require more details that can be documented otherwise. If a **Nursing Shift Summary** note is required,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

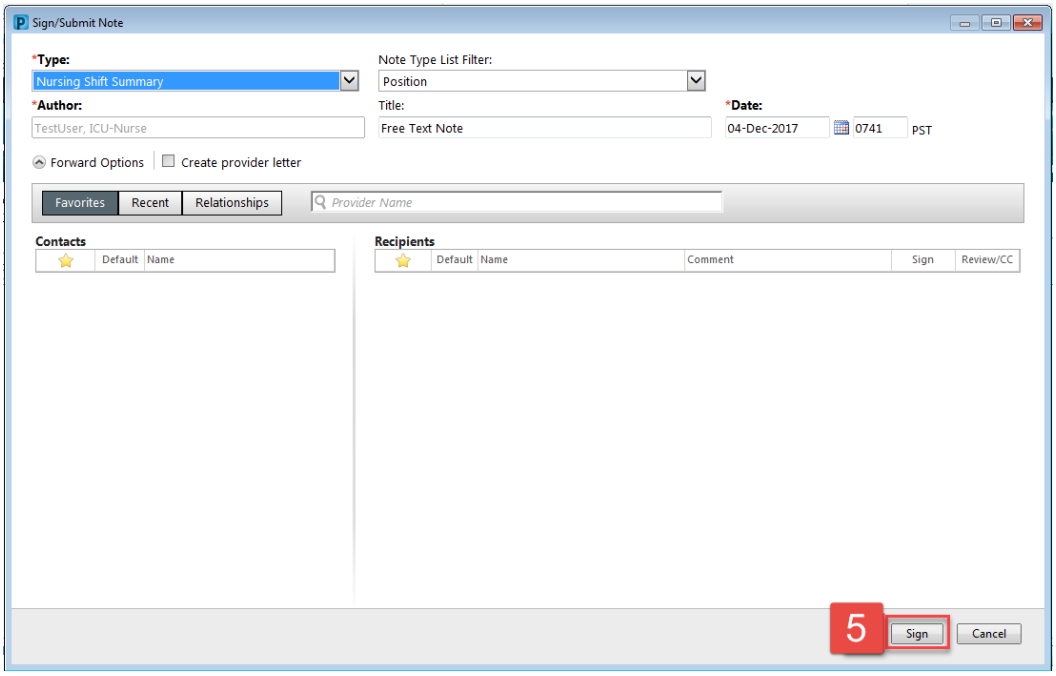
1. Review patient information in the **Handoff Tool**
2. Click on the **Nursing Shift Summary** blue link



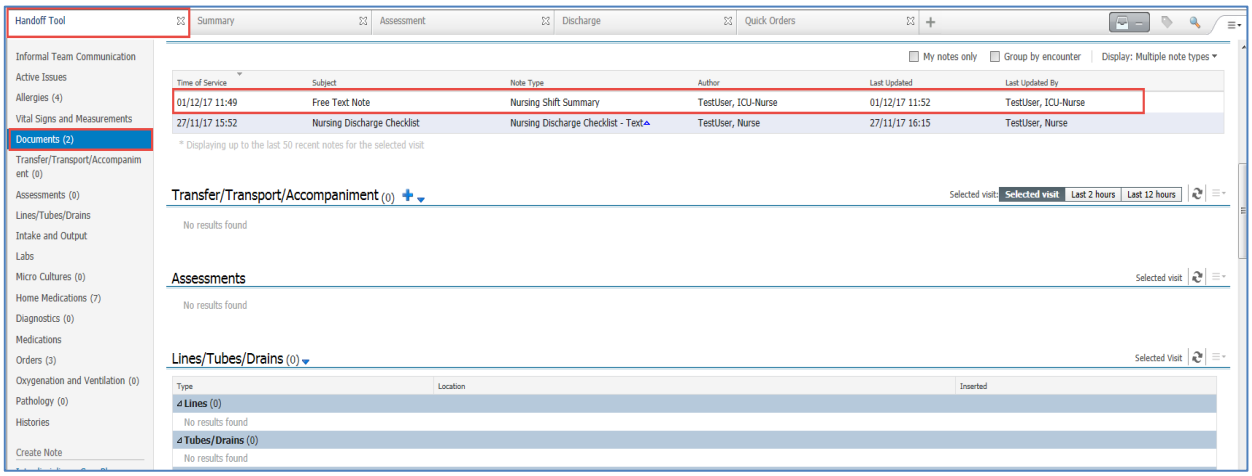
3. Enter required data. For this activity, type *Wife visited, very teary. Provided support and will follow up tomorrow.*
4. Click **Sign/Submit** button 



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

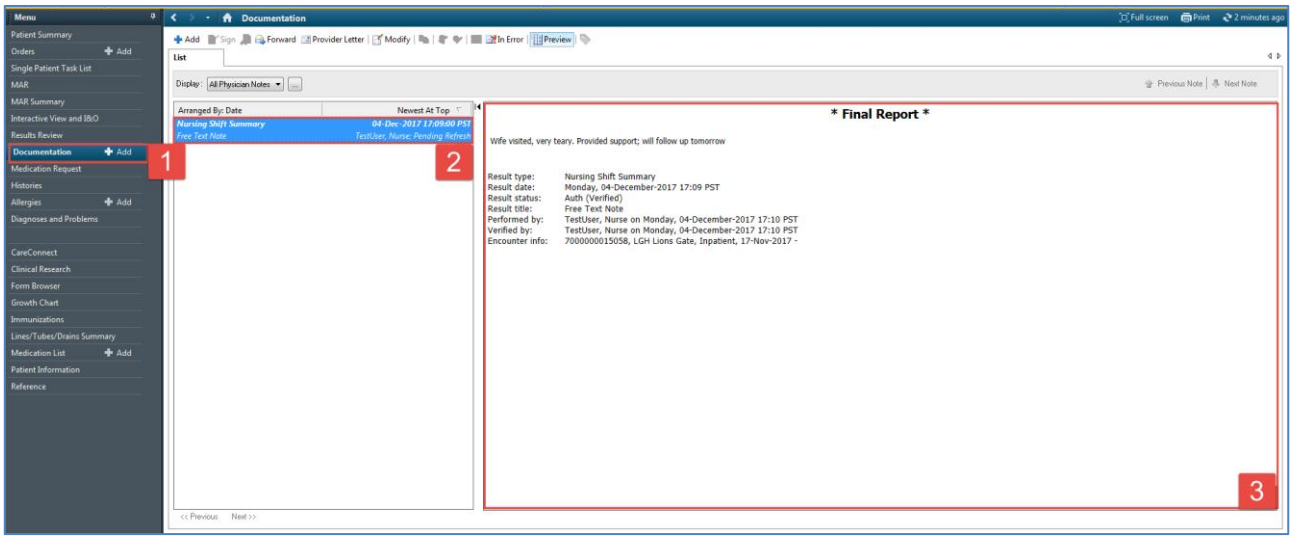


6. Click **Refresh** icon  . Once the page is refreshed, you and others will be able to see your **Nursing Shift Summary** note saved under **Documents** in the **Handoff Tool.**



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

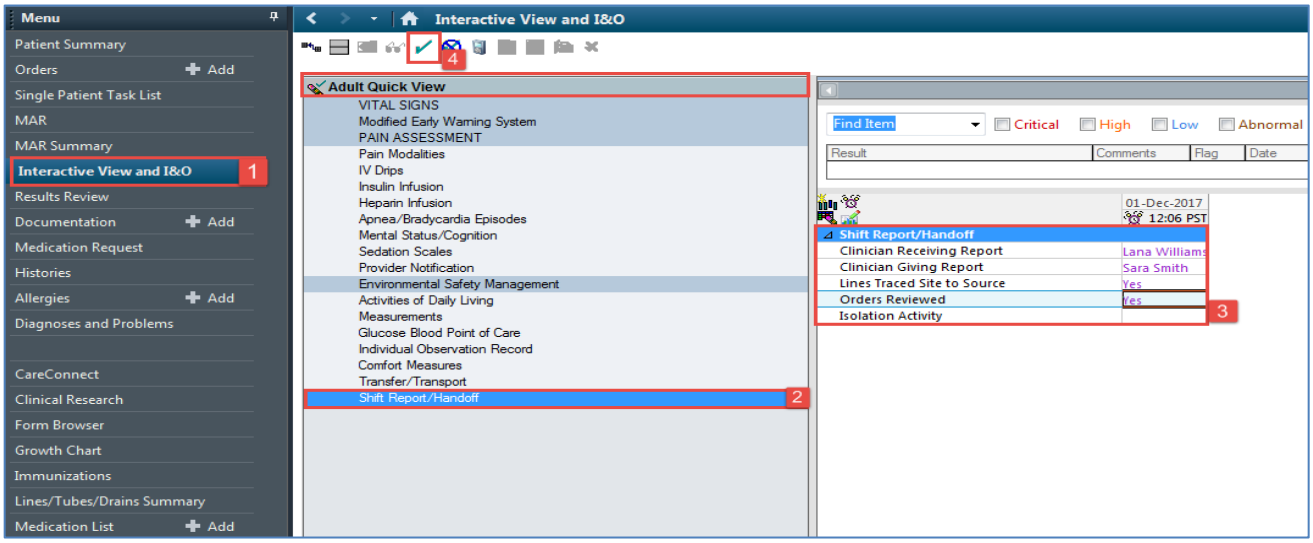
- A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses
- The note must be signed in order for it to be recorded to the patient chart and viewable by other team members
- Nurses and other team members can view signed notes from the Documentation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

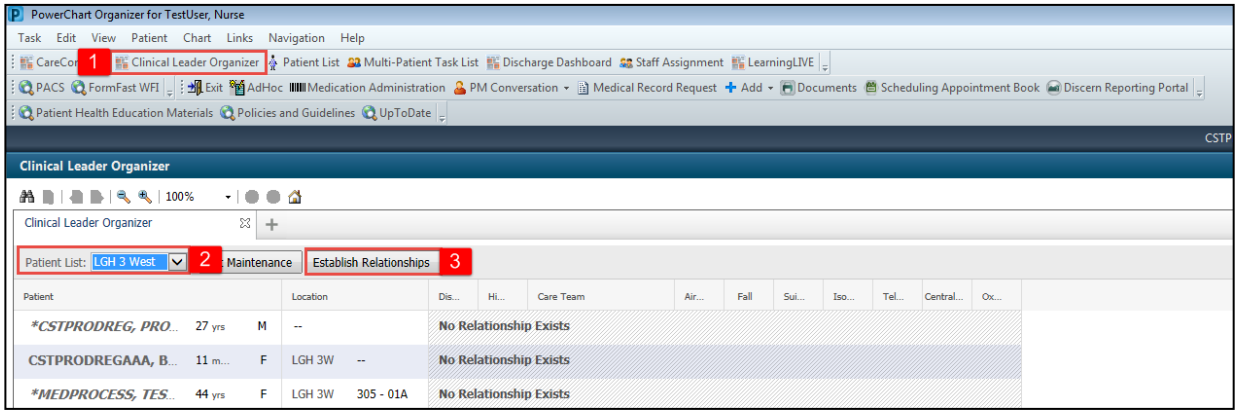
1 **Clinical Leader Organizer (CLO)** is an interactive organizer that supports communication and coordination across the continuum of care. It provides a high-level overview of patient data such as location, visit summary, risks and more. It is a very useful tool for understanding patient care goals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

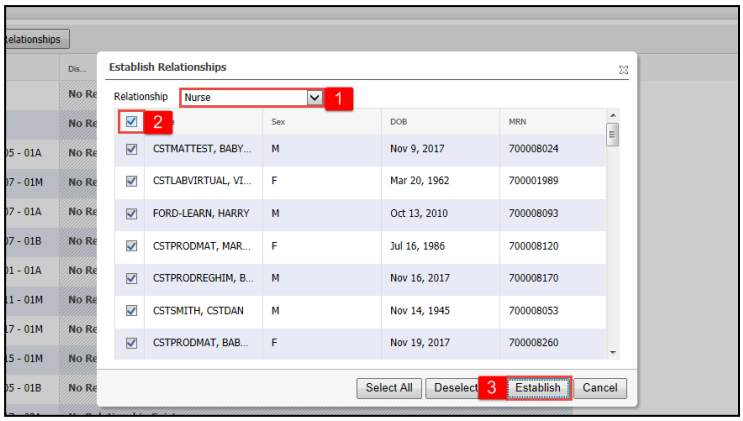
Let's review **Clinical Leader Organizer**:

1. 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**



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

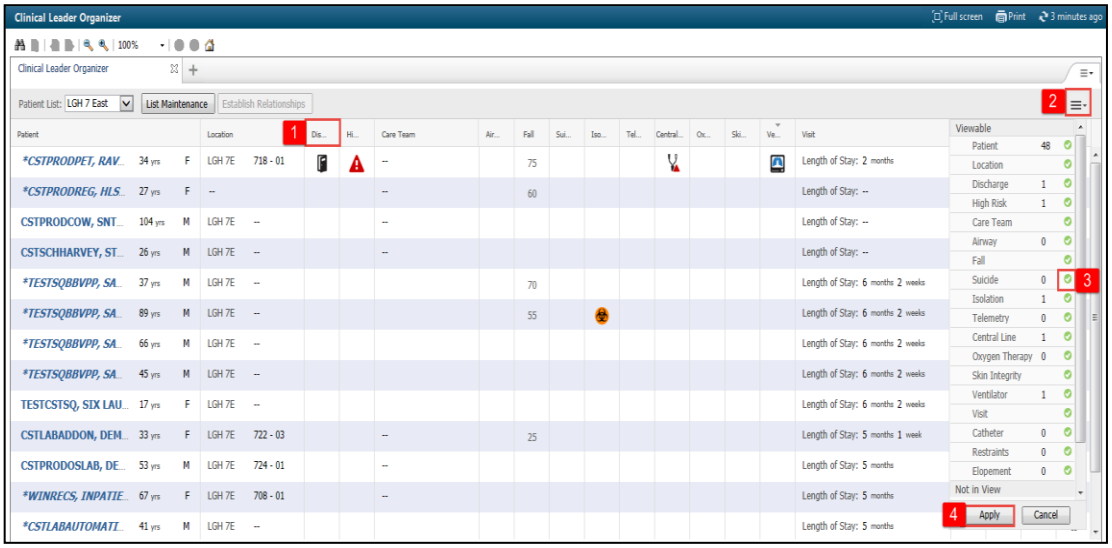
1. Select **Nurse** from the **Relationship** drop-down
2. Click top checkbox to select all patients
3. Click **Establish**



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.

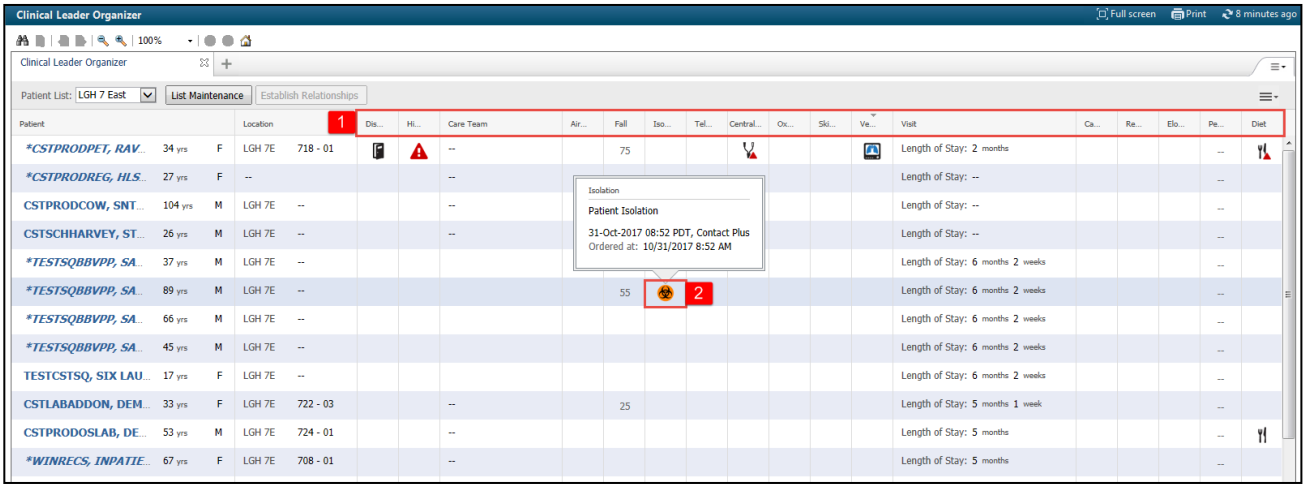
1. Hover over a column heading to see the full title of the column
2. Click the **Menu** icon 
3. Click the green check mark beside a viewable topic(s) of your choice to de-select it from the viewable columns
4. Click **Apply**

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



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



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:

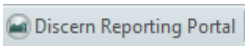
- Run a report for your unit/organization in the CIS

Activity 18.1 – Running Reports for your Unit/Organization

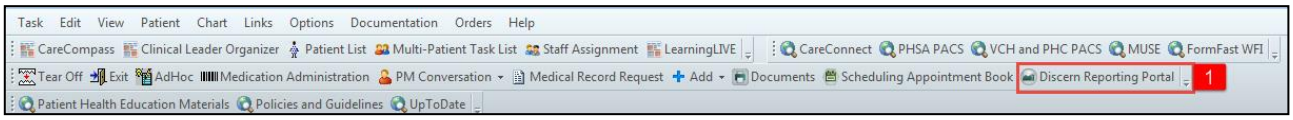
1 The reporting functionality in the Clinical Information System (CIS) allows users to run reports at a unit and/or organizational level. Reports are important for performing audits and in informing safe patient care. Some of the reports that can be generated include the following: number of falls; catheterized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

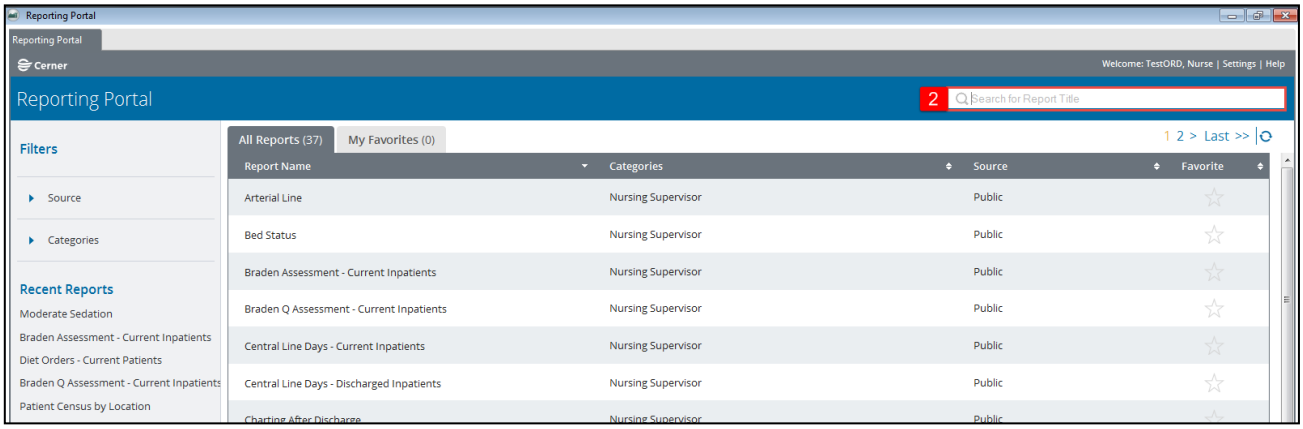
1. Navigate to **Discern Reporting** by selecting the **Discern Reporting Portal** button 

in the Toolbar to open the **Reporting Portal** window

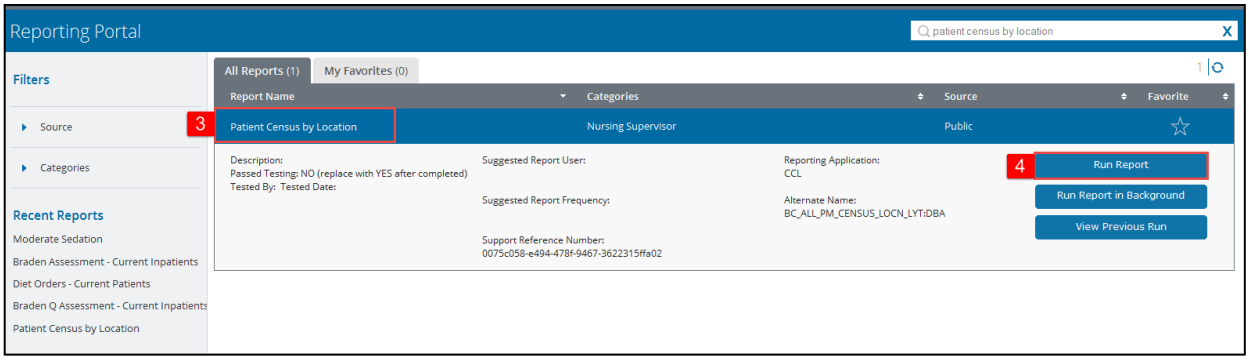


2. Locate **Patient Census by Location** by typing it into the search box

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



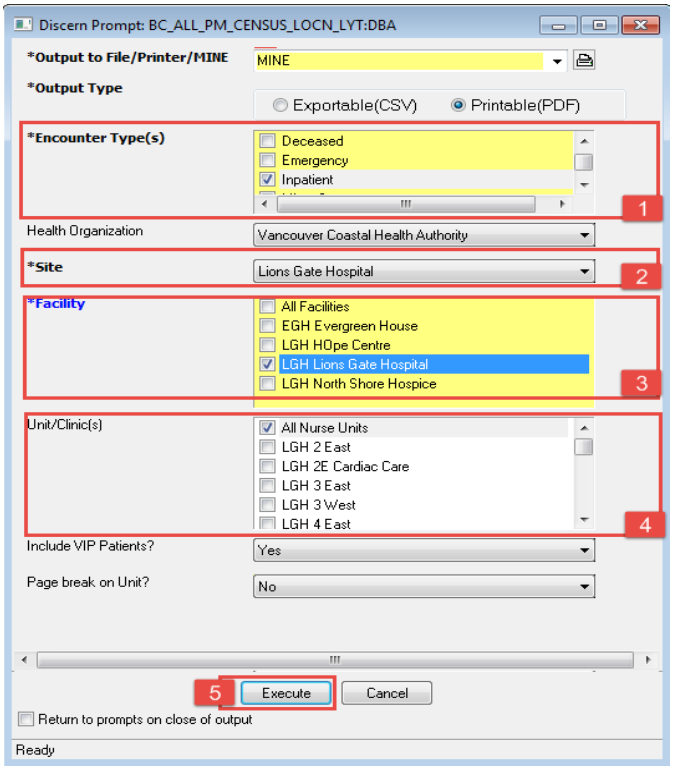
3. Click the name of the report to expand the field
4. Click **Run Report**



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

Select the following information:

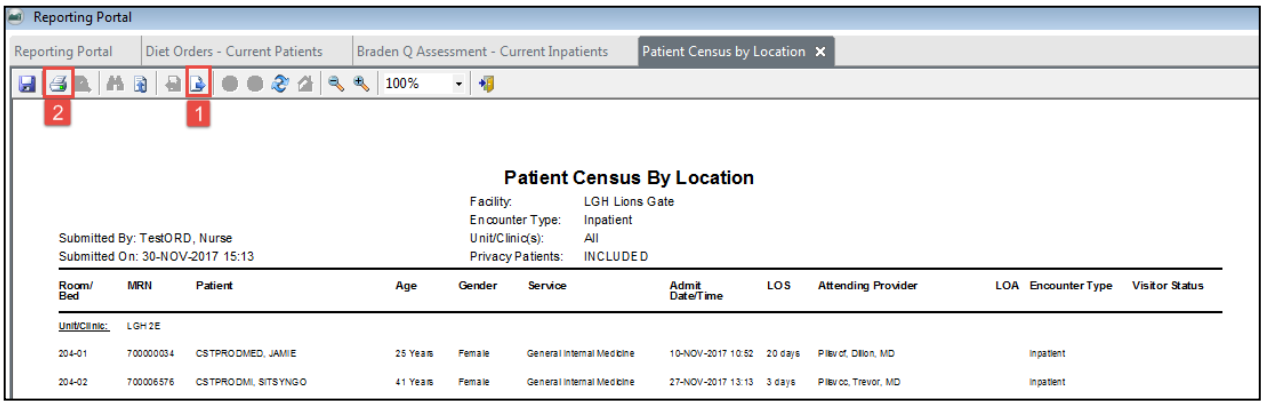
1. **Encounter Type** = *Inpatient*
2. **Site** = *Lions Gate Hospital*
3. **Facility** = *LGH Lions Gate Hospital*
4. **Unit/Clinic(s)** = *All Nurse Units*
5. Click **Execute**



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.



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

End of Workbook

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