

SELF-GUIDED PRACTICE WORKBOOK [N53]

CST Transformational Learning

WORKBOOK TITLE:

Nursing: Inpatient

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SELF-GUIDED PRACTICE WORKBOOK

Duration	8 hours
Before getting started	<ul style="list-style-type: none"> ■ Sign the attendance roster (this will ensure you get paid to attend the session). ■ Put your cell phones on silent mode.
Session Expectations	<ul style="list-style-type: none"> ■ This is a self-paced learning session. ■ A 15 min break time will be provided. You can take this break at any time during the session. ■ The workbook provides a compilation of different scenarios that are applicable to your work setting. ■ 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	<ul style="list-style-type: none"> ■ 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
-  Add a Patient from a Location Patient List to a Custom Patient List

SCENARIO

An 80 year old male presents to the ED with a fever and productive cough. He is admitted with a diagnosis of pneumonia and prescribed IV antibiotics. You begin your shift and receive the patient into your care.

As an inpatient nurse you will complete the following activities:



-  Set up a location patient list
-  Create a custom patient list

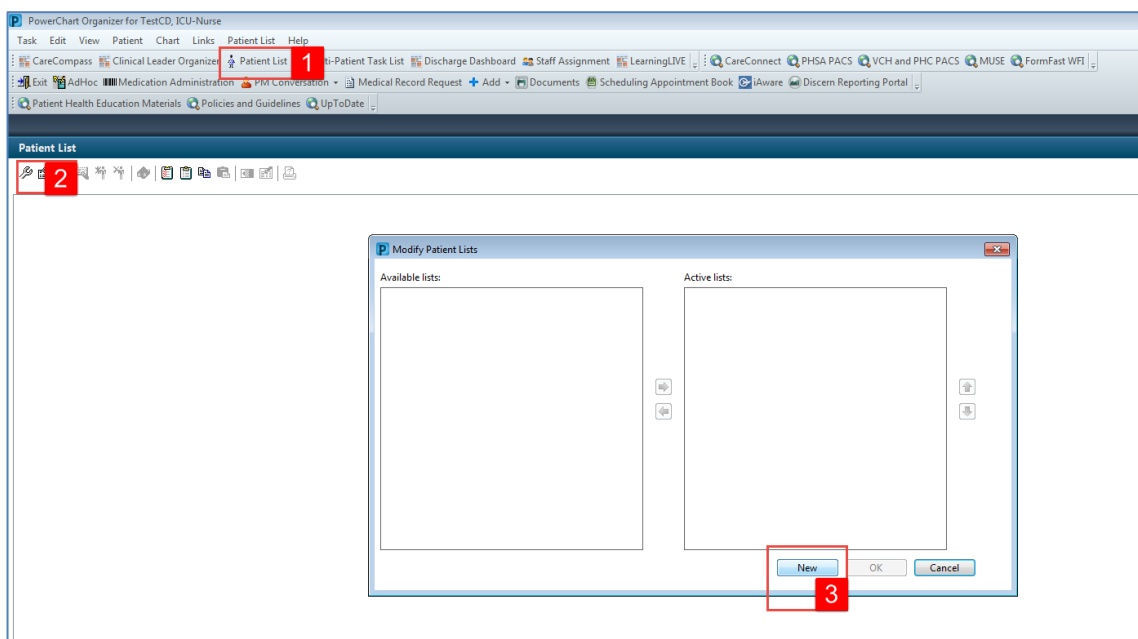
Activity 1.1 – Set Up a Location Patient List

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

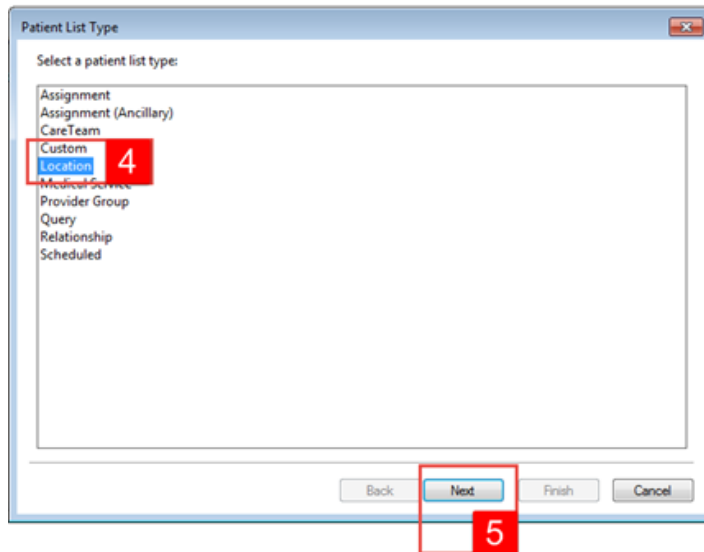
Note: if you are a Patient Care Coordinator or Charge Nurse, your landing page will be the Clinical Leader Organizer (CLO).

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

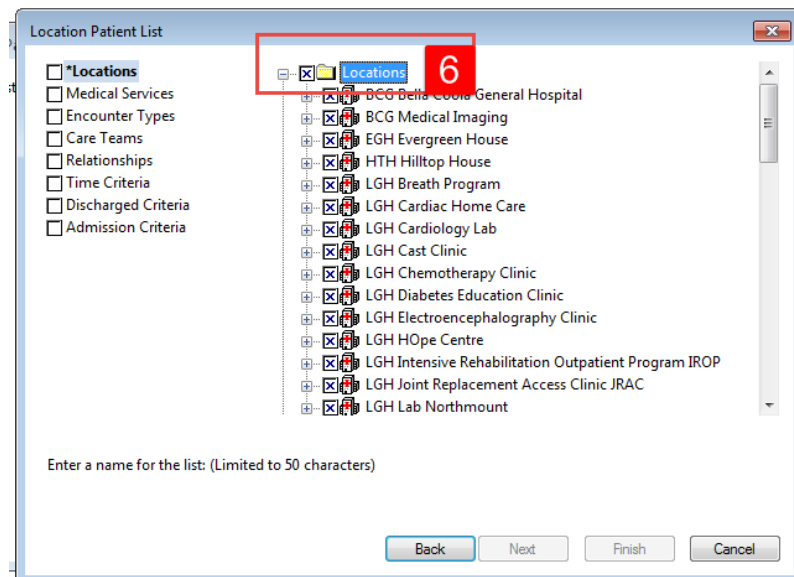


4. From the **Patient List Type** window select **Location**.
5. Click **Next**

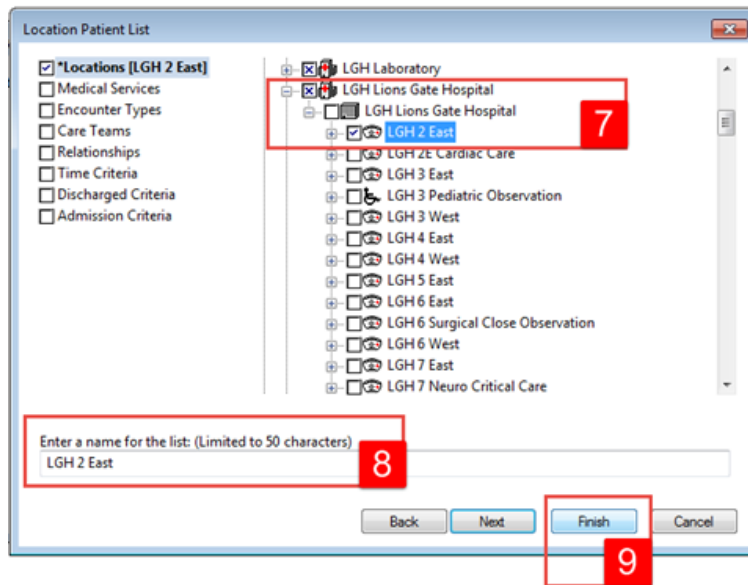



6. In the **Location Patient List** window a location tree will be on the right hand side. Expand the list of locations by clicking on the **tiny plus [+] sign** next to **Locations**.

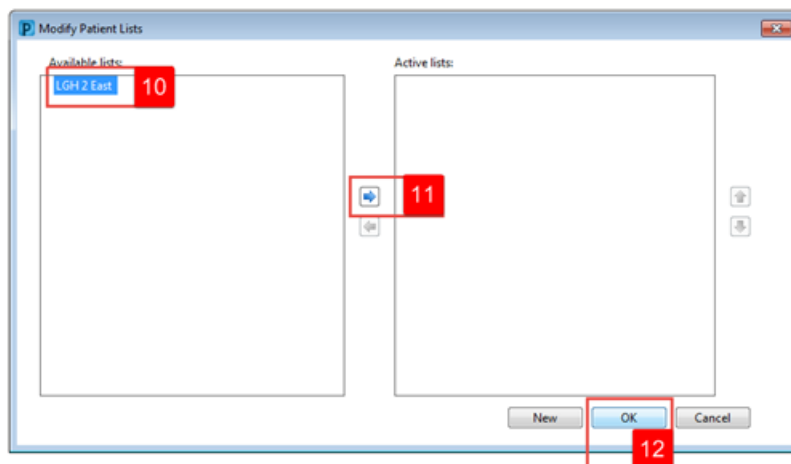
Note: Please do not rename Location Patient List. Name for Location will auto-populate.



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



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






Key Learning Points

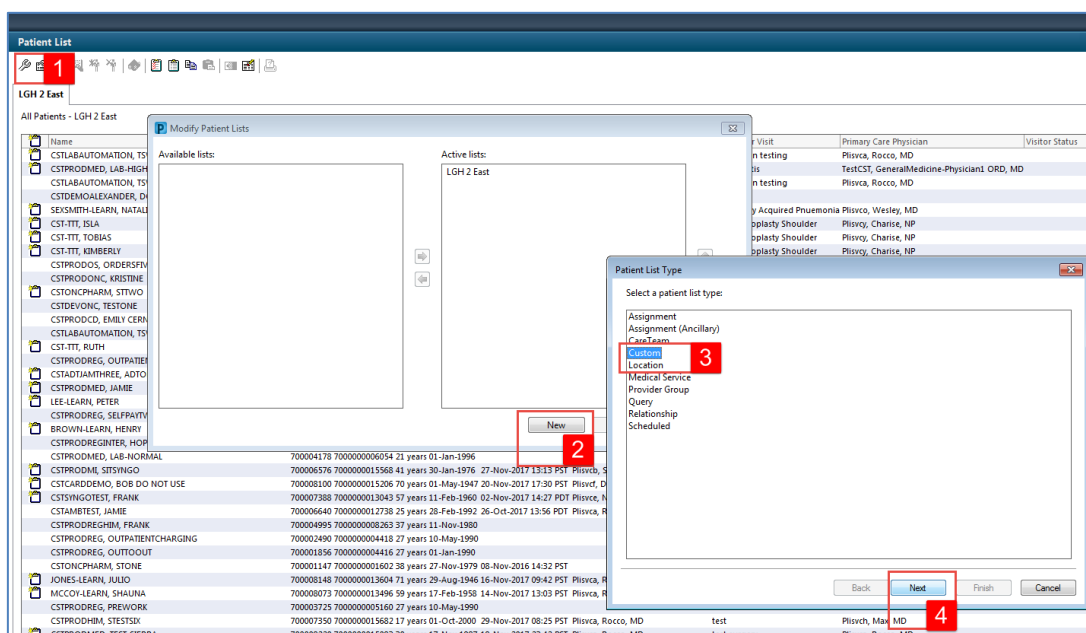
- Patient List can be accessed by clicking on the Patient List icon in the toolbar
- You can set up a patient list by location

Activity 1.2 – Create a Custom Patient List

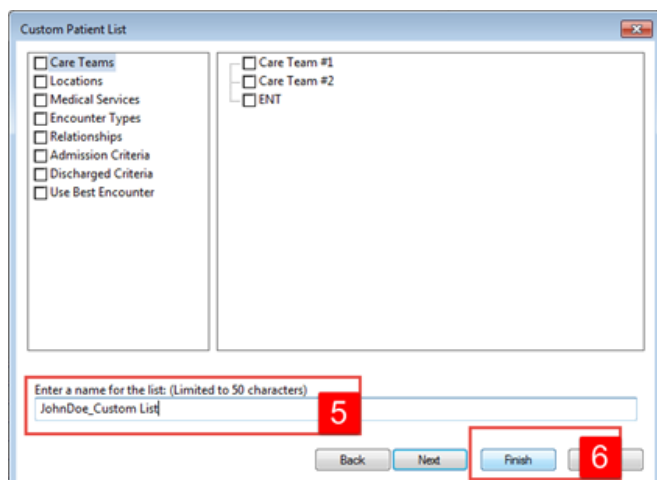
1


Next you need to create a **Custom List** that will contain only the patients under your care.

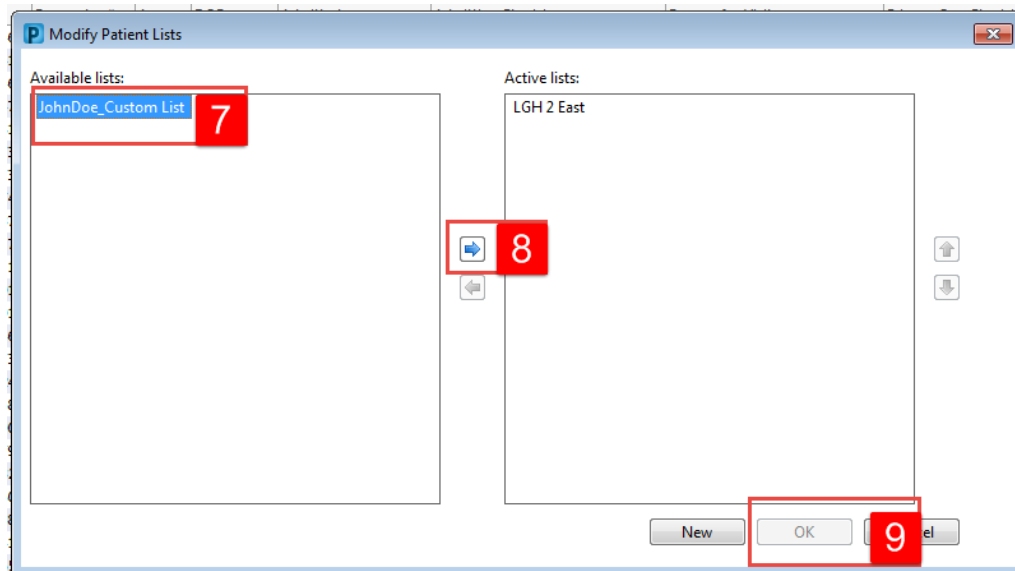
1. To create a **Custom List**, click the **List Maintenance** icon  in the **Patient List**
2. Click **New** in the bottom right corner of the **Modify Patient Lists** window
3. From the **Patient List Type** window, select **Custom**
4. Select **Next**



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



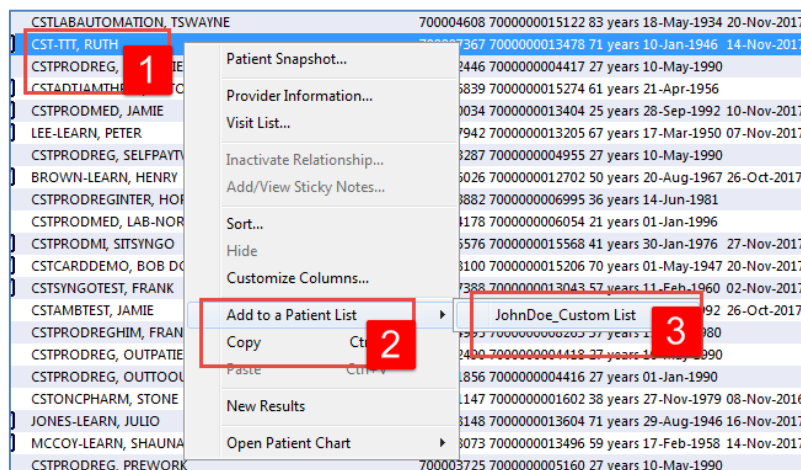
7. In the **Modify Patient Lists** window select your newly created **Custom List**
8. Click the **blue arrow** icon  to move your **Custom List** to the right, under **Active Lists**
9. Click **OK**




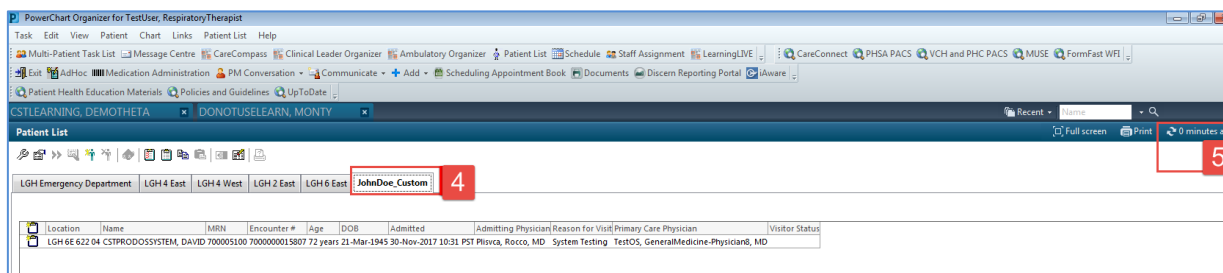
2


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

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




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



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




Key Learning Point

-  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:

-  Navigate CareCompass
-  Select the correct Patient List
-  Review and complete tasked activities

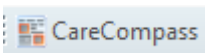
SCENARIO

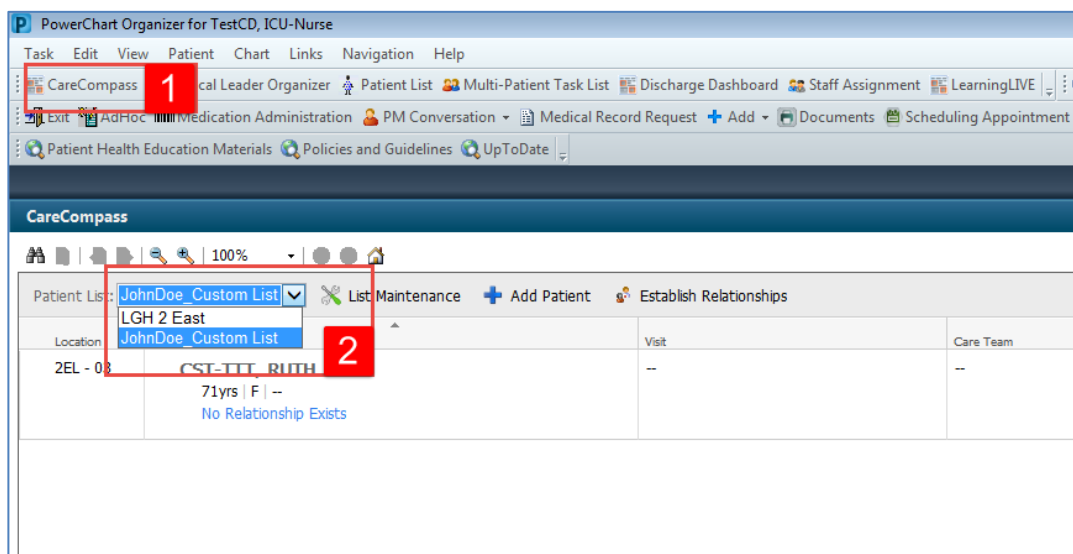
As an inpatient nurse you will complete the following activities:


-  Review CareCompass
-  Establish a relationship in the system with your patient and review patient information
-  Review and complete tasks in CareCompass

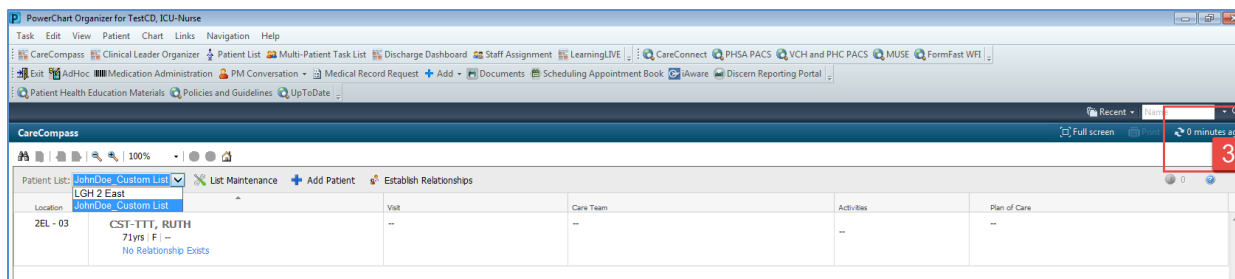
Activity 2.1 – Review CareCompass

- CareCompass** displays key information about your patients, including important details such as allergies, resuscitation status, reason for visit, and scheduled medications/tasks, orders, and results.

- Navigate back to **CareCompass** by clicking on  in the **Toolbar**
- Select **YourName_Custom** from the **Patient List** drop-down

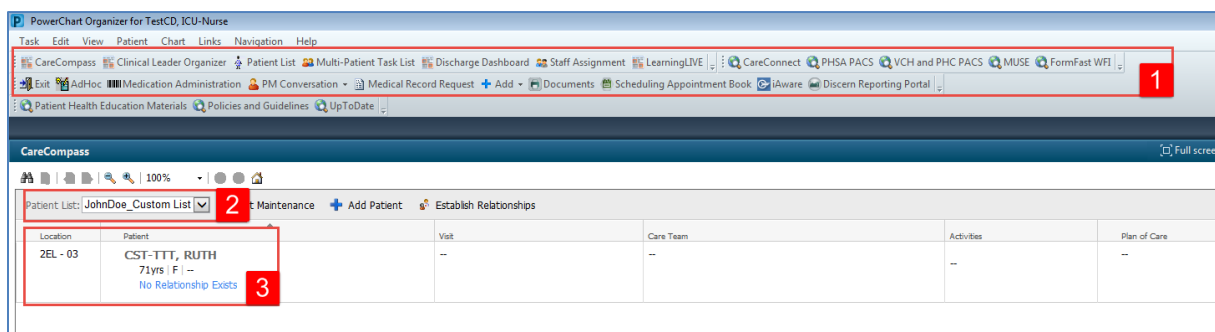


- Click the **Refresh** icon . Your patient is now visible on your custom list.



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. (You will establish a relationship in the next activity.)



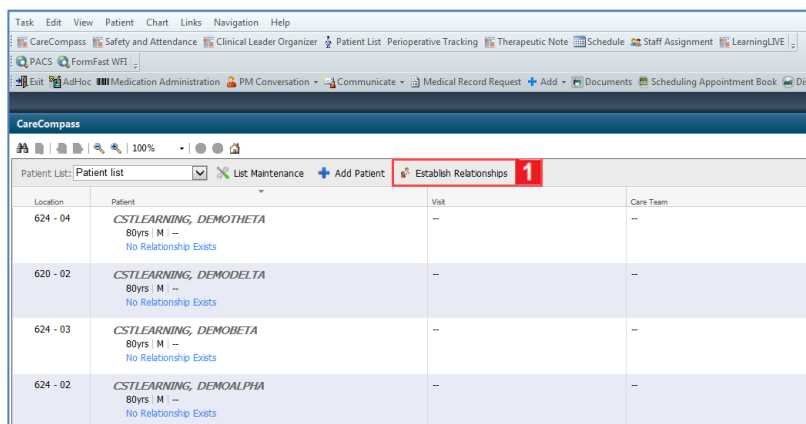
Key Learning Points

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

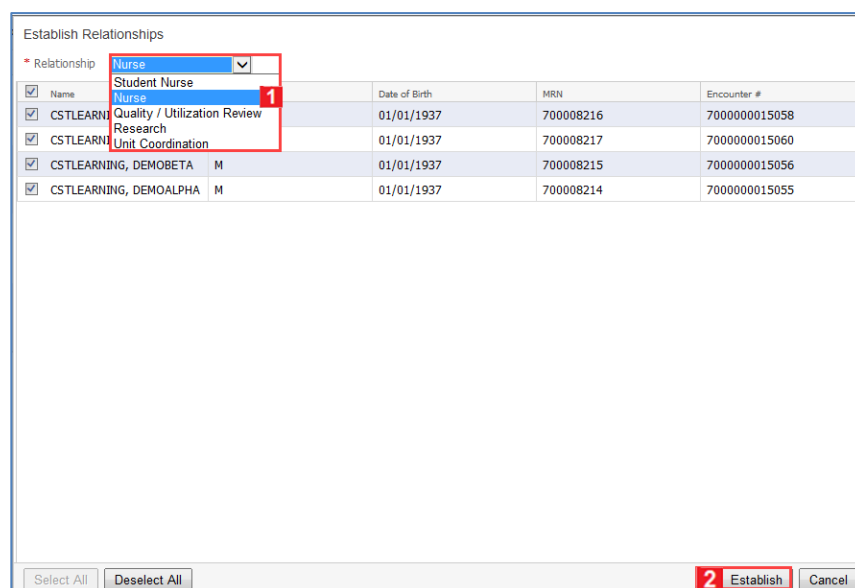
Activity 2.2 – Establish a Relationship and Review Patient Information in CareCompass

- 1 Now that you have created your custom 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
 1. From the **Relationship** drop-down select **Nurse**
 2. Click **Establish**

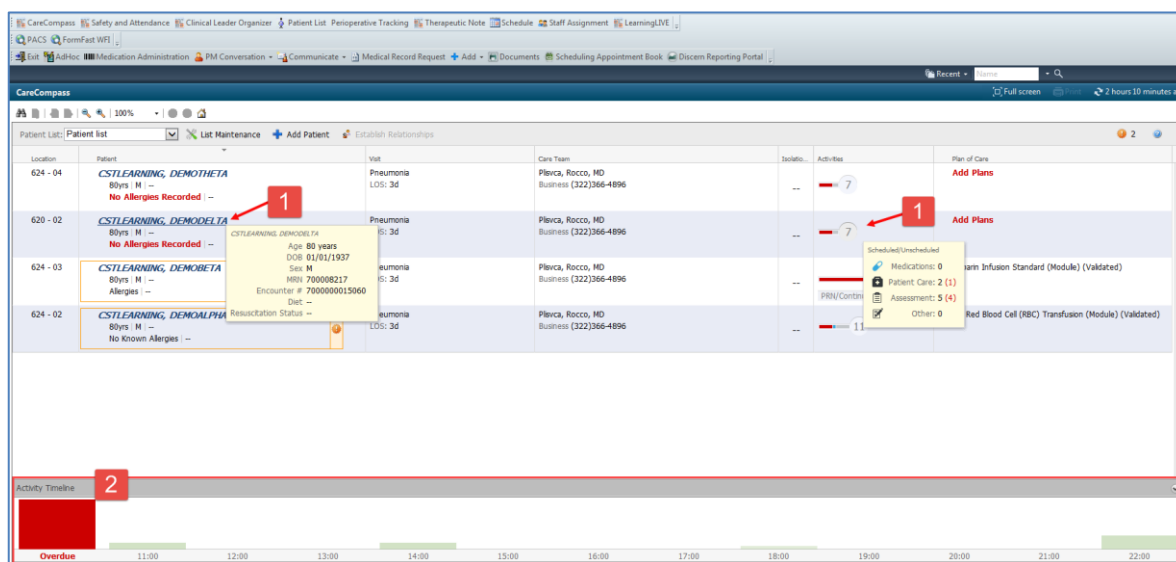


Once a relationship is established with your patients, additional information will appear on CareCompass.

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

3 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**. It provides a visual representation of certain activities that are due for the patients on your list.

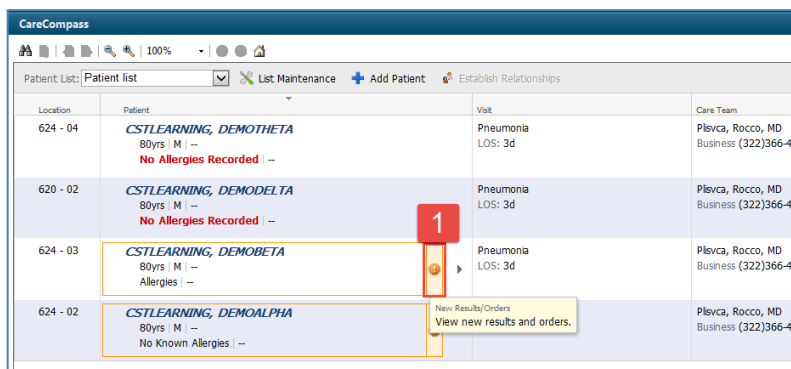


4 Notice the **orange exclamation** symbol next to your patient's name. This indicates that there are new orders and/or results requiring review. Note that there is also an exclamation mark on the top right corner of the **CareCompass** page, this shows the total number of patients with new orders.

Note: Indicates new critical results or STAT/NOW orders.

Indicates new non-critical results or orders for a patient.

1. Click the **orange exclamation** symbol.





5

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

Once you have marked the orders as reviewed, you are taken back to **CareCompass** and the orange exclamation symbol 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
-  Indicates new critical results or STAT/NOW orders

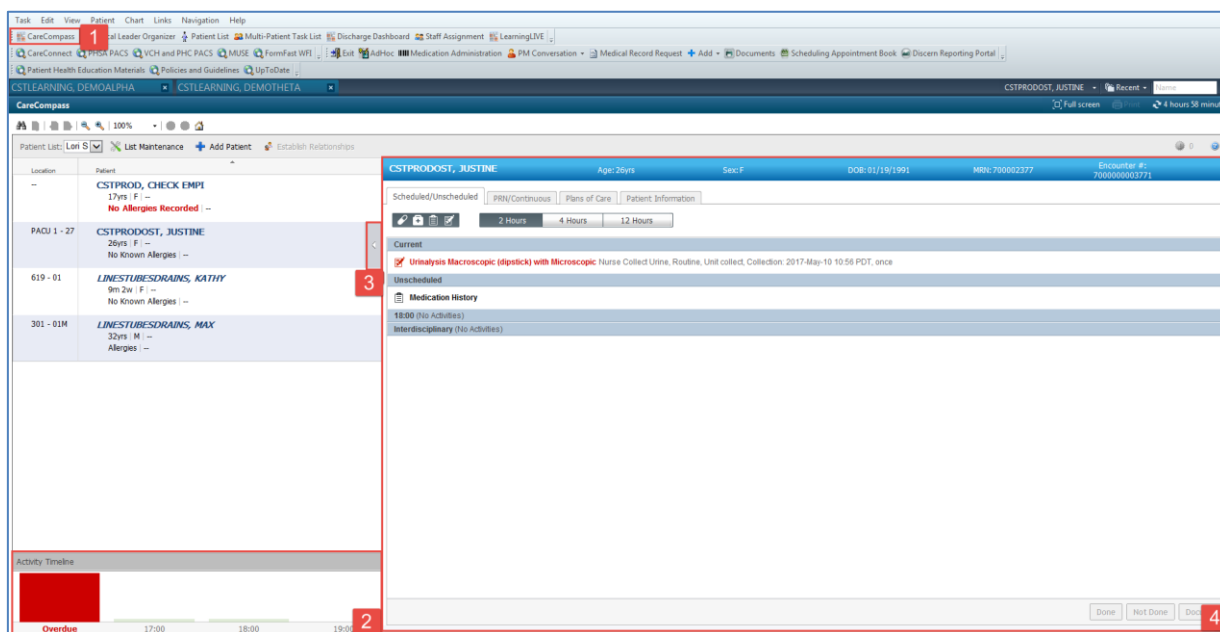
Activity 2.3 – Review and Complete Tasks in CareCompass

- 1 Tasks are activities that need to be completed for the patient. Tasks are generated by certain orders or rules in the system and are displayed in a list format so clinicians are reminded to complete specific patient care activities. They are meant to supplement your current paper to-do list and highlight activities that are outside of regular care.

Note: Not all orders trigger tasks. For example, vital signs assessments are part of routine daily care and are not tasked. Sputum specimen collection however is not a regular occurrence and is tasked.

Let's locate tasks for your patient:

1. Ensure you are viewing **CareCompass**.
2. Scheduled tasks for multiple patients are summarized in the **Activity Timeline**. (You can click on the red or light green shaded bars to view task details.)
3. Click the **grey forward arrow**  to the right of your patient's name to open the single patient task list.
4. Review the tasks for your patient in the task box.



The screenshot displays the CareCompass web application. At the top, there is a navigation bar with various icons and links. Below this, a sidebar on the left shows a list of patients. The main area is divided into two sections. The top section, labeled 'Activity Timeline', shows a horizontal bar with a red segment and a green segment. The bottom section, labeled 'Task List', displays a list of tasks for a selected patient, 'CSTPRODOST, JUSTINE'. The tasks are categorized into 'Current' and 'Unscheduled'. The 'Current' task is 'Unanalysis Macroscopic (stippled) with Microscopic Nurse Colled Urine, Routine, Unit colled, Collection: 2017-May-10 10:58 PDT, once'. The 'Unscheduled' task is 'Medication History'. The interface includes various filters and search options, and a 'Done' button at the bottom right.

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

To see different information you can navigate between:

1. **Scheduled/Unscheduled tasks tab**
2. **PRN/Continuous tab**
3. **Plans of Care tab**
4. **Patient Information tab**

The screenshot displays the CareCompass software interface. On the left, a 'Patient List' shows four entries for 'CSTLEARNING, DEMODELTA' with various identifiers. The main panel on the right is titled 'CSTLEARNING, DEMODELTA' and features four tabs at the top, numbered 1 through 4: 'Scheduled/Unscheduled', 'PRN/Continuous', 'Plans of Care', and 'Patient Information'. The 'Scheduled/Unscheduled' tab is active, showing a list of tasks under 'Current' and 'Unscheduled' sections. The 'Current' section includes 'Basic Admission Information Adult', 'Admission History Adult', 'Braden Assessment', 'Infectious Disease Screening', and 'Morse Fall Risk Assessment'. The 'Unscheduled' section includes 'Values and Belongings' and 'Admission Discharge Outcomes Assessment'. At the bottom left, an 'Activity Timeline' shows a red bar for 'Overdue' and a green bar for '14:00'. The bottom right has buttons for 'Done', 'Not Done', and 'Document'.

Note: When a patient is admitted, the Clinical Information System automatically generates multiple admission tasks. These tasks are tailored to the patient's age and location. **Basic Admission Information Adult** is one of these tasks.

Complete the **Basic Admission Information Adult** task:

5. Select **Basic Admission Information Adult**
6. Click **Document**

Note: If a task is associated with documentation, clicking **Document** takes you directly to the appropriate documentation within the patient's chart. Basic Admission Information is documented using a PowerForm (a standardized electronic documentation form). Clicking **Document** takes you directly to the form.

3

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

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

To complete this PowerForm:

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

Basic Admission Information - CSTLEARNING, DEMODELTA

*Performed on: 20-Nov-2017 1537 PST By: TestUser, Nurse

Allergies

Weight

Medication History

1 Mark All as Reviewed


2

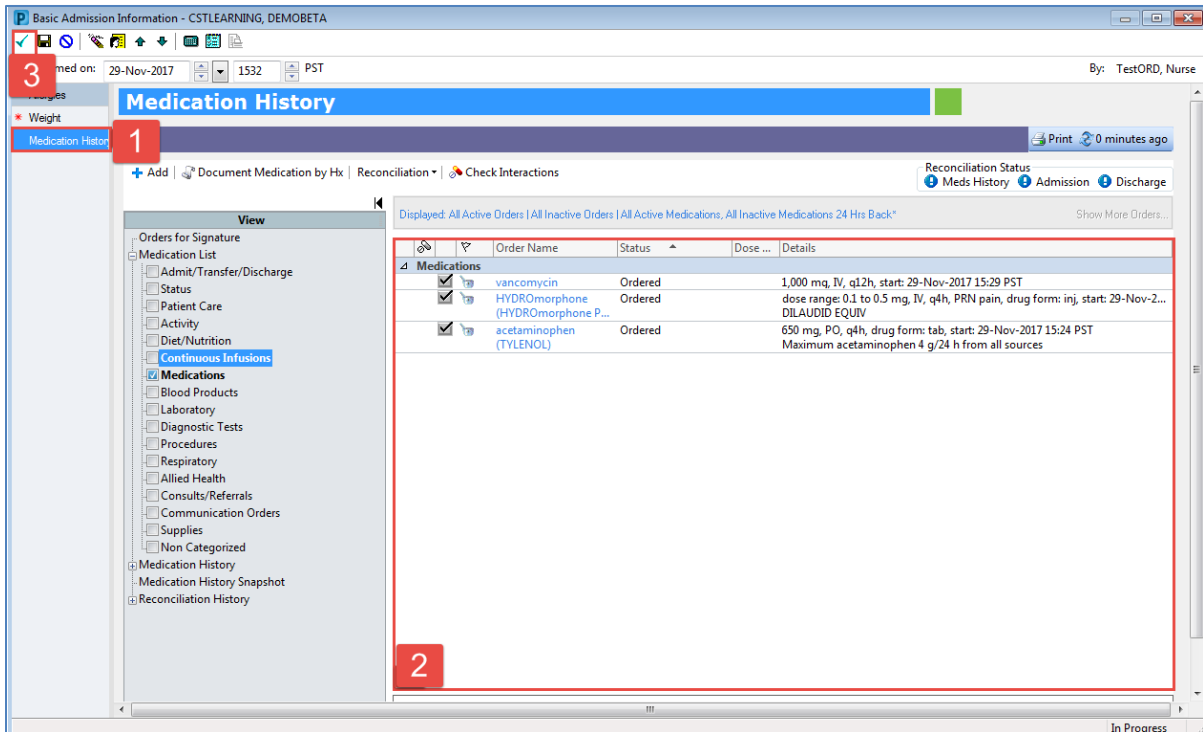
+ Add Modify No Known Allergies No Known Medication Allergies Reverse Allergy Check Display All

D/A	Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status
	No Known Allergies	Drug						Active

In Progress

4

1. Select **Medication History**
2. Review current medications that are ordered for your patient.
3. Click the **green checkmark** ✓ to sign your documentation and **Refresh** icon  to refresh the page. After signing the **PowerForm**, you will be brought back to **CareCompass**. Completing this documentation has removed the **Basic Admission Information Adult** task from the patient's task list.



Basic Admission Information - CSTLEARNING, DEMOBETA

med on: 29-Nov-2017 1532 PST By: TestORD, Nurse

Medication History

Print 0 minutes ago

Reconciliation Status: Meds History Admission Discharge

Displayed: All Active Orders | All Inactive Orders | All Active Medications, All Inactive Medications 24 Hrs Back*

Show More Orders...

Order Name	Status	Dose ...	Details
vancomycin	Ordered	1,000 mg, IV, q12h, start: 29-Nov-2017 15:29 PST	
HYDROMORPHONE (HYDROMORPHONE P...)	Ordered	dose range: 0.1 to 0.5 mg, IV, q4h, PRN pain, drug form: inj, start: 29-Nov-2...	
acetaminophen (TYLENOL)	Ordered	650 mg, PO, q4h, drug form: tab, start: 29-Nov-2017 15:24 PST	Maximum acetaminophen 4 g/24 h from all sources

Orders for Signature

- Medication List
- Admit/Transfer/Discharge
- Status
- Patient Care
- Activity
- Diet/Nutrition
- Continuous Infusions
- Medications
- Blood Products
- Laboratory
- Diagnostic Tests
- Procedures
- Respiratory
- Allied Health
- Consults/Referrals
- Communication Orders
- Supplies
- Non Categorized
- Medication History
- Medication History Snapshot
- Reconciliation History

In Progress

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.

Information documented in the BPMH pulls forward into the Admission Medication Reconciliation that the provider will complete.


5 Let's complete another admission task.

Complete the **Morse Fall Risk Assessment** task:

1. Select **Morse Fall Risk Assessment**
2. Click **Document**

Note: Clicking **Document** for Morse Fall Risk Assessment takes you directly to Interactive View and I&O to complete the appropriate documentation. Interactive View and I&O provides access to a variety of electronic flowsheets for documenting patient care, assessments, vital signs and intake/output.

6 Clicking **Document** takes you into the patient chart and to the appropriate documentation section.

1. Double-click the blue box  next to the section name **Morse Fall Score**. The entire section is now active for documentation, allowing you to move through the cells by pressing Enter on the keyboard after entering a value.

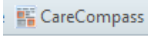
Document using the following data:

- **History of Fall in Last 3 Months Morse** = Yes
- **Type of Fall Morse** = *Unanticipated physiological*
- **Activity at Time of Fall Morse** = *Dressing/undressing*
- **Secondary Diagnosis Morse** = Yes
- **Use of Ambulatory Aid Morse** = *Crutches, cane, walker*
- **IV or IV Lock** = No
- **Gait Weak or Impaired Fall Risk Morse** = *Weak*
- **Mental Status Fall Risk Morse** = *Oriented to own ability*

A **Morse Fall Risk Score** is automatically calculated based on information input during documentation. Note for this activity the calculated score is **65**.

- Click the **green checkmark** ✓ to sign your documentation. You will notice that your documentation changes from purple text to black text once signed. This means it is now recorded to the patient chart.

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

- Navigate back to **CareCompass** by clicking  in the Toolbar
- Open the task box
- Select **Urine Culture (Urine C&S)**
- Click **Done**. A **Nurse Collect** box appears. Review the information and click **OK**.

Note: For the purpose of this workbook, all additional Admission tasks will not be addressed. In your clinical setting these admission tasks will need to be completed. It is important to review CareCompass and patient task lists throughout your shift to ensure timely review of new orders, tasks and more.

Key Learning Points

- 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
- Tasks can be viewed and completed from CareCompass
- Completing a task will remove it from the patient task list
- CareCompass should be reviewed frequently throughout the shift

PATIENT SCENARIO 3 – Accessing and Navigating the Patient Chart

Learning Objectives

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

- Access the patient's chart from CareCompass
- Navigate the patient's chart to learn more about the patient

SCENARIO

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

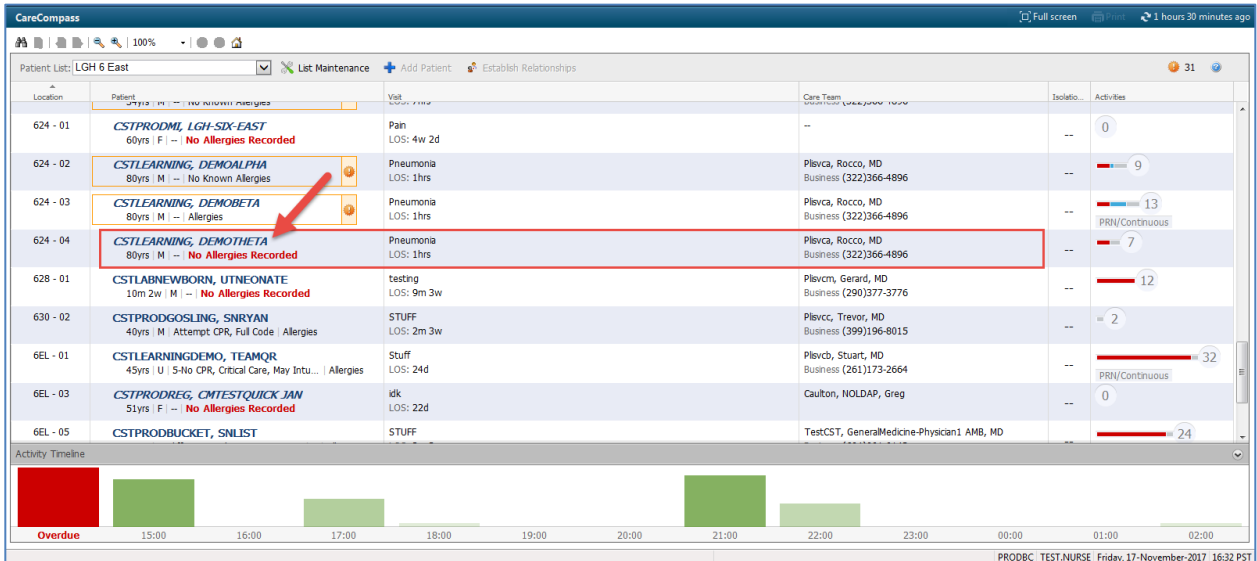
As an inpatient nurse you will be completing the following activities:

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

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


1

From **CareCompass**, click on patient's name to access the patient chart.



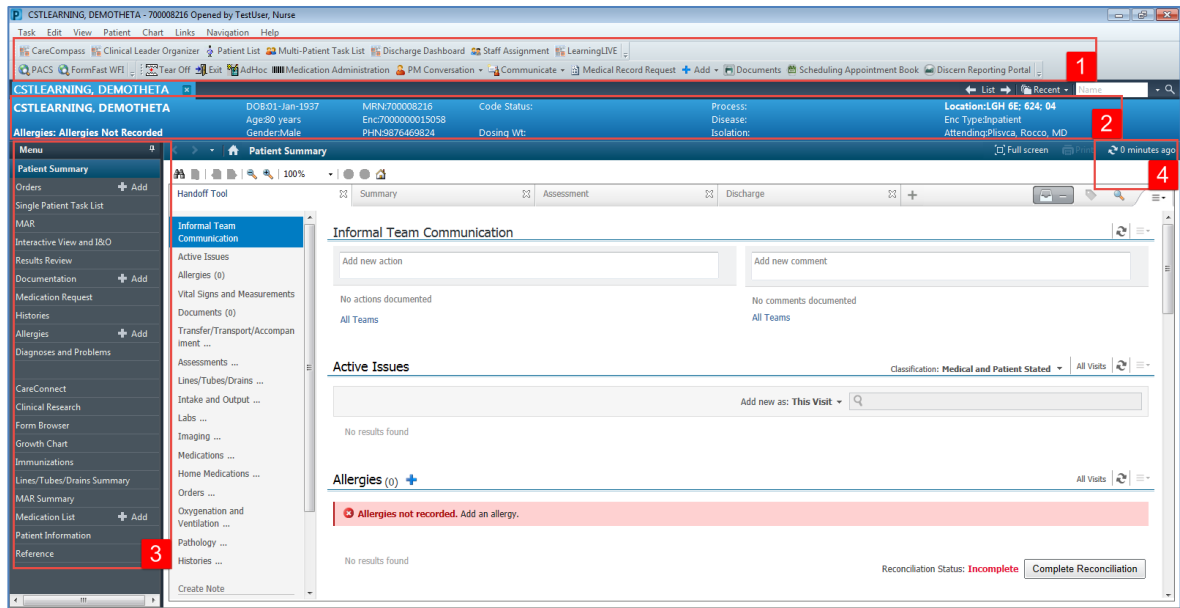
2

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 Informatics System.
2. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information displayed includes:
 - Name
 - Allergies
 - Age, date of birth, etc.
 - Encounter type and number
 - Code status
 - Weight
 - Process, disease and isolation alerts
 - Location of patient
 - Attending Physician
3. The **Menu** on the left allows access to different sections of the patient chart. This is similar to the coloured dividers within a paper-based patient chart. Examples of sections include Orders, Medication Administration Record (MAR) and more.
4. The **Refresh** icon  updates the patient chart with the most up to date entries when clicked. It is important to refresh the chart frequently especially as other clinicians may be accessing and documenting in the patient chart simultaneously.

PATIENT SCENARIO 3 – Accessing and Navigating the Patient Chart

Note: The chart does not automatically refresh. When in doubt, refresh!



The screenshot displays the CST Learning Patient Chart interface for a patient named Demotheta. The interface is divided into several sections:

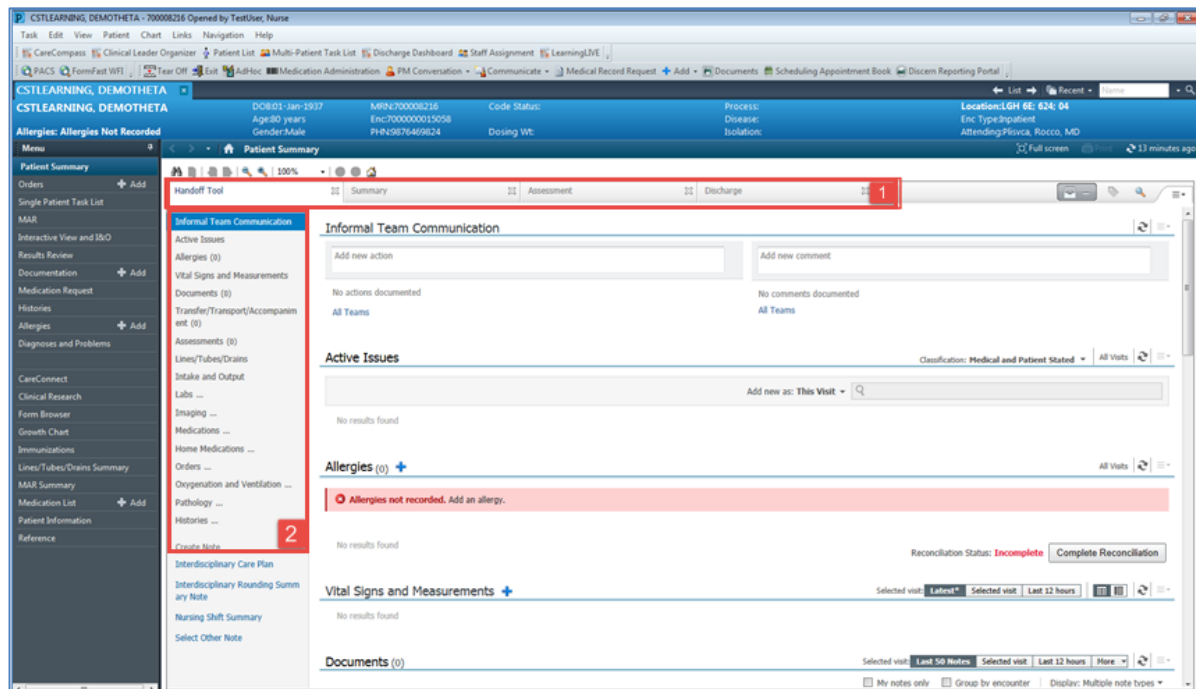
- Top Banner Bar:** Displays patient demographics including DOB (01-Jan-1937), Age (80 years), Gender (Male), MRN (700008216), Enc (7000000015058), PHN (9376469824), Code Status, Process, Disease, Isolation, Location (LGH 6E, 624, 04), and Enc Type (inpatient). It also shows the attending physician (Plavica, Rocco, MD) and a timestamp (0 minutes ago).
- Left Menu:** A vertical list of navigation options including Patient Summary, Orders, Single Patient Task List, MAR, Interactive View and ISO, Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, MAR Summary, Medication List, Patient Information, and Reference.
- Central Toolbar:** A horizontal bar with icons for various tools and functions, including a search icon, a refresh icon, and a full screen icon.
- Main Content Area:** Displays the patient summary, including Informal Team Communication, Active Issues, and Allergies. The Allergies section shows a red banner indicating "Allergies not recorded. Add an allergy."



Key learning Points

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



Activity 3.2 – Introduction to Patient Summary

- 1 Upon accessing the patient's chart you will see the **Patient Summary** page open. The **Patient Summary** will provide views of key clinical patient information.
 1. There are different tabs including **Handoff Tool**, **Summary**, **Assessment**, and **Discharge** that can be used to learn more about the patient. Click on the different tabs to see a quick overview of the patient.
 2. Each tab has different components. You can navigate through these using the component list on the left side of each tab.



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

Key Learning Points

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

PATIENT SCENARIO 4 – Patient Management Conversation (PM Conversation)

Learning Objectives

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

- Use PM Conversation

SCENARIO

Unit clerks will often update the patient information in the system. In some situations, the nurse will need to update patient information such as process alerts (e.g. falls risk alert) in the chart. In this scenario, you will be reviewing PM Conversation and some of its functionalities. You will then learn how to add a process alert.

As an inpatient nurse you will complete the following activities:

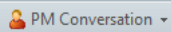
- Use PM Conversation

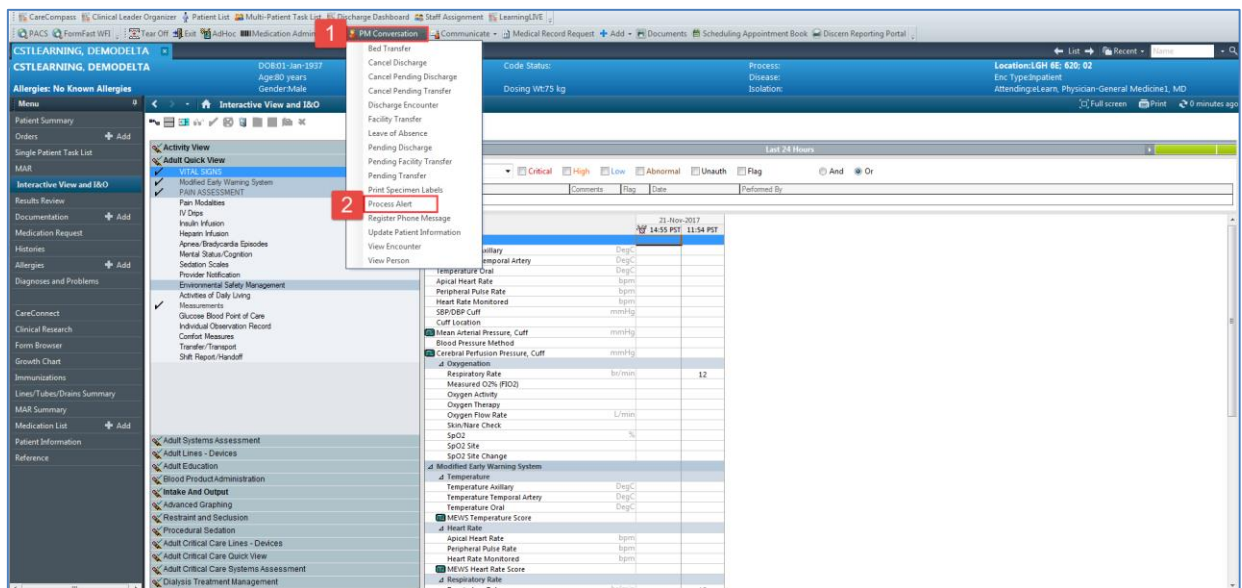
Activity 4.1 – PM Conversation

- 1 Patient Management Conversation (PM Conversation) provides access to manage alerts (such as violence risk, falls risk or isolation precautions), 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 high Morse Fall score a **Falls Risk** process alert should be added to the patient's chart. To do this:

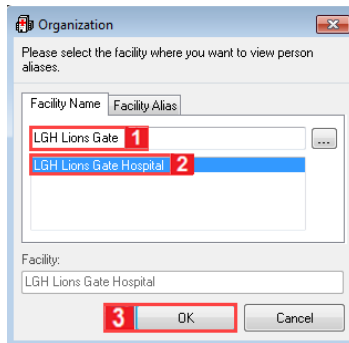
1. Click the drop-down arrow within **PM Conversation**  in the Toolbar
2. Select **Process Alert** from the drop-down menu



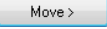
The screenshot displays the PM Conversation interface. The top toolbar includes a dropdown menu for 'PM Conversation'. A red box highlights the 'Process Alert' option in the dropdown menu. The main area shows patient information and a list of alerts. The patient's name is 'DORIS, DEMODELTA' and the location is 'EDM 66: 820: 02'. The patient's age is 80 years and gender is Male. The patient's weight is 75 kg. The patient's location is 'EDM 66: 820: 02'. The patient's physician is 'Attending: eam, Physician-General Medicine1, MD'. The patient's last update was '0 minutes ago'.

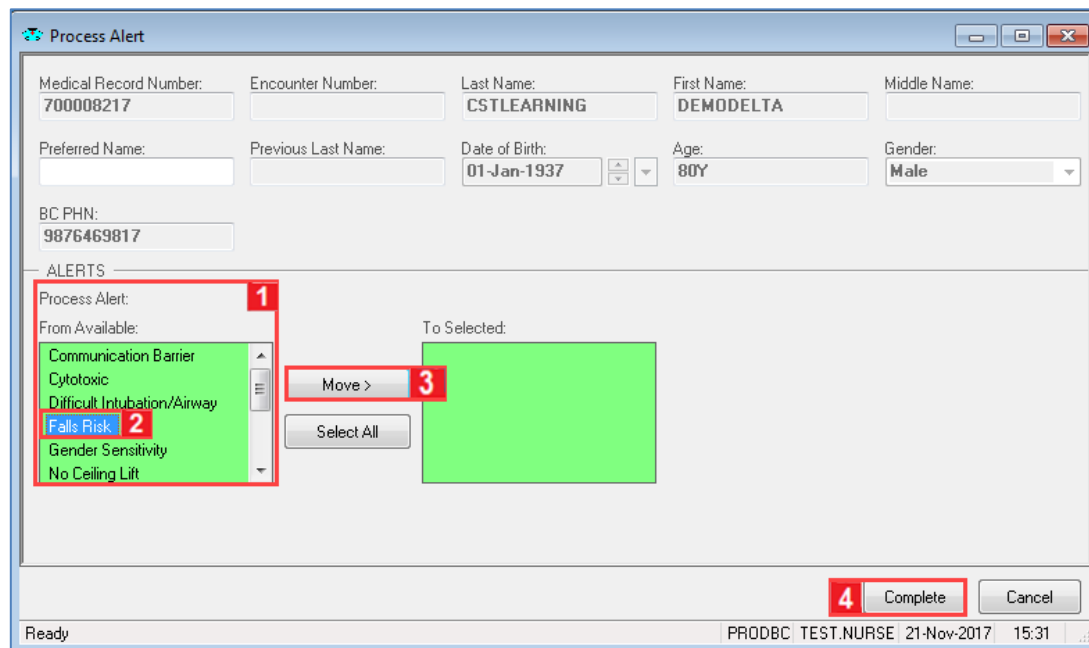
An organization window will display to select location.

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




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

1. Click into the empty **Process Alert** box. A list of alerts that can be applied to the patient will display. **Note:** This box will be empty until you click into it.
2. Select **Falls Risk**
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 in PM Conversation. Site policies and practices should be followed with regards to adding and removing specific flags and alerts.

3

1. Click **Refresh**  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.






Key Learning Points

- Using PM Conversation allows you to manage alerts, patient location, encounter information and demographics
- Updating Process Alerts in PM Conversation allow clinicians to see specific concerns related to the patient in the Banner Bar

PATIENT SCENARIO 5 - Orders

Learning Objectives







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

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

SCENARIO

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





As an inpatient nurse you will complete the following activities:

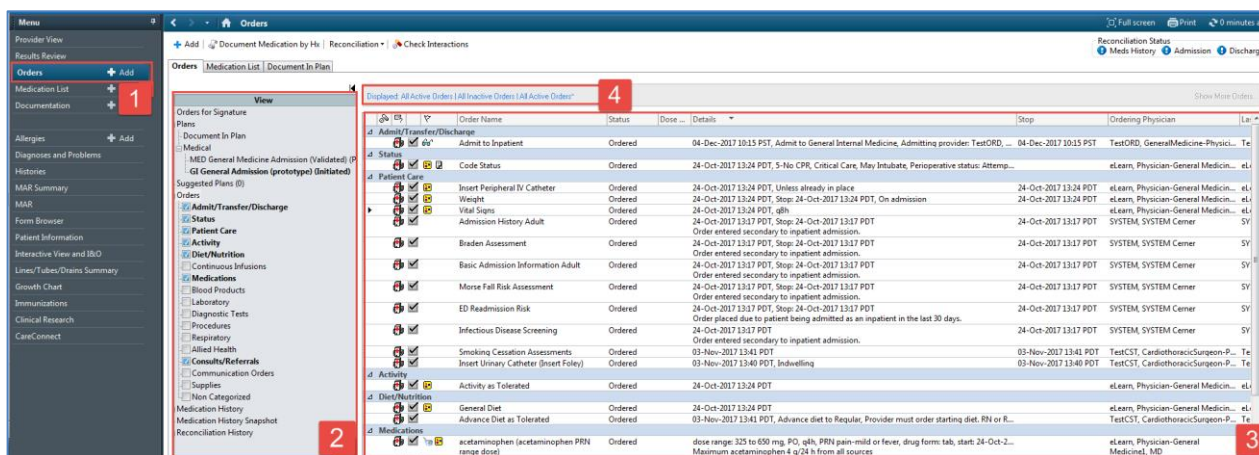
-  Review the Orders Profile
-  Place a no co-signature required order
-  Review order statuses and details
-  Place a verbal order
-  Complete an order
-  Review components of a PowerPlan

Activity 5.1 – Review Orders Profile

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

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

- Select **Orders** from the **Menu**
- On the left side of the Orders Profile is the navigator (**View**) which includes several categories including:
 - Plans**
 - Categories of Orders**
 - Medication History**
 - Reconciliation History**
- On the right side is the **Orders Profile** where you can:
 - Review the list of **All Active Orders**
Moving the mouse over order icons allows you to **hover to discover** additional information.
Some examples of icons and their meanings are:
 -  Order requires nurse review
 -  Additional reference text available
 -  Order is part of a PowerPlan (Order Set)
 -  Order requires Pharmacy verification
- 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

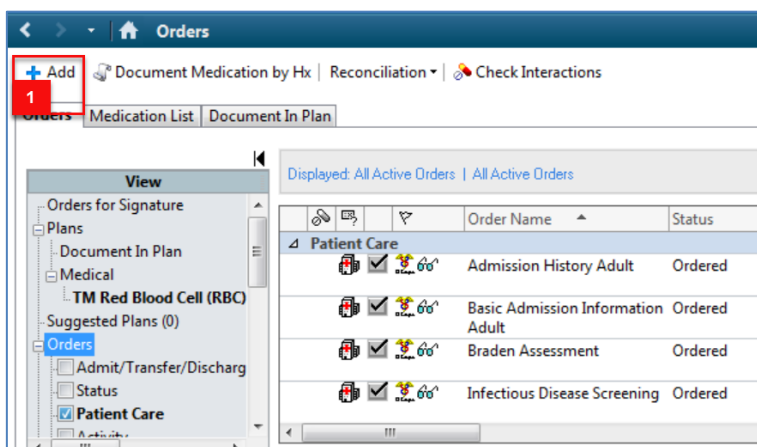
Activity 5.2 – Place an Order

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:

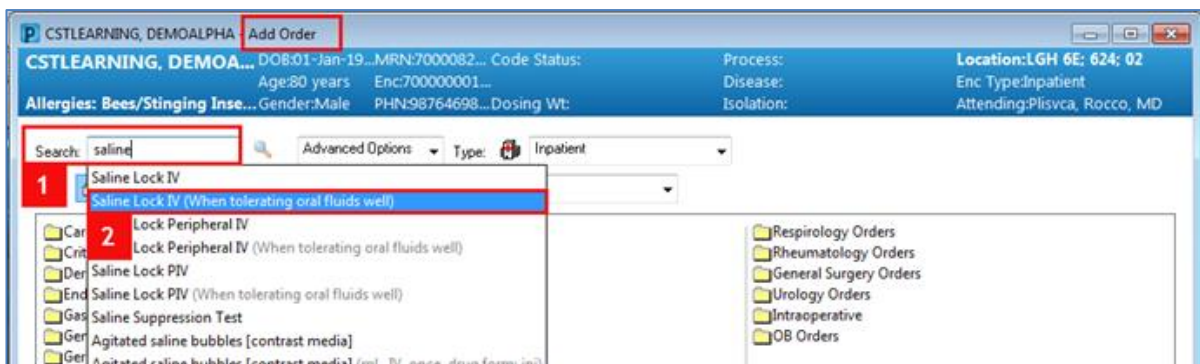
1. Click **Add** within the **Orders** page



The **Add Order** window opens

1. Type **saline lock** into the search window and a list of choices will display
2. Select **Saline Lock Peripheral IV (when tolerating oral fluids well)**

Note: In this example “(when tolerating oral fluids well)” is an order sentence. Order sentences help to pre-fill order details. Also, you will see 3 similar orders, select any one of these. All 3 orders will lead to the same order but allow for variation in search terms used.



The **Ordering Physician** window opens.

3. Type in the name of the patient's Attending Physician (Last name, First name)
4. Select **No Cosignature Required**
5. Click **OK**

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

7. Notice that the **Special instructions** box is pre-filled with **When tolerating oral fluids well**. Click **Sign**.

8. Click **Refresh**



Key Learning Points






- Nurses can place nurse initiated orders as no cosignature required orders
- Order sentences help to pre-fill additional information or details for an order

Activity 5.3 – 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


	Order Name	Status	Dose ...	Details	Proposal
	Insert Peripheral IV...	Processing		20-Nov-2017 11:46 PST	
	Insert Urinary Cath...	Ordered		20-Nov-2017 11:31 PST, Indwelling	
	Morse Fall Risk Assessment	Ordered		17-Nov-2017 14:05 PST, Stop: 17-Nov-2017 14:05 PST Order entered secondary to inpatient admission.	
	Vital Signs			20-Nov-2017 11:25 PST, q4h while awake	
Medications					
	furosemide	Ordered		20 mg, IV, as directed, order duration: 5 day, drug form: inj, start: 17-Nov-Administer pre red blood cell transfusion	

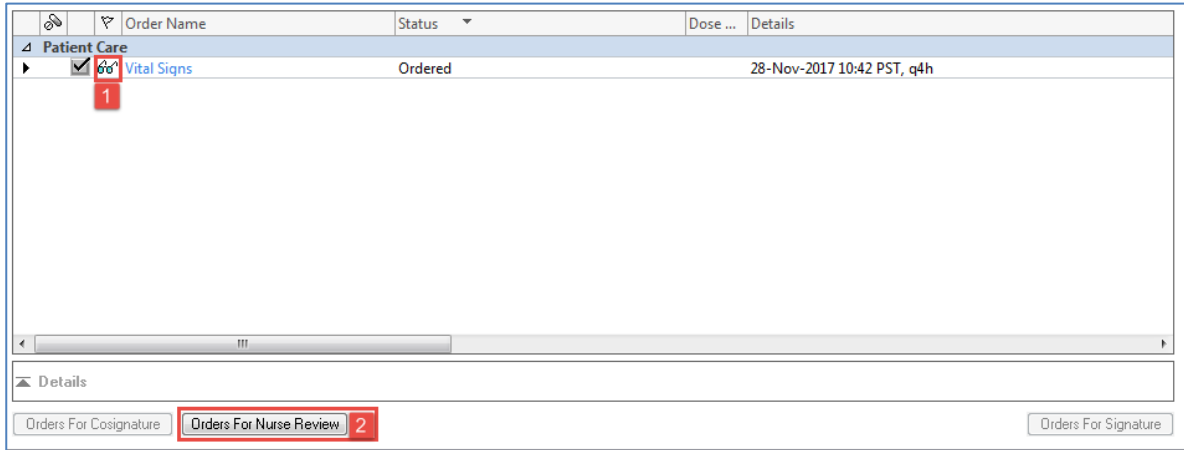
To see examples of order details review the screenshot below (your screen may be different):

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

	Order Name	Status	Dose ...	Details
Patient Care				
	Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h
Blood Products				
	Red Blood Cell Transfusion	Ordered		Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please call... Informed consent must be present on patient record Red Blood Cell Transfusion Details: Routine, Administer: 1 unit, IV, once, Administer each over: 120 - 180 Minutes, Irradiated, Please call when ready for pick up, 28-Nov-2017 11:04 PST Order Comment: Informed consent must be present on patient record

When new orders are placed in the chart, a nurse must review these new orders and document their review. Below we outline the steps for how this should be done. **Note:** Do not follow these steps in the system but instead refer to the screenshots to understand the process.

1. A **Nurse Review** icon  appears to the left of the order. This identifies the order as one that needs to be reviewed by a nurse.
2. Click the **Orders for Nurse Review** button to open the review window.



Order Name	Status	Dose ...	Details
<input checked="" type="checkbox"/> Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h

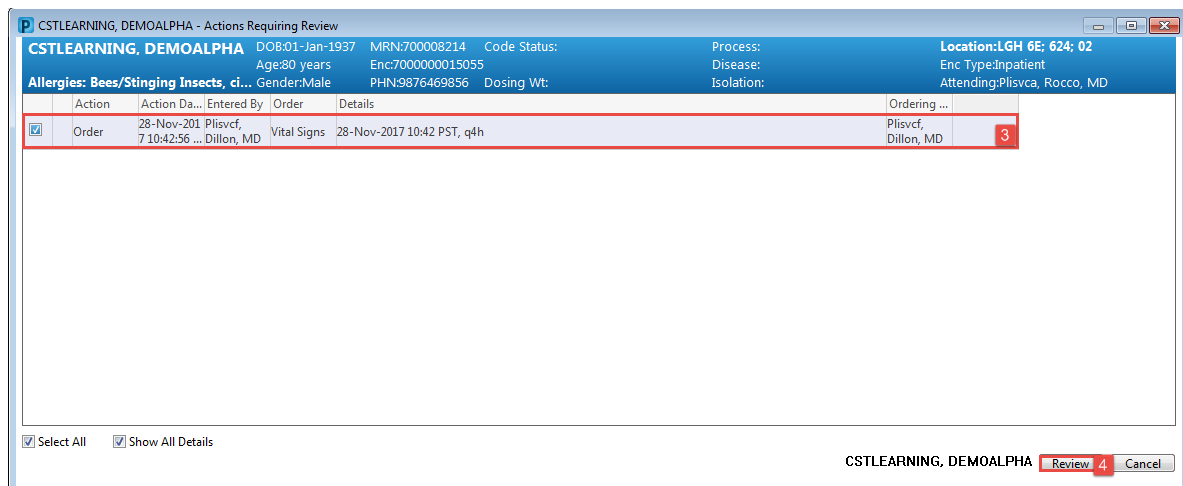
1

Details

Orders For Cosignature **Orders For Nurse Review 2** Orders For Signature

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

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



CSTLEARNING, DEMOALPHA - Actions Requiring Review

CSTLEARNING, DEMOALPHA DOB:01-Jan-1937 MRN:700008214 Code Status: Process: Location:LGH 6E: 624; 02
 Age:80 years Enc:7000000015055 Disease: Enc Type:Inpatient
 Allergies: Bees/Stinging Insects, cl... Gender:Male PHN:9876469856 Dosing Wt: Isolation: Attending:Plisvca, Rocco, MD

Action	Action Da...	Entered By	Order	Details	Ordering ...
<input checked="" type="checkbox"/> Order	28-Nov-201 7 10:42:56 ...	Plisvcf, Dillon, MD	Vital Signs	28-Nov-2017 10:42 PST, q4h	Plisvcf, Dillon, MD

3

Select All Show All Details

CSTLEARNING, DEMOALPHA **Review 4** Cancel

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

Key Learning Points

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

Activity 5.4 – Place a Verbal Order

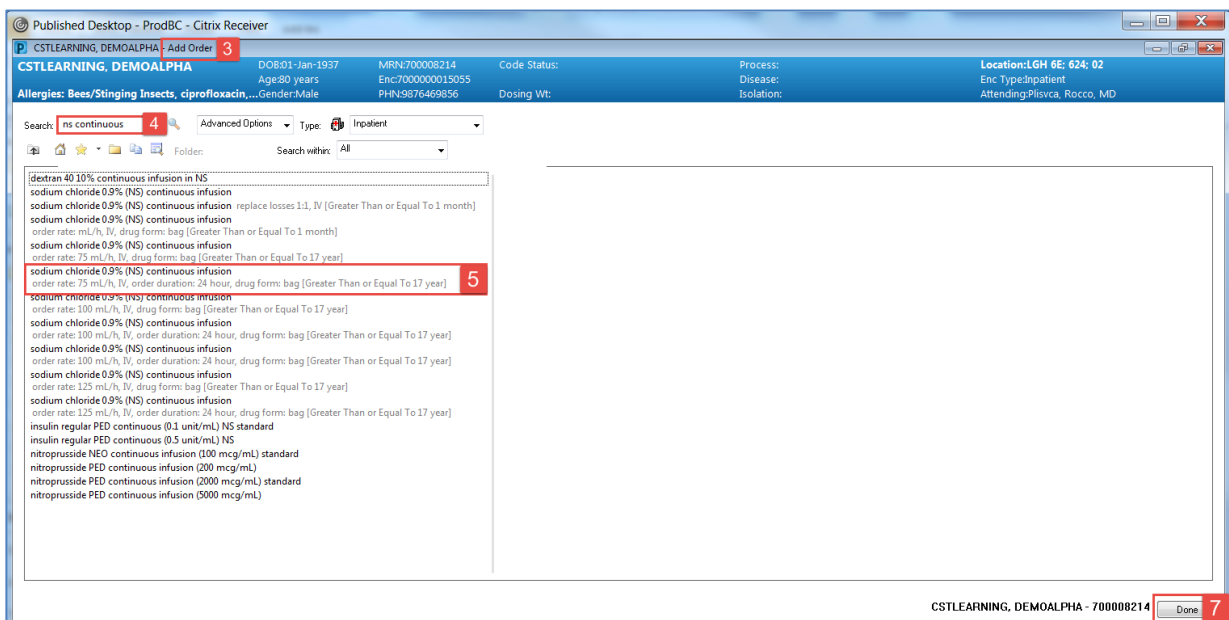
1

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.

Place a verbal order:

1. Select **Orders** from the **Menu**
2. Click **+ Add**
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]**



Published Desktop - ProDBC - Citrix Receiver

CSTLEARNING, DEMOALPHA | Add Order **3**

DOB: 01-Jan-1937 MRN: 700008214 Code Status: Process: Location: LGH 6E: 624: 02
 Age: 80 years Enc: 7000000015055 Disease: Enc Type: Inpatient
 Allergies: Bees/Stinging Insects, ciprofloxacin, ... Gender: Male PHN: 9876469856 Dosing Wt: Isolation: Attending: Plisvca, Rocco, MD

Search: **ns continuous** **4** Advanced Options Type: **Inpatient**

Folder: Search within: All

dextran 40 10% continuous infusion in NS
 sodium chloride 0.9% (NS) continuous infusion
 sodium chloride 0.9% (NS) continuous infusion replace losses 1:1, IV [Greater Than or Equal To 1 month]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: mL/h, IV, drug form: bag [Greater Than or Equal To 1 month]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 75 mL/h, IV, drug form: bag [Greater Than or Equal To 17 year]
sodium chloride 0.9% (NS) continuous infusion **5**
 order rate: 75 mL/h, IV, order duration: 24 hour, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 100 mL/h, IV, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 100 mL/h, IV, order duration: 24 hour, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 100 mL/h, IV, order duration: 24 hour, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 125 mL/h, IV, drug form: bag [Greater Than or Equal To 17 year]
 sodium chloride 0.9% (NS) continuous infusion
 order rate: 125 mL/h, IV, order duration: 24 hour, drug form: bag [Greater Than or Equal To 17 year]
 insulin regular PED continuous (0.1 unit/mL) NS standard
 insulin regular PED continuous (0.5 unit/mL) NS
 nitroprusside NEO continuous infusion (100 mcg/mL) standard
 nitroprusside PED continuous infusion (200 mcg/mL)
 nitroprusside PED continuous infusion (2000 mcg/mL) standard
 nitroprusside PED continuous infusion (5000 mcg/mL)

CSTLEARNING, DEMOALPHA - 700008214 Done **7**

The Ordering Physician window opens.

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

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

7. Click **Done** to close the **Add Order** window (refer to first screenshot within this activity)
8. **Orders for Signature** window opens and order details are displayed. Fill out data entry fields as needed
9. Click **Sign** and then click **Refresh** to update Orders Profile

10. The orders profile now displays the continuous infusion with a status of **Ordered**.



Key Learning Points

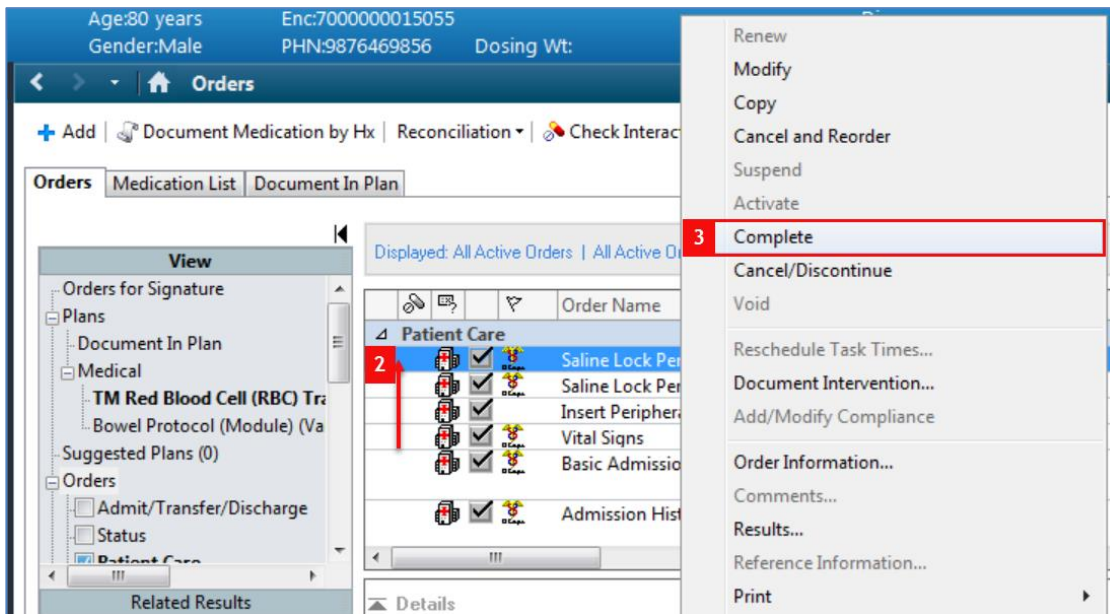
- Verbal orders are only encouraged to be entered when a physician cannot enter the order directly into the CIS themselves, for example in an emergency situation or when the physician is sterile in mid procedure
- Required fields are always highlighted yellow
- Verbal and phone orders that are entered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

Activity 5.5 – Complete or Cancel/Discontinue an Order

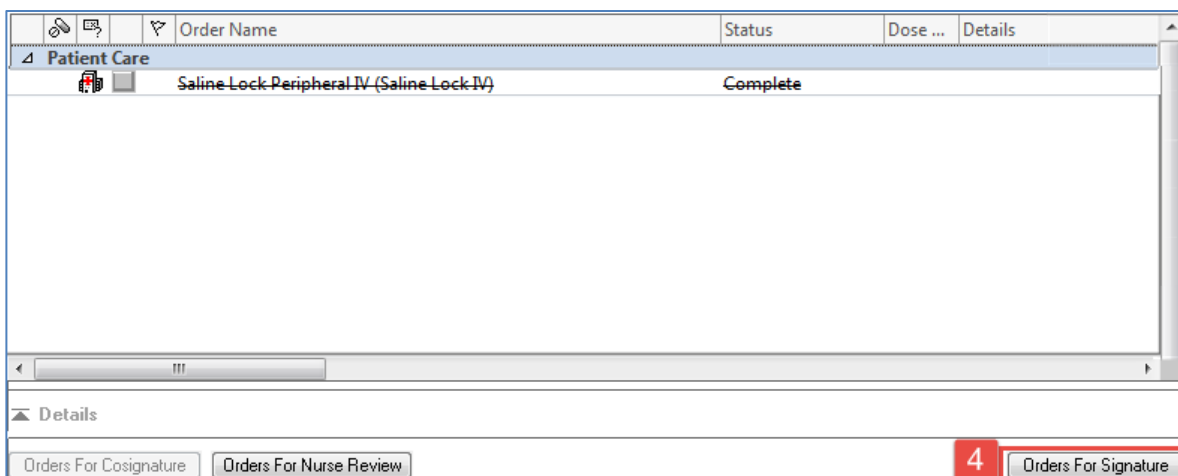
- 1 When a one-time order has been carried out, the order needs to be removed from the patient's order profile. This is done by completing the order.

Assuming we have inserted a saline lock PIV for our patient. Let's complete the order.

1. Review the **Orders Profile**
2. Right-click the order **Saline Lock Peripheral IV**
3. Select **Complete**



4. Click the **Orders for Signature** button.



- Review order for signature and click **Sign**. You will return to the orders profile where the order will show as processing.

Orders for Signature

Order Name	Status	Start	Details
LGH 3W; 331; 01B Enc:7000000015869 Admit: 01-Dec-2017 00:24 PST			
Patient Care			
Saline Lock Peripheral...	Complete	09-Dec-2017 14:16...	

Details

0 Missing Required Details Orders For Cosignature Orders For Nurse Review

5 Sign

- Refresh  the screen and the order will no longer be visible on the Orders Profile.

2

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

- Review the **Orders Profile**
- Right-click order **Encourage Fluids**
- Select **Cancel/Discontinue**

Menu

Patient Summary

Orders **1**

Single Patient Task List

MAR

MAR Summary

Interactive View and I&O

Results Review

Documentation **+** Add

Medication Request

Histories

Allergies **+** Add

Diagnoses and Problems

CareConnect

Clinical Research

Form Browser

Growth Chart

Immunizations

Lines/Tubes/Drains Summary

Medication List **+** Add

Patient Information

Reference

Orders

Document Medication by Hx | Reconciliation | Check Interactions

Medication List | Document In Plan

View

Displayed: All Active Orders | All Inactive Orders | All Orders (All Statuses)

Order Name	Status	Dose ...	Details
Vital Signs	Completed		30-Nov-2017 09:41 PST, Stop: 30-Nov-2017 09:41 PST, q8h, with vit
Pulse Oximetry	Ordered		30-Nov-2017 09:41 PST, q8h, with vit
Negative Pressure Wound Therapy	Ordered		30-Nov-2017 09:26 PST, 125 mmHg, 17-Nov-2017 14:17 PST, Stop: 17-Nov-2017 14:17 PST, Order entered secondary to inpatient
Morse Fall Risk Assessment	Ordered		05-Dec-2017 12:00 PST, BID, To be d
Intensive Care Delirium Screening Checklist (ICDSC)	Ordered		22-Nov-2017 10:55 PST, If not already
Insert Peripheral IV Catheter	Discontin...		17-Nov-2017 14:17 PST
Infectious Disease Screening	Ordered		Order entered secondary to inpatient
Encourage Fluids			
Central Venous Catheter Care			
Braden Assessment			
Basic Admission Information Adult			
Admission History Adult			
Activity			
Activity as Tolerated			
Diet/Nutrition			
General Diet			
Continuous Infusions			
sodium chloride 0.9% (NS) continuous infusion 1,000 mL			
sodium chloride 0.9% (NS) continuous infusion 1,000 mL			
sodium chloride 0.9% (NS) continuous infusion 1,000 mL			
sodium chloride 0.9% (NS) continuous infusion 1,000 mL			
heparin additive 25000 unit + dextrose 5% premix 300 mL			
Medications			
Vancomycin			

Details

Orders For Cosignature Orders For Nurse Review

Cancel/Discontinue **3**

Renew

Modify

Copy

Cancel and Reorder

Suspend

Activate

Complete

Void

Reschedule Task Times...

Document Intervention...

Add/Modify Compliance

Order Information...

Comments...

Results...

Reference Information...

Print

Advanced Filters...

Customize View...

Disable Order Information Hyperlink

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**. You will return to the order profile.

7. **Refresh** the screen and your order will no longer be visible on the order profile.

Key Learning Points

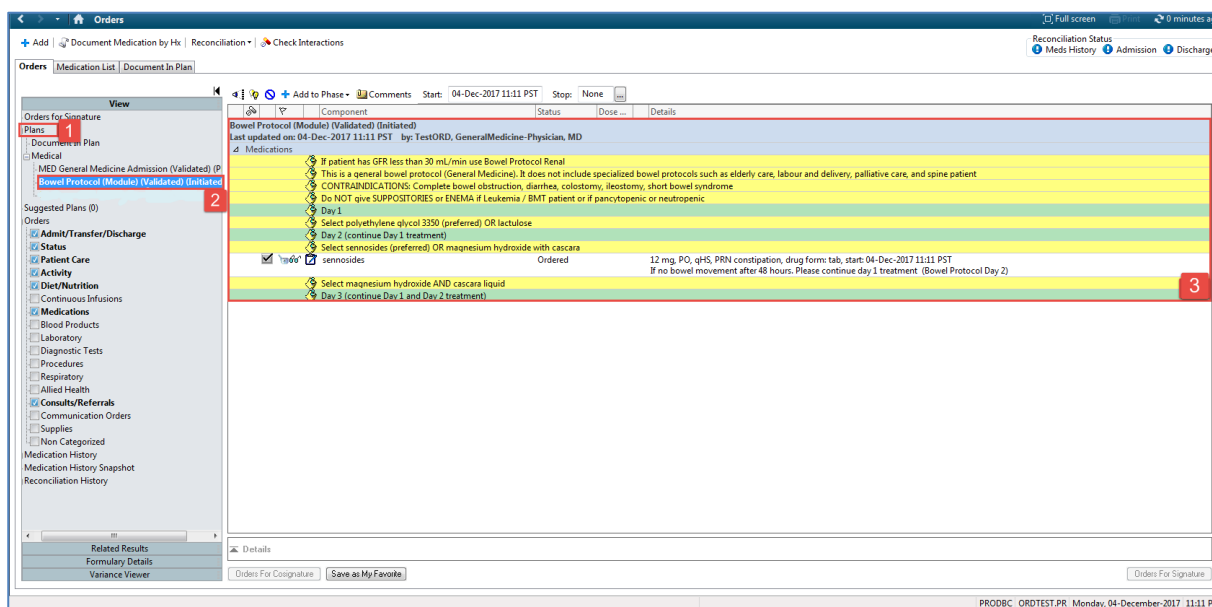
- Right-click to mark an order as completed or cancel/discontinued
- Once an order is cancelled or discontinued the order will be removed from the patient's Order Profile

Activity 5.6 – Review Components of a PowerPlan

- 1 A PowerPlan in the CIS is the equivalent of pre-printed 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. Select the **Bowel Protocol** PowerPlan
3. Review the orders within the PowerPlan (e.g. *Sennosides 12mg, PO, qHS, PRN*)





Key Learning Points

- The Orders Profile consists of the navigator (View) and the order profile
- The navigator (View) displays the lists of PowerPlans and clinical categories of orders
- The order profile page displays all of the orders for a patient

PATIENT SCENARIO 6 - Interactive View and I&O

Learning Objectives






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

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

SCENARIO

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

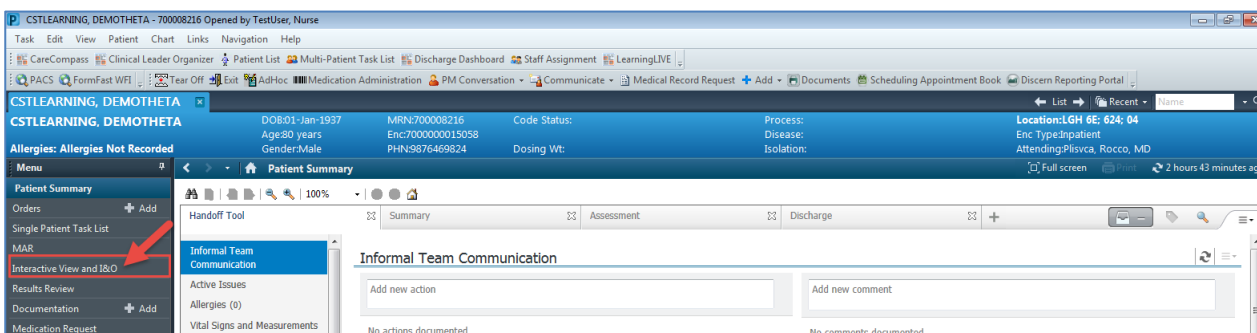
As an inpatient nurse you will complete the following activities:

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

Activity 6.1 – Navigate to Interactive View and I&O

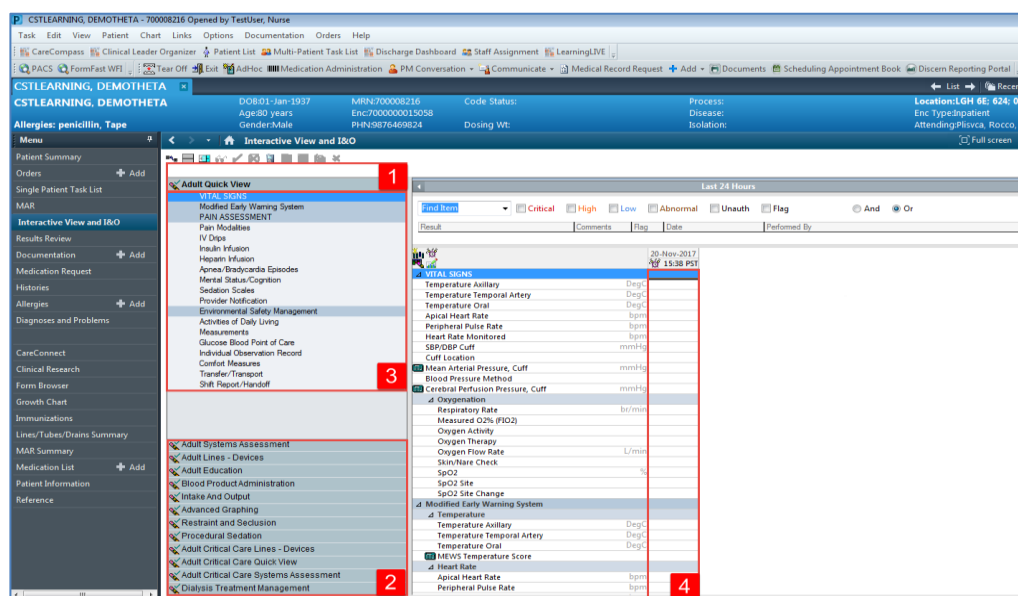
- 1 Nurses will complete most of their documentation in **Interactive View and I&O (iView)**. iView is the electronic equivalent of current state paper flow sheets. For example, vital signs and pain assessment will be charted in iView.

Select **Interactive View and I&O** 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 Quick View** band is expanded displaying the sections within it.
2. The set of bands below **Adult Quick View** are collapsed. Bands can be expanded or collapsed by clicking on their name.
3. A **section** is an individual flowsheet that contains related assessment and intervention documentation.
4. **Cells** are fields where data is documented.

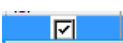



Key Learning Points

- Nurses will complete most of their documentation in iView
- iView contains flowsheet type charting

Activity 6.2 – Documenting in Interactive View and I&O

1 With the **Adult Quick View** band expanded you will see the **Vital Signs** section. Let's practice documenting in iView.


1. Select the **Vital Signs** component under **Adult Quick View**
2. Double-click the **blue box**  next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key.
3. Document using the following data:
 - **Temperature Oral** = 36.9
 - **Peripheral Pulse Rate** = 91
 - **SBP/DBP Cuff** = 140/90
 - **Mean Arterial Pressure, Cuff** = 107 (*Auto populated result*)

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, Systolic Blood Pressure (SBP) and Diastolic Blood Pressure (DBP) are required cells for the Mean Arterial Pressure calculation to function.

- **Respiratory Rate** = 16
- **Oxygen Therapy** = *Nasal cannula*
- **Oxygen Flow Rate** = 3
- **SpO2** = 99
- **SpO2 Site** = *Hand*

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

Note: Please disregard the values that are populated in the cells under the MEWS section. More information about MEWS documentation will be provided later in this workbook.

4. To sign your documentation, click the **green checkmark** icon 

PATIENT SCENARIO 6 - Interactive View and I&O

CSTLEARNING, DEMOTHETA - 700008216 Opened by TestUser, Nurse

Task Edit View Patient Chart Links Options Documentation Orders Help

DOB: 01-Jan-1937 MRN: 700008216 Code Status: Process/Falls Risk
Age: 80 years Enc: 7000000015058
Gender: Male PHN: 9876469824 Dosing Wt: Disease: Isolation:

Allergies: penicillin, Tape

Interactive View and I&O

Adult Quick View

VITAL SIGNS

Modified Early Warning System
PAIN ASSESSMENT
Pain Modalities
IV Drops
Insulin Infusion
Heparin Infusion
Apnea/Bradycardia Episodes
Mental Status/Cognition
Sedation Scales
Provider Notification
Environmental Safety Management
Activities of Daily Living
Measurements
Glucose Blood Point of Care
Individual Observation Record
Comfort Measures
Transfer/Transport
Shift Report/Handoff

Adult Systems Assessment
Adult Lines - Devices
Adult Education
Blood Product Administration

VITAL SIGNS

Temperature Axillary Deg 36.9
Temperature Temporal Artery Deg 36.9
Temperature Oral Deg 36.9
Apical Heart Rate bpm 91
Peripheral Pulse Rate bpm 91
Heart Rate Monitored bpm 91
SBP/DBP Cuff mmHg 140/90
Cuff Location
Mean Arterial Pressure, Cuff mmHg 107
Blood Pressure Method
Cerebral Perfusion Pressure, Cuff mmHg
Oxygenation
Respiratory Rate br/min 16
Measured O2% (FIO2)
Oxygen Activity
Oxygen Flow Rate L/min
Skin/Nare Check
SpO2 99
SpO2 Site Hand
SpO2 Site Change

Modified Early Warning System

- 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.

CSTLEARNING, DEMOTHETA - 700008216 Opened by TestUser, Nurse

Task Edit View Patient Chart Links Options Documentation Orders Help

DOB: 01-Jan-1937 MRN: 700008216 Code Status: Process/Falls Risk
Age: 80 years Enc: 7000000015058
Gender: Male PHN: 9876469824 Dosing Wt: Disease: Isolation:

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Interactive View and I&O

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Provider Notification
Environmental Safety Management
Activities of Daily Living
Measurements
Glucose Blood Point of Care
Individual Observation Record
Comfort Measures
Transfer/Transport
Shift Report/Handoff

Adult Systems Assessment
Adult Lines - Devices

VITAL SIGNS


Temperature Axillary Deg 36.8
Temperature Temporal Artery Deg 36.8
Temperature Oral Deg 36.8
Apical Heart Rate bpm 91
Peripheral Pulse Rate bpm 91
Heart Rate Monitored bpm 91
SBP/DBP Cuff mmHg 140/90
Cuff Location
Mean Arterial Pressure, Cuff mmHg 107
Blood Pressure Method
Cerebral Perfusion Pressure, Cuff mmHg
Oxygenation
Respiratory Rate br/min 16
Measured O2% (FIO2)
Oxygen Activity
Oxygen Flow Rate L/min
Skin/Nare Check
SpO2 99
SpO2 Site Hand
SpO2 Site Change

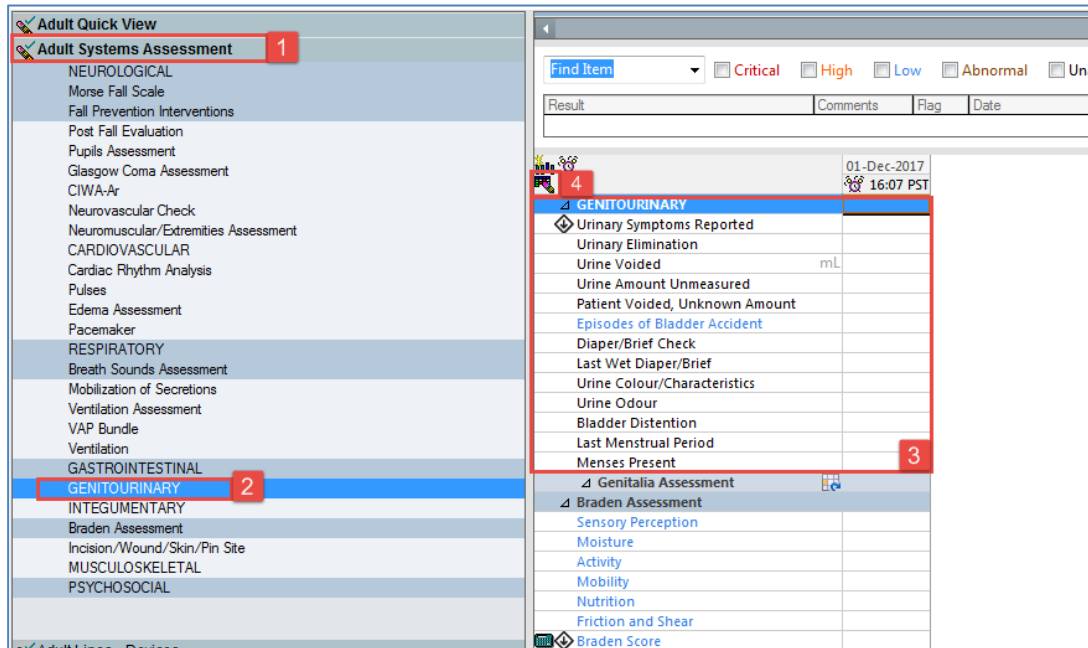
Modified Early Warning System

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.

2

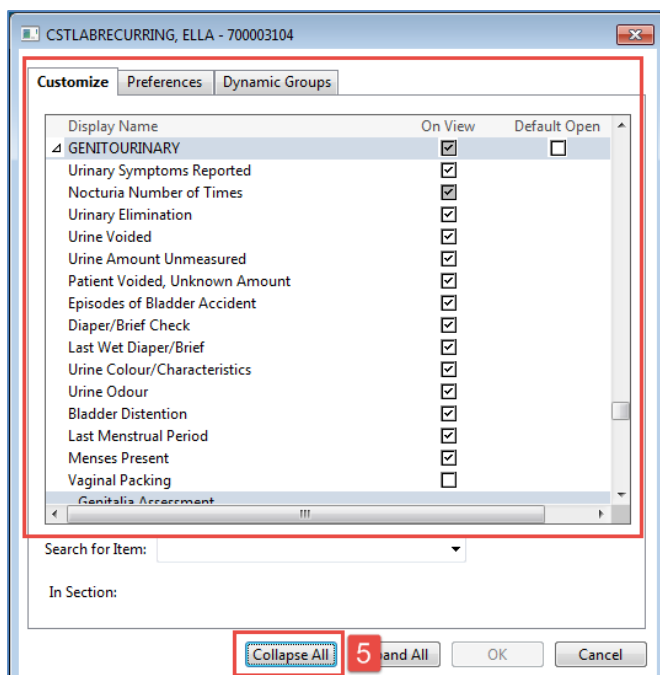
Let's pretend that you just did a bladder scan on your patient and now you want to document.

1. Click the **Adult Systems Assessment** Band in **iView**
2. Click the **Genitourinary** section in the **Adult 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 scan



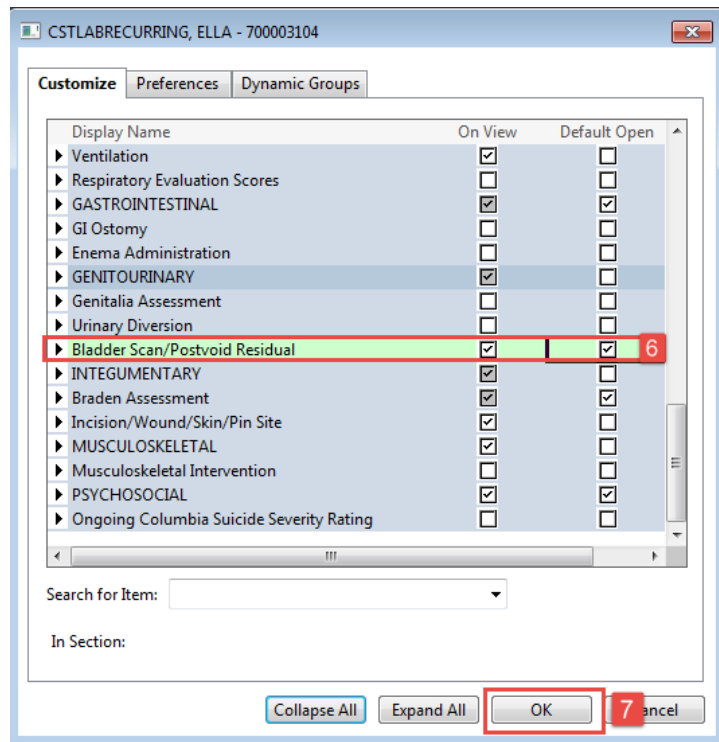
The screenshot shows the iView interface. On the left, the 'Adult Systems Assessment' band is selected, and the 'GENITOURINARY' section is highlighted. On the right, the 'GENITOURINARY' section is expanded, showing various assessment items. A red box labeled '1' points to the 'Adult Systems Assessment' band. A red box labeled '2' points to the 'GENITOURINARY' section. A red box labeled '3' points to the 'Customize View' icon. A red box labeled '4' points to the 'GENITOURINARY' section in the right-hand pane.



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.

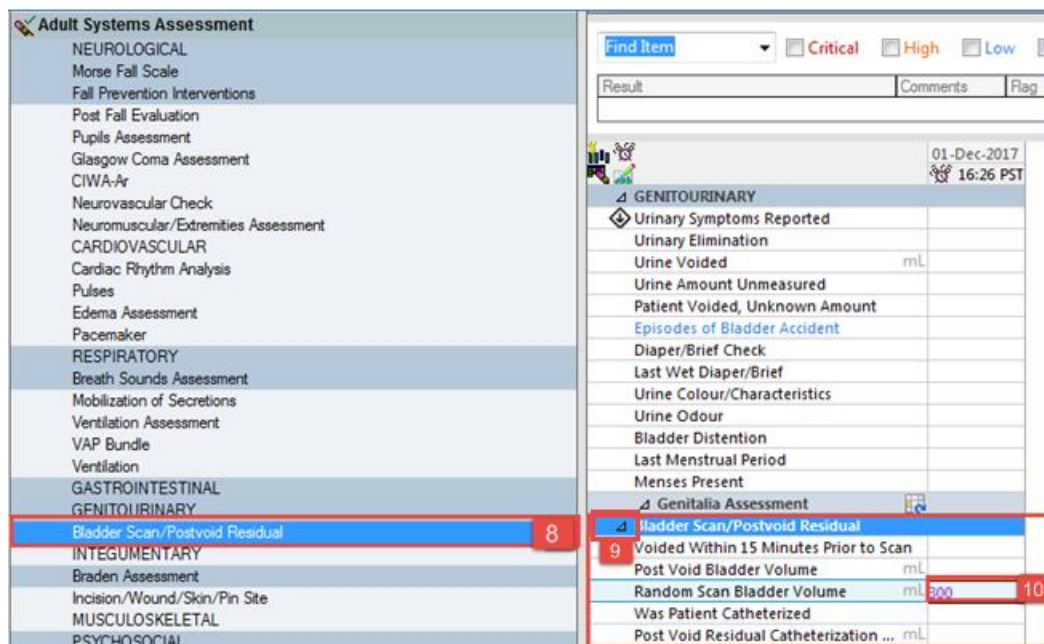


The screenshot shows the 'Customize' window with the 'Genitourinary' section selected. The 'On View' column has checkboxes for each item, and the 'Default Open' column has a checkbox for the section. The 'Collapse All' button is highlighted with a red box and a red box labeled '5'.

6. Now that all the sections are collapsed, find the **Bladder Scan/Postvoid Residual** section and click on the box ☒ under the **Default Open** column.
7. Click **OK**



8. You will now see that the **Bladder Scan/Postvoid Residual** section is listed under the Adult Systems Assessment Band
9. Click the small arrow  next to the **Bladder Scan/PostVoid Residual** section to expand the section.
10. Document the following assessment findings:
 - **Random Scan Bladder Volume = 300**
 - Press **Enter** on the keyboard and click **green checkmark** icon  to sign your documentation



Adult Systems Assessment

NEUROLOGICAL
Morse Fall Scale
Fall Prevention Interventions
Post Fall Evaluation
Pupils Assessment
Glasgow Coma Assessment
CIWA-Ar
Neurovascular Check
Neuromuscular/Extremities Assessment

CARDIOVASCULAR
Cardiac Rhythm Analysis
Pulses
Edema Assessment
Pacemaker

RESPIRATORY
Breath Sounds Assessment
Mobilization of Secretions
Ventilation Assessment
VAP Bundle
Ventilation

GASTROINTESTINAL

GENITOURINARY 8

Bladder Scan/Postvoid Residual

INTEGUMENTARY
Braden Assessment
Incision/Wound/Skin/Pin Site

MUSCULOSKELETAL

PSYCHOSOCIAL

Find Item ☐ Critical ☐ High ☐ Low

Result Comments Flag

01-Dec-2017 16:26 PST

GENITOURINARY

Urinary Symptoms Reported

Urinary Elimination

Urine Voided mL

Urine Amount Unmeasured

Patient Voided, Unknown Amount

Episodes of Bladder Accident

Diaper/Brief Check

Last Wet Diaper/Brief

Urine Colour/Characteristics

Urine Odour

Bladder Distention

Last Menstrual Period

Menses Present

Genitalia Assessment

Bladder Scan/Postvoid Residual

Voided Within 15 Minutes Prior to Scan

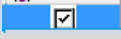

Post Void Bladder Volume mL

Random Scan Bladder Volume mL 10

Was Patient Catheterized


Post Void Residual Catheterization ... mL

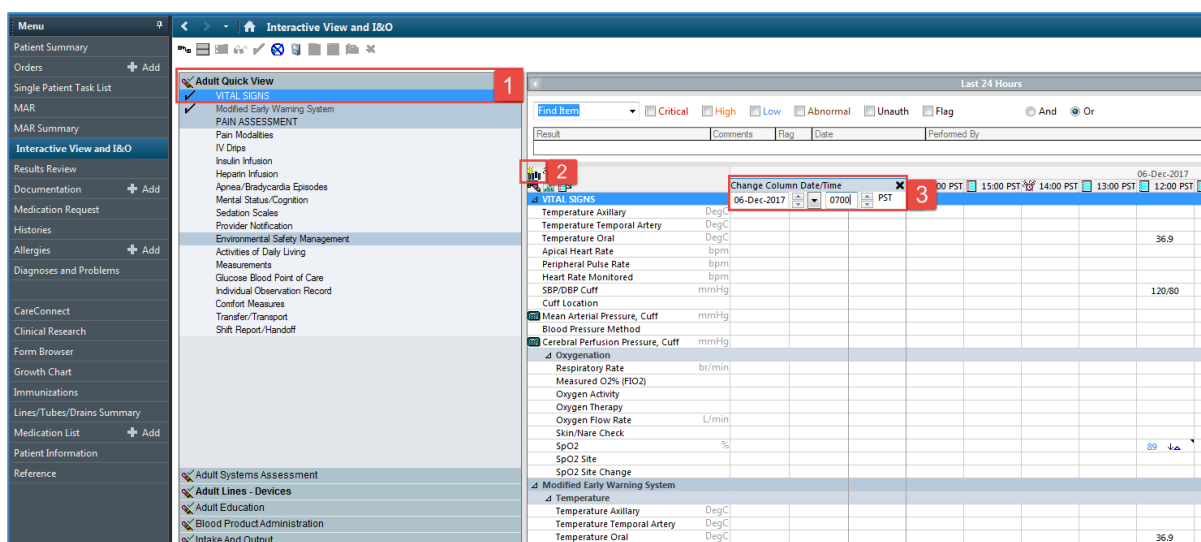
Key Learning Points


- Documentation will appear in purple until signed. Once signed, the documented text will become black and be recorded to the patient chart
- The latest 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

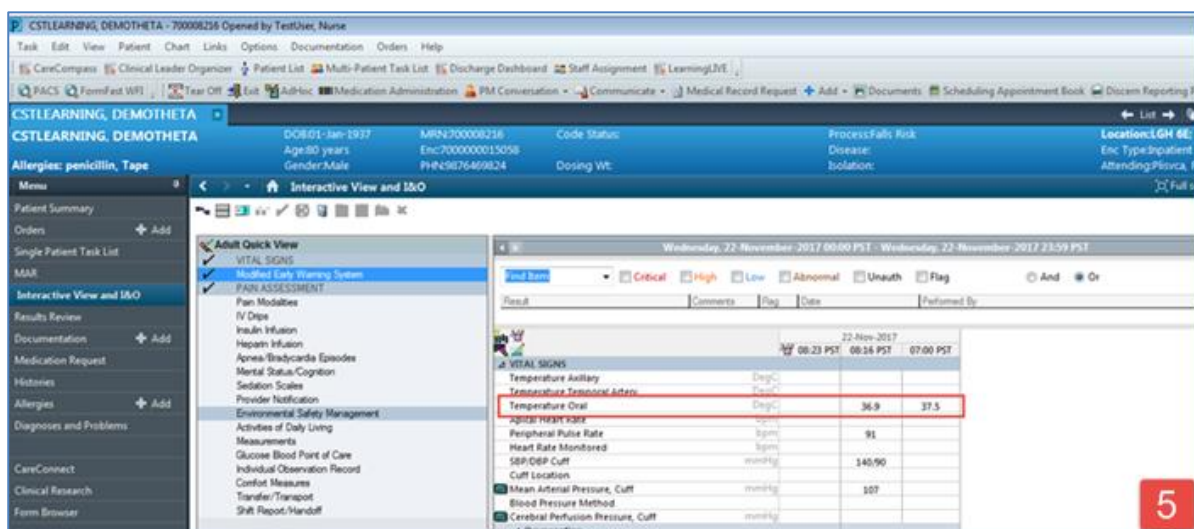
Activity 6.3 – Change the Time Column in iView

1 You can create a new time column and document under a specific time. For example, let's pretend it is now 12:00 pm and you still need to document your patient's 07:00am temperature.

1. Click on the **Adult Quick View Band** and select the **Vital Signs** section
2. Click the **Insert Date/Time** icon 
3. A new column and Change Column Date/Time window appears. Choose the appropriate date and time you wish to document under. In this example, use today's date and time of 0700.
4. Press the **Enter** key



5. In the new column, enter **Temperature Oral = 37.5** and click **green checkmark icon**  to sign your documentation. The documented text is now black and recorded in the chart.



Key Learning Points


- Documentation time can be adjusted in iView
- If required, you can create a new time column and document under a specific time

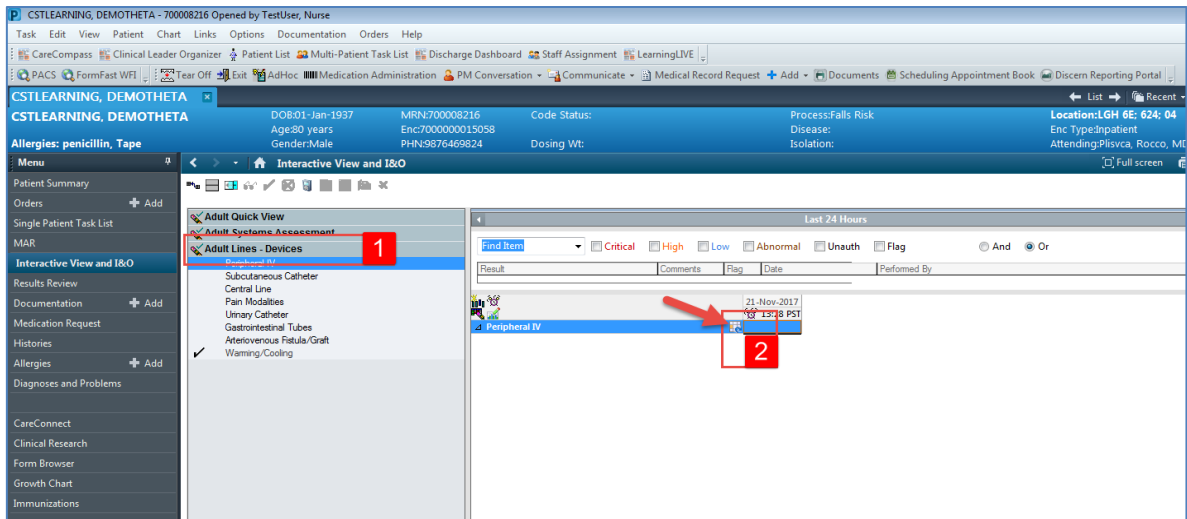
Activity 6.4 – Document a Dynamic Group in iView

1

Dynamic groups allow documented data to be the documentation and display of multiple instances of the same grouping of data elements. Examples of dynamic groups include wound assessments, IV Sites, chest tubes and more.

For the purposes of this scenario, assume that your patient requires a peripheral IV (PIV) to be inserted. After inserting the IV successfully, you are now ready to document the details of the IV insertion.

1. Click on the **Adult Lines – Devices** band
2. Now that the band is expanded, click on the **Dynamic Group** icon  to the right of the Peripheral IV heading in the flowsheet.



The screenshot displays the CSTLEARNING, DEMOTHETA patient interface. The top navigation bar includes tabs for Task, Edit, View, Patient, Chart, Links, Options, Documentation, Orders, and Help. Below this, a patient summary bar shows details for CSTLEARNING, DEMOTHETA, including DOB, Age, Gender, MRN, Enc, Code Status, Process/Falls Risk, Disease, Isolation, and Location. The left sidebar contains a menu with options like Patient Summary, Orders, Single Patient Task List, MAR, Interactive View and I&O, Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, and Immunizations. The main content area is titled 'Interactive View and I&O' and shows a list of 'Adult Lines - Devices' on the left and a 'Last 24 Hours' flowsheet on the right. The 'Adult Lines - Devices' list includes Subcutaneous Catheter, Central Line, Pain Modalities, Urinary Catheter, Gastrointestinal Tubes, Afternoon Venous Fistula/Graft, and Warming/Cooling. The 'Peripheral IV' entry is highlighted in the flowsheet, and a red arrow points to the 'Dynamic Group' icon (a blue square with a white grid) next to it. A red box with the number '1' highlights the 'Adult Lines - Devices' band, and a red box with the number '2' highlights the 'Dynamic Group' icon.


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

Select the following data to create a label:


- Peripheral IV Catheter Type: **Peripheral**
- Peripheral IV Site: **Forearm**
- Peripheral IV Laterality: **Left**
- Peripheral IV Catheter Size: **20 gauge**

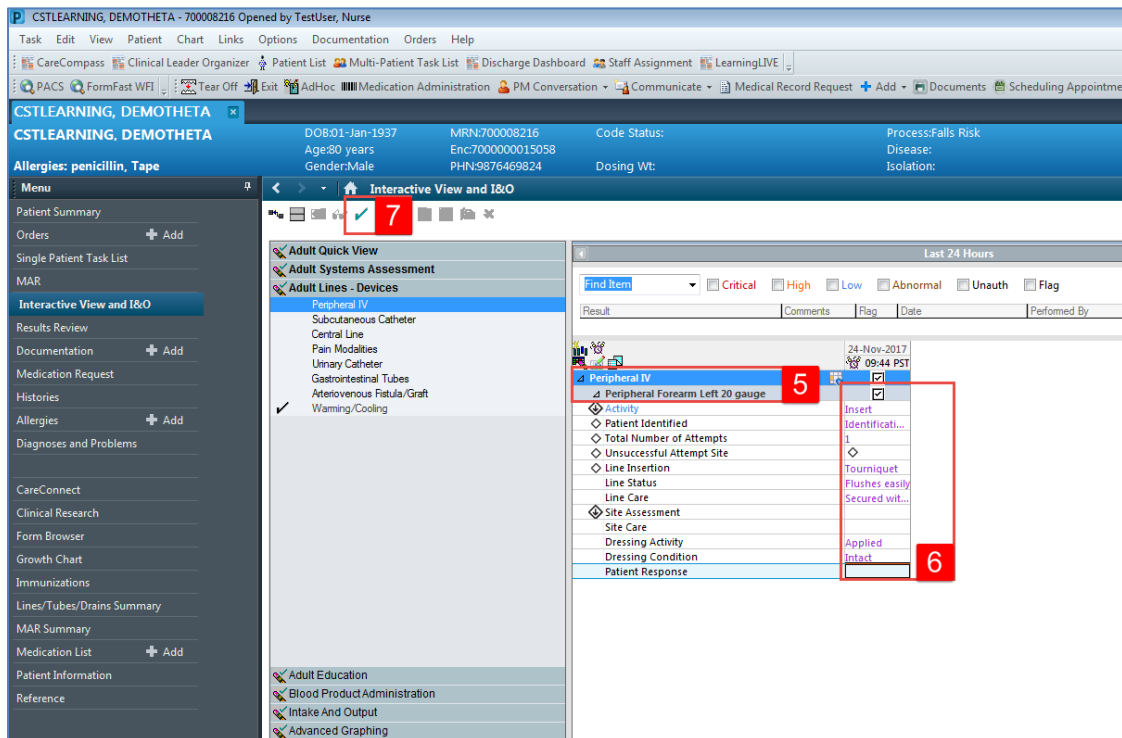
- Click **OK**

The screenshot shows the CSTLEARNING, DEMOTHETA - 70008216 patient record interface. The 'Dynamic Group' window is open, showing the 'Peripheral Forearm Left 20 gauge' label. The window includes sections for 'Peripheral IV Laterality' (Left selected) and 'Peripheral IV Catheter Size' (20 gauge selected). The 'OK' button is highlighted with a red box and the number 4.



5. The label created will display at the top, under the Peripheral IV section heading.
6. Double-click the **blue box**  next to the name of the section to document in several cells. You can move through the cells by pressing **Enter** on the keyboard.

Now document the activities related to this PIV using the following data:

- **Activity** = *Insert*
 - **Patient Identified** = *Identification band*
 - **Total Number of Attempts** = *1*
 - **Line Insertion** = *Tourniquet*
 - **Line Status** = *Flushes easily*
 - **Line Care** = *Secured with tape*
 - **Dressing Activity** = *Applied*
 - **Dressing Condition** = *Intact*
7. Click **green checkmark** icon  to sign your documentation. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.



The screenshot shows the CSTLEARNING, DEMOTHETA - 700008216 interface. The top bar displays patient information: DOB: 01-Jan-1937, Age: 80 years, Gender: Male, MRN: 700008216, Enc: 7000000015058, PHN: 9876469824, Code Status, Process: Falls Risk, Disease: Isolation. The left menu includes options like Patient Summary, Orders, MAR, Interactive View and I&O, Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, MAR Summary, Medication List, Patient Information, and Reference. The main area is titled 'Interactive View and I&O' and shows a list of activities under 'Peripheral IV'. A red box highlights the 'Peripheral IV' section, and another red box highlights the 'Activity' dropdown menu. A green checkmark icon is visible in the top right corner of the documentation area.

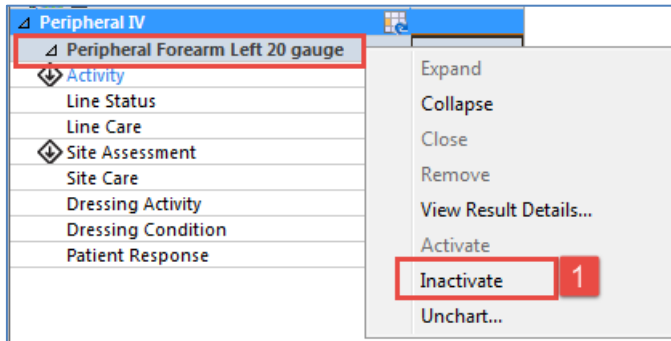
Note: A trigger icon  can be seen in some cells, such as Activity, indicating that there is additional documentation to be completed if certain responses are selected. The diamond icon  indicates the additional documentation cells that appear as a result of these responses being selected. These cells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

2

You can inactivate a dynamic group when it is no longer in use. For example, when an IV, drain or tube is removed.

To inactivate your PIV dynamic group section:

1. Right-click the dynamic group label for the **Peripheral Forearm Left 20 gauge**, and select **Inactivate**.

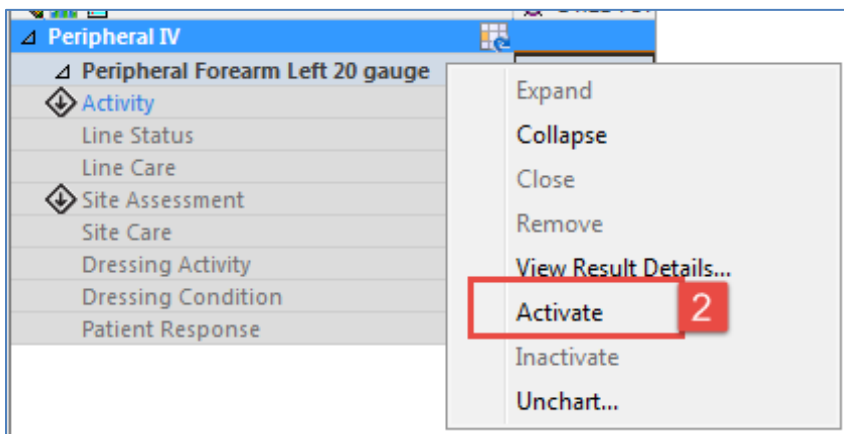


Note: The inactivated dynamic group remains in the view, but is unavailable, meaning clinicians cannot document on it. If there are no results for the time frame displayed, the inactive dynamic group is automatically removed from the display.

If you accidentally inactivate the wrong dynamic group you can re-activate the dynamic group.

To do this:

2. Right-click the dynamic group label for the **Peripheral Forearm Left 20 gauge**, select **Activate**.



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

Key Learning Points

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

Activity 6.5 – Modify, Unchart or Add a Comment in Interactive View

1 You realize upon reviewing your earlier charting that you wrote the incorrect Peripheral Pulse Rate value. Let's modify the Peripheral Pulse Rate.

1. Click on the **Vital Signs** section heading in the **Adult Quick View** band
2. Right-click on the documented value of **91** for **Peripheral Pulse Rate**
3. Select **Modify...**

The screenshot shows the 'Interactive View and I&O' for patient CSTLEARNING, DEMOTHEA. The 'Vital Signs' section is expanded, showing a table of vital signs. The 'Peripheral Pulse Rate' is listed as 91 bpm. A right-click context menu is open over the '91' value, and the 'Modify...' option is highlighted. The table includes fields for Temperature, Heart Rate, Blood Pressure, and Oxygenation.

Vital Sign	Unit	Value
Temperature Axillary	DegC	
Temperature Temporal Artery	DegC	
Temperature Oral	DegC	
Apical Heart Rate	bpm	36.9
Peripheral Pulse Rate	bpm	91
Heart Rate Monitored	bpm	14
SBP/DBP Cuff	mmHg	107
Cuff Location		
Mean Arterial Pressure, Cuff	mmHg	107
Blood Pressure Method		
Cerebral Perfusion Pressure, Cuff	mmHg	
Oxygenation		
Respiratory Rate	br/min	16
Measured O2% (FIO2)		
Oxygen Activity		

4. Enter in new **Peripheral Pulse Rate** = **80** and then click **green checkmark** icon ✓ to sign your documentation.
5. **80** now appears in the cell and an icon 📁 will automatically appear on bottom right corner to denote a modification has been made.

The screenshot shows the 'Interactive View and I&O' for patient CSTLEARNING, DEMOTHEA. The 'Vital Signs' section is expanded, showing a table of vital signs. The 'Peripheral Pulse Rate' is now 80 bpm. A right-click context menu is open over the '80' value, and the 'Modify...' option is highlighted. The table includes fields for Temperature, Heart Rate, Blood Pressure, and Oxygenation.

Vital Sign	Unit	Value
Temperature Axillary	DegC	
Temperature Temporal Artery	DegC	
Temperature Oral	DegC	
Apical Heart Rate	bpm	36.9
Peripheral Pulse Rate	bpm	80
Heart Rate Monitored	bpm	140/90
SBP/DBP Cuff	mmHg	107
Cuff Location		
Mean Arterial Pressure, Cuff	mmHg	107
Blood Pressure Method		
Cerebral Perfusion Pressure, Cuff	mmHg	
Oxygenation		
Respiratory Rate	br/min	16
Measured O2% (FIO2)		
Oxygen Activity		


2

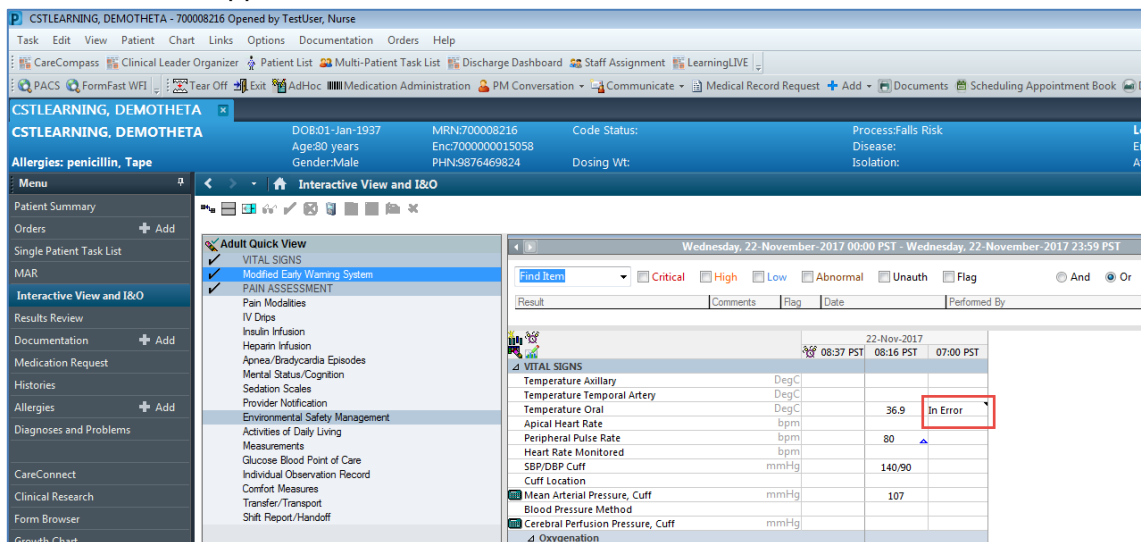
The unchart function will be used when information has been charted in error and needs to be removed. For example, a set of vital signs is charted in the wrong patient's chart.

For this scenario, let's say the temperature documented earlier was meant to be documented on one of your other patient's charts and needs to be uncharted.

1. Right-click on the documented value of **37.5** for Temperature Oral
2. Select **Unchart**

3. The **Unchart** window opens, select **Charted on Incorrect Patient** from the reason dropdown.
4. Click **green checkmark icon** ✓ to sign your documentation

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



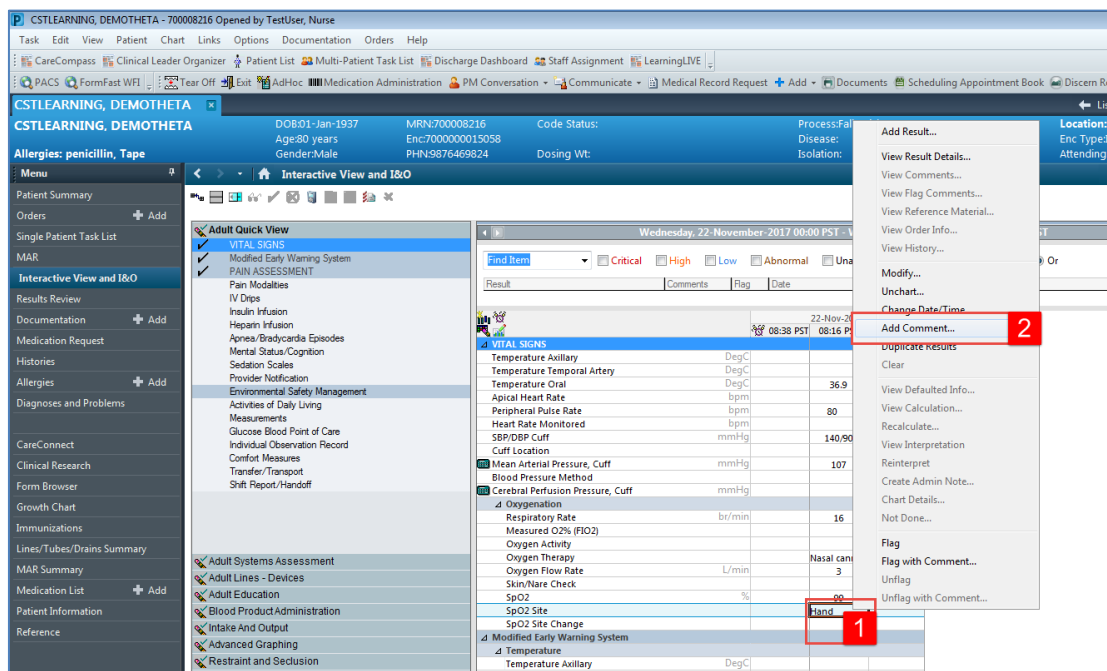
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3

A comment can be added to any cell to provide additional information. For example, you want to clarify that the SpO2 site that you documented was on the patient's right hand.



Let's add this comment.

- Right click on the documented value for SPO2 site, **hand**
- Select **Add Comment**



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3. The comment window opens, type *Right hand* and click **OK**.

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

Result	Comments	Flag	Date	Performed By
VITAL SIGNS				
Temperature Axillary				
Temperature Temporal Artery				
Temperature Oral				
Apical Heart Rate				
Peripheral Pulse Rate				
Heart Rate Monitored				
SBP/DBP Cuff				
Cuff Location				
Mean Arterial Pressure, Cuff				
Blood Pressure Method				
Cerebral Perfusion Pressure, Cuff				
Oxygenation				
Respiratory Rate				
Measured O2% (FIO2)				
Oxygen Activity				
Oxygen Therapy				
Oxygen Flow Rate				
Skin/Nare Check				
SpO2				
SpO2 Site				
SpO2 Site Change				
Modified Early Warning System				
Temperature				



Key Learning Points

- Always sign your documentation once completed
- Results can be modified and uncharted within iView
- A comment can be added to any cell in iView

PATIENT SCENARIO 7 – PowerForms

Learning Objectives





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

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

SCENARIO

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

As an inpatient nurse you will be completing the following activities:

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

Activity 7.1 – Opening and Documenting on PowerForms

- 1 Throughout your shift, you will document on your patient. One way of documenting on your patient is to complete PowerForms.

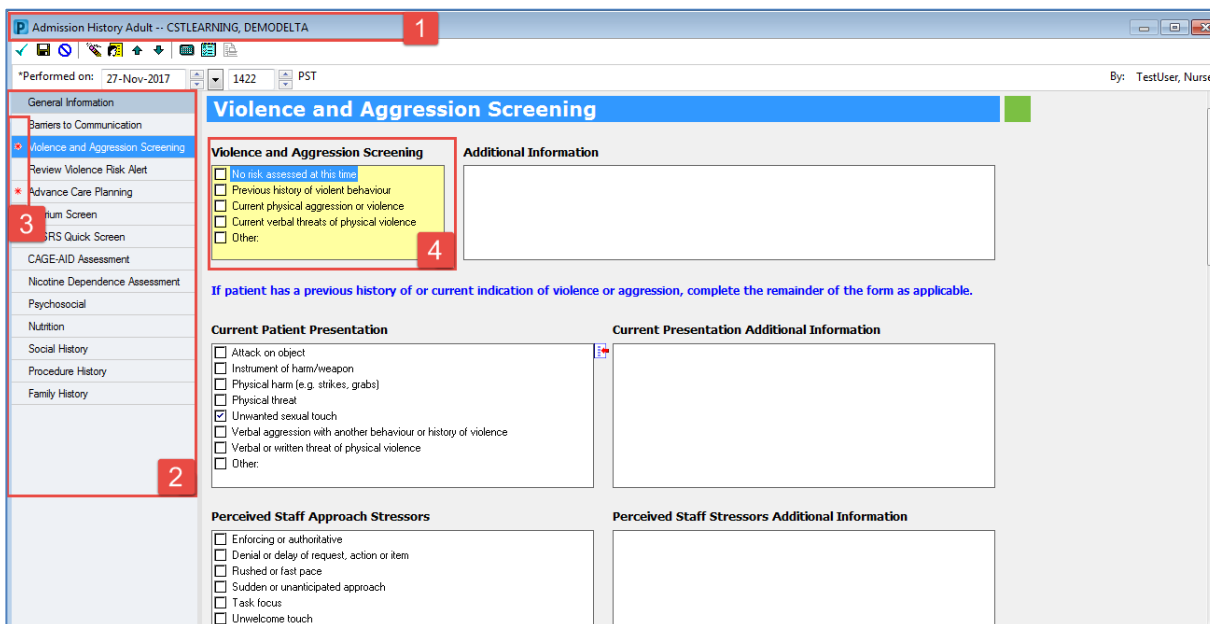
PowerForms are the electronic equivalent of paper forms currently used to document patient information. Data entered in **PowerForms** can flow between other parts of the chart including iView flowsheets, Clinical Notes, Allergy Profile, and Medication Profile.

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

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

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

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



Admission History Adult -- CSTLEARNING, DEMODELTA

*Performed on: 27-Nov-2017 1422 PST By: TestUser, Nurse

Violence and Aggression Screening

Violence and Aggression Screening

☐ No risk assessed at this time

☐ Previous history of violent behaviour

☐ Current physical aggression or violence

☐ Current verbal threats of physical violence

☐ Other:

Additional Information

If patient has a previous history of or current indication of violence or aggression, complete the remainder of the form as applicable.

Current Patient Presentation

☐ Attack on object

☐ Instrument of harm/weapon

☐ Physical harm (e.g. strikes, grabs)

☐ Physical threat

☒ Unwanted sexual touch

☐ Verbal aggression with another behaviour or history of violence

☐ Verbal or written threat of physical violence

☐ Other:

Current Presentation Additional Information

Perceived Staff Approach Stressors

☐ Enforcing or authoritative

☐ Denial or delay of request, action or item

☐ Rushed or fast pace

☐ Sudden or unanticipated approach

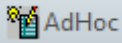
☐ Task focus

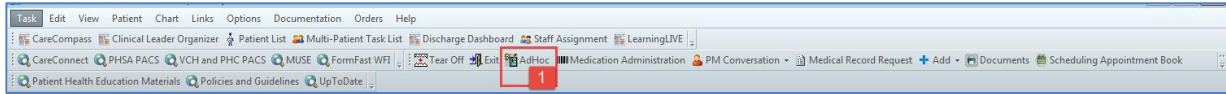
☐ Unwelcome touch

Perceived Staff Stressors Additional Information

In this example we are going to document on the **Advance Care Planning** PowerForm.

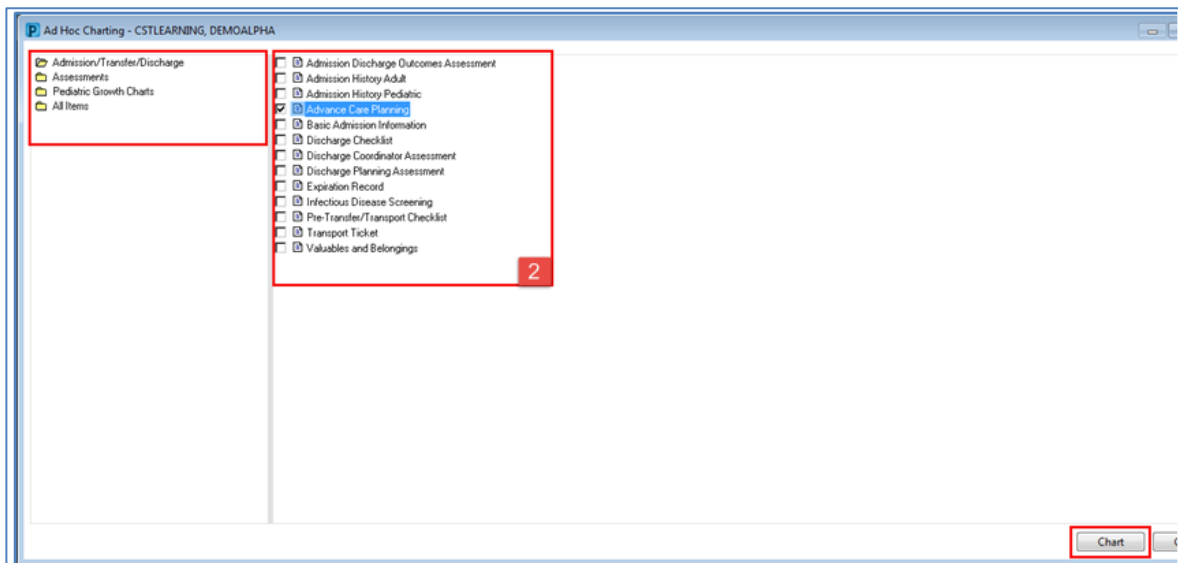
To **open** and **document** on a new PowerForm:

1. Click **AdHoc**  on the **Toolbar**



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


2. Select the **Advance Care Planning** PowerForm by selecting the title and clicking Chart



3. 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**
4. To complete PowerForm, click **green checkmark** icon ✓ to sign and then click the **Refresh** icon ↺.

Note: using the Save Form icon is discouraged because no other user will be able to view your saved documentation until it is signed. To sign use the green checkmark icon ✓.

Key Learning Points

- PowerForms are electronic forms used to chart patient information
- The AdHoc button  AdHoc 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 PowerForm
- Always Sign the PowerForm using green checkmark ✓ so that other users can see it in the chart

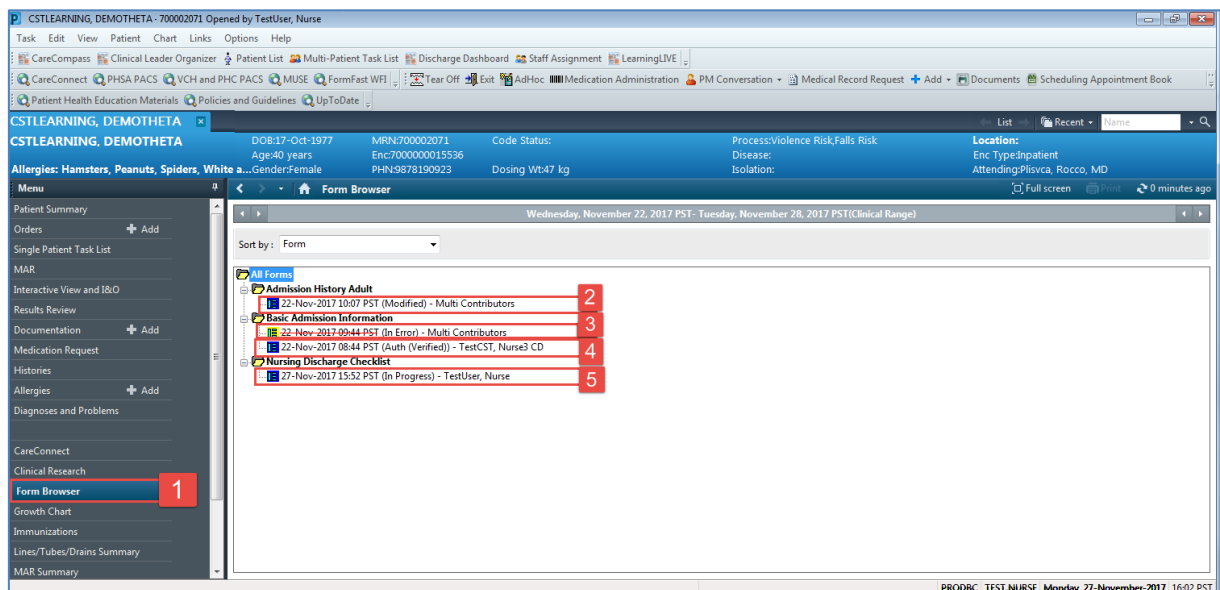
Activity 7.2 – Viewing an existing PowerForm

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 PowerForm can have different statuses (e.g. Modified, In Error, Auth Verified and In Progress)

Activity 7.3 – Modify an existing PowerForm

1

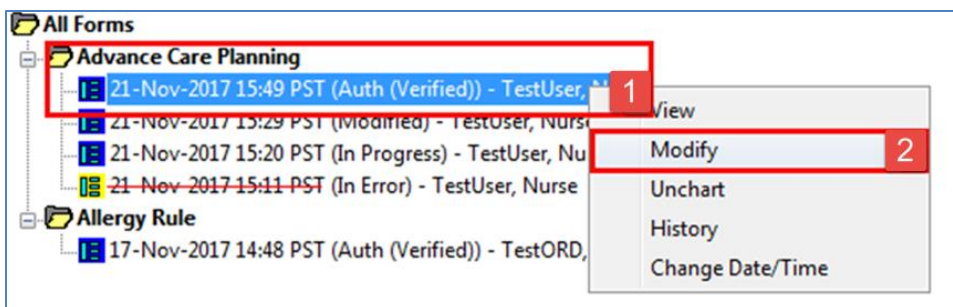
It may be necessary to modify PowerForms if information was entered incorrectly.



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.

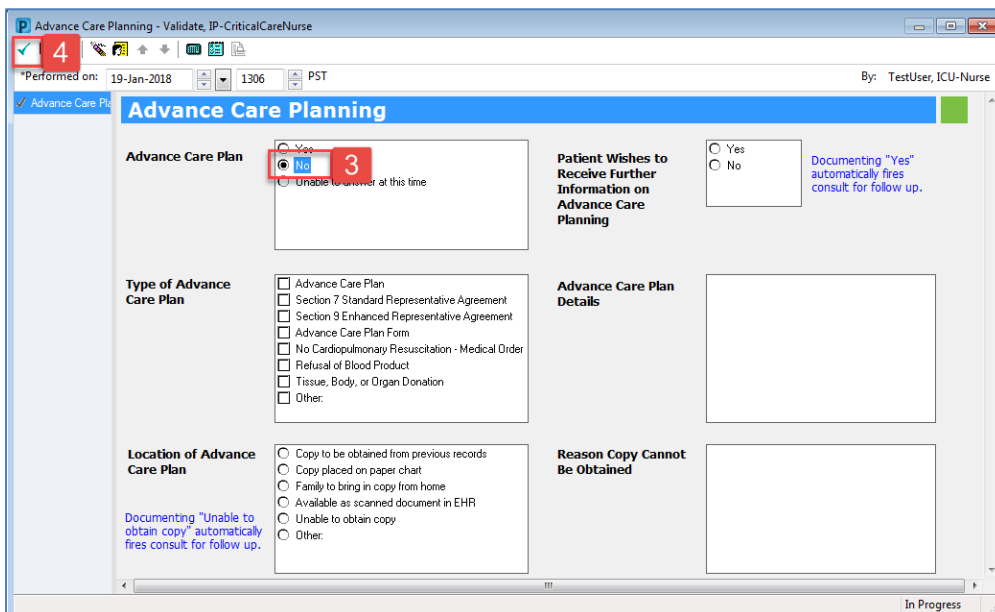
Let's modify the **Advanced Care Planning** form.

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 Plan** from Yes to **No**
4. Click **green checkmark**  to sign the documentation and then then click the **Refresh** icon .



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.

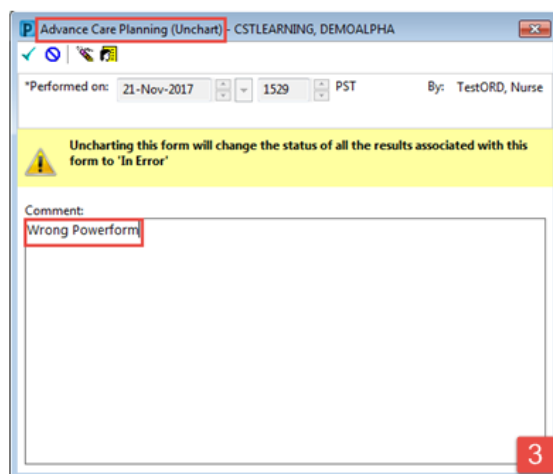
To unchart the PowerForm, within Form Browser:



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



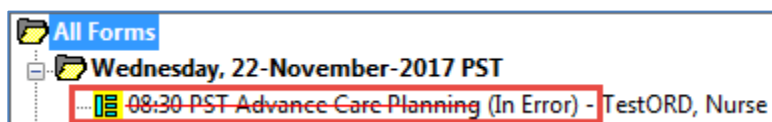
3. The Unchart window opens.

Enter a reason for uncharting in the comment box = *Wrong PowerForm*





4. Click **green checkmark**  to sign the documentation and then click the **Refresh** icon .

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



Key Learning Points

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

PATIENT SCENARIO 8 – Document an Allergy

Learning Objectives

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

- Document Allergies

SCENARIO

In this scenario, we will review how to add and document an allergy for your patient.

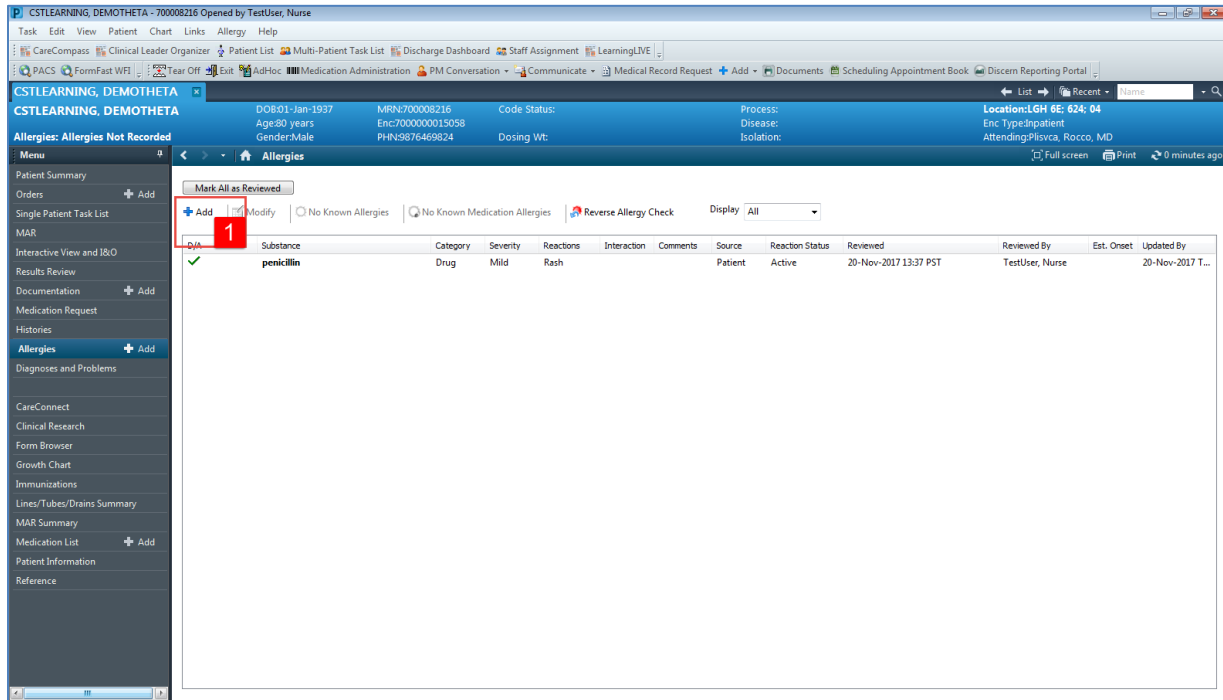
As an inpatient nurse you will complete the following activity:

- Add an allergy

Activity 8.1 – Add an Allergy

1 You notice mild redness to the patient's skin where there is tape applied. The patient then states that he remembers having a similar allergic reaction years ago to tape, but he forgot to mention it in the ED. To document this tape allergy:

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

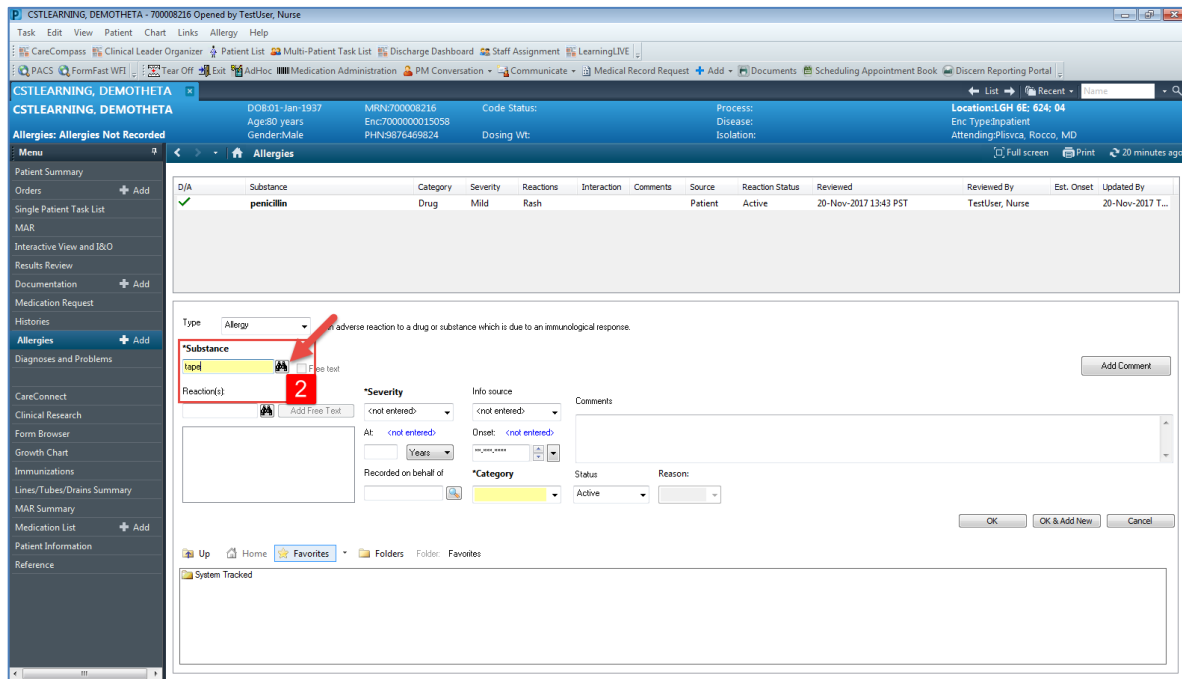


The screenshot shows the patient record for CSTLEARNING, DEMOTHETA. The Allergies section is active, displaying a table with one entry for penicillin. The 'Add' button in the top left of the Allergies section is highlighted with a red box and a red '1'.

Substance	Category	Severity	Reactions	Interaction	Comments	Source	Reaction Status	Reviewed	Reviewed By	Est. Onset	Updated By
penicillin	Drug	Mild	Rash			Patient	Active	20-Nov-2017 13:37 PST	TestUser, Nurse	20-Nov-2017 T...	

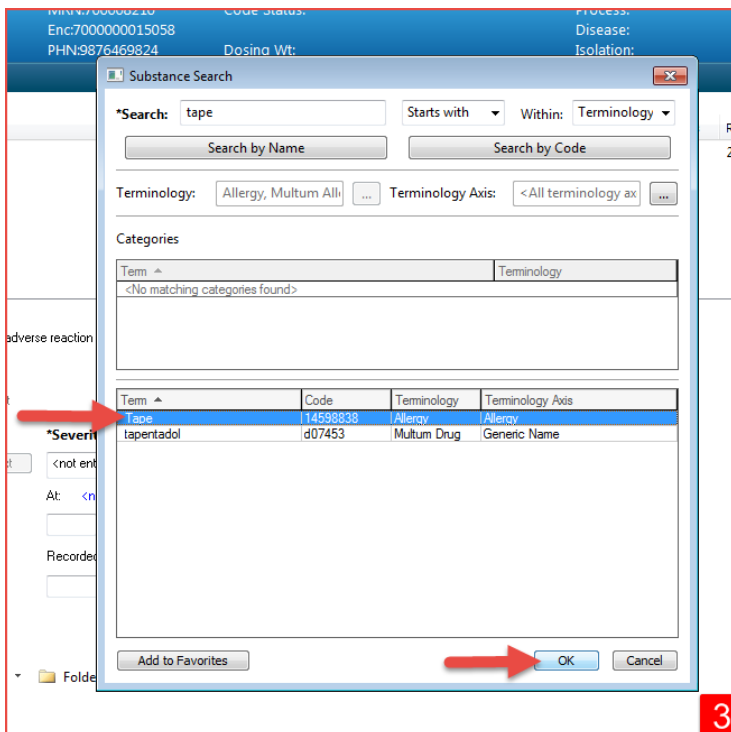
- In the **Substance** field type *tape* and click the **Search** icon .

Note: Yellow highlighted fields including substance and category are mandatory fields that need to be completed.



The screenshot shows the 'Allergies' form in the CSTLEARNING DEMOTHETA application. The Substance field is highlighted in yellow and contains the text 'tape'. A red box highlights the Substance field and the Search icon. A red arrow points to the Search icon. A red number '2' is next to the Search icon.


- The **Substance Search** window opens. Select **Tape** and click **OK**.



The screenshot shows the 'Substance Search' window. The search term 'tape' is entered. The search results show 'Tape' with code '14598838' and 'lapentadol' with code 'd07453'. A red arrow points to the 'Tape' result. A red number '3' is in the bottom right corner.

4. Select **Mild** in the **Severity** drop-down
5. Select **Patient** in the **Info source** drop-down
6. Select **Other** in the **Category** drop-down
7. Click **OK**

The screenshot shows the 'Allergies' form in the CSTLEARNING system. The form is titled 'Allergies: Allergies Not Recorded'. It contains a table with columns: DIA, Substance, Category, Severity, Reactions, Interaction, Comments, Source, Reaction Status, Reviewed, Reviewed By, Est. Onset, and Updated By. The table has one row with the following data: DIA (checkmark), Substance (penicillin), Category (Drug), Severity (Mild), Reactions (Rash), Interaction, Comments, Source (Patient), Reaction Status (Active), Reviewed (20-Nov-2017 13:43 PST), Reviewed By (TestUser, Nurse), Est. Onset (20-Nov-2017 T...), and Updated By (20-Nov-2017 T...). Below the table, there is a form for adding a new allergy. The form has fields for Type (Allergy), Substance (Free text), Reactor(s) (Free text), Severity (Mild), Info source (Patient), Category (Other), Status (Active), and Reason. Red boxes and numbers 4, 5, 6, and 7 highlight the Severity, Info source, Category, and OK button fields respectively.

8. Click the **Refresh** icon  and the tape allergy will now appear in the Banner Bar.

The screenshot shows the 'Allergies' form in the CSTLEARNING system after clicking the Refresh icon. The Banner Bar now shows 'Allergies: penicillin, Tape'. The table below shows two rows: DIA (checkmark), Substance (penicillin), Category (Drug), Severity (Mild), Reactions (Rash), Interaction, Comments, Source (Patient), Reaction Status (Active), Reviewed (20-Nov-2017 13:43 PST), Reviewed By (TestUser, Nurse), Est. Onset (20-Nov-2017 T...), and Updated By (20-Nov-2017 T...); and DIA (checkmark), Substance (Tape), Category (Other), Severity (Mild), Reactions (Rash), Interaction, Comments, Source (Patient), Reaction Status (Active), Reviewed (20-Nov-2017 14:43 PST), Reviewed By (TestUser, Nurse), Est. Onset (20-Nov-2017 T...), and Updated By (20-Nov-2017 T...).

Note: Allergies in the banner bar are sorted by severity (most to least). In this case penicillin causes a more severe reaction than tape. 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 listed first
- Yellow fields are mandatory fields that need to be completed

PATIENT SCENARIO 9 – 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

SCENARIO

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

As a nurse, you will complete the following activities:

-  Review and learn the layout of the MAR
-  Reschedule a medication
-  Request a medication in the MAR

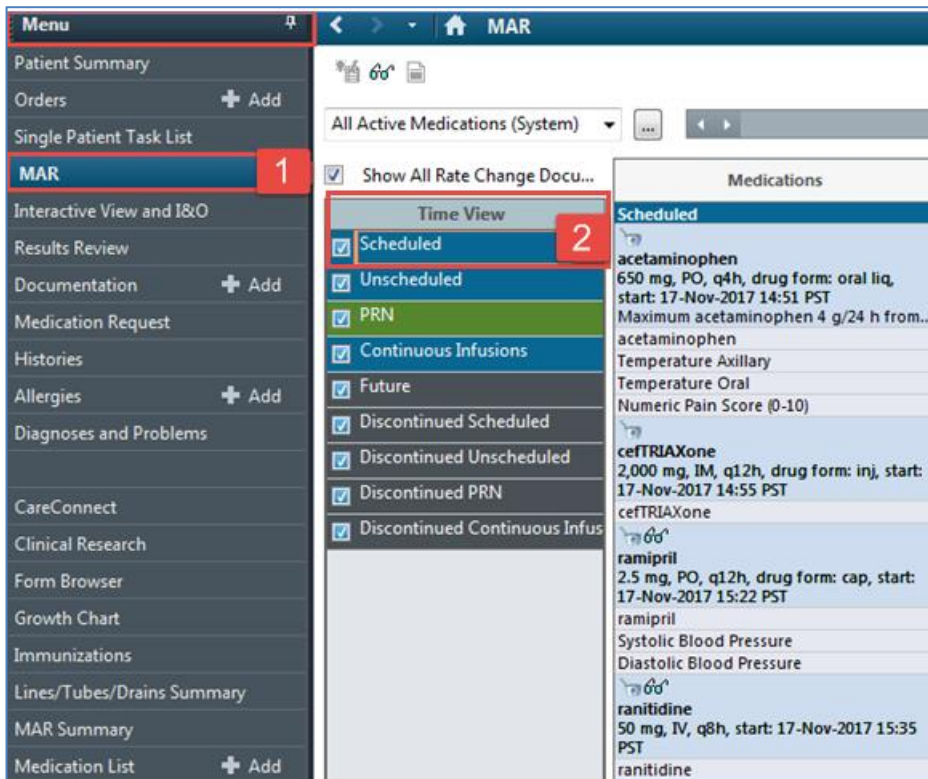
Activity 9.1 – Review the MAR

1

The MAR is a record of medications administered to the patient by 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 and PRN medications.

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



The screenshot shows the MAR interface. On the left, the 'Menu' is visible with 'MAR' selected. The main area displays 'All Active Medications (System)'. Under the 'Time View' section, 'Scheduled' is selected. The right pane shows a list of medications:

Medications
Scheduled
acetaminophen 650 mg, PO, q4h, drug form: oral liq, start: 17-Nov-2017 14:51 PST Maximum acetaminophen 4 g/24 h from...
acetaminophen Temperature Axillary Temperature Oral Numeric Pain Score (0-10)
cefTRIAxone 2,000 mg, IM, q12h, drug form: inj, start: 17-Nov-2017 14:55 PST cefTRIAxone
ramipril 2.5 mg, PO, q12h, drug form: cap, start: 17-Nov-2017 15:22 PST ramipril Systolic Blood Pressure Diastolic Blood Pressure
ranitidine 50 mg, IV, q8h, start: 17-Nov-2017 15:35 PST ranitidine

- [illegible]

[illegible]

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

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



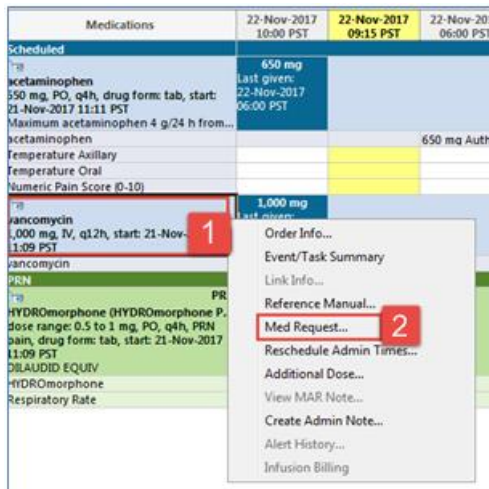
Key Learning Points

- The MAR is a record of the medication administered to the patient by 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

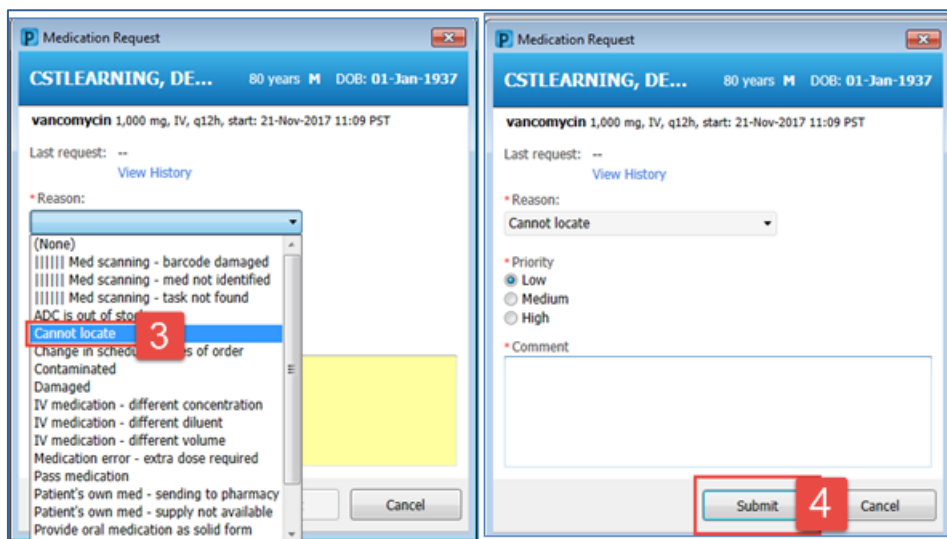
Activity 9.2 – Request a Medication

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**
2. Select **Med Request...**



3. Select **Cannot Locate** under reason
4. Click **Submit**






Key Learning Points

-  Right-clicking on medication order provides options such as Med Request
-  Med Request sends a message to pharmacy to send the medication

PATIENT SCENARIO 10 – Medication Administration

Learning Objectives




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

-  Administer Medication Using the Medication Administration Wizard
-  Document Administration of Different Types of Medication
-  Documenting patient response to medication (Med Response)

SCENARIO

In this scenario, you will be administering IV intermittent, IV continuous and PO medications. You will be using a Barcode Scanner to administer medication. The scanner scans both your patient's wristband and medication barcodes to correctly populate the MAR. The medications to be administered are: acetaminophen 650 mg PO Q4H, hydromorphone 0.5 mg – 1 mg PO Q4h PRN, vancomycin 1 g IV Q12h and IV normal saline at 75 mL/hr.

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

-  Administering medication using the Medication Administration Wizard (MAW) and the barcode scanner
-  Documenting administration of different types of medication
-  Documenting patient response to medication (Med Response)

Activity 10.1 – Administering Medication using the Medication Administration Wizard (MAW) and the Barcode Scanner

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

1 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

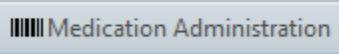
2 It is time to administer the following medications to your patient. You will scan all three medications sequentially.

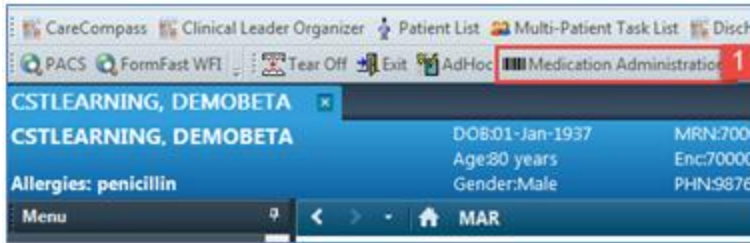
Occasionally a dose requires scanning two pills to make up the full dose. At other times, the dose requires only part of a pill.

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

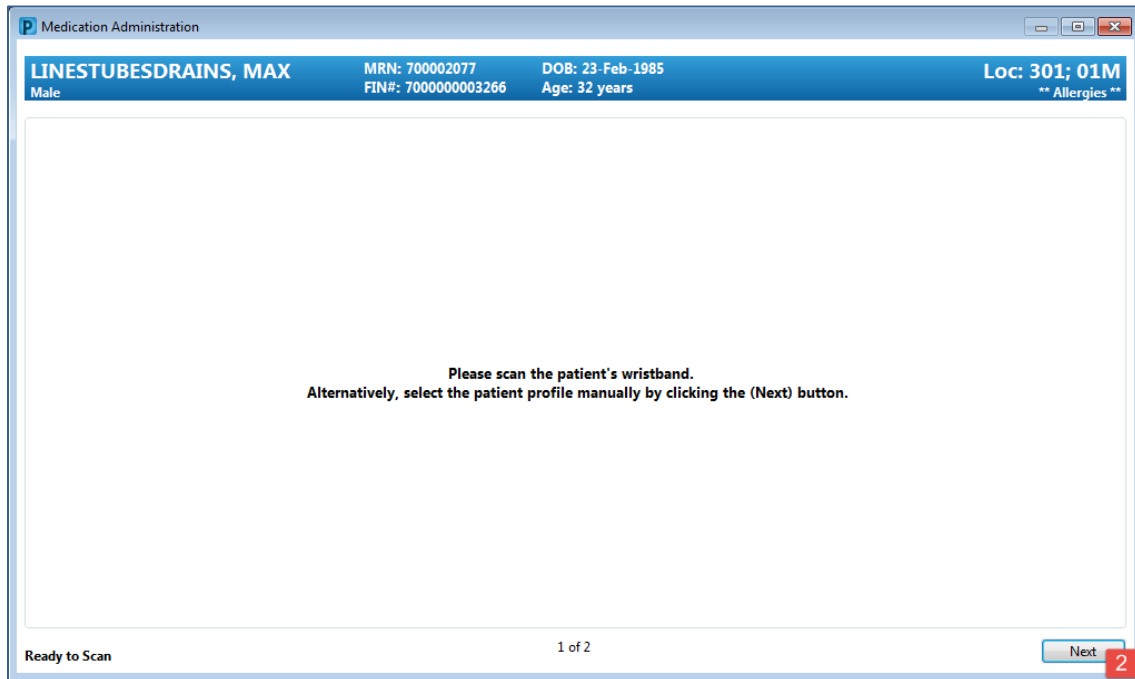
Note: IV normal saline does not have a barcode to be scanned as it is a Stores Item. Stores items are documented on the MAR differently and we will practice this later on.

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)  in the Toolbar



2. The **Medication Administration** window will open



3. Scan the patient's wristband, a window will open displaying the medications that you can administer.

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

Medication Administration

Nurse Review Last Refresh at 11:12 PST

CSTLEARNING, DEMODELTA MRN: 700008217 DOB: 01-Jan-1937 Loc: 620; 02
Male FIN#: 7000000015060 Age: 80 years ** No Known Allergies **

21-Nov-2017 09:57 PST - 21-Nov-2017 12:27 PST

Scheduled	Mnemonic	Details
21-Nov-2017 11:09 PST	vancomycin	1,000 mg, IV, start: 21-Nov-2017 11:09 PST
21-Nov-2017 11:11 PST	acetaminophen	650 mg, PO, drug form: tab, start: 21-Nov-2017 11:11 PST Maximum acetaminophen 4 g/24 h from all sources
PRN	hydromorphone	dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 21-Nov-...
	HYDROmorphone (HYDROmorphone PRN range dose)	DILAUDID EQUIV

Ready to Scan 2 of 2 Back 3

- Scan the medication barcode for **acetaminophen 325 mg** tabs.

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

Filtered Tasks

CSTLEARNING, DEMODELTA MRN: 700008217 DOB: 01-Jan-1937 Loc: 620; 02
Male FIN#: 7000000015060 Age: 80 years ** No Known Allergies **

Scanned:

Medication	Strength	Volume
acetaminophen	325 mg	1 tab

Qualified Tasks:

Scheduled	Mnemonic	Details	Qualifications
21-Nov-2017 11:11 PST	acetaminophen	650 mg, PO, drug form: tab, start: 21-Nov-2017 11:11 PST Maximum acetaminophen 4 g/24 h from all sources	Underdose 4

Scan additional ingredients or choose a task to continue. OK Cancel

- Now scan the second **acetaminophen 325 mg** tab barcode to complete the 2 tablet drug administration. After the second scan, the system finds an exact match for the prescribed dose.

Scheduled	Mnemonic	Details	Result
21-Nov-2017 11:09 PST	vancomycin	1,000 mg. IV, start: 21-Nov-2017 11:09 PST	
21-Nov-2017 11:11 PST	acetaminophen	650 mg. PO, drug form: tab, start: 21-Nov-2017 11:09 PST Maximum acetaminophen 4 g/24 h fr...	5
PRN	hydromorphone	dose range: 0.5 to 1 mg. PO, q4h, PRN p... HYDRomorphone (HYD... DELAUID EQUIV	

Now let's scan the next medication.

1. Scan your medication barcode for **hydromorphone 0.5 mg PO**
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.

Discrete: CSTLEARNING, DEMODELTA (1 of 1)

Range Dose Warning

You are administering a Range Dose order for HYDRomorphone. The range is from 0.5 mg to 1 mg.

Please verify you are administering the correct dose.

OK

3. Click the **Missing Details**  icon.

Medication Administration

Nurse Review Last Refresh at 11:12 PST

CSTLEARNING, DEMODELTA MRN: 700008217 DOB: 01-Jan-1937 Loc: 620; 02
Male FIN#: 7000000015060 Age: 80 years ** No Known Allergies **

21-Nov-2017 09:57 PST - 21-Nov-2017 12:27 PST

Scheduled	Mnemonic	Details	Result
21-Nov-2017 11:09 PST	vancomycin	1,000 mg, IV, start: 21-Nov-2017 11:09 PST	
21-Nov-2017 11:11 PST	acetaminophen	650 mg, PO, drug form: tab, start: 21-Nov-2017 11:09 PST	acetaminophen 650 mg, PO
<input checked="" type="checkbox"/> PRN	hydromorphone	dose range: 0.5 to 1 mg, PO, q4h, PRN...	HYDROMORPHONE 1 mg, PO, pain
	HYDROMORPHONE (HY...DILAUDID EQUIV		

Ready to Scan 2 of 2 Back Sign

4. A charting window will appear. Enter the following details:

- **Respiratory Rate** = 12
- **Hydromorphone** = 0.5 (changed from 1)

5. Click **OK**

Charting for CSTLEARNING, DEMODELTA

HYDROMORPHONE (HYDROMORPHONE PRN range dose)
dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 21-Nov-2017 11:09 PST
DILAUDID EQUIV

*Performed date / time: 21-Nov-2017 11:29 PST

*Performed by: TestUser, Nurse

Witnessed by:

Medication not given within the last 5 days.

Respiratory Rate: 12 breaths per minute

☐ Acknowledge Respiratory Rate: No Result found in previous 5 minutes. Trend

*HYDROMORPHONE: 0.5 mg Volume: 0 ml

Diluent: <none> ml

*Route: PO Site:

Reason: pain

Total Volume: 0 Infused Over: 0 minute

21-Nov-2017 1000 PST 21-Nov-2017 1100 PST 21-Nov-2017 1200 PST 21-Nov-2017 1300 PST 21-Nov-2017 1400 PST 21-Nov-2017 1500 PST

☐ Not Given Reason:

OK Cancel

Let's scan your last medication.

1. Scan the barcode for **vancomycin 1 g IV bag**.
2. The system finds an exact match of the IV medication in **Medication Administration** window. Since this medication is prepared by pharmacy and is reconstituted in 250 ml diluent of D5W, the volume of diluent will be auto-populated and will be forwarded to the intake and output record. Click **vancomycin 1,000 mg IV bag** in the Results column.

The screenshot shows the 'Medication Administration' window for patient CSTLEARNING, DEMOTHEA. The window displays a list of medications with columns for Scheduled, Mnemonic, Details, and Result. The vancomycin entry is highlighted with a red box, and a red arrow points to the 'vancomycin 1,000 mg, IV' result.

Scheduled	Mnemonic	Details	Result
11-Dec-2017 10:42 PST	acetaminophen	650 mg, NG-tube, drug form: tab, star...	acetaminophen 650 mg, NG-tube
11-Dec-2017 10:43 PST	vancomycin	1,000 mg, IV, start: 11-Dec-2017 10:43 ...	vancomycin 1,000 mg, IV
PRN	hydromorphone	dose range: 0.5 to 1 mg, NG-tube, q4h...	HYDROMORPHONE 0.5 mg, NG-tube, pain
Continuous	insulin regular	titrate, IV, 1 unit/h starting rate, 0 unit/h ...	
Continuous	insulin regular (human) ...	Protocol for Patient NOT currently receivi...	
Continuous	norepinephrine	titrate, IV, 0 mcg/min minimum rate, 20 ...	
Continuous	norepinephrine additive...		
Continuous	Sodium Chloride 0.9%	order rate: 125 mL/h, IV, drug form: bag,...	
Continuous	Sodium Chloride 0.9% (...)	order rate: 75 mL/h, IV, drug form: bag, ...	

3. The **Charting** window opens. The premixed volume (250 mL) of Vancomycin prepared by pharmacy is displayed and will automatically flow to I&O. Click **OK** after verification.

Note: If the premixed volume is entered manually by the nurse, the value will not flow to I&O.

Charting for: Validate, IP-CriticalCareNurse

vancomycin
1,000 mg, IV, administer over: 60 minute, drug form: bag, start: 2018-Jan-16 02:00 PST, bag volume (mL): 250

*Performed date / time : 16-Jan-2018 1039 PST

*Performed by : TestUser, ICU-Nurse

Witnessed by :

*vancomycin: 1,000 mg Volume : 250 ml **3**

Diluent : <none> ml

*Route : IV Site :

Total Volume : 250 Infused Over : 60 minute

2018-Jan-16 0900 PST	2018-Jan-16 1000 PST	2018-Jan-16 1100 PST	2018-Jan-16 1200 PST	2018-Jan-16 1300 PST	2018-Jan-16 1400 PST
	87.5	162.5			

☐ Not Given

Reason :

Comment...

OK **3** Cancel

Note: Nurses often mix own IV medications. If so, the barcode on the vial of the medication will be scanned. Enter the **type and amount of diluent** manually in the **Charting** window (screenshot below). The diluent volume will flow to I&O after you click **OK**. If the diluent volume is left blank, no medication volume will be populated in I&O.

Charting for: Validate, IP-CriticalCareNurse

vancomycin
1,000 mg, IV, drug form: inj, start: 2018-Jan-16 10:24 PST

*Performed date / time : 16-Jan-2018 1025 PST

*Performed by : TestUser, ICU-Nurse

Witnessed by :

*vancomycin: 1,000 mg Volume : 0 ml

Diluent : dextrose 5% ml **3**

*Route : IV Site :

Total Volume : 0 Infused Over : 0 minute

2018-Jan-16 0900 PST	2018-Jan-16 1000 PST	2018-Jan-16 1100 PST	2018-Jan-16 1200 PST	2018-Jan-16 1300 PST	2018-Jan-16 1400 PST

☐ Not Given

Reason :

Comment...

OK Cancel

- Now that you have scanned the patient and scanned all the three medications, you can complete your medication checks and administer the medication. Assuming this is complete, now you can sign for the medications administered.

The screenshot shows the 'Medication Administration' window for patient CSTLEARNING, DEMODELTA. Patient details include MRN: 700088217, DOB: 01 Jan 1977, and Age: 80 years. The interface displays a list of scheduled medications with checkboxes for administration. A red box highlights the 'Sign' button at the bottom right, which is labeled with a red '4'.

- After you click **Sign**, a **warning window** displays for you to double check the range dose medication. Click **Yes** to continue.

The warning dialog box states: 'Warning: HYDRomorphine 0.5 mg is not the correct dose as indicated on the order profile. The correct ordered dosage is HYDRomorphine 1 mg. Continue?'. It features 'Yes' and 'No' buttons. A red box highlights the 'Yes' button, which is labeled with a red '5'.

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

Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:54 PST	21-Nov-2017 11:57 PST	21-Nov-2017 11:54 PST	21-Nov-2017 11:11 PST	21-Nov-2017 11:09 PST
Scheduled						
acetaminophen 650 mg, PO, q4h, drug form: tab, start: 21-Nov-2017 11:11 PST Maximum acetaminophen 4 g/24 h from...	650 mg Not previously given				Complete	
Temperature Axillary						
Temperature Oral						
Numeric Pain Score (0-10)						
vancomycin 1,000 mg, IV, q12h, start: 21-Nov-2017 11:09 PST						Complete
PRN						
HYDRomorphine (HYDRomorphine P... dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 21-Nov-2017 11:09 PST	PRN	Med Response	1 mg Not previously given	Complete		
DILAUDID EQUIN						
HYDRomorphine						
Respiratory Rate						

-

7

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

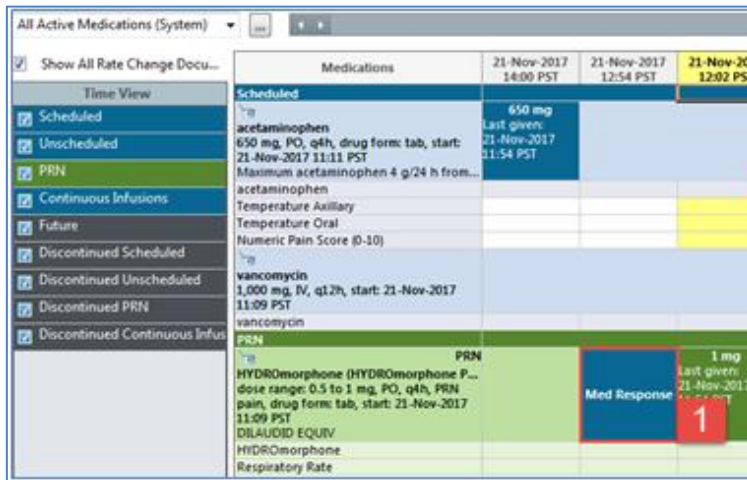
- Use barcode scanner to administer medications
- Medication volumes will flow from the MAR into the Intake and Output section of iView
- Often times, additional information will be required upon administration

Activity 10.2 – Documenting Patient Response to Medication (Medication Response)

1

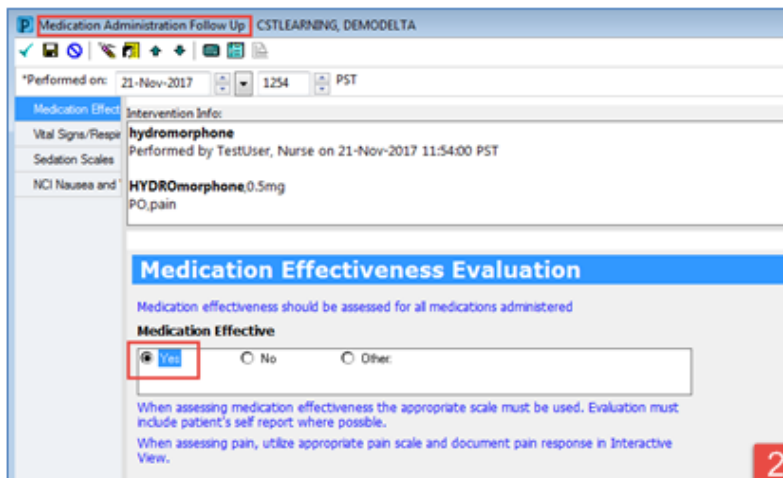
When you administer some PRN medications, it is necessary to document how the patient responds to the medication. You can do this directly in the MAR.

1. Click on the **Medication Response** cell and a Medication Administration Follow Up window will display.



The screenshot shows the 'All Active Medications (System)' window. On the left is a 'Time View' sidebar with options: Scheduled, Unscheduled, PRN, Continuous Infusions, Future, Discontinued Scheduled, Discontinued Unscheduled, Discontinued PRN, and Discontinued Continuous Infusions. The main area displays a grid of medication administration records. A cell for 'HYDROMORPHONE (HYDROMORPHONE P...)' is highlighted in red and labeled 'Med Response' with a red '1' in the bottom right corner. The grid also shows other medications like acetaminophen and vancomycin with their respective dosages and administration times.

2. In the **Medication Effectiveness Evaluation** field, click **Yes**.



The screenshot shows the 'Medication Administration Follow Up' window. The 'Medication Effect' tab is selected. The 'Intervention Info' section shows 'hydromorphone' and 'Performed by TestUser, Nurse on 21-Nov-2017 11:54:00 PST'. The 'Medication Effectiveness Evaluation' section has a blue header and a message: 'Medication effectiveness should be assessed for all medications administered'. Below this, the 'Medication Effective' section has three radio buttons: 'Yes' (selected and highlighted with a red box), 'No', and 'Other'. A red '2' is in the bottom right corner.

3. **Sign** and **Refresh** the screen. Now that you have documented the medication response it has disappeared from the MAR.

All Active Medications (System)				
<input checked="" type="checkbox"/> Show All Rate Change Docu...	Medications	21-Nov-2017 14:00 PST	21-Nov-2017 12:12 PST	21-Nov-2017 11:54 PST
Time View	Scheduled			
<input checked="" type="checkbox"/> Scheduled	acetaminophen	650 mg		
<input checked="" type="checkbox"/> Unscheduled	650 mg, PO, q4h, drug form: tab, start: 21-Nov-2017 11:11 PST	Last given: 21-Nov-2017 11:54 PST		
<input checked="" type="checkbox"/> PRN	Maximum acetaminophen 4 g/24 h from...			
<input checked="" type="checkbox"/> Continuous Infusions	acetaminophen			650 mg Auth (Ve
<input checked="" type="checkbox"/> Future	Temperature Axillary			
<input checked="" type="checkbox"/> Discontinued Scheduled	Temperature Oral			
<input checked="" type="checkbox"/> Discontinued Unscheduled	Numeric Pain Score (0-10)			
<input checked="" type="checkbox"/> Discontinued PRN	vancomycin			
<input checked="" type="checkbox"/> Discontinued Continuous Infus	1,000 mg, IV, q12h, start: 21-Nov-2017 11:09 PST			
	vancomycin			1,000 mg Auth (V
	PRN			
	PRN			
	HYDROmorphine (HYDROmorphine P...		1 mg	
	dose range: 0.5 to 1 mg, PO, q4h, PRN pain, drug form: tab, start: 21-Nov-2017 11:09 PST		Last given: 21-Nov-2017 11:54 PST	
	DILAUDID EQUIV			
	HYDROmorphine			* 0.5 mg Auth (V
	Respiratory Rate			12 Auth (Verifiec

Key Learning Point

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

Activity 10.3 – Administering Continuous IV fluids (Non-barcoded)

1

To administer normal saline continuous IV infusion, from the MAR:

- 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.


The screenshot shows the MAR interface. On the left, the 'MAR' menu item is selected. The main window displays a table of medications. A red box highlights the 'Sodium chloride 0.9%' medication, which is marked as 'Pending' and 'Not previously given'.

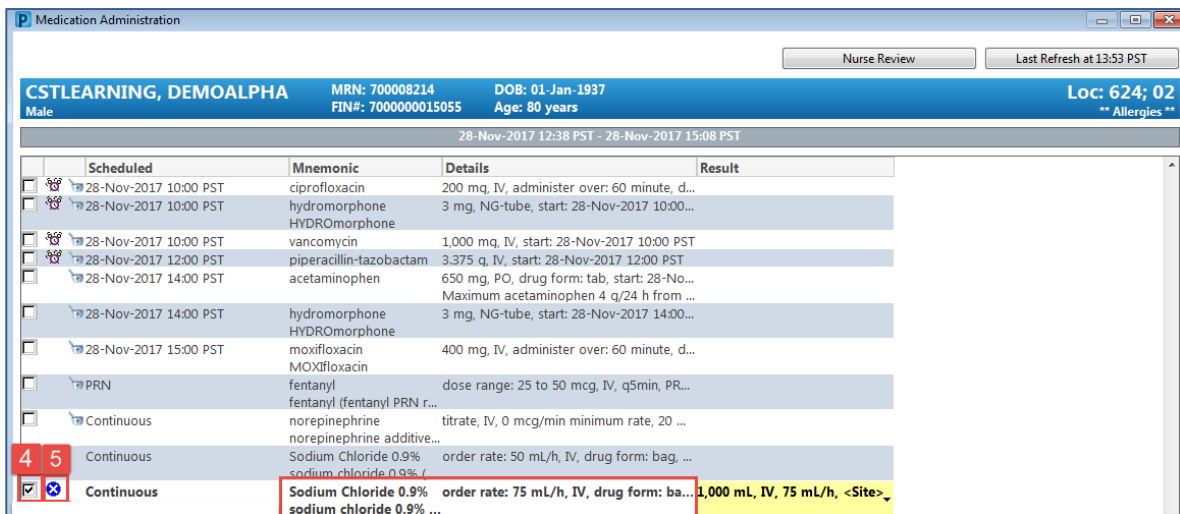
- To administer the infusion, click on **Medication Administration** from the toolbar.

The screenshot shows the software toolbar. The 'Medication Administration' button is highlighted with a red box and labeled with a red '2'.

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

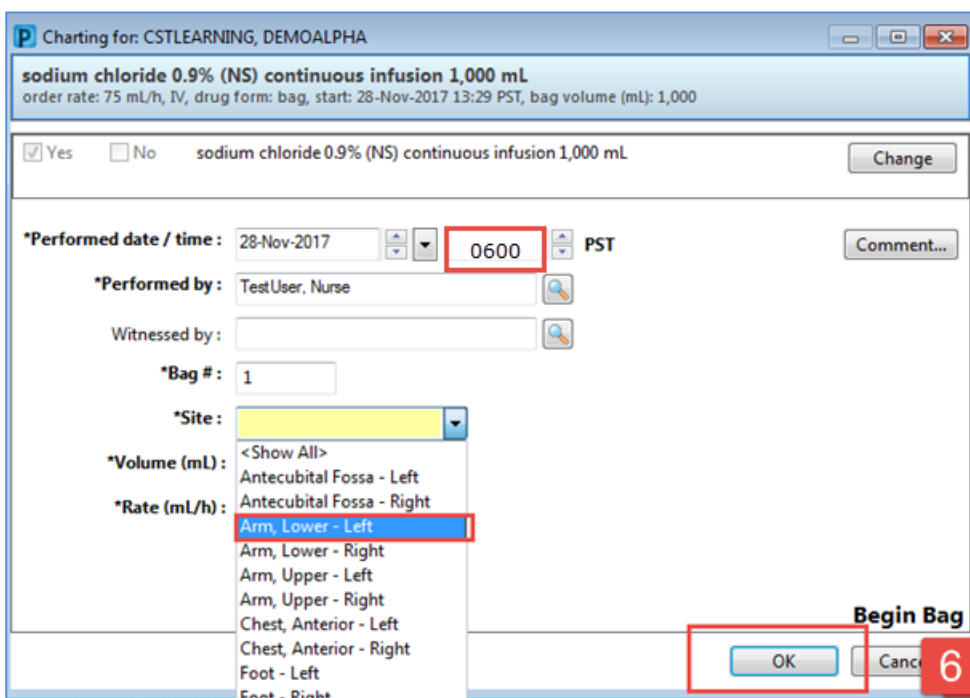
The screenshot shows the Medication Administration window. The patient information is displayed at the top: LINESTUBESDRAINS, MAX, MRN: 700002077, DOB: 23-Feb-1985, Loc: 301; 01M. The main area contains the instruction: "Please scan the patient's wristband. Alternatively, select the patient profile manually by clicking the (Next) button." A red box highlights the 'Next' button at the bottom right, labeled with a red '3'.

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



Scheduled	Mnemonic	Details	Result
<input type="checkbox"/> 28-Nov-2017 10:00 PST	ciprofloxacin	200 mg, IV, administer over: 60 minute, d...	
<input type="checkbox"/> 28-Nov-2017 10:00 PST	hydromorphone HYDROmorphone	3 mg, NG-tube, start: 28-Nov-2017 10:00...	
<input type="checkbox"/> 28-Nov-2017 10:00 PST	vancomycin	1,000 mg, IV, start: 28-Nov-2017 10:00 PST	
<input type="checkbox"/> 28-Nov-2017 12:00 PST	piperacillin-tazobactam	3.375 q, IV, start: 28-Nov-2017 12:00 PST	
<input type="checkbox"/> 28-Nov-2017 14:00 PST	acetaminophen	650 mg, PO, drug form: tab, start: 28-No... Maximum acetaminophen 4 q/24 h from ...	
<input type="checkbox"/> 28-Nov-2017 14:00 PST	hydromorphone HYDROmorphone	3 mg, NG-tube, start: 28-Nov-2017 14:00...	
<input type="checkbox"/> 28-Nov-2017 15:00 PST	moxifloxacin MOXifloxacin	400 mg, IV, administer over: 60 minute, d...	
<input type="checkbox"/> PRN	fentanyl fentanyl (fentanyl PRN r...	dose range: 25 to 50 mcg, IV, q5min, PR...	
<input type="checkbox"/> Continuous	norepinephrine norepinephrine additive...	titrate, IV, 0 mcg/min minimum rate, 20 ...	
<input checked="" type="checkbox"/> 4 5 Continuous	Sodium Chloride 0.9%	order rate: 50 mL/h, IV, drug form: bag, ...	
<input checked="" type="checkbox"/> Continuous	Sodium Chloride 0.9% sodium chloride 0.9% ...	order rate: 75 mL/h, IV, drug form: ba... 1,000 mL, IV, 75 mL/h, <Site>...	

6. Fill in the mandatory information, in this case: **Site = Arm, Lower-Left** and click **OK**
For the purpose of this scenario, please fill in **Performed time = 0600**



Charting for: CSTLEARNING, DEMOALPHA

sodium chloride 0.9% (NS) continuous infusion 1,000 mL
order rate: 75 mL/h, IV, drug form: bag, start: 28-Nov-2017 13:29 PST, bag volume (mL): 1,000

☒ Yes ☐ No sodium chloride 0.9% (NS) continuous infusion 1,000 mL Change

*Performed date / time: 28-Nov-2017 0600 PST Comment...

*Performed by: TestUser, Nurse Search

Witnessed by: Search

*Bag #: 1

*Site: Antecubital Fossa - Left
Antecubital Fossa - Right
Arm, Lower - Left
Arm, Lower - Right
Arm, Upper - Left
Arm, Upper - Right
Chest, Anterior - Left
Chest, Anterior - Right
Foot - Left
Foot - Right

*Volume (mL): <Show All>
1,000

*Rate (mL/h): 75

Begin Bag
OK Cancel 6

7. Click **Sign** and you will be brought back to the **MAR** where the sodium chloride 0.9% continuous infusion at 75mLh is now shown as complete.

sodium chloride 0.9% (NS) continuous infusion 1,000 mL order rate: 75 mL/h, IV, drug form: bag, start: 28-Nov-2017 13:29 PST, bag volume (mL): 1,000	Complete
Administration Information	
sodium chloride 0.9%	7

Note: do not use the following steps in the system, just review the screenshot below for reference.



8. All fluids administered through MAR and MAW should flow to the **Intake and Output** record within iView. Sometimes the volumes flow automatically. For continuous infusions the hourly volumes will need to be populated by double-clicking in the hourly cells. Always double check the volumes flow correctly

Sunday, 03-December-2017 06:00 PST - Wednesday, 06-December-2017 05:59 PST											
Today's Intake: 1000 mL		Output: 0 mL		Balance: 1000 mL		Yesterday's Intake: 0 mL		Output: 0 mL		Balance: 0	

PATIENT SCENARIO 11 – 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 result review.

You will complete the following activity:

-  Review results using Results Review

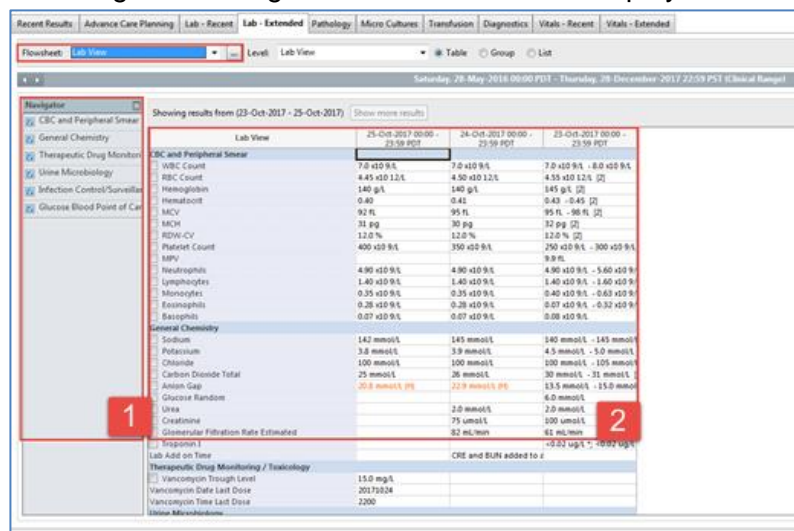
Activity 11.1 – Review Results Using Results Review

- 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.



The screenshot shows the 'Results Review' interface. On the left is the 'Navigator' pane with a tree view of categories. The 'Results Display' grid on the right shows lab results for a patient. A red box labeled '1' highlights the Navigator, and another red box labeled '2' highlights the Results Display grid.

Category	23-Oct-2017 00:00 - 23:59 PDT	24-Oct-2017 00:00 - 23:59 PDT	23-Oct-2017 00:00 - 23:59 PDT
CBC and Peripheral Smear			
WBC Count	7.0 x10 ⁹ /L	7.0 x10 ⁹ /L	7.0 x10 ⁹ /L - 8.0 x10 ⁹ /L
RBC Count	4.45 x10 ¹² /L	4.50 x10 ¹² /L	4.55 x10 ¹² /L [2]
Hemoglobin	140 g/L	140 g/L	145 g/L [2]
Hematocrit	0.40	0.41	0.43 - 0.49 [2]
MCV	92 fL	95 fL	95 fL - 98 fL [2]
MCH	31 pg	30 pg	32 pg [2]
RDW-CV	12.0 %	12.0 %	12.0 % [2]
Platelet Count	400 x10 ⁹ /L	350 x10 ⁹ /L	250 x10 ⁹ /L - 300 x10 ⁹ /L
MPV			9.9 fL
Neutrophils	4.90 x10 ⁹ /L	4.90 x10 ⁹ /L	4.90 x10 ⁹ /L - 5.60 x10 ⁹ /L
Lymphocytes	1.40 x10 ⁹ /L	1.40 x10 ⁹ /L	1.40 x10 ⁹ /L - 1.60 x10 ⁹ /L
Monocytes	0.35 x10 ⁹ /L	0.35 x10 ⁹ /L	0.40 x10 ⁹ /L - 0.63 x10 ⁹ /L
Eosinophils	0.28 x10 ⁹ /L	0.28 x10 ⁹ /L	0.07 x10 ⁹ /L - 0.52 x10 ⁹ /L
Basophils	0.07 x10 ⁹ /L	0.07 x10 ⁹ /L	0.00 x10 ⁹ /L
General Chemistry			
Sodium	142 mmol/L	145 mmol/L	140 mmol/L - 145 mmol/L
Potassium	3.8 mmol/L	3.9 mmol/L	4.5 mmol/L - 5.0 mmol/L
Chloride	100 mmol/L	100 mmol/L	100 mmol/L - 105 mmol/L
Carbon Dioxide Total	25 mmol/L	26 mmol/L	20 mmol/L - 31 mmol/L
Anion Gap	-0.5 mmol/L [2]	-2.9 mmol/L [2]	13.5 mmol/L - 15.0 mmol/L
Glucose Random			6.0 mmol/L
Urea		2.0 mmol/L	2.0 mmol/L
Creatinine		75 umol/L	100 umol/L
Glomerular Filtration Rate Estimated		82 mL/min	61 mL/min
Tropoin T			<0.02 ug/L - <0.02 ug/L
Lab Add on Time			CRP and BUN added to s
Therapeutic Drug Monitoring / Toxicology			
Vancomycin Trough Level	15.0 mg/L		
Vancomycin Dose Last Dose	20170824		
Vancomycin Time Last Dose	2200		
Urine Microbiology			

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**

The screenshot shows the 'Results Review' interface. On the left is a 'Menu' sidebar with various options. The 'Results Review' option is highlighted with a red box and a red number '1'. The main area shows a 'Recent Results' tab selected, with a red box and a red number '2' over the 'Recent Results' label. Below the tabs, there's a 'Quick View' button with a red box and a red number '4' over it. The 'Lab - Recent' tab is also visible with a red box and a red number '3' over it. The main content area displays a table of vital signs and oxygenation data for two dates: 28-Nov-2017 18:17 PST and 28-Nov-2017 18:13 PST. The table includes rows for Temperature Oral, Peripheral Pulse Rate, SBP/DBP Cuff, Systolic Blood Pressure, Diastolic Blood Pressure, Oxygenation, and Respiratory Rate. A 'Navigator' panel on the left shows 'VITAL SIGNS' and 'PAIN ASSESSMENT' sections.

5. Review your patient's recent lab results.

CBC and Peripheral Smear	
<input type="checkbox"/> WBC Count	1.5 x10 ⁹ /L (L)
<input type="checkbox"/> RBC Count	2.00 x10 ¹² /L (L)
<input type="checkbox"/> Hemoglobin	70 g/L (L)
<input type="checkbox"/> Hematocrit	0.15 (L)
<input type="checkbox"/> MCV	98 fL
<input type="checkbox"/> MCH	28 pg
<input type="checkbox"/> RDW-CV	15.3 % (H)
<input type="checkbox"/> Platelet Count	10 x10 ⁹ /L (L)
<input type="checkbox"/> NRBC Absolute	5.0 x10 ⁹ /L (H)
<input type="checkbox"/> Neutrophils	0.04 x10 ⁹ /L (L)
<input type="checkbox"/> Lymphocytes	0.15 x10 ⁹ /L (L)
<input type="checkbox"/> Monocytes	0.23 x10 ⁹ /L
<input type="checkbox"/> Eosinophils	0.01 x10 ⁹ /L
<input type="checkbox"/> Basophils	0.01 x10 ⁹ /L
<input type="checkbox"/> Metamyelocytes	0.73 x10 ⁹ /L (H)
<input type="checkbox"/> Myelocytes	0.23 x10 ⁹ /L (H)
<input type="checkbox"/> Promyelocytes	0.08 x10 ⁹ /L (H)
<input type="checkbox"/> Blast Cells	0.02 x10 ⁹ /L (H)
Blood Film Comment	Platelet Estimate - Decreased

Note the colours of specific lab results and what they indicate:

- **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, cultures, transfusions, medical imaging, and vital signs
- 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 12 – 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:

- Navigating to intake and output flowsheets within iView
- Reviewing and documenting in the intake and output record

Activity 12.1 – Navigating to Intake and Output Flowsheets Within iView

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

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 specific time ranges. The left portion of the I&O screen lists different intake and output categories. 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

1. Navigate to the **Interactive View and I&O** from the Menu

2. Select the **Intake and Output** band

The screenshot displays the iView software interface for a patient named CSTLEARNING, DEMOTHETA. The interface includes a menu on the left, a central list of flowsheet bands, and a main data entry area on the right.


Step 1: The menu on the left is expanded, and "Interactive View and I&O" is highlighted with a red box and a red number 1.

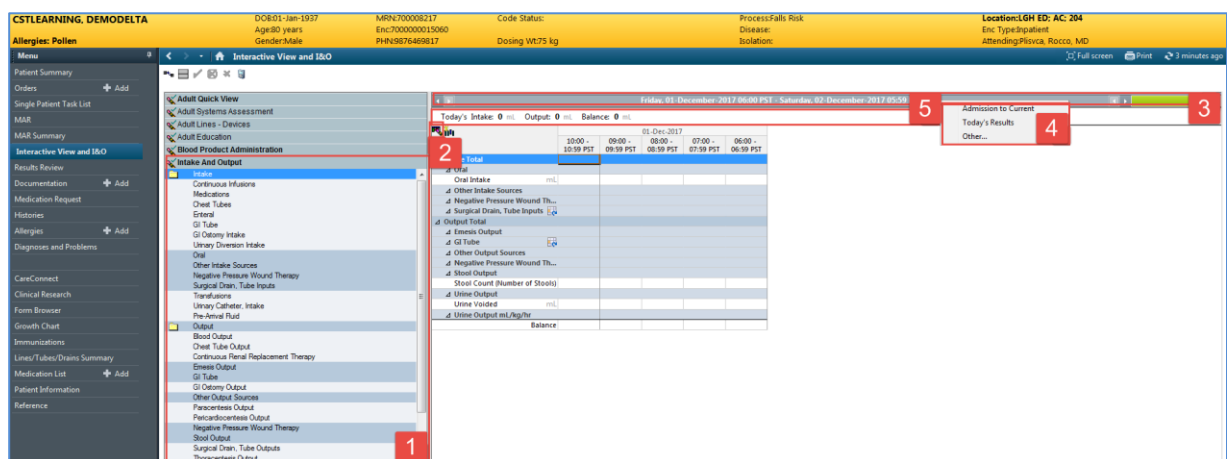
Step 2: In the central list of bands, "Intake And Output" is highlighted with a red box and a red number 2.

The main data entry area shows a table for "Wednesday, 22-November-2017 00:00 PST - Wednesday, 22-November-2017 23:59 PST". The table has columns for "Find Item", "Critical", "High", "Low", "Abnormal", "Unauth", "Flag", "And", "Or", "Result", "Comments", "Flag", "Date", and "Performed By". The table is currently empty.

- 2 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.

The intake and output screen can be described 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.



The screenshot displays the 'Interactive View and I&O' window for a patient named 'CST Learning, DEMODELTA'. The patient's information includes DOB (01-Jan-1937), Age (80 years), Gender (Male), MRN (7000000115080), Enc (7000000115080), PHN (9876469817), and Dosing (Wt 75 kg). The patient is currently in 'Admission to Current' status, with 'Today's Results' and 'Other...' options available. The I&O summary table shows 'Today's Intake: 0 mL', 'Output: 0 mL', and 'Balance: 0 mL'. The table also includes columns for 'Total', 'Oral Intake', 'Other Intake Sources', 'Negative Pressure Wound Th...', 'Surgical Drain, Tube Inputs', 'GI Tube', 'GI Output', 'Other Output Sources', 'Negative Pressure Wound Th...', 'Stool Output', 'Urine Output', 'Urine Voided', and 'Urine Output mL/kg/hr'. The 'Balance' row shows a total of 0 mL.

Key Learning Point

Intake and Output (I&O) is found as a band within iView and is where a patient's intake and output will be documented

Activity 12.2 – Reviewing and Documenting in the Intake and Output Record

1

Let's practice reviewing and documenting in the I&O record.

Previously a peripheral IV and sodium chloride infusion were initiated. An IV vancomycin dose was also given.

Review to ensure the appropriate values are displaying in the I&O record.

1. Continuous Infusions: sodium chloride 0.9%

- Double-click in each **hourly time column** since the sodium chloride infusion was initiated (at 0600). Values will populate to reflect the order of 75mL/hr.

Note: a partial volume will display if the infusion was not initiated on the hour.

2. Medications: vancomycin

- Value should display as a single dose amount
- Values will pull from Medication Administration Wizard (MAW) documentation

Today's Intake: 876.5 mL Output: 375 mL Balance: 501.5 mL Yesterday's Intake: 0 mL Output: 0 mL Balance: 0 mL												
	10:00 - 10:59 PST	09:00 - 09:59 PST	08:00 - 08:59 PST	07:00 - 07:59 PST	06:00 - 06:59 PST	24 Hour Total	Night Shift Total	05:00 - 05:59 PST	04:00 - 04:59 PST	03:00 - 03:59 PST	02:00 - 02:59 PST	01:00 - 01:59 PST
Intake Total	626.5	50	50	75	75							
Continuous Infusions	66.25	50	50	75	75							
sodium chloride 0.9% (NS) continuous infusion 1,000 mL				75	75							
Medications	510.25											
HYDROMORPHONE + sodium chl...	10.25											
vancomycin + dextrose 5%	500											
Oral	50											
Oral Intake	50											
Other Intake Sources												
Negative Pressure Wound Therapy												
Surgical Drain, Tube Inputs												
Output Total	375											
Emesis Output												
GI Tube												
Nasogastric (NG) tube Nare, left												
Output												
Irrigant Out												
Residual Discarded												
Gastrostomy (G) tube Left upper...												
Output												
Irrigant Out												
Residual Discarded												

Once you double click in the blank cells, the hourly volume of the continuous infusion will populate

Now let's practice documenting some intake and output values. For this activity, your patient drank **50 mL** and voided **375 mL** and now you need to document these values.

1. Locate **Oral** and **Urine Output** sections in the I&O navigator
2. In the flowsheet on the right, document the following by clicking into the appropriate cell.
 - **Oral Intake = 50 mL**
 - **Urine Voided = 375 mL**
3. Click **Sign**

The screenshot displays the CSTLEARNING DEMOTHETA I&O flowsheet. The interface includes a patient summary on the left, a central I&O navigator, and a detailed I&O flowsheet on the right. Red boxes and numbers highlight the required documentation steps:

- Box 3:** Points to the 'Intake And Output' section in the I&O navigator.
- Box 1:** Points to the 'Oral Intake' section in the I&O navigator.
- Box 2:** Points to the 'Urine Output' section in the I&O navigator.
- Box 1:** Points to the 'Oral Intake' section in the I&O flowsheet.
- Box 2:** Points to the 'Urine Output' section in the I&O flowsheet.

The I&O flowsheet shows the following data for Today's Intake and Output:

Category	Intake	Output	Balance
Intake Total	1318	0	1318
Output Total	0	0	0
Balance	1318	0	1318

A separate column exists for the fluid balance of your patient:




- 12 hour Day/Night Shift Total
- Hourly Total

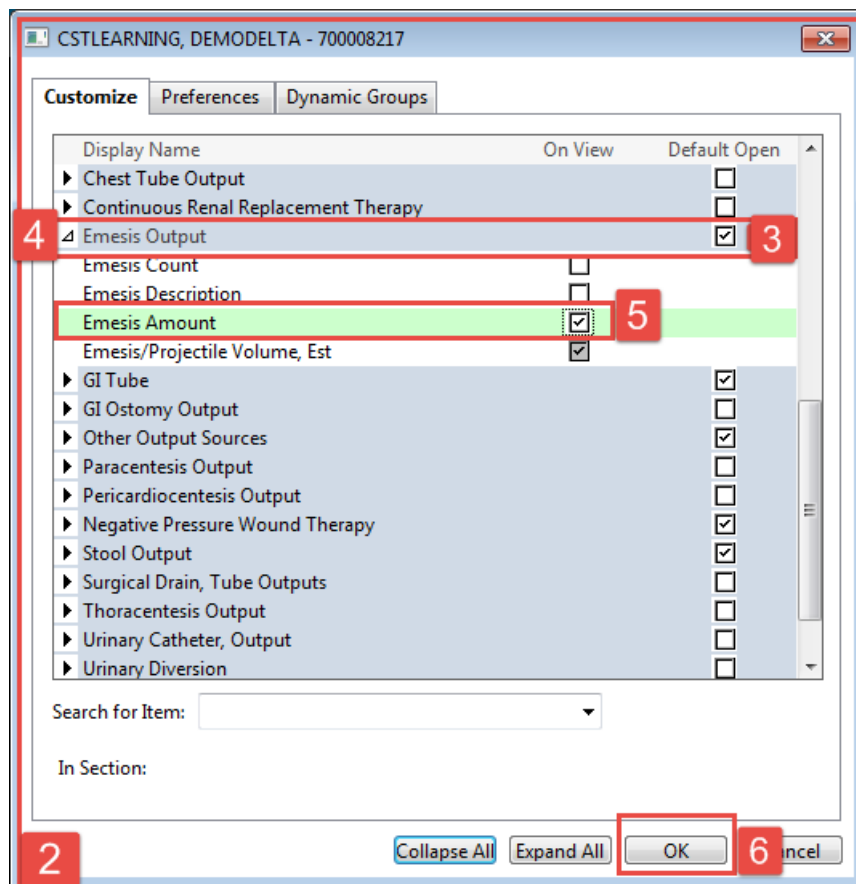
Note: It is important that you verify all volumes are entered correctly. The system automatically calculates fluid balances based on the volumes entered.

You can also unchart, modify or add a comment to any result.



- Right-click on a cell to see additional functions.

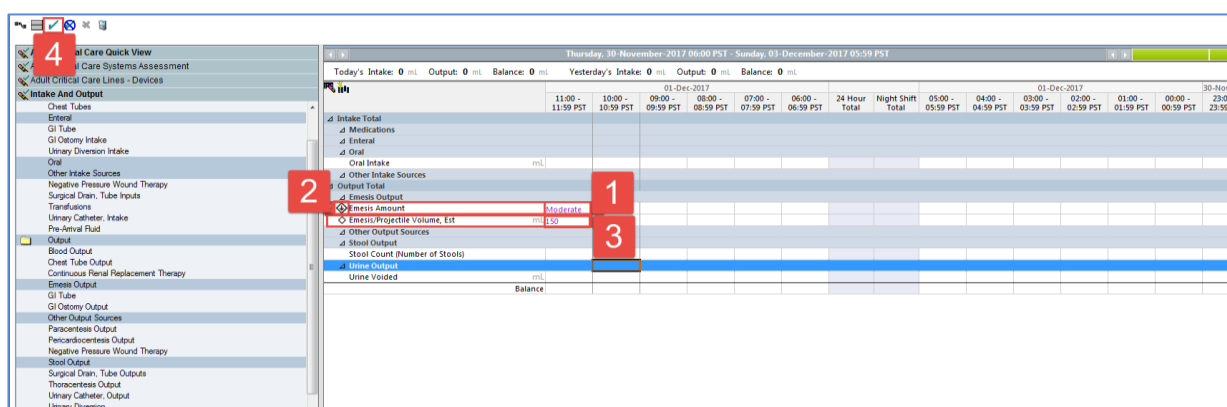
Now let's say your patient just vomited and you need to document the **Emesis Amount**. You need to add in this section because it is not yet active in the I&O band

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** section and click the box ☒ under the **Default Open** column
4. Open the **Emesis Output** section by clicking the arrow  to expand the section.
5. You want to document the volume the patient vomited, so click the box ☒ next to **Emesis Amount**. Click **OK**
6. Click the **Refresh** icon .




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.
3. Enter the following volume **Emesis/Projectile Volume, Est** = 150 and press **Enter** on your keyboard.
4. Click **green checkmark** icon  to sign. You will now see this volume displayed in the patient's fluid balance.



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
- Continuous infusion volumes will flow into I&O by double clicking on each hourly cell
- IV medications need to have the **Diluent Volume** entered upon administration in order for the volume of the med to flow to I&O
- Some values will require direct charting in the Intake and Output band e.g. oral intake
- It is important to verify all volumes in I&O are accurate. The system automatically calculates fluid balance totals based on these volumes
- Values can be modified and uncharted within Interactive View and I&O
- Use the Customize View icon  to add sections to I&O that may not already be active

PATIENT SCENARIO 13 - Modified Early Warning System (MEWS)

Learning Objectives

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

- Understand the purpose of using the Modified Early Warning System
- Document on MEWS
- Manage a MEWS alert

SCENARIO

In this scenario, you will be managing a MEWS alert for your patient.

You will complete the following activities:

- Document on the MEWS section in iView to trigger a MEWS alert
- Review the MEWS alert
- Document provider notification

Activity 13.1 – Document on MEWS Section in iView to Trigger a MEWS Alert

The purpose of the Modified Early Warning System (MEWS) is to aid in the early detection of patient deterioration so that timely attention can be provided to the patient by health care professionals.

MEWS is scored based on 5 key assessment parameters: systolic blood pressure, heart rate, respiratory rate, temperature, and level of consciousness. A score is then totaled based on the values documented. If the score is out of normal or expected range, or if new documentation for situational awareness factors indicates a change for the worse, an electronic alert will be triggered to warn nurses that the patient may be deteriorating and require timely attention.

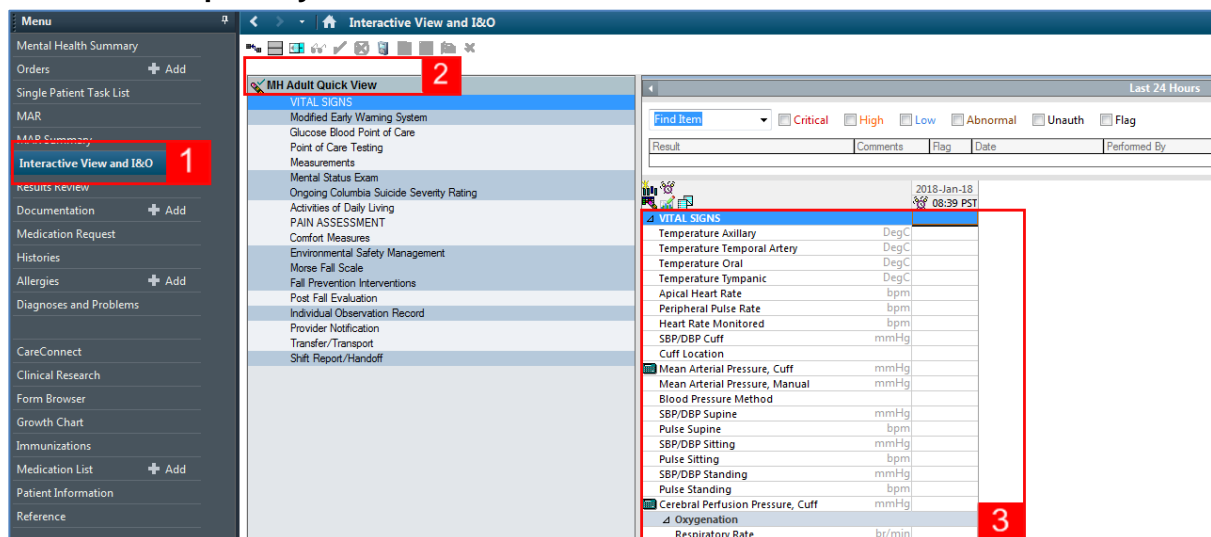
Note:

- For MEWS, level of consciousness is assessed using AVPU, which is an acronym for "alert, voice, pain, unresponsive".
- The MEWS alert is suppressed in some situations such as in palliative/comfort care patients, and in critical care areas

1

You will navigate to and review MEWS documentation.

- Select **Interactive View and I&O** from the menu
- Click on the **Adult Quick View Band**
- Document the following vital signs in the **VITAL SIGNS** section
 - Temperature Oral = 38**
 - Peripheral Pulse Rate = 105**
 - SBP/DBP = 100/60**
 - Respiratory Rate = 20**



The screenshot shows the iView software interface for documenting patient data. The left-hand menu has a red box labeled '1' around the 'Interactive View and I&O' option. The central pane shows a list of assessment items, with a red box labeled '2' around the 'MH Adult Quick View' option. The right-hand pane shows a table for documenting vital signs, with a red box labeled '3' around the 'VITAL SIGNS' section. The table includes fields for Temperature, Heart Rate, Blood Pressure, and Respiratory Rate, with values being entered or selected.

Find Item	Critical	High	Low	Abnormal	Unauth	Flag
VITAL SIGNS						
Temperature Axillary						
Temperature Temporal Artery						
Temperature Oral						
Temperature Tympanic						
Apical Heart Rate						
Peripheral Pulse Rate						
Heart Rate Monitored						
SBP/DBP Cuff						
Cuff Location						
Mean Arterial Pressure, Cuff						
Mean Arterial Pressure, Manual						
Blood Pressure Method						
SBP/DBP Supine						
Pulse Supine						
SBP/DBP Sitting						
Pulse Sitting						
SBP/DBP Standing						
Pulse Standing						
Cerebral Perfusion Pressure, Cuff						
Oxygenation						
Respiratory Rate						

4. Select the **Modified Early Warning System** section
5. Note the vital signs documentation has flowed into the MEWS section
6. **Double-click** the blue band to the right of the **Modified Early Warning System** section, under the current time column. A check mark ☒ will display, indicating the whole section is activated and the MEWS scores will be automatically calculated
7. Document AVPU
 - **AVPU** = *Alert and responsive*
8. Document on the **Situational Awareness Factors**:
 - For the purpose of this practice scenario, select **No** for all cells in this section.

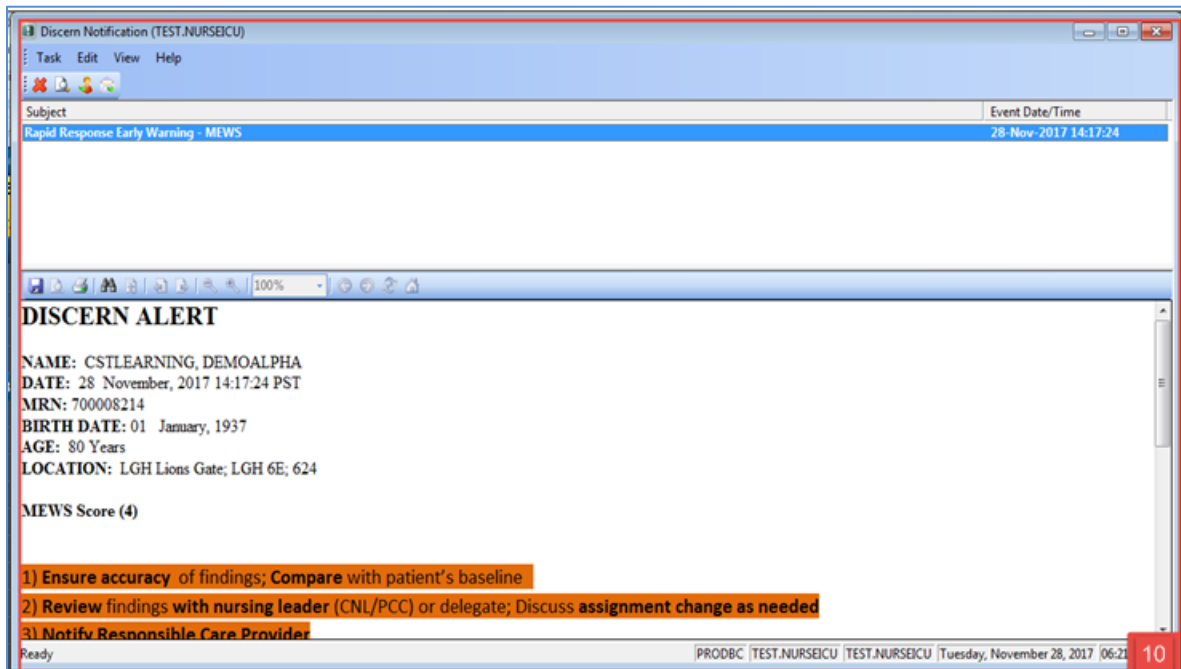
Note: The purpose of this section of documentation is to gather more information related to how the patient is doing, which provides context for those who see the MEWS alert.

9. Click the green check mark ☒ to sign your documentation. The purple text changes to black and is now saved in the chart.

The screenshot displays the 'Interactive View and I&O' interface. On the left, a sidebar lists various sections, with 'Modified Early Warning System' highlighted by a red box and the number 4. The main area shows the MEWS section with various vital signs and scores. A red box with the number 5 highlights the 'MEWS Systolic Blood Pressure Score' field. A red box with the number 6 highlights the blue band on the right of the MEWS section. A red box with the number 7 highlights the 'MEWS AVPU Score' field. A red box with the number 8 highlights the 'Situational Awareness Factors' section. A red box with the number 9 highlights the green checkmark at the top left of the main area.

Note: The patient has a slight fever with a soft BP and a higher heart rate, indicating that they may be getting sicker and need timely attention from the health care team. The calculated MEWS Total Score is 4, which will automatically trigger a MEWS alert in the system.

10. A **Discern Notification** window will appear. This is the MEWS alert.



Key Learning Points

- MEWS stands for Modified Early Warning System and is a scoring system that can trigger an electronic alert in the CIS
- The MEWS score is based on systolic blood pressure, heart rate, respiratory rate, temperature, and level of consciousness (AVPU = alert, voice, pain, unresponsive)
- If the MEWS score is out of normal range, an alert will be triggered in the CIS to warn the health care team that the patient may be deteriorating and require timely attention
- The MEWS alert is suppressed in some situations, such as for palliative/comfort care patients and in critical care areas

Activity 13.2 – Review the MEWS Alert

1

The MEWS alert appears when a MEWS score is calculated to be out of normal range for the patient. The alert itself provides the following information: patient demographics, the MEWS score, clinical decision support, and the score criteria.

All nurses who have established a relationship with the patient in the CIS will receive the MEWS alert upon logging into the system. In this scenario, you will follow the **MEWS protocol** to complete the MEWS alert task and document provider notification.

Note: Providers do NOT receive MEWS alerts, therefore it is the nurse's responsibility to follow up appropriately with the provider when alerted.

Review the **MEWS alert** which will help to identify what type of response is appropriate to initiate.

1. Review the **Patient Demographics**
2. Review the **MEWS Score**
3. Review the coloured **Clinical Decision Support** list to initiate appropriate action
4. Review the **MEWS Criteria**

Discern Notification (TEST.NURSEICU)

Task Edit View Help

Subject: Rapid Response Early Warning - MEWS Event Date/Time: 28-Nov-2017 14:17:24

DISCERN ALERT

NAME: CSTLEARNING, DEMOALPHA
DATE: 28 November, 2017 14:17:24 PST
MRN: 700008214
BIRTH DATE: 01 January, 1937
AGE: 80 Years
LOCATION: LGH Lions Gate; LGH 6E; 624

MEWS Score (4)


1) Ensure accuracy of findings; Compare with patient's baseline
2) Review findings with nursing leader (CNL/PCC) or delegate; Discuss assignment change as needed
3) Notify Responsible Care Provider
4) Activate Rapid Response Team/ Clinical Resource Team
4) Reassess and rescore every 2 hours. If no improvement after 2 hours, notify Responsible Care Provider

MEWS Criteria

Temperature Oral : 38 bpm - 1 point(s)
Peripheral Pulse Rate : 105 bpm - 1 point(s)
Respiratory Rate: 20 br/min - 1 point(s)
Systolic Blood Pressure : 100 bpm - 1 point(s)

Ready PRODBC TEST.NURSEICU TEST.NURSEICU Tuesday, November 28, 2017 02:18 PM

Note: It is up to the clinician to take the appropriate clinical steps after receiving a MEWS alert for a patient. In some cases, the patient may just need to be closely observed and re-assessed. In others, the provider or Rapid Response Team (where available) may need to be called to come and assess the patient immediately.

You can now click the red x icon  in the top **left** hand corner to delete the Discern Notification for the MEWS Alert.

Key Learning Points

- MEWS alerts display patient information, MEWS score and score criteria
- All nurses who have established a relationship with the patient in the CIS will receive the MEWS alert
- The clinical decision making support in the MEWS alert helps guide the clinician in taking the appropriate next steps in caring for the patient

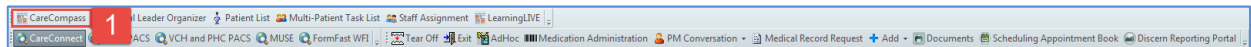
Activity 13.3 – Document Provider Notification

Once you receive a MEWS alert, you assess the patient and decide on further actions to take. In this scenario, we will contact the most responsible provider to let them know about the MEWS alert. After you notify the provider, you need to document that you have done so.

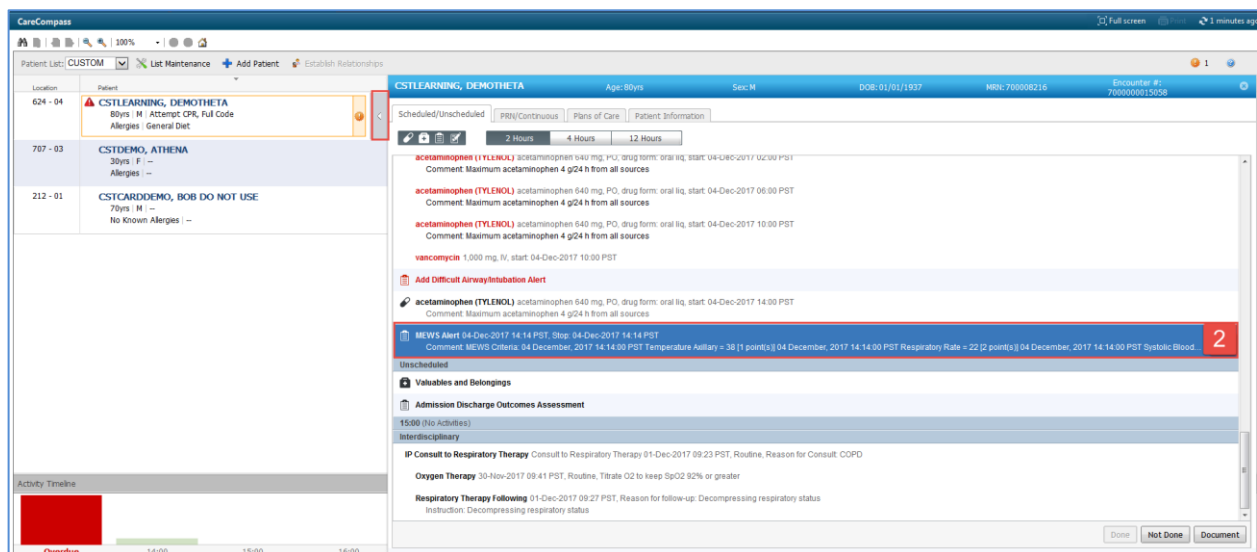
1

The MEWS alert automatically creates a task that can be viewed in **CareCompass**. The task is called MEWS Alert.

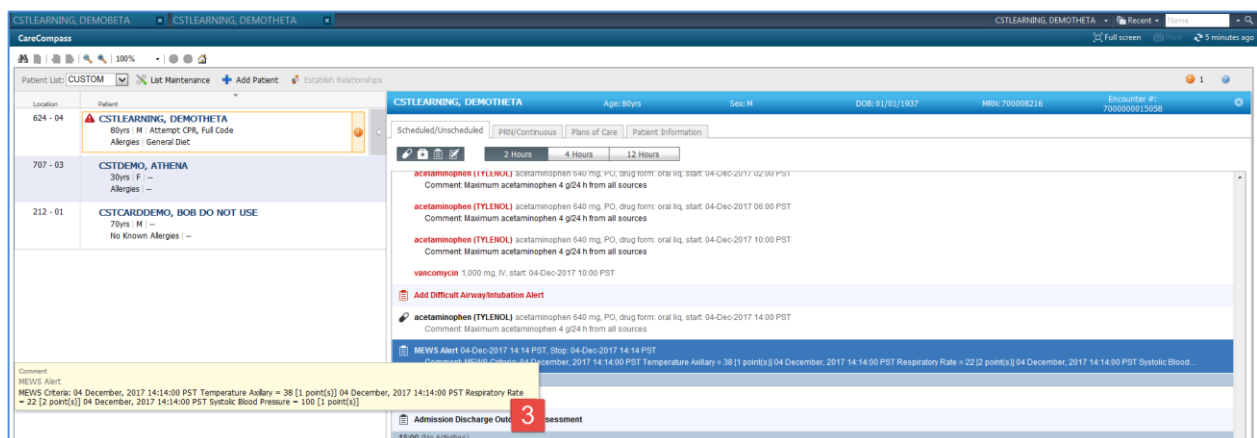
1. Navigate to CareCompass  from the Toolbar



2. Locate your patient and open the task box. Note the **MEWS Alert** task.



3. Hover over the task to display more information about the alert.



4. Click on the **MEWS Alert** task and then click **Document**. You will automatically be taken to the Provider Notification section for documentation.

Scheduled/Unscheduled PRN/Continuous Plans of Care Patient Information

2 Hours 4 Hours 12 Hours

vancomycin 1,000 mg, IV, start: 28-Nov-2017 22:00 PST

acetaminophen 650 mg, PO, drug form: oral liq, start: 29-Nov-2017 02:00 PST
Comment: Maximum acetaminophen 4 g/24 h from all sources

acetaminophen 650 mg, PO, drug form: oral liq, start: 29-Nov-2017 06:00 PST
Comment: Maximum acetaminophen 4 g/24 h from all sources

ranitidine 50 mg, IV, start: 29-Nov-2017 06:00 PST

MEWS Alert 26-Nov-2017 17:49 PST, Stop: 26-Nov-2017 17:49 PST
Comment: MEWS Criteria: 26 November, 2017 17:41:00 PST Temperature Oral = 38 [1 point(s)] 26 November, 2017 17:41:00 PST Peripheral Pulse Rate = 110 [1 p...

Add Difficult Airway/Intubation Alert

Add Difficult Airway/Intubation Alert

Done Not Done **Document**

5. In the Provider Notification section, document the following information:
 - **Provider Notification Reason** = *PEWS/MEWS Alert*
 - **Providers Notification Details** = *MEWS Alert score 4*
 - **Provider informed** = *type name of Attending Provider (last name, first name)*
 - **Physician Requested Interventions** = *No orders received and Continue to Monitor*
6. **Sign** documentation. Completing this documentation will automatically clear the MEWS Alert task from the patient's task list.

Interactive View and I&O

Adult Quick View

- VITAL SIGNS
- Modified Early Warning System
- PAIN ASSESSMENT
- Pain Modalities
- IV Drips
- Insulin Infusion
- Heparin Infusion
- Apnea/Bradycardia Episodes
- Mental Status/Cognition
- Sedation Scales
- Provider Notification
- Environmental Safety Management
- Activities of Daily Living
- Measurements
- Glucose Blood Point of Care
- Individual Observation Record
- Comfort Measures

Adult Systems Assessment

Adult Lines - Devices

Adult Education

Blood Product Administration

Intake And Output

Find Item

Critical High Low Abnormal Unauth Flag

Result Comments Plan Date Perform

2018-Jan-26

15:05 PST 15:01 PST 14:52 PST 14:40 PST

Provider Notification

Notification Reason PEWS/MEW...

Notification Details MEWS alert...

Provider at Bedside

Unable to Reach Provider

Provider Informed Train, Gene...

Provider Response Time 2018-Jan-26...

Provider Requested Interventions

Provider Requested Interventions

Orders received

No orders received

Continue to monitor

Other

7. In iView, navigate to **Adult Quick View**. Click on **Modified Early Warning System**
8. Complete documentation for **MEWS Action Taken** = *Notified Physician*.
9. Click **Sign**

The screenshot displays the iView software interface for the Modified Early Warning System (MEWS). The top navigation bar includes a 'Sign' button highlighted with a red box and the number 9. The left sidebar, under 'Adult Quick View', shows the 'Modified Early Warning System' option highlighted with a red box and the number 7. The main content area shows the MEWS documentation form. The 'MEWS Action Taken' dropdown menu is open, showing the 'Notified Physician' option highlighted with a red box and the number 8. The form also displays various MEWS scores and assessment factors.

Result	Comments	Bar	Date	Perfo
SBP/DBP Supine	mmHg		15:05 PST	2018-Jan-
SBP/DBP Sitting	mmHg		15:01 PST	
SBP/DBP Standing	mmHg		14:52 PST	
MEWS Systolic Blood Pressure Score			1	
AVPU				
MEWS AVPU Score			0	
MEWS Total Score			3	
Situational Awareness Factors				
Patient/Family/Caregiver Concerns				
Unusual Therapy				
Communication Breakdown				
Urine Less Than 0.5 ml/kg/h for 4 hours				
SpO2 Below 90% with FIO2 Higher Than...				
GCS Less Than or Equal to 12				
MEWS Action Taken				
PAIN ASSESSMENT				
Pain Present				


Key Learning Points

- It is the nurse's responsibility to notify the most responsible provider of MEWS alerts
- All provider notification can be documented in iView
- The MEWS Alert creates a task that drives the nurse to document about Provider Notification. Once the documentation is complete, the task drops off the patient's task list.

PATIENT SCENARIO 14 – 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

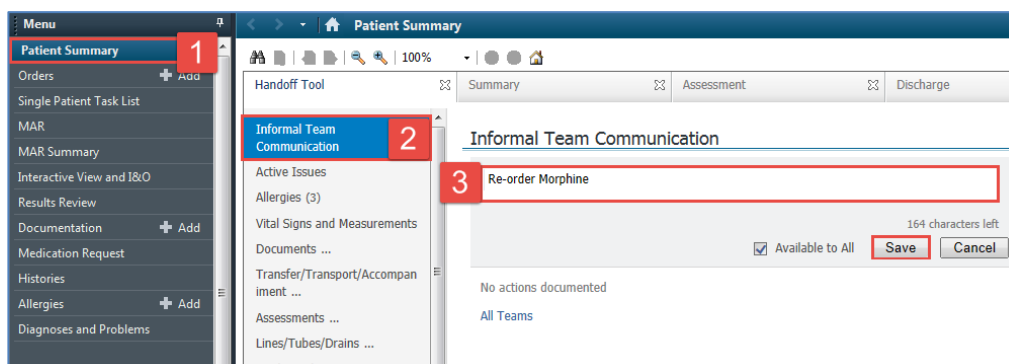
Activity 14.1 – Documenting Informal Team Communication

- 1 Within the **Handoff Tool** there is an **Informal Team Communication** component that can be used for documentation of informal communication between all interdisciplinary care team members. Use the **Add new action** section to create a list of to-do action items. Use the **Add new comment** section to leave a comment for the oncoming nurse or other team members.

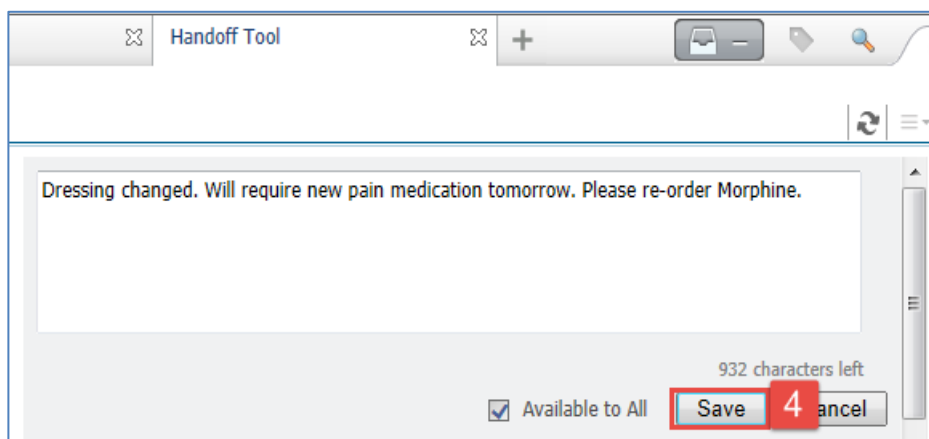
Note: Items documented within the Informal Team Communication component are **NOT** part of the patient's legal chart.

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 Morphine*. Click **Save**.



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



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

To do this:

- Click the **small box** to the left of the action note, or the **small circle with the x** to the right of the note.

Informal Team Communication

Add new action

☐ Re-order Morphine

TestUser, Nurse 04/12/17 16:53

5

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

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
- Any Informal Team Communication message will NOT be considered part of the patient's legal chart

Activity 14.2 – Documenting Nursing Shift Summary

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 than 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

The screenshot shows the 'Handoff Tool' interface. On the left is a sidebar with a list of categories. The 'Nursing Shift Summary' link is highlighted with a red box and a red number '2'. The main content area is titled 'Informal Team Communication' and contains sections for 'Active Issues' and 'Allergies (3)'. The 'Active Issues' section has a table with columns: Name, Classification, Actions, and Chronic. The 'Allergies' section has a table with columns: Substance, Reactions, Category, Status, Severity, Reaction Type, Source, and Comments. A red box highlights the 'Allergies' table, and a red number '1' is placed next to it. At the bottom right, there is a 'Reconciliation Status: Incomplete' and a 'Complete Reconciliation' button.

Name	Classification	Actions	Chronic
Pneumonia	Medical	This Visit	
Diabetes	Medical	This Visit	Chronic
Peripheral vascular disease	Medical	This Visit	Chronic

Substance	Reactions	Category	Status	Severity	Reaction Type	Source	Comments
Bees/Stinging Insects	--	Environment	Active	--	Allergy	--	--
ciprofloxacin	--	Drug	Active	--	Allergy	--	--
difenhydramine	--	Drug	Active	--	Allergy	--	--

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

The screenshot shows the 'CST Learning, DEMO ALPHA' interface. The top bar displays patient information: DOB: 01-Jan-1937, MRN: 7000000214, Code Status: Discharge, Location: LGH 6E 624 02. The left sidebar shows a list of categories, with 'Documentation' highlighted. The main content area is titled 'Free Text Note' and contains a text input field. A red box highlights the text input field, and a red number '3' is placed next to it. At the bottom right, there is a 'Sign/Submit' button, a 'Save' button, a 'Save & Close' button, and a 'Cancel' button. A red number '4' is placed next to the 'Sign/Submit' button.

Free Text Note

Tahoma 14

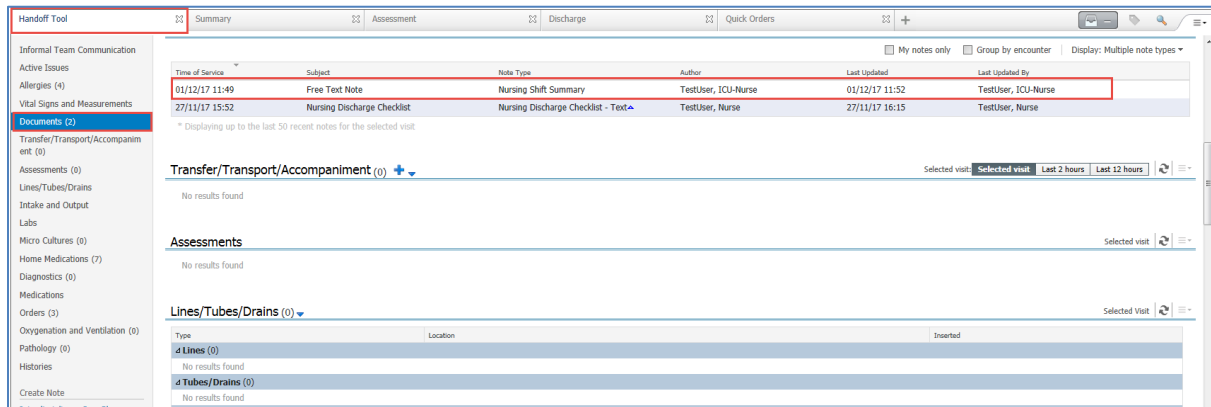
Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine.

Note Details: Nursing Shift Summary, TextORD, Nurse, 28-Nov-2017 14:07 PST, Free Text Note

Sign/Submit Save Save & Close Cancel

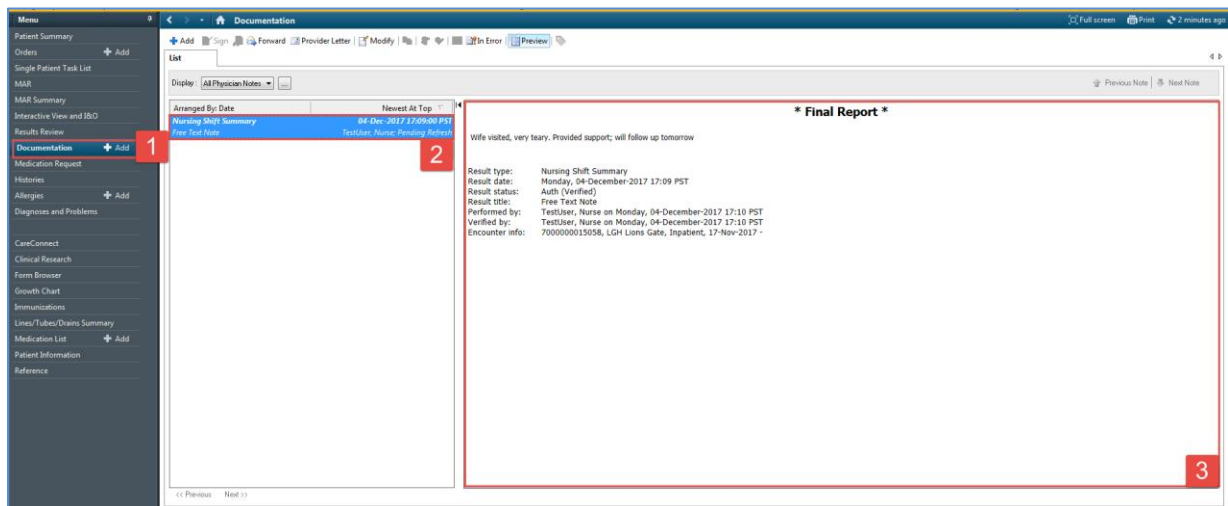
5. Click the **Refresh** icon

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



Now this note is in the patient's chart and other care team members can view it 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

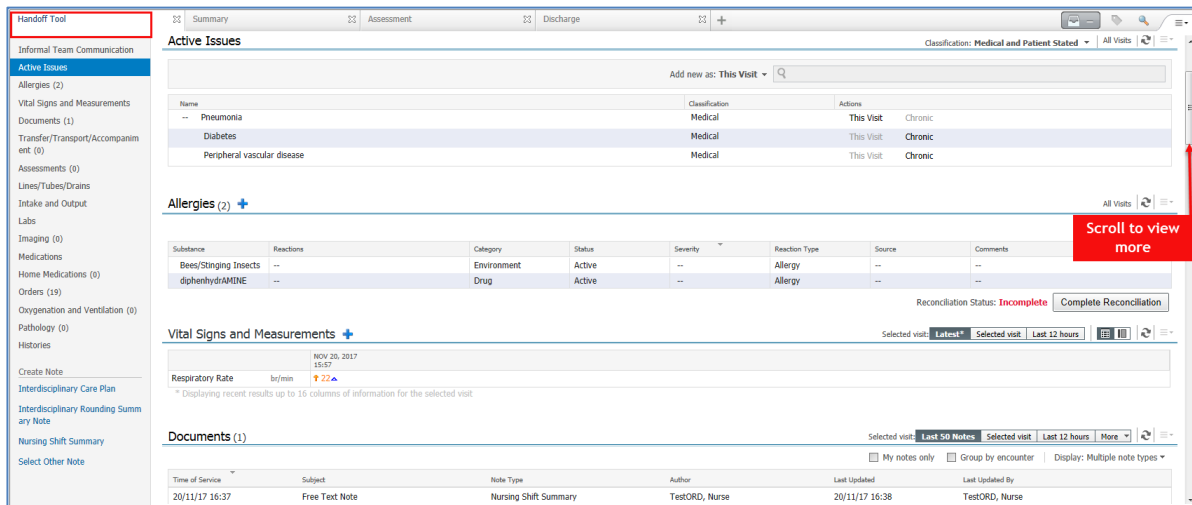
- A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses
- The note must be signed in order for it to be recorded to the patient chart and viewable by other team members
- Nurses and other team members can view signed notes from the Documentation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

Activity 14.3 – Handoff Tool

- 1 Use the Handoff Tool to review patient information with the oncoming nurse.

From the **Menu** select **Patient Summary**. From the **Handoff Tool Tab**:

1. Scroll down the page or access each component by clicking within the Handoff components on the left
2. This is where you can add any missing information if required



The screenshot displays the Handoff Tool interface. On the left is a navigation menu with categories like 'Informal Team Communication', 'Active Issues', 'Allergies (2)', 'Vital Signs and Measurements', 'Documents (1)', 'Transfer/Transport/Accompaniment (0)', 'Assessments (0)', 'Lines/Tubes/Drains', 'Intake and Output', 'Labs', 'Imaging (0)', 'Medications', 'Home Medications (0)', 'Orders (19)', 'Oxygenation and Ventilation (0)', 'Pathology (0)', 'Histories', 'Create Note', 'Interdisciplinary Care Plan', 'Interdisciplinary Rounding Summary Note', 'Nursing Shift Summary', and 'Select Other Note'. The 'Handoff Tool' tab is highlighted in the top navigation bar. The main content area is titled 'Active Issues' and shows a table of patient issues:

Name	Classification	Actions
Pneumonia	Medical	This Visit Chronic
Diabetes	Medical	This Visit Chronic
Peripheral vascular disease	Medical	This Visit Chronic

Below this is the 'Allergies (2)' section, which includes a table of allergies:

Substance	Reactions	Category	Status	Severity	Reaction Type	Source	Comments
Bees/Stinging Insects	--	Environment	Active	--	Allergy	--	--
diphenhydramINE	--	Drug	Active	--	Allergy	--	--

There is a red callout box on the right side of the Allergies table that says 'Scroll to view more'. Below the allergies table is the 'Vital Signs and Measurements' section, which shows a table of vital signs:

Respiratory Rate	bp/min
22	15/57

At the bottom is the 'Documents (1)' section, which shows a table of documents:

Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By
20/11/17 16:37	Free Text Note	Nursing Shift Summary	TestORD, Nurse	20/11/17 16:38	TestORD, Nurse

Key Learning Point

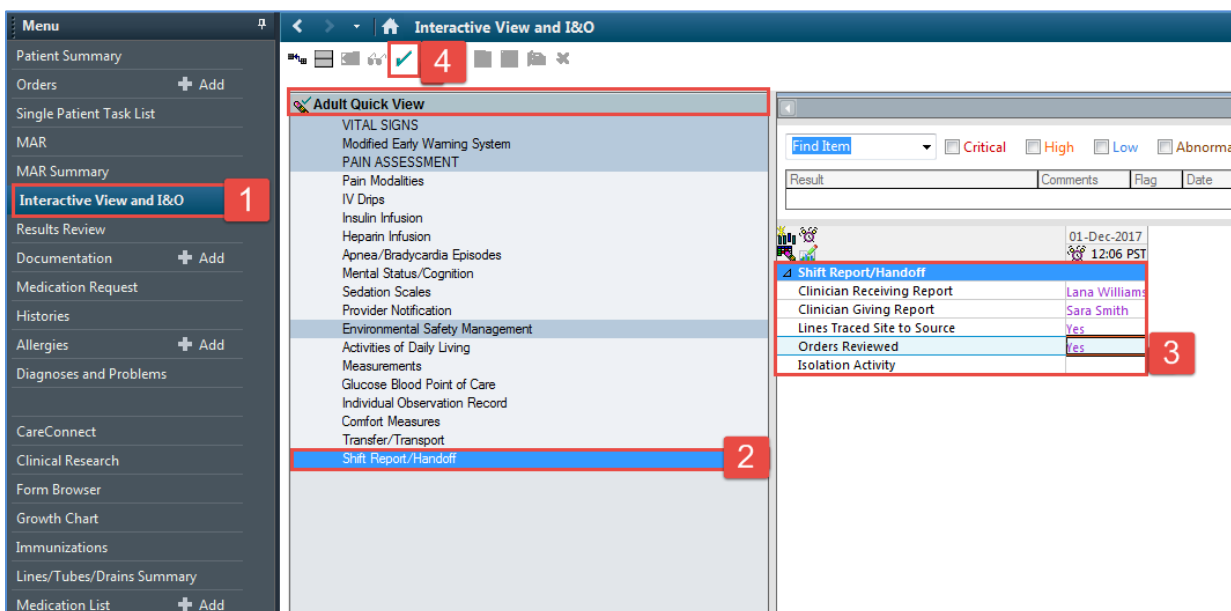
- 1 Use the Handoff Tool to review patient information with the oncoming nurse

Activity 14.4 – Documenting 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 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. Sign your documentation



The screenshot shows the iView interface with the following elements:

- Menu (Left):** A list of navigation options. 'Interactive View and I&O' is highlighted with a red box and a red '1'.
- Adult Quick View (Center):** A list of clinical categories. 'Shift Report/Handoff' is highlighted with a red box and a red '2'.
- Shift Report/Handoff Form (Right):** A form with the following fields:

Find Item	Critical	High	Low	Abnormal
Result				
Comments				
Flag				
Date				
01-Dec-2017 12:06 PST				
Shift Report/Handoff				
Clinician Receiving Report	Lana Williams			
Clinician Giving Report	Sara Smith			
Lines Traced Site to Source	Yes			
Orders Reviewed	Yes			
Isolation Activity				

 The 'Isolation Activity' field is highlighted with a red box and a red '3'.



Key Learning Point




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

PATIENT SCENARIO 15 - Printing a Document

Learning Objectives


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

-  Print a Document

SCENARIO

In this scenario, you will be reviewing how to print a discharge summary.

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

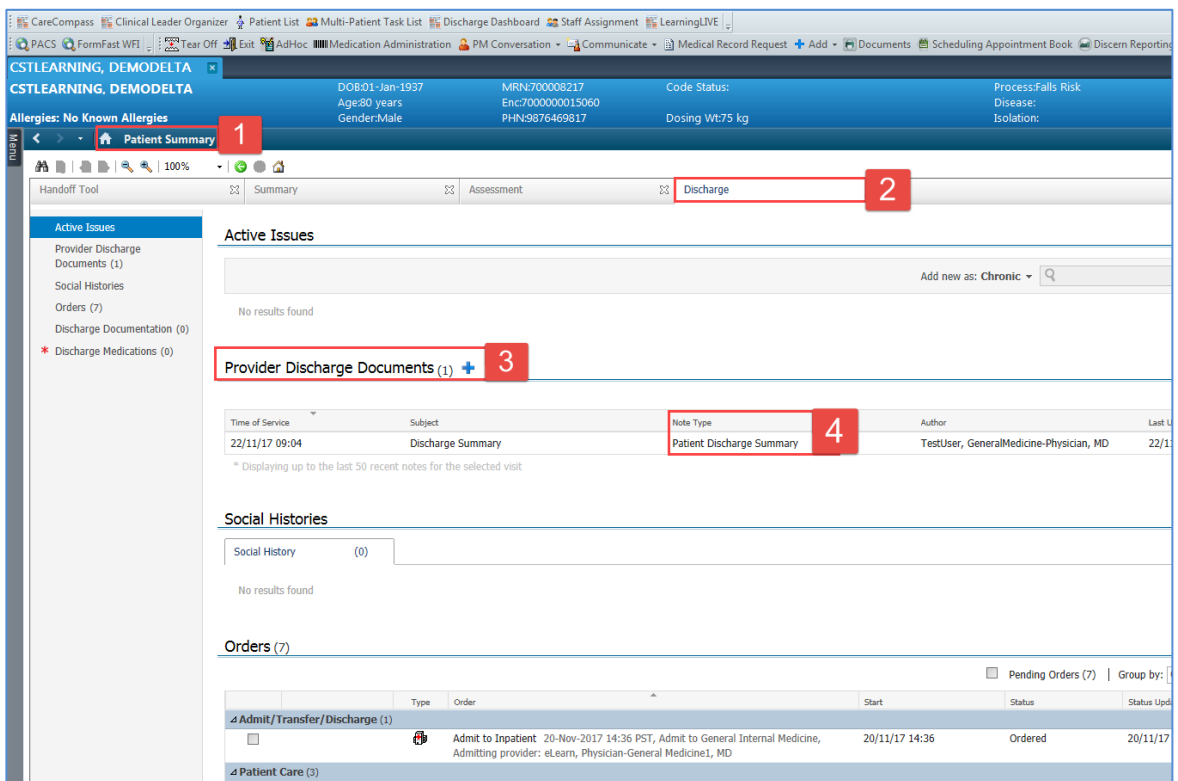
-  Printing a patient discharge summary

Activity 15.1 – Printing a Patient Discharge Summary

The Patient Discharge Summary is completed by the provider and summarizes for patients, information about their stay in hospital. It also includes follow-up appointment and medication information. It can be found in the Discharge tab of the Patient Summary section of the chart.

1

1. Navigate to the **Patient Summary** Workflow Page from the Menu
2. Select the **Discharge** tab
3. Scroll to find the **Provider Discharge Documents** component
4. Select **Patient Discharge Summary** document. The Patient Discharge Summary appears in a window on the right side of the screen.



CSTLEARNING, DEMODELTA

DOB: 01-Jan-1937 MRN: 700008217 Code Status: Process: Falls Risk
Age: 80 years Enc: 7000000015060 Disease: Isolation:
Gender: Male PHN: 9876469817 Dosing Wt: 75 kg

Allegies: No Known Allergies

Menu

- Handoff Tool
- Summary
- Assessment
- Discharge**

Active Issues

Add new as: Chronic

No results found

Provider Discharge Documents (1)

Time of Service	Subject	Note Type	Author	Last U
22/11/17 09:04	Discharge Summary	Patient Discharge Summary	TestUser, GeneralMedicine-Physician, MD	22/11/17

* Displaying up to the last 50 recent notes for the selected visit

Social Histories

Social History (0)

No results found

Orders (7)


Pending Orders (7) | Group by:

Type	Order	Start	Status	Status Upd
Admit/Transfer/Discharge (1)				
Admit to Inpatient	20-Nov-2017 14:36 PST, Admit to General Internal Medicine, Admitting provider: eLearn, Physician-General Medicine1, MD	20/11/17 14:36	Ordered	20/11/17
Patient Care (3)				

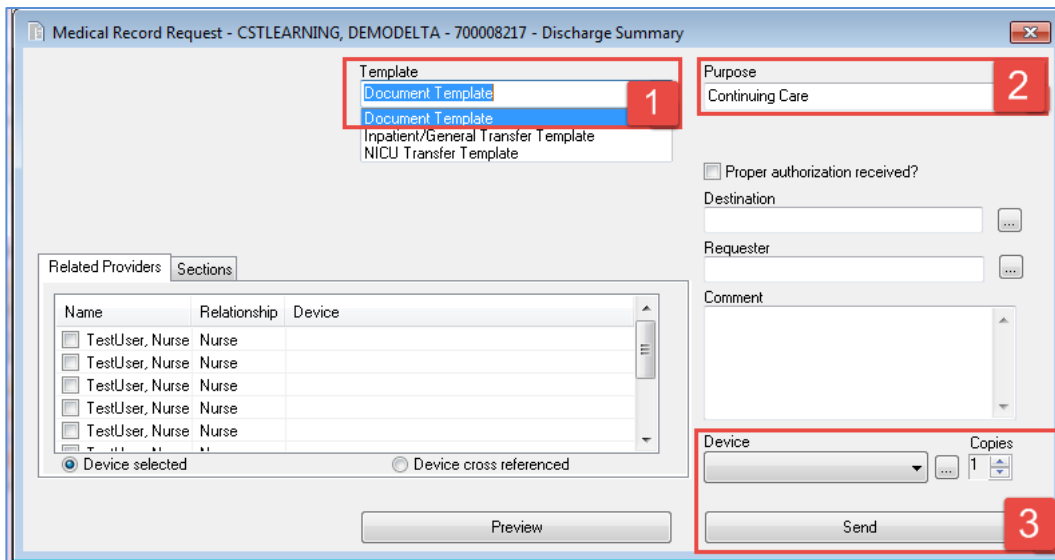
2

Navigate to the top right of the document and click **Print**.

1. From the Template drop-down list, choose **Document Template**
2. From the Purpose drop-down list, choose **Continuing Care**

Note: Please only practice the next step and do not send anything to print. Click  in place of clicking Send.

3. Ensure you choose the correct printer from the **Device** drop list click **Send**.



Medical Record Request - CSTLEARNING, DEMODELTA - 700008217 - Discharge Summary

Template: Document Template (1)

Purpose: Continuing Care (2)

Related Providers: TestUser, Nurse Nurse

Sections: Device selected

Device: (3)

Copies: 1

Send

Key Learning Points

- The patient discharge summary is completed by the provider to summarize for the patient, information about their hospital stay, follow-up appointments and medications
- You can preview documents by clicking on them in the respective workflow page component
- You may print documents from the same preview window

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 16 – 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 activity in order to review your patients for the day:

- Review the Clinical Leader Organizer (CLO)

Activity 16.1 – Review Clinical Leader Organizer (CLO)

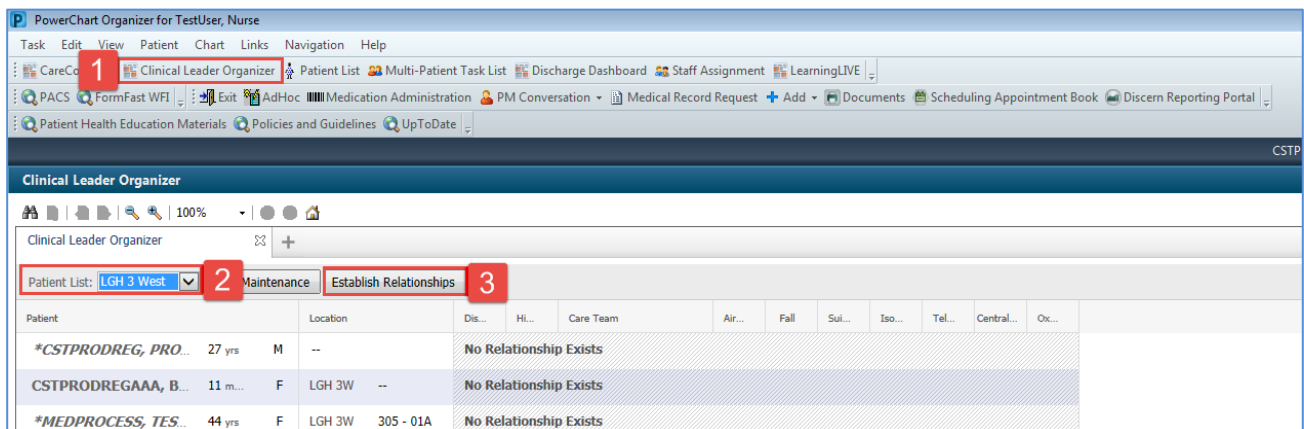
1 Clinical Leader Organizer (CLO) is an interactive organizer that supports communication and coordination across the continuum of care. It provides a high-level overview of patient data such as location, visit summary, risks and more. It is a very useful tool for understanding patient care goals and 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 the **Location List** you created in Activity 1.1
3. Click **Establish Relationship**

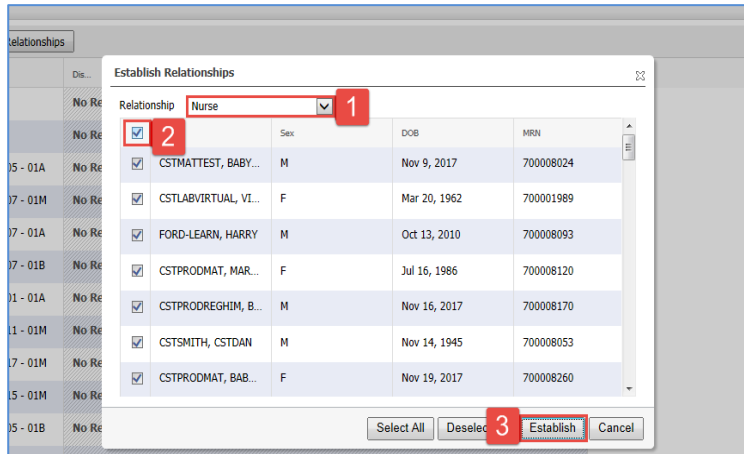


Patient	Location	Dis...	HL...	Care Team	Air...	Fall	Sul...	Iso...	Tel...	Central...	Ox...
*CSTPRODREG, PRO...	27 yrs M	--		No Relationship Exists							
CSTPRODREGAAA, B...	11 m... F	LGH 3W	--	No Relationship Exists							
*MEDPROCESS, TES...	44 yrs F	LGH 3W	305 - 01A	No Relationship Exists							

2

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

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

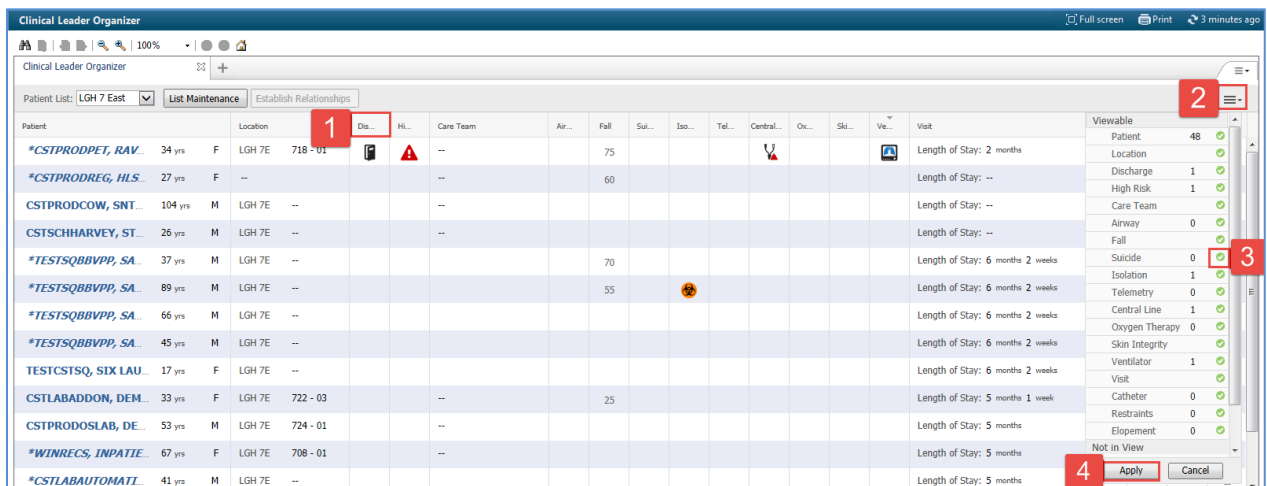


3

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 checkmark 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 the 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

The screenshot shows the Clinical Leader Organizer (CLO) interface. At the top, there's a header bar with the title 'Clinical Leader Organizer' and some navigation icons. Below the header, there's a search bar and a 'List Maintenance' button. The main area is a table with columns for Patient, Location, Dis., HI., Care Team, Air., Fall, Iso., Tel., Central., Ox., Ski., Ve., Visit, Ca., Ra., Elo., Pe., and Diet. The table contains several rows of patient data. A red box labeled '1' highlights the 'Dis.' column. A pop-up box labeled '2' is displayed over the 'Iso.' column, showing details for 'Patient Isolation' on 31-Oct-2017 08:52 PDT, Contact Plus, Ordered at: 10/31/2017 8:52 AM.

Patient	Location	Dis.	HI.	Care Team	Air.	Fall	Iso.	Tel.	Central.	Ox.	Ski.	Ve.	Visit	Ca.	Ra.	Elo.	Pe.	Diet
*CSTPRODPEI, RAV...	34 yrs F LGH 7E 718 - 02					75							Length of Stay: 2 months					
*CSTPRODREG, HILS...	27 yrs F --												Length of Stay: --					
CSTPRODROW, SNT...	104 yrs M LGH 7E --												Length of Stay: --					
CSTSCHHARVEY, ST...	26 yrs M LGH 7E --												Length of Stay: --					
*TESTSQBBVPP, SA...	37 yrs M LGH 7E --												Length of Stay: 6 months 2 weeks					
*TESTSQBBVPP, SA...	89 yrs M LGH 7E --					55							Length of Stay: 6 months 2 weeks					
*TESTSQBBVPP, SA...	66 yrs M LGH 7E --												Length of Stay: 6 months 2 weeks					
*TESTSQBBVPP, SA...	45 yrs M LGH 7E --												Length of Stay: 6 months 2 weeks					
TESTCSTSQ, SIX LAU...	17 yrs F LGH 7E --												Length of Stay: 6 months 2 weeks					
CSTLABADDON, DEM...	33 yrs F LGH 7E 722 - 03					25							Length of Stay: 5 months 1 week					
CSTPRODOSLAB, DE...	53 yrs M LGH 7E 724 - 01												Length of Stay: 5 months					
*WINRECS, INPATIE...	67 yrs F LGH 7E 708 - 01												Length of Stay: 5 months					

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

Key Learning Points

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

PATIENT SCENARIO 17 – 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

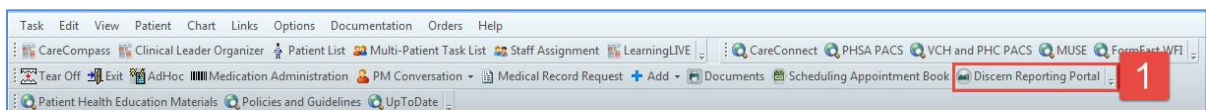
Activity 17.1 – Running Reports for your Unit/Organization

- 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, Educators, managers, or nurses who are frequently in charge will have the ability to run reports in the system.

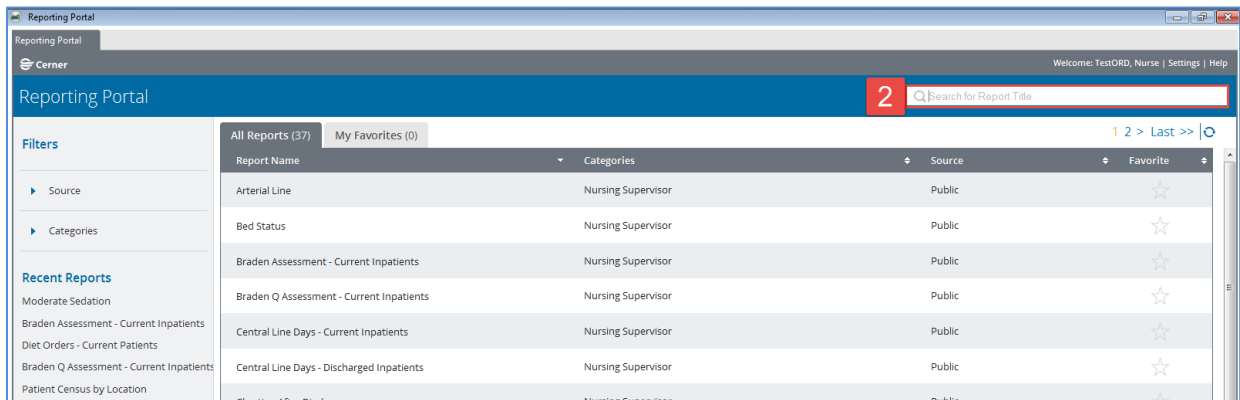
Assuming you are a charge nurse, generate a report for **Patient Census by Location**.

1. Navigate to **Discern Reporting** by selecting the  button in the Toolbar to open the Reporting Portal window

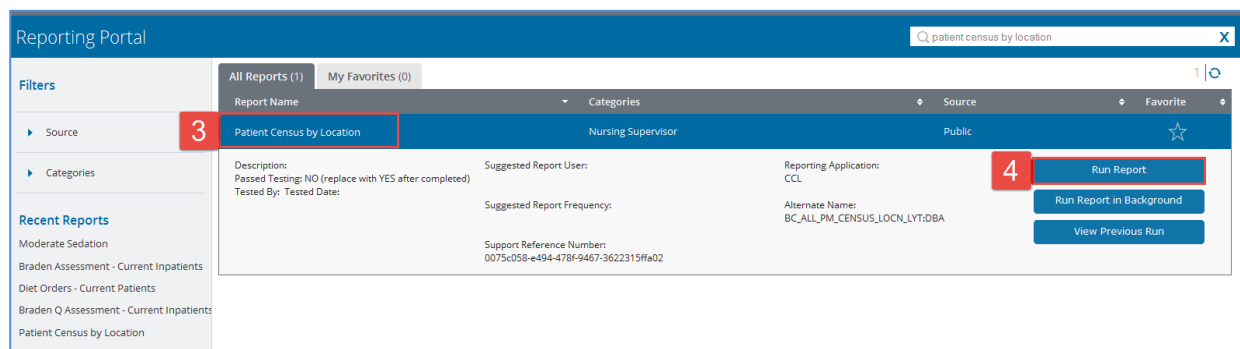


2. Locate **Patient Census by Location** by typing it into the search box

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**

Discern Prompt: BC_ALL_PM_CENSUS_LOCN_LYT:DBA

*Output to File/Printer/MINE: MINE

*Output Type: ☐ Exportable(CSV) ☒ Printable(PDF)

*Encounter Type(s): ☐ Deceased ☐ Emergency ☒ Inpatient

Health Organization: Vancouver Coastal Health Authority

*Site: Lions Gate Hospital

*Facility: ☐ All Facilities ☐ EGH Evergreen House ☐ LGH H0pe Centre ☒ LGH Lions Gate Hospital ☐ LGH North Shore Hospice

Unit/Clinic(s): ☒ All Nurse Units ☐ LGH 2 East ☐ LGH 2E Cardiac Care ☐ LGH 3 East ☐ LGH 3 West ☐ LGH 4 East

Include VIP Patients?: Yes

Page break on Unit?: No

Execute Cancel



☐ Return to prompts on close of output

Ready

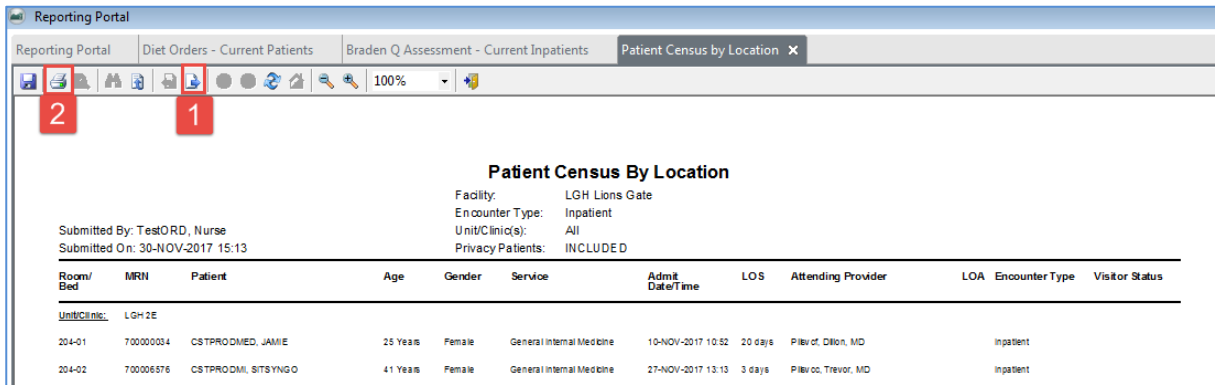
The **Patient Census by Location** report will now display.

3

Review the Report

1. Navigate the Report by clicking the Next Page  icon
2. To print the report, click on the Print  icon.

Note: For this activity, we will only view and not print the actual report.



Reporting Portal

Reporting Portal | Diet Orders - Current Patients | Braden Q Assessment - Current Inpatients | Patient Census by Location X

100%

2 **1**

Patient Census By Location

Submitted By: TestORD, Nurse
Submitted On: 30-NOV-2017 15:13

Facility: LGH Lions Gate
Encounter Type: Inpatient
Unit/Clinic(s): All
Privacy Patients: INCLUDED

Room/ Bed	MRN	Patient	Age	Gender	Service	Admit Date/Time	LOS	Attending Provider	LOA	Encounter Type	Visitor Status
<u>Unit/Clinic:</u> LGH 2E											
204-01	700000034	CSTPRODMD, JAMIE	25 Years	Female	General Internal Medicine	10-NOV-2017 10:52	20 days	Pillay, Dilon, MD		Inpatient	
204-02	700006576	CSTPRODMD, SITSYNGO	41 Years	Female	General Internal Medicine	27-NOV-2017 13:13	3 days	Pillay, Trevor, MD		Inpatient	

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.