

SELF-GUIDED PRACTICE WORKBOOK [N56]
CST Transformational Learning

WORKBOOK TITLE:

Nursing: Specialist Nurse

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SELF-GUIDED PRACTICE WORKBOOK

Duration	8 hours
Before getting started	<ul style="list-style-type: none">■ Sign the attendance roster (this will ensure you get paid to attend the session).■ Put your cell phones on silent mode.
Session Expectations	<ul style="list-style-type: none">■ This is a self-paced learning session.■ A 15 min break time will be provided. You can take this break at any time during the session.■ The workbook provides a compilation of different scenarios that are applicable to your work setting.■ Work through different activities at your own pace
Key Learning Review	<ul style="list-style-type: none">■ At the end of the session, you will be required to complete a Key Learning Review.■ This will involve completion of some specific activities that you have had an opportunity to practice through the scenarios.■ 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.

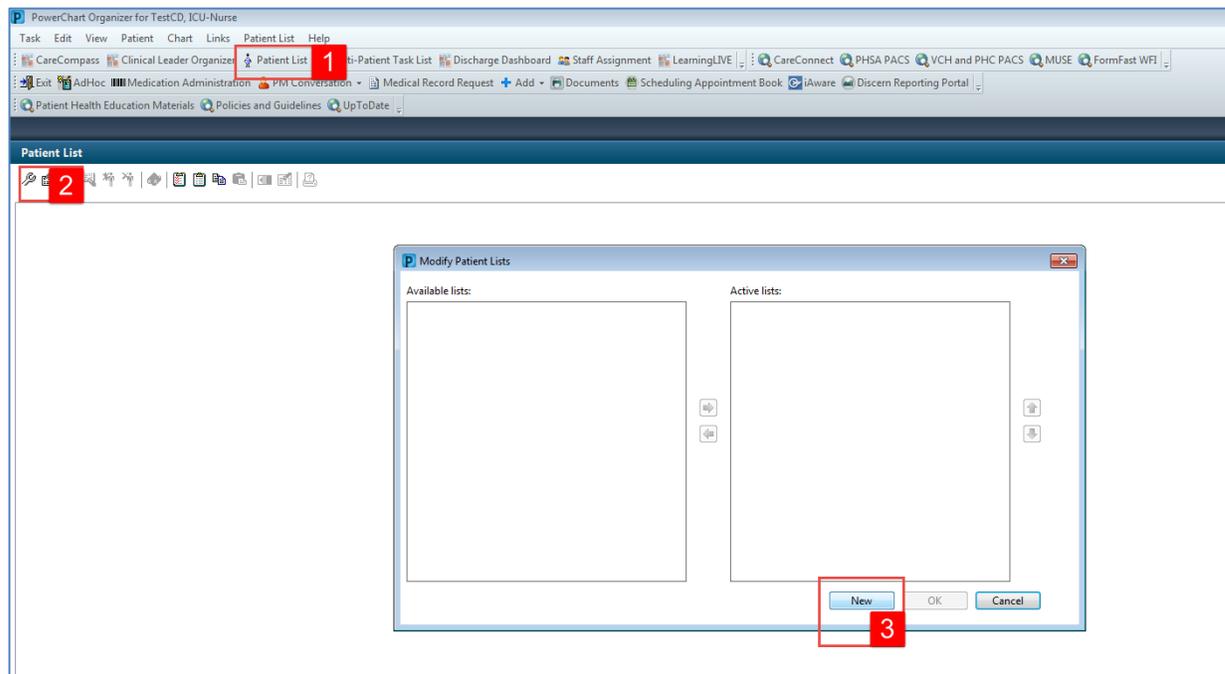
As a specialist nurse you will complete the following activities:

-  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

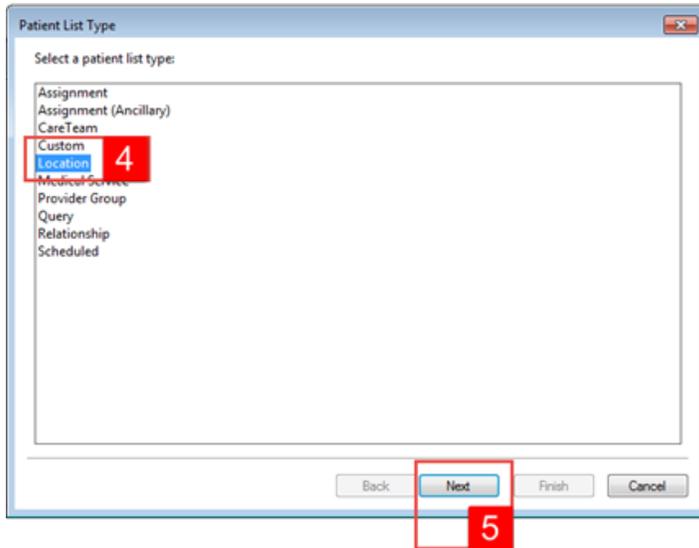
- 1 Upon logging into PowerChart, you will land on **Multi-Patient task List (MPTL)**. Before you can use the MPTL, you will need to set-up a patient list. The **Patient List** can be set up by location, to provide a view of all the patients that are on a specific unit/ floor you select. A custom list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

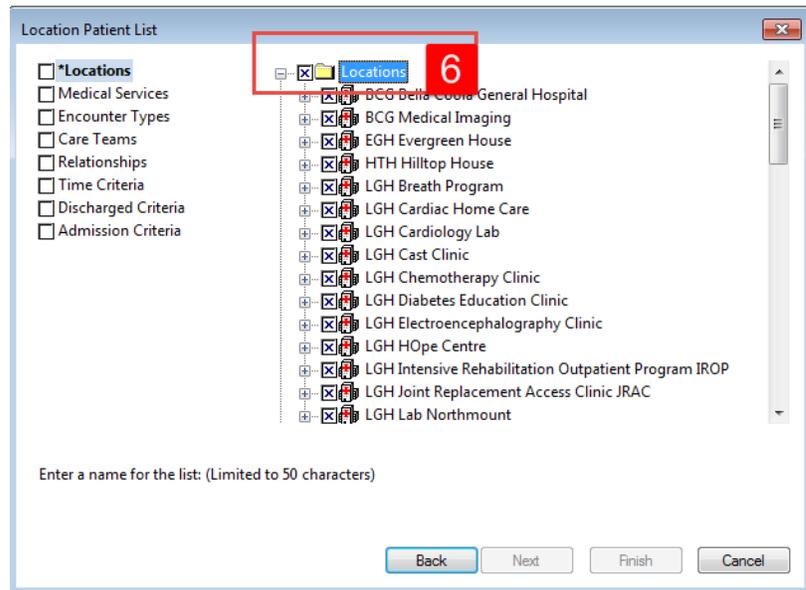


4. From the Patient List Type window select **Location**

5. Click **Next**

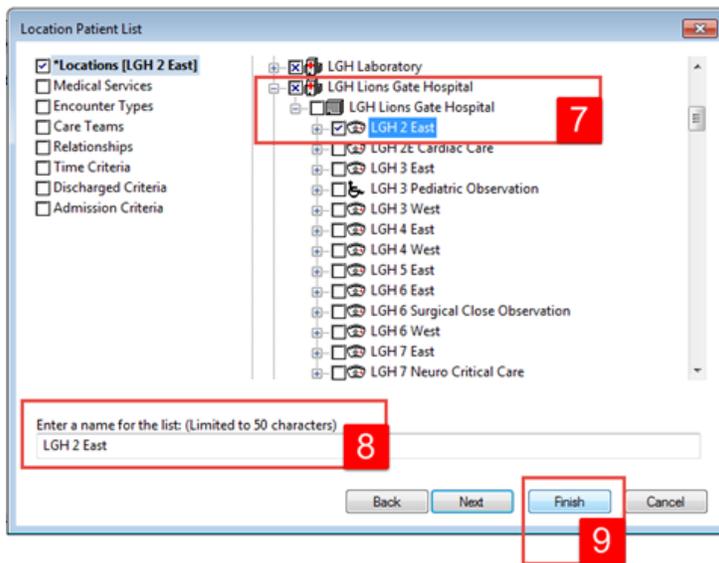


6. In the **Location Patient List** window, a location tree will be on the right-hand side. Expand the list by clicking on the **tiny plus +** sign next to the facility.

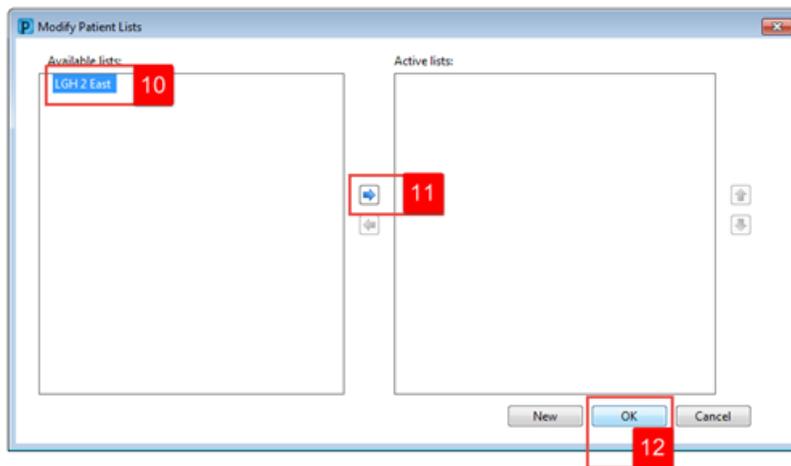


7. Scroll down until you find the location assigned to you. Expand the location and select your unit by checking the box next to it. Chose the location from today's handout.
8. Patient Lists need a name to differentiate them. Location lists are automatically named by the location.
9. Click **Finish**

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.



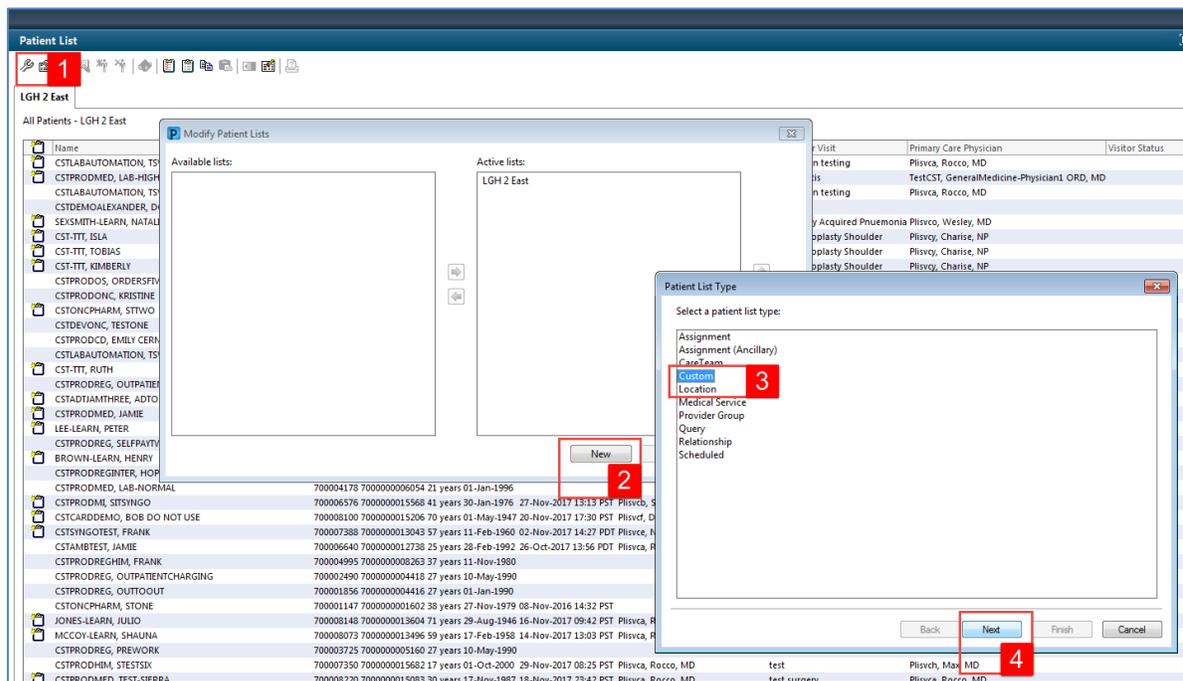
 **Key Learning Points**

- 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.

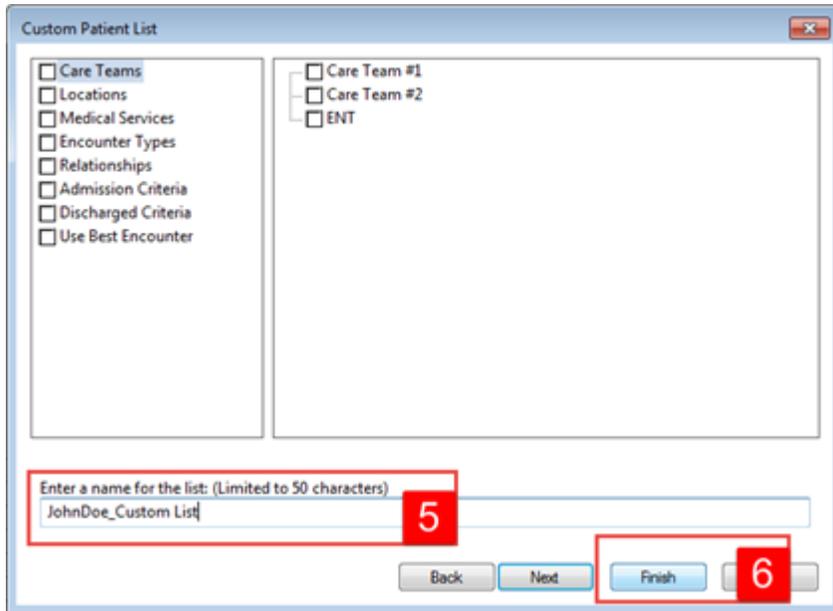
1. To create a **Custom List**, click the **List Maintenance** icon  in the **Patient List**.
2. Click **New** in the bottom right corner of the **Modify Patient Lists** window.
3. From the Patient List Type window select **Custom**.
4. Click **Next**



The screenshot displays the 'Patient List' application interface. The main window shows a list of patients under the heading 'All Patients - LGH 2 East'. A 'Modify Patient Lists' window is open, showing 'Available lists' and 'Active lists' sections. A red box labeled '1' highlights the 'List Maintenance' icon in the top toolbar. A red box labeled '2' highlights the 'New' button in the bottom right corner of the 'Modify Patient Lists' window. A 'Patient List Type' dialog box is open, showing a list of options: Assignment, Assignment (Ancillary), Case Team, Custom (highlighted with a red box labeled '3'), Location, Medical Service, Provider Group, Query, Relationship, and Scheduled. A red box labeled '4' highlights the 'Next' button at the bottom of the dialog box.

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

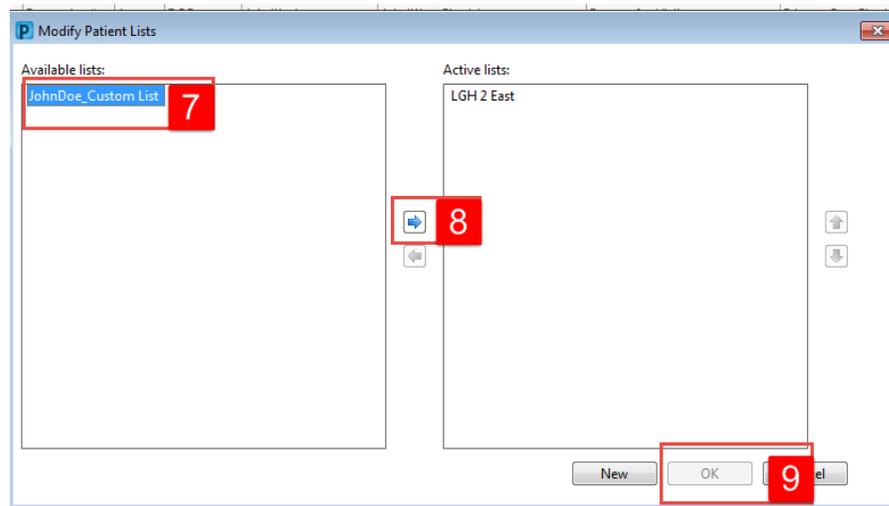
6. Click **Finish**



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

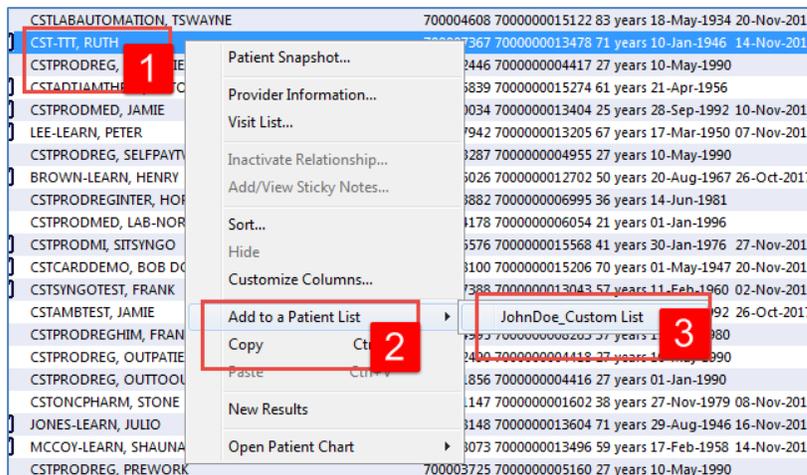
8. Click the **Blue Arrow** icon  to move the **Location** to the right **Active List**.

9. Click **OK**

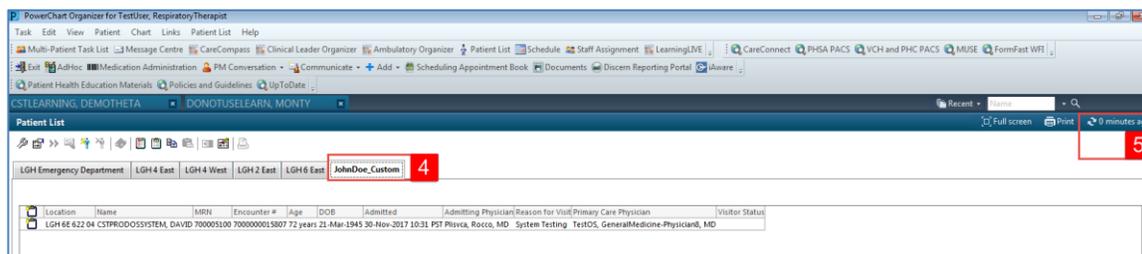


Activity 1.3 - Move Patients from the Location Patient List onto Your Custom Patient List

- At the beginning of each shift or assignment change, you will add your patients to your custom list from your location list.
 - 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.
 - Select **Add to a Patient List**.
 - Select **YourName_Custom List**.



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

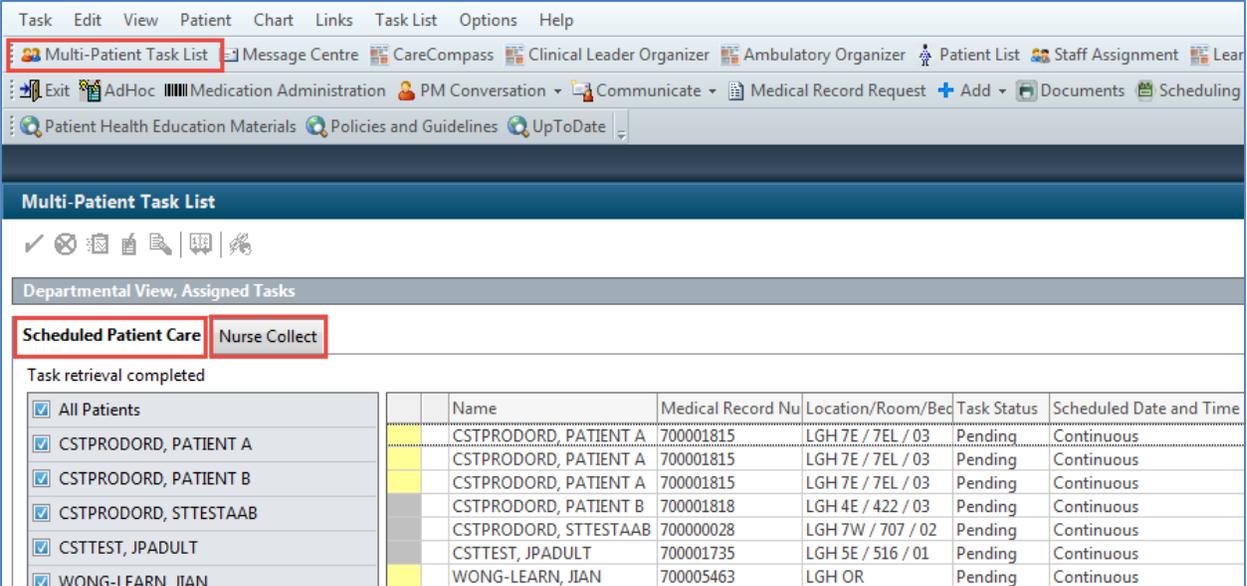
Activity 2.1 – Customize Your Multi-Patient Task List View

- 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.



Task Edit View Patient Chart Links Task List Options Help

Multi-Patient Task List Message Centre CareCompass Clinical Leader Organizer Ambulatory Organizer Patient List Staff Assignment Lear

Exit AdHoc Medication Administration PM Conversation Communicate Medical Record Request Add Documents Scheduling

Patient Health Education Materials Policies and Guidelines UpToDate

Multi-Patient Task List

Departmental View, Assigned Tasks

Scheduled Patient Care Nurse Collect

Task retrieval completed

<input checked="" type="checkbox"/> All Patients	Name	Medical Record Nu	Location/Room/Bed	Task Status	Scheduled Date and Time
<input checked="" type="checkbox"/> CSTPRODORD, PATIENT A	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous
<input checked="" type="checkbox"/> CSTPRODORD, PATIENT B	CSTPRODORD, PATIENT B	700001818	LGH 4E / 422 / 03	Pending	Continuous
<input checked="" type="checkbox"/> CSTPRODORD, STTESTAAB	CSTPRODORD, STTESTAAB	700000028	LGH 7W / 707 / 02	Pending	Continuous
<input checked="" type="checkbox"/> CSTTEST, JPADULT	CSTTEST, JPADULT	700001735	LGH 5E / 516 / 01	Pending	Continuous
<input checked="" type="checkbox"/> WONG-LEARN, JIAN	WONG-LEARN, JIAN	700005463	LGH OR	Pending	Continuous

- 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**

The screenshot shows the 'Multi-Patient Task List' window. At the top is a menu bar with 'Task', 'Edit', 'View', 'Patient', 'Chart', 'Links', 'Task List', 'Options', and 'Help'. Below the menu bar is a toolbar with various icons. The main area is titled 'Multi-Patient Task List' and contains a toolbar with icons for checkmark, cancel, print, save, search, and refresh. Below the toolbar is a grey information bar with 'Departmental View, Ass' and 'Assigned Tasks'. A context menu is open over 'Assigned Tasks', showing 'Customize Patient View...' with a red '2' next to it. Below the information bar is a 'Scheduled Patient Care' section with a 'Nurse Collect' button. The text 'Task retrieval completed' is displayed above a table.

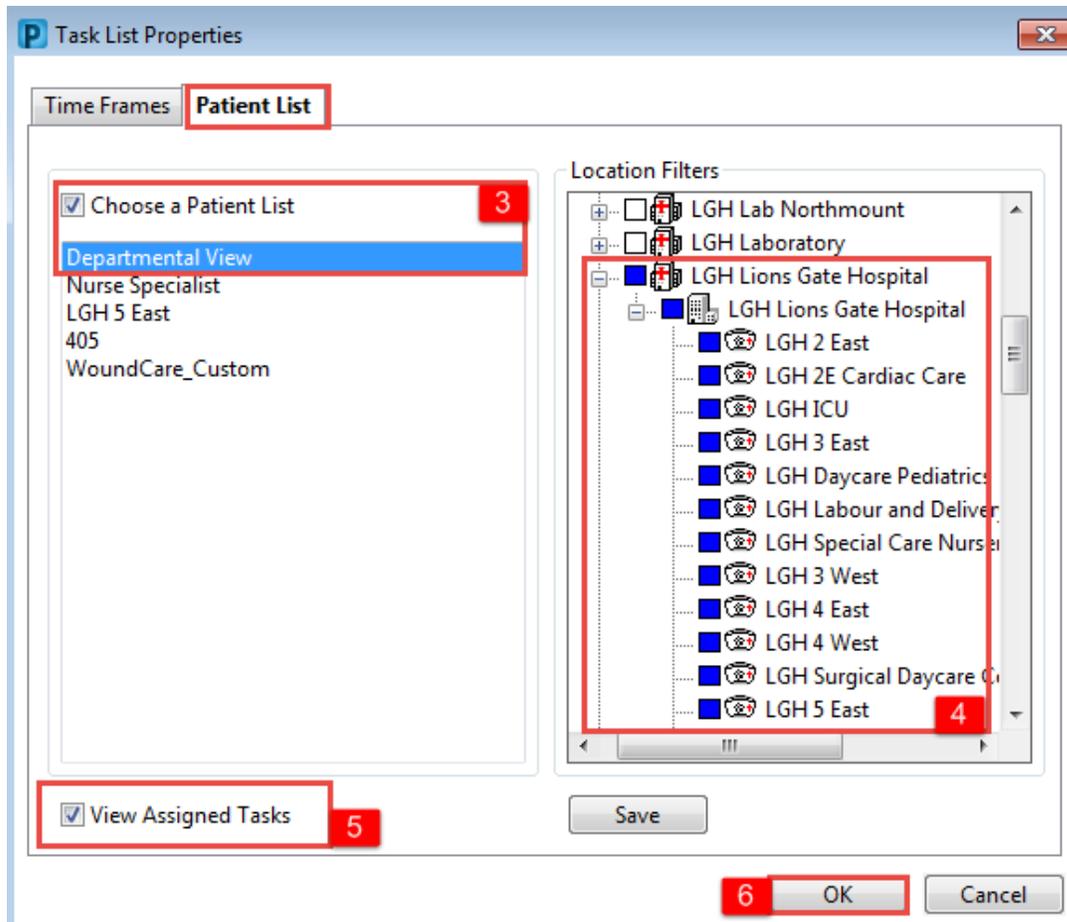
<input checked="" type="checkbox"/>		Name	Medical Record Number
<input checked="" type="checkbox"/>	All Patients		
<input checked="" type="checkbox"/>	CSTPRODAC, TRANSFER	CSTPRODAC, TRANSFER	700002858
<input checked="" type="checkbox"/>	CSTPRODORD, PATIENT A	CSTPRODORD, PATIENT A	700001815
<input checked="" type="checkbox"/>	CSTPRODORD, PATIENT A	CSTPRODORD, PATIENT A	700001815
<input checked="" type="checkbox"/>	CSTPRODPET, RAVNEET	CSTPRODORD, PATIENT A	700001815

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**



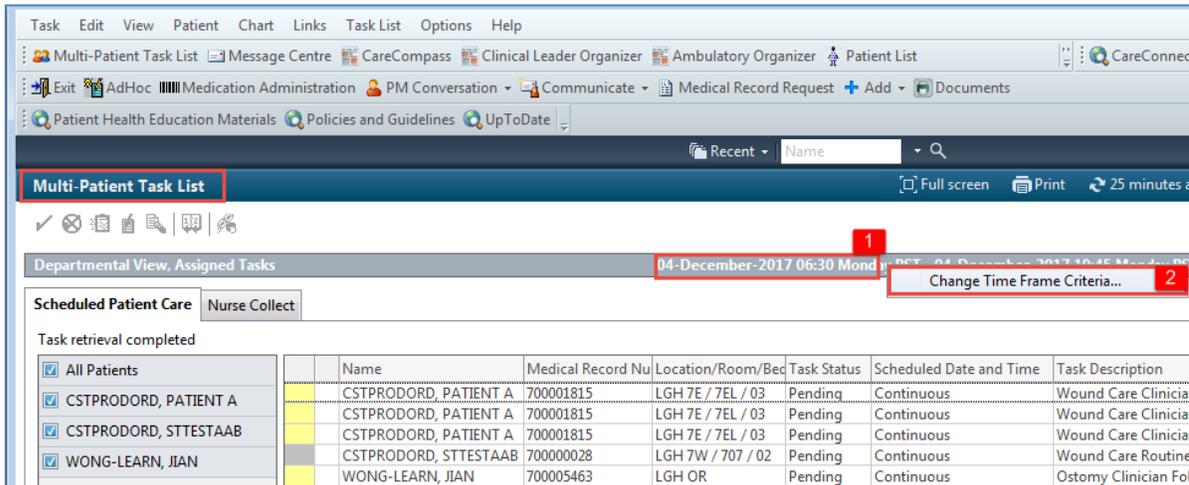
Note: The blue box  indicates the area has been selected. If you only manage certain units, click  those units eg:  **LGH Pediatric Asthma Clinic** and unselect the other locations.

- 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.

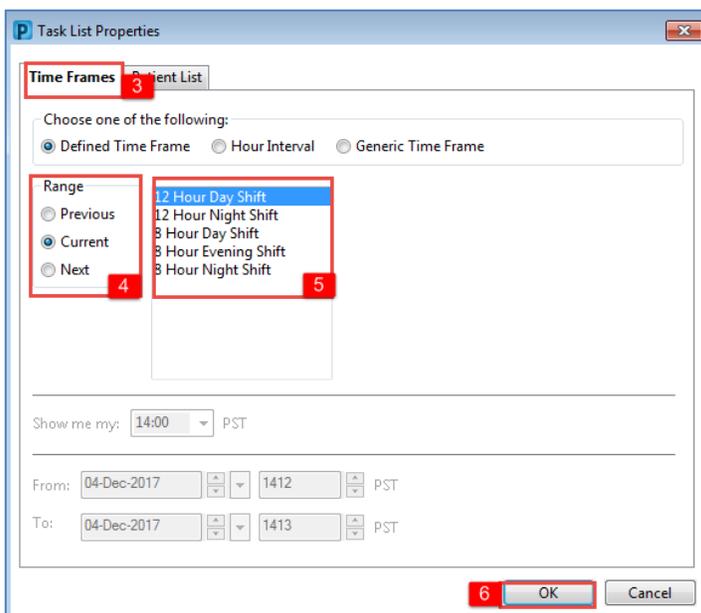
To select the appropriate Time Frame for your MPTL:

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



Within the **Task List Properties** window:

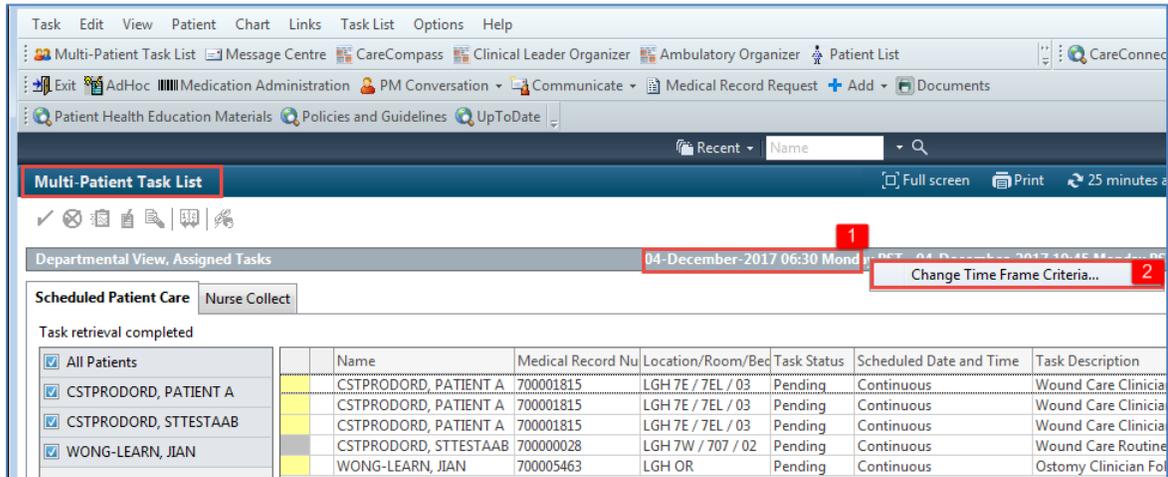
- Click on **Time Frames**
- Click your Range: **Current**
- Select time frame of **12-Hour Day Shift**
- Click **OK**



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

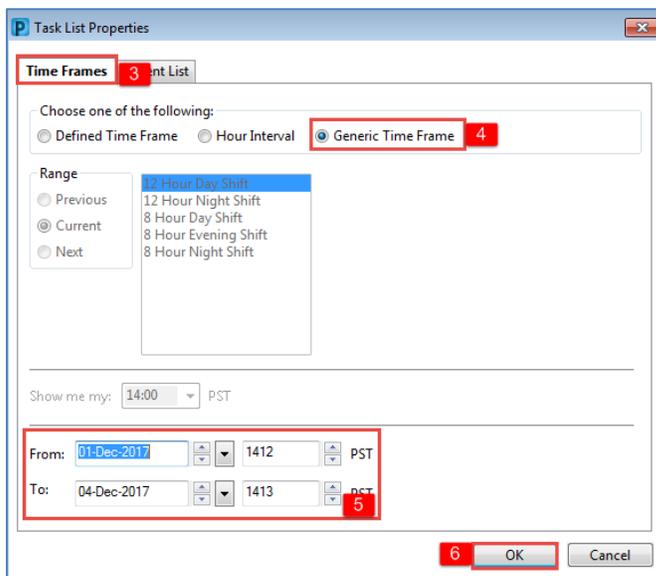
To select the appropriate Time Frame for your MPTL:

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 Frame**
5. Review the date and change the time by typing From = 0900 To: 1630
6. Click **OK**



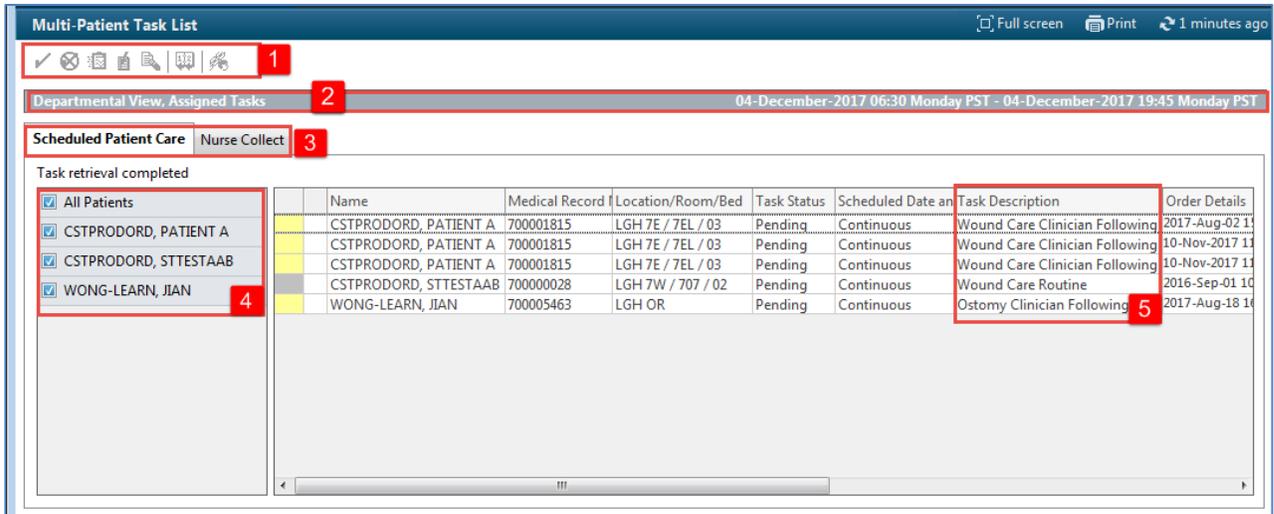
Note: If you forget to set up your Time Frame you will not see your tasks. Your patients will remain on your MPTL after they are discharged for several hours.

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

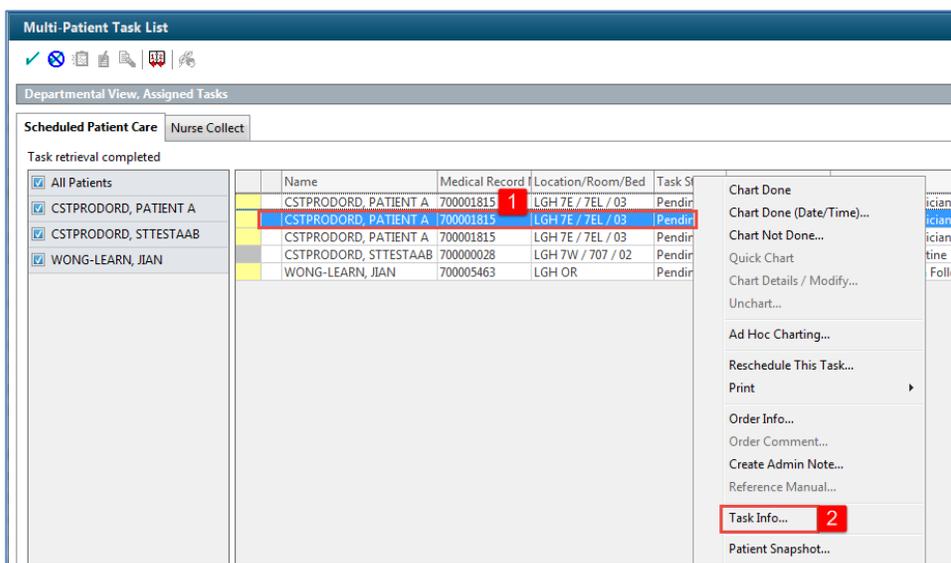
- 1 On your **MPTL**, review the following components:
 1. Task list toolbar - hover over the **icons** to discover their functions
 2. Information bar with name of the patient list (far left) and the set time frame (far right)
 3. Task categories (tabs)
 4. Navigator window with patient names with associated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



The screenshot shows the Multi-Patient Task List interface. At the top, there is a toolbar with various icons (1). Below it is an information bar showing the patient list name 'Departmental View, Assigned Tasks' and the time frame '04-December-2017 06:30 Monday PST - 04-December-2017 19:45 Monday PST' (2). There are tabs for 'Scheduled Patient Care' and 'Nurse Collect' (3). On the left, a patient navigator lists 'All Patients', 'CSTPRODORD, PATIENT A', 'CSTPRODORD, STTESTAAB', and 'WONG-LEARN, JIAN' (4). The main area displays a table of tasks with columns for Name, Medical Record, Location/Room/Bed, Task Status, Scheduled Date, Task Description, and Order Details (5).

Name	Medical Record	Location/Room/Bed	Task Status	Scheduled Date	Task Description	Order Details
CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following	2017-Aug-02 11
CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following	10-Nov-2017 11
CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following	10-Nov-2017 11
CSTPRODORD, STTESTAAB	700000028	LGH 7W / 707 / 02	Pending	Continuous	Wound Care Routine	2016-Sep-01 10
WONG-LEARN, JIAN	700005463	LGH OR	Pending	Continuous	Ostomy Clinician Following	2017-Aug-18 14

- 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...**



The screenshot shows the Multi-Patient Task List interface with a context menu open over a task row. The task row is highlighted in blue. The context menu includes options such as 'Chart Done', 'Chart Done (Date/Time)...', 'Chart Not Done...', 'Quick Chart', 'Chart Details / Modify...', 'Unchart...', 'Ad Hoc Charting...', 'Reschedule This Task...', 'Print', 'Order Info...', 'Order Comment...', 'Create Admin Note...', 'Reference Manual...', 'Task Info...' (2), and 'Patient Snapshot...'.

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

Task Information for: Wound Care Clinician Following

Task

General History Assignment

Task Description: Wound Care Clinician Following

Task ID: 185681019

Task Date / Time: 04-Dec-2017 15:21 PST

Status: Pending

Status Reason:

Reference Task ID: 2554174851

Task Type: Wound Care Nursing

Task Class: Continuous

Task Activity: Chart Result

Medication Order Type:

Order ID: 327437565

Location (Nurse Unit / Room / Bed): LGH 7E / 7EL / 03

Catalog Type Code: 636063

Event ID:

Not Done Reason:

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

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

	Name	Medical Record	Location/Room/Bed	Task Status	Scheduled Date and	Task Description	Order Details
	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following	2017-Aug-02 15:15 PDT
	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following	10-Nov-2017 11:41 PST
	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following	11 PST
	CSTPRODORD, STTESTAAB	700000028	LGH 7W / 707 / 02	Pending	Continuous	Wound Care Clinician Following	16 PDT, Constant ord
	WONG-LEARN, JIAN	700005463	LGH OR	Pending	Continuous	Wound Care Clinician Following	11 PDT, Reason for f

Context menu options:

- Chart Done
- Chart Done (Date/Time)...
- Chart Not Done...
- Quick Chart
- Chart Details / Modify...
- Unchart...

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

Assign a Relationship

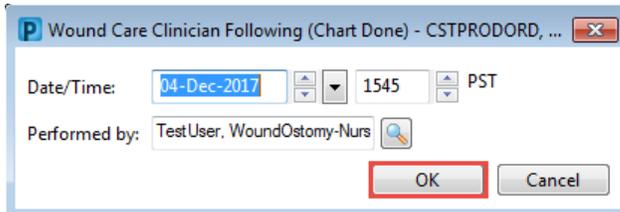
For Patient: CSTZEROONEPYLON, SITWOMONTY

Relationships:

- Nurse**
- Quality / Utilization Review
- Research
- Unit Coordination

OK Cancel

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

Multi-Patient Task List							
Departmental View, Assigned Tasks							
Scheduled Patient Care		Nurse Collect					
Task retrieval completed							
		Name	Medical Record	Location/Room/Bed	Task Status	Scheduled Date and Time	Task Description
<input checked="" type="checkbox"/>		CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following
<input checked="" type="checkbox"/>		CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Complete	04-Dec-2017 15:45	Wound Care Clinician Following
<input checked="" type="checkbox"/>		CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending	Continuous	Wound Care Clinician Following
		CSTPRODORD, STTESTAAB	700000028	LGH 7W / 707 / 02	Pending	Continuous	Wound Care Routine
		WONG-LEARN, JIAN	700005463	LGH OR	Pending	Continuous	Ostomy Clinician Following

 **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.

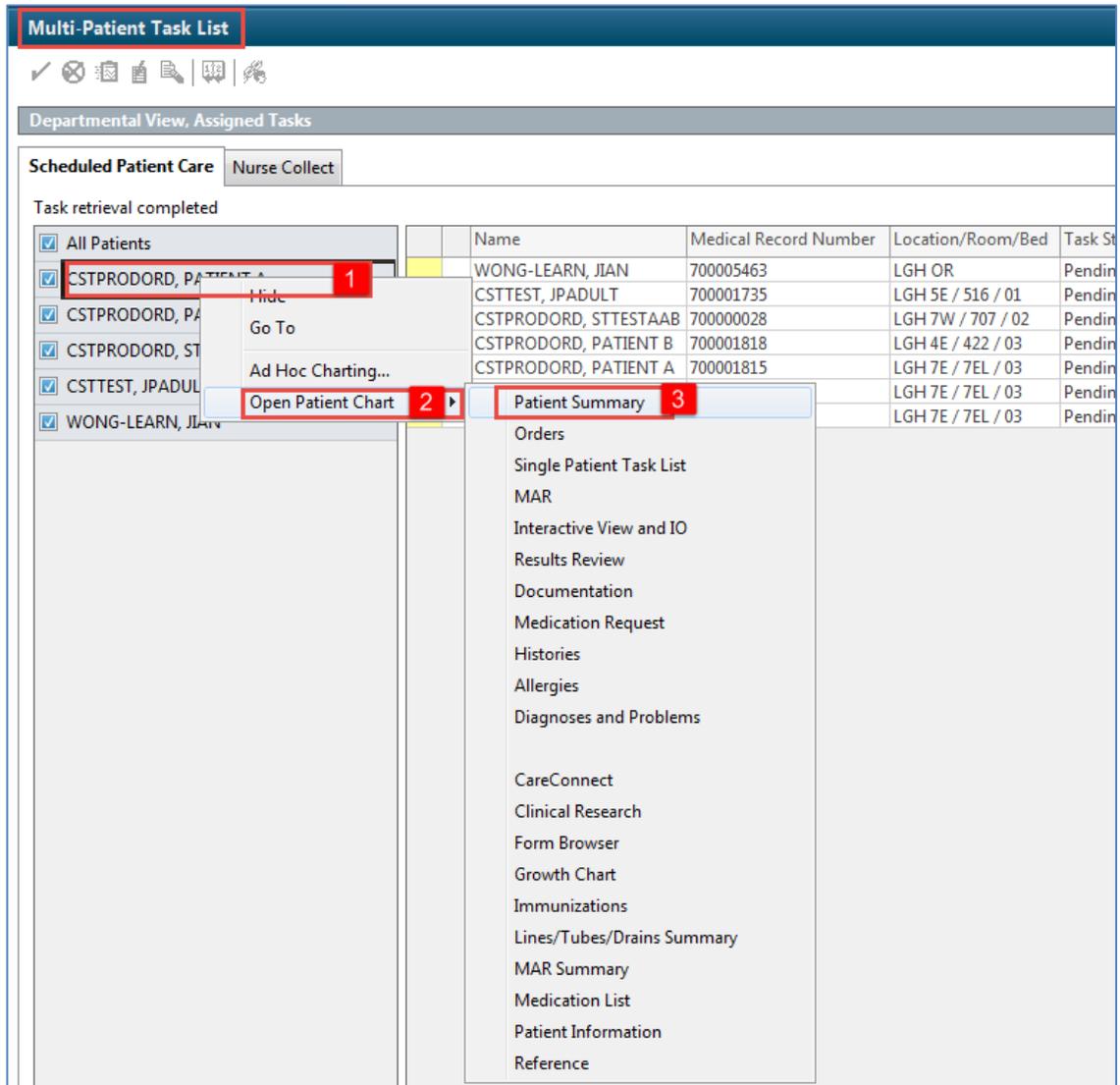
As a nurse you will be completing the following activities:

- 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**:

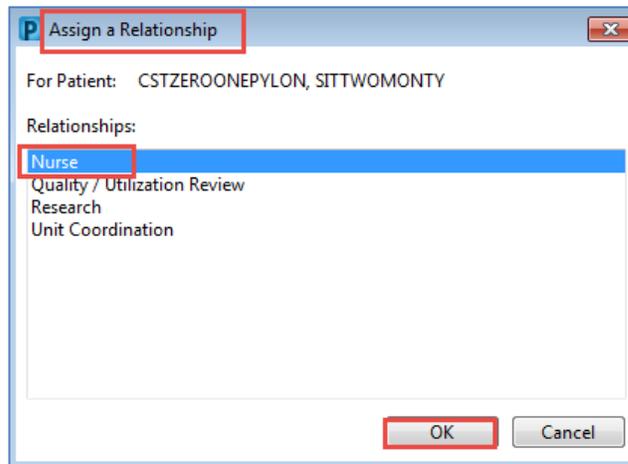
1. Right-click on patient's name
2. Select **Open Patient Chart**
3. Select **Patient Summary**



The screenshot shows the 'Multi-Patient Task List' interface. At the top, there is a toolbar with various icons. Below the toolbar, the 'Departmental View, Assigned Tasks' section is visible, with a 'Scheduled Patient Care' tab selected. A table of tasks is displayed, with columns for 'Name', 'Medical Record Number', 'Location/Room/Bed', and 'Task Status'. A right-click context menu is open over the patient 'WONG-LEARN, JIAN'. The menu items are: 'Hide', 'Go To', 'Ad Hoc Charting...', 'Open Patient Chart', and 'Patient Summary'. Red boxes and numbers highlight the following steps: 1. The patient's name 'WONG-LEARN, JIAN' in the table. 2. The 'Open Patient Chart' option in the context menu. 3. The 'Patient Summary' option in the context menu.

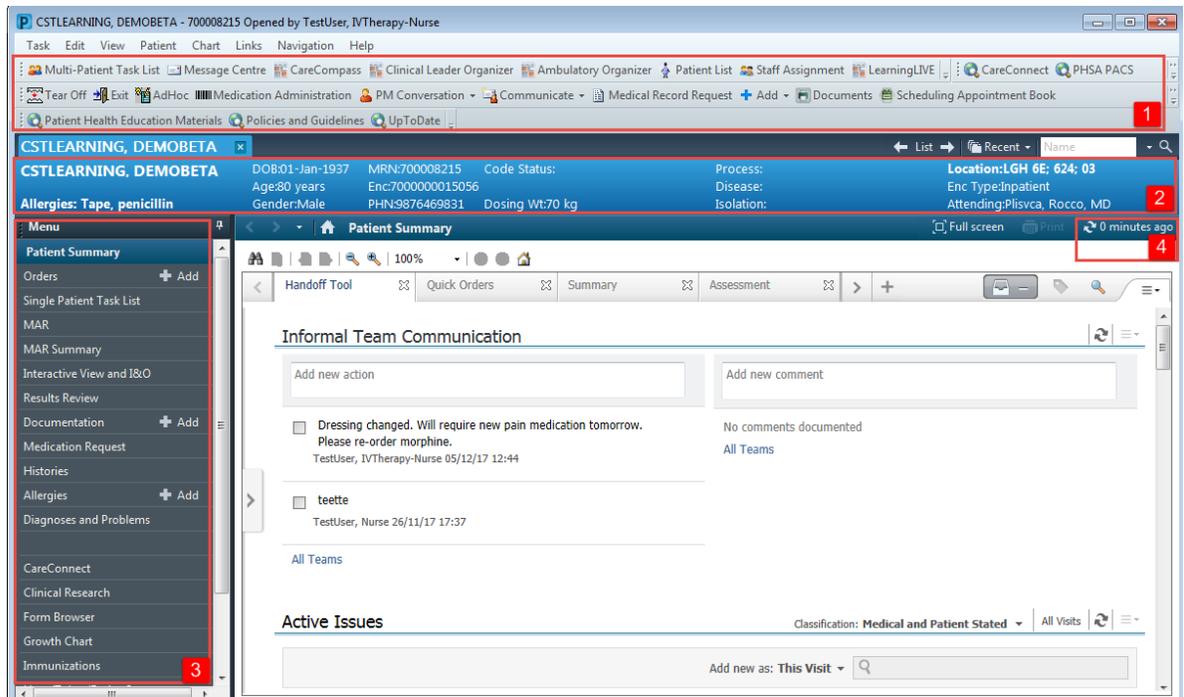
Task	Name	Medical Record Number	Location/Room/Bed	Task Status
<input checked="" type="checkbox"/>	WONG-LEARN, JIAN	700005463	LGH OR	Pending
<input checked="" type="checkbox"/>	CSTTEST, JPADULT	700001735	LGH 5E / 516 / 01	Pending
<input checked="" type="checkbox"/>	CSTPRODORD, STTESTAAB	700000028	LGH 7W / 707 / 02	Pending
<input checked="" type="checkbox"/>	CSTPRODORD, PATIENT B	700001818	LGH 4E / 422 / 03	Pending
<input checked="" type="checkbox"/>	CSTPRODORD, PATIENT A	700001815	LGH 7E / 7EL / 03	Pending
<input checked="" type="checkbox"/>	CSTTEST, JPADULT	700001815	LGH 7E / 7EL / 03	Pending
<input checked="" type="checkbox"/>	WONG-LEARN, JIAN		LGH 7E / 7EL / 03	Pending

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



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



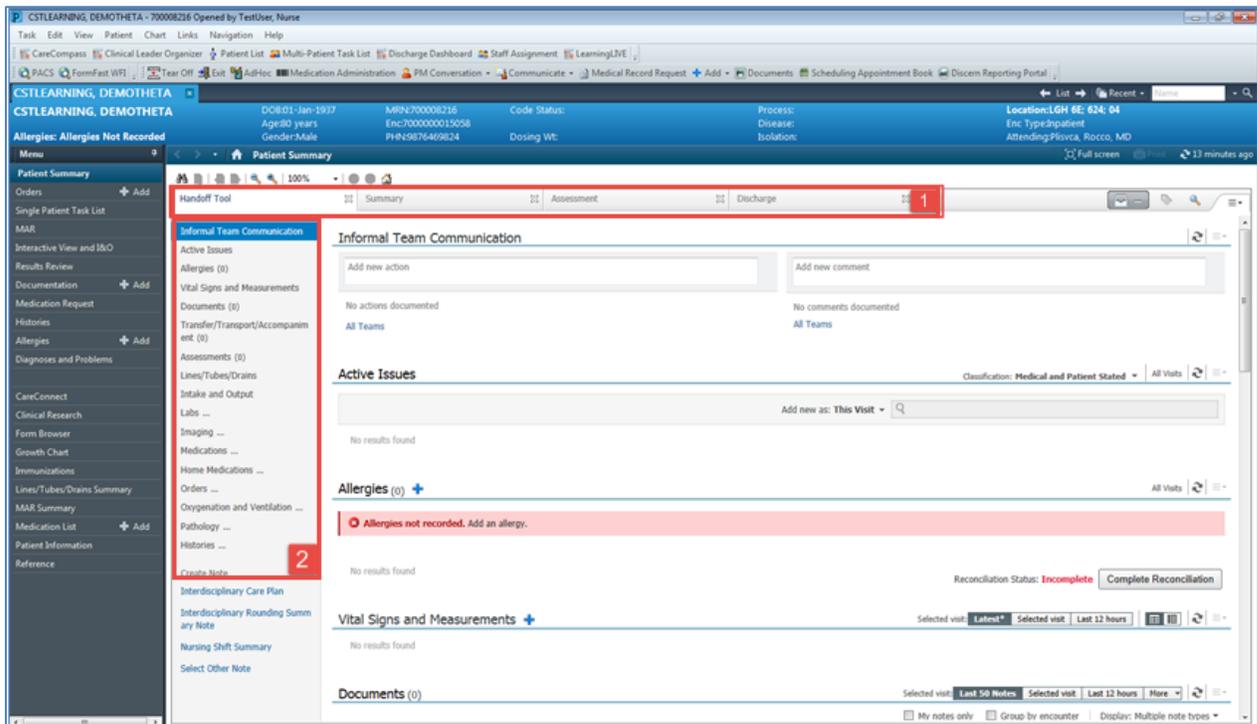
Key Learning Points

- 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  0 minutes ago.

Key Learning Points

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

PATIENT SCENARIO 4 - 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:

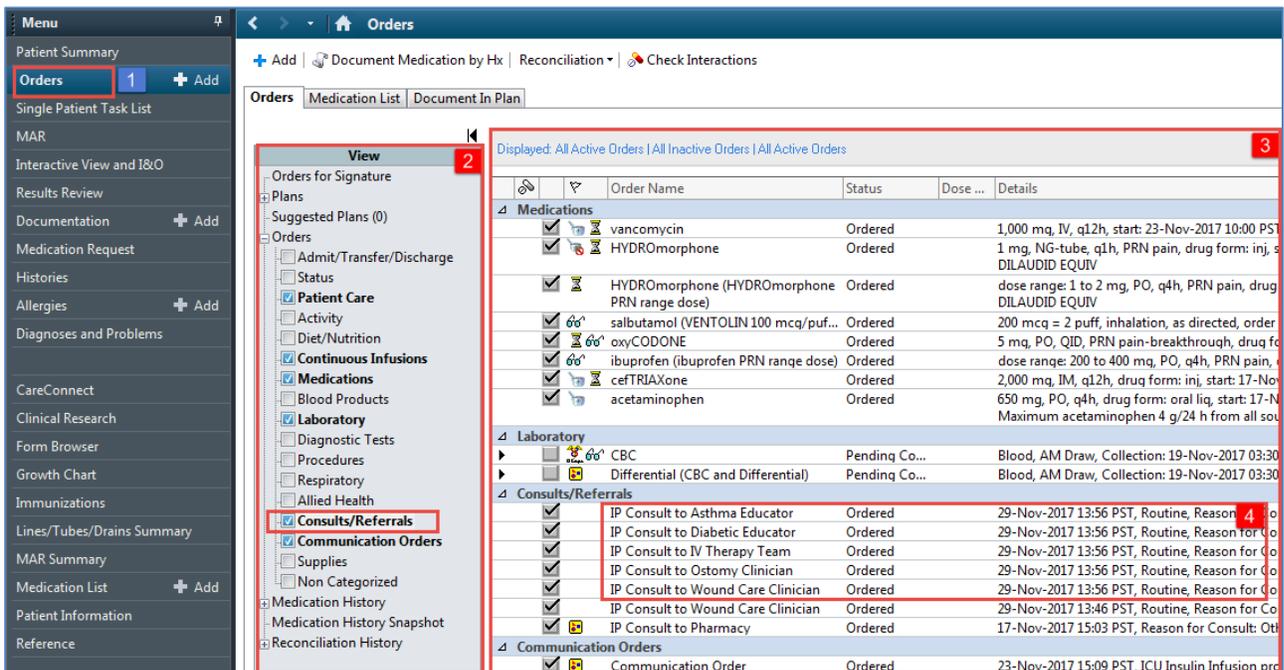
1. Select **Orders** from the **Menu**
2. On the left side of the Orders Page is the Navigator (**View**) which includes several categories including:
 - **Plans**
 - **Categories of Orders**
 - **Medication History**
 - **Reconciliation History**
3. On the right side is the **Order Profile** where you 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.



The screenshot shows the EHR interface for reviewing patient orders. The left sidebar contains a 'Menu' with 'Orders' selected. The main content area is titled 'Orders' and shows a list of orders. The 'View' sidebar on the left lists various order categories, with 'Consults/Referrals' selected. The main table displays the following orders:

Order Name	Status	Dose ...	Details
Medications			
vancomycin	Ordered	1,000 mg, IV, q12h, start: 23-Nov-2017 10:00 PST	
HYDROmorphone	Ordered	1 mg, NG-tube, q1h, PRN pain, drug form: inj, s	DILAUDID EQUIV
HYDROmorphone (HYDROmorphone PRN range dose)	Ordered	dose range: 1 to 2 mg, PO, q4h, PRN pain, drug	DILAUDID EQUIV
salbutamol (VENTOLIN 100 mcg/puf...	Ordered	200 mcg = 2 puff, inhalation, as directed, order	
oxyCODONE	Ordered	5 mg, PO, QID, PRN pain-breakthrough, drug fo	
ibuprofen (ibuprofen PRN range dose)	Ordered	dose range: 200 to 400 mg, PO, q4h, PRN pain, s	
cefTRIAxone	Ordered	2,000 mg, IM, q12h, drug form: inj, start: 17-Nov	
acetaminophen	Ordered	650 mg, PO, q4h, drug form: oral liq, start: 17-Nov	Maximum acetaminophen 4 g/24 h from all sou
Laboratory			
CBC	Pending Co...	Blood, AM Draw, Collection: 19-Nov-2017 03:30	
Differential (CBC and Differential)	Pending Co...	Blood, AM Draw, Collection: 19-Nov-2017 03:30	
Consults/Referrals			
IP Consult to Asthma Educator	Ordered	29-Nov-2017 13:56 PST, Routine, Reason for Co	
IP Consult to Diabetic Educator	Ordered	29-Nov-2017 13:56 PST, Routine, Reason for Co	
IP Consult to IV Therapy Team	Ordered	29-Nov-2017 13:56 PST, Routine, Reason for Co	
IP Consult to Ostomy Clinician	Ordered	29-Nov-2017 13:56 PST, Routine, Reason for Co	
IP Consult to Wound Care Clinician	Ordered	29-Nov-2017 13:56 PST, Routine, Reason for Co	
IP Consult to Wound Care Clinician	Ordered	29-Nov-2017 13:46 PST, Routine, Reason for Co	
IP Consult to Pharmacy	Ordered	17-Nov-2017 15:03 PST, Reason for Consult: Ott	
Communication Orders			
Communication Order	Ordered	23-Nov-2017 15:09 PST, ICU Insulin Infusion pro	

 **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

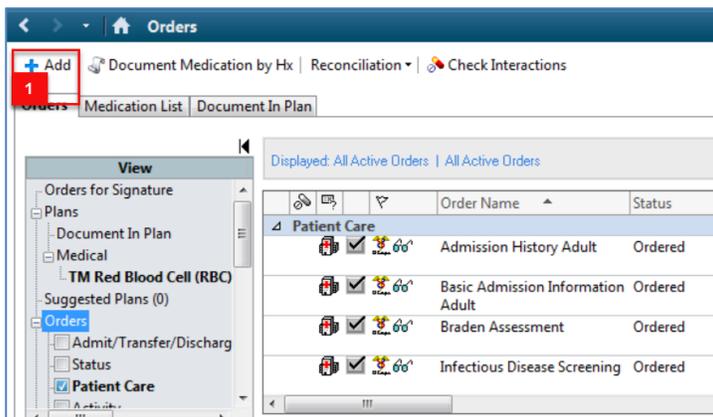
Activity 4.2 – Place a No Cosignature Required Order

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:

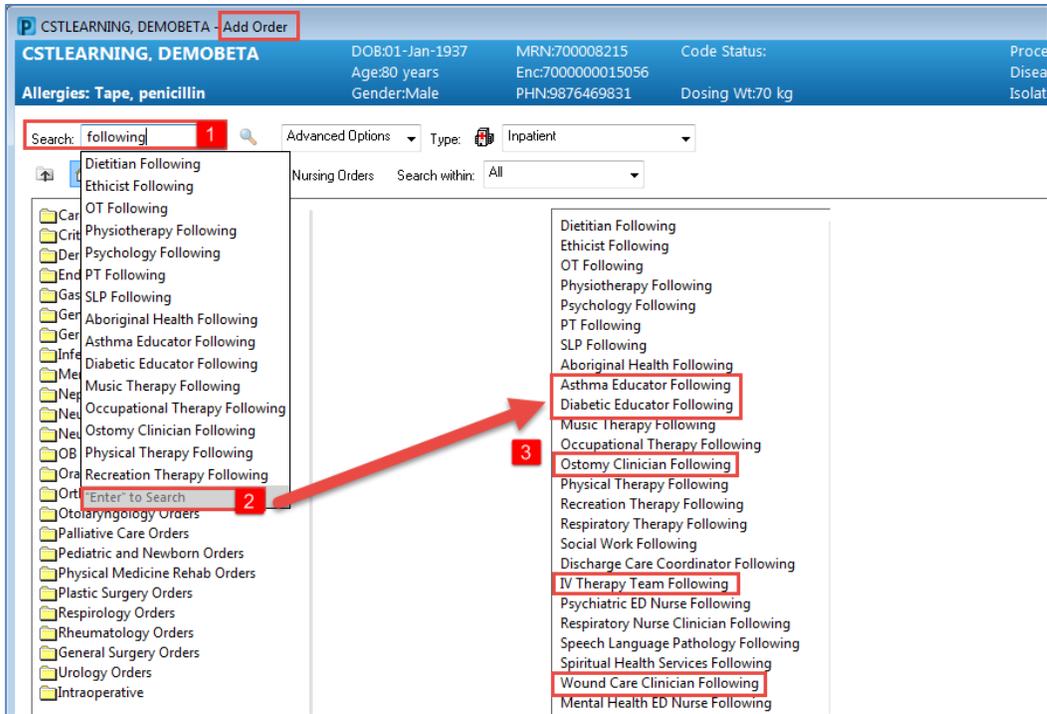
1. Click the **Add** button on the **Orders** page



The **Add Order** window opens.

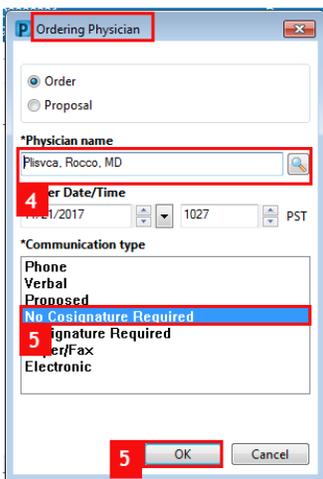
1. Type "*Following*" into the search window and a list of choices will display
2. Press the Enter key on your keyboard, it will display all of the **Following** orders
3. Select the Following order for your specialty (e.g., if you are a Diabetic Educator, please select **Diabetic Educator Following**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

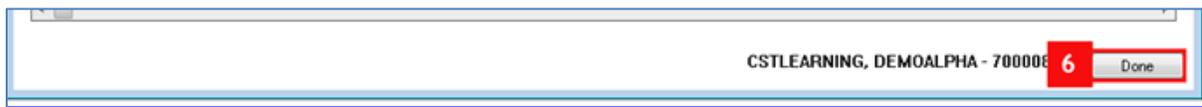


The **Ordering Physician** window opens.

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**.

Orders for Signature

▼ Details for **Asthma Educator Following**

Details | Order Comments

+ [Icons]

*Requested Start Date/Time: 29-Nov-2017 1441 PST

Reason for Follow-Up: Continuity of care

<No Items>

0 Missing Required Details | Orders For Cosignature | Orders For Nurse Review | **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

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

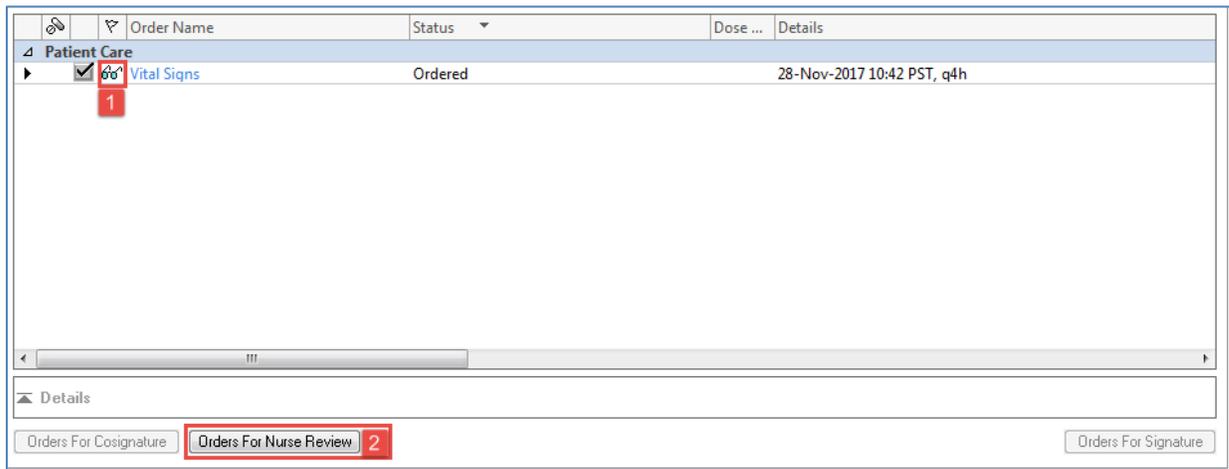
To review order details:

- 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

Order Name	Status	Dose ...	Details
Allied Health			
Asthma Educator Following	Ordered		29-Nov-2017 14:41 PST, Reason for follow-up: Continuity of care
Consults/Referrals			
IP Consult to Asthma Educator	Ordered		29-Nov-2017 13:56 PST, Routine, Reason for Consult: Education
IP Consult to Diabetic Educator	Ordered		29-Nov-2017 13:56 PST, Routine, Reason for Consult: Insulin Management
IP Consult to IV Therapy Team	Ordered		29-Nov-2017 13:56 PST, Routine, Reason for Consult: Need a PICC
IP Consult to Ostomy Clinician	Ordered		29-Nov-2017 13:56 PST, Routine, Reason for Consult: New Colostomy
IP Consult to Wound Care Clinician	Ordered		29-Nov-2017 13:56 PST, Routine, Reason for Consult: Chronic wound not healing

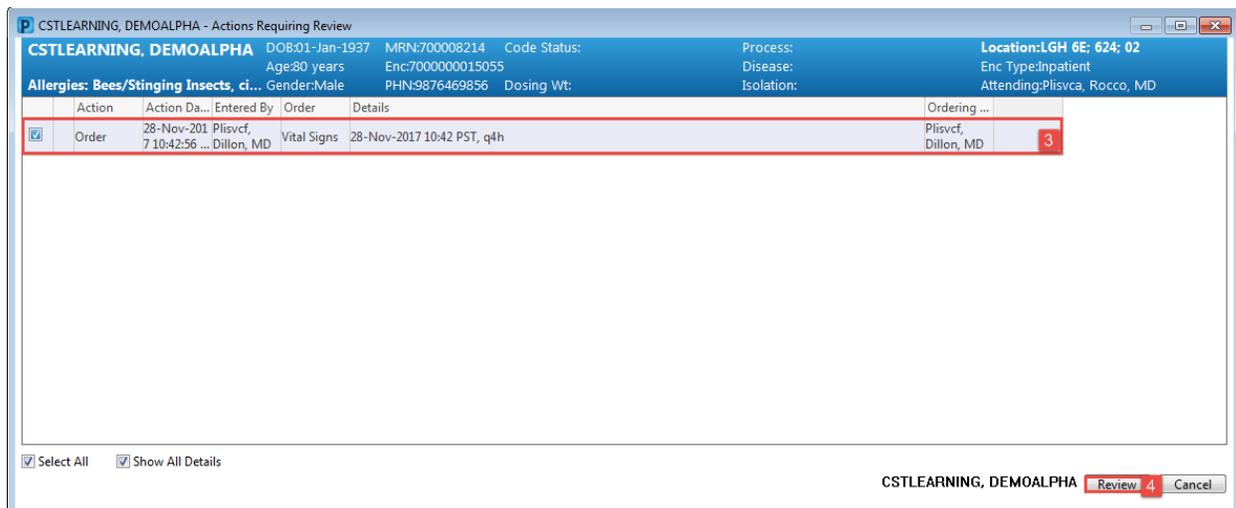
When new orders are placed in the chart, a nurse must acknowledge reviewing these new orders. Below we outline the steps for how this should be done. **Note:** Do not follow these steps in the system but instead refer to the screenshots to understand the process

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

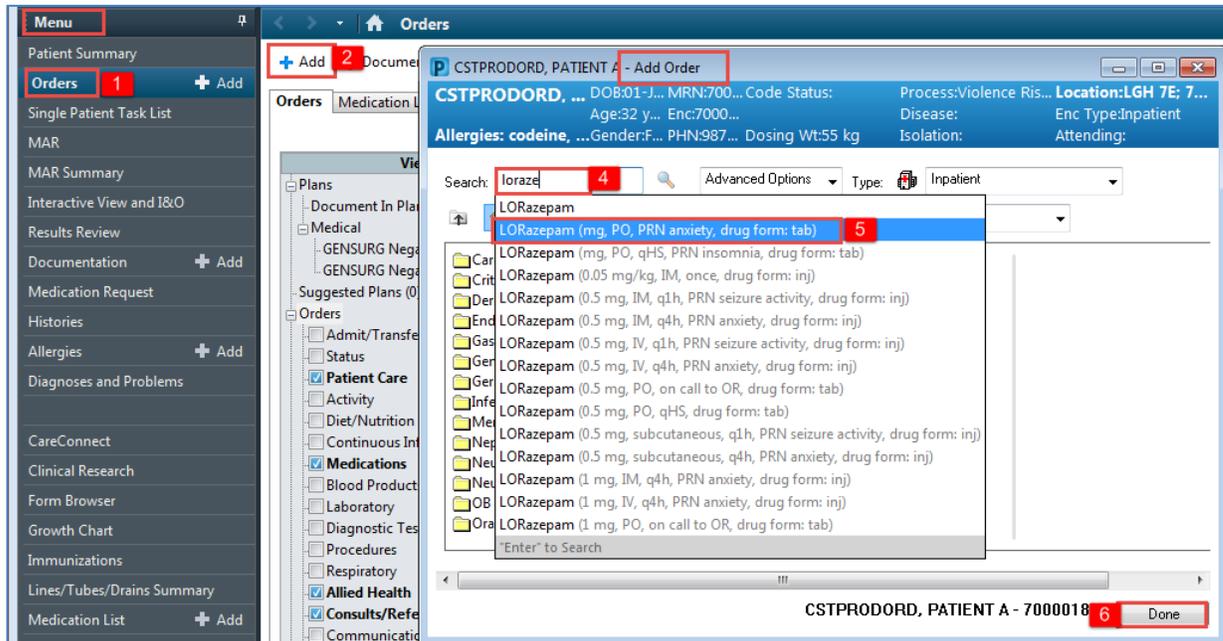
- 1 Similar to current practice, nurses can place verbal and telephone orders. In this activity we are going to practice placing a verbal order. **Verbal Orders** are only encouraged when there is no reasonable alternative for the provider to place the order in the CIS themselves, for example, in emergency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

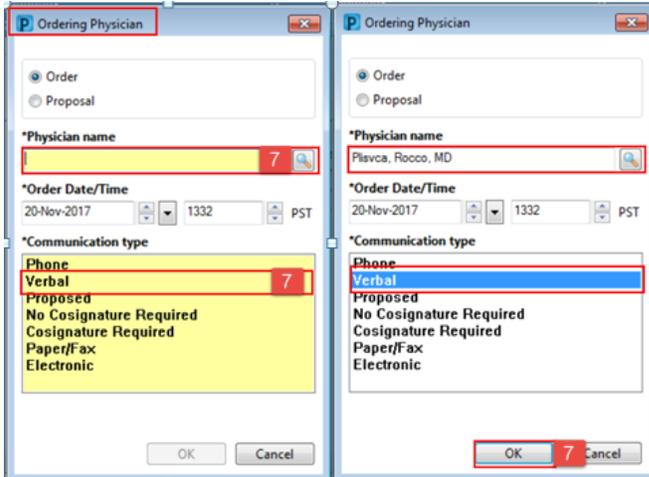
1. Select **Orders** from the **Menu**
2. Click the  button.
3. The **Add Order** pop-up window will appear
4. Type “loraze” in the search field, a drop-down list of order sentences display
5. Select *lorazepam (mg, PO, PRN anxiety, drug form tab)*
6. Click **Done**



The screenshot displays the CIS interface for adding an order. On the left, the 'Menu' is visible with 'Orders' selected (1). The main area shows the 'Orders' section with a '+ Add' button (2). The 'Add Order' window is open, showing patient information for CSTPRODORD, PATIENT A. The search field contains 'loraze' (4), and the search results list 'LORazepam (mg, PO, PRN anxiety, drug form: tab)' (5). The 'Done' button is highlighted (6).

The Ordering Physician pop-up window will appear.

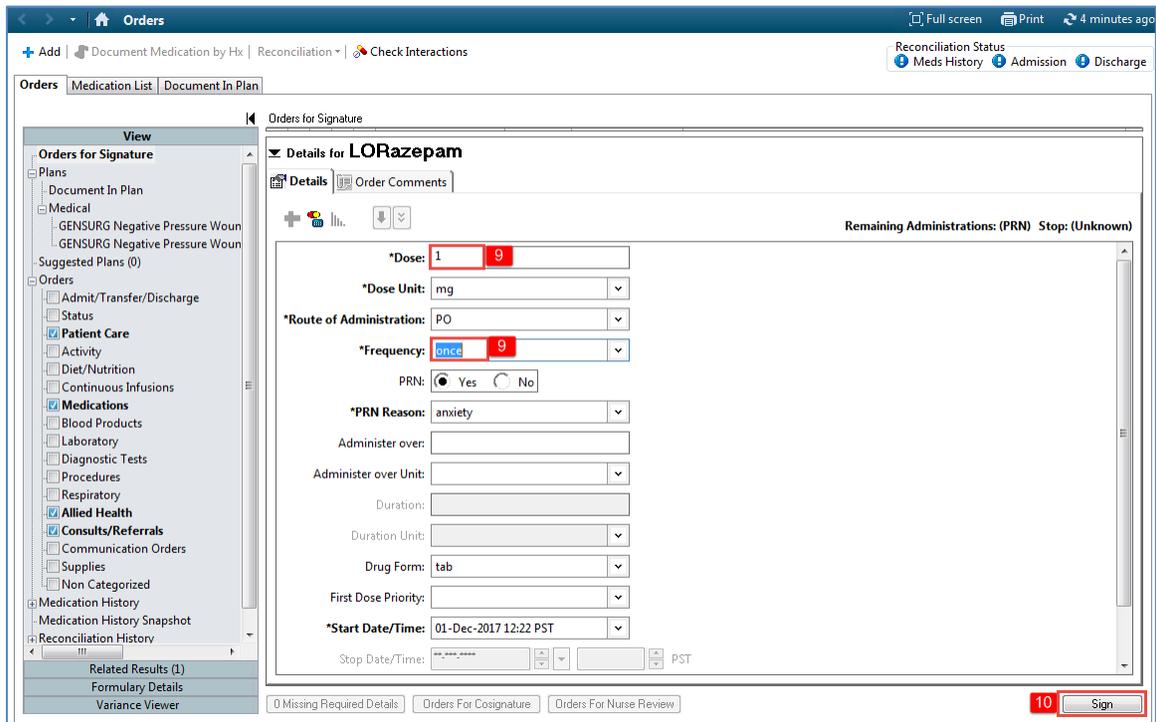
7. Fill out required fields highlighted with yellow and click **OK**
 - **Physician name** = *type name of Attending Physician (last name, first name)*
 - **Communication type** = *Verbal*



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**

Orders

+ Add | Document Medication by Hx | Reconciliation | Check Interactions

Orders Medication List Document In Plan

View

Orders for Signature

Plans

Suggested Plans (0)

Orders

Admit/Transfer/Discharge

Status

Displayed: All Active Orders | All Inactive Orders | All Active Orders

	Order Name	Status	Dose ...	Details
<input checked="" type="checkbox"/>	LORazepam	Ordered		1 mg, PO, once, PRN anxiety, c
<input checked="" type="checkbox"/>	vancomycin	Ordered		1,000 mg, IV, q12h, start: 29-N
<input checked="" type="checkbox"/>	HYDROmorphone (HYDROmorphone PRN range dose)	Ordered		dose range: 0.1 to 0.5 mg, IV, c DILAUDID EQUIV

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

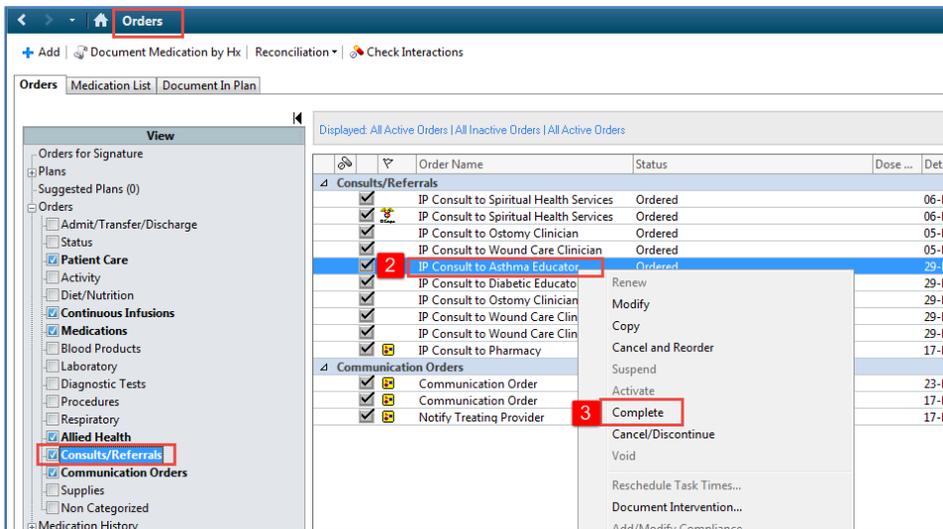
Activity 4.5 – Complete or Cancel/Discontinue an Order

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

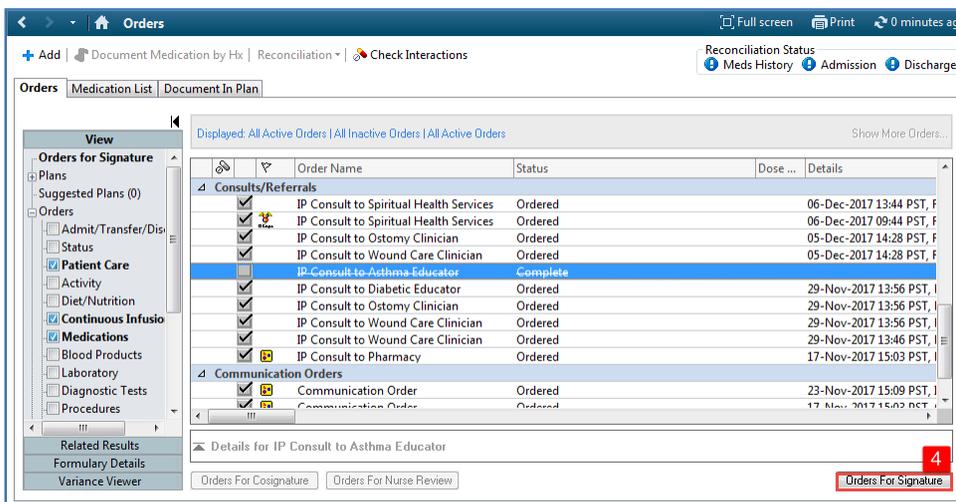
- 1 When a one-time order has been carried out, the order needs to be removed from the patient's order profile. This is done by Completing the order.

To complete an order:

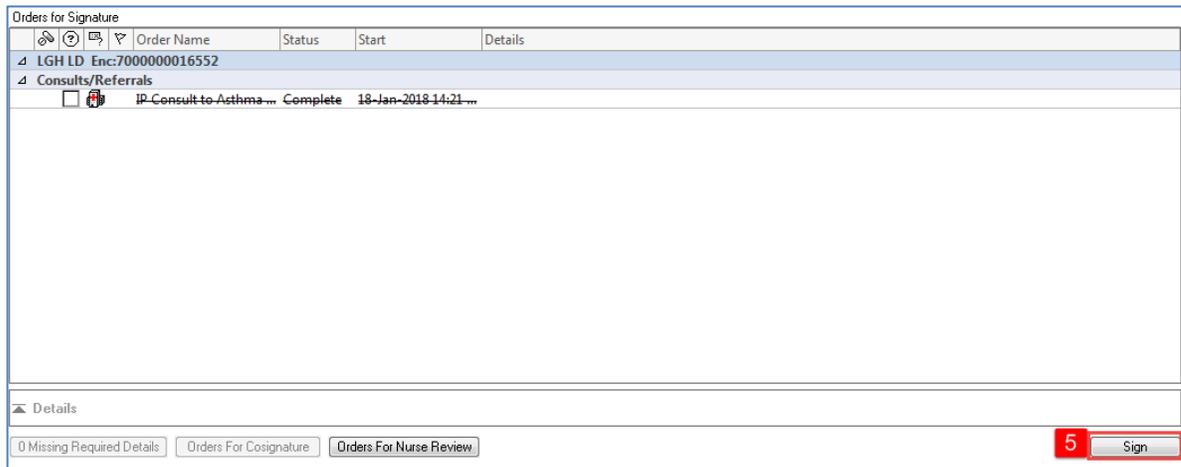
1. Review the **Order Profile**
2. Right-click the consult order for your specialty (e.g. IP Consult to Asthma Educator)
3. Select **Complete**



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



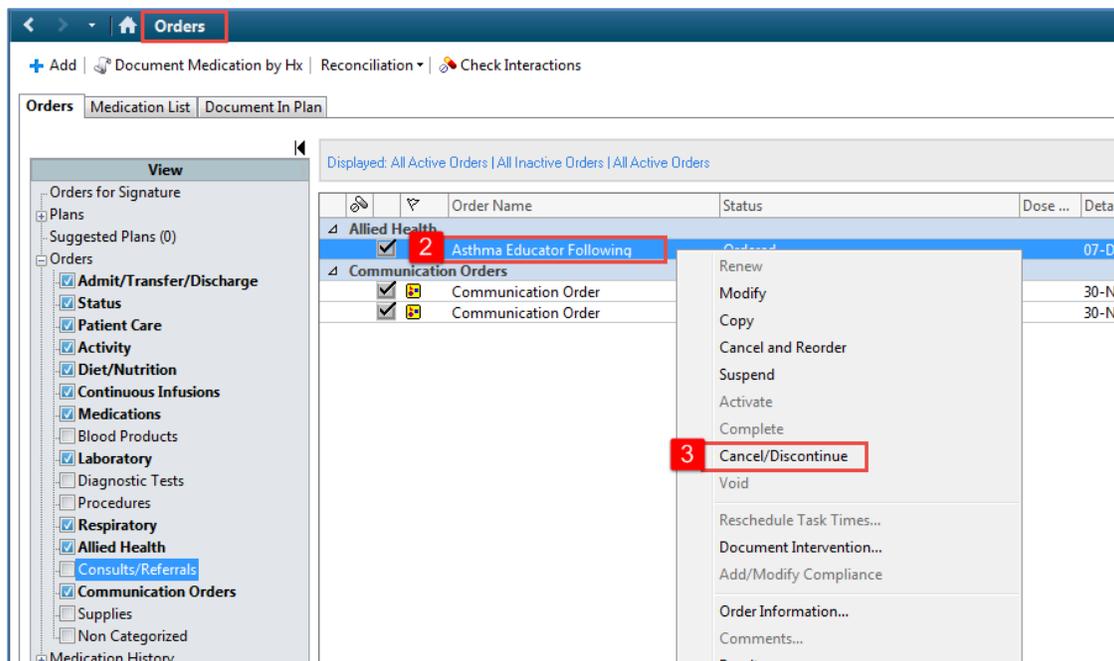
- Review order for signature and click **Sign**. You will return to the orders profile where orders will show as processing.



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

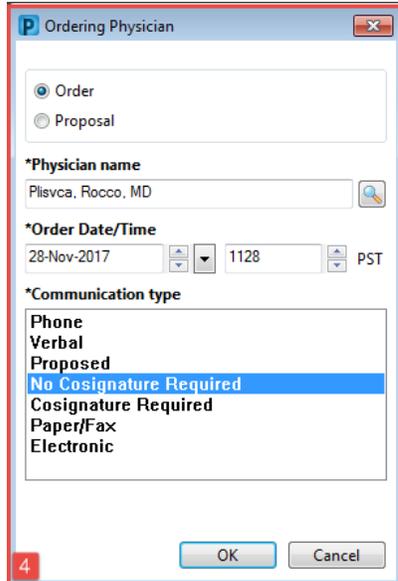
2 To Cancel/Discontinue an order:

- Review the **Order Profile**
- Right-click the **Following** order you placed earlier for your specialty(e.g., Asthma Educator Following)
- Select **Cancel/Discontinue**



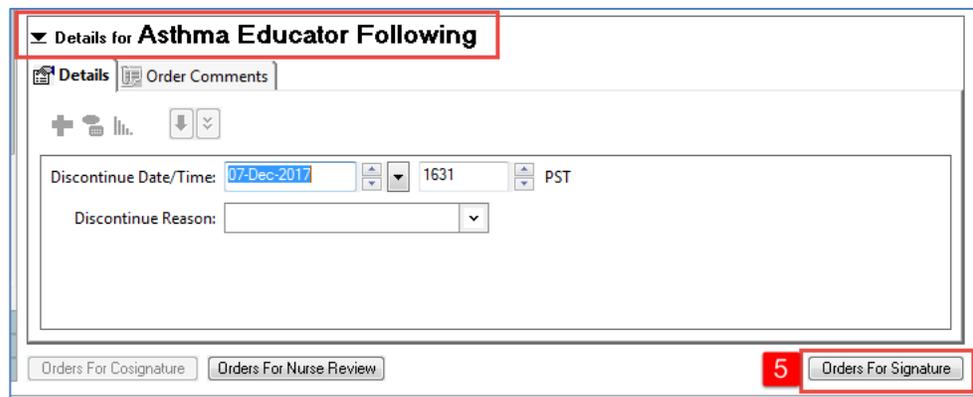
4. Ordering Physician pop-up window will appear. Fill out required fields highlighted yellow below and then click **OK**

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



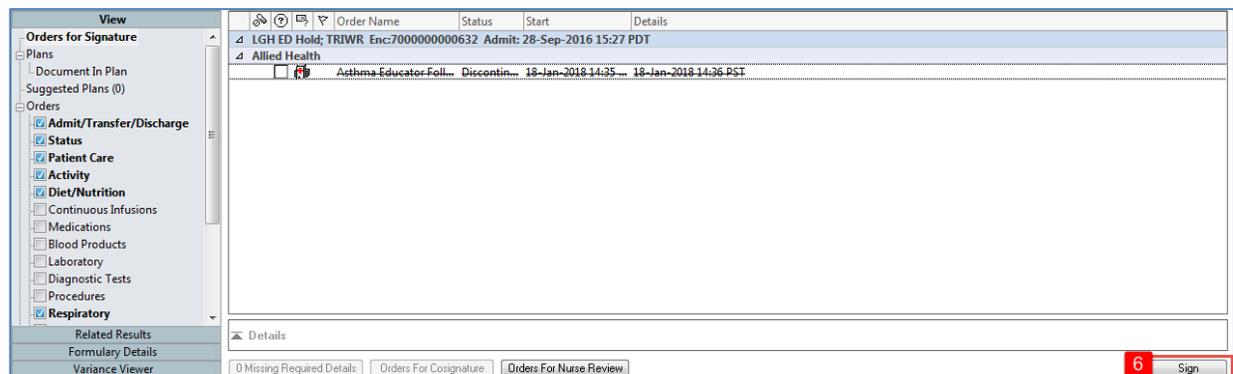
The image shows a pop-up window titled "Ordering Physician". It contains several fields: "Order" (selected) and "Proposal" (unselected) radio buttons; a text field for "Physician name" containing "Plisvca, Rocco, MD"; a date and time field for "Order Date/Time" set to "28-Nov-2017" at "1128" PST; and a list for "Communication type" with options: "Phone", "Verbal", "Proposed", "No Cosignature Required" (highlighted in blue), "Cosignature Required", "Paper/Fax", and "Electronic". At the bottom are "OK" and "Cancel" buttons. A red box highlights the "Physician name" and "Communication type" fields, and a small red box with the number "4" is in the bottom-left corner.

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



The image shows a web interface for "Details for Asthma Educator Following". It has tabs for "Details" and "Order Comments". Below the tabs are icons for a plus sign, speech bubble, bar chart, and arrows. A "Discontinue Date/Time" field is set to "07-Dec-2017" at "1631" PST. Below it is a "Discontinue Reason" dropdown menu. At the bottom, there are three buttons: "Orders For Cosignature", "Orders For Nurse Review", and "Orders For Signature" (highlighted with a red box and a red box with the number "5").

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



The image shows a web interface for an order profile. On the left is a "View" sidebar with a tree structure: "Orders for Signature" (expanded), "Plans", "Document In Plan", "Suggested Plans (0)", "Orders", "Admit/Transfer/Discharge", "Status", "Patient Care", "Activity", "Diet/Nutrition", "Continuous Infusions", "Medications", "Blood Products", "Laboratory", "Diagnostic Tests", "Procedures", "Respiratory", "Related Results", "Formulary Details", and "Variance Viewer". The main area shows a table with columns "Order Name", "Status", "Start", and "Details". The first row is "LGH ED Hold; TRIWR Enc:7000000000632 Admit: 28-Sep-2016 15:27 PDT". The second row is "Allied Health" with a checkbox. The third row is "Asthma Educator-Foll... Discontin... 18-Jan-2018 14:35 ... 18-Jan-2018 14:36 PST". At the bottom, there are buttons for "0 Missing Required Details", "Orders For Cosignature", "Orders For Nurse Review", and "Sign" (highlighted with a red box and a red box with the number "6").

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

Key Learning Points

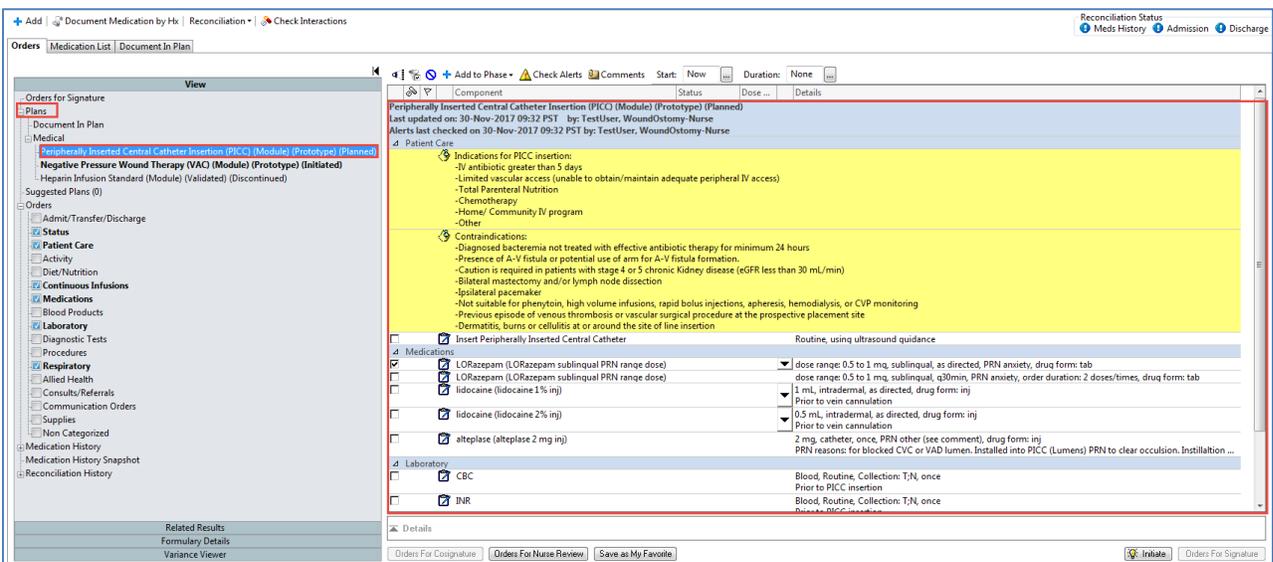
-  The Right-click to mark an order as completed or discontinued
-  Both of these actions will remove orders from patient's Order Profile

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



The screenshot shows the 'Orders Profile' for a 'Peripherally Inserted Central Catheter Insertion (PICC) (Module) (Prototype) (Planned)'. The left sidebar is set to 'View' and shows the 'Plans' category selected. The main content area displays the following information:

- Component:** Peripherally Inserted Central Catheter Insertion (PICC) (Module) (Prototype) (Planned)
- Status:** Planned
- Last updated on:** 30-Nov-2017 09:32 PST
- Alerts last checked on:** 30-Nov-2017 09:32 PST
- Indications for PICC insertion:**
 - IV antibiotic greater than 5 days
 - Limited vascular access (unable to obtain/maintain adequate peripheral IV access)
 - Total Parenteral Nutrition
 - Chemotherapy
 - Home/ Community IV program
 - Other
- Contraindications:**
 - Diagnosed bacteremia not treated with effective antibiotic therapy for minimum 24 hours
 - Presence of A-V fistula or potential use of arm for A-V fistula formation
 - Caution is required in patients with stage 4 or 5 chronic kidney disease (eGFR less than 30 mL/min)
 - Bilateral mastectomy and/or lymph node dissection
 - Ipsilateral pacemaker
 - Not suitable for phentoin, high volume infusions, rapid bolus injections, apheresis, hemodialysis, or CVP monitoring
 - Previous episode of venous thrombosis or vascular surgical procedure at the prospective placement site
 - Dermatitis, burns or cellulitis at or around the site of line insertion
- Medications:**
 - Insert Peripherally Inserted Central Catheter (Routine, using ultrasound guidance)
 - LORazepam (LORazepam sublingual PRN range dose) (dose range: 0.5 to 1 mg, sublingual, as directed, PRN anxiety, drug form: tab)
 - LORazepam (LORazepam sublingual PRN range dose) (dose range: 0.5 to 1 mg, sublingual, q30min, PRN anxiety, order duration: 2 doses/times, drug form: tab)
 - lidocaine (lidocaine 1% inj) (1 mL, intradermal, as directed, drug form: inj)
 - lidocaine (lidocaine 2% inj) (0.5 mL, intradermal, as directed, drug form: inj)
 - alteplase (alteplase 2 mg inj) (2 mg, catheter, once, PRN other (see comment), drug form: inj)
- Laboratory:**
 - CBC (Blood, Routine, Collection: T,N, once)
 - INR (Blood, Routine, Collection: T,N, once)

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:

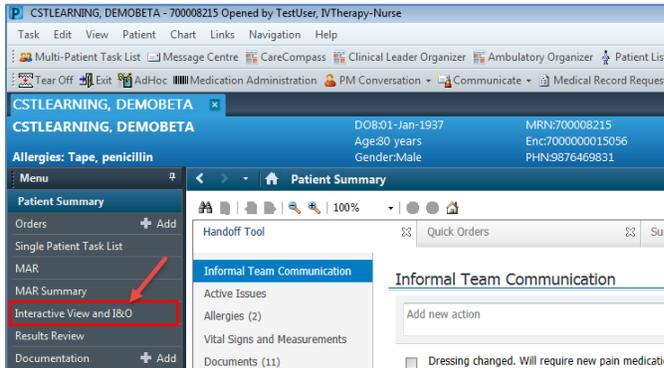
You will be completing the following activities:

- 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

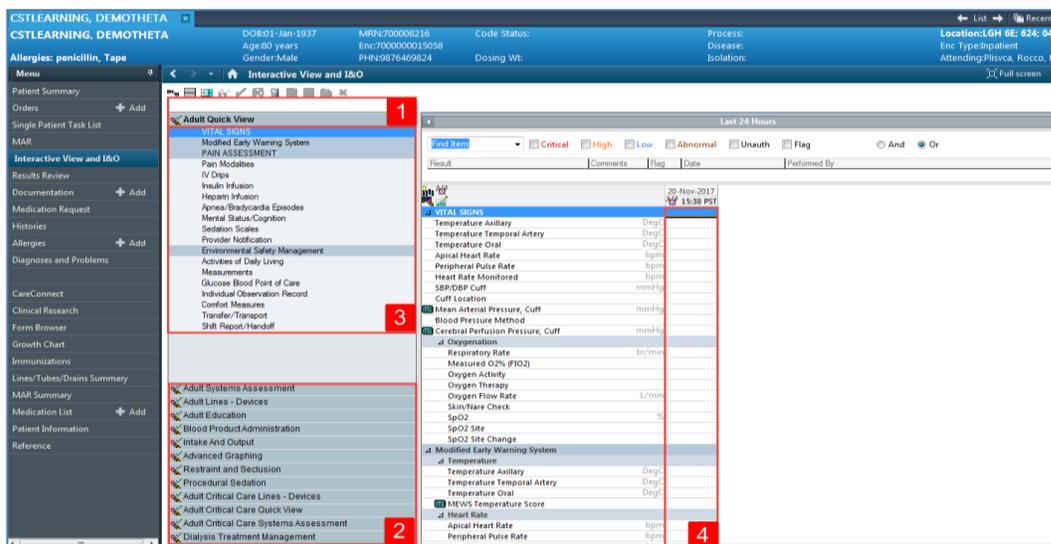
- 1 Nurses will complete most of their documentation in **Interactive View and I&O (iView)**. iView is the electronic equivalent of current state paper flow sheets. For example, vital signs, patient education and wound assessment will be charted in iView.

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



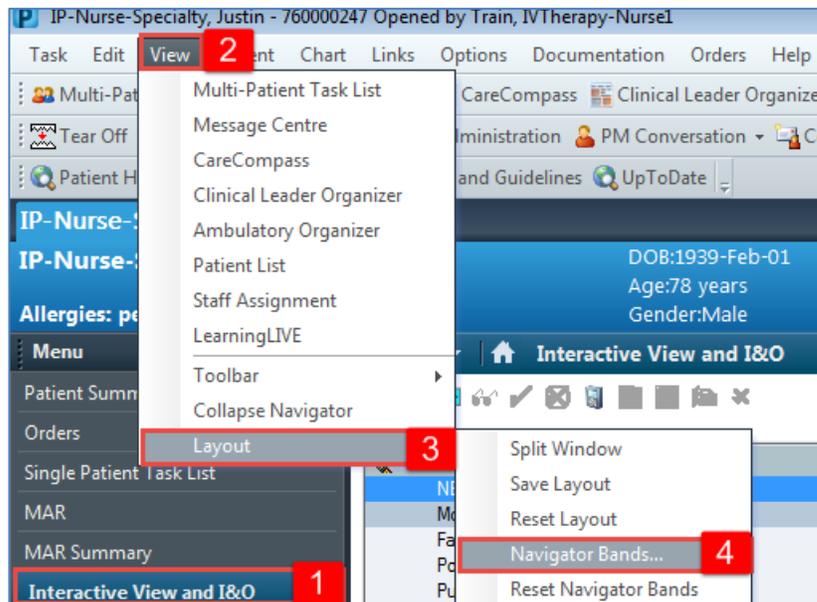
- 2 Now that the iView page is displayed, let's view the layout.

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.

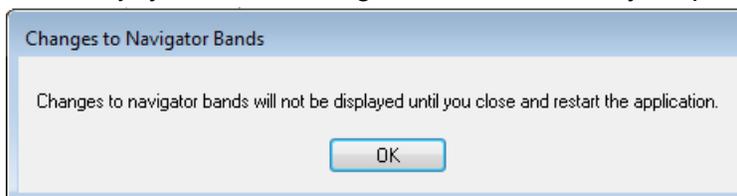


3 As specialty nurse, you may need to select more documentation Navigator Bands that are listed on your Navigator display. For example, Adult Quick View is a useful band to capture most nursing activities.

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



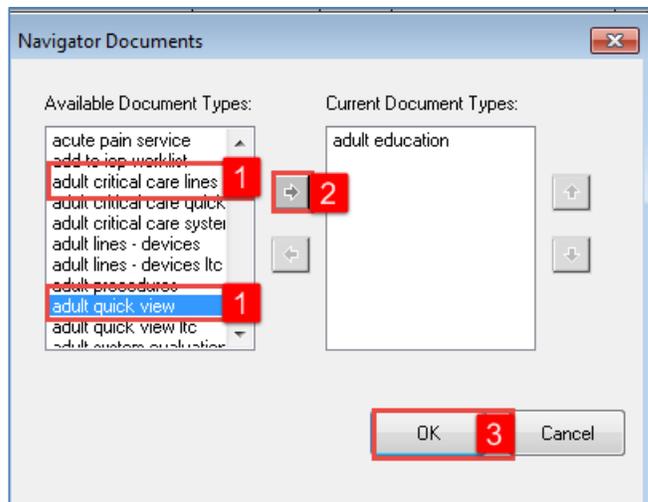
Unfortunately, you will have to go out and back into your patient's chart to see the added bands.



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

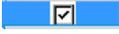
-  Nurses will complete most of their documentation in iView
-  iView contains flowsheet type charting
-  You may add or remove Navigator Bands as needed

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:

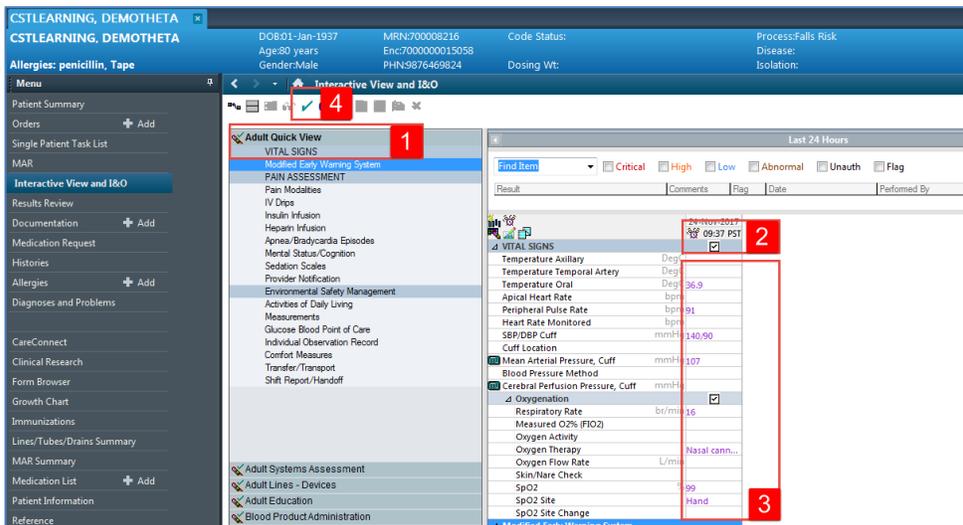
- **Temperature Oral = 36.9**
- **Peripheral Pulse Rate = 91**
- **SBP/DBP Cuff = 140/90**
- **Mean Arterial Pressure, Cuff = 107** (Auto-populated result)

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** 



The screenshot shows the iView interface for a patient named DEMOTHETA. The 'Adult Quick View' section is expanded, showing the 'Vital Signs' component. The 'Vital Signs' section is highlighted with a red box labeled '2'. The 'Checkmark' icon is highlighted with a red box labeled '3'. The 'Enter' key icon is highlighted with a red box labeled '4'. The 'Vital Signs' table shows the following data:

Item	Value
Temperature Axillary	Dep
Temperature Temporal Artery	Dep
Temperature Oral	36.9
Apical Heart Rate	bpm
Peripheral Pulse Rate	bpm
Heart Rate Monitored	bpm
SBP/DBP Cuff	mmHg
Cuff Location	
Mean Arterial Pressure, Cuff	mmHg
Blood Pressure Method	
Cerebral Perfusion Pressure, Cuff	mmHg
Oxygenation:	
Respiratory Rate	br/m
Measured O2% (FIO2)	
Oxygen Activity	
Oxygen Therapy	Nasal cann...
Oxygen Flow Rate	L/m
Skin/Nare Check	
SpO2	99
SpO2 Site	Hand
SpO2 Site Change	

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.

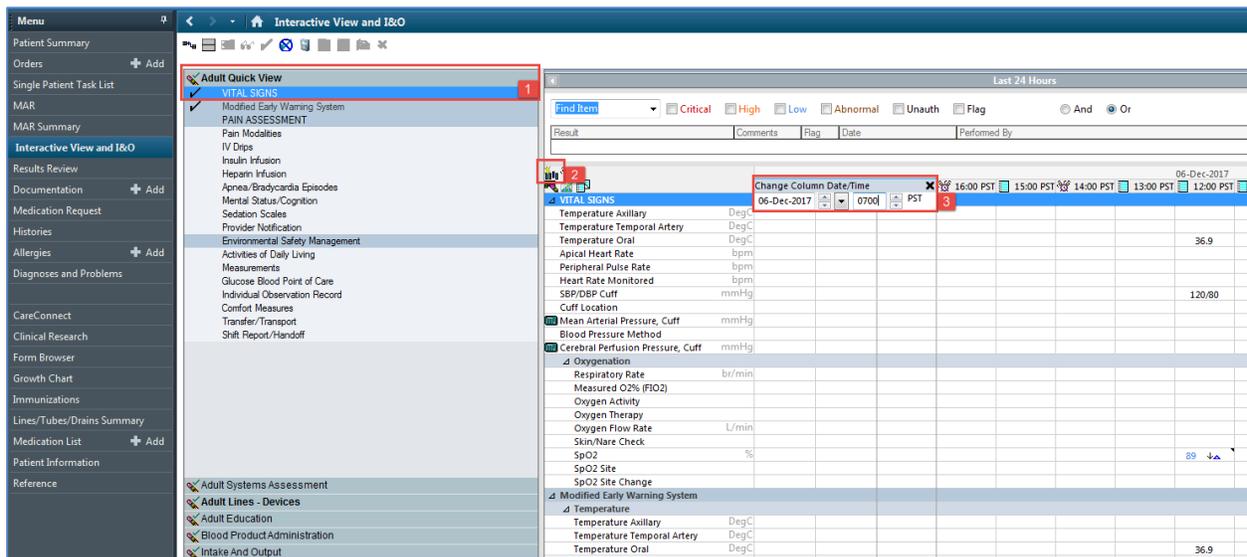
Key Learning Points

-  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.

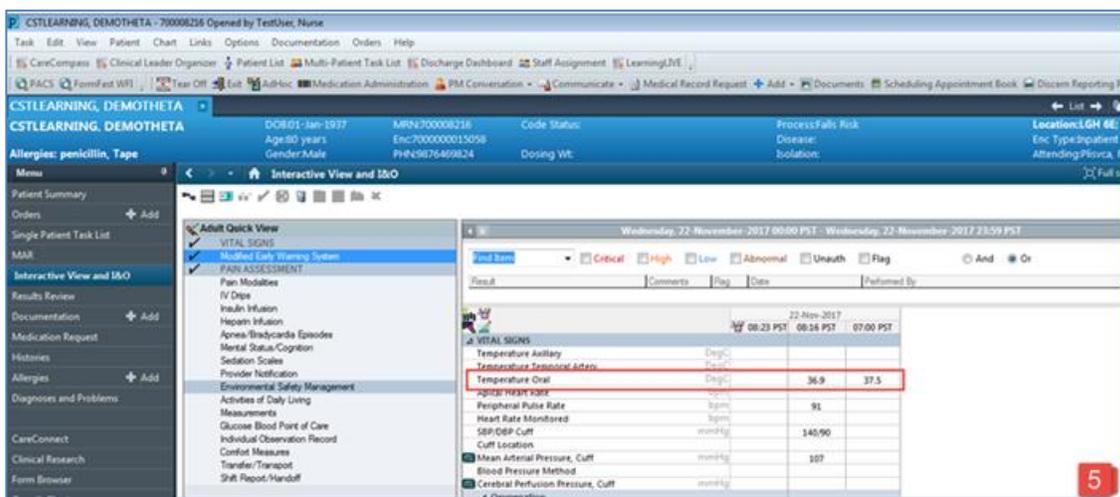
1. Start by clicking on the **Adult Quick View Band** and select the **Vital Signs** section.
2. Click the **Insert Date/Time** icon .
3. A new column and Change Column Date/Time window appear. Choose the appropriate date and time you wish to document under. In this example, use today's date and time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



The screenshot shows the EHR interface with the 'Adult Quick View' band. The 'Vital Signs' section is selected. A 'Change Column Date/Time' dialog box is open, showing the date '06-Dec-2017' and time '0700' selected. The 'Vital Signs' table is visible with columns for 'Date' and 'Time'.

Result	Comments	Flag	Date	Performed By
VITAL SIGNS			06-Dec-2017	
Temperature Axillary		DegC		
Temperature Temporal Artery		DegC		
Temperature Oral		DegC		36.9
Apical Heart Rate		bpm		
Peripheral Pulse Rate		bpm		
Heart Rate Monitored		bpm		
SBP/DBP Cuff		mmHg		120/80
Cuff Location				
Mean Arterial Pressure, Cuff		mmHg		
Blood Pressure Method				
Cerebral Perfusion Pressure, Cuff		mmHg		
Oxygenation				
Respiratory Rate		br/min		
Measured O2% (FIO2)				
Oxygen Activity				
Oxygen Therapy				
Oxygen Flow Rate		L/min		
Skin/Nare Check				
SpO2		%		89
SpO2 Site				
SpO2 Site Change				
Modified Early Warning System				
Temperature				
Temperature Axillary		DegC		
Temperature Temporal Artery		DegC		
Temperature Oral		DegC		36.9

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



The screenshot shows the EHR interface with the 'Adult Quick View' band. The 'Vital Signs' section is selected. The 'Vital Signs' table is visible with a new column for 'Time' added. The 'Temperature Oral' row is highlighted, showing a value of 37.5. A green checkmark icon is visible in the bottom right corner.

Result	Comments	Flag	Date	Time	Performed By
VITAL SIGNS			06-Dec-2017	07:00 PST	
Temperature Axillary		DegC			
Temperature Temporal Artery		DegC			
Temperature Oral		DegC		37.5	
Apical Heart Rate		bpm		91	
Peripheral Pulse Rate		bpm			
Heart Rate Monitored		bpm			
SBP/DBP Cuff		mmHg		140/90	
Cuff Location					
Mean Arterial Pressure, Cuff		mmHg		107	
Blood Pressure Method					
Cerebral Perfusion Pressure, Cuff		mmHg			
Oxygenation					
Respiratory Rate		br/min			
Measured O2% (FIO2)					
Oxygen Activity					
Oxygen Therapy					
Oxygen Flow Rate		L/min			
Skin/Nare Check					
SpO2		%			
SpO2 Site					
SpO2 Site Change					
Modified Early Warning System					
Temperature					
Temperature Axillary		DegC			
Temperature Temporal Artery		DegC			
Temperature Oral		DegC			

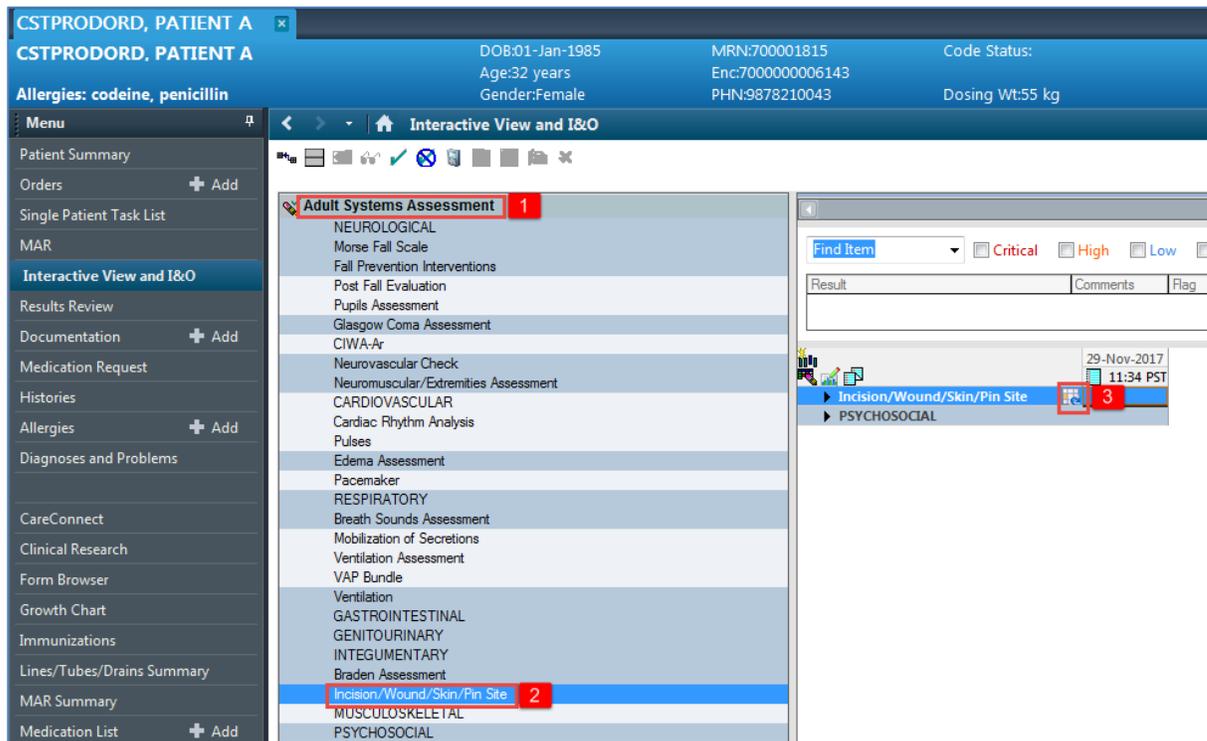
 **Key Learning Points**

- 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 of the Incision/Wound/Skin/Pin Site section heading in the flowsheet.



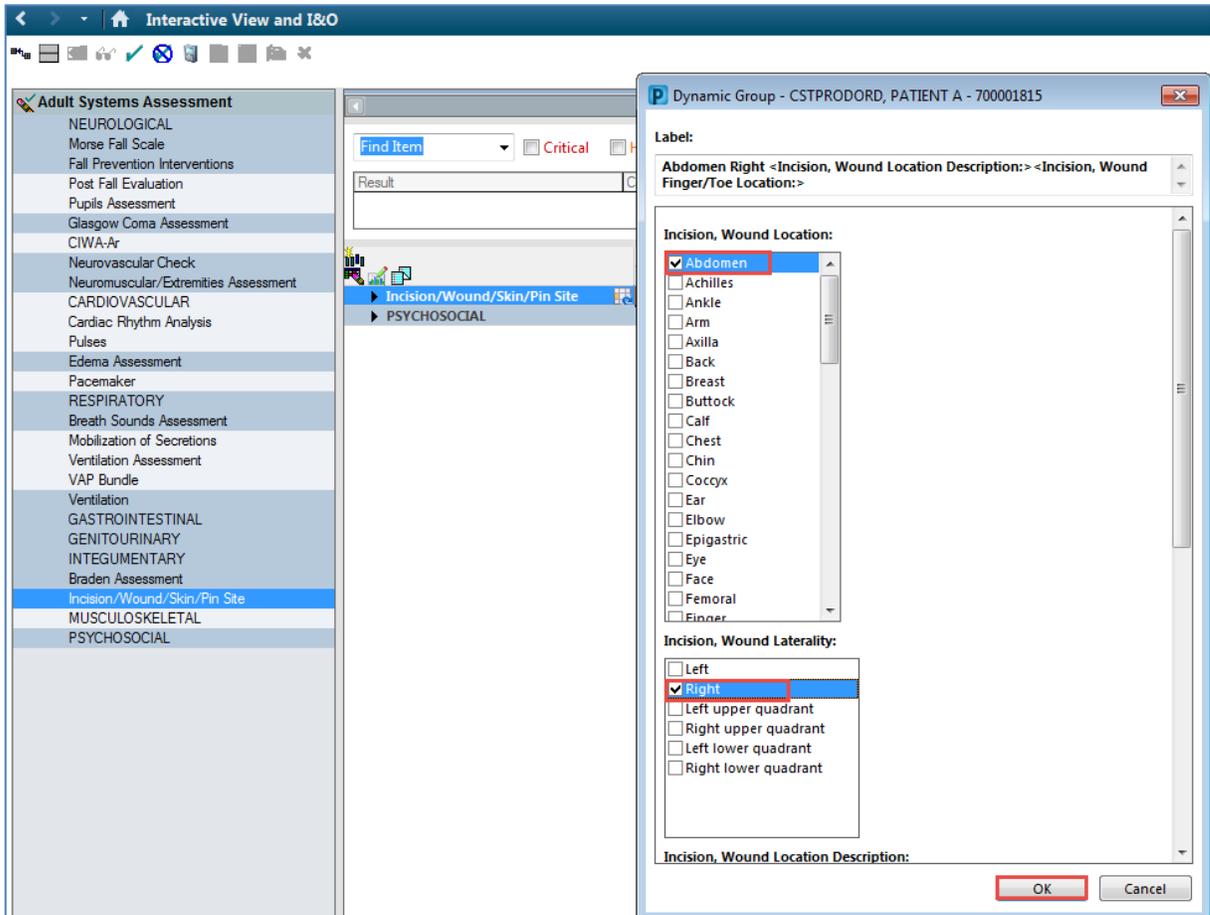
The screenshot displays the iView patient interface for CSTPRODORD, PATIENT A. The patient's demographic information is shown at the top: DOB: 01-Jan-1985, Age: 32 years, Gender: Female, MRN: 700001815, Enc: 700000006143, PHN: 9878210043, Code Status, and Dosing Wt: 55 kg. Allergies are listed as codeine and penicillin. The interface is in 'Interactive View and I&O' mode. The left-hand menu includes options like Patient Summary, Orders, Single Patient Task List, MAR, Interactive View and I&O (selected), Results Review, Documentation, Medication Request, Histories, Allergies, Diagnoses and Problems, CareConnect, Clinical Research, Form Browser, Growth Chart, Immunizations, Lines/Tubes/Drains Summary, MAR Summary, and Medication List. The central flowsheet shows the 'Adult Systems Assessment' band expanded, with a red box highlighting the band header and a '1' in a red box. The 'Incision/Wound/Skin/Pin Site' section is highlighted in blue, and a red box highlights the 'Dynamic Group' icon next to it, with a '2' in a red box. The right-hand panel shows a search bar and a table with columns for Result, Comments, and Flag. The date and time are 29-Nov-2017 11:34 PST.

- 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*

- Click **OK**



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

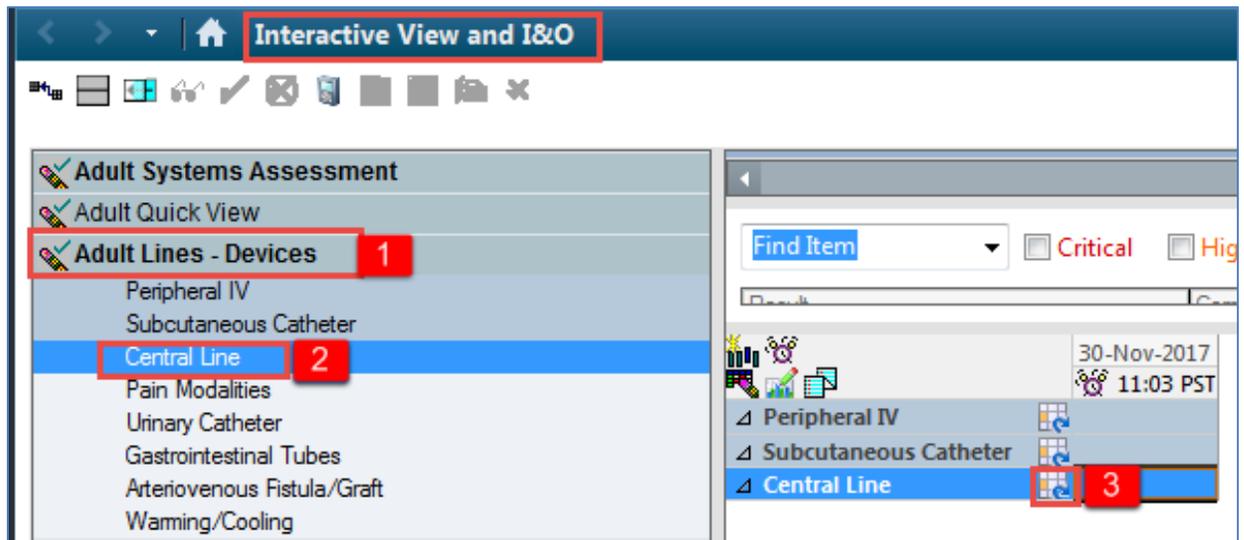
- Examples of Dynamic Groups include wound assessments, IV sites, chest tubes, etc
- Once documentation within a dynamic group is signed the label will be accessible for other clinicians to complete further documentation within the same dynamic group

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

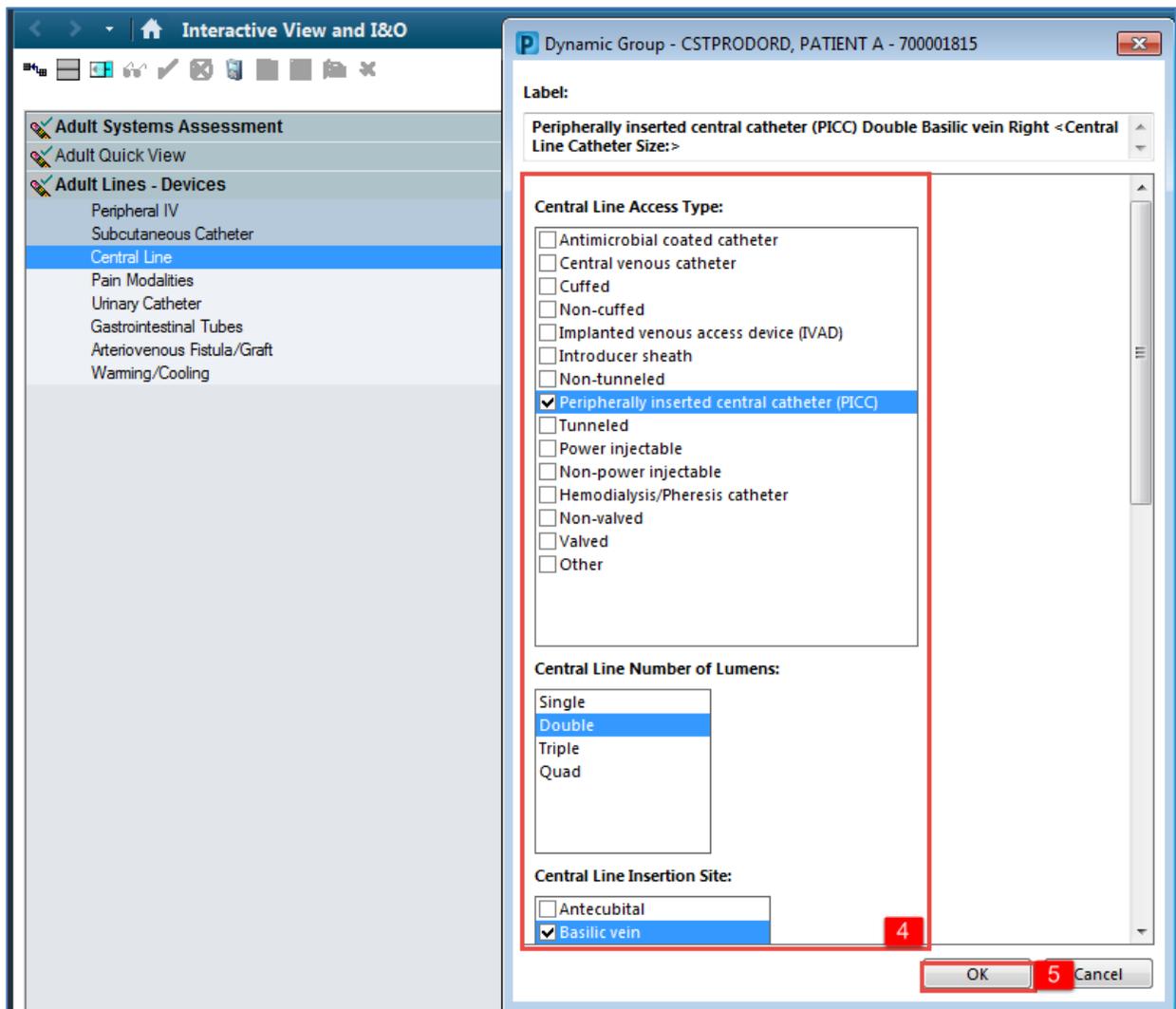


- The Dynamic Group window appears. A dynamic group allows you to label a line, wound or drain with unique identifying details. You can add as many dynamic groups as you need for your patient. For example, if a patient has two peripheral IVs, you can add a dynamic group for each IV.

Select the following to create a label:

- **Central Line Access Type** = *Peripherally inserted central catheter(PICC)*
- **Central Line Number of Lumens** = *Double*
- **Central line Insertion Site** = *Basilic vein*
- **Central Line laterality** = *Right*

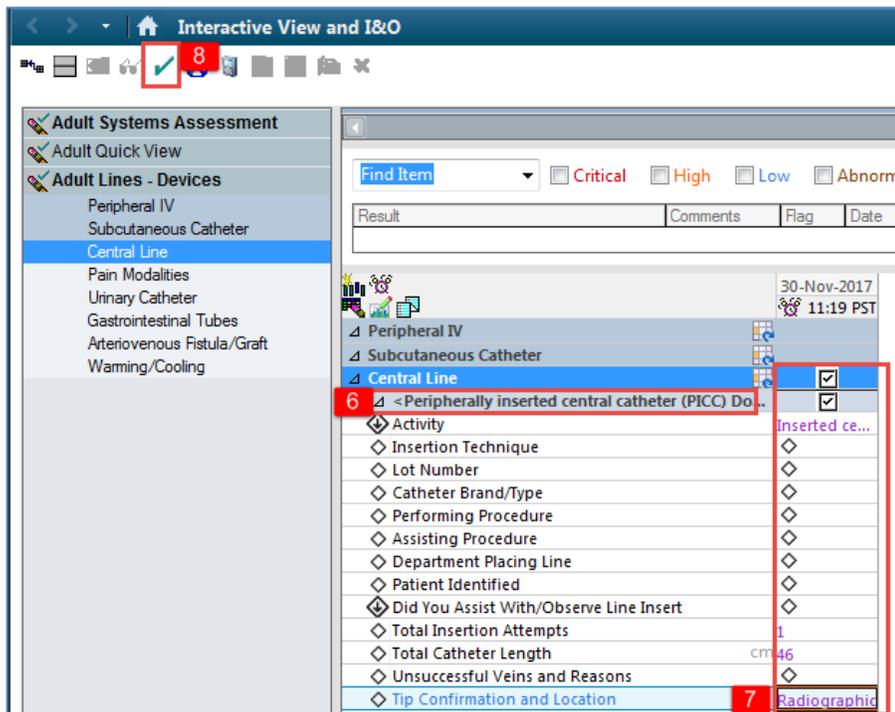
- Click **OK**



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

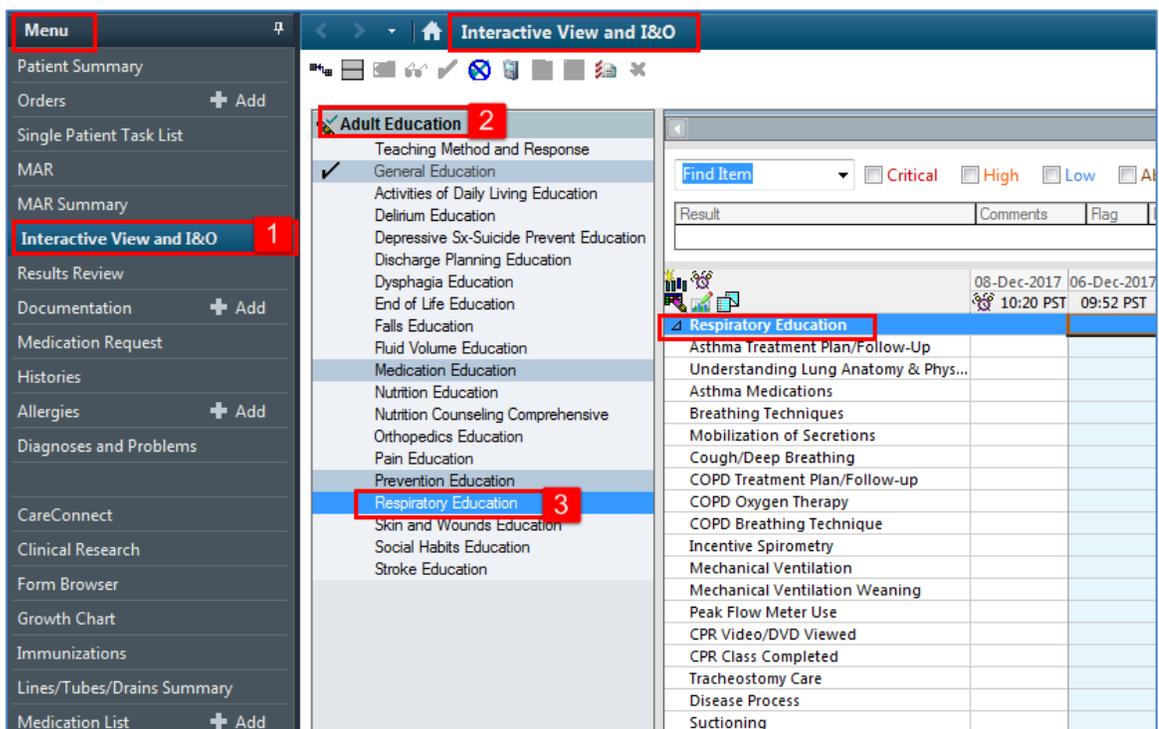
Note: When you discontinue a line, tube or drain, you may right-click. However, then you should be also inactive the line, tube or drain by right-clicking on the dynamic group  to indicate it is not available for documentation.

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 Iview:
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).



The screenshot shows the iView software interface. On the left is a dark navigation menu with 'Interactive View and I&O' highlighted in red and labeled with a red '1'. The main window title is 'Interactive View and I&O'. Below the title bar, the 'Adult Education' section is expanded and highlighted in red, labeled with a red '2'. Within this section, 'Respiratory Education' is selected and highlighted in blue, labeled with a red '3'. The right side of the screen shows a table with columns for 'Find Item', 'Critical', 'High', 'Low', and 'All'. Below the table, there are two dates: '08-Dec-2017' and '06-Dec-2017', with a time of '10:20 PST' and '09:52 PST' respectively. The table lists various respiratory education topics such as 'Asthma Treatment Plan/Follow-Up', 'Understanding Lung Anatomy & Phys...', 'Asthma Medications', 'Breathing Techniques', 'Mobilization of Secretions', 'Cough/Deep Breathing', 'COPD Treatment Plan/Follow-up', 'COPD Oxygen Therapy', 'COPD Breathing Technique', 'Incentive Spirometry', 'Mechanical Ventilation', 'Mechanical Ventilation Weaning', 'Peak Flow Meter Use', 'CPR Video/DVD Viewed', 'CPR Class Completed', 'Tracheostomy Care', 'Disease Process', and 'Suctioning'.

Key Learning Points

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

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

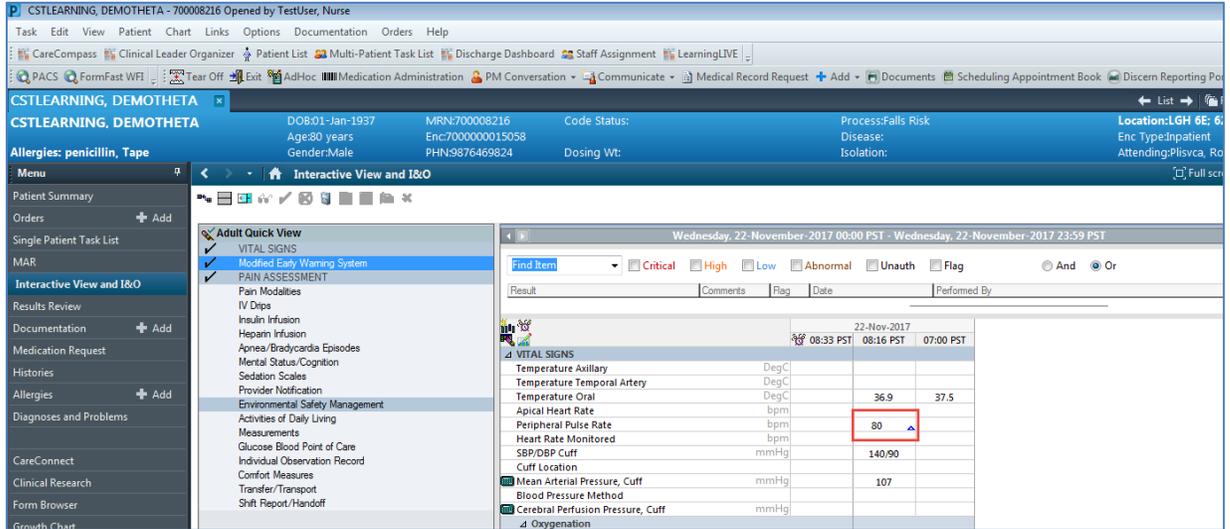
1 You realize upon reviewing your earlier charting that you wrote the incorrect Peripheral Pulse Rate value. Let's modify the Peripheral Pulse Rate.

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...**

The screenshot shows the Epic EMR interface for patient CSTLEARNING, DEMOTHETA. The 'Adult Quick View' band is active, and the 'Vital Signs' section is selected. The 'Peripheral Pulse Rate' is documented as 91 bpm. A context menu is open over the value 91, and the 'Modify...' option is highlighted.

Result	Comments	Flag	Date	Performed By
VITAL SIGNS			22-Nov-2017 08:30 PST	
Temperature Axillary		DegC		
Temperature Temporal Artery		DegC		
Temperature Oral		DegC	36.9	
Apical Heart Rate		bpm		
Peripheral Pulse Rate		bpm	91	
Heart Rate Monitored		bpm	1	
SBP/DBP Cuff		mmHg	107	
Cuff Location				
Mean Arterial Pressure, Cuff		mmHg		
Blood Pressure Method				
Cerebral Perfusion Pressure, Cuff		mmHg		
Oxygenation				
Respiratory Rate		br/min	16	
Measured O2% (FI02)				
Oxygen Activity				

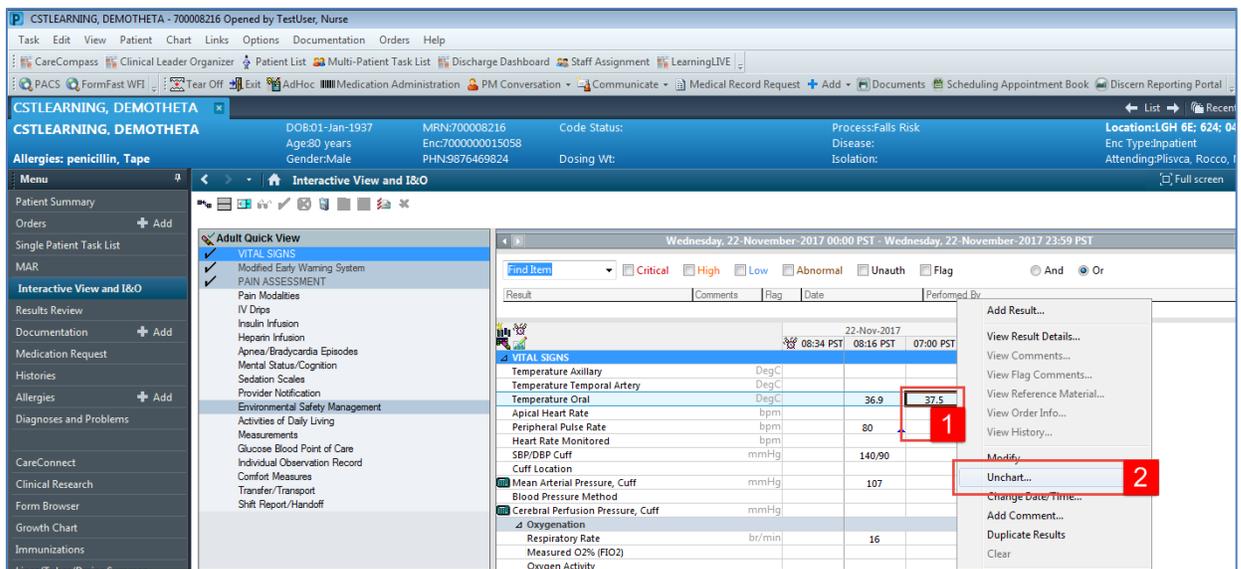
4. Enter in new **Peripheral Pulse Rate = 80** and then click **green checkmark icon** ✓ to sign your documentation.
5. **80** now appears in the cell and the corrected icon  will automatically appear on the bottom right corner to denote a modification has been made



- 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**



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

The screenshot shows the 'Unchart' dialog box for patient CSTLEARNING, DEMOTHETA. The 'Reason' dropdown menu is open, and 'Charted on Incorrect Patient' is selected. A red box with the number '3' highlights this selection. The 'Sign' button is also highlighted with a red box and the number '4'. The background shows the patient's chart with various data points and a list of uncharted items.

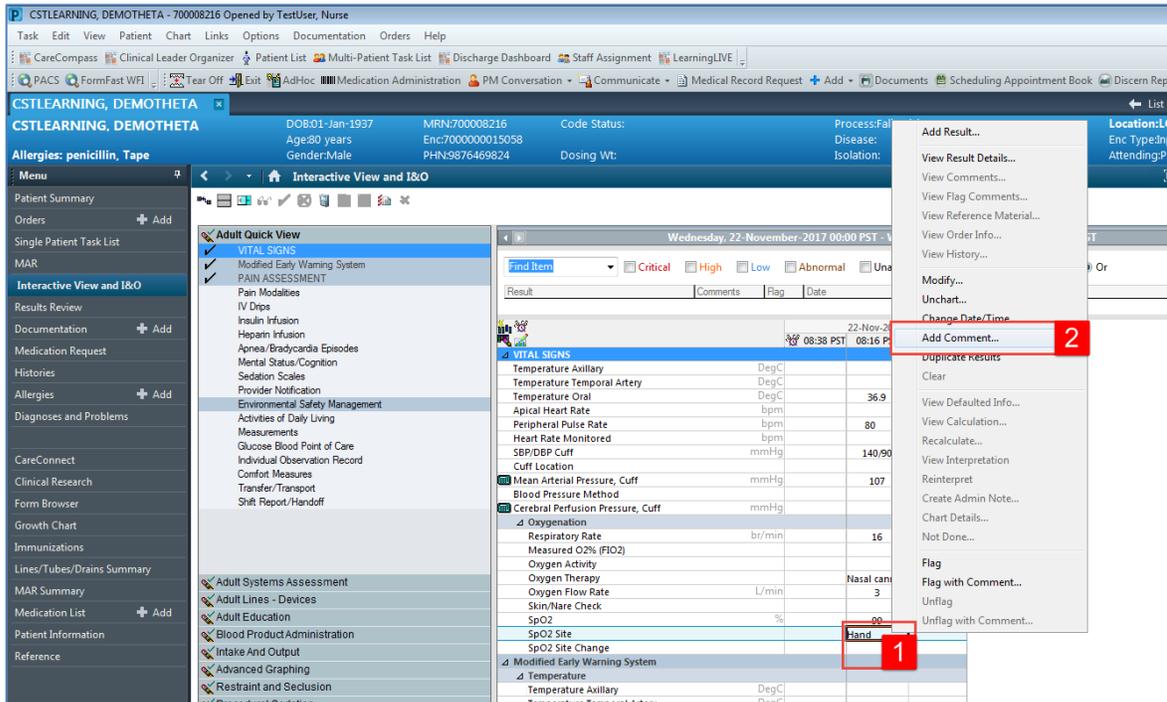
- You will see **In Error** displayed in the uncharted cell. The Result comment or annotation icon  will also appear in the cell.

The screenshot shows the 'VITAL SIGNS' section of the patient's chart. The 'Temperature Oral' value is 36.9. The cell contains the text 'In Error' with a red box around it. The chart also shows other vital signs such as 'Temperature Axillary', 'Temperature Temporal Artery', 'Apical Heart Rate', 'Peripheral Pulse Rate', 'Heart Rate Monitored', 'SBP/DBP Cuff', 'Cuff Location', 'Mean Arterial Pressure, Cuff', 'Blood Pressure Method', and 'Cerebral Perfusion Pressure, Cuff'.

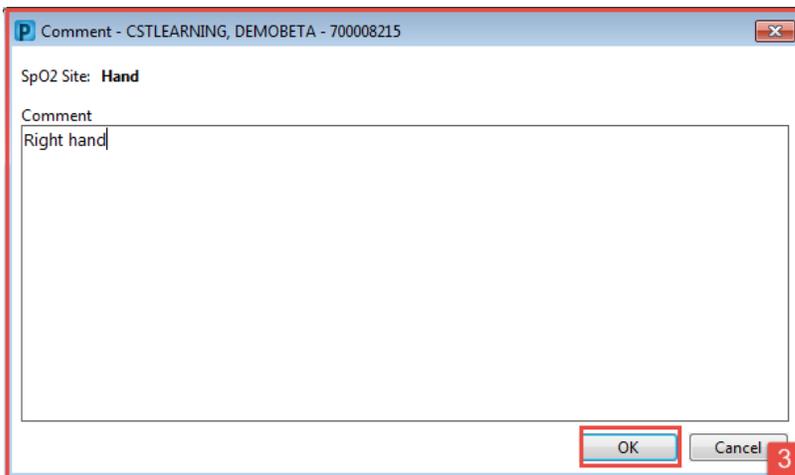
3

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.

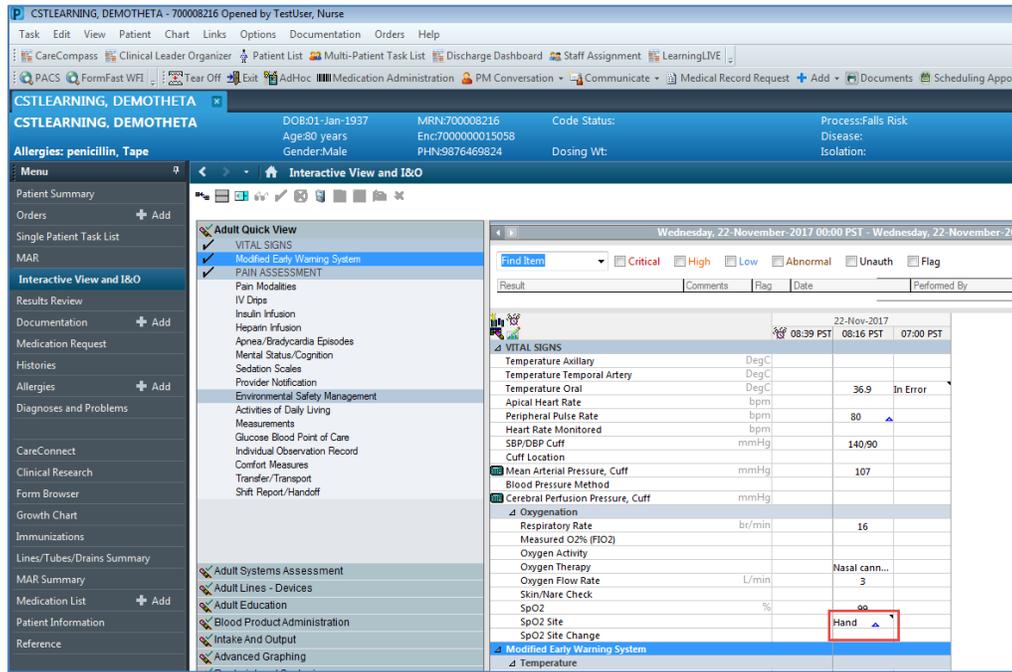
1. Right-click on the documented value for SPO2 site, **hand**
2. Select add comment



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



The screenshot shows the patient record for CSTLEARNING, DEMOTHETA. The interface includes a menu on the left, a central data table, and a right-hand panel. The data table displays vital signs and other clinical data for Wednesday, 22-November-2017. A red box highlights a 'Hand' entry in the 'SpO2 Site' column, which has a blue triangle icon next to it. Another red box highlights a 'Hand' entry in the 'SpO2 Site Change' column, which has a square icon with a downward arrow next to it.

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:

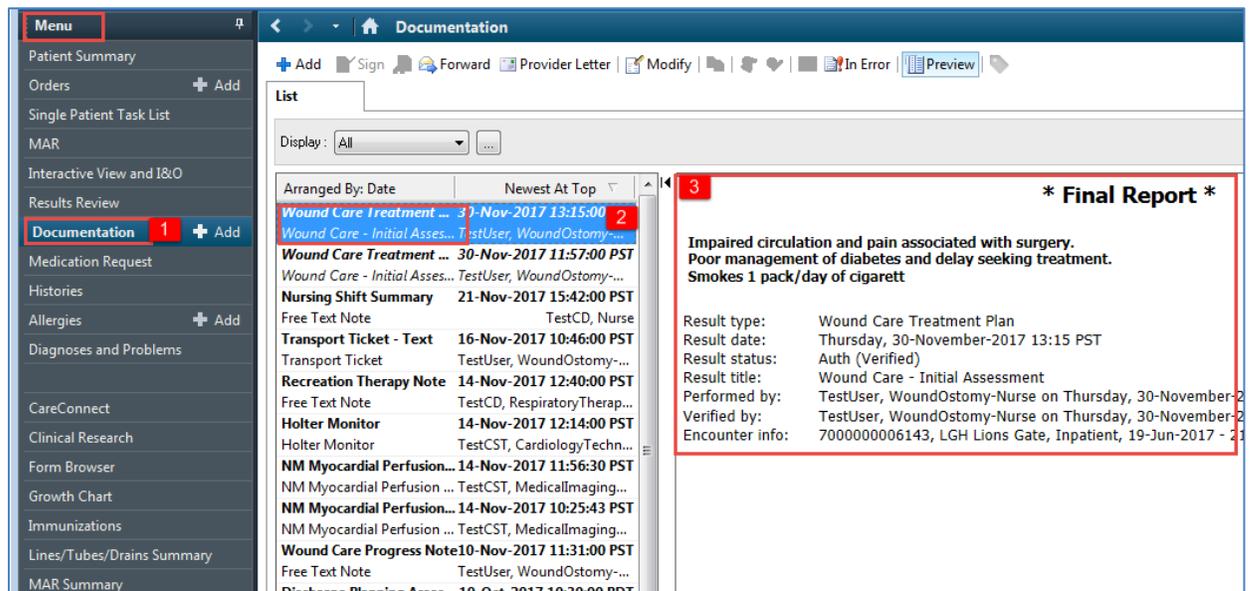
- Review documentation
- Create a nursing note
- Modify or unchart a nursing note

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



The screenshot shows the 'Documentation' tool interface. On the left, a 'Menu' sidebar lists various patient care options, with 'Documentation' highlighted and a red box around it. The main area displays a list of notes, with one note selected and its details shown on the right. A red box highlights the details of a 'Final Report' note, which includes the following information:

- * Final Report ***
- Impaired circulation and pain associated with surgery.
- Poor management of diabetes and delay seeking treatment.
- Smokes 1 pack/day of cigarett
- Result type: Wound Care Treatment Plan
- Result date: Thursday, 30-November-2017 13:15 PST
- Result status: Auth (Verified)
- Result title: Wound Care - Initial Assessment
- Performed by: TestUser, WoundOstomy-Nurse on Thursday, 30-November-2017 13:15 PST
- Verified by: TestUser, WoundOstomy-Nurse on Thursday, 30-November-2017 13:15 PST
- Encounter info: 7000000006143, LGH Lions Gate, Inpatient, 19-Jun-2017 - 21-Jun-2017

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.

Service Date/Time	Subject	Type	Facility	Author, Contributor(s)	Status
01-Dec-2017 08:27:00 PST	Asthma Teaching Plan Note	Interdisciplinary Care Plan	LGH Lions Gate	TestUser, IVTherapy-Nurse	Modified
30-Nov-2017 13:15:00 P...	Wound Care - Initial Assessment	Wound Care Treatment Plan	LGH Lions Gate	TestUser, WoundOstomy-...	Auth (Verified)
30-Nov-2017 11:57:00 P...	Wound Care - Initial Assessment	Wound Care Treatment Plan	LGH Lions Gate	TestUser, WoundOstomy-...	In Error
21-Nov-2017 15:42:00 P...	Free Text Note	Nursing Shift Summary	SGH Squamish	TestCD, Nurse	Auth (Verified)
16-Nov-2017 10:46:00 P...	Transport Ticket	Transport Ticket - Text	LGH Lions Gate	TestUser, WoundOstomy-...	Auth (Verified)
14-Nov-2017 12:40:00 P...	Free Text Note	Recreation Therapy Note	LGH Med Imaging	TestCD, RespiratoryTherap...	Auth (Verified)
14-Nov-2017 12:14:00 P...	Holter Monitor	Holter Monitor	LGH Cardiac Lab	TestCST, CardiologyTechni...	Auth (Verified)
14-Nov-2017 11:56:30 P...	NM Myocardial Perfusion Trea...	NM Myocardial Perfusion Treadmill	LGH Med Imaging	TestCST, MedicalImagingT...	In Progress
14-Nov-2017 10:25:43 P...	NM Myocardial Perfusion Rest	NM Myocardial Perfusion Rest	LGH Med Imaging	TestCST, MedicalImagingT...	In Progress
10-Nov-2017 11:31:00 P...	Free Text Note	Wound Care Progress Note	LGH Lions Gate	TestUser, WoundOstomy-...	Auth (Verified)
10-Oct-2017 10:30:00 P...	Discharge Planning Assessment	Discharge Planning Assessment - Text	LGH Lions Gate	TestORD, Nurse	Auth (Verified)

*** Final Report ***
Document Contains Addendum

Teaching Plan
(Please enter two sentences you could include in a teach specialty)

Addendum by TestUser, IVTherapy-Nurse on 09:31 PST (Verified)
Next session on Tuesday

Result type: Interdisciplinary Care Plan
Result date: Friday, 01-December-2017 08:27
Result status: Modified
Result title: Asthma Teaching Plan Note
Performed by: TestUser, IVTherapy-Nurse on Friday, 01-December-2017 09:06 PST
Verified by: TestUser, IVTherapy-Nurse on Friday, 01-December-2017 09:06 PST
Encounter info: 700000006143, LGH Lions Gate, Jun-2017 - 21-Jun-2017

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 .

Arranged By: Date Newest At Top

Interdisciplinary Care Plan	01-Dec-2017 08:27:00 PST
Asthma Teaching Plan Note	TestUser, IVTherapy-Nurse
Wound Care Treatment Plan	30-Nov-2017 13:15:00 PST
Wound Care - Initial Assessment	TestUser, WoundOstomy-Nurse

Impaired circ
Poor manage
Smokes 1 pa



Key Learning Points

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

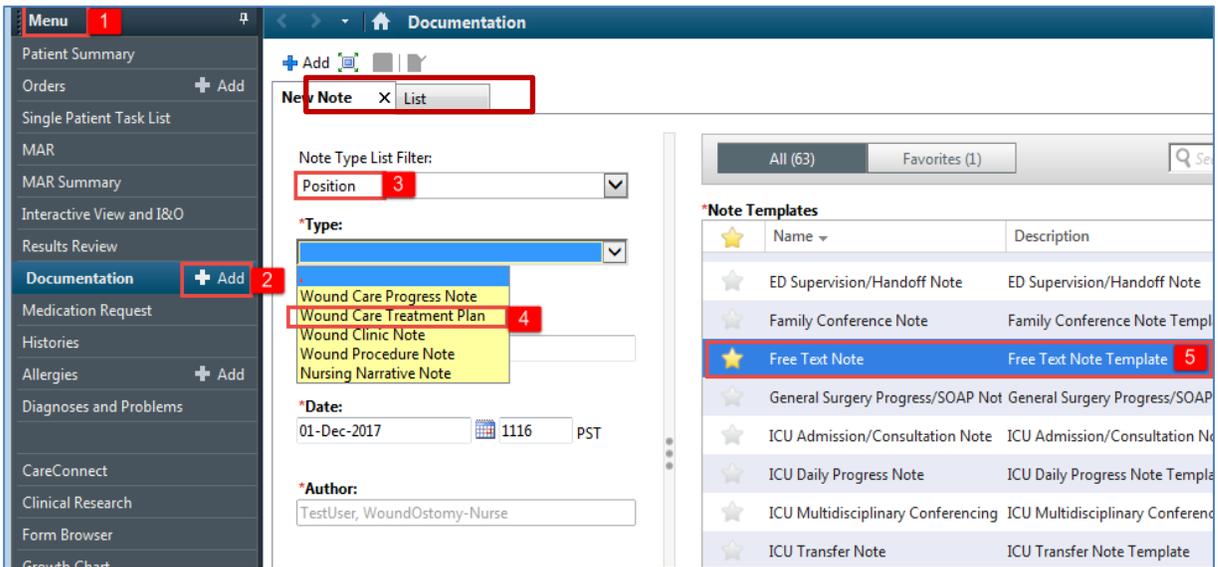
Activity 6.2a – Creating a Nursing note (For Wound Ostomy Nurses)

- 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

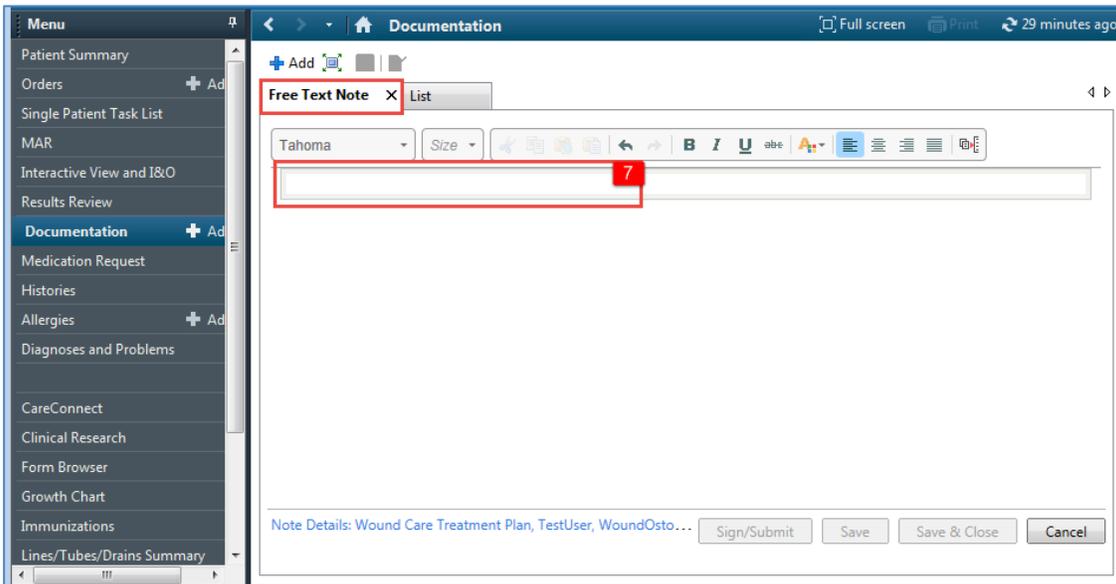
Note: The **List** tab is still visible and accessible while composing a new note.



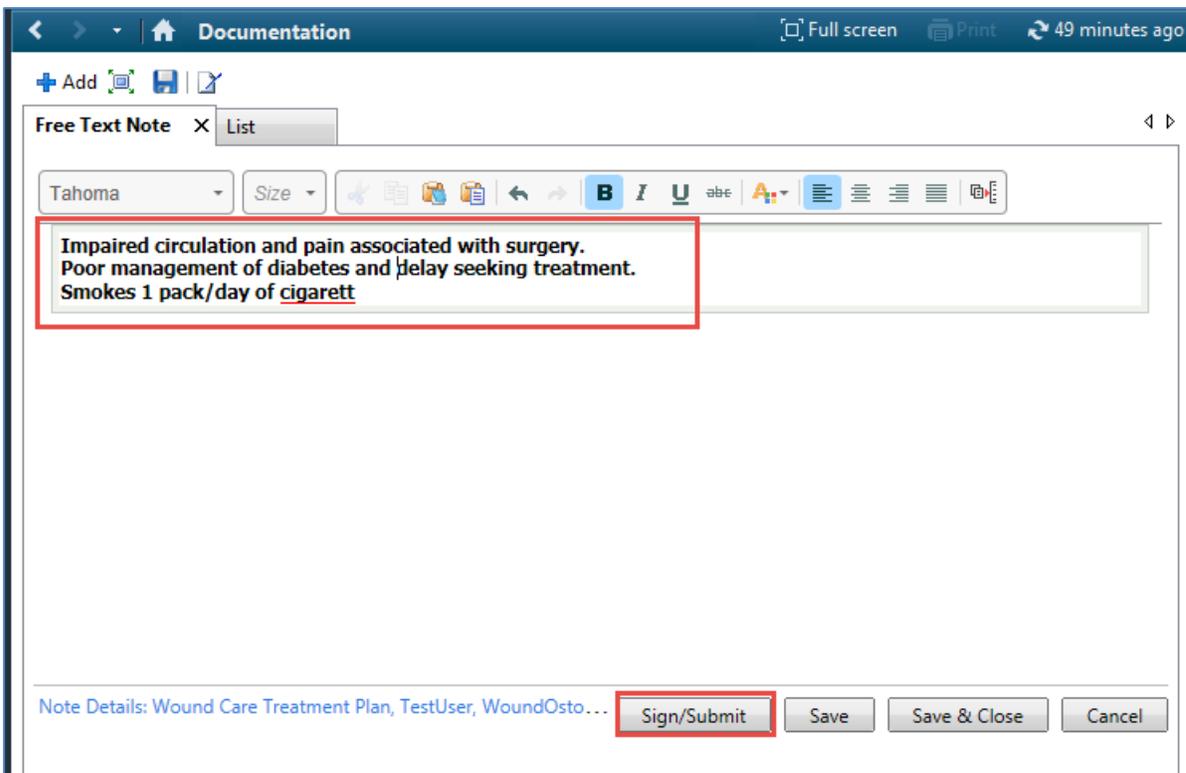
The screenshot shows the EHR interface for creating a new note. The 'Menu' is open, and 'Documentation' is selected. The 'Add' button is highlighted. The 'Note Type List Filter' is set to 'Position'. The 'Type' dropdown is open, showing 'Wound Care Treatment Plan' selected. The 'Note Templates' list is visible, with 'Free Text Note' selected.

Name	Description
ED Supervision/Handoff Note	ED Supervision/Handoff Note
Family Conference Note	Family Conference Note Template
Free Text Note	Free Text Note Template
General Surgery Progress/SOAP Not	General Surgery Progress/SOAP
ICU Admission/Consultation Note	ICU Admission/Consultation Note
ICU Daily Progress Note	ICU Daily Progress Note Template
ICU Multidisciplinary Conferencing	ICU Multidisciplinary Conferencing
ICU Transfer Note	ICU Transfer Note Template

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

- 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.

- 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.*

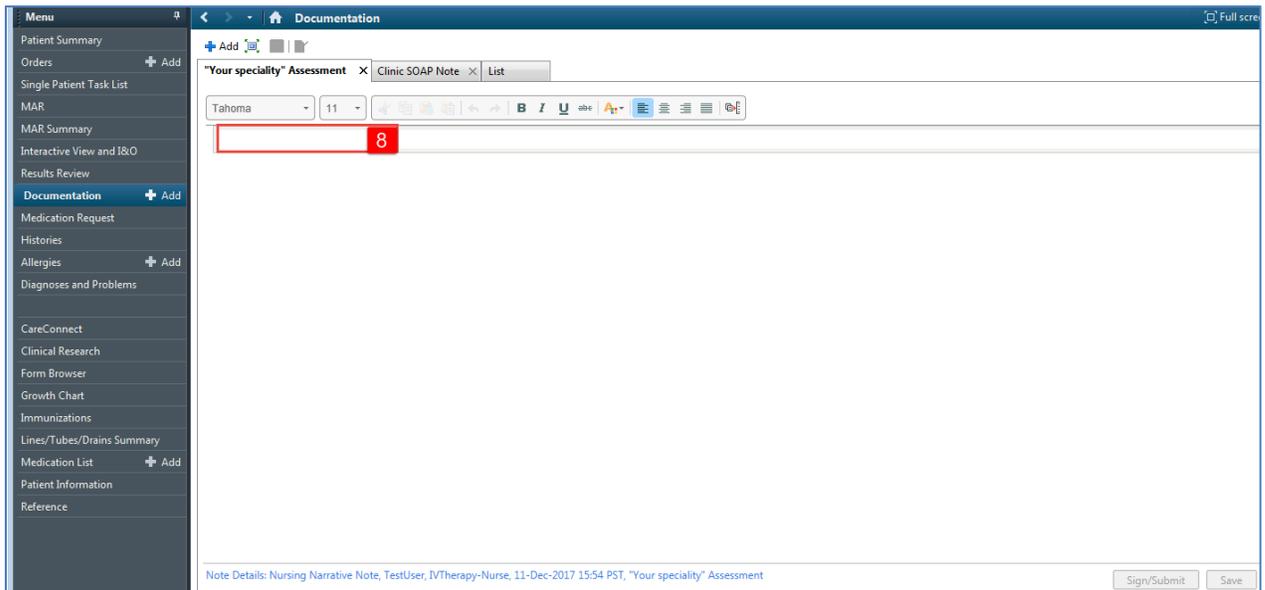
Note: It is important to label your note with an appropriate name. Otherwise, it will be displayed as a generic free text note.

6. On the right of your screen, under **Note Templates** select **Free Text Note**
7. Then click **OK**. A new note opens.

The screenshot shows the 'Documentation' window with a 'New Note' form and a 'Note Templates' list. Red boxes and numbers 1-7 indicate the steps described in the text.

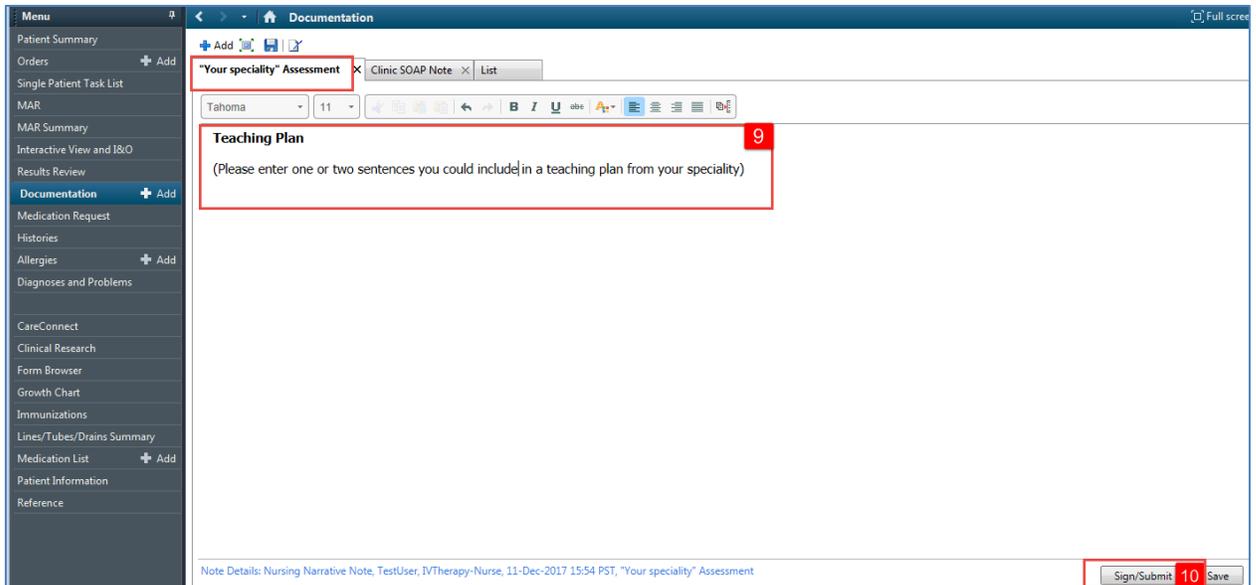
Name	Description
Free Text Note	Free Text Note Template
General Surgery Progress/SOAP Note	General Surgery Progress/SOAP Note Template
ICU Admission/Consultation Note	ICU Admission/Consultation Note Template
ICU Daily Progress Note	ICU Daily Progress Note Template
ICU Multidisciplinary Conferencing for Complex Patient	ICU Multidisciplinary Conferencing for Complex Patient Template
ICU Transfer Note	ICU Transfer Note Template
Infectious Disease Consult Note	Infectious Disease Consult Note Template
Kidney Care Clinic (KCC) Note	Kidney Care Clinic (KCC) Note Template
Lab Interpretation Note	Lab Interpretation Note Template
Limited Anesthesia Consult	Limited Anesthesia Consult Template
Lumbar Puncture	Lumbar Puncture Note Template
Medication Recommendation	Medication Recommendation Template
Newborn Admission H&P	Newborn Admission H&P Template
Newborn Consult Note	Newborn Consult Note Template
Newborn Discharge Note	Newborn Discharge Note

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 speciality)

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

Sign/Submit Note

*Type: Nursing Narrative Note

Note Type List Filter: Position

*Author: TestUser, ICU-Nurse

Title: Asthma Teaching Plan Note

*Date: 15-Dec-2017 14:10 PST

Forward Options | Create provider letter

Favorites | Recent | Relationships | Provider Name

Contacts: Default Name

Recipients: Default Name, Comment, Sign, Review/CC

11 Sign Cancel

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

Documentation

Full screen | Print | 1 hours 8 minutes ago

+ Add | Sign | Forward | Provider Letter | Modify | In Error | Preview

List

Display: All

Arranged By: Date	Newest At Top
Interdisciplinary Care Plan	01-Dec-2017 08:27:00 PST
Asthma Teaching Plan Note	TestUser, IVTherapy-Nurse, P...
Wound Care Treatment Plan	30-Nov-2017 13:15:00 PST
Wound Care - Initial Assessm...	TestUser, WoundOstomy-Nu...
Wound Care Treatment Plan	30-Nov-2017 11:57:00 PST
Wound Care - Initial Assessm...	TestUser, WoundOstomy-Nu...
Nursing Shift Summary	21-Nov-2017 15:42:00 PST
Free Text Note	TestCD, Nurse
Transport Ticket - Text	16-Nov-2017 10:46:00 PST
Transport Ticket	TestUser, WoundOstomy-Nu...
Recreation Therapy Note	14-Nov-2017 12:40:00 PST
Free Text Note	TestCD, RespiratoryTherapyS...
Holter Monitor	14-Nov-2017 12:14:00 PST
Holter Monitor	TestCST, CardiologyTechnici...
NM Myocardial Perfusion Tr...	14-Nov-2017 11:56:30 PST
NM Myocardial Perfusion Tre...	TestCST, MedicalImagingTec...
NM Myocardial Perfusion R...	14-Nov-2017 10:25:43 PST
NM Myocardial Perfusion Rest	TestCST, MedicalImagingTec...
Wound Care Progress Note	10-Nov-2017 11:31:00 PST

Previous Note | Next Note

*** Final Report ***

Teaching Plan

(Please enter two sentences you could include in a teaching plan from your specialty)

Result type: Interdisciplinary Care Plan
 Result date: Friday, 01-December-2017 08:27 PST
 Result status: Auth (Verified)
 Result title: Asthma Teaching Plan Note
 Performed by: TestUser, IVTherapy-Nurse on Friday, 01-December-2017 09:06 PST
 Verified by: TestUser, IVTherapy-Nurse on Friday, 01-December-2017 09:06 PST
 Encounter info: 700000006143, LGH Lions Gate, Inpatient, 19-Jun-2017 - 21-Jun-2017

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



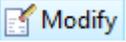
Key Learning Points

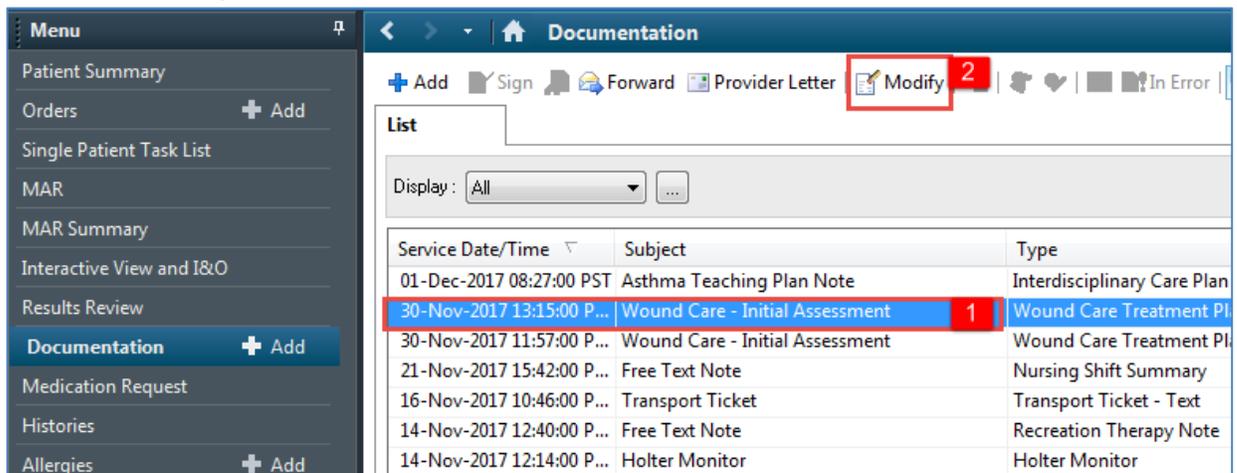
-  You can use the Documentation to create a narrative nursing note

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**:

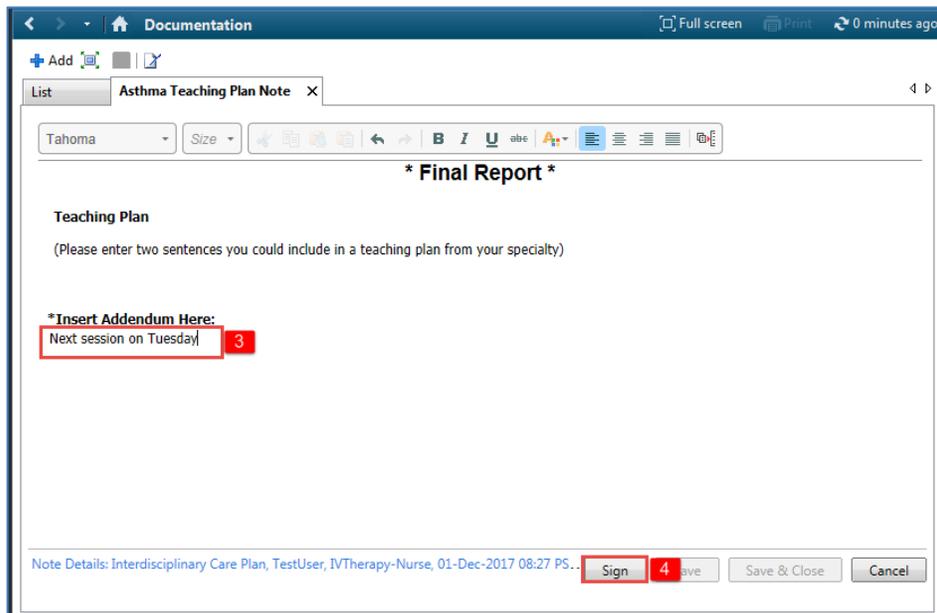
1. Select most recently completed note, such as *Interdisciplinary Care Plan – Asthma Teaching Plan Note*, within **Documentation**
2. Select **Modify** 



The screenshot shows the 'Documentation' interface. On the left is a 'Menu' with options like 'Patient Summary', 'Orders', 'MAR', and 'Documentation'. The main area shows a 'List' of notes. The 'Modify' button in the top right is highlighted with a red box and a '2' in a red circle. The row for '30-Nov-2017 13:15:00 P... Wound Care - Initial Assessment' is highlighted with a red box and a '1' in a red circle.

Service Date/Time	Subject	Type
01-Dec-2017 08:27:00 PST	Asthma Teaching Plan Note	Interdisciplinary Care Plan
30-Nov-2017 13:15:00 P...	Wound Care - Initial Assessment	Wound Care Treatment Pl
30-Nov-2017 11:57:00 P...	Wound Care - Initial Assessment	Wound Care Treatment Pl
21-Nov-2017 15:42:00 P...	Free Text Note	Nursing Shift Summary
16-Nov-2017 10:46:00 P...	Transport Ticket	Transport Ticket - Text
14-Nov-2017 12:40:00 P...	Free Text Note	Recreation Therapy Note
14-Nov-2017 12:14:00 P...	Holter Monitor	Holter Monitor

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



The screenshot shows the 'Asthma Teaching Plan Note' editor. The 'Insert Addendum Here' field is highlighted with a red box and a '3' in a red circle. The 'Sign' button is highlighted with a red box and a '4' in a red circle.

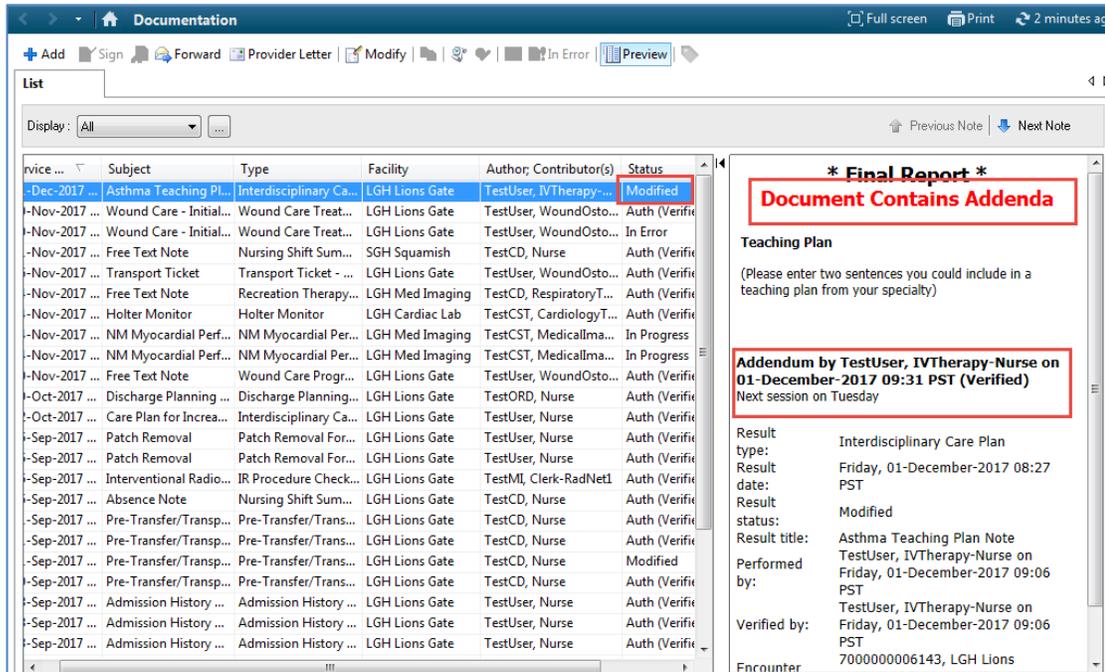
*** Final Report ***

Teaching Plan
(Please enter two sentences you could include in a teaching plan from your specialty)

***Insert Addendum Here:**
Next session on Tuesday

Note Details: Interdisciplinary Care Plan, TestUser, IVTherapy-Nurse, 01-Dec-2017 08:27 PS... **Sign** Save Save & Close Cancel

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

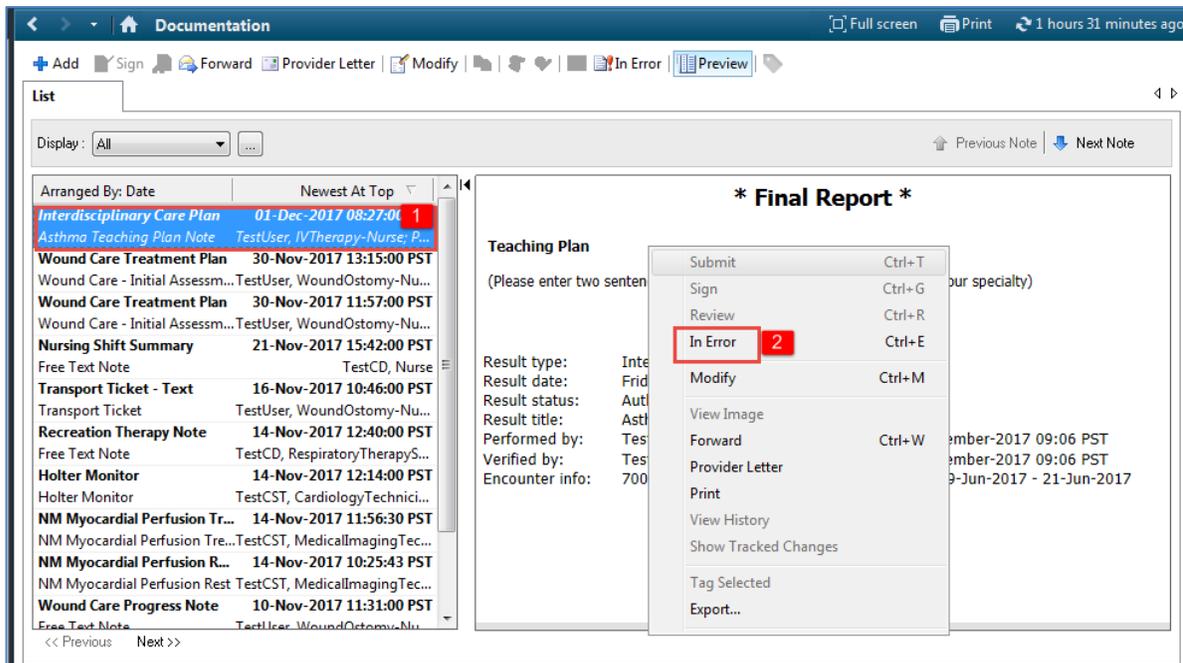


2

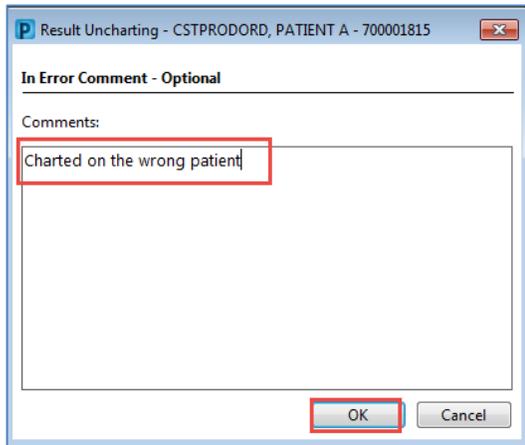
It may be necessary to unchart an existing note (e.g., if charted on the wrong patient). Uncharted notes are marked as **In Error**. You can only unchart a note that was initially created by yourself.

To unchart a note within **Documentation**:

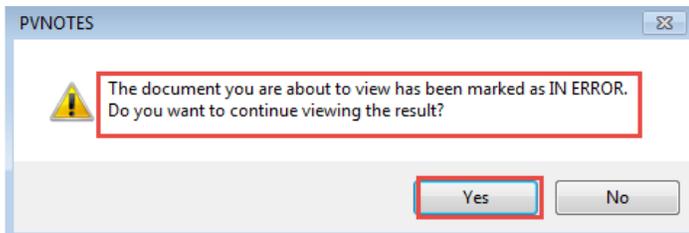
1. Select a note in the left pane. Use the specialty note you just created
2. **Right-click** anywhere in the right pane. Then select **In Error**



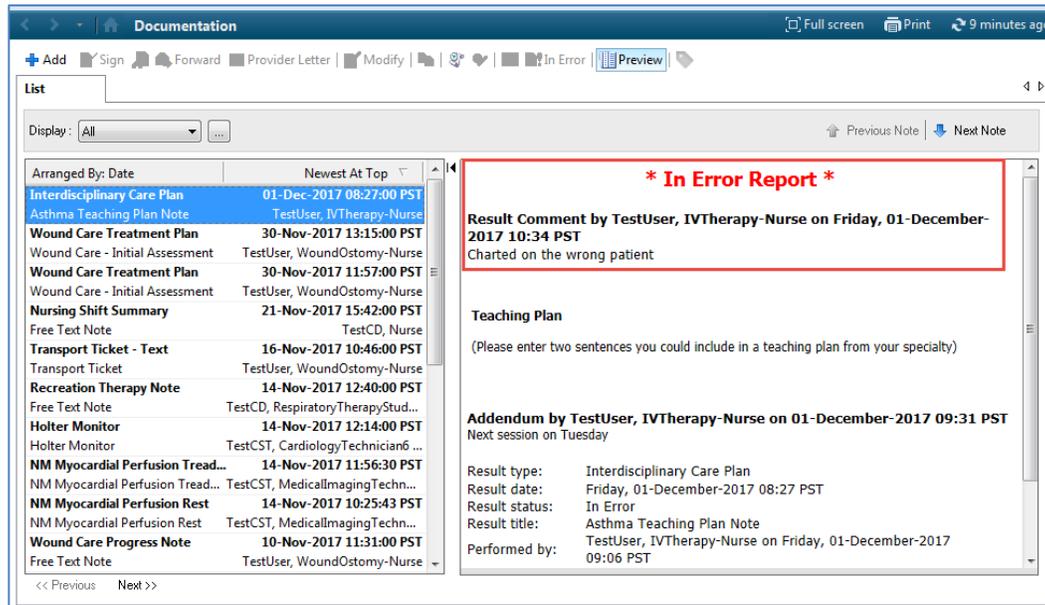
- In the Result Uncharting window, type = *Charted on the wrong patient* in the Comments box. Then click **OK**.



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



- 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.

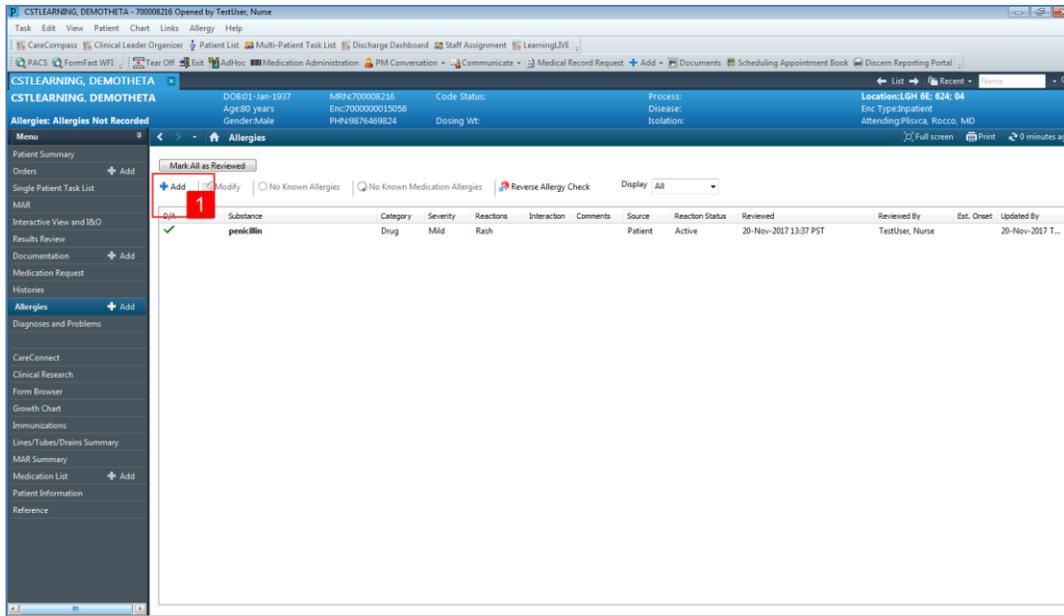
As a specialist nurse you will be complete the following activity:

- Add and save an allergy

Activity 7.1 – Add an Allergy

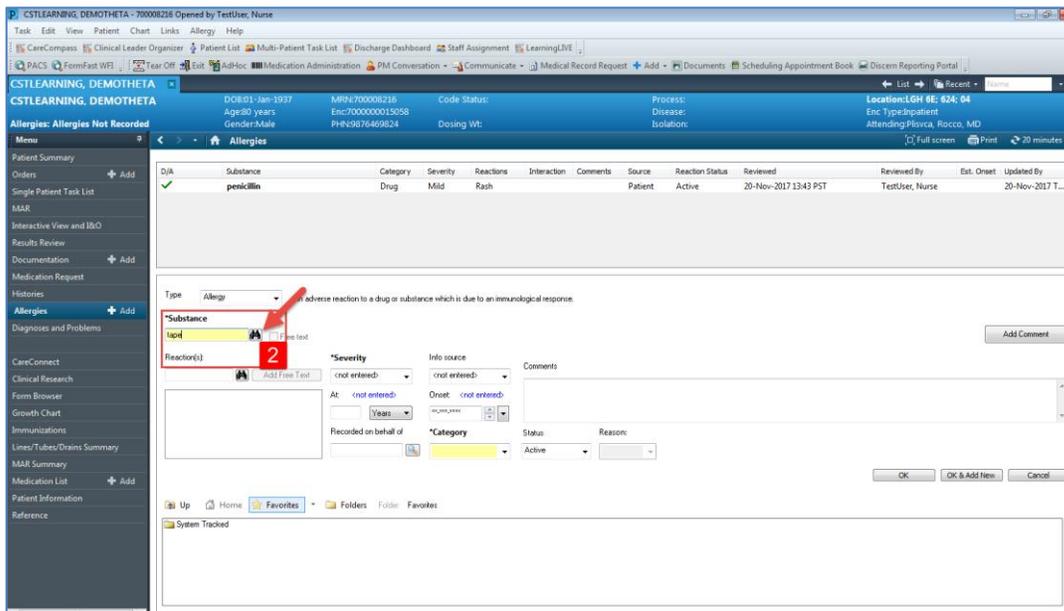
1 You notice mild redness to the patient’s skin where there is tape applied. The patient then states that he remembers having a similar allergic reaction to tape years ago, but he forgot to mention it in the ED.

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

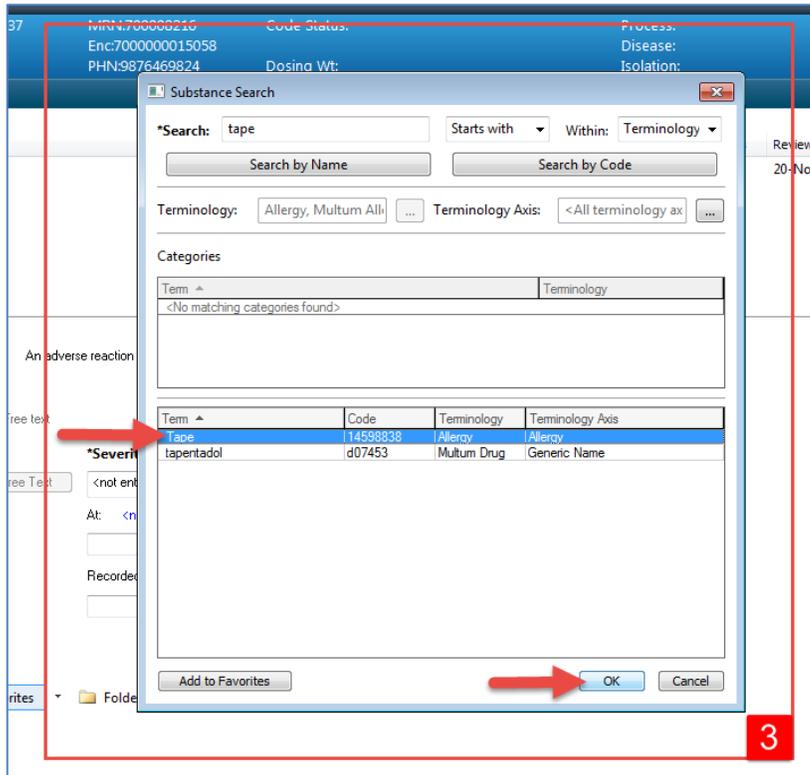


2. In the **Substance** field type = *Tape* and click the **Search** icon .

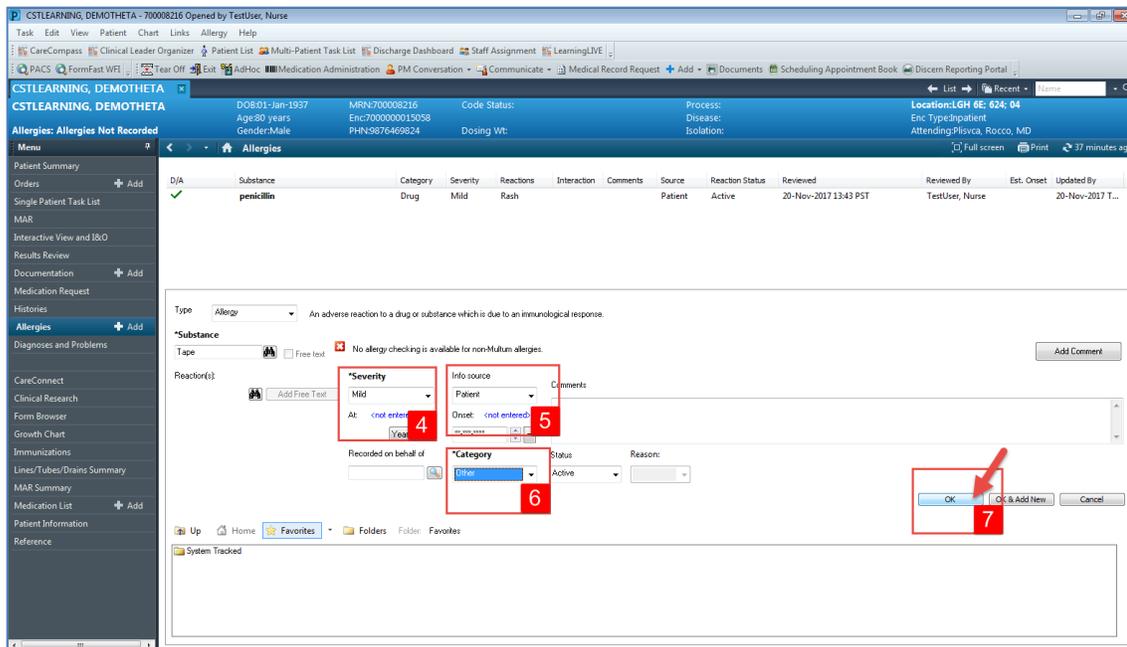
Note: Yellow highlighted fields including substance and category are mandatory fields that need to be completed.



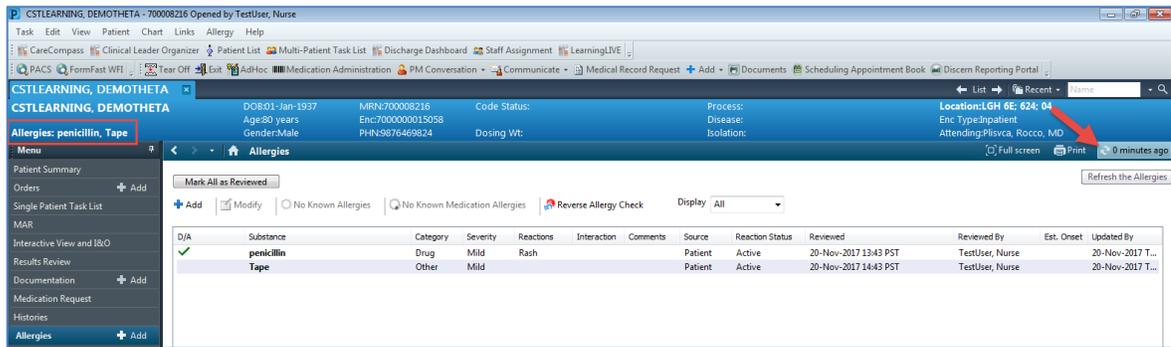
3. The **Substance Search** window opens. Select **Tape** and click **OK**.



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:

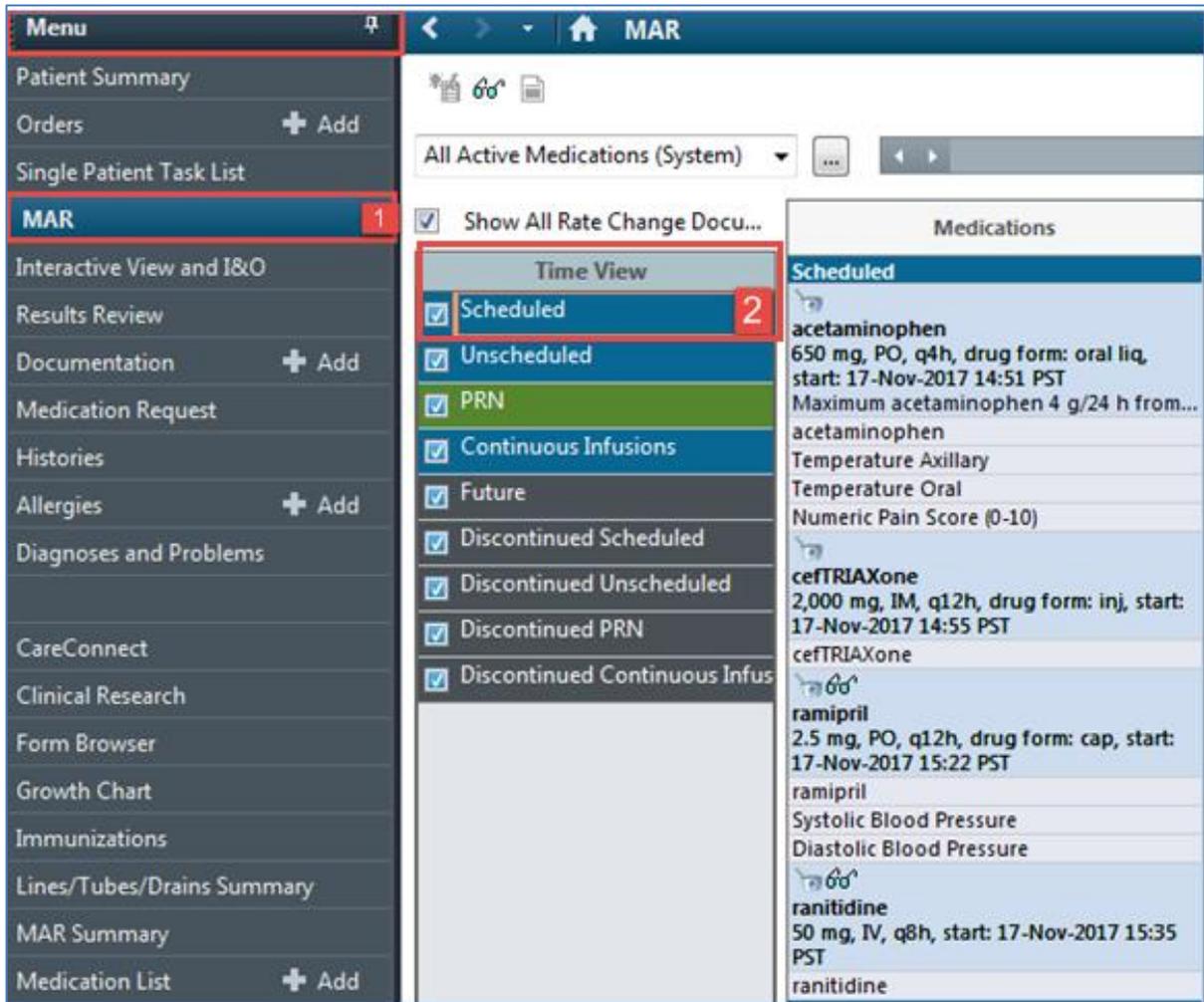
- Review the MAR

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.

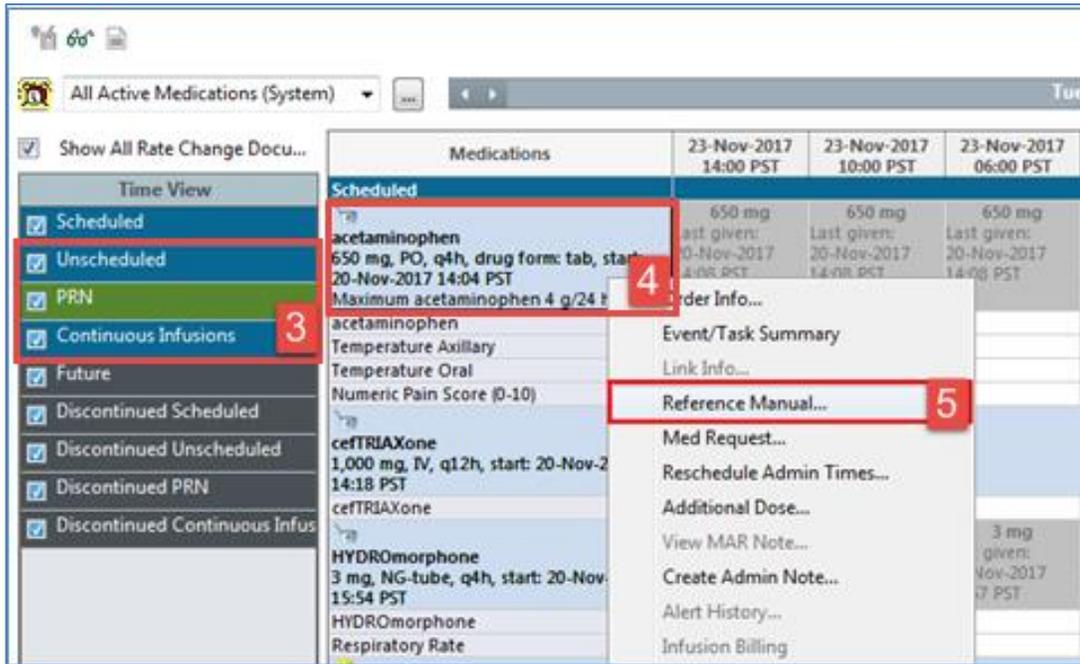
1. Go to the Menu and click **MAR**
2. Under **Time View** locate and ensure the **Scheduled** category is selected and is displaying at the top of the MAR list.



The screenshot displays the MAR interface. On the left, the 'Menu' is visible with 'MAR' selected and a red '1' next to it. The main area shows 'Time View' with 'Scheduled' selected and a red '2' next to it. The right pane displays a list of medications under the 'Medications' header, including 'Scheduled' items like acetaminophen, ceftriaxone, ramipril, and ranitidine.

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

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

Medications	30-Nov-2017 10:00 PST	30-Nov-2017 06:00 PST	30-Nov-2017 02:00 PST	29-Nov-2017 22:00 PST	29-Nov-2017 18:00 PST	29-Nov-2017 14:00 PST	29-Nov-2017 12:26 PST	29-Nov-2017 12:22 PST	29-Nov-2017 10:00 PST	28-Nov-2017 22:00 PST
Scheduled acetaminophen (TYLENOL) 640 mg, PO, q4h, drug form: oral liq, start: 29-Nov-2017 14:00 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:41 PST	640 mg Last given: 22-Nov-2017 12:26 PST			
PRN Maximum acetaminophen 4 g/24 h from all sources acetaminophen										
Discontinued Scheduled Temperature Axillary Temperature Oral Numeric Pain Score (0-10)										
Discontinued Unscheduled vancomycin 1,000 mg, IV, q12h, start: 29-Nov-2017 12:22 PST	1,000 mg Last given: 22-Nov-2017 10:00 PST			1,000 mg Last given: 22-Nov-2017 10:00 PST				1,000 mg Last given: 22-Nov-2017 10:00 PST		
Discontinued PRN vancomycin										
Discontinued Continuous Infus PRN HYDROMORPHONE (DILAUDID PRN range dose) dose range: 0.5 to 1 mg, PO, q1h, PRN pain, drug form: oral liq, start: 29-Nov-2017 12:24 PST HYDROMORPHONE Respiratory Rate							1 mg Not previously given			
Continuous Infusions sodium chloride 0.9% (NS) continuous infusion 1,000 mL order rate: 75 mL/h, IV, drug form: bag, start: 29-Nov-2017 12:23 PST, bag volume (mL): 1,000 Administration Information sodium chloride 0.9%							Pending not previously given			

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

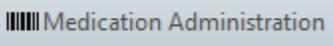
Medications will be administered and recorded electronically by scanning the patient’s wristband and the medication barcode. Scanning of the patient’s wristband helps to ensure the correct patient is identified. Scanning the medication helps to ensure the correct medication is being administered. Once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

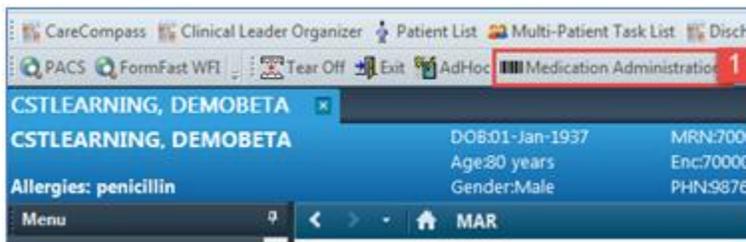
1 Tips for using the barcode scanner:

- 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.



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



- Scan the patient's wristband, a window will pop-up displaying the medications that you can administer.

25-Jan-2018 09:43 PST - 25-Jan-2018		
	Scheduled	Mnemonic
<input type="checkbox"/>	PRN	lorazepam LORazepam (ATIVAN)
<input type="checkbox"/>	PRN	Sodium Chloride 0.9% sodium chloride 0.9% (sodium chloride 0.9% (NS) bolus)

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 **Scheduled** heading to bring up the PRN medications

- 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.

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

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:

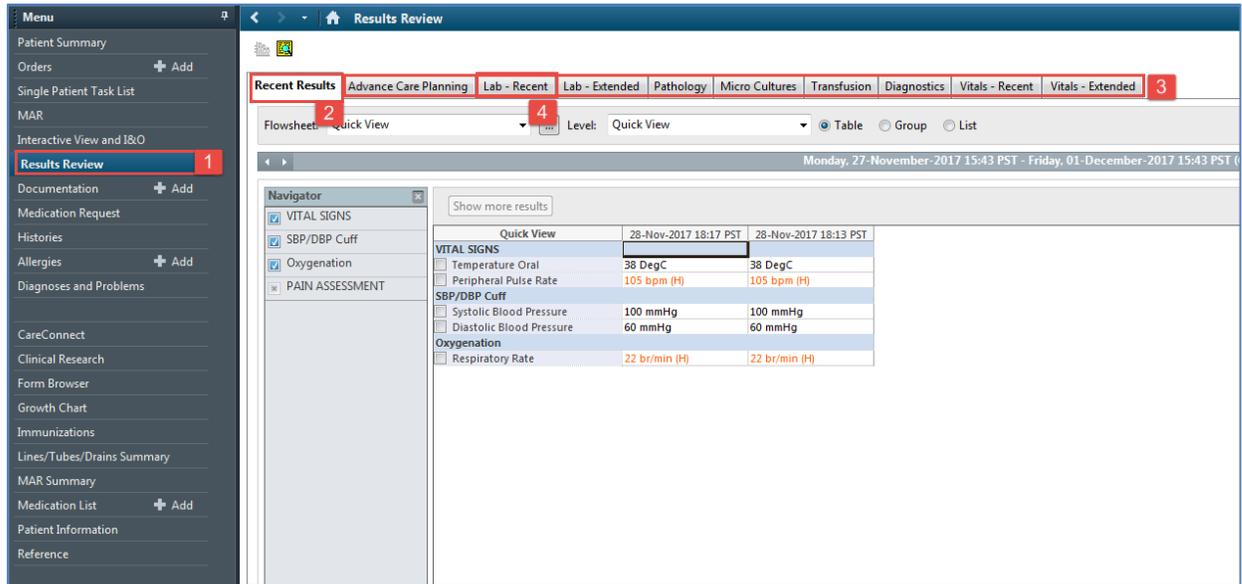
1. The left section is the Navigator. By selecting a category within the navigator, you can view related results, which are displayed within the grid to the right.
2. The grid to the right is known as Results Display

The screenshot shows a clinical flowsheet interface. On the left is a 'Navigator' pane with a tree view of categories: CBC and Peripheral Smear, General Chemistry, Therapeutic Drug Monitoring, Urine Microbiology, Infection Control/Surveillance, and Glucose Blood Point of Care. The main area is a 'Results Display' grid. The grid has columns for dates: 23-Oct-2017 00:00 - 23:59 PDT, 24-Oct-2017 00:00 - 23:59 PDT, and 23-Oct-2017 00:00 - 23:59 PDT. The grid contains data for various lab tests. A red box labeled '1' highlights the Navigator pane. A red box labeled '2' highlights the Results Display grid.

Lab View	23-Oct-2017 00:00 - 23:59 PDT	24-Oct-2017 00:00 - 23:59 PDT	23-Oct-2017 00:00 - 23:59 PDT
CBC and Peripheral Smear			
WBC Count	7.0 x10 ⁹ /L	7.0 x10 ⁹ /L	7.0 x10 ⁹ /L - 8.0 x10 ⁹ /L
RBC Count	4.45 x10 ¹² /L	4.50 x10 ¹² /L	4.35 x10 ¹² /L [2]
Hemoglobin	140 g/L	140 g/L	145 g/L [2]
Hematocrit	0.40	0.41	0.43 - 0.45 [2]
MCV	92 fL	95 fL	95 fL - 98 fL [2]
MCH	31 pg	30 pg	32 pg [2]
RDW-CV	12.0 %	12.0 %	12.0 % [2]
Platelet Count	400 x10 ⁹ /L	350 x10 ⁹ /L	250 x10 ⁹ /L - 300 x10 ⁹ /L
MPV			9.9 fL
Neutrophils	4.90 x10 ⁹ /L	4.90 x10 ⁹ /L	4.90 x10 ⁹ /L - 5.60 x10 ⁹ /L
Lymphocytes	1.40 x10 ⁹ /L	1.40 x10 ⁹ /L	1.40 x10 ⁹ /L - 1.60 x10 ⁹ /L
Monocytes	0.35 x10 ⁹ /L	0.35 x10 ⁹ /L	0.40 x10 ⁹ /L - 0.63 x10 ⁹ /L
Eosinophils	0.28 x10 ⁹ /L	0.28 x10 ⁹ /L	0.07 x10 ⁹ /L - 0.32 x10 ⁹ /L
Basophils	0.07 x10 ⁹ /L	0.07 x10 ⁹ /L	0.08 x10 ⁹ /L
General Chemistry			
Sodium	142 mmol/L	145 mmol/L	140 mmol/L - 145 mmol/L
Potassium	3.8 mmol/L	3.9 mmol/L	4.5 mmol/L - 5.0 mmol/L
Chloride	100 mmol/L	100 mmol/L	100 mmol/L - 105 mmol/L
Carbon Dioxide Total	25 mmol/L	26 mmol/L	30 mmol/L - 31 mmol/L
Anion Gap	20.8 mmol/L [2]	22.9 mmol/L [2]	13.5 mmol/L - 15.0 mmol/L
Glucose Random			6.0 mmol/L
Urea		2.0 mmol/L	2.0 mmol/L
Creatinine		75 umol/L	100 umol/L
Glomerular Filtration Rate Estimated		82 mL/min	61 mL/min
Triglycerides			<0.23 g/L, <0.02 g/L
Lab Add on Time			CRE and BUN added to i
Therapeutic Drug Monitoring / Toxicology			
Vancocycin Trough Level	15.0 mg/L		
Vancocycin Date Last Dose	20171024		
Vancocycin Time Last Dose	2200		
Urine Microbiology			

Review the most recent results for your patient:

1. Navigate to **Results Review** from the **Menu**
2. Review the **Recent Results** tab
3. Review each individual tab to see related results
4. Select **Lab – Recent** tab



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

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

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

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

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

Key Learning Points

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

PATIENT SCENARIO 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:

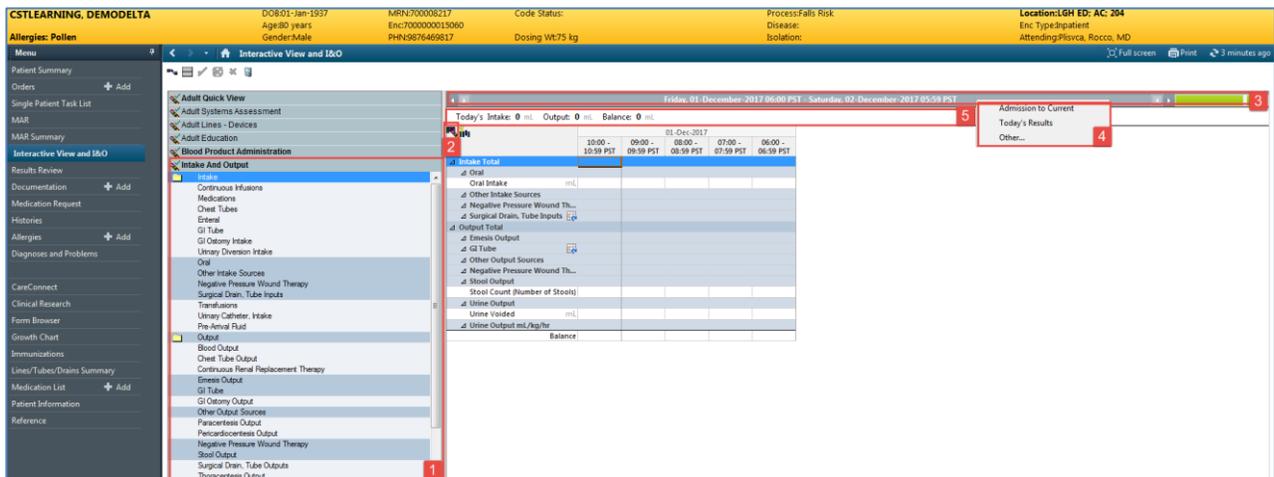
1. Select the **Interactive View and I&O** from the **Menu**
2. Select the **Intake And Output** band

The screenshot displays the iView interface for patient CSTLEARNING, DEMOTHEA. The top header shows patient information: DOB: 01-Jan-1937, Age: 80 years, Gender: Male, MRN: 700008216, Enc: 7000000015058, PHN: 9876469824, Code Status, Dosing Wt, Process: Falls Risk, Disease, and Isolation. The left sidebar menu has 'Interactive View and I&O' highlighted with a red box and a red '1'. The 'Adult Quick View' list in the center has 'Intake And Output' highlighted with a red box and a red '2'. The main content area shows a spreadsheet for 'Wednesday, 22-November-2017 00:00 PST - Wednesday, 22-Nov-2017 09:08 PST' with columns for 09:08 PST, 08:16 PST, and 07:00 PST. The spreadsheet lists various vital signs and measurements such as Temperature Axillary, Temperature Temporal Artery, Temperature Oral, Apical Heart Rate, Peripheral Pulse Rate, Heart Rate Monitored, SBP/DBP Cuff, Cuff Location, Mean Arterial Pressure, Cuff, Blood Pressure Method, Cerebral Perfusion Pressure, Cuff, and Oxygenation.

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

The screenshot displays the 'Interactive View and I&O' interface for patient CSTLEARNING, DEMOTHEA. The patient's demographic information is shown at the top: DOB 01-Jan-1937, Age 80 years, Gender Male, MRN 7000008216, Enc 700000015058, PHN 9876469824. The interface includes a left-hand menu with 'Interactive View and I&O' selected. The main area shows a table for documenting intake and output over a 24-hour period. The table has columns for time intervals (11:00-11:59 PST, 10:00-10:59 PST, 09:00-09:59 PST, 08:00-08:59 PST, 07:00-07:59 PST, 06:00-06:59 PST) and a 24 Hour Total column. The 'Intake' section includes 'Oral Intake' with a value of 50 mL. The 'Output' section includes 'Urine Voided' with a value of 375 mL. A red box highlights the 'Oral Intake' row, and another red box highlights the 'Urine Voided' row. A red circle with the number '3' is placed over a green checkmark icon in the top left of the table area.

	11:00 - 11:59 PST	10:00 - 10:59 PST	09:00 - 09:59 PST	08:00 - 08:59 PST	07:00 - 07:59 PST	06:00 - 06:59 PST	24 Hour Total
Intake							
Intake Total	378	528	103	103	102	102	
Continuous Infusions	28	28	103	103	102	102	
heparin additive 25000 unit + dextrose 5% premix 500 mL							
sodium chloride 0.9% (NS) continuous infusion 1,000 mL			75	75	75	75	
Medications			500				
vancomycin + dextrose 5%			500				
GI Tube			350				
Gastrostomy (G) tube Left upper quadrant 12 French Intake			300				
Flush			50				
Oral							
Oral Intake							50
Other Intake Sources							
Surgical Drain, Tube Inputs							
Output Total							
Emesis Output							
GI Tube							
Gastrostomy (G) tube Left upper quadrant 12 French Output							
Irrigant Out							
Residual Discarded							
Other Output Sources							
Stool Output							
Stool Count (Number of Stools)							
Urine Output							
Urine Voided							375
Urine Output mL/kg/hr							
Balance	378 mL	103 mL	103 mL	102 mL	102 mL		

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

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

The screenshot shows the 'Interactive View and I&O' window. At the top, it displays patient information: CSTLEARNING, DEMOTHETA, DOB: 01-Jan-1937, Age: 80 years, Gender: Male, MRN: 700008216, Enc: 7000000015058, PHN: 9876469824. The chart shows 'Today's Intake: 1366 ml, Output: 375 ml, Balance: 991 ml'. The table below has columns for 'Day Shift Total' and 12-hour shifts (11:59 PST to 09:59 PST). A red box highlights the 'Day Shift Total' column, and another red box highlights the hourly columns. A red '1' is placed under the Day Shift Total cell, and a red '2' is placed under the hourly cells.

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.

The screenshot shows the 'Interactive View and I&O' window. At the top, it displays patient information: CSTLEARNING, DEMOTHETA, DOB: 01-Jan-1937, Age: 80 years, Gender: Male, MRN: 700008216, Enc: 7000000015058, PHN: 9876469824. The chart shows 'Today's Intake: 1366 ml, Output: 375 ml, Balance: 991 ml'. The table below has columns for 12-hour shifts (11:59 PST to 06:59 PST). A red box highlights a cell in the 'Gastrostomy (G) tube Left upper quadrant 12 French' row, and a context menu is open over it, showing options like 'Add Result...', 'View Result Details...', 'View Defaulted Info...', 'View Comments...', 'Unchart...', 'Change Date/Time...', 'Modify...', 'Confirm', 'Add Comment...', 'Clear', 'Not Done...', 'View Interpretation', and 'Reinterpret'.

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

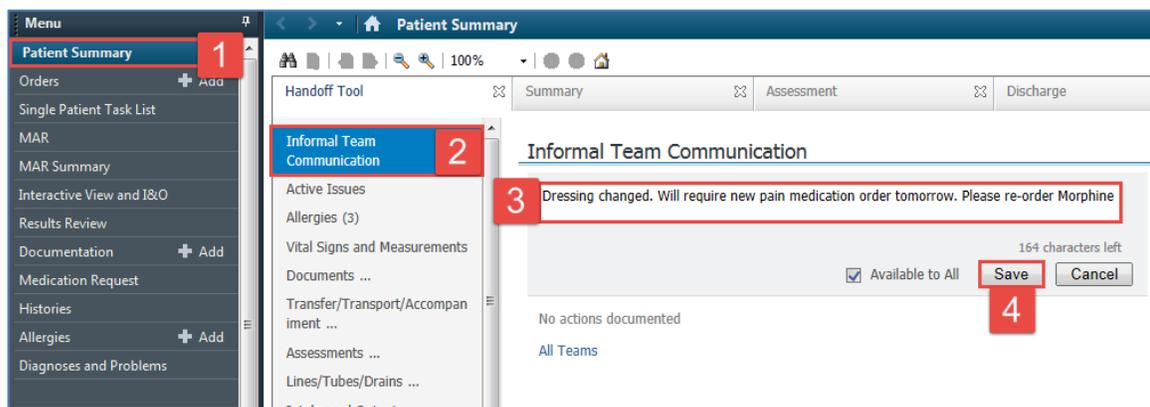
Activity 12.1 – Documenting Informal Team Communication

- 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

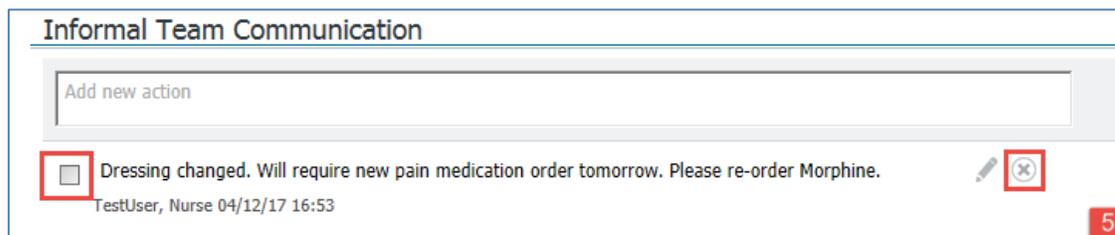
From the Menu select **Patient Summary**

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.

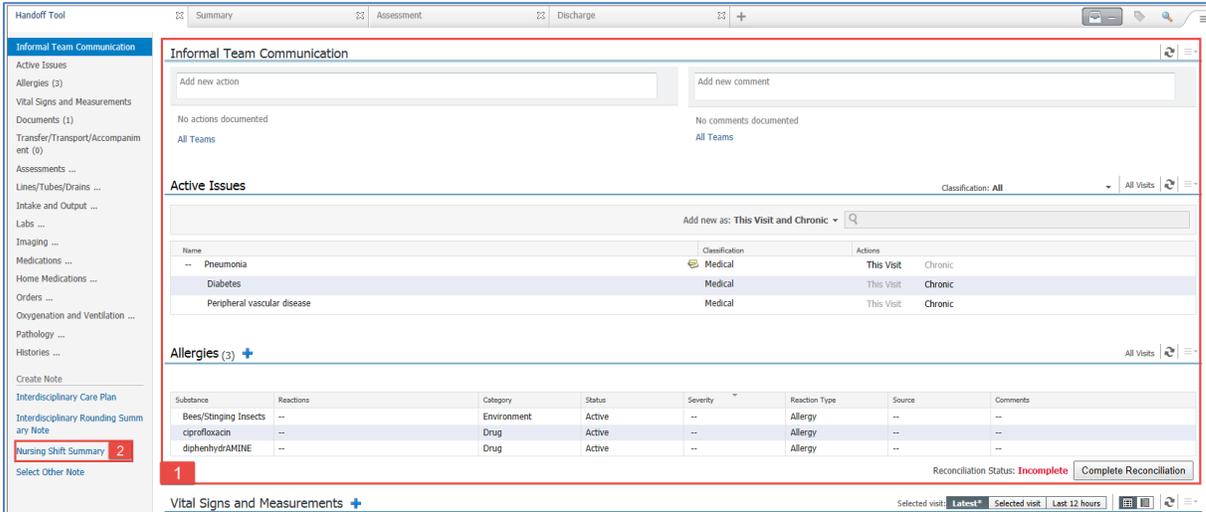
Activity 12.2 – Documenting a Nursing shift Summary Note

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



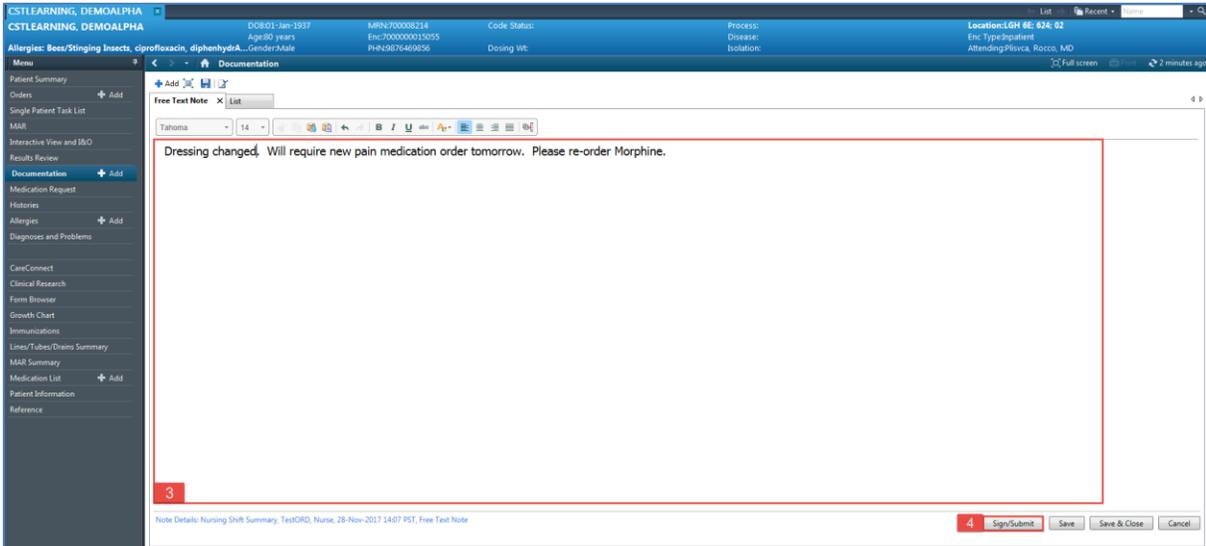
The screenshot shows the 'Handoff Tool' interface. The left sidebar contains a navigation menu with 'Nursing Shift Summary' highlighted in red and marked with a '2'. The main content area is titled 'Informal Team Communication' and includes sections for 'Active Issues' and 'Allergies (3)'. The 'Active Issues' table is as follows:

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

The 'Allergies (3)' table is as follows:

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

A red box labeled '1' highlights the 'Nursing Shift Summary' link in the sidebar and the 'Allergies' table.



The screenshot shows the 'iView' interface for documenting a 'Free Text Note'. The patient's name is 'Allergies: Bees/Stinging Insects, ciprofloxacin, diphenhydramine'. The text area contains the note: 'Dressing changed. Will require new pain medication order tomorrow. Please re-order Morphine.' A red box labeled '3' highlights the text area. At the bottom right, a red box labeled '4' highlights the 'Sign/Submit' button.

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**.

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

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

*** Final Report ***

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

Result type: Nursing Shift Summary
 Result date: Monday, 04-December-2017 17:09 PST
 Result status: Auth (Verified)
 Result title: Free Text Note
 Performed by: TestUser, Nurse on Monday, 04-December-2017 17:10 PST
 Verified by: TestUser, Nurse on Monday, 04-December-2017 17:10 PST
 Encounter info: 700000015058, LGH Lions Gate, Inpatient, 17-Nov-2017 -

Key Learning Points

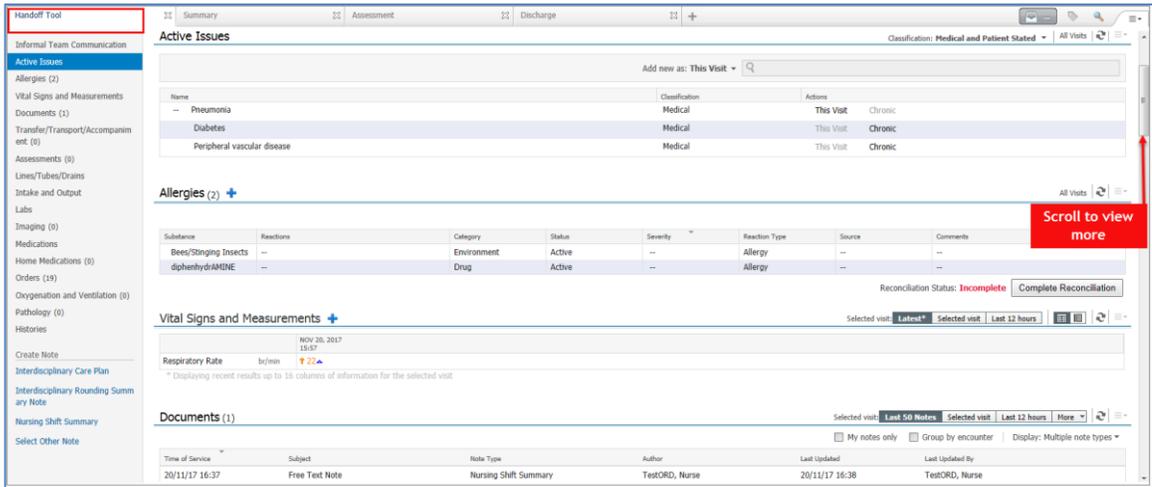
- A Nursing Shift Summary note is used to write a narrative note about what happened in a given shift for oncoming nurses.
- The note must be signed in order for it to be on the chart.
- Nurses can view notes like this from the Documentation tab in the Menu.

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.



The screenshot shows the Handoff Tool interface with a sidebar menu on the left and a main content area. The sidebar menu includes sections like Informal Team Communication, Active Issues, Allergies (2), Vital Signs and Measurements, Documents (1), Transfer/Transport/Accompaniment (0), Assessments (0), Lines/Tubes/Drains, Intake and Output, Labs, Imaging (0), Medications, Home Medications (0), Orders (19), Oxygenation and Ventilation (0), Pathology (0), Histories, Create Note, Interdisciplinary Care Plan, Interdisciplinary Rounding Summary Note, Nursing Shift Summary, and Select Other Note. The main content area is titled 'Handoff Tool' and has tabs for Summary, Assessment, and Discharge. It displays several sections: 'Active Issues' with a table of issues (Pneumonia, Diabetes, Peripheral vascular disease), 'Allergies (2)' with a table of allergies (Bees/Stinging Insects, diphenhydramine), 'Vital Signs and Measurements' showing a respiratory rate of 22, and 'Documents (1)' showing a free text note. A red callout box on the right says 'Scroll to view more' with an upward arrow pointing to the scrollbar.

Key Learning Points

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

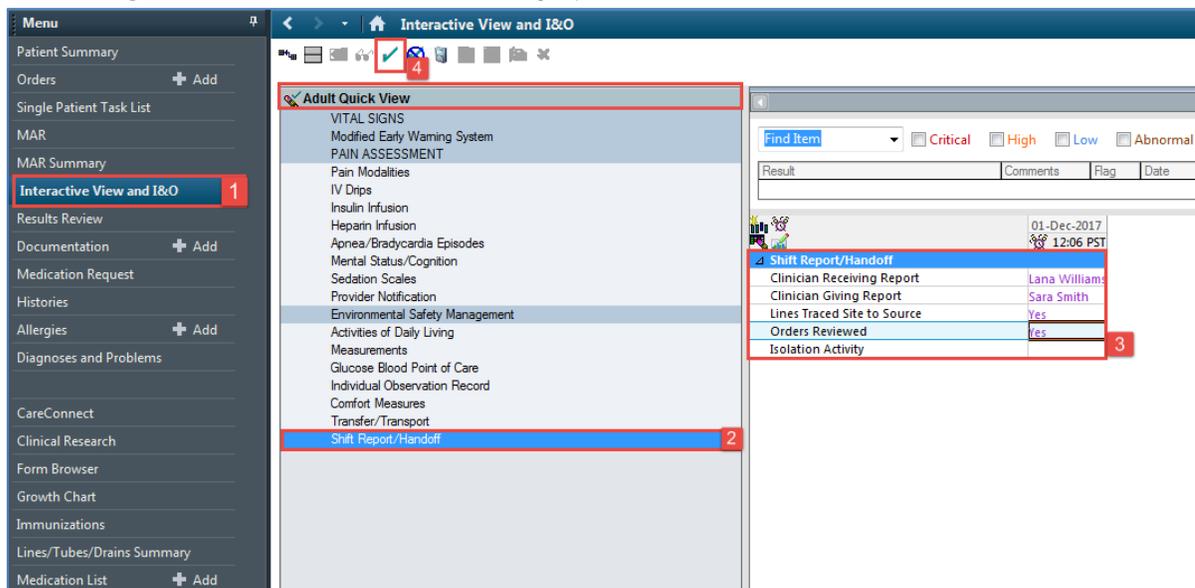
Activity 12.4 – Documenting Handoff in iView

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



The screenshot shows the iView software interface. On the left is a 'Menu' sidebar with 'Interactive View and I&O' highlighted and numbered '1'. The main area is titled 'Interactive View and I&O' and contains an 'Adult Quick View' section. Within this section, 'Shift Report/Handoff' is selected and numbered '2'. A green checkmark icon is visible in the top toolbar, numbered '4'. On the right, a data entry table is shown with the following content:

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

The table is numbered '3' in the bottom right corner.

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.