

SELF-GUIDED PRACTICE WORKBOOK [N61]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: Pediatric

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SELF-GUIDED PRACTICE WORKBOOK

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.■ 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.

Using Train Domain

You will be using the Train domain to complete activities in this workbook. It has been designed to match the actual Clinical Information System (CIS) as closely as possible.

Please note:

-  Scenarios and their activities demonstrate the CIS functionality not the actual workflow
-  An attempt has been made to ensure scenarios are as clinically accurate as possible
-  Some clinical scenario details have been simplified for training purposes
-  Some screenshots may not be identical to what is seen on your screen and should be used for reference purposes only
-  Follow all steps to be able to complete activities
-  If you have trouble to follow the steps, immediately raise your hand for assistance to use classroom time efficiently
-  Ask for assistance whenever needed

PATIENT SCENARIO 1 – Access and Set-up

Learning Objectives

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

- ☐ Navigate CareCompass
- ☐ Create a Patient List
- ☐ Complete Tasked Activities

SCENARIO

A 7 year old male presents to the ED with a fever and productive cough. He is admitted with a diagnosis of Pneumonia and prescribed IV antibiotics. You begin your shift and will be receiving the patient into your care. To start, log into the Clinical Information System (CIS) with your provided username and password.

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

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

Activity 1.1 – Set Up a Location Patient List

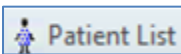

1

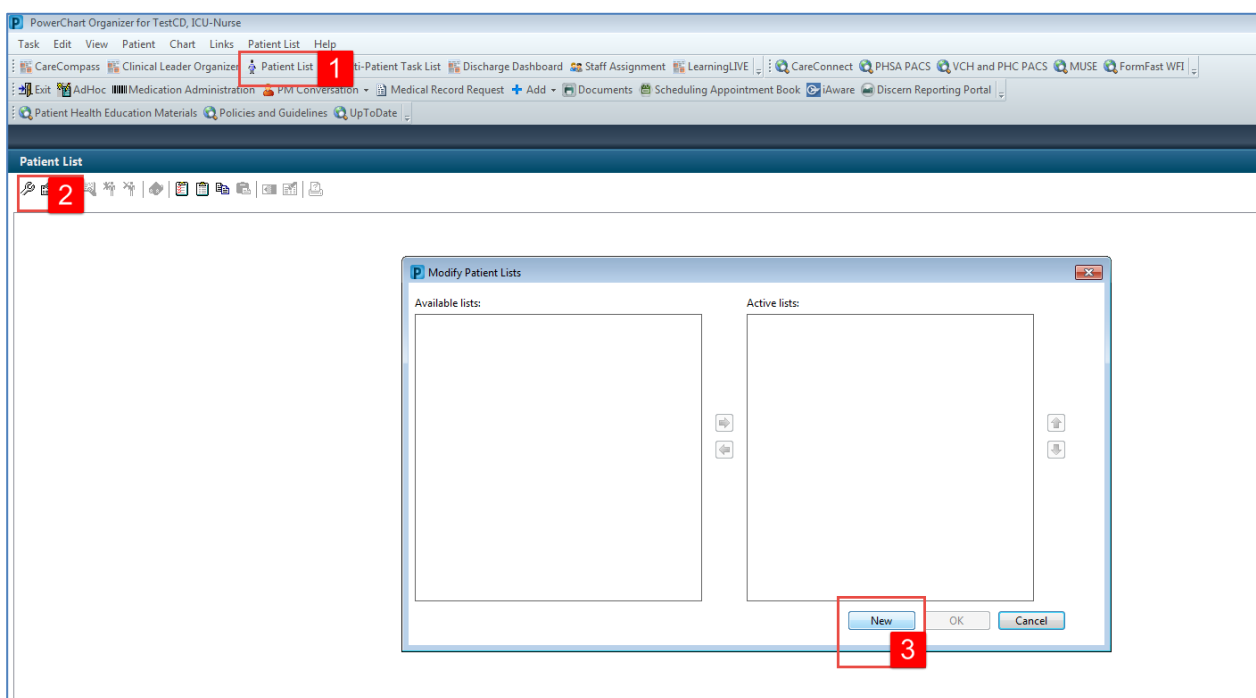
Upon logging in, you will land on CareCompass. **CareCompass** provides a quick overview of select patient information.

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

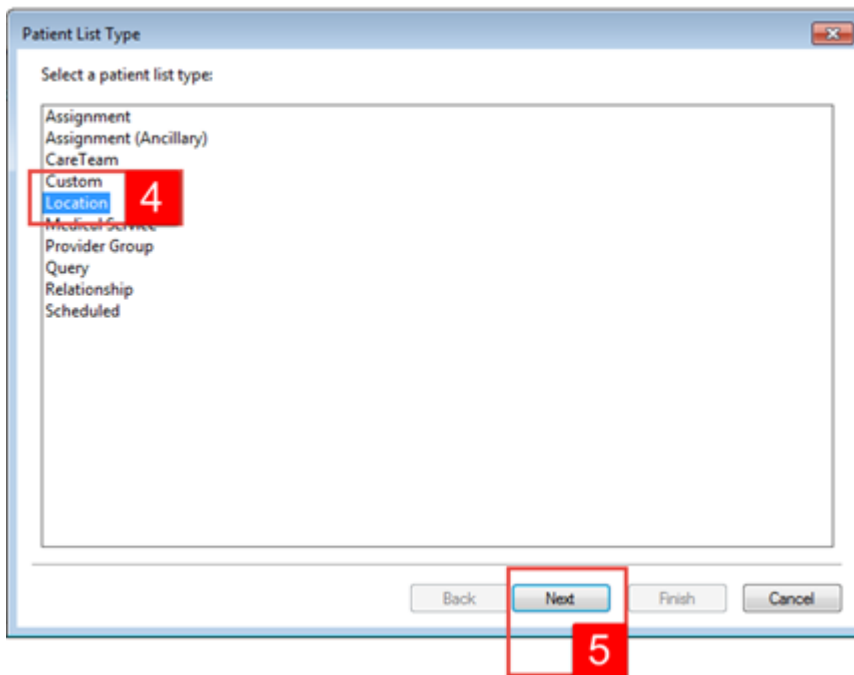
2

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

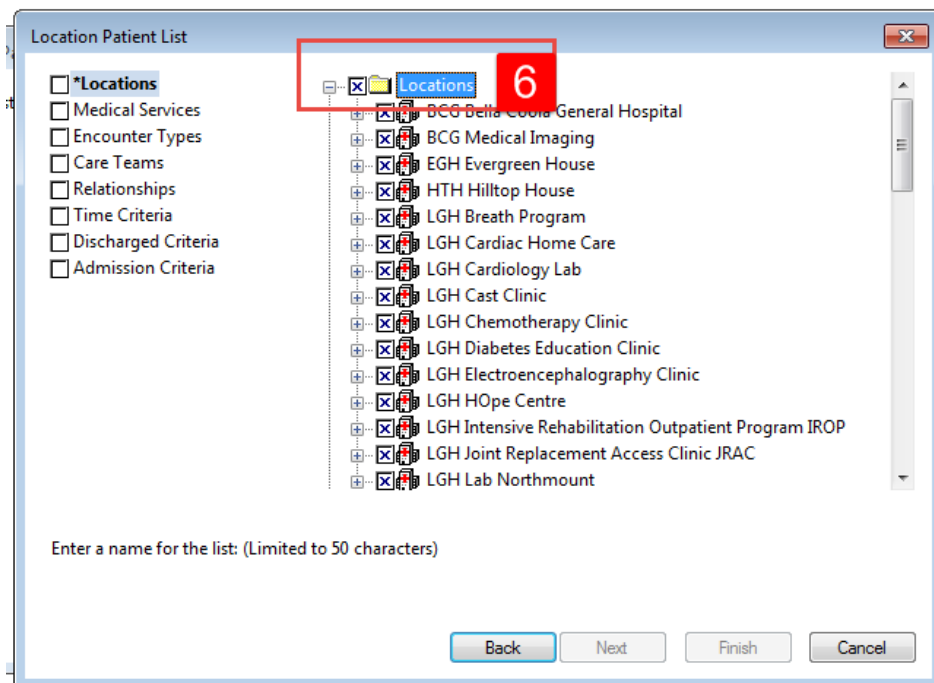
1. Select the **Patient List** icon  from the **Toolbar** at the top of the screen.
2. The screen will be blank. To create a location list, click the **List Maintenance** icon . When you hover over the wrench it will say **List Maintenance**.
3. Click the **New** button at the bottom right corner of the **Modify Patient Lists** window.



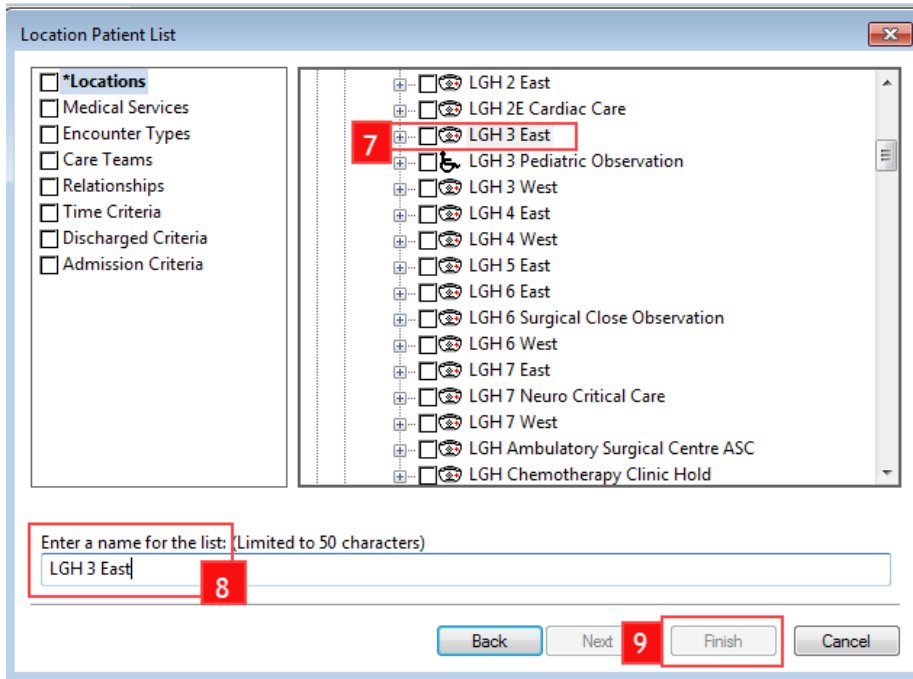
4. From the **Patient List Type** window select **Location**
5. Click the **Next** button at the bottom right corner.



6. In the **Location Patient List** window, a location tree will be on the right hand side. Expand the list by clicking on the tiny **plus** sign + next to the Locations. Select LGH Lions Gate Hospital.



7. Scroll down until you find the location assigned to you. Expand the location and select your unit, **LGH 3 East**. By checking the box next to it.
8. Patient Lists need a name to differentiate them. Location lists are automatically named by the Location.
9. Click the **Finish** button.



Location Patient List

☐ *Locations
☐ Medical Services
☐ Encounter Types
☐ Care Teams
☐ Relationships
☐ Time Criteria
☐ Discharged Criteria
☐ Admission Criteria

7 ☒ LGH 3 East

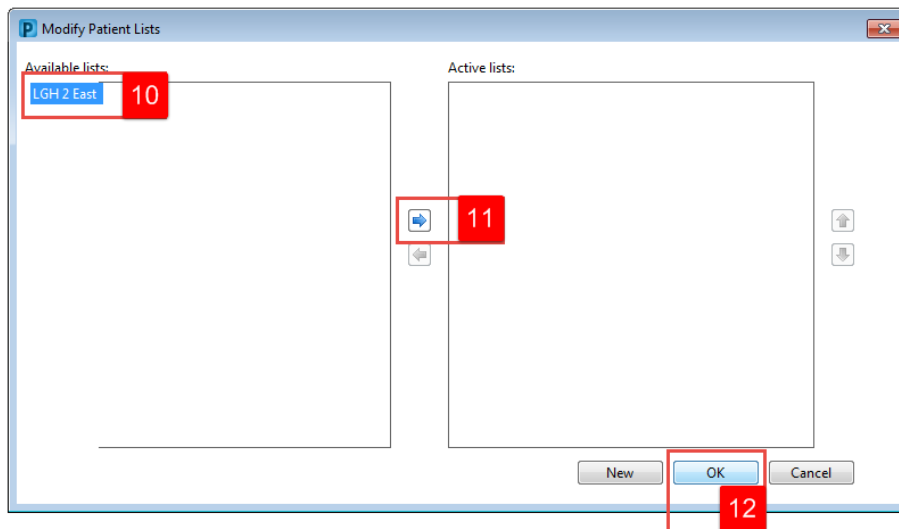
8 Enter a name for the list: (Limited to 50 characters)
LGH 3 East

9

10. In the **Modify Patient Lists** window select your **Location** list.

11. Click the **Blue Arrow** icon  to move the **Location** to the right **Active List**.

12. Click the **OK** button at the bottom right corner to return to **Patient Lists**. Your Location list should now appear.



Note: If working in different units/locations within the same shift, example: LGH 3 East and LGH 3 Pediatric Observation, it is recommended to create individual lists per location rather than selecting both locations at the same time. This is to assist locating your assigned patient(s) easier and to prevent slowing down the system to generate a long list.




Key Learning Points

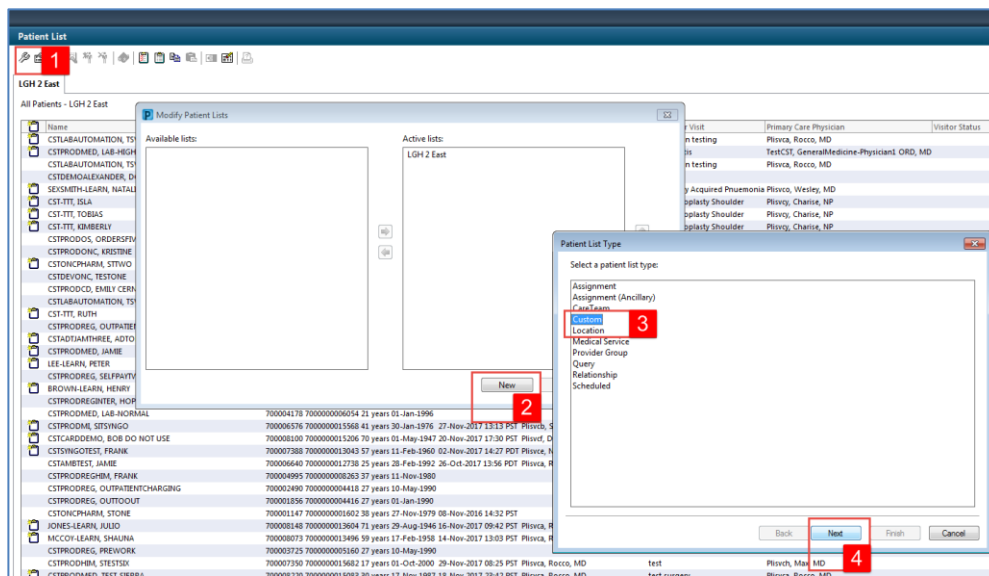
- Patient List can be accessed by clicking on the Patient List icon in the Toolbar.
- You can set up a patient list based on location.

Activity 1.2 – Create a Custom Patient List

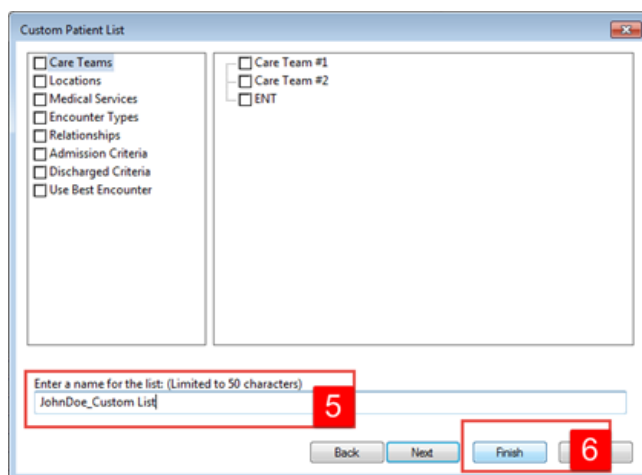
1


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

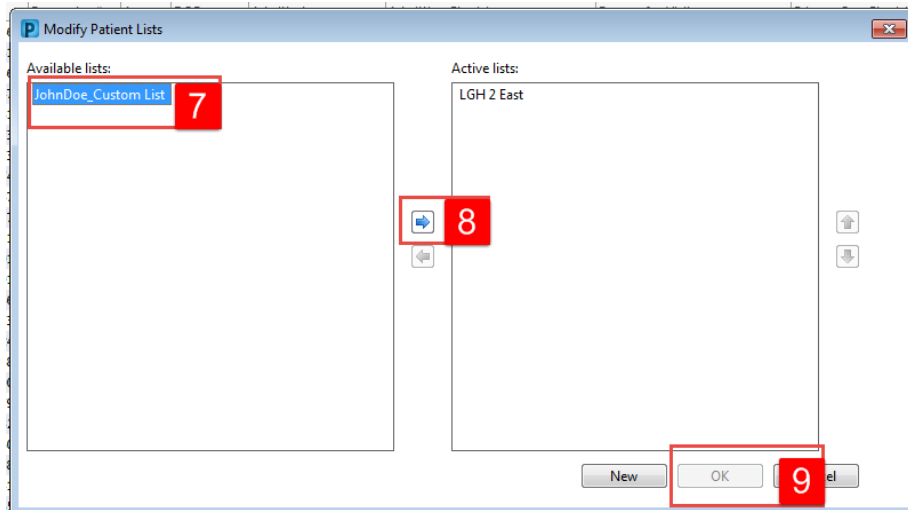
1. To create a **Custom List**, click the **List Maintenance** icon  in the **Patient List**.
2. Click the **New** button at the bottom right corner of the **Modify Patient Lists** window.
3. From the Patient List Type window select **Custom**.
4. Click the **Next** button at the bottom right corner.



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



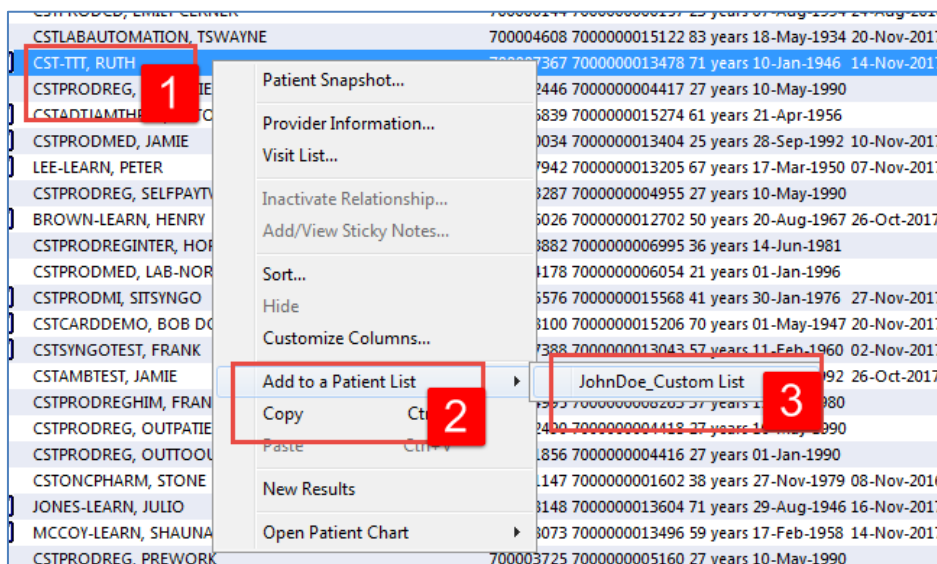
7. In the Modify Patient Lists window select your Custom List.
8. Click the **Blue Arrow** icon  to move your **Custom List** to the right **Active List**.
9. Click the **OK** button at the bottom right.




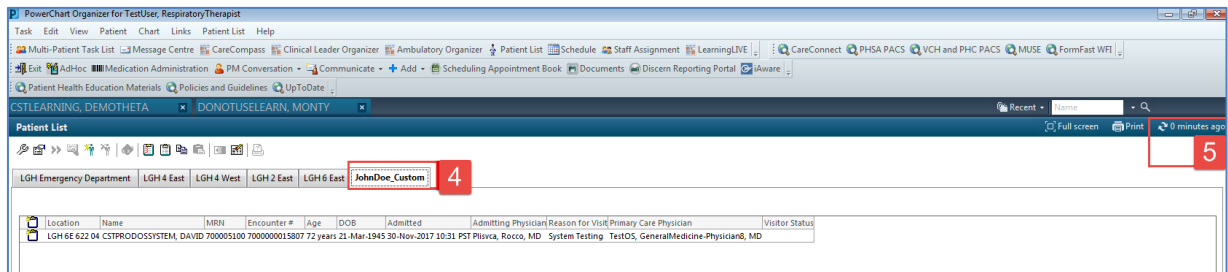
2

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


1. First, find your patient. Your patient is located on your **Location List**. Right click on the **patient name**.
2. Select **Add to a Patient List**.
3. Select **YourName_Custom List**



4. Select YourName_Custom Tab. The Tab will be empty.
5. Click the **Refresh** icon  to refresh your screen. Now your patient will appear in your Custom List.




Please check to ensure this is the patient assigned to you today.

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






Key Learning Points

-  You can create a Custom List that can consist of only the 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 a pediatric nurse you will be completing the following activities:

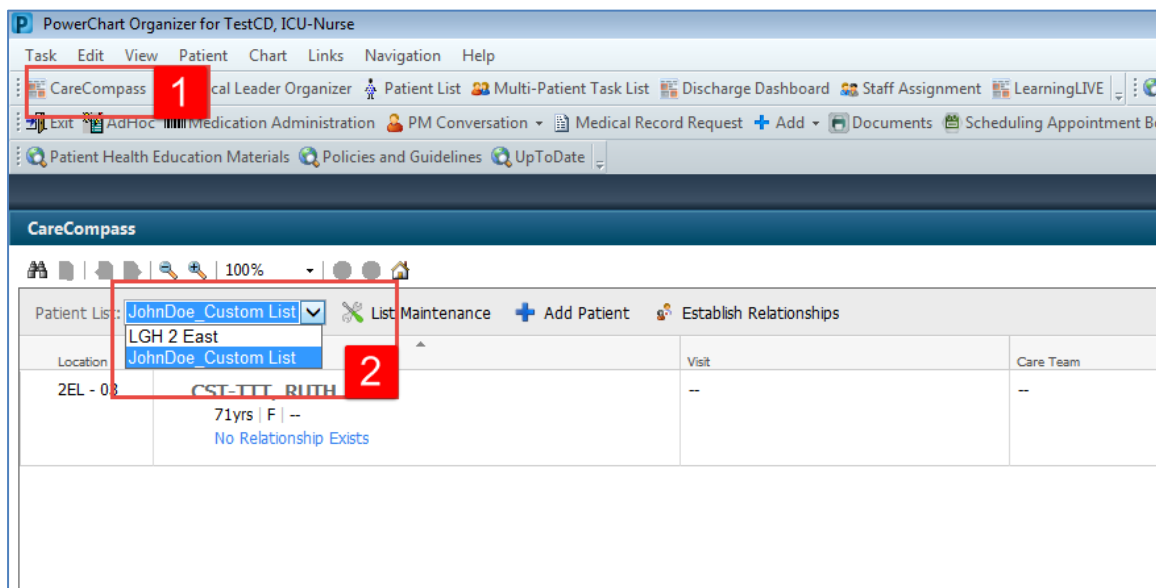
-  Review CareCompass
-  Establish a relationship in the system with your patients and review patient information
-  Review and complete tasks in CareCompass

Activity 2.1 – Review CareCompass

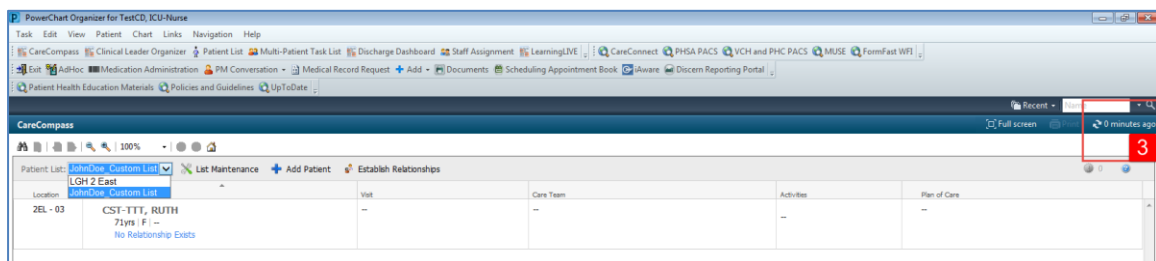
- 1 **CareCompass** displays information you need for your patients directly, including important details such as allergies, resuscitation status, reason for visit, and scheduled medications/tasks, orders, and results.

1. Navigate back to **CareCompass** by clicking on the **CareCompass** icon  in the Toolbar.
2. Select **YourName_Custom** (your custom list) from the **Patient List** drop-down

Note: If your custom list is not visible within CareCompass, click the Refresh icon  to populate the Patient List.

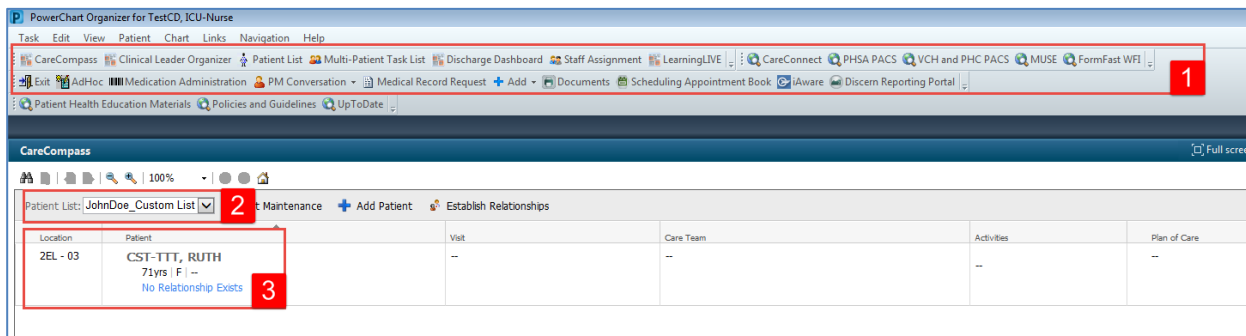


3. Click the **Refresh** icon . Your selected patients are now visible on your custom list.



2 Let's review Basic 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. The only information visible about a patient is their location, name and basic demographics until you establish a relationship.



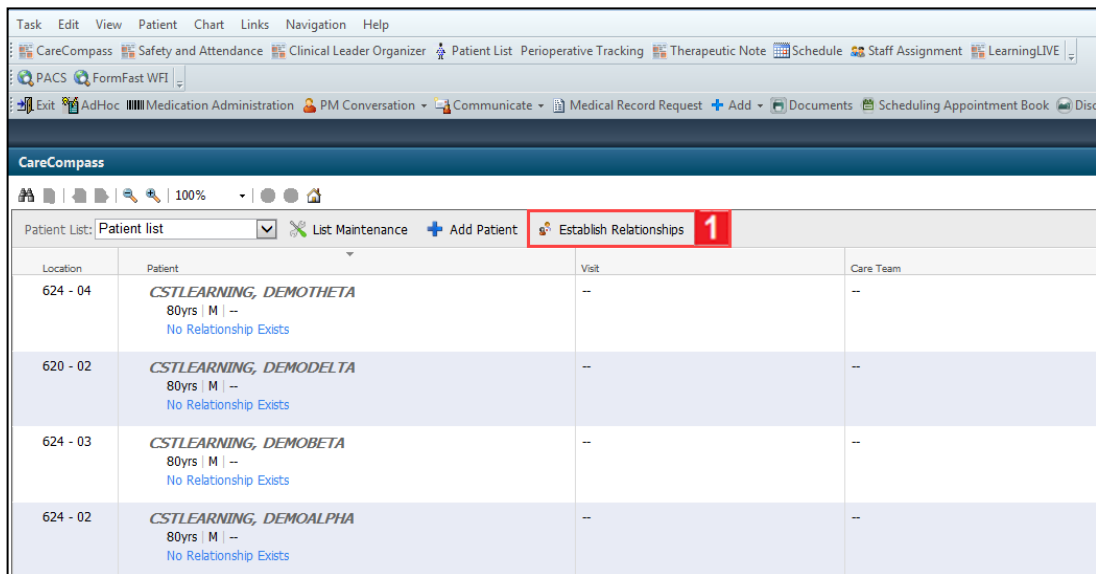
Key Learning Points

- 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

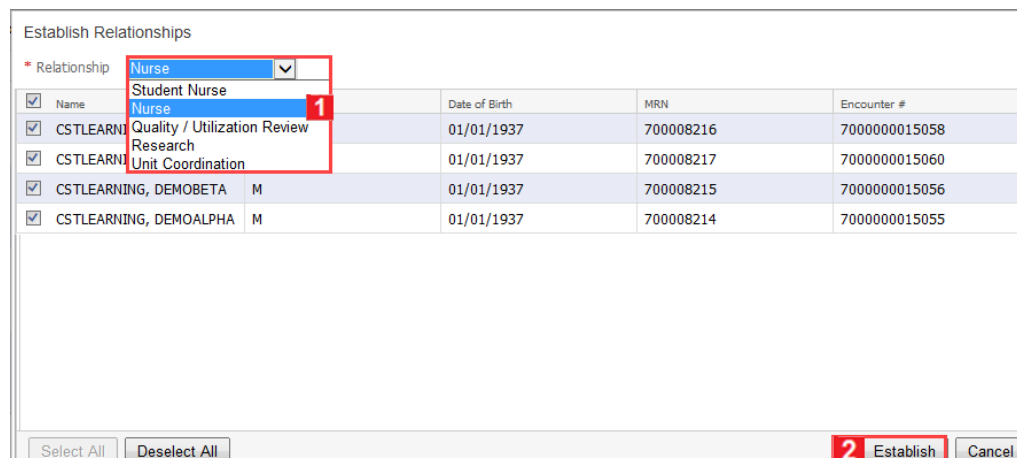
- 1 Now that you have created your custom list, you must establish a relationship with each of your patients in order to view more patient information or access patient charts.

1. Click **Establish Relationships**



Location	Patient	Visit	Care Team
624 - 04	CSTLEARNING, DEMOTHETA 80yrs M -- No Relationship Exists	--	--
620 - 02	CSTLEARNING, DEMODELTA 80yrs M -- No Relationship Exists	--	--
624 - 03	CSTLEARNING, DEMOBETA 80yrs M -- No Relationship Exists	--	--
624 - 02	CSTLEARNING, DEMOALPHA 80yrs M -- No Relationship Exists	--	--

- 2
1. From the **Relationship** drop-down select **Nurse**
 2. Click **Establish**



Name	Date of Birth	MRN	Encounter #
<input checked="" type="checkbox"/> CSTLEARNING, DEMOBETA	01/01/1937	700008216	7000000015058
<input checked="" type="checkbox"/> CSTLEARNING, DEMOALPHA	01/01/1937	700008217	7000000015060
<input checked="" type="checkbox"/> CSTLEARNING, DEMOBETA	01/01/1937	700008215	7000000015056
<input checked="" type="checkbox"/> CSTLEARNING, DEMOALPHA	01/01/1937	700008214	7000000015055

Select All Deselect All **2 Establish** Cancel

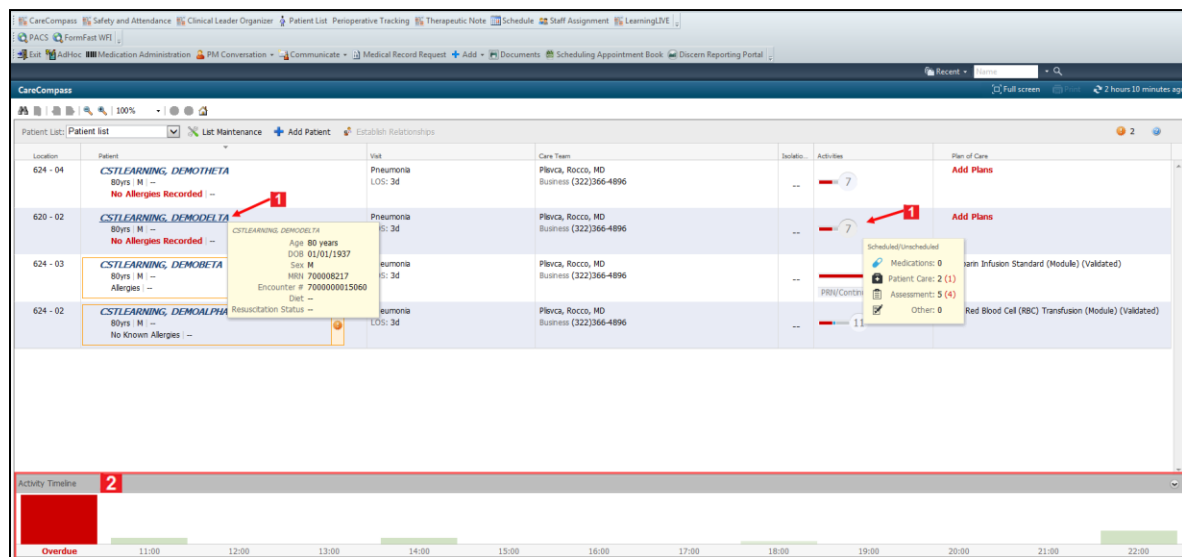
Once a relationship is established with your patients, additional information will appear on CareCompass.

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.



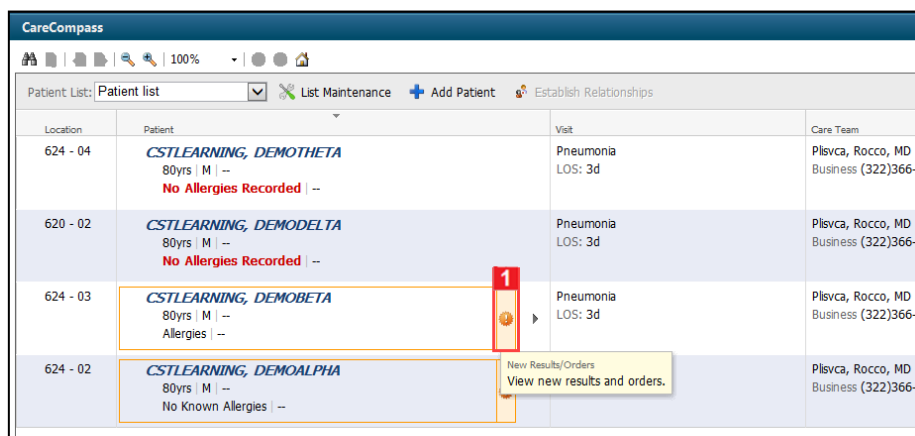
4

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

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

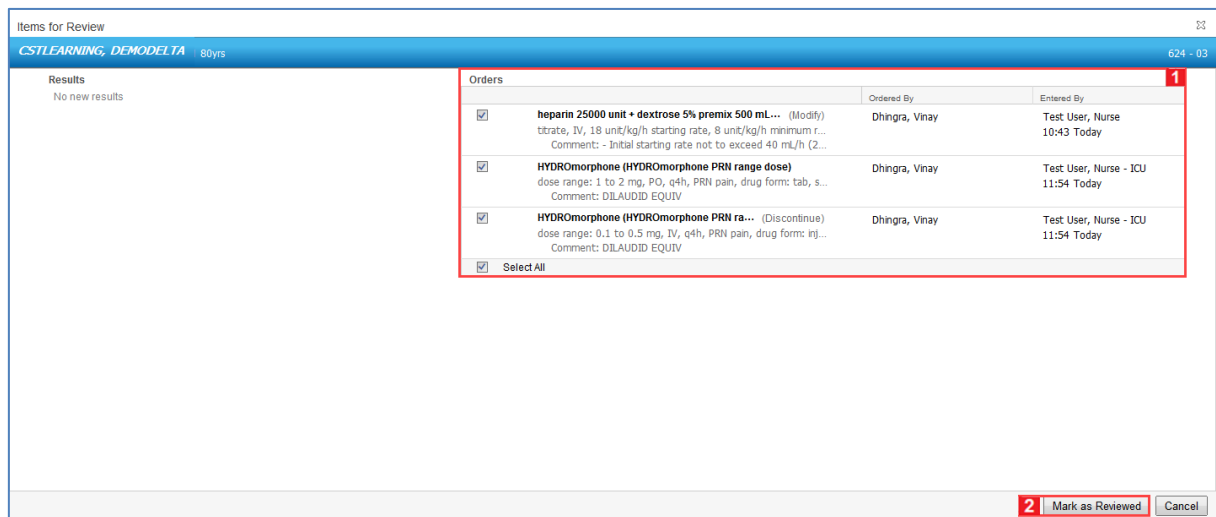
 Indicates new critical results or STAT/NOW orders.

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



Items for Review

CSTLEARNING, DEMODELTA 80yrs 624 - 03

Results
No new results



Orders	Ordered By	Entered By
<input checked="" type="checkbox"/> heparin 25000 unit + dextrose 5% premix 500 mL... (Modify) ttrate, IV, 18 unit/kg/h starting rate, 8 unit/kg/h minimum r... Comment: - Initial starting rate not to exceed 40 mL/h (2...	Dhingra, Vinay	Test User, Nurse 10:43 Today
<input checked="" type="checkbox"/> HYDROMORPHONE (HYDROMORPHONE PRN range dose) dose range: 1 to 2 mg, PO, q4h, PRN pain, drug form: tab, s... Comment: DILAUDID EQUIV	Dhingra, Vinay	Test User, Nurse - ICU 11:54 Today
<input checked="" type="checkbox"/> HYDROMORPHONE (HYDROMORPHONE PRN range dose) (Discontinue) dose range: 0.1 to 0.5 mg, IV, q4h, PRN pain, drug form: inj... Comment: DILAUDID EQUIV	Dhingra, Vinay	Test User, Nurse - ICU 11:54 Today

☒ Select All

2 Mark as Reviewed Cancel

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 access the patient chart
- Remember to select the correct role when establishing your 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

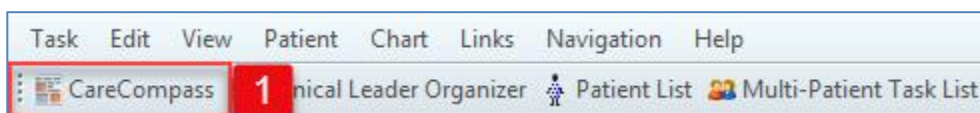
Activity 2.3 – Review and Complete Tasks in CareCompass


- 1 Tasks are activities that need to be completed for the patient. Tasks are generated by certain orders or rules in the system and show up in a list format to notify the clinician to complete specific patient care activities. They are meant to replace your current paper to-do list and highlight activities that are outside of regular care.

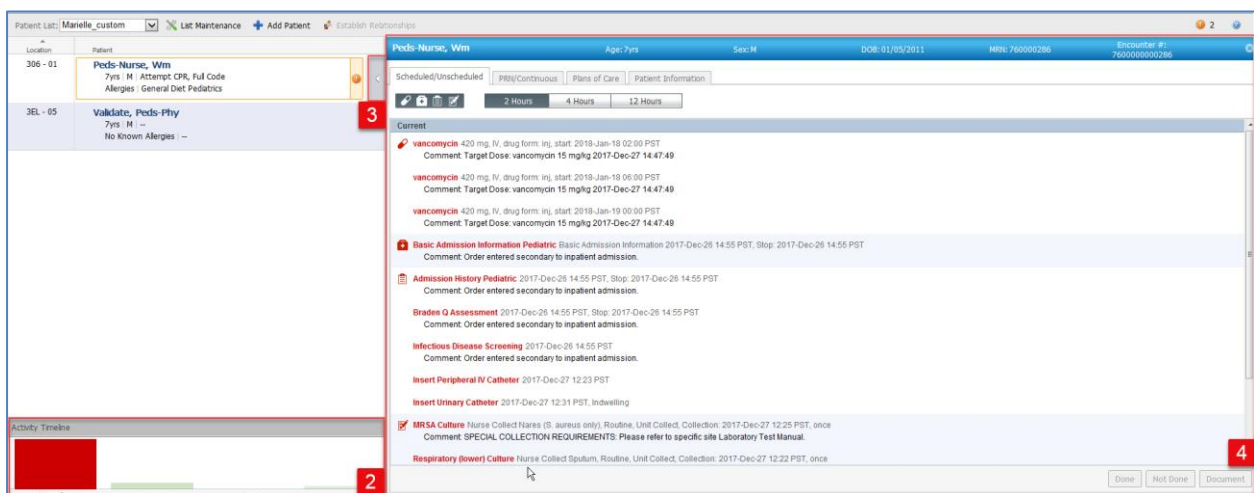
Note: Not all orders trigger tasks. For example, collecting a sputum sample is tasked as it is not a regular occurrence, whereas vital signs are part of basic daily care and therefore are not tasked.

Let's Locate tasks on your patient:

1. Clicking **CareCompass**  in the **Toolbar** navigates you back to CareCompass



2. Scheduled tasks for multiple patients are summarized in the **Activity Timeline**
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



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

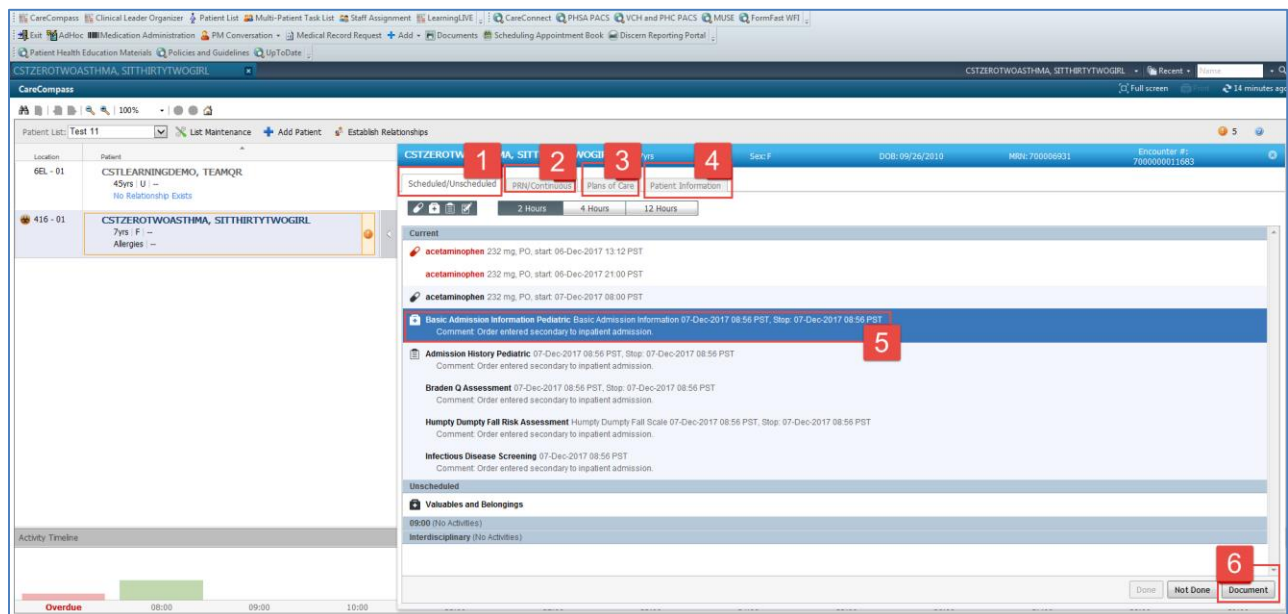
To see the different information you can navigate to:

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

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

Complete the Basic Admission Information task:


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



The screenshot shows the CareCompass interface for a patient named CSTZEROTWOASTHMA, SITHTHIRTYWOGIRL. The interface includes a top navigation bar with various tools and a main task list on the right. The task list is filtered by 'Current' and shows several tasks, including 'Basic Admission Information Pediatric'. A red box labeled '5' highlights the 'Basic Admission Information Pediatric' task. Another red box labeled '6' highlights the 'Document' button at the bottom right of the task list.

Note: If a task is associated with documentation, clicking Document button takes you directly to the appropriate documentation within the patient's chart. For Basic Admission Information Pediatric, this is a PowerForm. PowerForms are standardized electronic documentation forms.

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

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



To complete this PowerForm:

1. Click **Weight** and review the previously documented weight of 28 kg

The screenshot shows the 'Allergies' section of the PowerForm. The left sidebar has a red box around the 'Weight' button. The main area displays a table with the following data:

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

4

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

The screenshot shows the 'Medication History' section of the PowerForm. The left sidebar has a red box around the 'Medication History' button. The main area displays a table with the following data:

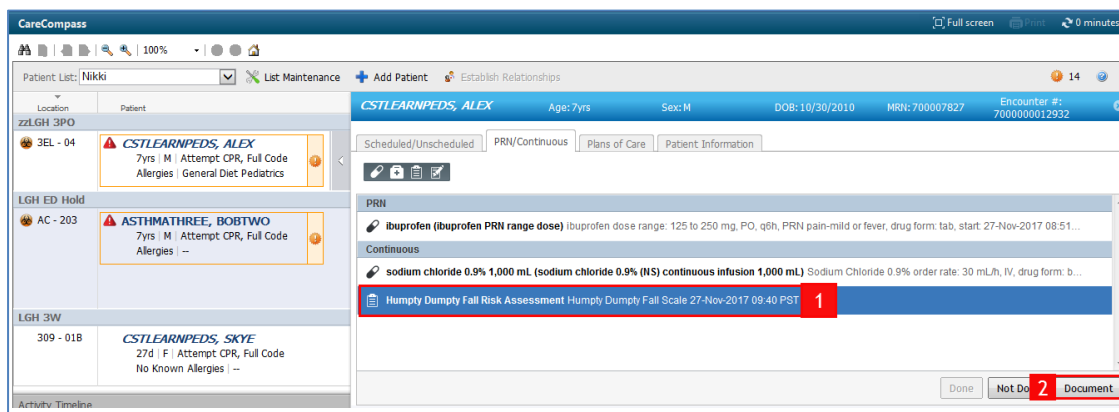
Order Name	Status	Dose	Details
vancomycin	Ordered	1,000 mg, IV, q12h, start: 29-Nov-2017 15:29 PST	
HYDRomorphone (HYDRomorphone P...)	Ordered	dose range: 0.1 to 0.5 mg, IV, q4h, PRN pain, drug form: inj, start: 29-Nov-2...	
acetaminophen (TYLENOL)	Ordered	650 mg, PO, q4h, drug form: tab, start: 29-Nov-2017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

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.

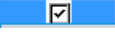
Complete the **Humpty Dumpty Fall Risk Assessment** task:

1. Select **Humpty Dumpty Fall Risk Assessment** task
2. Click **Document**



The screenshot shows the CareCompass interface for patient Alex, 7 years old, male, DOB 10/30/2010, MRN 700007827. The patient is currently in the PRN section. The 'Humpty Dumpty Fall Risk Assessment' task is selected in the PRN section, indicated by a red box and a red '1'. The 'Document' button is highlighted with a red box and a red '2'.

Note: Clicking Document for Humpty Dumpty 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.

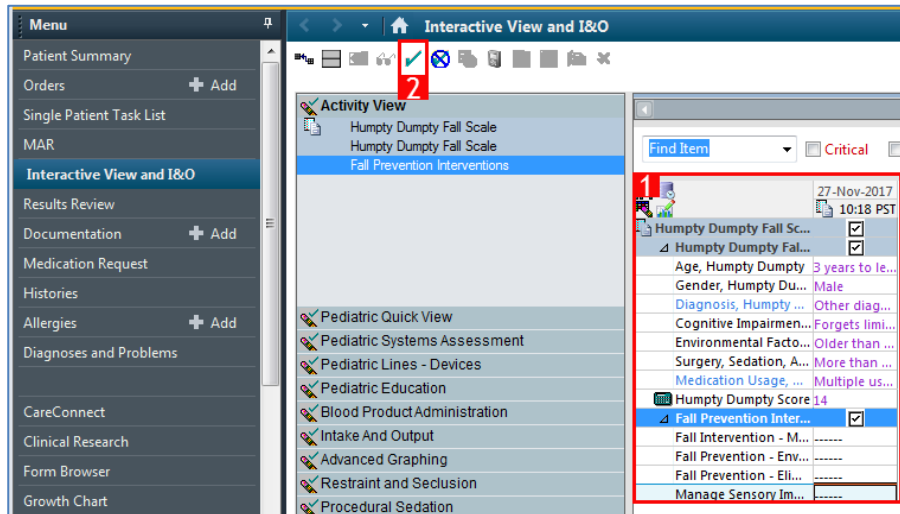
- 6
1. Double click the blue box  next to the section name **Humpty Dumpty Score**. The section is now active for documentation, allowing you to move through the cells by pressing Enter on the keyboard.

Document using the following data:

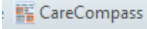
- **Age** = 7 years to less than 13 years
- **Gender** = Male
- **Diagnosis** = Other diagnosis
- **Cognitive Impairments** = Forgets limitations
- **Environmental Factors** = Older than infant-toddler placed in bed
- **Response to Surgery/Sedation/Anaesthesia** = More than 48 hours
- **Medication usage** = Multiple usage of medications

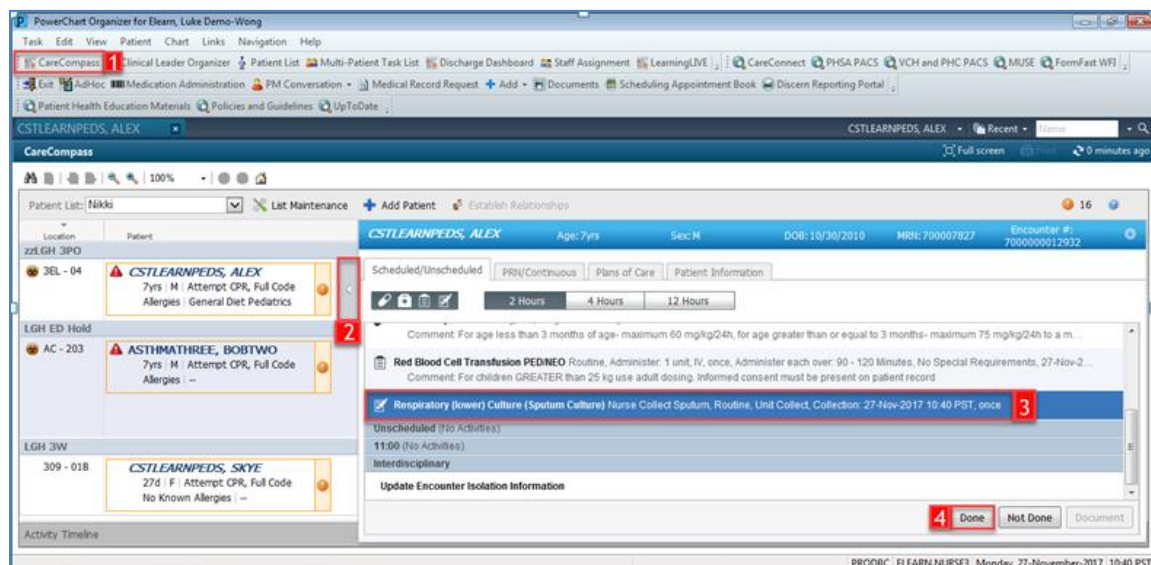
A **Humpty Dumpty Fall Risk Score** is automatically calculated based on the information inputted during documentation. Note for this activity it has calculated the score of **13**. For this workbook, there is no need to document the fall prevention interventions though you would in practice.

- Click the **green check mark** ✓ to sign your documentation. You will notice that your documentation changes from purple text to black text once signed.



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

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



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



Key Learning Points

- Tasks are 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

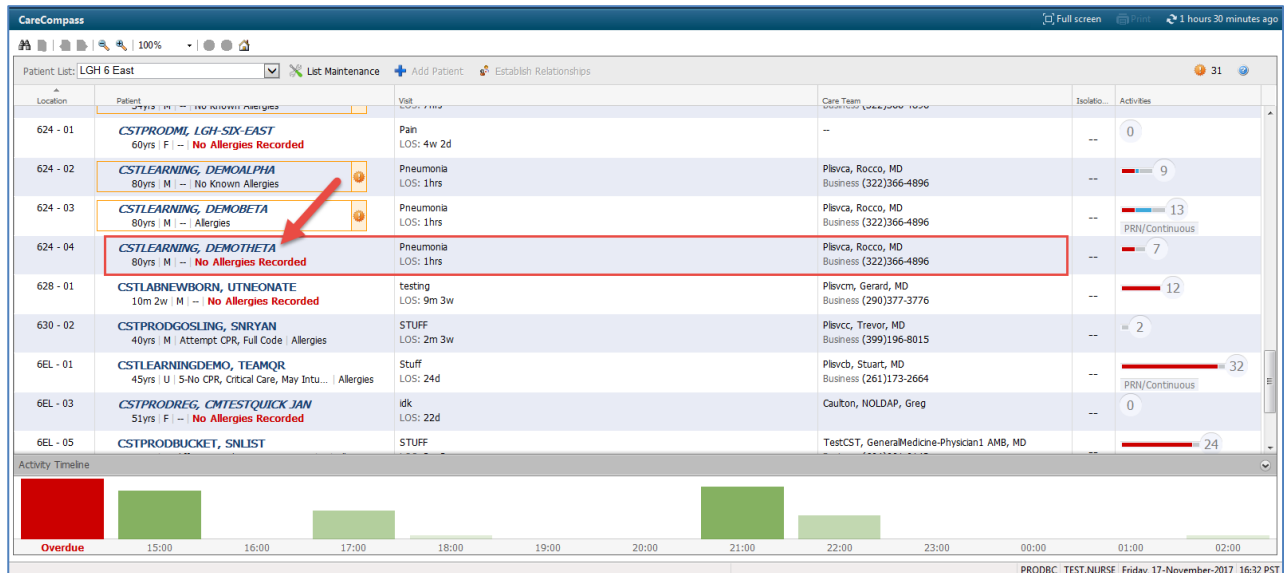
SCENARIO

As a pediatric 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

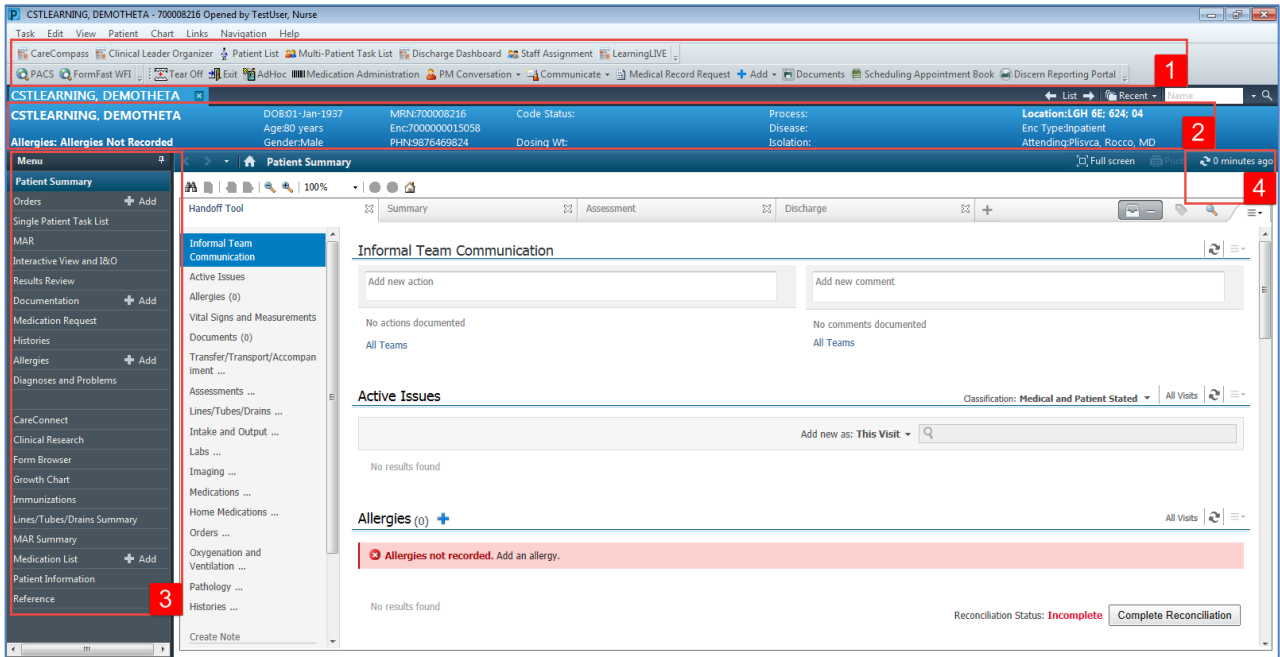
1 From **CareCompass**, click on patient's name to access the patient chart.







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

1. The **Toolbar** is located above the patient's chart and it contains buttons for you to navigate to other parts or functions of the Clinical Information System.
2. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information displayed includes:
 - Name
 - Allergies
 - Age, date of birth, etc.
 - Encounter type and number
 - Code status
 - Weight
 - Process, disease and isolation alerts
 - Location of patient
3. The **Menu** on the left allows access to different sections of the patient chart. This is similar to the coloured dividers within a paper-based patient chart. Examples of sections included are Orders, Medications Administration Record (MAR) and more.
4. The **Refresh** icon  updates the patient chart with the most up to date entries when clicked. It is important to click the **Refresh** icon frequently especially as other clinicians may be accessing and documenting in the patient chart simultaneously.

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



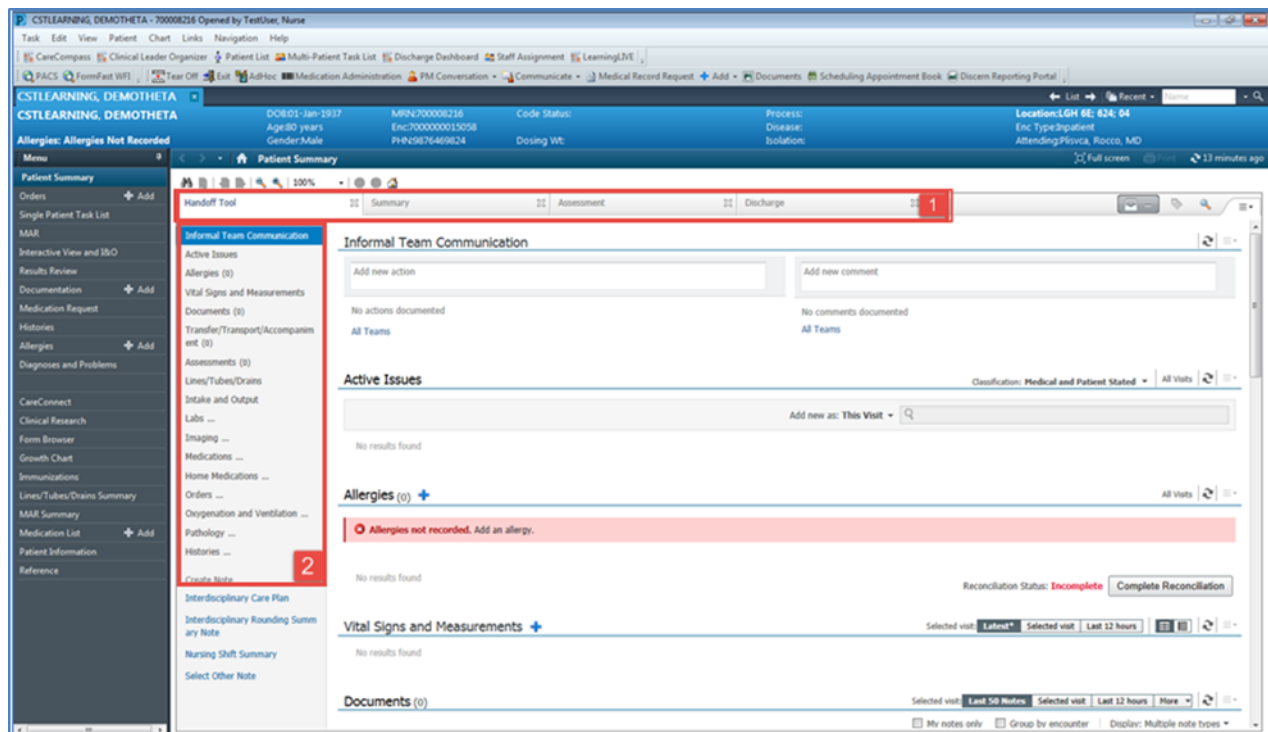
Key Learning Points



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

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  to get the most updated information on the patient. The icon will reset to 0 minutes  0 minutes ago.

Key Learning Points

-  Patient Summary will provide 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:

- Utilize PM Conversation

SCENARIO

Unit clerks will often update the patient information in the system. In some situations, the nurse will need to update a patient's alerts in the chart. In this scenario, you will be reviewing PM Conversation and some of its functionalities. You will then learn to place a process alert.

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

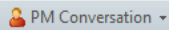
- Use PM Conversation

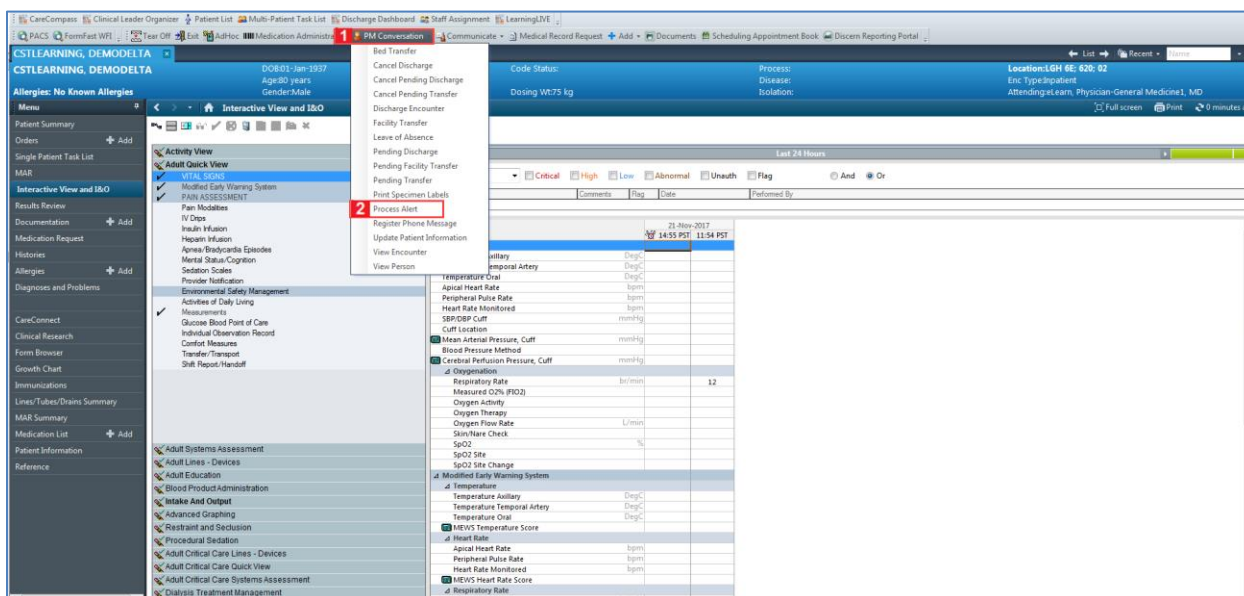
Activity 4.1 – PM Conversation

- 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.

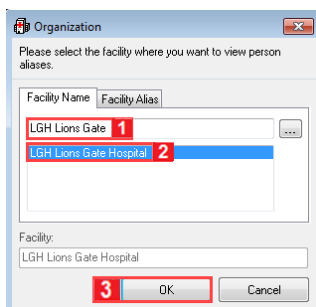
Since the patient has a high **Humpty Dumpty Falls Risk** score a **Falls Risk** process alert should be added to the patient's chart. To do this:

- Click the drop-down arrow to right of **PM Conversation**  in the Toolbar
- Select **Process Alert** from the drop-down menu




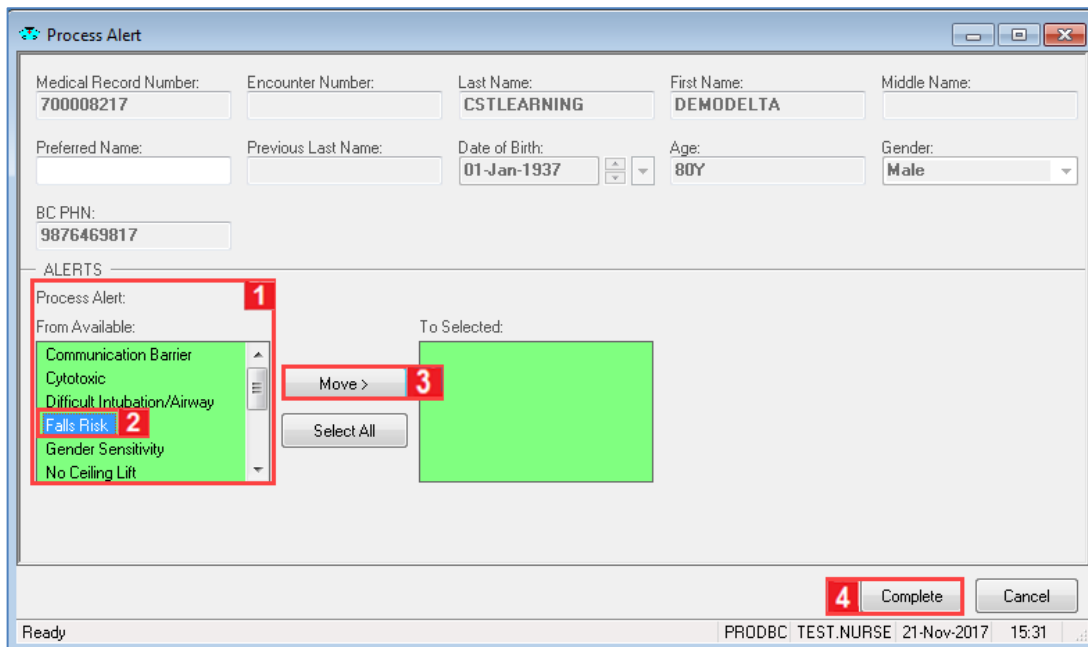
An organization window will display to select location.

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



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

1. Click on the empty **Process Alert** box. A list of alerts that can be applied to the patient will display. **Note:** This box will be empty until you click on 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 flags and alerts.

3 1. Click **Refresh** button  to update the chart.

2. Once complete, the **process alert** will appear within the banner bar of the chart where it is visible to 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 allows 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 Orders Page and Place Orders
-  Complete an Order
-  Review the General Layout of a PowerPlan

SCENARIO

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

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

Activity 5.1 – Review Orders Profile

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

To navigate to the **Order** page and review the orders:

- Select **Orders** from the **Menu**
- On the left side is 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 **Order Profile** where you can:
 - Review the list of Review the list of **All Active Orders**
 - Moving the mouse over order icons allows you to **hover to discover** additional information.
 - Some examples of icons are:



Order for nurse to review



Additional reference text available

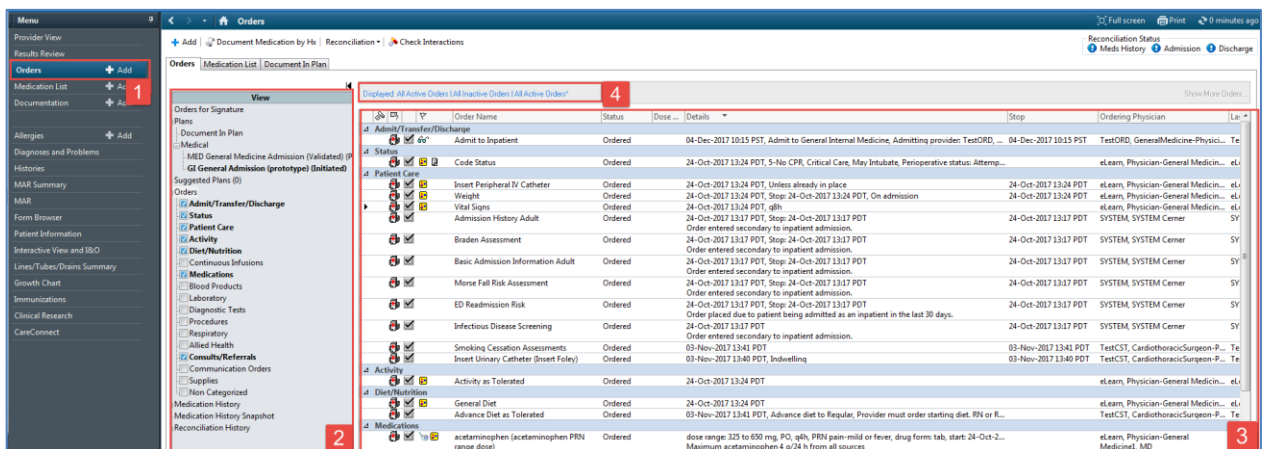


Order part of a PowerPlan



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

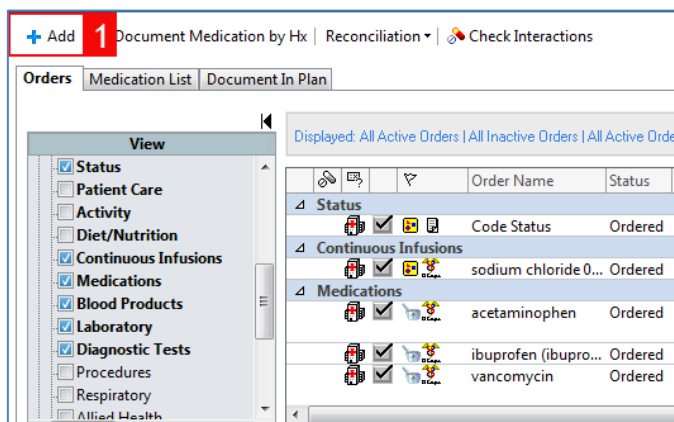
Activity 5.2 – Place an Order

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

- Orders 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, RNIA

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

1. Click the **Add** button  within the **Orders** page. The **Add Order** window opens.

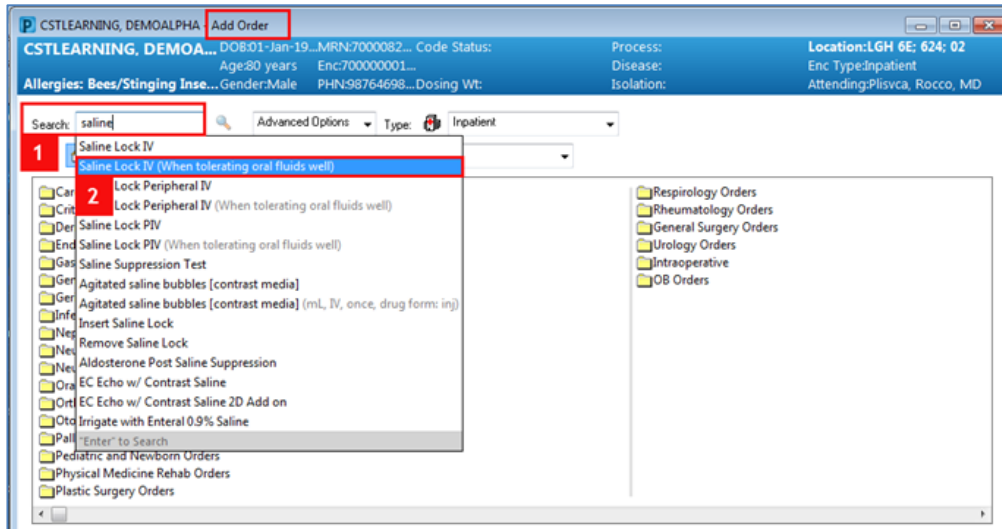


The **Add Order** window will open.

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.

Note: You will see 3 similar orders, select any one of these.



1 Add Order

CSTLEARNING, DEMOALPHA... DOB: 01-Jan-19... MRN: 7000082... Code Status: Process: Location: LGH 6E: 624; 02
Age: 80 years Enc: 700000001... Disease: Enc Type: Inpatient
Allergies: Bees/Stinging Inse... Gender: Male PHN: 98764698... Dosing Vt: Isolation: Attending: Plisvca, Rocco, MD

Search: saline Advanced Options Type: Inpatient

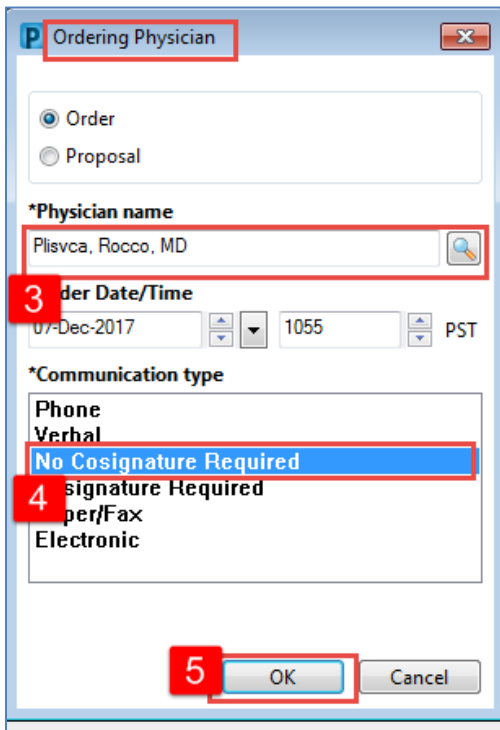
2 Saline Lock IV (When tolerating oral fluids well)

Lock Peripheral IV
Lock Peripheral IV (When tolerating oral fluids well)
Saline Lock PIV
Saline Lock PIV (When tolerating oral fluids well)
Saline Suppression Test
Agitated saline bubbles [contrast media]
Agitated saline bubbles [contrast media] (mL, IV, once, drug form: inj)
Insert Saline Lock
Remove Saline Lock
Aldosterone Post Saline Suppression
EC Echo w/ Contrast Saline
EC Echo w/ Contrast Saline 2D Add on
Irrigate with Enteral 0.9% Saline
Enter to Search
Pediatric and Newborn Orders
Physical Medicine Rehab Orders
Plastic Surgery Orders

Respirology Orders
Rheumatology Orders
General Surgery Orders
Urology Orders
Intraoperative
OB Orders

The **Ordering Physician** window opens.

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



Ordering Physician

Order
Proposal

*Physician name
Plisvca, Rocco, MD

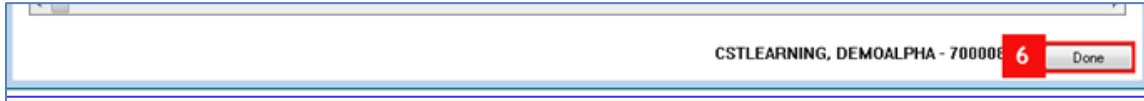
3 Order Date/Time
07-Dec-2017 1055 PST

*Communication type
Phone
Verbal
No Cosignature Required
Signature Required
Paper/Fax
Electronic

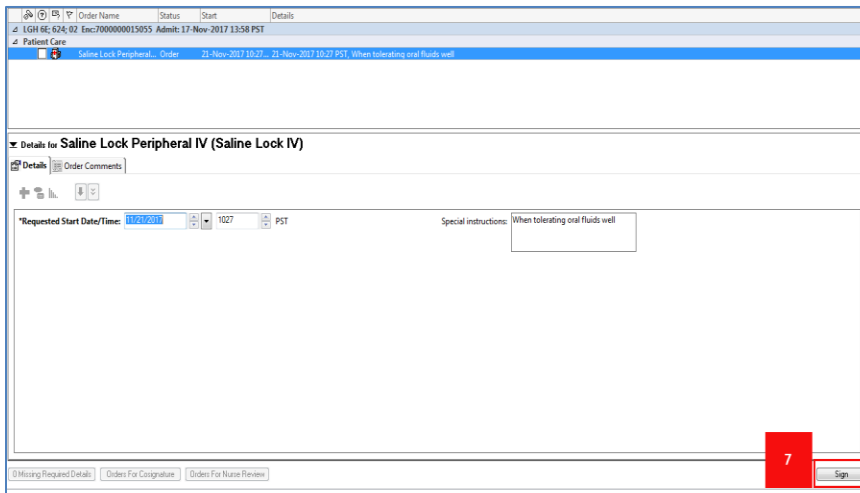
4

5 OK Cancel

6. Click **Done** button 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/details for an order

Activity 5.3 – Orders Statuses and Review



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
- **Proposal-** is proposed by non-providers. These are suggestions sent for provider review and should not be acted upon until signed by a provider. Once signed, these will become active and status will change to Ordered


	Order Name	Status	Dose ...	Details
	Insert Peripheral IV...	Processing		20-Nov-2017 11:46 PST
	Insert Urinary Cath...	Proposal		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	Proposal		20-Nov-2017 11:25 PST, q4h while awake
	Vital Signs	Ordered		17-Nov-2017 16:24 PST
Medications				
	furosemide	Ordered		20 mg, IV, as directed, order duration: 5 day, drug form: inj, start: 17-Nov- Administer pre red blood cell transfusion

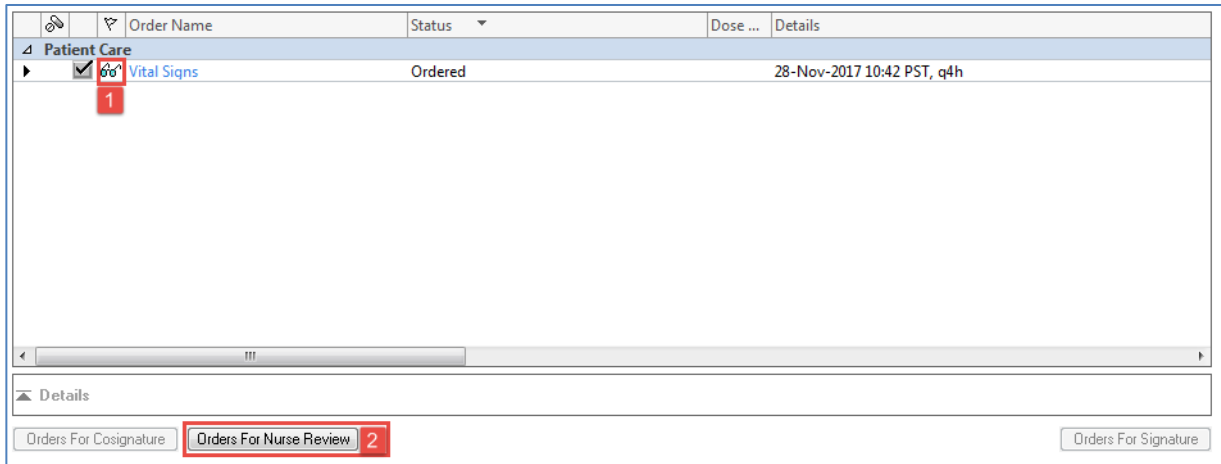
To review order details:


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

	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 callwhen ready for pick up, 28-Nov-2017 11:04 PST Order Comment: Informed consent must be present on patient record

2 When new orders are placed in the chart, a nurse must acknowledge reviewing these new orders.

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. The nurse should click the **Orders for Nurse Review** button to open the review window.



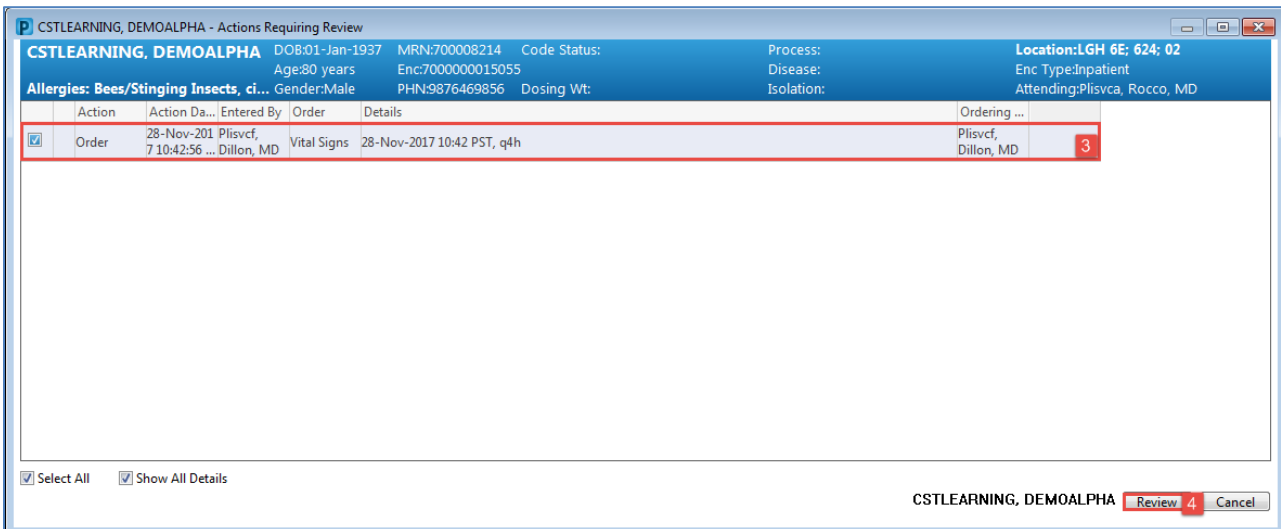
Order Name	Status	Dose ...	Details
Patient Care			
<input checked="" type="checkbox"/>  Vital Signs	Ordered		28-Nov-2017 10:42 PST, q4h

Details

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

An **Actions Requiring Review** window pops up. This window displays any new orders that have been placed by other clinicians that need to be acknowledge 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, ci... 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	Plisvcf, 7 10:42:56 ...	Vital Signs	28-Nov-2017 10:42 PST, q4h	Plisvcf, Dillon, MD

☒ Select All ☒ Show All Details

CSTLEARNING, DEMOALPHA **Review** Cancel

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

Key Learning Points


-  Nurses should always verify the status of orders
-  Hover to Discover to view additional information

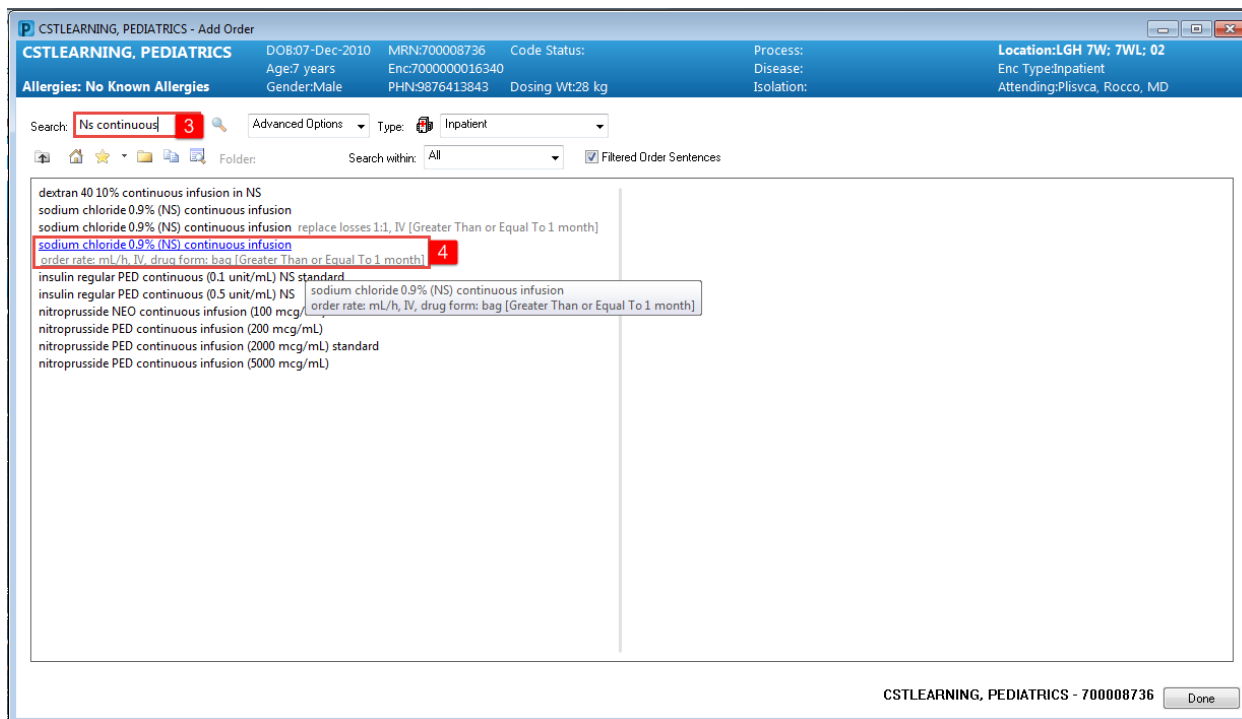
Activity 5.4 – Place a Verbal Order

- 1 Just like in current practice, nurses can place verbal and telephone orders. In this activity, we are going to practice placing a verbal order. **Verbal Orders** are only encouraged when there is no reasonable alternative for the provider to place the order in the CIS themselves, for example, in emergency situations.

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

To place a verbal order:

1. Select **Orders** from the **Menu**
2. Click the **Add** button . The **Add Order** window will appear
3. Type = *NS continuous* in the search field and press **Enter** key to search
4. Select **sodium chloride 0.9% (NS) continuous infusion order rate: mL/h, IV, drug form: bag [Greater Than or Equal To 1 month]**



CSTLEARNING, PEDIATRICS - Add Order

CSTLEARNING, PEDIATRICS DOB:07-Dec-2010 MRN:700008736 Code Status: Process: Location:LGH 7W; 7WL; 02
 Age:7 years Enc:70000000016340 Disease: Enc Type:Inpatient
 Gender:Male PHN:9876413843 Dosing Wt:28 kg Isolation: Attending:Plisvca, Rocco, MD
 Allergies: No Known Allergies

Search: **Ns continuous** 3 Advanced Options Type: Inpatient

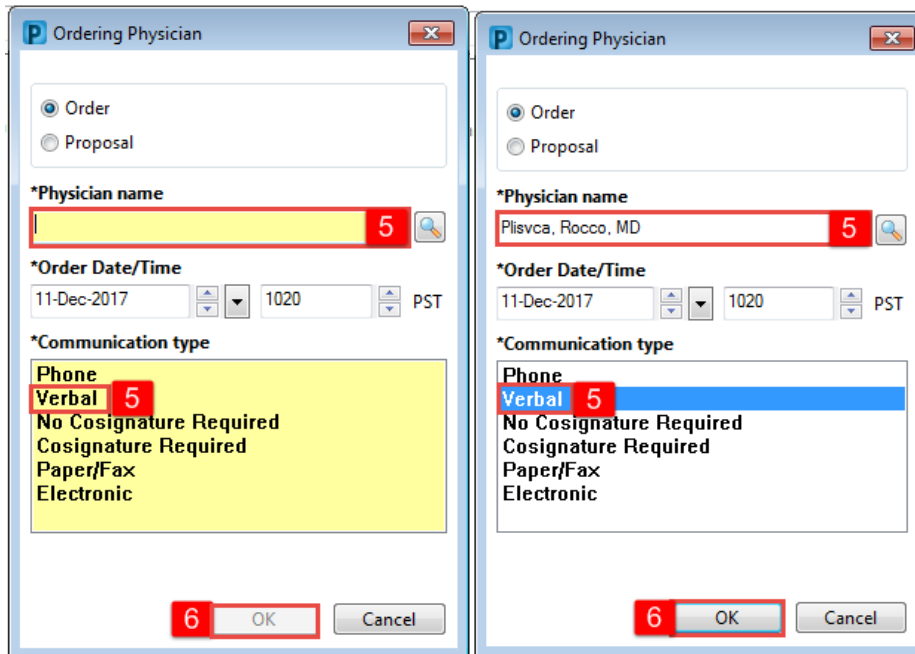
Search within: All Filtered Order Sentences

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] 4
 insulin regular PED continuous (0.1 unit/mL) NS standard
 insulin regular PED continuous (0.5 unit/mL) NS sodium chloride 0.9% (NS) continuous infusion
 nitroprusside NEO continuous infusion (100 mcg) order rate: mL/h, IV, drug form: bag [Greater Than or Equal To 1 month]
 nitroprusside PED continuous infusion (200 mcg/mL)
 nitroprusside PED continuous infusion (2000 mcg/mL) standard
 nitroprusside PED continuous infusion (5000 mcg/mL)

CSTLEARNING, PEDIATRICS - 700008736 Done

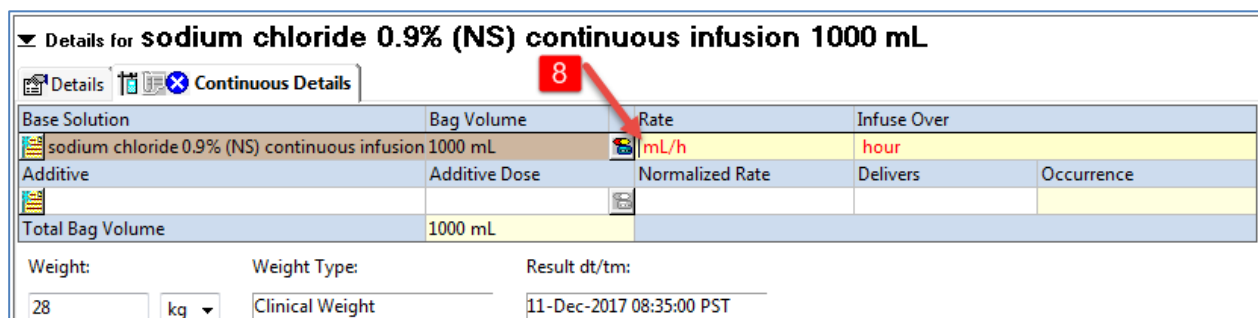
The Ordering Physician pop-up window will appear:

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




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

7. Click **Done** to close the Add Order window (refer to first screenshot within this activity)
8. Order for Signature window opens and order details display. Click in front of the Rate of **mL/h** and enter the rate of = 30



Base Solution	Bag Volume	Rate	Infuse Over	
sodium chloride 0.9% (NS) continuous infusion 1000 mL		mL/h	hour	
Additive	Additive Dose	Normalized Rate	Delivers	Occurrence
Total Bag Volume	1000 mL			

Weight: 28 kg Weight Type: Clinical Weight Result dt/tm: 11-Dec-2017 08:35:00 PST

9. Click on the Infuse Over cell titled **hour**. Note that the Rate will auto-calculate the infusion time to 33.3 hour.
10. Click **Sign** and click the **Refresh** icon .

Details for sodium chloride 0.9% (NS) continuous infusion 1000 mL

Details Continuous Details

Base Solution	Bag Volume	Rate	Infuse Over
sodium chloride 0.9% (NS) continuous infusion 1000 mL	1000 mL	30 mL/h	33.3 hour 9

Additive	Additive Dose	Normalized Rate	Delivers	Occurrence

Total Bag Volume 1000 mL

Weight: 28 kg Weight Type: Clinical Weight Result dt/tm: 11-Dec-2017 08:35:00 PST

Infusion instructions

0 Missing Required Details Orders For Cosignature Orders For Nurse Review

10 Sign

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

☒ sodium chloride 0.9% (NS) continuous infusion 1,000 mL **Ordered 11** order rate: 30 mL/h, IV, drug form: bag,

Key Learning Points

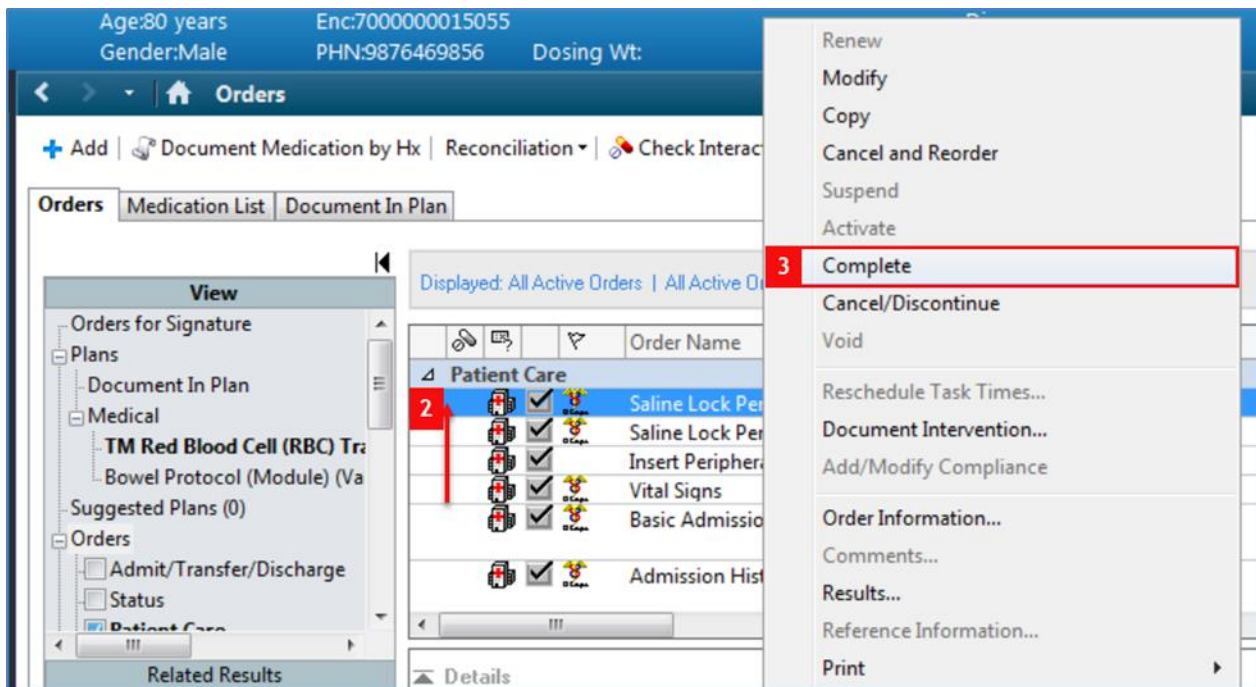
- Verbal orders are only encouraged to be entered when a physician cannot enter the order directly into the CIS themselves, for example in an emergency situation or when the physician is sterile in mid procedure.
- Required fields are always highlighted yellow.
- Verbal and phone orders that are entered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

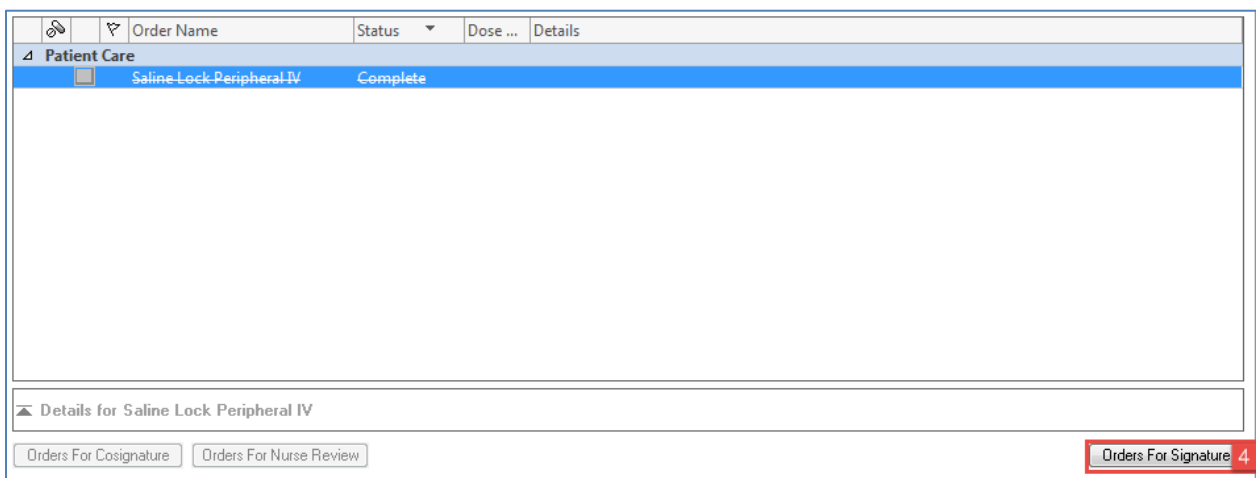
To complete an order:

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



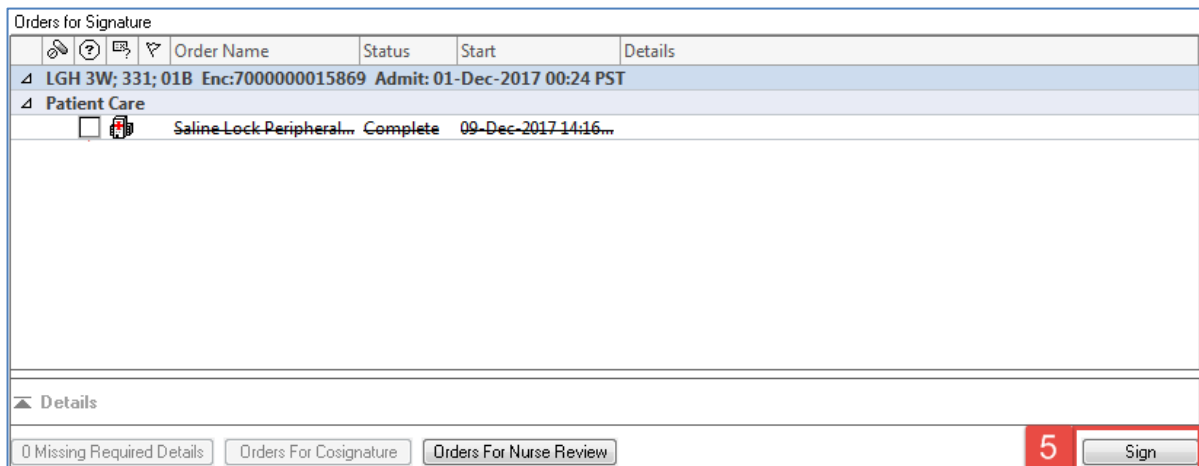
The screenshot shows the 'Orders' section of a clinical system. At the top, patient information is displayed: Age: 80 years, Gender: Male, Enc: 7000000015055, PHN: 9876469856, and Dosing Wt. The 'Orders' tab is active, showing a list of orders under the 'Patient Care' category. The order 'Saline Lock Peripheral IV' is selected, and a right-click context menu is open. The menu options include Renew, Modify, Copy, Cancel and Reorder, Suspend, Activate, Complete (highlighted with a red box and labeled '3'), Cancel/Discontinue, Void, Reschedule Task Times..., Document Intervention..., Add/Modify Compliance, Order Information..., Comments..., Results..., Reference Information..., and Print. A red arrow labeled '2' points to the 'Saline Lock Peripheral IV' order in the list.


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



The screenshot shows the 'Orders' section after the order has been completed. The 'Saline Lock Peripheral IV' order is now marked as 'Complete'. At the bottom of the screen, there are three buttons: 'Orders For Cosignature', 'Orders For Nurse Review', and 'Orders For Signature' (highlighted with a red box and labeled '4').

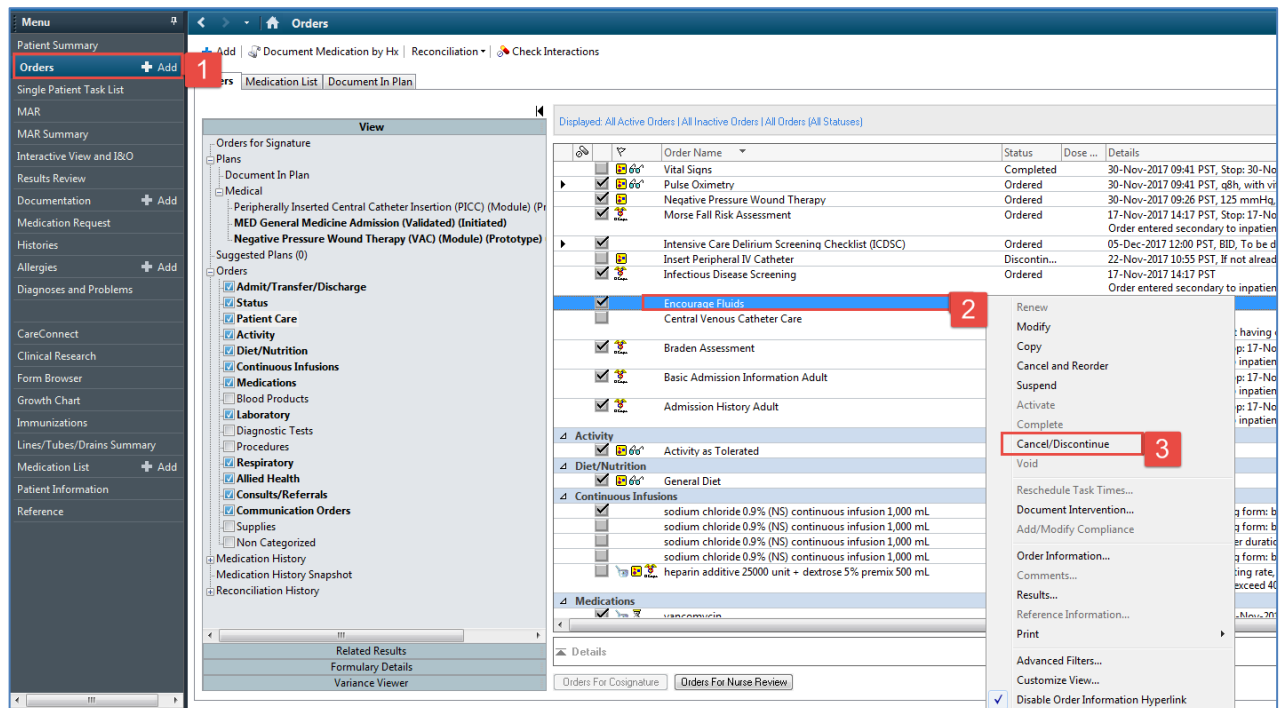
- Review order for signature and click **Sign**. You will return to the orders profile where order will show as processing.



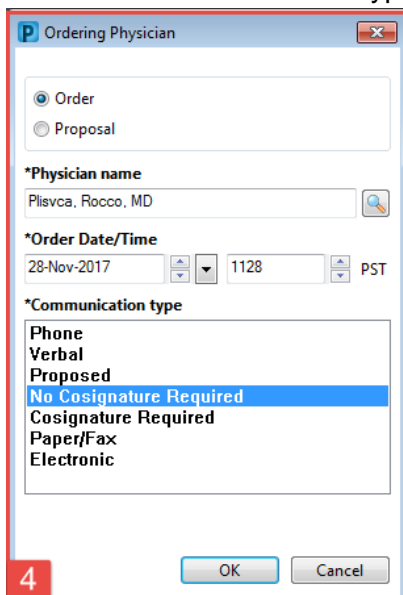
- Click the **Refresh** icon . Order will no longer be visible on the Orders Profile.

2 Now let's try to discontinue an order.

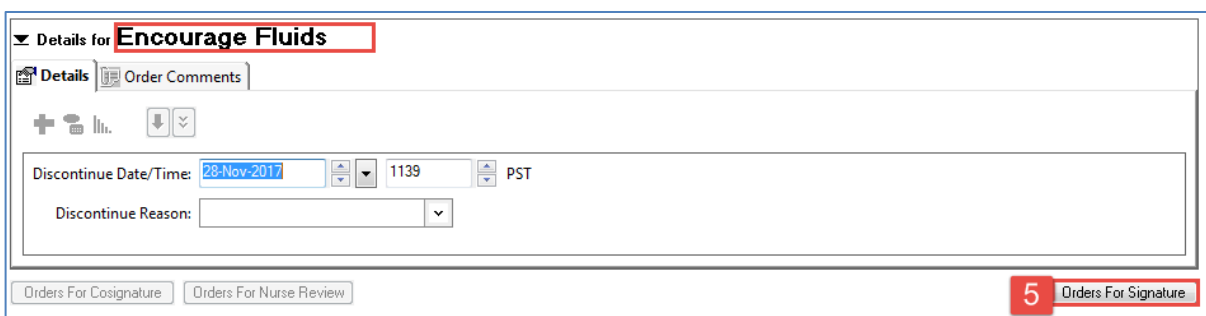
- Review order profile
- Right-click order **Encourage Fluids**
- Select **Cancel/Discontinue**




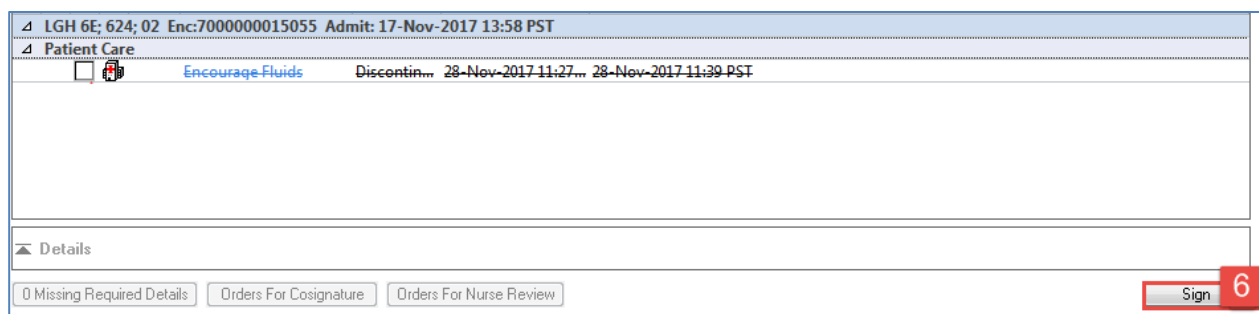
4. Ordering Physician pop-up window will appear. Fill out required fields highlighted yellow below and then click **OK**.
 - Physician name = *type name of Attending Physician (last name, first name)*
 - Communication type = *No Cosignature Required*


 A screenshot of the 'Ordering Physician' dialog box. It has a title bar with a close button. Inside, there are two radio buttons: 'Order' (selected) and 'Proposal'. Below is a text field for '*Physician name' containing 'Plisvca, Rocco, MD' with a search icon. Then, a section for '*Order Date/Time' with a date picker set to '28-Nov-2017', a time picker set to '1128', and a time zone dropdown set to 'PST'. Below that is a list for '*Communication type' with options: Phone, Verbal, Proposed, No Cosignature Required (highlighted in blue), Cosignature Required, Paper/Fax, and Electronic. At the bottom are 'OK' and 'Cancel' buttons. A red box with the number '4' is in the bottom left corner.



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


 A screenshot of the 'Details for Encourage Fluids' window. It has tabs for 'Details' and 'Order Comments'. Below the tabs are icons for adding, deleting, and saving. A section for 'Discontinue Date/Time' has a date picker set to '28-Nov-2017', a time picker set to '1139', and a time zone dropdown set to 'PST'. Below that is a 'Discontinue Reason' dropdown menu. At the bottom are three buttons: 'Orders For Cosignature', 'Orders For Nurse Review', and 'Orders For Signature' (highlighted with a red box and the number '5').

6. Review Order for signature and click **Sign**. You will return to the order profile. Click the **Refresh** icon . Order will no longer be visible on order profile, but can be filtered to see.


 A screenshot of the 'Patient Care' order profile. At the top, it shows patient information: 'LGH 6E; 624; 02 Enc:7000000015055 Admit: 17-Nov-2017 13:58 PST'. Below is a table with columns for order status, name, and dates. The first row shows 'Encourage Fluids' with a status of 'Discontin...' and dates '28-Nov-2017 11:27...' and '28-Nov-2017 11:39 PST'. Below the table is a 'Details' section with buttons for '0 Missing Required Details', 'Orders For Cosignature', and 'Orders For Nurse Review'. At the bottom right is a 'Sign' button (highlighted with a red box and the number '6') and a 'Refresh' icon.

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 but can be filtered to see.

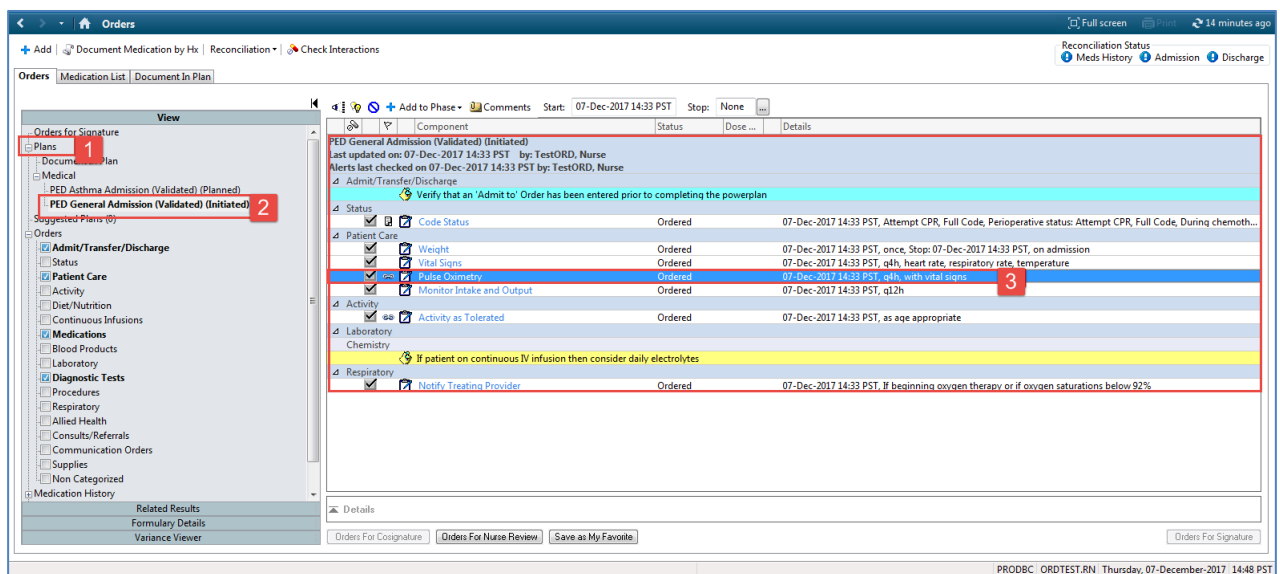
Activity 5.6 – Review Components of a PowerPlan

1

A PowerPlan in the CIS is the equivalent of preprinted orders in current state. 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.

While on the Orders Profile:

1. Locate the **Plans** category to the left side of the screen under **View**.
2. Select the **PED General Admission PowerPlan**.
3. Review orders within the PowerPlan: (*Pulse Oximetry, q4h, with vital signs*)



The screenshot shows the 'Orders' profile for a patient. The left sidebar has a 'View' tab with a 'Plans' category selected. The main area displays the 'PED General Admission (Validated) (Initiated)' PowerPlan. The 'Orders' section lists various orders, including 'Pulse Oximetry' which is highlighted with a red box and a red '3'.

Component	Status	Dose	Details
PED General Admission (Validated) (Initiated)	Initiated		
Admit/Transfer/Discharge	Ordered	07-Dec-2017 14:33 PST, Attempt CPR, Full Code, Perioperative status: Attempt CPR, Full Code, During chemoth...	
Code Status	Ordered	07-Dec-2017 14:33 PST, once Stop: 07-Dec-2017 14:33 PST, on admission	
Weight	Ordered	07-Dec-2017 14:33 PST, q4h, heart rate, respiratory rate, temperature	
Vital Signs	Ordered	07-Dec-2017 14:33 PST, q4h, with vital signs	
Pulse Oximetry	Ordered	07-Dec-2017 14:33 PST, q12h	
Monitor Intake and Output	Ordered	07-Dec-2017 14:33 PST, q12h	
Activity as Tolerated	Ordered	07-Dec-2017 14:33 PST, as age appropriate	
Respiratory	Ordered	07-Dec-2017 14:33 PST, If beginning oxygen therapy or if oxygen saturations below 92%	





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 iView and I&O (iView)
-  Document and Modify your Documentation in iView

SCENARIO

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

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

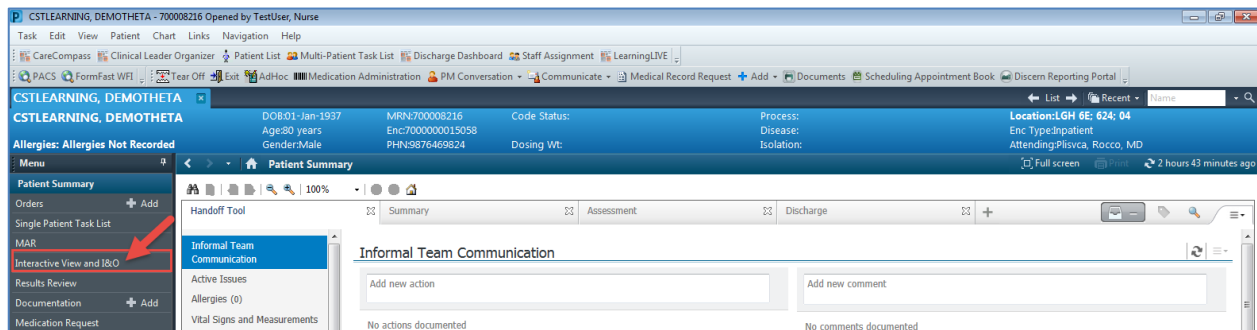
-  Navigate to Interactive View and I&O
-  Document in iView
-  Change the time column
-  Document a Dynamic Group in iView
-  Modify, unchart or add a comment in iView

PLEASE NOTE: Throughout this session, you may encounter a BMDI (Bedside Medical Device Integration) pop-up window asking you to associate your patient to a monitor; BMDI monitoring is not included in this classroom session, please close the window and continue through your workbook.

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 the current state paper flow sheets. For example, vital signs and pain assessment will be charted in iView.

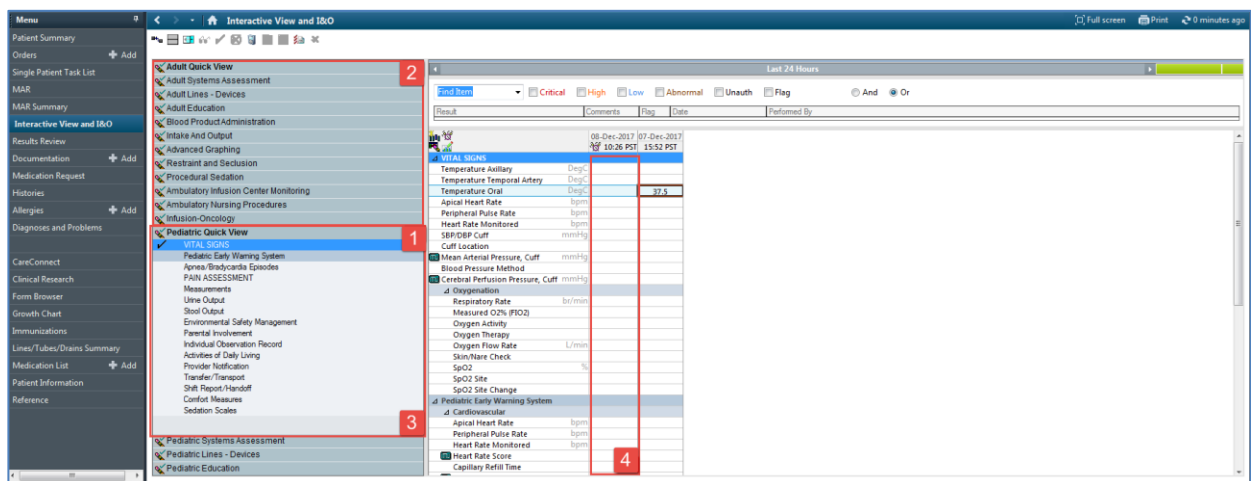
Navigate to **iView** by selecting **Interactive View and I&O (iView)** within the **Menu**.



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

1. A **band** is a heading that has a collection of flowsheets (**sections**) organized beneath it. In the image below, the **Pediatric Quick View** band is expanded displaying the sections within it.
2. The set of bands below **Pediatric 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. A **cell** is the field where data is documented.

Note: You are not required to document any data in this scenario.




Key Learning Points


- Nurse 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 **Pediatric Quick View** band expanded you will see the **Vital Signs** section. Let's practice documenting in iView.

1. Select the **Vital Signs** component under **Pediatric 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 **Enter** on the keyboard.
3. Document using the following data:
 - **Temperature Oral** = 37.2
 - **Peripheral Pulse Rate** = 91
 - **SBP/DBP Cuff** = 108/68
 - **Mean Arterial Pressure, Cuff** = *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.

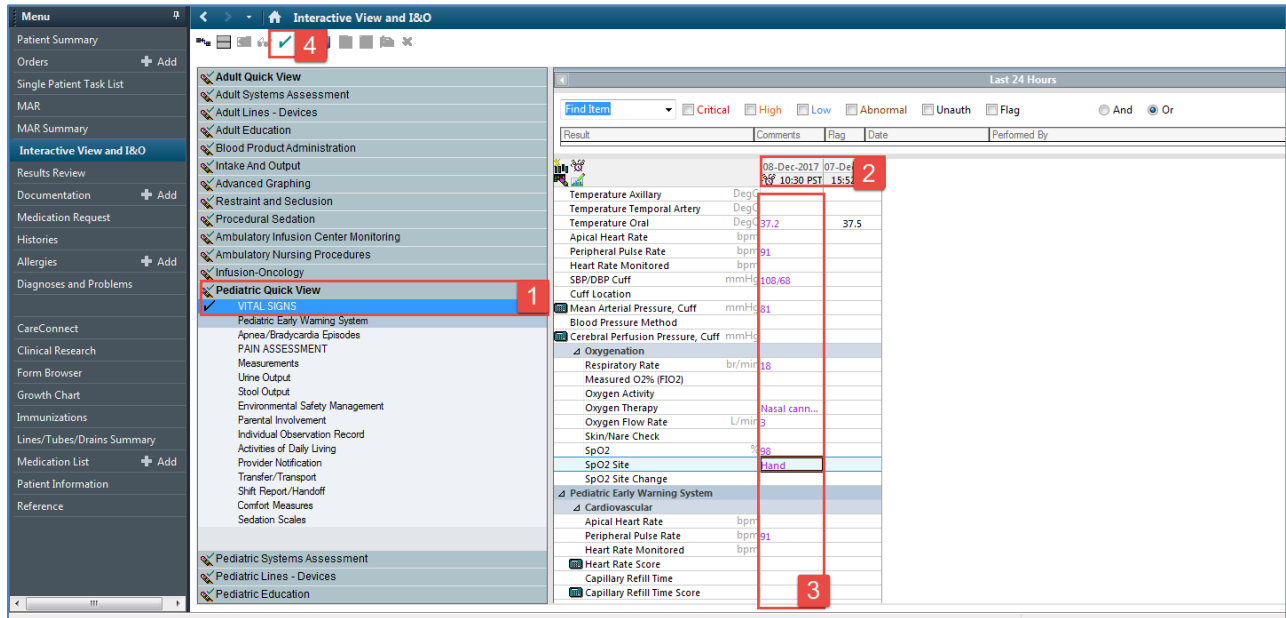
Continue to document using the following data:

- **Respiratory Rate** = 18
- **Oxygen Therapy** = *Nasal cannula*
- **Oxygen Flow Rate** = 3
- **SpO2** = 98
- **SpO2 Site** = *Hand*

Notice that the text is purple while documenting. This means that the documentation has not been signed and recorded in the chart just yet.

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

4. Click **green check mark** icon  to sign your documentation.



Menu

Patient Summary

Orders + Add

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

Adult Quick View

- Adult Systems Assessment
- Adult Lines - Devices
- Adult Education
- Blood Product Administration
- Intake And Output
- Advanced Graphing
- Restraint and Sedation
- Procedural Sedation
- Ambulatory Infusion Center Monitoring
- Ambulatory Nursing Procedures
- Infusion-Oncology

Pediatric Quick View 1

- Pediatric Early Warning System
- Apnea/Bradycardia Episodes
- PAIN ASSESSMENT
- Measurements
- Urine Output
- Stool Output
- Environmental Safety Management
- Parental Involvement
- Individual Observation Record
- Activities of Daily Living
- Provider Notification
- Transfer/Transport
- Shift Report/Handoff
- Comfort Measures
- Sedation Scales

Pediatric Systems Assessment

Pediatric Lines - Devices

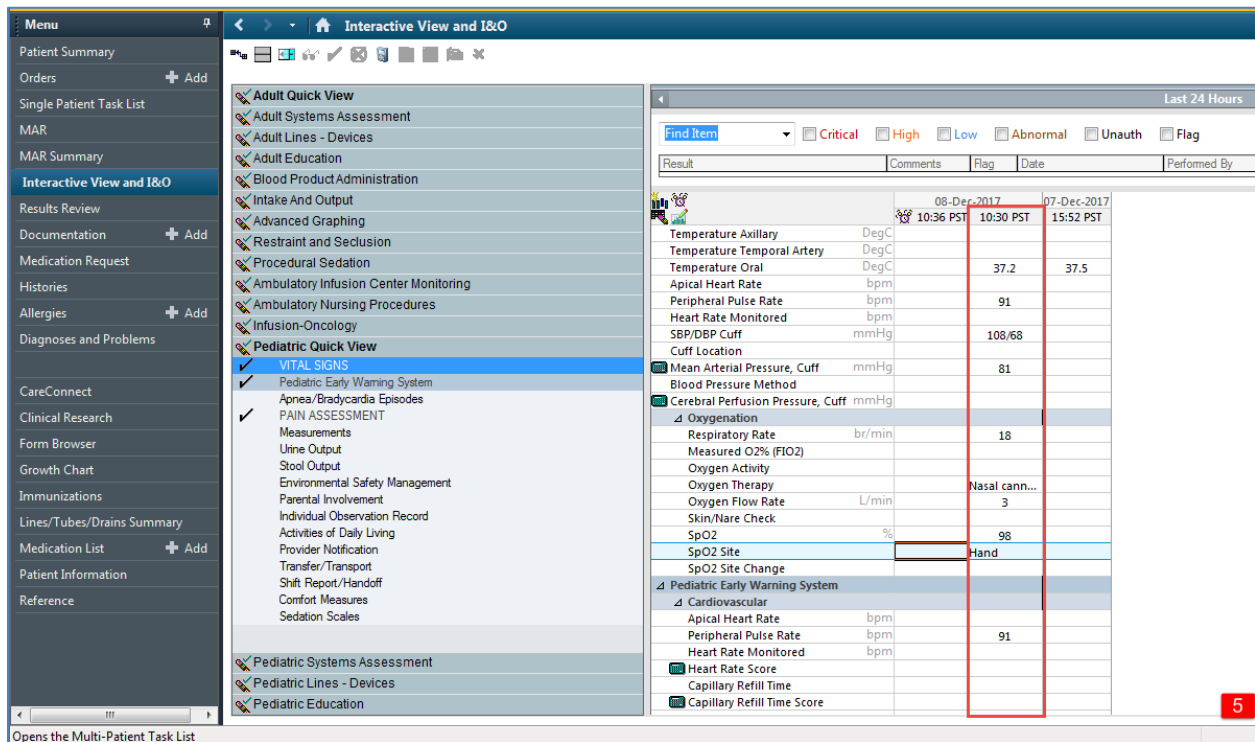
Pediatric Education

Find Item

08-Dec-2017 10:30 PST 15:52 PST 2

Result	Comments	Flag	Date	Performed By
Temperature Axillary	DegC			
Temperature Temporal Artery	DegC			
Temperature Oral	DegC		37.2	37.5
Apical Heart Rate	bpm			
Peripheral Pulse Rate	bpm		91	
Heart Rate Monitored	bpm			
SBP/DBP Cuff	mmHg		108/68	
Cuff Location				
Mean Arterial Pressure, Cuff	mmHg		81	
Blood Pressure Method				
Cerebral Perfusion Pressure, Cuff	mmHg			
Δ Oxygenation				
Respiratory Rate	br/min		18	
Measured O2% (FIO2)				
Oxygen Activity				
Oxygen Therapy			Nasal cann...	
Oxygen Flow Rate	L/min		3	
Skin/Nare Check				
SpO2	%		98	
SpO2 Site			Hand	
SpO2 Site Change				
Δ Pediatric Early Warning System				
Δ Cardiovascular				
Apical Heart Rate	bpm			
Peripheral Pulse Rate	bpm		91	
Heart Rate Monitored	bpm			
Heart Rate Score				
Capillary Refill Time				
Capillary Refill Time Score				

5. Once the documentation is signed the text becomes black. In addition, a new blank column appears after you sign in preparation for the next set of charting. The columns are displayed in real-time and the newest documentation is to the left.



Menu

Patient Summary

Orders + Add

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

Adult Quick View

- Adult Systems Assessment
- Adult Lines - Devices
- Adult Education
- Blood Product Administration
- Intake And Output
- Advanced Graphing
- Restraint and Sedation
- Procedural Sedation
- Ambulatory Infusion Center Monitoring
- Ambulatory Nursing Procedures
- Infusion-Oncology

Pediatric Quick View 1

- Pediatric Early Warning System
- Apnea/Bradycardia Episodes
- PAIN ASSESSMENT
- Measurements
- Urine Output
- Stool Output
- Environmental Safety Management
- Parental Involvement
- Individual Observation Record
- Activities of Daily Living
- Provider Notification
- Transfer/Transport
- Shift Report/Handoff
- Comfort Measures
- Sedation Scales

Pediatric Systems Assessment

Pediatric Lines - Devices

Pediatric Education


Find Item

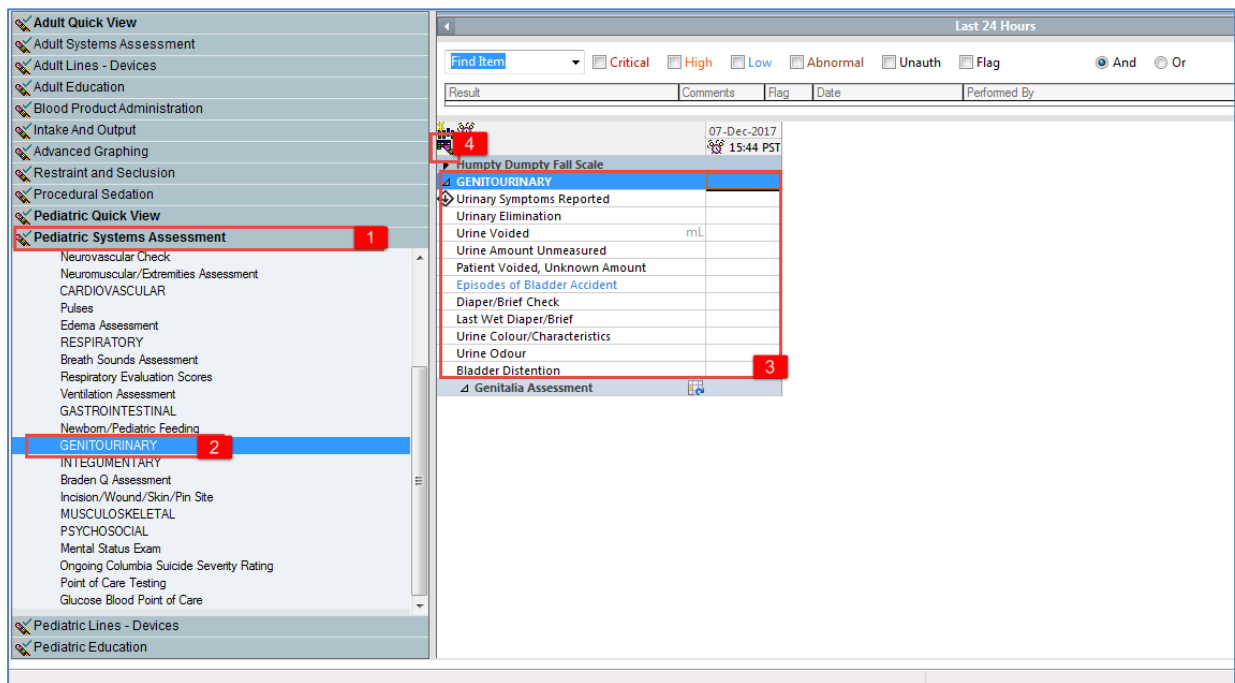
08-Dec-2017 10:30 PST 10:30 PST 15:52 PST 2

Result	Comments	Flag	Date	Performed By
Temperature Axillary	DegC			
Temperature Temporal Artery	DegC			
Temperature Oral	DegC		37.2	37.5
Apical Heart Rate	bpm			
Peripheral Pulse Rate	bpm		91	
Heart Rate Monitored	bpm			
SBP/DBP Cuff	mmHg		108/68	
Cuff Location				
Mean Arterial Pressure, Cuff	mmHg		81	
Blood Pressure Method				
Cerebral Perfusion Pressure, Cuff	mmHg			
Δ Oxygenation				
Respiratory Rate	br/min		18	
Measured O2% (FIO2)				
Oxygen Activity				
Oxygen Therapy			Nasal cann...	
Oxygen Flow Rate	L/min		3	
Skin/Nare Check				
SpO2	%		98	
SpO2 Site			Hand	
SpO2 Site Change				
Δ Pediatric Early Warning System				
Δ Cardiovascular				
Apical Heart Rate	bpm			
Peripheral Pulse Rate	bpm		91	
Heart Rate Monitored	bpm			
Heart Rate Score				
Capillary Refill Time				
Capillary Refill Time Score				

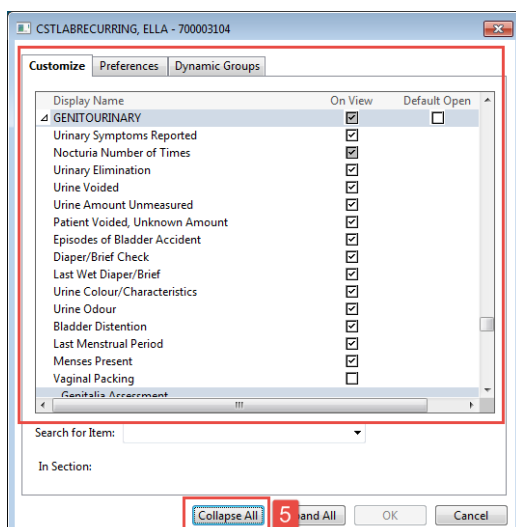
Opens the Multi-Patient Task List

2 For the purpose of this scenario, let's assume that you have just completed a post void residual (PVR) on your patient. Let's document this.

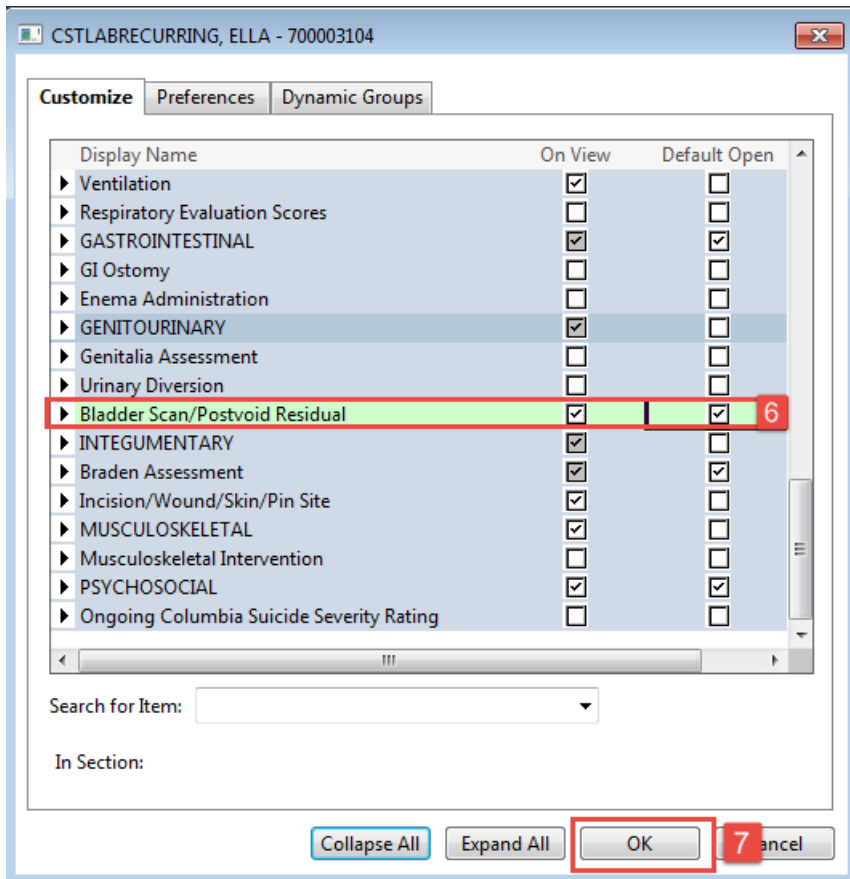
1. Click the **Pediatric Systems Assessment** band in **iView**.
2. Click the **Genitourinary** section in the **Pediatric Systems Assessment** band.
3. Notice that there is no visible place to document a PVR. This section needs to be manually added.
4. Click the Customize View icon  to search for a section regarding bladder scan.



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



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



CSTLABRECURRING, ELLA - 700003104



Customize Preferences Dynamic Groups

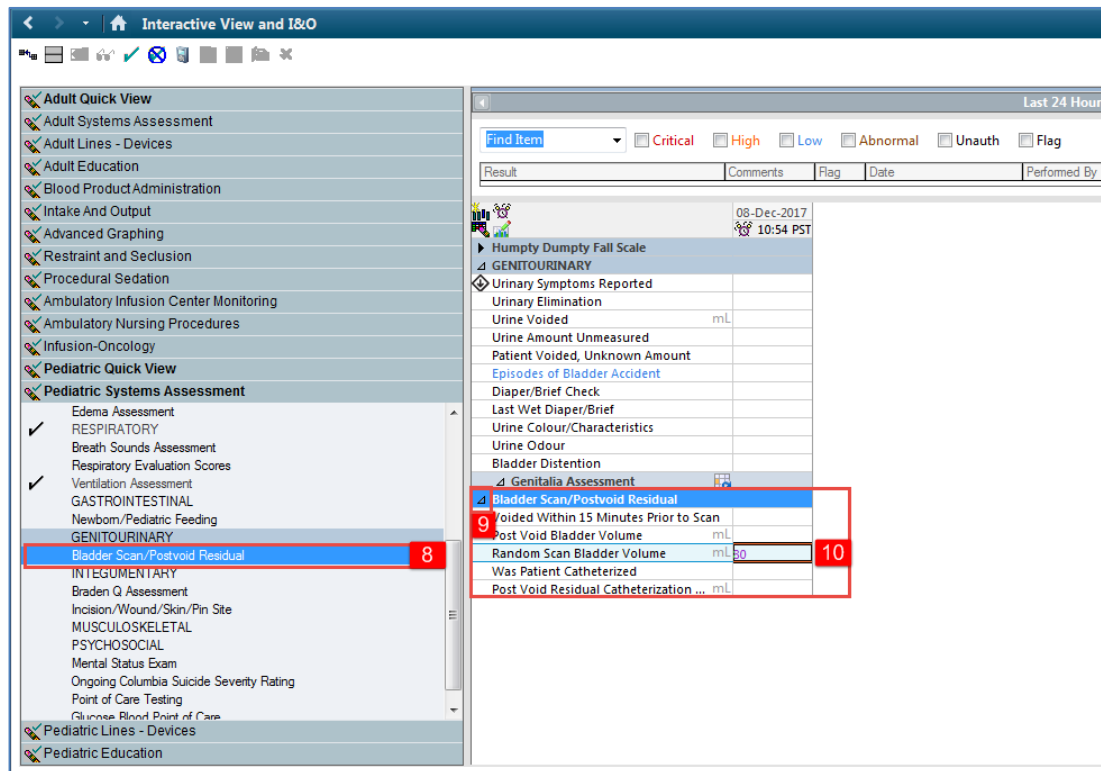
Display Name	On View	Default Open
▶ Ventilation	<input checked="" type="checkbox"/>	<input type="checkbox"/>
▶ Respiratory Evaluation Scores	<input type="checkbox"/>	<input type="checkbox"/>
▶ GASTROINTESTINAL	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
▶ GI Ostomy	<input type="checkbox"/>	<input type="checkbox"/>
▶ Enema Administration	<input type="checkbox"/>	<input type="checkbox"/>
▶ GENITOURINARY	<input checked="" type="checkbox"/>	<input type="checkbox"/>
▶ Genitalia Assessment	<input type="checkbox"/>	<input type="checkbox"/>
▶ Urinary Diversion	<input type="checkbox"/>	<input type="checkbox"/>
▶ Bladder Scan/Postvoid Residual	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
▶ INTEGUMENTARY	<input checked="" type="checkbox"/>	<input type="checkbox"/>
▶ Braden Assessment	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
▶ Incision/Wound/Skin/Pin Site	<input checked="" type="checkbox"/>	<input type="checkbox"/>
▶ MUSCULOSKELETAL	<input checked="" type="checkbox"/>	<input type="checkbox"/>
▶ Musculoskeletal Intervention	<input type="checkbox"/>	<input type="checkbox"/>
▶ PSYCHOSOCIAL	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
▶ Ongoing Columbia Suicide Severity Rating	<input type="checkbox"/>	<input type="checkbox"/>

Search for Item:




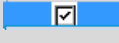



In Section:

Collapse All Expand All **OK** Cancel

8. You will now see that the **Bladder Scan/Postvoid Residual** section is available to document on in iView.
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 = 80**
 - Press **Enter** on the keyboard and click **green check mark icon**  to sign your documentation.




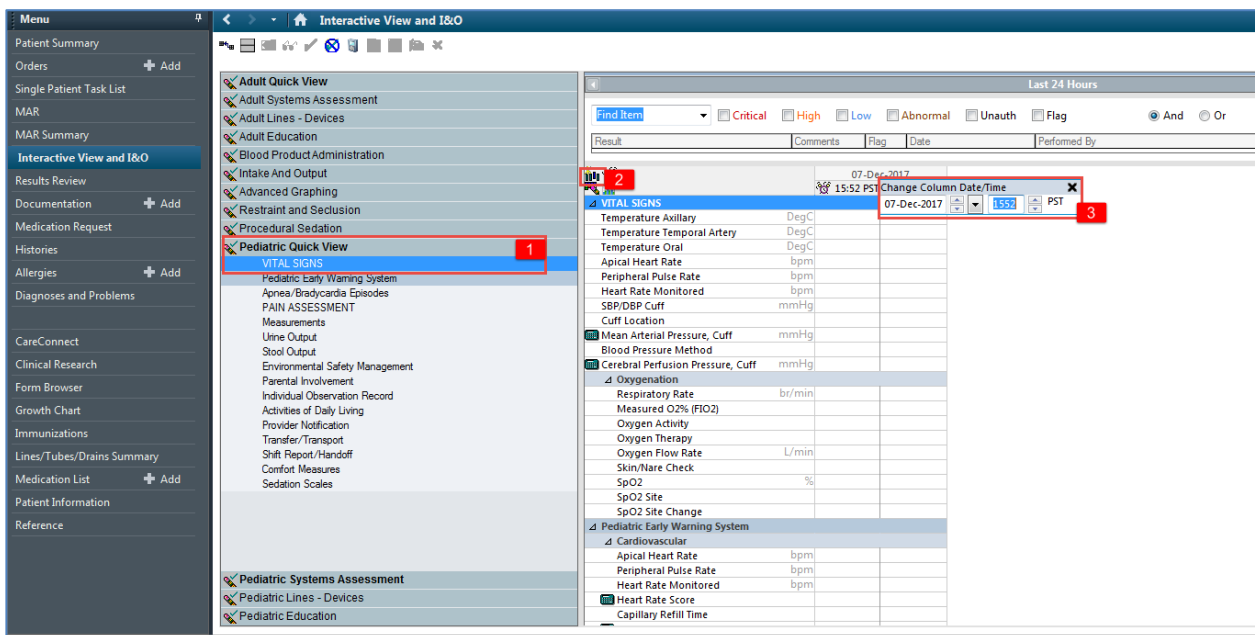
Key Learning Points

-  Documentation will appear in purple until signed. Once signed, the documentation will become black
-  The newest documentation displays in the left most column
-  Double-click the blue box  next to the name of the section to document in several cells, the section will then be activated for charting
-  You do not have to document in every cell. Only document to what is appropriate to your assessment
-  Use the Customize View icon  to find additional documentation that isn't automatically visible


Activity 6.3 – Change the Time Column

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

1. Start by clicking on the **Pediatric 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, the date will be today's date and time = 1000.
4. Press **Enter** on the keyboard. A new column will display.



The screenshot shows the Pediatric Quick View Vital Signs chart. On the left, the 'Pediatric Quick View' band is highlighted with a red box and a red '1'. In the center, the 'Vital Signs' section is expanded. On the right, the 'Change Column Date/Time' window is open, showing the date '07-Dec-2017' and time '15:52 PST'. A red box and a red '2' highlight the 'Change Column Date/Time' window. A red box and a red '3' highlight the '15:52 PST' time field.

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

Menu

- Patient Summary
- Orders + Add
- 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

Interactive View and I&O

Adult Quick View

- Adult Systems Assessment
- Adult Lines - Devices
- Adult Education
- Blood Product Administration
- Intake And Output
- Advanced Graphing
- Restraint and Seclusion
- Procedural Sedation

Pediatric Quick View

VITAL SIGNS

- Pediatric Early Warning System
- Apnea/Bradycardia Episodes
- PAIN ASSESSMENT
- Measurements
- Urine Output
- Stool Output
- Environmental Safety Management
- Parental Involvement
- Individual Observation Record
- Activities of Daily Living
- Provider Notification
- Transfer/Transport
- Shift Report/Handoff
- Comfort Measures
- Sedation Scales

Pediatric Systems Assessment

- Pediatric Lines - Devices
- Pediatric Education

Last 24 Hours

Find Item

07-Dec-2017 15:52 PST 15:52 PST

Result	Comments	Flag	Date	Performed By
VITAL SIGNS				
Temperature Axillary	DegC			
Temperature Temporal Artery	DegC			
Temperature Oral	DegC	37.5		5
Apical Heart Rate	bpm			
Peripheral Pulse Rate	bpm			
Heart Rate Monitored	bpm			
SBP/DBP Cuff	mmHg			
Cuff Location				
Mean Arterial Pressure, Cuff	mmHg			
Blood Pressure Method				
Cerebral Perfusion Pressure, Cuff	mmHg			
Oxygenation				
Respiratory Rate	br/min			
Measured O2% (FIO2)				
Oxygen Activity				
Oxygen Therapy				
Oxygen Flow Rate	L/min			
Skin/Nare Check				
SpO2	%			
SpO2 Site				
SpO2 Site Change				
Pediatric Early Warning System				
Cardiovascular				
Apical Heart Rate	bpm			
Peripheral Pulse Rate	bpm			
Heart Rate Monitored	bpm			
Heart Rate Score				
Capillary Refill Time				


Key Learning Points

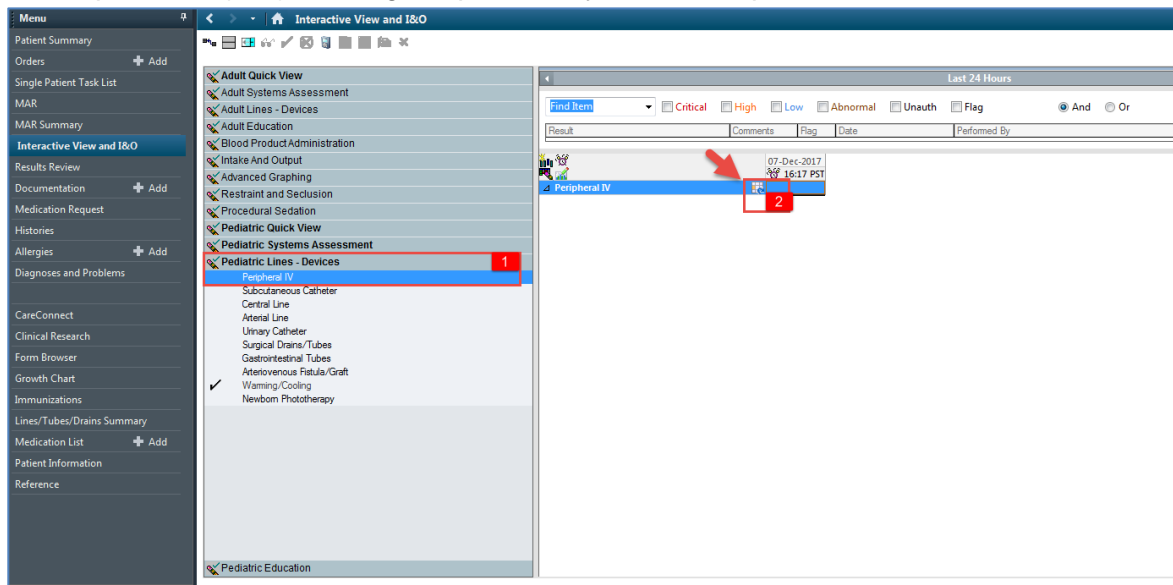
- If required, you can create a new time column and document under a specific time.
- Documentation time can be changed in iView.

Activity 6.4 – Document a Dynamic Group in iView

- 1 Dynamic groups allow the documentation and display of multiple instances of the same grouping of data elements. Examples of dynamic groups include wound assessments, IV sites, and more.

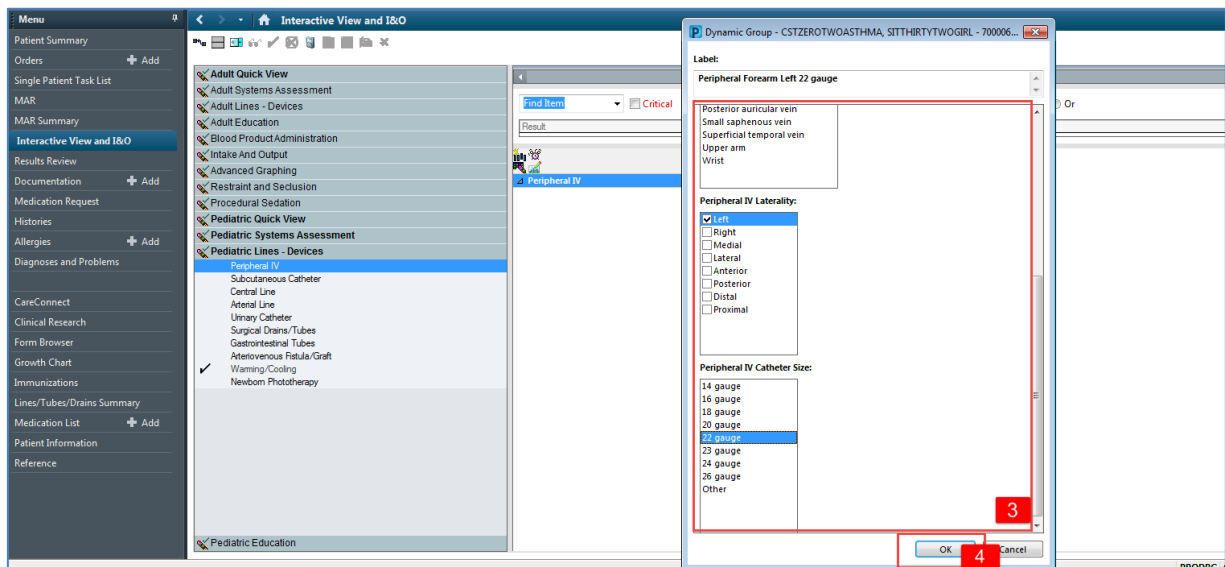
For the purposes of this scenario, let's assume that you have inserted a peripheral IV (PIV) on your patient. Document the details of the insertion by creating a dynamic group for this PIV.



1. Click on the **Pediatric Lines – Devices** band.
2. Now that the band is expanded, click on the **Dynamic Group** icon  to the right of the Peripheral IV (PIV) heading to open the Dynamic Group window.

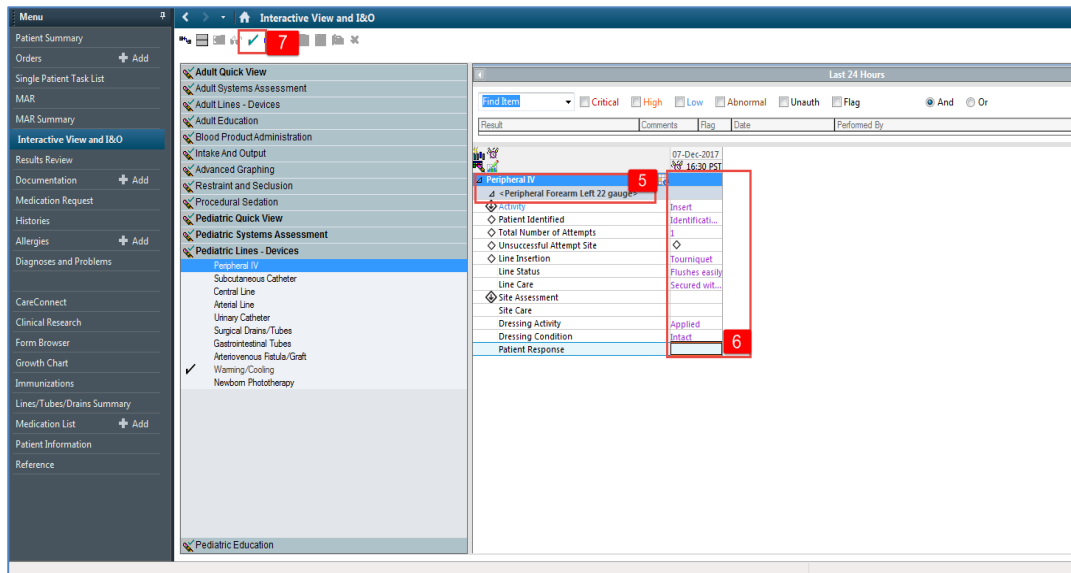




Selecting details from the dynamic group window will allow you to specifically label the PIV line. For example, if a patient has two PIVs, you can add a dynamic group for each IV. A dynamic group allows you to label a line, wound, or other patient care with specific details. You can add as many dynamic groups as you need for your patient.

3. Select the following data to create a label:
 - Peripheral IV Catheter Type: **Peripheral**
 - Peripheral IV Site: **Hand**
 - Peripheral IV Laterality: **Left**
 - Peripheral IV Catheter Size: **22 gauge**
4. Click **OK**



5. The created label will display at the top, under the Peripheral IV section heading. Now you can document your insertion of the peripheral IV.
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. 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 check mark icon**  to sign your documentation. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group. The label does not need to be re-created.



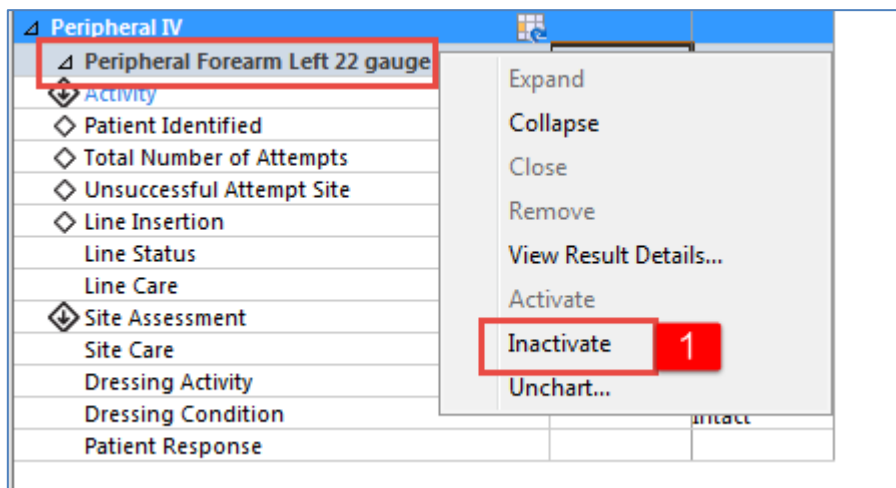
Note: A trigger icon  can be seen in some cells, such as Activity in the example above, indicating that there is additional documentation to be completed if certain responses are selected. The diamond icon  indicates the additional documentation cells that appear as a result of these responses being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

2

You can inactivate a dynamic group when it is no longer in use, such as when a drain or tube is removed. Let's assume that the PIV you inserted no longer flushes and therefore you have removed it. The dynamic group is no longer required and can be inactivated.

To inactivate your PIV dynamic group section, complete the following steps:

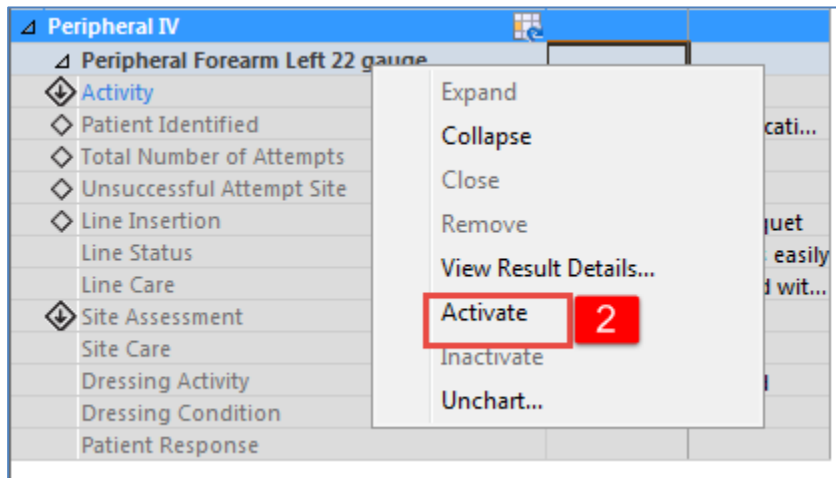
1. Right-click the dynamic group label for the **Peripheral Forearm Left 22 gauge** and select **Inactivate**.



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

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

2. Right-click the dynamic group label for the **Peripheral Forearm Left 22 gauge**, select **Activate**.



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

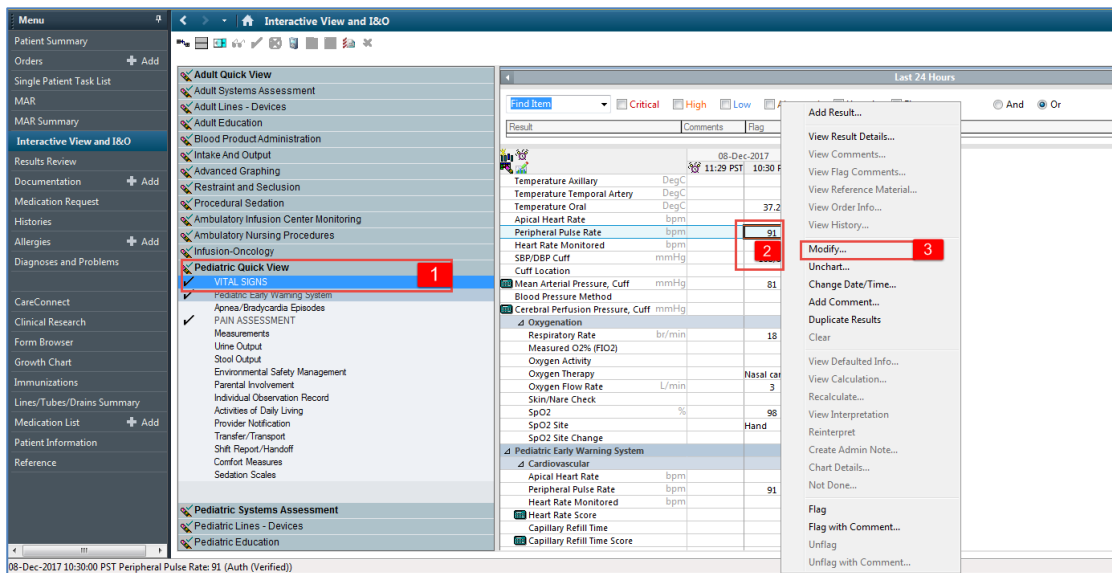
Key Learning Points

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

Activity 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.

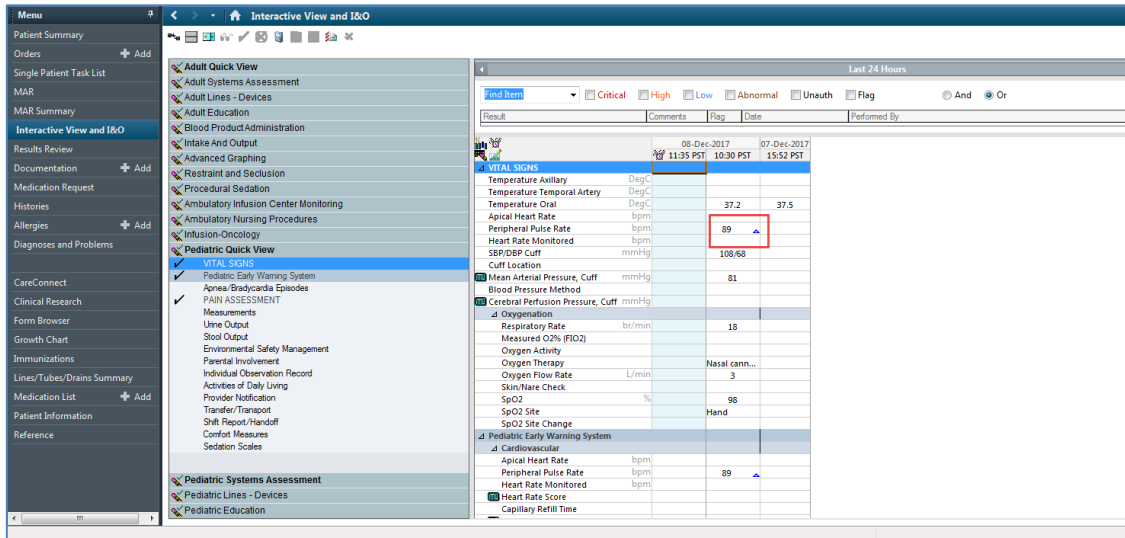
1. Click on the **Vital Signs** section heading in the **Pediatric Quick View** band.
2. Right-click on the previously documented value of **91** for **Peripheral Pulse Rate**.
3. Select **Modify...**



The screenshot shows the 'Interactive View and I&O' window. On the left, the 'Pediatric Quick View' band is expanded, and 'VITAL SIGNS' is selected. The main area displays a table of vital signs. The 'Peripheral Pulse Rate' is listed as 91 bpm. A right-click context menu is open over the value 91, and the 'Modify...' option is highlighted. The status bar at the bottom indicates '08-Dec-2017 10:30:00 PST Peripheral Pulse Rate: 91 (Auth (Verified))'.

Find Item	Critical	High	Low	Flag	Result	Comments	Flag
Temperature Axillary					DegC	11:29 PST 10:30 F	
Temperature Temporal Artery					DegC		
Temperature Oral					DegC	37.2	
Apical Heart Rate					bpm		
Peripheral Pulse Rate					bpm	91	
Heart Rate Monitored					bpm		
SBP/DBP Cuff					mmHg		
Cuff Location							
Mean Arterial Pressure, Cuff					mmHg	81	
Blood Pressure Method							
Cerebral Perfusion Pressure, Cuff					mmHg		
Oxygenation							
Respiratory Rate					br/min	18	
Measured O2% (FIO2)							
Oxygen Activity							
Oxygen Therapy						Nasal cat	
Oxygen Flow Rate					L/min	3	
Skin/Hair Check							
SpO2						98	
SpO2 Site						Hand	
SpO2 Site Change							
Pediatric Early Warning System							
Cardiovascular							
Apical Heart Rate					bpm		
Peripheral Pulse Rate					bpm	91	
Heart Rate Monitored					bpm		
Heart Rate Score							
Capillary Refill Time							
Capillary Refill Time Score							

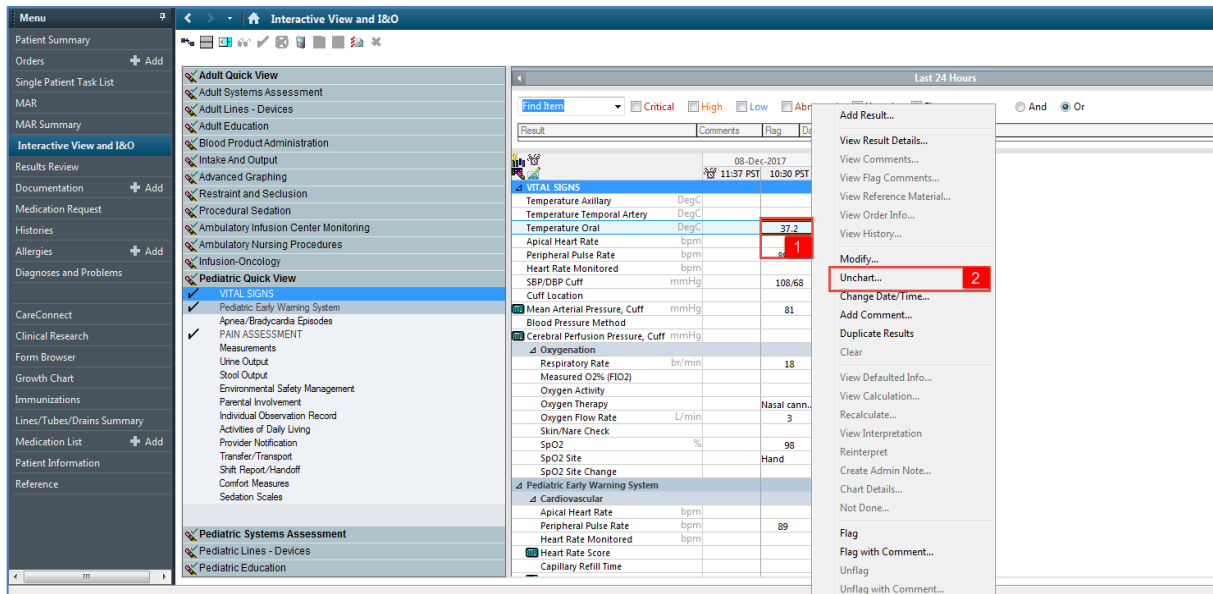
4. Enter in new **Peripheral Pulse Rate** = 89 and then click **green check mark icon** ✓ to sign your documentation.
5. **89** now appears in the cell and the corrected icon  will automatically appear on bottom right corner to denote a modification has been made.



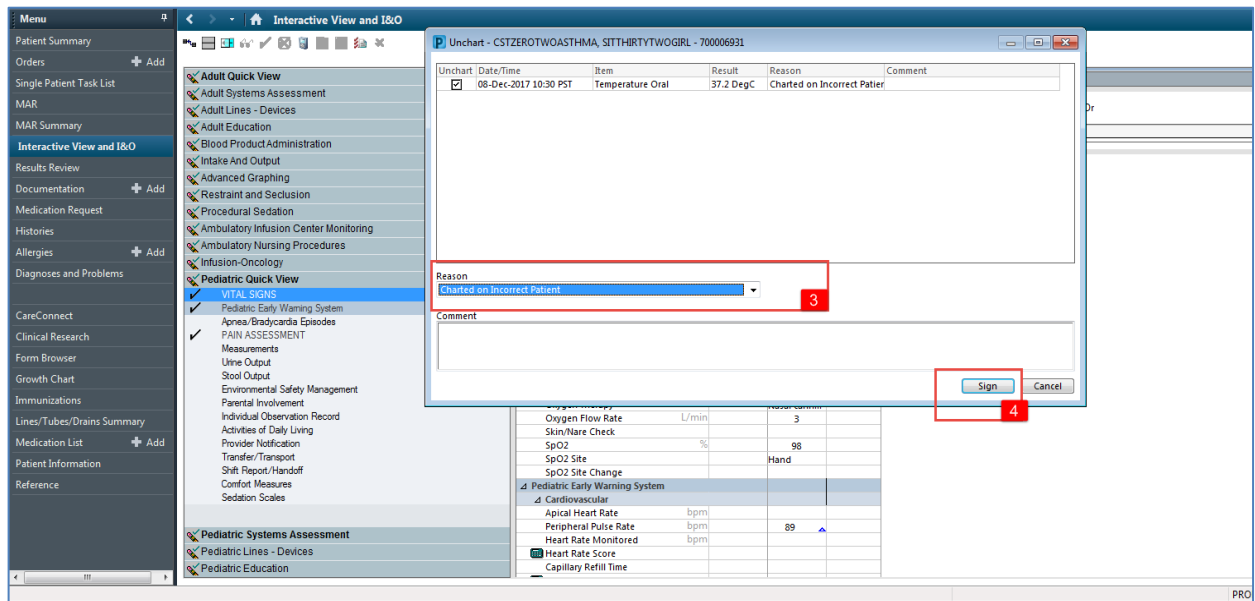
- 2 The unchart function will be used when information has been charted in error and needs to be removed. For example, a set of vital signs is charted in the wrong patient's chart.


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

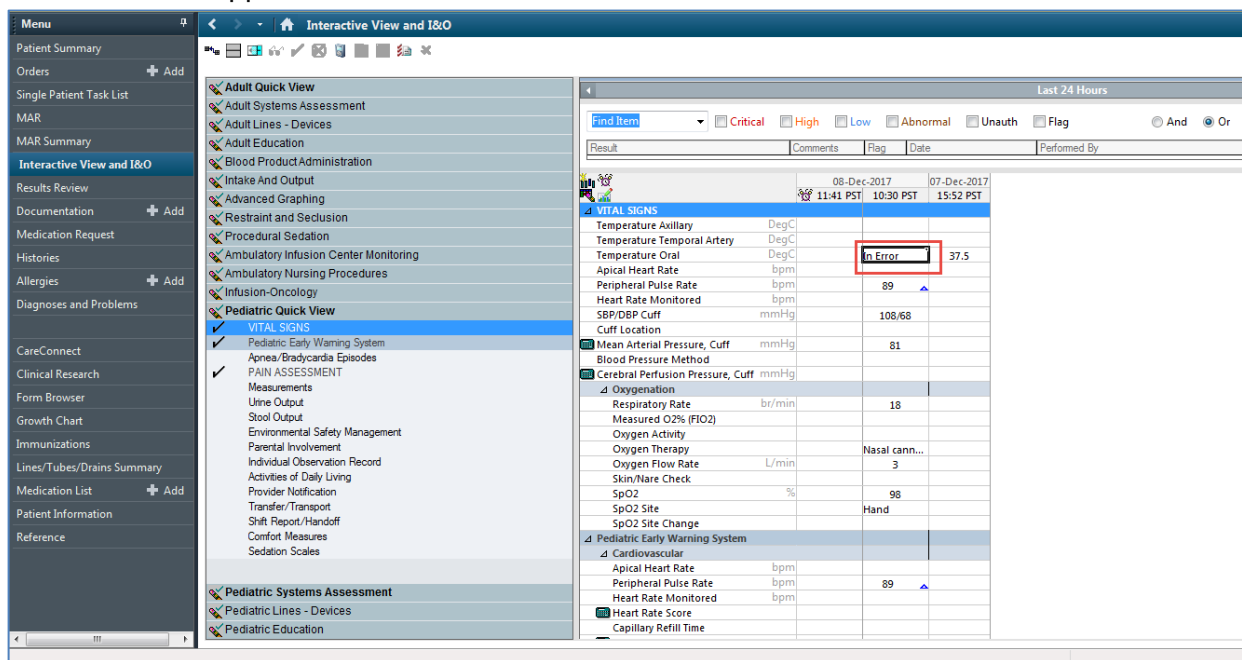
1. Right-click on the documented value of **37.5** for Temperature Oral.
2. Select **Unchart**



3. The **Unchart** window opens, select **Charted on Incorrect Patient** from the reason drop-down.
4. Click **Sign**



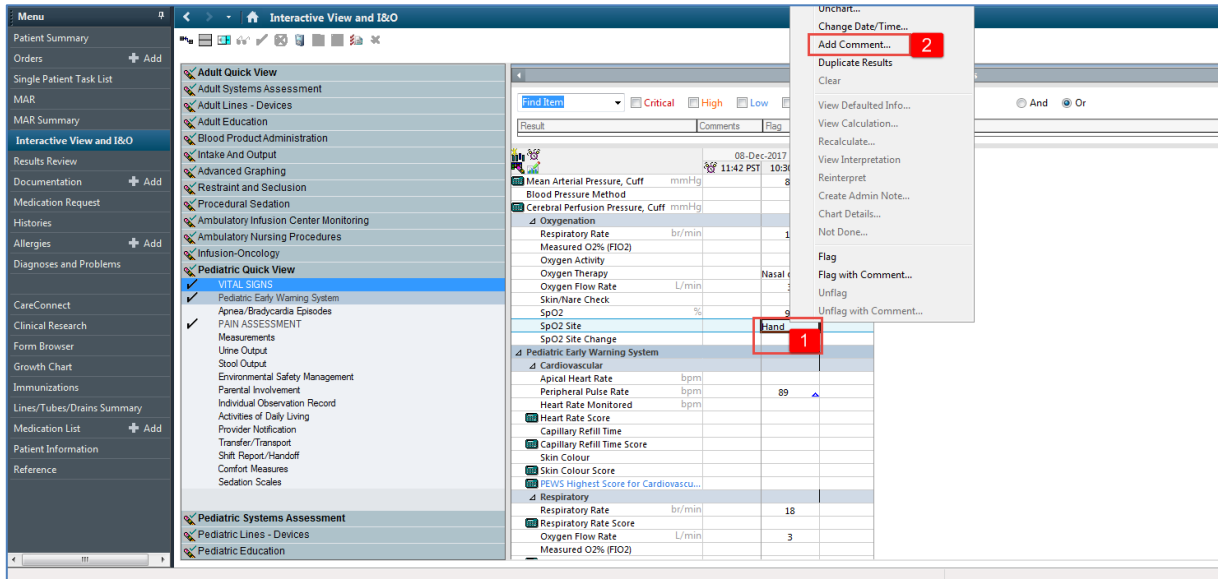
5. You will see **In Error** displayed in the uncharted cell. The result comment or annotation icon  will also appear in the cell.



- 3** 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.

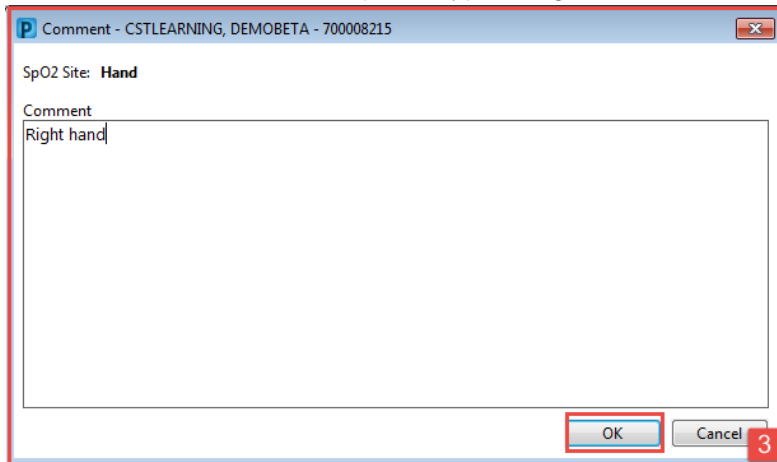
Let's add this comment.

1. Right click on the documented value for SPO2 site, **hand**
2. Select **Add Comment**





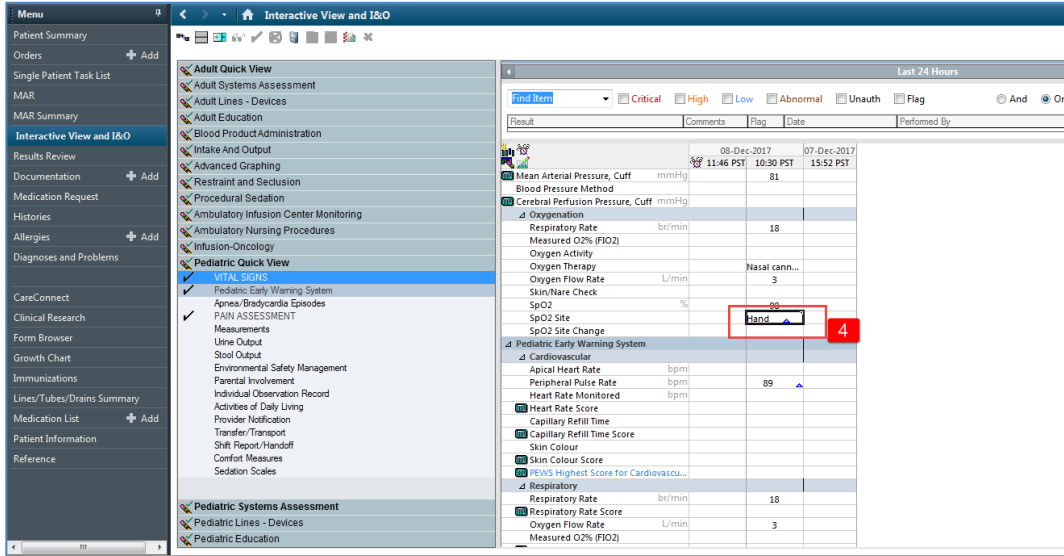
The screenshot shows the 'Interactive View and I&O' interface. On the left is a navigation menu with categories like 'Patient Summary', 'Orders', 'MAR', 'Results Review', 'Documentation', 'Histories', 'Allergies', 'Diagnoses and Problems', 'CareConnect', 'Clinical Research', 'Form Browser', 'Growth Chart', 'Immunizations', 'Lines/Tubes/Drains Summary', 'Medication List', 'Patient Information', and 'Reference'. The main area displays a table of vital signs and assessments. The 'SpO2' row is highlighted, and a right-click context menu is open over the 'hand' value. The menu options include 'Change Date/Time...', 'Add Comment...', 'Duplicate Results', 'Clear', 'View Defaulted Info...', 'View Calculation...', 'Recalculate...', 'View Interpretation', 'Reinterpret', 'Create Admin Note...', 'Chart Details...', 'Not Done...', 'Flag', 'Flag with Comment...', 'Unflag', and 'Unflag with Comment...'. The 'Add Comment...' option is highlighted with a red box and the number 2. The 'hand' value in the table is also highlighted with a red box and the number 1.

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








The screenshot shows a 'Comment' window titled 'Comment - CSTLEARNING, DEMOBETA - 700008215'. The window has a text area where the user has typed 'Right hand'. Below the text area are 'OK' and 'Cancel' buttons. The 'OK' button is highlighted with a red box and the number 3.

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.



The screenshot shows the 'Interactive View and I&O' interface. On the left is a navigation menu with categories like Patient Summary, Orders, MAR, Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, Medication List, Patient Information, and Reference. The main area displays a list of 'Adult Quick View' items, including Vital Signs, Pediatric Early Warning System, PAIN ASSESSMENT, Measurements, Urine Output, Stool Output, Environmental Safety Management, Parental Involvement, Individual Observation Record, Activities of Daily Living, Provider Notification, Transfer/Transport, Shift Report/Handoff, Comfort Measures, and Sedation Scales. Below this is a table of data for 'Last 24 Hours' with columns for 'Find Item', 'Critical', 'High', 'Low', 'Abnormal', 'Unauth', 'Flag', 'Date', and 'Performed By'. The table contains data for various vital signs and measurements, including Mean Arterial Pressure, Blood Pressure Method, Cerebral Perfusion Pressure, Oxygenation, Respiratory Rate, Measured O2% (FIO2), Oxygen Activity, Oxygen Therapy, Oxygen Flow Rate, Skin/Nare Check, SpO2, SpO2 Site, SpO2 Site Change, Pediatric Early Warning System, Cardiovascular, Apical Heart Rate, Peripheral Pulse Rate, Heart Rate Monitored, Heart Rate Score, Capillary Refill Time, Capillary Refill Time Score, Skin Colour, Skin Colour Score, PEWS Highest Score for Cardiovascu..., Respiratory, Respiratory Rate, Respiratory Rate Score, Oxygen Flow Rate, and Measured O2% (FIO2). A red box highlights a cell in the 'SpO2 Site' row, containing the value '88' and a pencil icon. A red number '4' is next to the box.



Key Learning Points

-  Always sign your documentation once completed
-  Dynamic groups are created within specific sections of iView
-  Dynamic groups allow for the documentation and display of grouped data elements such as multiple IV or wound sites
-  Results can be modified 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 a pediatric nurse you will be completing the following activities:

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

Activity 7.1 – Opening and Documenting on PowerForms

- 1 You will document on your patient throughout your shift. One form of documentation in the CIS is documenting in PowerForms. **PowerForms** are the electronic equivalent of paper forms currently used to chart patient information.

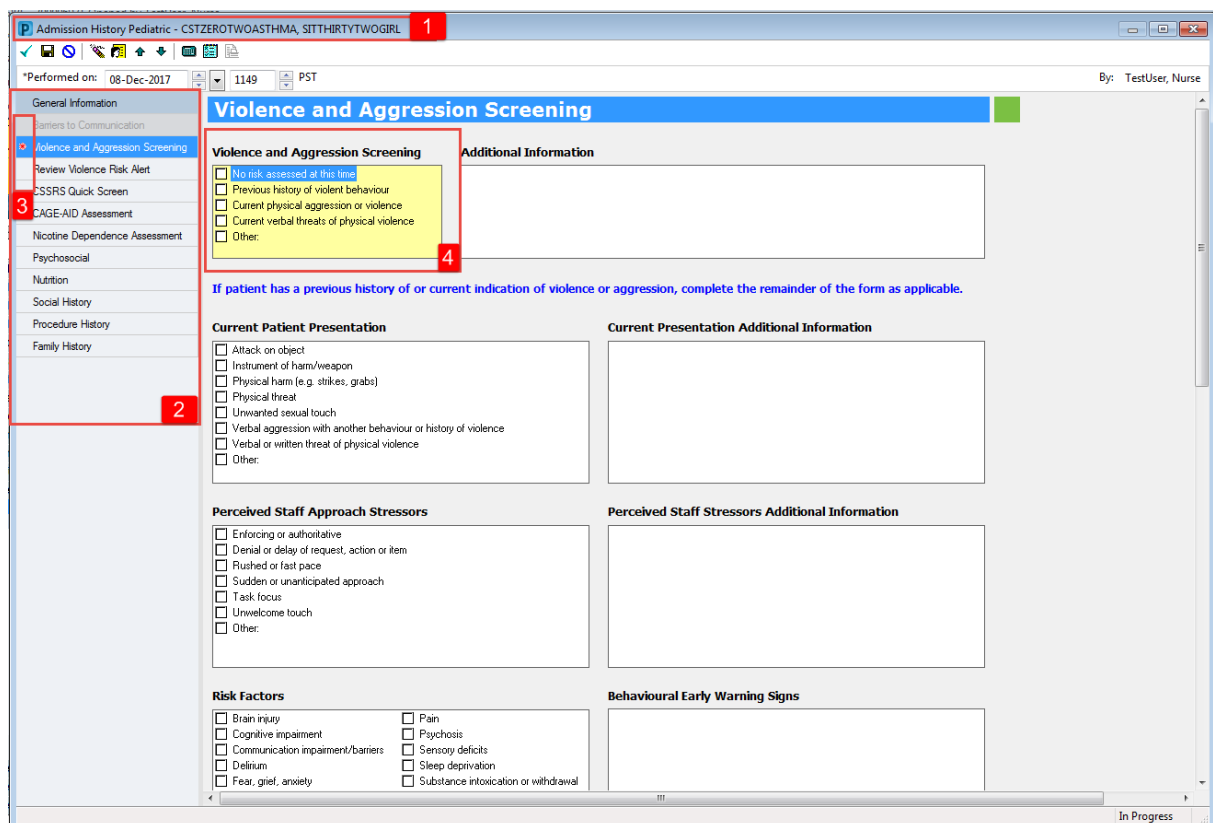
Data entered in **PowerForms** can flow throughout the patient's chart including iView flowsheets, Clinical Notes, the Problem List, Allergy Profile, and Medication Profile.

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

Let's look at a general overview of PowerForm features:

Note: You are not required to document any data in this scenario.

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.



The screenshot shows the PowerForm interface for a patient named CSTZEROTWOASTHMA, SITTTHIRTYTWO GIRL. The form is titled "Violence and Aggression Screening" and is marked as "In Progress". The interface includes a left sidebar with a list of sections, a main content area with various screening questions, and a right sidebar for additional information.

General Information

Admission History Pediatric - CSTZEROTWOASTHMA, SITTTHIRTYTWO GIRL

Performed on: 08-Dec-2017 1149 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

☐ Other:

Perceived Staff Stressors Additional Information

Risk Factors

☐ Brain injury

☐ Cognitive impairment

☐ Communication impairment/barriers

☐ Delirium

☐ Fear, grief, anxiety

☐ Pain

☐ Psychosis

☐ Sensory deficits

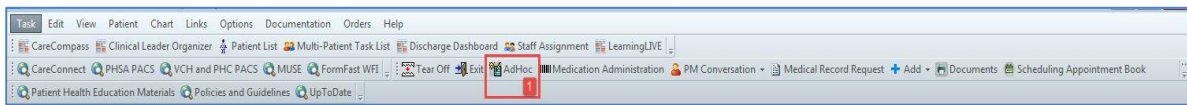
☐ Sleep deprivation

☐ Substance intoxication or withdrawal

Behavioural Early Warning Signs

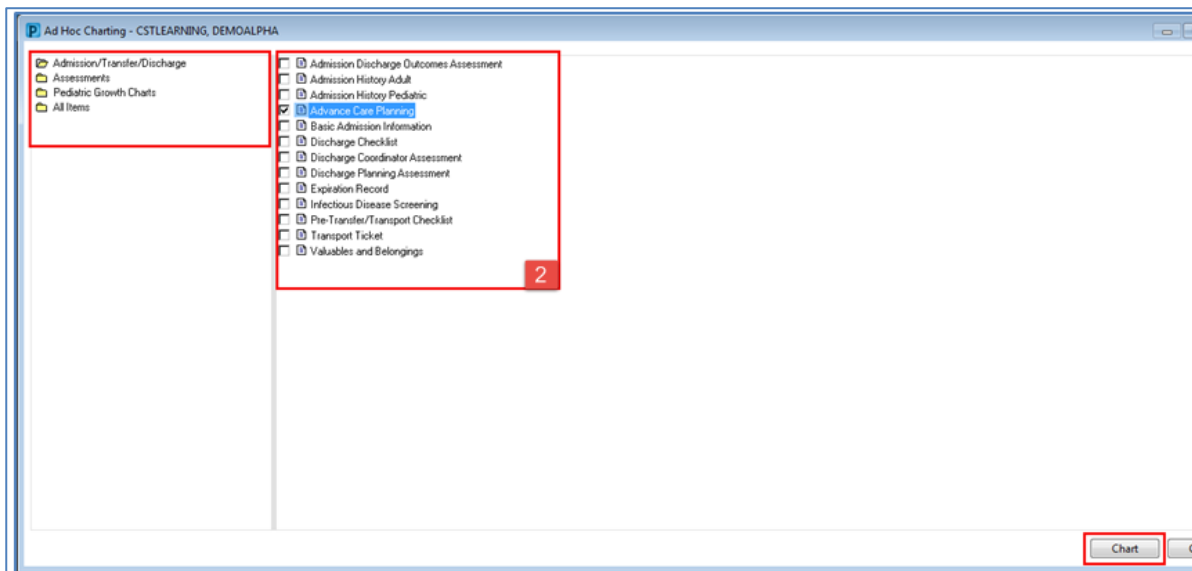
For this scenario, we are going to document on the **Advance Care Planning** PowerForm.

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

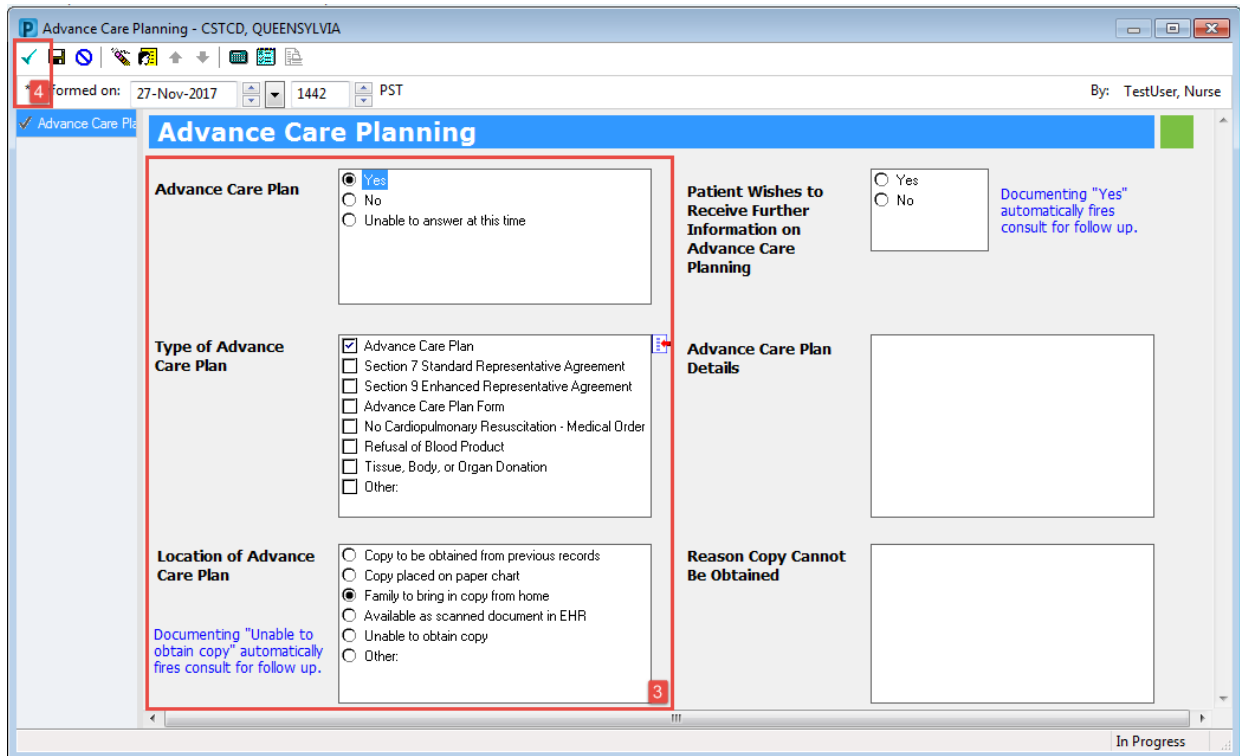
2. Select the **Advance Care Planning** PowerForm by selecting the title and clicking Chart





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 check mark** 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 documentation until it is signed using the green check mark icon .

Key Learning Points

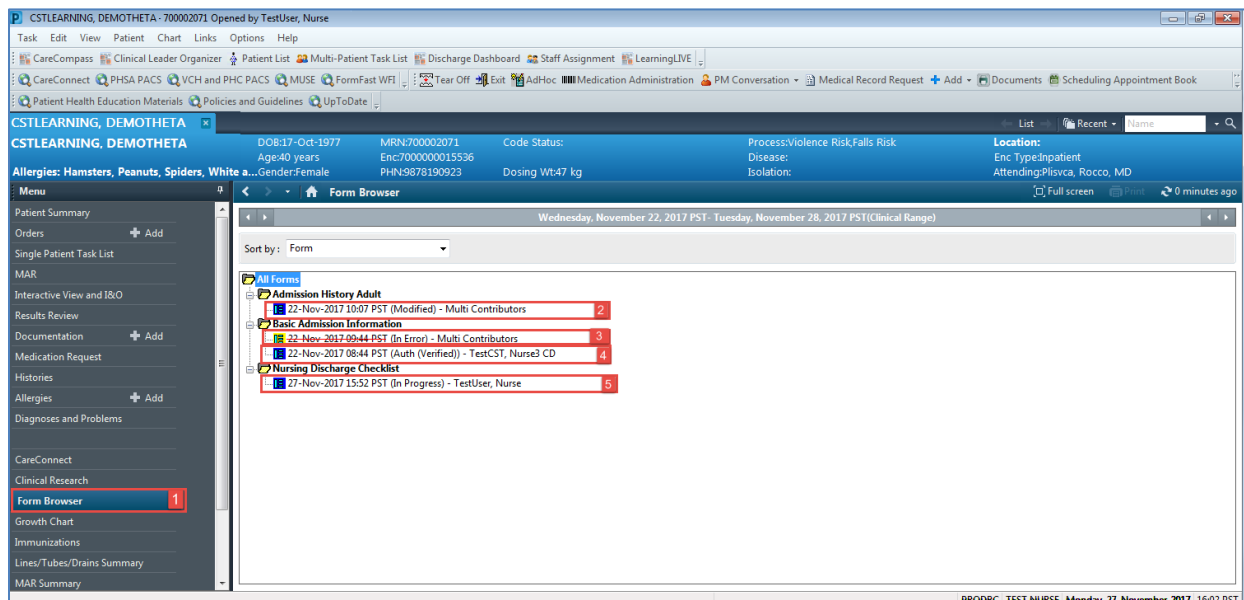
- PowerForms are electronic forms used to chart patient information
- The AdHoc button  AdHoc in the Toolbar allows you to locate a new PowerForm on an as needed basis
- PowerForms may be broken up into several sections. Section headings are displayed to the left side of PowerForm
- Always Sign the PowerForm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

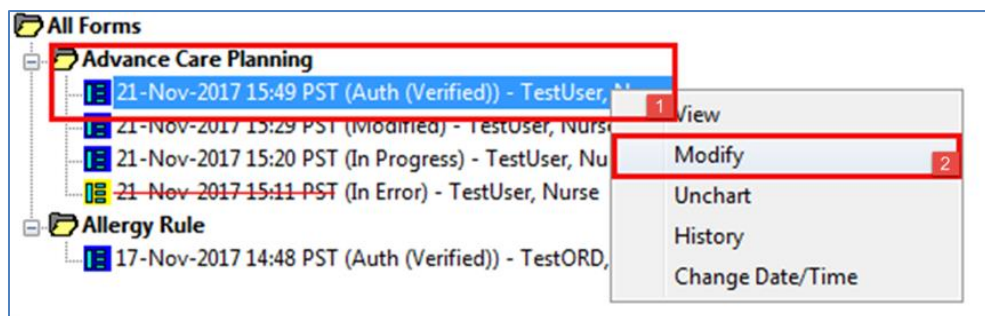
- 1 It may be necessary to modify PowerForms if information was entered incorrectly.

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.

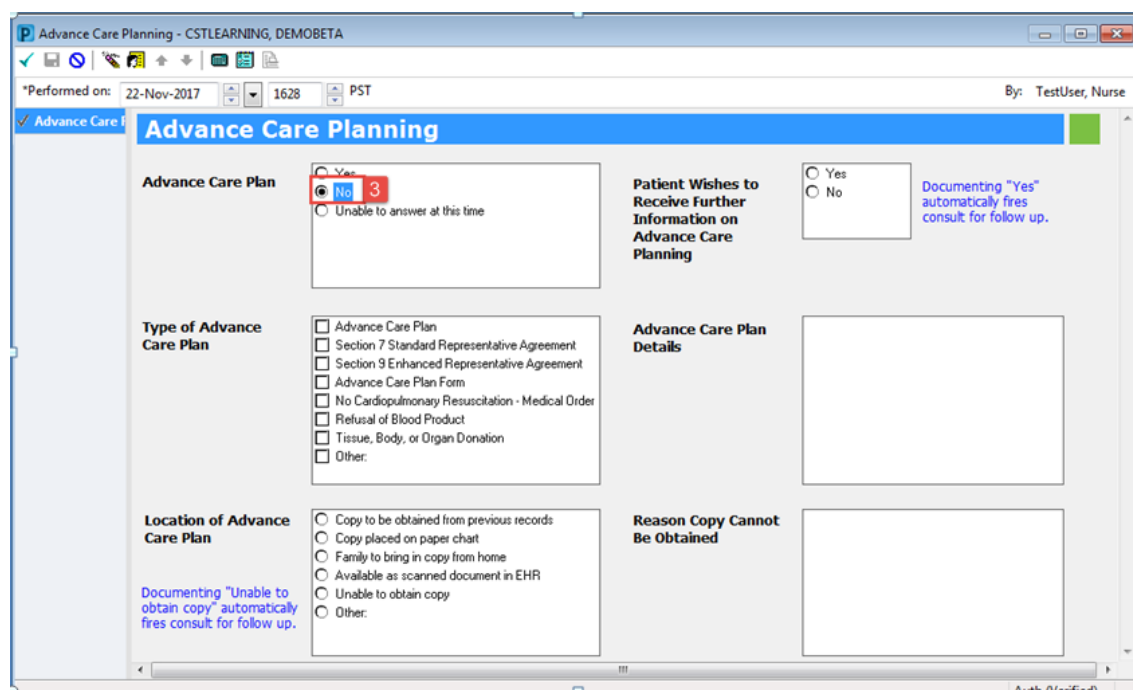
Let's modify the **Advanced Care Planning** form.



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**

A screenshot of the 'Advance Care Planning' form in the CSTLEARNING, DEMOBETA environment. The form is titled 'Advance Care Planning' and shows the 'Advance Care Plan' section. The 'No' radio button is selected, indicated by a red box and a red number '3'. Other sections include 'Type of Advance Care Plan', 'Location of Advance Care Plan', 'Patient Wishes to Receive Further Information on Advance Care Planning', 'Advance Care Plan Details', and 'Reason Copy Cannot Be Obtained'. The form is displayed in a window titled 'Advance Care Planning - CSTLEARNING, DEMOBETA'.

4. Click **green check mark**  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

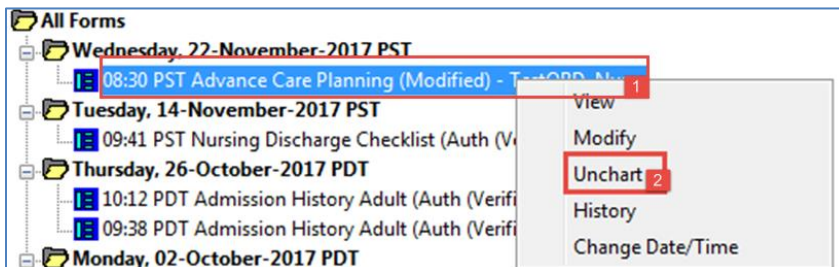
Activity 7.4 – Uncharting an Existing PowerForm

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.

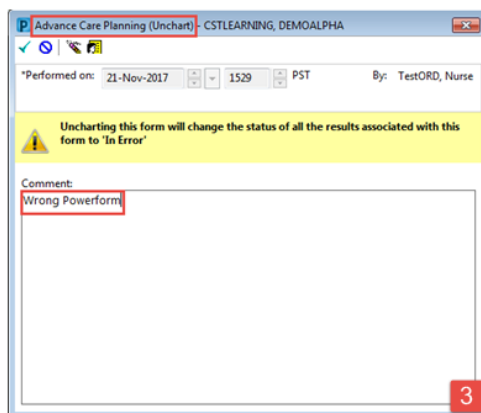
To unchart the PowerForm, within Form Browser:


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



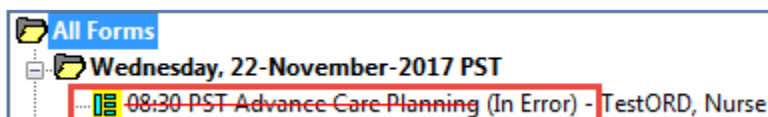
3. The Unchart window opens.

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





4. Click **green check mark** ✓ 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 a pediatric nurse you will be completing the following activities:

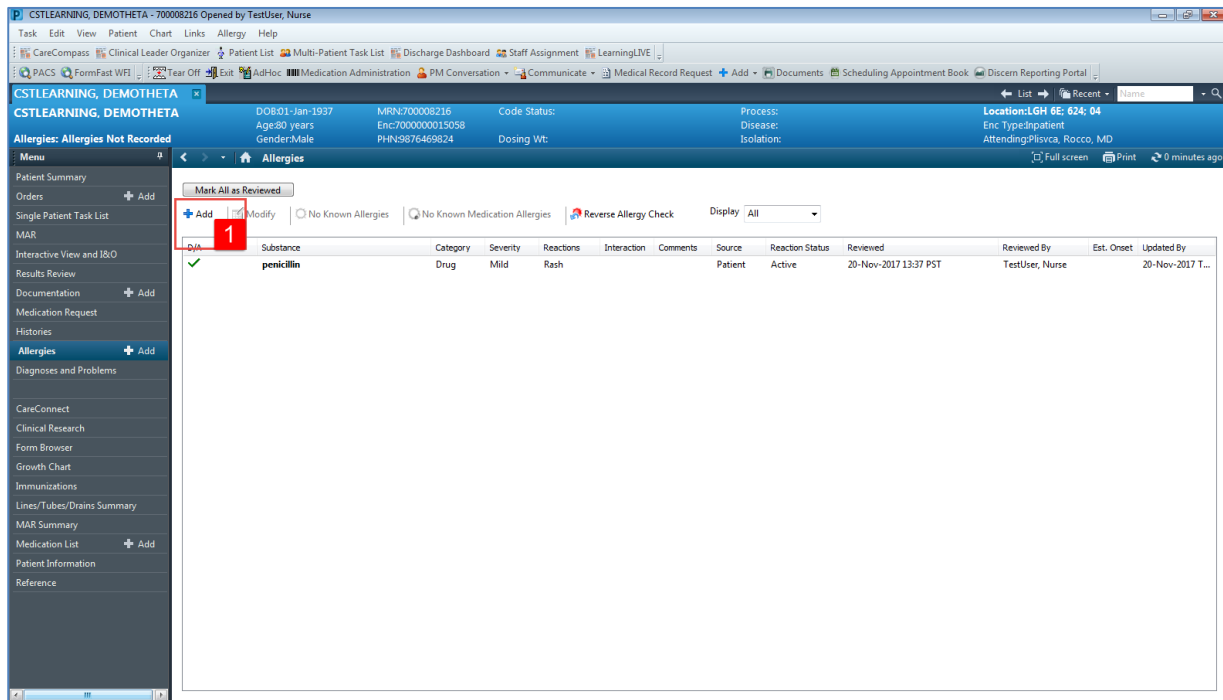
-  Add an allergy

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.

1. To document this tape allergy, navigate to the **Allergies** section of the **Menu** and click **+ Add**



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...

2. 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.

CSLEARNING, DEMOTHETA - 700008216 Opened by TestUser, Nurse

CSLEARNING, DEMOTHETA

DOB: 01-Jan-1937 MRN: 700008216 Code Status: Process: Location: LGH 6E: 624: 04
Age: 80 years Enc: 7000000015058 Disease: Enc Type: Inpatient
Gender: Male PHN: 9876469824 Isolation: Attending: Plisvca, Rocco, MD

Allergies: Allergies Not Recorded

Menu

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
Immunizations
Lines/Tubes/Drains Summary
MAR Summary
Medication List
Patient Information
Reference

Allergies

D/A	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 13:43 PST	TestUser, Nurse		20-Nov-2017 T...

Type: Allergy

*Substance: **tape**

Reaction(s):

*Severity: <not entered>

Info source: <not entered>

At: <not entered> Onset: <not entered>

Recorded on behalf of: *Category: Status: Active Reason:

OK OK & Add New Cancel

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

Substance Search

*Search: **tape** Starts with: Within: Terminology

Search by Name Search by Code

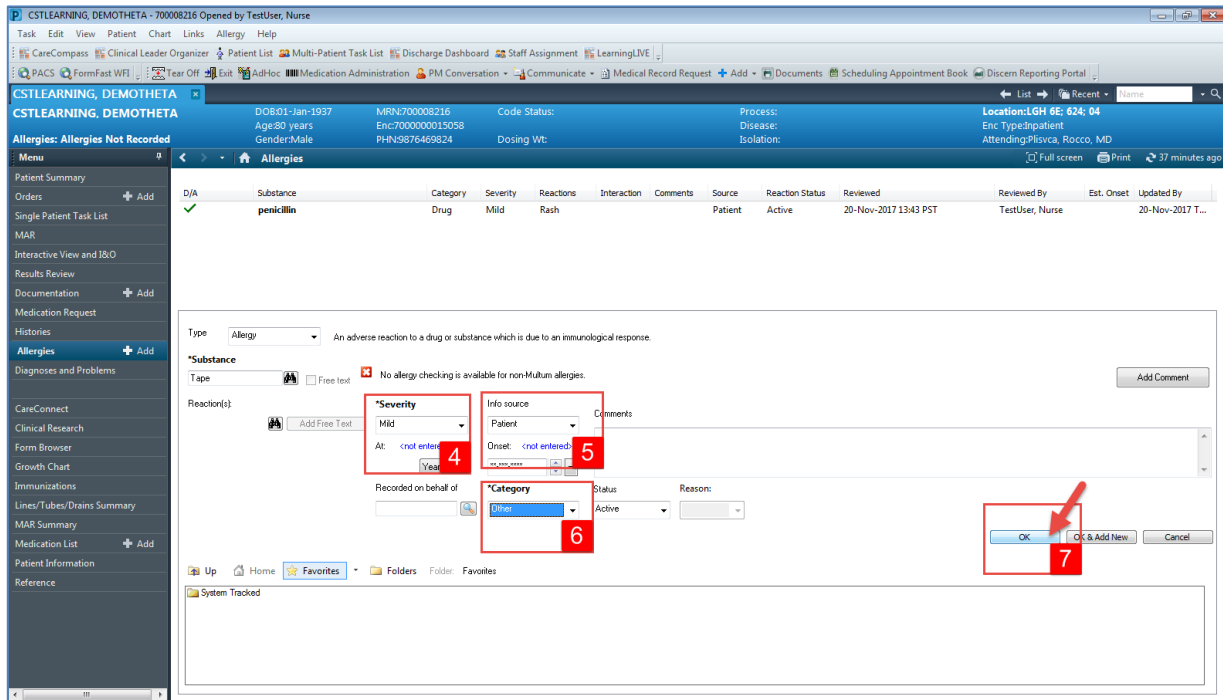
Terminology: Allergy, Multum All Terminology Axis: <All terminology ax

Categories

Term	Code	Terminology	Terminology Axis
<No matching categories found>			
Tape	114598838	Allergy	Allergy
tapentadol	d07453	Multum Drug	Generic Name

Add to Favorites **OK** Cancel

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**



CSLEARNING, DEMOTHETA - 700008216 Opened by TestUser, Nurse

Task Edit View Patient Chart Links Allergy Help

CareCompass Clinical Leader Organizer Patient List Multi-Patient Task List Discharge Dashboard Staff Assignment LearningLIVE

PACS Formfast WFI Tear Off Edit AdHoc Medication Administration PM Conversation Communicate Medical Record Request Add Documents Scheduling Appointment Book Discern Reporting Portal

CSLEARNING, DEMOTHETA

DOB: 01-Jan-1937 MRN: 700008216 Code Status: Process: Location: LGH BE: 624; 04
Age: 80 years Enc: 7000000015058 Disease: Enc Type: Inpatient
Gender: Male PHN: 9876469824 Dosing Wt: Isolation: Attending: Plisvica, Rocco, MD

Allergies: Allergies Not Recorded

Menu

Patient Summary

Orders Add

Single Patient Task List

MAR

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

MAR Summary

Medication List Add

Patient Information

Reference

D/A 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 13:43 PST TestUser, Nurse 20-Nov-2017 T...

Type Allergy An adverse reaction to a drug or substance which is due to an immunological response.

*Substance

Tape Free text

No allergy checking is available for non-Mutun allergies.

Add Comment

Reaction(s)

Add Free Text

*Severity

Mild

Info source

Patient

Comments

At: not entered

Onset: not entered

Year

Recorded on behalf of

*Category

Other

Status

Active

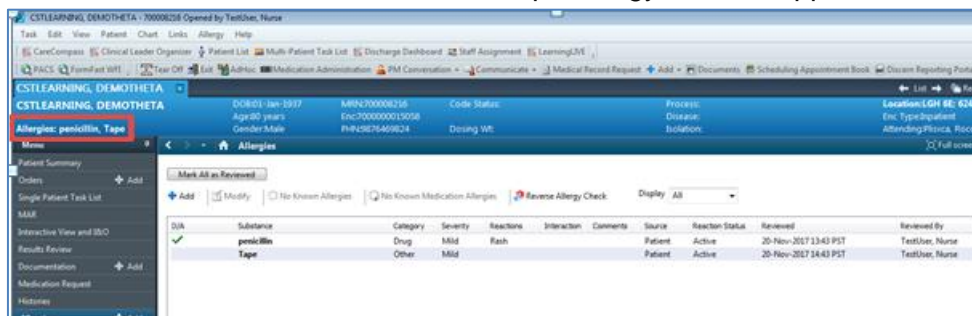
Reason

OK Add New Cancel

Up Home Favorites Folders Folder Favorites

System Tracked

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



CSLEARNING, DEMOTHETA - 700008216 Opened by TestUser, Nurse

Task Edit View Patient Chart Links Allergy Help

CareCompass Clinical Leader Organizer Patient List Multi-Patient Task List Discharge Dashboard Staff Assignment LearningLIVE

PACS Formfast WFI Tear Off Edit AdHoc Medication Administration PM Conversation Communicate Medical Record Request Add Documents Scheduling Appointment Book Discern Reporting Portal

CSLEARNING, DEMOTHETA

DOB: 01-Jan-1937 MRN: 700008216 Code Status: Process: Location: LGH BE: 624; 04
Age: 80 years Enc: 7000000015058 Disease: Enc Type: Inpatient
Gender: Male PHN: 9876469824 Dosing Wt: Isolation: Attending: Plisvica, Rocco, MD

Allergies: penicillin, Tape

Menu

Patient Summary

Orders Add

Single Patient Task List

MAR

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

MAR Summary

Medication List Add

Patient Information

Reference

D/A 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 13:43 PST TestUser, Nurse

✓ Tape Other Mild Patient Active 20-Nov-2017 14:43 PST TestUser, Nurse

Mark All as Reviewed

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

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
-  Reschedule a Medication Dose
-  Request a Medication

SCENARIO

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

As a pediatric nurse you will be completing 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. Navigate to the **MAR** section of the **Menu**
2. Under **Time View** locate click through the various tabs including Scheduled, PRN, and Continuous Infusions. Now select the **PRN** category.
3. Review the medication information for acetaminophen 420 mg, PO, Q6H PRN.

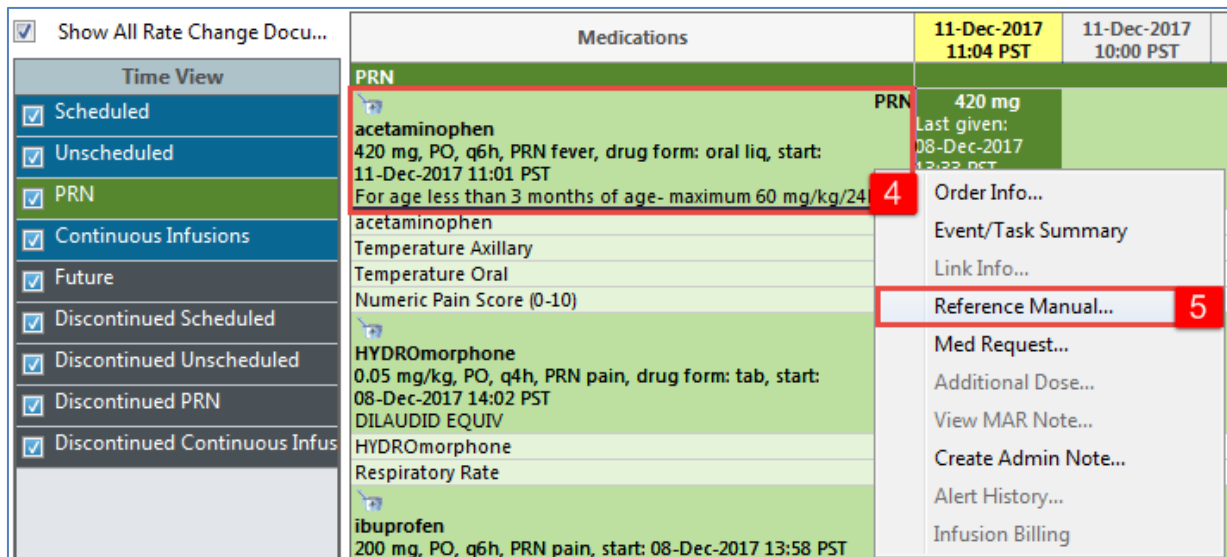
Menu		MAR			
Patient Summary					
Orders	+ Add				
Single Patient Task List					
MAR	1				
MAR Summary					
Interactive View and I&O					
Results Review					
Documentation	+ Add				
Medication Request					
Histories					
Allergies	+ Add				
Diagnoses and Problems					
CareConnect					
Clinical Research					
Form Browser					

Time View		Medications			
<input checked="" type="checkbox"/> Scheduled					
<input checked="" type="checkbox"/> Unscheduled					
<input checked="" type="checkbox"/> PRN	2				
<input checked="" type="checkbox"/> Continuous Infusions					
<input checked="" type="checkbox"/> Future					
<input checked="" type="checkbox"/> Discontinued Scheduled					
<input checked="" type="checkbox"/> Discontinued Unscheduled					
<input checked="" type="checkbox"/> Discontinued PRN					
<input checked="" type="checkbox"/> Discontinued Continuous Infusions					

		Sunday, 10-December-2017 11:04 PST			
		11-Dec-2017 11:04 PST	11-Dec-2017 10:00 PST	11-Dec-2017 08:53 PST	
PRN					
acetaminophen		420 mg			
420 mg, PO, q6h, PRN fever, drug form: oral liq, start: 11-Dec-2017 11:01 PST		Last given: 08-Dec-2017 13:33 PST			
For age less than 3 months of age- maximum 60 mg/kg/24h, f...					
acetaminophen					
Temperature Axillary					
Temperature Oral					
Numeric Pain Score (0-10)					
PRN		0.05 mg/kg			
HYDROMORPHONE		Last given: 08-Dec-2017 14:04 PST			
0.05 mg/kg, PO, q4h, PRN pain, drug form: tab, start: 08-Dec-2017 14:02 PST					
DILAUDID EQUIV					
HYDROMORPHONE					
Respiratory Rate					
PRN		200 mg			
ibuprofen		Last given: 08-Dec-2017 14:53 PST			
200 mg, PO, q6h, PRN pain, start: 08-Dec-2017 13:58 PST					

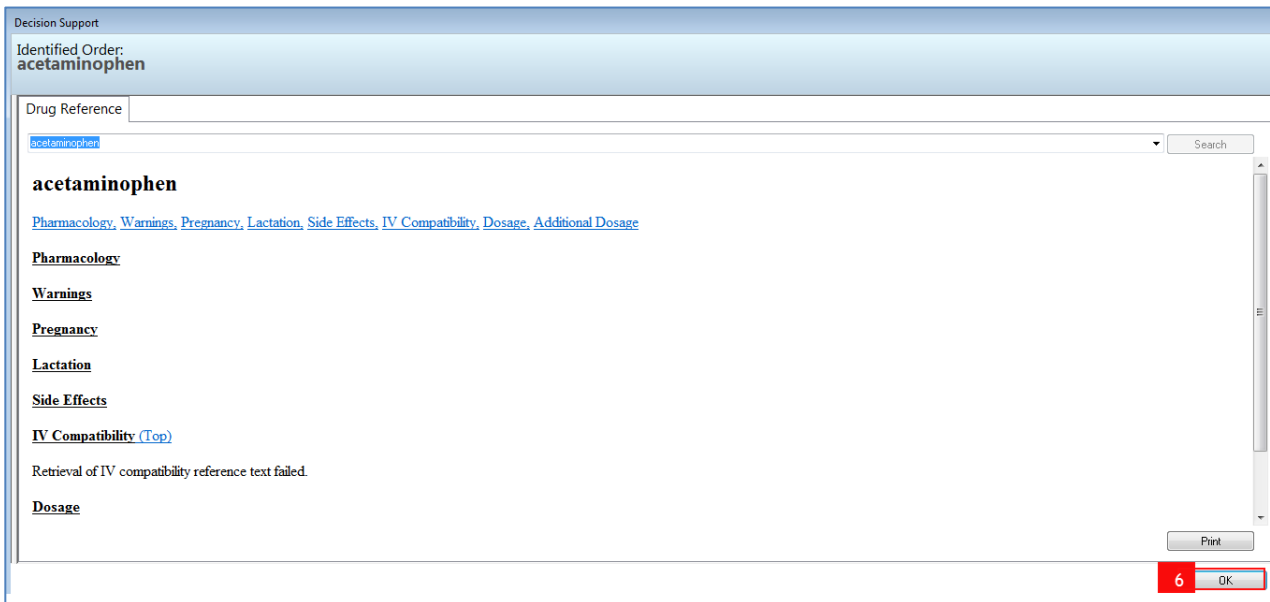
The CIS links you directly to the Reference Manuals for medications through the MAR. Let's review medication details for Acetaminophen.

4. Right-click on the medication name (acetaminophen)
5. Select **Reference Manual**. The Decision Support window will pop-up.






The screenshot shows a 'Medications' window with a list of medications. A right-click context menu is open over the acetaminophen entry. The menu options include: Order Info..., Event/Task Summary, Link Info..., **Reference Manual...** (highlighted with a red box and number 5), Med Request..., Additional Dose..., View MAR Note..., Create Admin Note..., Alert History..., and Infusion Billing. The acetaminophen entry is highlighted with a red box and number 4.

6. Review the Drug Reference Guide for acetaminophen and click **OK** to exit the Decision Support window.



The screenshot shows the 'Decision Support' window for acetaminophen. The 'Drug Reference' tab is selected. The window displays various sections: Pharmacology, Warnings, Pregnancy, Lactation, Side Effects, IV Compatibility (Top), and Dosage. The 'OK' button is highlighted with a red box and number 6.

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

-  – Indicates the medication order has not been verified by pharmacy
-  – Indicates the order needs to be reviewed by the nurse
-  – Indicates the medication is part of a PowerPlan

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

7. The Clinical Range is defaulted to display 24 hours in the past and 24 hours into the future. This totals a period of **48 hours**. (If you prefer to see only your 12 hour shift, you can right click on the Clinical Range bar to adjust the time frame that is displayed).
8. The dates/times are displayed in **reverse chronological order**. (this differs from the current state paper MARs)
9. The current time and date column will always be highlighted in yellow.

MAR

All Orders with Active Tasks in Tir

7

Sunday, 10-December-2017 11:04 PST - Tuesday, 12-December-2017 11:04 PST (Clinical Range)

Show All Rate Change Docu...

Time View

Scheduled

Unscheduled

PRN

Continuous Infusions

Future

Discontinued Scheduled

Discontinued Unscheduled

Discontinued PRN

Discontinued Continuous Infus

8

Medications

Temperature Oral

Numeric Pain Score (0-10)

HYDROMORPHONE

0.05 mg/kg, PO, q4h, PRN pain, drug form: tab, start: 08-Dec-2017 14:02 PST

DILAUDID EQUIV

HYDROMORPHONE

Respiratory Rate

ibuprofen

200 mg, PO, q6h, PRN pain, start: 08-Dec-2017 13:58 PST

ibuprofen

Temperature Axillary

Temperature Oral

ibuprofen (ibuprofen PRN range dose)

dose range: 125 to 250 mg, PO, q6h, PRN pain, drug form: tab, start: 08-Dec-2017 14:40 PST

9

0.05 mg/kg

Last given: 08-Dec-2017 14:04 PST

PRN

200 mg

Last given: 08-Dec-2017 14:53 PST

PRN

250 mg

Last given: 08-Dec-2017 14:53 PST

11-Dec-2017 11:04 PST

11-Dec-2017 10:00 PST

11-Dec-2017 08:53 PST

11-Dec-2017 08:52 PST

11-Dec-2017 06:00 PST

11-Dec-2017 02:00 PST




11-Dec-2017 00:00 PST

10-Dec-2017 22:00 PST

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 – Reschedule a Medication

1

Medications can be rescheduled directly from the MAR. Let's assume that your patient is being examined and you need to reschedule their vancomycin medication time.


1. Right click on the next dose of vancomycin that you want to reschedule.
2. Select **Reschedule This Dose...**

Medications	2018-Feb-01 18:00 PST	2018-Feb-01 14:35 PST	2018-Feb-01 12:00 PST	2018-Feb-01 09:00 PST
Scheduled				
 vancomycin 420 mg, IV, q6h, drug form: inj, start: 2017-Dec-29 08:27 ... Max Dose 2000mg/dose Tar...	420 mg [2] Not previously given		420 mg [2] Not previously given	420 mg [2] Not previously given
vancomycin				
PRN				
acetaminophen 420 mg, PO, q6h, PRN fever, drug form: oral liq, start: 2017-Dec-29 08:22 PST For age less than 3 months o...				
acetaminophen				
Temperature Axillary				
Temperature Oral				

Order Info...
 Task Info...
 Chart Details....
 Quick Chart...
 Chart Done...
 Chart Not Done...
 Unchart...
Reschedule This Dose...

3. Review the pop-up and click **Yes** to continue to reschedule this dose.

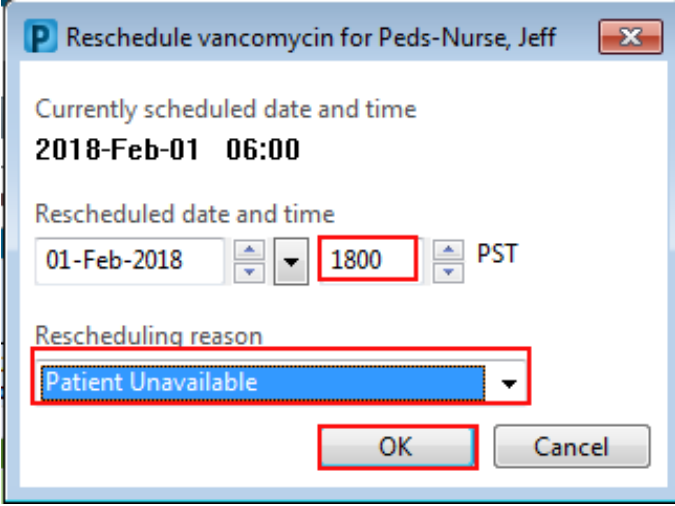
Reschedule dose only or reschedule all future admin times

 Rescheduling this dose will only affect the selected dose and will not affect other future scheduled doses for this order. Do you want to continue to reschedule this dose only or would you like to reschedule all future admin times?

Select 'Yes' to continue to reschedule this dose.
 Select 'No' to reschedule future admin times.
 Select 'Cancel' to cancel rescheduling.

PATIENT SCENARIO 9 – Review Medication Administration Record (MAR)

4. You want to reschedule the medication administration time to a later time. Change the **Time** field to 1800, **Rescheduling reason**= Patient Unavailable, and click **OK**.



P Reschedule vancomycin for Peds-Nurse, Jeff

Currently scheduled date and time
2018-Feb-01 06:00

Rescheduled date and time
01-Feb-2018 1800 PST

Rescheduling reason
Patient Unavailable

OK Cancel

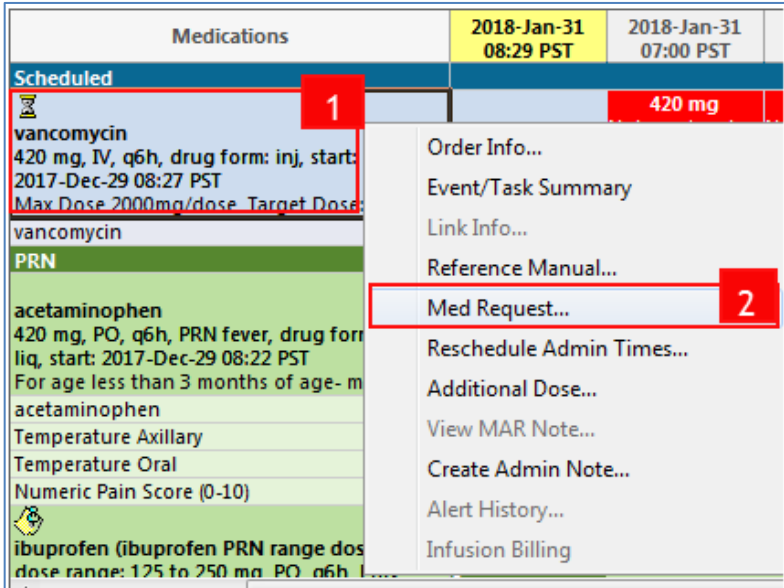
 **Key Learning Points**



- Right-clicking on medication tasks provides options such as rescheduling a medication dose

Activity 9.3 – Request a Medication

- 1 With the CIS, you can place medication requests to Pharmacy directly from the patient's chart. For this scenario, let's assume that you can't find the Vancomycin IV medication vial. You need to submit a **Med Request** to Pharmacy.

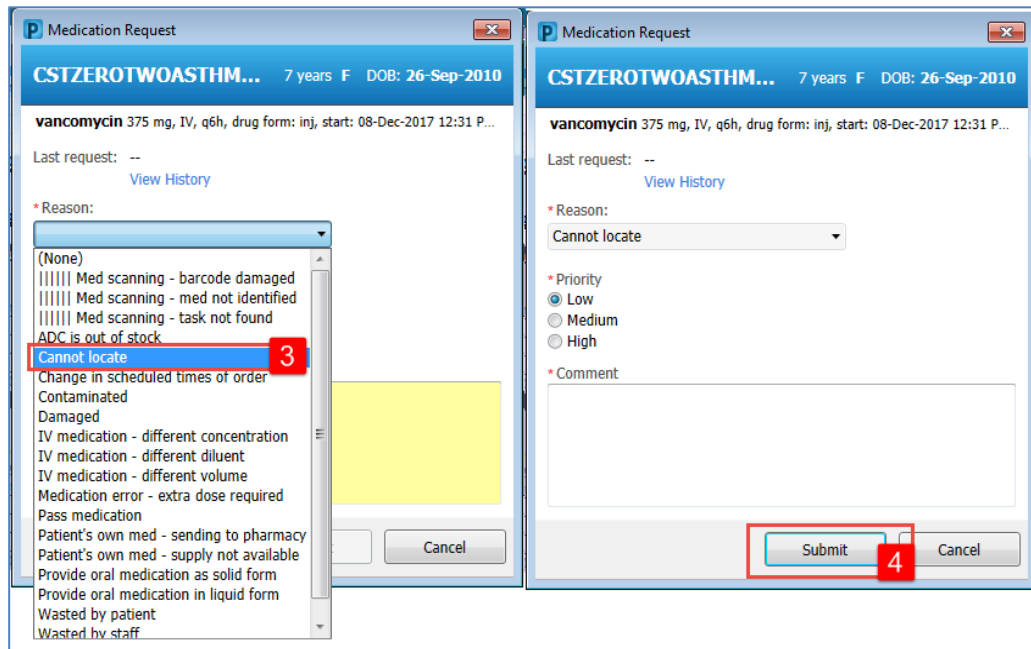
1. Right- click on the **medication order name**
2. Select **Med Request...**



Medications	2018-Jan-31 08:29 PST	2018-Jan-31 07:00 PST
Scheduled		
 vancomycin 420 mg, IV, q6h, drug form: inj, start: 2017-Dec-29 08:27 PST Max Dose 2000mg/dose Target Dose:		420 mg
vancomycin PRN acetaminophen 420 mg, PO, q6h, PRN fever, drug form: liq, start: 2017-Dec-29 08:22 PST For age less than 3 months of age- m		
acetaminophen Temperature Axillary Temperature Oral Numeric Pain Score (0-10)		
 ibuprofen (ibuprofen PRN range dose range: 125 to 250 mg PO q6h		

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

PATIENT SCENARIO 9 – Review Medication Administration Record (MAR)



The image displays two side-by-side screenshots of a 'Medication Request' window for a patient named CSTZEROTWOASTHM... (7 years F, DOB: 26-Sep-2010). The medication is vancomycin 375 mg, IV, q6h, drug form: inj, start: 08-Dec-2017 12:31 P... The window includes a 'Last request: --' field and a 'View History' link. The 'Reason' dropdown menu is open, showing various options, with 'Cannot locate' highlighted (marked with a red box and number 3). The 'Priority' section has radio buttons for Low (selected), Medium, and High. The 'Comment' field is empty. The 'Submit' button is highlighted (marked with a red box and number 4).




 **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: Salbutamol 200 mcg Q4H PRN, Ibuprofen 125 to 250 mg PO Q6H PRN, Vancomycin 420 mg IV Q6h and IV normal saline at 30 mL/hr.

Note: Pediatric nurses are still required to calculate safe dosages per policy. On the WOW, nurses

can click the Windows button  in the lower left corner of the screen to access the Windows calculator.

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

-  Administer medication using the Medication Administration Wizard (MAW) and the barcode scanner
-  Document 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

- 1 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**.

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.

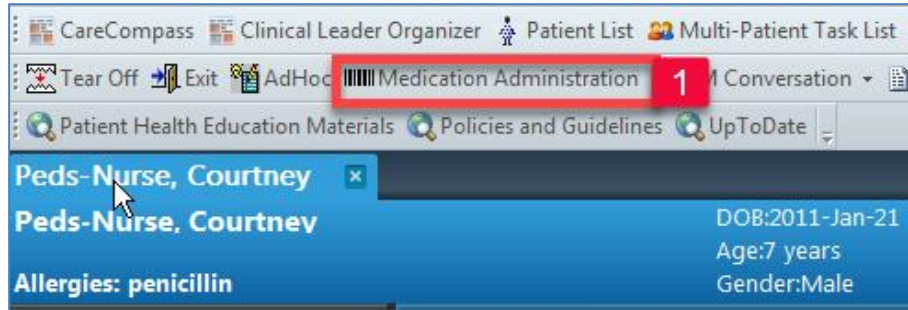
For older patients and crushed medications, occasionally a dose requires scanning two pills to make up the full dose.

- PO medication: **Salbutamol 200 mcg = 2 puffs**, the drug form is inhaler
- Range dose medication: **Ibuprofen 125 to 250 mg** PRN for pain, the drug form is liquid
- IV medication: **Vancomycin 420 mg, IV**, mixed by the nurse

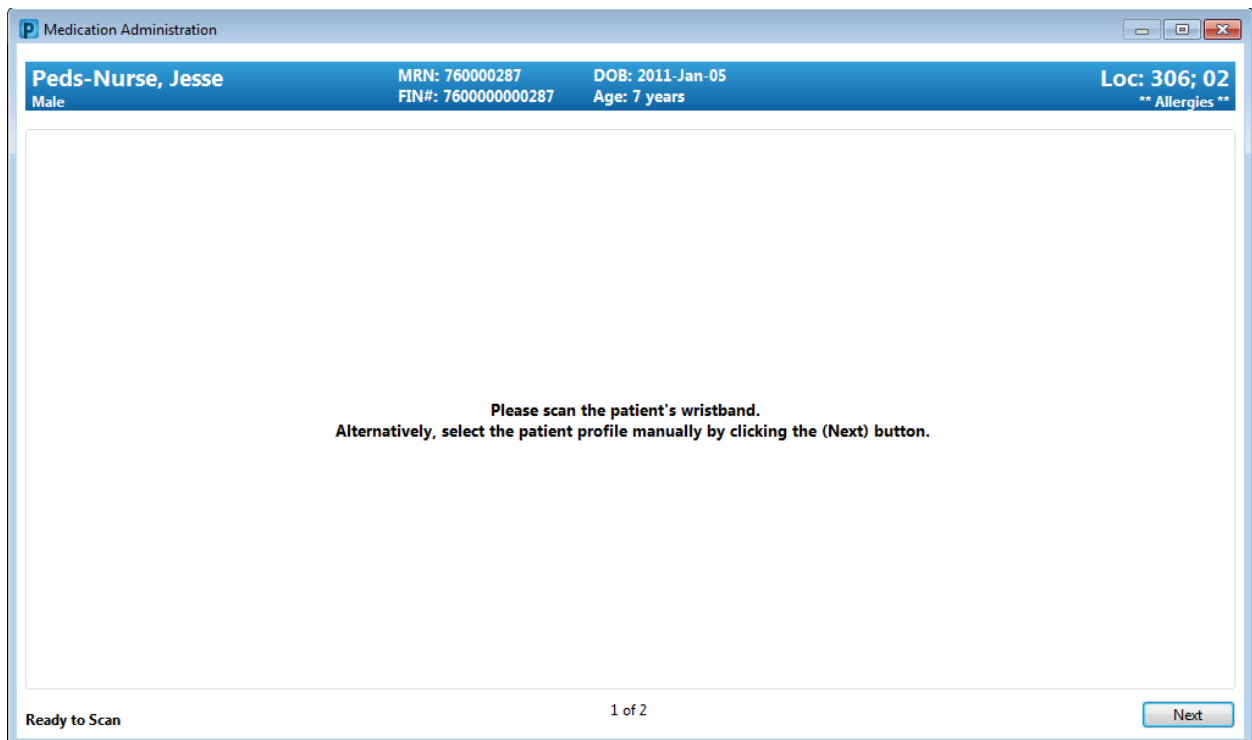
Note: IV normal saline does not have a barcode to be scanned as it is a Stores Item. Stores items are documented on the MAR differently and we will practice this later on.

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.

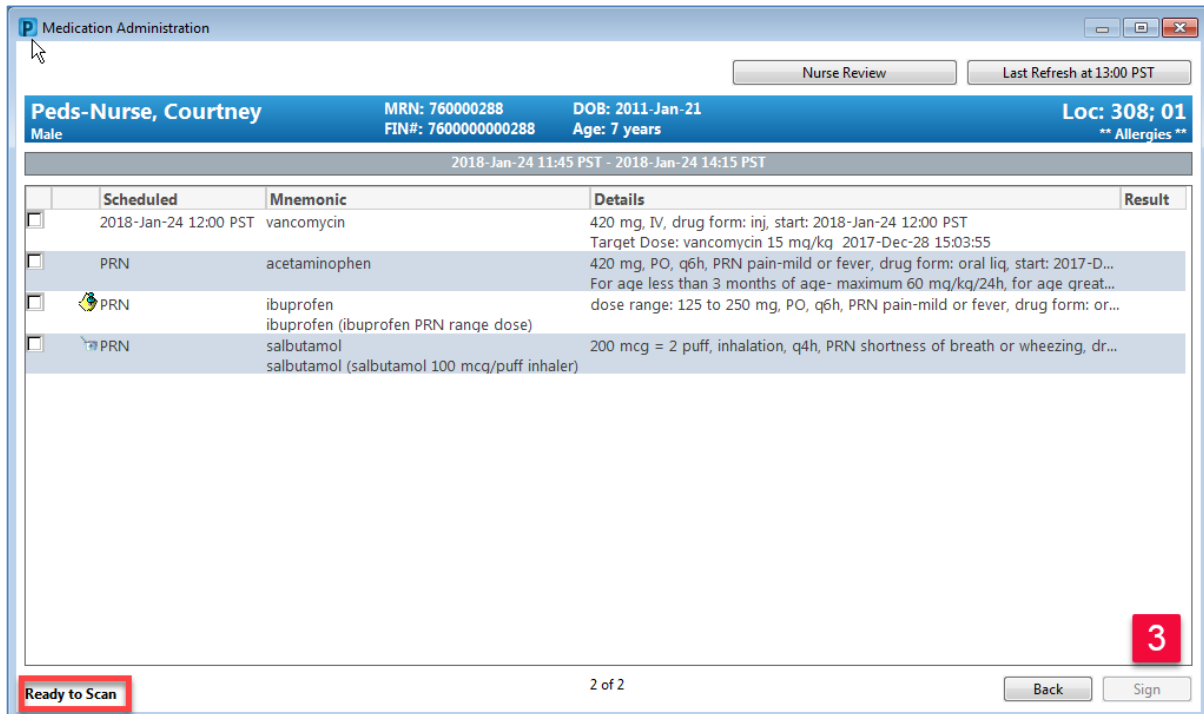


2. The **Medication Administration** pop-up window will appear.



3. Scan the patient's wristband, a window will pop-up 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.

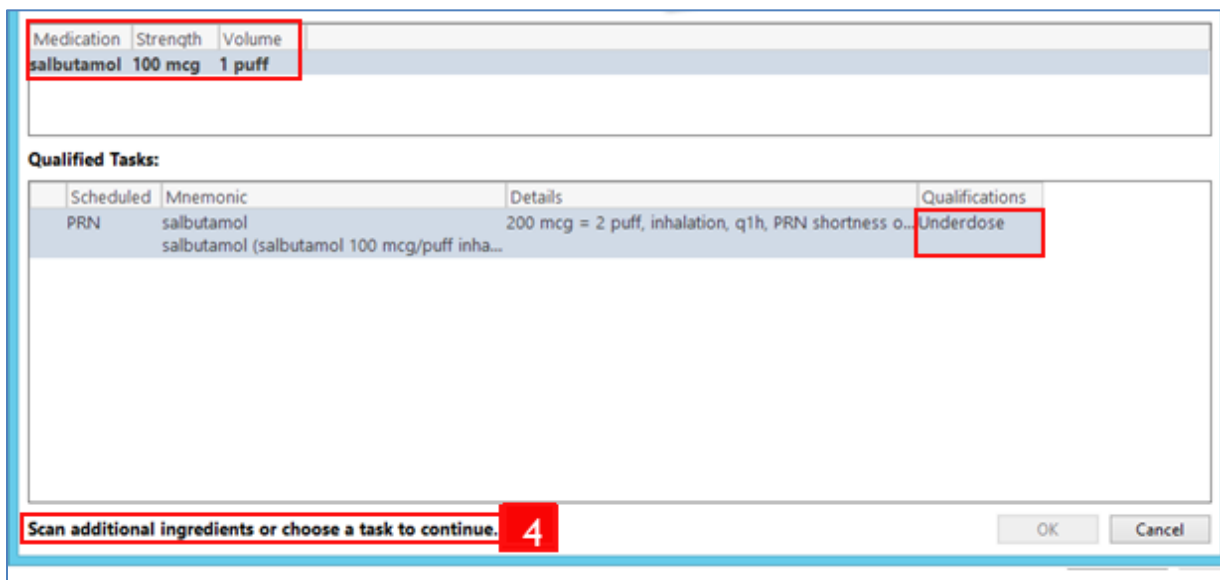


The screenshot shows the 'Medication Administration' window for a patient named Courtney. The window displays patient information, a list of scheduled and PRN medications, and a 'Ready to Scan' button. A red box highlights the 'Ready to Scan' button, and a red circle with the number 3 is in the bottom right corner.

Scheduled	Mnemonic	Details	Result
2018-Jan-24 12:00 PST	vancomycin	420 mg, IV, drug form: inj, start: 2018-Jan-24 12:00 PST Target Dose: vancomycin 15 mg/kg 2017-Dec-28 15:03:55	
PRN	acetaminophen	420 mg, PO, q6h, PRN pain-mild or fever, drug form: oral liq, start: 2017-D...	
PRN	ibuprofen	For age less than 3 months of age- maximum 60 mg/kg/24h, for age great...	
PRN	ibuprofen (ibuprofen PRN range dose)	dose range: 125 to 250 mg, PO, q6h, PRN pain-mild or fever, drug form: or...	
PRN	salbutamol	200 mcg = 2 puff, inhalation, q4h, PRN shortness of breath or wheezing, dr...	
	salbutamol (salbutamol 100 mcg/puff inhaler)		

Ready to Scan 2 of 2 Back Sign

4. Scan the medication barcode for **Salbutamol 100 mcg**, inhaler



The screenshot shows the 'Medication Administration' window for a patient named Courtney. The window displays patient information, a list of scheduled and PRN medications, and a 'Ready to Scan' button. A red box highlights the 'Ready to Scan' button, and a red circle with the number 3 is in the bottom right corner.

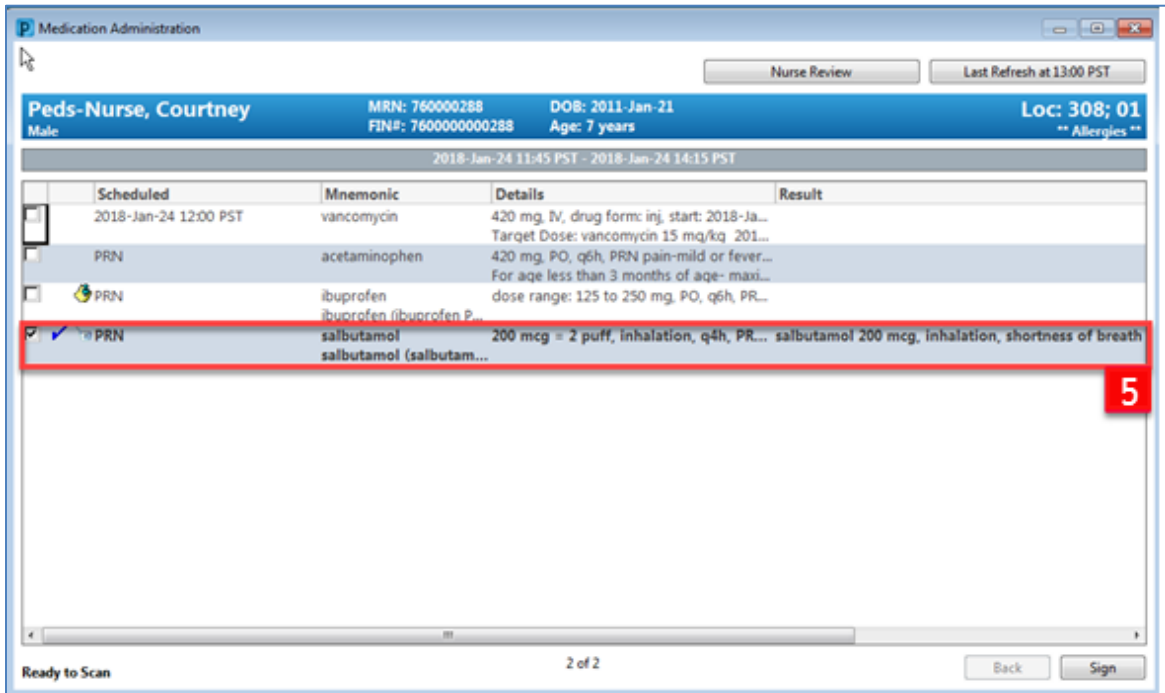
Medication	Strength	Volume
salbutamol	100 mcg	1 puff

Qualified Tasks:

Scheduled	Mnemonic	Details	Qualifications
PRN	salbutamol	200 mcg = 2 puff, inhalation, q1h, PRN shortness o...	Underdose
	salbutamol (salbutamol 100 mcg/puff inha...		

Scan additional ingredients or choose a task to continue. 4 OK Cancel

- Because the full Salbutamol dose is 200 mcg (two puffs), you will need to scan the barcode again. After the first scan, you will receive a pop-up window telling you that the first scan is an underdose and to scan again.



Medication Administration

Nurse Review Last Refresh at 13:00 PST

Peds-Nurse, Courtney MRN: 760000288 DOB: 2011-Jan-21 Loc: 308; 01
Male FIN#: 7600000000288 Age: 7 years ** Allergies **

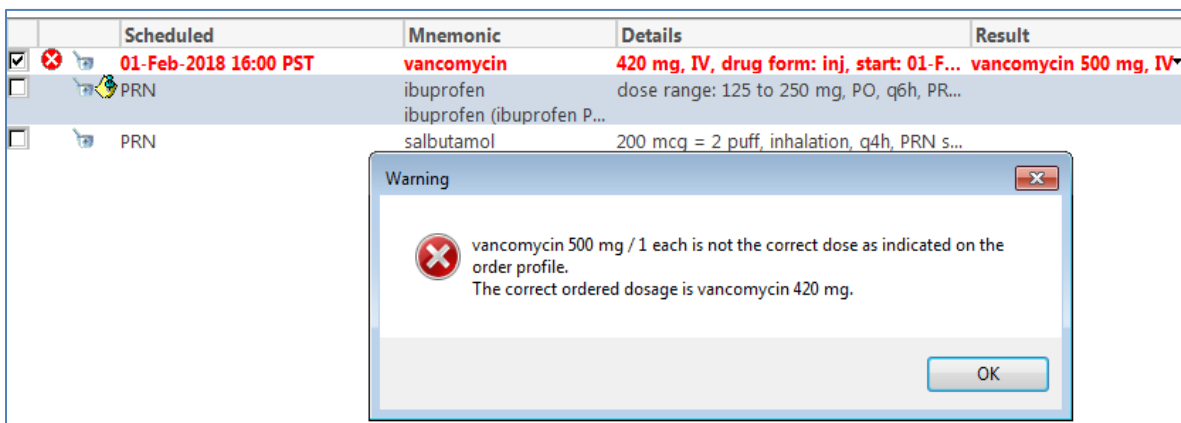
2018-Jan-24 11:45 PST - 2018-Jan-24 14:15 PST

	Scheduled	Mnemonic	Details	Result
<input type="checkbox"/>	2018-Jan-24 12:00 PST	vancomycin	420 mg, IV, drug form: inj, start: 2018-Ja... Target Dose: vancomycin 15 mg/kg 201...	
<input type="checkbox"/>	PRN	acetaminophen	420 mg, PO, q6h, PRN pain-mild or fever... For age less than 3 months of age: maxi...	
<input type="checkbox"/>	PRN	ibuprofen	dose range: 125 to 250 mg, PO, q6h, PR...	
<input checked="" type="checkbox"/>	PRN	salbutamol	200 mcg = 2 puff, inhalation, q4h, PR... salbutamol 200 mcg, inhalation, shortness of breath	
		salbutamol (salbutam...		

Ready to Scan 2 of 2 Back Sign

Let's administer your next medication.

- Scan the barcode for **vancomycin 500 mg IV**. The system finds a match of the IV medication. Note this amount is for the vial used for reconstituting, not the ordered dosage. This will trigger a warning pop-up about the dosage and the medication text will be red.




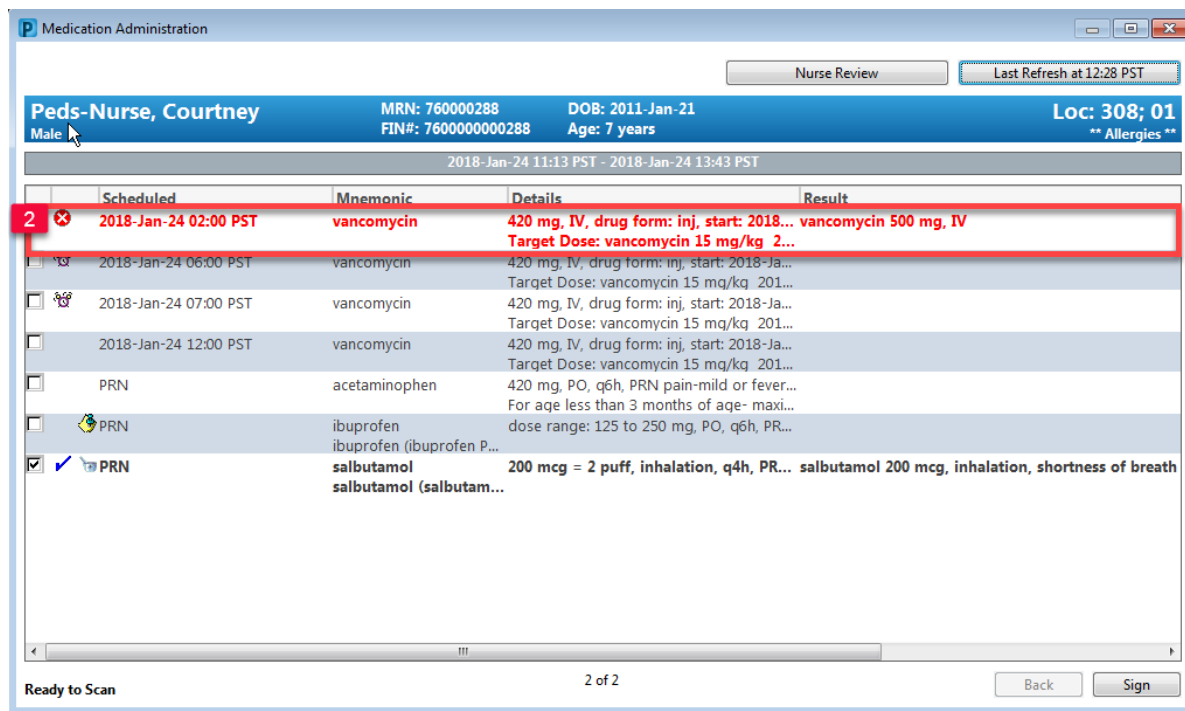
	Scheduled	Mnemonic	Details	Result
<input checked="" type="checkbox"/>	01-Feb-2018 16:00 PST	vancomycin	420 mg, IV, drug form: inj, start: 01-F...	vancomycin 500 mg, IV
<input type="checkbox"/>	PRN	ibuprofen	dose range: 125 to 250 mg, PO, q6h, PR...	
<input type="checkbox"/>	PRN	salbutamol	200 mcg = 2 puff, inhalation, q4h, PRN s...	

Warning

vancomycin 500 mg / 1 each is not the correct dose as indicated on the order profile.
The correct ordered dosage is vancomycin 420 mg.

OK

- Because you need to modify the dosage to be given and add the diluent volume for the reconstitution, click the **red X** icon  next to the medication.



Medication Administration window showing patient information and a list of scheduled medications.

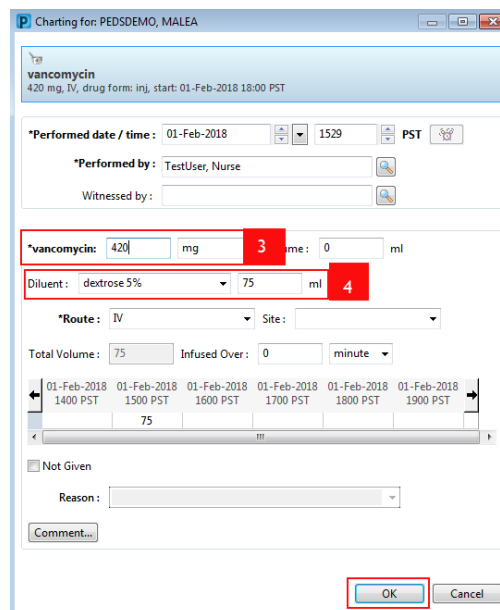
Patient: Peds-Nurse, Courtney, Male, MRN: 760000288, FIN#: 7600000000288, DOB: 2011-Jan-21, Age: 7 years, Loc: 308; 01, Allergies: **

Time range: 2018-Jan-24 11:13 PST - 2018-Jan-24 13:43 PST

	Scheduled	Mnemonic	Details	Result
2	2018-Jan-24 02:00 PST	vancomycin	420 mg, IV, drug form: inj, start: 2018-... Target Dose: vancomycin 15 mg/kg 2...	vancomycin 500 mg, IV
	2018-Jan-24 06:00 PST	vancomycin	420 mg, IV, drug form: inj, start: 2018-Ja... Target Dose: vancomycin 15 mg/kg 201...	
	2018-Jan-24 07:00 PST	vancomycin	420 mg, IV, drug form: inj, start: 2018-Ja... Target Dose: vancomycin 15 mg/kg 201...	
	2018-Jan-24 12:00 PST	vancomycin	420 mg, IV, drug form: inj, start: 2018-Ja... Target Dose: vancomycin 15 mg/kg 201...	
	PRN	acetaminophen	420 mg, PO, q6h, PRN pain-mild or fever... For age less than 3 months of age- maxi...	
	PRN	ibuprofen	dose range: 125 to 250 mg, PO, q6h, PR...	
	PRN	salbutamol	200 mcg = 2 puff, inhalation, q4h, PR...	salbutamol 200 mcg, inhalation, shortness of breath

Ready to Scan 2 of 2 Back Sign

- Change the dose to be administered to 420 mg (on the unit you will reconstitute and draw up this amount as ordered).
- Update the **Diluent** to dextrose 5% (D5W) and type 75 ml for your diluent. **Note:** It is important to document your diluent so that it will flow into the Intake & Output.



Charting for: PEDSDEMO, MALEA

vancomycin
420 mg, IV, drug form: inj, start: 01-Feb-2018 18:00 PST

*Performed date / time: 01-Feb-2018 1529 PST

*Performed by: TestUser, Nurse

Witnessed by:

*vancomycin: 420 mg 3

Diluent: dextrose 5% 75 ml 4

*Route: IV Site:

Total Volume: 75 Infused Over: 0 minute

Timeline: 01-Feb-2018 1400 PST to 1900 PST

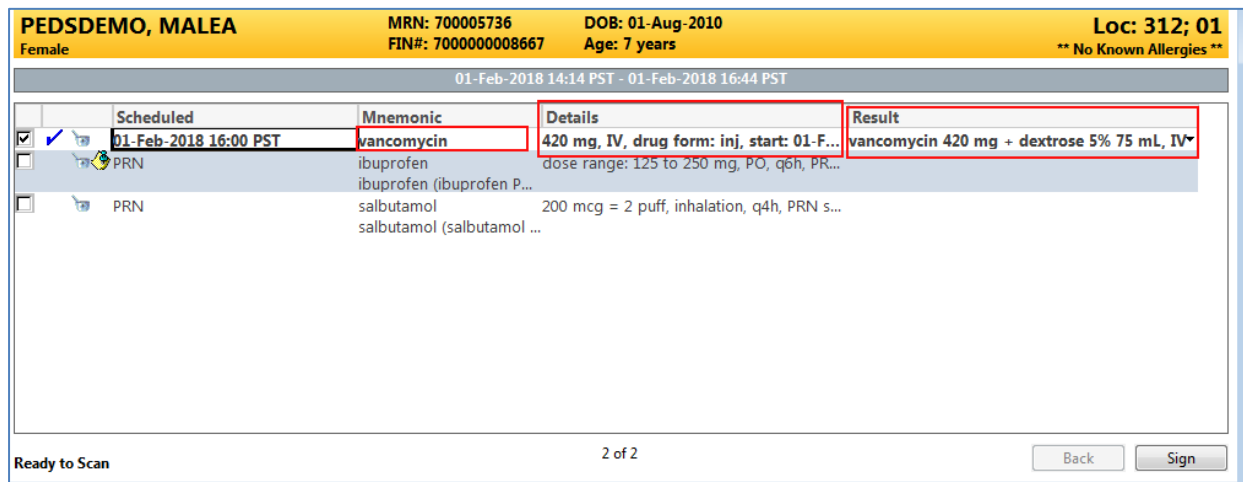
Reason: Not Given

Comment:


OK Cancel

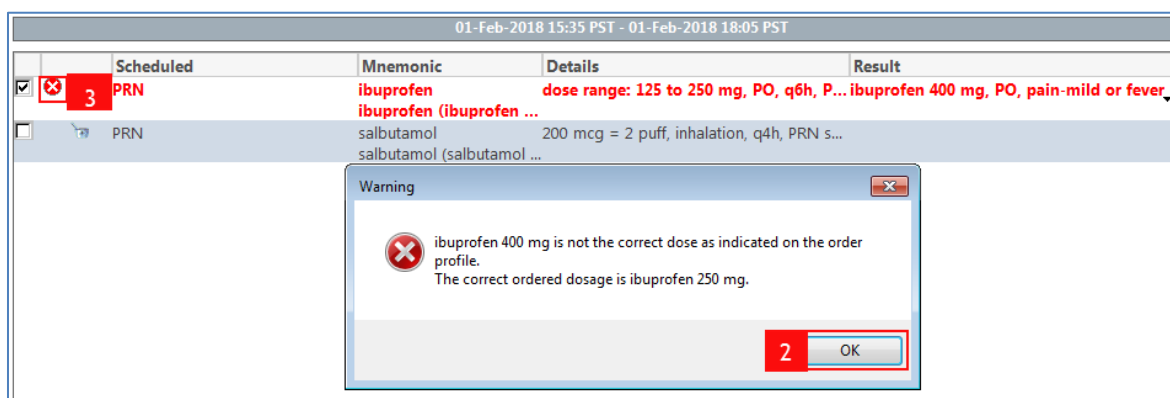
Note: Powdered and liquid medications require this extra step in order to administer **partial doses**. This is because the medication barcode on the vial will be for the *entire contents* of the vial/bottle. You will *a/ways* need to update the window to the actual dose administered and the diluent amount or volume drawn up for accurate ins and outs.

Once you have updated your medication window, click **OK** and you will see that the text for Vancomycin is no longer red and the **Details** and **Result** are updated to reflect the accurate amount of diluent and drug that you will be signing for.



Now let's scan the ibuprofen. The dose ordered is ibuprofen 125 to 250 mg, PO Q6H, PRN and we are only administering Ibuprofen 200mg, PO now.

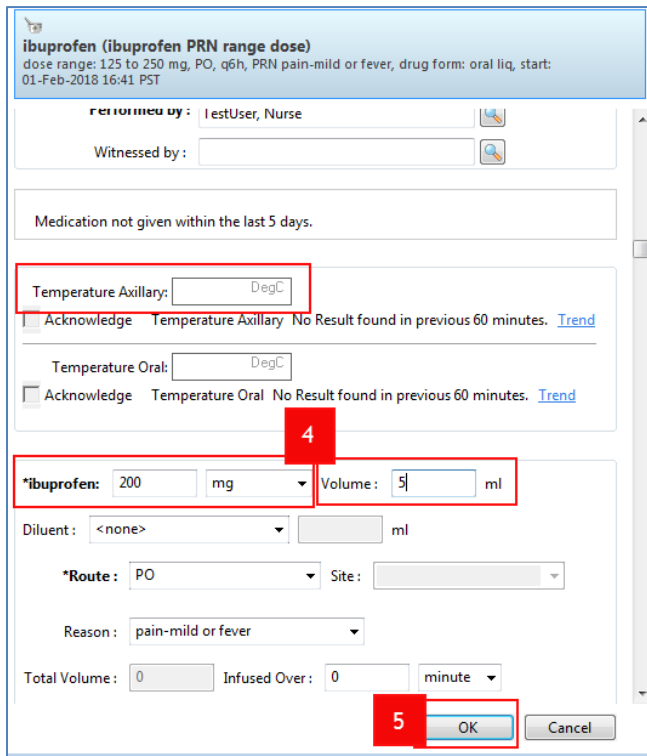
1. Scan your medication barcode for **ibuprofen 400 mg/ 10ml**. The barcode is for the entire bottle.
2. Once again you will get a warning window about the correct dosage and the medication text will be red. Click **OK**.
3. Click the **red X**  by the medication to edit the details of administration. This will open the window to edit the medication details.



- Perform your dosage calculation as you normally would, keeping in mind that you can access the Windows calculator on your computer if needed. Edit the **Medication** and **Volume** fields to the accurate dosage and volume to be administered.

Note: There is an optional field for documenting a temperature if the medication is being given for fever rather than pain and will allow you to view a trend graph if fever has been ongoing.

- Click **OK** to close the window.



- Notice the text has now changed from red to black and reflects the accurate dosage you will be signing for. Click **Sign**.

Scheduled	Mnemonic	Details	Result
01-Feb-2018 16:01 PST	vancomycin	420 mg, IV, drug form: inj, start: 01-F...	vancomycin 420 mg + dextrose 5% 75 mL, IV
PRN	ibuprofen	dose range: 125 to 250 mg, PO, q6h, P...	ibuprofen 200 mg, PO, pain-mild or fever
	ibuprofen (ibuprofen ...		
PRN	salbutamol	200 mcg = 2 puff, inhalation, q4h, PR...	salbutamol 200 mcg, inhalation, shortness of bre...
	salbutamol (salbutam...		


2 of 2

Back **6** Sign

Now that you have scanned the patient and scanned all the three medications, you can complete your medication checks and administer the medication.

7. Congratulations, you have successfully administered three medications! The medications will now appear as **Complete** on the MAR. Note the blue **Med Response** box beside ibuprofen. This is for follow-up documentation when you recheck your patient's pain or fever after administration.

Scheduled	
vancomycin 420 mg, IV, q6h, drug form: inj, start: 01-Feb-2018 18:00 PST	Complete
vancomycin	7
PRN	
ibuprofen (ibuprofen PRN range dose) dose range: 125 to 250 mg, PO, q6h, PRN pain-mild or fever, drug form: oral liq, start: 01-Feb-2018 16:41 PST	Med Response Complete [2]
ibuprofen	
Temperature Axillary	
Temperature Oral	
PRN	
salbutamol (salbutamol 100 mcg/puff inhaler) 200 mcg = 2 puff, inhalation, q4h, PRN shortness of breath or wheezing, drug form: inhaler, start: 01-Feb-2018 15:05 PST	Complete [2]
salbutamol	

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

Scheduled	
vancomycin 420 mg, IV, q6h, drug form: inj, start: 01-Feb-2018 18:00 PST	
vancomycin	* 420 mg Auth (N)
PRN	
ibuprofen (ibuprofen PRN range dose) dose range: 125 to 250 mg, PO, q6h, PRN pain-mild or fever, drug form: oral liq, start: 01-Feb-2018 16:41 PST	Med Response 250 mg Last given: 01-Feb-2018 17:19 PST
ibuprofen	* 200 mg Auth (N)
Temperature Axillary	
Temperature Oral	
PRN	
salbutamol (salbutamol 100 mcg/puff inhaler) 200 mcg = 2 puff, inhalation, q4h, PRN shortness of breath or wheezing, drug form: inhaler, start: 01-Feb-2018 15:05 PST	200 mcg Last given: 01-Feb-2018 17:19 PST
salbutamol	* 200 mcg Auth (N)

Key Learning Points

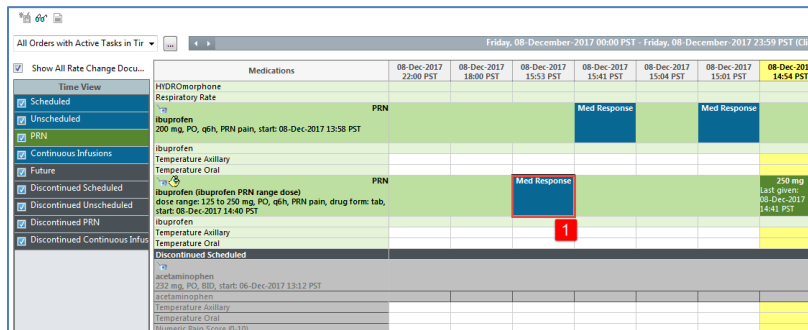
- Use barcode scanner to administer medications.
- Medication volumes will flow from the MAR into the Intake and Output section of iView.
- Liquid and powder medications require manual correction of dosages and volumes because their barcodes (unless mixed by pharmacy) are for the entire bottle or vial.
- Some dosages require scanning a medication twice to scan the complete dose.

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

1

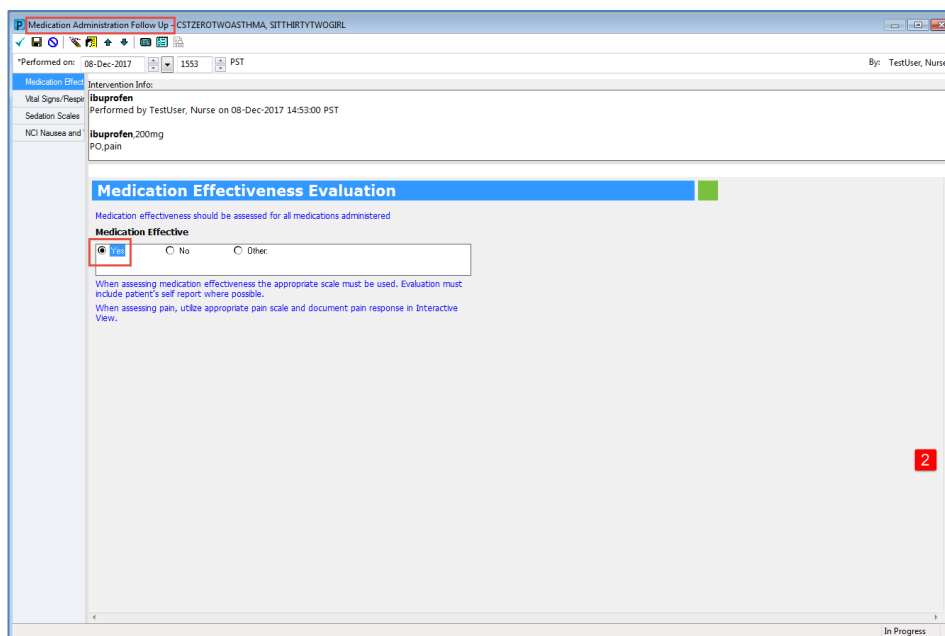
When you administer some PRN medications, it is necessary to document how the patient responds to the medication. You can do this directly in the MAR.

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



Medications	08-Dec-2017 22:00 PST	08-Dec-2017 18:00 PST	08-Dec-2017 15:53 PST	08-Dec-2017 15:41 PST	08-Dec-2017 15:04 PST	08-Dec-2017 15:01 PST	08-Dec-2017 14:54 PST
HIDROMORPHONE							
Respiratory Rate							
ibuprofen (ibuprofen PRN range dose)							Med Response
200 mg, PO, q6h, PRN pain, start: 08-Dec-2017 13:58 PST							Med Response
ibuprofen							
Temperature Axillary							
Temperature Oral							
ibuprofen (ibuprofen PRN range dose)							250 mg
dose range: 125 to 250 mg, PO, q6h, PRN pain, drug form: tab, start: 08-Dec-2017 14:40 PST							Last Given: 08-Dec-2017 14:48 PST
ibuprofen							
Temperature Axillary							
Temperature Oral							
Discontinued Scheduled							
acetaminophen							
325 mg, PO, 880, start: 08-Dec-2017 13:12 PST							
acetaminophen							
Temperature Axillary							
Temperature Oral							
Numeric Pain Score (0-10)							

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



Medication Administration Follow Up: CSTZEROTWOASTHMA, SITHRTYTWOGIRL

*Performed on: 08-Dec-2017 15:53 PST By: TestUser, Nurse

Medication Effectiveness Evaluation

Medication effectiveness should be assessed for all medications administered



Medication Effective

☒ Yes ☐ No ☐ Other

When assessing medication effectiveness the appropriate scale must be used. Evaluation must include patient's self report where possible.

When assessing pain, utilize appropriate pain scale and document pain response in Interactive View.

In Progress

3. Click **green check mark** icon  to sign and click the **Refresh** icon . Now that you have documented the medication response it has disappeared from the MAR.

All Orders with Active Tasks in Tir		Friday, 08-December-2017 00:00 PST			
Show All Rate Change Docu...		08-Dec-2017 22:00 PST	08-Dec-2017 18:00 PST	08-Dec-2017 14:57 PST	08-Dec-2017 14:53 PST
Time View					
<input checked="" type="checkbox"/> Scheduled					
<input checked="" type="checkbox"/> Unscheduled					
<input checked="" type="checkbox"/> PRN					
<input checked="" type="checkbox"/> Continuous Infusions					
<input checked="" type="checkbox"/> Future					
<input checked="" type="checkbox"/> Discontinued Scheduled					
<input checked="" type="checkbox"/> Discontinued Unscheduled					
<input checked="" type="checkbox"/> Discontinued PRN					
<input checked="" type="checkbox"/> Discontinued Continuous Infus					
Medications					
PRN					
HYDROMORPHONE					
0.05 mg/kg, PO, q4h, PRN pain, drug form: tab, start: 08-Dec-2017 14:02 PST					
DILAUDID EQUIV					
HYDROMORPHONE					
Respiratory Rate					
PRN					
ibuprofen					
200 mg, PO, q6h, PRN pain, start: 08-Dec-2017 13:58 PST					
ibuprofen					
Temperature Axillary					
Temperature Oral					
PRN					
ibuprofen (ibuprofen PRN range dose)					
dose range: 125 to 250 mg, PO, q6h, PRN pain, drug form: tab, start: 08-Dec-2017 14:40 PST					
ibuprofen					
Temperature Axillary					
Temperature Oral					

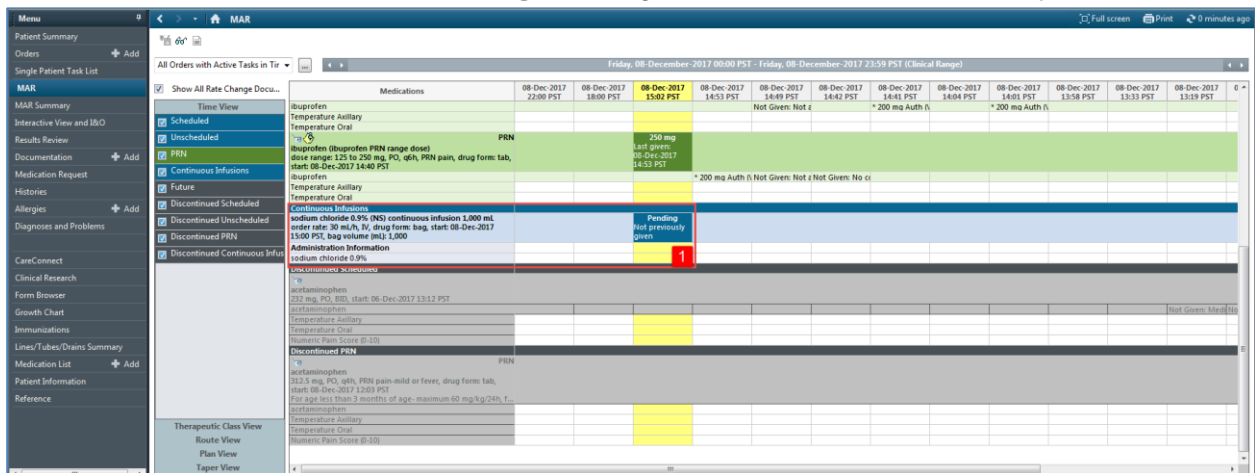
Key Learning Point

- 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 the normal saline continuous IV infusion, from the MAR:

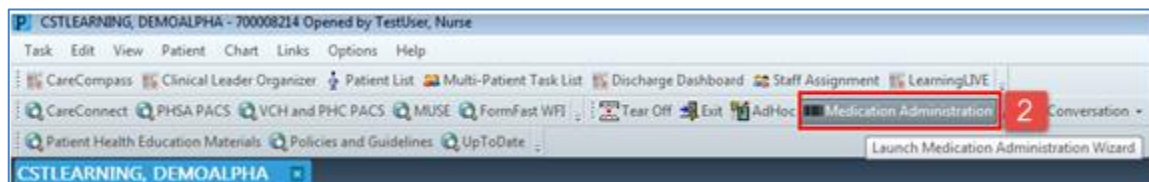
- From the **MAR**, review the order details for the **sodium chloride 0.9% continuous infusion**. Note the status is **Pending** meaning it has not been administered yet



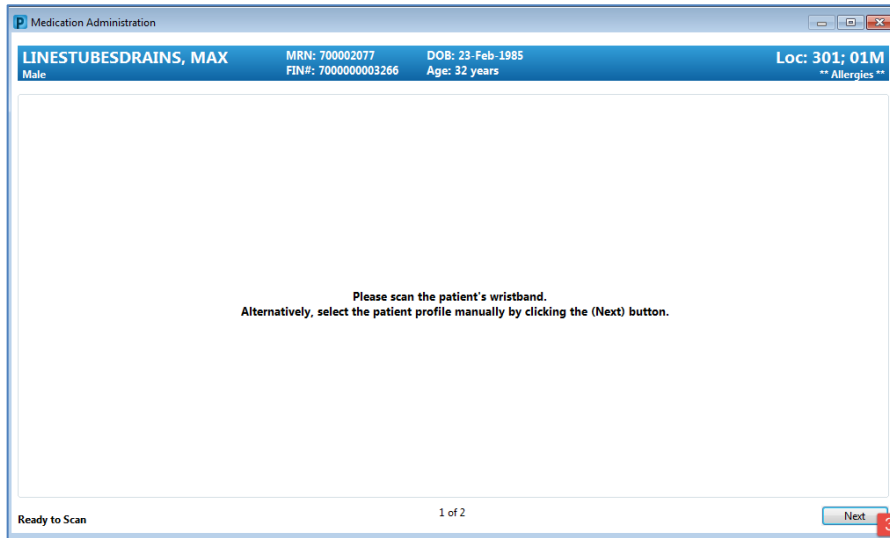
Medications	08-Dec-2017 22:00 PST	08-Dec-2017 18:00 PST	08-Dec-2017 15:02 PST	08-Dec-2017 14:53 PST	08-Dec-2017 14:49 PST	08-Dec-2017 14:42 PST	08-Dec-2017 14:04 PST	08-Dec-2017 14:01 PST	08-Dec-2017 13:58 PST	08-Dec-2017 13:33 PST	08-Dec-2017 13:19 PST
ibuprofen											
Temperature Axillary											
Temperature Oral											
ibuprofen (ibuprofen PRN range dose)											
dose range 125 to 250 mg, PO, q6h, PRN pain, drug form: tab,											
start: 08-Dec-2017 14:40 PST											
250 mg											
Last given: 08-Dec-2017 14:53 PST											
Continuous Infusions											
Sodium chloride 0.9% (NS) continuous infusion 1,000 mL											
order rate: 30 mL/h, IV, drug form bag, start: 08-Dec-2017											
13:00 PST, bag volume (mL): 1,000											
Administration Information											
Sodium chloride 0.9%											
Unconsumed: 1,000 mL											
Acetaminophen											
325 mg, PO, BID, start: 08-Dec-2017 13:12 PST											
Acetaminophen											
Temperature Axillary											
Temperature Oral											
Summit Pain Score (0-10)											
Discontinued PRN											
Acetaminophen											
325 mg, PO, q6h, PRN pain-mild or fewer, drug form: tab,											
start: 08-Dec-2017 13:03 PST											
For age less than 3 months of age, maximum 60 mg/kg/24h, 1											
Acetaminophen											
Temperature Axillary											
Temperature Oral											
Summit Pain Score (0-10)											

- To administer the infusion, click on the **Medication Administration** button

 Medication Administration from the Toolbar at the top of the page.



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




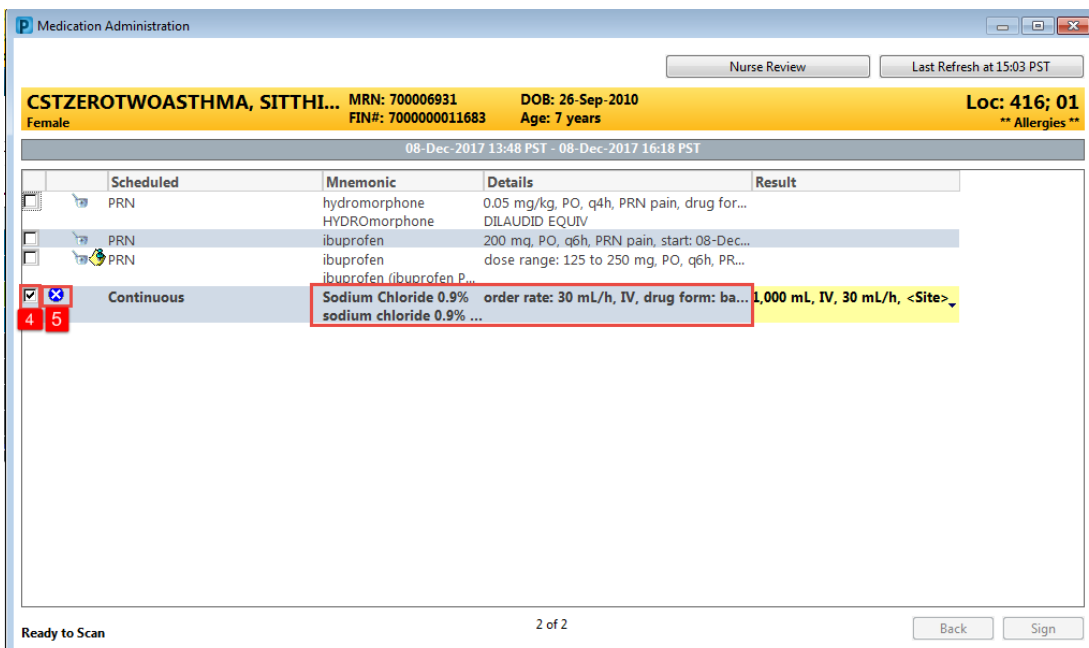
Medication Administration

LINESTUBESDRAINS, MAX MRN: 700002077 DOB: 23-Feb-1985 Loc: 301; 01M
Male FIN#: 700000003266 Age: 32 years ** Allergies **

Please scan the patient's wristband.
Alternatively, select the patient profile manually by clicking the (Next) button.

Ready to Scan 1 of 2 Next **3**

4. A list of ordered medications that can be administered appears in the Medication Administration window. The next step would be to scan the barcode on the medication, but with items that do not have a barcode, such as Normal Saline, we cannot do this. Instead, scroll down to manually select the small box on the left beside the order for the **Sodium Chloride 0.9% (NS) continuous infusion 1,000mL, order rate: 30 ml/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



Medication Administration

Nurse Review Last Refresh at 15:03 PST

CSTZEROTWOASTHMA, SITHI... MRN: 700006931 DOB: 26-Sep-2010 Loc: 416; 01
Female FIN#: 7000000011683 Age: 7 years ** Allergies **

08-Dec-2017 13:48 PST - 08-Dec-2017 16:18 PST

	Scheduled	Mnemonic	Details	Result
<input type="checkbox"/>	PRN	hydromorphone	0.05 mg/kg, PO, q4h, PRN pain, drug for...	
<input type="checkbox"/>	PRN	HYDROMorphone	DILAUDID EQUIV	
<input type="checkbox"/>	PRN	ibuprofen	200 mg, PO, q6h, PRN pain, start: 08-Dec...	
<input type="checkbox"/>	PRN	ibuprofen	dose range: 125 to 250 mg, PO, q6h, PR...	
<input checked="" type="checkbox"/>	Continuous	ibuprofen (ibuprofen P...	order rate: 30 mL/h, IV, drug form: ba...	1,000 mL, IV, 30 mL/h, <Site>
4 5		Sodium Chloride 0.9%	sodium chloride 0.9% ...	

Ready to Scan 2 of 2 Back Sign

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 the **Performed time** = 0600

PATIENT SCENARIO 10 – Medication Administration

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

Witnessed by :

*Bag # : 1

*Site : <Show All>
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

Begin Bag
OK Cancel

7. Click the **green check mark icon** ✓ to sign your documentation and you will be brought back to the **MAR** where the sodium chloride 0.9% continuous infusion at 30ml/hr is now shown as complete.
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 populate by double clicking in the hourly cells. Always double check the volumes flow correctly.

Adult Quick View

- Adult Systems Assessment
- Adult Lines - Devices
- Adult Education
- Blood Product Administration
- Intake And Output
 - Intake
 - Continuous Infusions
 - Medications
 - Chest Tubes
 - Enteral
 - GI Tube
 - GI Ostomy Intake
 - Urinary Diversion Intake
 - Other Intake Sources
 - Negative Pressure Wound Therapy
 - Surgical Drain, Tube Inputs
 - Transfusions
 - Urinary Catheter, Intake
 - Pre-Arrival Fluid
 - Output
 - Blood Output
 - Pharyngeal Tube Output
- Advanced Graphing
- Restraint and Sedation
- Procedural Sedation
- Ambulatory Infusion Center Monitoring
- Ambulatory Nursing Procedures
- Infusion-Oncology
- Pediatric Quick View
- Pediatric Systems Assessment
- Pediatric Lines - Devices
- Pediatric Education

Thursday, 07 December 2017 06:00 PST - Sunday, 10 December 2017 05:59 PST

Today's Intake: 500 mL, Output: 0 mL, Balance: 500 mL Yesterday's Intake: 0 mL, Output: 0 mL, Balance: 0 mL

	08-Dec-2017	09-Dec-2017	10-Dec-2017
	21:00 - 21:59 PST	20:00 - 20:59 PST	19:00 - 19:59 PST
Intake Total			500
Continuous Infusions			
sodium chloride 0.9% (NS) continuous infusion 1,000 mL			30
Medications			500
vancomycin + dextrose 5% mL			500
Output Total			0
GI Tube			
Other Output Sources			
Negative Pressure Wound Th...			
Surgical Drain, Tube Inputs			
Balance			500 mL

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



Key Learning Points

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

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.

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

-  Review results using Results Review

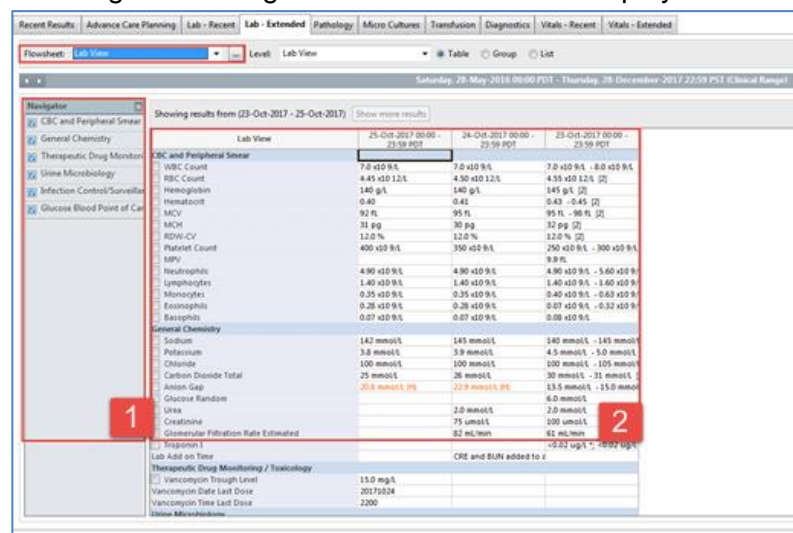
Activity 11.1 – Using Results Review

- 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 person such as labs, iView entries such as 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.

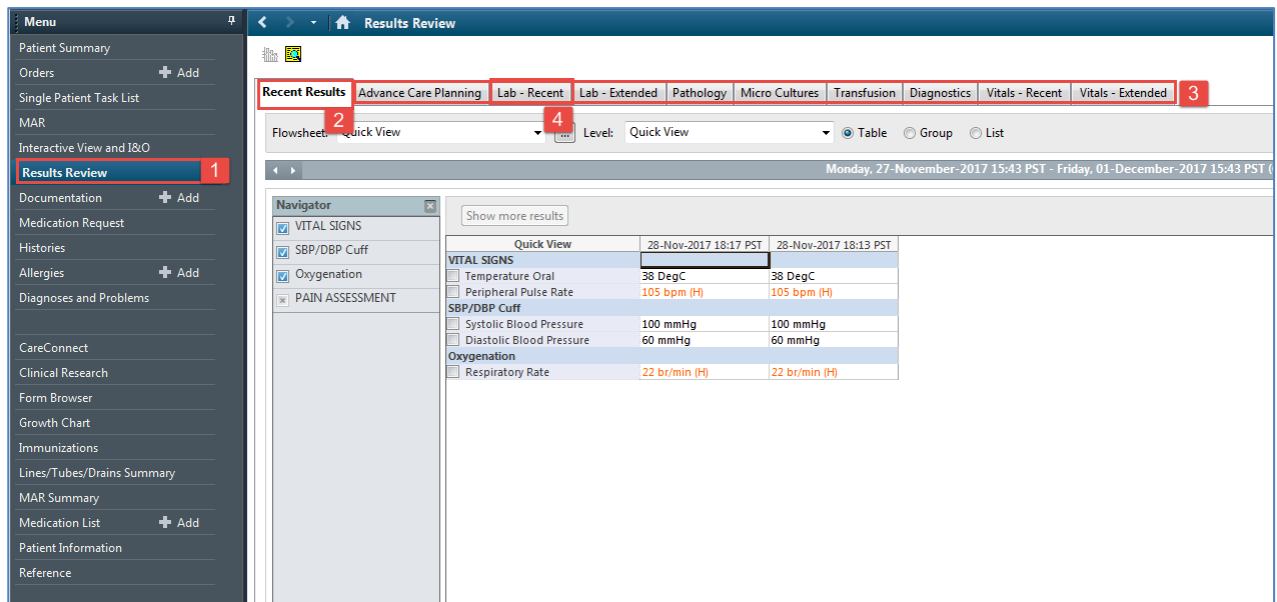


The screenshot shows the 'Results Review' interface. On the left is the 'Navigator' pane with a tree view of categories: CBC and Peripheral Smear, General Chemistry, Therapeutic Drug Monitoring, Urine Microbiology, Infection Control/Surveillance, and Glucose Blood Point of Care. A red box labeled '1' highlights the Navigator. The main area is the 'Results Display' grid, which shows a table of lab results for a patient. The grid has columns for different dates and times. A red box labeled '2' highlights the Results Display grid.

Lab View	25-Oct-2017 00:00 - 23:59 PDT	26-Oct-2017 00:00 - 23:59 PDT	27-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	0.43	0.43	0.43 - 0.45 (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 - 0.60 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	0.08 x10 ⁹ /L
General Chemistry			
Sodium	142 mmol/L	143 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
Oxalate	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	10.5 mmol/L (2)	12.9 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		79 umol/L	100 umol/L
Glomerular Filtration Rate Estimated		82 mL/min	61 mL/min
Inspiron			10.52 ug/L - 10.92 ug/L
Lab Add on Time			CHE and BUN added to d
Therapeutic Drug Monitoring / Toxicology			
Vancomycin Trough Level	15.0 mg/L		
Vancomycin Date Last Dose	20171024		
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 tab to see related results
4. Select **Lab – Recent**



Menu

- Patient Summary
- Orders + Add
- Single Patient Task List
- MAR
- Interactive View and I&O
- Results Review 1**
- Documentation + Add
- Medication Request
- Histories
- Allergies + Add
- Diagnoses and Problems
- CareConnect
- Clinical Research
- Form Browser
- Growth Chart
- Immunizations
- Lines/Tubes/Drains Summary
- MAR Summary
- Medication List + Add
- Patient Information
- Reference

Results Review

Recent Results 2 Advance Care Planning Lab - Recent 4 Lab - Extended Pathology Micro Cultures Transfusion Diagnostics Vitals - Recent Vitals - Extended 3

Flowsheet 2 Quick View 4 Level: Quick View Table Group List

Monday, 27-November-2017 15:43 PST - Friday, 01-December-2017 15:43 PST

Navigator

- VITAL SIGNS
- SBP/DBP Cuff
- Oxygenation
- PAIN ASSESSMENT

Show more results

	28-Nov-2017 18:17 PST	28-Nov-2017 18:13 PST
VITAL SIGNS		
Temperature Oral	38 DegC	38 DegC
Peripheral Pulse Rate	105 bpm (H)	105 bpm (H)
SBP/DBP Cuff		
Systolic Blood Pressure	100 mmHg	100 mmHg
Diastolic Blood Pressure	60 mmHg	60 mmHg
Oxygenation		
Respiratory Rate	22 br/min (H)	22 br/min (H)

5. Review your patient's recent **lab result**.

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 (!)
<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 coloured 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 pediatric nurse you will be completing the following activities:

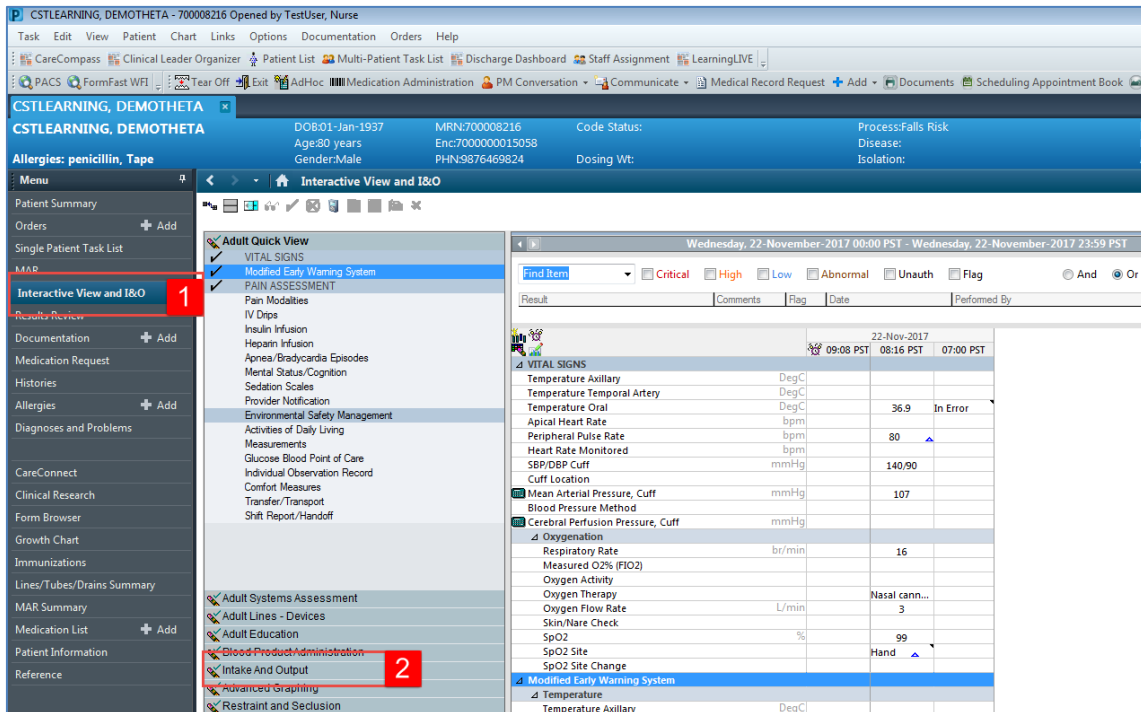
-  Navigate to intake and output flowsheets within iView
-  Review and document in the intake and output record

Activity 12.1 – Navigate to Intake and Output Flowsheets Within iView

- 1 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. 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 left sidebar contains a menu with various options. The 'Interactive View and I&O' option is highlighted with a red box and the number 1. The 'Intake and Output' band is also highlighted with a red box and the number 2. The main window shows a list of vital signs and other patient data for Wednesday, 22-November-2017.

Find Item	Critical	High	Low	Abnormal	Unauth	Flag	And	Or
Result								
Comments								
Flag								
Date								
Performed By								


	09:08 PST	08:16 PST	07:00 PST
VITAL SIGNS			
Temperature Axillary	DegC		
Temperature Temporal Artery	DegC		
Temperature Oral	DegC	36.9	In Error
Apical Heart Rate	bpm		
Peripheral Pulse Rate	bpm	80	
Heart Rate Monitored	bpm		
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 Therapy		Nasal cann...	
Oxygen Flow Rate	L/min	3	
Skin/Nare Check			
SpO2	%	99	
SpO2 Site		Hand	
SpO2 Site Change			
Modified Early Warning System			
Temperature			
Temperature Axillary	DegC		

- 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 as per below:

1. The **I&O navigator** lists the sections of measurable I&O items

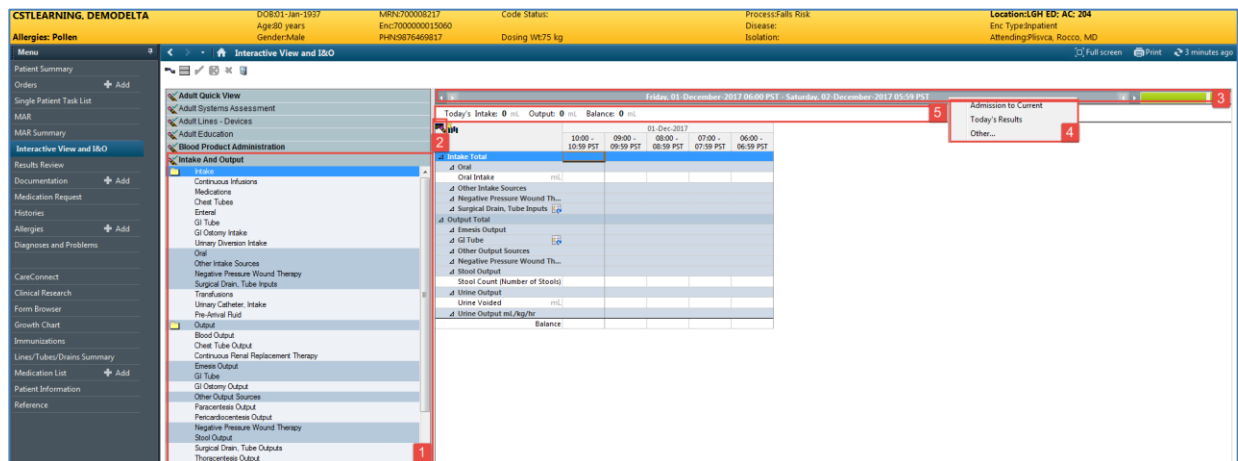
The dark grey highlighted sections (for example, Oral) are active and are automatically visible in the flowsheet.

2. To add other **Intake or Output sources**, you will need to click on the **Customize View icon**  to select the appropriate section to be added in.

3. The **grey information bar** indicates the date/time range that is currently set to be displayed.

4. To change the date/time range being displayed:
 - Right-click on the **grey bar** and select a **new date/time range** (Admission to Current, Today's Results or Other)

5. The I&O summary at the top of the flowsheet displays a quick overview of today's intake, output, balance, and more.



Key Learning Points

- Intake and Output (I&O) 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.

Activity 12.2 – Review and Document in the Intake and Output Record

- 1 Let's practice reviewing and documenting in the I&O record. For this scenario, let's assume that previously a peripheral IV and sodium chloride infusion were initiated. An IV vancomycin dose was also given.

Review that appropriate values are displayed in I&O record.

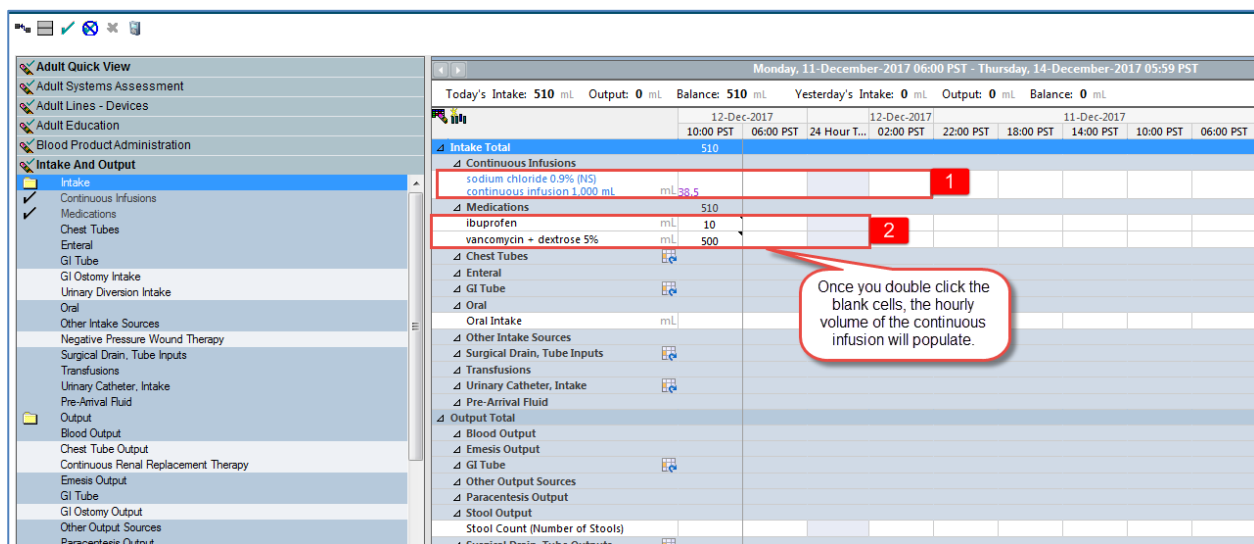
1. Continuous Infusions: sodium chloride 0.9%

- Double-click in each **hourly time column** since the sodium chloride infusion was initiated (at 0600). Values will populate to reflect the order of 30 mL/hr.

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

2. Medications: vancomycin and Ibuprofen

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



Monday, 11-December-2017 06:00 PST - Thursday, 14-December-2017 05:59 PST

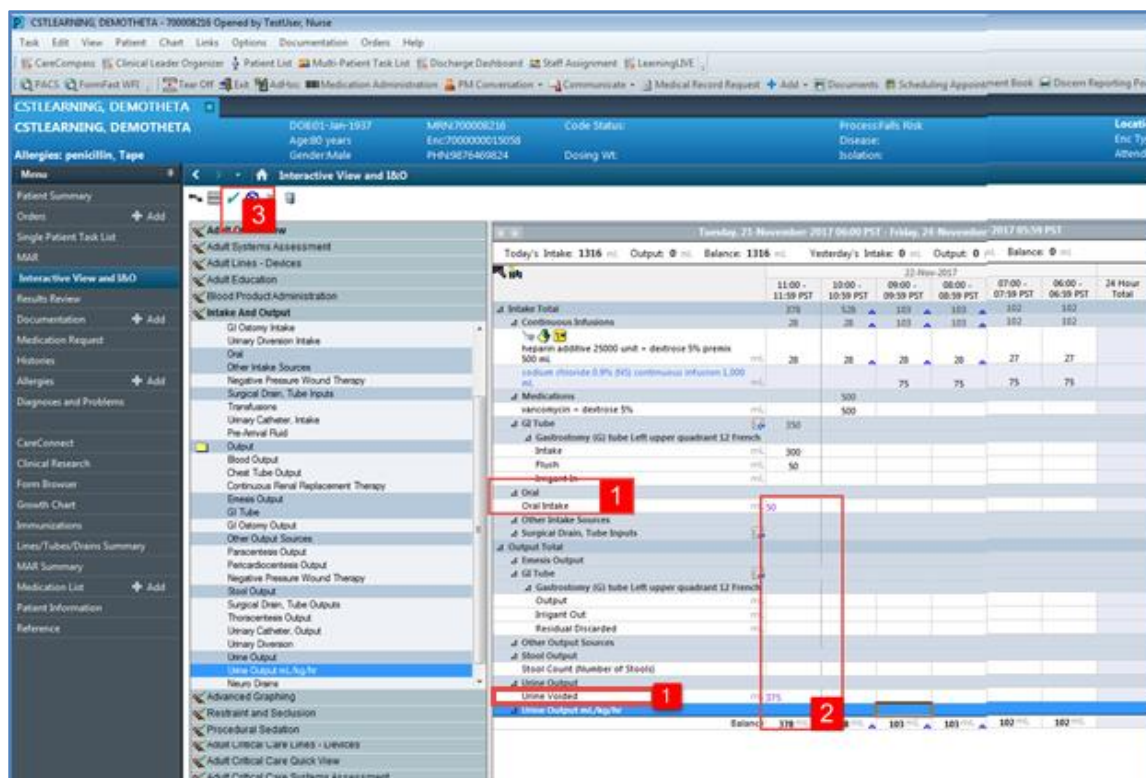
Today's Intake: 510 mL Output: 0 mL Balance: 510 mL Yesterday's Intake: 0 mL Output: 0 mL Balance: 0 mL

	12-Dec-2017 10:00 PST	06:00 PST	24 Hour T...	12-Dec-2017 02:00 PST	22:00 PST	18:00 PST	14:00 PST	10:00 PST	06:00 PST
Intake Total	510								
Continuous Infusions									
sodium chloride 0.9% (NS)									
continuous infusion 1,000 mL	38.5								
Medications	510								
ibuprofen	10								
vancomycin + dextrose 5%	500								
Output Total	0								
Blood Output									
Chest Tube Output									
Continuous Renal Replacement Therapy									
Emesis Output									
GI Tube									
GI Ostomy Output									
Other Output Sources									
Paracentesis Output									
Stool Count (Number of Stools)									
Surgical Drain, Tube Outputs									

Once you double click 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 **100 mL** and voided **175 mL** and now you need to document these values.

1. Locate the **Oral and Urine Output** section in the I&O navigator
2. In the flowsheet on the right, document the following by clicking into the appropriate cell.
 - **Oral Intake = 100 mL**
 - **Urine Voided = 175 mL**
3. Click the **green check mark icon** ✓ to sign your documentation.



3 (Green checkmark icon in the I&O navigator)

1 (Oral Intake cell in the flowsheet)

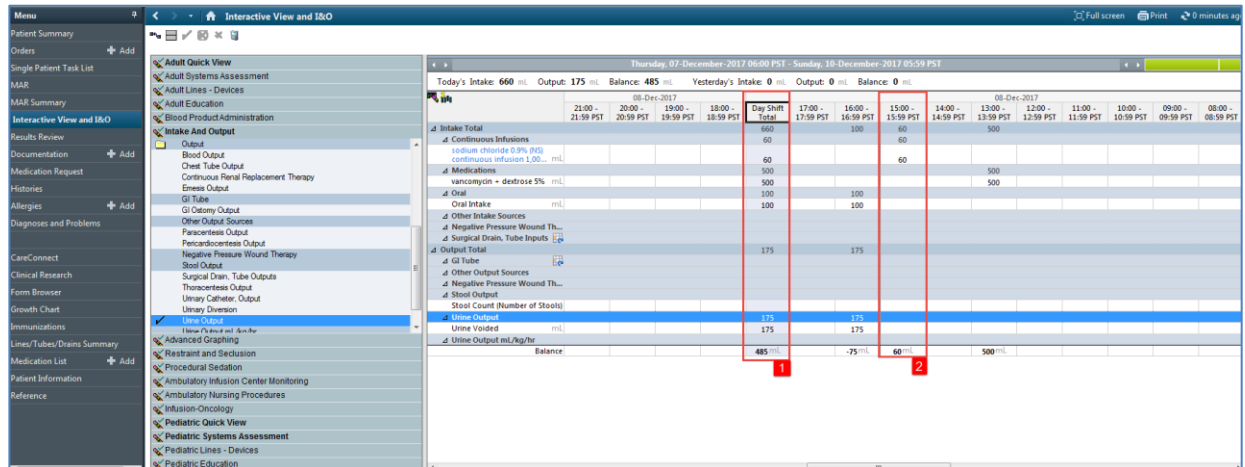
1 (Urine Voided cell in the flowsheet)

2 (Green checkmark icon in the flowsheet)

		Tuesday, 21 November 2017 06:00 PST		Friday, 24 November 2017 05:59 PST			
		11:00 - 11:59 PST	12:00 - 01:59 PST	02:00 - 03:59 PST	04:00 - 05:59 PST	06:00 - 07:59 PST	08:00 - 09:59 PST
Intake							
Intake Total		375	525	103	103	102	102
Continuous Infusions		28	28	103	103	102	102
Heparin additive 25000 unit + dextrose 5% premix 500 mL		28	28	28	28	27	27
Sodium chloride 0.9% (0.9%) continuous infusion 1,000 mL				75	75	75	75
Medications			500				
Vancomycin + dextrose 5%			500				
GI Tube		0	350				
Gastrostomy (GI) tube Left upper quadrant 12 French							
Intake			300				
Flush			50				
Surgicath							
Output							
Oral Intake			100				
Other Intake Sources							
Surgicath Drain, Tube Inputs							
Output Total			100				
GI Tube							
Gastrostomy (GI) tube Left upper quadrant 12 French							
Output							
Residual Discarded							
Other Output Sources							
Stool Output							
Stool Count (Number of Stools)							
Urine Output							
Urine Voided			175				
Urine Output and Residual			175				
Balance		375	525	103	103	102	102

A separate column exists for the balance of your:

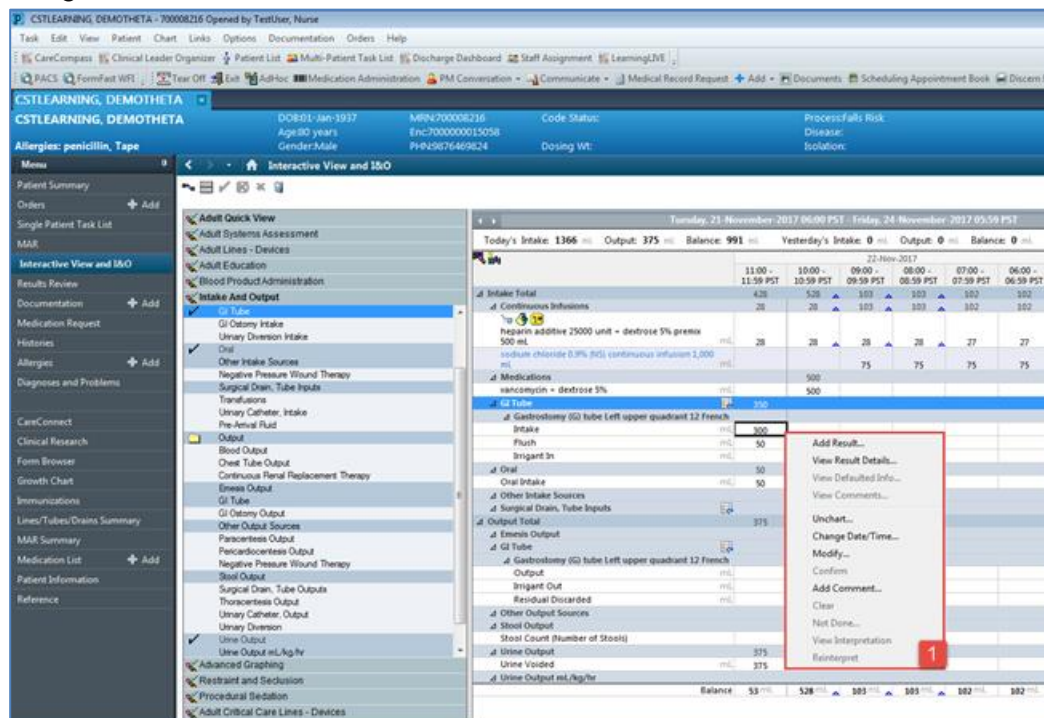
- 12 hour Day/Night Shift Total
- Hourly Total




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

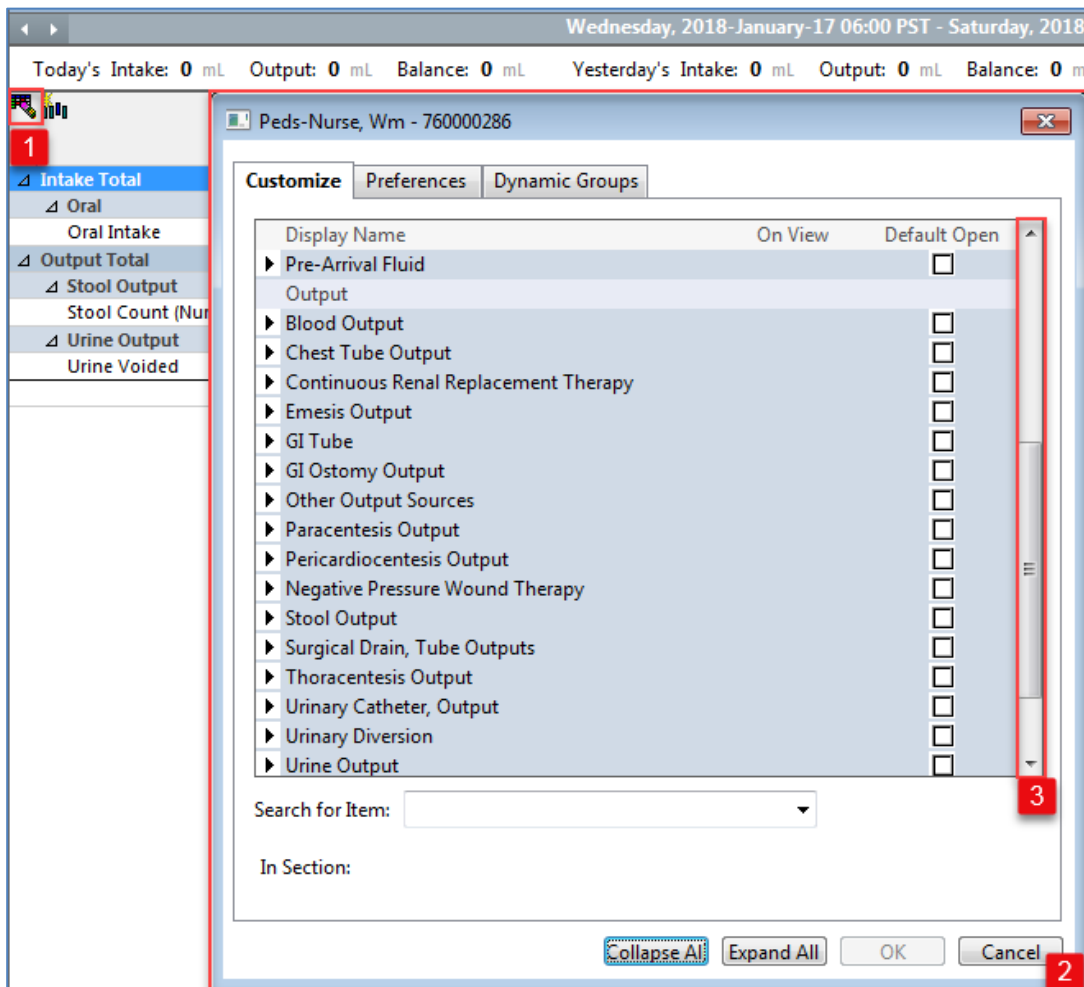
You can also unchart, modify or add a comment to any result.


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

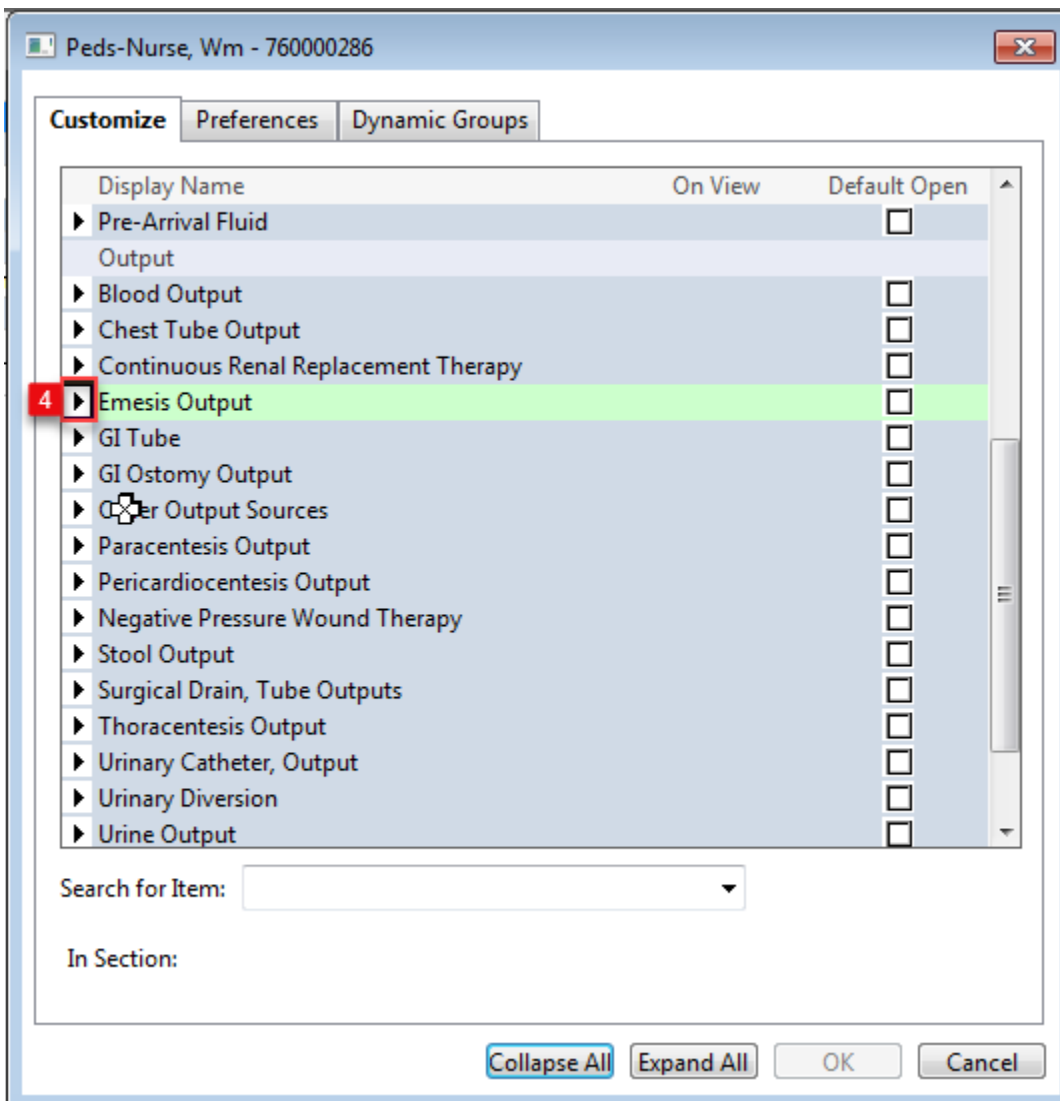


Now let's say your patient just vomited and you need to document the Emesis Amount. You need to add in this section because it is not yet active in the I&O band

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.



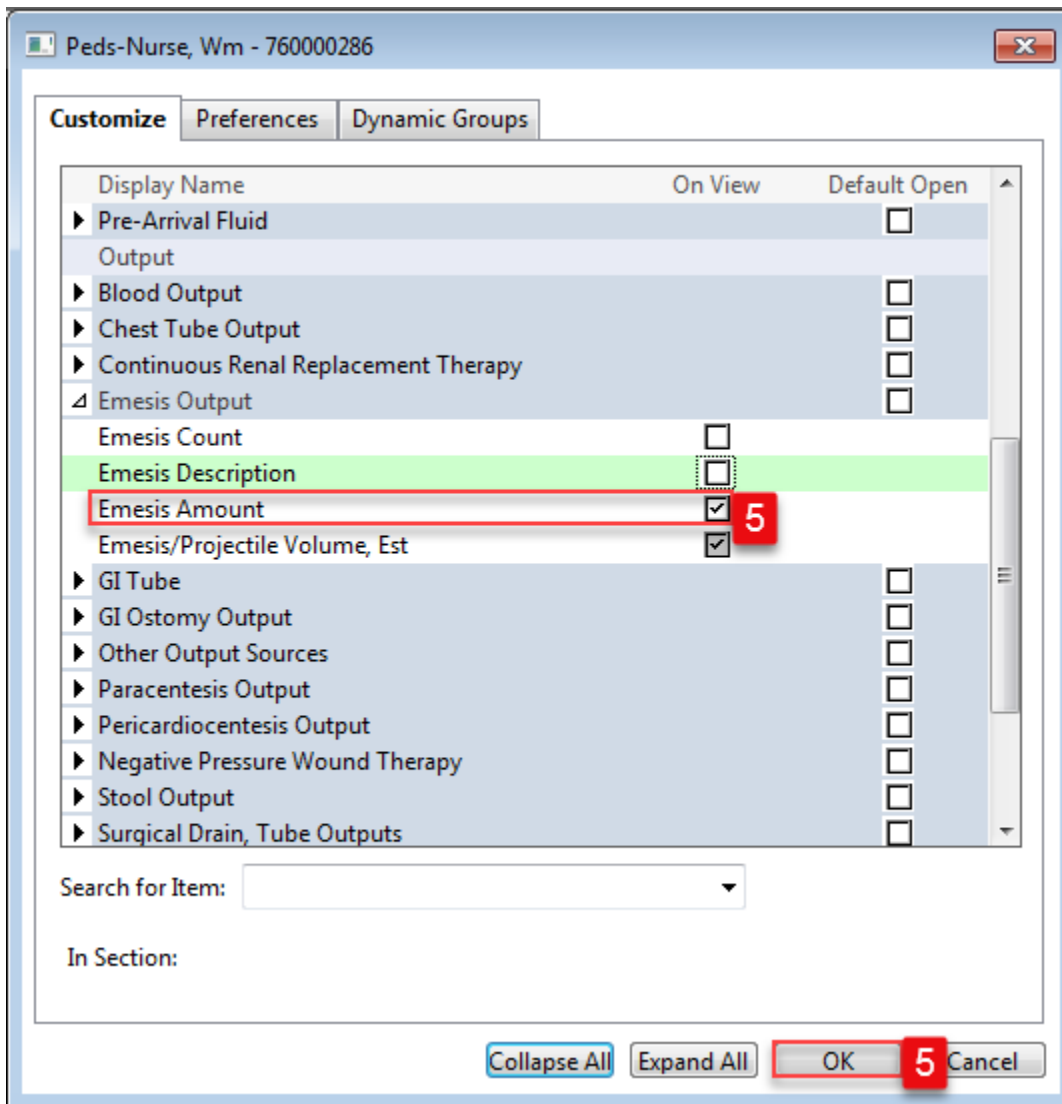
The screenshot shows a software window titled "Peds-Nurse, Wm - 760000286" with a close button in the top right. Below the title bar are three tabs: "Customize", "Preferences", and "Dynamic Groups". The "Customize" tab is active, displaying a list of medical output categories. Each category has a right-pointing arrow and a "Default Open" checkbox. The "Emesis Output" row is highlighted in green, and a red square with the number "4" is positioned over its expand arrow. Below the list is a "Search for Item:" text box and an "In Section:" label. At the bottom are four buttons: "Collapse All", "Expand All", "OK", and "Cancel".

Display Name	On View	Default Open
▶ Pre-Arrival Fluid		<input type="checkbox"/>
Output		
▶ Blood Output		<input type="checkbox"/>
▶ Chest Tube Output		<input type="checkbox"/>
▶ Continuous Renal Replacement Therapy		<input type="checkbox"/>
4 ▶ Emesis Output		<input type="checkbox"/>
▶ GI Tube		<input type="checkbox"/>
▶ GI Ostomy Output		<input type="checkbox"/>
▶ Other Output Sources		<input type="checkbox"/>
▶ Paracentesis Output		<input type="checkbox"/>
▶ Pericardiocentesis Output		<input type="checkbox"/>
▶ Negative Pressure Wound Therapy		<input type="checkbox"/>
▶ Stool Output		<input type="checkbox"/>
▶ Surgical Drain, Tube Outputs		<input type="checkbox"/>
▶ Thoracentesis Output		<input type="checkbox"/>
▶ Urinary Catheter, Output		<input type="checkbox"/>
▶ Urinary Diversion		<input type="checkbox"/>
▶ Urine Output		<input type="checkbox"/>

Search for Item:

In 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**.

In the appropriate time column, document **Emesis Amount** = *Moderate* in the cell.

	10:00 - 10:59 PST	09:00 - 09:59 PST
Intake Total		
Oral		
Oral Intake mL		
Output Total		
Emesis Output		
Emesis Amount		
Emesis/Projectile Volume, Est mL		
Stool Output		
Stool Count (Number of Stools)		
Urine Output		
Urine Voided mL		
Balance		

1. 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.
2. Enter the following volume **Emesis/Projectile Volume, Est** = 150 and press **Enter** on your keyboard.
3. Click the **green check mark** icon  to sign your documentation. You will now see this volume displayed in the patient's fluid balance!




Interactive View and I&O


3

Activity View
 Pediatric Quick View
 Pediatric Systems Assessment
 Pediatric Lines - Devices
 Pediatric Education
 Blood Product Administration
Intake And Output
 Intake
 Continuous Infusions
 Medications
 Chest Tubes
 Enteral
 GI Tube
 GI Ostomy Intake
 Urinary Diversion Intake
 Oral
 Other Intake Sources

Today's Intake: 0 mL Output: 0 mL Balance: 0 mL

	10:00 - 10:59 PST	
Intake Total		
Oral		
Oral Intake mL		
Output Total		
Emesis Output		
Emesis Amount		
Emesis/Projectile Volume, Est mL	150	2
Stool Output		
Stool Count (Number of Stools)		
Urine Output		
Urine Voided mL		
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 - Pediatric Early Warning System (PEWS)

Learning Objectives




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

-  Understand the purpose of using the Pediatric Early Warning System
-  Document on PEWS
-  Manage a PEWS alert

SCENARIO

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

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


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

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


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

PEWS is scored based on Cardiovascular, Respiratory, Behaviour, and Situational Awareness Factors, as well as use of bronchodilators and persistent vomiting. A score is then totaled based on the values documented. If the score is out of normal or expected range, an electronic alert will be triggered to warn providers and nurses that the patient may be deteriorating and require timely attention.

- 2 You will navigate to and review PEWS documentation.

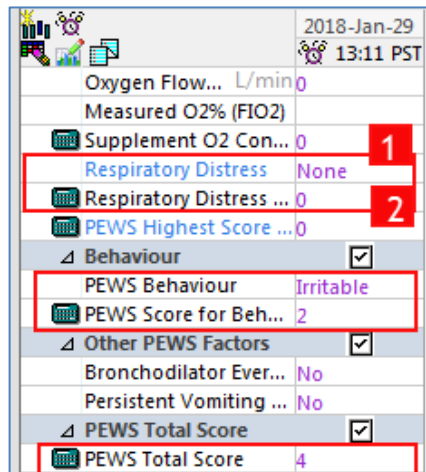
1. Select **Interactive View and I&O** from the menu
2. Click on the **Pediatric Quick View** band
3. Document the following vital signs in the **VITAL SIGNS** section
 - **Temperature Axillary** = 36.8
 - **Apical Pulse Rate** = 120
 - **SBP/DBP Cuff** = 108/66
 - **Mean Arterial Pressure, Cuff** (double click for automated result): 80
 - **Respiratory Rate** = 20
 - **SpO2** = 99
 - **SpO2 Site** = *Foot*
4. Select the **Pediatric Early Warning System** section.
5. Double-click the blue band for **Pediatric Early Warning System**. A check mark  will display, indicating the whole section is activated and the PEWS scores will be automatically calculate.



Important: In the PEWS section, notice that there are calculator icons  for certain fields. This indicates that the field will auto-populate with a calculated result once documentation is typed in the box above it. In order for the PEWS system to generate a **PEWS Total Score** and trigger alerts when appropriate, *each field with a calculator must have a score*. PEWS alerts will not be triggered without a completed PEWS Total Score which could delay timely interventions.


Example:

1. Enter Respiratory Distress documentation= None (documented by nurse)
2. Respiratory Distress Calculated Score= 0 (auto-populated by system based on documentation)



2018-Jan-29 13:11 PST	
Oxygen Flow... L/min	0
Measured O2% (FIO2)	
Supplement O2 Con...	0
Respiratory Distress	None
Respiratory Distress ...	0
PEWS Highest Score ...	0
Behaviour	<input checked="" type="checkbox"/>
PEWS Behaviour	Irritable
PEWS Score for Beh...	2
Other PEWS Factors	<input checked="" type="checkbox"/>
Bronchodilator Ever...	No
Persistent Vomiting ...	No
PEWS Total Score	<input checked="" type="checkbox"/>
PEWS Total Score	4

Note: the vital signs documentation from above has flowed to the PEWS section.

6. Document additional information using the following data:
 - **Cap Refill Time** = 1-2 Seconds
 - **Skin Colour** = Pink
 - **Oxygen Flow Rate** = 0
 - **Respiratory Distress** = None
 - **PEWS Behaviour** = Irritable
 - **Bronchodilator Every 15 Minutes** = No
 - **Persistent Vomiting Following Surgery** = No
 - **PEWS Total Score: 4** (auto populated)
 - **PEWS Score 2 or Higher** = Yes
7. Document on the Situational Awareness Factors.
 - a. For the purpose of this practice scenario, select **No** for all cells in this section.
8. Click the **green check mark** icon  to sign your documentation. The purple text changes to black and is now saved in the chart.

Your patient's clinical findings will trigger the PEWS alert in the CIS and you will document your findings in iView.

PATIENT SCENARIO 13 - Pediatric Early Warning System (PEWS)

Menu

Patient Summary

Orders + Add

Single Patient Task List

MAR

MAR Summary

Interactive View and I&O 1

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

Adult Quick View

Adult Systems Assessment

Adult Lines - Devices

Adult Education

Blood Product Administration

Intake And Output

Advanced Graphing

Restraint and Seclusion

Procedural Sedation

Ambulatory Infusion Center Monitoring

Ambulatory Nursing Procedures

Infusion-Oncology

Pediatric Quick View 2

Pediatric Early Warning System 3

VITAL SIGNS 4

Apnea/Bradycardia Episodes

PAIN ASSESSMENT

Measurements

Urine Output

Stool Output

Environmental Safety Management

Parental Involvement

Individual Observation Record

Activities of Daily Living

Provider Notification

Transfer/Transport

Shift Report/Handoff

Comfort Measures

Sedation Scales

Pediatric Systems Assessment

Pediatric Lines - Devices

Pediatric Education

Interactive View and I&O

Find Item

Critical High Low Abnormal Unauth Flag

Result Comments Flag Date Performed By

15:31 PST 14:04 PST 10:30 PST 15:52 PST

Pediatric Early Warning System 5

Cardiovascular

Apical Heart Rate bpm 20

Peripheral Pulse Rate bpm 89

Heart Rate Monitored bpm

Heart Rate Score

Capillary Refill Time ~2 seconds

Capillary Refill Time Score

Skin Colour pink

Skin Colour Score

PEWS Highest Score for Cardiovascu...

Respiratory

Respiratory Rate br/min 20 18

Respiratory Rate Score

Oxygen Flow Rate L/min 3

Measured O2% (FIO2)

Supplement O2 Concentration Score

Respiratory Distress

Respiratory Distress Score

PEWS Highest Score for Respiratory

Behaviour

PEWS Behaviour

PEWS Score for Behaviour

Other PEWS Factors

Bronchodilator Every 15 Minutes

Persistent Vomiting Follow Surgery

PEWS Total Score

PEWS Total Score 4

PEWS Total Score

Situational Awareness Factors

Interactive View and I&O

Find Item

Critical High Low Abnormal Unauth Flag

Result Comments Flag Date Performed By

15:31 PST 14:04 PST 10:30 PST 15:52 PST

Adult Quick View 8

Adult Systems Assessment

Adult Lines - Devices

Adult Education

Blood Product Administration

Intake And Output

Advanced Graphing

Restraint and Seclusion

Procedural Sedation

Ambulatory Infusion Center Monitoring

Ambulatory Nursing Procedures

Infusion-Oncology

Pediatric Quick View

VITAL SIGNS

Pediatric Early Warning System

Apnea/Bradycardia Episodes

PAIN ASSESSMENT

Measurements

Urine Output

Stool Output

Environmental Safety Management

Parental Involvement

Individual Observation Record

Activities of Daily Living

Provider Notification

Transfer/Transport

Shift Report/Handoff

Comfort Measures

Sedation Scales

Pediatric Systems Assessment

Pediatric Lines - Devices

Pediatric Education

Capillary Refill Time Score

Skin Colour

Skin Colour Score

PEWS Highest Score for Cardiovascu...

Respiratory

Respiratory Rate br/min 20 18

Respiratory Rate Score

Oxygen Flow Rate L/min 3

Measured O2% (FIO2)

Supplement O2 Concentration Score

Respiratory Distress

Respiratory Distress Score

PEWS Highest Score for Respiratory

Behaviour

PEWS Behaviour

PEWS Score for Behaviour

Other PEWS Factors

Bronchodilator Every 15 Minutes

Persistent Vomiting Follow Surgery

PEWS Total Score

PEWS Total Score 4

PEWS Total Score

Situational Awareness Factors

Patient/Family/Caregiver Concern

Unusual Therapy

Watcher Patient

Communication Breakdown

PEWS Score 2 or Higher

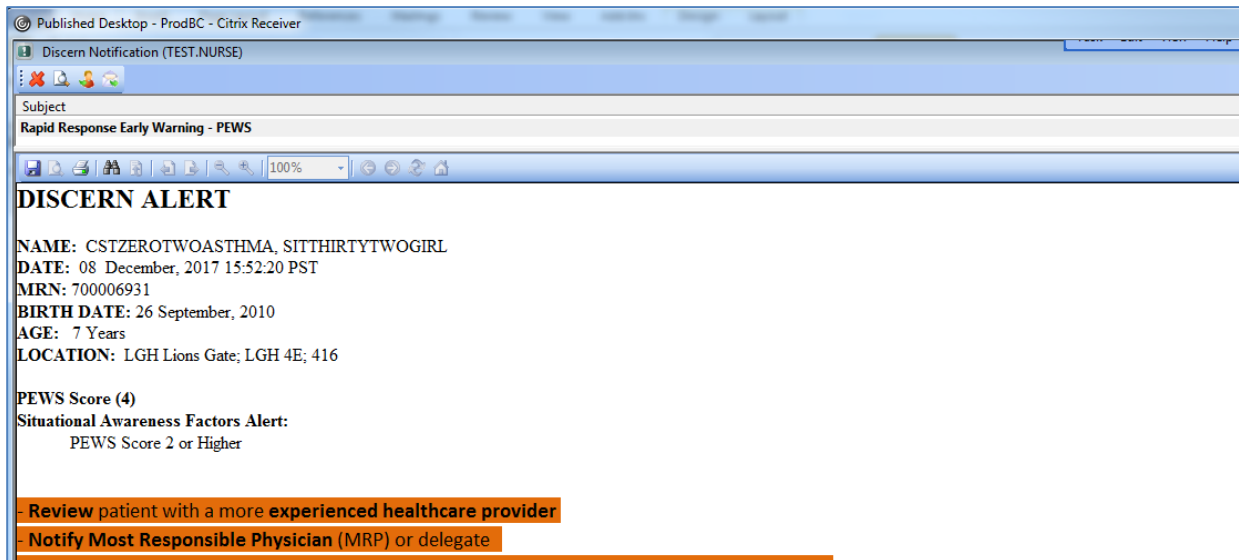
PEWS Action Taken

PEWS Action Taken

7

Note: The patient is tachycardic and is displaying irritable behaviour indicating that they may be getting sicker; they need timely attention from the health care team. The calculated PEWS Total Score is 4, which will automatically trigger a PEWS alert in the system.

9. A Discern Notification window will appear. This is the PEWS alert.



Key Learning Points

- PEWS stands for Pediatric Early Warning System and is a scoring system that can trigger an electronic alert in the CIS.
- The PEWS score is based on Cardiovascular, Respiratory, Behaviour, and Situational Awareness Factors, as well as use of bronchodilators and persistent vomiting.
- If the PEWS 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 PEWS alert is suppressed in some situations, such as for palliative/comfort care patients and in the ICU.

Activity 13.2 – Review the PEWS Alert

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

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

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

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

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

DISCERN ALERT

NAME: PEWS, MATTHEW
DATE: 11 December, 2017 12:47:34 PST
MRN: 700001666
BIRTH DATE: 25 January, 2012
AGE: 5 Years
LOCATION: LGH Lions Gate, LGH ED Hold; ACWR

PEWS Score (4)

- Review patient with a more experienced healthcare provider
- Notify Most Responsible Physician (MRP) or delegate
- MRP or delegate communicates a plan of care to mitigate contributing factors of deterioration
- Increase frequency of assessments and document as per plan
- Reassess adequacy of resources available and escalate to meet deficits
- Consider internal or external transfer to higher level of care

PEWS Criteria
PEWS Highest Score for Respiratory: 2 point(s)
Respiratory Rate: 38 br/min - 1 point(s)
Respiratory Distress: Moderate - 2 point(s)
Behaviour: Irritable - 2 point(s)
Situational Awareness Factors:
PEWS Score 2 or Higher: Yes

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

You can now click the red x icon  to delete the Discern Notification for the MEWS Alert.

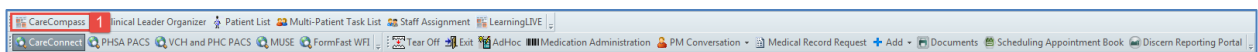
Key Learning Points

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

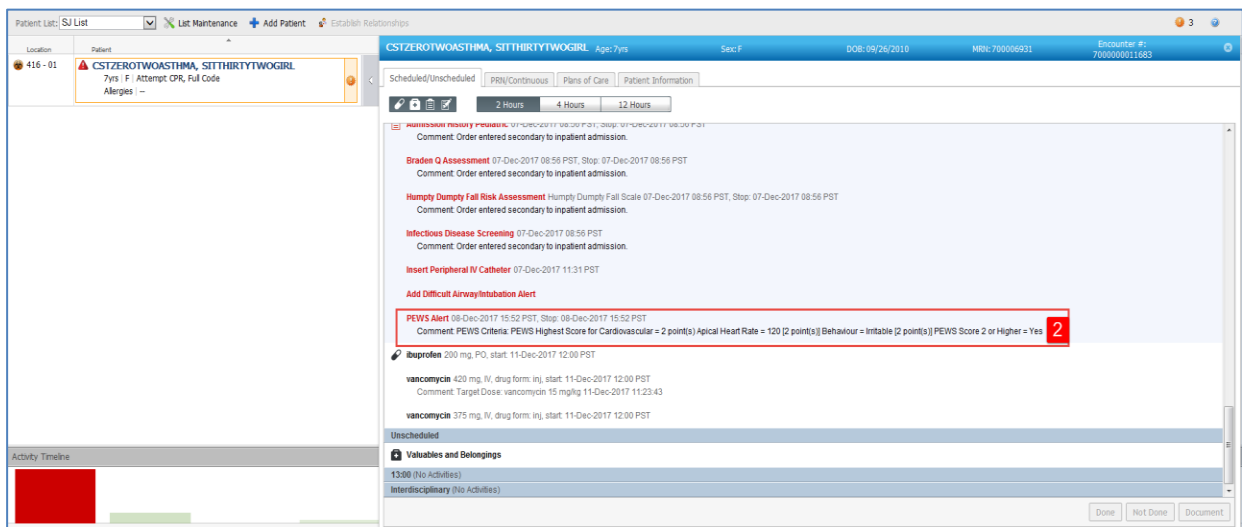
Activity 13.3 – Document Provider Notification

- 1 Once you receive a PEWS 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 PEWS alert. After you notify the provider, you need to document that you have done so.
- 2 The PEWS alert automatically creates a task that can be viewed in CareCompass. The task is called PEWS Alert.

1. Navigate to **CareCompass**  from the Toolbar.



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



The screenshot shows the CareCompass interface for a patient named CSTZEROTWOASTHMA, SITTHIRTYTWO GIRL. The patient's location is 416-01. The PEWS Alert task is highlighted with a red box and a red '2' in the bottom right corner. The task details are as follows:

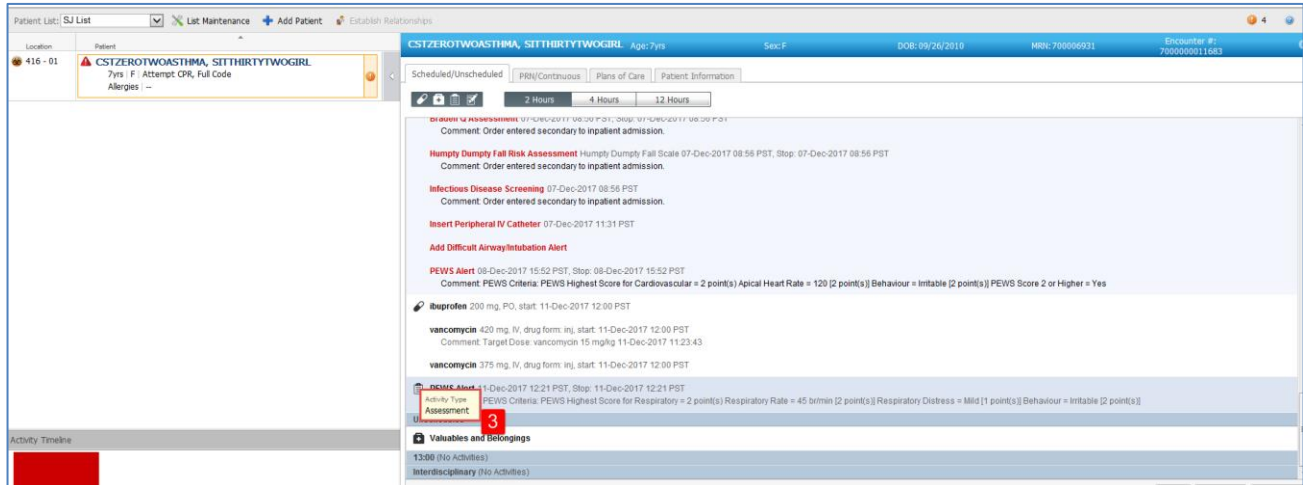
- PEWS Alert** 08-Dec-2017 15:52 PST, Stop: 08-Dec-2017 15:52 PST
- Comment: PEWS Criteria: PEWS Highest Score for Cardiovascular = 2 point(s) | Apical Heart Rate = 120 (2 point(s)) | Behaviour = Intable (2 point(s)) | PEWS Score 2 or Higher = Yes

Other tasks visible in the list include:

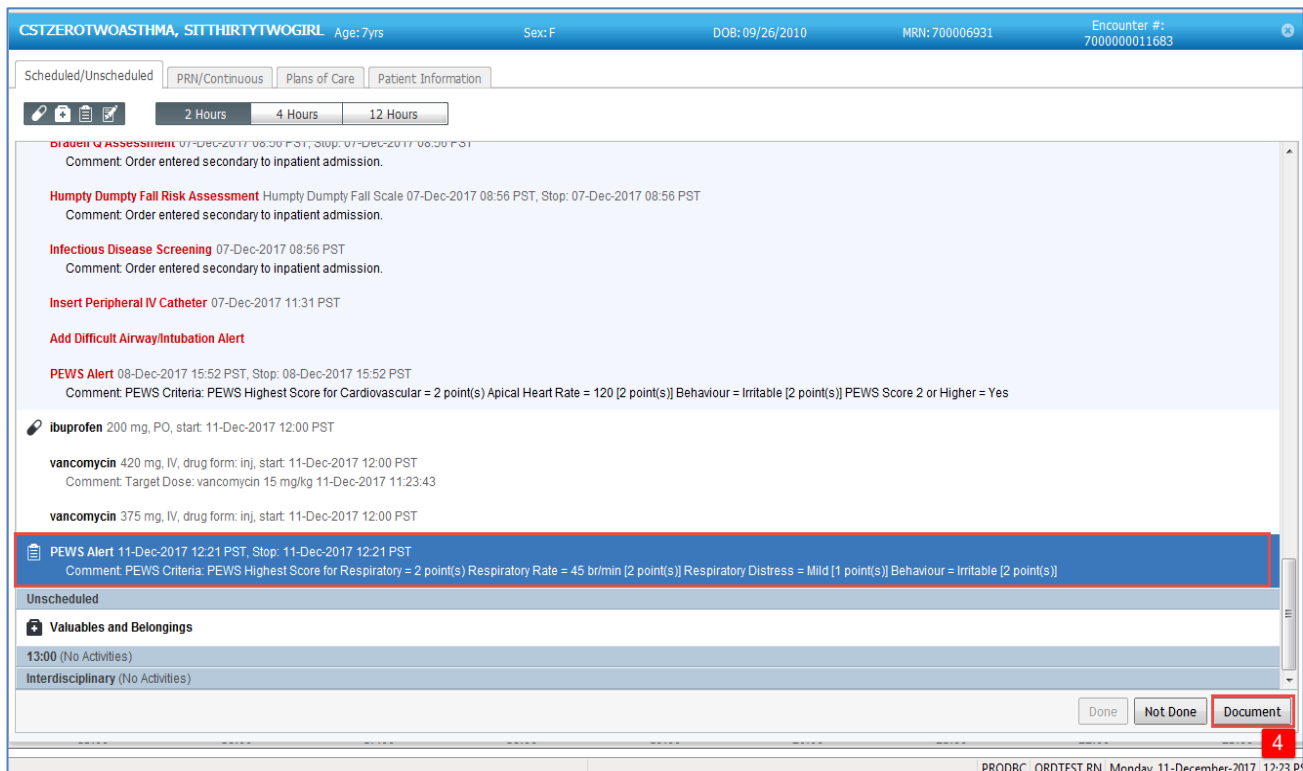
- Admission Review** 07-Dec-2017 08:00 PST, Stop: 07-Dec-2017 08:00 PST
- Braden Q Assessment** 07-Dec-2017 08:58 PST, Stop: 07-Dec-2017 08:58 PST
- Humpy Dumpty Fall Risk Assessment** 07-Dec-2017 08:58 PST, Stop: 07-Dec-2017 08:58 PST
- Infectious Disease Screening** 07-Dec-2017 08:58 PST
- Insert Peripheral IV Catheter** 07-Dec-2017 11:31 PST
- Add Difficult Airway/Intubation Alert**
- ibuprofen** 200 mg, PO, start: 11-Dec-2017 12:00 PST
- vancomycin** 420 mg, IV, drug form: inj, start: 11-Dec-2017 12:00 PST
- vancomycin** 375 mg, IV, drug form: inj, start: 11-Dec-2017 12:00 PST

The bottom section of the screen shows 'Activity Timeline' with a red bar indicating a period of activity from 12:00 to 13:00. Below this, there are sections for 'Valuables and Belongings' and 'Interdisciplinary (No Activities)'.

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

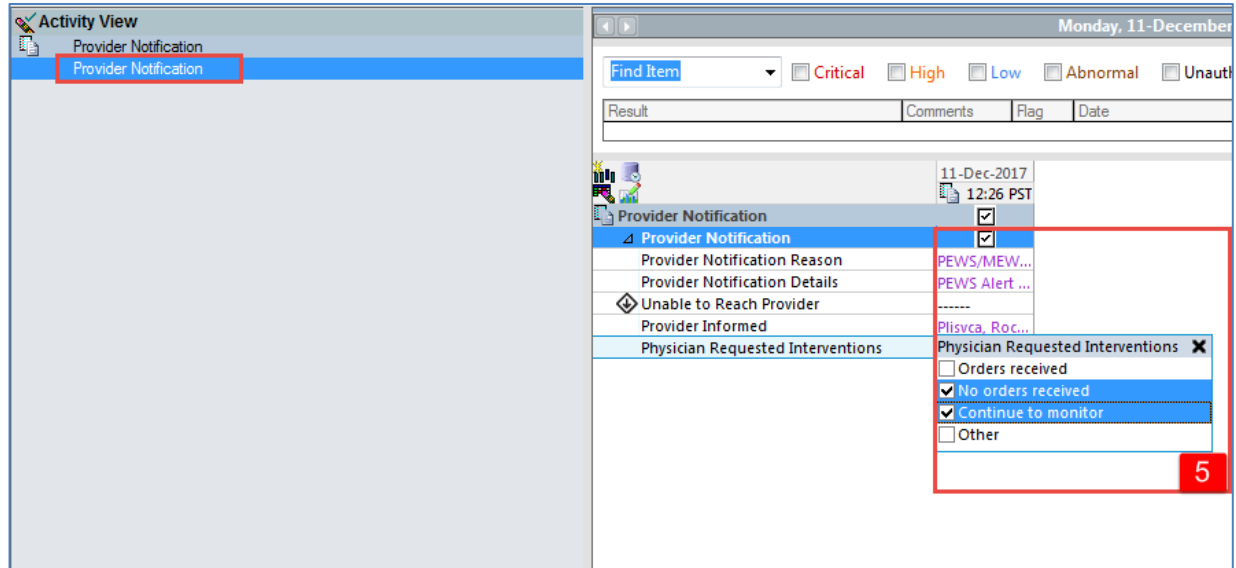


The screenshot shows the patient care interface for CSTZEROTWOASTHMA, SITHIRTYTWOGRIL. The interface includes a patient list on the left, a patient information header, and a main task area. The PEWS Alert task is highlighted with a red box and a red number 3, indicating it is the task to be hovered over for more information.

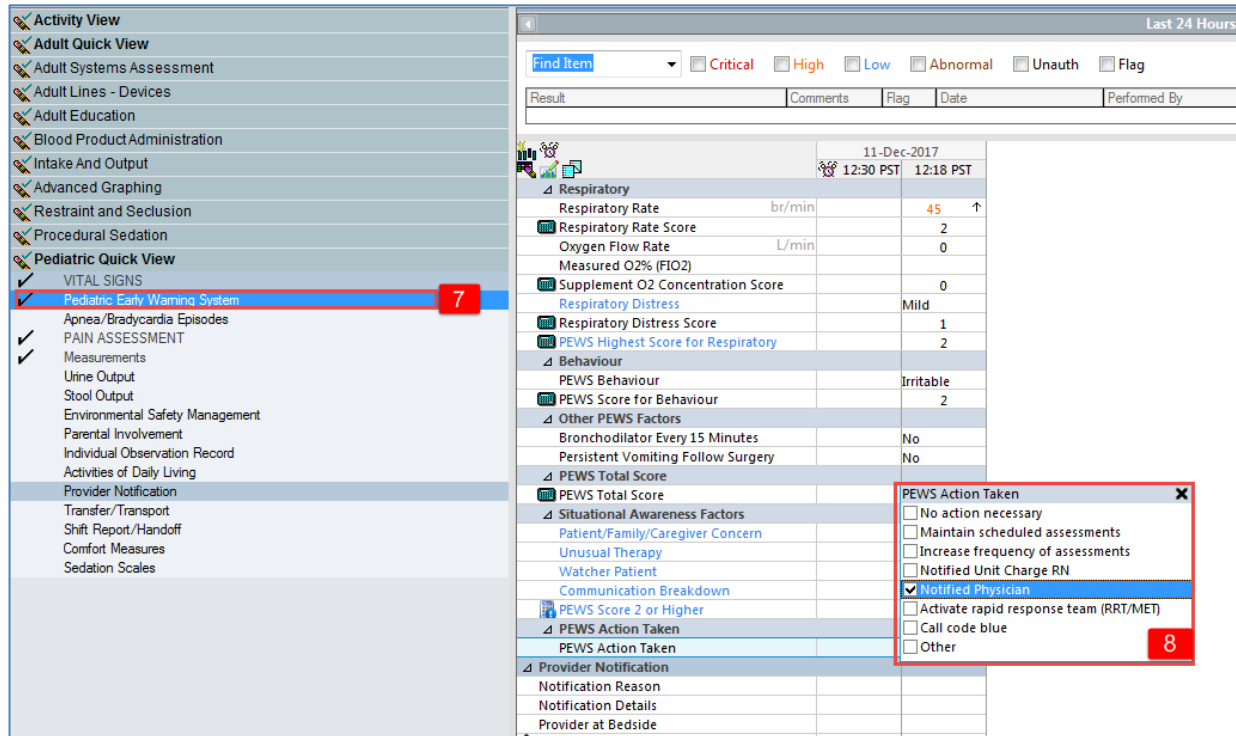
4. Click on the **PEWS Alert** task and then click **Document**. You will automatically be taken to the Provider Notification section for documentation.


The screenshot shows the patient care interface for CSTZEROTWOASTHMA, SITHIRTYTWOGRIL. The PEWS Alert task is selected, and the Document button is highlighted with a red box and a red number 4, indicating it is the button to be clicked for documentation.

5. In the Provider Notification section, document the following information:
 - **Provider Notification Reason** = *PEWS/MEWS Alert*
 - **Providers Notification Details** = *PEWS Alert score 4*
 - **Provider informed** = *enter your provider (last name, first name)*
 - **Physician Requested Interventions** = *No orders received, Continue to Monitor*



6. Click the **green check mark** icon ✓ to sign your documentation. Completing this documentation will automatically clear the PEWS Alert task from the patient's task list.
7. Click on the **Pediatric Early Warning System** section in iView
8. Complete documentation for PEWS Action Taken = *Notified Physician*. Then click the **green check mark** icon ✓ to sign.



Find Item	Critical	High	Low	Abnormal	Unauth	Flag
Result	Comments	Flag	Date	Performed By		
11-Dec-2017						
12:30 PST 12:18 PST						
Respiratory						
Respiratory Rate	br/min		45	↑		
Respiratory Rate Score			2			
Oxygen Flow Rate	L/min		0			
Measured O2% (FIO2)						
Supplement O2 Concentration Score			0			
Respiratory Distress			Mild			
Respiratory Distress Score			1			
PEWS Highest Score for Respiratory			2			
Behaviour						
PEWS Behaviour			Irritable			
PEWS Score for Behaviour			2			
Other PEWS Factors						
Bronchodilator Every 15 Minutes			No			
Persistent Vomiting Follow Surgery			No			
PEWS Total Score						
Situational Awareness Factors						
Patient/Family/Caregiver Concern						
Unusual Therapy						
Watcher Patient						
Communication Breakdown						
PEWS Score 2 or Higher						
PEWS Action Taken						
Provider Notification						
Notification Reason						
Notification Details						
Provider at Bedside						


Key Learning Points

- It is the nurse's responsibility to notify the most responsible provider of PEWS alerts where appropriate
- All provider notification can be documented in iView
- The PEWS 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 pediatric 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

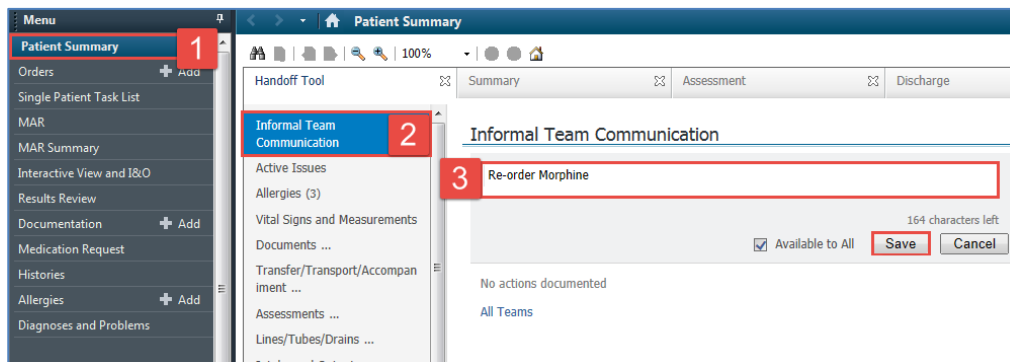
1

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.

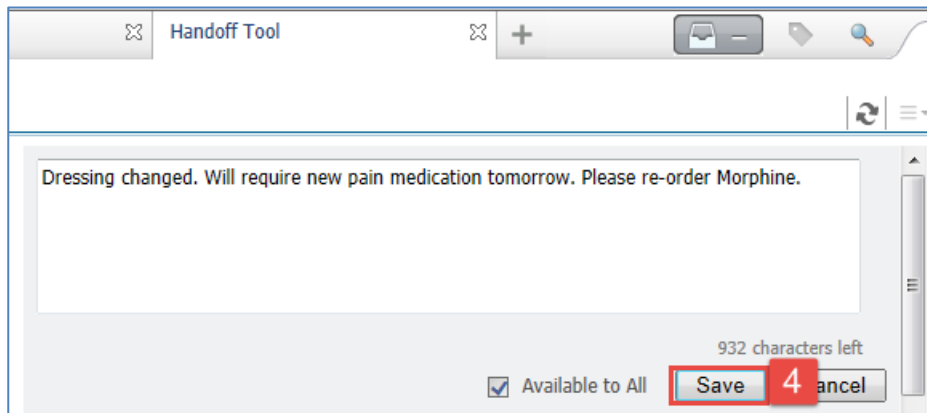
Note: Items documented within the Informal Team Communication component are **NOT** part of the patient's legal chart.

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**.



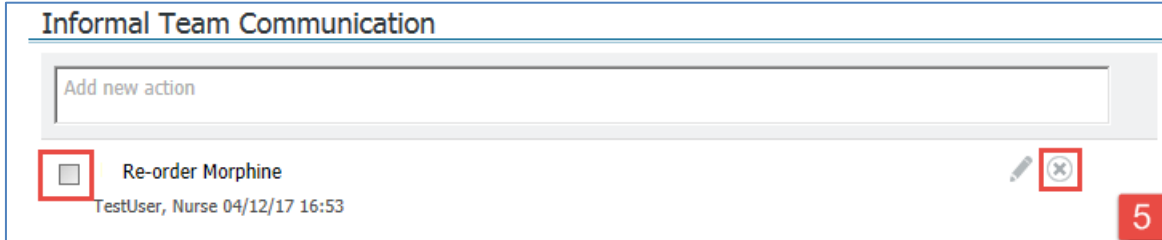
4. Under **Add new comment** type = *Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine*. Click **Save**



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

To do this:

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



The screenshot shows a section titled "Informal Team Communication". Below the title is a text input field with the placeholder "Add new action". Below the input field is a list of actions. The first action is "Re-order Morphine" by "TestUser, Nurse 04/12/17 16:53". To the left of this action is a small square box, and to the right is a small circle with an 'x' inside. A red box highlights the small square box. A red box with the number "5" is in the bottom right corner.

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

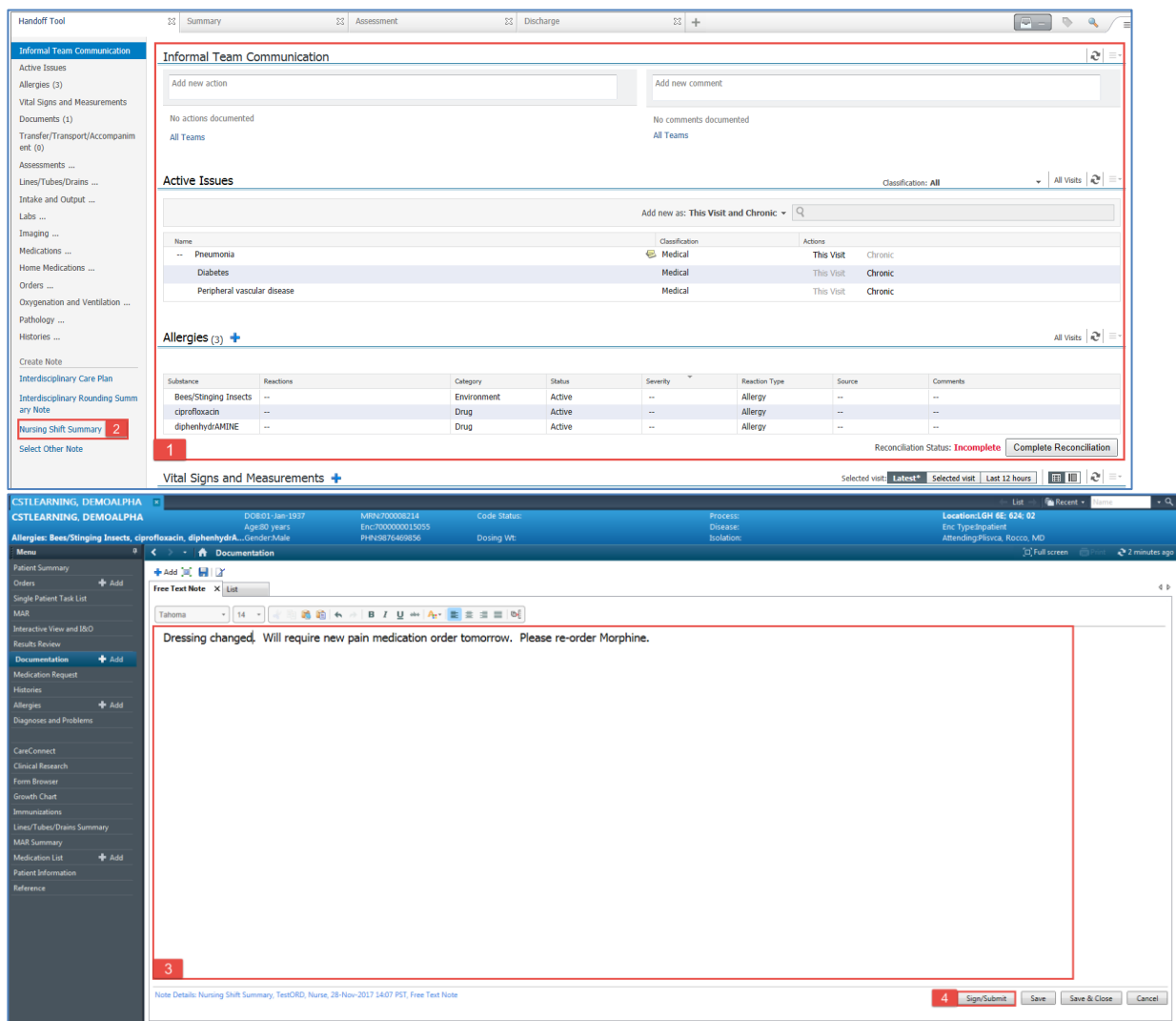
Key Learning Points

- 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
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 displays the Handoff Tool interface for a patient named DEMOALPHA. The left sidebar shows the 'Nursing Shift Summary' link highlighted in red. The main content area shows the 'Informal Team Communication' section with a table of active issues and allergies. The 'Allergies' table lists three items: Bees/Stinging Insects, ciprofloxacin, and diphenhydramine. The 'Vital Signs and Measurements' section is also visible. Below the Handoff Tool, the iView interface shows the 'Documentation' section with a 'Free Text Note' being entered. The note text is: 'Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine.' The bottom of the iView window shows the 'Sign/Submit' button highlighted in red.

Name	Classification	Action
Pneumonia	Medical	This Visit Chronic
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	--	--
diphenhydramine	--	Drug	Active	--	Allergy	--	--

Reconciliation Status: Incomplete Complete Reconciliation

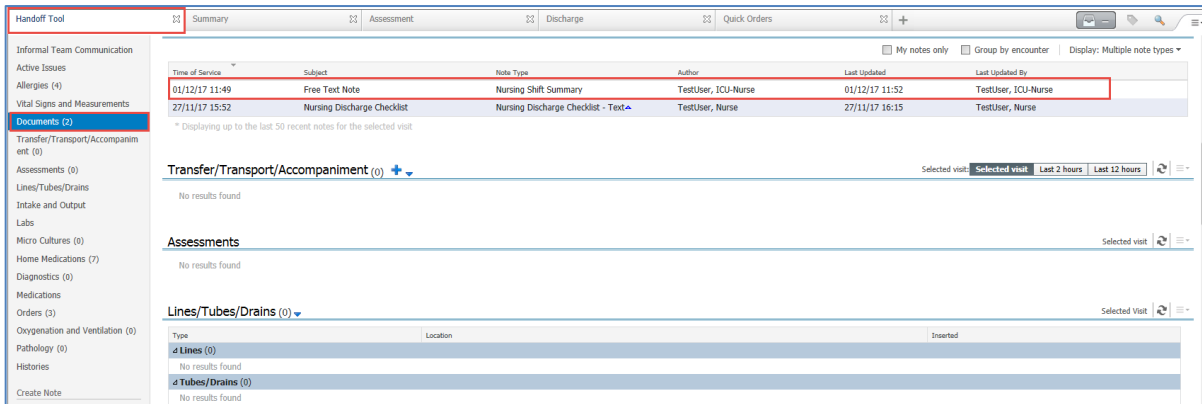
Selected visit: Latest* Selected visit: Last 12 hours

Free Text Note: Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine.

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**.



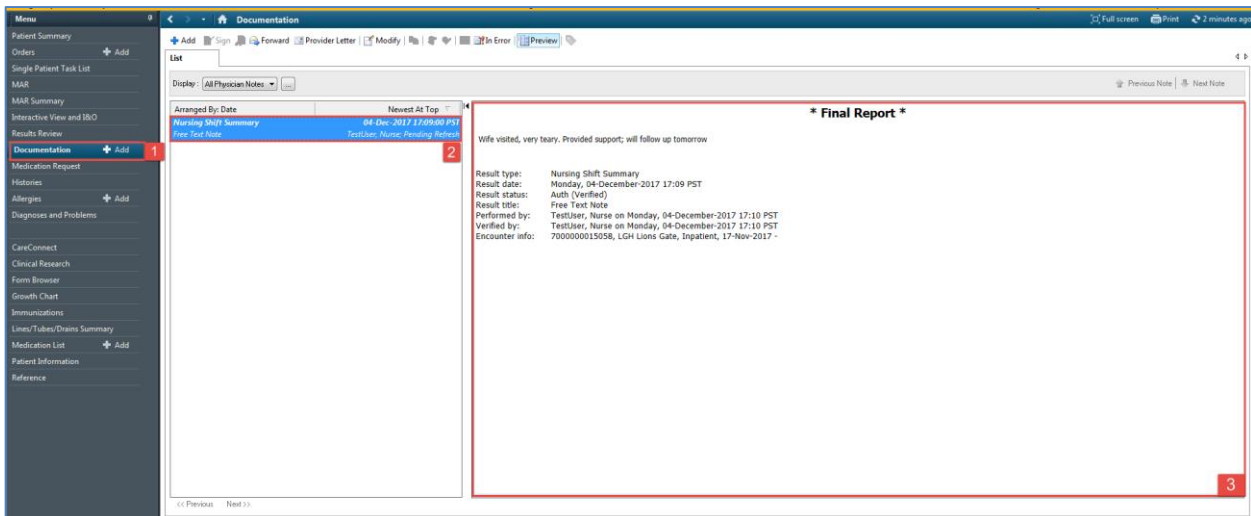
The screenshot shows the 'Handoff Tool' interface. On the left is a sidebar menu with categories like 'Informal Team Communication', 'Active Issues', 'Allergies (4)', 'Vital Signs and Measurements', 'Documents (2)', 'Transfer/Transport/Accompaniment (0)', 'Assessments (0)', 'Lines/Tubes/Drains', 'Intake and Output', 'Labs', 'Micro Cultures (8)', 'Home Medications (7)', 'Diagnostics (0)', 'Medications', 'Orders (3)', 'Oxygenation and Ventilation (0)', 'Pathology (0)', 'Histories', and 'Create Note'. The 'Documents (2)' category is selected. The main area displays a table of documents:

Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By
01/12/17 11:49	Free Text Note	Nursing Shift Summary	TestUser, ICU-Nurse	01/12/17 11:52	TestUser, ICU-Nurse
27/11/17 15:52	Nursing Discharge Checklist	Nursing Discharge Checklist - Text	TestUser, Nurse	27/11/17 16:15	TestUser, Nurse

Below the table, there are sections for 'Transfer/Transport/Accompaniment (0)', 'Assessments', and 'Lines/Tubes/Drains (0)', each showing 'No results found'.

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



The screenshot shows the 'Documentation' interface. On the left is a sidebar menu with categories like 'Patient Summary', 'Orders', 'Single Patient Task List', 'MAB', 'MAB Summary', 'Interactive View and I/O', 'Scrub Review', 'Documentation', 'Medication Request', 'Histories', 'Allergies', 'Diagnoses and Problems', 'CareConnect', 'Clinical Research', 'Form Browser', 'Growth Chart', 'Immunizations', 'Lines/Tubes/Drains Summary', 'Medication List', 'Patient Information', and 'Reference'. The 'Documentation' category is selected. The main area displays a list of documents:

Arranged By: Date	Nearest At Top
Nursing Shift Summary	04-Dec-2017 17:09:00 PST
Free Text Note	TestUser, Nurse Pending Review

Below the list, there is a section for 'Final Report' with the following details:

*** Final Report ***

Wife visited, very busy. Provided support; will follow up tomorrow

Result type: Nursing Shift Summary
 Result date: Monday, 04-December-2017 17:09 PST
 Result status: Auth (Verified)
 Result title: Free Text Note
 Performed by: TestUser, Nurse on Monday, 04-December-2017 17:10 PST
 Verified by: TestUser, Nurse on Monday, 04-December-2017 17:10 PST
 Encounter info: 70000000115058, LGH Lions Gate, Inpatient, 17-Nov-2017

Key Learning Points

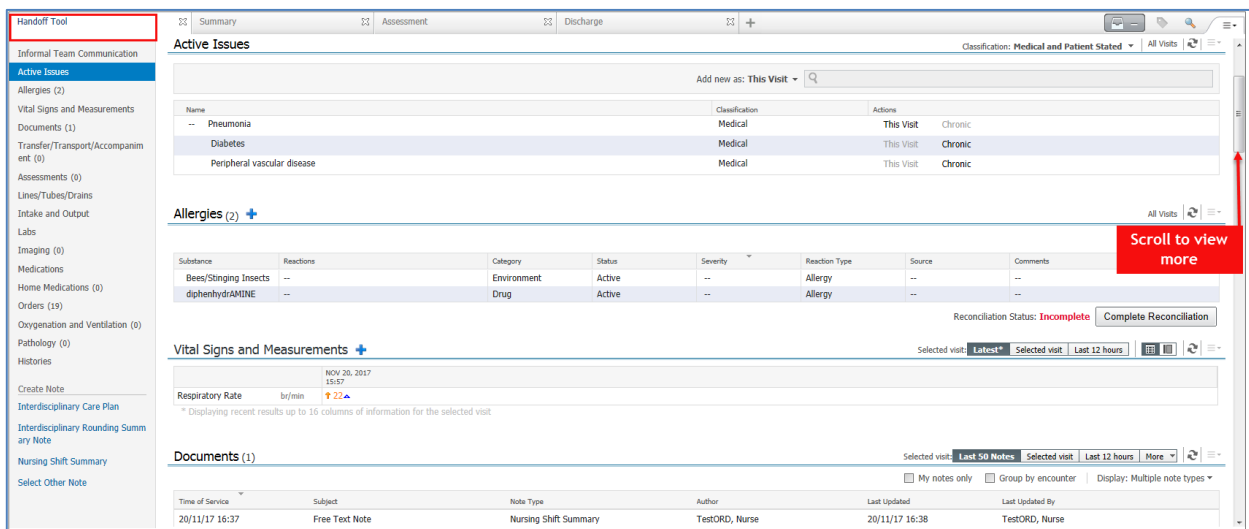
- A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses
- The note must be signed in order for it to be recorded to the patient chart and viewable by other team members
- Nurses and other team members can view signed notes from the Documentation 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 options 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 main content area is titled 'Handoff Tool' and includes tabs for 'Summary', 'Assessment', 'Discharge', and '+'. The 'Summary' tab is active, showing sections for 'Active Issues', 'Allergies (2)', 'Vital Signs and Measurements', and 'Documents (1)'. The 'Active Issues' section lists conditions like Pneumonia, Diabetes, and Peripheral vascular disease. The 'Allergies' section shows reactions to Bees/Stinging Insects and diphenhydramine. The 'Vital Signs and Measurements' section displays a respiratory rate of 22. The 'Documents' section shows a 'Nursing Shift Summary' note. A red callout box on the right says 'Scroll to view more' with an upward arrow. A reconciliation status bar at the bottom indicates 'Incomplete'.

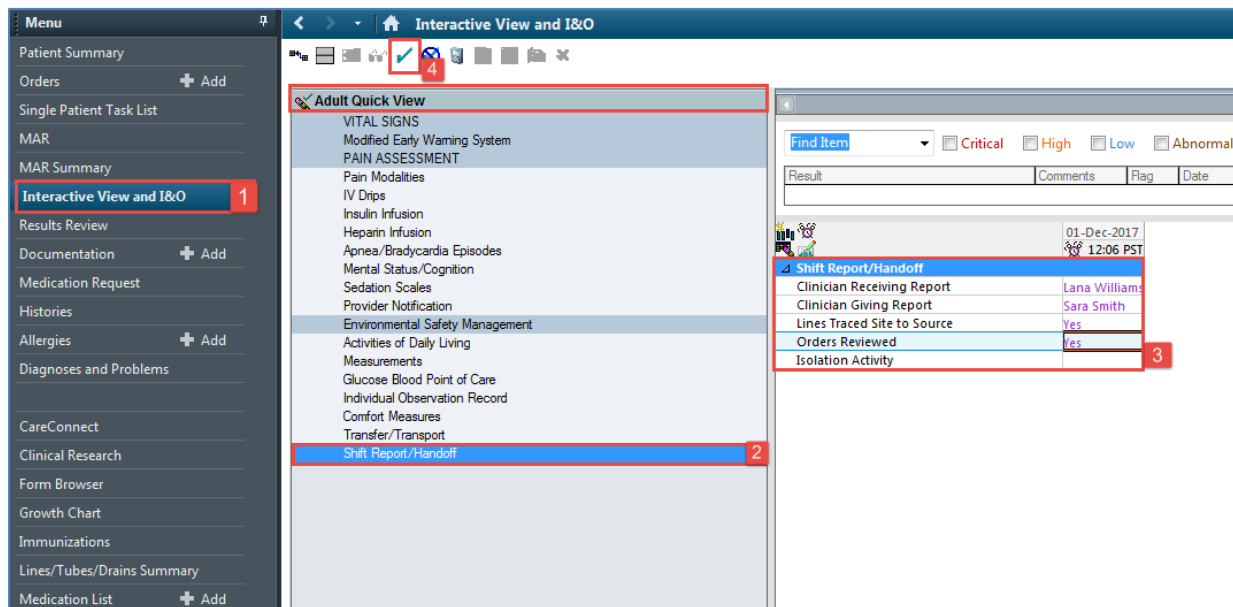
Key Learning Point

- 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. Click the **green check mark icon**  to sign your documentation.



Menu

- Patient Summary
- Orders + Add
- Single Patient Task List
- MAR
- MAR Summary
- Interactive View and I&O** 1
- 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

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
- Transfer/Transport
- Shift Report/Handoff** 2

Shift Report/Handoff

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				

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.

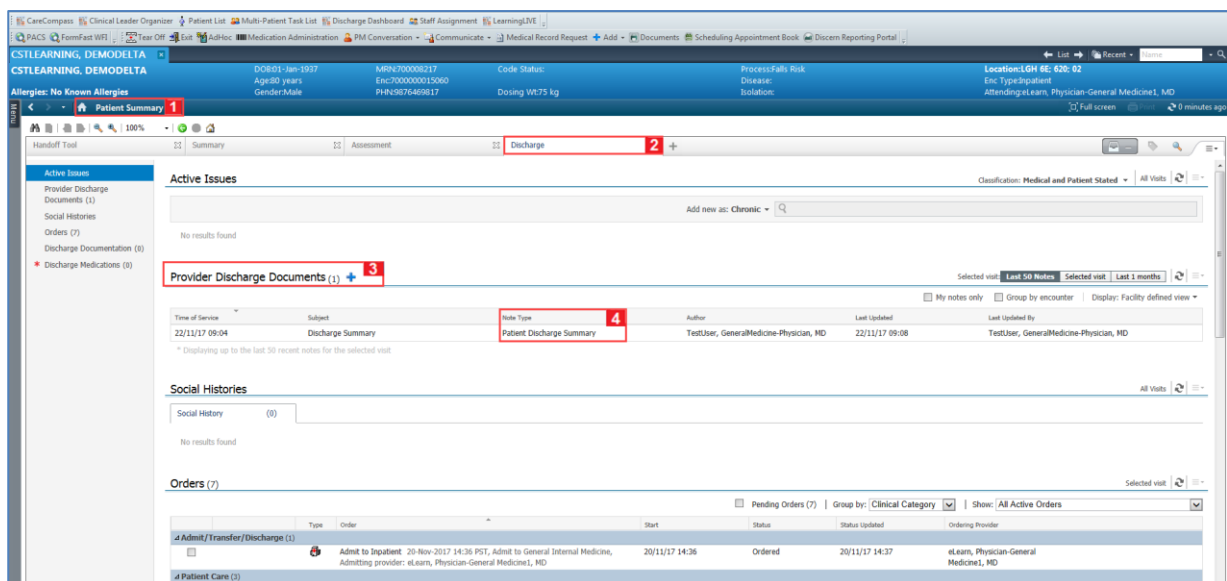
As a pediatric nurse you will be completing the following activities:

- ☐ Printing a patient a discharge summary

Activity 15.1 – Printing a Patient Discharge Summary

1 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.

- 2
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.




The screenshot displays the Patient Summary workflow page. The top navigation bar includes various system links. The main content area shows the Patient Summary section with tabs for Summary, Assessment, and Discharge. The Discharge tab is selected. Under the Discharge tab, there is a section for 'Provider Discharge Documents' which contains a table with one document: 'Patient Discharge Summary'. The document is highlighted with a red box. The table also shows the time of service, subject, note type, author, last updated, and last updated by. Below the table, there are sections for 'Social Histories' and 'Orders'.

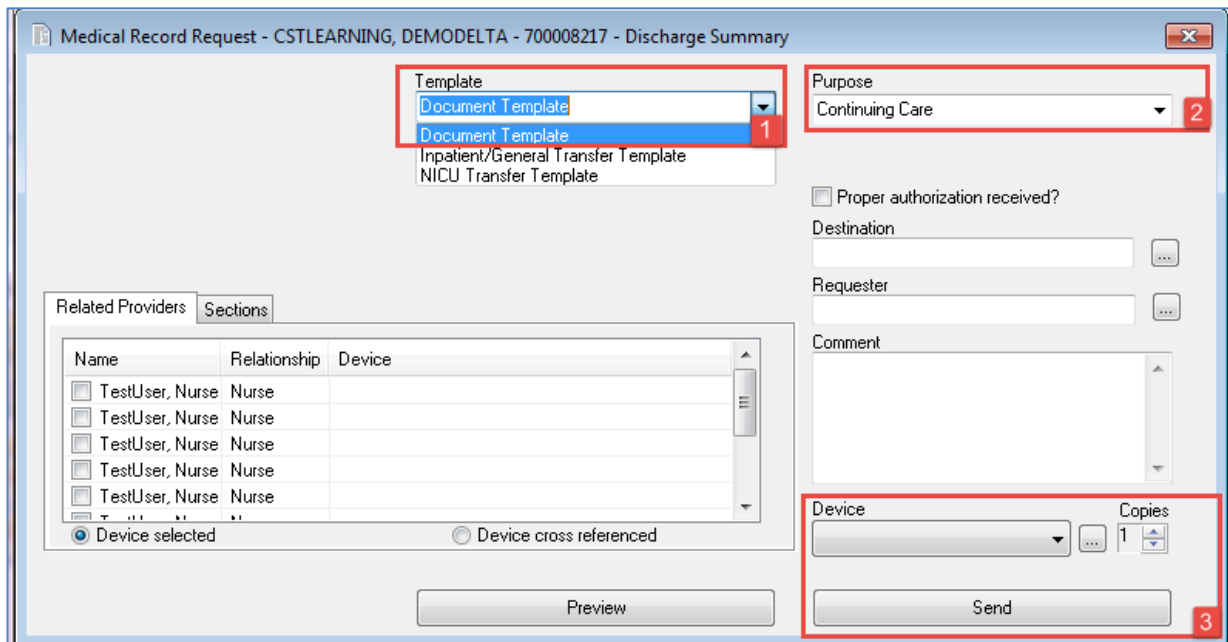
Time of Service	Subject	Note Type	Author	Last Updated	Last Updated By
22/11/17 09:04	Discharge Summary	Patient Discharge Summary	TestUser, GeneralMedicine-Physician, MD	22/11/17 09:08	TestUser, GeneralMedicine-Physician, MD

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

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
Document Template
Inpatient/General Transfer Template
NICU Transfer Template

Purpose
Continuing Care

☐ Proper authorization received?

Destination
Requester
Comment

Related Providers Sections

Name	Relationship	Device
<input type="checkbox"/> TestUser, Nurse	Nurse	
<input type="checkbox"/> TestUser, Nurse	Nurse	
<input type="checkbox"/> TestUser, Nurse	Nurse	
<input type="checkbox"/> TestUser, Nurse	Nurse	
<input type="checkbox"/> TestUser, Nurse	Nurse	

☒ Device selected ☐ Device cross referenced

Device
Copies 1

Preview 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 it 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 16.0 – Navigating Clinical Leader Organizer (CLO)


Learning Objectives

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

-  Review 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 Clinical Leader Organizer (CLO)

Activity 16.1 – Review Clinical Leader Organizer (CLO)

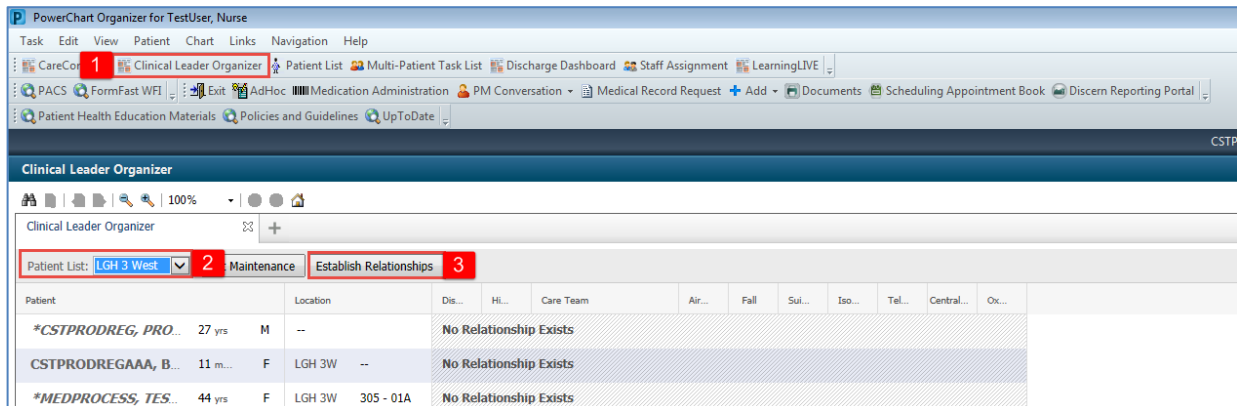
- Clinical Leader Organizer (CLO)** is an interactive organizer that supports communication and coordination across the continuum of care. It provides a high-level overview of patient data such as location, visit summary, risks and more. It is a very useful tool for understanding patient care goals and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

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

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

Let's review **Clinical Leader Organizer**

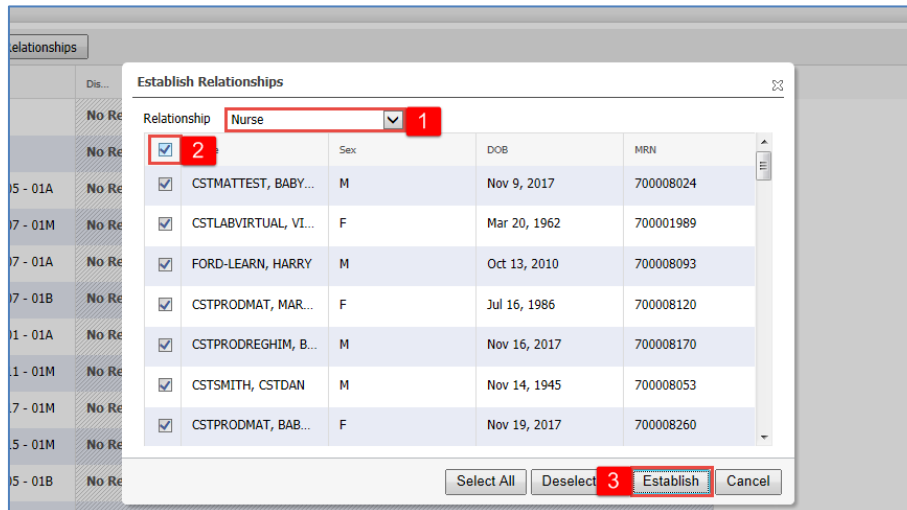
1. Select **Clinical Leader Organizer** from the toolbar
2. Confirm that the displayed **Patient List** is your unit
3. Click **Establish Relationship**




Patient	Location	Dis...	HI...	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**.

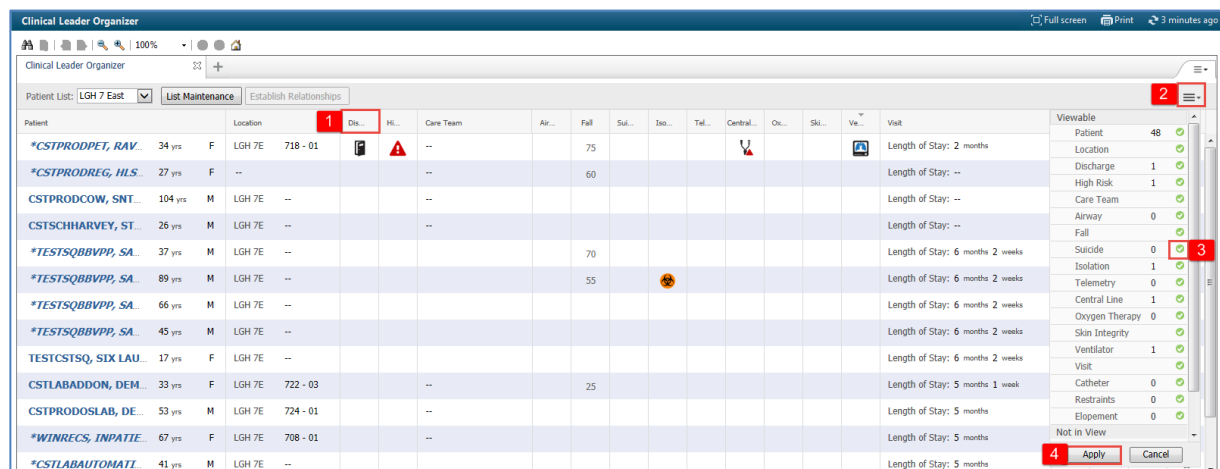
1. Select **Nurse** from the **Relationship** drop-down
2. Click top checkbox to select all patients
3. Click **Establish**



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.

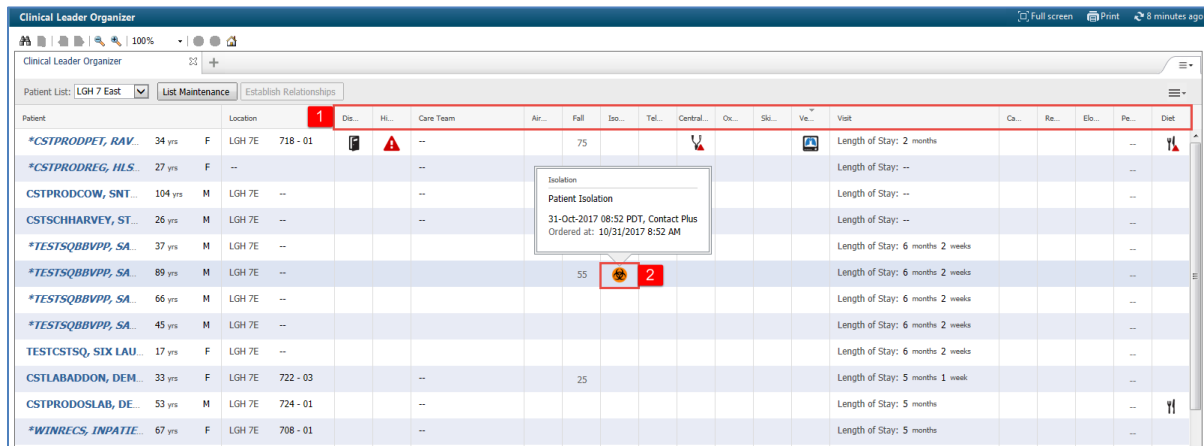
1. Hover over a column heading to see the full title of the column
2. Click the **Menu** icon 
3. Click the green check mark beside a viewable topic(s) of your choice to de-select it from the Viewable columns
4. Click **Apply**

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



4 Clicking on icons within the CLO provides additional information. The system displays a pop-up box when an icon is clicked on.

1. The topic(s) that you de-selected above 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. The patient list is displayed with columns for Patient, Location, Dis., HI., Care Team, Air, Fall, Iso., Tel., Central, Oc., Sk., Ve., Visit, Ca., Re., Eo., Pe., and Diet. A pop-up box titled "Isolation Patient Isolation" is displayed over the table, showing details for a patient named "31-Oct-2017 08:52 PDT, Contact Plus" and "Ordered at: 10/31/2017 8:52 AM".

Patient	Location	Dis.	HI.	Care Team	Air	Fall	Iso.	Tel.	Central	Oc.	Sk.	Ve.	Visit	Ca.	Re.	Eo.	Pe.	Diet
*CSTPRODPET, RAV...	34 yrs F	LGH 7E	718 - 01			75							Length of Stay: 2 months					
*CSTPRODREG, HLS...	27 yrs F	--											Length of Stay: --					
CSTPRODCOW, SNT...	104 yrs M	LGH 7E	--										Length of Stay: --					
CSTSCHARVEY, 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 17.0 – 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:

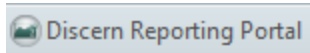
-  Run a report for your unit/organization in the CIS

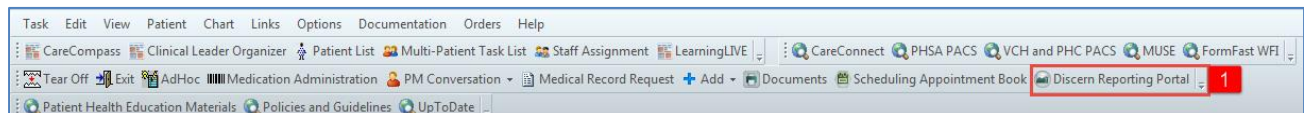
Activity 17.1 – Running Reports for your Unit/Organization

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

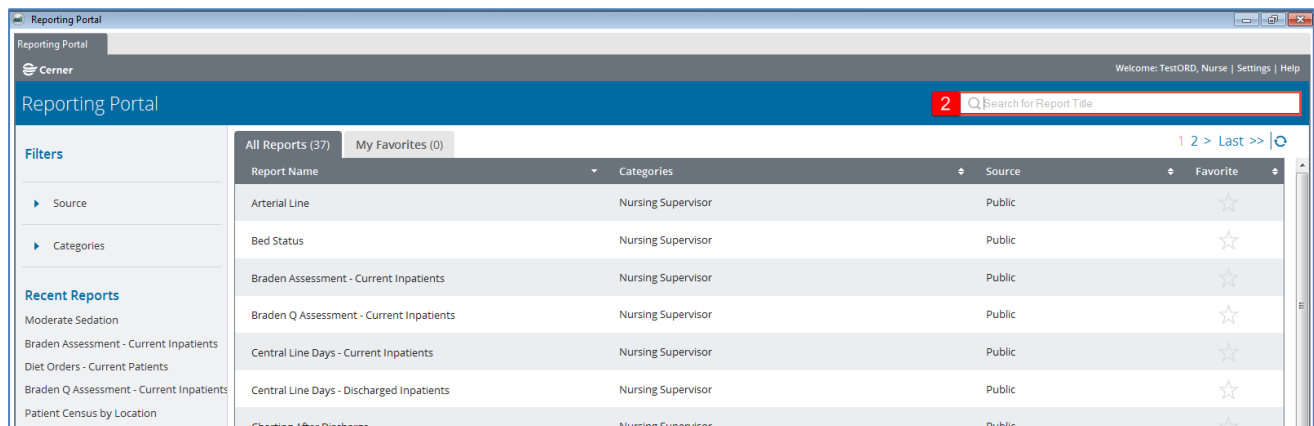
Assuming you are a charge nurse, generate a report for **Patient Census by Location**.

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

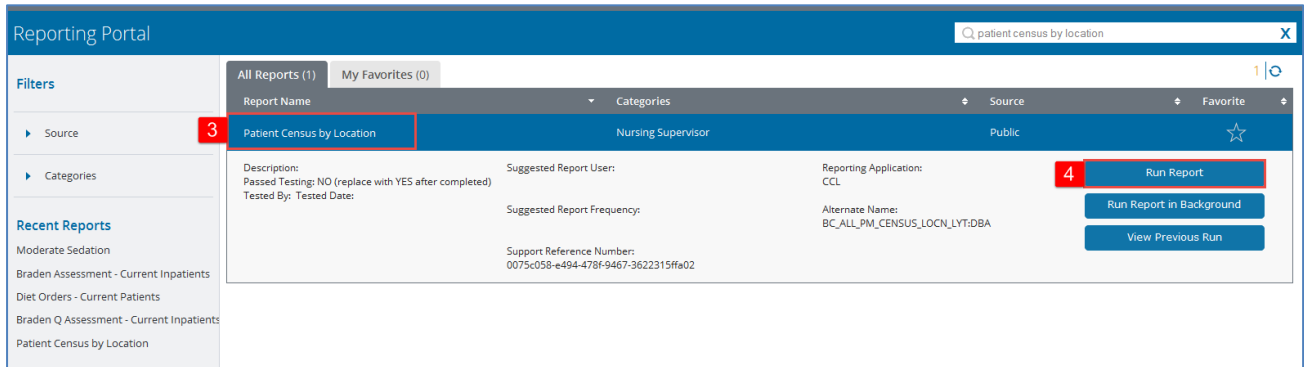


2. Locate **Patient Census by Location** by typing it into the search box

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**



Reporting Portal

Search: patient census by location

Filters

Source: Patient Census by Location (3)

Categories

Recent Reports

Moderate Sedation

Braden Assessment - Current Inpatients

Diet Orders - Current Patients

Braden Q Assessment - Current Inpatients

Patient Census by Location

All Reports (1) My Favorites (0)

Report Name	Categories	Source	Favorite
Patient Census by Location	Nursing Supervisor	Public	☆

Description: Passed Testing: NO (replace with YES after completed)
Tested By: Tested Date:

Suggested Report User:

Suggested Report Frequency:

Support Reference Number: 0075c058-e494-478f-9467-3622315ffa02

Reporting Application: CCL

Alternate Name: BC_ALL_PM_CENSUS_LOCN_LYT:DBA

Run Report (4)

Run Report in Background

View Previous Run

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 HOpe 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%

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	CSTPRODMED, JAMIE	25 Years	Female	General Internal Medicine	10-NOV-2017 10:52	20 days	Pillay, Dilon, MD		Inpatient	
204-02	700006576	CSTPRODM, 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

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