SELF-GUIDED PRACTICE WORKBOOK [N56]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: Specialist Nurse

TABLE OF CONTENTS

SELF-GUIDED PRACTICE WORKBOOK

Duration	8 hours
Before getting started	■ Sign the attendance roster (this will ensure you get paid to attend the session). ■ Put your cell phones on silent mode.
Session Expectations	■ This is a self-paced learning session. ■ A 15 min break time will be provided. You can take this break at any time during the session. ■ The workbook provides a compilation of different scenarios that are applicable to your work setting. ■ Work through different activities at your own pace
Key Learning Review	■ At the end of the session, you will be required to complete a Key Learning Review. ■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios. ■ Your instructor will assist you.

USING TRAIN DOMAIN

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

Please note:

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

PATIENT SCENARIO 1 - Patient List

Learning Objectives

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

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

SCENARIO

You arrive at work and see which patients you will be caring for today. You will use the Patient List and Multi-Patient Task List (MPTL) to identify your patients and organize your day. You begin by logging in and reviewing new and existing patient orders and tasks that need to be completed during your shift.

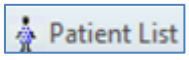
As a specialist nurse you will complete the following activities:

- Create a Location Patient List
- Create a Custom Patient List
- Move patients from the Location Patient List onto your Custom Patient List
- Add documentation iView Navigator Bands

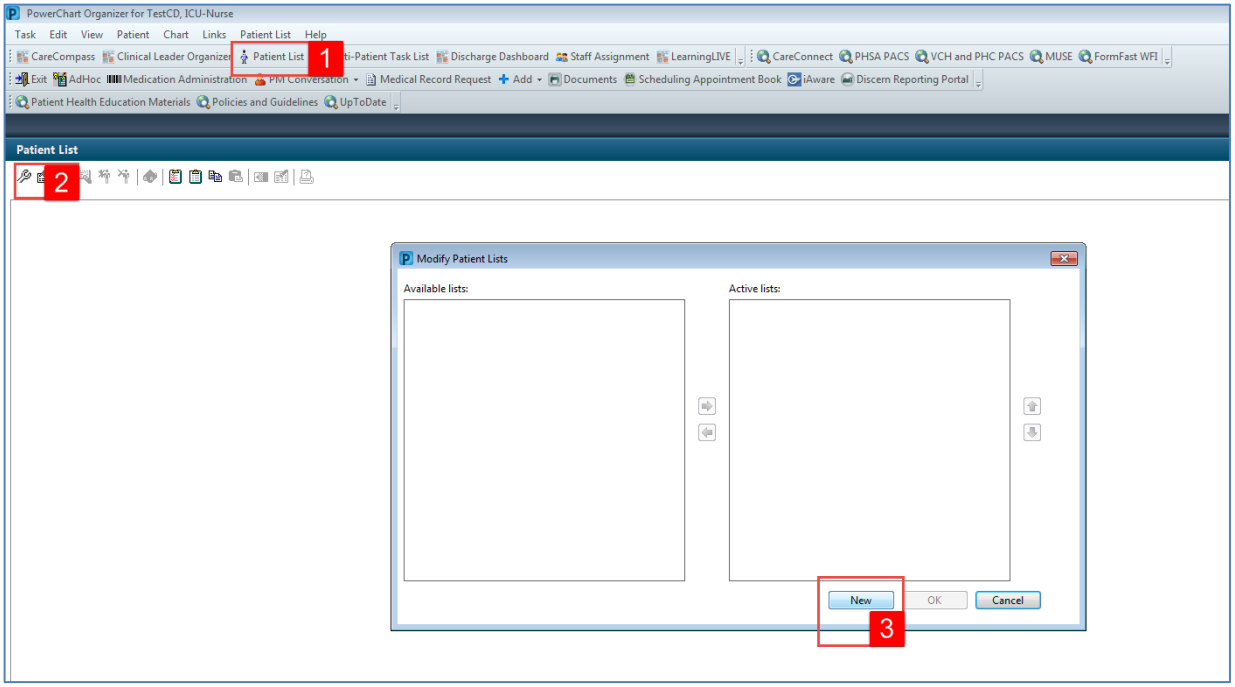
Activity 1.1 – Set up a Location Patient List

1 Upon logging into PowerChart, you will land on **Multi-Patient task List (MPTL)**. Before you can use the MPTL, you will need to set-up a patient list. The **Patient List** can be set up by location, to provide a view of all the patients that are on a specific unit/ floor you select. A custom list can also be created to capture patients you are covering.

2 At the start of your first shift (or when working in a new location), you will need to create a **Location List** that consists of all patients assigned to your unit. This is a one-time exercise.

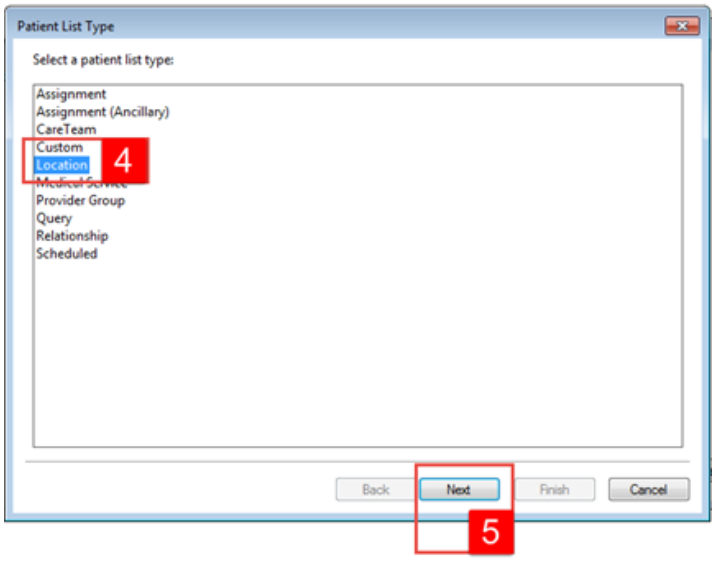
1. Select the **Patient List** icon 

from the **Toolbar** at the top of the screen.
2. 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 in the bottom right corner of the **Modify Patient Lists** window.

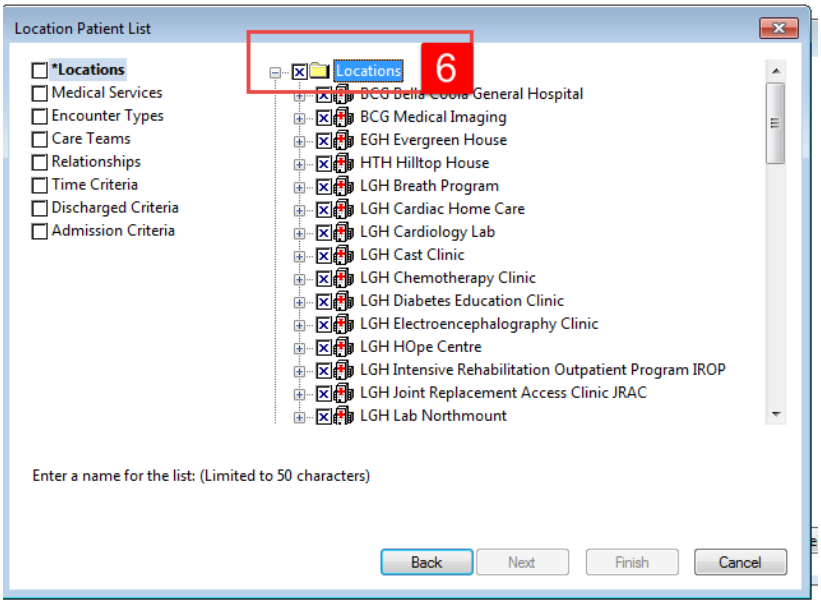


4. From the Patient List Type window select **Location**

5. Click **Next**



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

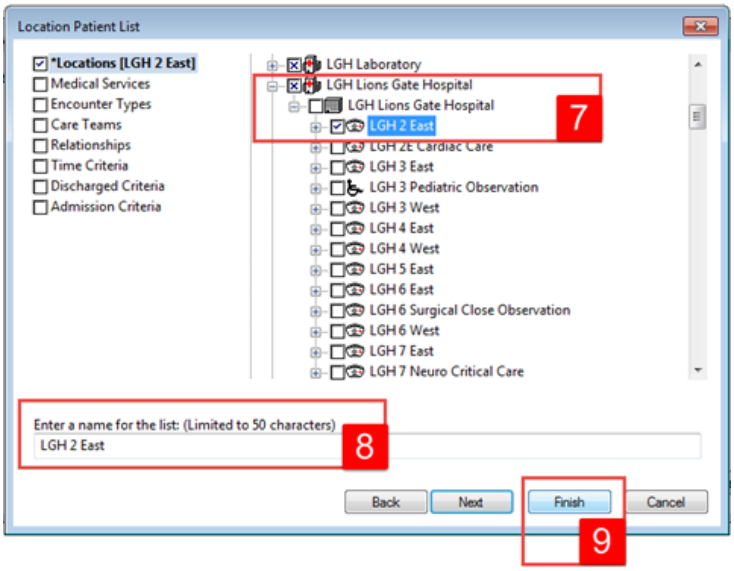


7. Scroll down until you find the location assigned to you. Expand the location and select your unit by checking the box next to it. Chose the location from today's handout.

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

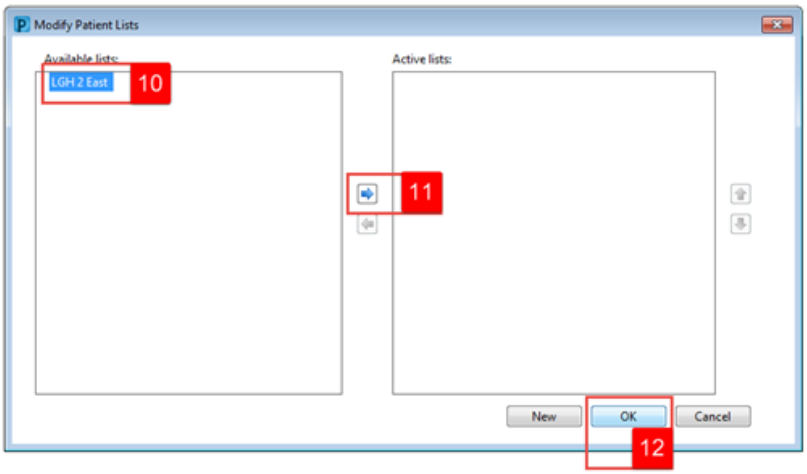
9. Click **Finish**

Note: You may cover several units. In that case, you would select all the units you cover to locate all your patients in the hospital



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 **OK** to return to **Patient Lists**. Your Location list should now appear.



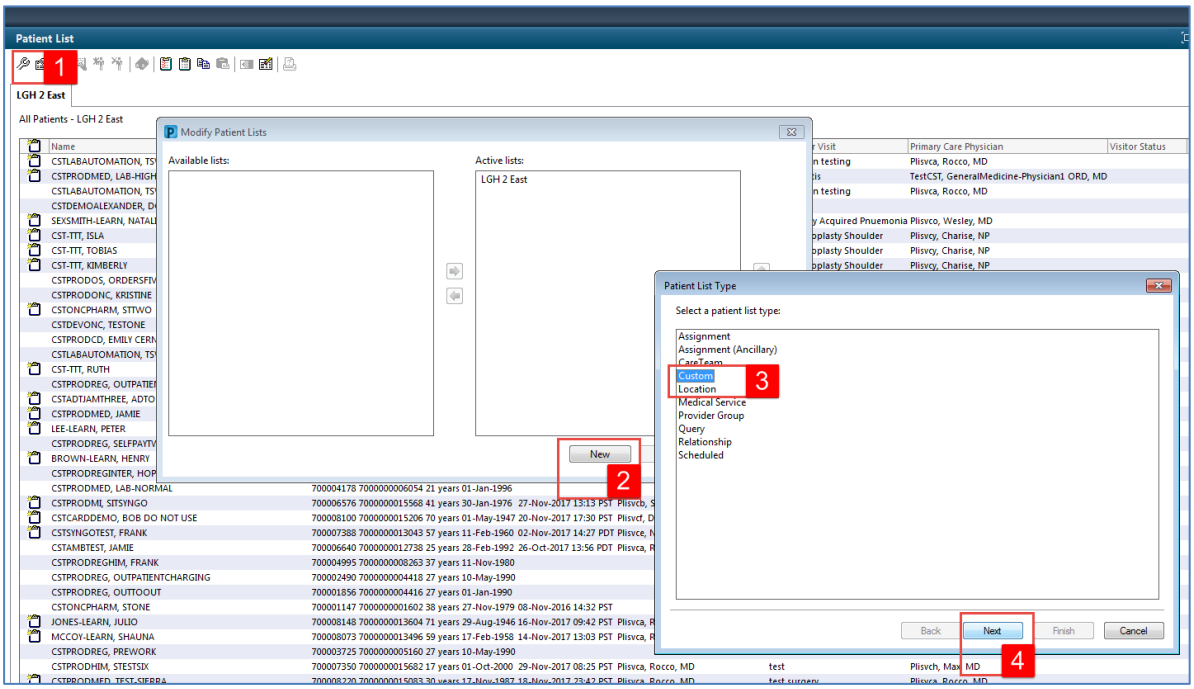
Key Learning Points

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

Activity 1.2 – Create a Custom Patient List

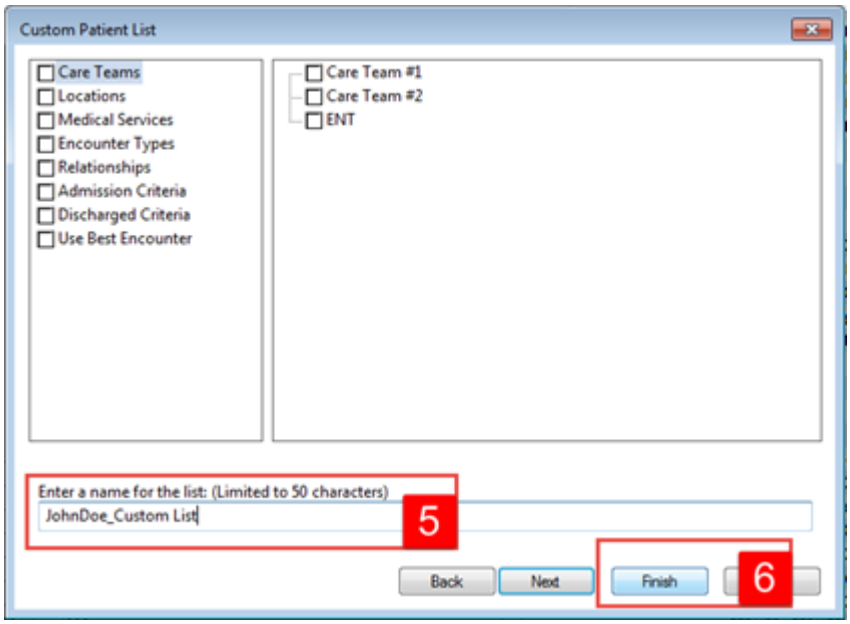
1 Next, you need to create a **Custom List** that will contain only the patients that you are covering.

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



5. **The Custom Patient List** window opens. **Custom Lists** need a unique name. Type YourName_Custom (for example: JohnDoe_Custom).

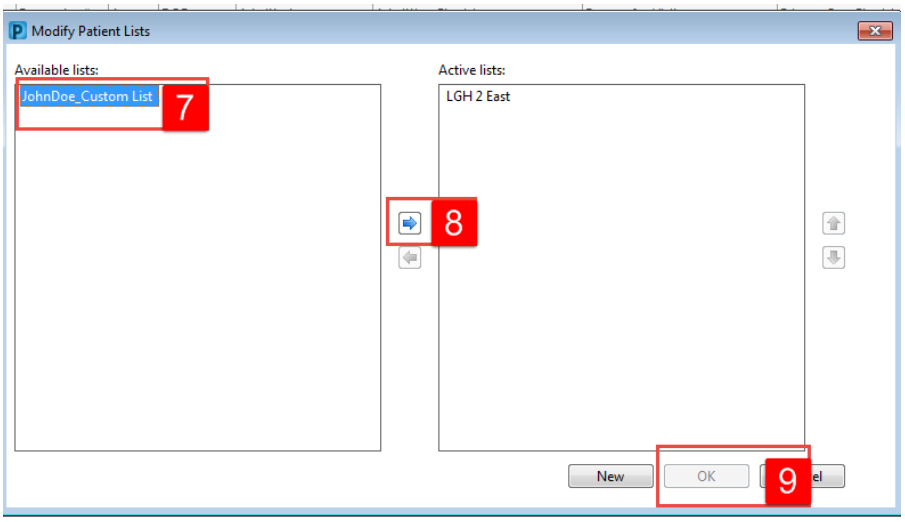
6. Click **Finish**



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

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

9. Click **OK**



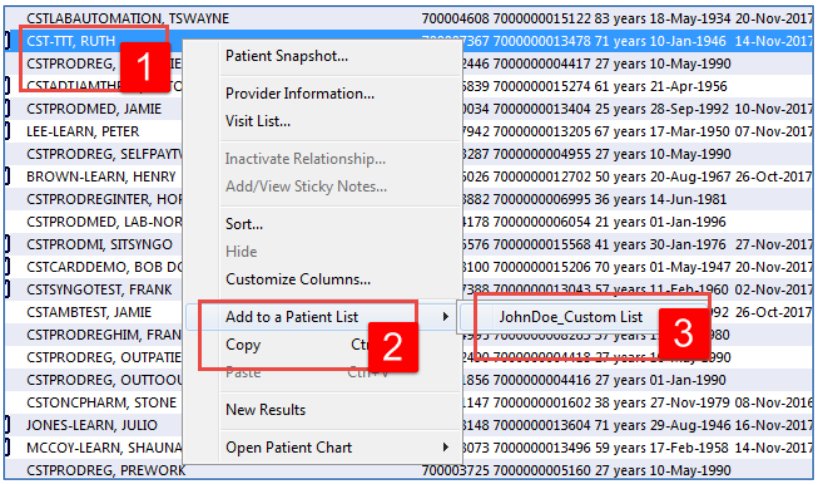
Activity 1.3 - Move Patients from the Location Patient List onto Your Custom Patient List

1 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**. Using today's handout sheet, select your patient's correct name. Use this custom list for the train session today.

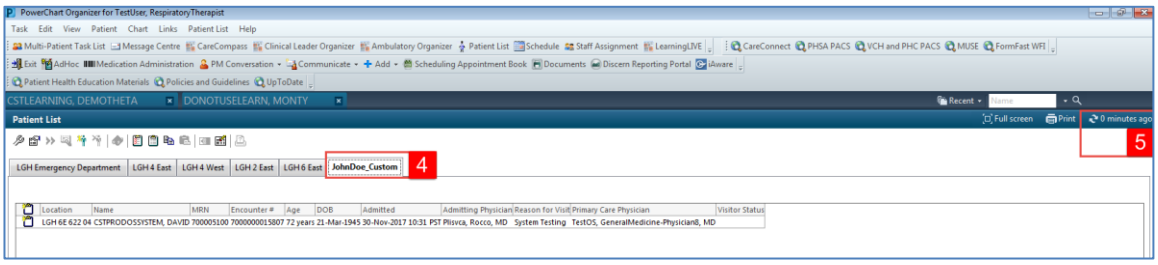
2. Select **Add to a Patient List**.

3. Select **YourName_Custom List**.



4. Select YourName_Custom tab. The tab may be empty.

5. Click the **Refresh** icon  to refresh your screen. Now your patient will appear in your Custom List. Please ensure the patient you have just added to your custom list is the patient assigned to you today.



Note: You can remove a patient from your custom list by highlighting the patient and clicking the Remove Patient icon or right-click on the patient's name.

Key Learning Points

- You can create a Custom List that will consist of only patients that you are caring for on your shift by adding and removing patients.
- The Custom list is used if you have a few patients assigned to you. This is your own personal list and the patient will stay on it until you remove the patient. Always add a patient to the custom list from the location list.
- You will maintain your Custom list and the CIS (Clinical Information System) will maintain your location list.

PATIENT SCENARIO 2 - Multi-Patient Task List

Learning Objectives

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

- Locate Patients on the MPTL
- Complete Tasks on the MPTL

SCENARIO

You will use the **Patient List** and **Multi-Patient Task List (MPTL)** to locate and identify your patients The tasks help organize your day. Today you will use your custom list for all the activities except this scenario. But in the Hospital, you will use the MPTL throughout the day to see new patient activities related to you.

As a specialty nurse, complete the following activities:

- Customize your Multi-Patient Task List View
- Review Multi-Patient Task List Functionality

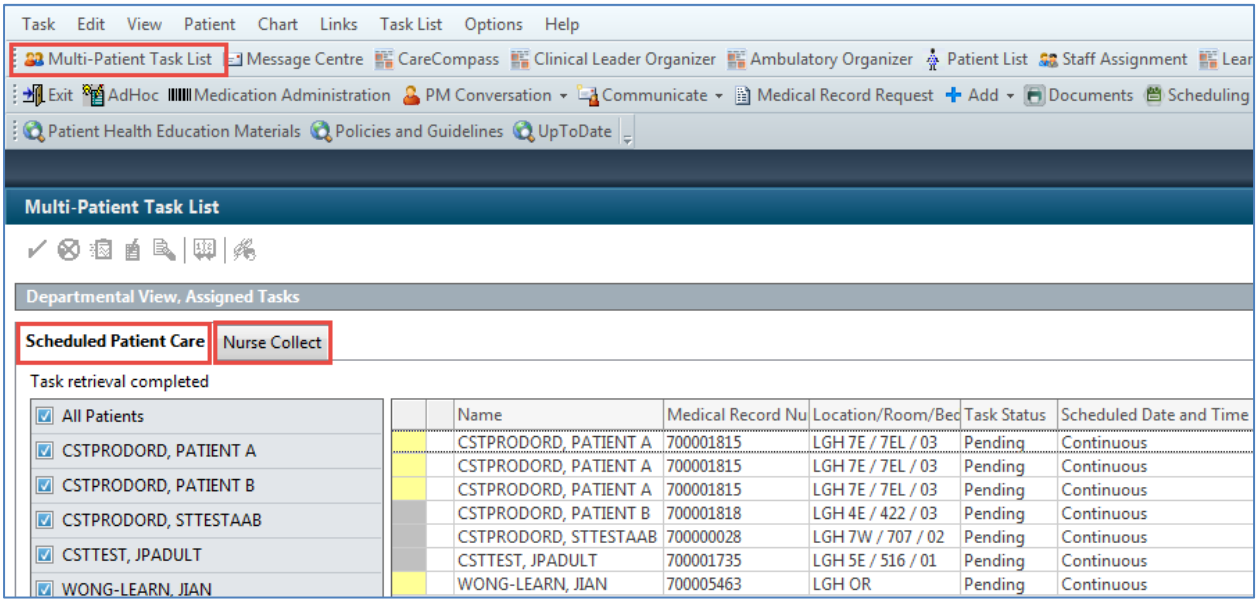
Activity 2.1 – Customize Your Multi-Patient Task List View

1 As a specialty nurse, the first page you will see upon logging is the **Multi-Patient Task List (MPTL)**.

MPTL displays your patient list and a list of tasks associated with the patients. 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 you to complete specific patient care activities. They are meant to supplement your current paper to-do list and highlight activities that are outside of regular care.

Note: Not all orders create tasks. Examples of tasks include orders for a consult, ventilator settings, important communications and specific therapies or treatments.

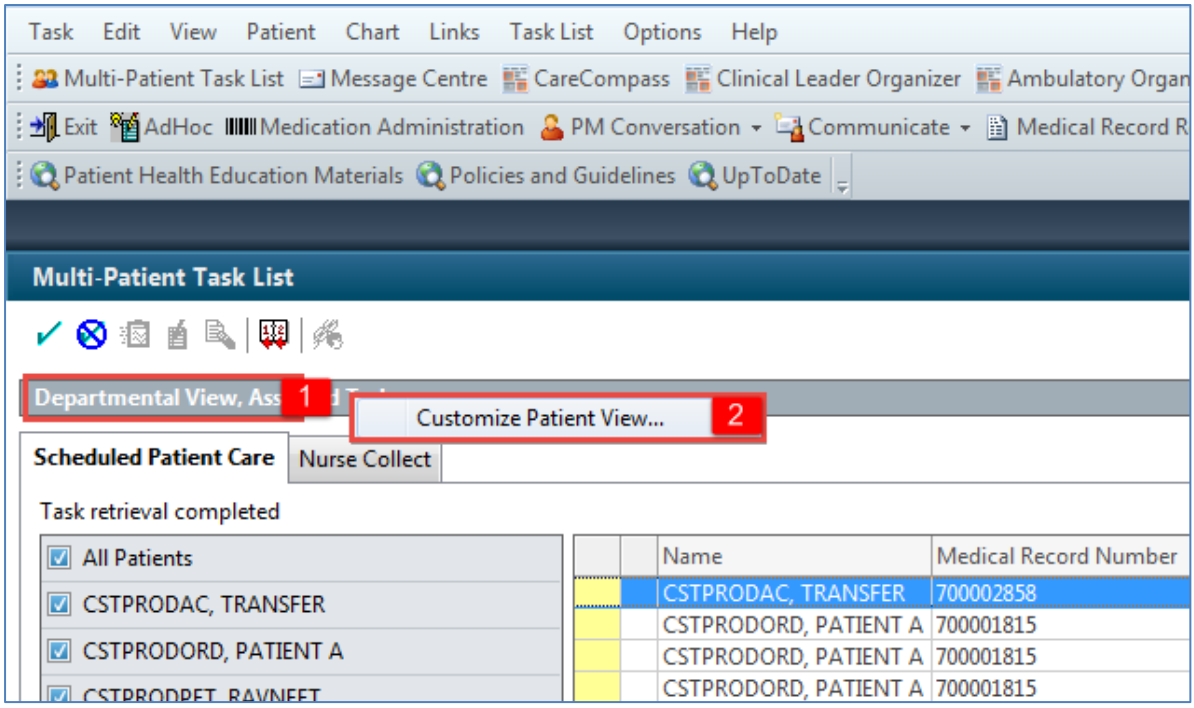
The **MPTL** has tabs for task categories (e.g, Scheduled Patient Care, Nurse Collect). Note that each specialty may have different tabs.



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

Note: For the classroom purposes, use only the patient in your custom list for any workbook activities. However, in the hospital, follow these steps to see your patients.

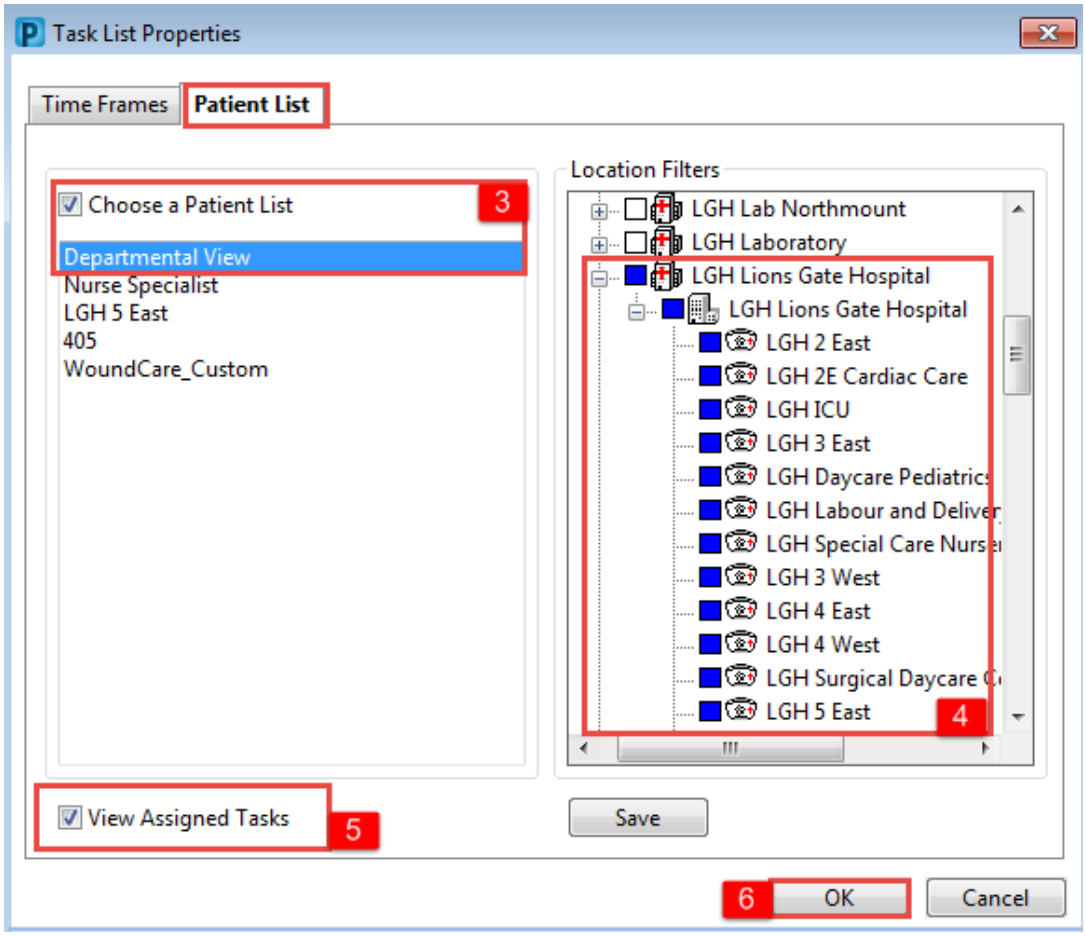
1. Right-click on **Assigned Tasks** in the grey information bar
2. Select **Customize Patient View**



Within the **Task List Properties** window:

3. In the Patient List tab, select **Choose a Patient List** and select **Departmental View**
4. Select the appropriate location using the location filter (use the + symbol to expand the location tree until you find the desired unit).

   Note: Only choose locations for units you are working on. If you cover the whole hospital, in that case, you can choose the whole hospital, e.g., **LGH Lions Gate Hospital**.
5. Ensure **View Assigned Tasks** is checked as this will ensure tasks display on your **MPTL**.
6. Click **OK**



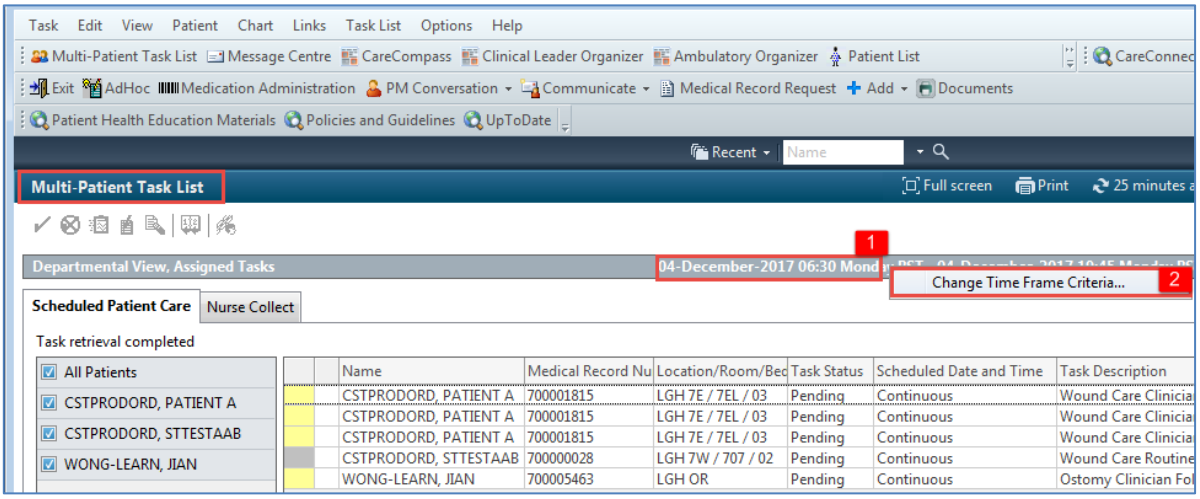
Note: The blue box indicates the area has been selected. If you only manage certain units, click those units eg: LGH Pediatric Asthma Clinic and unselect the other locations.

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

In this practice scenario, you work a 12-hr or an 8-hr shift.

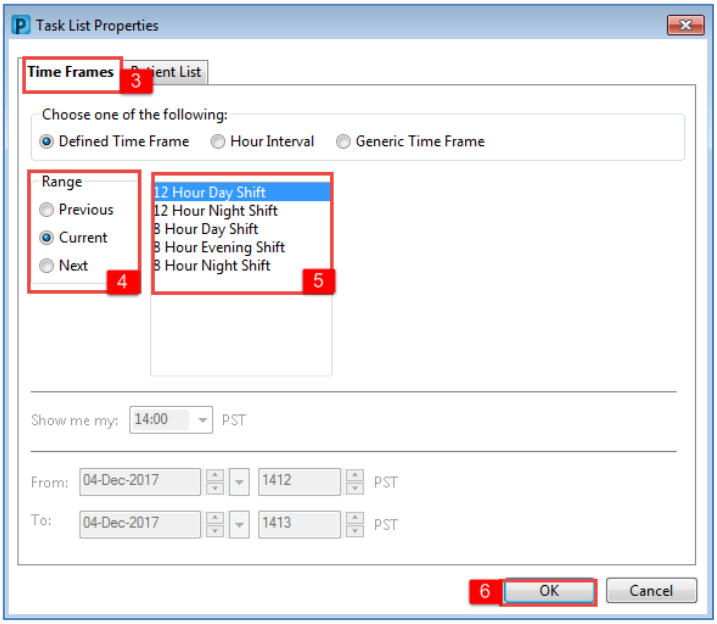
To select the appropriate Time Frame for your MPTL:

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



Within the **Task List Properties** window:

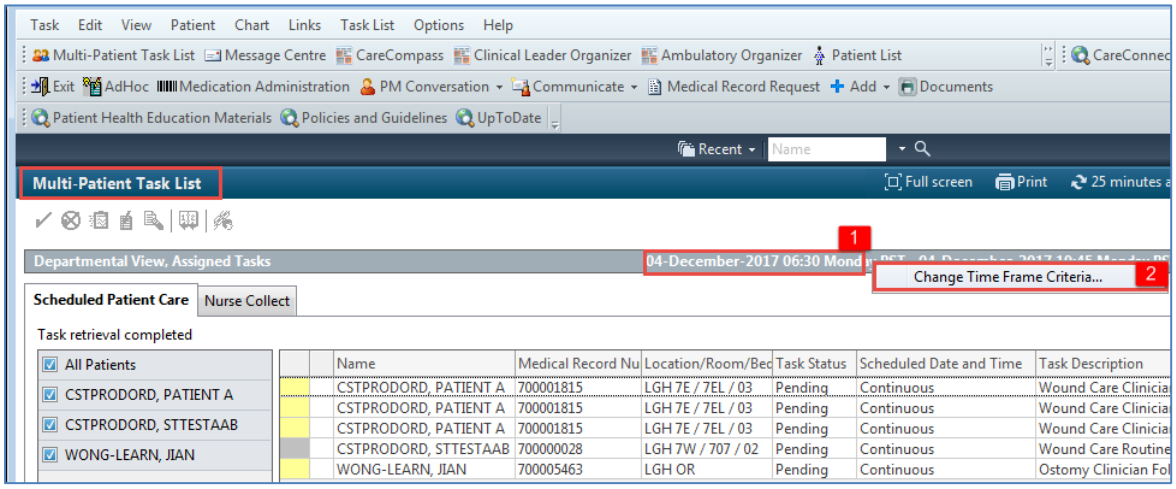
3. Click on **Time Frames**
4. Click your Range: **Current**
5. Select time frame of **12-Hour Day Shift**
6. Click **OK**



4 Not everyone works an 8 or 12-hours shift. If that is the case you may select a Generic Time Frame.

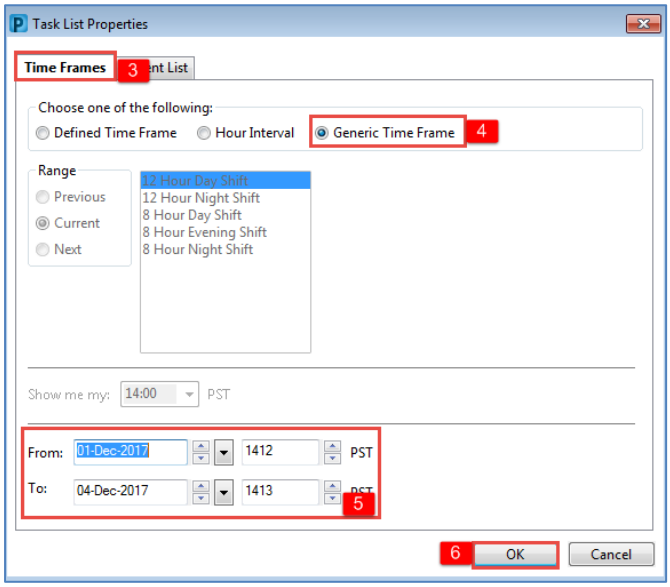
To select the appropriate Time Frame for your MPTL:

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



Within the **Task List Properties** window:

3. Select **Time Frames**
4. Click **Generic Time Frames**
5. Review the date and change the time by typing From = *0900* To: *1630*
6. Click **OK**



Note: If you forget to set up your Time Frame you will not see your tasks. Your patients will remain on your MPTL after they are discharged for several hours.

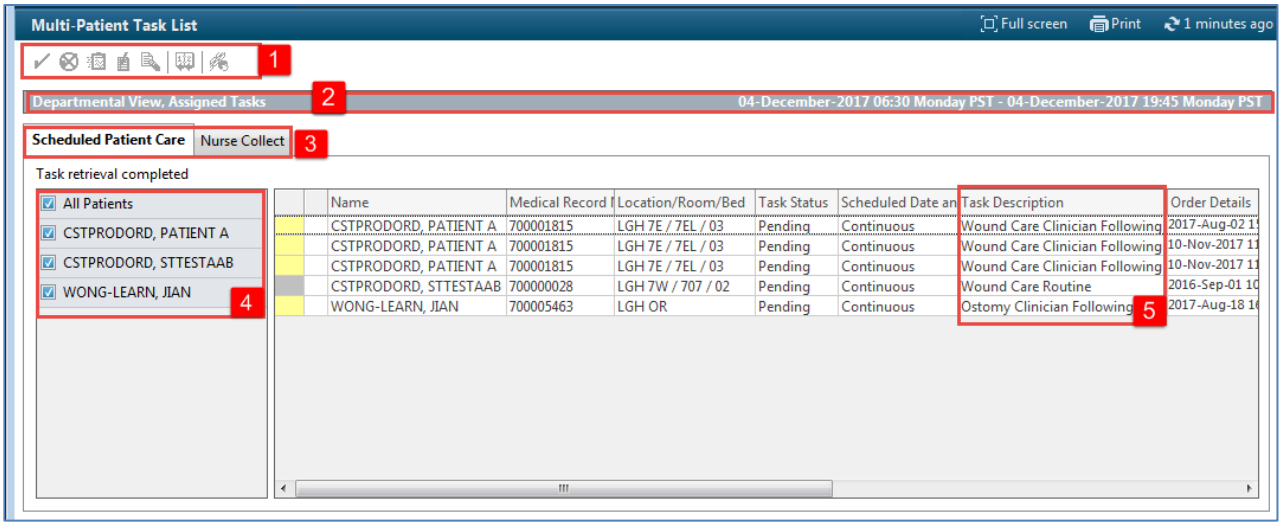
Key Learning Points

- You can customize the patient list for MPTL
- You can change the time frame for MPTL to view tasks within certain time range
- When a patient is discharged from the unit, their profile will fall on the location list, but the patient will remain on your MPTL for you to continue you charting for the day.

Activity 2.2 – Review Multi-Patient Task List Functionality

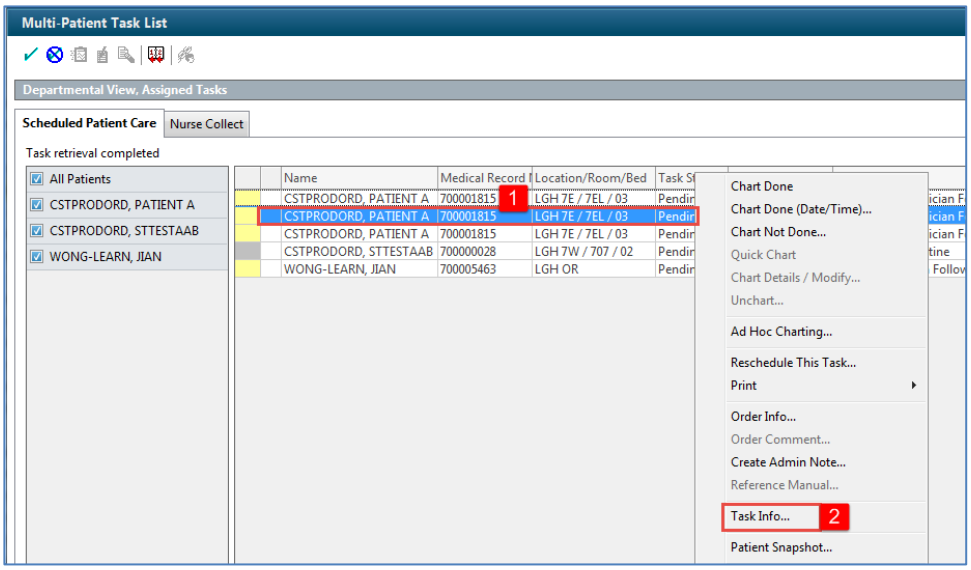
1 On your **MPTL**, review the following components:

1. Task list toolbar - hover over the **icons** to discover their functions
2. Information bar with name of the patient list (far left) and the set time frame (far right)
3. Task categories (tabs)
4. Navigator window with patient names with associated tasks
5. List of patient tasks

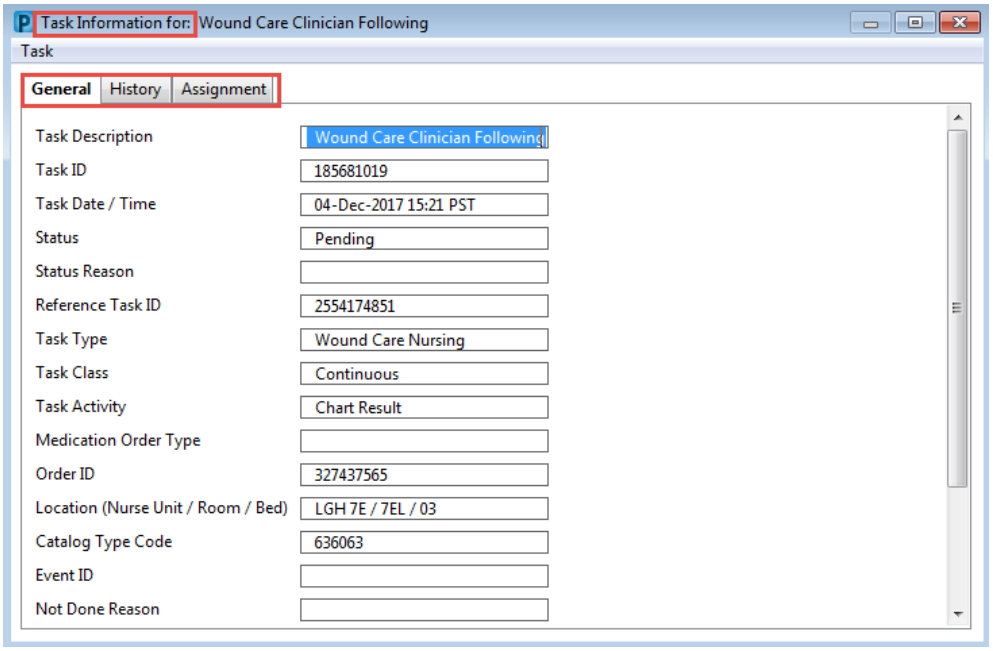


2 Locate your patient and review one of their tasks details.

1. Right-click anywhere on the patient task row for your selected patient
2. Select **Task Info…**.

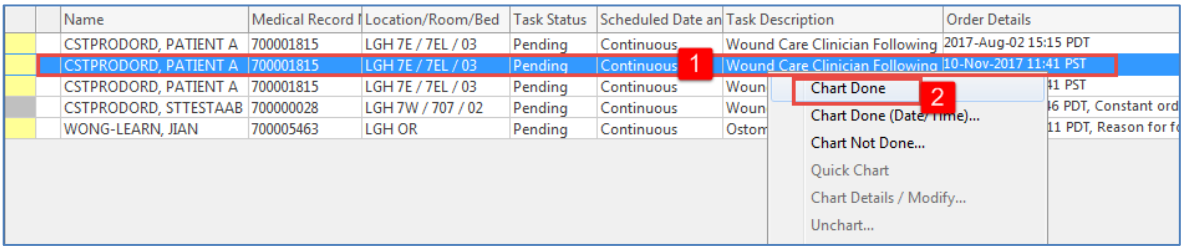


3. You can then review the task details in the pop-up window by clicking on the **General**, **History** and **Assignment** tabs.

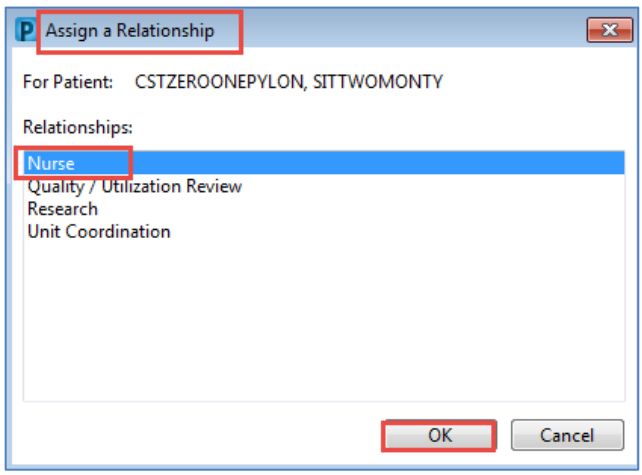


3 After you locate a task for your patient, you can chart **Chart Done** or **Chart Not Done** on the task:

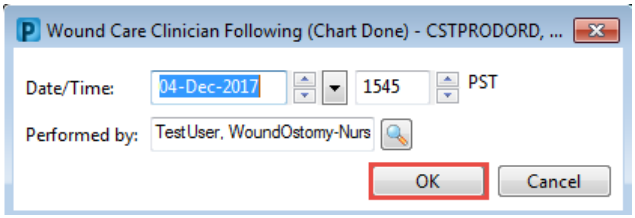
1. Right-click anywhere on the task row
2. Select Chart **Done**



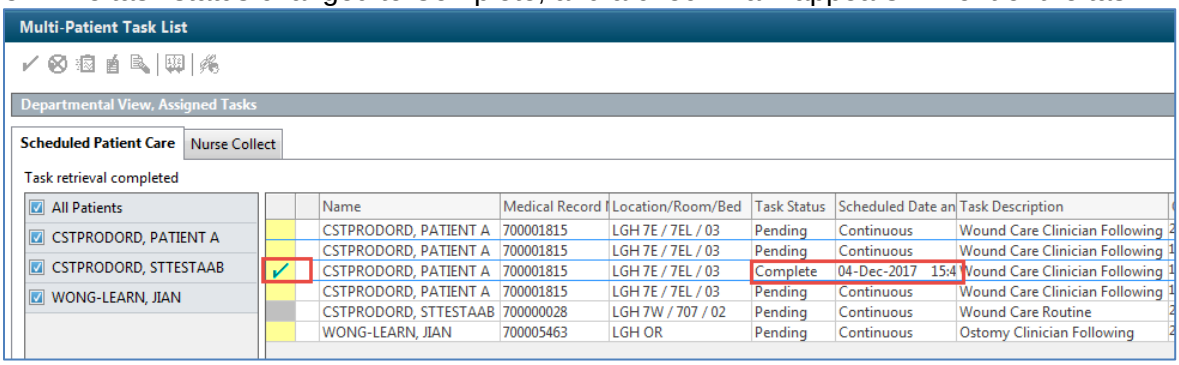
3. If prompted to assign a relationship, select **Nurse** and then click **OK**.



4. Click **OK** in the pop-up window



5. The task status changed to Complete, and a check mark appears in front of the task



Key Learning Points

- Task list toolbar, Information bar, Task categories, Navigator, and List of patient task are components of the MPTL
- You chart on a task by right-clicking on the task, then select **Chart Done** or **Chart Not Done**

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 Multi-Patient Task List
- Navigate the patient's chart to learn more about the patient

SCENARIO

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

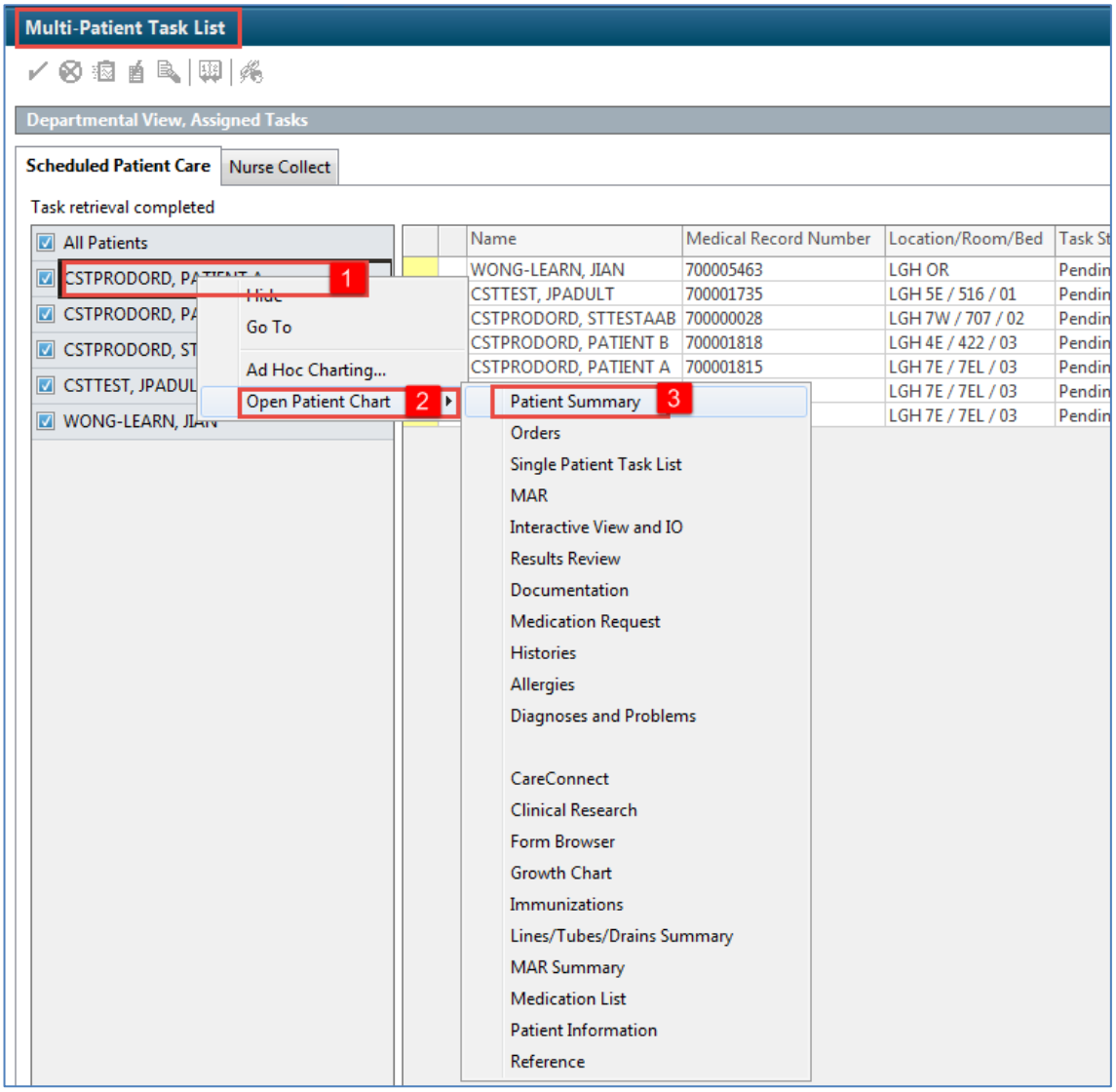
As a nurse you will be completing the following activities:

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

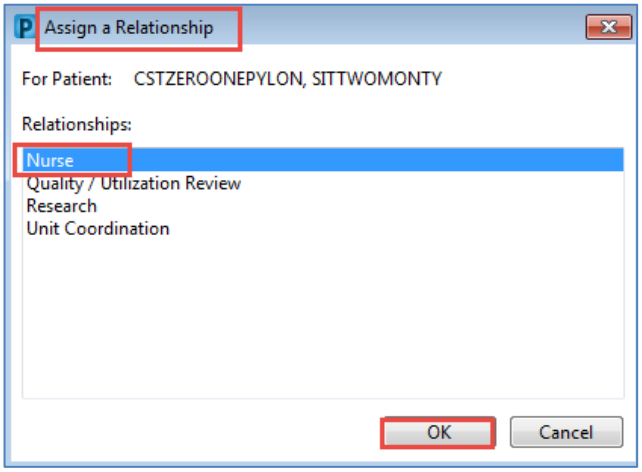
Activity 3.1 – Introduction to Banner Bar, Toolbar and Menu

1 To access patient chart from the **Multi-Patient Task List**:

1. Right-click on patient's name
2. Select **Open Patient Chart**
3. Select **Patient Summary**



4. If prompted to assign a relationship, select **Nurse** and then click **OK**.



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

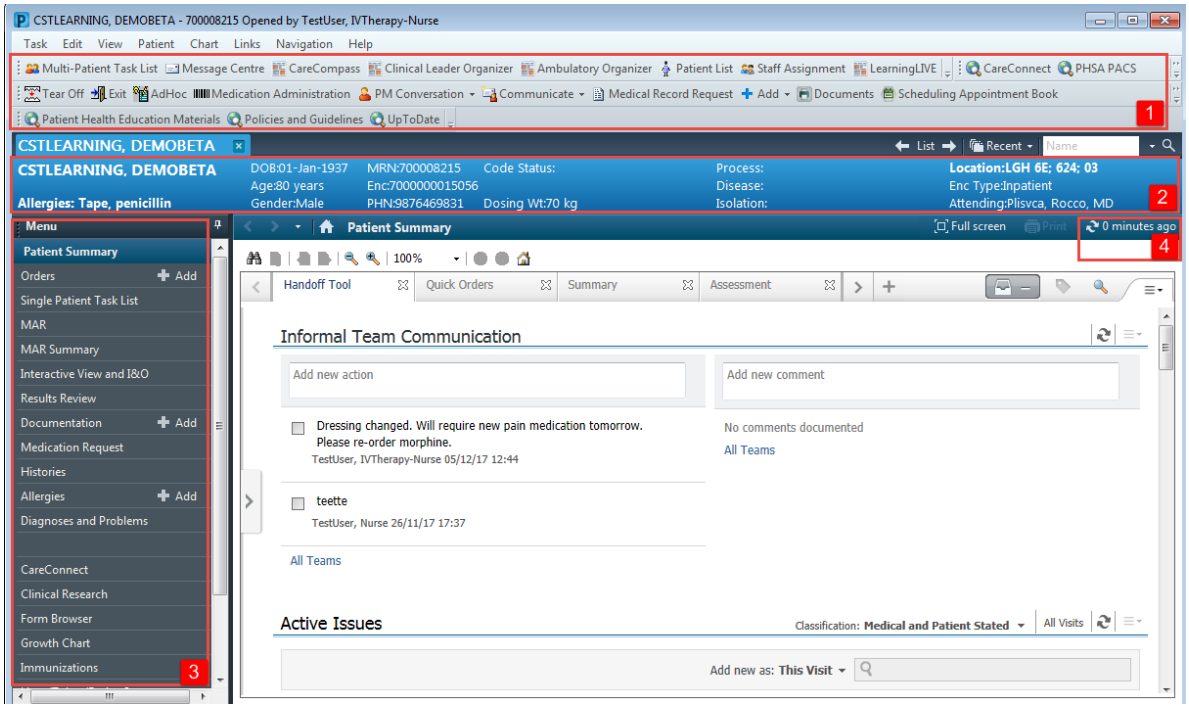
1. The **Toolbar** is located at the top of the patient's chart and it contains buttons that allow you to access various tools within the Clinical Informatics System.

2. The **Banner Bar** displays patient demographics and important information that is visible to anyone accessing the patient's chart. Information displayed includes:
    - Name
    - Allergies
    - Age, date of birth, etc.
    - Encounter type and number
    - Code status
    - Weight
    - Process, disease and isolation alerts
    - Location of patient
    - Attending Physician

3. The **Menu** on the left allows access to different sections of the patient chart. This is similar to the coloured dividers within a paper-based patient chart. Examples of sections included are Orders, Medication Administration Record (MAR) and more.

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

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



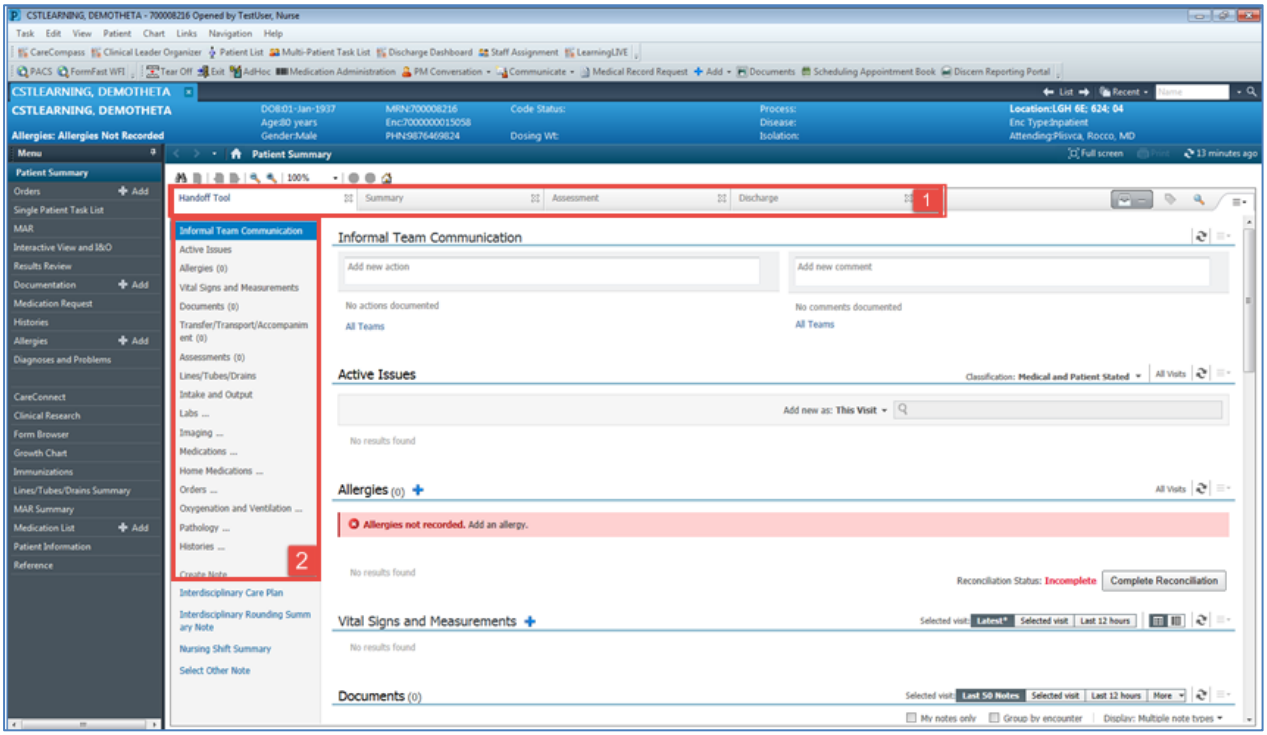
Key Learning Points

- 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** section 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** button  . Notice the time since last the refresh is displayed and will reset to 0 minutes 
.

Key Learning Points

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

PATIENT SCENARIO 4 - Orders

Learning Objectives

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

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

SCENARIO

As a specialist nurse, you will need to be able to review orders for your patient. You will also need to place orders for your patient in certain situations. To do so you will complete the following activities:

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

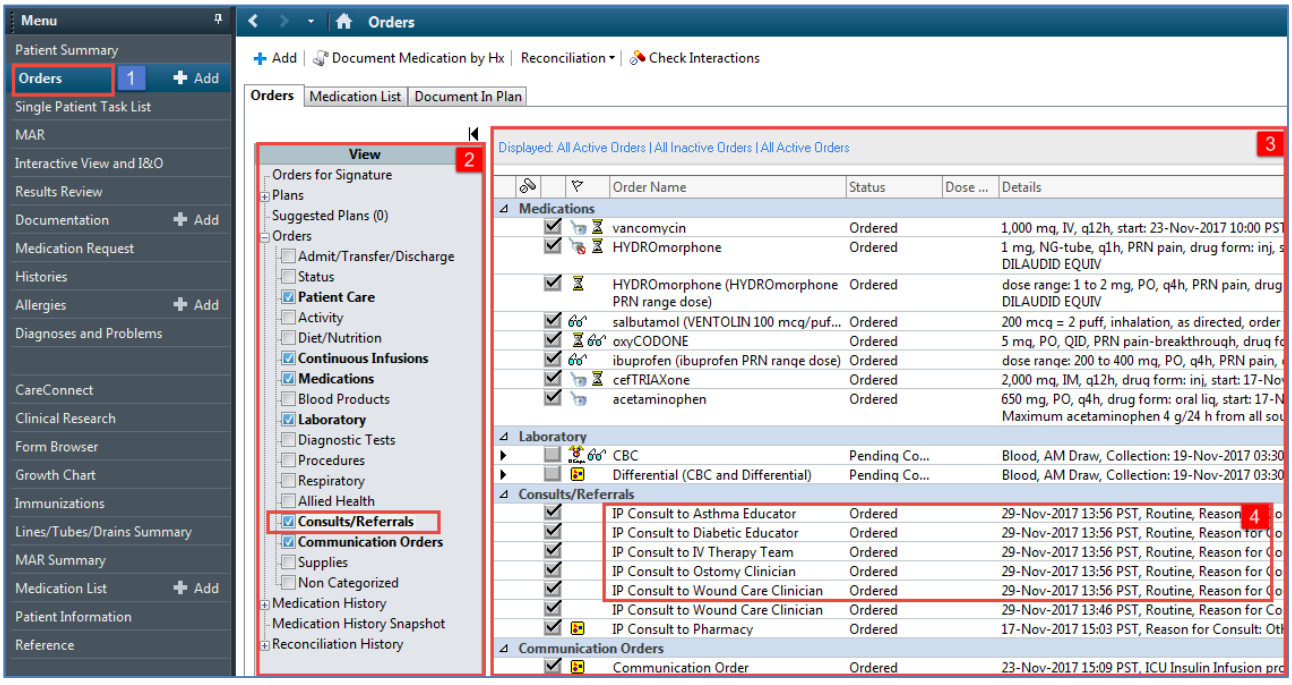
Activity 4.1 – Review Orders Profile

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

1 To navigate to the **Order Profile** and review the orders:

1. Select **Orders** from the **Menu**
2. On the left side of the Orders Page is the Navigator (**View**) which includes several categories including:
   - **Plans**
   - **Categories of Orders**
   - **Medication History**
   - **Reconciliation History**
3. On the right side is the **Order Profile** where you can:
   - Review the list of orders
     Moving the mouse over order icons allows you to **hover to discover** additional information.
     Some examples of icons are:
     - Order for nurse to review
     - Additional reference text available
     - Order part of a PowerPlan
     - Order waiting for Pharmacy verification

4. Locate the **IP (inpatient) Consult** orders (e.g. IP Consult to Asthma Educator) and review the details.



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 of the orders for a patient

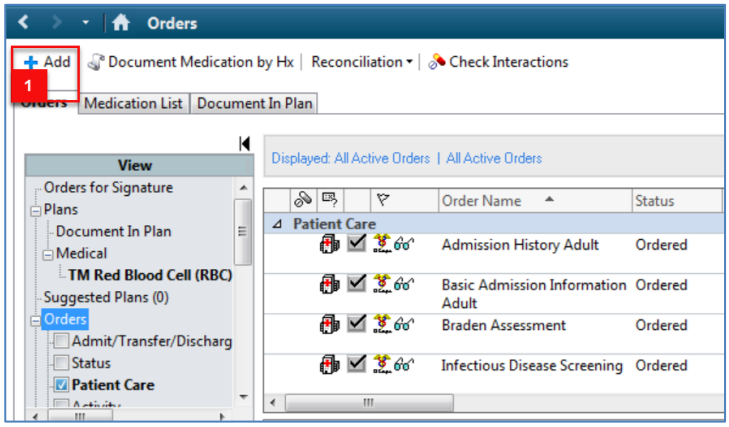
Activity 4.2 – Place a No Cosignature Required Order

Specialist Nurses can place the following types of orders:

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

1 To place an order that does **not** require a cosignature:

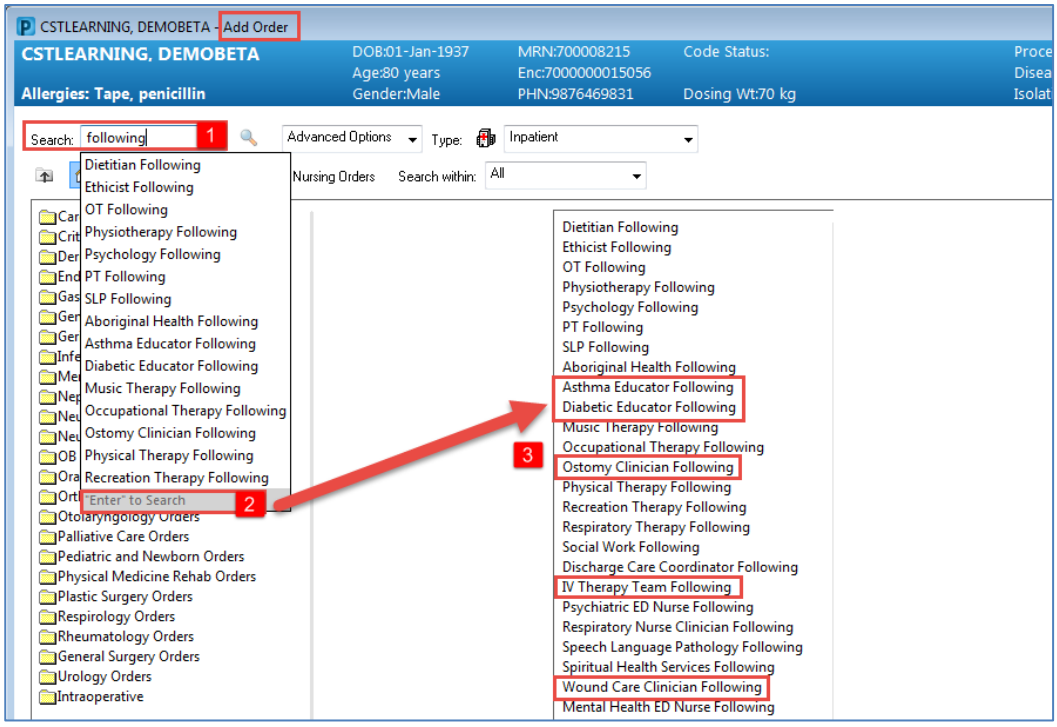
1. Click the **Add** button on the **Orders** page



The **Add Order** window opens.

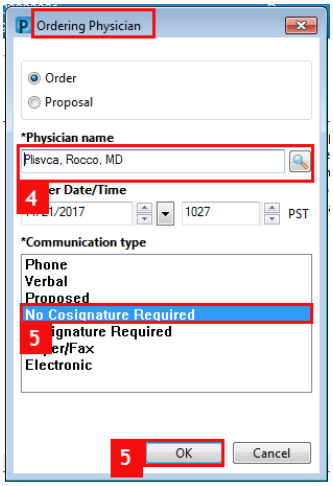
1. Type "*Following"* into the search window and a list of choices will display
2. Press the Enter key on your keyboard, it will display all of the **Following** orders
3. Select the Following order for your specialty (e.g., if you are a Diabetic Educator, please select **Diabetic Educator Following** order)

Note: The Following order is a continuous order which will not fall off the multi-patient task list. This type of orders is needed if you need to continue to follow this patient after your initial consult.

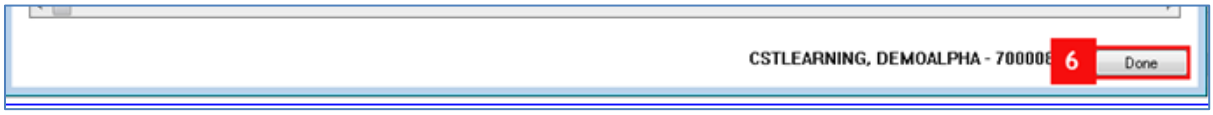


The **Ordering Physician** window opens.

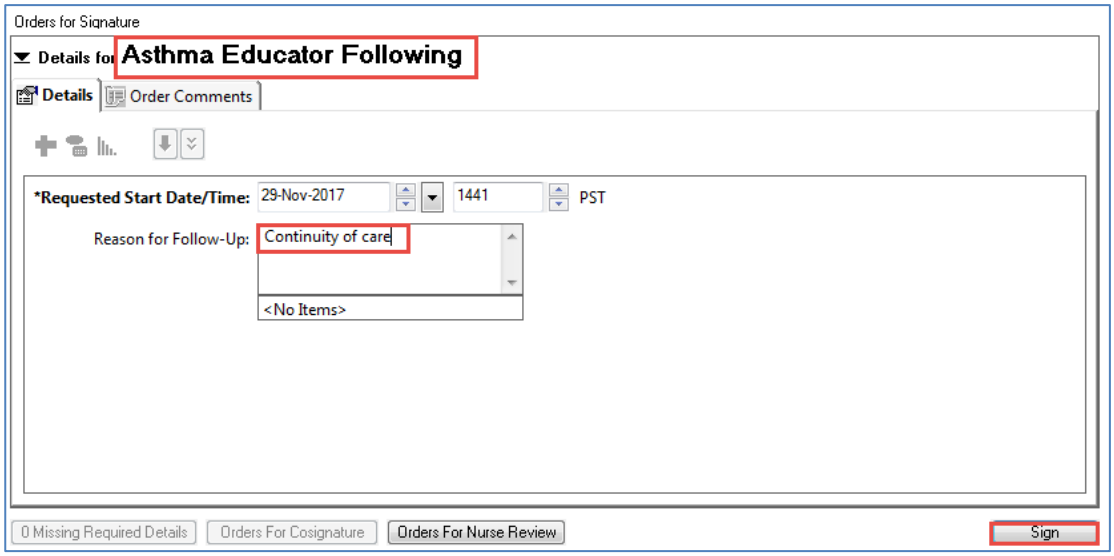
4. Type in the name of the patient's Attending Physician
5. Select **No Cosignature Required** and click **OK**



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



7. In the **Reason for Follow-Up:** please type in *Continuity of care*. Then click **Sign.**



8. Click **Refresh** 

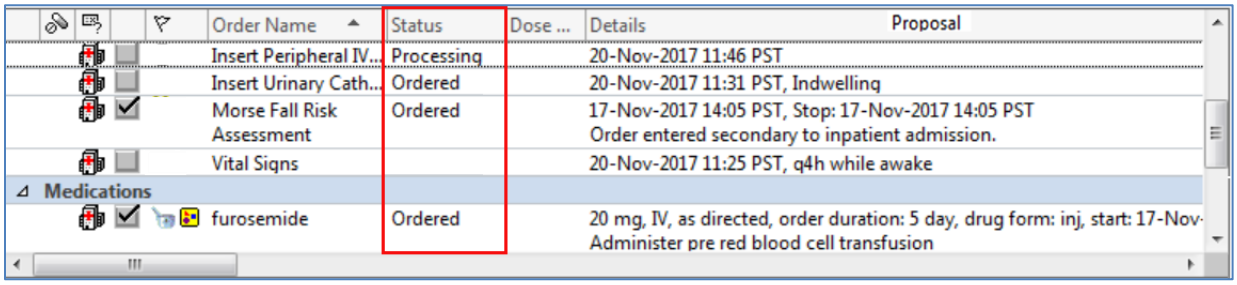
Key Learning Points

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

Activity 4.3 – Review Order Statuses and Details

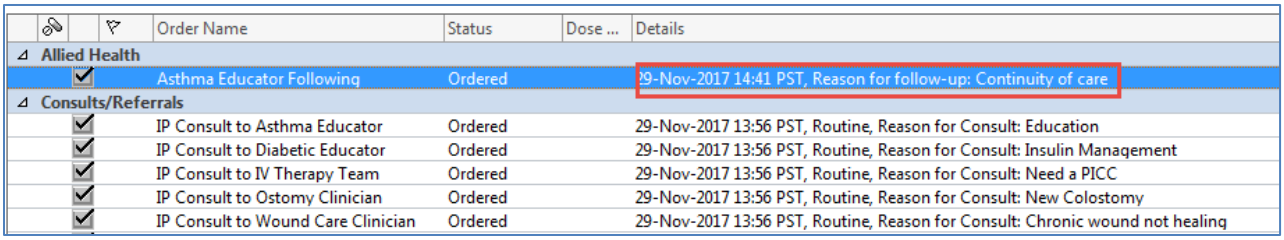
1 To see examples of different order statuses, review the image below:

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



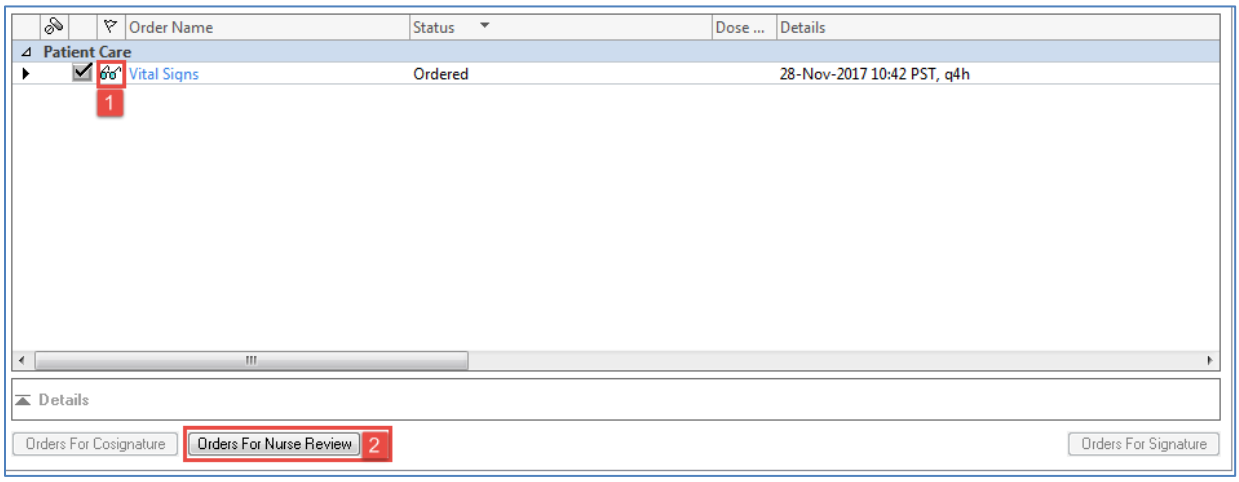
To review order details:

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



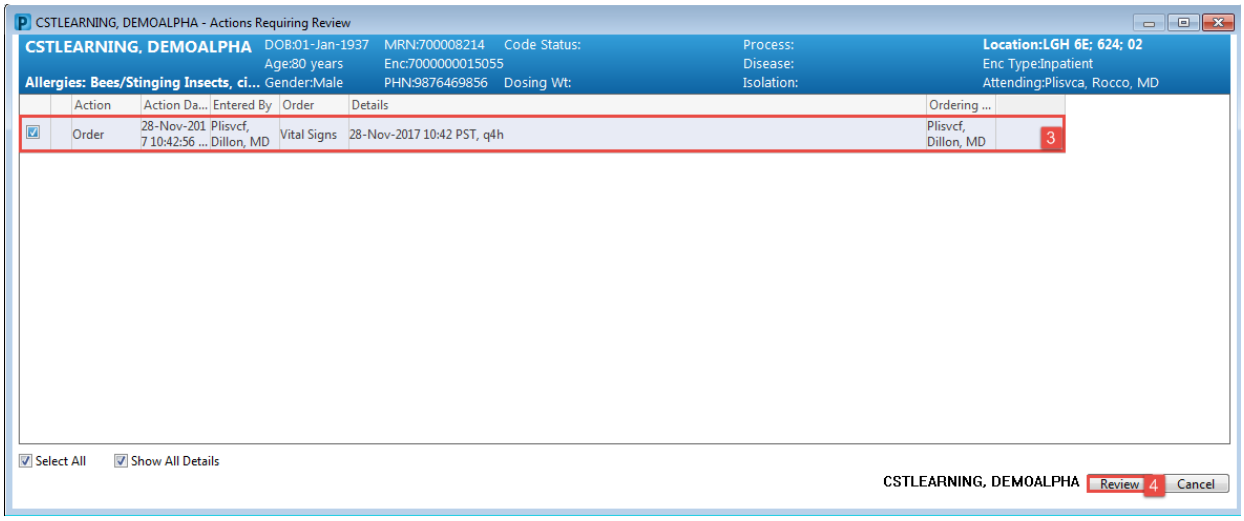
When new orders are placed in the chart, a nurse must acknowledge reviewing these new orders. Below we outline the steps for how this should be done. **Note:** Do not follow these steps in the system but instead refer to the screenshots to understand the process

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



An **Actions Requiring Review** window pops up. This window displays any new orders that need to be acknowledged as reviewed by a nurse

3. Review order details
4. Click **Review**



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

Key Learning Points

- Always review and verify the status of orders
- Hover to Discover to view additional order information

Activity 4.4 – Place a Verbal Order

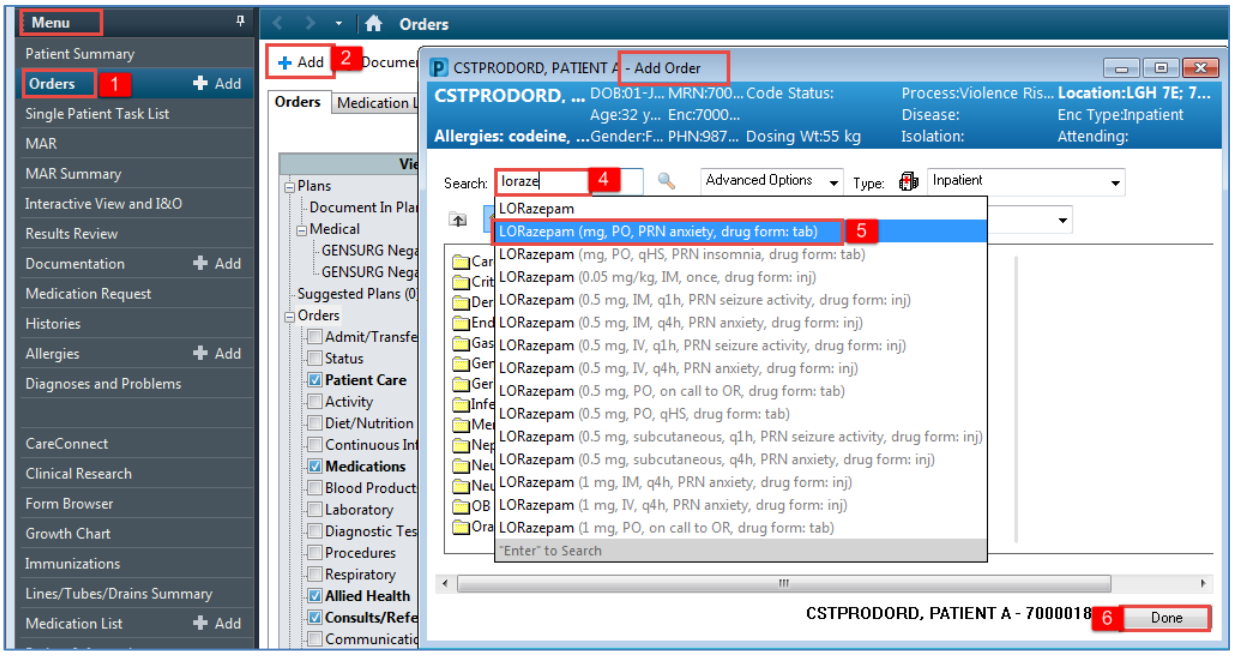
1 Similar to current practice, nurses can place verbal and telephone orders. In this activity we are going to practice placing a verbal order. **Verbal Orders** are only encouraged when there is no reasonable alternative for the provider to place the order in the CIS themselves, for example, in emergency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

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

In this practice scenario, your patient is anxious, and you obtained a verbal order for Ativan (LORazepam) 1 mg PO, once PRN for anxiety.

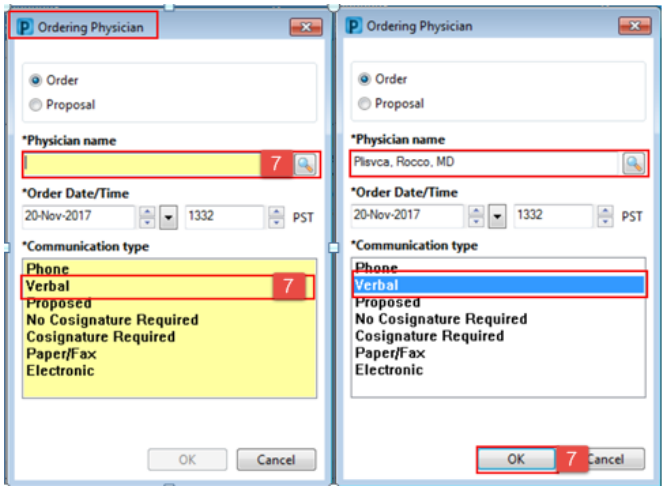
To place a verbal order:

1. Select **Orders** from the **Menu**
2. Click the + Add button.
3. The **Add Order** pop-up window will appear
4. Type "*loraze"* in the search field, a drop-down list of order sentences display
5. Select *lorazepam (mg, PO, PRN anxiety, drug form tab)*
6. Click **Done**



The Ordering Physician pop-up window will appear.

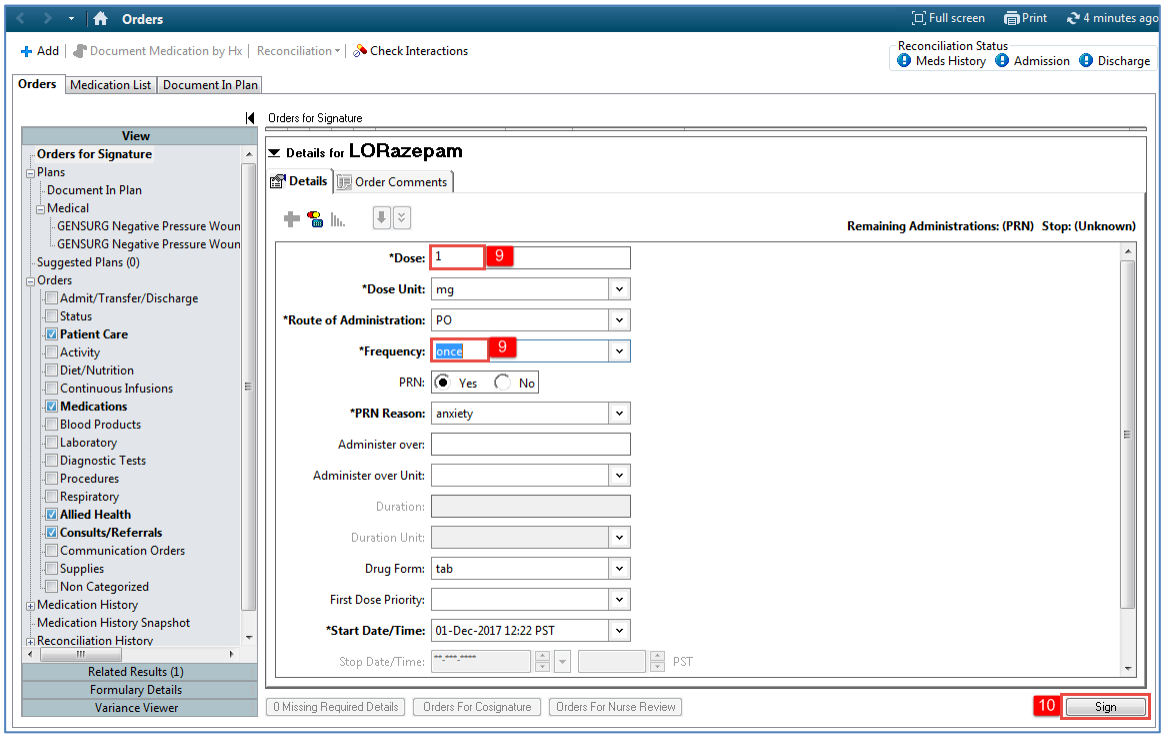
7. Fill out required fields highlighted with yellow and click **OK**
    - **Physician name** = *type name of Attending Physician (last name, first name)*
    - **Communication type** = *Verbal*



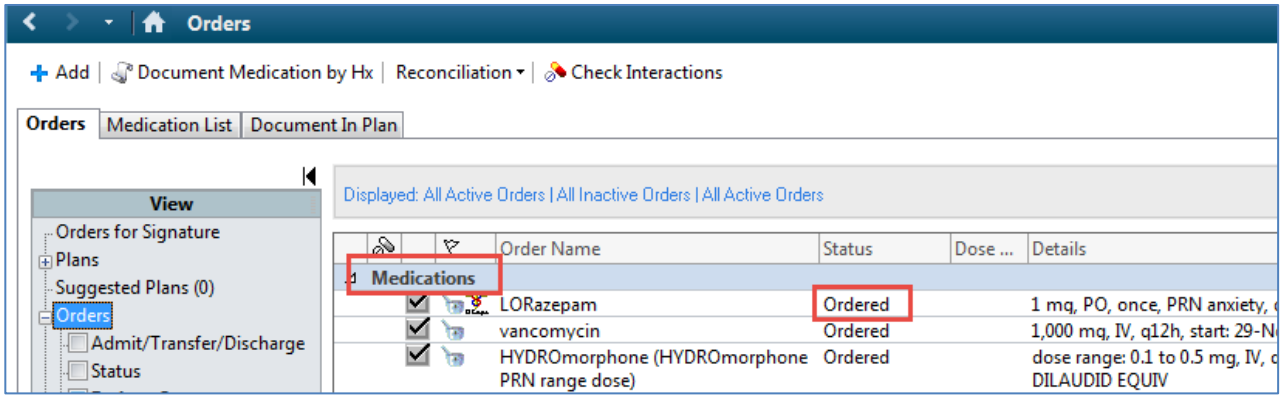
Note: If this were a telephone order, the communication type, Phone, would be selected.

8. Click **Done**
9. Order Details window opens. Fill out data entry fields:
    - Dose = *1*
    - Frequency = *once*

10. Click **Sign** and Refresh the screen. You will return to Orders page.



Note: You can locate the new order under **Medications** category with a status of **Ordered**



Key Learning Points

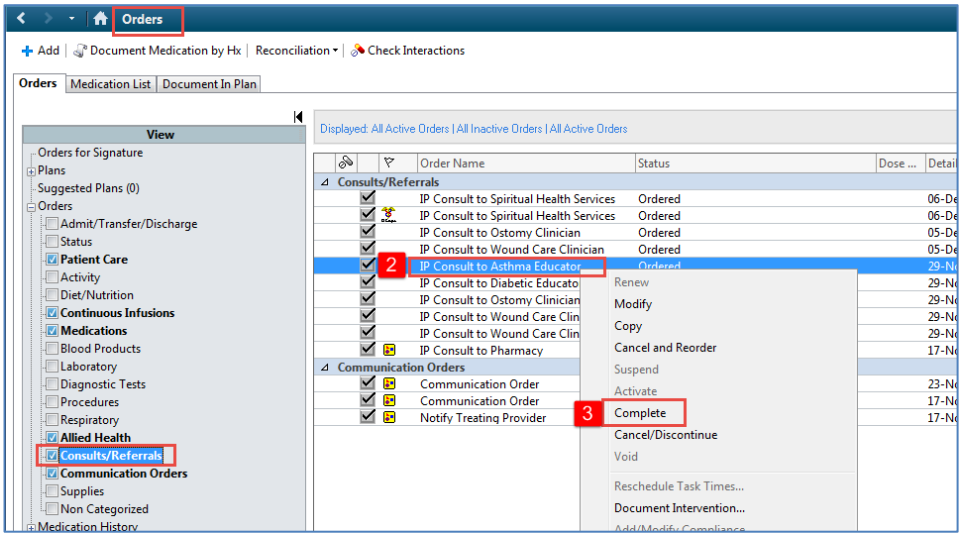
- Verbal orders are only encouraged to be entered when a physician cannot enter the order directly into the CIS themselves, for example, in an emergency situation or when the physician is sterile in mid-procedure
- Required fields are always highlighted yellow
- Verbal and phone orders that are entered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

Activity 4.5 – Complete or Cancel/Discontinue an OrderOrders can be documented as completed or discontinued depending on the type of order.

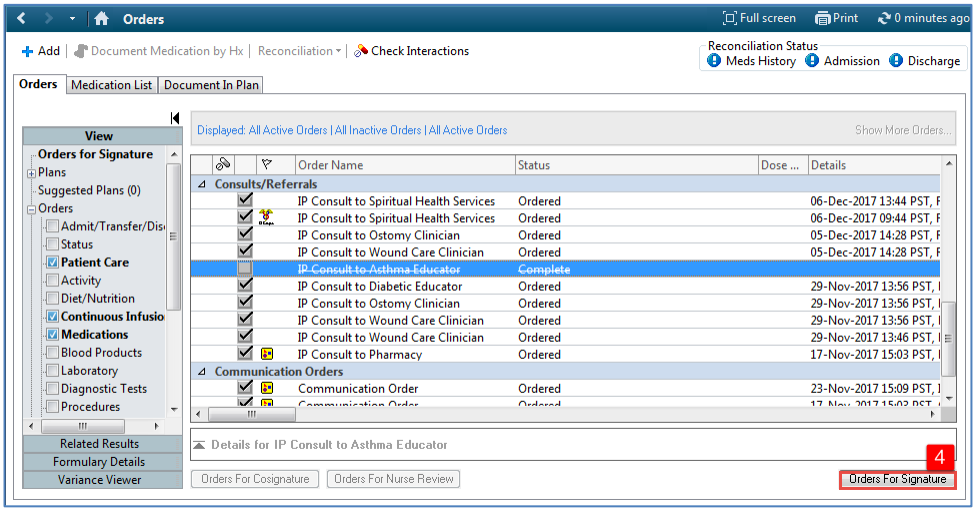
1 When a one-time order has been carried out, the order needs to be removed from the patient's order profile. This is done by Completing the order.

To complete an order:

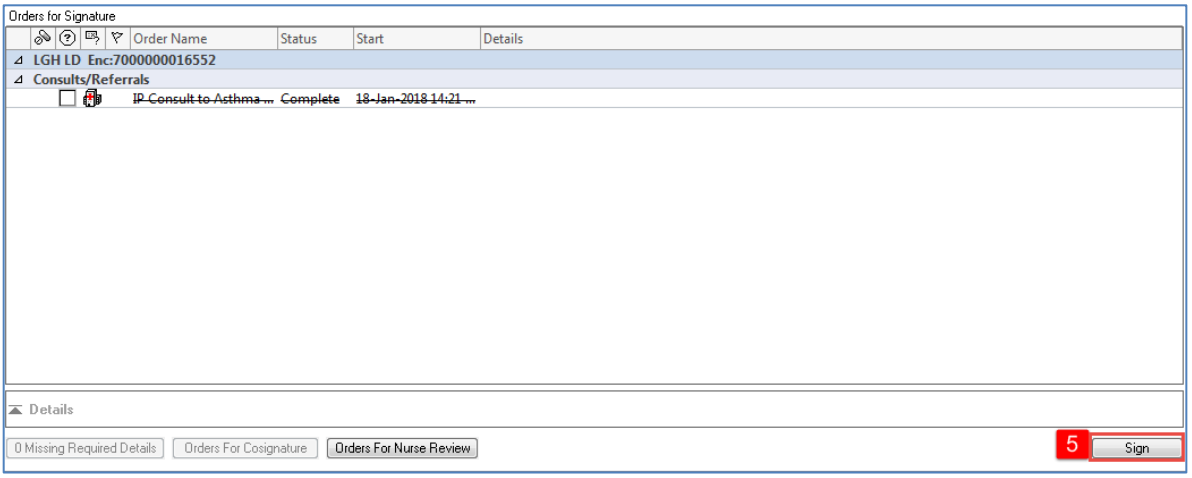
1. Review the **Order Profile**
2. Right-click the consult order for your specialty (e.g. IP Consult to Asthma Educator)
3. Select **Complete**



4. Click the Orders For Signature button



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



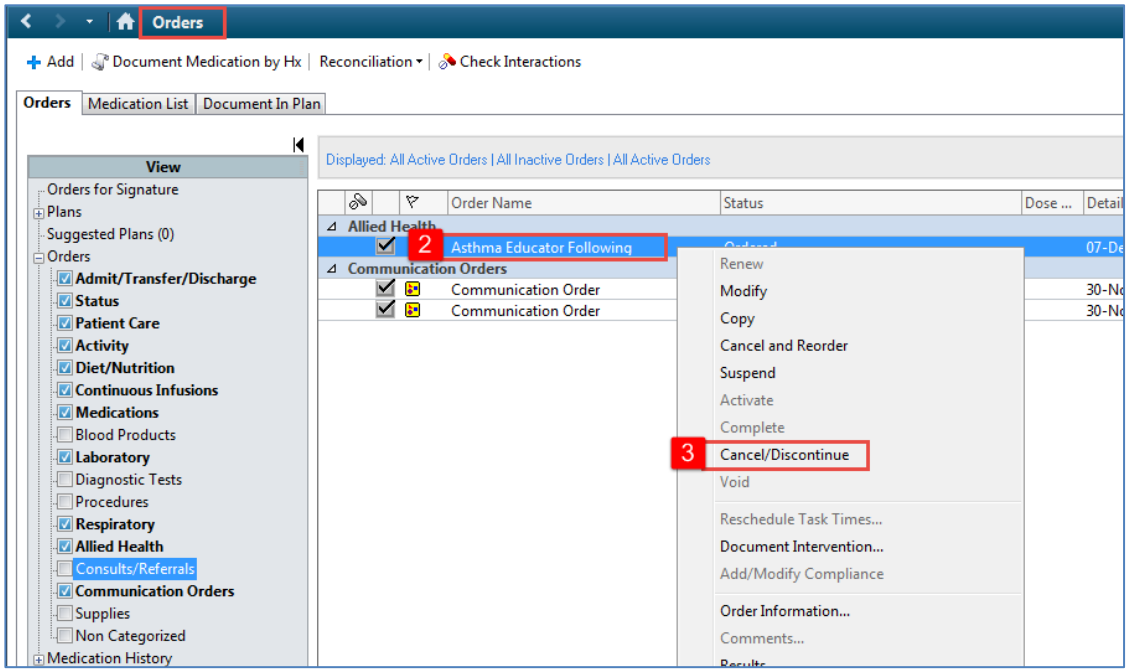
Refresh  page. The order will no longer be visible in the Orders Profile.

2 To Cancel/Discontinue an order:

1. Review the **Order Profile**

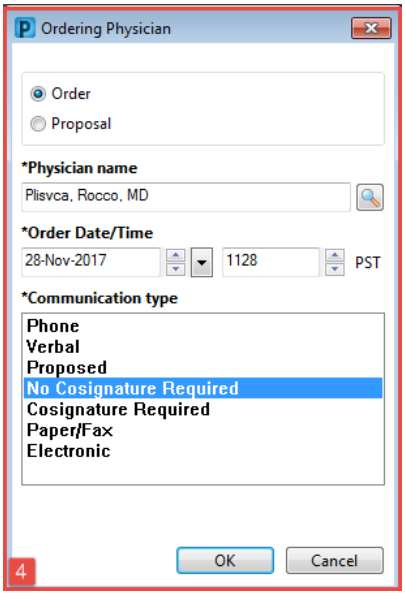
2. Right-click the **Following** order you placed earlier for your specialty(e,g., Asthma Educator Following)

3. Select **Cancel/Discontinue**

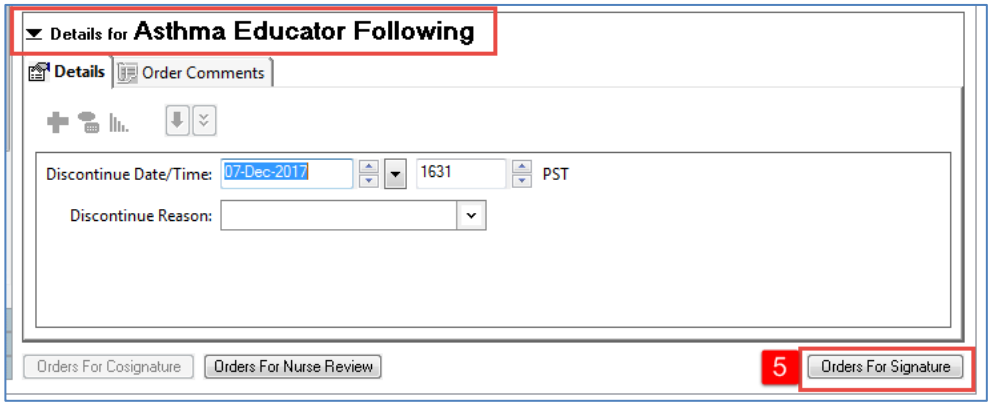


4. Ordering Physician pop-up window will appear. Fill out required fields highlighted yellow below and then click **OK**

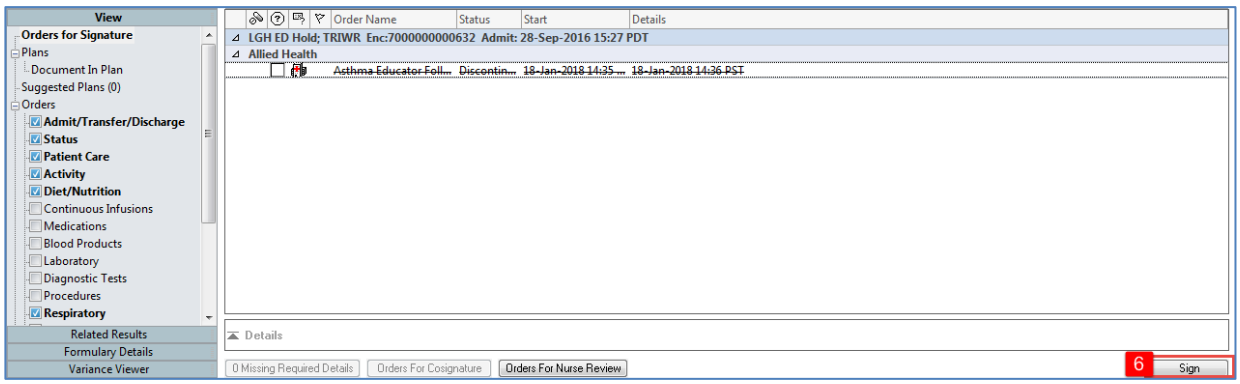
- Physician name = *type name of Attending Physician (last name, first name)*
- Communication type = *No Cosignature Required*



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



6. Review the order for signature and click **Sign**. You will return to the order profile.



Refresh  page. The order will no longer be visible on order profile.

Key Learning Points

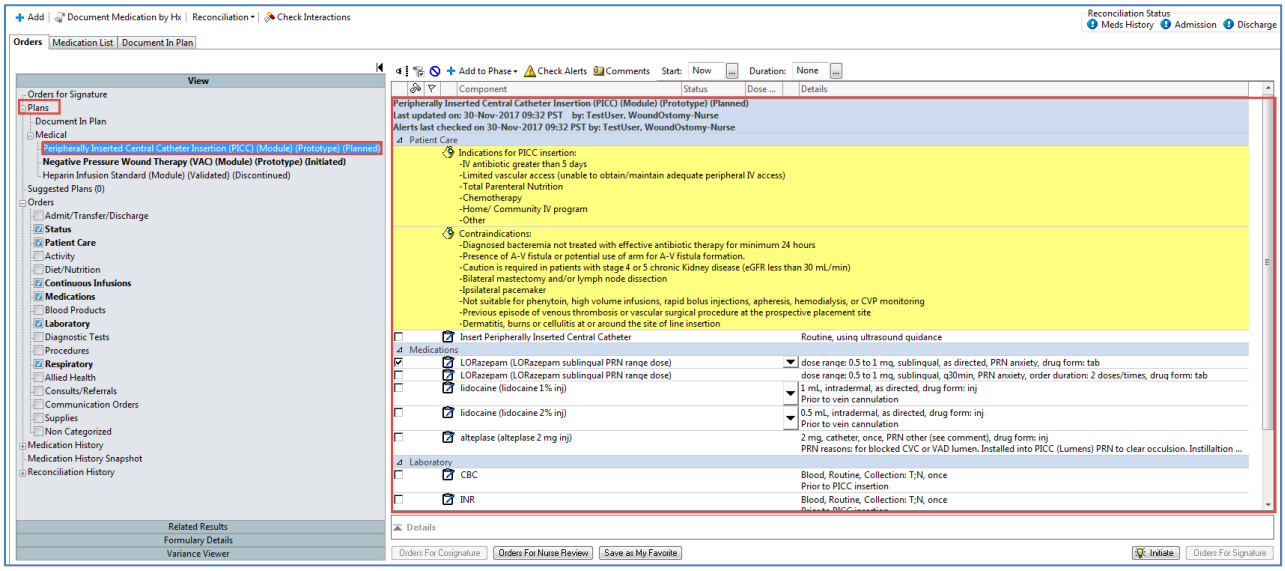
- The Right-click to mark an order as completed or discontinued
- Both of these actions will remove orders from patient's Order Profile

Activity 4.6 – Review Components of a PowerPlan

1 A PowerPlan in the CIS is the equivalent of preprinted orders in the 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.

Let's review a PowerPlan. From the **Orders Profile**: PowerPlans are only viewed on the Orders page.

1. Locate the **Plans** category to the left side of the screen under **View**
2. Select the **Peripherally Inserted Central Catheter (PICC)**
3. Review orders within the PowerPlan



Note: A PowerPlan needs to be initiated before you can act on the orders in the PowerPlan. If the PowerPlan is in a planned state, it needs to be initiated by the provider or the nurse.

Initiated PowerPlan becomes active immediately and its orders create respective tasks and actions for other care team members.

A PowerPlan that is **not** initiated remains in a **planned** stage allowing to prepare orders for a future activation as needed.

Key Learning Points

- The Orders page 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 5 - Interactive View and I&O

Learning Objectives

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

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

SCENARIO

In this scenario, you will be charting on your patient in the **Interactive View and I&O (iView)**. You will need to complete the following activities:

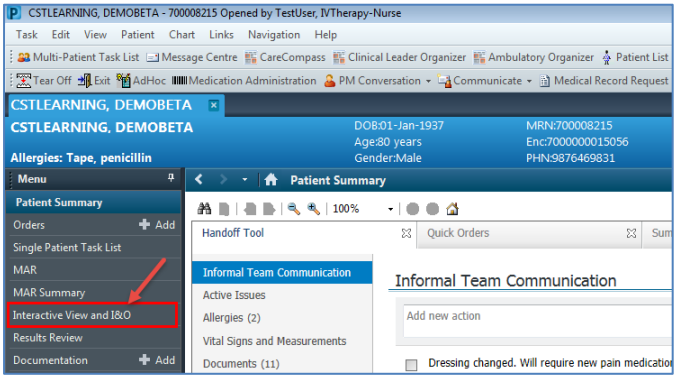
You will be completing the following activities:

- Navigate to Interactive View and I&O (iView)
- Document in iView
- Change the time column
- Document a dynamic group in iView (practice Activity 5.4 that is specific to your specialty)
- Modify, unchart or add a comment in iView

Activity 5.1 – Navigate to Interactive View and I&O

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

Select **Interactive View and I&O** within the **Menu**.



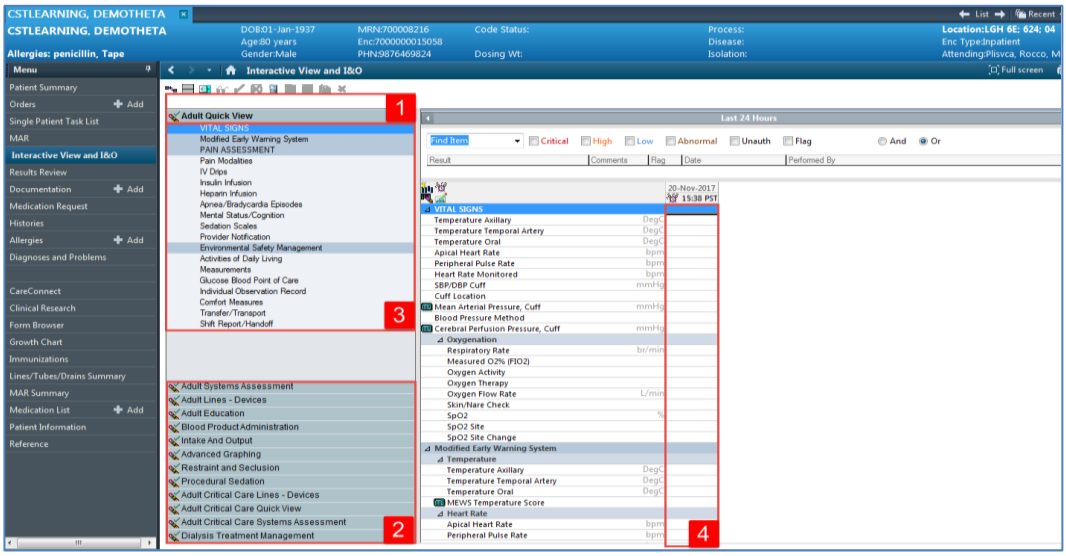
2 Now that the iView page is displayed, let's view the layout.

1. A **band** is a heading that has a collection of flowsheets (**sections**) organized beneath it. In the image below, the **Adult Quick View** band is expanded displaying the sections within it.

2. The set of bands below **Adult Quick View** are collapsed. Bands can be expanded or collapsed by clicking on their name.

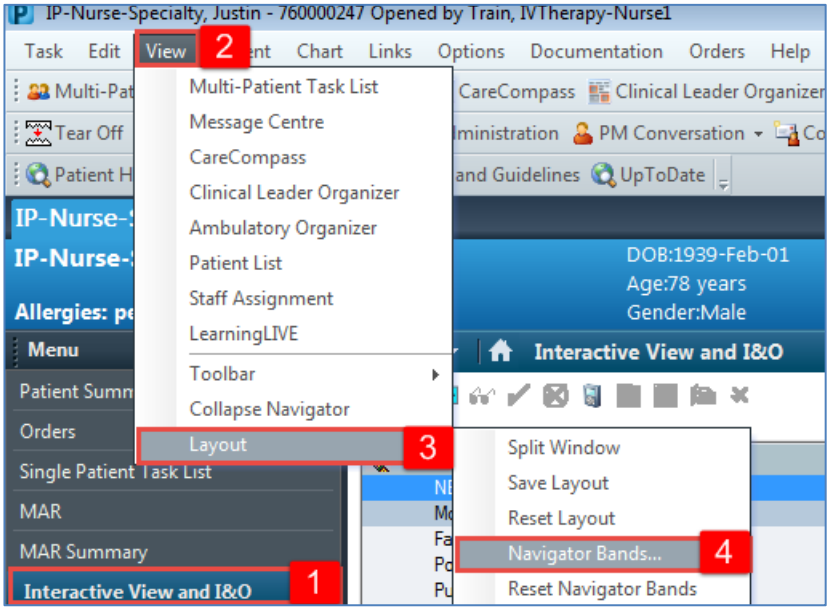
3. A **section** is an individual flowsheet that contains related assessment and intervention documentation.

4. A **cell** is an individual field where data is documented.

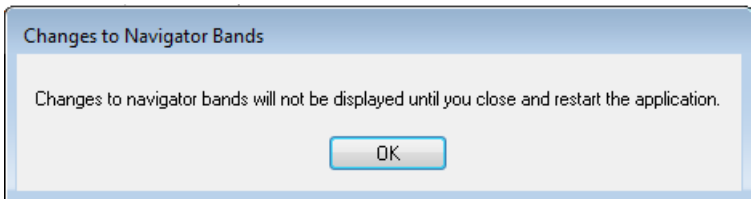


3 As specialty nurse, you may need to select more documentation Navigator Bands that are listed on your Navigator display. For example, Adult Quick View is a useful band to capture most nursing activities.

1. Click and open the **Interactive View and I&O** page from the M**enu**
2. Locate and select the **View** Tab in the **Toolbar**
3. Click **Layout**
4. Click **Navigator Bands**



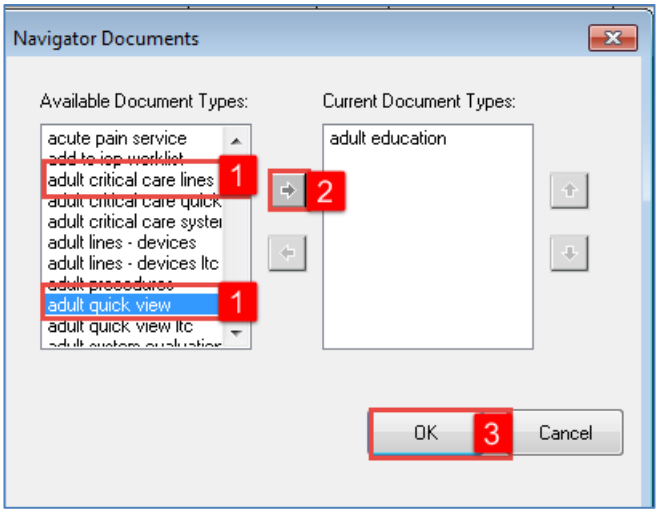
Unfortunately, you will have to go out and back into your patient's chart to see the added bands.



If needed, repeat the steps above after clicking OK to the **Changes to the Navigator Bands display**.

Now select the required band from the Available Document Types: **adult quick view** and **Intake and Output** bands **(**Educator Nurse**) adult critical care lines** bands **(**Wound/Ostomy and IVT nurses**)** and move it across  to the Current Document Types and click **OK.** The bands allow you to have a further assessment and intervention documentation.

You will require the **adult quick view** band and **intake and output** band for the next activities.



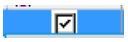
Note: You will only have to add bands once and it will be available each time you open PowerChart. You may also remove bands it needed.

Key Learning Points

- Nurses will complete most of their documentation in iView
- iView contains flowsheet type charting
- You may add or remove Navigator Bands as needed

Activity 5.2 – Document and Modify Your Documentation in iView

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

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

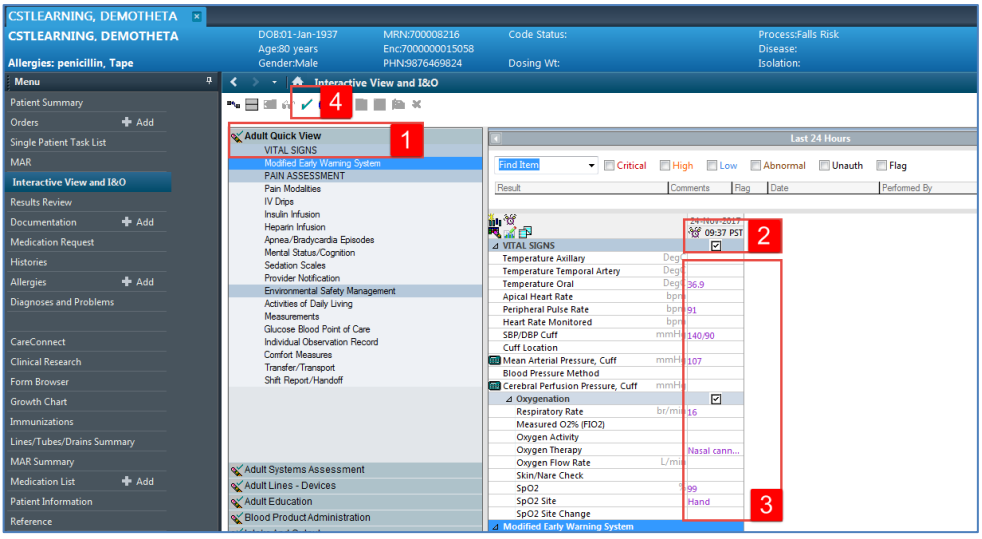
2. Document the following data:
   - **Temperature Oral** = *36.9*
   - **Peripheral Pulse Rate** = *91*
   - **SBP/DBP Cuff** = *140/90*
   - **Mean Arterial Pressure, Cuff** = *107* (Auto-populated result)

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

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

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

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



Once the documentation is signed the text becomes black. In addition, notice that a new blank column appears after you sign in preparation for the next set of charting. The columns are displayed in actual time. You can now document a new result for the patient in this column. The newest documentation is to the left.

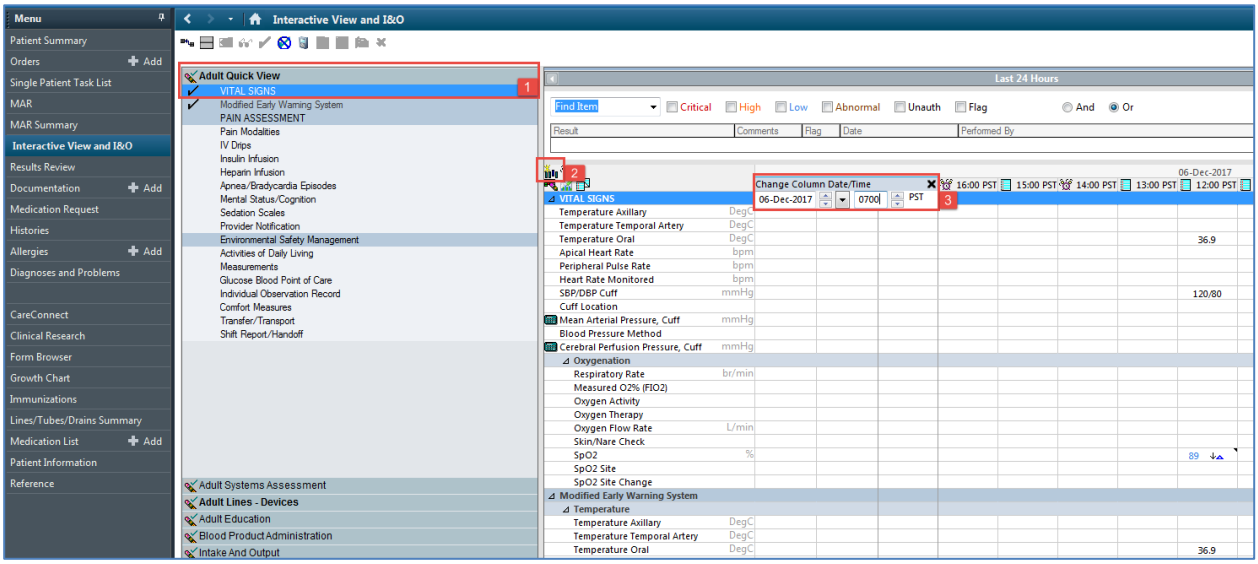
Key Learning Points

- 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

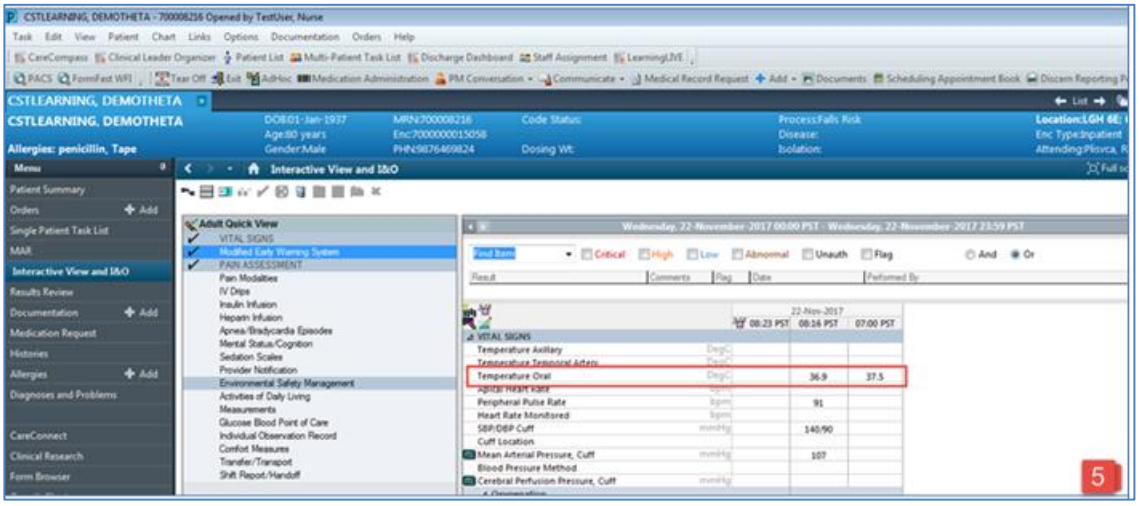
Activity 5.3 – Change the Time Column

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 07:00 am temperature.

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



5. In the new column, enter Temperature Oral = *37.5* and click the **green checkmark** icon to sign



Key Learning Points

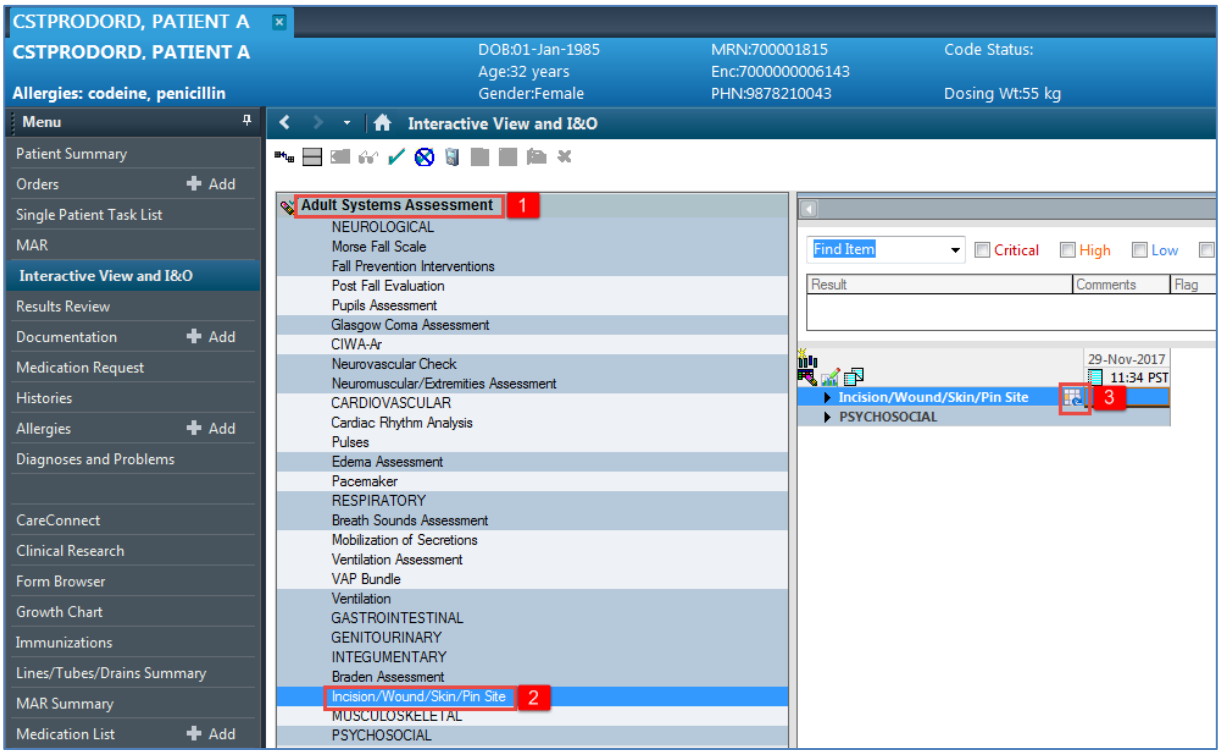
- Documentation time can be changed in iView.
- If required, you can create a new time column and document under a specific time

Activity 5.4a – Document a Dynamic Group in iView (For Wound Ostomy Nurse)

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.

In this scenario, your patient has a right abdominal wound and you document your assessment for the first time.

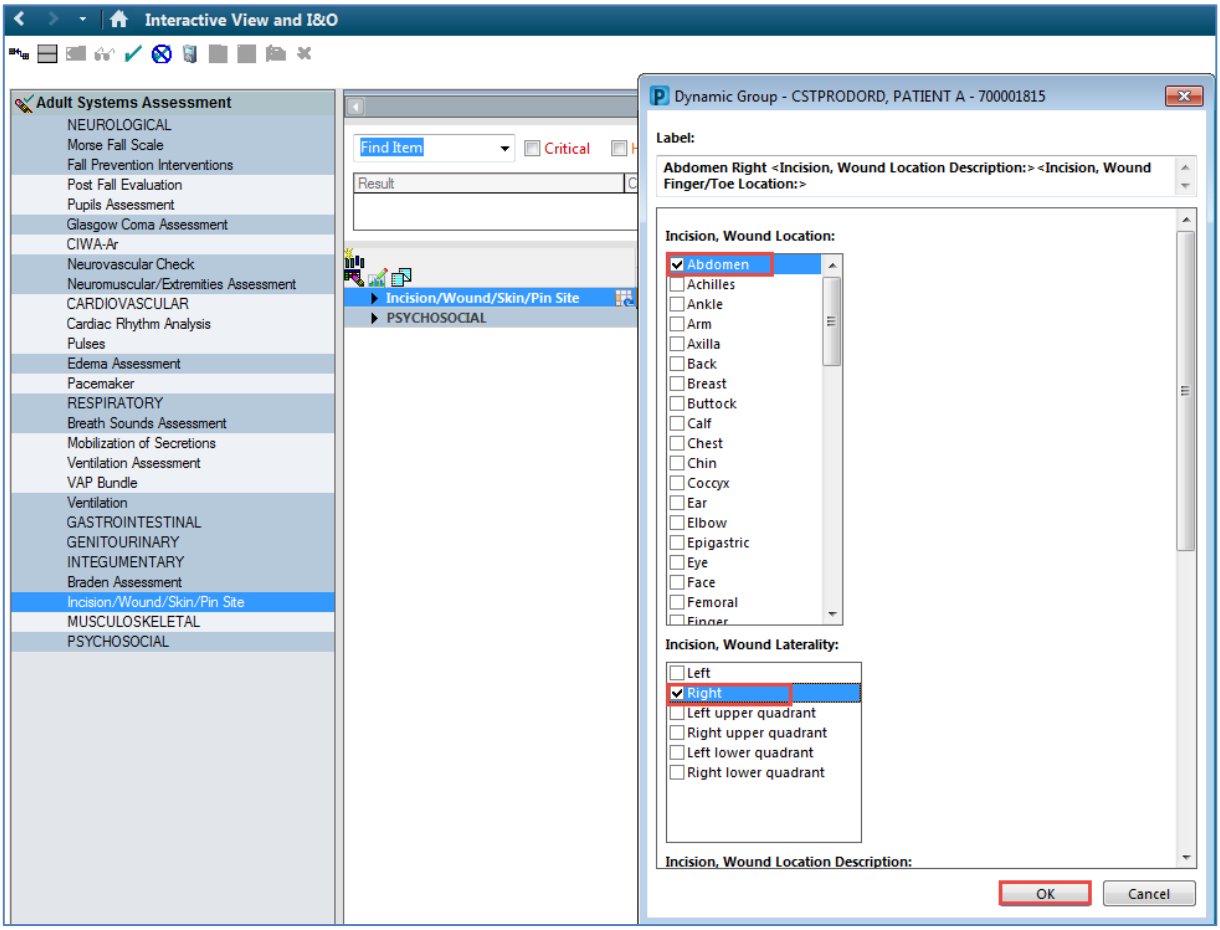
1. Click on the **Adult System Assessment** band
2. Now that the band is expanded, click on **Incision/Wound/Skin/Pin Site** section
3. Click on the **Dynamic Group** icon to the right Incision/Wound/Skin/Pin Site section heading in the flowsheet.



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

   Select the following to create a label:
   - **Incision, Wound Locations** = *Abdomen*
   - **Incision, Wound Laterality** = *Right*

5. Click **OK**

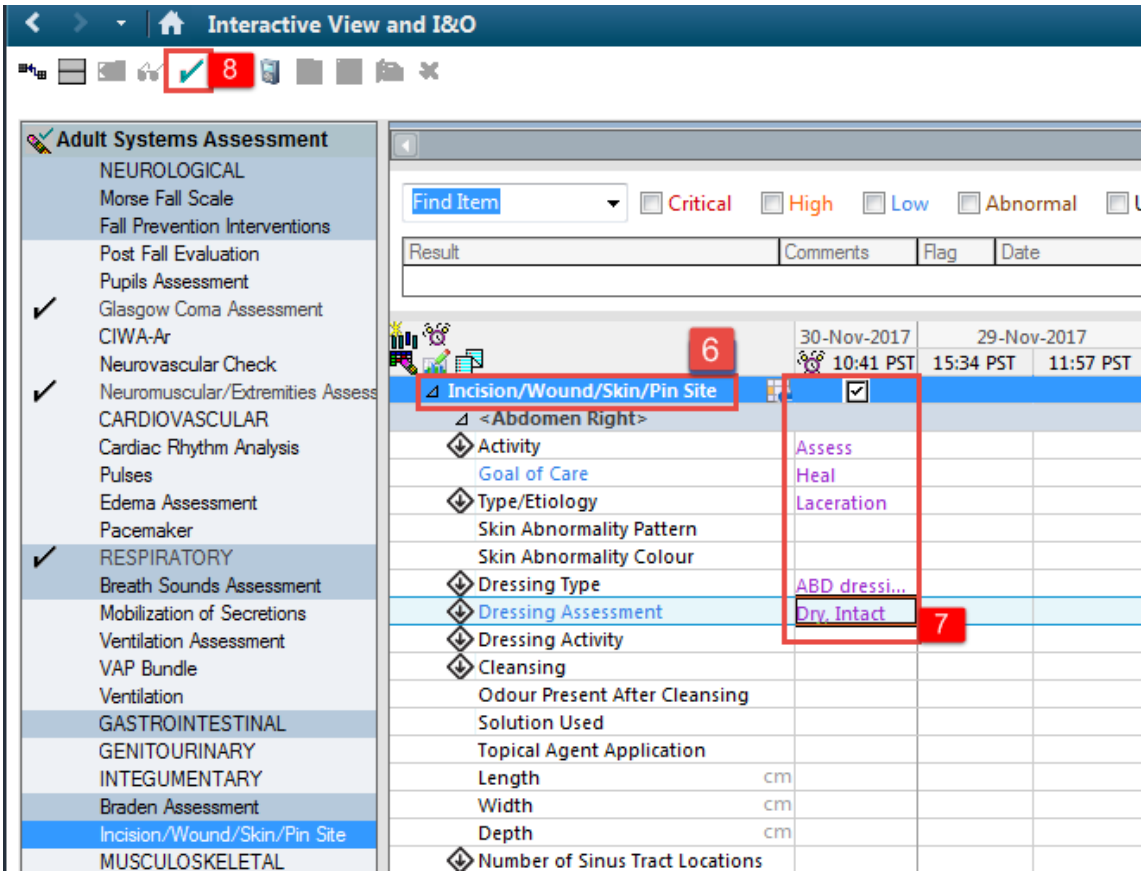


6. The label created will display at the top, under the **Incision/Wound/Skin/Pin Site** section heading.

7. Double-click the **blue box**  next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key.

   Now document the activities related to this wound:
   - **Activity** = *Assess*
   - **Goal Of Care** = *Heal*
   - **Type/Etology** = *Laceration*
   - **Dressing Type** = *ADB dressing*
   - **Dressing Assessment** = *Dry, Intact*

8. Click **green checkmark** icon ✓ to sign your documentation. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.



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

Note: When you discontinue a line, tube or drain, you may right-click. However, then you should be also inactive the line, tube or drain by right-clicking on the dynamic group  to indicate it is not available for documentation.

Key Learning Points

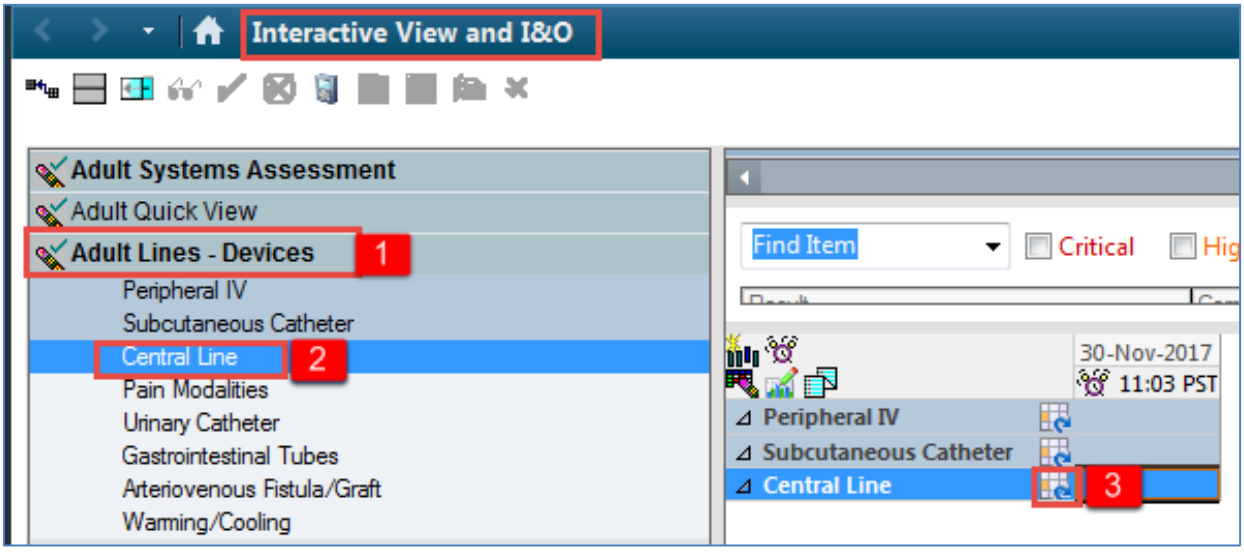
- Examples of Dynamic Groups include wound assessments, IV sites, chest tubes, etc
- Once documentation within a dynamic group is signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group

Activity 5.4b – Document a Dynamic Group in iView (for IV Therapists)

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.

As an IV Therapist, you are aware that your patient requires a Peripheral inserted central catheter(PICC) to be inserted. After inserting the PICC line successfully, you are now ready to document the details of the PICC insertion.

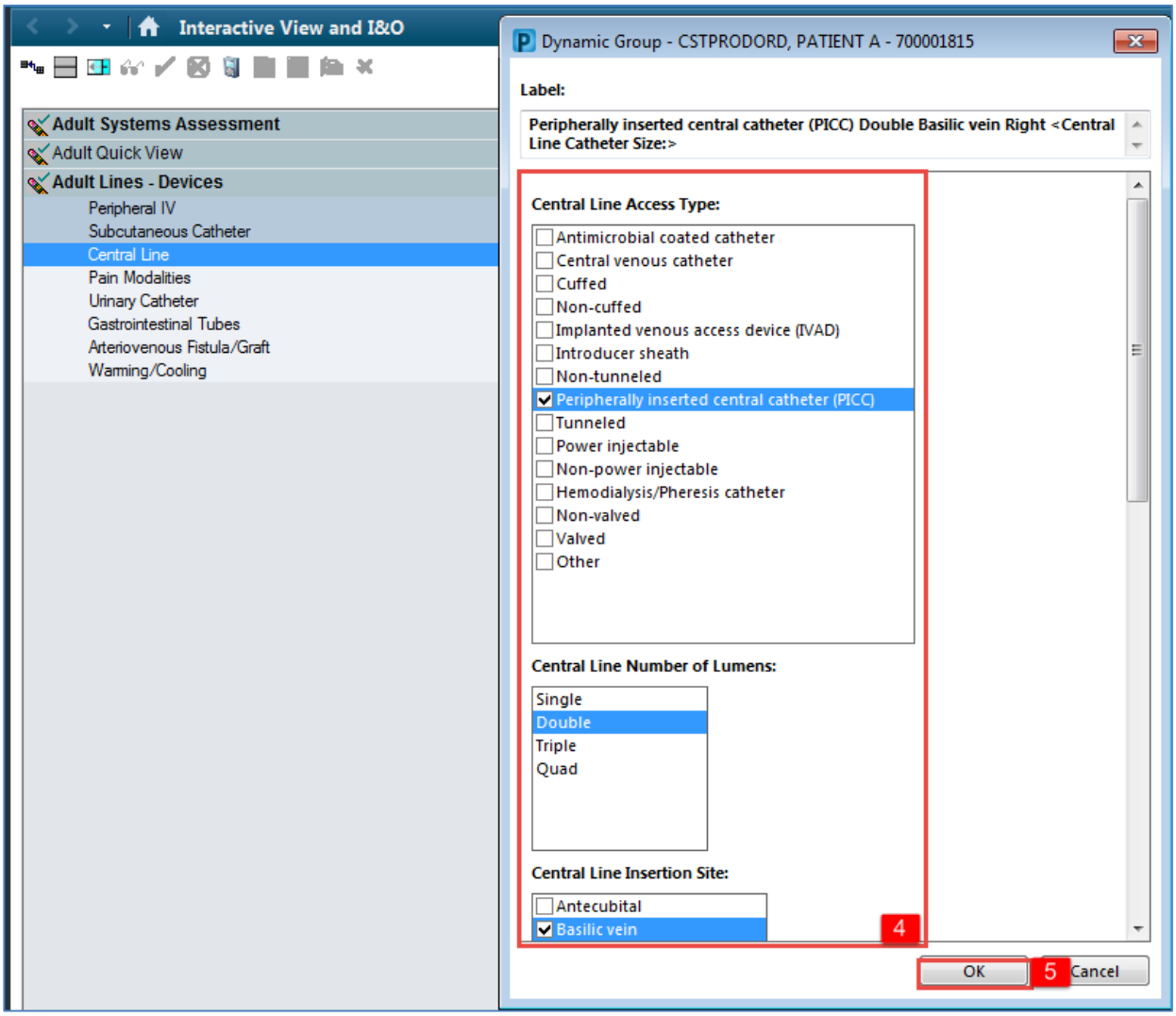
1. Click on the **Adult Lines – Devices** band
2. Click on the **Central Line** section
3. Click on the **Dynamic Group** icon to the right of the Central Line heading in the flowsheet



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

   Select the following to create a label:
   - **Central Line Access Type** = *Peripheral inserted central catheter(PICC)*
   - **Central Line Number of Lumens** = *Double*
   - **Central line Insertion Site** = *Basilic vein*
   - **Central Line laterality** = *Right*

5. Click **OK**

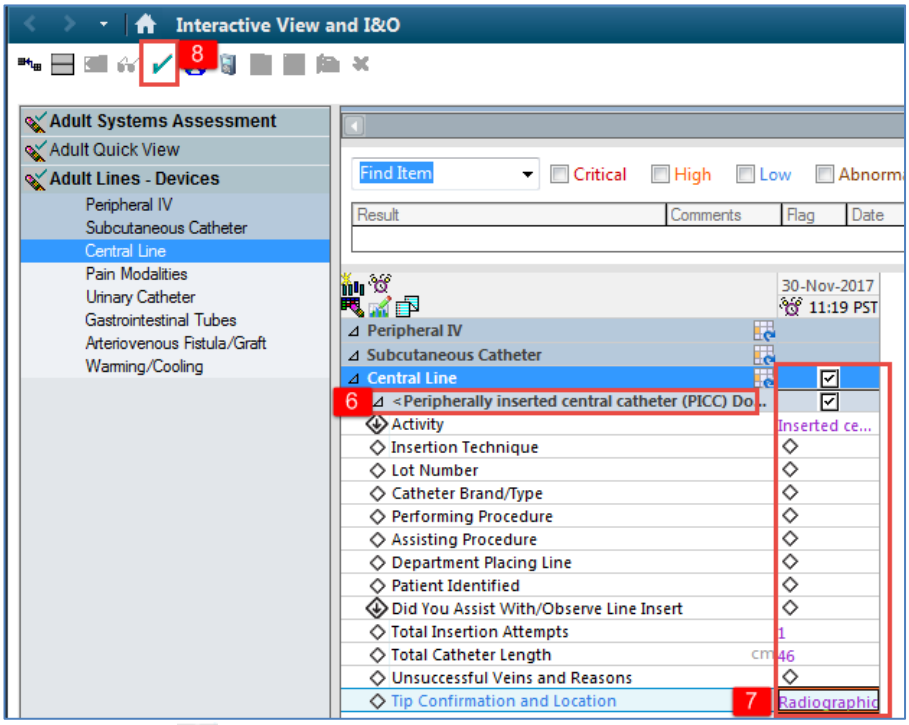


6. The label created will display at the top, under the **Central Line** section heading.

7. Double-click the **blue box** next to the name of the section to document in several cells. You can move through the cells by pressing the **Enter** key.

   Now document the activities related to this PIV:
   - **Activity** = *Inserted central line*
   - **Total Insertion Attempts** = *1*
   - **Total Catheter Length** = *46*
   - **Tip Confirmation and Location** = *Radiologist*

8. Click **green checkmark** icon to sign your documentation. Once signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group.



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

Note: When you discontinue a line, tube or drain, you may right-click. However, then you should be also inactive the line, tube or drain by right-clicking on the dynamic group to indicate it is not available for documentation.

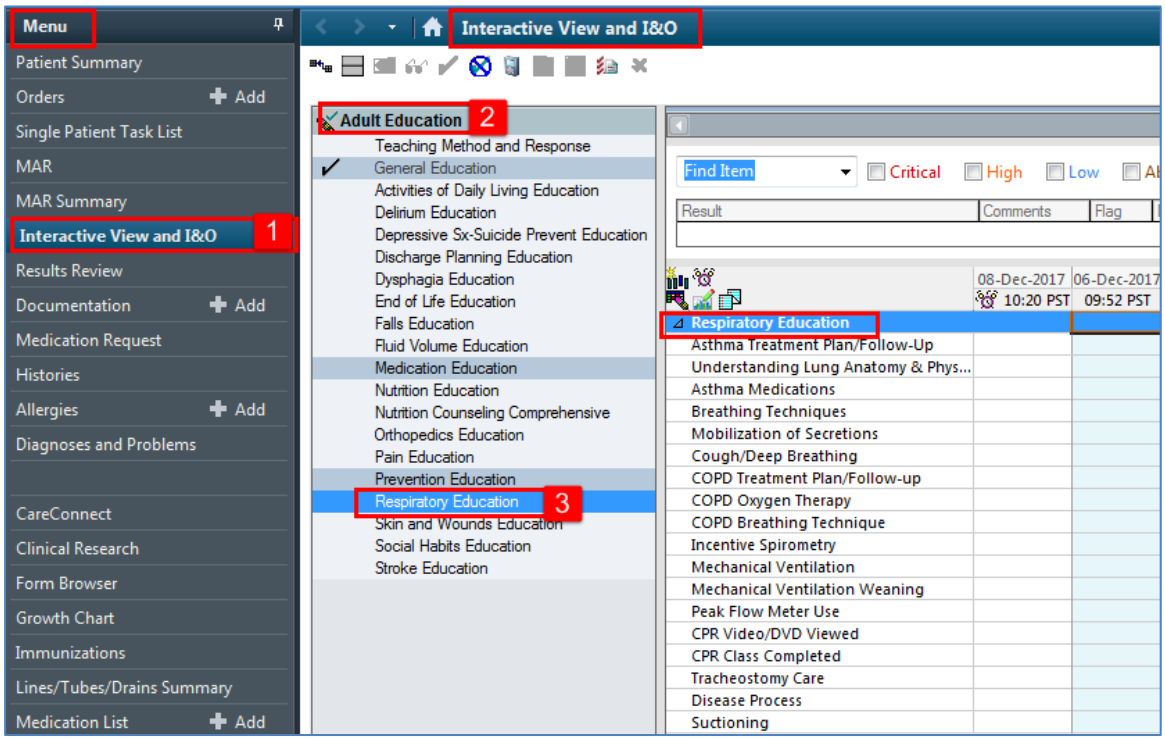
Key Learning Points

- Examples of Dynamic Groups include wound assessments, IV sites, chest tubes, etc
- 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

Activity 5.4c – Document Patient Education in iView (for Patient Educators)

1 As a Patient Educator, you can follow the following steps to document patient education in Ivew:

1. Go to the **Menu** and click **Interactive View and I&O**
2. Click on the **Adult Education** band
3. Select an appropriate section for your patient. For example, if you are an Asthma Educator, you can select the **Respiratory Education** section or a Diabetic Educator would choose the **General Education** section.
4. Then you can continue to document on your patient (using the skills as you have learned in Activity 5.2).



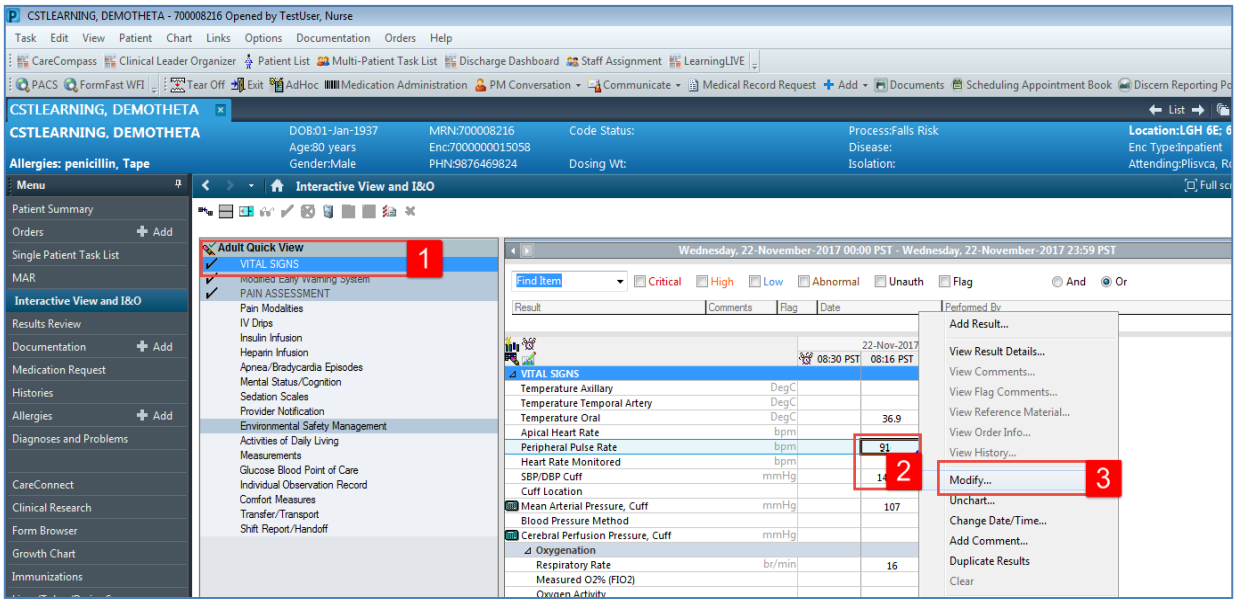
Key Learning Points

- Patient education can be documented in the Adult Education band
- Navigator Bands may be add to provide additional documentation flowsheets as needed

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

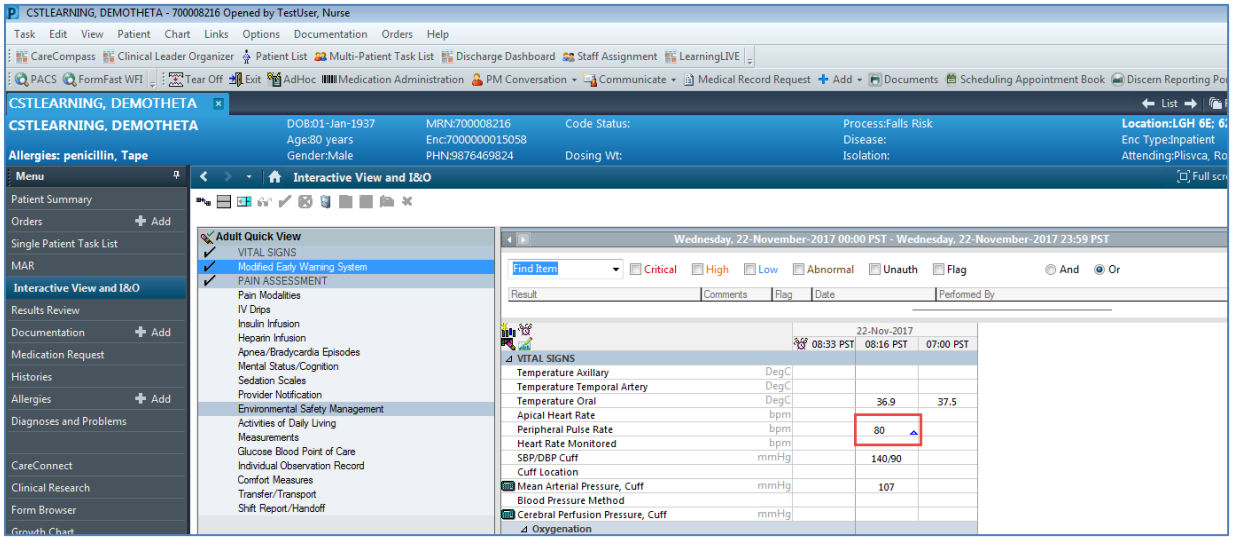
1 You realize upon reviewing your earlier charting that you wrote the incorrect Peripheral Pulse Rate value. Let's modify the Peripheral Pulse Rate.

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



4. Enter in new **Peripheral Pulse Rate** = *80* and then click **green checkmark** icon ✓ to sign your documentation.

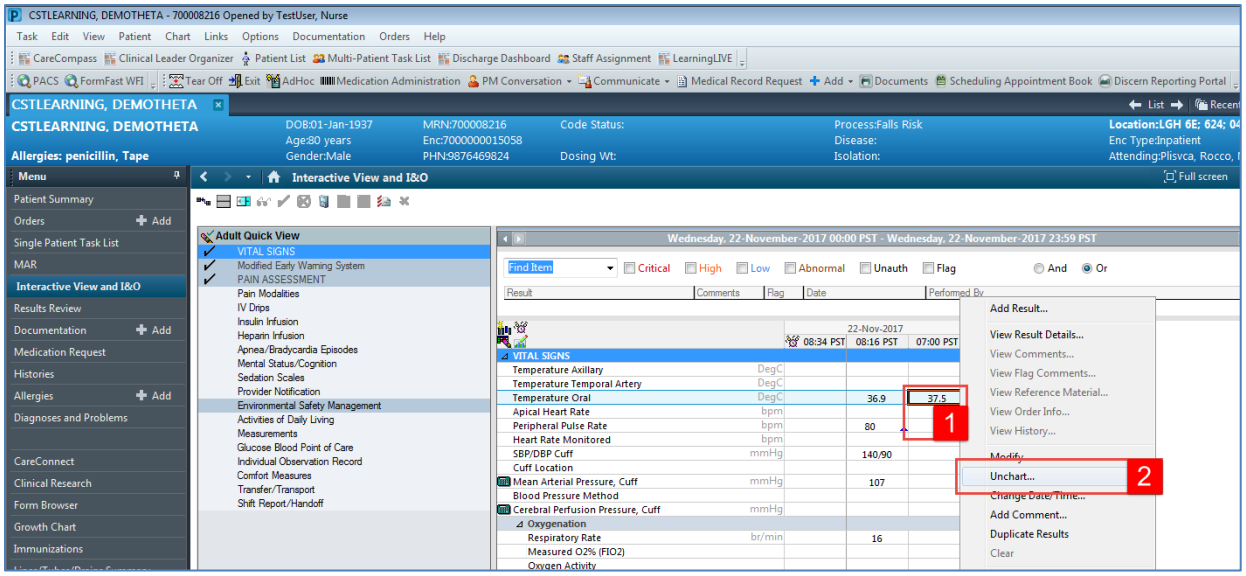
5. **80** now appears in the cell and the corrected icon will automatically appear on the bottom right corner to denote a modification has been made



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.

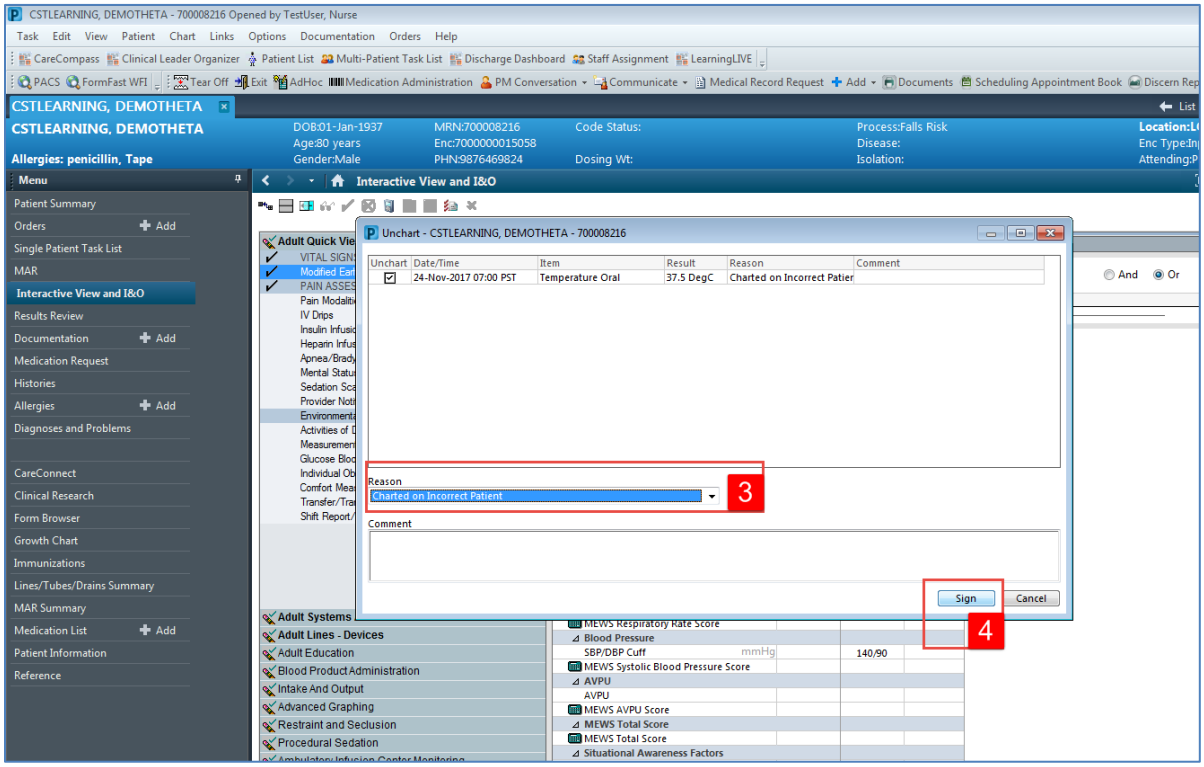
For this scenario, let's say the temperature documented earlier was meant to be documented on one of your other patient's charts. Therefore, it needs to be uncharted.

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

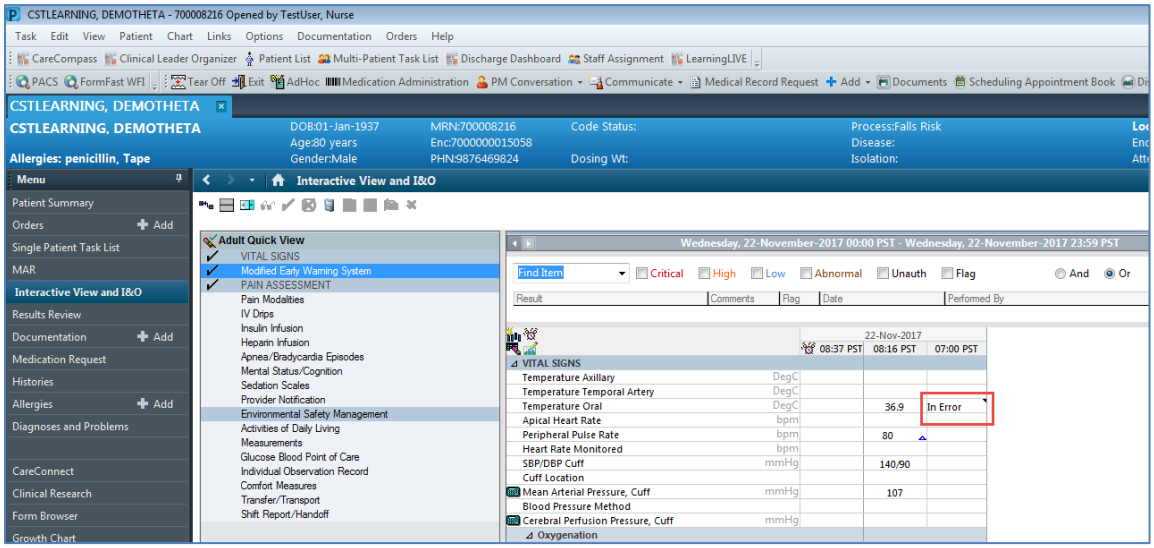


3. The Unchart window opens, select **Charted on Incorrect Patient** from the Reason drop-down.

4. Click **Sign**

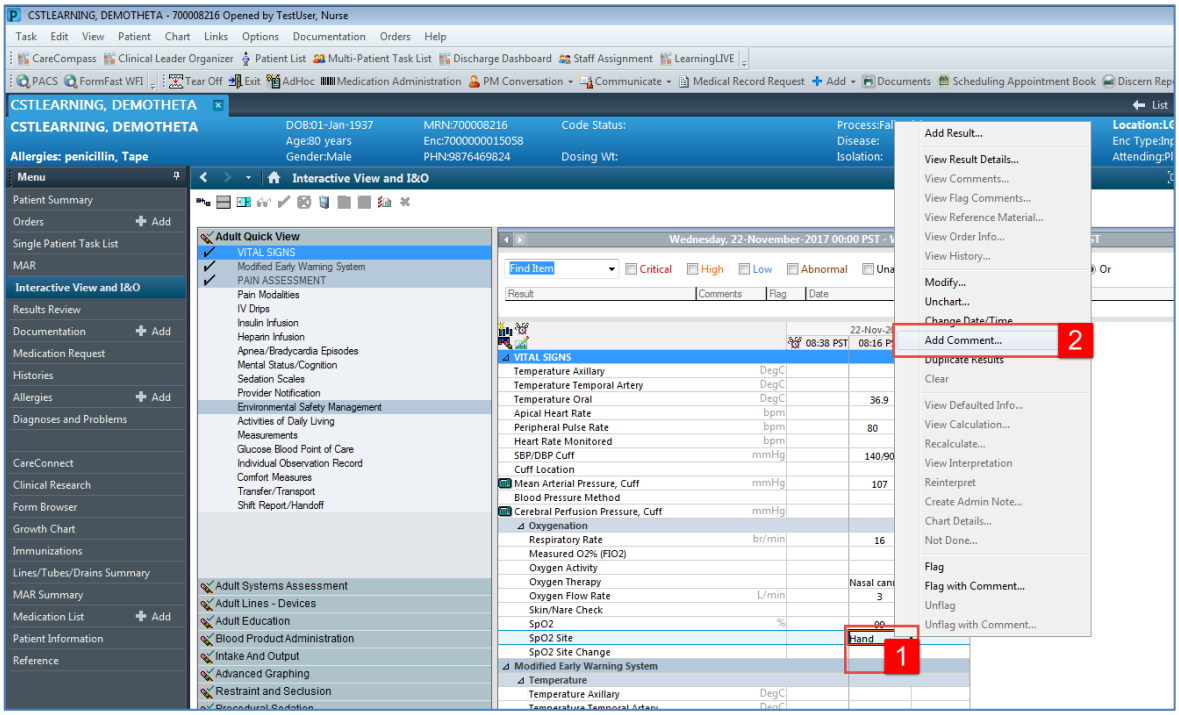


5. You will see **In Error** displayed in the uncharted cell. The Result comment or annotation icon will also appear in the cell.

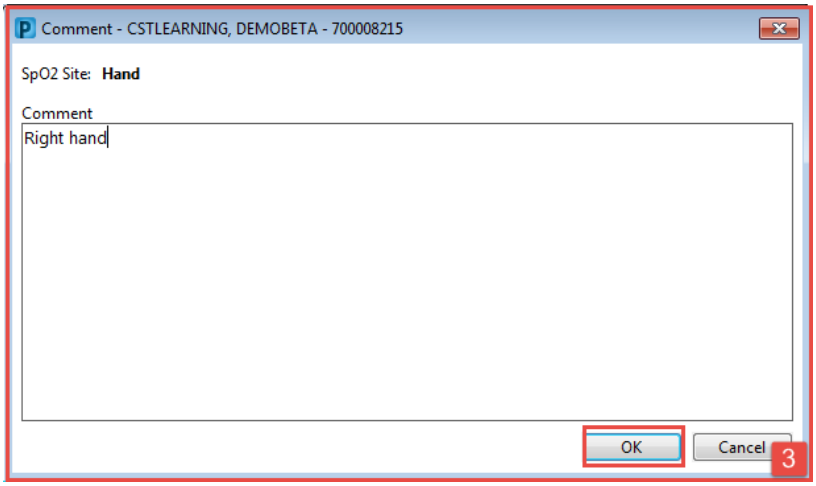


3 A comment can be added to any cell to provide additional information. For example, you want to clarify that the SpO2 site that you documented was on the patient's right-hand.

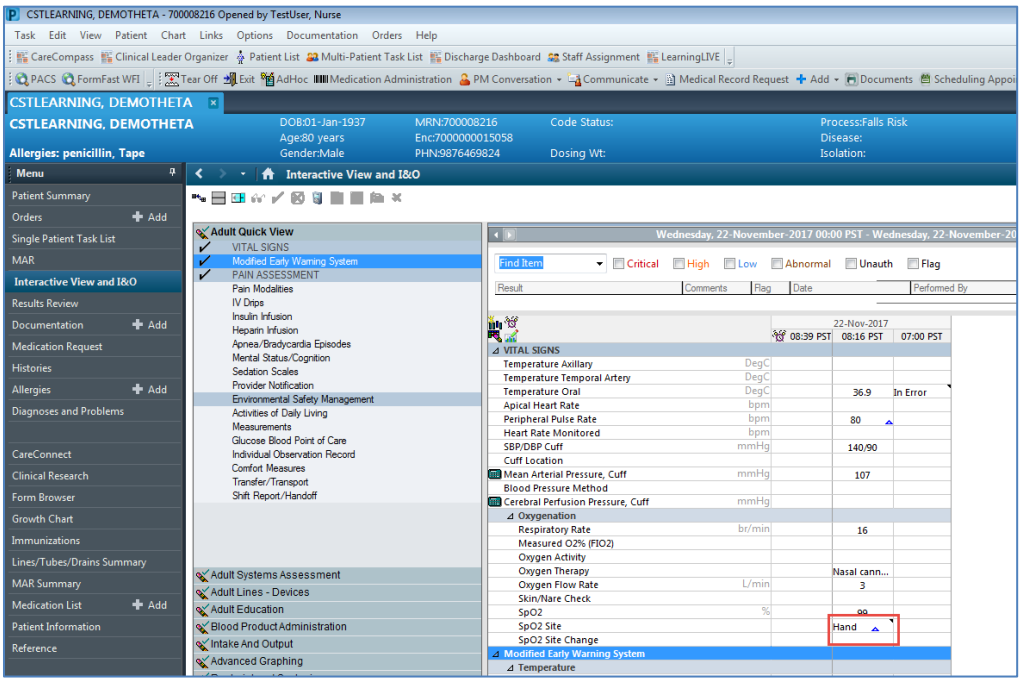
1. Right-click on the documented value for SPO2 site, **hand**
2. Select add comment



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



4. The Corrected icon and Result Comment or Annotation icon will display in the cell. In order to review comment, right-click on cell and select View Comments



Key Learning Points

- Results can be modified and uncharted within iView
- A comment can be added to any cell

PATIENT SCENARIO 6 – Documentation

Learning Objectives

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

- Create a narrative nursing note
- Modify or unchart a narrative nursing note

SCENARIO

In some situations, a narrative nursing note is required to document, for example, the patient's treatment plan. You will be completing the following activities:

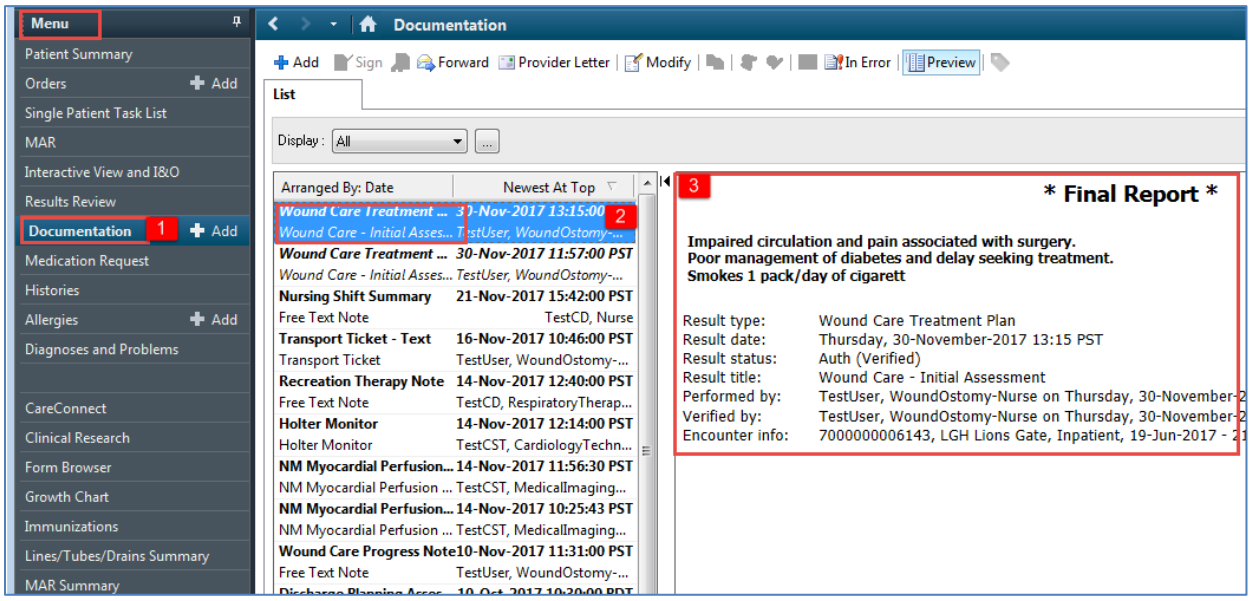
- Review documentation
- Create a nursing note
- Modify or unchart a nursing note

Activity 6.1 – Review Documentation

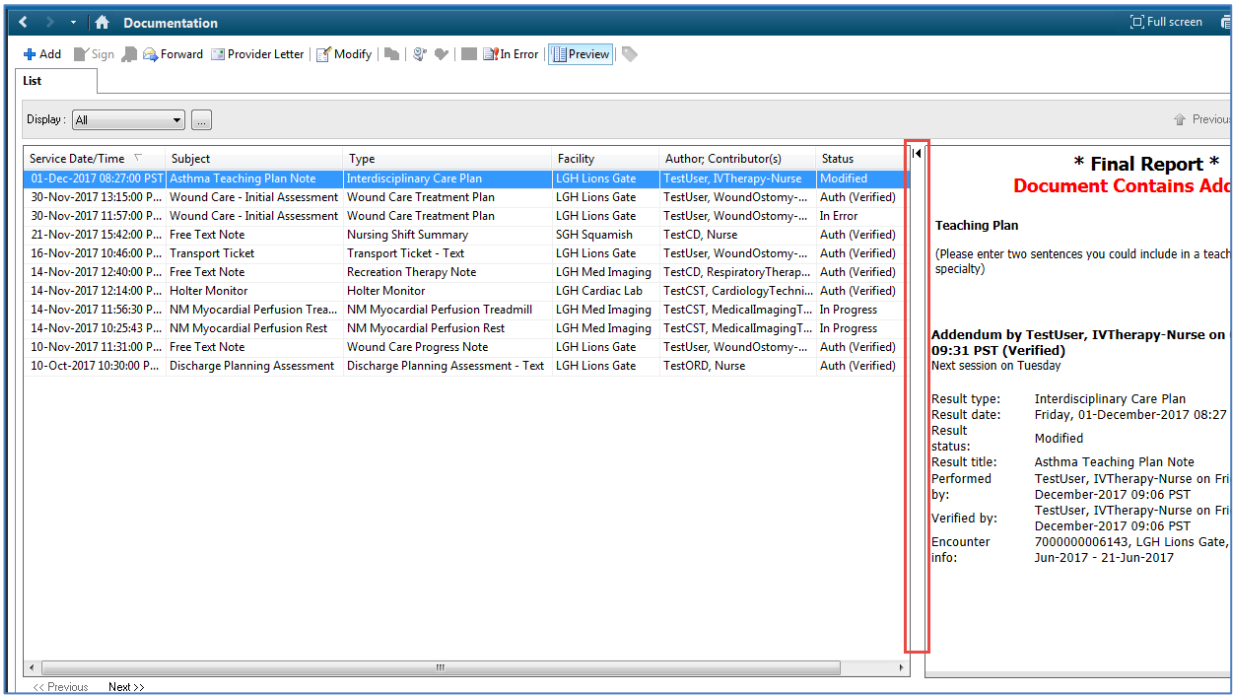
1 There may be instances where iView and Powerforms do not capture all the information during a patient event and you may want to supplement with a narrative note. You can create a narrative note using the **Documentation** tool. You can also use this tool to view or modify an existing note.

To navigate to the **Documentation**:

1. Select **Documentation** from the **Menu.**
2. On the left side of the Documentation is a list of existing notes
3. On the right side, it displays the details of an existing note



4. If you enlarge the left pane of Documentation by sliding the bar to the right, you will see more columns on the left side.

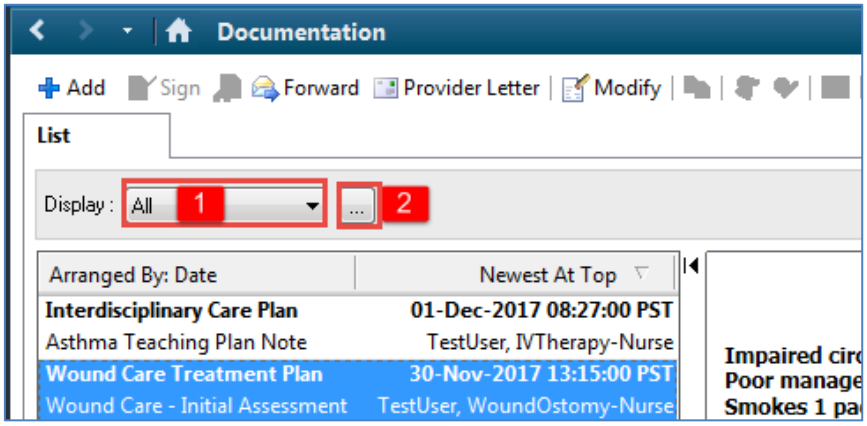


5. As shown in the **Status** column above, a note can be in one of the following statuses:

   - **Modified**: The note has been modified by a user
   - **In Error**: The note has been entered incorrectly and has been uncharted
   - **Auth (Verified)**: The note has been completed and signed
   - **In Progress**: The note is saved 🖬 and it is not complete and cannot be viewed by another user.

Note: You can filter your documents list by:

1. Selecting an existing filter dropdown from the **Display** field, or
2. You can see and select more advanced filters by clicking on ... .



Key Learning Points

- The Documentation lists all existing notes for the patient
- You can view an existing note in the Documentation tool.

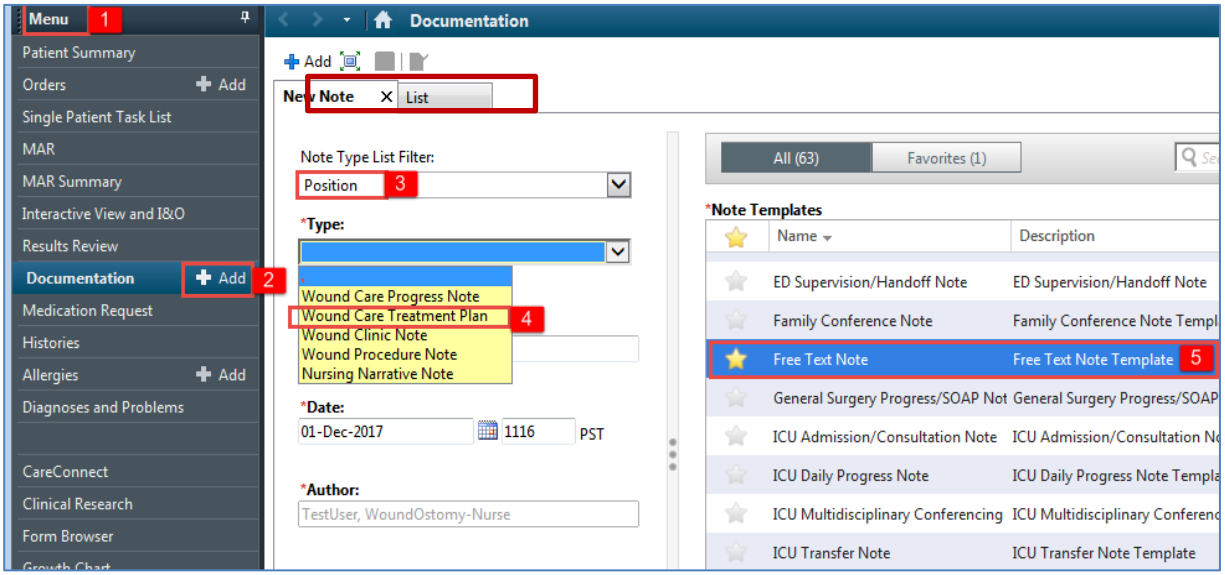
Activity 6.2a – Creating a Nursing note (For Wound Ostomy Nurses)

1 In this activity, you will create a free text note to document your initial assessment of the patient's wound.

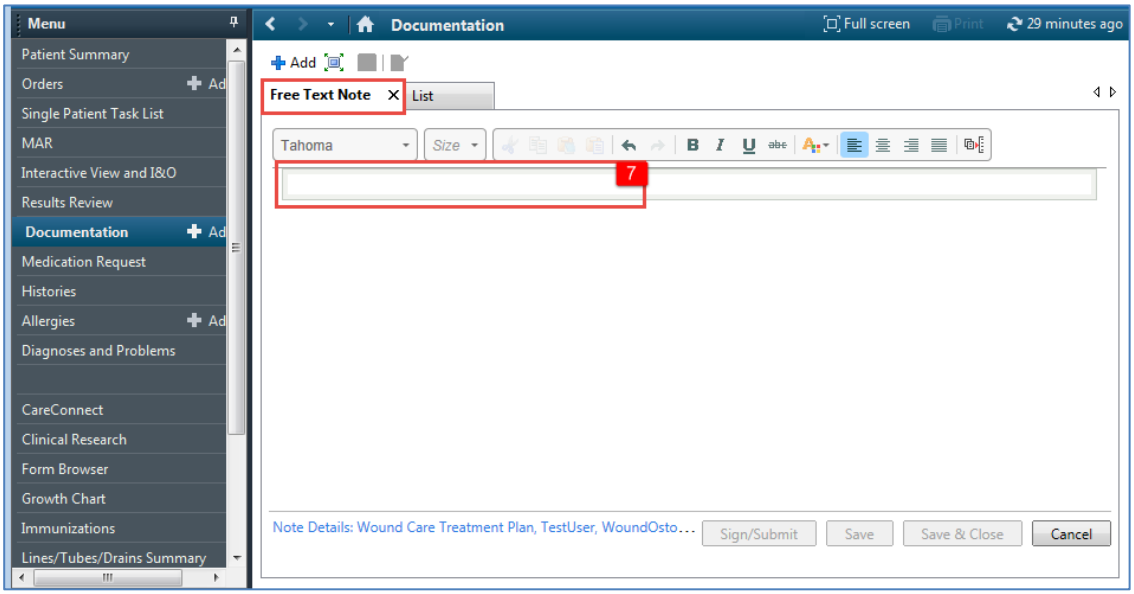
To document a wound care nursing note:

1. Go to the **Menu**
2. Locate **Documentation** and click **+Add**
3. Confirm *position* for **Note Type List Filter:**
4. Select *Wound Care Treatment Plan* Under for **Type**
5. Under **Note Templates** select *Free Text Note*
6. Click **OK.** A new note opens

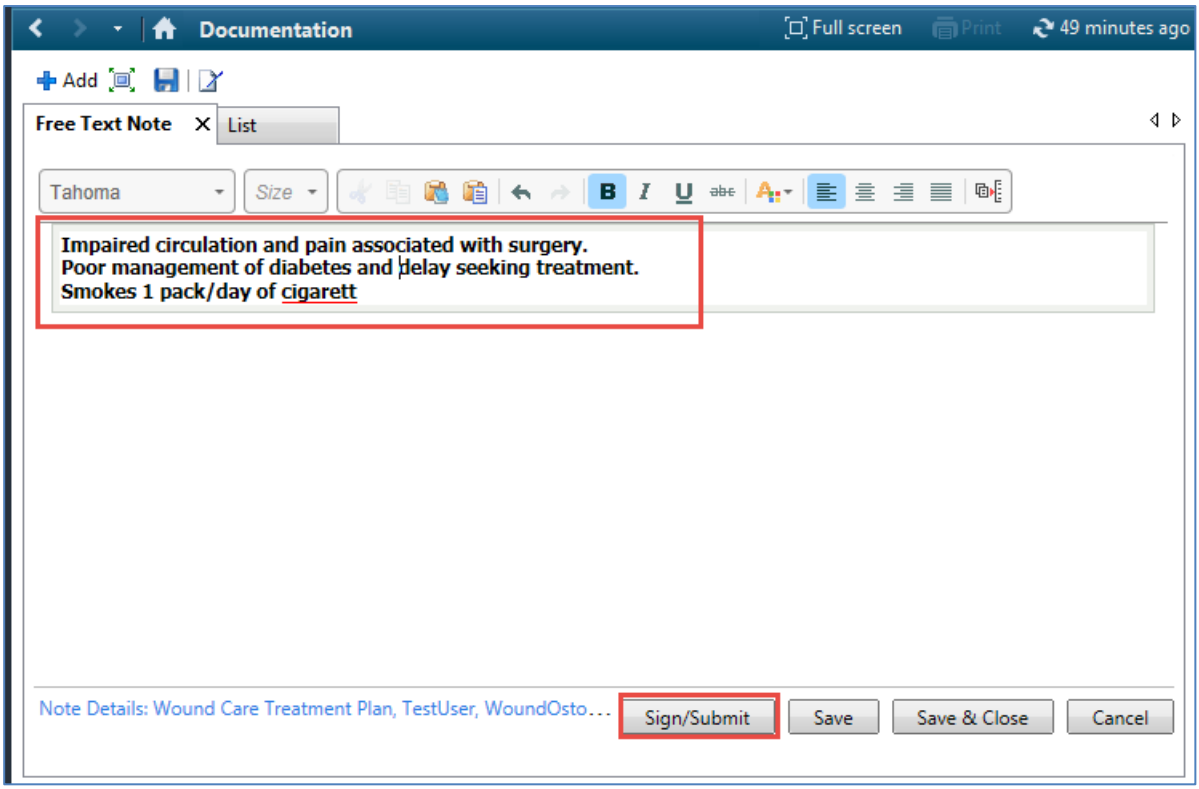
   Note: The **List** tab is still visible and accessible while composing a new note.



7. Hover the first line to open the text box

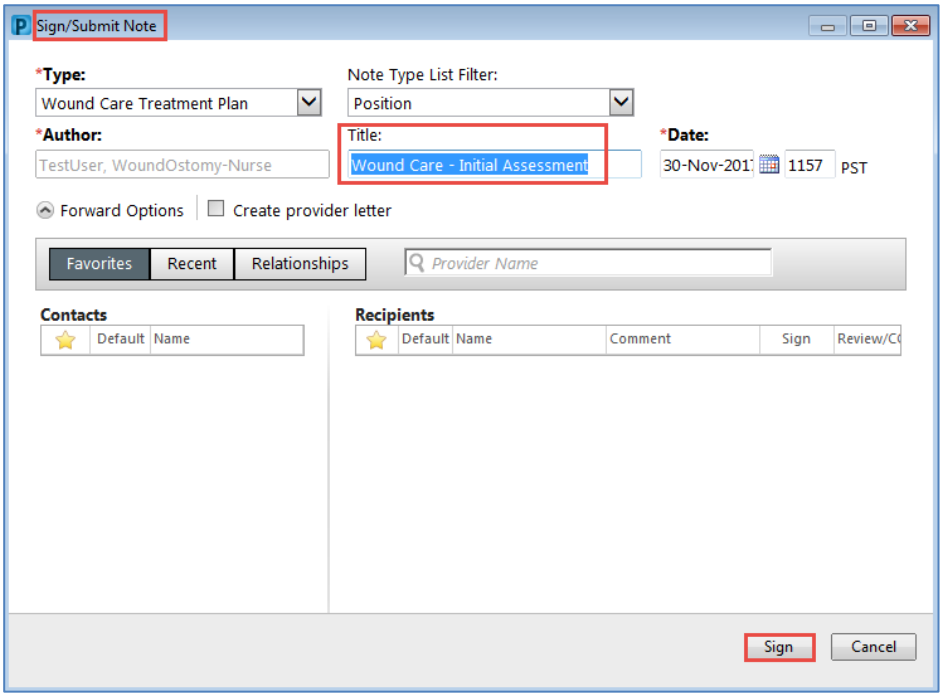


8. Document the following note in the text box = *Impaired circulation and pain associated with surgery. Poor management of diabetes and delay seeking treatment. Smokes 1 pack/day of cigarette.*
   Then click the **Sign/Submit** button



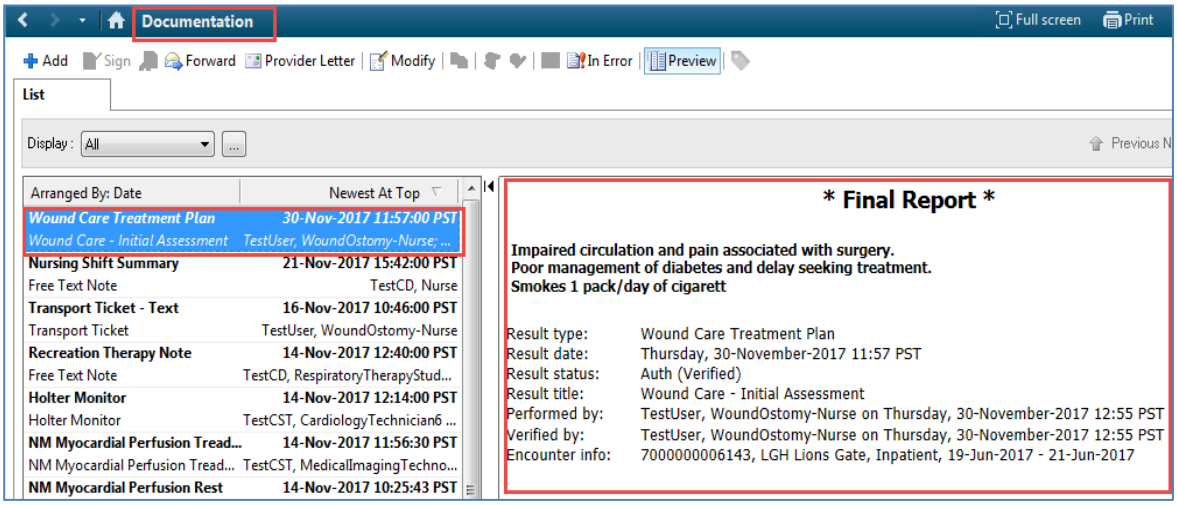
Note: The tool has spelling check functionality and underlines spelling errors

9. In the Sign/Submit Note window, Type in your note title (e.g., *Wound Care – Initial Assessment*) in the Title field. Then click **Sign** button



Note: It is important to label your note with an appropriate name. Otherwise, it will be displayed as a generic free text note.

10. The system brings you back to Documentation. Click on the title of your note and the note details will display on the right side.



Congratulations, you have successfully created a nursing note for your patient!

Key Learning Points

- You can use the Documentation tool to create a nursing note

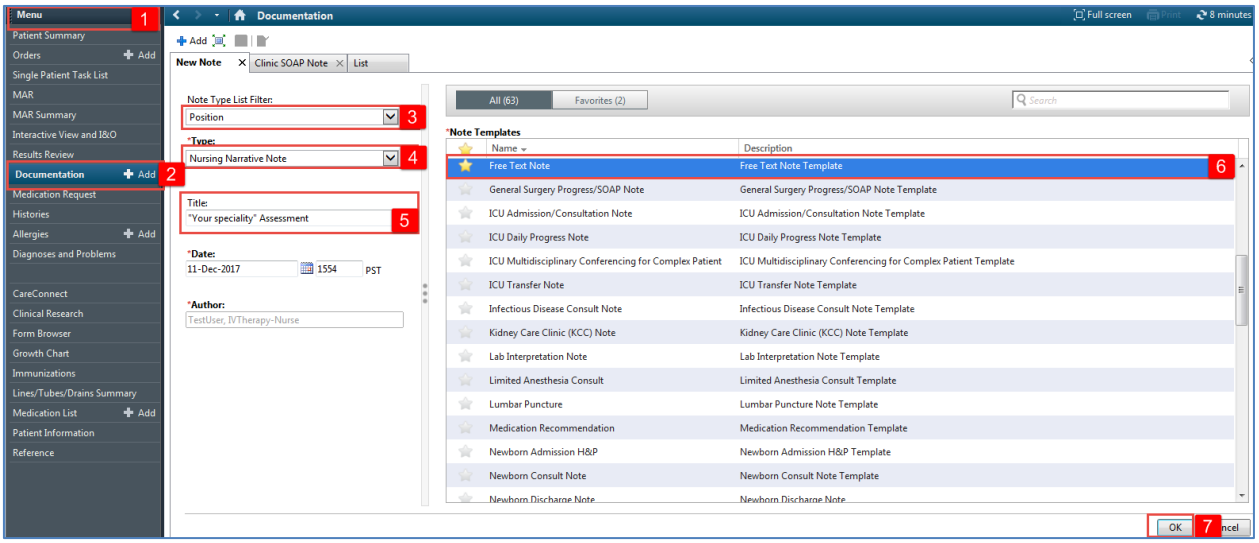
Activity 6.2b – Creating a Nursing Note (For IV Therapy Nurses and Patient Educators)

1 In this practice scenario, you will create a new free text note to document your teaching plan.

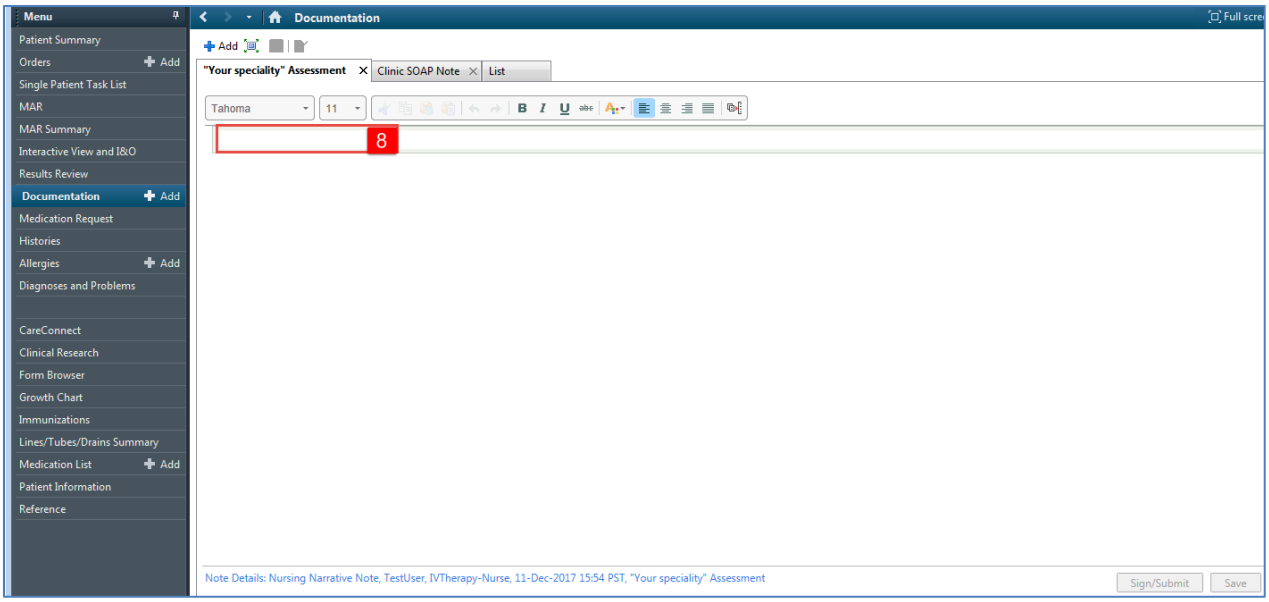
To document your teaching plan:

1. Navigate to the **Menu**
2. Locate **Documentation** and click **+Add**
3. Confirm **Position** for Note Type List Filter:
4. From the Type dropdown list, Select **Nursing Narrative Note**
5. In the Title: box enter = **"***Your specialty" Assessment.*

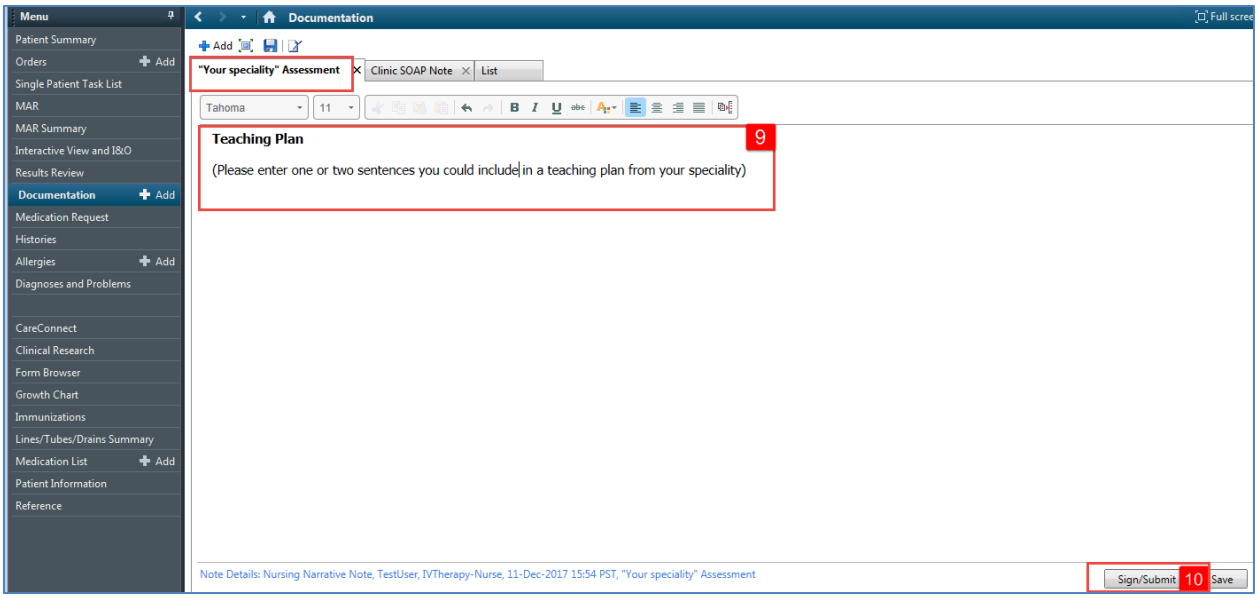
   Note: It is important to label your note with an appropriate name. Otherwise, it will be displayed as a generic free text note.
6. On the right of your screen, under **Note Templates** select **Free Text Note**
7. Then click **OK.** A new note opens.



8. Hover the first line to open the text box

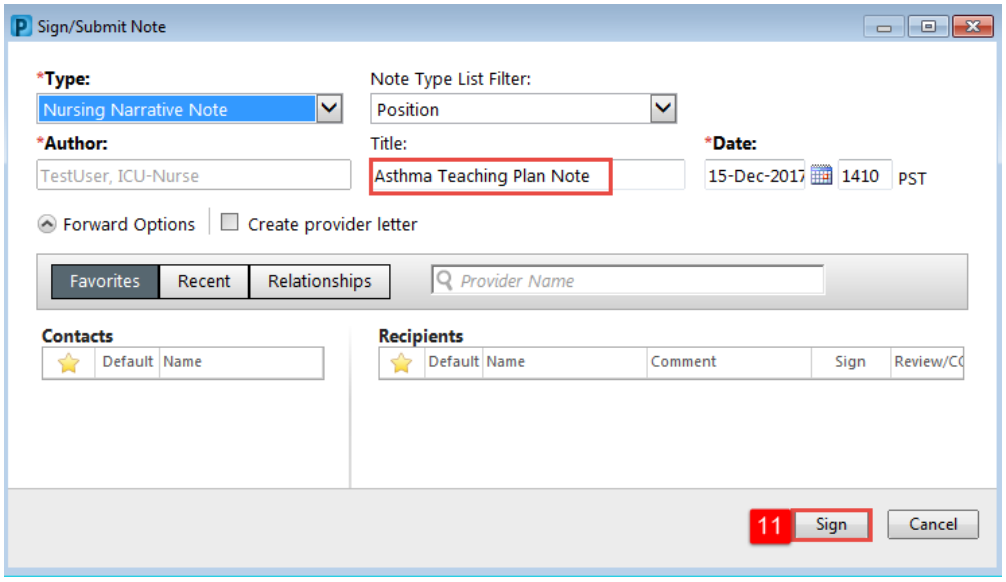


9. Document the following note in the text box = *Teaching Plan (Bold), (Please enter two sentences you could include in a teaching plan from your specialty)*
10. Then click in **Sign/Submit** button

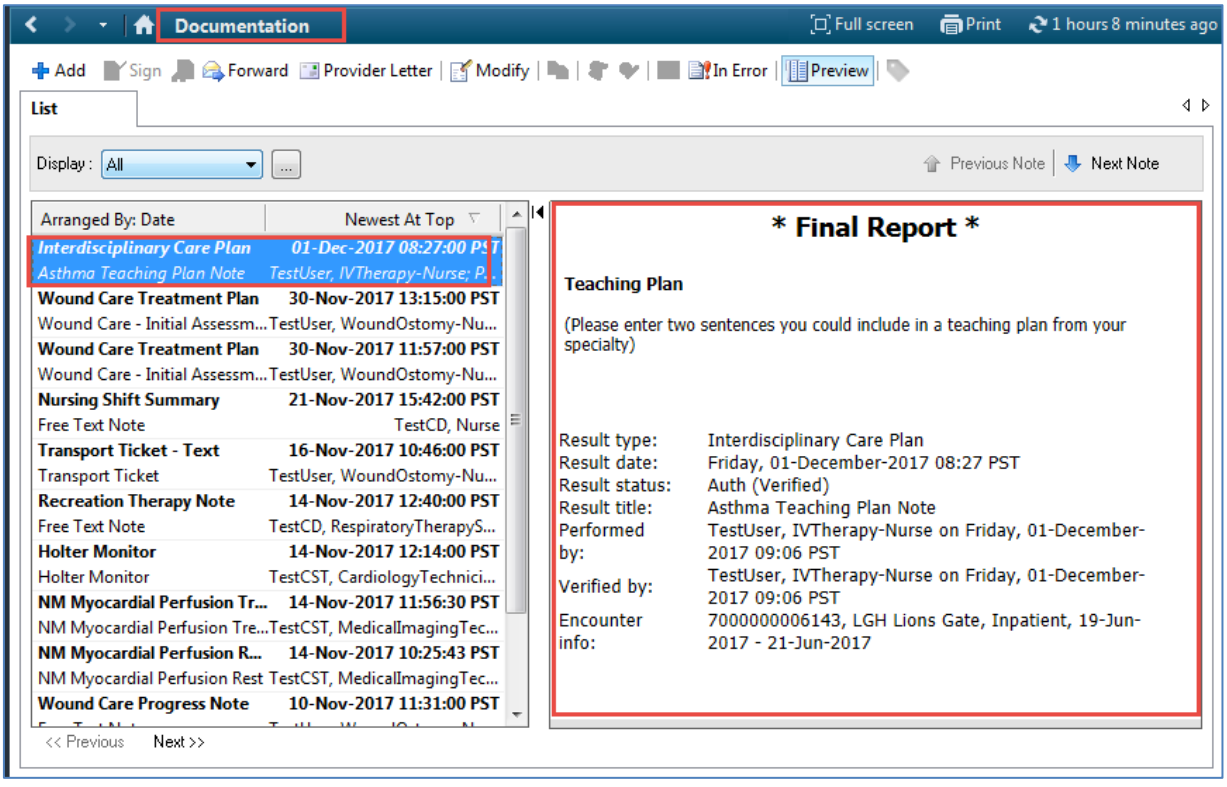


The tool has spelling check functionality and it underlines spelling errors

11. In the Sign/Submit Note pop-up window, review and click on the **Sign** button



12. The system brings you back to Documentation. Click on the title of your note and the note details display on the right side.



Congratulations, you have successfully created a narrative nursing note for your patient!

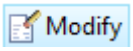
Key Learning Points

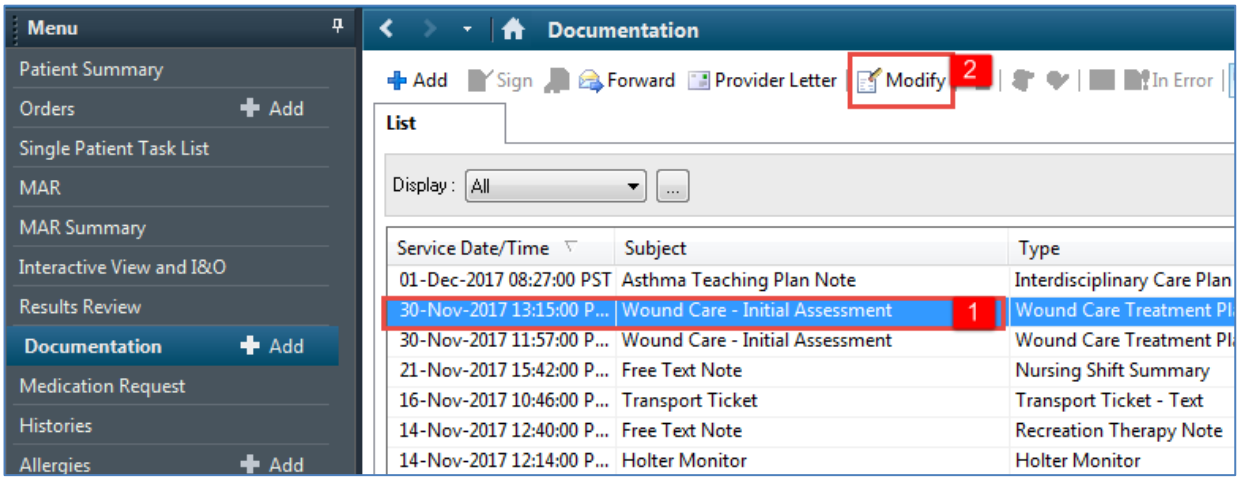
- You can use the Documentation to create a narrative nursing note

Activity 6.3 – Modify or Unchart a Nursing Note

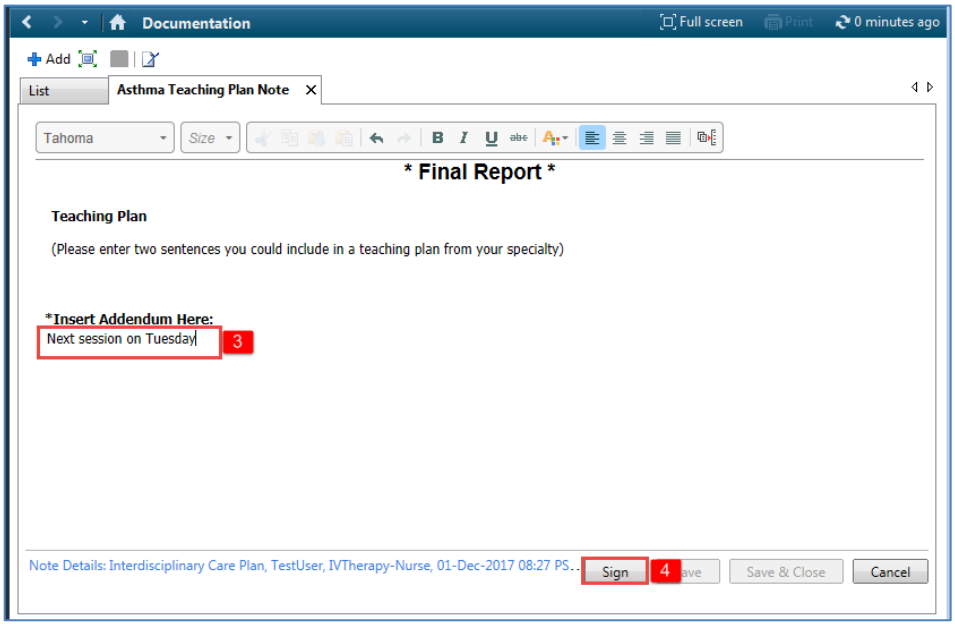
1 It may be necessary to modify a note if information needs to be added or clarified. Let's modify the note you just created in the previous activity. **Note:** You are only able to modify your documentation by inserting an addendum.

To modify a note within **Documentation**:

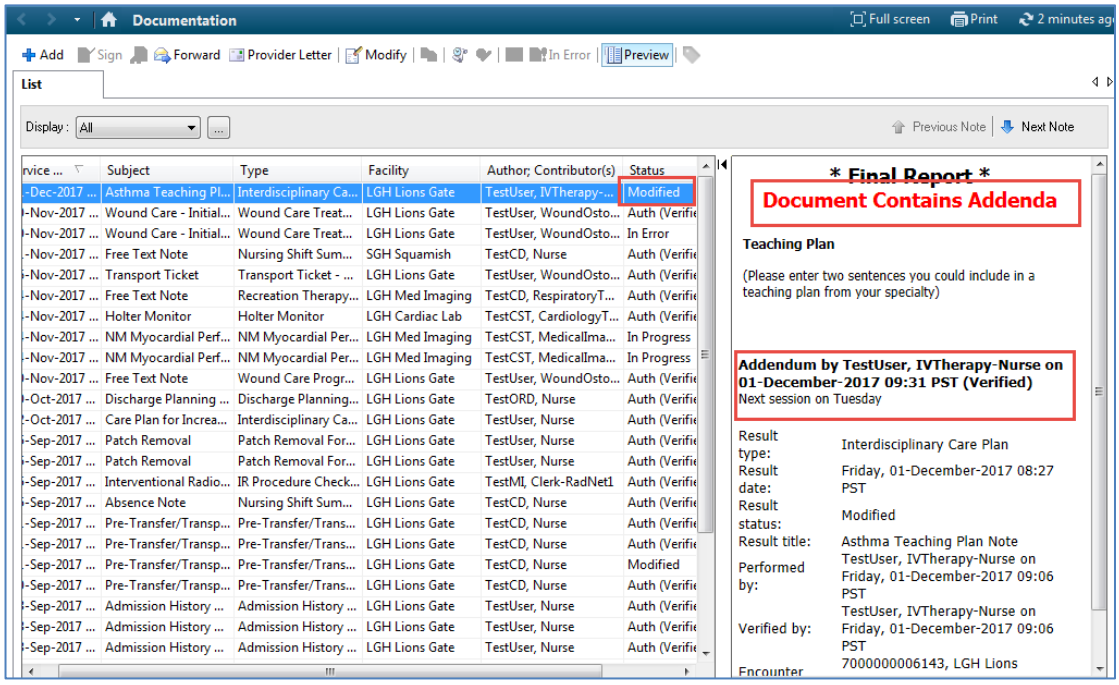
1. Select most recently completed note, such as *Interdisciplinary Care Plan – Asthma Teaching Plan Note,* within **Documentation**
2. Select **Modify** 



3. Under ***Insert Addendum Here:**, type = *Next session on Tuesday*
4. Click **Sign**.



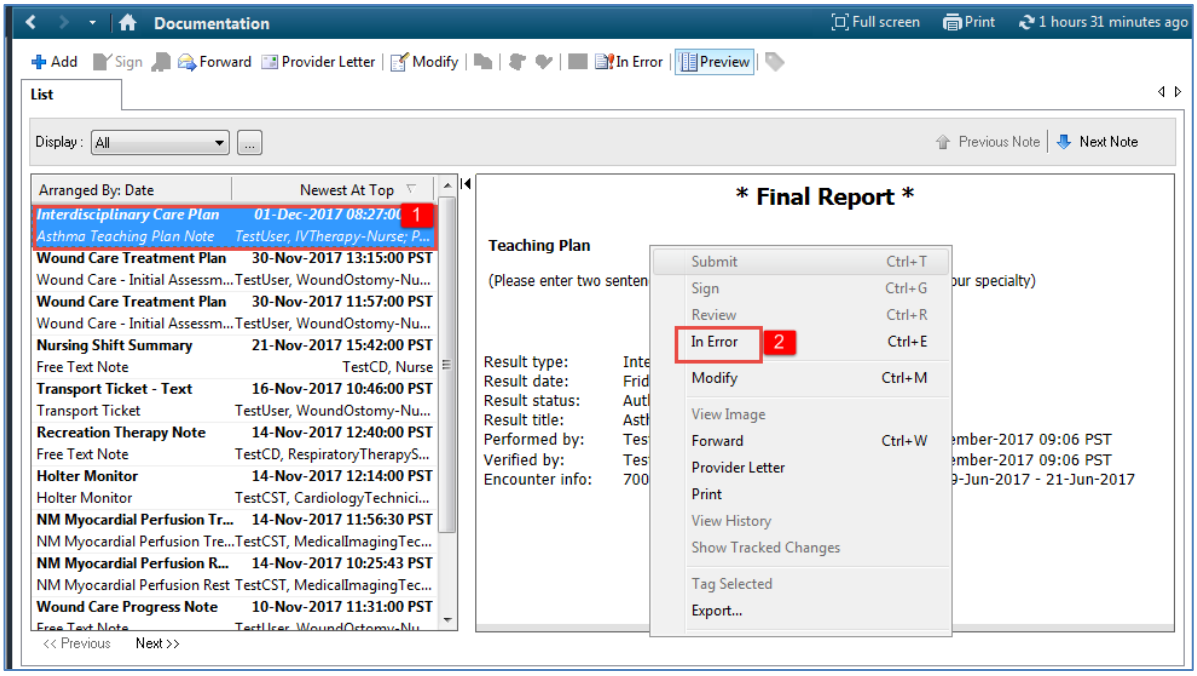
5. When you return to the Documentation, it will show that the note has been modified.



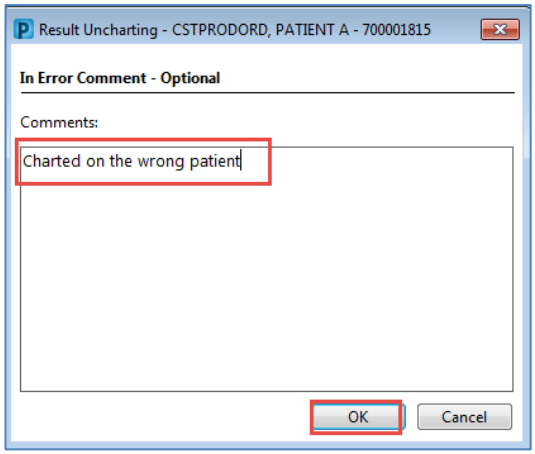
2 It may be necessary to unchart an existing note (e.g., if charted on the wrong patient). Uncharted notes are marked as **In Error**. You can only unchart a note that was initially created by yourself.

To unchart a note within **Documentation**:

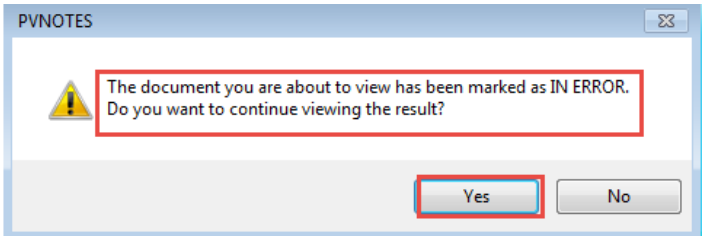
1. Select a note in the left pane. Use the specialty note you just created
2. **Right-click** anywhere in the right pane. Then select **In Error**



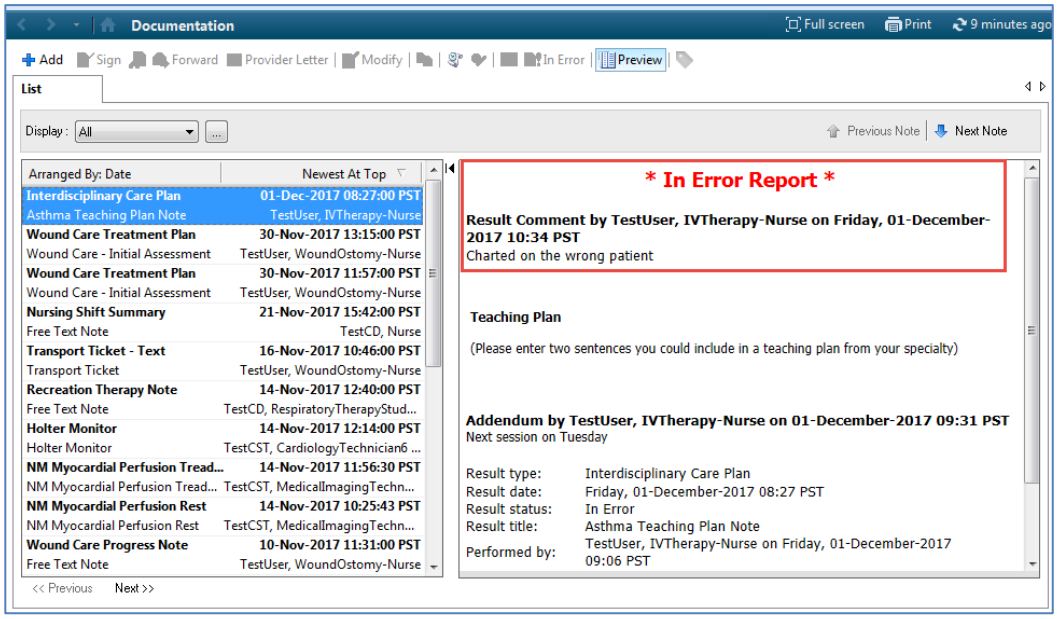
3. In the Result Uncharting window, type = *Charted on the wrong patient* in the Comments box. Then click **OK**.



4. Click **Yes** when you are asked if you want to continue to view the result.



5. In Documentation, the note is marked as **In Error Report**.



Key Learning Points

- A note can be modified by inserting an addendum. A modified note will show up as (Modified)
- You can only unchart a note that was initially created by you

PATIENT SCENARIO 7 - 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.

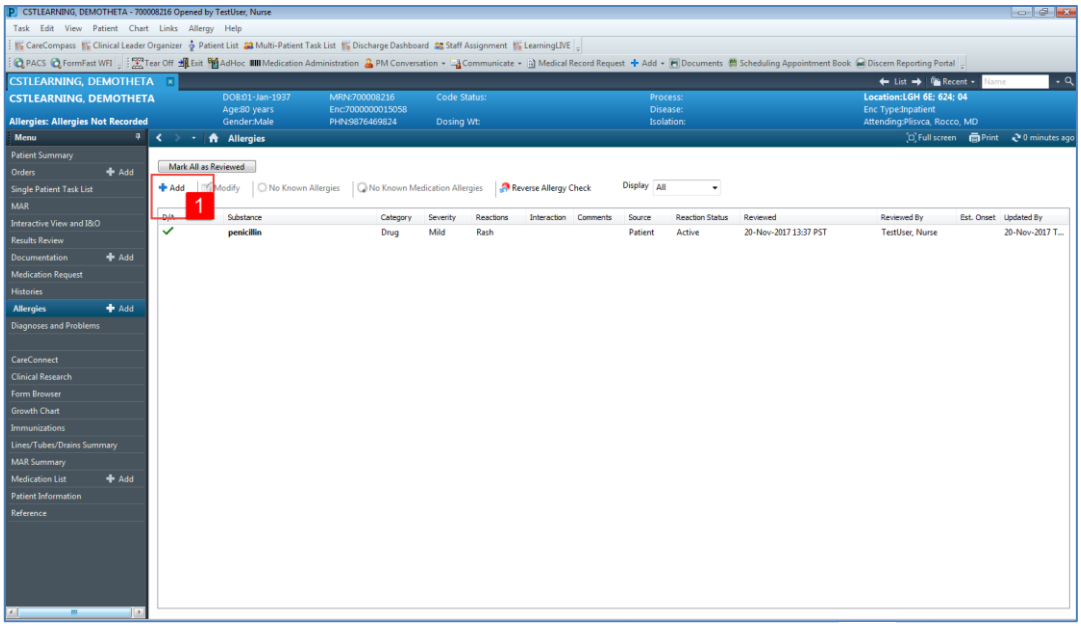
As a specialist nurse you will be complete the following activity:

- Add and save an allergy

Activity 7.1 – Add an Allergy

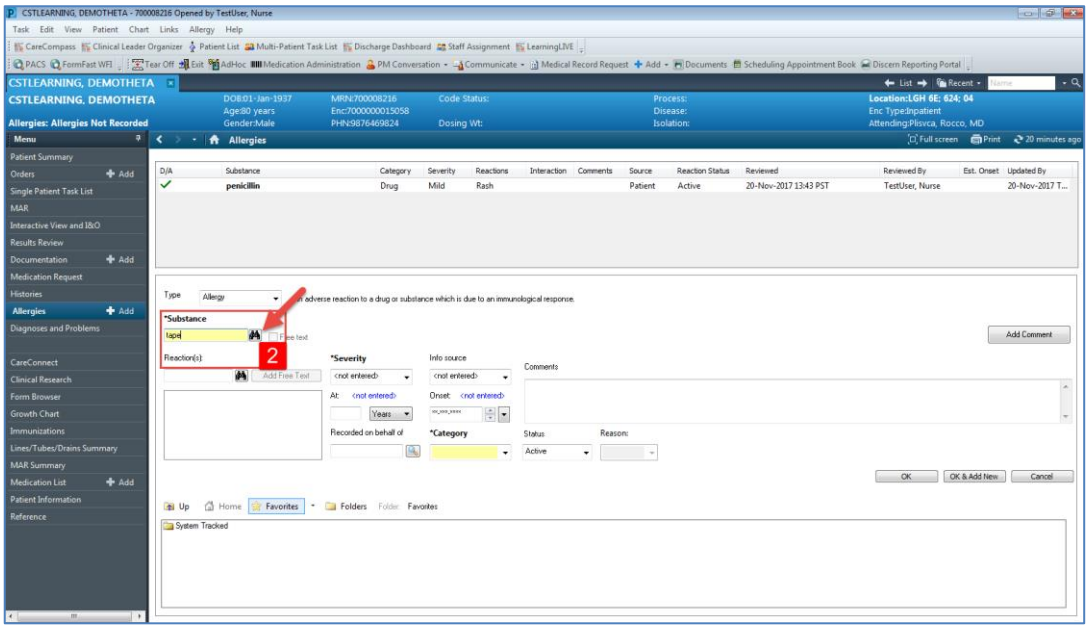
1 You notice mild redness to the patient's skin where there is tape applied. The patient then states that he remembers having a similar allergic reaction to tape years ago, but he forgot to mention it in the ED.

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

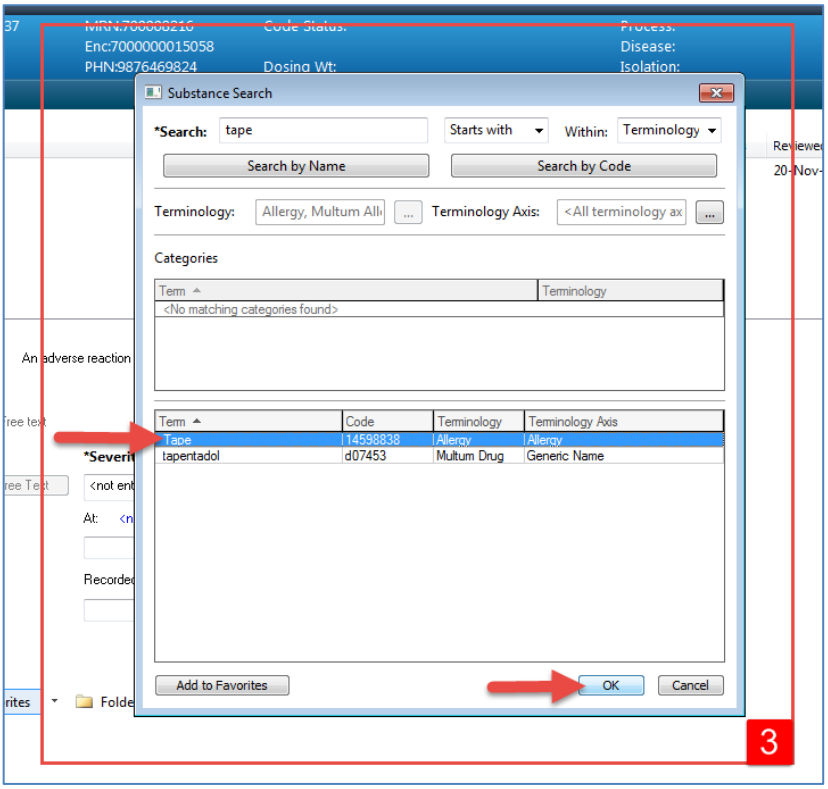


2. In the **Substance** field type = *Tape* and click the **Search** icon .

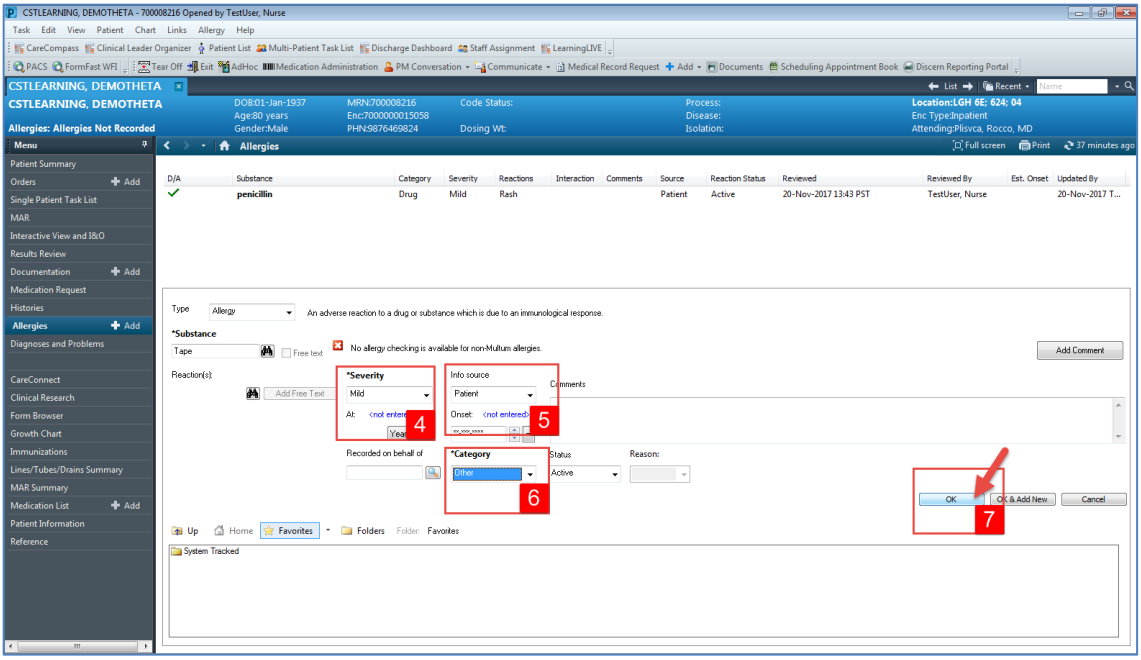
Note: Yellow highlighted fields including substance and category are mandatory fields that need to be completed.



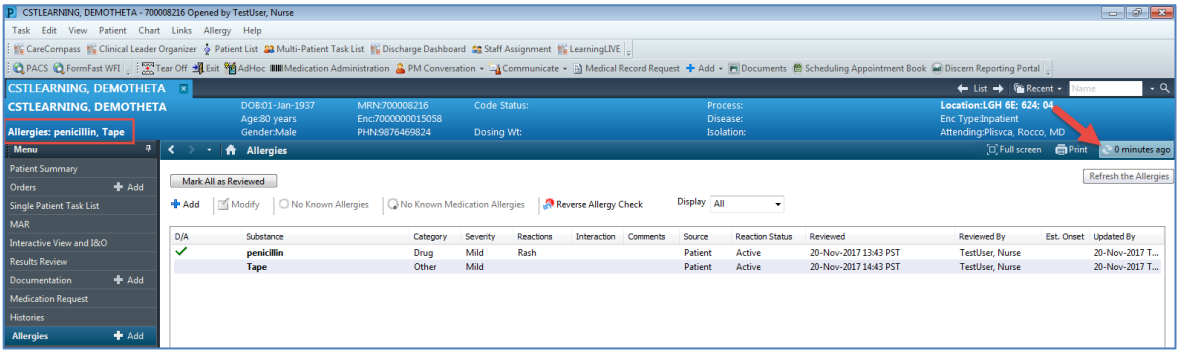
3. The **Substance Search** window opens. Select **Tape** and click **OK**.



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**



8. Refresh the screen and the tape allergy will now appear in the Banner Bar.



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

Key Learning Points

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

PATIENT SCENARIO 8 - 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

SCENARIO

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

As a nurse, you will complete the following activities:

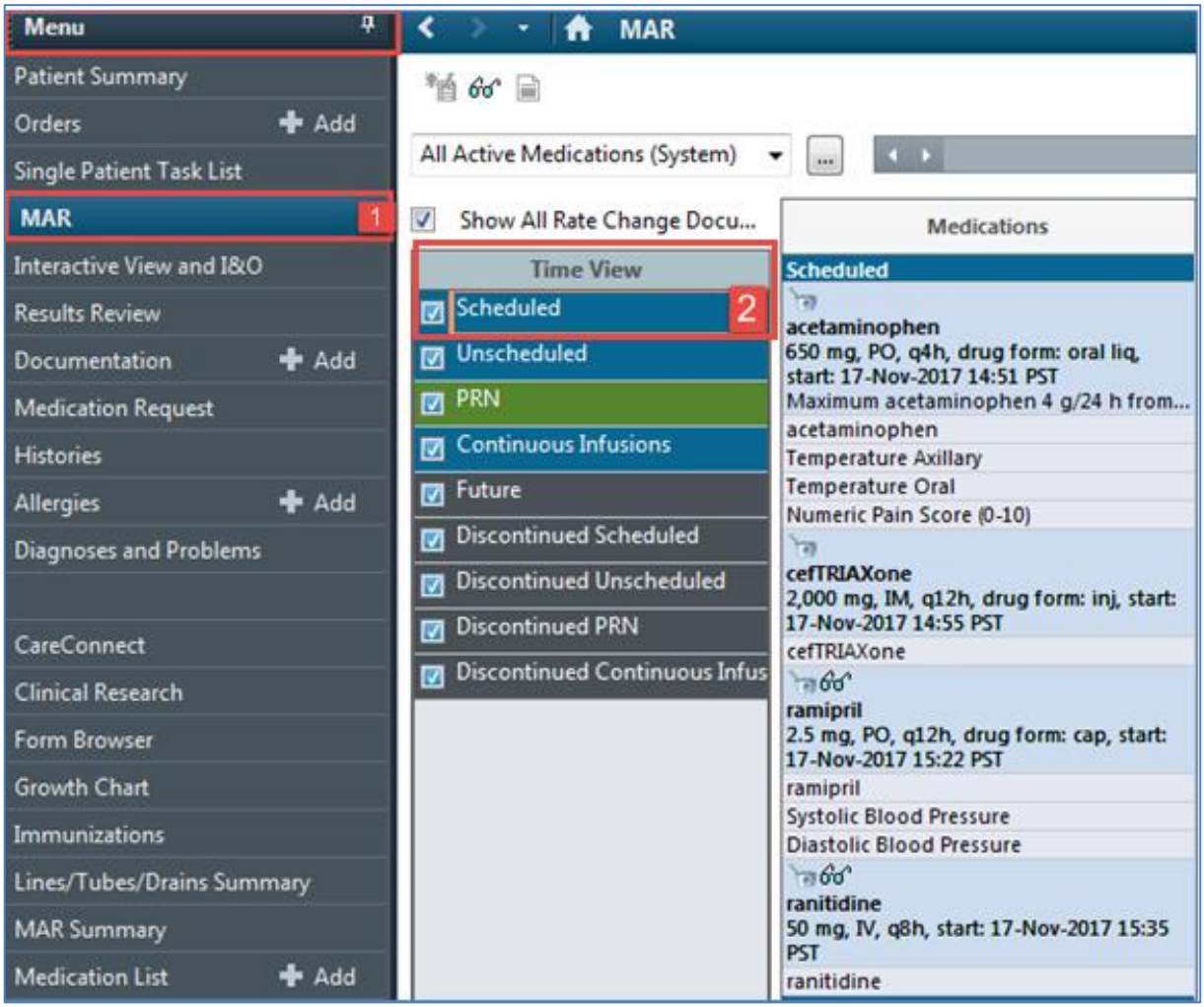
- Review the MAR

Activity 8.1 – Review the MAR

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

You will be locating and reviewing your patient's scheduled, unscheduled and PRN medications.

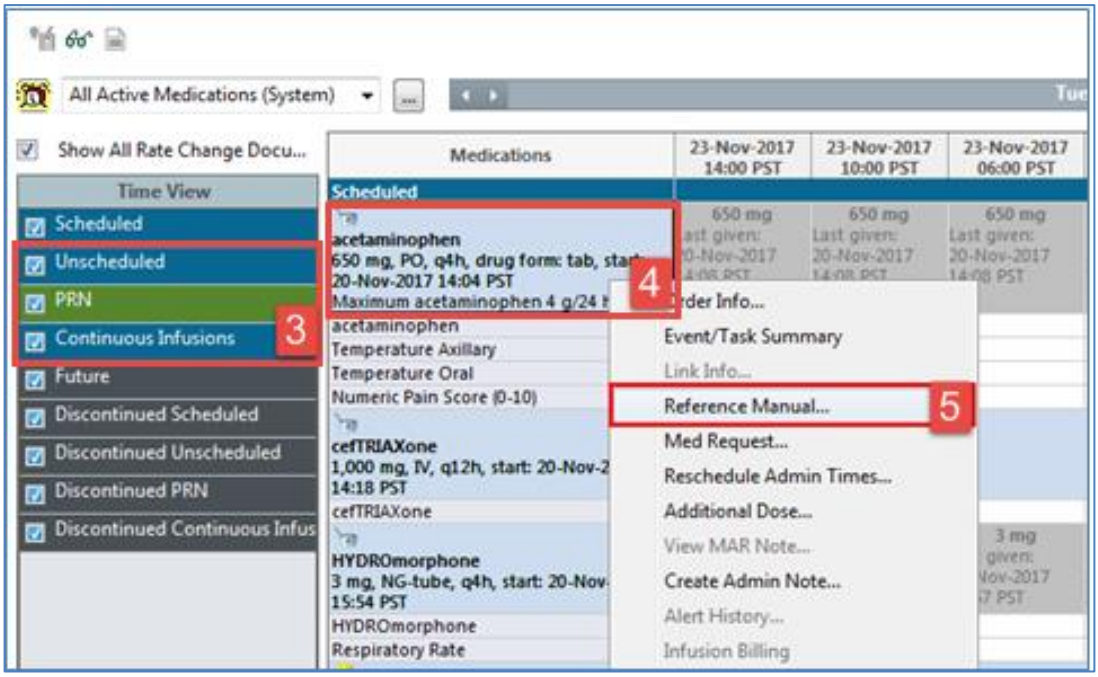
1. Go to the Menu and click **MAR**
2. Under **Time View** locate and ensure the **Scheduled** category is selected and is displaying at the top of the MAR list.



3. Next, select in order, **Unscheduled**, **PRN** and **Continuous Infusions**, bringing each section to the top of the list for your review.

4. Review the medications on the MAR, e.g. acetaminophen 650 mg PO Q4H. Be sure to review all medication information.

5. If you wish to review the Reference Manual, right-click on the medication name and select the Reference Manual.



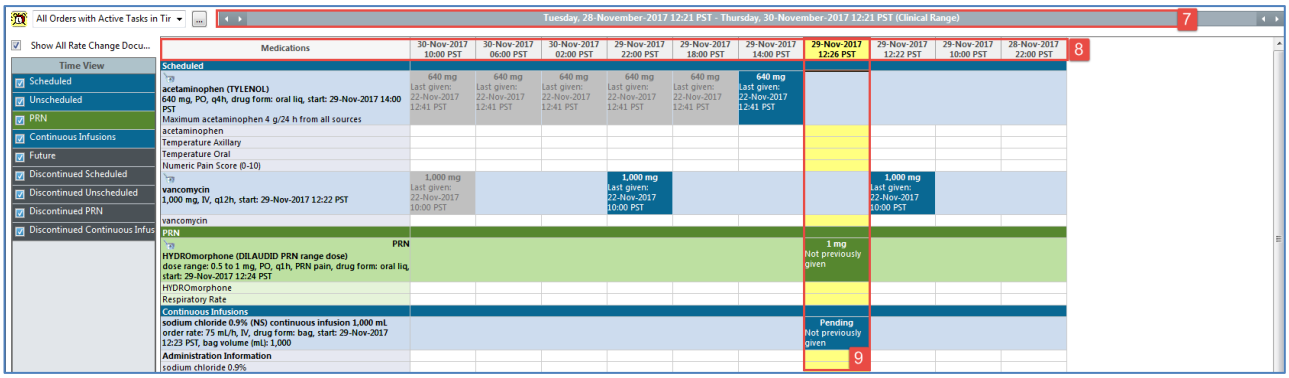
6. Note the icons that may appear on the MAR. Examples include:
   - – Indicates the medication order has not been verified by pharmacy
   - – Indicates the order needs to be reviewed by the nurse
   - – Indicates the medication is part of a PowerPlan

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

7. The Clinical Range is defaulted to display 24 hours in the past and 24 hours 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 current state paper MARs)

9. The current time and date column will always be highlighted in yellow



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

- **Scheduled medications -** blue
- **PRN medications** – green
- **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

PATIENT SCENARIO 9 - Medication Administration

Learning Objectives

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

- Administer medication using Medication Administration Wizard
- Document administration medication

SCENARIO

In this scenario, you will be administering a dose of Ativan (lorazepam) 1 mg SL, once, PRN for anxiety which was ordered earlier. You will be using a Barcode Scanner to administer the medication. The scanner scans both your patient's wristband and the medication to correctly populate the MAR.

As a specialist nurse, you will complete the following activity:

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

Activity 9.1 – Administering Medication using Medication Administration Wizard and Barcode Scanner

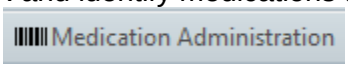
Medications will be administered and recorded electronically by scanning the patient's wristband and the medication barcode. Scanning of the patient's wristband helps to ensure the correct patient is identified. Scanning the medication helps to ensure the correct medication is being administered. Once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

1 Tips for using the barcode scanner:

- Point the barcode scanner toward the barcode on the patient's wristband and/or the medication (Automated Unit Dose- AUD) package and pull the trigger button located on the barcode scanner handle
- To determine if the scan is successful, there will be a vibration in the handle of the barcode scanner and/or, simultaneously, a beep sound
- When the barcode scanner is not in use, wipe down the device and place it back in the charging station

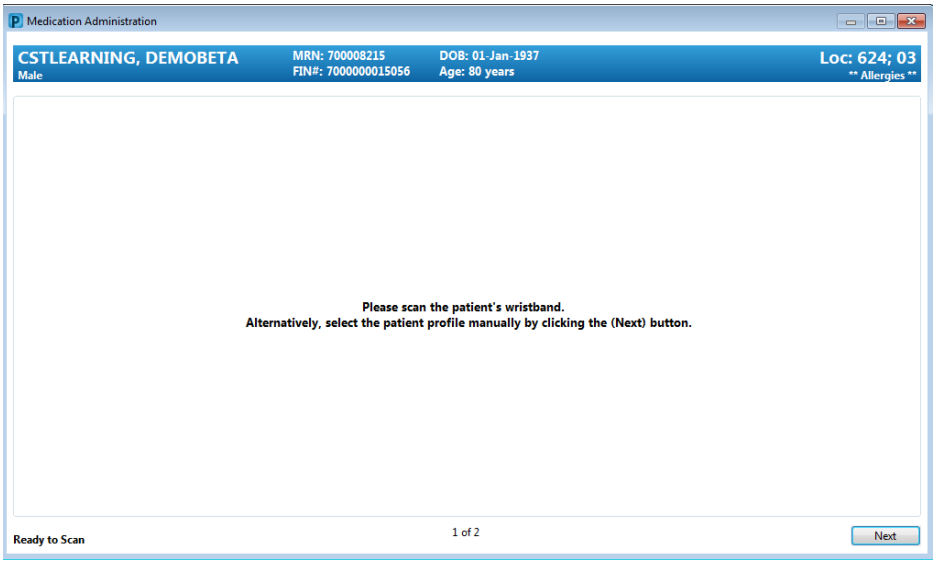
2 Your patient is getting anxious and it is time to administer Ativan (lorazepam) 1 mg, PO, PRN for anxiety to your patient. You have reviewed the MAR and obtained one tab of Ativan 1 mg tab. The Ativan tab comes with a barcode.

Let's begin the medication administration following the steps below.

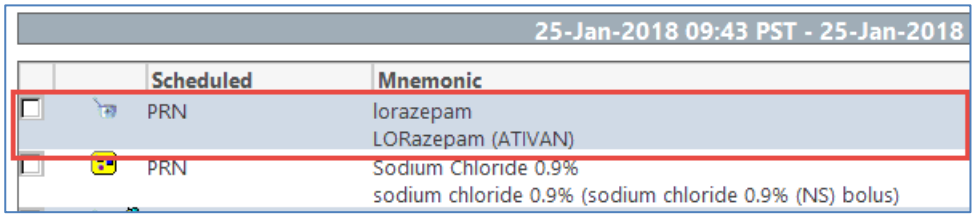
1. Review medication information in the MAR and identify medications that are due. Click Medication Administration Wizard (MAW) 

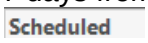
in the toolbar.

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.



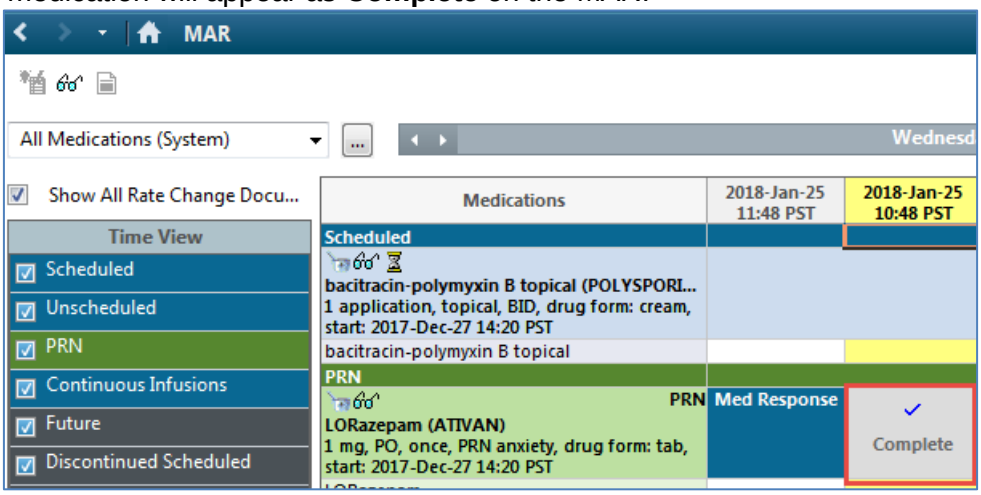
Note: this list populates with medications that are scheduled for 1 hour ahead or any overdue medications in the last 7 days from the current time. If you have a long list of Medications, click on the Scheduled  heading to bring up the PRN medications

4. **Scan** the medication barcode for **Lorazepam 1 mg** tab. The system finds an exact match for the prescribed medication and dose.

Note: If the pharmacy has not verified this medication, click yes to continue.

5. Administer medication to patient, then click on the **Sign** button

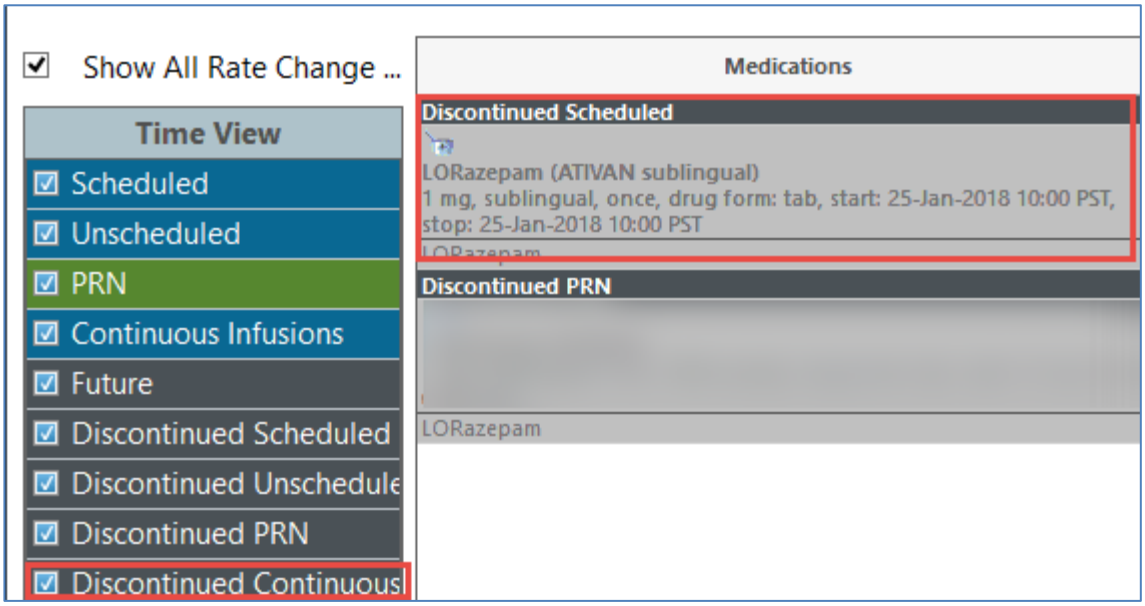
6. Congratulations, you have successfully administered and documented the medication! The medication will appear as **Complete** on the MAR.



Note: You may also complete the Med Response indicating if it was effective.

7. Refresh the page and you will be able to see more details. Because this medication was ordered at **once**, it is automatically discontinued after administration.

   Select **Discontinued PRN**, then you can review the details.



Key Learning Points

- Use Medication Administration Wizard and the barcode scanner to administer medications.

PATIENT SCENARIO 10 - 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 in Result Review.

You will complete the following activity:

- Review results using Results Review

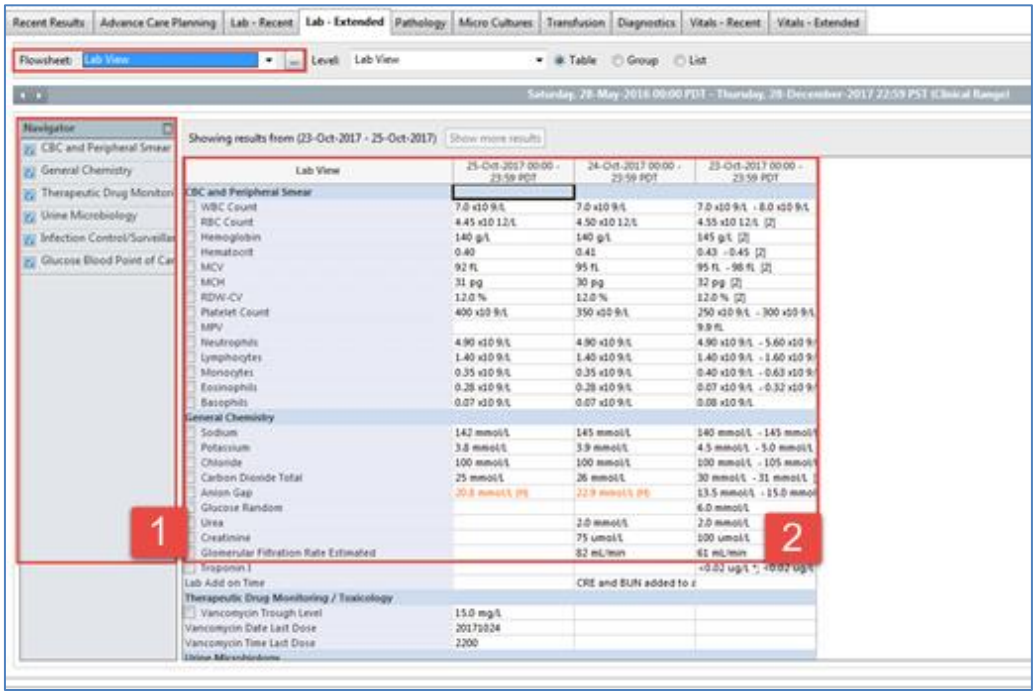
Activity 10.1 – Using Results Review

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.

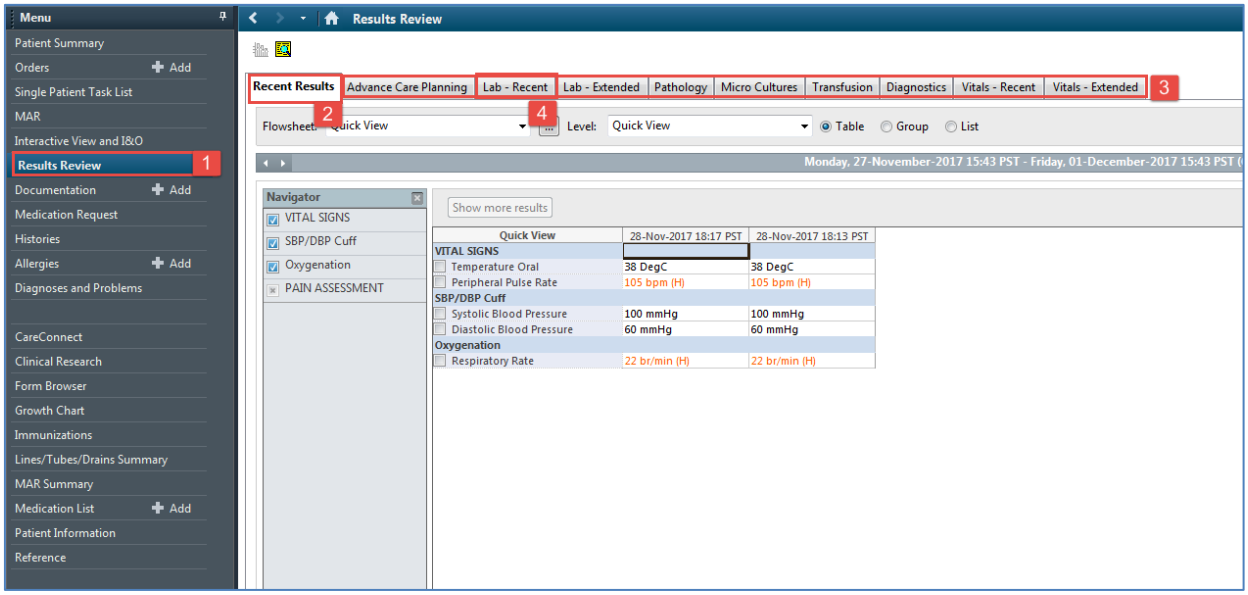
Flowsheets are divided into two major sections:

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

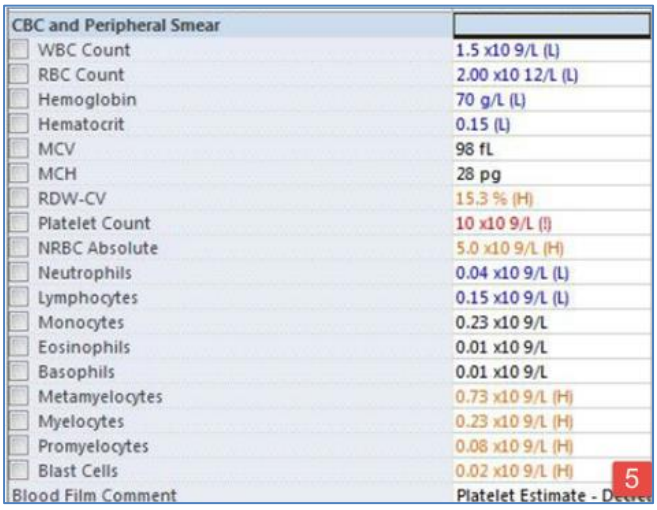


Review the most recent results for your patient:

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** tab



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



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 11 - Document Intake and Output

Learning Objectives

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

- Review and Document Intake and Output

SCENARIO

As a nurse, you will complete the following activities:

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

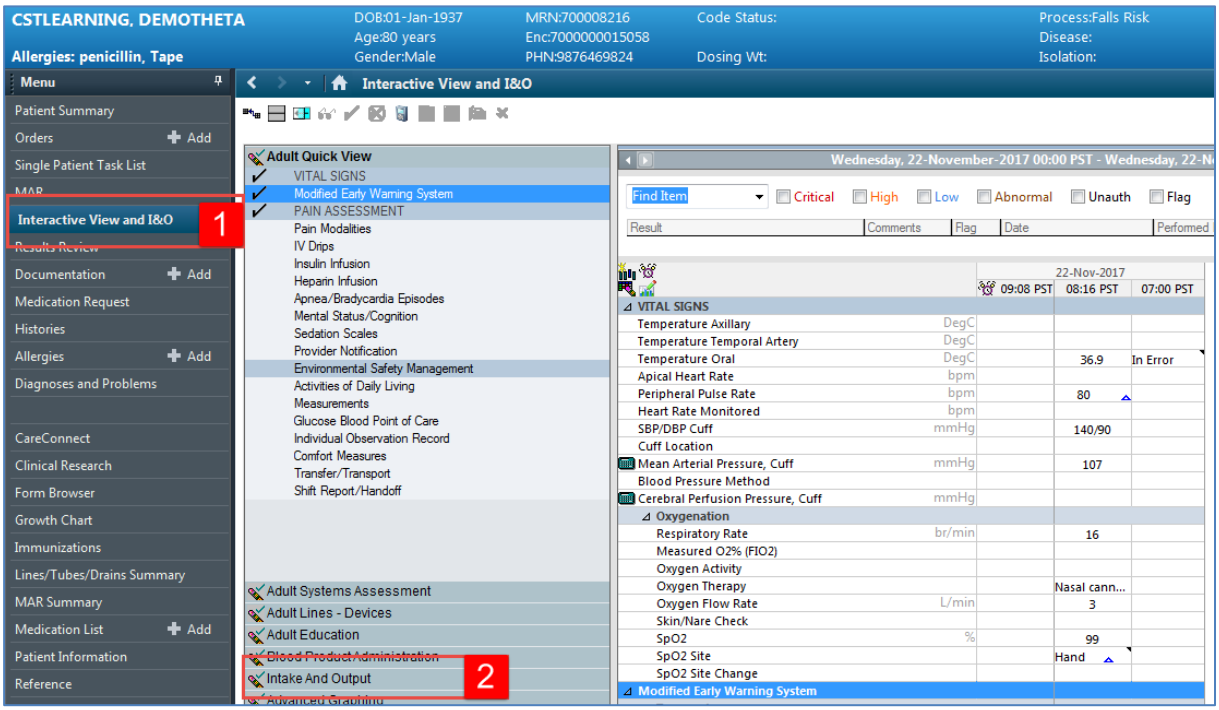
Activity 11.1 – Navigate to Intake and Output Flowsheets Within iView

Intake and Output (I&O) is found as a band within iView and is where a patient's intake and output will be documented. From here, you are able to review specific fluid balance data as well as 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 To navigate to the **Intake and Output** flowsheets:

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



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.

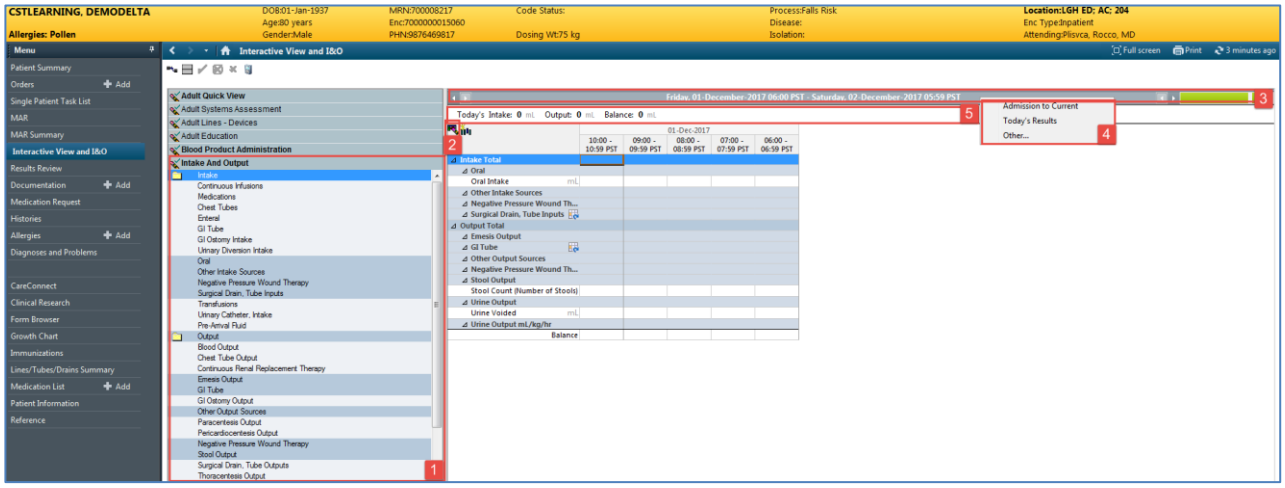
2. To add other **Intake or Output sources**, you will need to click on the **Customize View icon**  to select the appropriate section to be added in.

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) record is found as within iView and is where a patient's intake and output will be documented

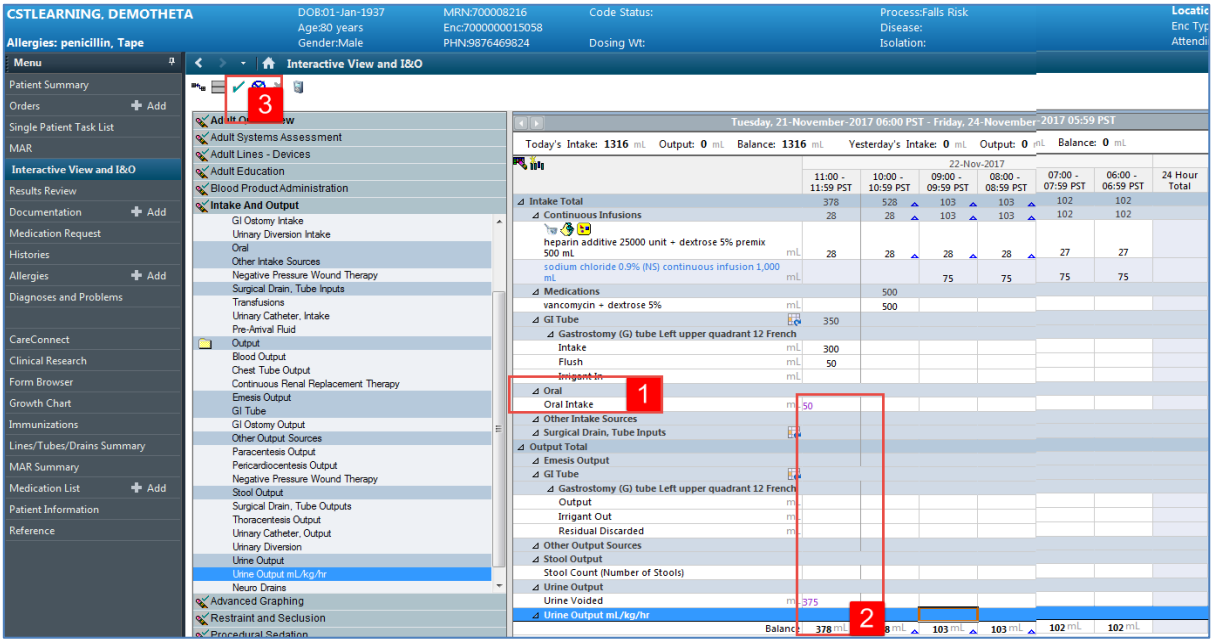
Activity 11.2 – Review and Document in the Intake and Output Record

1 Let's practice reviewing and documenting in the Intake and Output (I&O) record.

For this activity, your patient drank 50 mL of fluids and voided 375 mL of urine and now you need to document these values.

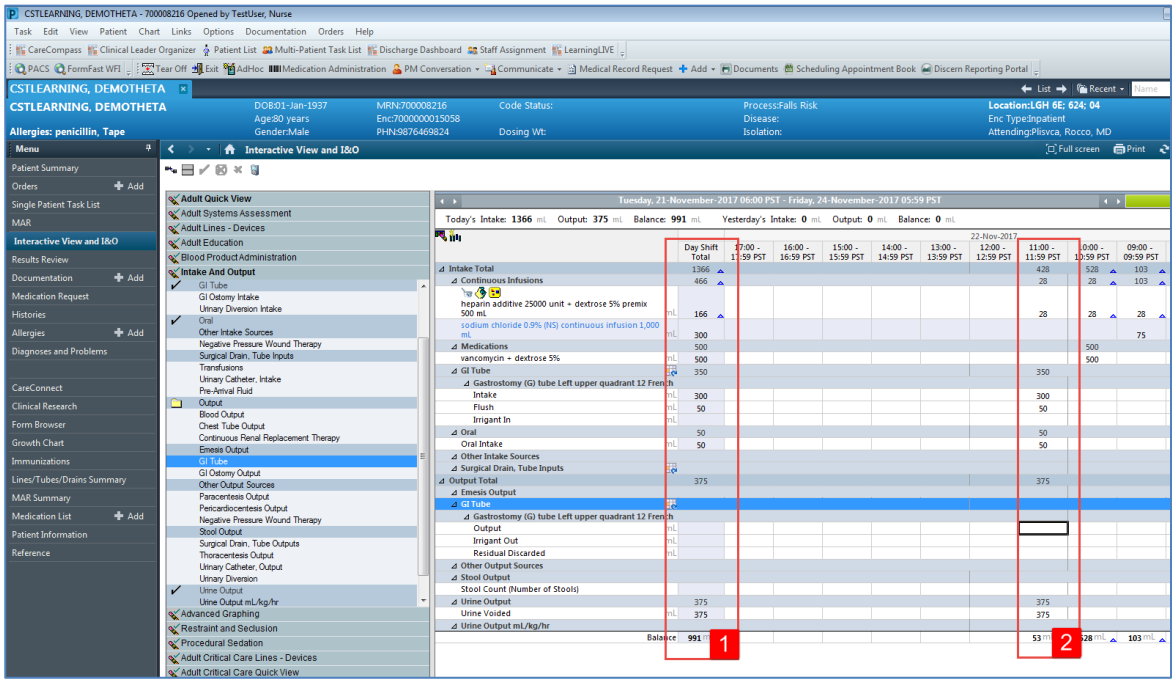
Within the **Intake And Output** band:

1. Locate the **Oral** section in the I&O navigator
2. In the flowsheet on the right, document the following by clicking on the appropriate cell.
   - **Oral Intake** = *50 mL*
   - **Urine Voided** = *375* mL
3. Click **green checkmark** icon to sign



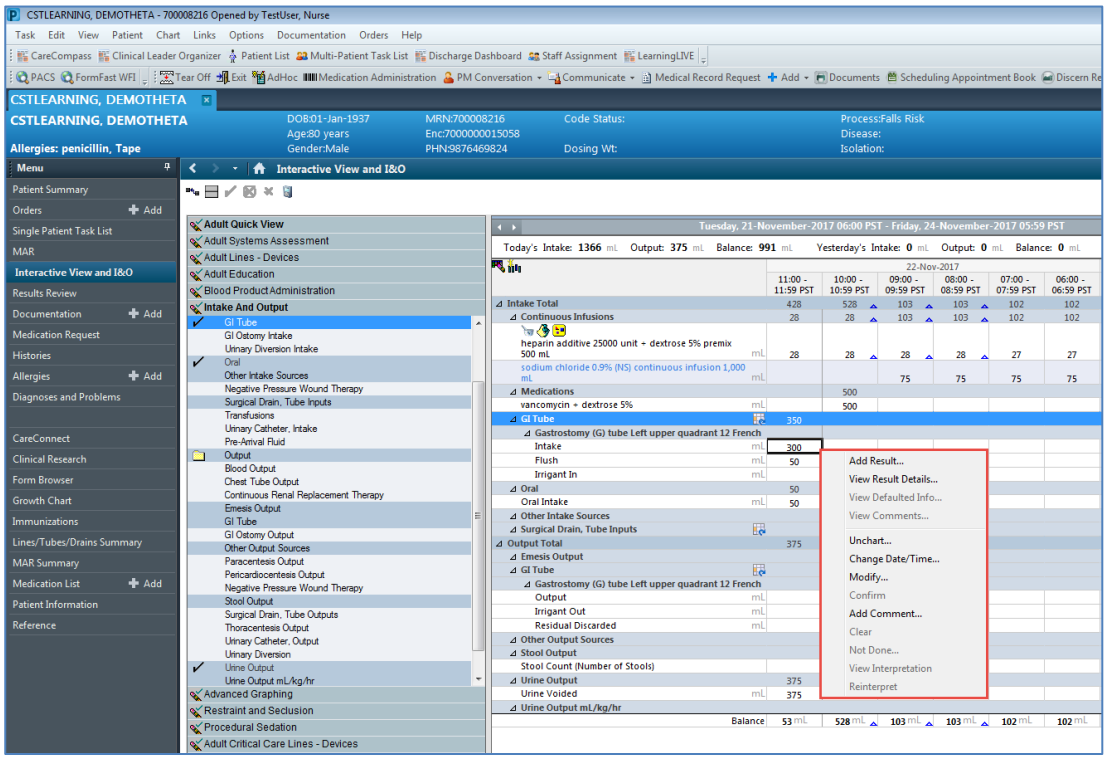
A separate column exists for the fluid balance of your patient:

1. 12-hour Day/Night Shift Total
2. 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.

Additional functions can be viewed by right-clicking the cell, as shown below.



Key Learning Points

- Some values will require direct charting in the intake and output band e.g. oral intake
- Time columns are organized into hourly intervals
- In the I&O navigator, the dark grey highlighted sections are active and are automatically populated in the flowsheet
- Values can be modified and uncharted within Interactive View and I&O

PATIENT SCENARIO 12 - End of Shift Activities

Learning Objectives

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

- Perform End of Shift Activities

SCENARIO

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

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

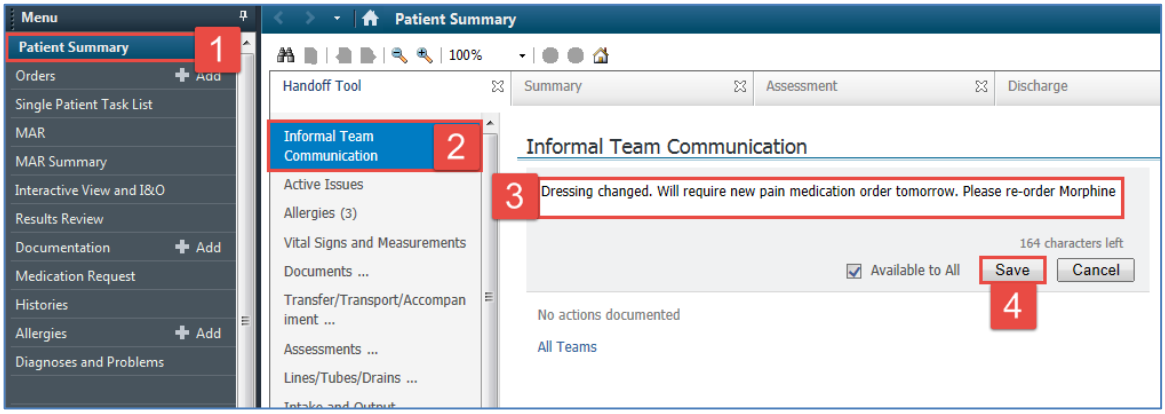
Activity 12.1 – Documenting Informal Team Communication

1 Within the **Handoff Tool** notice that there is an **Informal Team Communication** component that can be documented to and viewed by all team members to communicate in an informal way. Use this to leave a comment for the oncoming nurse or other team members.

Note: The Informal Team Communication is NOT part of the patient's legal chart

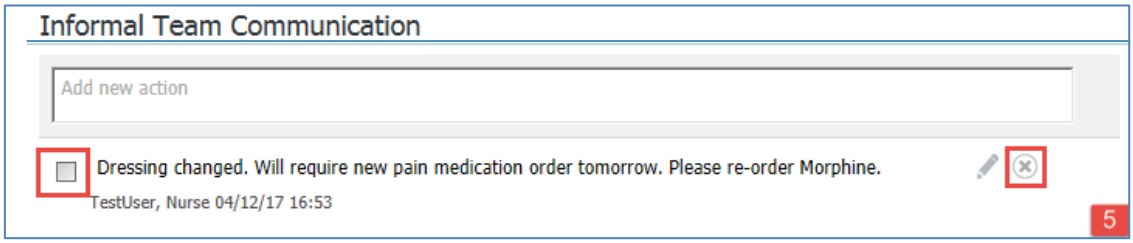
From the Menu select **Patient Summary**

1. Within the **Handoff Tool** tab
2. Select the **Informal Team Communication** component
3. Enter the following: *Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine.*
4. Click **Save**



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 note, or the **small circle with the x** to the right of the note.



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

Key Learning Points

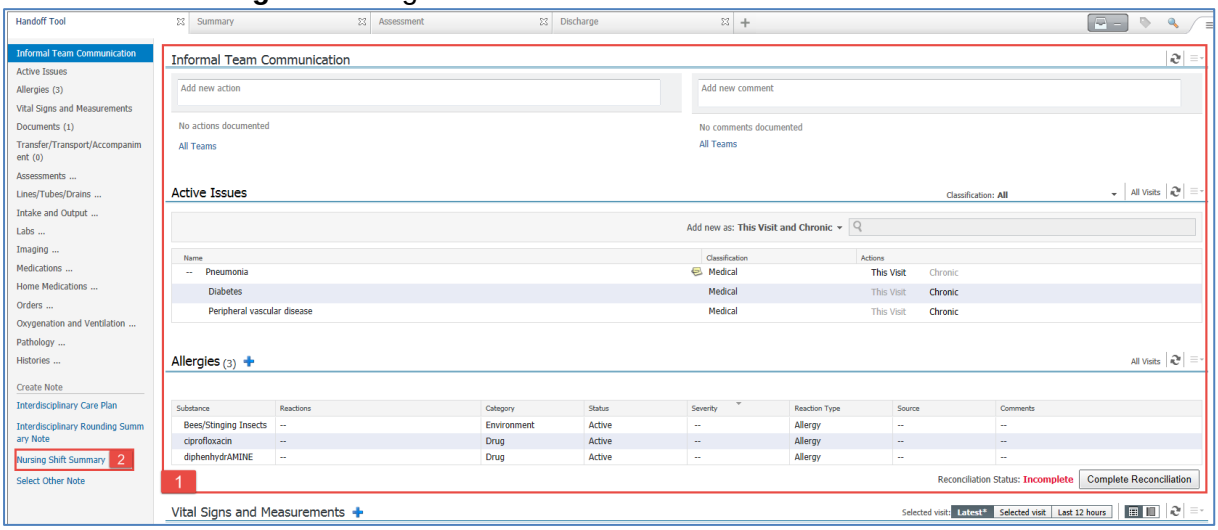
- The Informal Team Communication component is a way to leave a message for another clinician.
- An Informal Team Communication message is NOT part of the patient's legal chart.

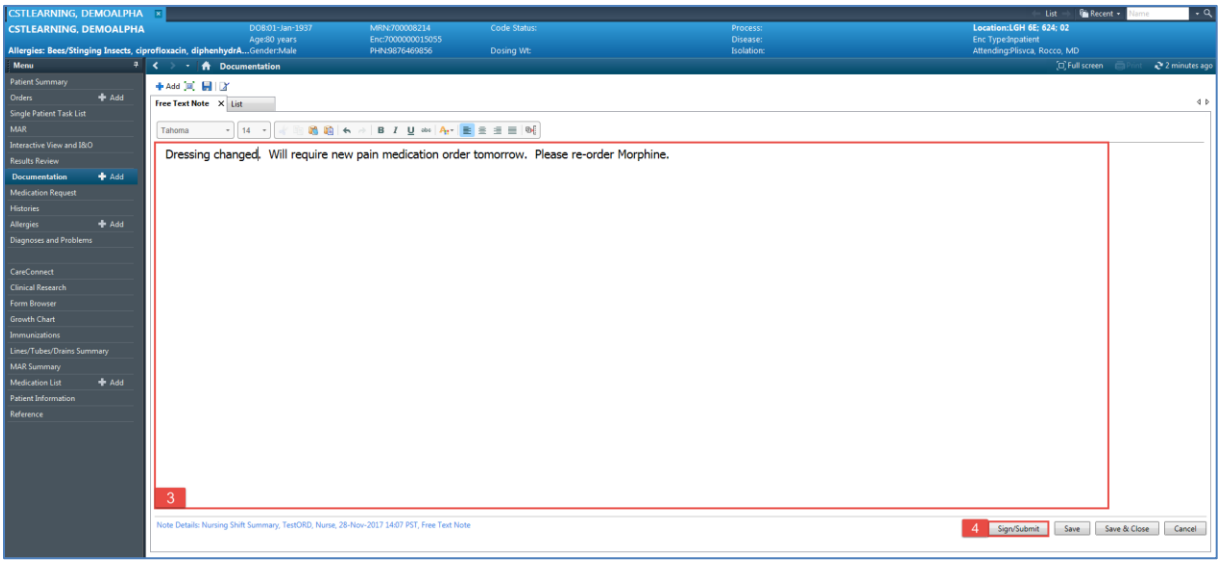
Activity 12.2 – Documenting a Nursing shift Summary Note

1

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

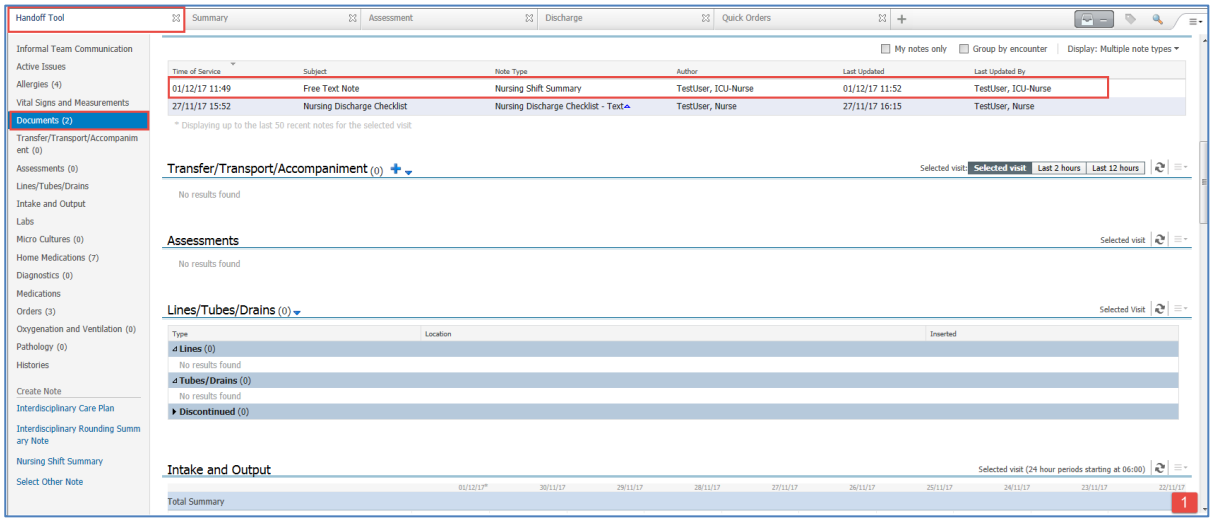
1. Review patient information in the **Handoff Tool**
2. Click on the **Nursing Shift Summary** blue link
3. Enter required data on *Wife visited, very teary. Provided support; will follow up tomorrow*
4. Click **Sign/Submit**
    - Click **Sign** in the Sign/Submit note window





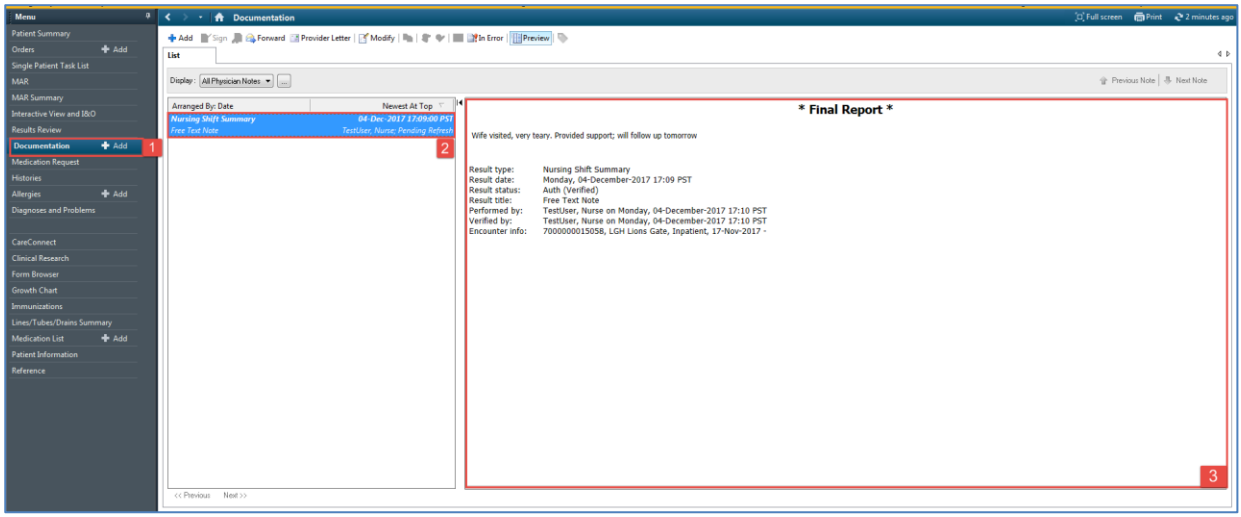
Click the **Refresh** icon 

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



Now this note is in the patient's chart and other nurses can view it by completing the following steps:

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



Key Learning Points

- A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses.
- The note must be signed in order for it to be on the chart.
- Nurses can view notes like this from the Documentation tab in the Menu.

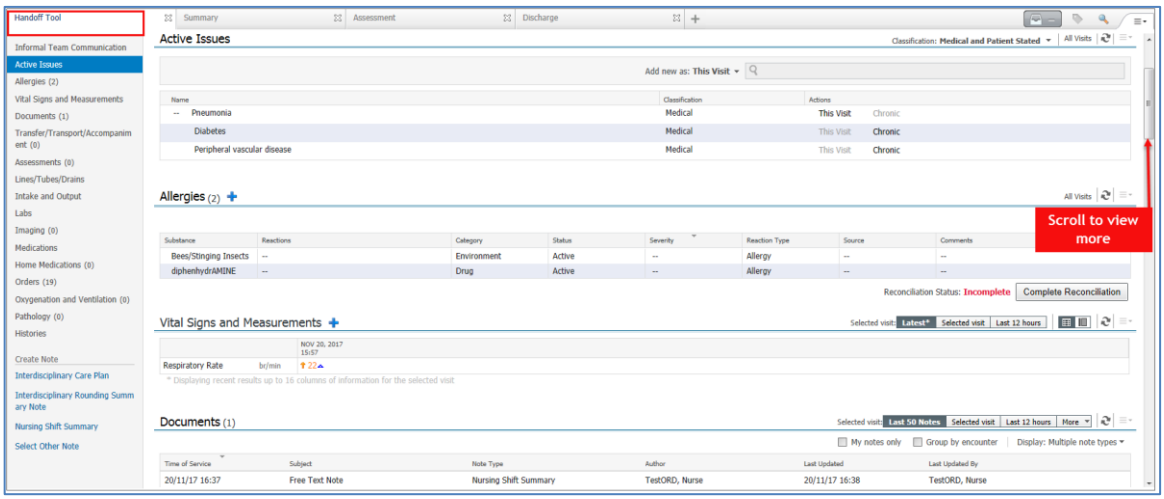
Activity 12.3 – Handoff Tool

1 Use 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 on the Handoff components on the left.

2. This is where you can add any missing information if required.



Key Learning Points

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

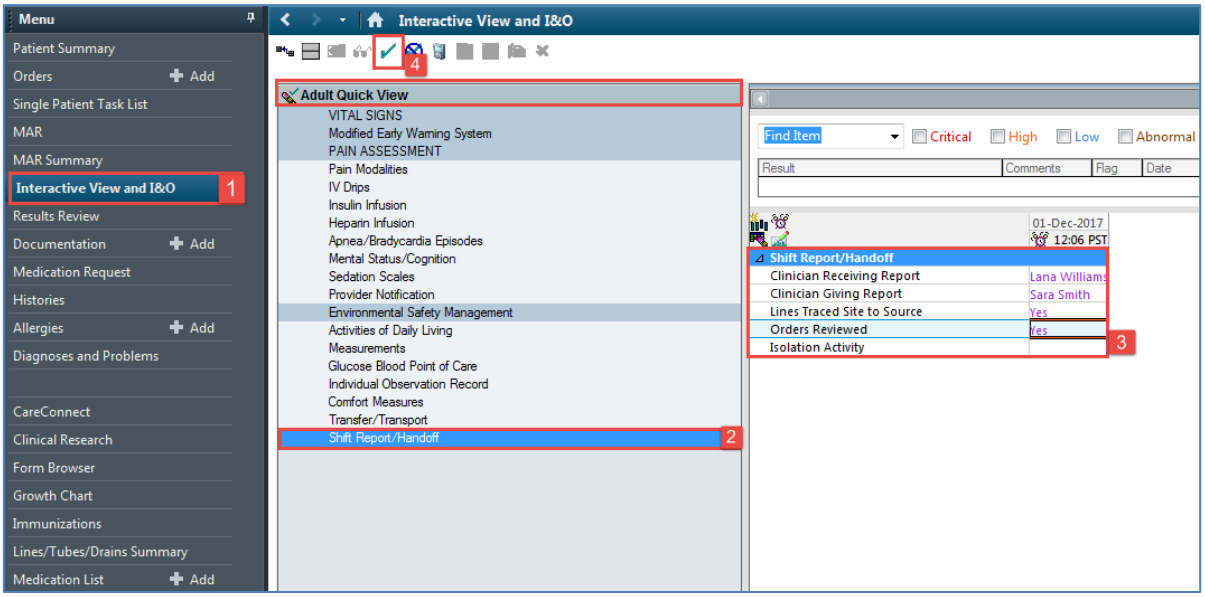
Activity 12.4 – Documenting Handoff in iView

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*

4. **Isolation Activity** = *leave blank if not on isolation*

   Click **green checkmark** icon to sign your documentation



Key Learning Points

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

End of Workbook

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